MR. EGLET: And I may have recross. I'm not sure yet.

THE COURT: I think you have to work out the details with him. We need to admonish the jury.

MR. ROGERS: So we're done?

THE COURT: Yes.

[Bench Conference Ends]

[Court Admonishes Jury]

[Proceedings Concluded at 5:00 p.m.]

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

Stephanie McMeel

STEPHANIE MCMEEL, Transcriber

Antoinette M Franks

ANTOINETTE M. FRANKS, Transcriber

Alexandra MacDonald

ALEXANDRA MACDONALD, Transcriber

FRANSESCA ST. JOHN, Transcriber

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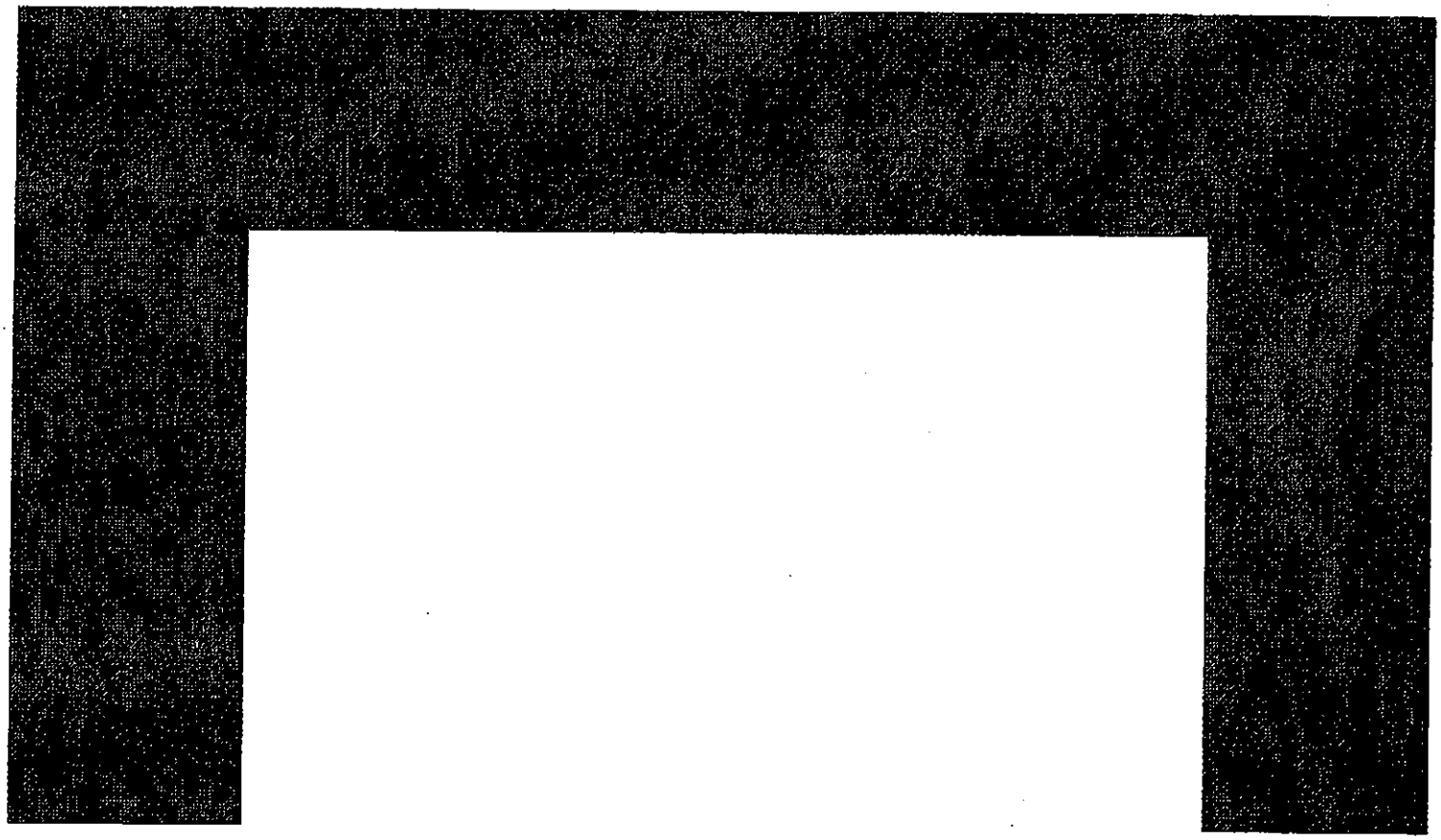

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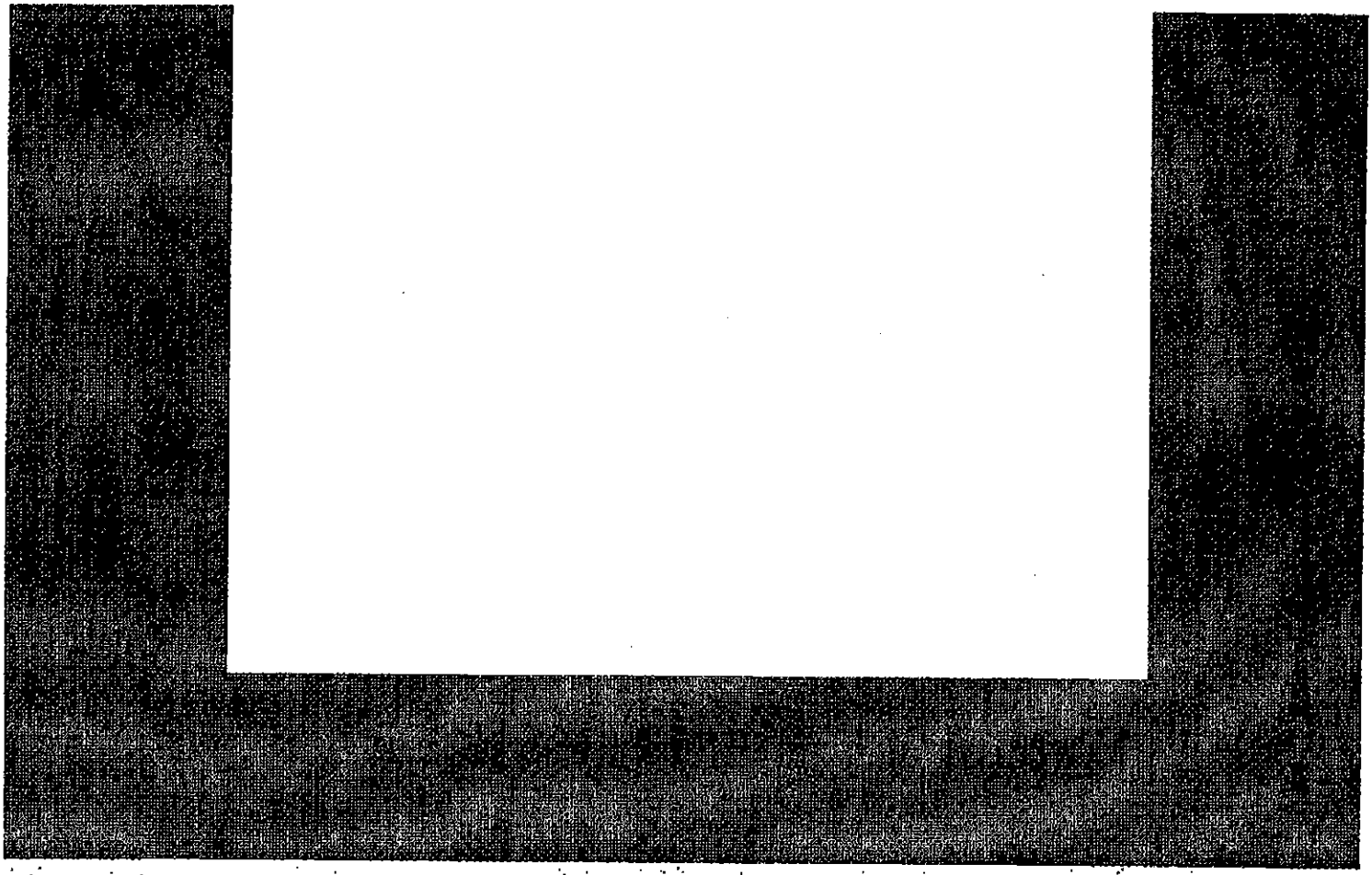

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DISTRICT COURT

CLARK COUNTY, NEVADA

WILLIAM JAY SIMAO, individually and CHERYL ANN SIMAO, individually, and as husband and wife,	CASE NO. A539455
Plaintiff,	DEPT. NO X
v.	
JENNY RISH; JAMES RISH; LINDA RISH; DOES I - V; and ROE CORPORATIONS I - V, inclusive,	
Defendants.	

TRIAL BRIEF REGARDING EXCLUSION OF FUTURE SURGERY FOR FAILURE TO DISCLOSE COMPUTATION OF FUTURE DAMAGES UNDER NRCP 16.1(a)(1)(C)

In support of Defendant JENNY RISH's oral argument re: Exclusion of future surgery for failure to disclose computation of future damages under NRCP 16.1 (a)(1)(C), the following

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Memorandum of Points and Authorities are provided to the court.

DATED this 29th day of March, 2011.

ROGERS, MASTRANGELO, CARVALHO & MITCHELL

STEPHEN H. ROGERS, ESQ.
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Attorneys for Defendant Jenny Rish

MEMORANDUM OF POINTS AND AUTHORITIES

I. STATEMENT OF FACTS

During trial, Plaintiff's treating physician, Dr. McNulty, provided expert testimony regarding the necessity and cost of a future medical surgical procedure (a spinal cord stimulator). This information was never provided to the Defense prior to trial, in the form f an opinion by any expert or treating provider, nor was a computation of damages provided to Defendant as required under NRCP 16.1(a)(1)(C). Plaintiff should be precluded from requesting damages for future medical care as a result of this failure to disclose.

II. LAW AND ARGUMENT

A. Defendants have been unfairly prejudiced by Plaintiffs failure to disclose the necessity of future surgery and to provide a timely computation of damages as required by NRCP 16.1 (a)(1)(C)

NRCP 16.1(a)(1)(C) required Plaintiff to provide a computation of damages:

> A computation of any category of damages claimed by the disclosing party, making available for inspection and copying as under Rule 34 the documents or other evidentiary matter, not privileged or protected from disclosure, on which such computation is based, including materials bearing on the nature and extent of injuries suffered.

NRCP 26(e) requires a party to supplement the disclosures made under NRCP 16.1(a). The sanction for failing to disclose evidence according to the rules is exclusion at trial. Rule 37 makes clear that if a party fails to disclose information required under Rule 16.1 or 26(e), the party "is not . permitted to use the evidence at trial," unless the failure is justified or harmless. Plaintiff failed

002552
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to comply with these rules.

At the hearing on the motion in limine, Plaintiff **specifically stated** that there were no "undisclosed, hidden opinions". (Tr. pp 39). The court denied Defendant's motion, on the basis that there was no new opinions:

> Well, here's the thing, this motion is denied, but let me say why it's denied, it's because the way it's drafted, new/undisclosed medical treatment and opinions. It's denied because it's my understanding there aren't any new or undisclosed medical treatment and opinions that have not yet been turned over to the Defense.

(Tr. Pp 42)

Dr. McNulty's opinion regarding the necessity of future treatment was never provided to the Defense. Nor did the required computation of damages include information regarding the future care (a spinal cord stimulator). This court should not allow Plaintiff to request future damages due to the failure to provide this information prior to trial.

B. Justice requires that Defendants be provided all medical opinions and documentary evidence, along with computation of damages, prior to trial

Our system of civil justice is founded on the premise that a party be given sufficient notice of evidence to be presented at trial. The discovery rules are designed "to take the surprise out of trials of cases so that all relevant facts and information pertaining to the action may be ascertained in advance of trial." *Washoe County Bd. of Sch. Trustees v. Pirhala*, 84 Nev. 1, 5, 435 P.2d 756, 758 (1968).

"Gamesmanship' and actions designed to minimize adequate notice to one's adversary have no place within the principles of professionalism governing the conduct of participants in litigation." *Collins v. CSX Transp., Inc.*, 441 S.E.2d 150, 153-54 (N.C. Ct. App. 1994). The discovery rules are designed to make trials "fair contest[s] with the basic issues and facts disclosed to the fullest practicable extent." *U.S. v. Proctor & Gamble*, 356 U.S. 677, 682 (1958) (internal quotation marks omitted).

Supplemental expert material is regularly excluded where the supplement "comes too late to be `seasonable,'" and would compromise the other party's pretrial preparation. See, e.g., *Wilson v. Bradlees of New England, Inc.*, 250 F.3d 10, 20 (1st Cir. 2001). In *Leiper v. Margolis*, for example, the plaintiff was not entitled to introduce testimony from one of her physicians concerning plaintiff's ailments that were not disclosed until shortly before trial. 111 Nev. 1012, 1014-1015, 899 P.2d 574, 575 (1995). "All parties have an interest in reaching finality with respect to discovery so that they can assess the strengths and weaknesses of their position, as well as their adversary's position" with sufficient time before trial to plan accordingly. *Fed. Deposit Ins. Corp. v. Wrapwell Corp.*, 2000 WL 1576889, *3 (S.D.N.Y. 2000). Providing a medical report on the eve of trial is of no value to a defendant in preparation for trial.

Even though an medical expert is also a treating physician, a report is still required whenever the doctor's treatment is procured in connection with the litigation. 10 FED. PROC. § 26.50 ("Identity and Report of Treating Physician"). The question is "whether the treating physician developed his relationship with plaintiff-and his opinions-close in time to the litigation or at the request of counsel." *Kirkham v. Societe Air France*, 236 F.R.D. 9 (D.D.C. 2006).

002554

C. Testimony regarding future surgery must be disclosed pre-trial

Testimony regarding causation, prognosis and future treatment must be disclosed in a pre-trial report. See, e.g., *Griffith v. Northeastern Illinois Regional Commuter Railroad Corp.*, 233 F.R.D. 513 (N.D. Ill. 2006); *Kirkham*, 236 F.R.D. 9. The reason for this is well-founded, the treating physician's treatment and impressions aside from the investigative question of causation or the predictive issue of future treatment would already be included in the medical records:

> When a treating physician's testimony is limited to his observation, diagnosis and treatment, the medical records provide a significant amount of information about the physician's likely testimony. However, the medicalrecords alone provide little or no information about any opinions the physician may render regarding what caused the injury, or whether the plaintiff will be unable to work in the future.

Griffith, 233 F.R.D. at 518. In this case, the opinion that future surgery would be necessary was precisely the type of prediction of potential future treatment that required disclosure.

002554

"If the defendant is going to be exposed to a claim for surgery or expenses associated with surgery, there should be some advanced warning given the defendant with respect to the fact that he is going to be facing such a claim." *Fahey v. SafecoInsurance Co.*, 714 A.2d 686, 693 (Conn. App. 1998) (the Connecticut appellate court found the trial court properly excluded expert testimony regarding future surgery). It is only proper to impose the consequences of plaintiff's failure to disclose upon the plaintiff, rather than the defendant. *Id.*

Dr. McNulty, a treating provider, last saw the patient over one year prior to trial. Therefore, Dr. McNulty had no understanding, from a treating provider's standpoint, of the Plaintiff's current medical condition. Instead, Dr. McNulty offered **expert** opinions regarding the necessity of future surgery, and the cost thereof.

Dr. McNulty never wrote an expert report and never complied with NRCP 26's requirements for expert testimony. As a treating provider, Dr. McNulty was asked about future surgery during his deposition, but he did not provide any opinions at that time. When Dr. McNulty offered opinions which did not relate to his actual care and treatment of Plaintiff, he became an expert witness. As these opinions were never properly disclosed as an opinion for trial, his opinion should have been excluded.

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III. CONCLUSION

Plaintiff should be precluded from requesting damages for a future surgery for the failure to comply with NRCP 16.1, NRCP 26, and for failing to provide disclosure of expert opinions, and a computation of damages including future surgery, as required under those rules.

DATED this 29th day of March, 2011.

ROGERS, MASTRANGELO, CARVALHO & MITCHELL

STEPHEN H. ROGERS, ESQ.
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300 South Fourth Street, Suite 710
Las Vegas, Nevada 89101
Attorneys for Defendant Jenny Rish

M:\Rogers\Rish adv. Simao\Pleadings\trial brief re future damages.wpd

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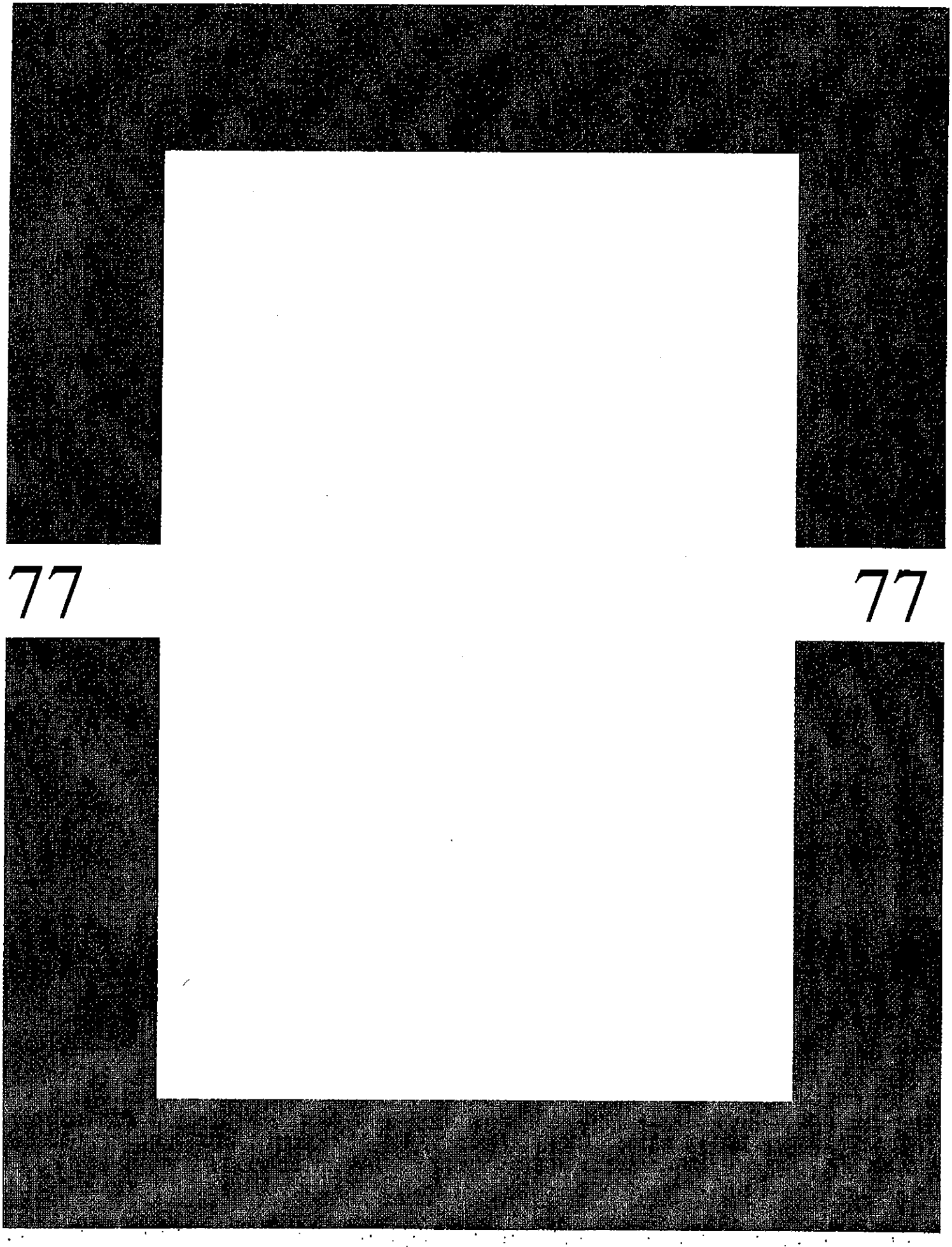

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DISTRICT COURT

CLARK COUNTY, NEVADA

CHERYL A. SIMAO and WILLIAM J. SIMAO, Plaintiffs,	CASE NO. A-539455
v.	DEPT. X
JAMES RISH, LINDA RISH and JENNY RISH, Defendants.	

BEFORE THE HONORABLE JESSIE WALSH, DISTRICT COURT JUDGE

WEDNESDAY, MARCH 30, 2011

REPORTER'S TRANSCRIPT
TRIAL TO THE JURY
DAY 8 - VOLUME 1

APPEARANCES:

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

For the Defendants James and Linda Rish: BRYAN W. LEWIS, ESQ.
Lewis and Associates, LLC

For the Defendant Jenny Rish: STEVEN M. ROGERS, ESQ.
CHARLES A. MICHALEK, ESQ.
Hutchison & Steffen, LLC

RECORDED BY: VICTORIA BOYD, COURT RECORDER

002557
002557
002557

TABLE OF CONTENTS

002558

002558

EXHIBITS

002559

002559

WEDNESDAY, MARCH 30, 2011 AT 12:54 P.M.

[Outside the Presence of the Jury]

THE COURT: [Audio Begins] -- that needs to be addressed. And counsel know that there's an issue with respect to the way that the exhibits have been marked? Clerk has advised me.

MR. WALL: The way they've been marked?

THE COURT: No.

MR. ADAMS: She wants you to put in front of the jury what's admitted.

MR. WALL: Oh, okay.

MR. ROGERS: Okay, wait one moment. I still didn't get an answer to a couple questions.

THE COURT: We really don't have time to address this argument now. We intend to bring our jury in. I think you can make this record at a later point in time.

MR. MICHALEK: Actually, Your Honor, the problem is I can't. They're expecting to bring Stan Smith in today to testify. And the problem is I need to have the opportunity to make my record beforehand which is why I contacted the Court at 12:30 to say we had an issue. And I'm sorry that MR. ADAMS, you know, we certainly are happy to have him raise his issue regarding Dr. Wang but we requested a half hour beforehand to discuss this very important issue. The Plaintiff's counsel --

MR. ADAMS: You were already scheduled --

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MR. MICHALEK: -- has dropped on us an expert report of Stan Smith yesterday at 1:32 p.m. while we were here in the courtroom. They served it upon our office. Now this report adds 2.6 million dollars in future life care based upon the testimony of Dr. McNulty. It is not appropriate, Your Honor, during trial to supplement an expert report with new opinions and adding 2.6 million dollars to the testimony. There's no authority for that whatsoever.

There is a time and a place for a cutoff of discovery and I understand that the experts can supplement their reports. But during trial, a new opinion of 2.6 million dollars? Without even one judicial day's notice to the Defense? That is clearly improper, Your Honor. There is no way that Mr. Smith should be able to discuss the cost of future life care when he provides this opinion in a new expert report to us less than 24 hours ago and it wasn't even given to us here at counsel table. It was sent back to us to our office.

And then again this morning, there was a second supplement of purported to be future care based upon Dr. Wang's testimony. We need to have an opportunity, you know, to get these experts report timely and they weren't provided timely. There is no authority that you can supplement during trial an expert report of a new opinion. This is clearly improper, Your Honor. So I would ask that Mr. Smith be

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002561

precluded from giving any future life care opinion based upon this new information which was never disclosed and it's under 16.1 or 26 and certainly not timely.

Secondly, Your Honor, if you're not going to do that, then I request a continuance and a mistrial so that we can hire our own expert to go over these numbers and these figures that they haven't been provided. And certainly there doesn't seem to have been any time that we can get these witnesses in even if I could find one on a spur of the moment and bring them in here between now and Wednesday when there seems to be the Court's issues. So my solution would be just mistrial, continue it, you know, a month or two and we'll get the proper expert.

But the Defense can't be prejudiced. We are irrevocably prejudiced by this. And I will note, Your Honor, that when you granted their motion to allow Dr. McNulty to testify, the argument from the Plaintiff and Mr. Adams was well, they were provided notice four months ago. There was an expert report and it provided notice of the future surgery. I don't agree with that. But let's take that as true. If that's true, Your Honor, then this report should have been given to us four months ago. It can't be -- it's got to be equal. If we were on notice four months ago that there was a need for a future surgery, then this expert should have given his report to us four months ago. Not yesterday. And so, you

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know, the rules have got to be applied both ways. If that was your Court's ruling, then this expert's got to be precluded from giving a life care opinion that wasn't disclosed to us less than 24 hours ago.

THE COURT: Mr. Adams.

MR. ADAMS: Here's the deal, Your Honor, we keep rehashing everything that we kind of rehashed throughout the course of this trial. They start with their premise that the spinal cord stimulator is a surprise to them. Let's just rehash what we already argued and you've already ruled on. Number one, they took Dr. Seibel's deposition on August 20th, 2010. He put them on notice. Number two, Kathy Hartman put them on notice when she put the spinal cord stimulator in their report.

Now let's talk about what they did when they got that report. They filed a motion in limine before this Court to exclude Kathleen Hartman and this Court ruled if the foundation is laid during trial, she's permitted to testify. That's the second time they were put on notice.

Now this is the incredible one. How do they even get out of this? They had the opportunity to hire the right expert. They hired Dr. Fish and as Mr. Eglet attaches a Court's exhibit yesterday, the February 9th, 2011, one month before this trial, Dr. Fish generated a report. It's a Court's exhibit. In there, Dr. Smith renders opinions with

regard to the spinal cord stimulator. How they can say it's a surprise when it's their own expert, Your Honor?

Now, starting from the premise that the spinal cord stimulator is not a surprise because it clearly isn't a surprise. They next try to attack Dr. McNulty. Dr. McNulty, they attack in the two ways. They say, first of all, he should give us a report. Okay. Or he should be excluded. Yet again we've argued this in pretrial motions. You specifically ordered on all fours by the way on the case law in Nevada, I can go through the drafter's note to 16.1 or I can go through the Piper case, but that's already been argued. As the Court knows, treating physicians don't need to author an expert report. The foundation for the spinal cord stimulator was laid through Dr. McNulty as a treating physician. Piper says that he can do that for prognosis, future care, future medical needs and his past treatment by the way.

Next what do they do? They try to say that if a treating physician doesn't give a report or doesn't give a report, then he should be excluded altogether based on the fact he didn't comply with the report. Perhaps the most disingenuous argument made of all in their brief, they cite the Leiper, L-E-I-P-E-R, v. Margolis case for that standpoint. Mr. Wall actually pulled that case. The Leiper case and I'm just going to read from the hold it, Your Honor. Well, let me

002564

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give you a little bit of facts. The District Court in that case based on Defense motion excluded the treating physician. So the treating physician wasn't able to testify. Okay. On appeal, the Supreme Court says and I quote, we conclude that the District Court abused its discretion in prohibiting Leiper, the Plaintiff's physician, from, or excuse me, the Plaintiff from calling Dr. Miller as a witness. So they overturned that ruling. So this Court has been consistent with Nevada law with regard to all these issues that we've been discussing, okay.

Why are they trying to exclude Dr. McNulty's opinion? Why are they trying to exclude the spinal cord stimulator which we know that they were already put on notice of? Because they know Dr. Smith is going to come in and testify. Our expert, who they did not oppose, they didn't oppose by the way, okay, the four million -- what his opinions were, but based as this Court knows and I guess I'll get the statute just so that we're clear for the record. Nevada statute allows for -- I've got too many pieces of paper here. And the statute is NRS 50.285 allows for expert opinions to form opinions as the evidence is presented at or during trial. Specifically, NRS 50.281, subsection 1. The facts or data in the particular case upon which an expert bases his opinion or inferences may be those perceived by or made known to him, the expert, at or before the hearing.

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In this case, when Dr. McNulty testified, we've been ordering the daily transcripts. We provided the daily transcripts to Dr. Smith. Dr. Smith then used the information that was presented in this Court from the daily transcript, from Dr. McNulty's testimony and refined his opinions based on the evidence that came in at trial, okay?

Now, one thing that Mr. Michalek has said, I agree with. There's no obligation to give them a report. And there isn't. There is no obligation for me to give Stan Smith's updated report to Mr. Michalek. But I figure Mr. Michalek and the Defense would come in here and say guess what, these are new opinions. We don't even know what the base of his opinions are. We can't see how he calculated those opinions. Some in an effort to streamline this trial, I gave them that report. No way did I give them the report from Dr. Smith's opinions from when Dr. McNulty testified. But yesterday, after Dr. Wang testified with regard to the adjacent seminal breakdown. I sent that information also to Dr. Smith who generated another report. And 20 minutes after I receive it, I sent it over to Defense counsel and I have ROCs for both reports.

My point is, Your Honor, is an expert is allowed to rely on the evidence as it comes through -- in through trial. We're clear on that through Nevada law. I was under no obligation to give that information to the Defense. But I

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wanted the trial to streamline. I didn't want the cross-examine to be -- cross-examination to be belabored and they're not knowing what's going on. So I gave it to them. That's why I gave it to them. So if they're like berating the point if we're giving them information, you know, then I apologize for that. I just wanted to streamline the way the evidence and the way this case is going to pursue.

Going back to my original premise, they were on notice at least three times of the spinal cord stimulator. So the fact that somebody testifies to it at the time of trial, they cannot claim surprise especially when one of those prongs is their own expert.

MR. MICHALEK: Your Honor, the only thing I can to that is I am stunned. I am stunned that counsel would ignore the obligations under 16.1 and 26. The statute that counsel cited in no way reduces the obligation of counsel to provide to opposing counsel a supplement, a timely supplement of the expert report. And the fact that he says well, he's just trying to streamline things. To provide notice 24 hours ahead of time or less than 24 hours ahead of time? No, that's clearly improper.

The fact is, Your Honor, they had a duty, every expert is under the duty to timely and properly supplement the reports. And that occurs prior to trial. Not even during trial. This is an entirely new opinion. It's just not even a

002567

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basic supplementing the numbers, which is one thing. This is -- this expert, Mr. Smith, had never heard of the testimony of Dr. McNulty before. And he's giving a totally new opinion based upon that testimony. So it's not something basic like a supplement, you know, where maybe some interest rates have changed and there's a higher figure. That at least I could understand. This is an entirely new opinion that we were never given notice of.

Now, counsel makes reference to well there was notice four months ago. I disagree with that. But let's assume that's true, Your Honor, that they were on notice four months ago or we were on notice of four months ago. They had the obligation for the last four months to provide us a supplement of this expert's report. You cannot withhold a supplement to the report if both sides are on notice and wait to spring it at trial. That's what's called trial by ambush. That does not happen in Nevada. That's why we have the Rules of Civil Procedure. The rules are there so that if an expert improperly supplements his opinion that expert is stricken. That's why we have the rules. And clearly there was no compliance with these rules. There was no proper supplementation. At 1:32 p.m., Mr. Rogers and I are here in trial. I'm not being aware of any notice. He can send it to my office but certainly no one's there. I guess arguing with counsel earlier, he is saying we called Ms. [sic] Eglet. I

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guess they did contact Ms. Mastrangelo by sending the supplement there. So I mean it sort of goes both ways.

We're being held to different standards here. These guys should never -- Mr. Smith should not be allowed to testify. He did not timely supplement his report. The future damages should be stricken and if that's not stricken, then I request a continuance and a mistrial so I can find my own expert. Dr. Wang, unfortunately is not familiar with the numbers as he testified yesterday. He can't comment upon the surgeries in Las Vegas. I have no way to counter Dr. McNulty's opinions. I have no way to counter Dr. Smith's opinions. And so we are irreparably harmed. If this information were to go forward, I request either exclusion on this basis or a mistrial and a continuance.

MR. ADAMS: No way to counter Dr. McNulty's opinions. Dr. Fish authored a report. They could have countered it through Dr. Fish. They chose not to. He testified in his report that it wasn't reasonable. That's the position they took. Instead of, okay, giving, you know, this information that our economists or having Dr. Smith, you know, or Dr. Fish rebut it, you know, when he was testifying. They didn't choose to do that. Okay.

One component I guess -- one of the other areas and I forgot to mention in my earlier argument is, they're attacking Dr. McNulty from being able to render this opinion

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when he hasn't seen the Plaintiff in a year. Well, as Dr. McNulty testified, his partner Dr. Lee is seeing my client. And in fact, it was just last month, okay, right at the time of the authored report by Dr. Smith when Dr. Lee said that he is recommending pain management. Not a future surgery. With regard to the repair. So at that point, last month, at the time that Dr. Smith authored his report, they had the most updated information. Again, Dr. Lee, treating physician, doesn't need to author a report. He put it in his medical records. That's what the treating physicians do. They had ample notice of this as late as last month from their own expert and from one of the treating physicians here. They just can't claim surprise. And for them just to disregard NRS 50.285 that experts can't formulate opinions on evidence that comes in at trial is just incredible. I mean why else would we have that statute?

With regard to the timeliness, we got the transcript the day before -- the day I got the transcript, I sent it to Dr. Smith. That next morning I get the report. I do the supplement. I did serve it at their office because that's how they've been serving me medical records in this case. Figured I'd use the same method of delivery. And then when Dr. Smith gave me his second report based on the testimony of Dr. Wang from yesterday, I gave it to them within 20 minutes of receiving it. There's no prejudice here because they have

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their own economist. He's drafted a 35-page report in which he talks about his, you know, his qualifications. I mean there's no prejudice to them. They've got -- and he said he's not even available till Monday, they've got geez, four, what four days for him to look at this report. Actually two reports, of which I was under no obligation to even give them.

I mean they should have used this -- if I didn't give them the report, they would have to use the same method that I used. Getting the transcript, sending to their expert, their expert take the time, extrapolate, read the transcript and then formulate his opinions. Here I've shortcutted that circuit for them and just given them the reports.

MR. MICHALEK: Your Honor, he keeps referring to these treating physicians. We're not talking about treating physicians and we're not talking about notice. I've already explained to the Court that we can go back four months and say the Defense is on notice. The Plaintiffs are on notice, too. Stan Smith is an economic expert. He is not a treating physician. He has a responsibility under the NRS 16.1 and 26 to timely supplement his reports. He did not do so.

Secondly, Mr. Scoob [phonetic] as the Court is aware is a rebuttal expert. Not -- and we didn't give him opinions of his own. He is simply here to rebut the opinions and the methodology of Stan Smith regarding economic damages. So no, I can't simply give numbers to some expert, his rebuttal. He

can't come up with numbers on his own.

So we are irrevocably prejudiced by this. Again, I'll keep it simple. The fact is if we were on notice four months ago of some expert in a deposition saying hey, there is a future damages, then they were on -- at that obligation, if they wanted Stan Smith to come into this courtroom and testify about 2.6 million dollars in futures, he needed to supplement his report prior to trial. He did not do so. It was not timely. We were not on notice of it. It has nothing to do with the treating physician. This is an expert that has a responsibility to disclose. He did not timely disclose. I'm not asking for him to be stricken in full. I just want the 2.6 million that he says that we weren't on notice of prior to trial, that be, for him to be excluded.

If not, then I got to request a continuance so that I can get experts to counter this stuff, Your Honor.

THE COURT: Mr. Michalek, the objection's noted for the record. The motion is denied, the motion for mistrial is denied. Let's bring our jury panel in.

MR. WALL: Your Honor, can I bring my first witness in, too?

THE COURT: Yes.

[Jury In]

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

MR. WALL: Yes, Your Honor.

MR. ROGERS: Yes.

THE COURT: Very well. We've brought this witness back again. Since it's a new day, we'll ask you to be re-sworn by the Clerk, sir.

ADAM ARITA, PLAINTIFF'S WITNESS, SWORN

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

THE WITNESS: Adam Arita, A-R-I-T-A.

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

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

DIRECT EXAMINATION CONTINUED

BY MR. WALL:

Q Dr. Arita, welcome back. By the way, how many times have you testified before in Court?

A This'll be the third time.

Q Was Monday the second time?

A Yes.

Q Okay. Thanks for coming back. I want to pick up just where we left off which was at Mr. Simao's appointment with Southwest Medical on October 6, 2005, when he came back as you testified on Monday for a checkup on neck and shoulder pain and headaches. What medications was he taking at that time?

A As highlighted, he was taking Ibuprofen,

002573

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Cyclobenzaprin and Butalbital.

Q And what specific physical examination finding was documented by Mr. Hill's examination of Mr. Simao on that date?

A His vital signs that are indicated and --

Q Under the part that's highlighted under observation.

A The neck that was supple, no adenopathy and no carotid bruits.

Q And what does that mean?

A That the neck was soft, that it didn't have any palpable glands and that there was no sounds coming from the neck vessels.

Q Does the fact that the neck was supple or soft on October 6, 2005 during the physical examination rule out any underlying cervical spine problems?

A No, it doesn't.

Q Why not?

A Because that is a general assessment of the neck, not specifically focused on the spine itself. The spine has to be examined differently than for just a general neck assessment. And that's what this is is just a general neck assessment. It's not one specifically focused on the spine itself.

Q Provocative testing of the cervical spine, what's that?

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A There is a certain test that we call Spurling sign which is basically when you extend your head back up towards the sky, bend it to the side that you think there might be a problem and then push down on the head. And if that is positive, then the patient will have reproduced pain from that side of the neck down let's say the arm.

Q And does it appear on October 6, 2005 that the physician's assistant, Mr. Hill, did any provocative test like that on Mr. Simao's cervical spine?

A No, he did not.

Q What was Mr. Hill's clinical assessment of Mr. Simao on that date?

A It was migraine headaches with muscle contracture complement.

Q And did Mr. Hill's assessment of Mr. Simao at that time deal at all with his documented neck pain?

A No, it was focused specifically on the migraine headaches. So he was starting anti-seizure, anti-migraine medicine called Topamax.

Q And was he also on -- placed on I'm going to call it carisoprodol but is that the correct pronunciation?

A It's also known as Soma which is a muscle relaxant.

Q Is that normally a treatment for migraines or for something else?

A It's usually for muscle tension in general. It's

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not necessarily specific for a migraine headache.

Q Now on this October 6, 2005 visit, does it appear that Mr. Simao was seen by a physician?

A No, he was seen by a physician assistant.

Q Did Mr. Hill obtain additional x-ray evaluations of Mr. Simao or at least refer them on October 18th, 2005?

A Apparently there was one done on October 18th, 2005 for a cervical spine which was read as a negative cervical spine.

Q Was this similar to the type of x-ray he had on the day of the accident to the cervical spine?

A Yes, it's the same type.

Q And does a normal plain film x-ray of the cervical spine even six months following a motor vehicle accident with an initial presentation of neck pain and an initial clinical assessment of neck sprain rule out any significant underlying cervical spine problems?

A No, it does not.

Q Why not?

A Because again as we talked about last time I was here, this is specifically for bones and you would not see ligamentous or muscular damage or disc tears or herniations that you would see on a different type of imaging study.

Q All right. The next appearance -- the next time Mr. Simao went to Southwest Medical was December 21st, 2005. What

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was the purpose of that visit?

A It was physical therapy.

Q Was it an evaluation for possible physical therapy?

A Yes.

Q And what history was obtained from Mr. Simao at that time?

A It was he had neck and shoulder, left shoulder pain and that he was a new patient that was having shoulder pain off and on over the last several months, had gotten worse over the last few weeks and he tried a number of medications including Soma which just made him sleepy. And then he does not do any activities which can cause or worsen the pain. He's trying to use some modalities like heat and it didn't seem to help.

Q So according to that record, Mr. Simao reported that the pain was getting worse and wasn't relieved with Soma?

A Yes.

Q What pertinent findings were documented during the physical examination at that time?

A He had a full range of motion of his neck and shoulders. He has palpable tenderness in the musculature of his trapezius, both sides, and it's painful more so on the left. And there was nothing else documented that was significant.

Q What was the clinical assessment of Mr. Simao at

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that time?

A That he had ongoing trapezial pain, a muscle strain and that they recommended supportive care.

Q And what was recommended for him? What was the --

A Heat, a trial of a non-steroidal anti-inflammatory medication called Feldene and referral for physical therapy for the neck and trapezius.

Q And what does Feldene do?

A It's an anti-inflammatory medication that's used to decrease swelling and help with pain.

Q Now on this date, December 21st, 2005, does it appear that that was the first time since the motor vehicle accident that Mr. Simao was actually seen by a physician?

A Yes.

Q And was that Dr. Sigh [phonetic]?

A Yes.

Q Now you said he was referred to physical therapy. Based on the review of the records, did the physical therapy that Mr. Simao was referred for relieve his neck symptoms?

A No.

Q And after the course of physical therapy when Mr. Simao was evaluated at Southwest Medical by Mr. Hill again on March 9th, 2006, what history was obtained at that time?

A He was having continued neck pain and the left shoulder and left upper extremity were also a problem for him

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pain wise. And he had been through a series of chiropractic physical therapy treatments without any improvement.

Q So the past treatments that he had undergone at that point based on the record, had they worked or not?

A No, they had not.

Q And the record shows under assessment the word fairly chronic neck pain. What does chronic neck pain mean?

A It implies something that's ongoing and long term as opposed to something that is immediate and not expected to last very long.

Q So when we see in the records the word chronic or chronicity, that means long term pain?

A Yes. In pain management, usually six months is used as a cutoff. So something that's acute usually is less than six months and something that's chronic is generally longer than six months. So that would be another use for that term.

Q And what positive physical examination finding was documented by Mr. Hill at this March 9th, 2006 appointment?

A Full range of motion of his spine and the extremities, no nuchal rigidity, no Kernig sign, negative Brzezinski test and that he does complain of discomfort radiating to his left shoulder with numbness, with range of motion of his neck and his shoulder.

Q So when they tested him for range of motion, he had

a reaction?

A Okay, just so we can be clear as to some of these terms. The nuchal rigidity refers to the back of the neck and so if there's stiffness, that would be something, that would be nuchal rigidity. So if somebody has a very stiff neck, then that's a sign of meningitis, for example. He doesn't seem to have that. And then the other thing they mentioned here is a negative Kernig sign. So it's basically, you know, when they're trying to extend the neck that it doesn't reproduce any pain as well. And that Brzezinski test as well. So flexion and the extension don't seem to reproduce the pain in his neck.

Q What about the next sentence that's highlighted? What does that mean?

A The patient does complain of discomfort radiating to his left shoulder with numbness, with range of motion of his neck and shoulder. So it's kind of -- it's sort of contradicting what was just said. Because he's saying in the next sentence here that basically with moving his neck he can cause some numbness into his shoulder from his neck. So that's kind of what I interpret that statement to mean. And just so you understand that some of these notes are templated so that when somebody puts in an entry, some of this is already there and somebody doesn't necessarily go back and correct it and they delete that certain statement and you'll

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see that they inserted a certain statement that's specific but some of the other wording may be not necessarily something they did.

Q So in terms of trying to resolve that --

MR. ROGERS: Objection, Your Honor. Your Honor, the doctor's testifying as a custodian of records on records that he didn't generate or produce. He was never designated as an expert in this area.

THE COURT: Let's have some clarification on the foundation.

MR. WALL: Could we approach for a moment, Your Honor?

THE COURT: Yes.

[Bench Conference Begins]

MR. WALL: If the objection is, you know, not to be able to review those records, in his deposition, Mr. Rogers asked him on page 20 to review all of the records from 2005 and forward from Southwest Medical. We even took about five or ten minute to allow Dr. Arita to review them all. That's on page 50. He asked for his medical opinions based on that and the review of the records. That's on page 51 of the deposition. He asked him to comment on those records on 52 and 53 of the deposition.

Then the conclusions that he made, he presented to the jury in his opening statement. So at this point he has adopted that in his obvious request let's review the records.

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MR. ROGERS: What's happening here is that the doctor's not offering an opinion regarding the Plaintiff's condition or his symptoms or his treatment as he did in the deposition. He's actually discussing things like templates and forms used by Southwest Medical. He's never been designated in this area. And he's never offered an opinion in this area. It's not something that a treating provider testifies to.

MR. EGLET: He was a treating physician at Southwest Medical and so he's essentially the person most knowledgeable at Southwest Medical. Not the expert. So he's allowed as part of his treatment that he would use other physicians' records. These are not -- rely on anything but the records at Southwest Medical. And as Mr. Wall pointed out, Mr. Rogers, if there was any opposition this door wasn't opened, it was opened by him in the deposition by having him review these records.

MR. ROGERS: That does haven't anything to do with the treating physician testimony. This is something of a different nature.

MR. EGLET: Treating physicians are allowed to give opinions regarding causation [indiscernible] other records that he relied on.

MR. WALL: [Indiscernible] I'm not spending more time.

THE COURT: Okay. Noted for the record.

[Bench Conference Ends]

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BY MR. WALL:

Q Dr. Arita, on that date, what was the clinical assessment made by Mr. Hill of Mr. Simao?

A Tension headaches, migraine headaches, and cervicalgia with left upper extremity radiculopathy.

Q And cervicalgia means what?

A It means neck pain.

Q So that neck pain with left upper extremity radiculopathy, is that what's described in the paragraph above that's highlighted?

A Yes.

Q And what was Mr. Hill's plan for Mr. Simao at that time?

A That he would obtain a cervical MRI.

Q And what would be the reason for that?

A To look for some of the other injuries that may have been missed on that plain radiological film that was taken of the neck, to look for things like herniated discs, to look for ligamentous tears, muscle injuries, soft tissues problems in general.

Q Does the chronicity or long term existence of the pain factor into the decision at that point by Mr. Hill to get an MRI?

A Yes.

MR. ROGERS: Objection, calls for speculation. He's asked

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to testify about someone else's intentions.
BY MR. WALL:
Q Based on your --
THE COURT: Overruled.
BY MR. WALL:
Q And your answer was?
A Yes. When you're looking at something that isn't just immediate as an acute problem, then you start to think about something like the soft tissue injuries that may have been missed on that. And it didn't get better. So therefore, it's appropriate to get something like that in a longer term situation like this, where the neck pain continues. There's more symptoms that are suggestive of an actual disc problem or some kind of nerve problem in the neck. And therefore, a cervical MRI would be more helpful to visualize those kinds of problems.
Q Why did it take 11 months for Mr. Simao's treating providers, the physician's assistants or nurses, to refer him for an MRI for the evaluation of his chronic nonresponsive neck pain and radiculopathy?
A Well, I think that Mr. Simao was merely following instructions that he was given by his midlevel providers to say that this was going to probably get better in six months or so. And the fact that he had come back obviously indicated it hadn't. So just by the fact that he had not been there

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every month, let's say, following up was some of the recommendations based on his midlevels not necessarily that he wasn't having a problem ongoing all this time. So just because he didn't have it for 11 months doesn't mean he didn't -- he couldn't have benefited from it being done seven months later or eight months later.

Q Let me ask you this. Is a history of approximately 11 months of chronic neck pain with the development of left upper extremity radiculopathy consistent with a diagnosis of a simple soft tissue neck injury or sprain or strain of the cervical spine?

A No.

Q Why not?

A Usually something of that nature, as in a simply strain or sprain, is going to get better in less than six months. And you would think that you wouldn't have neurological changes with that type of injury. So the fact that he's having some neurological type problems here with numbness, with movement of his neck is indicating there may be something more serious going on in his neck, something that wasn't apparent to the providers that had seen him prior to this and would be missed on the plain x-ray.

Q The records reflect that Mr. Simao underwent that MRI of the cervical spine on March 22nd, 2006. What were the results of that study?

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A He had facet hypertrophy at the C3/4 level on the left side. And that may have been causing some left C4 nerve root impingement, or some pressure on that nerve.

Q And that was according to the report of the radiologist?

A Yes.

Q What would be the cause of those described findings on March 22nd, 2006 in that MRI?

A In general, things like facet hypertrophy are considered degenerative type changes, and you wouldn't necessarily say that was something that just occurred as a result of something acute. So it tends to be something that goes along with something that's been happening a long time.

Q So if it's degenerative or age related, would it be -- actually, the existence of the facet hypertrophy, would that be caused by a motor vehicle accident?

A I wouldn't expect to be something you would see this soon after an accident.

Q Okay.

A It just seems to be something that was there was there a long time. And exactly when it started to occur I don't know. You wouldn't be able to tell that just by looking at this one MRI. You'd have to have a series of MRIs to really follow it and know if it were developing.

Q Now were these age related or degenerative changes

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noted on Mr. Simao's MRI in March of 2006 symptomatic before the accident on April 15th, 2005?

A I have no records to indicate that that was the situation, that it was of a symptomatic nature before.

Q And by way of the review of his Southwest Medical records and obtaining and history from Mr. Simao, had he ever had or been treated for any significant neck pain or upper extremity radiculopathy prior to the motor vehicle accident?

A No.

Q So if the facet hypertrophy noted in the MRI is age related or degenerative, can a motor vehicle -- well, let me back that up. Can trauma to the cervical spine cause these previously asymptomatic degenerative changes to become symptomatic?

A Yes.

MR. ROGERS: Objection, Your Honor. That's vague as to the cervical spine. They've not limited to the diagnoses in this case. And second, it's vague as to trauma. The doctor hasn't established a foundation on any understanding of this accident.

THE COURT: I thought we agreed to no speaking objections.

Could you please clarify, Mr. Wall?

BY MR. WALL:

Q An age related change is related in this MRI report.

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A Yes.

Q The existence of that facet hypertrophy would have predated the accident. You testified a moment ago before the accident it was asymptomatic. There were no pain symptoms.

A Yes.

Q Can trauma, like a motor vehicle accident, cause an asymptomatic degenerative age related change to become -- can it cause it to become symptomatic?

MR. ROGERS: Same objection.

MR. WALL: That's very specific.

THE COURT: Overruled.

You may answer the question.

THE WITNESS: Okay. So it's basically like the straw that broke the camel's back. So you're at a certain point that it could be something that tips over into a problem. It may not be a problem before a certain event, such as a trauma or an accident. But once this thing happens and there's some swelling or some other kinds of changes took place during this event, it could become symptomatic. And that's possibly what happened.

BY MR. WALL:

Q Let me ask this. When Mr. Simao returned back to see Mr. Hill on March 30th, 2006, what was Mr. Hill's assessment of Mr. Simao?

A Well, it looks like this is a referral for an

orthopedic consultation. It's what it indicates that the patient is having cervicalgia, the neck pain, the headaches, the left upper extremity radiculopathy with a cervical that was examined with an MRI showing the C3/4 facet hypertrophy, left neural foramen narrowing at C4, central disc bulge at 4/5. So --

Q The assessment that we've highlighted at the bottom.

A A bulging disc at c4/5, cervicalgia with left upper extremity radiculopathy, cervical radiculopathy.

Q So as of March 30th, 2006, the physician's assistant, Mr. Hill, gave a referral to an orthopedic surgeon?

A Yes.

Q And which orthopedic spine surgeon was it that initially evaluated Mr. Simao?

A I believe it was Dr. Patrick McNulty.

Q Dr. McNulty first saw Mr. Simao in April of 2006. Did he refer him to pain management?

A He would be referred to pain management for bilateral C3/4, 4/5 intra-articular facet blocks with concomitant bilateral C4 and 5 selective nerve root blocks, documenting immediate post injection pain relief.

Q Now were all of those procedures that were referred by Dr. McNulty to pain management actually performed on Mr. Simao?

A No.

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Q In fact, Mr. Simao was next seen at the pain management center --

MR. WALL: Page 63.

BY MR. WALL:

Q -- on May 10th, 2006, is that right?

A Yes.

Q Now does the pain management center for Southwest Medical have its own physician's assistants?

A Yes, it does.

Q It appears from this record that the physician's assistant who saw Mr. Simao on May 10th, 2006 was a Douglas Young, is that right?

A Yes.

Q All right. And what history was obtained from Mr. Simao by the physician assistant at the pain management center on that date?

A He had worsening neck pain, hand pain over the past year, his history for current migraine headaches, and he had been involved in a rear end motor vehicle collision while driving the vehicle. He was stopped and rear ended by another car, had whiplash type injury, and noticed increasing frequency of his migraine headaches and increasing pain over his left trapezial area.

Q And the beginning of that highlighted portion says a history or insidiously worsening pain. What does insidious

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mean to you?

A It means to slowly, ongoing, gradual, increasing.

Q What positive findings did Mr. Young document during that initial evaluation at the pain management center?

A Tenderness to palpation over the left trapezius and parathoracic muscles with multiple trigger points.

Q What are trigger points?

A They're tender muscle that tends to radiate pain elsewhere than where you actually notice the tenderness in the muscle.

Q How does that happen?

A This is a type of problem that refer to as myofascial pain, which generally means of muscle tissue. And it's thought that over time, when somebody has, let's say, some kind of an injury in the muscle itself, it becomes swollen. It becomes tender. And then it sort of creates a cycle where there's less blood flow to the area, because of the swelling. It then can start to die. Some of the muscle tissue itself can die. It can form scar tissue. And that tissue itself can then become triggering for pain problems. And so, this whole process is what we term myofascial pain. And something that you identify in an exam is something called a trigger point. So if you push on somebody's muscle where that spot creates the pain, it'll not only reproduce that pain in that area, but it'll jump or move to another spot.

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Q And what treatment was rendered to Mr. Simao by the physician's assistant at that time?

A He performed trigger point injections.

Q And what's a trigger point injection?

A You identify that particular trigger point, the muscle tissue that's tender and reproduces the pain and radiates, and then you can insert a needle. One technique that's used is just to needle it just by itself with nothing. Other people will inject a little bit of local anesthetic. And some people will not only inject local anesthetic, will put a little bit of a steroid into it as well. And Douglas Young did that. He put a local anesthetic and a steroid into that muscle and massaged the muscle. That was the trigger point injection.

Q And at what location was the trigger point injection giving on that date?

A It was in his neck, with a term paracervical, his strap muscle in the neck, which is a trapezius muscle, and the parathoracic muscles, which are the muscles that are aligned along the side of the chest.

Q What other intervention did Mr. Young recommend for Mr. Simao on May 10th, 2006?

A He referred the patient for a cervical transforaminal steroid injection on the left side at 3/4.

Q Now last week Dr. Rosler explained to us the purpose

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of a selective nerve root block, that type of injection, and demonstrated how it's performed.

A Okay.

Q What's the difference between a selective nerve root block and a transforaminal epidural steroid injection?

A Usually, there's less amount of medication that's injected with a selective nerve root block. So that -- what we're trying to be doing with that is to be more specific and selective than just doing a transforaminal epidural. They're very similar. And you would almost say they're the same thing. But let's say you perform a selective nerve root block as opposed to the transforaminal epidural steroid injection. You're using a smaller volume, like let's just say one-mill of local anesthetic. And that particular anesthetic is more concentrated than the one you use for the epidural steroid injection. But you can still use steroid, and it can be very similar. And it's sometimes difficult to say which one of the two it is. But in the specific instance that you're being diagnostic as opposed to therapeutic, if you're wanting to figure out if it is that specific nerve root in that one level, you would use a very small amount of local anesthetic injected at that one nerve as opposed to injecting a steroid and a larger volume of local anesthetic to spread. So it's trying to be more specific.

Q So in this case, what would be the purpose of

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recommending a left C3/4 transforaminal epidural steroid injection?

A It's trying to be therapeutic, as in treat that specific level for pain. But it may involve more than just that one nerve root.

Q And who ultimately performed the procedure that was recommended?

A It was performed by Dr. Siegel [phonetic], who was my partner at that time.

Q He was also a pain management physician at Southwest Medical?

A Yes.

Q And that was on June 7th, 2006?

A Yes.

Q When Mr. Simao was reevaluated by the P.A., Mr. Young, following that epidural injection, what kind of response was documented to that first initi- -- that first cervical spine injection?

A That he had gotten better, and that he noticed a decrease in severity and frequency of his headaches, and that he was still having some pain in his left trapezial area.

Q That was about two weeks after the injection?

A Correct.

Q The injection was June 7th. This report is June 20th?

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A Right.

Q And what did Mr. Young do with Mr. Simao at that time?

A He did some trigger point injections again.

Q Why would those be necessary on that date?

A Because he had some continued reproduction of that pain in that area of his body which he felt could be benefited by the trigger point injections. So the specific targets were the areas that were tender, that caused the radiating pain in that specific area.

Q So there was still pain --

A Yes.

Q -- even though there was a good response initially to the injection?

A Yes.

Q What interval history did Mr. Young obtain from Mr. Simao a few months later, now two months later, August 24th, 2006?

A He had an exacerbation of his left trapezial pain, and that he didn't really have the best result that he could have gotten, let's say, from the transforaminal epidural steroid injection that was performed. And he had some reduction in his headaches, but that was over the C4 distribution on the left was continuing and getting worse with more frequent episodes of -- being brought on.

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Q And this is Mr. Young's note where he says we had discussed in the past the results of his transforaminal epidural steroid injections were not stellar. That's Mr. Young's note, is that right?

A Yes.

Q Did the fact that Mr. Simao did not get long lasting or permanent relief of his symptoms from this transforaminal epidural steroid injection indicate that it wasn't beneficial and it wasn't even necessary?

A No.

Q Why not?

A We're trying to help the patient get better or some relief. And this is something that did afford him that relief. And just the fact that it's coming back doesn't mean it wasn't useful or helpful to the patient at that time. So I think it was still helpful and still necessary to do to try to help him get better.

Q What about from a diagnostic standpoint? Was it helpful?

A It was a little bit helpful in that he got better and noticed improvement from that specific level. But again, it's not as specific as the other type of procedure we mentioned, the left selective nerve root block of C4.

Q So then after August 24th, 2006, when the not so stellar results were discussed with Mr. Simao, what did Mr.

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Young recommend?

A A left C4 selective nerve root block.

Q And that's the one you've talked about, the same type of injection that's more selective?

A Right, because you're using a smaller volume of local anesthetic.

Q And what else did he say they might consider?

A That we could perform what's called a radio frequency procedure.

Q All right. After reviewing the records available to you and obtaining a history for Mr. Simao, on the day that you first saw him, did you agree with Mr. Young's assessment and recommendation for a left C4 selective nerve root block?

A Yes.

Q Now we're up to the date October 3rd, 2006, that you first saw Mr. Simao at Southwest Medical, is that right?

A Correct.

Q Did you perform that procedure?

A I did.

Q And was that on the date, October 3rd, 2006?

A Yes.

Q What response did you document to Mr. Simao's left C4 selective nerve root block when you saw him on that -- when you saw him for follow-up on October 11th, 2006?

A That he had attained a 50 to 75 percent relief from

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the procedure immediately after, and that he had -- still had ongoing pain. So there was still pain rated at seven to eight out of 10.

Q So this is eight days after that selective nerve root block. What do those results mean to you?

A That is was fairly specific for that left C4 nerve root, and that he had that 50 to 75 percent relief. So that would indicate to me that that was the target that we were trying to go after. It was the pain generator in my opinion.

Q Fifty to 75 percent, is that significant to you?

A Yes.

Q What did you recommend?

A That the patient have the radio frequency procedure, which is a pulsed radio frequency left C4 selective nerve root block.

Q Now at some point in this area of time, did you -- did Mr. Simao basically ask you to take over and assume his care from the midlevel providers at Southwest Medical?

A He did.

Q And did you do that?

A I did.

Q When did you perform the first cervical selective nerve root block with pulsed radio frequency on the left side at C4?

A I believe it was in November. November 18th, 2006.

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Q All right. I'm going to ask you, if you would --

MR. WALL: May he step down, Your Honor?

THE COURT: Yes.

BY MR. WALL:

Q -- to take the spine model and explain to us what the selective nerve root block with a pulse radio frequency means --

A Sure.

Q -- what you did to Mr. Simao.

A Okay. Again, like we talked about the last time I was here, the cervical spine. This is the head. This is the bottom. These are seven thorac- -- or cervical vertebrae, the 12 thoracic vertebrae, and the five lumbar vertebra. So when you're counting down from the skull here, this is the first one, cervical one. This is cervical two, cervical three, cervical four. So at 3/4, you come down to this level, and you can see the exiting nerve root here. So if you place a needle under x-ray guidance into that hole there, next to this nerve, then you will contact it. Then I will verify that it is in contact with it by pulsing it with some electricity to indicate that they do have that sensation of electricity at that location. And then we will then administer a small volume of local anesthetic to numb the nerve. And then we will heat the nerve with this needle to about 42 degrees Celsius. And at that particular temperature, it sort of stuns

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the nerve. And at that point, it then will decrease the amount of pain that you will receive from that nerve.

Q Now that 40- -- what'd you say, 42 degrees Celsius?

A Yes.

Q Is that about 106 or 107 degrees Fahrenheit?

A It sounds about right.

Q All right. Now, obviously, our normal body temperature is 98.6 on average?

A Yes.

Q So it's not burning the nerve. It's just warming the area?

A Right. There's some confusion about the difference between a radio frequency ablation, which is also termed a rhizotomy, and a radio frequency modulation, which is this pulse radio frequency procedure. And the basic difference is the temperature that you're heating it to. When you have an ablation, you heat it up much hotter, like 80 or 90 degrees Celsius temperature, and you're going to basically fry that nerve. Whereas if you're heating it to just 42 degrees Celsius, it is definitely warmer than the body will be and will definitely have some effect on the nerve. And that's the idea behind this procedure is that you're going to stun it somehow, and then a period of time will transpire, two or three months at least, before the nerve sort of goes back to normal.

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Q What was Mr. Simao's response to this pulsed radio frequency treatment of his left C4 nerve?

A That he still had seven to eight out of 10 average pain, but he believed that the procedure did help.

Q And this was January 10th, 2007, so roughly two months after you did the procedure.

A Correct.

Q Did he come back and see you again on March 22nd, 2007?

A Yes.

Q So we're now four months after this injection. What was his clinical status when you evaluated him at that time?

A He still had that pain of seven to eight out of 10 in his neck and shoulder, and that he had underwent that procedure that we just discussed. And he didn't want to necessarily have surgery at the time, but he wanted to have something else done. So we went ahead and thought it was reasonable to redo that procedure again.

Q Now this record says that the selective nerve root block with pulse radio frequency was two months ago. In fact, it appears it was about four months earlier, right?

A Correct.

Q And so, since it worked somewhat, Mr. Simao wanted to do it again?

A Yes.

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Q And is that reasonable?

A Yes.

Q And let me ask this. What does an initial symptomatic relief of the pain in some patients after this injection, but then it wears off with time, why does that happen?

A Well, in this procedure we weren't intentionally trying to do irreversible damage to the nerve. We're just trying to modulate or change it to be less painful. And it was successful in that sense that we did have that result that it was less painful for that period of time that transpired. Now it does happen that it wears off, and that's exactly what happened here. It wore off.

Q Is that normal and expected that it would wear off after a few months?

A Yes.

Q Is it reasonable to continue to treat patients who had an initial reasonable response to this pulse radio frequency with continued injections?

A Yes.

Q Especially to try to avoid surgery?

A Yes.

Q Did you repeat the procedure?

A Yes, we did.

Q Did you repeat -- was that on March 22nd of 2007?

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A Yes.

Q And it's the exact same procedure where you warm the area around the nerve?

A Correct.

Q And you did this procedure?

A Yes.

Q What was Mr. Simao's clinical status when you evaluated on it -- evaluated him on April 9th, which would have been a little over two weeks after the second pulse radio frequency procedure?

A He said that his pain improved in his left shoulder and trapezial area. And he rated his pain overall at three out of 10, and that there was still specific areas in the left medial scapular and paravertebral areas around C2 that were painful. And I turned those trigger points.

Q And did you perform trigger point injections for him at that time?

A Yes, I did.

Q The reduction of pain to three out of 10 two to three weeks after the second pulse radio frequency, did you consider that to be significant?

A Yes.

Q Why?

A Because it was over 50 percent and it was still beyond the period of time that you would consider just a

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temporary local anesthetic effect from that procedure. It was something that was related to the pulse radio frequency itself.

Q Did Mr. Simao's neck pain and left upper extremity radicular symptoms eventually return?

A Yes.

Q Did he come back to the surgery center for another cervical selective nerve root block with pulse radio frequency?

A Yes. It was scheduled for the -- June 12th, 2007.

Q So this time it was about a little less than three months after the first one?

A Yes.

Q Or after the second one actually. So the first one lasted about three to four months. The second one lasted two to three months?

A Correct.

Q Is that normal?

A It can happen that you get decreasing benefit from the procedure over time.

Q After the -- what would have been the third pulse radio frequency on June 12th, 2007, did you have an opportunity to evaluate Mr. Simao six days later, on June 18th, 2007?

A Yes, I did.

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Q And what was your evaluation?

A That his pain overall was rated at a four to five out of 10, and that he, again, had the same kind of trigger points in his trapezius muscle.

Q Had the third one not worked as well as the first or the second?

A Yes.

Q And what medications was Mr. Simao taking for his chronic pain syndrome at that time?

A Ibuprofen, Butalbital, Soma, Valdyne, amitriptyline, LYRICA, and morphine.

Q Does that represent a significant medical regiment for Mr. Simao?

A Yes.

Q Was it working to control his chronic pain?

A It was helping him.

Q Did it relieve all of his pain?

A No.

Q By this point, had Mr. Simao failed medical therapy, physical therapy, and injection therapy?

A Yes.

Q To whom did you refer him after this third procedure?

A Dr. Patrick McNulty.

Q The spine surgeon?

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A Yes.

Q Was that June 18th, 2007 date the last time that you had an opportunity to see and evaluate Mr. Simao?

A Yes.

Q Now did you give a deposition in this case?

A I did.

Q A deposition is sworn testimony. You take the same oath that you took today and Monday, is that right?

A Yes.

Q Do you recall being asked about the appropriateness of the cervical fusion surgery for Mr. Simao at the time of your deposition?

A Yes, I do.

Q Was your deposition in November of 2008?

A Yes, it was.

Q So it was actually four months prior to the surgery?

A Yes.

Q And at that time, were you still treating Mr. Simao?

A No.

Q Were you still with Southwest Medical?

A No.

Q In that deposition, in November of 2008, did you, at that time, state that you felt medical therapy would be in Mr. Simao's best interest rather than proceeding with surgery?

A I did mention that.

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Q And could you tell us why you had concerns about whether the -- about the performance of an anterior cervical fusion surgery and why you felt that medical therapy would be more beneficial? And in fact, you referred him back to Dr. McNulty for a potential surgical opinion.

A At the time I was at the deposition, I had not had any other follow up with this patient. And I had only been given my records up to the point where I treated the patient. So I saw the records from April 15th, 2005, from the accident that he was at the urgent care at Southwest Medical, to the point where I saw him last in June 18, 2007.

At that point, they did mention that the patient was referred to another surgeon, Dr. Grover, who did some injections with Dr. Rosler, and that, you know, he was being considered for this procedure, this cervical fusion. And they also showed me another MRI that was dated September 9th, 2007, which was negative. And they asked me well, why is it that you see this report here in front of you and you had the other report that you were treating him with him based -- back in March of 2006. And I said well, there's some difference between the opinions between one radiologist and another. And that doesn't necessarily mean there weren't the same findings or the same things on that film, because I didn't have a copy of the film. They didn't bring the film for me to look at. They just gave me the report. And I said well, you know,

clearly, there is some potential that either the first MRI was misread or the second one wasn't quite the same as the first one in terms of the way that it was interpreted. So there are definite concerns that I would say that you need further testing to figure out is the situation. Was it the, you know, first MRI or the second MRI.

And so, you know, I said based on that, you know, there's more medical intervention that needs to be done. There's -- you need more tests. And I didn't have all the results that Dr. Grover and Dr. Rosler were doing at the time, because they didn't bring any of that for me to see at the deposition. So that's why, at that point, my opinion was, you know, there's enough concern here that the patient should have further medical intervention and not necessarily have surgery right away, because it wasn't clear to me from that standpoint that there wasn't something surgical to go after.

And my time at Southwest Medical was based on those information that you already have seen up to this point with the MRI that was dated in March of 2006, showing that facet hypertrophy on the left. And that was the target and the pain generator that I was working with.

Now at the point where there was this question about being sent for a C3/4 and a 4/5 intracervical fusion, I had no other information to go on. I didn't have any discography information. I didn't have any other further follow-up tests,

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like a CT myelogram, or anything else that could verify the first MRI versus that second MRI.

Q Because at the time of your deposition, how long had it been since you'd actually seen and treated Mr. Simao?

A So this was November of --

Q 2008.

A -- 2008 versus when I left in June of 2007. So it had been over a year.

Q In fact, have you learned that he had further evaluation -- further medical evaluation before surgery was performed?

A Yes. He did have a CT of his neck that verified that he did have that facet hypertrophy at C3/4. He also had cervical --

MR. ROGERS: Your Honor --

THE WITNESS: -- discography --

MR. ROGERS: -- Dr. Arita is now exceeding the scope of his treatment.

THE COURT: Would counsel approach, please?

MR. WALL: Sure.

[Bench Conference Begins]

MR. WALL: Here's what's taking place. We gave him [indiscernible] limited amount of the records available [indiscernible] conclusion to the jury during opening statement. I have a right to have him explain why he made

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that conclusion and what it's based on.

MR. ROGERS: No. What I gave him at the deposition was the records that the Plaintiff had produced. The deposition makes that clear. I handed the doctor all the records that the Plaintiff had produced at that time. Now there's an additional problem here. He's never been disclosed as an expert. He's now commenting on the other doctors' records, including Dr. Rosler's, that had nothing to do with Southwest Medical where he was working.

Also, the Plaintiff just asked this doctor why he concluded as he did. Your Honor has heard a motion filed by the Plaintiff seeking to exclude issues of secondary gain. It was Dr. Arita who testified that the reason why he would not recommend surgery for this Plaintiff was secondary gain. The Plaintiff has now opened the door --

MR. WALL: [Indiscernible].

MR. ROGERS: Dr. Arita is conceding it in front of the jury in his answer. The fact that is his testimony under oath was that the reason why was because, in his opinion, due to inconsistencies between the physical exam and the pain complaints, between the film and the complaints, and the Plaintiff's pain response to injection, and taking all of this information into consideration, he would recommend against surgery because of his opinion, the Plaintiff exhibited signs of secondary gain. That was constrictly [sic] medical opinion

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that he offered. That's why we opposed that motion to exclude that issue. Now that the Plaintiff has asked him about that, opened the door to it, the defense is entitled to cross-examine on the reasons why he recommended against surgery.

MR. WALL: You excluded that testimony because it was entirely speculative. It was [indiscernible] you know, maybe the guy had pain before [indiscernible]. I don't know. I mean it's so speculative [indiscernible] definitely [indiscernible].

MR. ROGERS: You asked him why, and he answered.

THE COURT: So [indiscernible] he's incorrect, the position of the doctor's testimony [indiscernible] depositions [indiscernible].

MR. WALL: Deposition testimony [indiscernible] into [indiscernible].

MR. ROGERS: One moment, Your Honor.

THE COURT: Did he use those words?

MR. ROGERS: He said --

THE COURT: Or that [indiscernible]?

MR. ROGERS: -- specifically on this patient. He said especially with this patient when he used the term secondary gain. He was speaking directly about the Plaintiff.

THE COURT: Let's see the deposition.

[Pause]

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THE COURT: Let's take a break. Let's give the jury a break [indiscernible] find it.

[Bench Conference Ends]

THE COURT: Ladies and gentlemen, we're going to take a brief break rather than have you sit there and wait. Reminding you of your duty not to discuss this case, not to form or express an opinion, not to do any research on the case.

[Recess]

[Outside the Presence of the Jury]

THE MARSHAL: Please come to order.

THE COURT: I was just handed a note from the Bailiff who was handed a note from one of the jurors. It says, how many more days is this trial anticipated to be? On Monday, April 4, 2005, this will cause financial hardship on myself. Too many references to 2005, I guess.

I don't know who this was, but Marshall Diamond said he thought it was Ms. Prince. So any thoughts?

THE MARSHAL: It was Ms. Prince, I'm just not sure -- I'm not sure if she's Number 5.

MR. EGLET: I think, quite frankly, we're going to be able to finish -- we'll be able to finish this case on Monday, but --

THE COURT: You do?

MR. EGLET: I do. Yeah, I mean, I think -- I mean, it's

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my understanding that Dr. Winkler --

MR. WALL: Tuesday.

MR. EGLET: Well, I think we'll finish on Monday, quite frankly. I mean, I -- Dr. Winkler's got to testify on Monday, he's a very short witness. I mean, he is very, very short. And so I think we'll have all the other witnesses done by then.

THE COURT: Are you including closings in there?

MR. EGLET: Yeah, I mean I don't -- we got the whole afternoon. I think we can get closings.

THE COURT: It will take the whole afternoon for closings. That's my experience.

MR. EGLET: Well, Mr. Wall is giving the closing, not me, Your Honor, so --

THE COURT: Oh, it will be --

MR. EGLET: -- I suspect it will be faster.

THE COURT: It will be more concise?

MR. EGLET: More concise.

THE COURT: Not to put you on the spot, Mr. Wall.

MR. WALL: I would not say such a thing on the record.

THE COURT: Yeah, what about jury instructions?

MR. EGLET: We know Mr. Rogers is very concise in his arguments.

THE COURT: When are we supposed to settle jury instructions?

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UNIDENTIFIED SPEAKER: When would you like to do that, Your Honor? We'll make ourselves available.

MR. EGLET: Yeah, we can do that Friday, we can do it tomorrow, whatever the Court wants. We probably -- there's probably not going to be that much disagreement. It's mostly all stocks.

UNIDENTIFIED SPEAKER: I would assume so. I mean, if you want -- do you want -- do we have to do it even -- we could do it on a morning.

THE COURT: I wish we could.

MR. EGLET: At the worst case scenario, we argue on Tuesday. That's the worst case scenario in this case, but I think there's a reasonable chance we'll finish on Monday. That's -- but, you know, I'm optimistic. If we start early on tomorrow and get going today, we start early tomorrow -- or an hour early on Friday, I think we'll be -- you know, we'll be close to -- I think quite frankly the only witness we're going to have left is Winkler and he's short.

THE COURT: Who?

MR. EGLET: He's actually very tall, but his testimony will be short.

THE COURT: What kind of witness is Winkler?

MR. EGLET: He's a radiologist, Your Honor. He just reads films.

THE COURT: Just reads films? Mr. Adams?

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MR. EGLET: Sits in a dark room and looks at pictures.

MR. ADAMS: I think we're going to be arguing on Tuesday, Your Honor, but that's just my gut the way things are going.

THE COURT: What do you think, Mr. Wall?

MR. WALL: Which one do you want me to disagree with, is that -- I would say Monday or Tuesday.

THE COURT: Yeah. Mr. Rogers?

MR. ROGERS: I just -- I got a text from my secretary advising that Dr. Wang is not available on Thursday. That might affect when we can close the case.

THE COURT: Well, did you find the portion of the --

MR. EGLET: The Court can order Dr. Wang to be here by the way. He has not been released as a witness and you have jurisdiction to order that witness to be here tomorrow.

MR. ROGERS: He has patients to see, much like the importance of your upcoming visit, Your Honor, and these are patients who need to be taken care of. We've already covered this.

MR. EGLET: He committed himself as an expert in this case, it's -- he's in the middle of his testimony. You have jurisdiction to order him to be here or hold him in contempt, Your Honor.

THE COURT: Did counsel find the portion of the deposition testimony of --

MR. ADAMS: I did, Judge.

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MR. ROGERS: Wait up a moment. We'd like to excuse the witness before we address this because this is part of the cross-examination.

THE COURT: Very well. If you would wait in the hallway, please, Dr. Arita.

THE WITNESS: Sure.

MR. ROGERS: Now, since it was Defense counsel who broached this topic, it's -- I'd like to take the charge on the testimony that we're looking to and I have a copy for you, if you'd like to follow along, or do you want me to just recite it to you?

THE COURT: No, I would like to see if you have one.

MR. ROGERS: If you start on Page 66.

THE COURT: All right.

MR. ROGERS: It's Lines 11 through 24 and there the doctor testifies that he warned the Plaintiff against surgery because of the normal appearing MRI findings and he explained to him that surgery isn't always a good course of action. Then we turn to Page 74, there beginning on Line 5, the question is,

> "Now you testified earlier about concerns you had about surgery in a more generic sense involving this Plaintiff in your conversation with him near the end of treatment. Would those same concerns that you expressed to your patient apply to this

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two-level fusion as it would to any procedure?

"A: Especially this specific patient and the information that we've gone over, I would definitely have a reservation on recommending surgery to him.

"Q: Okay, there's some patients medical providers deem to be more appropriately handled by ongoing pain management?

"A: Right.

"Q: When you last saw the Plaintiff, what was your opinion about the appropriate future care?

"A: I think that pain management would probably be a better option for him than having a surgical procedure.

"Q: Have you already given the bases for that opinion or is there something you would add to that in addition to what you've already said?

"A: I think that having the benefit of knowing that this is a legal matter now, would even more likely give -- would allow me to give the opinion that it would probably be in his best interest not to have surgery because I think that there are secondary type gains that are being sought by considering surgery in this particular legal case. It almost validates some kind of injury that took place, as opposed to well, this may have been

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something that he had all along and has nothing to do with this accident that took place on April 15, 2005."

And then finally we turn to Page 80, beginning on Line 11, the question is posed by the Plaintiff's counsel. It reads,

"Right, but people get injured all the time and just because they seek recovery doesn't mean they are being dishonest about stuff, even if they're going to gain or not gain. Would you agree even a substantial amount of money isn't worth having a significant pain or needing a surgery or anything like that?"

And the answer was,

"You're right that somebody could not have a complaint and just say it's because I want to complain or there's some other kind of event to initiate the complaint, like an accident, but I think that pain is -- is a very complicated thing and there's more issues than the physical things to explain it than the other issues, as in psychological issues or these legal issues. And I think those are equally as important, if not more important, than the physical things."

And then he goes on to explain why he does not

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relate the neck and head and shoulder pain to the accident. He concludes at the bottom of Page 81,

"I don't think that the pain problem was something that he would have been bringing up had he not been in the accident, okay, but I think it's not necessarily a direct result of the accident."

Here, the doctor has expressed concern about recommending surgery for reasons that were elicited in the question posed to the doctor on direct exam, but that are being avoided by the witness at this time. Dr. Arita's deposition testimony was the basis for the Defendant's opposition to the motion to exclude secondary gain issues, because the Plaintiff's own treating provider made it -- or brought it into issue. Dr. Arita did say that secondary gain existed here and now that he's asked -- been asked the question by Plaintiff's counsel, why did you recommend against surgery, the Defense is permitted to cross-examine all of the reasons why, not simply the ones he's choosing to give the jury today.

THE COURT: Mr. Wall?

MR. WALL: Judge, that's absolutely incorrect. First of all, all of this in his deposition was quoted to the Court in the opposition -- I guess it was our motion, so it was probably the reply brief, from Dr. Arita. And you said, as the law allows, that he can testify to any medical

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inconsistencies that he saw, but since there's no evidence to support secondary gain, that should not be mentioned.

And what happened is basically that we patterned our examination of him right down the line of the Court. And the portion that Mr. Rogers initially read on Page 66, I think it was, of the deposition was, "I warned him that if he had surgery it may still be a problem for him, as in the pain, that it may not completely relieve the pain." And that's exactly where we were going. By the way, you didn't know at that time that there were more medical evaluations done for him before you had the surgery.

What's interesting is that in Mr. Rogers' opening he told this jury that Dr. Arita warned the Plaintiff against surgery, "Don't do this." And that the surgery certainly wasn't related to the motor vehicle accident.

So I followed right down the Court's order and when he talked about the medical reasons why he had concerns about surgery based on the limited records that he had at the time that he treated him, the question I asked him was -- one second. "Would you please explain the concerns you had regarding the surgery and why you felt that medical therapy would be more beneficial?" Which is exactly what he testified to in the deposition as the primary reason.

The other reason -- if that's another reason that he stated in his deposition that had to do with secondary gain,

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is out pursuant to the Court's order. He's not qualified to talk about secondary gain, it's entirely speculative, and what he said in the deposition was, I saw this facet hypertrophy, which wasn't caused by the accident.

So now you're saying that there's a lawsuit and we're here deposing me, so that's a concern in medical legal cases. That's not specific enough, that's why it was excluded in the first place, and I walked right through that concern in his deposition, addressed -- I don't know what -- if he says in his deposition -- in his opening that he warned him not to do the surgery, was he going to elicit from Dr. Arita that the reason you told him not to do the surgery is because I thought there were secondary gain reasons?

I'm going to presume that his purpose in putting that in the opening was not to violate another court order. I'm going to presume that it's exactly what Dr. Arita said in his deposition, that there were medical concerns that he had and medical reasons and that's why I asked him about the medical reasons he had at the time of his deposition where he wasn't sure that surgery wasn't the appropriate thing. He then sent him back to the spine surgeon.

So, I'd submit it on that.

MR. ROGERS: Yes, I --

THE COURT: Any concluding argument?

MR. ROGERS: Yes, briefly. You'll note that none of

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these questions solicited, or even suggested, secondary gain. Plaintiff's counsel keeps saying that secondary gain is not a medical reason, however this pain management physician volunteered it. I simply asked, why did you recommend against surgery and he said especially for this patient, and then he began discussing secondary gain, clearly demonstrating that this is a medical issue for pain management providers.

That however goes back to the original motion. Today's concern is that Dr. Arita is now being asked to offer an opinion about future surgery for this patient. He's being asked to examine records from providers unaffiliated with Southwest Medical, never shown to him before. He's being asked to offer expert opinion testimony.

And then on top of that, he's being asked to explain why he has changed an opinion that he gave in his deposition. And the Defense, if you follow the Plaintiff's lead, is precluded from cross-examining the bases for his opinions. He's already said there are reasons unrelated to secondary gain to this jury, however in his deposition, if we're to let them know the real and the full truth of his opinion, demonstrates that he was concerned about secondary gain as well. And that's the reason, in response to the Plaintiff's question, why doctor did you recommend against surgery? That's the reason why. That's the reason he volunteered.

THE COURT: The reason the Court made its pretrial ruling

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was because there was no evidence of any secondary gain. There's nothing contained within this transcript that you've now spent the last few minutes arguing about that would cause me to change that ruling. The motion is denied and noted for the record.

MR. WALL: Thank you, Your Honor.

MR. ROGERS: How do we address then the doctor's intended testimony on matters that move him from being a treating provider to an expert? He's now beginning to comment on records from Drs. Grover and Rosler?

MR. WALL: He's not commenting. All he said was, when I had my deposition taken, I wasn't aware that they ultimately did more medical evaluation and treatment before they decided to do surgery. And there aren't any more questions where -- he's not going to walk through Dr. Grover's records or Dr. Rosler's records.

MR. ROGERS: He already did. He just talked about the CT discogram. I mean, that -- they've basically converted him to an expert now.

MR. WALL: That's not correct.

THE COURT: Is this the witness that Mr. Rogers gave reports to that this witness hadn't seen and then -- is that the witness we're talking about?

MR. ROGERS: At his deposition we asked him questions about his causation opinion. He said, I didn't see the

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Plaintiff until a year-and-a-half after. Defense counsel said, doctor, here are the records produced by the Plaintiff from your group, Southwest Medical. If you would, take some time and look through them and let's discuss this. And that's where Plaintiff's counsel said he's qualified to discuss these other records.

MR. WALL: That's right. Mr. Rogers showed him records way beyond his treatment of them and then elicited a causation opinion, which he then communicated to the jury.

THE COURT: I think it's fair game. Let's bring our jury in.

MR. ROGERS: Dr. Rosler is fair game?

THE COURT: I think the information that you provide at the deposition --

MR. ROGERS: And that's limited to the Southwest Medical records. He's now moving outside of Southwest Medical.

THE COURT: I don't know what you gave him. I wasn't at the deposition.

MR. ROGERS: Okay. I think counsel doesn't dispute this?

MR. WALL: I haven't shown him any record past the time that he stopped his treatment of Mr. Simao.

MR. ROGERS: How does he know anything about the CT discogram?

MR. WALL: Well, whether he knows about it, I'm not walking through the records with him as a records review

expert. Is he aware now that he's had surgery? Yeah, he is.

MR. ROGERS: He's never been affiliated with Drs. Grover and Rosler, that's the point.

MR. WALL: It doesn't matter.

MR. ROGERS: I just came to get the minutes.

THE COURT: Oh, sure. I don't re -- even recall what the last question was that you asked --

MR. WALL: The last was -- question was, would you please explain why you had concerns about the fusion surgery and felt that medical therapy would be more beneficial, when in fact you referred him to Dr. McNulty for a surgical opinion.

THE COURT: Yeah, I think that's a fair question.

MR. ROGERS: Your Honor, can I do an offer of proof, either before or after --

MR. WALL: After.

MR. ROGERS: -- Dr. Arita concludes?

MR. EGLET: We've got a witness that we've got to get on today.

THE COURT: We're going to bring our jury in. We're bringing our jury in right now.

[Within the Presence of the Jury]

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

MR. WALL: Yes, Your Honor.

MR. ROGERS: Yes, Your Honor.

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THE COURT: Okay. We're -- whenever you're ready, Mr. Wall.

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

DIRECT EXAMINATION CONTINUED

BY MR. WALL:

Q Dr. Arita, do you fault Mr. Simao for taking the advice of his treating spine surgeons after failing all medical treatment and proceeding to the fusion surgery

A No.

MR. ROGERS: Your Honor, we --

BY MR. WALL:

Q We --

MR. ROGERS: -- just have a running objection to this line of questioning.

THE COURT: Sure. Noted for the record.

MR. WALL: Thank you.

BY MR. WALL:

Q Are you aware that he underwent a cervical fusion at C-3/4 and C-4/5 by Dr. McNulty in March of 2009?

A Yes.

Q Are you also aware that Mr. Simao developed recurrent axial neck pain and upper extremity ridiculer symptoms after the surgical reconstruction by Dr. McNulty?

A Yes.

MR. ROGERS: Same objection as earlier, Your Honor.

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THE COURT: Noted for the record.

MR. ROGERS: This is getting into expert testimony.

THE WITNESS: Yes, I am.

BY MR. WALL:

Q Does the failure of surgical intervention to provide Mr. Simao with long lasting relief from his chronic pain mean that in and of itself the surgery was unnecessary?

A No.

Q Why not?

A The --

MR. ROGERS: Your Honor, this is the same objection they brought up with Dr. Fish. You know -- we'll approach.

[Bench Conference Begins]

MR. ROGERS: Plaintiff's counsel repeatedly objected to any comments by Dr. Fish, [indiscernible] on surgery. You'll recall that there was some concern about that, Plaintiff's counsel and the Court, so that he seemed excessively tongue tied about surgery questions. Now Plaintiff is soliciting testimony from this pain management physician about surgery. The Court has already entered a ruling on this.

MR. EGLET: Ruling that the motion on Dr. Fish and the limit of his testimony on surgery was that because he was a surgeon, he was not a spine surgeon, he could not come in here and state that the spine surgery was unreasonable or unnecessary. What Dr. Arita is talking about, from a pain

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management physician's perspective, is that, just like Dr. Rosler testified to and just like I elicited from Dr. Fish on cross-examination, is sometimes these surgeries don't work, sometimes they don't make the patient better, sometimes they make the patient worse. That doesn't make the surgery -- the decision to do surgery necessarily unreasonable.

So it's two different things and Dr. Rosler testified to that and I elicited cross-examination of Dr. Fish on that very subject. What Dr. Fish was specifically excluded from doing was coming in and saying, Dr. McNulty should have never done this surgery. It's a different situation. It's apples and oranges.

MR. ROGERS: No --

THE COURT: It's entirely different, including [indiscernible] posed by Mr. Wall to this witness was not objectionable. So I think you need to listen carefully to the question before you make your objection. Overruled.

MR. ROGERS: Okay.

[Bench Conference Ends]

MR. WALL: The objection's overruled, Your Honor?

THE COURT: It was.

BY MR. WALL:

Q Do you recall the question?

A Yes. The answer is no.

Q Do I recall the question? All right. Why does the

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fact that the surgery didn't provide Mr. Simao with long lasting relief from his chronic pain syndrome, why doesn't that indicate that the surgery wasn't indicated?

A Well, I think there's a little difference of opinion on this because if you look at one way, this decision is between a surgeon and a patient on whether they should go forward with this and clearly the decision was made to do it. And so that particular decision has already been made. Now you're looking back now and saying retrospectively well, he still has a pain problem. So it must have been a mistake or it wasn't the right level or something went wrong. That doesn't mean that. The surgery went forward, it was successful and I believe that the patient did have relief initially but unfortunately he did have pain recur.

Now because the pain recurred doesn't mean that the surgery itself was a failure. It could mean that he developed scar tissue. That can happen over a period of time. So the actual problem they went after, it may have been fixed surgically at the time that the surgery was done. And it was a success. But now he's got a new problem perhaps that maybe some scar tissue developed after his surgery and that's why this pain problem occurred. So that's the reason I'm answering no because he could have -- he did have a success, technically a successful surgery and it's unfortunate that the problem still persisted but it may not because the surgery's

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not successful.

Q Well, have you treated patients while you practicing pain management who had undergone spinal reconstructive surgery and didn't get the anticipated result from the surgery?

A That's frequently what kind of patient we see in pain management because what'll happen is the patients that get better and they stay better, they don't come to see us. So we will see the patients that have failed medical and surgical therapies and that's the kind of patients we typically see.

Q In all of those cases, do you form the opinion if it didn't work, the surgery must not have been necessary?

A No, that's exactly the reason I'm explaining this to you that basically something can happen after surgery that has nothing to do with the surgery itself, you know, where, you know, it was a technically successful surgery and the patient had a good result but something happens later and they develop scar tissue and nobody can foresee something like that. People heal differently.

Q All right. Thank you. Was the medical care and treatment rendered by you and the other providers at Southwest Medical Associates to Mr. Simao necessary, reasonable and causally related to the injuries he sustained from the April 15th, 2005 motor vehicle accident?

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A Yes.

Q Okay.

MR. EGLET: One second.

BY MR. WALL:

Q Oh, when you talked about scar tissue, is that something that develops or causes pain as a result of surgical intervention?

MR. ROGERS: Your Honor, this testimony is speculative. No one has testified to such findings.

THE COURT: Overruled. You may answer the question, doctor.

THE WITNESS: Frequently, scar tissue can occur and is probably the explanation for most of these persistent pain problems that happen after a technically successful surgery.

BY MR. WALL:

Q The body forms scar tissue around an area where there's surgical intervention?

A Correct.

Q Okay.

A I mean for something just -- so everybody understands this concept, some people will have hypertrophic scars or keloids form on the outside of their body. So those are clearly abnormal things that people heal differently than somebody else that doesn't have that particular problem. So this is something that could happen on the inside of the body

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as well. Some people will form scar tissue. Other people won't to the same type of surgery.

Q Are your conclusions that you've stated regarding Mr. Simao's medical care and treatment more likely right than wrong?

A Yes.

Q And in fact, are you certain?

A As far as I can be.

Q Was the billing associated with the treatment that you and the medical providers at Southwest Medical Associates gave to Mr. Simao customary and reasonable for patients in Clark County, Nevada?

A I would say it's below what most people charge, yes, so I'd say it is very reasonable.

Q And are your conclusions regarding the care rendered by you and Southwest Medical Associates to Mr. Simao and their associated costs more likely true than not?

A Yes.

Q In fact, are you certain?

A Yes.

Q Do you believe that Mr. Simao will ever be pain free as a result of the serious injuries he sustained from the motor vehicle accident on April 15th, 2005?

MR. ROGERS: I'm going to object for foundation, Your Honor.

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THE COURT: You rephrase it?

BY MR. WALL:

Q Do you believe that based on all the treatment that's been provided and the things that you've reviewed, that Mr. Simao will be pain free as a result of the accident?

A In my --

MR. ROGERS: Same objection.

THE COURT: Overruled. You may answer.

BY MR. WALL:

Q You may answer.

A In my opinion, no, I think he will be probably requiring ongoing pain management.

Q Are your conclusions regarding his pain more likely right than wrong?

A Yes.

Q And beyond that, are you certain?

A Yes.

Q Have all the conclusions that you've shared with us here today been to a reasonable degree of medical probability?

A Yes.

Q And does that mean they're based on medical reason?

A Yes.

Q Thank you very much, doctor.

MR. WALL: Pass the witness.

THE COURT: Mr. Rogers.

MR. ROGERS: Thank you.

CROSS-EXAMINATION

BY MR. ROGERS:

Q Doctor, you testified on direct that you don't do pain management anymore, is that right?

A Yes, that's correct.

Q Okay. How long has it been since you've pain management?

A Since August of 2007.

Q Since you left Southwest Medical?

A That's correct.

Q When you performed pain management on a regular basis, were the majority of the spine conditions that you treated related to car accidents?

A I would say most of them were chronic degenerative changes from people that were elderly, that didn't necessarily have accidents. Some of them might have had it. But I would say on the average no. We saw more patients that just had degenerative changes that were not results of car accidents.

Q Okay. And you saw the Plaintiff first a year and a half after the accident? In October?

A Of 2006, right.

Q Right. And you don't know anything about the accident?

A Other than what we discussed about him being in a

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van that was rear ended.

Q Okay. The Plaintiff told you that he had headaches before the accident, right?

A Yes, he said he had migraine headaches.

Q Okay. However, he told you that he didn't treat, need to treat for those headaches before the accident?

A To my knowledge, he wasn't on anything other than Fiorinal so he did have some kind of medication but it was not frequently used.

MR. ROGERS: Okay. Let's -- I'm going to publish the deposition, Your Honor.

THE COURT: Any objection?

MR. WALL: No, Your Honor.

THE COURT: So ordered.

BY MR. ROGERS:

Q Before we get to that question, do you have that April 5 record?

A Yeah, the first visit?

Q Yes.

A Yes.

Q May I see that?

A This one?

Q Yes, please. Actually the medication he was taking on the date of the incident for headaches was Butalbital. You're aware that that's commonly prescribed for tension

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headaches?

A Well, I can tell you that you can see this with people that have migraine headaches as well. And there are mixed type of headache problems besides just pure migraine headaches.

Q When he presented to you, did he have any classic migraine symptoms like aura, one-sidedness?

A No, not when he presented to me.

Q Did he have any headaches at all?

A I believe he mentioned that he had occipital pain but I don't remember the fact if he had mentioned anything about a migraine headache at all.

Q Okay. Let's turn back to that question of which I published the deposition. And if you would, turn to page 35. Actually make that 36. Well, start at 35, line 23 and read to yourself through 36.

A Is that starting with did he ever tell you about any symptoms he had before April of '05?

Q Right. And read that to yourself and I'll read with you in just a moment, through page 36.

A So I'm starting with line 25 as my answer?

Q You can start at 23 as well.

A Okay. The question on line 23 is did he ever tell you about symptoms he had before April of 2005?

Q Yeah, just -- I need to see if there's any

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objectionable stuff here. Let me read with you. If you would just read that to yourself.

A Okay.

Q I can screen it as we go. Okay. There's -- it's fine as is. Remember, the question before was whether you're aware that he was treating for headaches before the car accident. And I'll read the question and the answer at the time of your deposition.

"Q Did he ever tell you about any symptoms he had before April of 2005?

"A He mentioned that he did have headaches but he told me that the headaches were something that came and went. They come and go. They weren't something that he said he had continuously and it was a serious enough problem that he had to seek medical treatment for the headache that he had before the accident.

"Q You weren't aware then that he treated for migraines at Southwest Medical Associates before April 2005?

"A No, I was not aware of that.

That was your testimony at that time?

A Yes.

Q Okay. Were you aware that he had headaches with facial numbness before the car accident?

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A Well, with the facial numbness, you can have migraine. I mean that could be a symptom of a migraine headache.

Q True. The question is were you aware of it?

A Well, I did have a history of him being on medication for headaches. So I mean I'm not sure what you're asking.

Q Did he report those symptoms to you when you took his history?

A No, not to me.

Q All right. And as far as the headache issue, at the time he was treating with you again, so the jury's with us, this is roughly a year and a half after the accident. At the time he treated with you, headaches weren't a major complaint, right?

A Yes, that's correct.

Q Now, you've reviewed the MRIs in this case. Have you seen the films or just the reports?

A Both.

Q All right. And you agree that there are no findings on the MRIs that can be caused only by a car accident?

A Yes.

Q You agree that the conditions shown on those MRIs can result from degeneration?

A Yes.

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Q And that they can result from years of manual labor?
A Yes.
Q Your opinion at the time that you and I met at this deposition in November of 2008 was that the Plaintiff's symptoms were caused by his C3,4 facet hypertrophy, right?
A Yes.
Q And that's that overgrowth in the bone?
A Yes.
Q And that facet hypertrophy was not caused by this accident?
A That's correct.
Q It was either preexisting or had no relation to this accident?
A That's correct.
Q And the injections that you performed were targeted as you described to the jury at the C4 nerve root, which is right where that bony overgrowth was?
A Yes.
Q You agree that if there is a disc injury, it has a potential of healing, right?
A Yes.
Q However, a facet hypertrophy does not heal?
A No.
Q In your opinion, isn't it true that you have found that the car accident did not cause the pain in the

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Plaintiff's neck and shoulder?

A My specific recollection was I said that the facet hypertrophy on the left side at C3,4 was not caused by the accident. And I didn't believe that the pain was necessarily caused by the accident but I did mention to you at the time that it can be an exacerbation of something at the time of the accident that wasn't necessarily a problem. So something that was asymptomatic before can become symptomatic after.

Q Let's turn to your deposition again and this time to page 79. And if you would, read along with me. Lines 8 through 15. You testified.

"Q So directly" --

MR. EGLET: Did you say page 79, counsel?

MR. ROGERS: Yes.

MR. EGLET: Line 8 starts in the middle of an answer. In fact, way down at the end of the answer.

MR. ROGERS: It's a line of questioning that counsel and the Court have already expressed some --

MR. EGLET: May we approach?

THE COURT: He doesn't have a copy of it so I don't know what you're talking about.

[Bench Conference Begins]

THE COURT: Is that your copy? Thank you. What page?

MR. ROGERS: 79 or well, yeah.

MR. EGLET: The question is actually on page 78. And the

answer starts at the middle of page 78 and it is through most of 79.

MR. ROGERS: Is there any of that language though in there that we discussed? That's what I'm doing is trying to keep the record clean, Your Honor. If all of that's fine, I'll read it all.

MR. EGLET: Can I finish reading that?

THE COURT: I want to read at the beginning and read.

MR. EGLET: Can I please review it?

THE COURT: I want to read the beginning, Mr. Rogers.

MR. ROGERS: I'm sorry.

THE COURT: I don't know where you're beginning.

MR. ROGERS: Oh, Mr. Eglet's --

MR. EGLET: Again, he was beginning on line 8 on page 79, which is in the middle of the answer and that's why I had a concern.

MR. ROGERS: You'll see, it's all the same though. It's not taking anything out of context.

MR. EGLET: All right.

MR. ROGERS: It's on the question.

MR. EGLET: I think now that I've read it, it's fine. He can read it from there and I have no problem with it.

[Bench Conference Ends]

BY MR. ROGERS:

Q Okay. Doctor, I'm going to start now at the

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question posed on page 78. And if you would read along with me. Again, this was your testimony at the November 2008 deposition. Oh, and this is line 2.

"Q Now taking this information into account, in your opinion, did this car accident cause the facet hypertrophy?

"A No. It is in my opinion that his facet hypertrophy was either preexisting or has no relation to this particular accident.

"Q Okay.

"A And the reason that I think the facet hypertrophy is not related to the accident is I don't think you are going to find that kind of degenerative change take place in such a short period of time. I think that was already there. And I also think that if you want to explain the occipital headache as a possibility of this accident, there may be some cause and effect to that. I think there is some possibility that he may have suffered the occipital lesion as a result of hitting his head on the cage and therefore that may have resulted in like I say occipital neuralgia or something along those lines. But the fact is that was never really much of a major complaint later in the times that I saw him as opposed to when he first

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presented. I think in the first presentation in April" --

And this is April 2005, correct?

A Yes.

Q Date of the accident.

"A I think in the first presentation in April and maybe even through May or later up until maybe six months after that may have been directly something related to the accident. But then after that first six months, it didn't seem to be as much of a problem, those occipital pains that he first mentioned on that accident date. So directly answering your question in my opinion, I don't believe that the facet hypertrophy is the result of the accident itself. And I don't think that the pain he was having in his left shoulder and his neck was a direct result of the accident. I think it may have exacerbated that problem but it certainly didn't cause it. And that's my opinion."

That was your testimony at that time, correct?

A Yes.

Q In your opinion, there are reasons for the Plaintiff's complaints that are not reflected in the findings like the MRI and in your physical exam, correct?

A Yes.

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Q In your opinion, the Plaintiff's complaints are not the direct result of this car accident?

A Okay. I think you're taking that out of context because what you just read had to do with the facet hypertrophy and you're asking if that was caused by the accident and I said no, I don't believe it was caused by the accident. It was a degenerative change. I agree to that. But as far as the pain problem in general being caused by the accident, I don't -- that is different from what you're asking about the facet hypertrophy.

Q Turn to page 81.

A Okay.

Q Lines 16 through 24.

A Right.

Q If you would read that to yourself.

A Okay.

Q And I'll recite it. And read along with me.

"A And again when it comes down to what is my opinion, my opinion is he didn't have this facet hypertrophy as a result of this particular accident that he was involved in in April of 2005. And I don't think that the pain problem was something that he would have been bringing up had he not had this accident, okay? But I think it's not necessarily a direct result of the accident is what I'm saying."

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Is that correct?

A Yes.

Q You're aware that the Plaintiff now claims that this surgery that he underwent didn't work. You have suggested to this jury that it could possibly be related to formation of scar tissue at the surgical site. However, you haven't seen the Plaintiff now in several years, correct?

A Yes.

Q You can't state then to a reasonable degree of medical probability that whatever symptoms he is complaining of today is related to scar tissue?

A Based on my experience and with patients that I've seen in my clinic before, this is not that unusual and so although you're asking me specifically about this patient and not having seen him since the last of 2007, that's correct. But again, based on my experience and what kinds of patients I've seen, this is the kind of a problem that can occur.

Q Okay. Now when you were treating the Plaintiff, I want to turn to the physical exam that you performed on January 10, 2007. This is Exhibit 18, pages 84 through 45 [sic]. At the time that you examined the Plaintiff, he presented and I'll go down the list of your findings.

A Okay.

Q In no acute distress, correct?

A Yes.

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Q No tenderness in the cervical spine?
A That's correct.
Q Normal and painless cervical range of motion?
A Correct.
Q No pain to axial loading?
A Correct.
Q Are you aware that a couple of doctors have come in here and testified that they administered an axial loading test and that it elicited pain?
A Yes.
Q When you did it, it did not?
A Correct.
Q Next was he had a normal motor exam?
A That's correct.
Q That has to do with the nerves, correct?
A That's correct.
Q And he had normal detent and reflexes?
A That's also correct.
Q He had intact grip strength?
A Yes.
Q This has to do with the hands?
A Correct.
Q And intact sensory exam?
A Yes, correct.
Q All of these have to do with nerves?

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A Yes.

Q Your finding on January 10, 2007 was normal except for some deficit at the C4 dermatome where that facet hypertrophy or bone overgrowth was?

A Correct.

Q You didn't find any evidence of disc injuries at C3,4 and C4,5 at this exam?

A Correct.

Q And yet at this very same exam, the Plaintiff complained of pain at 7 to 8 of 10, is that correct?

A That's correct.

Q And he was not disabled? And he was working?

A Correct.

Q And you found that there was an inconsistency between the Plaintiff's reported pain and your normal findings on exam?

A Yes.

Q Because everything on exam was basically normal?

A Yes. And can I make a clarification about the pain rating?

Q Does this have to do with our discussion at your deposition about --

A Yes.

Q -- the habit that people can get into reporting the pain?

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A Yes.

Q Just to move things along, let me see if I bet this right. When a patient reports pain, you find sometimes in your practice that they develop a habit of reporting a number. And that number might not accurately reflect their actual pain score, correct?

A At that moment in time.

Q Okay.

A Yes.

Q And with that taken into consideration, you were still concerned that there was an inconsistency between your normal physical exam and findings and the Plaintiff's report and pain?

A I did mention that as a possible thing that might not be completely understood on why you have a normal exam but have this kind of a pain. I did mention that, yes.

Q And in other words, his complaints did not completely correlate with the physical findings?

A Correct.

Q Now you've offered some testimony about limitations that you find physician's assistants have, correct? Do you know the first PA who the Plaintiff saw, Nancy Bansen [phonetic]?

A I don't know her personally.

Q She treated the Plaintiff on the date of the

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incident. Do you know Britt Hill?

A No.

Q Who saw him before and after?

A No.

Q Do you know the nurse who saw him three weeks after the accident or pardon me, nearly four weeks, named Keeley [phonetic] Johnson?

A No, I don't.

Q Now if Britt Hill testified that if the Plaintiff had reported neck pain to him, he would have written it down, do you have any reason to disagree with it?

A No.

Q Do you know of any specific instance where Mr. Hill, Ms. Keeley, Ms. Johnson or Ms. Bansen ever failed to report complaints that a patient made to them?

A No.

Q Do you know Dr. Tsai?

A No.

Q I don't know if I'm pronouncing that right. It's T-S-A-I.

A I don't know him.

Q Okay. Mr. Hill, if he testified that Dr. Tsai was his supervising or precepting physician, you have any reason to dispute that?

A No.

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Q And you don't know of any specific instance in which Dr. Tsai failed to properly supervise a PA?

A No.

Q Now you've suggested that PAs can sometimes miss things. However, you don't know of any specific instances in this case where anything was missed?

A No.

Q When the Plaintiff returned to treatment after that four and a half to five month gap, remember he treats on the date of the incident, then roughly three or four times over a month and a half and then he stops. And he returns four and a half months later in October.

A Yes.

Q Are you with me on this?

A Yes.

Q When he returns to treatment, he got the shoulder and the neck x-ray and then he stopped treating again for two months. Do you suggest that that's Southwest Medical's fault that he stopped treating again?

A I wouldn't say it's their fault but it was those midlevel providers that recommended that interval of time that he went that long.

Q Do you see anywhere in those October records where Southwest Medical Associates suggested to him that he go that long a time in October?

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A As far as how long it's been between the last visit in October.

Q This would relate to the plan, right. The treatment plan.

A Well, it says on May 26, 2005, that --

Q Hold it, I think we're on different pages here.

A Okay.

Q May 26 is before the four and a half month gap. My question was, doctor, when the Plaintiff returned to treatment after that four and a half month gap, it's October. He goes in and gets the shoulder and the neck x-ray and then he stops treating again for two months. The question was do you fault Southwest?

A No, I don't fault them.

Q And the follow up question was do you see any suggestion in the records at that time that he stop treating for any period of time?

A So are we talking about the time between May and October? That period of time? Or are we talking about after October?

Q Yeah, I might not be being clear. The Plaintiff stopped treating in May. Then he returned in October.

A In October.

Q And then he got a shoulder and a neck x-ray and then he stopped treating again. And this is now from October to

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December.

A Okay.

Q And the question is do you see any suggestion in the records that the Plaintiff stop treating in October for those two months?

A All I see from that time period is that he was seen back in October and then he had some x-rays and he did have some physical therapy and then he came back in December is my understanding of the way the records are stating.

Q Okay. Now when the Plaintiff returned to Britt Hill, he ordered that -- and complained of neck pain. Let me start over. When the Plaintiff returned to Britt Hill after these two breaks in treatment, four and a half month and the two month?

A Yes.

Q He complained of neck pain at that time and at that time Britt Hill ordered the cervical MRI, correct?

A Yes.

Q Now that was appropriate for him to do since the Plaintiff was complaining of it at that time?

A Yes.

MR. WALL: Judge, could we approach for a moment please?

THE COURT: Yes.

[Bench Conference Begins]

MR. EGLET: You know, we have Dr. Smith from Chicago and

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this is the only day he was available. I didn't know that there was going to be all these hearings outside the presence of the jury today which burned -- mistrial motions and everything which burned literally an hour and a half today. And now it's clear that this cross-examination is going on much longer. It's after 3:00. We've got to get this witness on and out of here today. So we need to stop this witness' testimony because he's local. We can bring him back. And get Dr. Smith on and off now.

MR. ROGERS: I'm nowhere near done.

MR. EGLET: Yeah.

THE COURT: Okay. When can this witness return? Any idea?

MR. EGLET: I'll have to talk to him. I mean, you know, I'm not sure but we'll get him back.

THE COURT: All right.

[Bench Conference Ends]

THE COURT: So for scheduling purposes, Dr. Arita, we are going to have to ask you to come back yet another day. I'm told by counsel there's an out-of-state witness who has to leave today. On behalf of the Court and counsel, I apologize for the inconvenience. I guess we'll see you another day.

THE WITNESS: I think I'm just about as happy as the jury.

THE COURT: Who is the next witness, Mr. Wall?

MR. WALL: Dr. Stan Smith, Your Honor.

THE COURT: Good afternoon, Doctor.

THE WITNESS: Good afternoon, Your Honor.

THE COURT: Please remain standing. Raise your right hand to be sworn.

STAN SMITH, PLAINTIFF'S WITNESS, SWORN

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

THE WITNESS: Thank you. My name is Stan V. Smith. S-M-I-T-H.

THE COURT: Okay. Mr. Wall, whenever you're ready.

MR. WALL: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. WALL:

Q Is it Dr. Smith?

A Yes.

Q Doctor, what is -- and what is your profession?

A I'm an economist. So I have a PhD in economics. I'm not a medical doctor.

Q All right. And what is economics as that term is used in your field?

A Well it's a fairly broad field. Some economists work for the U.S. government and gather statistics and make economic predictions. And I actually started out my career as an economist at the Federal Reserve board of governors in

1972. Some economist work in private industry and make forecasts for certain -- you know, like automotive industry or computer industry. And I also worked at JP Morgan Chase after working for the government for a number of years.

Some economists do some teaching in academia and I taught at the University of Chicago and also DePaul University. And then some economists do private consulting, private economic consulting. And for the last 25 years I've had an economic and financial consulting firm.

Q Doctor, what is labor economics as that term is used in your field?

A Well it's the branch of economics that specializes in looking at issues regarding employment and wages and things like that.

Q Do economists have any involvement in the calculation of the economic consequences of injury?

A Sure. That's a common -- what we call a common forensic economic issue. The economist would look at what happens if someone's been injured. What are the consequences of that injury? It could be in many different areas.

Q And generally what methods are used by economists in the calculation of the economic consequences of an injury?

A Well the methods involve looking at issues that regard what things may cost in the future. How prices may change in the future. Also bringing future costs back to

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present so issues regarding present value.

Q And what types or sources of information do economists typic- -- let me try that one again -- what types or sources of information do economists typically rely upon in making those calculations?

A Well there's three primary sources of information. The U.S. government publishes a great deal of data -- gathers a great deal of data on the economy and on prices and on all -- inflation rates and discount rates and all sorts of things like that.

We also have a private academic studies done at -- you know, in published, and peer reviewed economic journals. Dozens of journals all over the country, or economists will publish information and economic data. And then there's also the specific individual information that's particular to each individual case. So there -- so really three sources of data.

Q All right. Great. Thank you. At our request did you make calculations regarding certain economic consequences about William Simao's injury?

A Yes. I did.

Q And are the calculations that you made of this -- of the type typically made and relied upon by economists in the practice of your profession?

A Yes. They are.

Q Can you describe your qualifications for u, please?

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A Sure. After graduating high school in Milwaukee, Wisconsin where I grew up, I went to Cornell University in upstate New York. I got a Bachelor of Science degree in operations research, which is a branch of engineering. It's primarily management science and statistics and computer science.

And then came back to Chicago where I've been ever since. I went to graduate school. It's my parents' hometown. I got a masters degree and a PhD in economics at University of Chicago. So that's my formal education.

Q Now has the PhD program in economics at the University of Chicago produced any leaders in the economic community?

A It's generally considered one of the moral centers for research that began. I got there in the late 1960's. They began giving the Nobel Prize while I was there in early 1970. And over the last 40 years or so, of all of the hundreds of universities around the world where people do economic research, the University of Chicago has captured about one half of all the Nobel Prize's awarded in the last 40 years. And then all the other hundreds of universities around the world from Princeton, Harvard, and Stanford and Cambridge and -- have gathered the other half of the faculty -- have gathered the other half. So it's become known as an economic research powerhouse.

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Q Have you published in the field?

A I've published a fair amount. Yes.

Q Could you review what published works you've created that are relevant to your calculations or the type of calculations that you've made in this case?

A Okay. Well I wrote the first text book in the field of forensic economics. It was called --

Q What is forensic mean?

A Well it's that -- it's those methodologies and economic procedures that apply really in litigation. So we wouldn't necessarily be here talking about the international trade between India and China. There's lots of economic issues that wouldn't come into a courtroom. But those issues that come into a courtroom we refer to as forensic economic issues.

So with Dr. Michael Berkshire, University of West Virginia I co-authored the first text book in the field of forensic economics. I taught the first course in the field of forensic economics at DePaul University. I've published chapters in text books that have since been written as a guest author. Maybe half a dozen other books, 30 or 40 articles or so.

Q When did you write your book?

A 1990 it was published.

Q Do you continued to teach in the field of forensic

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economics?

A I taught in the early '90s at DePaul University. I haven't taught since then.

Q Okay. Please tell us your past experience in loss estimate.

A Well I -- first I think was asked to make some estimates for litigation in the early 1980s so that's about coming close to 30 years now. And over the course of time I've worked on perhaps maybe some, I don't know, close to 10,000 matters.

Q All right. Thank you.

What categories of economic cost did you calculate in this case?

A Well in this case you asked me to look at three particular issues. One issue was cost of medical procedures that would need to be done over the course of time.

Secondly the loss of enjoyment of life that Mr. Simao has sustained as a result of his injuries. And the third is the consequence of and the loss of society that his wife has sustained as a result of the injuries that he has received.

Q Now medical costs are pretty much self explanatory in terms of what that means, but what is meant by the term reduction in value of life, or loss of the enjoyment of life?

A Well loss of enjoyment of life is something

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economists have been studying now since the late 1960s. Really has to do with looking at the impact of an injury on really four principal areas in life.

One, has there been an impact in career or the ability to engage in and enjoy the occupation of your choice. And sometimes a person may not be necessarily stopped from working, but the work may be more difficult. There may be pain associated with working. So there could be some impact on the area of the enjoyment from engaging in your career and your work.

Secondly, there's the impact on social and leisure activities, how has that changed.

The impact on activities of daily living, you know, if some people are severely injured. Can they, you know, tie their shoes? Can they, you know, can they engage in their life management?

And then fourthly their own internal emotional state. So how have they internally reacted to the issues regarding the injury? So all of that are the various areas -- like the four primary areas where we would imagine that there could be an impact on a given injury from loss of enjoyment.

Q And then what is meant by the term loss of society or relationship?

A Well when we have a key relationship with someone, whether it's parent/child or spouse/spouse, There -- another

person can be affected significantly and in particular in marriages where you depend on, you know, you have an interdependent, but also a co-dependant relationship. So there are certainly things you would expect to do with your spouse, engage in with your spouse, have a relationship in certain ways. Emotional, physical, all sorts of different aspects to it. And that can be changed, impacted, impaired, when one person has sustained a significant injury.

Q So that's a loss by the other person in the relationship?

A Yes. Right. It impacts the other person's life, very definitely.

Q Without describing any of the actual values you calculated for these categories, please tell us about the methodology that you employed to make calculations regarding the economic consequences of Mr. Simao's injuries.

A Well with regard to this -- the three different areas. Shall I discuss the medical area, first? Or --

Q Well what did you review in the case. Let's start there.

A Okay. Well in terms of review I had a fair amount of documentation. My report lists about -- actually more than 18, approximately 18 items, but in particular we conducted an interview with Mr. and Mrs. Simao, we had all sorts of information about career. I've got really lost of

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depositions. I don't know that you want me to list them all. But -- so court documents as well as answers to interrogatories the accident report, the life care plan, and some medical costs for surgeries, etcetera. And information about earnings and career. I think I mentioned that.

That was -- that's specific to this case, as well as then just general information from the government about increase sin health care costs, medical costs, and things like that.

Q Now what type of research have you conducted regarding how to value a -- the enjoyment -- a person's enjoyment of life.

A Well I -- that was actually an aspect of my PhD thesis in terms of research on the value of life. So I've published peer reviewed original research on the value of a statistical life, but my thesis was one drop in the bucket of dozens and dozens of articles published on the value of a statistical life since the late 1960s. So I've kept abreast of that research and read that research and digested it over the years in addition to contributing to it.

Q Could you describe the methodology you used to calculate William's loss of enjoyment of life?

A Well so for loss of enjoyment of life it's actually a fairly simple process. If a person is familiar with literature and that's a large piece of work, so most

002662

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economists have specialty areas. And one of my specialty areas has been being -- not only having contributed to, but being familiar with all the other contributions on the value of life. I and other economists have published what we call some summary reviews of that literature.

And I would say most economists -- and I actually mentioned about six or seven of those reviews in my report, that most economists would agree that the starting point for any analysis is the statistically average value, if you average all the values that have been published for the value of a statistical life, is approximately $5 to $6,000,000 -- about I think 5.5 is the figure that I used in my report, a 5.4.

Q Now explain what that means.

A Well, what it means is -- $5.4 million is the result of many studies. So what are these studies? These studies look really at what does it -- what are we paying to preserve loss of life by looking at what we pay to reduce risk. So for example one of the studies looks at what would it cost for a carbon -- what does a carbon monoxide detector cost? Some -- I think the study that was published in that area was somewhere around $40 in average cost.

If we know that we buy a carbon monoxide detector to reduce our risk of death. So some of them -- if we install 100,000 carbon monoxide detectors that would cost say

$4,000,000. So when you and I and other people go down the isle of a Sears Hardwares or a TruValue or Ace and we buy a carbon monoxide detector for $40, we are reducing -- and install it in our house, we're reducing the chance that someone in our home may die from carbon monoxide.

And if -- every time 100,000 of those purchases are made one life is saved, then $4,000,000 has been spent to save one statistical life. It could be the life of a two year old. It could be the life of an 80 year old. It's the -- it's an average life of someone in this country.

So studies have been conducted to examine what are we paying to reduce the rate of death and how much does that cost ultimately for each statistical life saved -- an average life saved. That's -- many studies -- most of the studies were originally done in what we call the willingness to pay to reduce to rate of death.

Q Now this methodology for determining the average value of a life, is that something that's generally accepted within the accounting community?

A Yeah. Economic community. Uniformly the --

Q Oh the economic community. I'm sorry.

A Yes. The U.S. government uses the methodology routines whether it's the EPA or the Federal Highway Administration, or the Federal Aviation Administration. In fact it's a -- it's mandated by law that all government

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agencies that spend money or cause money to be spent to reduce the rate of death have to analyze what does it cost for each life saved.

So we've got over the last 30 years since the law was first signed in -- by Jimmy Carter and then renewed by every president since Jimmy Carter, we have an analysis by every government agency that administers regulations that result in life saving, they must measure and submit to Congress -- actually submit to the Office of Management of the Budget which then reports to Congress each year the costs of the various different rules and regulations -- the cost per life saved. So we have over the course of years dozens and dozens and dozens of such reports analyzing the cost of life saving.

But those aren't the academic studies that I rely on. I rely on academic studies on what you and I and we -- not what Congress or the government does -- what we do. It turns out what we as individuals spend on life saving is a very similar range, the $5/$6,000,000 range. Very similar to what the average cost of life saving is within the U.S. government.

Q Not only is it endorsed by the government, but it's accepted by those in the economic -- economics?

A Yes. And also in industry. It's the standard approach in U.S. industry in making products safer and how

much to spend on safety design of products.

Q Is it peer reviewed?

A It's the -- it is not only peer reviewed, it's the only methodology that's been accepted to any degree for the last 40 years.

Q Now how are all of these published works regarding the value of life relevant to determining the economic consequences of the injury to Mr. Simao?

A Well we start for any -- in any case we start with what's the value of a statistical life. So while 5.5 million is the average value. I believe that the literature shows for the value of a statistical life, for the purposes of my work in a forensic setting, I reduce that by about 25 percent. And use as an estimate of the value of an average life about 4.1 million.

I do that because we understand that no research is perfect. So if we want to be conservative I apply a conservative factor and use 4.1 million instead of 5.5 million.

So if we know or assume 4.1 million is a value of a statistical life, if someone -- what is that life? That life is of someone who on average in this country is about 32/33 years old with 45 years left to live. So our starting point is that we know that the value of a statistically average person of that 45 future years is about 4.1 million.

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Q And so you use -- 5.4 million or 5.5 million is what's generally accepted in the economic community. But you use a lesser one so that your numbers are as conservative as possible?

A To make sure that if there is any measurement error I'm on the more conservative side of those errors. So that we can safely say that it -- that these values are at least that high, if not higher.

Q And this methodology, this concept, it's been generally accepted within the scientific community?

A More than generally accepted, it's the universally accepted --

Q Is your opinion regarding reducing in value of life based more on particularized facts rather than assumption, conjecture, or generalizations?

A Yes.

Q Is it based upon the results of a technique, experiment, or calculation?

A It's based on literally dozens and dozens of what you might call sophisticated economic measurements or techniques. Yes.

Q And what are -- what known standards were your calculations controlled by?

A Well the general standards in the field of economics that including having statistical confidence levels of 95

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percent is the standard for peer review publication.

Q And has that been well researched?

A Extensively researched. It's a very broad body of economic literature.

Q Is there a potential error rate?

A Well as we -- as I said earlier we look -- the standard for economic literature is a 95 percent confidence interval. Which means that the chance of error we say is one chance in 20, or a five percent error rate. That's pretty much the standard in all social science, economics, sociology, psychology, etcetera.

Q Now this methodology did you develop it just for the purposes of this particular case?

A No.

Q Is it a method that you and other economists have been using for years?

A Over -- well over 20 years. Yes.

Q And not just in litigation?

A Correct.

Q Are your opinions limited to matters within the scope of your knowledge and expertise as an economist?

A Yes.

Q Has this methodology been found to assist juries in determining damages for a person's loss of enjoyment of life?

A Hundreds of times. Yes.

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Q Has it been accepted in courts in Nevada and throughout the United States?

A By now over one third of the U.S. -- one third -- I'm sorry, over two thirds of the states or two thirds of the Federal geographic circuits.

Q Have you offered testimony in the state of Nevada and throughout the United States specifically employing this methodology?

A Yes.

Q Approximately how many times have you testified regarding the value of life?

A Like I said in over two thirds of states over -- well right around 200 times.

Q And does that include the loss in society and family relationships?

A Many times that's an aspect of the testimony. Yes.

Q Have you been admitted to testify in Nevada Courts before as an expert economist?

A I think probably over a dozen times by now.

Q All right.

MR. WALL: Your Honor, at this time I would offer Dr. Smith as an expert in the field of economics.

THE COURT: Any objection?

MR. ROGERS: Yes, Your Honor. Can we approach?

THE COURT: Yes.

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[Bench Conference Begins]

MR. ROGERS: I'm glad I finally got up here. Your Honor, the fact is I'm not disputing his qualifications, but it's the foundation. He hasn't actually spoken what the Plaintiffs -- he doesn't know what they personally feel their value of lost life is. Under Banks versus Sunrise Hospital, I think that there is a foundation that this witness can't meet. IE actually speaking to the individuals involved and getting their understanding. So I would object to this witness on foundational grounds. And I would say, either allow me the opportunity now to voir dire him regarding his actual knowledge of the Plaintiff, but that's what I would --

MR. EGLET: Well that's --

MR. WALL: He's already testified [indiscernible].

MR. EGLET: Yeah. He testified that he reviewed them and this is disqualifications portion on the economist. We've offered him as an [indiscernible] economist. That is just cross examination.

THE COURT: Did you say you hadn't interviewed --

MR. ROGERS: I have the depositions of William Simao that says that he's never spoken with Stan Smith, and never spoken with Stan Smith and never spoken with anybody from his office. So yes, I do offer that --

MR. EGLET: Well this witness just testified that he has spoken with him, so you know the foundation is made through

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this witness.

THE COURT: I'll [indiscernible] for cross-examination.

[Bench Conference Ends]

MR. WALL: Your Honor, again we offer Dr. Smith.

THE COURT: So ordered. Motion is granted.

MR. WALL: Thank you very much.

BY MR. WALL:

Q All right, Doctor, what major facts were used by you to produce loss estimates regarding William and Cheryl Simao?

A Well, a significant amount of information in the interview regarding the impact of the injury on Mr. Simao, and then the impact on the relationship experienced by Mrs. Simao. You also provided us information from the trial testimony regarding certain costs of the spinal-cord simulator, and also regarding surgery based on Dr. Wang's testimony.

Q What assumptions did you use, if any?

A Well, I think the broadest assumption I used with regard to the loss of enjoyment of life, as well as the loss of society or relationship is that each of -- Mr. Simao and Mrs. Simao could be regarded as average and normal individuals from the point of view of the ability to experience a quality of life or enjoy the quality of life.

So that I did not see from the interview or from any of the depositions, or any of the information that one would regard them as people who are outside the broad range of

normal.

I think a couple of examples of outside the broad range of normal could be, for example, I've worked for people who were incarcerated and then also injured, and experienced loss of enjoyment of life. So you couldn't say that someone who's spending a long time in jail would have the ability to experience the normal enjoyment of life.

You could also have someone who may have had some pre-existing severe mental difficulties of some sort. They may not be able to experience a loss of enjoyment of life even -- and then -- and if they are injured they may not have been what you might consider to be a normal or a standard prior to that injury.

So I did not see anything that led me to think that we couldn't apply the 4.1 million or that average figure, you know, for each of Mr. And Mrs. Simao. So that's I think the primary assumption.

Q Is it common to use those types of assumptions?

A Yes, when there's the absence of what I would consider to be major significant circumstances, which sometimes -- rarely there are, but sometimes we come across people who are not in the broad range of normal.

Q Doctor, based on all the methods and calculation -- methods of calculation that you've talked about today, did you form opinions to a reasonable degree of economic probability

as to the economic consequences of Mr. Simao's injuries?

A Yes.

Q Are you familiar with the exhibit, Exhibit 1 that's already been admitted in this case as to the past medical expenses by Mr. Simao?

MR. WALL: May I approach, Your Honor?

THE COURT: Yes.

THE WITNESS: Yes, I have reviewed these.

BY MR. WALL:

Q All right. You didn't have to do any calculations for those. They were just added up; is that right?

A Correct.

Q And what is that amount?

A That amount is 194,000 --

Q One-hundred and ninety-four thousand.

A -- 380 dollars.

Q All right. Is it also common in forensic economics to have to be advised of numbers -- strike that.

Is it common in forensic economics to calculate numbers based on actual testimony at trial?

A Yes.

Q And have you been kept abreast of certain testimony in this case?

A Yes.

Q Have you had the opportunity to review certain

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exhibits admitted into evidence during the testimony by Dr. Patrick McNulty, an orthopedic spine surgeon?

A Yes.

MR. MICHALEK: Objection, Your Honor. We just renew our objection.

THE COURT: Noted for the record.

BY MR. WALL:

Q Do you understand and have you had a chance to review actually a transcript of testimony of Dr. McNulty to outline the costs associated with a spinal-cord stimulator for Mr. Simao as part of his future medical treatment?

A Yes. I have the transcript from March 23rd.

Q And were you able to take the numbers that were actually generated and testified to by Dr. McNulty, and use them as part of a formulation using your expertise in economics of certain costs of those stimulator [sic]?

A Yes.

Q How did you do that?

A So we analyze medical costs by looking at what does the item cost, how long will the item last. Some things need to be -- some procedures need to be redone. Some things need to be redone every several years. So we look at the repetitive nature of those over the course of time.

Depending upon what the item is, it will have a slightly different growth rate. So for example, when we

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looked at the issue of -- look at the earlier report. So we have several costs for this stimulator. I think there's a total of six different costs.

We have different -- we have the annual cost of the stimulator, and then the trial stimulator, the stimulator, and then some replacement every five years, and some leads, and some follow-up visits, and things like that. So these items grow.

Q What do you mean they grow?

A The costs of these items in the future we expect will grow roughly equal to what the costs of what medical services have grown in the last 20 years. So I use the last 20-years' average, which has been --

Q When you're projecting a cost that may occur in the future, what do you have to do to tell us how much money today needs to be set aside to cover that cost, medical cost in the future?

A So there's two things.

We look at how the price of that item may increase over the cost -- or course of time. And medical services have increased at approximately two percent, 2.2 actually above inflation for the last 20 years.

Candidly, most economics are predicting that things will actually -- that the costs won't be lower, that growth rates won't be lower in the future, higher in the future. I'm

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assuming that they will be the same as they would be over the last 20 years.

Q So if I need a procedure done that right now costs $100,000, and I need it done ten years from now, you can project through the use of widely accepted statistics what that cost might be in ten years for that procedure?

A Yes. I would grow that 2.2 percent plus whatever inflation forecast we would need. But in this case we don't specifically need an inflation forecast for ordinary inflation.

Q But you don't stop there.

A Right. We don't stop there. Because if we just added up all those future dollars we'd be estimating way too much money.

Q Because?

A Money in the future is not worth as much as money today. So if you told me, "Well, somebody is supposed to get $10,000 next year," you only need say $9,800 today to invest in a safe government treasury bill that can grow to be that 10,000 next year.

So next year's money is worth less today. Money two years from now is worth -- you know -- is worth even less than money one year from now.

Q Is that what we mean by the present value of these expenses?

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A Right. So those future expenses are discounted or reduced by subtracting the amount of interest that could be earned each year. So if you know what amounts of money you need in the future, you can estimate what amount you need today that you can invest and have it grow with interest so that each future year you can take out what you need to pay, and still have the rest invested.

And so by the end of the course of however many years you need the money for, then there would be nothing left at the end.

Q All right. So if I know now that I need a procedure in ten years that costs $100,000 now, you have to do two things. You have to figure out in ten years what that procedure is going to cost.

A Yes.

Q And then once you figure that out, you have to figure out how much money I have to set aside now basically and invest it at normal growth rates so that I'll have that much money in ten years when I need that procedure.

A That's exactly those two steps, yes.

Q All right. And did you do that for each of the different things that Dr. McNulty testified were going to be necessary with respect to the spinal-cord stimulator?

A Yes.

Q And they had different rates at which they would

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become necessary. So you had to do all the different calculations?

A Right. Because some things aren't needed now, and then there's a replacement on average every five years of the stimulator, the leads every roughly two years, follow-ups roughly every, let me see --

Q Follow-up visits twice a year?

A Follow-up visits twice a year, yes, et cetera.

Q All right. When you took all of that into consideration, were you able to determine what a present value would be to cover the spinal-cord stimulator and the other concomitant things that Dr. McNulty said would go along with that?

A I did, after determining, you know, that these things would be needed until the year 2042.

Q How did you figure 2042?

A Simply I believe what you or Dr. McNulty indicated would be the eventual long-term needs.

Q And the reason you chose 2042, is that based on the government's statistics showing the life expectancy of Mr. Simao?

A Well, that's when he would turn 76. So his actual life expectancy is a few years longer than that. We were advised -- I can't tell you exactly why. We were advised to take the costs out to 2042.

Q All right. That's about 31 years from now?

A Yes.

Q All right. So what is that -- well, here's the actual life-expectancy chart. If you look to your right there's a screen there that shows that a white male who is currently 47 years old would live an average of 31.6 more years. Do you see that to your right on the screen?

A Correct.

Q And that takes us to 2042?

A Yes.

Q So what is the present value of Mr. Simao's future life care based on the stimulator and the other things that are necessary to go along with it, as testified to by Dr. McNulty?

A So the total cost -- and by the way, what I earlier said about life expectancy, I was looking at Mrs. Simao's life expectancy, yes.

Q Do women live longer?

A Women -- she's I think perhaps even born a few years later. But yes, her life expectancy is longer. So I was just looking at the wrong number. His life expectancy is to 2042.

And if we -- so if we take those six items, and we grown them into the future, and then discount them assuming an interest rate based on U.S. treasury bills, the cost of those six items, the amount of money we need today to pay for all

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those future costs is 2,608,889.

Q That's how many 2011 dollars we need to cover those future medical needs for Mr. Simao in the future?

A Right. So if you take that amount of money and invest it in a safe U.S. treasury bill, and then every year you take out the things that were prescribed by Mr. McNulty [sic], I mean obviously the first year you need the stimulator, and then the permanent replacement stimulator, and then every five years the additional replacements, lead revisions, follow-ups of various sorts, and pay for those at each point in time in which Mr. McNulty [sic] indicated these things need to be paid for, then at the end of 2042 when Mr. Simao is at his statistically average life expectancy, that fund will then have been depleted if medical services continue to grow at 2.2 percent above inflation, and if we can earn about 1.6 percent above inflation in U.S. treasury bills.

Q And this is all within the -- using a method accepted within the economic community?

A It's a very standard -- it's really about pretty much the only approach there is.

Q Similarly, have you had the opportunity to review a transcript or an exhibit admitted into evidence during the testimony of Dr. Jeffrey Wang regarding the cost of a future fusion surgery for Mr. Simao as part of his future medical treatment?

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A Yes.

MR. MICHALEK: Same objection, Your Honor.

THE COURT: Noted for the record.

THE WITNESS: Yes, I did.

BY MR. WALL:

Q And in fact you reviewed the transcript or the exhibit?

A The exhibit I believe, yes.

Q All right. And did you go through the same process to determine what -- well, let me ask this.

Well, did you use the same process that you used for the stimulator and all the things that go along with it?

A Yes.

Q And when did you factor in -- what time period did you factor in for the necessity of the future fusion surgery?

A Twenty years from 2009, which would make it 2029.

Q Twenty years from the date of the surgery?

A Yes.

Q The initial surgery?

A About 18 years from now.

Q And you used the same methodology?

A Same growth and discounting, yes.

Q I think Dr. Wang indicated that the costs that he indicated was reasonable was somewhere in the area of $67,000?

A The figure I was told is 64,527.

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In the Supreme Court of Nevada

Case Nos. 58504, 59208 and 59423

JENNY RISH,

Appellant,

vs.

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

Respondents.

APPEAL

from the Eighth Judicial District Court, Clark County
The Honorable JESSIE WALSH, District Judge
District Court Case No. A539455

APPELLANT'S APPENDIX
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TABLE OF CONTENTS TO APPENDIX

MR. EGLET: No.

MR. ROGERS: That takes into consideration everything, the MRIs, the diagnoses, the surgery, the discogram. He's reviewed it all, and he's already made a record of that. It is -- so his opinion is limited to the injury that the Plaintiff is claiming.

MR. EGLET: He didn't preface the question that way. He did not preface the question that way. He's claiming he prefaced the question that -- is it could be Plaintiffs have had internal disc disruption without destroying all the structures surrounding the disc, because that's what he's talking about. That's what Dr. Fish. He says oh, yeah, it would have had to destroy all the structures surrounding the disc. Well, it's a spectrum. If you're on the high end of the spectrum, yeah, that may be the case. But now when you're down here where we are, where it's simply internal disc disruption and a tear.

And so, it's way overbroad, Judge. It's the same thing. It's the same thing.

THE COURT: You know, here's the thing. I think it's just such an odd analogy that Fish gave [indiscernible] the way you posed it to this witness. But in any event, the Court sustains the objection.

MR. ROGERS: Okay.

[Bench Conference Ends]

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BY MR. ROGERS:

Q Now. Doctor, you have reviewed all of the records from Drs. Grover, Rosler, and McNulty, correct?

A Yes.

Q And you have reviewed all of the MRIs and CT scans?

A Yes.

Q Including the post discogram CT?

A Yes.

Q All right. And after viewing all of the diagnostic studies and all of the records provided by the treating providers, do you have an understanding of what it was those treating providers diagnosed the Plaintiff with?

A I believe they felt that the discs were injured at C3/4 and C4/5.

Q Okay. And it is those diagnoses that I want to explore in this line of questioning. If a patient sustains an injury resulting in those diagnoses, from a traumatic force, is the typical presentation that they simply stopped treating the day after that trauma?

MR. EGLET: Same objection, Your Honor.

THE COURT: Sustained.

BY MR. ROGERS:

Q When you teach at the medical school, you teach residents and fellows there. Do you even discuss with them the incidents of traumatic injury to the cervical spine?

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A Sure.

Q And have you ever taught your fellows and residents about how a traumatic spine injury presents?

A All the time. Our residents and fellows cover the emergency room, and they see spine trauma all the time. So we're constantly lecturing them.

Q Okay. In reviewing the diagnostic studies in this case, did you see evidence of a traumatic injury to the cervical spine?

A I saw no radiographic evidence of any injury to the cervical spine.

Q Okay. If you would, I want you to come down and take a look at a couple of the films that were taken following the incident. And let's discuss with the jury what it is those films show. All right. Just walk on up.

A Do you have a pointer or something.

Q I have a makeshift one.

A I'll use it. So this is an x-ray taken of the cervical spine, which is the neck. The date is 4/15/05, which is the date of the incident. And this is looking at the neck from the side. And essentially, I see no evidence of any trauma. We look for the alignment of the bones. We look for any subluxations. Often times, we can --

Q Doctor, what is a subluxation?

A That's where the bone can slip backwards or

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forwards, sort of a malalignment. We obviously can see the bones on the x-ray. So if there's a fracture, we hope that we can pick it up. Even if the bones look normal, there are sometimes where the soft tissues are injured, and we look at the soft tissue lines. And this line here is the soft tissue line. It's darker here, because that's sort of the windpipe. That's where you sort of swallow and you breathe through. So that's why it's darker. It's air. But this is the soft tissue line which represents the soft tissues in front of the spine. This is anteriorly. This is posteriorly, because, obviously, this is -- these are the teeth here, and that's the chin.

In particular, when you're looking at the upper cervical spine, there is not much room. What that means is that normally the soft tissue is -- the line is right close to the vertebral bodies, whereas down lower in the spine you can see the disc space is much greater. So typically, we see more room here. Here, in the upper cervical spine -- this is C3/4 and this is 4/5 -- you can see that there's not much of a soft tissue window there.

Can you go to the next slide?

This is an example of an expanded soft tissue window. There's not an obvious fracture on this patient, but you can see these arrows denote the soft tissue swelling here. So from here to here --

MR. EGLET: Your Honor, may we have that taken down? May we approach, Your Honor?

THE COURT: Sure.

Witness might want to step back to the stand. You might be more comfortable, sir.

[Bench Conference Begins]

MR. EGLET: They're showing an x-ray of somebody that's not our client on the right.

THE COURT: Is that right?

MR. EGLET: It's never been produced, never been displayed [indiscernible]. It's never been identified, never showed to us, ever.

MR. ROGERS: The Plaintiff has shown demonstratives throughout the trial that have never been disclosed to the defense.

MR. EGLET: We have not shown an x-ray or an MRI of a patient who is not even in this case.

THE COURT: Well, you're supposed to [indiscernible]. The implication is that it's the Plaintiff's x-ray, but that's not the Plaintiff's.

MR. EGLET: That's not the Plaintiff's x-ray.

MR. ROGERS: He didn't imply that. In fact, he said this is of a different patient.

MR. EGLET: He's trying to show an x-ray of somebody, some other patient, who allegedly had -- I don't know if he's

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claiming this person had soft tissues injuries and try to say see, compare. Here's somebody with soft tissue injuries in their x-ray. We never seen this. We never had our experts be able to review this. This -- you can't do that.

MR. ROGERS: A perfect example of something that the Plaintiff has done in this case that's exactly like this is the Defendant requested fluoroscopy and a CT scan of the discogram CT, and the Plaintiff never produced it. We requested it in the subpoena to Dr. Rosler's office as well and never got it. Dr. Rosler, however, came to court and had it. There are documents that have been shown to this jury by the Plaintiff that have not been disclosed to the defense.

MR. EGLET: That was part of his medical report. We didn't --

MR. ROGERS: It should have been part of his medical report. It was not.

MR. EGLET: That was part of Dr. Rosler's medical report. We didn't have it. He had it here with him in trial and pulled it out, and they didn't object. Okay. There's no objection.

MR. ROGERS: They got it marked in as an exhibit.

MR. EGLET: They could have marked it as an exhibit if they wanted to, but they --

MR. ROGERS: Throughout trial this is going on though. The spinal cord [indiscernible].

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MR. EGLET: They were of the Plaintiff.

MR. ROGERS: There was never any disclosure on that either. And they have the films.

THE COURT: You've already made a --

MR. EGLET: We actually have a further record to make on that, because I want to -- remind me. I want to put in there the report of Dr. Fish, who specifically addressed the spinal cord stimulator and said our client didn't need one. So they were clearly on notice. It's in his reports. And that's just -- but that's an issue that has nothing to do with this. They're showing an actual x-ray --

THE COURT: Uh-huh.

MR. EGLET: -- of somebody who is not the Plaintiff in this case and somebody I guess who allegedly had some type of soft tissue injuries to try to say see, here's a person who had real injuries and this is what their x-ray will look like. Nobody is claiming he fractured anything in here. So this is just unbelievable.

MR. WALL: Everything we've shown has been of our client.

MR. EGLET: Yeah.

THE COURT: Everything -- what?

MR. EGLET: Everything we've shown has been of our client not somebody who --

THE COURT: I understand.

MR. EGLET: -- we don't even know who it is .

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THE COURT: I just want the record to reflect that this is the first time I'm hearing you [indiscernible] large complaint about something that occurred with Dr. McNulty's testimony. I didn't know you had any objection to any evidence that was reviewed during the course of his testimony. I think the record should be clear on that. I'm hearing this for the first time. The Court sustains this objection.

MR. EGLET: Will the jury be admonished that they were to disregard his testimony during that x-ray and ignore that x-ray?

MR. ROGERS: Then the defense does intend, however, to show an animation at this point.

MR. EGLET: I have not seen this animation.

MR. ROGERS: I hadn't seen any of the Plaintiff's either, and particularly, again, relating back to --

MR. EGLET: We weren't doing it -- we didn't present any evidence in animations. Those were in opening statement. If you're going to present this as evidence, it has to be an exhibit that's been marked and we have to have seen it. And it's not.

THE COURT: Will you -- before you did your opening there was some discussion of the animation. You or Mr. Wall was the one who did it.

MR. EGLET: Yeah.

THE COURT: Was that provided to Mr. Rogers before trial?

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MR. EGLET: Yes.

MR. ROGERS: No.

MR. EGLET: He had the opportunity to review the animations. He was told what they were. And they never asked to review the animations. We never were even told about this animation. And that's in opening statement. That's not evidence. This is evidence they're producing.

MR. ROGERS: This is not evidence. It's a demonstrative. It's just testimony. He's just showing --

MR. EGLET: He's using the evidence in his testimony. It's evidence, Judge.

THE COURT: Let's take a 10-minute break.

[Bench Conference Ends]

THE COURT: Ladies and gentlemen of the jury, I'm going to ask you to disregard what you just saw on the screen and any testimony related to what you just saw on the screen, and instruct you to disregard it. We're going to take about a 10-minute break for the members of the jury while counsel and I discuss a few things.

Reminding you of your obligation not to discuss this case, not to form or express any opinion, not to do any research on any subject connected with this case.

[Jury Out]

[Outside the Presence of the Jury]

THE COURT: Okay. We're on the record outside the

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presence of the jury. I was just curious about this --

MR. EGLET: Can we have the doctor dismissed from the stand while we argue this, Your Honor?

THE COURT: Oh, Dr. Wang, would you please wait in the hallway.

[Pause]

THE COURT: My sense is that jurors are getting a little impatient. What about this animation?

MR. ROGERS: I could show it right now and the Plaintiff can decide whether they still object. I could have him draw it as well. It would simply take a little longer. But either way, it's just a visualization of the testimony he's going to give them about his opinions in this case.

THE COURT: Let's see it.

MR. ROGERS: Sure.

[Counsel Confer]

THE COURT: How long does it take to watch it?

MR. ROGERS: It's not a moving animation. It's a still image.

MR. HENRIOD: Just -- you know, it's a model.

THE COURT: That's not an animation, is it?

MR. ROGERS: I may -- that may not be the right word, but --

MR. HENRIOD: There's 12 slides. Should I go?

MR. ROGERS: Yes.

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You have that on your monitor?

THE COURT: Yes.

MR. ROGERS: Okay.

MR. EGLET: That's -- the last one was just what we objected --

MR. ROGERS: Right.

MR. EGLET: -- right? That's --

MR. ROGERS: Yes. We're not to the animation yet.

MR. EGLET: Okay.

MR. ROGERS: These are still images of --

MR. EGLET: All right.

MR. ROGERS: -- diagnostic studies which he was going to discuss with the jury, injuries that he has seen to the cervical spine. This is the animation or drawing that he would show. And these are additional films. So the only drawing was the one you just saw. The others are films.

Yeah. And then there's some -- I think the other films are from the Plaintiff's MRI. Yes, this is the Plaintiff's first cervical MRI.

MR. EGLET: This is our client, right?

MR. ROGERS: Yes.

MR. EGLET: Okay. Is that it?

MR. ROGERS: Yes.

MR. EGLET: Okay. So the MRI imaging is fine. Everybody has used that. But here's the thing is that under Rule

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16.1(a)(2), disclosure of expert testimony, (a)(2)(b), it specifically provides that the report shall contain a complete statement of all opinions to be expressed and the basis and reasons there, the data or other information considered by the witness in forming the opinions, any exhibits to be used as a summary of or support for the opinions. This animation -- well, the still slides of -- he's showing, they've never been produced. This is the first time we've ever seen them. And one of them, I'm not even sure what it shows. It looks like he's trying to show some tear of a --

Could you put that back up, that --

It looks like -- yeah, it looks like it's showing a tear -- well, yeah, this shows a tear of the --

MR. WALL: Cord.

MR. EGLET: Yeah, this shows a tear of all the muscles and stuff behind the -- at the point of the spine is [indiscernible], a full thickness tear into the middle of the disc. It shows all kinds of things that have nothing to do with this case, because that didn't occur here. This image -- and I think there was a couple of them. This image clearly falls under the province of 16.1, where it would -- any exhibits to be used a summary of or support for the opinions. This was never produced, never even identified at any point by the defense. And so, this is clearly a violation of 16.1. And it's not relevant, because none of these type of injuries

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happened here. What they're showing here is complete full thickness tears of all the tendons, the ligaments, the muscles, the tearing down of the house to get to the coffee table, in the back of this spine picture here, portions of the spine picture, as well as a tear from the outside of the disc in all the way into the middle of the disc, which is not anything of what happened here. These were annular tears. That's not an annular tear. That's like somebody's spine being ripped apart. You do that to somebody's spine, you're also going to rip their cord and turn them into a paraplegic and or a quadri- -- well, at this level in the cervical spine they're going to be quadded. This is a quadriplegic type injury, Your Honor.

THE COURT: Mr. Rogers.

MR. ROGERS: Well, this is an anatomy lesson. Every single expert who's gotten up here has used models, has discussed things with the jury, and all relating to the anatomy to put this case into context. Do those models precisely resemble the Plaintiff's neck and back? No, they don't. If the doctor needs to draw it, so be it. But it'll be much faster and we'll get through it soon, get to their cross-exam sooner if this can come in.

MR. EGLET: Well, I'm not worried about getting to my cross-exam sooner right now. I'm worried about this witness and this attorney, again, violating the rules, which is what's

going on here. We showed them all our models at the 2.67. We identified everything in our 16.1 productions of all demonstrative exhibits that would be used in this case. Nothing has been a surprise to them. This is a complete surprise. And what this is for is trying to make up for that ridiculous testimony that Dr. Fish gave that -- about comparing a house and a coffee table to your disc and the outside structure, that you have to knock down all the walls to get to your disc, and they're trying to somehow, you know, support that testimony with what is -- clearly has nothing to do with the injuries in this case. But the simple fact of the matter is under 16.1, they've got to provide this, identify it at a minimum and provide it, show it to us. They never have. And this has no representation of anything close to what happened in this case, Your Honor.

THE COURT: Sustain the objection. Of course, the Plaintiff's MRI slides are fair game, Mr. Rogers.

MR. EGLET: And one other thing, Your Honor, while we're off the record. Where's that report?

MR. ROGERS: Well, let me a record though.

THE COURT: Off the record or on the record?

MR. EGLET: I mean on the record. One other thing on the record is Mister --

Excuse me, Steven.

Mr. Rogers brought this up. And I want to point out

that in Dr. Fish's addendum number five to his report, dated February 9th, 2011, he specifically addresses the issue of a spinal cord stimulator. He calls it a dorsal column stimulator, but it is the same thing. On the last page, second to the last paragraph, paragraph number 9, he says there's no indication that based upon the motor vehicle accident a dorsal column stimulator is needed in this case.

So, clearly, they were on notice. In fact, they had their witness -- their expert witness addressed that very issue in one of his supplemental reports. And I'd like to file this as a court's exhibit.

MR. ROGERS: I'll make a record to that.

THE COURT: So ordered.

MR. ROGERS: The point of it was that suggestion was made in a nurse's life care plan, and there was no medical foundation for it. A motion on that issue was brought to the Court. Your Honor said that the nurse will not be allowed to testify that unless proper foundation is laid, which meant that a doctor must opine that a future procedure like a spinal cord stimulator is necessary.

That doctor's evidence didn't come in until the middle of trial, although the Plaintiff clearly came prepared with Power Point presentation and with a script for Dr. McNulty to testify about it. Never once disclosed the spinal cord stimulator to the defense. That report that the

Plaintiff just submitted was in response to the nurse's report. So the spinal cord stimulator wasn't an issue until Dr. McNulty took the stand in a very scripted and prepared way with no disclosure.

One more point. The Plaintiff never produced the demonstratives that they showed to the jury in the opening statement. Never. They say they did. They did not. I never saw them once. So there's absolutely no unfairness going on here. If they don't want that exhibit up, then I will ask Dr. McNult- -- or pardon me -- Dr. Wang to either draw one or to describe it verbally to them. Let's go on.

THE COURT: Mr. Adams.

MR. ADAMS: I would just -- two things, Your Honor. First, with regard to the spinal cord stimulator, we've already argued this, but I'd just like to point out just so we have a complete record. The defense took the deposition of Dr. Siegel [phonetic]. The spinal cord stimulator was discussed at length at Dr. Siegel's deposition. He clearly talked about what he needed to be able to form a future treatment plan, one of which was this diagnostic procedure. If the Plaintiff received a positive result from this upcoming diagnostic procedure, then there was a wide range of modalities, including a spinal cord stimulator or a morphine pump, that would be available for the Plaintiff.

Dr. Siegel goes on to provide that diagnostic

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treatment. Plaintiff does have a positive result. He's then sent over to a spine surgeon, Dr. Lee. And just last month, in February, Dr. Lee says there's no surgical indication but pain management. As been the testimony in this case, spinal cord stimulator is a pain management device. They need to look only through the medical records and the deposition of Dr. Siegel that was taken August 20th, I believe, 2010. And they've had the opportunity -- oh, by the way, Dr. Fish did review Dr. Siegel's deposition. He testified -- Dr. Fish testified to that under oath at his deposition. So at least Dr. Fish was prepared for the spinal cord stimulator. Perhaps the defense wasn't, but their expert was. That's number one.

Number two, at the 2.67, and I can pull the transcript if you want it, Your Honor, we did discuss the exhibits, the animations that we were going to show to the jury. Mr. Rogers didn't seem to have a problem with that. In fact, I had all my models, everything that you've seen in court, the spine, the sob legs [phonetic], the two little discs that we've been taking out, the witness has been using, they were all there for him to see. He didn't seem to have a problem. We had all the demonstratives as we do. And you can check with the clerk. It's inside of our exhibit book. We've listed all the demonstratives we plan on using both in opening and throughout this trial. Again, got the transcript. Mr. Rogers didn't seem to have a problem with it.

So they were available for him, Your Honor, and he's seen all the models. So --

MR. ROGERS: Available to me in the same sense that the spinal cord stimulator was. If I connect invisible dots, yes, it's available to me. Were they handed to me? No. Was there a medical record that said the Plaintiff is going to require a future spinal cord stimulator? No. There were suggestions. There were illusions to it. Never once did a doctor mention it. The Plaintiff knew it was coming but never noticed the defense. And that seems to be a pattern that's going on here. But I don't want to waste all day rehashing something we've already argued. Dr. Wang is in from out of town. He cannot come back. Let's finish this direct and let them get onto their cross, and we can argue about this stuff later on.

THE COURT: Okay. You've made your record.

[Recess]

[Within the Presence of the Jury]

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

MR. ROGERS: Yes, Your Honor.

MR. EGLET: Yes, Your Honor.

THE COURT: Very well. Mr. Rogers -- wait just a moment. Wait just a moment, please.

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

MR. ROGERS: Thank you.

DIRECT EXAMINATION CONTINUED

BY MR. ROGERS:

Q Okay. Doctor, let's turn to the MRI films. And if you would come down and explain to the jury what it is that you can see on these films.

A Well, this appears to be what we call a sagittal MRI of the cervical spine, which is the neck, meaning it's kind of taken sort of in the midline of the patient's neck. This is dated March 22nd, 2006, so I believe that this is the first MRI that was obtained following the accident.

What we typically look for are signs of trauma. These are the square shaped bones in the neck here and these things between the bones are typically called the discs. And I believe those are the things that are at issue here. Typically when we see traumatic disruption of the discs, what we can see is increased -- sort of a tear through the disc, the disc usually stands out, it's usually brighter, in the sense that when you have a tear there's a little bit of bleeding and that fluid in there registers as being brighter. So what you can see here is that this is the C-3/4 disc, this is C-4/5. And when I look at these two discs, I really don't see much of a difference between the discs throughout the rest of the spine. So when I stand back and look at this, I really don't see any evidence of a traumatic injury to the disc here at C-3/4, C-4/5.

In addition, it's important to understand the surrounding elements around the spine. The disc itself is in the center and there's all these structures around it. What I typically use as an analogy when I teach my residents and fellows is that you typically don't see an isolated injury of the disc without some type of injury to some other structure.

And what I usually use as an example is if you have sort of a pretzel. If you have a pretzel that's circular -- not the stick pretzel, but a circular pretzel, next time you have one try to break it one place. You can't do it without breaking it another place. That's just the way the pretzel is and I kind of use that to illustrate that to -- when I'm doing teaching that when you see an injury in one place, you have to look for an injury at the other time -- at another spot, because somehow it has to get in there.

Now, there is an anterior longitudinal ligament, which is a ligament that runs along the anterior part of the spine. There's a posterior longitudinal ligament, which runs along the posterior aspect of the spine. There are also interspinous ligaments, these are the bones that are connected to the bones here and there are interspinous ligaments that connect these bones.

MR. EGLET: May we approach, Your Honor?

THE COURT: Yes.

[Begin Bench Conference]

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MR. EGLET: See, what this witness is doing -- they obviously talked to him during the break -- is he's getting that testimony in what I objected to without Mr. Rogers asking him the question. He's going into well, you have to have all these structures torn up before you can have injury to the disc. My objection was that the question was broad, vague, overbroad, over -- vague, ambiguous. He doesn't isolate the situation here and he's saying typically, which is talking about other patients.

So basically what they've done now is they've circumvented the Court's order. You sustained the objection, talked to him in the hallway during the break, and so he's coming up and just giving this testimony when there's no question pending and he's circumventing the Court's order, where you sustained the objection to this very testimony, Judge.

MR. ROGERS: The objection was as to the diagram and to the unrelated x-rays. It wasn't to the testimony. His testimony always has been that, in his opinion, there was no traumatic injury to these discs.

MR. EGLET: I'm not talking --

MR. ROGERS: That's nothing new.

MR. EGLET: I'm not talk --

MR. ROGERS: That was disclosed in deposition and in reports. There's no order on that question.

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MR. EGLET: I'm not talking about -- he has a short memory. I'm not talking about anything we argued outside the presence with the diagram that had never been disclosed. I'm talking about the previous objections that were made up here that were sustained, that the witness is precluded from going into and now they're just circumventing the Court's order by not actually asking a question and having him come up in front of the jury and give that testimony. Typically this, typically that and it has nothing to do with this case or the specific injuries in this case. I would object and I would ask his testimony be stricken.

MR. ROGERS: There's been complete disclosure on the issue that he's discussing right now and he is speaking specifically of the Plaintiff's condition.

MR. EGLET: No, he's not. He's saying typically, typically you see this, typically you see that. He said -- you'll notice, I didn't come up here when he's saying -- when he was saying I didn't see any injury to the disc, when he said that testimony and he was pointing to the slide. When I came up and objected was when he starts talking about the other structures around the disc, the ligaments and muscles, which he's going into right now. That's what he's going into, that's what you sustained the objection on.

They're circumventing this Court's order by not asking him questions. It is so painfully obvious what they're

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doing, it's incredible. I mean, I don't know how many times we have to go through these violation of pretrial orders and now violating the Court's orders on sustaining objections. How much longer is that going on?

MR. ROGERS: [Indiscernible], Your Honor. Is it that the question is it vague or it calls for a narrative?

THE COURT: There's two things. One, he's testifying in the narrative without a particular question being posed. And two, he's testifying generally rather than specifically as to this Plaintiff. So sustain the objection on both of those grounds.

MR. EGLET: And I'd ask that the jury be admonished to disregard his last testimony.

MR. ROGERS: I mean, I --

MR. EGLET: Regarding what typically occurs.

MR. ROGERS: Your Honor, every witness who has gotten on the stand has talked in terms of typical. For example, to say that this surgery is generally 85 to 90 percent successful, what does that have to do with the Plaintiff when it wasn't successful? We're talking in typicals or generalities. Every doctor, I can go on with examples of this, is talking about this is how this condition presents, this is how this treatment is generally done. This is no different from what all the treatment providers have testified to.

MR. EGLET: Again, he's comparing apples to oranges. The

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85 percent to 90 percent success rate was in direct response to their two experts opinions in this case, that if the C-3/4, C-4/5 disc would have been -- were injured in this case, then when he had the surgery his pain should have gone away. And so those were in response to the fact that well, yeah, 85 to 90 percent of the time that happens, but 10 to 15 percent it doesn't and Mr. Simao fell into that 10 or 15 percent of the time. So it went directly to this patient. He's -- it's a totally different comparison.

THE COURT: I think it is. I think it is. Let's move on.

MR. ROGERS: Okay.

[End Bench Conference]

THE COURT: The objection is sustained. The jury will disregard any statements the witness gave regarding typically or generally, the jury is focused on what happened in the particular instance involving Plaintiff.

Please proceed, Mr. Rogers.

MR. ROGERS: Thank you.

BY MR. ROGERS:

Q As you look at the tissue surrounding the [indiscernible] that were fused in this case, do you see any evidence of damage?

A No.

Q Okay. Were there other -- I think there was another

slide you were going to point to, Doctor, at C-3 and C-4. If you would address those so that the jury knows what you're looking for there.

A This is a cross-sectional cut of the same MRI. It's at C-3/4 and what you can see here, these are the facet joints. This is the facet joint on the left side, that's demarcated by the L, and this is the right side. And you can see that they're not the same. We call this facet tropism, meaning the alignment of the facet is typically horizontal, this as you can see is oblique.

If you go to the next slide, please? This is the level below that. You can see both facets are symmetrical and they're horizontal.

Next slide, please. And again, you can't see the facet on this axial cut, but you can see that this is horizontal. So can you go back two slides, please? So what we typically get from this -- or what I see on this MRI is that the facets at all the other levels, or at least the C-4/5 and C-5/6, which I've just shown you, the facets are horizontal on both sides, meaning that this is a bit of an anomaly on the right side. This facet probably should be horizontal and that's what we call facet tropism. That's a congenital finding. We do not see that in trauma -- in traumatic situations.

Q Okay. Very good, thank you. Go ahead and have a

seat.

Now, as we've discussed, the Plaintiff claims that he has internal disc disruption caused by this accident. Is it likely that a muscle sprain/strain would mask a traumatic internal disc disruption at C-3/4 and C-4/5? Masking meaning cover up the symptoms of it?

A No.

Q Okay. Why is that?

A Well, if a patient sustains a traumatic disc injury, this is a fairly significant injury that causes significant pain. I would not expect a muscle sprain to mask or not cause the patient to experience that type of pain.

Q Okay. You prepared a report after examining the Plaintiff, that you examined him a month before he underwent the surgery. And in that report you reached some opinions. Now I want to go through the exam first and then I want to discuss the opinions.

Did you perform a physical examination on the Plaintiff?

A I did.

Q Okay. And in that physical examination did you find that the Plaintiff was -- let me go through this in order. Was the Plaintiff taking pain medication at the time you examined him?

A No.

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Q Okay. Tell the jury about the neck exam that you performed.

A Well, he appeared to have a good range of motion, a full range of motion. When I did push on the base of his neck, it did cause some discomfort, pushing sort of right in the midline at the base. And when I did a Spurling maneuver, which is typically when I extend the neck, cock it to the side and rotate it, it kind of is an extreme position. It can stretch the nerve, and when I performed that on the left side it did is -- did cause some shooting pain to the left shoulder.

Q Okay. What does that indicate to you?

A That's typically indicating there's some nerve irritation because in that position you're sort of stretching the nerve and it can kind of activate that nerve.

Q Okay. Does that suggest a certain level of the neck?

A I guess that would suggest more of C-4/5. C-4/5 typically would affect the C-5 nerve root and the C-5 nerve root distribution typically goes to the shoulder.

Q Okay. And what's the sensitivity of this Spurling's test?

A Oh --

Q In other words, how specific is it to diagnosing a nerve condition as opposed to a muscle condition?

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A It's not very sensitive or specific. It's one of the physical exam maneuvers that we teach our fellows and residents and that I perform on my patients.

Q Okay. And when you looked at the MRI, did you see any evidence of a nerve compression at C-4/5?

A I did not.

Q Is it uncommon that a Spurling's maneuver might show something different than the diagnostics show?

A Well, the Spurling's is not really that sensitive or that specific. It's a pretty extreme position, so even someone with arthritis or even someone who's not very limber, if you really sort of cock their head to the side, rotate it, it can probably reproduce some discomfort.

Q Okay. Does that Spurling's maneuver then suggest any internal disc disruption at C-3/4 and C-4/5?

A No.

Q What about the left shoulder exam?

A Well, we did two tests -- or I did two tests. I did a Neer or Hawkins and these are classic sort of shoulder exam findings. One is where you have them point their thumbs down and not have their arms directly to the side, they bring them a little bit forward and this -- you ask the patient to hold their hands up and then you sort of resist them and that will strain the supraspinatus, which is the rotator cuff. That's fairly specific for that. And so when I did that to him, it

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did reproduce some rotator cuff irritation or symptoms that are consistent with rotator cuff issues.

And then there's a Hawkins test where you sort of abduct the arm and rotate it and then kind of compress it. And that can also give some hint of rotator cuff pathology within the shoulder. And they were both positive.

Q Okay. And to your knowledge has the Plaintiff undergone any treatment for a rotator cuff condition?

MR. EGLET: Your Honor, may we approach?

THE COURT: Yes.

[Begin Bench Conference]

MR. EGLET: I'm going to object and move to strike this testimony. This witness has never stated in any report or in his deposition and to a reasonable degree of medical probability that our client has a rotator cuff tear. He's talking about possibilities, okay, in these tests. So they're irrelevant, just like everything else when they're talking about possibilities. It's to a reasonable degree of medical probability. He's suggesting to this jury that my client has a rotator cuff tear, but he can't state that to a reasonable degree of medical probability and it was never disclosed on the initial reports that this was his opinion or in his deposition.

MR. ROGERS: He's already testified that his tests are not that sensitive, that these are the findings that he --

MR. EGLET: No, he talked about the Spurling test not being that sensitive. He didn't say these tests were not that sensitive. He simply described the tests and said they're suggestive of a rotator cuff injury. He has never testified or stated in any report that my client had a rotator cuff injury so it's improper.

MR. ROGERS: He didn't say that in his opinion the Plaintiff has this condition. I simply asked to your knowledge has the Plaintiff undergone any treatment --

MR. EGLET: It doesn't matter. It's suggesting --

MR. ROGERS: -- for rotator cuff --

MR. EGLET: It's suggesting to the jury to speculate that my client may have a rotator cuff injury and that may be the problem. That's the whole reason for the Morsicato, is doing exactly what the Supreme Court said the doctor cannot do in Morsicato.

MR. ROGERS: No, Morsicato --

THE COURT: Why would you ask this question if there's no evidence of --

MR. ROGERS: Because what we're doing is going through the physical exam and what did those positive findings indicate and then how do they correlate with the diagnostic studies. And that's how the Plaintiffs are trying to substantiate the conclusion reached by their physician.

MR. EGLET: He's suggest --

THE COURT: So you want to mislead the jury into thinking there is an issue here that there's no evidence of?

MR. EGLET: Right.

MR. ROGERS: What I'm saying is that these findings that the Plaintiff has more or less characterized the jury as sacrosanct, over and over Dr. McNulty and Grover talk about the Spurling sign and how important it was that the Spurling's test was administered by them, but not before and how that distinguishes their examination from all the previous providers.

MR. EGLET: We're not talking about a Spurling's test. We're past that testimony.

THE COURT: I know.

MR. EGLET: We're talking about these tests --

MR. ROGERS: It's the same --

MR. EGLET: No, it's not. It's the Neers and the Hawkins test, which are rotator cuff injury tests. He's suggesting to this jury that my client had a rotator cuff injury. I would -- I want a curative instruction to this jury that there is no evidence that Mr. Simao had a rotator cuff injury in this case, because that is the state of the evidence.

MR. ROGERS: That's not at all.

MR. EGLET: It is too. It has to be a reasonable degree of medical probability and this is a clear violation of Morsicato.

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THE COURT: Sustain the objection.

[End Bench Conference]

THE COURT: Objection sustained. The jury will disregard any reference to a rotator cuff injury. The Court's not aware of any evidence of it.

Please proceed, Mr. Rogers.

MR. ROGERS: Thank you.

BY MR. ROGERS:

Q When you examined the Plaintiff a month before he had surgery, would you describe the pain that he complained of as "severe and intolerable" as Dr. Grover did?

MR. EGLET: Objection, Your Honor. Pain is subjective to the patient.

THE COURT: Sustained. Ask you to rephrase.

MR. EGLET: Speculation.

BY MR. ROGERS:

Q Did the Plaintiff, when you examined him, complain of pain that was severe and intolerable as Dr. Grover reported?

A No.

Q Okay. Was he still working at the time that you examined him?

A Yes.

Q When you examined the Plaintiff did you reach a determination whether surgery was a good idea for him?

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A I did. I did not feel that surgery was appropriate in this situation.

Q Okay. And I see in that same report that you recommended against it. Why is that?

A Well, at the time that I generated that report I did not feel that the pain generator had been identified. These types of surgeries are quite controversial, especially when there's no definitive pain generator and these patients typically don't do well after surgery when you've not identified what's causing the pain.

Q Drs. Grover and McNulty testified that this is a surgery that, in their hands, generally has an 85 to 90 percent success rate. Is that your experience?

A I would agree with that. This surgery typically has a very high success rate.

Q And in your opinion, why is it that this one didn't succeed?

A Well, as I stated before, I -- you have to identify what's causing the pain. If you haven't identified the pain generator then patients can have the surgery and they may still have the pain.

Q Now in that same report, after you examined the Plaintiff and recommended against surgery, you stated that up to -- it was either up to or no more than 25 percent of the Plaintiff's ongoing treatment is related to the incident. Do

you recall that?

A I believe at the time that I generated that report, I had stated that up to 25 percent of the patient's symptoms could be possibly attributed to the incident.

Q Okay. And what symptoms were you speaking of at that time?

A Well, it would be the patient's subjective reports of neck pain.

Q Okay. And you had already reached the conclusion that there was no evidence of injury at the levels that were fused?

MR. EGLET: Objection; leading.

THE COURT: Sustained.

BY MR. EGLET:

Q Okay. When you formulated this opinion, had you reached a determination about whether there was injury at levels C-3/4 and C-4/5?

A Yes.

Q And what was your opinion?

A I did not feel that there was any evidence that there was any injury at C-3/4 or C-4/5.

Q Why then attribute up to 25 percent of treatment from that date forward to the accident, which had happened, what, a couple -- a few years before?

A Well, I'd like to give the patient the benefit of

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the doubt. I mean, if he's saying that he's reporting pain, even though I don't see a radiographic imaging that shows that there's trauma and I can't prove that there's any traumatic injury based on the radiographic studies, I try to give the patient the benefit of the doubt and say if he's reporting symptoms, then you can apportion up to 25 percent based on his subjective reports of pain.

Q Can injury at C-3/4 and C-4/5, such as the Plaintiff has claimed, cause the headaches that he complained of?

A Are you referring to injury of the disc or the --

Q Yes, the disc.

A Well, there's not a reliable association between cervical pathology and headaches. There is a paper published showing that if you have C-1, C-2 facet arthritis, that that can reliably cause headaches and I have fused patients that have C-1, C-2 arthritis, but there are patients that have cervical pathology that can get headaches associated with it, but there's not a reliable association between the two.

Q Okay. And in reviewing the records, you saw the pain diagrams that the Plaintiff filled out and the way that he etched or wrote out the areas where the headache was experienced. Is there any particular dermatomal pattern that would come up from the neck to cause the headaches that he described?

A Well, the problems with the front of the head, sort

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of the forehead, that doesn't fit with any cervical pathology, as far as a nerve root issue. The C-2 nerve root can contribute up to the occipital nerve, which can sort of innervate the back of the scalp, and so I guess you would -- if there's sort of a distribution of a nerve root, I guess it would be more likely C-2.

Q Okay.

MR. ROGERS: Give me just a moment to catch up in my notes.

BY MR. ROGERS:

Q Now, Drs. McNulty and Grover testified that they have seen traumatic spinal cord injuries without any other structures being damaged.

MR. EGLET: Your Honor, I'm going to object to that. That misstates prior testimony. They didn't say spinal cord injuries --

THE COURT: Would counsel approach, please?

[Begin Bench Conference]

MR. EGLET: That testimony was clear that they've seen disc injuries -- disc injuries, not spinal cord injuries. They never said -- in fact, what they said is, well yeah, if you get a severe spinal cord injury, you may see these injuries to the structures surrounding the disc, but what their testimony was no, there's a -- I'm sorry, there's the -- can't remember the term that Dr. McNulty used, but there's a

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range of injuries and they talked about the severe spinal cord injuries, when you end up with paraplegic or quads, that you may have injuries to the surrounding structures of the cord and the discs, but when it comes to a disc injury, you're not going to see necessarily, in fact most often not, this type of injury. So that completely misstates their prior testimony.

MR. ROGERS: Actually, I took a note of that testimony as it was given and it does not misstate.

MR. EGLET: You're note is wrong. I -- it absolutely misstates it. They never said that a spinal -- an injury to the spinal cord can't cause injuries to the surrounding structures. They were talking about discs. He's completely misrepresenting the doctor in this case.

THE COURT: Ask you to rephrase it, please. I'm going to sustain the objection and ask you to rephrase.

[End Bench Conference]

BY MR. ROGERS:

Q Doctor, have you seen traumatic spinal cord injuries without any other structure being damaged?

A Yes.

Q Okay. What is the difference between a spinal cord injury and a spinal disc injury in this context, meaning whether there's surrounding tissue damage?

A Well, the spinal cord can be injured without any of the other structures being disrupted. You would typically see

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MRI evidence of a spinal cord damage in that situation and we see that not infrequently in our trauma center.

As far as disc disruption alone without any damage to the surrounding structures, I can't recall seeing any traumatic disc disruption without some disruption of the anterior longitudinal ligament or the posterior longitudinal ligament or some other fracture or ligament tear because there are structures around the disc that actually are weaker than the disc itself.

MR. EGLET: Your Honor, may we approach?

THE COURT: Yes.

[Begin Bench Conference]

MR. EGLET: This opinion was never, ever, ever disclosed by this witness in this case. First of all, it's incredible. I've never -- I've been doing this for 24 years and I've never heard a spine surgeon make that statement. It's a lie. But second of all, it has never been disclosed in any reports. I mean, this is a huge opinion and it's never been disclosed in any reports or in any testimony in his deposition ever has he given this opinion. They're required under disclosures to give us all the opinions in their written reports, quite frankly, of any opinion that their expert is going to give. This was never given and they're simply trying to bootstrap what happened to Dr. Fish in this case. This is absolutely improper.

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THE COURT: You know what I want to know, Mr. Rogers, how is this relevant? This case isn't about a spinal cord injury. How is this testimony even relevant?

MR. ROGERS: Well, he shifted from a discussion of the cord to the disc, that's the relevance of it. And second, he --

MR. EGLET: He just testified --

MR. ROGERS: Let me finish, please. He did testify that in his opinion there was no disc injury as a result of this accident and in part it's because there's no evidence of damage to the surrounding structures. This isn't --

MR. EGLET: That was not his testimony he just gave.

THE COURT: Not just now.

MR. EGLET: That's not what he just said. It's not what he just said. That's what he said awhile ago, which I didn't object to. What this witness just said right now is that in his view you cannot have a disc injury without injuring the surrounding structures of the spine. Just from a pure medical scientific basis, that is intellectually dishonest.

Aside from that, it's a huge opinion in this case that has never been disclosed in any document or in any deposition testimony. They cannot spring an opinion like that on us in trial with their paid, specifically retained expert.

MR. ROGERS: It's -- there's nothing new to this, Your Honor. I know that Plaintiff's counsel characterizes it as

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new, and does so with a certain enthusiasm that might seem to persuade, but it is not new, it's not groundbreaking. This is nothing that the Plaintiff's counsel hasn't encountered before. This -- I mean --

MR. EGLET: No, I --

MR. ROGERS: You can't say that you've never encountered this.

MR. EGLET: I have never encountered this ever with -- in any spine case where any Defense expert has come in and said that in order to injure a disc you have to injure the surrounding structures of the disc, which will show up in an MRI, which is his testimony. It's absolutely false. It's scientifically not true.

But aside from all of that, aside from the fact it's intellectually dishonest, it is an opinion that is nowhere disclosed in any report or deposition of this witness. Have you noticed that Mr. Rogers, in response here, hasn't said oh yes, it was, here it is in his report --

MR. ROGERS: I did.

MR. EGLET: -- here it is in his deposition? No, it's never been disclosed. Not this opinion. The opinion -- his opinion that my client's discs weren't injured was disclosed, but this opinion that you cannot have a disc injury without injuring the surrounding structures has never been disclosed.

MR. ROGERS: It was discussed at the deposition.

MR. EGLET: No, it wasn't.

MR. ROGERS: Plaintiff's counsel has done a fairly effective job of making the Defense counsel appear to be doing something it is not. We are not being tricky here. There is nothing new about this testimony. There's nothing new about this evidence.

MR. EGLET: It is not in any report ever disclosed. It's a failure to disclose under 16.1. I request it be stricken from the record.

THE COURT: Sustain the objection.

[End Bench Conference]

THE COURT: Jury will disregard the witness' last couple of statements.

BY MR. ROGERS:

Q Doctor, in your opinion, did the injections that the Plaintiff underwent at Southwest Medical Associates and under Dr. McNulty's hand and Dr. Rosler for that matter, did they isolate a pain generator?

A No.

Q When Dr. McNulty recommended surgery back in December of 2007, for the first time I mean, was there any evidence of traumatic disc injury at that time?

A I don't see any evidence of any traumatic disc injury.

Q And was that changed by the discogram that was done

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about eight months later by Dr. Rosler?

A No.

Q Do you perform your own injections to determine whether to perform surgery?

A No.

Q Why not?

A Well, I'm a surgeon, I'd rather be doing surgery than doing injections, but some of the injections are very subjective and I think it's better for an independent person to do the injections.

Q Okay. Well, as you know Dr. McNulty ultimately decided to perform the two-level fusion. In your opinion, did the Plaintiff need that surgery?

A No.

Q There's been some discussion about discography in this case. Would you have recommended discography in this case?

A Well, at the time the discography was done the patient -- I'm not sure there's any evidence that there was any discogenic. The patient had some nerve root blocks, which had given about 75 percent, maybe 80 percent relief at times, which would suggest that it was primarily a nerve issue and not a disc issue. And so I'm not sure I would have made the jump to consider that there was a discogenic component to this patient's pain.

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Q There were fissures shown in that post-discogram CT scan at C-3/4, C-4/5 and C-5/6, all three levels. Can a person have fissures without experiencing pain?

A Oh yes.

Q Can you develop fissures on a degenerative basis?

A Yes.

Q Okay. In this case one of the jurors asked a question, which was how can there be fissures at two levels and only one level has pain on the discogram. What's the answer to that?

MR. EGLET: Objection to the form of the question; misstates the prior testimony. There's two levels of pain, not one.

THE COURT: Sustained. Ask you to rephrase it.

MR. ROGERS: I was just describing the question, but let's do it in the abstract.

BY MR. ROGERS:

Q If there are two levels that have fissures in the cervical spine, only one of which has pain provoked during a discogram, how is that possible?

A Well, we don't have all the answers when it comes to explaining pain. Certainly we see degenerative changes with fissures, which causes disc disruption through the normal aging process and there are patients that are symptomatic, some are not symptomatic. The discography is not a completely

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reliable test. You're putting a needle into someone's disc, you're pressurizing that disc, sometimes it causes pain, sometimes it doesn't. It's just another piece of information that you have to take into account when you trying to access what's the cause of any patient's pain.

Q Okay. Now, about a month again after you examined the Plaintiff he underwent the surgery. We've learned during the course of this trial that he is going to introduce evidence of a future spinal cord stimulator. Does it surprise you to learn that this surgery was not successful?

A Well, unfortunately no. That's one of the reasons why I did not feel surgery was indicated.

Q Well, can you tell now after not having seen the Plaintiff for a couple years almost, whether he needs a future spinal cord stimulator?

A I'm not sure I can make that assessment. There's -- it's multi-factorial. Any time you take into account any type of treatment, whether it's surgery or a spinal cord stimulator, you have to do a full assessment, you have to do an exam. I'm not sure as I sit here today I can make a recommendation one way or another.

Q Okay. And if Dr. McNulty testified that, since he hasn't seen the Plaintiff for more than a year, he doesn't know whether he can recommend a spinal cord stimulator at this time, would --

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MR. EGLET: Objection; that misstates Dr. McNulty's testimony, Your Honor.

MR. ROGERS: It does not, Your Honor.

THE COURT: I think you may need to clarify it, Mr. Rogers.

BY MR. ROGERS:

Q Dr. McNulty testified that he hasn't seen the Plaintiff for a year. He testified to this jury that he doesn't know yet whether he could recommend the spinal cord stimulator --

MR. EGLET: Objection, Your Honor. That misstates the -- Dr. McNulty's testimony.

THE COURT: I think it may. Sustained.

BY MR. ROGERS:

Q In your opinion, would tests need to be administered for the final determination of whether the Plaintiff needs a spinal cord stimulator?

A Well, as I stated it, it's multi-factorial. I think he'd have to just gather all the information. As I sit here today, I haven't examined the patient or spoken to the patient in two years. I'm not sure I could recommend a spinal cord stimulator. I think if he's treating physician is recommending it, he probably should take into account all the information, should probably see the patient now. If he hasn't seen the patient in a year, it would probably be a good

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idea to get updated on the current condition.

Q Now, yesterday the Judge instructed the jury that this accident could have caused injury.

MR. EGLET: Your Honor, objection. That misstates the Court's instruction, a curative instruction. And I move to strike that statement, Your Honor.

THE COURT: Will counsel approach, please?

MR. ROGERS: Thank you.

[Begin Bench Conference]

MR. EGLET: The question, first of all, misstates what the Court's instruction was. The Court read the instruction to the jury and now he's trying to -- obviously he's trying to get around that instruction with this witness. And also, there's a motion in limine as to whether this accident -- this witness cannot even testify as to --

MR. WALL: What's the question at the end of this?

MR. ROGERS: Yeah, the question is, the Court has instructed the jury that this accident could have caused this injury, you've testified that it did not, what are the bases for that opinion --

MR. WALL: Why do you have to go with what her order was? Her order was very clear. If you want to ask him, did it cause a certain injury, that's one thing, but to couch it in terms of her order, I think, is inappropriate with this witness.

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MR. EGLET: To couch it in the instruction, first of all, it misrepresents what your instruction was.

THE COURT: I believe it does.

MR. ROGERS: I don't think it does that at all.

THE COURT: Well, here's the instruction. I have it --

MR. EGLET: We can have the Judge read the instruction.

MR. ROGERS: Well, the instruction simply reads that there's a presumption that the accident was sufficient to cause injury and I'll use that language. I don't --

MR. EGLET: I don't --

MR. ROGERS: That's fine.

MR. EGLET: This is not clumsy argument, Judge, where he's using the instruction --

MR. ROGERS: The distinction is simply this, the instruction allowed the jury to make a final determination and that's why I'm asking Dr. Wang, what supports your determination the injury was not caused and then he'll just revisit what we've discussed and we're done.

MR. EGLET: He doesn't have to preface these and couch them with the instruction.

THE COURT: I agree.

MR. EGLET: It doesn't need that.

THE COURT: I agree, sustain the objection. Ask you to rephrase it.

[End Bench Conference]

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THE COURT: Jury will disregard counsel's question.

BY MR. ROGERS:

Q In the final analysis, Doctor, and I've asked this with other witnesses, the Plaintiff claims injury from this accident and you've reached the opinion that he did not sustain an injury at C-3/4 and C-4/5. If the Plaintiff did not have neck pain before, but he had it after, how do you justify your opinion?

A Well, neck pain is very multi-factorial. There can be a lot of reasons for neck pain. I think in this situation --

MR. EGLET: Your Honor, objection. This is a violation of Morsicato. He's speculating.

THE COURT: Well, I don't know if he is. The Court doesn't want him to speculate. Perhaps you could refocus your question.

BY MR. ROGERS:

Q The focus is, what's the foundation of your opinion given -- in light of the fact that the Plaintiff denies prior neck pain and complaints --

MR. EGLET: Well, Your Honor, I'm going to object to that. It's not that the Plaintiff denies --

THE COURT: Will counsel approach, please? Let's not have speaking objections. I thought we all agreed on that.

[Begin Bench Conference]

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MR. EGLET: That's exactly what your question suggested, that he just denies it, that it might be there. Now we need a curative instruction on this, Judge.

THE COURT: Wait a minute. Wait a minute.

MR. ROGERS: Oh, criminy.

THE COURT: I don't [indiscernible] with this, because it looks like it could be -- his answer could very easily violate any number of previous orders, so I'm not really sure what you're intending to elicit by this question.

MR. ROGERS: Just how is that this opinion can be true when the Plaintiff says he didn't have it before.

THE COURT: And what do you think the answer is going to be?

MR. ROGERS: I don't know. This is an open-ended question.

MR. EGLET: That's a big problem.

MR. ROGERS: That's the risk of direct.

MR. EGLET: [Indiscernible] of his neck pain, because he just -- he just started talking about neck pains and multi-factorial, there can be a lot of reasons for neck pain. That's a violation of Morsicato, okay. He's saying -- basically what he's saying is, I don't know. That was his answer in his deposition, is I don't know. Now he's speculating it could be a lot of things, it could be this, it could be that, that's a violation of Morsicato, Your Honor.

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THE COURT: Well, if he's going to respond to the question I don't know, that's probably an acceptable answer, but the question as posed, I think, is fairly --

MR. EGLET: He's not going to say I don't know; we all know that.

THE COURT: -- fairly dangerous, considering the pretrial rulings, so I'm going to ask you to rephrase the question. Sustain the objection.

[End Bench Conference]

BY MR. ROGERS:

Q Okay. Can the Plaintiff have neck pain that has nothing to do with the levels at C-3/4 and C-4/5?

MR. EGLET: Your Honor, objection. This calls for speculation. Can the Plaintiff?

MR. ROGERS: I'll ask him to state it to a probability.

THE COURT: Very well.

BY MR. ROGERS:

Q You may answer, please.

A Yes.

Q In your opinion, is that the case?

A I don't see an injury at C-3/4 and C-4/5. I don't believe that's the cause of his neck pain.

Q So just to clarify your opinions then, in your opinion, did the Plaintiff sustain injury as a result of this accident that required treatment beyond May 2005?

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MR. EGLET: Objection; asked and answered, Your Honor.

THE COURT: Sustained.

BY MR. ROGERS:

Q In your opinion, would any future treatment that the Plaintiff undergoes, such as this suggested spinal cord stimulator, be related to the car accident?

A I would not relate that to the car accident.

Q Are all of the opinions that you have provided to the jury today to a reasonable degree of medical probability?

A Yes.

Q Okay. Thank you, Doctor.

THE COURT: Mr. Eglet?

MR. EGLET: May we approach, Your Honor?

THE COURT: Sure.

[Begin Bench Conference]

MR. EGLET: I'd need to know what the plan is, because there's no way I'm going to finish this witness by 5:00.

MR. ROGERS: I told the court at the outset that Dr. Wong doesn't have the technical ability to come back to come back, and that we should get through those matters fast we should get through those matters fast so that they can get done. That's something that I can't cure. I've been assured of that.

THE COURT: I don't know what to tell you.

MR. EGLET: Well, if I don't finish my cross-examination

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at 5:00 and it's time to recess I'm going to move to strike this witness.

MR. ROGERS: Well, let's move fast then.

MR. EGLET: I'm going to move at the pace that I need to move to get the questions out.

THE COURT: Let's proceed.

[Pause]

MR. EGLET: Your Honor, we're going to need to publish some depositions in this case of Dr. Wong.

Robert, do you have the list?

I'd like to publish the original deposition of Dr. Wong in Mary Crotty [phonetic] versus Southwest Gas Corporation case.

THE COURT: Any objection?

MR. ROGERS: No. Let's get this going.

THE COURT: So ordered.

MR. EGLET: I'd like to publish the original deposition transcript in the Simao case, Your Honor.

THE COURT: Any objection, Mr. Rogers?

MR. ROGERS: No.

THE COURT: So ordered.

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

THE COURT: Yes.

MR. EGLET: Doctor, I'm going to set these depositions up here so they're easy to you to grab. We put these big

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stickers -- when I refer to Crotty and the others you can see which deposition transcript it is.

I'd also ask that the depositions of the doctor be published in the Varvello versus Rex Lexi ACT Dancom [phonetic] case.

THE COURT: And objection?

MR. ROGERS: No, Your Honor. Just to expedite things though, perhaps we could just publish the depositions in total so that we can get the exam.

THE COURT: I think that's what we're trying to do. So ordered as to the last one.

MR. EGLET: And the deposition transcript in the Nancy Smith versus Western Cab Incorporate.

THE COURT: So ordered.

MR. EGLET: And deposition transcript in the Marjory Shultz versus [Indiscernible] Young [phonetic] case, Your Honor.

THE COURT: So ordered.

MR. EGLET: And deposition transcript in the Lemon versus Vault [phonetic] Transportation case.

THE COURT: So ordered.

MR. EGLET: And finally the deposition in the Lye [phonetic] versus Alderson [phonetic] case, Your Honor.

THE COURT: So ordered.

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BY MR. EGLET:

Q Okay, Doctor, you are familiar with what's called adjacent segmental breakdown, correct?

A Yes.

Q And you can have adjacent segmental break down where there is a two-level fusion in the cervical spine in either the level above or below the fusion -- fused segments breakdown. Correct?

A Yes.

Q Okay. And according to the most recent literature, if a patient has a cervical fusion they have a three percent chance every year, on a cumulative basis ever year, of adjacent segmental breakdown requiring another fusion. Correct?

A Yes.

Q And at ten years it's about a 25 percent probability that they will have adjacent segmental breakdown requiring another fusion. Correct?

A Yes.

Q Okay. So at 20 years from the date of the surgery it's more likely than not that a patient who has had a surgical fusion will have adjacent segmental breakdown requiring another fusion. Correct?

A I'm not a statistician. I don't know if it's additive that way.

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MR. EGLET: Let's put up slide -- is it number 8, Brendan? Slide number 8, please.

BY MR. EGLET:

Q All right. And could you take a look in your transcript in the Varvello case on page -- and you remember testifying -- well, let me just do it this way. All these depositions are in front of you. You were retained as a defense expert in all these cases, weren't you?

A I can't recall all the cases. I guess I would have to look at my records.

Q Well, you see, each of those are depositions of you in each of those cases. Do you have any reason to disagree to my representation that you were the defense expert in each one of those cases?

A No, I think I actually was, but I just --

Q Okay.

A -- don't have the records.

Q And your deposition was taken in each one of these cases, correct? You've got them in front of you.

A Yes.

Q Okay. And you were put under oath in those depositions, right?

A Yes.

Q Same oath you took here in the court?

A Yes.

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Q Sworn to tell the truth, correct?
A Yes.
Q Okay. Turn to page 8 of your Varvello deposition.
A Okay.
Q Okay? Starting on line 13 you were asked the following questions and gave the following answers:

"Q All right. Assuming that Mr. Varvello lives to a -- to his life expectancy, is your opinion that Mr. Varvello, if in fact he succumbs to the surgery at C-4-5, will more likely than not require an adjacent segment fusion. Correct? And your answer is:

"I don't know how long this guy will live but like I said, if you do the math there's a greater than 50 percent chance at 20 years after the fusion according to the most recent -- according to the most current statistics that they would need another surgery."

That was your testimony, correct?

MR. ROGERS: Your Honor --

MR. EGLET: You agree with that --

MR. ROGERS: Your Honor, I'm going to post an objection. It's an improper impeachment because plaintiff's counsel asked about a two-level fusion and the likelihood of a future adjacent segment breakdown. This question is about single

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level.

BY MR. EGLET:

Q And a two-level fusion for a adjacent segmental breakdown, does the probability increase for adjacent segmental breakdown or decrease for adjacent segmental breakdown?

A It decreases.

Q So when you have two levels fused, you're telling us that there's a decrease in the probability for a adjacent segmental breakdown at one of the adjacent segments?

A Yeah. That's what the studies show.

Q Okay. Well that's not what you testified previously, is it Doctor?

A I'd be happy to take a look at it.

Q Okay. Well let's -- we'll get to that. That's a later question here. But let me just ask you this. We'll take the two-level fusion out of it. A fusion in the cervical spine, at 20 years out from that fusion there is a more likely than not, greater than 50 degree chance that that person's going to have adjacent segmental breakdown at one of the adjacent levels, either above or below. Correct?

MR. ROGERS: It's the same objection, Your Honor.

THE COURT: Noted for the record. Overruled.

THE WITNESS: You said 50 degree.

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BY MR. EGLET:

Q No. 50 percent.

A Right.

Q Greater than 50 percent, right. Isn't that what you said here?

A Well --

Q Look at your testimony. Isn't that what you said?

A Well, what I was about --

Q Isn't that what you said? Yes or no?

A Do you want me to answer the first question --

Q I want you to answer my question. Isn't it true that you testified in Varvello, when asked be about whether a patient was going to have surgery at C-4-5 -- in this case the patient had had the surgery at the C-4-5 -- you testified when asked whether it would be more likely than not that they'll require an adjacent segment fusion in the future, you said:

> "I don't know how long this guy will live but like I said, if you do the math there's a greater than 50 percent chance at 20 years after the fusion, according to the most current statistics, that they would need another fusion."

That was your testimony, correct?

A So --

Q Was that your testimony, correct?

A I don't dispute that that's what I said.

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Q Okay. All right. You would agree that at -- if someone had a fusion in their neck, at 20 years out from that fusion, they have a greater than 50 percent probability of having adjacent segmental breakdown requiring another fusion. Correct?

MR. ROGERS: Your Honor. It's the same objection. Because there's a distinction between two- and single-level fusion.

MR. EGLET: I'm not asking him about two- or single --

THE COURT: And that distinction's been noted for the record. I think the jury understands that.

BY MR. EGLET:

Q Do you understand the question?

A If you could repeat it.

Q All right. You would agree that, if someone has a fusion in their neck, that at 20 years out from a fusion surgery there's a greater than 50 percent probability that they're going to have adjacent segmental breakdown at either the level below or the level above that fusion requiring another surgery. Correct?

A Well, what I. --

Q It's a yes or no answer, Doctor.

A I don't think I can answer it yes or no.

Q Okay. Well, the C-6 levels in the neck -- or actually the C-5/6 and C-6/7 levels in the neck are the two

most common levels that spine surgeons operate on. Correct?

A I'm sorry, could you say those levels again?

Q The C-5/6 and the C-6 levels of the cervical spine are the most common levels that spine surgeons operate on. Correct?

A I think that's correct.

Q Eighty percent of the surgeries in the neck are done at that level -- at those levels. Correct?

A Well, the majority of the surgeries are done. I don't know whether it's 80 percent according to the latest figures.

Q All right. Well, let's take a look at your deposition testimony. And let's take a look at Smith, please. And if you will turn to page 24 of Smith and we're going to read --

MR. EGLET: This is starting on slide 9, Brendan.

BY MR. EGLET:

Q We're going to read starting on line 15 of Smith and we're going to continue on to page 26. Okay? When you were asked -- or your testimony in the Smith case was this:

> "If you look at the numbers, it is about 25 percent of patients at about ten years and there are some studies that are higher and some studies that are lower. Now if you look at some have the risk factors for a developing adjacent segmental

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breakdown the state of the adjacent segment at the time of the index surgery is actually related to the development of adjacent segment disease.

"What that means is is that if you have a fusion and the disk next to it is completely normal it has a less likely chance of developing adjacent segment problems. But if the disk adjacent to the fusion already has some arthritis in it it has a much higher chance of developing adjacent segment disease required surgery and that is fairly intuitive.

"We did a study on our patients we presented at the North American Spine Society. I believe it was the 1999 or 2000 annual meeting. I do believe it was in New Orleans, Louisiana, and for our results we know that if patients have pre-existing disease, there can be up to an 80 percent chance of them requiring adjacent segment surgery.

"So if you have a fusion and the next segment is already arthritic, it is an extremely high rate of that requiring surgery. And I believe Ms. Smith had an MRI documenting that there were degenerative changes at C-6/7 well before the accident of March 1st, 2003.

"Now, on top of that, the C-5/6 and the C-6

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level in the neck are the two most common levels that we operate on. Anatomically we think it is because there is more motion at those two levels and they are more likely to break down.

"But if you look at any surgeon's case histories there is probably about 80 percent of the surgery we do in the neck is located at the C-5/6 or C-6 level."

Did I read that correctly?

A I think you did.

Q So you testified previously that up to 80 percent in most spine surgeon's case histories for cervical spines, those are the two levels that were fused. Correct?

A Yes.

Q All right. And as we just read, this is because there is more motion at those two levels and they are more likely to break down. Correct?

A That's one of the theories.

Q Okay. So if you have an adjacent segment which is inclusive of one of those two levels as Mr. Simao's does in this case the rate of adjacent segmental breakdown is even higher. Correct? Because his adjacent level is at C-5/6, below. Correct? C-3/4 was fused. The C-4/5 was fused. To the level of 4 is C-5/6. Correct?

MR. ROGERS: Your Honor. I'm going to object to

relevance. To my understanding, the claim isn't about adjacent segment, it's about now a future spinal cord stimulator.

THE COURT: Will counsel approach please?

[Bench Conference]

MR. ROGERS: I don't know what this has to do with the plaintiff's injury claim because no one has recommended an adjacent level fusion.

MR. EGLET: The point is he's going to recommend it. He's going -- he's been recommending it through his prior testimony. And I mean, he's testifying -- we've made this accommodation, he's testifying more in our case in chief, although that's just a technicality. There's case law throughout the country, and two cases particularly in the 9th circuit that allows a plaintiff to prove an element in damages --

MR. ROGERS: Keep it down a little.

MR. EGLET: -- [indiscernible] defense witness. And that's consistent with Nevada law. Nevada [indiscernible] 3.01 it says in determining whether any proposition has been proved, i.e. it now meets [indiscernible] you should consider all the evidence bearing on the question without regard to which party produced it. No part precluded from proving an element of our damages through a defense [indiscernible].

MR. ROGERS: And they're certainly exceeding the

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scope of the direct. I mean, this isn't cross-examination on any of his testimony. He's never offered an opinion on this and I can't tell you how many times the plaintiff objected to his testifying to things that they said weren't disclosed before and now they seek to elicit a previously undisclosed opinion from him? This is crazy.

MR. EGLET: He did testify to that on direct examination, not with the kind of pinpoint [indiscernible] when he said no treatment after May of '05 was related.

MR. ROGERS: What does that have to do with adjacent segmental breakdown?

MR. EGLET: This is a future medical treatment [indiscernible].

MR. ROGERS: But what does that have to do --

THE COURT: Mr. Adams has correctly stated the law and I think, given the testimony that the jury has heard thus far, this is fair game. So overrule the objection.

MR. ROGERS: All right.

[Bench Conference Ends]

BY MR. EGLET:

Q Okay. Doctor. Getting back to where we were. So if you have -- we've established that Mr. Simao's cervical spine fusion is at the C-4 -- the C-3/4 and the C-4/5 levels. Correct?

A Yes.

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Q The surgery he's had. And the C-5/6 is an adjacent level to that. Correct?

A Yes.

Q Below. And so if you have an adjacent segment which is inclusive of one of those two levels as Mr. Simao does, the rate of adjacent segmental breakdown is even higher, correct?

A In my opinion, yes.

Q In your opinion, yes. Okay. So if the patient has pre-existing disease at one of the levels adjacent to the fused segment then the statistic at 20 years from the date of the original fusion can be as high as 80 percent for the adjacent level to break down and require another fusion. Correct?

MR. ROGERS: I'm going to object again, Your Honor, because of the difference between single- and double-level fusions. Go ahead doctor.

THE COURT: Noted for the record.

BY MR. EGLET:

Q That was your testimony, correct, Doctor? Isn't that correct, Doctor?

A I believe --

Q Yes or no.

A -- that the question you asked was not what you read right out of here. And that's the only reason --

Q Well, let's look.

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A I'm not --

Q Let's go to the next page of this testimony. Continuing on. Okay. This is you still talking:

"So I base my formulation on the fact that having a fusion I think the rate of adjacent segment disease is about three percent. If there is already pre-existing disease it can be up to 80 percent and then if the adjacent segment is at C-5/6 or C-6/7, which it was in Ms. Smith's case, it adds an even greater risk.

"So if you add all that together it makes it very likely, if you look at the statistics that she would have required surgery at the C-6/7 level which was adjacent to her previous fusion at C-5/6. And that was prior to the accident on March 1st, 2003.

Now did I read that correctly, Doctor?

A Yes.

Q So you have testified under oath in the past that if a patient has pre-existing disease at one of the adjacent levels to the fused segment, then the statistic of 20 years from the date of the original fusion can be as high at 80 percent for the adjacent level to break down and require a future fusion. Correct?

A That's not correct -- the only part that's not correct.

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Q It's just a yes or no question, Doctor.
A Your statement is not correct.
Q Okay. That's fine. Let me look at this again. See if I can get this right. Because I want to make sure I get it right. Okay. So you state here:

"So I base my formulation on the fact that having a fusion I think the rate of adjacent segment disease is about three percent. If there is already pre-existing disease it can be up to 80 percent."

And what you're talking about there is pre-existing disease at one of the adjacent levels, correct?
A Yes.
Q Okay. Up to 80 percent. So you agree that you testified in this case that if someone has a fusion in their neck and at one of the adjacent levels to the of that fusion they already had some pre-existing disease, then at 20 years their rate of having a adjacent segmental breakdown, instead of being just over 50 percent is if you will up to as high as 80 percent. Correct?
A See, I think that misrepresents what I testified here.
Q Well, let's go back and read the whole thing again. Okay. I want to make sure this is right --
MR. ROGERS: Your Honor, this has been asked and answered. He's already answered that yes, you're accurately

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reading my testimony from the unrelated case.

THE COURT: Well, it's been asked --

MR. ROGERS: We don't need to read it again.

THE COURT: -- I don't know that it's been answered yet. But you'll have an opportunity to redirect.

BY MR. EGLET:

Q Let's read this whole thing, okay? All right.

"If you look at the numbers, it is about 25 percent of patients at about ten years."

So your testimony there was that at ten years from the surgery the probability is 25 percent that a particular patient will have an adjacent segmental breakdown and need a fusion at the adjacent segment. Correct?

A Yes.

Q Okay.

"And there are some studies that are higher and some studies that are lower. Now if you look at some of the risk factors for developing adjacent segmental disease the state of the adjacent segment at the time of the index surgery is actually related to the development of the adjacent segment disease. Now some of the risk factors are one, is the adjacent segment at the time of the surgery" --

Did it already have some degenerative disease in it? Correct? That's a risk factor, right?

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A Yes.

Q Another risk factor is is it at the C-5/6 or C-6/7 level, the adjacent segment. Correct?

A The C-5/6 and the C-6/7 are the levels at risk.

Q Okay. So those levels as well as whether it was degenerative. Right?

A If there's pre-existing degeneration.

Q Pre-existing degenerative disease. Okay. So you state that:

> "What that means is is that if you have a fusion and the disc next to it is completely normal it has a less likely chance of developing adjacent segment problems but if the disc adjacent to the fusion already has some arthritis in it it has a much higher chance of developing adjacent segment disease requiring surgery and that is fairly intuitive."

Correct? So what you're saying there is that if the adjacent segment already has some arthritis, some degenerative changes, then it's a higher probability that they are going to have adjacent segment breakdown requiring a future surgery. Correct?

A I believe that to be true.

Q All right. Then you talk about the study you did in '99 and 2000 whether you presented it to NASS in New Orleans

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and you say there that Ms. Smith had on her MRI that there was degenerative changes at C-5/6 before the March 1st, 2003 accident. Correct?

A Yes.

Q Okay. Now go up. And then you say:

"Now, on top of that the C-5/6 and C-6 level in the neck are the two most common levels that we operate on. Anatomically we think it is because there is more motion at those two levels and they are more likely to break down but if you look at any surgeon's case histories there's probably about 80 percent of surgery we do in the neck is located at C-5-6 or C-6-7. So if you have an adjacent segment which is inclusive of one of those two levels, as Ms. Smith does, the rate of adjacent segment disease is even higher."

Right?

A I believe so, yes.

Q You finally state:

So you base in the Smith case you based your formulation on the fact that having a fusion:

"I think the rate of adjacent segment disease is about three percent."

And that's cumulative, per year. Correct?

A Yes.

Q Okay. If there is already pre-existing disease -- that alone, at the adjacent level it could be up to 80 percent. Correct?

A Yes.

Q And the 80 percent you're talking about there is at 20 years, right? It's not one year, right?

A That's the point where I could not answer yes or no because you are mixing two studies together. You're almost correct. But if you ask me for yes or no and you're not --

Q Okay.

A -- completely accurate and do not allow me to explain --

Q All right. Let me --

A -- then I can't --

Q -- just get to the point.

A -- answer yes or no.

Q The point is here that if there's no -- if it's at greater than 50 percent that you're going to have adjacent segmental breakdown from a fusion in your neck at the level above or level below without these risk factors, if it's over 50 percent at 20 years, if you add these risk factors in then it's much higher than that. Correct? The probability becomes much higher, correct?

A The problem is you're mixing -- you're almost correct but you're mixing two studies in the summary statement

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when you --

Q No. I'm actually not mixing two studies. But let me try again. I'm just saying in general terms, okay --

A You put in 20 years. We didn't do our study -- when you talk about the 80 percent, we didn't follow them out to 20 years. So when you say 20 years you're referring to the original study done by Hillerbrand and Bowlman [phonetic] --

Q Okay.

A -- which did go out --

Q Well, when you used 80 percent, how many years were you talking about?

A Well, I don't have that study in front of me.

Q Okay. So you don't know. So let's forget about 80 percent. Okay? Let's just forget about the number of 80 percent. You've already said that the statistics show that at 20 years it's greater than 50 percent, right? Is it? Well, okay.

A It's close but the reason why it's not a simple yes or no is because in science you can't extrapolate the evidence. I know it sounds --

Q I understand that, Doctor. Listen, I was a economics and statistics major. I know. I understand that if in fact you just extrapolated the evidence and you went three percent a year on a cumulative basis actually it would be 17 years when you hit 51 percent. Wouldn't it?

A Well, that's what I was trying to say. It's not --

Q We're not talking about 17 years. We're talking about 20 years where you testified at 20 years it's greater than 50 percent. That's your testimony in the past, correct?

A Yes.

Q Okay. So if you add the risk factors that it's either a C-5-6 or C-6-7 disc that is adjacent to the fused segment and you add the risk factor that the adjacent disc had some pre-existing degenerative changes in it before the surgery than the probability of the adjacent segmental breakdown becomes even higher. Correct?

MR. ROGERS: I'm going to object again, as before, Your Honor. I'll just keep a running objection so I don't have to interrupt. Because there is this distinction between a single- and two-level fusion.

THE COURT: Noted for the record.

THE WITNESS: In my opinion that is correct.

BY MR. EGLET:

Q Thank you. That's all I'm trying to get at, Doctor. Because all you've been stated here today is your opinions, right?

A Well, I guess if we refer to the medical record, some of those are --

Q Well, okay. But your opinions -- when you state an opinion about your conclusions in this case they are your

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opinions, correct?

A When I stated my opinions I believe those are my opinions.

Q So, now what, Doctor -- well, first of all you understand that Mr. Simao was 45 years old on the date of his cervical spine fusion. Correct?

A I believe that's about correct.

Q Okay.

MR. EGLET: And could you put up slide 11 please.

BY MR. EGLET:

Q And this is Exhibit 59, Doctor. According to the U.S. life expectancy tables, his life expectancy from today is 31.6 years. Correct? He's 49; a white male; 31.6 years. Correct?

A It does say 31.6. I just don't see the other.

Q Go up to the column to show it's white male. White male. Go down the column. You're in the wrong column. So at 49 --

MR. EGLET: How would are you? Are you 49? Forty-seven; 31.6 years.

BY MR. EGLET:

Q Do you see that? Forty-seven. This is total. This is white male right here. This is white female; they live longer than us. Do you see that.

A I do see the number. I'm not familiar with this

table. I haven't had a chance to look at it, but I do see that number.

Q That's what it says, right. It's an exhibit in this courtroom and that's what it says. His life expectancy is 31.6 years.

A I wouldn't argue with that.

Q All right. So assuming Mr. Simao lives to his normal life expectancy, you would expect him to have adjacent segmental breakdown at an adjacent segment requiring another fusion. Correct?

A I'm sorry. What is the first part of that question?

Q Assuming Mr. Simao lives to his life expectancy, another 31.6 years, you would expect that he would have adjacent segmental breakdown at the C-5-6 level requiring additional fusion surgery. Correct?

A I think there's a high chance that could happen.

Q High probability, correct?

A Well, I --

Q Greater than 50 percent.

A I think there's a high chance that could happen.

Q Greater than 50 percent, correct?

A That I can't answer specifically because I'm not a statistician and that's what I was --

Q How about more likely than not.

MR. ROGERS: Your Honor, that's asked and answered.

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THE COURT: I don't know that that one was.

BY MR. EGLET:

Q More likely than not. I mean, Doctor, you already told us that at 20 years it's 50 percent, or higher than 50 percent, and then you add these new risk factors, it gets even higher, correct?

A I would say that it's high and it's probably around that --

Q Okay.

A -- but I'm not a statistician so I can't say exactly.

Q I understand. I understand. And -- okay. So what would be the cost of that surgery? Approximately. And when I ask you the cost I'm talking about the surgeon's fee, the anesthesiologist fee, the hospital stay fee, the use of the surgery room and the equipment.

A I have no idea.

Q You have no idea? You perform these surgeries, don't you?

A I work at UCLA. They do all the billing and collecting, and I don't know how much I make per case or what costs are in other departments such as anesthesia and the nurses and things like that.

Q Well, let me represent to you that the surgery he's already had in this case for the two-level fusion in his neck

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that the total cost for that surgery was $97,527.06. Does that sound reasonable to you?

A I'm sorry. What was the number again?

Q $972,527.06?

A As I said before. I don't know what the cost is. It sounds reasonable.

Q It sounds reasonable to you. And --

MR. ROGERS: Your Honor, we're getting into speculation. The relevance of this future procedure hasn't been --

MR. EGLET: We have not had to speak to objections, Your Honor.

THE COURT: Would counsel approach, please.

[Bench Conference Begins]

MR. ROGERS: Quickly. It's not relevant. It's not relevant in that they haven't established a need for a number they intend to post in front of the jury. And second, reasonableness is generally a local standard. Necessity and standard of care are national. But if the doctor has testified that he doesn't know the charges because he works in an academic hospital and he's not from here, what are they asking him about reasonable charges in Las Vegas for?

MR. EGLET: I'm allowed to ask him. If he doesn't know he doesn't know. Our case is not over, Judge.

THE COURT: Yeah, I know that. But he's already answered the question in any event.

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MR. EGLET: I'm sorry?

THE COURT: He's already answered.

[Bench Conference Ends]

BY MR. EGLET:

Q Now, in Los Angeles, where you practice, for a two-level fusion in the cervical spine, would that be a number that you would think would be customary and reasonable for that type of surgery; $97,527?

A As I say I don't know what we charge and what we collect on these things. I don't think I can answer that question.

Q Well, let's assume this. Now this was for a two level fusion, right? Not a single level fusion, this charge. Because he had a 3-4 4-5 level. Correct?

A If that's what you're telling me was from a two-level I would take your word for it.

Q Well, this is for Mr. Simao. You know he had a two-level fusion in his cervical spine, 3-4, 4-5. Correct?

A Yes.

Q To be fair, a two-level fusion, would there be some additional charges as compared to a single-level fusion. Is that correct?

A I think it would be more expensive.

Q Little bit more expensive for the hard ware, right?

A Well, there's hardware, there's grafting, there's OR

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time.

Q Hardware, grafting, OR time. So would it with fair, in your opinion, to take off 25 percent, 30 percent? What do you think.

A As I stated I don't see these type of figures. UCLA does all this for us so I don't want to speculate on this.

Q So you never see your bills, what's charged?

A No.

Q Okay. You know, it's interesting because I've seen some of your depositions in the past where you have testified about whether charges by other physicians were customary and reasonable. Do you recall that?

A Sure.

Q Okay. So you have given testimony before in other cases, in fact testimony here in Nevada about what charges including surgeries were customary and reasonable, right?

A Well I can -- I think if it's in the same ball park. If it's $5 million for a surgery it seems a little unreasonable. These numbers, as I stated, I don't find problems with these numbers.

Q So you think that's customary and reasonable, right?

A Again, it seems to be in the ball park.

Q And so my simple question for you is, I mean, you provided this testimony in the past about what's customary and reasonable charges. If I represent to you, which exhibits are

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in evidence, this is the case that that is the amount of the two-level fusion, based on that in today's dollars, what do you think, ball park, would be a customary and reasonable charge for a single-level fusion?

A It would probably be less.

Q Okay. I understand it's going to be less. I'm asking you how much less. Do you think it would be 80,000? 70,000? What do you think?

A Probably about a third less, maybe.

Q A third less. So that's about 33 -- let's give you the benefit of the doubt, a little bit more safe. Take off $34,000. Right? A third would be -- $34,000 would be a little bit more than a third, right?

A I believe so, according to my math.

Q Well, if it was -- actually if it was $96,000 it would be $32,000 would be a third, right. So if we took off $3,000 off of that that would leave us with $64,527. Correct?

A I believe that's about right.

Q You believe that would be a reasonable and customary charge for a single-level fusion in the neck for adjacent segmental breakdown. Correct?

A I think that's reasonable.

Q Your Honor. I would ask that this exhibit -- this to be marked as plaintiff's next exhibit in order.

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THE COURT: Very well.

MR. EGLET: And I would move for admission of this exhibit.

THE COURT: Any objection?

MR. ROGERS: Yes. Same objections as stated earlier. Relevance, foundation and speculation.

THE COURT: Noted for the record. And it will be admitted.

[Plaintiff's Exhibit 167 Received]

BY MR. EGLET:

Q Now, Doc, let's move to another area. Doctor, you were charged by the California Fair Political Practices Commission with violating the California political reform act. Correct?

A I believe so.

Q Specifically you were charged with three counts of violating government codes 87-300 of the California political reform act. Correct?

A I'm not sure if that's the right number.

Q During your employment with UCLA, you prepared and submitted application statements to the UCLA conflict of interest review committee and the institutional review board as a principal investigator for approval to receive funding from nongovernmental entities for medical research you conducted at UCLA. Correct?

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A Yes.

Q In conjunction with these applications you filed a form 700-U under penalty of perjury declaring whether you had a financial interest in the nongovernmental funding sources. Correct?

A Yes.

Q UCLA established a conflict of interest review committee to provide an independence substantive review of the form 700-U filed by a principal investigator whenever there is a positive financial disclosure in the nongovernmental funding source for the principal investigator's research. Correct?

A Yes.

Q Okay. If a principal investigator fails to disclose his financial interest in a nongovernmental entity on his form 700-U in connection with his research project application the review by the conflict of interest review committee is circumvented. Correct?

A Yes.

Q In three separate instances, you failed to disclose your financial interest on the Form 700-U you filed in conjunction with the application for nongovernmental funding of your research projects, correct?

A Yes.

Q In Count I, you were charged with acquiring options on 18,000 shares of stock in Facet Solutions, Inc., correct?

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A Yes.

Q On July 24th, 2006, you submitted an application statement to the California Conflict of -- UCLA's Conflict of Interest Committee and the Institutional Review Board for approval to receive an undisclosed amount of funding from Facet Solutions, Incorporated, a nongovernmental entity, correct?

A Yes.

Q The funding was for a research project in which you were listed as the principal investigator, correct?

A Yes.

Q In conjunction with the application statement, you prepared and signed under penalty of perjury a Form 700-U on July 24th, 2006, declaring that you did not have an investment interest in Facet Solutions, Incorporated, correct?

A Yes.

Q Okay. You were charged with violating the Political Reform Act by failing to disclose your investment interest in Facet Solutions, Incorporated on the Form 700-U, correct?

A Yes.

Q In Count II, you were charged with receiving $24,000 in consulting fees and 2,500 shares of Fizomed stock in June of 2005, correct?

A Yes.

Q On September 28th, 2006, you submitted an amended

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application statement to UCLA's Conflict of Interest Review Committee and the Institutional Review Board for approval to receive $102,660 in funding from Fizomed, a nongovernmental entity, correct?

A Yes.

Q The funding was for a research project in which you were listed as the principal investigator, correct?

A Yes.

Q In conjunction with this application statement, you prepared and signed under penalty of perjury a Form 700-U on or about September 28th, 2006 declaring that you did not have any interest in Fizomed, correct?

A Yes.

Q You were charged with violating the Political Reform Act by failing to disclose your investment interest in Fizomed on the Form 700-U, correct?

A Yes.

Q In Count III, you were charged with receiving payments totaling $37,954 from Medtronic in 2006, correct?

A Yes.

Q On January 7th, 2007, you submitted an application statement to UCLA's Conflict of Interest Review Committee and the Institutional Review Board for approval to receive $50,000 in funding from Medtronics, a nongovernmental entity, correct?

A Yes.

Q The funding was for a research project in which you were listed as the principal investigator, correct?

A Yes.

Q In conjunction with the application statement, you prepared and signed under penalty of perjury a Form 700-U on January 10th, 2007, declaring that you did not have any interest in Medtronics, correct?

A Yes.

Q You were charged with violating the Political Reform Act by failing to disclose your interest in Medtronics, correct?

A Yes.

Q You entered into a stipulation decision and order with the Fair Political Practices Commission regarding these charges, correct?

A Yes.

Q In the stipulation and order, you agreed that you violated the Political Reform Act, correct?

A Yes.

Q In the stipulation and order, you agreed that all the counts, all three counts were true and accurate, correct?

A Yes.

Q You agreed to the issuance of the decision and order by the Fair Political Practice Commission finding you guilty of all three counts, correct?

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A Yes.

Q You also agreed to pay a fine in conjunction with this decision and order, correct?

A Yes.

Q As a result of UCLA looking into this, you were removed from your position as executive director of UCLA Spine Center, correct?

A Well, they issued a statement saying that, but.

Q That's what UCLA put in their press release, correct?

A Yes.

Q Now, Doctor, medicine is an art, correct? There's a lot of art in medicine?

A I've heard that term used.

Q You wouldn't disagree with that, correct? There's art in medicine, it's not all pure science, right?

A True, I've heard that term used.

Q All right. Now, and you had patients in your practice over the last number of years that have been referred for second opinions, correct?

A Yes.

Q And on occasion those second opinions have come back and they have disagreed with your opinions or recommendations for treatment, correct?

A Yes.

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Q And that's because physicians don't always agree, right?

A That's true.

Q Okay. You have treated patients over your career who have been involved in injuries that were caused by the negligence or fault of some other person or company, correct?

A I have treated patients in that situation.

Q And you have had occasion where some of these patients were submitted by the defense or a defense medical examination or a defense records review, correct?

A Yes.

Q Okay. And you've seen some of these physicians sometimes disagree on your diagnosis of injury, correct?

A It can happen.

Q Okay. And you've seen these physicians sometimes on occasion disagree on the appropriate treatment plan for the patient, correct?

A Yes.

Q Okay. And you have seen these physicians who have conducted these defense medical examinations of your patients disagree with you on what the cause of the patient's particular problem is on occasion, correct?

A Yes.

Q Okay. And that didn't make you wrong on all those occasions, did it, Doctor?

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A Not from my point of view.

Q Okay. You agree that it is appropriate for a patient to rely on their doctors for their advice and recommendations, correct?

A I think that's reasonable.

Q Okay. Particularly when the patient is not a doctor or has no medical training, correct?

A True.

Q Okay. So if a patient relies on their doctor's recommendation for treatment and goes forward with that treatment and has complications from the treatment, that's not the patient's fault, is it, correct?

A I would not fault the patient.

Q Okay. If a patient relies on their doctors for recommendations for surgery, and the surgery was not the best or most appropriate treatment for that patient, that's not the patient's fault, is it, Doctor?

A I don't believe so.

Q Okay. You can't fault the patients for that, right? They're just following doctor's orders, correct?

A Well, as I stated, I wouldn't fault the patient.

Q Now, Dr. McNulty's treatment of Mr. Simao was within the standard of care, correct?

A I don't believe Dr. McNulty fell below the standard of care in his treatment.

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Q So his treatment was within the standard of care, correct?

A Yes.

Q Okay. Dr. McNulty has his indications for spine surgery, and someone else's indication for spine surgery may be different on occasion than Dr. McNulty's, correct?

A Yes.

Q Okay. You agree that Mr. Simao followed his physician's recommendations with respect to the treatment he received, correct?

A Yes.

Q Okay. He followed his physician's instructions with respect to the diagnostic procedures he underwent, correct?

A That's correct.

Q He followed his physician's recommendations with respect to the surgical procedures he underwent, correct?

A Yes.

Q Okay. And you don't believe that any of Mr. Simao's treating physicians were negligent or fell below the standard of care in their treatment of Mr. Simao, do you?

A I do not believe they were below the standard of care.

Q Now, you believe Dr. McNulty to be a competent spine surgeon, correct?

A I have no reason to doubt his competence.

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Q And you have no reason to doubt that Dr. Grover is competent in spine surgery, correct?

A Again, I have no reason to doubt his competence.

Q And you have no reason to doubt that Dr. Rosler is a competent pain management physician, correct?

A No.

Q You have no reason to doubt that Dr. Arita is a competent pain management physician, correct?

A Yes.

Q Okay. And Dr. McNulty, Dr. Rosler, Dr. Grover and Dr. Arita are all board certified fellowship trained in either spine surgery or pain management, correct?

A I guess I would assume so. I have not seen their CVs or can recall whether or not they've done fellowships.

Q All right. You have no reason to believe that Drs. McNulty, Rosler, Grover and Arita are not well trained, well respected, well thought of, excellent spine surgeons and pain management surgeons/physicians, correct?

A That's correct.

Q Dr. McNulty, Rosler and Grover are all treating physicians of Mr. Simao and have given testimony or documented conclusions in this matter, correct?

A I believe so.

Q Yeah? And all of these physicians are well respected in their subspecialty fields in our community,

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correct? You have no reason to disagree with that, right?

A Yeah, are you asking me in the community of Las Vegas?

Q Yes.

A Well, I don't, I don't practice in Las Vegas. I'm not sure.

Q You have no reason to disagree with that, right?

A I don't have any reason to disagree.

Q All right. Now, you don't believe that any of these treating physicians would inaccurately document their medical records of Mr. Simao, do you?

A I don't believe so.

Q You don't believe that any of these treating physicians would give false testimony when expressing their conclusions regarding the injuries Mr. Simao sustained from the motor vehicle accident, do you?

A I don't think so.

Q Okay. Mr. Simao's primary treating physicians have documented and testified to the fact that his cervical spine injuries were directly and causally related to the April 2005 motor vehicle accident, correct?

A I'm sorry, could you repeat that?

Q Sure. Mr. Simao's primary treating physicians, the people we were just talking about, Dr. McNulty, Dr. Rosler, Dr. Grover, have documented and testified to the fact that his

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cervical spine injuries were directly and causally related to the April '05 motor vehicle accident, correct?

A I'm not aware if they testified. I have not seen their testimony, so I --

Q Weren't you provided with their deposition transcripts in this case?

A Yes.

Q You read their deposition transcripts, correct?

A Yes.

Q They all testified in their depositions under oath that they causally related his cervical injuries, C3-4, 4-5, to this motor vehicle accident.

MR. ROGERS: Your Honor, that misrepresents the deposition testimony.

THE COURT: Would counsel approach please?

[Bench Conference Begins]

MR. ROGERS: I mean Dr. Arita in particular --

MR. EGLET: I didn't ask Dr. Arita. I never said Dr. Arita. I said Rosler, McNulty and Grover. That's what I said. Listen to my questions. So if your objection's about Arita, that wasn't --

MR. ROGERS: The question was over Arita.

MR. EGLET: Well, that's, I didn't ask about that.

THE COURT: All right. Let's proceed.

[Bench Conference Ends]

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BY MR. EGLET:

Q Do you remember the question, Doctor?

A If you could repeat it.

Q Sure. Mr. Simao's primary treating physicians, Dr. McNulty, Rosler and Grover -- well, actually you said you didn't know, and I had asked you if you were provided those three physicians' depositions and you said yes. I asked you if you're read those depositions and you said yes.

So the question that was pending was, isn't it true that those treating physicians testified in their depositions under oath that Mr. Arita's [sic] C3-4 and 4-5 disc injuries were caused by the motor vehicle accident in April 2005, correct?

MR. ROGERS: Mr. Simao.

MR. EGLET: Simao, excuse me. Thank you. I do that.

THE WITNESS: I'm sorry, you threw in Dr. Arita's name.

BY MR. EGLET:

Q No, I did not throw in Dr. Arita's name.

MR. ROGERS: Yes.

THE COURT: You did.

MR. EGLET: Did I?

THE WITNESS: Yes.

MR. EGLET: It's late in the day.

BY MR. EGLET:

Q All right, let me start over. You've reviewed the

depositions of Dr. Rosler, McNulty and Grover, correct?

A Yes.

Q You've read them, right?

A Yes.

Q Isn't it true that those physicians, those treating physicians testified in their deposition that Mr. Simao's C3-4 and 4-5 disc injuries were caused by the April '05 motor vehicle accident, correct?

A I believe they did.

Q Okay. Now, you were hired by the defense in this case, correct?

A Yes.

Q You were not hired by me or my firm, correct?

A That is correct.

Q You were not retained by the judge, correct?

A That is correct.

Q You're being paid by defense counsel, correct?

A For today, yes.

Q Well, you've been paid by them for reviewing the records, correct?

A Yes.

Q Rendering your reports, your multiple reports in this case, correct?

A Yes.

Q Okay. You were paid by the defense counsel for your

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time in preparing for your testimony here today, correct?

A Not yet but I will be.

Q Well, you're going to be paid, right?

A Yes, I will definitely invoice.

Q All right. And you were not independently selected to review these records or write a report, correct? In other words, you weren't selected by me and my firm and Mr. Rogers and his firm, or you weren't selected by the judge? You were selected by the defense attorneys, correct?

A Yes.

Q Okay. All right, you've been asked to render opinions in this case as to causation by the defense, correct?

A Yes.

Q You would agree with me that trauma can cause a disc injury, correct?

A It can.

Q Okay. You would agree that this April 15, '05 motor vehicle wreck did cause trauma to my client's body, correct?

A I believe it caused a cervical strain.

Q The motor vehicle accident did cause trauma to my client's body, correct?

A Yes.

Q All right. You agree that history is an important component in determining causation, correct?

A It's one of the factors.

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Q You're aware that my client has no history of any neck pain before this April '05 motor vehicle wreck, correct?

A I have not seen any documentation.

MR. EGLET: Your Honor, I move to strike that testimony.

THE COURT: The jury will disregard the witness' last statement. Ask you to rephrase it.

BY MR. EGLET:

Q You are aware my client has no history of any neck pain before this April 14th, 2005 motor vehicle wreck, correct, Doctor?

A Yes.

Q Before the April 15th, 2000 [sic] motor vehicle accident, he never had any complaints of radicular symptoms, correct?

A Yes.

Q You're aware that there's no -- that there is no other documentation of my client ever having any other neck pain, even minor neck pain on any other single day in his entire life before this April '05 motor vehicle wreck, correct?

A I'm sorry, could you repeat the first part of that question?

Q You are aware that there is no documentation of my client ever having any other neck pain, even minor neck pain on any other single day in his entire life before this April

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15th, 2005 motor vehicle wreck, correct?

A Yes.

Q So, for the 17,175 days Mr. Simao has been alive, or had been alive before the April 15th, 2005 motor vehicle wreck, he had zero documented days of neck pain, correct?

A Yes.

Q Okay. And before the 4/15/05 motor vehicle wreck, Mr. Simao was never diagnosed with the need for spine surgery of any kind, correct?

A Yes.

Q He was never referred to a spine surgeon for consultation, correct?

A Yes.

Q Nor a pain management physician, correct?

A Yes.

Q Before this motor vehicle accident, he was never even recommended for an MRI of his neck, correct?

A Yes.

Q Or a CT scan, correct?

A That's correct.

Q Or even an x-ray, correct?

A That is correct.

Q Mr. Simao, before this motor vehicle wreck, had never been diagnosed with any disc injuries in his neck, correct?

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A That's correct.

Q And before this motor vehicle wreck, no physician ever diagnosed him with a condition that would require a spinal cord stimulator, correct?

A That's correct.

Q You are aware that my client had documented neck pain after the April 15th, 2005 motor vehicle wreck, correct?

A Yes.

Q You are also aware my client had documented radicular symptoms after the April 15th, 2005 motor vehicle wreck, correct?

A Are you talking about which timeframe, or are you talking about at any time in point following that incident?

Q After the motor vehicle wreck, correct?

A At any point? I just want to clarify the question. I just want to make sure I understand.

Q I think the question's pretty simple. You are aware my client had documented ridiculer symptoms after the April 5th, 2005 -- April 15th, 2005 motor vehicle wreck, correct?

A I believe so.

Q Okay. And the pain in his neck and the symptom, and the ridiculer symptoms were all documented to have started after the motor vehicle wreck, correct?

A That's correct.

Q Dr. McNulty concludes that Mr. Simao suffered a disc

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disruption at C3-4 and C4-5, correct?

A Yes.

Q So does Dr. Grover, correct?

A I believe so.

Q So does Dr. Rosler, correct?

A I believe so.

Q And Dr. McNulty, Dr. Grover and Dr. Rosler have all stated that the cause of Mr. Simao's neck injuries was the motor vehicle wreck, correct?

A I believe so.

Q Following his treatment and diagnosis of Mr. Simao, Dr. McNulty deemed him an appropriate candidate for surgery, correct?

A Yes.

Q So did Dr. Grover, correct?

A I believe so.

Q And Dr. McNulty is board certified and fellowship trained in spine surgery just like you, correct?

A Well, as I stated earlier, I haven't seen his CV, so I can't attest to that.

Q Do you have any reason to dispute that?

A No.

Q Dr. Grover is also board certified and fellowship trained in spine surgery just like you, correct?

A I would assume so, yes.

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Q Now --

A Well, I'm sorry, did you say board certified in spine surgery?

Q Board certified and fellowship trained in spine surgery, correct, Dr. Grover? He's a board certified orthopedic surgeon with fellowship training in spine surgery just like you, correct?

A Yeah. When you had said board certified in spine surgery, there's only one organization that does board certification in spine surgery, which is not very common in the medicine world today.

Q Now, you disagree with Dr. Grover and Dr. McNulty's conclusions, well and Dr. Rosler for that matter, that his cervical spine injuries were directly and causally related to the April 15th motor vehicle wreck, correct? You disagree with them, right?

A Well, I think you had asked me earlier did the injury injure the spine, or did the accident the spine, and I believe I said yes.

Q Let me clarify. You disagree with Dr. McNulty and Dr. Grover's conclusions that Mr. Simao has disc injuries at C3-4 and C4-5 as a result of the April 2005 motor vehicle wreck, correct?

A Yes.

Q Okay. But physicians sometimes disagree, correct?

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A Yes.
Q In your initial evaluation of Mr. Simao, you opined that the fact that he is -- strike that. Skip that.
Now, you have been doing defense medical examinations for a number of years, correct?
A I'm -- I guess defined number, probably about six years maybe.
Q Okay. That's a number, right?
A Sure.
Q Okay. You're aware that defense counsel has the power of subpoena, correct?
A Sure.
Q Okay. You know that defense counsel can subpoena past medical records, employment files and other data of the injured plaintiff to investigate any previous injuries or medical treatment they have received, correct?
A I believe so.
Q Okay. Mr. Rogers and his firm has hired you in a number of other cases they were defending, correct?
A I've definitely worked with their firm in prior cases.
Q Okay. And you've worked with Mr. Rogers and his firm in the past, other than this case, correct?
A Yes.
Q Okay. You're aware that Mr. Rogers and his firm are

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outstanding lawyers, correct?

A Sure.

Q Okay. And Mr. Rogers and his firm is one of the best defense firms in Nevada, aren't they? You've worked with a number of defense firms, haven't you?

MR. ROGERS: Your Honor, this is flattering, but I don't know if the doctor can have foundation to respond to that.

BY MR. EGLET:

Q It's not just flattery, it's true.

A Yeah, I don't know how to judge defense firms.

Q All right, fair enough. But you know that Mr. Rogers and his firm know how to investigate someone's previous medical history, correct?

A I would think so.

Q Okay. They know how to get previous medical records if they exist, correct?

A Yes.

Q In your experience with Mr. Rogers and his firm is that when you asked their firm for records, if those records exist, they provide those records to you, correct?

A Sure.

Q Okay. Now, Mr. -- and this is where to start putting up these exhibits. There's a monitor to your right there. The exhibits are already in evidence and we're going to go through them real quickly. It's Exhibit 18.

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Mr. Simao was seen for medical evaluation and treatment approximately three hours and 15 minutes after being involved in a rear end motor vehicle crash on April 15th, 2005, correct?

A Yes.

Q He had complained of neck pain at the time of that initial evaluation, correct?

A Yes.

Q He also complained of back pain at that time, correct?

A Can you scroll down a little bit on the --

Q It's highlighted there for you. You see post motor vehicle, complained of neck, back and left shoulder pain?

A Oh, yes.

Q Okay. And he complained of left shoulder pain, correct?

A Yes.

Q You've read that, right? At the time of his initial evaluation on April 15th, 2005, it was documented that Mr. Simao had midline cervical spine tenderness, correct?

A Yes.

Q Mr. Simao was diagnosed with a left elbow sprain on that date, correct?

A Yes.

Q He was also diagnosed with a neck sprain after being

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involved in this motor vehicle accident that day, correct?

A Yes.

Q He was treated for his neck sprain with prescriptions for ibuprofen and Flexeril, correct?

A Yes.

Q And after his medical evaluation on April 15th, '05, Mr. Simao was told to return to the clinic or seek primary care follow up if he was not improving in the next week to ten days, correct?

A Yes.

Q Mr. Simao was never seen by a physician during his evaluation on April 15th, 2005, correct?

A I believe it was a physician's assistant.

Q So he wasn't seen by an actual physician, correct?

A I believe that's correct.

Q Okay. Mr. Simao was never seen by a physician at Southwest Medical during the course of his treatment he received thereafter his motor vehicle crash until December 21st, 2005 when he was seen by Dr. Dean Tsai [phonetic], correct?

A I believe that's correct.

Q Okay. Mr. Simao's clinical assessment by the physician's assistant who evaluated him on May 4th, 2005, was status post motor vehicle accident with potential closed head trauma, correct?

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A Yes.
Q The PA, Mr. Hill, referred Mr. Simao for a CT scan of his head, correct?
A Yes.
Q Mr. Hill in his written referral to radiology for the CT scan documented that he was having a recurrent occipital pain, correct?
A Yes.
Q Mr. Simao was referred for an MRI of his head on May 12th, 2005, correct?
A I'm sorry, he said MRI of the head?
Q MRI of the head on May 12th, 2005, correct?
A Yes, he was referred for an MRI.
Q One of the reasons for the referral of Mr. Simao for an MRI of his head was to look for a possible intracranial lesion, correct?
A Yes.
Q Intracranial lesions can result in significant neurological problems or even death, correct?
A Well, they can.
Q When Mr. Simao returned to Southwest Medical on May 26th, 2005, he was told that the results of the MRI of his head and brain were normal, correct?
A Yes.
Q And the plan for Mr. Simao on that date was to

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continue his current medications as needed and to schedule a routine follow up as needed in the next six months, correct?

A Yes.

Q Mr. Simao did not wait six months before being reevaluated at Southwest Medical, correct?

A That's correct.

Q It was a little over four months when he was next seen at Southwest Medical on October 6th, 2005, correct?

A Yes.

Q And the documented reason for his visit at that time was to check up on his neck, shoulder pain and headaches, correct?

A Yes.

Q Okay. Mr. Simao was referred for a repeat cervical spine x-ray in October 2005, correct?

A Yes.

Q And that was by Mr. Hill, the PA, right?

A I believe so.

Q And another set of x-rays of the cervical spine were performed in order to evaluate potential clinical problems of his cervical spine, correct?

A I believe so.

Q Mr. Simao was seen at Southwest Medical on December 21st, 2005 for neck and left shoulder pain, correct?

A Yes.

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Q This is the first time he was actually seen by a physician at Southwest Medical, correct?

A I believe that's correct.

Q And his evaluating physician at that time documented that Mr. Simao had been complaining of neck and shoulder pain off and on for the past several months, correct?

A Yes.

Q Clinical assessment of Mr. Simao's physician on December 21st, 2005 was ongoing trapezial discomfort which he believed -- which he believed to be a muscle strain, correct?

A Yes.

Q You are aware that Dr. Rosler and Dr. McNulty and Dr. Grover testified in this case that patients with cervical disc injuries are almost always initially diagnosed as having a sprain/strain injury; are you aware of that testimony?

A I'm sorry, they gave that testimony in their deposition or here in trial?

Q Here in court.

A I wasn't here for that.

Q Do you agree with Dr. Rosler's -- Dr. Rosler, McNulty and Grover that patients with cervical disc injuries are almost always initially diagnosed as having a sprain or strain as the initial working diagnosis, yes or no?

A Well, they can be.

Q Mr. Simao was recommended for physical therapy on

December 21st, 2005, correct?

A Yes.

Q Mr. Simao did not get symptomatic relief from the physical therapy sessions he attended during the first three months of 2006, correct?

A I believe he had ongoing pain despite the physical therapy.

Q Mr. Hill, the PA, reevaluated Mr. Simao on March 9th, 2006, he documented no improvement through a series of treatment with both chiropractic and physical therapy, correct?

A Yes.

Q Now, Mr. Hill at that time documented complaints of discomfort radiating to his left shoulder with numbness, with range of motion of his neck and his shoulder, correct?

A Yes.

Q And on 3/9/06, Mr. Hill diagnosed Mr. Simao with episodic tension headaches, correct?

A Yes.

Q He also diagnosed him with migraine headaches, correct?

A Yes.

Q And he also diagnosed him on that date with cephalalgia with upper left extremity radiculopathy, correct?

A Yes.

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Q Mr. Hill ordered an MRI of Mr. Simao's cervical spine due to the chronicity of his neck pain with left upper extremity radiculopathy with no improvement with conservative treatment on March 9th, 2006, correct?

A Yes.

Q And Mr. Hill referred Mr. Simao for an orthopedic evaluation on March 30th, 2006, because of a clinical assessment of bulging disc at C4-5 and cephalalgia with left upper extremity radiculopathy, correct?

A Yes.

Q Dr. McNulty performed his initial orthopedic spine evaluation of Mr. Simao a little more than a year after his motor vehicle wreck, correct?

A Yes.

Q And this was the first time Mr. Simao was seen by a spine specialist, correct?

A I believe that's correct.

Q Okay. Dr. McNulty documented Mr. Simao having a one-year history of posterior cervical thoracic pain with occipital radiation and trapezial radiation and bilateral periscapular radiation with left upper extremity parasthesias on April 18th, 2006, correct?

A Yes.

Q And Dr. McNulty's initial -- Dr. McNulty's initial clinical assessment of Mr. Simao was that of a primary issue

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of axial cervical pain, correct?

A Yes.

Q Okay. On April 18th, '06, Dr. McNulty referred Mr. Simao for pain management evaluation to define pain generators in his cervical spine, correct?

A I believe so.

Q Now, you met Mr. Simao on only one occasion before relating your opinions in this matter, correct?

A Yes.

Q You met with Mr. Simao on February 10th, 2009, correct?

A Yes.

Q And that was here in Las Vegas, correct?

A Yes.

Q And you met -- you met him with your co-defense partner, Dr. Fish, didn't you?

A Possibly. I can't recall.

Q Well, you were both in the same room when you were talking to and evaluating Mr. Simao, weren't you?

A I don't have an independent recollection, but I would not argue that.

Q That happens when you guys are on the same case a lot, doesn't it?

A If we happen to be examining the patient the same day, we may try to do the history together to save time for

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him.

Q Coordinate your efforts, right?

A Well, we still ask our own questions independently, but it saves having to ask the same questions to the, to the patient being examined.

Q Now, you interviewed Mr. Simao during your evaluation and obtained a history from him which you mentioned on your February 10th, 2009 report, correct?

A Yes.

Q In that history you obtained from Mr. Simao, you documented that he was involved in a motor vehicle wreck on April 15th, 2005, correct?

A Yes.

Q You documented that after an initial evaluation at Urgent Care, Mr. Simao told you that several days later he went back because he was still having symptoms, correct?

A Yes.

Q You documented in your initial evaluation of Mr. Simao that, quote, since that time, meaning the April 15th, 2005 motor vehicle accident, he claims that -- he claims that he's had pain in his left shoulder, back of his head and base of his neck, correct?

A Yes.

Q Okay. In formulating your opinions in this case, you did not take into account the history you directly

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obtained from Mr. Simao that he had had pain in the base of his neck since the time of the April 2005 motor vehicle wreck, did you?

A I disagree with that.

Q Okay. You have opined here that there was a gap in his neck symptoms from April 15th, 2005 until October 6th, 2005, correct?

A Yes.

Q In your initial evaluation of Mr. Simao, you documented that he has had physical therapy, TENS unit massage, heat, ice, ultrasound, which he states did not help him at all, correct?

A Yes.

Q Most patients that have a sprain or a strain of their neck do not remain symptomatic with complaints related to those injuries after six to nine months, correct?

A That's correct.

Q Okay. You documented in your initial evaluation of Mr. Simao that according to the medical records, it was not until nine months following the motor vehicle accident that Mr. Simao began some physical therapy for his cervical symptoms, correct?

A Yes.

Q Now, it was not Mr. Simao, but rather his midlevel medical providers at Southwest Medical that did not refer him

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to physical therapy to treat his symptoms for the nine months after his motor vehicle wreck, correct?

A No.

Q The patient doesn't refer themselves to physical therapy, do they?

A No.

Q They're referred by a medical provider, correct?

A Yes.

Q And so the medical -- the midlevel medical providers did not refer him for physical therapy until he was finally seen by a doctor on December 21st, 2005, correct?

A That's correct.

Q There is an additional expense incurred in treating patients with physical therapy modalities for their symptomatic complaints for injuries, correct?

A I'm not sure I understand the question. Are you saying it cost more?

Q Well, physical therapy is not free, is it?

A No, it costs money.

Q Okay. Physical therapy is not always ordered following presumed soft tissue injuries that people may sustain because those symptoms more likely than not resolve after three to six months, even without treatment, correct?

A Well, I always order physical therapy.

Q Well a lot of physicians don't, right? They just

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say let's see if it goes away, right?

A Well, I think if you look at the statistics on these types of soft tissue injuries, the patients have better chance of recovery if you do physical therapy.

Q Well, I don't disagree with you. But my point is there's a lot of primary care physicians out there, and midlevel medical providers like we have in this case, who don't necessarily order physical therapy for their patients when they come in with sprain/strain complaints, injury complaints, do they? They give them some medications and muscle relaxers and pain medication and say let's see if it goes away. That occurs, doesn't it, Doctor.

MR. ROGERS: Objection, Your Honor. It started off with a lot of people, and now it's become it occurs. It's compound.

THE COURT: Sustain the objection. Let's move on.

BY MR. EGLET:

Q Okay. Does that occur, Doctor?

A It can occur.

Q Okay. Now, you agree that people's pain can be made worse as a result of surgery, correct, spine surgery?

A I guess it depends on the situation.

Q Well, there's a lot of spine surgeries that are done out there and after the patient recovers from the surgery procedure itself, their pain is in fact worse, that occurs,

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doesn't it?

A It can occur.

Q It's documented in the literature, isn't it, Doctor?

A Well, it can occur.

Q Okay. And there's a lot of people who have spine surgery where their pain doesn't get any better, it stays the same after they recover from the surgical procedure, correct?

A Yes.

Q No guarantees with surgeries, spine surgery, correct?

A That's correct.

MR. EGLET: Your Honor, may we approach?

[Bench Conference Begins]

MR. EGLET: I've probably got 30 to 45 minutes. So I don't know what the Court wants to do. That's why --

MR. ROGERS: He can't come back.

THE COURT: I would expect there would be some redirect.

MR. ROGERS: I do have a little, yes. But not very long, five, ten minutes.

THE COURT: Is there any way we can bring him back?

MR. ROGERS: I don't think we have --

MR. EGLET: That's a problem. He says he can't come back.

MR. ROGERS: I mean, this has now happened twice, though. I mean, it doesn't --

THE COURT: That's the problem with these half days.

MR. ROGERS: Because it's Dr. Wong is unavailable to come back.

THE COURT: Well, I don't know what to tell you. But I'm not in a position to do anything except ask you to bring him back.

MR. EGLET: I can -- I don't know -- I can try to get 30 minutes, but I just can't. I've been going very fast. I've skipped a lot of stuff and I probably have some more stuff I can skip, but.

MR. ROGERS: Speed it up, I guess is --

MR. EGLET: I have sped it up. You know what, I've been going really fast.

THE COURT: And I think you've been moving along, but I don't intend to cut you short even if you finish in 30 or 40 minutes. I don't know that it's realistic to, assuming that you can follow up in five or ten minutes.

MR. ROGERS: I think it is.

THE COURT: So --

MR. EGLET: I can just ask for the Court's guidance. Whatever you want to do. Obviously you know our position, if the witness can't come back we're going to move to strike him. But, I'm willing to try to finish it here. So whatever the Court wants to do.

THE COURT: I think he's going to have to come back.

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MR. ROGERS: I don't think he can. I can ask him. I'm told this was a -- this was our shot, that's why he was taken out of order.

THE COURT: All right.

MR. ROGERS: So, what do we do?

THE COURT: First, Mr. Eglet, Mr. Wall, let me ask you about tomorrow's schedule.

MR. EGLET: We have Dr. Arita returning. And we have Dr. Smith, and tomorrow is the only day he's going to be -- I mean, we can push it to the limit, he's going to be out of town after that, so we got to do him tomorrow.

THE COURT: Who are you starting with?

MR. EGLET: Arita I think. [Indiscernible]. Arita's going on pretty fast; I don't expect a whole lot longer [indiscernible], and we could, potentially could have time to finish this witness tomorrow if that's what the Court's talking about. We've got to get [indiscernible]. Dr. Arita, this will be the third or fourth time he's been down here waiting in the hallway.

MR. ROGERS: Can we stay an additional half hour and get Dr. Wong's testimony completed?

THE COURT: Even if you can finish in 30 minutes, we still have to do --

MR. ROGERS: Only five to ten minutes as I promised.

THE COURT: Which is beyond the --

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