SUPERIOR COURT OF THE STATE OF CALIFORNIA
IN AND FOR THE COUNTY OF EL DORADO
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MICHAEL AVENI and ANNE HUNT,

Plaintiffs,

vs.

VINCENT MINI; and DOES 1 through 30,

Defendants.

No. PC 20120594

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Deposition of
E. FLETCHER EYSTER, M.D.
Tuesday, March 31, 2015
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L.J. HART & ASSOCIATES, INC.
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Reported by: KAREN FORSTER, CSR License 8691, RPR

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I N D E X

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E X H I B I T S

BE IT REMEMBERED, that on Tuesday, the 31st day of March, 2015, commencing at the hour of 1:33 p.m. thereof, at Medical Evaluation Services, 87 Scripps Drive, Suite 116, Sacramento, California, before me, Karen Forster, a Certified Shorthand Reporter, in and for the County of Sacramento, State of California, there personally appeared

E. FLETCHER EYSTER, M.D.,

herein called as an expert witness by the Plaintiff, who, being by me first duly sworn, was thereupon examined and interrogated as hereinafter set forth.

EXAMINATION

By: S. DAVID ROSENTHAL, Attorney at Law, counsel on behalf of the Plaintiff, MICHAEL AVENI:

Q Will you state your full name for the record.

A Edward Fletcher Eyster.

Q All right. Doctor, do you live -- you currently live in Healdsburg?

A Pardon me?

Q Do you live in Napa County, sir?

A Yes.

Q Where is that?

A Napa County?

Q Yes. No. I know where Napa County is. Where in Napa County?

A St. Helena.
Q St. Helena. Okay. I'm sorry. I'm not sure where I came up with Healdsburg. That might be Sonoma County, huh?
Anyway, your practice, sir, is in San Francisco; is that true?
A Correct.
Q Is that called the Neurospine Institute Medical Group?
A Correct.
Q Is your partner Bruce McCormack?
A Correct.
Q How long have you guys been together?
A Twelve years.
Q And you have a Website that's called neuro -- I think it's neurospine.org; is that correct?
A That's -- yes.
Q Okay. Is the information contained on that Website accurate, sir?
A I haven't looked at it for years. It's mostly McCormack wrote it.
Q Okay. When did you first start doing medical-legal work?
A Well, I've always done it. I'd practiced in Florida for 23 years. I was expert for the Department

of Professional Care in Florida, the Florida Board of Medicine. Florida, as I'm sure you've heard, is a very litigious state so I gave thousands of depositions, mostly as a treater. I did very few expert cases there, mostly for the University of Florida as a neurosurgical expert.

Q Okay. And what kind of litigation was that?

A Well, they were standard of care issues for the Department of Neurosurgery at the University of Florida.

Q All right. So, if I understand then, those were medical malpractice cases?

A Correct.

Q And, typically, you were retained as an expert for the defense in the medical malpractice cases?

A Correct.

Q And you did that over the course of 23 years when you were in Florida?

A Right. And I did some expert cases for the plaintiff, also. Most of those were children of attorneys that were involved in motor vehicle accidents.

Q Okay. So, when you say you did some cases for the plaintiffs, you're talking about in civil cases, --

A That's right.

Q -- not medical malpractice case?

A Not medical malpractice.
Q Okay. And so are you saying that you only did a few of those?
A Yes. I mean, I -- at that time, my clinical practice was around 3 or 400 cases a year so I had very little time. Surgical cases a year.
Q All right. When you say "surgical cases," you're a neurosurgeon; is that right?
A Correct.
Q Do you focus on the spine?
A I mean, where -- I mean, up until about 15 years ago neurosurgery did all spine work.
Q Do you treat other areas of the body?
A Yeah. I mean, I would do 40 or 50 brain tumors a year. I had probably 15, 20 percent of my practice was acute trauma. I would -- anything from gunshots to motor vehicle accidents with intracranial penetration. We did a lot of spine work, trauma, acute dislocation, a few paralysis. We used to say 80 percent of our nighttime work was trauma. And we were -- back then, you were required to be on trauma call if you had acute care privileges in a hospital. That's changed these days.
Q Okay. So, when you say "acute trauma," you're talking about being on call as a surgeon in the

emergency room?
A Yes. We were Level I and then Level II trauma center; so you had to be there.
Q All right. And then when did you move to San Francisco?
A 1996.
Q Was that specifically to start the practice with Dr. McCormack?
A No. I had had a medical event, cardiac, and I had a complication and lost a leg and thought my neurosurgical career was ended, and I trained in San Francisco, and Dr. Wilson, who is chairman of the department, brought me out and sort of rehabilitated. I started working at the university pro bono and then full time and then transferred to Dr. McCormack.
Q All right. In what period of time was it you went through that process that you just described where you came to San Francisco?
A '93 to '96.
Q Okay. And then you started with McCormack when again?
A 2001, I think.
Q So, in between '96 and 2001, where were you -- what were you doing?
A I was on staff at UCSF.

Q All right. And, your injury, has that -- has that resulted in a continuing interference with your ability to perform surgery?
A Yes. I mean, I am an amputee, and neurosurgery is a full-body sport. It requires both legs and both arms because we have a lot of hand equipment as well as foot equipment to operate. Microscope, cautery, ultrasound - a lot of the instrumentation is controlled with foot pedals, and I need one foot to stand on and could not do that, and so I restricted myself since that event to only doing assistant surgery.
Q All right. And, approximately, how many surgeries are you participating in currently as an assistant surgeon?
A At the present time, I'm limiting to probably, starting this year, to surgery once a month, four to five cases.
Q Okay. And I'm -- just to clarify, so when you say one time a month, you mean you're doing four to five different --
A Procedures.
Q -- surgeries?
A During that one day.
Q Okay. All right. Have you ever performed a

surgery utilizing an artificial disc?
A Not as a primary.
Q Did artificial discs start being used at some point after your injury and after you started being an assistant surgeon?
A They started being used in Europe, and Germany primarily, in the late 1990s. They were finally certified for use in the U.S. around, I think, 2004 or '5, FDA approved. And they're still only approved for one level, but that's changing.
Q When you say that's changing, you expect that it will be certified by the FDA for use at multiple levels?
A Well, the artificial disc, for most of us, has been a huge disappointment. Almost nobody does the artificial disc lumbar anymore because the results have been not up to speed. It's hoped in the cervical area that its advantage would be to prevent adjacent-level disease, which occurs 30 percent per year after an anterior fusion. So far, that hope has not been realized. The results, essentially, are the same.
Q So --
A That's why most people that want to do it can't get certification through the Blues or major insurance carriers.

Q I want to make sure I understand. So you mean -- the adjacent-level issue that you're talking about, are you referring to lumbar spine?
Is that the reason, it's not efficacious in the lumbar spine, or are you referring to the cervical spine?
A The cervical.
Q Generally speaking, the artificial discs aren't real good for use in a lumbar spine?
A Well, they're still -- I mean, they are still FDA approved. It's just the bloom is off that rose. I mean, there's very few people that believe that. I mean, we hoped it, but right now the current state of the art is that they're not satisfactory.
Q They are efficacious for use in the cervical spine?
A They're still being done, but the enthusiasm that was originally there 10 years ago has waned. We still believe in the concept, but, so far, statistically, the results are not what we wish.
Q And what you mean by that is that the principal advantage is that it would avoid the adjacent-level syndrome that exists when you do a fusion; is that correct?
A That's correct.

Q And you're saying that over the last 10 years we've learned that the artificial discs do not have that benefit?
A Well, that's -- that's the general trend is a guy, Dr. Mummaneni at UCSF that's head of the national cooperative effort of looking at that, and he lectures and has written extensively on it, and I've just heard him speak. I hear him speak, you know, several times a year and know him personally, and he still believes in the concept; but, so far, he can't prove statistically that there is an advantage.
Q Is there an authoritative study that you have in mind when you talk about that conclusion regarding --
A No. I would refer to his opinion. I mean, he's probably the most -- has written more about it than anybody else in the U.S.
MR. HAVEN: What's his name?
THE WITNESS: Praveen Mummaneni.
MR. HAVEN: Mummaneni?
THE WITNESS: Mummaneni. I can't pronounce it; but, if you go to the neurosurgical Website at UCSF, he's head of the cervical spine section.
MR. ROSENTHAL Q: Okay. Are you aware of specific literature published by Dr. Mummaneni that addresses this issue?

A No. I've heard him talk dozens of times.
Q So is it mostly lectures and your personal interaction with him; is that fair to say?
A Well, I mean, he has published extensively, and there is a national cooperative study that he's involved in, but I can't -- I don't rely on a single source. My fund of knowledge includes his lectures, my reading, and going to numerous meetings and talking to other people that try to use it, and most of them have -- they'll still do it if it's requested, but it's not usually people's first choice.
Q All right. And then, in terms of the number of artificial disc procedures that you participate in, is there any way for you to estimate that?
A Oh, very few. Three or four. Just enough to really get a concept of how difficult it is to do.
Q Were those surgeries performed by Dr. McCormack?
A Yes.
Q Does Dr. McCormack -- any idea how many artificial disc procedures Dr. McCormack has performed?
A No. I don't know for sure.
Q Okay. Did he ever get into a situation where he was recommending or using the artificial disc procedure?

A Well, I mean, a lot of people try to go through utilization review. In this case, Dr. Orisek does the procedure, but he doesn't go by utilization review because he does them usually on a lien basis, in my experience, and you don't need authorization for that. So I think he's probably done more than anybody in California, I suspect.
Q Are you talking about Dr. Orisek?
A Yeah.
Q What do you know about Dr. Orisek?
How are you able to state that?
A Well, I've just seen -- I've read his reports for the last several years, and I think he's said that he's done hundreds of them.
Q I mean, have you done any kind of research to decide if there are other surgeons that have performed hundreds of artificial disc procedures as well?
A No. There's nobody that's done that, I don't think.
Q How do you know that?
A Well, I mean, just 99 percent of the time if you put a request it's going to be denied by Blue Cross or whoever the funding authority is.
Q Is that based on your experience?
A Yes, and others. Listening to others talk,

it's very difficult to get authorization.
Q Any criticism as to the qualifications of Dr. Orisek?
A No.
Q Any criticism of the competence of Dr. Orisek?
A No.
Q Any opinions about Dr. Orisek's utilization of the -- or the efficaciousness or non-efficaciousness of Dr. Orisek's utilization of the cervical disc procedure?
A In opposition, I'm asked to review a lot of different records, and so I've personally probably reviewed several dozen of his cases, and I see that he often recommends it based on his interpretation of the MRI. I personally have had a hard time seeing what he sees on the MRI, and that's why I don't want to argue with him. We're both spine surgeons. So I say I will defer to a board certified neuroradiologist like at UC Davis or CPMC or UC San Francisco. And I've been looking at MRIs since they first came out, you know, 30 years ago, but I would defer my opinion to a board certified neuroradiologist on what I see.
Q Okay. Is that your custom and practice to consult board certified neuroradiologists in all of your cases?
A I would often do that, yes.

Q So you, typically, don't interpret the MRIs yourself?
A No, no. I insist on looking at the films myself.
Q And then you, typically, take that film after you've reviewed it and take it to neuro -- a board certified neuroradiologist for their opinion concerning the film?
A Well, in our practice, it's usually a board certified neuroradiologist that's done the interpretation.
Q Is that the custom and practice, also, for Dr. McCormack?
A Well, it's just the -- I guess how fortunate we are in San Francisco that the neuroradiologists we use primarily is Dr. Barakos at CPMC, and I've attended lots of his lectures. He has conferences once a week.
Q Who is that? Doctor who?
A Jerry Barakos.
Q Does Dr. Barakos do medical-legal work?
A I think he does, yes.
Q And, in this case, have you reviewed any information provided by Arthur Dublin?
A By who?
Q Arthur Dublin?

A Yes.
Q And what have you reviewed?
A His interpretation of the radiological studies involved in these two cases.
Q Did he give you an interpretation that was different than an interpretation that you made?
A No. They were the same.
Q Have you ever worked with Arthur Dublin before?
A I don't know him personally, no. I just know his -- he's at UC Davis.
Q Okay. Did you -- have you ever worked with Arthur Dublin in a medical-legal context before this case?
A Yes. I mean, on several cases I've asked people to -- when there's a variance of opinion that somebody says there's acute disc, and I can't see it, it looks like a degenerative process, I'll say, "Let's get somebody that's the authority to decide. You don't have to take my opinion."
Q Okay. So, in this particular case, you looked at the MRI film, sir?
A I look at the -- I don't render a report complete without looking at the imaging.
Q Okay. And so, with regard to Michael Aveni,

specifically, did you look at the MRI films?
A Yes, I did.
Q And there was actually two MRIs; correct?
A Yes. I looked at both of them.
Q Okay. And, when you reviewed the MRI films, did you reach any opinion as to whether the findings were acute versus degenerative?
A Yes. I felt they were degenerative.
Q Okay. What is it that you felt you needed Arthur Dublin or any board certified radiologist to tell you?
A Repeat the question.
Q Sure. If you were able to look at the disc -- I thought you said that you would defer to a board certified neuroradiologist, and, I'm wondering, if you were able to look at the films yourself and determine it was degenerative versus acute, why did you need a neuroradiologist to review the films?
A Well, because there was going to be a dispute. I saw that Dr. Orisek thought they were acute changes, and I disagreed with that, and I said, "Why take one spine surgeon against the other? Get the expert."
Q So the only context in which you've actually worked with Dr. Dublin has been in medical-legal context; true?

A That's right. These have been about three or four cases that have arisen in this environment that I've -- you know, they knew Dr. Dublin. I don't. So I said, "I don't care who he is as long as he's board certified and competent."
Q All right. You didn't ask -- for instance, you've worked with Dr. Barakos many times; true?
A Yes, I have.
Q Did you ask for his involvement in this case?
A No. I mean, I suggested his name, I think, for whoever wants to use it; but the requirement is that the reader be a board certified neuroradiologist.
Q Okay.
A You're well aware that 80 percent of the MRIs are not read by neuroradiologists.
Q And so you -- did you suggest to Mr. Pawloski that he run this particular matter by Dr. Barakos?
A No. I just said a board certified neuroradiologist.
Q All right. And I want to get back to you mentioned, in this context, when you talk about the medical-legal context is a little bit different than, you know, when you're actually providing care to patients; is that fair to say?
A Correct.

Q Okay. You're not Dr. Aveni's treating physician; correct?
A Correct.
Q All right. And you took the Hippocratic Oath when you got out of medical school; right?
A Yes.
Q And that says, basically, that you act in the best interest of your patient; right?
A Correct.
Q Okay. And that Hippocratic Oath doesn't apply to Dr. Aveni in your -- in this situation; right?
A Well, it does to me. I still try to make medical recommendation based on what's the best interest of the -- whether he's a plaintiff, defendant, or what, I mean, I'm seeing the patient, looking at the facts, and trying to come up with a best treatment recommendation regardless of the situation.
Q Okay. But your motivation here, sir, and your involvement in this case is not to treat the patient; right?
A My motivation is not to say what the defense wants or what the plaintiff wants. My motivation is to look at the facts and render a medical opinion about what's best for this patient, and so that doesn't vary if I -- I saw 20 patients last Thursday. The same

motivation of each patient: What are the facts?, What are the findings?, and What does this patient need? That's all I do with these except that I spent a lot of time looking at past history, because I found that sometimes the historical information that you get as an acute treater is not accurate. When we have 45 minutes to see a new patient, we don't have time to look at a pile of medical records about past history, and that's why I feel the difference between the treating testimony and an expert testimony is that a treater can't expect to address causation because he is not familiar with the stack of medical records that we go through.

Q Okay. What medical records did you have that Dr. Orisek did not have?

A Well, I think on Aveni there was no significant past medical records. If you're talking about the other patient, I mean, here 8 or 9 inches of medical records that then Dr. Orisek was not aware of.

Q Okay. So I want to -- I represent Michael Aveni. Mr. Haven represents Anne Hunt.

A Okay.

Q So at least, unless I indicate otherwise, I'm talking about Michael Aveni. Okay?

A Okay. I have no idea who you are. You didn't introduce yourself. You could be the dogcatcher for all

I know.
Q Okay. Well, that might be in another life maybe; but, in this life, I represent -- I apologize for that. I should have introduced myself. I'm Dave Rosenthal, and I represent Michael Aveni. Okay?
A Okay. Thank you.
Q So I want to get back to the original question, which is what records do you have regarding Michael Aveni that Dr. Orisek does not have?
A I don't think there's any significant past medical records for Dr. Aveni regarding his cervical spine.
Q Okay. So, in terms of the advantage that you would traditionally have or that you have in most cases over a treating doctor, you don't feel you have that in Dr. Aveni's case over Dr. Orisek; correct?
A No. I mean, there's nothing in the past to impugn prior symptomatic cervical disc disease in Dr. Aveni.
Q Okay. As far as you -- based on your review of the information, including Dr. Aveni's deposition, Dr. Aveni had no prior neck pain?
A Correct.
Q No prior upper back or shoulder pain?
A Correct.

Q And no -- no extremity pain?
A Correct.
Q Okay. Now, in terms of the pain that he had following the motor vehicle collision, what do you believe to be the cause of that pain?
A I think that he was symptomatic from the motor vehicle collision; that it would be classified of an aggravation of a preexisting asymptomatic condition.
Q Okay. And, when you say "aggravation of preexisting asymptomatic condition," are you referring to some type of processes going on in the spine?
A Yes. He had some mild degenerative changes.
Q Okay. Where --
A Actually, they were -- I mean, at 59, he was very lucky. It's usually much worse.
Q One of the things I saw on your Website, between ages 30 and 50, people are more susceptible to disc herniation; is that fair to say?
A I'm not sure I would agree with that, but people develop degenerative changes in asymptomatic people. I mean, we've taken now hundreds of patients or volunteers and done MRI scans on them, and, by the time you're in your early forties, 43, almost 70 percent of the people will have at least as much as he had on his MRI.

MR. ROSENTHAL: All right. Could you have that marked as Exhibit A, please.
(Whereupon Plaintiffs' Exhibit A was marked for identification.)
MR. ROSENTHAL Q: By the way, Doctor, do you have a C.V. with you?
A Yes.
MR. ROSENTHAL: Can I see that? All right. And I'm going to have this marked as Exhibit B.
(Whereupon Plaintiffs' Exhibit B was marked for identification.)
MR. ROSENTHAL Q: Is this an accurate and up-to-date C.V.?
I'm sorry?
A Yes.
Q Okay. Just a slight pause after I'm done, as you know.
Okay. You've handed me a document dated March 13th, 2005. It looks like an invoice for services; is that correct?
A Correct.
Q All right.
MR. PAWLOSKI: Did you say 2005 or 2015?
MR. ROSENTHAL: I'm sorry. 2015.
MR. PAWLOSKI: Okay.

MR. ROSENTHAL: I have a problem with transposing numbers. I apologize.
Q Is this -- does this contain a summary of all the work that you've done to date?
A I think so, yeah.
MR. PAWLOSKI: On just Mr. Aveni, or is that for -- I don't know. Can I see?
MR. ROSENTHAL: Well, it does -- good clarification.
Q Is this only with regard to Dr. Aveni?
A Yeah. Hunt is here.
MR. ROSENTHAL: Since we're doing it, would you mind handing me Miss Hunt as well.
All right. So this would be Exhibit C.
(Whereupon Plaintiffs' Exhibit C was marked for identification.)
MR. ROSENTHAL: And then, with regard to Hunt, we'll make it D.
(Whereupon Plaintiffs' Exhibit D was marked for identification.)
MR. ROSENTHAL Q: So, with regard to this invoice date of March 13th, 2015, this is Exhibit C. This is relating to Michael Aveni; correct?
A Correct.
Q All right. And what, typically, -- your

examination, you charge $850 an hour for that?
A Yes.
Q All right. And you spent an hour with your exam with Dr. Aveni?
A Yes.
Q And it talks about travel. So what do you charge per hour for travel?
A Two fifty.
Q Okay. And then you had to come to Sacramento -- or where was the examination?
A Here.
Q Okay. So you charge for your travel to and from Sacramento?
A To what?
Q To and from Sacramento?
A Yes.
Q They have good surgeons, generally speaking, in the Sacramento area, sir?
A Are there what?
Q Are there, generally, some good spine surgeons in the Sacramento area?
A Yes. As a general rule, yes.
Q Okay. Are you personally aware of some good surgeons here?
A Yeah. I mean, there's some excellent

surgeons. Several of them are members of the faculty at UCSF.
Q All right. And then it says, "Review of Records and Deposition Transcripts," and how much is that per hour?
A Here is the fee schedule.
Q Okay. Do you know offhand the rate per hour?
A Eight fifty.
Q Okay. And so what's indicated here would have been the total up through February 25th, 2015?
A Correct.
Q All right. And then, preparation of your report, one and a half hours at 1,275, is that the same rate, eight fifty an hour?
A Right.
Q Okay. And then you're charging what for your deposition today?
That would be a thousand dollars?
A Per hour.
Q Okay. And then your travel time of course here today from San Francisco -- from San Francisco or from Napa?
A San Francisco, my office.
Q All right. So it's going to be another, basically, probably about the same one and a half hours?

A Yeah.
Q Or would that be three hours?
A No. It's probably two hours.
Q Okay. All right. And then --
A That's about the time I made it up today.
Q All right. And then I'm just wondering if there's any additional work that you did for preparation of this deposition that's not shown on this invoice?
A Usually, there's an hour prep getting -- going back over this getting ready for the deposition.
Q Okay. And then, in terms of trial, sir, what do you charge at trial?
A Five thousand a half day.
Q Okay. All right. And then we've marked Exhibit D. This is, essentially, the summary of the charges with regard to Anne Hunt; true?
A Correct.
Q All right. I mean, that was separate and apart -- the work is separate; right?
A Correct.
Q Okay. In terms of the travel time, did you split that?
Is that what happened there?
A It should have been split, yes.
Q Okay. So you did -- it took you a total of

three hours to drive roundtrip on February 25th, and you charged half to Anne Hunt and half to Dr. Aveni; is that fair to say?
A Yes.
(Whereupon Plaintiffs' Exhibit E was marked for identification.)
MR. ROSENTHAL Q: All right. And then, Exhibit E then, is that your fee schedule?
A That's correct.
Q And that's up-to-date?
A Correct.
Q Now, you work -- the work that you're doing with Mr. Pawloski, when were you first contacted?
A I think that's in there. There's some e-mails.
MR. PAWLOSKI: These exhibits, are you finished with them? Because I want to give them back to the reporter just so we don't get them mixed up.
MR. ROSENTHAL: All right. And this would be next in order.
(Whereupon Plaintiffs' Exhibit F was marked for identification.)
MR. ROSENTHAL Q: Okay. Are these all the e-mail communications you have in your file, sir?
A Correct.

Q Then it looks like the first e-mail contact was on January 22nd, 2015; is that correct?
A Correct.
Q And who is Lisa Wilson?
A She's the contact person here at Liberty.
Q Okay. Liberty Medical Consultants, is that what this is?
A Yes.
Q Okay. And they provide, essentially, lawyers with the opportunity to have -- well, strike that.
They connect lawyers in litigation with doctors; is that fair to say?
A Yeah. They're the administrative arm of what we do. They handle the gathering of records, initial correspondence, and collating the records from a chronological order, dictation of the reports, transcription services, billing, the scheduling of depos, trials. Everything administratively required regarding this, they do.
Q I got you. Did somebody else provide any of the summary medical records or other information?
A No. We don't use anybody like that.
Q Okay. Well, I mean, did Liberty Mutual -- anybody from Liberty Mutual --
MR. PAWLOSKI: It's not Liberty Mutual. It's

Liberty Med-Legal.
MR. ROSENTHAL: Liberty Med-Legal.
Q Did anybody from Liberty Med-Legal do any medical summaries; deposition summaries; anything like that?
A No.
Q Okay. You did all the work yourself?
A Yes.
Q All right. And do they have -- they charge some percentage of the fees that are charged?
A It comes out of their percentage for me.
Q And do you know what that is?
A They get 30, 35 percent.
Q All right. And they handle all of your med-legal work here in the Sacramento area?
A In this area they do, yes.
Q Okay. And, with regard to your work in the Sacramento region, what percentage would you say is for the plaintiff versus defense? I'm talking about med-legal work.
A In this area through Liberty Medical, it's almost a hundred percent defense.
Q Okay. Is that something that has changed over time?
A In our office in San Francisco, it fluctuates

a great deal between plaintiff and defense work.
Q Okay. But here in Sacramento it's a hundred percent for defense?
A Well, I think through this -- well, it's not a hundred percent. I can remember several plaintiff cases, but there's usually some connection with one of the attorneys that had a personal case that needed doing.
Q Okay. And in terms of -- let's talk about maybe the last five years. Has your -- the percentage of time that you spend doing medical-legal, has that remained pretty constant; increased; decreased?
A It really -- it varies a great deal. I do a number of different things. Probably 30 percent of my time is research and development. We have several medical devices that we've taken through cadaver patient series. We've traveled extensively doing clinical studies. We've published extensively. It's in the literature attached. I own about four or five patents now. We're continuing to do research. We have an office in Lafayette where we do that. We have biomedical people that we hire to do the physics and the development. Then I do a portion of my time for the Medical Board of California evaluating neurosurgical problems.

Q Are you -- now you said -- if I may stop you, you said about 30 percent of your time is spent with your research --
A Yes.
Q -- on devices?
A Well, research there. And I've, also, -- coming from Florida, I had a marine interest, and I'm working with a research lab with Florida Institute of Technology on that project.
Q Is this still within the 30 percent?
A Yes.
Q Okay. I got you. Okay. So then what percentage would be clinical?
A Clinical is probably another 30 percent. I see patients two full days a week. I do a clinic up in Mendocino. There used to be five neurosurgeons in Santa Rosa and four in Eureka, but it's now two guys. So there's a huge population that's underserved, and so we go up there every week. And once or twice a month we'll spend two days there, and we see patients from mostly Eureka, Fortuna, the 101 corridor, Fort Bragg, Mendocino --
Q But that's all included within the 30 percent of your clinical?
A Yeah. And then I see patients from UCSF.

Workmen comp. at UCSF is right next door, and so we'll see those people with spine problems.
Q Is that -- do you consider that part of your clinical or part of your --
A That's part of the clinical.
Q And then 40 percent in med-legal, or am I skipping something?
A As far as timewise, yeah, the med-legal and peer review. Also, I do a chunk of time reviewing neurosurgical practices around the country. There's a lot of small hospitals that have one or two neurosurgeons, and it's usually the OR executive committee or something will wonder about standard of care issues, and so we'll go in there and look at 30 or 40 cases and report to them, and that takes -- when that happens, it can take up a huge amount of time.
Q Okay. Now, I'm a little unclear. Are we in the -- is this part of what you consider med-legal?
A Well, I would -- I mean, I guess with the board of medicine that would be med-legal, too.
Q Okay.
A So, between peer review, board of medicine, we do a lot of standard of care or malpractice referrals, and 80 percent of that is plaintiff; but the majority of the civil cases, such as this, are probably defense

cases.
Q Okay. And so let me just focus on that civil part of civil cases. How much -- what percentage of your time do you think you spend on those civil cases?
A I spend almost no time during the daytime unless I'm traveling like coming up here for a depo. So I'm in my office every night going through stuff like that. So I would say probably 50 percent of the time I'm reviewing records in the evening, on the weekend.
Q Okay. But, in terms of the overall time that you spend as a working physician, --
A Yeah.
Q -- any way to characterize how much time you spend doing the med-legal civil stuff?
A I would say probably 30 to 40 percent of the time.
Q Okay. And what percentage of your income does that generate?
A Probably 70 to -- plus percent.
Q Okay.
A And research presents zero income.
Q Okay. All right. And then so, in terms of actual amounts that you earn doing medical-legal, how much has that been, say, within the last three or four years?

A Probably 5 to 600,000.
Q Okay. Would you say that over the last five years that you've increased the amount of med-legal civil work that you've been doing?
A I don't think so. I can't go any harder.
Q Yeah. Okay. So that's remained pretty constant over the last five years or so?
A Yeah. In fact, it's probably dropping a little bit, but I'm just not as full of beans as I used to be.
Q All right. Now, you mentioned you had seen the materials that was provided by Dr. Dublin. Was that his report?
A His report only.
Q Did you ever speak to him?
A No.
Q Anything that you're -- specifically in that report that you're relying on in formulating your opinions?
A No. I mean, my opinion seems to be validated by his report. I mean, I felt they were all degenerative changes.
Q He didn't necessarily add any new information to you that you already had; he just confirmed what you had already decided?

A Correct.
Q With regard -- did you ever review anything from Larry Neuman?
A From who?
Q Larry Neuman. Do you know who that is?
A No, I have no idea.
Q How about Rick Roberts? Did you ever review any materials from him?
A No.
Q All right. Did you consider the amount of forces that were involved in the collision in arriving at your opinions?
A No. They were sufficient to cause an injury. That's for sure.
Q All right. And sufficient to cause, for instance, a myofascial injury, soft tissue injury?
A Correct.
Q Sufficient to cause a disc herniation?
A It could have.
Q Okay. Well, I mean, in terms of the forces -- you're not saying it did, but, in terms of the forces that were involved, they were sufficient to cause disc injury; true?
MR. PAWLOSKI: Wait. Objection. Incomplete hypothetical, lacks foundation.

Go ahead.
THE WITNESS: I've not read his report, you know, but I'm just going from the patient -- both the patients' description of the injury.
MR. ROSENTHAL Q: So you have the deposition of Michael Aveni. You've reviewed that; right?
A Yes.
Q The deposition of Miss Hunt, Anne Hunt?
A Yes.
Q The deposition of Mr. Mini, the driver of the truck; true?
A I don't think I saw him, no.
Q Okay. Have you seen any pictures of the vehicles involved in the collision?
A No.
Q Have you seen any property damage estimates or anything like that?
A I saw a couple. There was one for $9,000 to the car, but that was in Dr. Orisek's record. That's the only one I've seen.
Q Okay. All right. Did you feel like you had enough information based on everything that you reviewed to decide whether there was a disc injury in this case or not?
A Yes. I just thought that the description of

injury was -- I mean, of the accident from their description was sufficient that it's very similar to dozens of other cases I reviewed that you could get similar injuries.

Q Okay. And, when we say "similar injuries," that's what I'm kind of saying. And I'm not tying you down in this specific case, but, in general, in an accident like this, you could suffer a soft tissue injury; right?

A Correct.

Q And, in general, in an accident like this, you can sustain a disc injury?

MR. PAWLOSKI: Well, sustained objection for foundation, but go ahead. Incomplete hypothetical.

THE WITNESS: When you say a disc injury, we look for evidence, objective evidence, of a disc injury.

MR. ROSENTHAL Q: And here is where I want to make sure that we understand each other, Doctor. I'm just talking about in your experience, your clinical experience in your treating your patients and knowing what you know about their situations, you can sustain a disc injury in an accident similar to this; correct?

MR. PAWLOSKI: Well, objection. Vague, speculation, lacks foundation.

MR. ROSENTHAL: Well, objection coaching the

expert witness, but anyway --
MR. PAWLOSKI: No. I'm making legal objections, every one of those.
MR. ROSENTHAL: Yeah, I know.
MR. PAWLOSKI: Every one was a legal objection.
MR. ROSENTHAL: Yeah, every one was an unsustainable legal objection. But, anyway, go ahead.
THE WITNESS: It's possible to get a disc injury. I believe the patients were factual. Dr. Aveni, particularly, I found he was factual in his recount of the accident and his deposition. I would not say the same for Miss Hunt; but, for Dr. Aveni, he was truthful and forthcoming, and I think he was honest in his complaints, and he did have some objective findings.
MR. ROSENTHAL Q: Okay. What were those objective findings?
A Mainly reproduction of the pain with certain neck motions, the tenderness, and, neurologically, he was totally intact. So, objectively, you're only left with the patient's subjective complaints, and the only objective findings you have is some slight restricted range of motion of the spine and some tenderness.
Q And you're talking about an examination that you performed recently; true?

A Correct.
Q So, the restricted range of motion, is that due to the motor vehicle collision?
A Or due to the pain that he was complaining about.
Q Okay. Well, is the pain -- the pain is due to -- the restricted range of motion is due to the pain that he's talking about?
A Correct.
Q Is the pain that he's talking about due to the motor vehicle collision?
A As far as -- I believe the evidence is that his complaints are caused by the motor vehicle accident.
Q Okay. And what are the cause of -- what are the underlying cause of those complaints?
In other words, is it myofascial?
Is it aggravation of disc disease?
What is it?
A His complaints, subjective, are all muscular-type complaints. He had no radiological -- I mean, no neurological findings or neurological complaints. His objective findings were limited on exam to some muscle restriction. There were no objective radiological evidence of injury. I think his complaints were mostly myofascial, but he had underlying

degenerative disc disease and well could have a component of what's called discogenic or facetogenic-type pain, either one. He had some mild degeneration in both.

Q Okay. So -- and, when you say "both," they're actually two different things; right?

You're talking about disc -- potentially, there's a component of discogenic disease; correct?

A Could be, yes.

Q Okay. Potentially, there's also an element of facet-mediated pain?

A Correct.

Q Okay. And those are -- those are from the facet joints?

A Correct.

Q Okay. And is it your belief, more likely than not, that there was discogenic pain, a component of discogenic pain?

A No, I can't say that with any reasonable probability.

Q Okay.

A His complaints -- most of his complaints were muscular, and they would be classified as myofascial.

Q So is it your opinion that, more likely than not, his ongoing complaints today are due to a -- are

myofascial in nature?
A Correct.
Q Could be discogenic, but you don't feel that's more than likely?
A Not more than likely and certainly in improving.
Q And, in terms of facet, it's possible, but not more than likely?
A Not probable, but possible.
Q When you looked at the MRI, did you see that there was a disc herniation at C6-7 on the first MRI?
A No, I did not.
Q What did you see at C6-7 on the first MRI?
A They were degenerative complex, both -- when the disc darkens and dehydrates, part of the process is some flattening and bulging of the posterior longitudinal ligament and eventually some spur formation or osteophyte formation, and that's what we saw in him, in my opinion, was disc end folding, but it was not a herniation.
Q Okay. So --
A Certainly not acute.
Q What would you -- how would you characterize the pathology at C6-7 as shown on the first MRI?
A Age-related changes.

Q Okay. I mean, was it -- you're saying that it was not a herniation, though; correct?
A It was not a herniation.
Q Okay. You were saying a disc bulge?
A Well, I -- the proper definition of herniation is greater than 4 millimeters of disc material, and certainly it was nothing like that. He had -- he had a -- let me see. I want to make sure I don't mix the two up. I thought he had a very teeny anterior disc osteophyte complex at 5-6 and more extensive degeneration at 6-7, but there was no significant stenosis of the canal or the nerve outlets at either level.
Q Was there any foraminal stenosis?
A Not of any significant, no.
Q How do you determine whether foraminal stenosis on an MRI is significant?
A By if they have radiculopathy, one thing; but just we look at MRIs all day long, every day, and examine patients, and when people have significant foraminal stenosis enough to cause nerve root compression it's usually more than you see here. You, also, can test for foraminal compression on exam, and it's very specific, and he did not have that, and he had no neurological symptoms. He had some effervescent

tingling in the past, but not when I saw him.
And most of us think that people with acute whiplash or myofascial injuries have a lot of contracture of their cervicothoracic musculature, and they actually get what we call physiological thoracic outlet syndrome, and it comes and goes. It's largely positional. But, when people are in a lot of pain, they tend to contract with that; and, if you have a narrow thoracic outlet to start with, then that could cause it. That type of hypothesis is totally unprovable, I mean, because you would have to be able to do an MRI with them in that position, which you can't do. And, actually, we can see thoracic outlet compression now on MRI. It's that good. You can actually see edema. But that's not in this type of situation.
Q All right.
A But, if you look for it, you can often elicit that type of history.
Q He describes in his -- in the medical records and in the -- and in his deposition some complaints in both arms; right?
A Yes.
Q And he's got some numbness and some referred pain in his arms?
A When I saw him, he had some headaches,

referred pain to the head, but he did not -- I did not elicit a history of numbness in the arms the time I saw him.

Q Did he ever describe that as something that would kind of come and go?

MR. PAWLOSKI: The headaches or the --

MR. ROSENTHAL: I'm sorry. The numbness in the arms.

THE WITNESS: Well, he would not give me that numbness as a complaint when I examined him on the 10th of March.

MR. ROSENTHAL Q: One of the things that can happen is you can have some degenerative process in your spine, and it is asymptomatic until a traumatic event, and then it becomes symptomatic; is that fair to say?

A That's exactly what I'm saying when I say he had an aggravation of a previous asymptomatic condition.

Q You're saying that he did?

A Yes. I think he had -- that's the diagnosis that I would opine to him.

Q Okay. But I thought you said that you felt it was more likely than not that he did not have a component of discogenic pain?

A I cannot prove it. I said he had preexisting degenerative cervical disc disease that's asymptomatic.

And so we say the accident lit up that degenerative changes causing mostly myofascial-type pain.
Q Okay. But are you saying that it's likely that the trauma lit up the preexisting degenerative changes causing it to become symptomatic?
A Correct.
Q Okay. And that is the reason for the underlying -- the myofascial symptoms that he's having?
A Correct.
Q Okay. Are you making a distinction between cervical degenerative changes in general and discogenic degenerative changes?
A No. I think they're all part of the same complex.
Q All right. So Dr. Aveni's symptoms were due to a traumatic aggravation of preexisting -- some preexisting degenerative process?
A Correct.
Q We don't know what that was because we don't have a -- exactly what that was because we don't have a pre-accident MRI; correct?
A Correct. But the changes on MRI that were done within months of the accident showed changes that clearly had to take years to form.
Q There was a second MRI. You saw that?

A Yes.
Q And it appeared to show a difference at the C6-7 level; is that correct?
A Yeah. I went over that again last night, and I, frankly, have a hard time -- I mean, there's a little central bulge at 6-7, and I'm not sure if it's a feature of the technique or a real finding, but it's an insignificant difference between the two MRIs, in my opinion.
Q Okay. You saw Dr. Orisek's deposition?
A Yes.
Q He said there was a resorption of the disc at C6-7?
A Yes.
Q And you disagree with that?
A I do, yes.
Q Okay. You didn't see -- you didn't appreciate a significant difference between the two MRIs?
A I did not.
Q Do you have -- do you isolate which degenerative changes -- in other words, at C5-6 or C6-7 -- that were aggravated by the trauma?
A No. I don't think you can really tell. I mean, they're, essentially, minimal degenerative changes at both levels that are not significantly difference

between one another. I would defer again to Dr. Dublin, but I don't think that there was any significant difference.

Q All right. With regard to the medical care that Dr. Aveni received, was the chiropractic care that he received reasonable?

A There is good clinical validation or evidence-based literature to support chiropractic care in the first three months after an acute injury. There is no evidence to base improvement on chiropractic care after three to four months.

Q All right. So is it your opinion the chiropractic care that he received within the first three months of the collision was reasonable?

A Yes.

Q And made necessary by the accident?

A Correct.

Q Well, did you review the bills and determine if any of it --

A I did not review the bills.

Q All right. What about the first MRI? Was it reasonable to have an MRI with regard to the cervical spine?

A Yes. In today's time, I think it's the usual and customary.

Q Okay.
A We used to say that you don't do an MRI until you have evidence of nerve root compression or spinal cord compression, but that's before we had an MRI on every corner.
Q With regard to the --
MR. PAWLOSKI: MRIs R Us.
MR. ROSENTHAL Q: So the first MRI was reasonable?
A Yeah.
Q What about the second MRI? Was that, also, reasonable?
A Yeah. I mean, it's -- according to somebody, there was another accident, but in 2012. So it makes sense to get another one to see if there's a difference.
Q Okay. Was it your impression that the MRI for the second accident was caused -- strike that.
Was it your impression that the need for the second MRI was for an accident that he had in 2012?
A Was caused by what?
Q Sure. Was it your impression from review of the records that the need for the second MRI was caused by another accident that he had in 2012?
A No.
Q Okay. So was -- the second MRI, it was

reasonable, and it was made necessary by the first accident; correct?
A Well, our practice is probably typical with everybody else. If somebody wants to send a patient to us for consultation, the MRI has to be no more than a year, preferably less than six months; and, if we decide or even thinking about surgery, an MRI that's over a year old, we'll repeat it. So I think the question of surgery arose again, and the MRI that's done in 2011 is outdated.
Q Okay.
A It made sense to repeat it.
Q All right. So, if they did a third MRI a year later, that would be reasonable as well?
A Well, I think that the accident is 2010. You repeated the MRI 2013. I don't see any reasonable need to do another one unless there's dramatic change in symptomatology.
Q Okay. It's your feeling that Dr. Aveni is not a good candidate for a disc replacement procedure?
A Absolutely. I mean, it's interesting. Dr. Orisek first wanted to do it at 6-7, but when he got the second MRI he changed it to 5-6. And I think that not only it's not reasonable; that would be probably disastrous. Because, if he did 5-6, and you've got

degenerative changes at 6-7, you're bound to get adjacent-level problems there. And, if you do 6-7, and you know you've got some degeneration at 5-6, you're just asking for a problem. You don't have to wait for adjacent-level disease. It's already there.

Q Given the length of time that Mr. Aveni -- Dr. Aveni has had his symptoms, do you feel it's likely that those symptoms are going to continue into the future?

A On a sporadic basis, yes.

Q Sporadic basis for the rest of his life?

A No. I mean, that -- we don't know. I mean, there's a lot of us who have been symptomatic for years and then finally realized it didn't bother you anymore.

Q In terms of probability, how long would you say that it's probable that he's going to continue to have symptoms?

A Well, I think if it's just myofascial and there's no underlying pathology, the usual symptomatology, the median, or when half the people are well, it's before six months; but, like any natural population distribution, you never get to the end of the bell-shaped curve. There's always some people that are there years out.

Q Well, what we do know is, and I think from

your testimony is, that Dr. Aveni's pain, up until this time, was caused by the motor vehicle collision; true?
A Correct.
Q Okay. So he, obviously, falls outside the bell curve; true?
A No. He's still in it; he's just further down the slope.
Q Okay. And, if I understood correctly, I thought you said that there was some underlying pathology that is contributing to his myofascial pain?
A Well, there's some pathology there. You can't ignore that, and so, you know, you say, Well, it could be part of the problem.
Q Well, given all we know, is it likely that these symptoms are going to persist in some capacity for the rest of his life?
A I don't think you can say probable, but it is possible.
Q If you had to limit it to probable, do you have a timeframe?
A No.
Q Five years? Ten years?
A No.
Q Can't do that?
A I'd say under five.

Q All right. And you'd feel like injections would help?
A Pardon me?
Q Do you feel like injections would help Dr. Aveni?
A Adjustments, chiropractic adjustments?
Q I'm sorry. I misspoke.
Injections, do you think there are any type of injection that might be beneficial to Dr. Aveni?
A Oh, no, no.
Q Okay. What about facet injections?
A You know, it's something people try. I mean, -- I mean, facet injections, everybody thinks they're the new kid on the block, but they're not. We did facet injections in the 1980s and early 1990s on everybody all the time. I did them. We thought it was the best thing since Cracker Jacks for a while, and then we -- and now nobody ever has heard that we've been down this road before, and so everybody is doing facet injections.
What happened in the interim was diskography came along, and so everybody got a diskogram: You must have a painful disc; we'll inject that. And, boy, we paid for that philosophy. And nobody does diskography anymore, but you can bring in all these pain guys out

there that you've taken away their number one thing, and so now you see it's something to replace it and it's called facet injections.

And maybe they'll get further than they did before, but I have people -- I just saw some this week that had facet injections, and the first time it's wonderful, and they get a couple months. And the second time, well, it's not so wonderful. You know, they got maybe a month. And then the third time it doesn't work. But yet you see over and over, "Well, you need facet injections, up to three a year, for life." But those of us in the business, when we follow these patients, it's extremely rare that anybody even asks for the fourth injection. They just give up on it themselves. So are we really doing anything of benefit, or is it just placebo?

Q Is that what you feel about it; that the facet injections are a placebo?

A It could be. It's not been proven to the otherwise at this point.

Q Okay. Epidurals, same thing?

A Epidurals have clear indications, and that is nerve root compression with a radiculopathy, and they are safe in the lumbar spine because there's not much around the nerve root. The nerve root comes out.

There's nothing important.
In the cervical spine, you've got the vertebral artery of the brainstem. I've seen a couple strokes after epidurals. I mean, you're millimeters away from their artery when you inject. And a lot of people inject what they call interlaminar injections. I've seen five people paralyzed from the neck down with intralaminar injections. So it's not a free lunch. There's significant catastrophes. And, unless something has proven efficacy, you're just taking a risk. So I don't recommend cervical epidurals for anybody. Sometimes we'll do a transforaminal injection. You can do that if the guy is good. But, interlaminar, when you see somebody that's just had pain before and now is a quad, it makes you pause.
Q I want to -- I don't want to be presumptuous. Are these your reports regarding Plaintiffs Aveni and Hunt?
A Yeah.
MR. ROSENTHAL: Could I mark those separately.
(Whereupon Plaintiffs' Exhibits G, H and I were marked for identification.)
MR. ROSENTHAL Q: This is a March 10, 2015, report. Is that the only report that you prepared with

regard to Dr. Aveni?
A I think so, yes.
MR. ROSENTHAL: Okay.
THE WITNESS: And this is Dr. Dublin's report. I guess you have that.
MR. ROSENTHAL Q: And then you have Anne Hunt's report?
A Yes.
Q It's just one report?
A Yes.
Q I'm going back to A. Is this a printout of the site that you and Dr. McCormack maintain?
A Yes.
Q I'm not going over specifics, but Dr. McCormack is responsible for putting that content on the Website?
A Yes.
Q Do you think it's all accurate?
A I think it, basically, is accurate, yes. The previous question you asked, certainly trauma occurs more frequently during that age group.
Q And, I mean, when you say "trauma," you mean traumatic injury to a disc --
A Yes.
Q -- in that 30 to 50 age group?

A Yes. The most common cause of death after age 40 is trauma.
Q Reckless young people in the world.
A Huh?
Q There's so many reckless young people in the world.
A Us old farts, too.
MR. ROSENTHAL: That's all the questions I have for you at this point.

EXAMINATION

By: RONALD R. HAVEN, Attorney at Law, counsel on behalf of the Plaintiff, ANNE HUNT:

Q Dr. Eyster, I'm Ron Haven. I represent Anne Hunt. I'm not going to repeat everything that was asked of you before, but I would like to ask you, specifically with respect to Miss Hunt, how long did you spend examining her?
A With the examination?
Q Yes, sir.
A I don't recall. I mean, we devote an hour. We charge an hour whether we spent that much time. I don't recall, but part of that time it's history-taking and then examination.
Q All right. Let me ask you, you know, just point-blank. You say in your impression that the

accident that we're talking about here caused soft tissue injuries to the cervicothoracic spine as well as the cervical spine; is that correct?
A Correct.
Q Can you describe for me what the injury was that she received?
A Well, I mean, she had probably a hyperextension flexion-type injury. She had underlying degenerative changes that were probably aggravated by the accident.
Q Okay. Was she still complaining of pain when you examined her?
A Pardon?
Q Was she still complaining of pain on the date that you examined her?
A Yes. Absolutely, yes.
Q The pain that she was complaining of on that day, was that caused by the accident?
A Yes. Well, part of it was. I think, in reviewing the medical records, I had some reservations about the thoracic.
Q The upper thoracic?
A Yes.
Q Okay. We know that she had some treatment going back to the late '90s, early 2000, timeframe; is

that right?
A Yes.
Q Okay. When was the last time prior to this accident that she received any treatment on her neck?
A 2005.
Q Okay. It was in 2005 she did receive some neck therapy at that time?
A Well, it was to the midback. I mean, I have records from Dr. Farr, the chiropractor, that, like a lot of chiropractic records, don't give you a wealth of information.
Q You're not a chiropractor, are you?
A Pardon me?
Q You're not a chiropractor?
A No.
Q And you don't pretend to be an expert in chiropractic issues?
A No, I don't.
Q Okay.
A Fortunately, I had a lot of them as patients, but -- his records -- in fact, the first record we have is a pain diagram that was filled out by the patient.
Q What's the date of that?
A It doesn't have a date, but it's got the 1994 injury on it.

Q Okay.
A And she had circled the neck, the lower scapula, and the lumbar in the right.
Q What I want to ask you, though, is when was the last time that Dr. Farr actually treated her neck?
A Her midthoracic seems to be last treated by him in 2005.
Q So when did he last treat her neck?
A The neck, I don't know. I mean, the pain diagram also included the neck. In his records, from what I can read, he talks about the low back he treated and then the midback, and then some of the records also have cervicothoracic, but I can't see that he actually treated those.
Q Okay. Is there any evidence that she had any treatment for her cervical injuries between 2005 and 2010?
A No.
Q Are you aware of what her activity level was before this accident?
A Well, she works in the produce department at a grocery store.
Q Do you know what that means, what that involves?
A Unfortunately, I do. I worked my way through

college.
Q All right. So you're lifting heavy boxes?
A And unloading semis in the dark.
Q All right. So she was doing those kinds of things. What else did she do between 2005 and --
A She stacked the produce. She had to arrange the displays. It's back-bending work. I mean, it's --
Q Okay. Do you have any reason to believe that she was complaining of symptoms between 2005 and 2010 in the cervical area?
A No. But, I mean, we -- what troubled me was the diagrams that Dr. Aveni had of her spine when she was being treated by him after the accident.
Q What troubles you about that?
A Well, he primarily marks the midback, some of the low back, and also the neck; but, if you look at his scribbling, it goes down to the upper lumbar, includes the base of the neck, and that's where most of her symptoms were back when she was receiving treatment with Dr. Farr in the midthoracic area, which is where Dr. Aveni keeps marking his pain diagram.
Q So we have -- we have Dr. Farr up to about 2005, and then we have Dr. Aveni with similar symptoms in 2010 and later; is that correct?
A Yes. I mean, as far as the midback, the

thoracic. I think her cervical may be new. I can't prove that it's not. But at least the areas treated by Dr. Aveni on his pain diagram seem to be the same ones that Dr. Farr treated back in 2005, and she tells me that they're still definitely work-related that she gets those symptoms. So, one, you have to assume she's done the same work that caused it before and caused treatment for 10 years; and then she did the same work for five more years, and then she has the same symptoms again after doing that work again.

Q And, also, after her accident?

A Pardon me?

Q And, also, after her accident?

A Yes, yes.

Q Okay. Based on your knowledge of the accident, is the accident severe enough to cause her injury to her neck area?

A Yes.

MR. PAWLOSKI: Lacks foundation. Go ahead.

THE WITNESS: I mean, I -- I mean, I think they both had what we call a myofascial injury from the accident.

MR. HAVEN Q: Okay. And, in her case, also, did this injury light up her preexisting condition which, apparently, had been asymptomatic for five years?

A Well, it lit up part of the condition that's asymptomatic. At least I think the records don't allow you to come down firmly one way or the other. It could well be, according to Dr. Farr's record, that she had some cervical complaints. I think his records are inadequate to answer the question, "Did those complaints continue, or were they part of the thoracic complaints with" -- I mean, if you have a thoracic disc that's hot in the mid to upper back, you can get cervical complaints with it because it aggravates the same muscle group.

Q But it's fair to say that Dr. Farr's records document a thoracic problem, but they do not document a cervical problem after about 2003; isn't that true?

A That's probably true, yeah.

Q All right. So, when it comes to the thoracic injury, from a medical causation standpoint now, from a medical causation standpoint, you would agree that she suffered a neck injury or a cervical injury for the first time in this accident?

A I'm not sure. I mean, because we have records going back where the neck is circled by the patient in a questionnaire that, apparently, is 1994 vintage. Because she -- on that same page she referenced a 1994 injury.

Q Okay. So we have a pain diagram 16 years before our accident --
A Yeah.
Q -- that documents a neck injury; --
A Correct.
Q -- is that what you're saying? Okay.
Do we have any additional documentation of a neck injury after 2003?
A No, we do not.
Q Can you say if it's more probable than not that from 2003 to 2010 at the time of this accident that she was suffering neck symptomatology?
A I can't say that, but, more probably than not, she was. I think, more probable than not, she continued with the midback problem which was work-related.
Q All right. You would expect somebody who does that kind of work to have a backache once in a while, wouldn't you?
A I quit.
Q Okay. Wise choice.
Do you have a fellowship in spine surgery?
A Neurosurgery does not have a requirement for that.
Q So the answer is no then; correct?
A Right.

Q All right. I was confused by what you said about Dr. Dublin. I thought you said Dr. Dublin's reading of the radiological images was the same as yours; is that correct?
A Right.
Q All right. He simply confirmed your opinion?
A Yes.
Q You don't consider Dr. Dublin to be more of an expert in reading MRIs and x-rays than you are, do you?
A Well, that's what -- I mean, he's a board certified neuroradiologist. I defer my opinion to such a person with those credentials.
Q Well, you're a board certified neurosurgeon, aren't you?
A Correct.
Q And part of what you do as a board certified neurosurgeon is look at radiological images and then do surgeries based on what you see there?
A Yes. I mean, often we do it in concert. If there's any question, we will review it with a neuroradiologist.
Q All right.
A But, I mean, a lot of times we might come in with a footdrop and a huge ruptured disc at 4-5, and you don't need to waste time getting somebody to look at

that. But, when you're looking at something that somebody says one thing, and you don't see that, then those are the type of questions, "What do you see with no preamble?" Such as this case, "Just tell me what you see."

Q Okay. Let's go back to Anne Hunt's thoracic issues.

A Uh-huh.

Q Did you find any record of complaints in her thoracic back after 2005 up until the time of this accident?

A I have no medical records at all for that period of time.

Q Okay. In her deposition, did she say that she was not having problems in the neck and the cervical spine -- excuse me -- in the thoracic spine for five years before this accident?

A Well, she also said that --

Q Did she -- just answer my question. Did she say that?

A Yes. I think she said that in her deposition.

Q And she also said what?

A That she was only treated for a lumbar problem --

Q Uh-huh.

A -- by Dr. Farr. And she told me the only injury she had was to the low back and working at the workmen's comp. injury.
Q All right. Have you reviewed the workers' comp. records to determine what her complaints were in that workers' comp. claim?
A The only records I have are from that period of time with Dr. Farr's records.
Q So then the answer is, no, you haven't reviewed that?
A No, I have not, no.
Q All right. Did you review the Kaiser records regarding Miss Hunt?
A I did.
Q Did you find anything in the Kaiser records that was inappropriate?
A No.
Q Would you believe that the orthopedic treatment and evaluation that she had at Kaiser was appropriate for her injury?
A Yes.
Q All right. Was there anything that Kaiser did in evaluating her neck and thoracic injury that you felt wasn't reasonable?
A Yes.

Q What was that?
A I'll have to go back and see, but I think they -- that she was referred to their --
Q The acupuncturist?
A Well, part of her treatment was for the knee, which is outside of my field of expertise, at Kaiser; but, as far as the referral to Dr. Bertsch, I thought that was appropriate.
Q Did you think that Dr. Bertsch's treatment of Ms. Hunt was appropriate and necessary?
A Yes.
Q All right. So just we have to go take another deposition here so I'm trying to hit the mountaintops if I can.
Did you see anything in the Kaiser records regarding the treatment of Ms. Hunt's spine that was unreasonable or unnecessary?
A No.
Q All right. Did you see anything -- strike that.
MR. HAVEN: That's all I have. Thank you.
MR. ROSENTHAL: I think we're done.
MR. PAWLOSKI: Okay.
MR. HAVEN: One more question.
Q Do you do civil med-legal stuff outside of

Sacramento? When you work for this group here where we're at right now, do you do similar for other groups in other parts of the state?

A No other groups. I used to do QME work, which I guess is workmen's comp. evaluation.

Q All right. But you have this agreement where you work with this outfit here in Sacramento. You don't have similar agreements with other outfits in other cities?

A Well, there's a group called Benchmark that does QME work that I worked for years ago, and then I'm trying to distance myself from them. I still have a contract, but I don't -- there's one lady there that had her own shop, and she sold it to them, and she helped me when I first started doing QME work, and I never heard of that before I came to California, and she's a dear, and I'll see her -- about one patient for her a year or something like that.

MR. HAVEN: Thank you very much.

(Whereupon the proceedings were concluded at 2:58 p.m.)

CASE: AVENI vs. MINI, et al.
DATE: March 31, 2015

I hereby declare under penalty of perjury that I have read my deposition transcript, made the changes and corrections that I deem necessary, and approve the same as now true and correct. I hereby state there are: (Check one)

_____NO CORRECTIONS

_____CORRECTIONS ATTACHED

_____
E. FLETCHER EYSTER, M.D.

_____
DATE SIGNED

--o0o--

DEPONENT'S CHANGES OR CORRECTIONS

DEPONENT: E. FLETCHER EYSTER, M.D.
CASE: AVENI vs. MINI, et al.
Job No: 15-5373
Date of Deposition: March 31, 2015

NOTE: If you are adding to your testimony, print the exact words you want to add. If you are deleting from your testimony, print the exact words you want to delete. Specify with "add" or "delete" and sign this form.

PAGE	LINE	CHANGE/ADD/DELETE
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I hereby certify that I have read my deposition transcript, made those changes and corrections that I deem necessary, and approve the same as now true and correct.

Deponent's Signature:_____Date_____

CERTIFICATE OF CERTIFIED SHORTHAND REPORTER

I, KAREN FORSTER, a Certified Shorthand Reporter, licensed by the State of California, being empowered to administer oaths and affirmations pursuant to Section 2093(b) of the Code of Civil Procedure, do hereby certify:

That the witness named in the foregoing deposition was present at the time and place specified;

That the witness was by me sworn to testify the truth, the whole truth and nothing but the truth;

That the said proceeding was taken before me in shorthand writing, and was thereafter transcribed, under my direction, by computer-assisted transcription;

That the foregoing transcript constitutes a full, true and correct record of the proceedings which then and there took place;

That I am a disinterested person to the said action;

IN WITNESS WHEREOF, I have hereunto subscribed my signature on this _2nd_ day of _April_, 2015.

_____

KAREN FORSTER, RPR
California CSR # 8691

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April 2, 2015 Job No. 15-5373

E. FLETCHER EYSTER, M.D.
87 Scripps Drive, Suite 116
Sacramento, California 95825

--o0o--

Re: AVENI vs. MINI, et al.
Date taken: March 31, 2015

--o0o

Dear Dr. Eyster:

Your deposition in the above matter is now available at this office for you to read, correct and sign for 30 days from the date of this letter. You may wish to discuss with your attorney whether he/she requires that it be read, corrected, if necessary, and signed.

Please call for an appointment within the next 30 days on any weekday, between the hours of 9:00 a.m. and 3:00 p.m.

If you do not desire to read your deposition and wish to waive signature, please sign your name and date below, and return this letter to our office.

_____ _____
SIGNATURE DATE

Sincerely,

L.J. HART & ASSOCIATES, INC.
BARRON & RICH
Certified Shorthand Reporters

cc: S. DAVID ROSENTHAL, Attorney at Law
KEITH R. PAWLOSKI, Attorney at Law
RONALD R. HAVEN, Attorney at Law

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April 2, 2015 Job No. 15-5373

ROSENTHAL & KREEGER, LLP
ATTN: S. DAVID ROSENTHAL, Attorney at Law
2251 Douglas Boulevard, Suite 120
Roseville, California 95661

--o0o

Re: AVENI vs. MINI, et al.
Deposition of: E. FLETCHER EYSTER, M.D.
Date taken: March 31, 2015

--o0o

Dear Mr. Rosenthal:

We wish to inform you of the disposition of this original transcript. The following procedure is being taken by our office.

_____ The witness has read and signed the deposition. (See attached.)
_____ The witness has waived signature.
_____ The time for reading and signing has expired.

XXX The sealed original deposition is being forwarded to your office.
XXX Other.(Due to trial date of April 6, 2015)

Sincerely,

L.J. HART & ASSOCIATES, INC.
BARRON & RICH
Certified Shorthand Reporters

cc: RONALD R. HAVEN, Attorney at Law
KEITH R. PAWLOSKI, Attorney at Law