12:21:17 THE COURT: Here's what I'm going to do. I'm
12:21:18 going to grant the motion. If there's a -- if there's
12:21:21 something that you think should have been that is a
12:21:23 reasonable inference that was raised by something that
12:21:26 the doctor said, and he makes an objection, you're
12:21:30 going to come up to the bench, we're going to talk
12:21:32 about it. And if it's something that I agree should --
12:21:36 is reasonably inferred from something that the doctor
12:21:38 said, we're going to allow it.
12:21:40 MR. CLOWARD: That's fair.
12:21:41 MR. JAFFE: Your Honor, what I'd also like to
12:21:42 put in the order then is that if any such reasonable
12:21:46 inferences, I'd like them brought out outside the
12:21:49 presence of the jury so that we can deal with it
12:21:51 beforehand. Because if Dr. Kaffcan gets on the stand
12:21:54 and says, "You know, with her pain and ongoing
12:21:58 problems, I think she's a reasonable candidate for a
12:22:01 stimulater down the line," well, ding ding ding. Good
12:22:04 luck unringing that bell.
12:22:07 And now I got to come up and argue that that's
12:22:09 not a reasonable inference and he's going to say,
12:22:11 "Well, it is because she's had ongoing pain and
12:22:13 problems and whatever."
12:22:14 We need to hear those things before.
12:22:16 THE COURT: If it's something -- if it's

something that you know, Mr. Cloward, before --

MR. CLOWARD: Absolutely.

THE COURT: -- the doctor testifies, make sure he knows about it so we can talk about it outside the presence beforehand.

MR. CLOWARD: Absolutely.

MR. JAFFE: Thank you, your Honor.

THE COURT: I would agree.

MR. CLOWARD: Nobody wants a mistrial. Nobody wants those kinds of things. I agree.

THE COURT: Okay.

MR. CLOWARD: We can for sure do that.

THE COURT: All right. So the motion is granted.

Number -- Defendant's motion No. 2 to preclude any treating physician who did not provide an expert report from improperly rebutting defense experts.

MR. JAFFE: Okay. Your Honor, this gets --

THE COURT: I think there's a couple of these rebuttal motions, isn't there? Maybe I am wrong.

MR. JAFFE: No. 5 gets into --

MR. SMITH: Oh, yeah.

MR. JAFFE: -- A rebuttal issue, but it's a slightly different one.

Here's the thing, Judge: I understand that a

12:23:14 doctor has the right to support his opinions, but when
12:23:16 a doctor is going to go so far as to say "I disagree
12:23:20 with the defense expert, I disagree with Dr. Schifini
12:23:24 or Dr. Ziegler, or whoever it may very well be, I
12:23:28 disagree with that," that is crossing the line into an
12:23:31 expert opinion that should have been disclosed.
12:23:34 Because what he's now doing is directly
12:23:37 rebutting a defense expert by name, by opinion, and
12:23:43 that's where it crosses over. When a doctor gets up
12:23:46 and then says, without naming the expert, "I disagree
12:23:50 with the opinion that this was preexisting and all she
12:23:55 suffered is a soft issue injury," that is rebutting an
12:24:00 expert opinion. And that is where that needs to have
12:24:04 been disclosed as an expert report.
12:24:08 Bear in mind, they had the plaintiff examined
12:24:12 by a doctor who did an IME to comment upon the defense
12:24:17 experts who is going to be testifying. And I want to
12:24:20 make sure also that we're not going into areas where
12:24:23 it's effectively going to be cumulative, where you're
12:24:26 going to have Dr. Muir and Dr. Kaffcan and Dr. Whoever
12:24:29 getting up and saying, "We disagree with Dr. Ziegler."
12:24:31 If they've hired Dr. Gross to do that, then let
12:24:35 Dr. Gross do that. Don't allow doctors to get up and
12:24:39 say, "I disagree with this, this, and this."
12:24:41 If they're going to sit up there and support

12:24:43 their treatment and their opinions, that's one thing.
12:24:46 To go the next step and cross that line and say,
12:24:51 "Dr. Ziegler on the defense is wrong, Dr. Schifini on
12:24:55 the defense is wrong, this opinion by a defense doctor
12:24:58 or somebody else is stated is wrong," that is now an
12:25:02 expert opinion that goes beyond their treatment and
12:25:06 their chart.
12:25:07 That's where I believe this motion is asking
12:25:10 for the relief, your Honor. We're asking that the
12:25:12 Court only allow them to testify to the parameters that
12:25:18 the Court has already stated, not go beyond that to
12:25:21 attack a defense expert or rebut a defense expert by
12:25:25 name or by his opinion.
12:25:27 THE COURT: Mr. Cloward, let me ask you a
12:25:28 question.
12:25:29 MR. CLOWARD: Sure.
12:25:30 THE COURT: Let's say as a plaintiffs' lawyer
12:25:32 you decided to be real tricky and you don't give your
12:25:39 treating doctors anything prior to their deposition, so
12:25:43 they treat the -- they treat the patient. They --
12:25:46 litigation is filed. The defense takes a deposition of
12:25:51 the doctors.
12:25:54 After the depositions are taken, then you give
12:25:57 your treating doctors the expert reports from the
12:25:59 defense. And you say, "We plan on asking you all kinds

of questions at the time of trial about these expert opinions, about these expert reports, and you're going to say all kinds of -- how you disagree with them."

MR. CLOWARD: Sure.

THE COURT: You don't name your doctors as experts. They're just treating doctors.

MR. CLOWARD: Sure.

THE COURT: You don't tell the other side that you plan on having them rebut these opinions. You just do that.

Isn't that trial by ambush?

MR. CLOWARD: No.

THE COURT: Tell me why.

MR. CLOWARD: No. 1, I wouldn't do that. I don't -- I don't -- you know, the rules allow you to do certain things. That doesn't mean you do them. I wouldn't do that. I hope that you know me well enough to know that I won't do that, because I do think that is trial by ambush. But I think that the rule specifically contemplates that that type of a thing will happen.

Specifically, that the amendment that the drafters' note says, and I'll quote it for the record, says, "A treating physician is not a retained expert merely because the witness will opine about the

12:26:57 diagnosis, prognosis, or causation of the patient's injuries," here's the important part, "or because the witness reviews documents outside his or her medical chart in the course of providing treatment or defending that treatment."

So I think the rule contemplates that that exact thing will happen, that the -- that the doctor will -- I mean, the shoe can always be on the other foot. Say the defense, for instance, they depose Dr. Muir early on. They get Dr. Muir to say, "You know, this is why I did what I did. I did it because of this, this, this, and this."

Then they hire Dr. Duke. Dr. Duke reviews Dr. Muir's deposition and says, "You know what, Dr. Muir is wrong because of X, Y, and Z. Okay. He shouldn't have done this surgery. He shouldn't have done this. He shouldn't have done that."

So he's criticizing the treatment that Dr. Muir performed.

So you mean to tell me that Dr. Muir can't come at the time of trial and talk about why Dr. Duke is wrong, and why his opinions, Dr. Muir's opinions are actually correct? I mean, you know, either you're going to have to have numerous depositions in every single case or you're going to have to realize that at

12:28:17 some -- some times there is a certain element of
12:28:21 unfairness.
12:28:23 And it's the difference between, you know,
12:28:26 trial by ambush and just, hey, you know what, Dr. Muir
12:28:29 was deposed a year and a half ago. Dr. So-and-so were
12:28:33 all deposed months after that. Dr. Muir had an
12:28:36 opportunity to review that information and he reviewed
12:28:38 it. The difference is is that Dr. Muir, anticipating
12:28:46 Mr. Jaffe's argument -- trying to do two things at
12:28:48 once. Sorry, Judge.
12:28:50 But it's not unfair. What would be unfair
12:28:55 would be to allow or to preclude Dr. Muir from
12:28:59 defending his opinions, defending his treatment,
12:29:03 defending what he did.
12:29:03 Now, I agree with Mr. Jaffe that what would be
12:29:06 unfair and what would constitute trial by ambush is to
12:29:12 say, this example: Dr. Muir is deposed. He gives all
12:29:16 of his opinions. "I treated the person. I did X,Y,
12:29:18 and Z."
12:29:19 Dr. Duke is deposed. Dr. Duke also criticizes
12:29:23 Dr. Kaffcan, Dr. Muir, and let's say Dr. Roesler is
12:29:25 involved. Now what would be inappropriate is to have
12:29:28 Dr. Muir get up there and rebut every single one of
12:29:30 those opinions as it relates to Dr. Kaffcan,
12:29:34 Dr. Roesler, and his own treatment. That would be

12:29:37 unfair.

12:29:38 But Dr. Muir should have a right in every
12:29:40 single case to get up there and defend the opinions
12:29:44 that he's given, defend his treatment. And if that's
12:29:47 to talk about the criticism that Dr. Schifini or
12:29:51 whoever else has made, then that's -- it is what it is.

12:29:56 MR. JAFFE: Okay. First off, your Honor, he's
12:29:58 allowed to defend his opinions, and he's got certain
12:30:02 things behind him to do it: Medical training, medical
12:30:05 experience, medical knowledge. You can explain all
12:30:07 that to the jury through his medical knowledge,
12:30:10 training, experience. That is what is typically
12:30:14 allowed. To then sit here and say Dr. Schifini is
12:30:17 wrong about this having given us a report is going
12:30:20 beyond.

12:30:20 But here's the disconnect with that argument.
12:30:24 Dr. Belsky, who is a treating doctor, when she took
12:30:28 issue with one of the defense experts, wrote a report
12:30:32 rebutting him. Why is that necessary if that's not the
12:30:37 case?

12:30:39 So their own conduct through their own
12:30:41 treating doctor made an expert under that exact
12:30:46 circumstance in that one scenario, did exactly what
12:30:50 Mr. Cloward is arguing that they don't have to do.
12:30:55 That -- when Dr. Belsky writes that report, that is

fair. That's where she now can talk about those opinions and directly rebut that expert because she has been made a rebuttal expert on that point.

For Dr. Muir and Dr. Kaffcan to sit here and start talking, and I don't know where Dr. Duke's name came up because he's not in this case, but to sit here and have them start criticizing other doctors, especially since they've been deposed, and if memory serves me correct, your Honor, you were quite prescient because I don't believe they did see the reports of the defense experts. But for them to get up there and start talking about it when they haven't rendered an opinion to that effect is crossing the line into expert testimony, your Honor, and I don't believe that would be fair.

MR. CLOWARD: Your Honor, may I add one more thing?

THE COURT: No.

Here's the deal, guys. Mr. Jaffe, I -- I'm going to deny the motion. I'm going to allow them to talk about these things, and it's primarily because of that last line of that section of the rule. It says "Or to defend their opinions."

I don't like that line. I don't know that that the Supreme Court or -- I guess it was the Supreme

12:32:20 Court thoroughly thought that out when they -- when we
12:32:25 adopted this new version of 16.1. But -- because I
12:32:29 think it opens us up to that scenario that I suggested.
12:32:36 MR. JAFFE: Your Honor, will I get to then, in
12:32:39 cross-examination, be allowed to raise the fact that
12:32:41 they have never in their chart or in any written format
12:32:44 or in a deposition contradicted those opinions
12:32:48 directly? I mean, I think that's fair
12:32:51 cross-examination and fair argument if that's the
12:32:56 interpretation of that rule.
12:32:59 THE COURT: I don't know why not.
12:33:00 MR. JAFFE: Thank you.
12:33:01 THE COURT: I mean, I think that's probably a
12:33:02 valid question to ask them, but -- if they didn't write
12:33:04 it down, somewhere. But I don't know that there's an
12:33:06 obligation for them to write it down somewhere, under
12:33:08 the rule. I don't know that there's an obligation
12:33:11 under the rule that they do a rebuttal report, even
12:33:14 though Dr. Belsky may have.
12:33:16 I don't know that there's an obligation under
12:33:17 the rule that these other doctors do. And I have a
12:33:25 rule -- I'm concerned with the language of the amended
12:33:29 rule because I think it opens us up to trial by ambush
12:33:34 in a way because doctors are going to be allowed to
12:33:38 offer opinions to defend their opinions, to defend

12:33:44 their conclusions, that doesn't necessarily have to be
12:33:48 disclosed prior to trial. I don't know that I like it,
12:33:50 but I think that's the way the rule is written, so I'm
12:33:53 going to allow it.
12:33:54 So your motion No. 2 is denied.
12:33:58 I don't know if you really care what I think
12:34:02 about the rule, but I figure I'd tell you.
12:34:05 MR. JAFFE: That's fine.
12:34:06 MR. SMITH: No. 3, your Honor.
12:34:07 THE COURT: No. 3 is to admit evidence of
12:34:10 medical liens. I already did that. You can make a
12:34:12 record if you want.
12:34:13 MR. SMITH: All right. Very briefly, your
12:34:14 Honor, because I know we're running long here.
12:34:16 There's a few reasons why Plaintiff -- why
12:34:19 evidence of medical liens needs to be admissible in
12:34:21 this case and in any personal injury case.
12:34:24 First of all, and I don't think this will be
12:34:25 the case here, but like you said, we never know what
12:34:27 comes out at trial. Sometimes it's a lot different
12:34:30 that what we found out through discovery. If, for any
12:34:34 reason, the plaintiff claimed that she couldn't get
12:34:35 some treatment or she couldn't -- because she couldn't
12:34:38 afford it or that some treatment was unavailable to her
12:34:40 because she couldn't afford it, particularly where she

was treated on liens, then we feel like, you know, the liens in that situation would become admissible to rebut that inference.

THE COURT: Might.

MR. SMITH: Secondly, liens show bias and interest. Now I know the plaintiffs are going to ask each one of Defendant's experts how much they were retained for, how much they charge hourly, you know, how much did you make on this case, and what have you. A treating physician who is treating on a lien has essentially garnered an interest in the case. They now have an interest in this case and they're more likely to get their money from this case if the plaintiff gets a verdict in her favor. And the larger that verdict is, the more likely they are to get the full amount of their lien.

So that bias is something that we feel needs to be -- it's fair game. Especially where they're going to expose the bias of our experts who have been retained on the defendant's behalf, that bias exists then for the plaintiff's treating physician. So for that reason we feel like the evidence of liens need to be -- is admissible.

THE COURT: Well, let me just address that real quick because the -- you're probably right. They

will ask about how much your experts are being paid, how much they have been paid, but you're going to probably ask the treating doctors and their experts the same thing, which I think evens the playing field.

Because their experts aren't going to come for free. They're going to be charged 5 or 10 grand a day. Their experts have charged a whole bunch more than that as well, I would assume so.

MR. SMITH: But the difference is that their experts stands to make on top -- their treating physicians stand to make on top of that what they're being paid to come testify at trial an additional sum. So that exposes a bias that goes beyond the bias that our retained experts do. Because if we get a defense verdict, our retained experts don't get any more money. So there's an additional bias there.

THE COURT: I understand.

MR. SMITH: And then finally, in Lobato, which is one of the governing cases we have in Nevada, it says that the only restrictions on collateral source -- or excuse me, the only restrictions -- sorry.

"To show bias and interest, any facts which might color a witness's testimony should be admissible." And so like I said, I think that interest that the physician -- treating physician has gained in

12:37:05 the case shows bias which color a witness's testimony.
12:37:09 And then Lobato specifically says "While the
12:37:12 Court generally has great deference to limit what
12:37:17 evidentiary information comes in, that deference for
12:37:19 the trial court is specifically narrowed where the
12:37:22 evidence shows bias."
12:37:22 And then it says "Then the Court should only
12:37:25 preclude it if it's repetitive, irrelevant, vague,
12:37:29 speculative, or harassment." Now, none of these
12:37:31 reasons are reasons why -- which we want to offer
12:37:35 evidence of the treatment on liens. We're not going
12:37:38 to, you know, repeatedly pound that in. I'm not going
12:37:41 to ask that same question to every doctor multiple
12:37:44 times, anything like that. It's relevant because it
12:37:46 shows their bias, you know.
12:37:47 So under Lobata we feel like liens and
12:37:52 information and evidence of liens should be admissible.
12:37:55 THE COURT: Okay. Because of the fact that I
12:37:57 think liens are collateral source, I have to weigh
12:38:02 the -- weigh and balance the Proctor versus Castelletti
12:38:06 decision against the Lobato decision to determine
12:38:09 whether or not I think that the bias in the value of
12:38:12 testimony regarding the bias outweighs the Castelletti
12:38:15 preclusion of all collateral sources. And I have to
12:38:20 come down on the side of Proctor and say that

collateral sources are inadmissible for any reason.

MR. SMITH: And just for the record, your Honor, it's our position that a lien is not a collateral source, because it's not --

THE COURT: I know.

MR. SMITH: -- it's not been paid. It's not, you know, evidence of payment by, for example, a health insurer. So we feel there's a distinction there that needs to be recognized.

THE COURT: Okay. All right. Let's go on to the next one.

Motion in Limine No. 4: "To limit Plaintiff's presentation of past medical special damages at trial to amounts actually paid by or on behalf of Plaintiff."

I see this as a collateral source issue also.

MR. JAFFE: Okay. Your Honor, and to address that collateral source issue then, Defendant relies heavily on -- I believe it's the Tri-County case. First of all, the Tri-County case addresses this in a worker's compensation setting, so it's different than a personal injury setting. But one of the important distinctions in that case -- and let me turn to it so I can get the citation correct.

Because -- so Tri-County states "Because the amount of worker's compensation payments actually paid

12:39:51 necessarily incorporates the written-down medical
12:39:54 expenses, it is not necessary to resolve whether the
12:39:57 collateral source rule applies to medical provider
12:39:59 discounts in other context. The Court leaves it open
12:40:01 for interpretation."
12:40:03 Plaintiff wants to rely and say their
12:40:06 interpretation applies in this context, where the Court
12:40:08 specifically says "We're not determining that here."
12:40:10 So just to assert our position on that, the plaintiff
12:40:17 has to establish, well, per the Nevada jury
12:40:20 instructions to recover medical special damages, the
12:40:22 plaintiff has to establish that they were the
12:40:25 reasonable value of those and that they were
12:40:28 necessarily incurred. And amounts which have been
12:40:31 billed which have not been paid have therefore not been
12:40:35 incurred, particularly where there's going to be or
12:40:37 there could be some sort of a lien reduction later on,
12:40:40 or also where a third party purchaser has come in and
12:40:44 purchased that lien for a lesser amount, that then
12:40:47 becomes the amount paid as opposed to the amount of the
12:40:50 original bill.
12:40:51 So the jury instruction requires that they be
12:40:54 necessary and that they be incurred. And where it's a
12:40:57 lien and it hasn't been paid, it hasn't been incurred,
12:41:00 and there's still the possibility that that has either

12:41:04 been reduced already by a lien or that will be reduced
12:41:07 in the future by a lien reduction.
12:41:12 Now, Plaintiff is going to argue that that,
12:41:15 you know, makes some sort of a windfall to the
12:41:18 defendant because if the plaintiff prevails -- sorry.
12:41:23 They're going to argue that there's a windfall
12:41:25 to us. That's not the case. If she prevails, even if
12:41:28 she's limited to the amounts that have been billed --
12:41:30 or excuse me, the amounts that have been paid,
12:41:32 Defendant is going to have to, you know, pay that
12:41:34 amount. There's no windfall. She's not going to be
12:41:38 made -- Defendant is not getting some sort of reduction
12:41:40 on the amount. The defendants are going to have to pay
12:41:43 the amount that has been paid on her behalf.
12:41:45 And my final point is that the Howell case,
12:41:49 it's not a controlling case. It's a California case.
12:41:51 But where we don't have a case particularly
12:41:54 specifically on point on this issue, and the Tri-County
12:41:57 case makes it clear that that's up for determination,
12:41:59 you know, we look to the California law.
12:42:01 And Howell, it states that "To award more to
12:42:06 the plaintiff is to place her in a better financial
12:42:10 position than before. To award more to the plaintiff
12:42:13 than has actually been billed" -- sorry -- "that has
12:42:16 actually been paid. It is to put her in a better

financial position than she would have been before the action."

In fact, it actually results in a windfall to her if she is allowed to stick this number up there, which is just a number that's been written by the doctor, but is not an amount that they're actually expecting to be paid. Or in certain situations they have already been paid less than that amount by a third party purchaser.

So we feel like this is not a collateral source. And that Tri-County has left that open to the courts to, you know, ultimately they are going to have to determine that issue, but it hasn't been determined at this time.

THE COURT: All right. Here's my thoughts on this, because -- and you may not care about what my thoughts are.

But as far as billed versus incurred, I think that -- I think the requirement in Nevada is that in order to put the bills up in front of a jury, you have to have somebody to testify that the amount that were billed are reasonable and necessary, causally related to the incident in question.

So if there's a doctor that testifies that the bills that are incurred, the numbers on the billing

12:43:26 sheet are reasonable and necessary, I think that the
12:43:30 defendant's option at that point is to bring in
12:43:36 somebody that says no, they're not. If they're not
12:43:40 reasonable and necessary -- let's say a chiropractor
12:43:44 bills $500 for a visit, and everybody agrees that's not
12:43:47 reasonable and necessary. Well, you're going to have
12:43:49 to bring somebody that says that's not reasonable and
12:43:52 necessary, and if you can convince the jury that the
12:43:54 bill should really be $120 as opposed to the $500 for a
12:43:58 visit, then the jury is only going to award $120.
12:44:02 Now, that amount, that's the determination of
12:44:07 what's reasonable and necessary bill for the treatment.
12:44:10 I think the whole issue about what's paid, what's on a
12:44:15 lien, what's not on a lien, maybe if it was written
12:44:18 off, all of those things I think are collateral
12:44:21 sources.
12:44:21 And I think the Proctor versus Castelletti
12:44:24 case, and there's other cases, that basically say
12:44:28 collateral sources are not relevant for any purpose
12:44:31 because a negligent defendant is not entitled to get a
12:44:35 benefit from the fact that the plaintiff had insurance,
12:44:38 or that the plaintiff was able to get his bills
12:44:42 reduced, or the plaintiff was able to get a doctor to
12:44:46 write off bills. I mean, those are all collateral
12:44:49 sources in my mind that a negligent defendant shouldn't

12:44:52 be able to benefit from.
12:44:53 Now if the defendant is not negligent, you
12:44:55 don't have to worry about it, because, you know, then
12:44:58 the plaintiff isn't going to get a verdict. Then
12:45:01 you're not going to have to worry about a number
12:45:03 anyways. But if the defendant is determined to be
12:45:05 negligent by the jury, then that negligent defendant
12:45:08 should not be able to benefit from the fact that the
12:45:11 plaintiff had collateral sources, which either reduced
12:45:13 or eliminated or did whatever it did to the bills that
12:45:16 were otherwise determined to be reasonable and
12:45:18 necessary.
12:45:19 MR. SMITH: Okay. And just to note on that,
12:45:23 Proctor versus Castelletti says collateral sources of
12:45:25 payment, and -- where it's just a lien and there has
12:45:28 been no payment issued, you know, it's our position
12:45:31 that that is not a collateral source because the rule
12:45:34 specifically says collateral sources of payment. And,
12:45:37 you know, it's not something that has been paid. And
12:45:39 if it has been paid, and it's been paid for a lesser
12:45:42 amount, and there's another motion that will get into
12:45:46 us, is that not then the reasonable value of medical
12:45:49 expenses incurred? That will be addressed more fully
12:45:52 in our subsequent motion.
12:45:54 THE COURT: Okay. I understand the argument.

12:45:58 Motion in Limine No. 4 is going to be denied, though, based on the collateral source issue we just discussed.

12:46:12 All right. Let's move on to the next binder now that it's a quarter to 1:00.

12:46:16 MR. JAFFE: We got four motions left.

12:46:19 THE COURT: Next one I have is Defendant's Motion in Limine No. 5: "To preclude Plaintiff's expert from commenting on, referencing to, or rebutting any defense expert praiser to defense expert's testimony."

12:46:35 MR. JAFFE: Basically, Judge --

12:46:36 THE COURT: You want him to recall their people.

12:46:39 MR. JAFFE: Yes. If they're going to be rebutting a defense opinion, and they were brought in or wrote opinions as rebuttal opinions, then they need to be presented as rebuttal, not as pat of the case in chief. Otherwise, what you've got is the plaintiff telling the jury all these problems with my expert and telling the problem -- everything -- the jury everything that's wrong with my expert before the jury has had an opportunity to even hear my expert and weigh it themselves.

12:47:09 It's prejudicing unduly my case because it's

given certain experts the opportunity in rebuttal to deprive the jury of the opportunity to weigh my experts' opinion and testimony on its own without having yet been colored by a plaintiff expert in rebutting them before they've heard it.

I believe that it's a deprivation of my client's due process rights because of the fact that their expert then has not had an opportunity to be heard and to speak on that topic, clear without the jury having been colored before they testify. And simply to say well, I'm not going to make, you know, this expert testify twice, well, that was their choice.

If that's their choice is to have an expert function in a rebuttal capacity, even if it's in a direct and then in a rebuttal capacity, I think it's completely unfair. And the jury needs to be allowed to hear my side of the case, unbiased, unfettered without having been colored by a plaintiff's expert testifying and rebutting testimony that has not yet been presented.

In -- otherwise, I'm not being an opportunity to present a direct case. My direct case inherently becomes a rebuttal and a defense of their opinions before the jury has had the chance to give it fair opportunity.

12:48:47 THE COURT: Let me ask you this, Mr. Jaffe.
12:48:48 MR. JAFFE: Yes, sir.
12:48:49 THE COURT: Let's assume for sake of argument
12:48:52 that you said this is a two-week trial. Let's say the
12:48:55 plaintiff plans on going the first week and you plan on
12:48:57 going the second week.
12:48:58 MR. JAFFE: Um-hum.
12:48:59 THE COURT: Let's assume that you have an
12:49:00 expert that is going to be out of the country the
12:49:03 second week so he has to testify Wednesday or Thursday
12:49:05 the first week. And just bear with me for a minute.
12:49:09 MR. JAFFE: Sure.
12:49:10 THE COURT: And then you come and you tell the
12:49:12 Court, "Your Honor, we have an expert that is going to
12:49:15 be out of the country the second week. We need to call
12:49:18 him out of order during the first week. I understand
12:49:20 it's going to be during the plaintiff's case in chief.
12:49:22 I understand the plaintiffs aren't going to have their
12:49:24 experts on until Thursday and Friday. We need to put
12:49:26 our expert on on a Wednesday."
12:49:29 MR. JAFFE: Um-hum.
12:49:29 THE COURT: And if Mr. Cloward objected to
12:49:31 that --
12:49:31 MR. JAFFE: Um-hum.
12:49:32 THE COURT: -- based upon your argument that

12:49:34 you've just made, I would have to exclude your witness
12:49:37 from testifying then and then he wouldn't be able to
12:49:39 testify at all because he wouldn't be here the second
12:49:42 week. Right?
12:49:43 MR. JAFFE: Well, two things on that, your
12:49:44 Honor, first off, if there is something along those
12:49:48 lines, I have no problem. And if they were going to
12:49:53 sit here and say this expert needs to testify, I can't
12:49:56 call him back because he's going to be out of the
12:49:58 country that week, that's a different story and that's
12:50:01 the courtesies that we extend each other as attorneys
12:50:05 during the course of a trial.
12:50:07 Second, there's other ways to do that. We --
12:50:09 if -- ironically, Dr. Duke's name was brought up
12:50:19 before. That happened to me where Dr. Duke, the court
12:50:23 trial schedule changed in the middle of trial, and the
12:50:27 day that Dr. Duke was scheduled to testify was a day
12:50:30 that the trial judge was no longer available because of
12:50:33 a personal circumstance that invaded that day, and we
12:50:37 said, fine, we'll go videotape the testimony that day.
12:50:40 If you know an expert is not going to be around in
12:50:42 advance and you can't work it into the schedule, for
12:50:46 whatever reason that may very well be, you know. If,
12:50:49 for example, I had an expert who can only testify on
12:50:53 the Wednesday of the first week, and Mr. Cloward said

12:50:56 to me, "I'd love to accommodate you, but here's the
12:51:00 problem: I've got two other experts who can only
12:51:02 testify that day. I can't see how we can get them in,"
12:51:04 then I got to videotape my testimony and present it to
12:51:07 the jury by videotape. That's how we do those things.
12:51:09 But when there's an extraordinary circumstance
12:51:11 that comes out for that, that is how we make that
12:51:14 accommodation. This is not an extraordinary
12:51:16 circumstance. If it is a extraordinary circumstance, I
12:51:19 will always accommodate an attorney, just the same as I
12:51:22 would expect to be accommodated back and have been
12:51:25 accommodated back.
12:51:26 But where it's not an extraordinary
12:51:28 circumstance, sir, that's where I believe that the
12:51:33 rebuttal testimony must be presented as rebuttal.
12:51:36 THE COURT: I guess the concern I have is with
12:51:38 the extra expense and the extra time that it would
12:51:42 cause, and that's what Mr. Cloward brings up in his
12:51:45 opposition. I mean, we all know when you call an
12:51:50 expert --
12:51:50 MR. JAFFE: Um-hum.
12:51:50 THE COURT: -- it's going to cost, depending
12:51:52 on the doctor, but most of the times you're spending
12:51:55 5,000 for a half day, 10,000 for a full day.
12:51:58 MR. JAFFE: Um-hum.

12:51:59 THE COURT: So if they have to bring somebody
12:52:00 for one day for their testimony and it cost them 5 or
12:52:03 10 grand, and then have to bring them back in rebuttal,
12:52:05 even if it's just for a half hour, they're going to end
12:52:08 up spending that 5 grand.
12:52:10 MR. JAFFE: Your Honor, and I can very well
12:52:12 assure -- feel very well assured that any plaintiff
12:52:15 would sit there and say that their client's rights
12:52:18 supersede my costs. Similarly, my client's rights
12:52:23 supersede their costs. That's my position.
12:52:25 THE COURT: Okay. You want to say anything,
12:52:26 Mr. Cloward?
12:52:27 MR. CLOWARD: Yes, I do. A couple of things.
12:52:28 No. 1, the question wasn't answered. The question was
12:52:34 if this situation took place, your expert had to show
12:52:37 up during the first week and Mr. Cloward objected, are
12:52:41 you saying that you're, you know, his client's due
12:52:45 process would be violated if I allowed that to happen.
12:52:48 And the answer wasn't -- there was no answer given.
12:52:53 Instead it was, you know, the conversation was
12:52:55 conflated and there was discussion about, you know,
12:52:59 courtesies that were given, and, well, it would be an
12:53:01 extraordinary circumstance. But the question that the
12:53:03 Court presented was, "Is it really a violation of due
12:53:07 process to allow an expert to testify out of turn?"

12:53:11 No. Absolutely not. And the purpose of
12:53:16 trial, and one of the overarching principles is the
12:53:20 right to a quick and speedy determination. And it
12:53:24 would be completely overburdensome to say, "Hey, these
12:53:28 rules are unflinching. It's going to be a violation of
12:53:31 his client's rights to allow these guys to give certain
12:53:36 testimony out of turn, force them to come back." If
12:53:39 you don't force them to come back, I mean, it just
12:53:42 seems it just seems really -- I don't -- I want to have
12:53:50 respect to Mr. Jaffe, but the argument is just really
12:53:53 nonsensical to me.
12:53:55 I mean, the other thing that I think is more
12:53:57 important that needs to be pointed out is that they're
12:54:02 giving opinions in defense of their treatment. And so
12:54:05 it's not like they're giving, you know, true rebuttal
12:54:09 opinions. All they're doing is saying, "Yeah, you know
12:54:12 what, I don't agree with Dr. Schifini because where he
12:54:15 says that I should have done this or this because of
12:54:17 this."
12:54:18 So it's not like you're hiring -- it's not --
12:54:21 I mean, you can't think of it the same thing. I could
12:54:24 see possibly if there's an argument to be made about
12:54:29 Ms. -- or Dr. Belsky that, you know, maybe there's an
12:54:32 argument that she would have to be called after, you
12:54:37 know, because she was designated as a true rebuttal

expert.

But in regard to Dr. Muir and Dr. Kaffcan, if they give opinions in defense of their treatment, I don't think you need to have them come back, you know, a week later to say, "Oh, well you know, I heard Dr. Schifini testified to X, Y, and Z. Well, let me defend my treatment now a week later and tell you why I think that that's not appropriate."

I just think that that would create a log jam with the system, costs would go through the roof, and it just would really be unfair to the plaintiffs.

THE COURT: Okay. Last word.

MR. JAFFE: Sure, your Honor.

Again, the question is what's paramount, costs or rights. My client's rights are paramount. And I believe they did answer your Honor's question, but if Mr. Cloward is concerned that I didn't, I'll -- I will answer it.

Your Honor, rights are more important than costs. If there is an intervening event, like somebody is scheduled to be out of the country, like somebody has a family matter or an emergency or a wedding or a graduation, or whatever it may very well be, that's where we accommodate people out of order.

Otherwise, basically what Mr. Cloward is

12:55:56 saying is it's all right for me to come in and just
12:55:59 say, you know, I really think I would rather have the
12:56:01 jury hear from my expert before your doctor testifies,
12:56:04 so let me just do it for that reason. If there's a
12:56:08 compelling reason for it, that's -- then that's a
12:56:10 different story. Otherwise, the court rules lay out an
12:56:15 order of a trial: Direct case, defense case, rebuttal,
12:56:21 defense rebuttal. That's the order of it.
12:56:27 THE COURT: All right.
12:56:29 Based on NRS 50.115, which talks about
12:56:33 avoiding needless consumption of time and expenses, I
12:56:38 understand your client's rights, Mr. Jaffe, but I think
12:56:42 that I'm going to probably allow them to testify once
12:56:50 and then not have to call them back.
12:56:57 Was Dr. Belsky the only one that was
12:56:58 identified only as a rebuttal witness?
12:57:00 MR. CLOWARD: Correct.
12:57:00 MR. JAFFE: They also have Dr. Croft who did
12:57:05 give initial biomechanical and causation opinions, but
12:57:10 then wrote supplemental reports rebutting my expert's.
12:57:15 He's out of San Diego.
12:57:18 THE COURT: I would probably allow him to
12:57:20 testify once as well. I mean, if Dr. Belsky only did a
12:57:23 rebuttal report, I would say she probably has to be
12:57:27 called only in rebuttal.

12:57:28 MR. JAFFE: The same would also be true then
12:57:29 for Dr. Gross who wrote an initial report, then did a
12:57:33 second rebuttal report. He was hired solely as an
12:57:37 expert. He's not a treating doctor.
12:57:38 THE COURT: Was his initial report as an
12:57:40 initial expert?
12:57:41 MR. JAFFE: Initial expert report, and then a
12:57:43 second report as a rebuttal.
12:57:45 MR. CLOWARD: He was -- he was -- he was never
12:57:47 designated. He just did supplemental reports, not
12:57:50 necessarily -- they weren't designated as rebuttal. He
12:57:54 wasn't designated as a rebuttal expert.
12:57:56 THE COURT: I think, based on what I'm
12:57:57 hearing, I think Belsky is the only one that I'm going
12:57:59 to require it, can only testify after the defendant's
12:58:03 case.
12:58:03 MR. CLOWARD: Let me provide some clarity.
12:58:04 Because Dr. Belsky is a treating physician.
12:58:07 THE COURT: Oh.
12:58:08 MR. CLOWARD: So she just -- basically what
12:58:10 happened is Dr. Schifini wrote a report that criticized
12:58:14 her -- every single thing that she did, so she felt
12:58:18 compelled to --
12:58:18 THE COURT: So she's going to testify as a
12:58:20 treating doctor.

12:58:20 MR. CLOWARD: Yes. Exactly.
12:58:22 THE COURT: All right. I'm not going to make
12:58:24 these people come back and testify twice. I understand
12:58:27 the order that we're supposed to do things. And if --
12:58:30 if you feel that it's necessary that we instruct the
12:58:35 jury on how it should be done as opposed to the how it
12:58:41 is happening, I'll entertain that.
12:58:45 MR. JAFFE: Okay.
12:58:48 THE COURT: But Motion in Limine No. 5 is
12:58:51 going to be denied.
12:59:01 All right. No. 6 is defendant's motion in
12:59:02 limine "To preclude video and or animated depictions of
12:59:06 plaintiff's surgical procedures."
12:59:07 Are we actually talking about the actual
12:59:09 surgeries or are we talking about demonstrative video?
12:59:12 What are we talking about?
12:59:13 MR. SMITH: I believe demonstrative. I have
12:59:14 not been -- no actual surgical videos have been
12:59:18 disclosed to me, so I think we're talking purely here
12:59:21 about demonstrative, you know, videos of a similar
12:59:25 surgery.
12:59:26 THE COURT: Is it just demonstrative,
12:59:26 Mr. Cloward?
12:59:30 MR. CLOWARD: Correct, your Honor. Nothing --
12:59:31 no actual photographs of anybody, any blood or

anything.

THE COURT: You planning on using it during an expert's testimony, or when are you planning on using it?

MR. CLOWARD: During opening statements, during direct examination of experts, and during closing.

MR. SMITH: First of all, your Honor, we've never -- we haven't seen it at this point, so I don't know exactly what video we're talking about. I can imagine, because I've seen similar videos before in trials that I've done.

But our point on this, and this includes animations as well, is that these are unfairly prejudicial because they inflame the jury. You know, the average the lay person who isn't used to seeing, you know, blood, the amount of blood that comes with, you know, any type of surgery, finds these type of videotape shocking. You know, and that's their intended purpose.

I know Plaintiff wants to claim that these are to explain to the jury the processes and the surgery that was undergone, but there are other was of doing that that are less inflammatory. The doctors are going to be able to testify. There's x-rays. You know,

there's photographs. They can use models. They can use charts. All that can be explained very thoroughly without depicting a gory image up there of the surgical process and the blood and gore that comes with that.

MR. CLOWARD: Your Honor, we would agree. We have no intention of showing any blood or gruesome photographs. These are animations. They're cartoon figures to explain to the jurors the procedures that are performed.

MR. SMITH: And with respect to those, your Honor, I mean, we haven't seen them, so I don't know exactly, you know, what I'm speaking to on that. But part of this is to address the -- or they're trying show the jury, you know, the pain that the plaintiff felt when they underwent these or, you know, the extreme nature of this procedure. And that ignores the factual that the plaintiff was under anesthesia. This isn't something that she observed. This isn't something that she felt.

If Plaintiff wants to explain to them how she felt before and/or after the surgery, you know, she's going to have the opportunity to do that in her deposition. But to put this depiction up and try to, you know, explain to the jury this is how Plaintiff felt or this is, you know, imagine the terror or

13:01:42 undergoing this, you know, needle going into your back,
13:01:46 that's inflammatory.
13:01:47 The doctors are going to be able to explain
13:01:49 the procedures that they've undergone. There's ample
13:01:53 other ways to demonstrate the procedures that the
13:01:55 Plaintiff has undergone without showing some
13:01:57 inflammatory depiction, whether it's a real video or an
13:02:00 animation. You know, these inflame the jury. That's
13:02:03 why they are unfairly prejudicial.
13:02:05 THE COURT: I don't know that they necessarily
13:02:06 inflame the jury. I don't -- I haven't seen it either.
13:02:09 Because I haven't seen it, I'm not going to simply
13:02:14 preclude it today. I would like to see it or at
13:02:18 least -- Mr. Cloward, why don't you let the other side
13:02:21 see it before trial.
13:02:22 MR. CLOWARD: Absolutely.
13:02:23 THE COURT: And if it's -- here's the deal,
13:02:26 guys: As far as videos and stuff like that, I look at
13:02:29 it as any other demonstrative exhibit. It's not going
13:02:33 back to the jury. It's nothing that they're going to
13:02:35 use to try to explain.
13:02:36 It's just like if you were drawing a chart or
13:02:40 drawing a picture, or writing something during your
13:02:42 opening or closing on a board. As long as it's not
13:02:49 gory and bloody and nasty, I probably would allow it to

13:02:53 help explain. If, after you've seen it, it doesn't
13:02:58 look like it's going to be used to explain, it's going
13:03:00 to be used for some other reason, address it before we
13:03:03 start trial.
13:03:04 MR. SMITH: Fair enough.
13:03:04 I believe the parties, we have a stipulation
13:03:07 that we're disclosing all demonstrative a week prior to
13:03:09 prior.
13:03:10 THE COURT: So for now I'm going to deny it
13:03:12 because neither you nor I have seen it. I'm not going
13:03:16 to -- I'm not going to preclude some demonstrative
13:03:20 video or exhibit because we don't know yet even what it
13:03:24 looks like.
13:03:26 You folks are here for a settlement
13:03:27 conference? We're not ready for you yet. I'm still
13:03:29 doing my 9:00 o'clock calendar.
13:03:30 RIGHT 2*:
13:03:31 UNIDENTIFIED SPEAKER: Okay.
13:03:32 THE COURT: You're welcome to sit around.
13:03:36 Defendant's Motion No. 7: "To admit all
13:03:38 evidence of purchase of liens and evidence of the
13:03:41 amounts of which liens were purchased."
13:03:43 I think we've addressed already, haven't we?
13:03:45 MR. JAFFE: To some extent, your Honor, but
13:03:47 what I'd like to add is this: The amount that a lien

may have been purchased for, in other words, if the plaintiff goes for treatment, a provider or a facility liens the care, but then turns around and sells the lien to another third party source, like Canyon Medical, you see especially in all these involving the surgery center that's involved here.

That's relevant because, let's say the surgery center says that their bill is $15,000. And they're going to get up there and say, "Well that's a -- that's usual and customary. It's fair. It's whatever may very well be," whatever the verbiage that you're going to use.

But if they turnaround and sell it for $4,000 I should be allowed to raise the fact that they accepted less from a private payer who's buying that lien, to cross-examination them on whether what they're saying about 15,000 is fair and reasonable. So if they're going to accept 4- or 5- or 7-, or whatever it may very well be, from a private payer, I believe is proper impeachment testimony and proper impeachment questioning.

THE COURT: Still collateral source.

MR. JAFFE: I know.

THE COURT: The reason they charge less or that they sell it for less is because there is always

13:05:17 the risk that there's no recovery.
13:05:20 MR. JAFFE: Well, if that's the case, then
13:05:21 they can get up there and say that.
13:05:27 THE COURT: It's still a collateral source
13:05:27 I'll not going to allow it.
13:05:30 MR. JAFFE: Okay.
13:05:30 THE COURT: Motion No. 7 is denied. Sorry.
13:05:36 No. 8 is: "To preclude Plaintiff's expert
13:05:39 Terrance Dineen from testifying."
13:05:43 MR. JAFFE: Okay. Judge, there's two things
13:05:45 with respect to Mr. Dineen. First, he wrote two
13:05:49 reports predicated on the plaintiff getting future
13:05:54 surgeries that had long since been stipulated out.
13:05:59 What had happened was the plaintiff had hired
13:06:03 Dr. Jeffrey Gross, who wrote a report initially saying
13:06:08 the plaintiff was going to need another cervical
13:06:10 fusion, and was going to need another lumbar fusion,
13:06:13 and then was going to have X additional treatment and
13:06:17 costs, et cetera, et cetera.
13:06:19 Mr. Dineen formulated an opinion based upon
13:06:23 that. What then happened is that Dr. Gross wrote a
13:06:29 second opinion, a second report, taking one of the
13:06:32 surgeries out. But he said as to the other one it was
13:06:35 possible.
13:06:36 So we were -- we have filed a motion or were

13:06:41 ready to file a motion to exclude that testimony, given
13:06:47 the fact that there was not stated to a degree of
13:06:50 probability and what happened is we entered into a
13:06:52 stipulation now taking that second surgery out of the
13:06:55 case. So now both future spinal surgeries were gone.
13:07:01 Mr. Dineen was never provided with that.
13:07:04 Dr. -- Terrance Dineen rather was never provided with
13:07:07 that. Terrance Dineen still didn't know about it, even
13:07:10 though months and many months had gone by, by the time
13:07:13 I took his deposition. And when I went up to Reno and
13:07:17 I took his deposition, he was still standing on
13:07:19 opinions based upon Dr. Gross's first report of two
13:07:23 future surgeries that had no basis whatsoever in this
13:07:28 case, that were now out of the case both by Dr. Gross
13:07:31 and by the plaintiff's own admission and recognition
13:07:35 through a supplemental report and through that
13:07:38 stipulation. Dineen didn't know it. So now the whole
13:07:41 foundation for his opinions is completely shot.
13:07:44 On top of it, Terrance Dineen -- it's very
13:07:55 clear that his opinions were bought, and here's why.
13:08:02 The plaintiff owns a small business in which she
13:08:10 basically provides lessons, acting, singing, and
13:08:13 dancing lessons, for children.
13:08:18 There was originally a claim related to wages
13:08:23 that we've stipulated out of this case. But what

13:08:26 happened was of course the personal impact on her from
13:08:31 a loss remained.
13:08:34 Well, what Mr. Dineen said was, "I'm just
13:08:39 going to give her the median wage for producers in
13:08:42 Las Vegas based upon a study that was done."
13:08:47 And we've had several years of actuals that he
13:08:51 didn't take into account and decided to dismiss. So I
13:08:54 asked him, "If we had a guy who's producing shows on
13:08:59 the strip earning $1 million or several hundred
13:09:03 thousand dollars a year," I forgot the exact figure
13:09:06 that I said, "and he's in an accident and can't work
13:09:09 anymore, are you going to be saying that his loss is
13:09:12 51,000 or whatever it is, that median number, a year?"
13:09:16 He said, "No."
13:09:17 "Why no?"
13:09:18 "Well, we've got his actual figures to work
13:09:20 off of."
13:09:21 So here's a guy who is deciding to change like
13:09:26 a chameleon to whatever best suits the purposes of
13:09:30 which he's been paid. Irrespective of a standard.
13:09:35 On top of it, we've got a guy who's basing
13:09:39 reports somewhere opinions about future limitations on
13:09:42 surgical recommendations that don't exist.
13:09:47 Now, what ends up happening is I also take
13:09:50 Dr. Gross's deposition and Dr. Gross of course hasn't

13:09:53 changed his opinion regarding the future care as it
13:09:56 relates to the surgeries, but because of the fact that
13:10:00 the surgeries are now out, what he did was he removed
13:10:03 certain other costs that were in his life care plan
13:10:09 that related to those two surgeries.
13:10:11 Now, Dineen comes in with a new report well
13:10:15 after he's been deposed and still doesn't really change
13:10:23 anything except for the fact that he's now
13:10:26 acknowledging that there's this change in Gross' report
13:10:31 and opinions.
13:10:34 Well, he still hasn't changed. And there is
13:10:36 now no foundation to exist. He does not pass the
13:10:41 Hallmark test because he has not issued report
13:10:48 reasonably relying on a foundation of evidence that
13:10:51 will be presented to the jury.
13:10:54 And for that reason, Mr. Dineen must be
13:10:59 stricken.
13:11:00 MR. CLOWARD: Your Honor, to say that
13:11:04 Mr. Dineen only relied on Dr. Gross's report would be
13:11:06 inaccurate. That was just one portion of the report.
13:11:09 That's why when Dr. -- or Mr. Dineen reviewed that
13:11:14 additional information, he said, "My opinion doesn't
13:11:16 change. The reason my opinion doesn't change is
13:11:18 because I relied on a wide variety of information,
13:11:22 including my personal examination and discussion and

13:11:27 interview with Margie Seastrand."

13:11:31 In fact this is quoting from their -- their
13:11:37 reply. This is page 4 of their reply, they're citing
13:11:42 Mr. Dineen's deposition. He says, "why are you" --
13:11:44 question, "Why are you using 45 percent functional
13:11:48 capacity on an ongoing basis?"

13:11:50 His answer is, "Because that's where we are
13:11:52 right now, you know, with the functional capacity
13:11:55 checklist, and we don't know what is going to happen in
13:11:57 the future, you know. But we do know at this point
13:12:00 that that's what -- that's what the data tells us, also
13:12:04 including the medical records my interview with her."

13:12:07 So he's using 45 percent based on his
13:12:12 analysis, based on his interview, based on the medical
13:12:15 records, based on where she was right then and there.

13:12:20 And that's why, when Dr. Gross supplemented
13:12:22 his opinion, saying, "Hey, she doesn't need these two
13:12:26 surgeries in the future," Mr. Dineen says, "Yeah, well,
13:12:29 that doesn't really change for me because I was basing
13:12:32 it on my interview and where she was when I met with
13:12:35 her, at 45 percent." And his opinion didn't change.

13:12:40 There was one other point that was made. I
13:12:44 can't remember what it was. But, you know, obviously
13:12:47 had he relied solely on Dr. Gross's report, I think
13:12:50 there might be some traction for the argument to be

13:12:53 being advanced by Mr. Jaffe, but that's just not the
13:12:55 case. He relied on a bunch of different things.
13:12:57 That's why his opinion didn't change.
13:13:00 MR. JAFFE: Here's the problem, Judge: All of
13:13:04 that information was known well in advance of his
13:13:07 deposition. I take his deposition. I lock him in.
13:13:11 Now all of a sudden because Gross writes a new report
13:13:15 six months after that deposition, acknowledging
13:13:20 basically just the reduction in the life care numbers
13:13:23 to reflect an opinion he stated well before Dineen was
13:13:27 deposed, that's not a basis for Dineen to now come in
13:13:31 with a new report. That's not newly disclosed or newly
13:13:34 learned or newly available information. All of that
13:13:38 information was available well in advance, months in
13:13:40 advance of Dineen's deposition.
13:13:43 That whole agreement, knocking out both
13:13:46 surgeries, was done in July, 2012. Dineen wasn't
13:13:50 deposed until four months later and he still didn't
13:13:52 know it. And he still to this day hasn't affected --
13:13:56 or rather amended that opinion to reflect the fact that
13:13:59 Gross has taken out those surgeries.
13:14:01 And, you know, I agree that there's a lot of
13:14:05 things that any expert is going to rely on, but in this
13:14:08 case he testified that he expressly relied on the Gross
13:14:12 reports. And when he expressly relies on reports that

13:14:17 have no foundation, because the expert and the attorney
13:14:20 have already knocked those out of the case months
13:14:23 before, there's no foundation for his opinion. And his
13:14:27 opinion is flawed.
13:14:29 It lacks foundation and evidence present in
13:14:32 the case. It was not present in the case when he was
13:14:35 deposed, yet he stood behind it. And he's sitting out
13:14:39 there on an island with no support. Either that or
13:14:41 he's sitting there hanging on a tree limb that is not
13:14:44 attached to anything anymore.
13:14:46 There's no foundation for it, anymore, Judge.
13:14:49 And we believe that Dineen needs to be stricken.
13:14:52 THE COURT: Here's what I'm going to do. At
13:14:54 this point, I'm not going to strike him because I want
13:14:56 to see if there's foundation other than Gross' report
13:14:59 for his testimony.
13:15:02 So I'm going to deny it at this point. Seems
13:15:05 likes most of the arguments that you've made,
13:15:07 Mr. Jaffe, I think go to weight as opposed to
13:15:10 admissibility. But there may be a foundational deficit
13:15:18 if his -- if his opinions are all based upon Gross'
13:15:22 report and Gross' report isn't there anymore.
13:15:25 Or if the opinion that he -- or the report
13:15:28 that he based his opinions on was completely changed.
13:15:31 Then I would -- I would tend to agree that there may be

13:15:36 a foundational element lacking. But I'm going to have
13:15:39 to kind of see what he says initially as far as the
13:15:42 foundation for his opinions.
13:15:44 MR. JAFFE: Then, your Honor, if that's the
13:15:44 case, I'm going to ask for a pretrial evidentiary
13:15:47 hearing on Dineen's foundation for his opinions so that
13:15:50 we can address this before we start a trial.
13:15:52 Here's the problem: Dineen talks about some
13:15:55 big numbers. And if the plaintiff is going to put
13:15:58 those up in an opening statement in front of a jury and
13:16:00 those may not be admitted because of a foundational
13:16:06 lapse with Terrance Dineen, those numbers can't be
13:16:10 unrung. And it's still out there.
13:16:13 You -- we all know, jurors write. And when
13:16:17 jurors start hearing evidence in the case, the first
13:16:19 thing they hear is a plaintiff's opening statement and
13:16:22 jurors are writing because they're taking everything
13:16:24 down.
13:16:24 So if that's the case, your Honor, I'm going
13:16:26 to ask that the Court hold an evidentiary hearing on
13:16:30 Dineen's foundation for testifying before trial starts.
13:16:34 MR. CLOWARD: Your Honor, I think we can
13:16:36 easily cure this by providing you with his deposition.
13:16:39 The portion of the deposition that I just read, he
13:16:42 indicated that he relied on other things other than

13:16:45 Dr. Gross's report. He said in -- I mean, in
13:16:48 deposition that I cited that they cited in their reply,
13:16:53 he indicated that he relied on other things.
13:16:56 So, I mean, it's as simple as a supplemental
13:16:59 brief. We can get you his report, get you the items
13:17:02 that he says that he relied on, get you his deposition.
13:17:05 And if you feel like there's a foundational deficit,
13:17:07 then we can revisit the issue. But I don't think we
13:17:11 need to have this evidentiary hearing.
13:17:14 THE COURT: Well, why don't we do this. Why
13:17:16 don't you give me whatever you think I need to look at.
13:17:21 And then maybe at the time of the calendar call, we can
13:17:24 talk about whether or not we need to do a hearing or
13:17:26 not.
13:17:26 MR. CLOWARD: That's fair.
13:17:27 MR. JAFFE: That's fine, your Honor. The one
13:17:28 thing I need to say, though, is this: Dineen wrote
13:17:31 that new report six months after my deposition. So the
13:17:35 deposition is not fully representative of the issues --
13:17:40 THE COURT: I understand.
13:17:40 MR. JAFFE: -- and that's why I believe at
13:17:42 this point the evidentiary hearing is necessary.
13:17:45 THE COURT: Well, why don't you give me the
13:17:47 original report, the deposition, the supplemental
13:17:49 report. Let me take a look at them.

13:17:54 MR. JAFFE: And the Gross reports?
13:17:56 THE COURT: That's fine.
13:17:57 MR. JAFFE: Okay. Do you want any briefing with it?
13:17:59 THE COURT: Yeah. If you want additional briefing, that's fine. Give me whatever you think I need to look at.
13:18:04 13:18:06 MR. CLOWARD: Fair enough, Judge. Okay.
13:18:08 Thank you, your Honor.
13:18:11 THE COURT: I think that's the end of motions in limine for today.
13:18:12 MR. JAFFE: It is, your Honor. Thank you very much for your time and your indulgence.
13:18:14 13:18:16 MR. CLOWARD: Thank you, Judge.
13:18:20 THE COURT: Thanks, guys.
13:18:21 MR. CLOWARD: Thank you.
13:18:22 THE COURT CLERK: On --
13:18:23 MR. JAFFE: I'm sorry to delay your settlement conference and everybody's lunch.
13:18:24 13:18:27 THE COURT: That's all right.
13:19:34 MR. JAFFE: There was quite a lot of commentary from the bench. I want to make sure we accurately reflect your rulings and your orders.
13:19:35 13:19:39 13:19:42 THE COURT: Thanks.
13:19:42 MR. JAFFE: Thanks.

13:19:43 THE COURT: Thanks, guys.

(The proceedings were concluded)

* * * * * * * * *

REPORTER'S CERTIFICATE

STATE OF NEVADA)
:SS
COUNTY OF CLARK)

I, PEGGY ISOM, CERTIFIED SHORTHAND REPORTER DO HEREBY CERTIFY THAT I TOOK DOWN IN STENOTYPE ALL OF THE PROCEEDINGS HAD IN THE BEFORE-ENTITLED MATTER AT THE TIME AND PLACE INDICATED, AND THAT THEREAFTER SAID STENOTYPE NOTES WERE TRANSCRIBED INTO TYPEWRITING AT AND UNDER MY DIRECTION AND SUPERVISION AND THE FOREGOING TRANSCRIPT CONSTITUTES A FULL, TRUE AND ACCURATE RECORD TO THE BEST OF MY ABILITY OF THE PROCEEDINGS HAD.

IN WITNESS WHEREOF, I HAVE HEREUNTO SUBSCRIBED MY NAME IN MY OFFICE IN THE COUNTY OF CLARK, STATE OF NEVADA.

_____
PEGGY ISOM, RMR, CCR 541

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$1 [4] 31/21 33/15 36/13 125/9
$10,000 [3] 34/10 34/11 34/12
$100 [1] 33/16
$100,000 [2] 34/5 35/1
$120 [2] 105/9 105/10
$15,000 [1] 122/8
$4,000 [1] 122/13
$5 [2] 35/11 36/16
$5 million [1] 35/11
$500 [2] 105/5 105/9

'

'81 [1] 60/9
'85 [1] 60/9

1

10 [9] 12/25 20/21 32/16 33/4 36/18 37/2 38/9 99/6 112/3
10,000 [1] 111/24
100 percent [1] 45/1
101 [1] 73/11
10:38 [1] 3/2
11 [3] 1/22 3/1 47/5
12 [3] 28/21 49/17 51/3
12:00 [1] 79/24
13 [2] 51/4 54/16
14 [1] 54/17
15 [5] 59/24 64/20 64/21 64/23 64/24
15,000 [1] 122/17
16 [6] 1/2 61/24 64/19 64/21 64/23 64/24
16.1 [6] 38/13 38/19 39/9 40/16 40/23 96/2
17 [2] 64/22 65/1
18 [2] 68/13 73/16
19 [1] 73/17
1:00 [1] 107/5

2

20 [14] 5/11 6/19 6/20 7/7 7/16 7/19 16/1 32/16 60/5 66/8 66/8 66/9 77/17 79/18
200 [1] 32/17
2003 [3] 6/10 6/12 6/14
2004 [2] 60/9 60/10
2010 [1] 6/6
2011 [1] 39/6
2012 [1] 128/17
2013 [2] 1/22 3/1

3

30-some-odd [1] 58/7
31.6 [1] 55/4
316-4111 [1] 2/12
316-4114 [1] 2/12
32 [3] 57/17 57/20 57/25

4

4111 [1] 2/12
4114 [1] 2/12
444-4444 [1] 2/5
444-4455 [1] 2/6
4444 [1] 2/5
4455 [1] 2/6
45 percent [3] 127/5 127/13 127/21
460 [1] 2/11

5

5,000 [1] 111/24
50 [2] 20/5 32/17
50.115 [1] 115/10
500 [1] 32/17
51,000 [1] 125/13
541 [2] 1/24 134/17

6

636515 [1] 3/6

7

7.70 [9] 31/11 32/24 33/9 34/16 34/19 35/5 35/13 35/21 35/24
70 [3] 48/5 48/7 48/9
702 [4] 2/5 2/6 2/12 2/12
7455 [1] 2/10

8

80-year-old [1] 51/19
801 [1] 2/4
89101 [1] 2/5
89128 [1] 2/11

9

99 percent [1] 43/16
9:00 o'clock [1] 121/16

:

:SS [1] 134/2

A

a -- that [1] 67/22
A.M [1] 3/2
A636515 [1] 1/1
abide [1] 42/19
ability [4] 7/12 7/23 10/5 134/11
able [27] 15/13 15/22 22/13 22/23 24/6 25/15 25/15 37/15 38/17 47/15 51/9 52/10 52/13 54/25 57/25 59/6 69/11 77/1 77/22 86/10 105/22 105/23 106/1 106/8 110/2 118/25 120/3
about [144]
absolutely [13] 21/3 29/9 45/1 51/1 58/11 58/11 60/21 66/23 67/24 88/2 88/6 113/1 120/16
abuse [2] 27/7 28/1
accept [2] 40/19 122/18
accepted [2] 76/13 122/15
accident [37] 6/5 7/7 7/11 7/19 8/7 8/16 8/22 9/10 14/1 14/1 15/17 19/19 28/6 30/2 51/8 51/19 52/6 59/15 60/4 62/6 62/7 62/8 63/1 63/13 63/23 69/12 69/12 70/7 70/10 70/10 70/17 71/8 71/16 75/21 76/8 79/5 125/11
accidents [15] 5/9 5/11 6/17 8/19 9/20 9/24 9/25 12/2 12/4 15/14 15/25 60/5 60/12 60/25 61/7
accommodate [3] 111/1 111/10 114/24
accommodated [2] 111/11 111/12
accommodation [1] 111/8
according [1] 22/1
account [5] 58/21 58/24 59/1 70/19 125/7
ACCURATE [1] 134/11
accurately [1] 132/23
acknowledging [2] 126/9 128/8
act [1] 45/24
acting [1] 124/22
action [1] 104/2
actual [6] 23/24 58/5 117/14 117/18 117/25 125/16
actually [25] 3/21 4/24 6/2 10/25 21/4 26/25 40/4 41/18 41/21 45/6 48/25 49/19 54/19 55/15 69/19 71/22 84/3 92/23 101/14 101/25 103/24 103/25 104/3 104/6 117/14
actuals [1] 125/6
add [2] 95/16 121/25
addiction [2] 27/13 28/1
addition [2] 39/13 86/3
additional [6] 40/10 99/12 99/16 123/18 126/22 132/5
address [10] 10/23 42/16 52/4 52/22 75/14 98/24 101/16 119/13 121/3 130/7
addressed [5] 29/14 30/10 61/16 106/23 121/23
addresses [2] 45/22 101/19
admissibility [1] 129/20
admissible [6] 62/3 97/16 98/2 98/23 99/24 100/17
admission [1] 124/15
admit [2] 97/10 121/20
admitted [1] 130/11
adopted [1] 96/2
advance [5] 42/7 110/22 128/5 128/14 128/15
advanced [2] 81/22 128/1
advocacy [2] 73/10 73/11
affect [1] 55/6
affected [2] 9/22 128/19
affects [1] 6/10
affirmative [1] 83/18
afford [2] 97/24 97/25
after [19] 48/5 48/8 65/4 65/10 69/1 73/25 76/7 79/24 82/21 83/25 90/23 93/6 113/24 116/15 119/21 121/1 126/7 128/8 131/18
afterwards [1] 49/10
again [5] 33/6 36/5 71/3 82/11 114/14
against [3] 30/12 53/11 100/21
ago [12] 5/11 6/19 6/21 7/16 7/19 12/3 29/13 60/6 68/18 74/5 82/21 93/5
agree [40] 6/13 7/2 8/2 15/14 16/20 19/6 24/6 25/23 26/15 29/2 29/9 31/14 32/14 33/18 34/21 43/15 44/17 55/22 56/15 57/23 63/25 69/25 70/11 71/2 78/1 80/23

A

agree... [14] 83/22 84/3 84/4 85/6 85/20 86/20 87/7 88/8 88/10 93/15 113/17 119/5 128/22 129/25
agreeing [1] 18/7
agreement [1] 128/16
agrees [1] 105/5
ahead [3] 3/7 32/9 39/1
ALISON [2] 2/4 3/9
all [86] 3/16 4/13 5/1 7/22 8/25 9/6 10/1 13/10 13/18 16/7 17/9 17/20 20/13 21/20 24/1 25/1 31/20 34/18 38/8 40/21 44/19 44/20 47/3 47/4 47/22 48/9 48/19 49/21 52/10 52/18 52/22 53/5 54/3 58/21 59/8 60/12 60/17 63/6 64/4 65/7 66/5 66/18 72/15 73/22 75/16 76/22 79/23 79/25 83/7 85/10 88/13 89/11 90/25 91/3 93/6 93/17 94/10 97/13 97/18 100/24 101/10 101/19 104/15 105/15 105/24 107/4 107/20 110/3 111/19 113/16 115/1 115/9 117/2 117/11 118/8 119/2 121/7 121/20 122/5 128/4 128/7 128/13 129/21 130/14 132/20 134/5
alleged [3] 6/10 8/16 73/18
allegedly [1] 6/17
alleges [1] 71/9
allow [48] 5/15 10/17 11/2 11/13 11/16 21/16 25/15 28/18 28/19 30/22 31/5 32/19 35/25 37/10 37/13 42/5 44/18 46/10 46/20 49/25 50/6 50/13 50/20 54/5 59/19 63/11 64/14 68/10 73/16 79/8 79/9 79/14 80/8 80/25 80/25 87/9 89/23 90/10 91/15 93/12 95/20 97/4 112/25 113/6 115/13 115/22 120/25 123/5
allow -- I [1] 79/8
allowed [22] 6/21 7/8 8/3 34/25 44/2 53/12 55/5 70/14 70/19 70/23 74/1 80/19 86/21 86/25 94/8 94/13 96/5 96/24 104/4 108/16 112/18 122/14
allowing [8] 7/15 11/11 11/12 28/15 31/7 37/13 68/22 74/24
allows [1] 33/9
almost [1] 16/24
alone [1] 51/25
along [5] 12/9 21/11 21/12 85/1 110/6
already [12] 17/15 38/3 58/25 80/5 80/15 86/4 90/11 97/11 103/1 104/8 121/23 129/2
also [18] 3/14 15/16 26/22 28/23 29/10 39/16 53/14 67/15 84/23 87/11 89/18 93/20 101/15 102/18 115/18 116/1 125/24 127/11
always [6] 17/21 45/11 84/5 92/8 111/10 122/25
am [3] 59/18 61/21 88/20
ambulance [1] 20/10
ambush [9] 43/3 83/20 85/5 86/20 91/11 91/19 93/4 93/16 96/23
amended [5] 38/23 39/9 44/15 96/22 128/20
amendment [5] 39/10 40/10 40/11 40/12 91/22
amount [15] 98/15 101/25 102/19 102/20 102/20 103/11 103/13 103/14 104/6 104/8 104/21 105/11 106/21 118/17 121/25
amounts [7] 31/8 37/11 101/14 102/14 103/8 103/9 121/22
ample [1] 120/4
analysis [8] 55/14 69/4 70/18 71/15 71/18 72/21 74/21 127/14
and/or [2] 80/2 119/21
anecdotal [1] 78/18
anesthesia [1] 119/17
animated [1] 117/12
animation [1] 120/8
animations [2] 118/14 119/7
another [11] 42/1 51/22 62/24 66/12 66/14 66/16 84/25 106/21 122/4 123/16 123/17
answer [7] 72/13 83/1 112/19 112/19 114/16 114/18 127/7
answered [1] 112/14
answers [1] 82/9
anticipate [2] 4/8 49/5
anticipated [1] 19/13
anticipating [1] 93/8
any [54] 5/22 8/20 13/1 19/10 31/18 31/19 32/11 33/10 35/16 40/7 40/21 41/1 42/6 44/9 51/5 51/22 52/5 52/7 52/8 53/20 55/1 56/12 60/2 60/11 60/12 60/22 61/10 63/20 65/4 68/1 69/5 69/15 74/1 80/3 81/14 82/17 85/14 87/12 88/16 96/6 97/17 97/21 99/15 99/22 101/1 105/19 107/10 112/7 117/25 118/18 119/6 120/19 128/23 132/3
anybody [5] 34/5 34/10 34/12 34/24 117/25
anymore [6] 15/20 15/22 125/12 129/10 129/11 129/22
anything [23] 6/20 7/13 9/15 19/18 27/6 32/5 41/7 44/18 45/12 45/12 45/13 54/2 55/22 61/2 61/3 67/25 82/20 90/19 100/14 112/11 118/1 126/8 129/10
anyway [1] 18/17
anyways [1] 106/6
apologize [1] 64/25
appearances [2] 2/1 3/8
application [2] 13/22 16/4
applies [4] 15/19 26/15 102/3 102/7
apply [1] 43/7
apportionment [1] 14/18
appreciate [2] 4/12 4/25
appropriate [6] 14/15 32/7 43/17 43/21 49/9 114/8
are [135]
areas [1] 89/18
aren't [4] 8/25 22/25 99/5 109/18
arguably [1] 59/16
argue [7] 25/17 32/9 56/2 77/23 87/20 103/3 103/6
argued [2] 19/14 80/5
arguing [5] 4/16 26/16 55/11 58/6 94/24
argument [44] 15/7 16/15 17/21 18/11 21/8 23/22 23/24 23/25 25/22 26/24 38/16 40/19 47/23 50/9 51/12 51/22 53/12 54/11 54/13 55/12 55/23 55/23 55/24 56/9 58/6 59/3 60/1 60/24 73/9 73/9 73/19 77/20 77/23 80/5 93/9 94/16 96/9 106/25 109/3 109/25 113/10 113/22 113/24 127/25
arguments [7] 4/19 12/8 18/23 25/2 26/13 52/4 129/18
Arizona [1] 39/5
around [3] 110/21 121/19 122/3
as [154]
ask [39] 5/18 6/8 6/22 8/17 9/7 14/25 23/13 24/13 24/13 25/16 25/24 26/22 29/4 31/1 31/12 31/21 32/3 33/3 33/13 33/15 33/16 36/2 36/9 36/16 48/10 54/5 54/6 67/13 76/24 81/13 90/14 96/14 98/6 99/1 99/3 100/13 109/1 130/5 130/20
asked [12] 7/20 9/21 9/24 46/17 68/18 71/24 76/17 81/14 85/13 85/13 86/24 125/8
asking [10] 9/6 10/19 36/13 53/3 55/3 67/14 75/5 90/8 90/9 90/25
asks [3] 31/3 31/17 33/14
assert [1] 102/9
assume [3] 99/8 109/3 109/8
assure [1] 112/7
assured [1] 112/7
at [67] 8/25 9/8 19/11 20/17 26/14 26/18 28/2 28/21 30/14 31/17 31/19 31/21 33/8 36/13 39/11 40/1 40/3 40/3 45/18 47/5 48/25 49/7 49/23 49/24 50/21 50/25 53/5 54/3 61/21 62/6 62/16 63/14 65/4 65/12 72/9 72/11 72/22 72/23 72/24 73/5 81/18 82/3 85/21 91/1 92/21 92/25 93/9 97/20 99/12 101/13 104/14 105/2 110/3 118/9 120/13 120/18 127/10 127/21 129/13 129/17 131/11 131/12 131/21 131/25 132/7 134/6 134/8

A

attached [1] 129/10
attack [2] 74/18 90/12
attempt [2] 13/23 28/25
attorney [32] 19/9 20/13 20/17 21/11 21/13 21/21 21/23 22/6 22/12 22/17 23/1 23/9 23/12 23/14 23/18 23/25 24/3 24/8 24/15 24/16 24/20 31/17 33/12 33/14 65/8 66/2 67/15 68/4 68/5 68/11 111/10 129/1
attorney-driven [9] 19/9 21/13 21/21 22/6 22/12 23/1 23/25 24/15 24/20
attorneys [5] 19/11 19/14 24/1 26/4 110/11
automatically [1] 52/17
available [3] 110/18 128/13 128/14
AVENUE [1] 2/10
average [1] 118/16
avoid [1] 83/20
avoiding [1] 115/11
award [9] 34/4 34/10 34/12 35/2 55/3 57/20 103/21 103/23 105/10
awarding [1] 30/16
awards [1] 35/1
aware [1] 6/11

B

back [21] 10/10 17/1 17/4 33/6 43/20 47/3 68/17 71/9 73/7 82/10 110/9 111/11 111/12 112/3 113/7 113/8 114/4 115/14 117/3 120/1 120/20
back -- it's [1] 33/6
backdoor [2] 72/14 72/18
backwards [1] 10/25
bad [1] 33/17
balance [1] 100/20
based [45] 4/5 5/22 7/2 17/24 22/3 22/8 22/24 23/5 26/17 31/13 31/18 31/18 32/4 32/8 34/2 35/22 36/10 39/7 40/7 48/19 50/16 50/19 51/22 51/25 58/24 62/4 63/18 64/11 69/5 69/23 76/25 81/2 107/2 109/25 115/10 116/13 123/20 124/12 125/5 127/13 127/14 127/14 127/15 129/21 129/24
basically [12] 5/7 13/14 47/14 48/6 74/13 78/21 105/18 107/12 114/25 116/20 124/22 128/9
basing [5] 31/25 58/14 58/23 125/21 127/19
basis [12] 30/1 42/8 56/8 57/5 65/12 69/20 74/19 82/23 83/8 124/13 127/6 128/11
be [215]
be -- is [1] 98/23
be -- it's [1] 98/18
bear [2] 89/15 109/11
became [1] 39/3
because [139]
become [2] 28/25 98/2
becomes [6] 32/13 32/18 32/24 81/12 102/20 108/23
Beecroft [2] 38/21 39/11
been [58] 15/24 16/17 16/18 30/14 37/15 42/24 45/11 54/12 57/10 61/19 65/9 71/3 74/8 82/22 83/12 84/15 86/5 86/18 86/22 86/23 87/3 89/6 89/14 95/3 95/8 98/19 99/2 101/6 102/14 102/15 102/15 102/24 102/24 103/1 103/8 103/9 103/14 103/24 103/25 104/1 104/5 104/8 104/13 106/16 106/19 106/20 106/20 108/4 108/10 108/18 108/19 111/11 117/18 117/18 122/1 123/13 125/20 126/7
before [36] 1/19 4/24 16/1 18/3 45/16 46/25 48/5 48/8 64/13 65/10 74/1 75/11 76/17 77/1 82/11 83/25 84/5 87/24 88/1 103/23 104/1 107/22 108/5 108/10 108/24 110/15 115/3 118/11 119/21 120/15 121/3 128/10 129/3 130/7 130/21 134/6
before-and-after [3] 48/5 48/8 65/10
BEFORE-ENTITLED [1] 134/6
beforehand [2] 87/15 88/5
behalf [5] 65/19 66/3 98/20 101/14 103/14
behind [4] 42/14 56/9 94/9 129/7
being [13] 7/20 12/19 51/23 53/12 62/19 66/7 66/8 67/8 68/11 99/1 99/12 108/21 128/1
belief [1] 14/2
believe [25] 15/22 29/13 30/6 32/25 33/5 33/10 39/4 39/6 39/11 55/9 63/8 65/20 74/13 90/8 95/10 95/14 101/18 108/6 111/14 114/16 117/17 121/6 122/19 129/12 131/21
believes [1] 62/8
bell [1] 87/19
Belsky [9] 83/5 94/17 94/25 96/19 113/23 115/15 115/23 116/14 116/18
Ben [1] 3/9
bench [2] 87/6 132/22
benefit [4] 84/25 105/21 106/1 106/8
BENJAMIN [2] 2/3 2/6
best [2] 125/19 134/11
better [3] 60/20 103/22 103/25
between [4] 64/1 65/15 78/6 93/3
beyond [14] 21/18 28/24 33/8 38/18 42/23 53/1 61/12 65/16 67/11 80/19 90/6 90/11 94/15 99/13
bias [25] 25/14 50/10 65/20 65/22 66/4 66/7 66/10 66/16 67/8 67/11 67/19 68/1 98/5 98/17 98/19 98/20 99/13 99/13 99/16 99/22 100/1 100/6 100/15 100/22 100/23
biases [3] 30/12 34/1 34/2
big [2] 32/24 130/9
bill [4] 102/21 105/9 105/12 122/8
billed [5] 102/15 103/8 103/24 104/18 104/22
billing [1] 104/25
bills [8] 34/25 35/2 104/20 104/25 105/5 105/22 105/24 106/10
binder [1] 107/4
biomechanical [9] 52/20 61/25 62/14 70/18 70/20 70/21 71/15 72/5 115/19
biomechanics [2] 54/1 64/6
biomedical [1] 72/1
black [1] 44/4
blanche [3] 41/7 42/6 42/10
blindsided [1] 83/15
blood [11] 55/7 56/5 56/17 57/22 58/17 58/17 117/25 118/17 118/17 119/4 119/6
bloody [1] 120/25
board [1] 120/24
body [9] 5/12 5/17 8/15 9/4 9/9 15/18 59/14 59/15 86/11
boils [1] 21/2
book [1] 3/17
both [13] 9/19 19/24 25/22 26/7 26/16 27/4 30/21 30/25 33/24 65/25 124/5 124/14 128/16
both-way [1] 25/22
bottom [1] 62/6
bought [1] 124/20
box [1] 32/21
boy [3] 7/18 7/19 35/7
BRASIER [2] 2/4 3/9
brief [3] 25/19 47/2 131/5
briefing [2] 132/3 132/6
briefly [1] 97/13
briefs [1] 37/21
bring [15] 4/11 30/1 30/8 37/23 47/21 54/25 55/5 59/21 66/10 66/17 79/7 105/2 105/7 112/1 112/3
brings [2] 66/18 111/18
broad [6] 13/8 13/13 13/22 15/10 29/19 71/4
broad-stroke [1] 13/22
broader [1] 15/8
brought [5] 30/7 40/12 87/13 107/16 110/14
bucks [1] 35/10
build [1] 20/25
building [1] 31/10
buildup [6] 19/9 21/21 21/23 22/7 22/12 24/21
built [1] 51/18
Bulla [1] 39/10
Bulla's [1] 38/22
bump [1] 70/22
bunch [6] 83/24 84/20 84/20 84/21 99/7 128/2
bunion [1] 56/15
bunions [2] 55/20 57/7
Busby [3] 65/8 66/17 67/15
Busby's [1] 68/11

B

business [2] 65/4 124/21
but [154]
buying [2] 64/5 122/15

C

calendar [2] 121/16 131/12
California [2] 103/16 103/20
call [14] 47/8 47/17 48/11 48/17 49/2 49/5 49/7 49/15 72/5 109/15 110/9 111/19 115/14 131/12
called [4] 21/11 47/16 113/24 115/25
calling [4] 47/25 48/7 48/24 79/13
calls [1] 70/21
came [3] 69/1 75/16 95/6
can [75] 7/5 8/24 8/25 12/13 22/18 23/10 24/13 28/12 30/13 31/1 32/3 33/23 36/9 36/22 36/24 37/17 39/14 39/15 39/16 40/1 40/3 40/3 40/4 40/10 40/13 41/4 42/20 42/20 45/11 45/19 45/24 50/23 56/23 56/25 59/14 64/2 65/17 73/13 73/15 74/21 74/22 76/11 76/18 76/24 77/24 78/1 79/15 80/13 81/24 83/14 84/18 87/14 88/4 88/12 92/8 94/10 95/1 97/11 101/23 105/8 110/24 111/2 111/3 112/6 116/15 118/10 119/1 119/1 119/2 123/3 130/7 130/22 131/5 131/8 131/12
can't [46] 8/23 8/23 14/5 18/14 18/14 26/18 28/2 29/6 29/7 31/12 35/13 36/25 40/17 42/23 42/23 43/2 43/7 45/15 45/20 50/1 50/4 53/21 58/16 60/25 66/19 73/20 79/7 79/8 79/8 79/14 79/15 81/19 82/6 82/10 82/19 82/19 82/20 86/10 92/20 110/8 110/22 111/3 113/21 125/11 127/23 130/12
candidate [1] 87/17
candidly [1] 4/18
cannot [4] 34/16 58/11 58/11 78/8
Canyon [1] 122/4
cap [2] 30/18 30/19
capacity [4] 108/14 108/15 127/6 127/8
car [1] 30/2
cardiac [1] 18/7
care [23] 19/15 21/14 34/3 34/8 40/18 45/14 45/17 46/8 46/9 46/14 46/19 80/11 80/20 81/9 81/15 86/7 86/8 97/6 104/16 122/3 126/1 126/4 128/9
cars [1] 63/21
carte [3] 41/7 42/5 42/9
cartoon [1] 119/7
case [89] 1/1 3/6 6/10 9/23 10/6 10/13 14/22 19/8 19/9 20/14 21/1 21/9 21/15 22/6 24/21 30/8 30/18 30/19 31/20 32/5 36/11 39/4 39/6 39/7 40/21 40/23 41/8 44/7 48/3 50/17 51/24 52/9 52/21 55/9 59/5 60/22 61/20 62/16 65/9 65/10 67/23 67/25 74/15 75/20 83/4 92/25 94/3 94/20 95/6 97/17 97/17 97/19 98/9 98/11 98/12 98/13 100/1 101/18 101/19 101/22 103/7 103/15 103/16 103/16 103/17 103/19 105/18 107/18 107/25 108/17 108/22 108/22 109/17 115/7 115/7 116/16 123/2 124/5 124/14 124/14 124/25 128/2 128/24 129/2 129/6 129/6 130/5 130/15 130/19
cases [6] 10/2 12/6 25/12 38/7 99/19 105/18
Castelletti [6] 50/18 50/20 100/20 100/23 105/17 106/14
causally [1] 104/22
causation [8] 14/16 38/10 46/6 70/16 70/24 72/4 92/1 115/19
cause [5] 36/1 37/14 55/16 72/7 111/18
caused [2] 62/19 71/8
caveat [1] 24/4
CCR [2] 1/24 134/17
center [2] 122/6 122/8
centered [1] 22/17
certain [12] 31/4 37/16 47/25 54/24 57/10 91/16 93/1 94/8 104/7 108/1 113/6 126/4
certainly [7] 3/24 8/24 22/18 32/10 43/9 67/10 78/17
CERTIFICATE [1] 134/1
CERTIFIED [1] 134/4
CERTIFY [1] 134/5
cervical [2] 86/2 123/16
cetera [3] 57/22 123/19 123/19
challenge [2] 35/25 37/18
challenges [1] 37/14
chameleon [1] 125/19
chance [2] 13/4 108/24
change [9] 41/3 125/18 126/7 126/9 126/23 126/23 127/19 127/21 128/3
changed [5] 82/12 110/16 126/1 126/11 129/24
changes [1] 38/13
changing [1] 86/8
characterization [1] 70/17
charge [2] 98/8 122/24
charged [3] 29/16 99/6 99/7
charges [1] 29/19
chart [12] 41/14 42/22 42/25 43/13 45/12 80/22 81/7 82/8 90/7 92/4 96/6 120/22
charts [4] 80/13 81/2 81/3 119/2
checklist [1] 127/9
chest [1] 17/4
chief [2] 107/19 109/17
children [1] 124/23
chiropractic [1] 40/4
chiropractor [1] 105/4
choice [2] 108/12 108/13
cholesterol [3] 55/8 56/17 57/22
church [2] 65/12 65/16
Circuit [2] 39/4 39/6
circumstance [7] 94/23 110/19 111/6 111/9 111/9 111/14 112/23
circumstances [3] 78/10 79/1 79/17
citation [1] 101/23
cite [1] 38/21
cited [2] 131/2 131/2
cites [1] 38/19
citing [1] 127/3
civil [3] 13/15 65/2 67/21
claim [3] 65/3 118/21 124/24
claimed [2] 62/18 97/22
claiming [1] 10/7
clarification [2] 23/17 36/3
clarified [1] 66/25
clarify [2] 17/23 64/9
clarity [1] 116/17
CLARK [3] 1/5 134/3 134/14
classes [1] 64/5
CLAYTON [3] 2/9 3/12 3/15
clear [6] 17/19 23/23 24/10 103/19 108/9 124/20
client [11] 9/24 10/6 21/12 24/12 24/16 27/10 52/14 54/7 54/11 54/12 54/14
client's [9] 43/11 54/3 108/7 112/8 112/9 112/17 113/6 114/15 115/12
clients [2] 24/1 33/25
clinical [4] 38/18 41/14 43/12 80/2
closing [7] 12/8 26/13 26/13 26/17 60/24 118/7 120/24
CLOWARD [26] 2/3 3/9 9/18 12/1 17/24 23/19 27/10 33/3 35/6 35/14 39/1 47/15 51/9 76/24 88/1 90/14 94/24 109/22 110/25 111/18 112/12 112/16 114/17 114/25 117/23 120/14
Cloward's [1] 15/7
co [8] 54/24 55/5 55/15 55/15 57/21 58/8 58/21 59/1
co-morbidities [8] 54/24 55/5 55/15 55/15 57/21 58/8 58/21 59/1
collateral [24] 49/17 49/21 49/24 50/14 50/16 99/20 100/19 100/24 101/1 101/4 101/15 101/17 102/3 104/10 105/15 105/19 105/24 106/9 106/14 106/17 106/18 107/2 122/22 123/4
collision [3] 53/15 62/19 63/16
color [2] 99/23 100/1
colored [3] 108/4 108/10 108/18

C

colors [1] 65/13
come [41] 4/17 7/8 9/19 10/1 35/18 38/1 40/17 40/24 41/4 41/9 42/5 42/20 43/22 44/18 48/6 48/23 50/23 52/10 61/19 63/2 76/3 79/4 81/13 81/16 82/1 82/2 83/24 87/6 87/20 92/21 99/5 99/12 100/25 102/18 109/13 113/7 113/8 114/4 115/1 117/3 128/11
comes [16] 4/7 59/21 66/22 72/10 73/4 74/23 80/22 81/25 84/5 85/16 97/20 100/4 111/7 118/17 119/4 126/6
coming [3] 4/8 42/23 82/7
comment [8] 22/18 43/22 44/13 48/21 49/3 49/8 50/4 89/16
commentary [1] 132/22
commenting [2] 32/12 107/9
comments [2] 45/6 68/22
commissioner [5] 38/21 38/22 39/10 39/11 48/12
companies [1] 35/8
compelled [1] 116/23
compelling [1] 115/5
compensation [2] 101/20 101/25
complained [1] 86/19
complaining [1] 20/16
complaint [2] 20/21 76/7
complaints [6] 9/22 9/22 20/16 21/5 21/7 34/11
complete [1] 42/12
completely [6] 84/3 86/17 108/16 113/4 124/18 129/24
complies [2] 31/16 31/25
compromise [1] 68/7
concern [10] 29/17 32/25 34/17 36/5 36/6 36/7 37/9 48/3 48/4 111/16
concerned [4] 16/13 18/10 96/22 114/17
concluded [1] 133/4
conclusions [3] 62/4 80/10 97/1
concoct [1] 22/19
condition [2] 7/17 61/10
conditions [7] 5/8 54/18 54/21 55/8 59/10 59/12 78/20
conduct [1] 94/21
conference [2] 121/15 132/19
confides [1] 67/6
conflated [1] 112/21
confuse [7] 5/3 5/19 8/18 10/20 11/6 11/17 53/22
confused [1] 10/9
consideration [1] 9/1
consistent [3] 46/24 62/18 63/23
constitute [1] 93/16
CONSTITUTES [1] 134/10
consult [1] 71/25
consultations [3] 78/13 78/14 78/15
consumption [1] 115/11
contained [1] 84/9
contemplated [3] 43/24 86/23 86/23
contemplates [2] 91/20 92/6
context [2] 102/4 102/7
continue [1] 86/9
continues [2] 82/18 86/12
contradicted [1] 96/7
contrary [1] 32/9
controlling [1] 103/16
conversation [1] 112/20
convince [5] 39/1 63/5 65/5 78/4 105/8
convinced [1] 78/22
cop [2] 62/7 68/19
correct [11] 5/14 11/8 12/16 22/16 60/7 68/20 92/23 95/9 101/23 115/17 117/24
correctly [2] 47/14 51/8
correspondence [1] 64/3
cost [3] 81/22 111/22 112/2
costs [9] 48/10 49/10 112/9 112/10 114/10 114/14 114/20 123/19 126/4
could [7] 12/14 51/16 59/16 67/13 67/21 102/17 113/21
couldn't [5] 54/12 97/22 97/23 97/23 97/25
counsel [12] 14/10 18/12 24/23 24/24 25/5 25/10 59/1 60/23 65/19 67/7 68/2 85/25
counter [1] 50/9
counter-argument [1] 50/9
country [4] 109/9 109/15 110/10 114/21
COUNTY [8] 1/5 101/18 101/19 101/24 103/18 104/11 134/3 134/14
couple [6] 3/22 12/6 50/22 75/16 88/19 112/13
course [9] 4/8 15/3 39/23 57/7 84/25 92/4 110/12 125/1 125/25
courses [1] 70/6
court [26] 1/4 1/20 28/23 29/12 29/14 30/4 39/9 40/12 41/4 42/10 42/15 42/20 90/10 90/11 95/25 96/1 100/3 100/5 100/7 102/4 102/7 109/14 110/15 112/24 115/6 130/20
courtesies [2] 110/11 112/22
courtroom [2] 29/18 71/23
courts [1] 104/12
coverage [1] 29/8
covered [1] 29/1
crash [7] 6/7 11/24 17/3 18/22 20/9 51/6 68/14
create [6] 7/9 21/7 52/17 55/18 60/17 114/9
created [4] 12/20 16/24 16/25 52/18
creates [1] 32/21
creating [3] 8/6 13/2 72/19
creative [1] 73/2
credibility [3] 10/2 68/24 74/18
credible [1] 69/6
criticism [2] 44/24 94/5
criticisms [1] 43/22
criticize [3] 44/21 44/22 44/22
criticized [1] 116/21
criticizes [1] 93/20
criticizing [2] 92/18 95/7
Croft [1] 115/18
cross [8] 12/9 55/10 56/23 78/6 90/2 96/5 96/9 122/16
cross-examination [4] 12/9 96/5 96/9 122/16
cross-examine [1] 56/23
cross-examining [1] 55/10
cross-over [1] 78/6
crosses [1] 89/9
crossing [2] 89/5 95/13
cumulative [2] 47/8 89/19
cure [1] 130/23
curious [1] 54/9
current [3] 7/17 8/8 9/15
customary [1] 122/10
cut [2] 74/12 84/13
cuts [1] 53/11

D

damage [5] 63/21 64/12 68/15 72/23 73/6
damages [3] 14/17 101/13 102/11
dancing [1] 124/23
danger [3] 66/6 68/21 69/22
data [1] 127/11
DATED [1] 1/22
day [11] 36/14 99/6 110/17 110/17 110/19 110/20 111/3 111/24 111/24 112/2 128/19
deal [4] 55/1 87/14 95/19 120/17
dealing [2] 50/22 70/7
decided [2] 90/18 125/7
deciding [1] 125/18
decision [5] 22/18 29/11 29/13 100/21 100/21
defend [11] 41/13 44/11 45/2 52/9 94/3 94/4 94/8 95/23 96/25 96/25 114/7
defendant [16] 3/12 3/15 19/8 19/13 24/25 29/8 51/4 101/17 103/5 103/10 103/12 105/20 105/25 106/2 106/6 106/7
defendant's [13] 3/22 28/20 54/2 68/13 79/25 88/15 98/7 98/20 105/2 107/7 116/15 117/11 121/20
defendants [3] 1/11 29/1 103/13
defending [4] 92/4 93/13 93/13 93/14
defense [39] 5/9 12/8 25/13 25/24 38/19 39/17 40/2 42/7 44/3 44/16 54/10 54/20 62/22 70/15 82/5 83/17 88/17 89/3 89/8 89/16 90/3 90/4 90/4 90/12 90/12 90/21 90/25 92/9 94/18 95/11 99/14 107/10 107/10 107/16 108/23 113/14 114/3 115/7 115/8

D

defense's [1] 38/16
defer [1] 62/25
deference [2] 100/3 100/4
deficit [2] 129/20 131/7
definitely [1] 26/17
definition [5] 74/6 74/10 75/19 75/24 76/5
definitions [1] 76/13
degree [2] 7/6 124/2
delay [1] 132/18
demonstrate [1] 120/5
demonstrative [7] 117/15 117/17 117/20 117/22 120/19 121/7 121/11
denied [12] 10/16 10/18 11/2 11/12 26/10 54/16 68/9 73/16 97/5 107/1 117/10 123/7
deny [3] 95/20 121/9 129/17
depend [1] 10/23
depending [1] 111/22
depends [1] 85/12
depicting [1] 119/3
depiction [2] 119/23 120/7
depictions [1] 117/12
depose [3] 48/9 84/15 92/9
deposed [17] 21/6 41/15 48/15 48/19 49/6 81/11 83/4 83/12 93/5 93/6 93/17 93/20 95/8 126/7 128/11 128/18 129/7
deposition [38] 12/22 45/13 46/17 52/8 62/25 63/8 73/25 73/25 81/23 82/10 82/11 82/21 83/25 84/6 85/4 85/11 85/18 86/16 90/19 90/21 92/14 96/7 119/23 124/10 124/11 125/25 127/4 128/6 128/6 128/8 128/15 130/23 130/24 131/2 131/6 131/18 131/19 131/24
depositions [14] 41/15 46/12 74/4 74/23 80/2 80/11 81/11 81/25 84/10 84/12 85/8 86/11 90/23 92/24
deprivation [1] 108/6
deprive [1] 108/2
DEPT [1] 1/2
description [1] 62/7
designate [2] 40/20 40/22
designated [7] 40/16 41/17 48/5 113/25 116/10 116/11 116/12
designation [2] 40/14 40/16
designed [7] 5/3 5/23 7/9 8/10 13/5 33/1 34/19
detectives [1] 47/1
determination [3] 103/19 105/11 113/3
determine [8] 9/21 30/11 69/17 71/24 72/6 72/11 100/21 104/13
determined [3] 104/13 106/6 106/11
determining [4] 70/3 72/4 72/21 102/8
diabetes [1] 55/7
diagnosis [3] 38/10 46/6 92/1
diagnostics [1] 22/3
diagram [1] 20/22
did [32] 4/19 19/18 39/21 40/2 40/6 44/8 44/10 62/1 64/23 69/17 71/13 72/5 88/16 89/16 92/11 92/11 92/11 93/14 93/18 94/23 95/10 97/11 98/9 106/10 106/10 114/16 115/18 115/23 116/2 116/10 116/22 126/3
didn't [33] 9/25 13/3 14/14 14/14 19/18 21/5 39/23 39/24 39/24 40/7 47/17 47/21 50/2 52/7 52/8 63/13 69/15 74/5 74/5 74/9 75/22 76/10 79/3 81/8 84/1 96/14 114/17 124/8 124/17 125/7 127/21 128/3 128/18
Diego [1] 115/21
difference [4] 23/17 93/3 93/8 99/9
different [18] 4/7 23/20 23/24 25/3 37/3 41/18 41/22 47/19 52/2 63/10 68/25 70/25 88/24 97/20 101/20 110/10 115/6 128/2
differently [2] 49/20 51/18
diligent [1] 85/7
Dineen [21] 123/9 123/11 123/20 124/6 124/7 124/8 124/17 124/19 125/3 126/6 126/16 126/19 126/21 127/18 128/10 128/11 128/17 129/12 130/8 130/12 131/17
Dineen -- it's [1] 124/19
Dineen's [4] 127/4 128/15 130/6 130/21
ding [3] 87/18 87/18 87/18
dire [12] 28/15 28/25 30/5 30/23 31/7 74/3 75/11 76/18 77/1 77/5 77/13 77/14
direct [5] 108/15 108/22 108/22 115/7 118/6
directed [1] 19/14
direction [3] 19/11 20/17 134/9
directly [3] 89/7 95/2 96/8
disability [2] 38/12 46/7
disagree [10] 35/20 40/4 85/19 89/2 89/3 89/5 89/10 89/21 89/24 91/3
disciplines [1] 78/6
disclosed [5] 89/6 89/14 97/2 117/19 128/12
disclosing [1] 121/7
disclosure [1] 38/20
disconnect [1] 94/16
discounts [1] 102/4
discovery [4] 12/22 48/12 82/9 97/21
discuss [7] 7/15 24/6 44/2 44/16 53/5 55/14 59/2
discussed [3] 39/10 86/18 107/3
discussion [9] 16/23 33/5 33/11 34/18 35/16 38/22 53/20 112/21 126/25
discussions [3] 32/23 33/8 35/10
dismiss [1] 125/7
dismissed [1] 86/5
distinction [1] 101/8
distinctions [1] 101/22
DISTRICT [3] 1/4 1/20 39/5
do [90] 3/17 3/19 4/12 5/19 6/20 7/13 8/8 9/15 13/17 16/17 17/3 17/4 17/18 18/16 19/18 21/12 21/24 24/8 29/14 39/23 42/9 45/5 46/25 53/22 54/2 54/25 55/6 55/22 56/16 57/24 58/8 58/11 60/17 61/2 61/4 61/9 67/22 68/8 69/15 69/16 69/17 70/2 70/4 71/25 72/9 72/10 72/10 72/16 73/3 73/6 73/13 74/19 76/18 77/24 79/11 79/12 81/2 81/14 83/14 83/18 85/13 87/1 88/12 89/22 89/23 91/10 91/14 91/15 91/16 91/17 91/18 91/18 93/9 94/9 94/24 96/18 96/21 99/14 110/13 111/5 112/13 115/4 117/4 119/22 127/10 129/13 131/10 131/13 132/3 134/4
DOCKET [1] 1/1
doctor [60] 6/9 6/11 7/11 7/15 7/20 7/22 8/23 8/24 12/12 12/14 12/15 20/11 20/12 24/16 25/14 42/8 43/3 43/6 44/18 45/11 45/15 45/20 50/1 50/5 55/19 57/11 59/4 59/6 68/22 71/5 71/6 75/1 75/9 75/11 78/7 82/19 84/14 85/15 85/20 86/8 86/17 87/5 87/8 88/3 89/1 89/2 89/9 89/16 90/4 92/7 94/17 94/22 100/13 104/6 104/24 105/23 111/23 115/3 116/4 116/25
doctor's [1] 82/11
doctors [69] 6/19 7/4 7/5 8/3 8/20 9/25 14/2 14/22 15/1 15/24 16/6 16/17 20/15 20/24 22/13 24/1 26/3 40/10 41/4 42/5 42/15 42/20 43/11 45/24 46/6 47/18 47/22 50/13 55/10 56/10 56/23 57/1 58/14 58/16 60/14 61/2 62/3 69/10 70/1 70/11 70/15 71/5 72/19 73/22 74/21 74/22 76/7 76/8 76/9 78/11 80/9 81/1 82/17 83/7 84/8 84/19 84/23 89/23 90/19 90/22 90/24 91/5 91/6 95/7 96/21 96/24 99/3 118/24 120/3
documents [2] 17/8 92/3
does [15] 5/24 7/25 24/25 30/4 33/13 39/20 41/7 43/10 43/19 43/20 50/10 53/9 65/22 78/7 126/12
doesn't [31] 6/20 17/16 24/2 25/1 27/18 31/2 35/24 37/24 40/17 41/9 52/3 52/16 54/20 64/3 65/25 67/20 73/12 75/1 75/2 75/7 75/9 77/24 81/8 91/16 97/1 121/1 126/7 126/22 126/23 127/17 127/19

D

doing [10] 27/19 29/18 30/4 41/6 56/24 75/24 89/7 113/16 118/23 121/16
dollar [4] 32/11 32/12 32/20 35/16
dollars [1] 125/10
don't [125] 5/17 9/3 9/6 11/5 12/7 14/6 14/7 14/8 15/1 15/12 15/15 15/20 15/21 18/22 18/23 21/24 22/7 24/14 24/19 27/12 28/7 28/19 30/15 30/16 30/17 30/17 31/18 31/19 32/20 33/17 34/3 34/8 34/24 34/25 35/23 37/23 37/25 37/25 38/1 40/24 42/9 43/12 43/16 43/21 44/10 44/13 47/15 47/25 48/11 49/2 49/8 49/24 51/9 53/4 54/1 56/18 57/8 57/11 57/13 58/4 58/22 61/18 63/20 63/22 64/6 64/6 65/4 66/10 66/17 67/24 69/14 71/4 73/3 73/4 73/5 73/8 73/22 75/23 76/11 78/3 78/14 78/22 82/6 82/16 83/23 84/23 85/23 89/23 90/18 91/5 91/8 91/15 91/15 94/24 95/5 95/10 95/14 95/24 95/24 96/11 96/15 96/17 96/20 97/2 97/6 97/18 99/15 103/17 106/3 113/8 113/9 113/17 114/4 118/9 119/11 120/10 120/11 120/14 121/12 125/23 127/9 131/8 131/10 131/11 131/23
don't -- I [1] 113/9
done [16] 4/24 12/23 26/4 30/14 44/9 70/18 83/13 86/6 92/16 92/17 92/17 113/18 117/6 118/12 125/5 128/17
door [4] 23/21 24/9 32/19 73/7
dovetails [2] 41/23 80/4
down [13] 21/3 23/22 38/3 48/14 48/22 48/23 87/18 96/15 96/16 100/25 102/1 130/18 134/5
Dr [14] 22/1 44/6 83/5 92/10 93/17 93/20 93/20 95/5 110/14 110/15 110/17 116/2 124/7 126/21
Dr. [98] 20/20 22/1 39/19 39/20 39/21 40/1 40/5 41/10 41/10 41/11 43/17 43/18 43/19 43/19 43/21 43/23 44/6 44/8 44/15 44/19 44/20 44/25 44/25 56/4 58/1 71/23 72/20 73/17 73/24 75/6 75/15 75/17 75/19 76/11 77/17 77/18 83/4 83/4 83/5 87/15 89/3 89/4 89/20 89/20 89/20 89/21 89/22 89/23 90/3 90/3 92/10 92/13 92/13 92/14 92/15 92/19 92/20 92/21 92/22 93/4 93/5 93/6 93/8 93/12 93/21 93/21 93/21 93/23 93/24 93/25 94/2 94/5 94/13 94/17 94/25 95/4 95/4 96/19 113/17 113/23 114/2 114/2 114/6 115/15 115/18 115/23 116/18 116/21 123/15 123/21 124/12 124/14 125/25 125/25 126/19 127/16 127/24 131/1
Dr. Belsky [5] 83/5 94/17 94/25 96/19 115/23
Dr. Belsky is [1] 116/18
Dr. Belsky that [1] 113/23
Dr. Belsky the [1] 115/15
Dr. Croft [1] 115/18
Dr. Duke [3] 92/13 92/13 92/21
Dr. Gross [6] 89/22 89/23 123/21 124/14 125/25 127/16
Dr. Gross's [5] 124/12 125/25 126/19 127/24 131/1
Dr. Jeffrey [1] 123/15
Dr. Kaffcan [10] 43/19 43/23 44/20 83/4 87/15 89/20 93/21 93/24 95/4 114/2
Dr. Muir [28] 39/19 39/21 40/1 43/17 43/18 43/19 43/21 44/6 44/8 44/15 44/19 44/25 44/25 83/4 89/20 92/10 92/15 92/19 92/20 93/4 93/6 93/8 93/12 93/21 93/23 94/2 95/4 114/2
Dr. Muir's [2] 92/14 92/22
Dr. Roesler [2] 93/21 93/25
Dr. Schifini [20] 39/20 40/5 41/10 71/23 72/20 73/17 73/24 75/6 75/15 75/17 75/19 76/11 77/17 89/3 90/3 94/5 94/13 113/17 114/6 116/21
Dr. So-and-so [5] 20/20 41/11 56/4 58/1 93/5
Dr. Villablanca [1] 41/10
Dr. Whoever [1] 89/20
Dr. Ziegler [5] 22/1 77/18 89/4 89/21 90/3
drafters' [1] 91/23
drawing [2] 120/22 120/23
drawn [2] 81/19 82/3
driven [16] 19/9 20/13 21/13 21/21 21/23 22/6 22/12 23/1 23/9 23/12 23/14 23/25 24/3 24/8 24/15 24/20
driver [1] 51/13
druggy [1] 27/14
DSM [1] 74/13
due [6] 8/9 42/12 43/11 108/7 112/17 112/24
Duke [7] 92/13 92/13 92/21 93/20 93/20 110/15 110/17
Duke's [2] 95/5 110/14
during [24] 4/6 4/8 26/22 26/24 27/1 46/9 46/17 46/19 62/19 62/25 77/4 80/11 81/9 85/3 85/10 109/16 109/17 110/12 112/16 118/2 118/5 118/6 118/6 120/23
duty [1] 12/21
dynamic [2] 4/15 86/8

E

each [5] 48/10 66/9 67/9 98/7 110/11
early [2] 48/2 92/10
earning [1] 125/9
easily [2] 66/25 130/23
easy [4] 19/5 24/21 49/19 54/19
EDCR [1] 31/11
effect [7] 7/24 18/6 56/21 57/8 57/21 58/9 95/13
effectively [1] 89/19
effects [1] 57/12
Eglet's [1] 37/21
eight [1] 47/18
either [11] 15/21 20/15 24/15 30/12 48/9 48/20 92/23 102/25 106/9 120/11 129/8
element [3] 72/25 93/1 130/1
eleven [1] 48/15
elicit [1] 5/23
eliminated [1] 106/10
else [6] 19/23 51/10 51/10 51/17 90/5 94/6
else's [1] 45/17
emergency [1] 114/22
emphasize [1] 28/25
end [9] 31/21 36/14 53/14 53/15 79/19 79/20 79/22 112/4 132/10
ends [1] 125/24
enforce [3] 13/14 13/15 31/14
engineer [4] 70/19 70/21 72/1 72/5
engineer's [1] 70/20
enough [17] 10/21 11/19 11/20 19/3 25/6 25/7 26/11 46/4 46/21 59/22 64/16 67/6 67/6 72/6 91/17 121/5 132/8
ensure [1] 28/23
entered [1] 124/3
entertain [1] 117/7
entire [4] 13/21 37/17 37/19 41/25
entitled [6] 28/21 34/9 35/5 78/19 105/20 134/6
equal [1] 52/18
equally [5] 26/6 26/15 32/3 34/7 57/19
especially [5] 33/1 34/17 95/8 98/18 122/5
ESQ [4] 2/3 2/4 2/9 2/10
essentially [4] 8/14 27/15 45/25 98/11
establish [2] 102/10 102/12
establishes [1] 67/18
et [3] 57/22 123/19 123/19
et cetera [3] 57/22 123/19 123/19
even [20] 6/18 20/23 30/7 34/1 47/16 71/4 74/9 75/23 78/15 78/25 80/19 82/22 86/18 96/18 103/7 107/23 108/14 112/4 121/12 124/8
even -- if [1] 34/1
evens [1] 99/4
event [1] 114/20
ever [1] 72/10
every [20] 20/6 20/13 30/10 30/14 30/18 40/21 40/23 48/16 72/13 74/14 74/15

E

every... [9] 81/6 82/7 82/11 85/11 92/24 93/23 94/2 100/13 116/22
everybody [4] 45/17 58/24 74/14 105/5
everybody's [1] 132/19
everything [8] 41/8 44/19 74/20 83/14 83/19 107/21 107/22 130/17
evidence [36] 4/6 4/11 4/17 13/15 21/3 21/4 21/13 22/24 23/11 26/14 26/18 27/1 27/21 28/3 52/10 54/17 59/9 59/11 59/19 60/2 60/21 61/18 63/14 63/18 97/10 97/16 98/22 100/6 100/11 100/17 101/7 121/21 121/21 126/14 129/5 130/15
evidentiary [5] 100/4 130/5 130/20 131/9 131/22
exact [6] 52/19 74/15 86/24 92/7 94/22 125/10
exactly [16] 17/1 30/3 32/25 34/16 34/19 35/13 42/3 47/20 52/15 69/4 76/16 85/2 94/23 117/1 118/10 119/12
examination [6] 12/9 96/5 96/9 118/6 122/16 126/25
examine [1] 56/23
examined [1] 89/15
examining [1] 55/10
example [4] 6/2 93/17 101/7 110/24
examples [1] 9/3
except [1] 126/8
excess [1] 34/11
exclude [10] 5/2 11/23 13/23 26/12 27/6 28/8 59/11 62/9 110/1 124/1
Excluding [2] 54/17 59/9
excuse [2] 99/21 103/9
exhibit [2] 120/19 121/12
exist [8] 5/25 15/20 15/21 18/24 18/25 55/6 125/23 126/12
existed [1] 65/18
existing [3] 9/8 9/8 65/15
exists [2] 12/19 98/20
expansion [1] 43/9
expect [3] 5/19 78/20 111/11
expectancy [18] 55/2 55/7 55/17 55/22 56/3 56/16 56/21 57/8 57/12 57/18 57/21 58/2 58/7 58/9 58/20 58/25 59/17 59/20
expecting [1] 104/7
expense [1] 111/17
expenses [3] 102/2 106/23 115/11
experience [5] 4/6 74/16 78/16 94/10 94/12
experiences [1] 78/18
expert [66] 9/14 19/21 38/12 38/14 38/20 40/14 40/15 40/15 40/16 40/18 40/23 42/14 43/6 45/20 45/21 45/25 73/15 80/3 83/5 83/6 88/16 89/3 89/6 89/8 89/10 89/13 89/14 90/6 90/12 90/12 90/24 91/1 91/2 91/24 94/22 95/2 95/3 95/13 107/9 107/10 107/20 107/22 107/23 108/4 108/8 108/12 108/13 108/18 109/9 109/14 109/20 110/8 110/21 110/24 111/20 112/15 112/25 114/1 115/3 116/4 116/6 116/7 116/12 123/8 128/23 129/1
expert's [4] 43/22 107/10 115/20 118/3
expertise [1] 78/3
experts [43] 16/18 18/4 18/5 19/1 19/17 21/25 22/7 22/23 25/24 38/17 41/16 41/17 42/15 45/6 45/25 52/20 61/6 61/12 68/14 70/14 70/15 70/20 70/23 80/25 81/1 88/17 89/17 91/6 94/18 95/11 98/7 98/19 99/1 99/3 99/5 99/7 99/10 99/14 99/15 108/1 109/19 111/2 118/6
experts' [1] 108/3
explain [9] 94/10 118/22 119/8 119/20 119/24 120/3 120/21 121/1 121/2
explained [1] 119/2
expose [2] 67/4 98/19
exposes [1] 99/13
exposure [1] 28/22
exposures [1] 28/16
expound [1] 75/22
expressed [1] 85/10
expressly [2] 128/24 128/25
extend [2] 25/1 110/11
extends [1] 65/16
extent [9] 14/19 16/1 38/11 46/7 48/4 55/1 78/17 83/23 121/24
extra [2] 111/17 111/17
extraordinary [5] 111/6 111/8 111/9 111/13 112/23
extrapolate [1] 76/2
extrapolation [1] 43/8
extreme [1] 119/16

F

facility [1] 122/2
fact [46] 5/23 6/16 7/2 12/2 13/9 15/25 22/13 31/18 31/24 32/4 47/17 48/18 49/4 50/5 50/7 51/24 52/14 52/16 52/24 54/5 54/7 61/8 65/18 65/23 66/17 66/22 67/4 68/1 68/24 75/20 76/6 77/23 81/6 85/9 96/5 100/18 104/3 105/21 106/8 108/7 122/14 124/2 126/2 126/8 127/2 128/20
fact -- and [1] 31/24
fact -- based [1] 31/18
factors [1] 53/18
facts [13] 31/13 31/18 31/19 32/1 32/8 34/4 34/8 35/22 35/23 36/10 36/11 53/23 99/22
factual [2] 21/8 119/17
fail [1] 39/25
failing [2] 47/8 49/15
fair [55] 10/21 11/19 11/20 15/16 16/3 16/19 19/3 19/4 25/6 25/7 26/6 26/11 42/17 43/1 43/10 44/14 44/17 46/4 46/21 48/1 48/21 49/3 49/8 49/12 49/13 50/5 50/12 50/12 54/1 54/15 55/10 55/24 57/19 57/19 57/25 59/22 64/16 68/6 73/12 75/13 77/2 83/23 86/14 87/10 95/1 95/15 96/8 96/9 98/18 108/24 121/5 122/10 122/17 131/15 132/8
fairly [1] 29/11
fairness [3] 61/12 82/4 83/17
faker [1] 76/4
faking [1] 51/16
family [2] 67/23 114/22
far [7] 36/8 76/21 76/23 89/2 104/18 120/18 130/2
fault [1] 16/10
favor [2] 13/18 98/14
Fax [1] 2/12
federal [1] 39/8
feel [11] 8/18 69/19 98/1 98/17 98/22 100/16 101/8 104/10 112/7 117/5 131/7
fees [1] 48/10
felt [5] 116/22 119/15 119/19 119/21 119/25
female [1] 53/19
few [2] 18/3 97/15
field [2] 81/19 99/4
figure [5] 32/11 32/20 33/2 97/7 125/10
figures [4] 32/13 35/16 119/8 125/16
file [2] 45/18 124/1
filed [4] 66/12 66/22 90/21 123/25
filing [2] 66/14 67/3
final [1] 103/15
finally [1] 99/18
financial [2] 103/22 104/1
find [2] 15/22 83/14
finds [2] 23/12 118/18
fine [12] 16/15 28/10 37/8 57/1 64/1 80/18 86/13 97/8 110/20 131/16 132/2 132/6
firm [6] 2/3 23/20 24/5 24/7 24/12 26/1
first [16] 3/19 5/2 75/15 94/7 97/18 101/19 109/5 109/11 109/16 110/6 110/25 112/16 118/8 123/11 124/12 130/15
five [3] 56/6 58/18 74/9
flag [1] 8/5
flat [1] 20/16
flawed [1] 129/4
flip [2] 26/5 42/4
fluid [4] 4/15 10/22 86/8 86/8
folks [1] 121/14
follow [6] 33/7 34/18 36/7 36/9 36/24 36/25
follow-up [2] 36/24 36/25
follow-ups [1] 33/7

F

foot [1] 92/9
force [3] 52/18 113/7 113/8
forces [5] 64/7 70/3 70/7 70/18 72/6
FOREGOING [1] 134/10
forget [3] 77/9 77/10 77/11
forgot [1] 125/10
form [2] 70/23 81/8
formal [1] 38/12
format [1] 96/6
formed [3] 46/9 46/18 80/11
formulated [1] 123/20
found [1] 97/21
foundation [14] 56/13 57/4 79/7 124/18 126/12 126/14 129/1 129/3 129/5 129/11 129/15 130/3 130/6 130/21
foundational [6] 56/9 72/25 129/20 130/1 130/11 131/7
four [5] 47/16 48/18 58/2 107/6 128/18
FOURTH [1] 2/4
Frasier [1] 58/19
free [1] 99/6
Friday [1] 109/19
friends [1] 66/8
front [4] 48/12 57/17 104/20 130/10
frontal [1] 53/17
full [3] 98/15 111/24 134/10
fully [2] 106/23 131/19
function [1] 108/14
functional [2] 127/5 127/8
fundamental [1] 83/17
funny [1] 28/17
fusion [2] 123/17 123/17
future [13] 38/11 46/7 80/20 81/15 85/15 103/2 123/12 124/5 124/13 125/22 126/1 127/10 127/18

G

gain [12] 25/1 25/3 73/18 73/21 74/2 74/12 75/22 75/25 76/14 76/21 76/23 76/25
gained [1] 99/25
game [7] 16/19 26/6 48/1 54/1 55/10 57/19 98/18
garnered [1] 98/11
gatekeeper [1] 58/13
general [3] 13/13 29/19 58/24
generally [2] 29/14 100/3
get [60] 6/19 10/9 20/2 28/12 29/15 31/2 33/6 39/7 40/24 44/10 44/13 44/16 45/1 45/7 46/1 46/1 53/25 56/25 58/16 62/22 66/6 66/7 66/9 66/16 67/13 68/23 71/14 72/20 73/2 73/7 75/3 75/3 78/12 78/14 78/14 78/15 84/18 89/23 92/10 93/23 94/3 95/11 96/4 97/22 98/13 98/15 99/14 99/15 101/23 105/20 105/22 105/23 106/4 106/21 111/3 122/9 123/3 131/5 131/5 131/6
gets [12] 16/10 41/25 45/1 45/2 68/17 75/2 75/9 87/15 88/18 88/21 89/9 98/13
getting [8] 18/9 35/8 38/13 56/4 63/12 89/21 103/12 123/12
give [27] 4/2 13/20 35/10 35/11 40/17 41/7 41/9 44/19 45/15 60/20 69/8 69/23 73/24 74/1 75/6 82/25 83/2 90/18 90/23 108/24 113/6 114/3 115/19 125/4 131/11 131/23 132/6
given [10] 15/25 16/7 42/6 48/18 94/4 94/14 108/1 112/19 112/22 124/1
gives [3] 17/8 41/12 93/17
giving [5] 9/3 69/7 69/23 113/14 113/15
go [28] 3/7 3/23 20/19 28/24 32/9 39/1 42/23 46/25 47/3 50/10 53/9 57/9 61/12 65/16 68/12 71/9 72/11 73/5 80/19 81/20 82/10 89/2 90/2 90/11 101/10 110/20 114/10 129/19
goes [11] 14/16 14/17 14/17 14/18 33/8 52/25 67/11 68/1 90/6 99/13 122/2
going [235]
going -- I [1] 37/12
gone [3] 81/22 124/5 124/9
good [8] 3/11 33/20 33/22 35/18 55/23 64/4 70/9 87/18
gore [1] 119/4
gory [2] 119/3 120/25
got [48] 5/6 14/7 14/8 14/8 14/13 14/23 15/14 15/16 15/17 20/5 20/7 20/19 20/20 20/20 20/21 20/22 20/23 43/18 51/8 53/19 55/19 56/3 56/5 56/8 57/3 57/20 58/17 61/6 66/13 74/14 78/23 81/18 81/23 82/3 82/25 83/1 83/2 83/13 83/17 85/6 87/20 94/8 107/6 107/19 111/2 111/4 125/16 125/21
gotten [2] 82/8 82/9
governing [1] 99/19
graduation [1] 114/23
grand [3] 99/6 112/3 112/5
grant [1] 87/2
granted [23] 10/16 10/17 11/5 11/11 23/15 24/18 24/21 25/5 27/4 28/12 31/5 38/5 46/11 46/23 49/16 51/3 59/18 64/19 64/21 64/24 68/9 79/18 88/14
great [1] 100/3
greater [3] 33/15 33/16 36/7
Gross [13] 83/5 89/22 89/23 116/2 123/15 123/21 124/14 125/25 127/16 128/7 128/21 128/24 132/1
Gross' [4] 126/9 129/15 129/21 129/22
Gross's [5] 124/12 125/25 126/19 127/24 131/1
gruesome [1] 119/6
guess [15] 5/21 7/4 14/5 18/19 48/4 48/23 63/12 68/17 68/21 71/2 78/17 79/25 80/17 95/25 111/16
guy [8] 35/8 44/21 44/22 44/23 79/7 125/8 125/18 125/21
guys [9] 3/18 30/21 61/19 65/5 95/19 113/6 120/18 132/15 133/1

H

had [39] 6/6 8/21 9/25 12/6 17/2 17/3 17/4 17/20 21/9 42/15 48/5 57/10 60/2 60/15 60/19 63/18 67/22 84/14 86/4 87/22 89/15 93/6 105/21 106/9 107/23 108/8 108/24 110/24 112/15 123/13 123/14 123/14 124/9 124/13 125/6 125/8 127/24 134/6 134/12
half [7] 13/13 37/1 49/7 58/2 93/5 111/24 112/4
HALL [3] 2/9 3/12 3/14
Hallmark [5] 55/13 56/1 58/12 74/21 126/13
Hallmark-type [1] 74/21
hand [1] 55/25
hands [1] 43/7
hanging [1] 129/9
happen [7] 31/15 37/24 48/9 91/21 92/7 112/18 127/9
happened [12] 6/5 16/1 18/3 62/9 62/11 82/21 110/15 116/21 123/14 123/21 124/3 125/1
happening [3] 17/2 117/7 125/24
happens [1] 4/9
happy [1] 66/13
harassment [1] 100/9
Hardwick [1] 29/13
harmony [1] 39/8
HARRIS [5] 2/3 23/19 24/5 24/7 24/12
has [60] 7/11 7/12 7/16 7/22 7/23 8/8 8/19 9/14 12/21 15/14 17/7 17/13 29/8 29/20 30/12 43/1 45/11 52/10 53/22 54/2 56/3 56/5 57/4 60/19 62/1 74/16 74/20 75/17 75/19 86/4 86/9 86/18 89/1 90/11 94/6 95/2 98/10 99/25 100/3 102/10 102/12 102/18 102/25 103/14 103/24 103/24 104/11 106/15 106/19 106/20 107/23 108/8 108/19 108/24 109/10 114/22 115/24 120/6 126/13 128/21
hasn't [6] 102/24 102/24 104/13 125/25 126/11 128/19
hate [1] 67/9
have [199]
have -- there's [1] 29/25
haven't [10] 14/23 42/24 67/14 82/12 95/12 118/9 119/11 120/11 120/12 121/23
having [6] 42/6 91/9 94/14 108/4 108/10 108/18
he [115] 14/13 15/7 17/15

H

he... [112] 17/16 20/13 36/15 40/2 40/2 40/3 40/4 43/4 43/4 43/4 43/5 43/5 44/3 45/2 45/12 45/19 45/19 50/6 50/7 50/7 52/8 52/16 52/24 53/6 58/10 58/11 62/8 62/9 62/15 62/25 62/25 63/13 63/14 63/18 64/2 64/9 65/10 65/25 66/1 66/2 66/3 72/2 73/20 74/5 74/13 74/15 74/15 75/7 75/9 75/11 75/22 75/23 76/4 76/12 76/17 76/24 77/1 77/24 84/14 84/16 85/13 86/10 87/5 88/4 92/15 92/16 92/17 93/7 93/14 93/17 109/10 110/2 110/3 113/17 116/3 116/9 116/9 116/9 116/10 116/11 123/11 123/23 124/11 125/6 125/14 126/3 126/3 126/11 126/12 126/13 126/22 127/4 127/24 128/2 128/10 128/18 128/19 128/24 128/24 128/25 129/6 129/7 129/23 129/24 130/2 130/24 130/25 131/1 131/3 131/3 131/6 131/6

he's [48] 15/5 15/11 16/13 17/15 17/17 28/7 43/6 43/6 43/6 52/7 53/20 63/19 64/3 65/9 65/11 65/18 65/24 66/1 73/19 73/24 74/1 74/12 75/7 75/9 75/22 76/3 76/3 76/19 76/22 84/1 85/17 87/21 89/7 92/18 94/4 94/7 94/8 95/6 110/9 115/21 116/4 125/11 125/20 126/7 126/8 127/13 129/7 129/9

head [2] 8/13 10/7

health [1] 101/7

healthy [1] 58/23

hear [9] 35/4 35/6 35/6 38/6 87/24 107/23 108/17 115/3 130/16

heard [3] 108/5 108/9 114/5

hearing [7] 116/14 130/6 130/15 130/20 131/9 131/13 131/22

heart [3] 18/4 18/9 55/8

heavily [1] 101/18

heightened [1] 68/23

held [2] 43/14 85/17

help [1] 121/1

helpful [1] 62/12

helping [1] 70/23

her [58] 6/10 7/17 8/8 8/21 9/25 10/3 10/5 10/5 12/22 12/22 14/2 17/3 20/17 20/19 21/6 27/12 51/13 52/20 53/23 53/23 53/24 55/4 57/18 63/22 65/4 65/8 65/11 65/11 65/11 65/19 65/19 65/24 66/1 66/3 66/18 67/7 67/14 68/2 68/4 68/11 76/7 76/7 76/8 76/9 87/16 92/3 97/24 98/14 103/14 103/22 103/25 104/4 116/22 119/22 125/1 125/4 127/12 127/21

here [24] 5/22 9/2 15/11 20/22 24/25 31/9 42/4 43/3 47/1 61/21 66/13 78/21 80/8 94/13 95/4 95/6 97/14 97/19 102/8 110/3 110/8 117/19 121/14 122/6

here's [26] 9/13 9/16 13/24 17/22 45/4 54/4 58/22 58/22 60/18 66/11 70/13 71/21 85/25 87/1 88/25 92/2 94/16 95/19 104/15 111/1 120/17 124/20 125/18 128/4 129/13 130/8

HEREBY [1] 134/5

HEREUNTO [1] 134/13

herring [1] 60/23

hey [23] 17/6 20/12 20/19 24/7 27/16 44/8 44/21 51/13 53/20 55/18 58/16 58/22 60/14 60/18 60/24 71/24 72/20 73/4 74/25 84/6 93/4 113/4 127/17

hide [1] 47/21

high [1] 58/17

higher [5] 53/16 53/19 53/19 69/8 69/23

highly [1] 29/15

him [30] 35/11 37/23 45/16 45/16 45/16 45/21 52/19 62/17 63/15 66/3 68/2 71/24 73/4 74/17 74/19 76/17 76/18 77/1 77/5 77/14 84/2 84/16 94/9 94/19 107/13 109/16 110/9 115/22 125/8 128/6 129/14

hire [2] 20/11 92/13

hired [5] 25/24 41/16 89/22 116/3 123/14

hiring [1] 113/20

his [72] 20/2 20/6 25/25 40/2 45/2 45/12 45/14 45/18 52/8 52/9 53/12 54/1 62/4 62/10 62/25 63/7 63/9 63/15 64/10 65/20 68/4 75/18 76/1 76/21 76/25 77/15 85/4 85/4 85/17 89/1 90/13 92/3 92/22 93/13 93/13 93/18 93/25 94/4 94/8 94/11 105/22 111/18 112/17 113/6 116/5 124/10 124/11 124/18 124/20 125/12 125/16 126/1 126/4 127/7 127/13 127/14 127/17 127/21 128/3 128/5 128/6 129/3 129/3 129/16 129/21 129/21 129/24 130/3 130/6 130/23 131/5 131/6

history [1] 10/6

hit [2] 8/12 51/13

hold [2] 11/1 130/20

home [1] 72/16

honestly [1] 37/12

Honor [83] 3/11 4/12 5/13 8/12 9/11 10/21 13/7 17/23 20/1 21/18 25/18 27/24 29/10 30/6 33/22 34/14 35/5 35/15 36/2 37/8 37/19 39/2 41/3 42/1 48/3 49/11 50/21 52/2 55/1 56/14 57/2 58/10 59/5 59/23 61/7 61/11 62/24 63/7 64/16 64/25 68/21 73/10 73/23 74/25 75/14 77/7 77/8 78/5 79/21 80/6 80/18 82/24 85/2 87/11 88/7 88/18 90/9 94/7 95/9 95/14 95/16 96/4 97/9 97/14 101/3 101/16 109/14 110/6 112/6 114/13 114/19 117/24 118/8 119/5 119/11 121/24 126/18 130/4 130/19 130/22 131/16 132/9 132/12

Honor's [1] 114/16

HONORABLE [1] 1/19

hooked [1] 27/17

hop [1] 23/8

hope [2] 15/6 91/17

hospital [1] 72/10

hour [2] 84/13 112/4

hourly [1] 98/8

how [41] 4/7 4/7 4/10 6/9 11/9 14/8 25/25 26/1 31/22 32/5 32/16 36/7 36/14 36/16 37/5 37/7 40/13 56/20 57/13 57/16 59/20 61/15 61/18 61/22 62/8 62/11 63/2 65/22 91/3 98/7 98/8 98/9 99/1 99/2 111/3 111/5 111/7 117/6 117/6 119/20 119/24

Howell [2] 103/15 103/21

however [3] 7/9 43/4 44/1

huh [1] 8/1

hum [5] 109/7 109/21 109/24 111/21 111/25

human [1] 86/11

hundred [1] 125/9

hurt [3] 20/25 52/14 52/16

hypothetical [15] 5/3 5/16 6/8 7/1 10/18 10/19 11/3 11/6 11/12 11/13 31/13 32/1 35/22 35/23 36/10

hysterectomy [1] 55/21

I

I -- here's [1] 54/4

I -- I [3] 17/18 71/2 78/17

I -- I'm [1] 95/19

I'd [5] 87/11 87/13 97/7 111/1 121/25

I'll [9] 5/20 20/7 31/10 71/22 77/10 91/23 114/17 117/7 123/5

I'm [88] 4/3 4/4 4/23 10/17 11/2 11/13 11/16 12/7 13/18 16/12 20/19 23/13 30/22 31/5 31/14 33/12 34/4 34/9 34/11 34/23 34/23 35/2 35/5 35/7 35/12 45/5 45/5 46/10 46/20 48/9 48/10 48/11 48/21 49/21 50/20 51/18 51/19 51/20 55/5 57/8 58/3 59/11 61/12 61/14 61/22 63/4 63/11 63/23 64/4 71/18 72/20 73/4 73/16 78/22 79/8 81/20 81/21 82/1 82/2 83/22 86/13 87/1 87/1 95/19 95/20 96/22 97/3 100/12 108/11 108/21 115/13 116/13 116/14 117/2 119/12 120/12 121/9 121/10 121/11 121/15 125/3 129/13 129/14 129/17 130/1 130/5 130/19 132/18

I've [24] 12/6 12/8 17/20 20/5 20/7 21/9 21/9 23/3 30/14 31/15 33/21 37/5

I

I've... [12] 37/21 71/11 71/11 71/16 71/17 71/17 71/18 71/21 74/14 111/2 118/11 118/12
idea [1] 30/17
ideas [1] 38/1
identified [4] 12/16 38/17 65/9 115/16
identifies [1] 12/24
identifying [1] 45/21
if [197]
if -- I [1] 18/22
if -- ironically [1] 110/14
ignores [1] 119/16
image [1] 119/3
imagine [2] 118/11 119/25
IME [1] 89/16
impact [17] 8/20 51/15 53/10 53/15 53/17 61/10 63/16 63/20 64/11 69/3 69/16 70/3 70/8 72/6 72/16 72/17 125/1
impacted [3] 4/17 52/19 52/20
impacting [1] 7/17
impassion [1] 29/20
impeachment [2] 122/20 122/20
impermissible [1] 6/8
implies [1] 24/14
imply [4] 16/9 27/13 29/7 67/2
importance [1] 60/22
important [15] 7/11 7/20 8/7 16/5 30/24 30/25 35/25 37/10 39/13 40/9 72/24 92/2 101/21 113/13 114/19
impression [1] 63/16
impressions [3] 63/9 63/11 64/1
improper [6] 5/23 5/24 6/14 7/3 12/20 13/8
improperly [1] 88/17
in [304]
inaccurate [1] 126/20
inadmissible [1] 101/1
inappropriate [14] 7/14 8/9 13/4 17/13 21/15 39/22 43/23 51/23 53/21 66/20 69/9 72/15 74/20 93/22
incident [4] 18/3 18/4 52/25 104/23
incidents [4] 8/15 59/25 60/2 60/19
inclination [1] 5/15
inclined [2] 64/14 83/22
include [3] 16/16 49/22 77/6
included [3] 80/12 80/21 81/7
includes [1] 118/13
including [3] 49/14 126/25 127/12
incorporates [1] 102/1
incurred [7] 102/14 102/16 102/23 102/24 104/18 104/25 106/23
indicated [6] 19/16 22/3 23/5 130/25 131/3 134/7
indication [1] 81/3
individual [1] 51/23
individuals [1] 51/6
indulgence [1] 132/13
infer [4] 23/10 23/11 65/17 67/21
inference [15] 8/6 12/17 12/20 13/2 16/24 16/25 27/16 47/7 49/15 51/14 52/17 84/10 87/4 87/21 98/3
inferences [2] 86/16 87/13
inferred [1] 87/8
inflame [4] 55/18 118/15 120/8 120/11
inflammatory [3] 118/24 120/2 120/7
information [15] 12/18 22/9 67/14 69/6 72/14 74/12 74/24 93/7 100/4 100/17 126/22 126/24 128/5 128/13 128/14
inherently [1] 108/22
initial [9] 18/11 33/2 36/6 40/16 115/19 116/2 116/5 116/6 116/7
initially [3] 48/5 123/15 130/2
injured [24] 8/16 9/9 20/10 21/5 51/10 51/11 51/13 51/16 51/21 51/23 52/25 53/6 53/13 53/20 53/21 54/7 54/12 54/12 54/14 71/25 72/5 72/12 72/22 73/5
injuries [27] 6/6 6/18 8/21 8/21 9/4 9/5 9/7 9/9 9/21 14/19 15/17 28/4 28/6 51/5 51/5 52/7 52/9 54/18 59/10 59/12 60/3 61/7 62/18 63/22 75/21 78/12 92/2
injury [23] 6/5 6/9 6/10 6/12 6/13 10/7 52/24 53/12 53/16 53/24 54/2 54/2 54/3 54/21 64/7 64/17 72/7 72/16 72/17 76/7 89/12 97/17 101/21
injury -- in [1] 52/24
insignificant [1] 70/22
insinuating [1] 19/10
instance [3] 39/19 84/24 92/9
Instead [1] 112/20
instruct [1] 117/5
instruction [1] 102/22
instructions [1] 102/11
insurance [8] 29/1 29/7 29/24 35/8 50/3 50/6 65/3 105/21
insurer [1] 101/8
intend [1] 4/19
intended [1] 118/20
intent [1] 8/17
intention [1] 119/6
intentionally [2] 5/18 75/24
interacts [1] 65/11
interest [5] 98/6 98/11 98/12 99/22 99/24
interpretation [4] 43/10 96/10 102/5 102/7
interrogatory [1] 83/2
intervening [1] 114/20
interview [4] 127/1 127/12 127/14 127/20
into [29] 8/25 23/23 28/13 29/15 31/2 38/13 41/4 41/25 42/11 42/20 45/20 53/25 57/9 58/21 58/24 59/1 68/12 70/19 85/16 88/21 89/5 89/18 95/13 106/21 110/22 120/1 124/3 125/7 134/8
introducing [1] 28/3
invaded [1] 110/19
investigation [2] 62/2 63/15
invite [1] 35/19
invites [5] 33/4 33/7 33/7 33/18 35/17
inviting [6] 32/12 32/16 32/22 32/23 34/18 35/9
involved [4] 51/6 52/24 93/22 122/6
involving [2] 75/20 122/5
ironically [1] 110/14
irrelevant [1] 100/8
Irrespective [1] 125/20
is [363]
Is it [1] 112/24
island [1] 129/8
isn't [12] 10/6 14/10 14/12 41/19 67/4 88/20 91/11 106/4 118/16 119/18 119/18 129/22
ISOM [3] 1/24 134/4 134/17
issue [36] 18/4 18/5 18/7 24/19 25/4 25/14 28/14 28/20 29/25 30/2 30/10 30/16 37/21 38/25 41/25 45/7 48/2 50/11 50/15 55/18 59/17 59/20 67/16 67/23 76/20 84/5 88/23 89/12 94/18 101/15 101/17 103/18 104/13 105/13 107/2 131/8
issued [2] 106/16 126/13
issues [17] 4/15 4/20 10/12 14/16 14/17 14/17 14/18 15/23 17/1 29/16 30/12 30/20 31/4 32/22 55/19 77/2 131/19
it [291]
it's [157]
it's -- I [1] 30/9
items [1] 131/5
its [1] 108/3
itself [3] 63/13 63/24 79/16

J

JACOB [2] 2/10 3/14
JAFFE [26] 2/9 2/9 3/12 3/12 3/14 12/7 15/12 25/25 34/23 37/12 40/5 43/16 47/23 61/4 63/2 83/23 84/11 85/2 85/7 93/15 95/19 109/1 113/10 115/12 128/1 129/19
Jaffe's [2] 55/23 93/9
jam [1] 114/9
Jeffrey [1] 123/15
Jerry [1] 65/8
judge [22] 1/19 1/20 13/24 19/6 38/7 58/3 70/13 71/21 71/23 77/12 81/18 83/16

J

judge... [10] 84/5 88/25 93/10 107/12 110/18 123/10 128/4 129/11 132/8 132/14
judges [3] 4/23 31/9 49/20
July [1] 128/17
JUNE [2] 1/22 3/1
juror [3] 30/11 32/14 34/22
jurors [16] 7/10 7/18 28/22 29/6 30/15 31/12 32/12 33/25 54/5 57/11 60/18 69/7 119/8 130/14 130/15 130/17
jury [66] 5/4 5/19 5/24 8/18 8/19 8/25 10/20 11/6 11/17 11/23 16/5 18/20 23/10 23/11 29/15 29/20 30/10 30/14 31/17 33/18 37/18 40/24 47/24 48/24 49/9 53/22 54/8 54/14 57/17 65/14 65/17 66/11 67/21 68/24 69/22 74/3 74/25 75/2 77/15 87/14 94/11 102/10 102/22 104/20 105/8 105/10 106/7 107/20 107/21 107/22 108/2 108/10 108/16 108/24 111/5 115/3 117/6 118/15 118/22 119/14 119/24 120/8 120/11 120/20 126/15 130/10
just [108] 4/2 4/11 8/4 8/5 13/3 13/14 16/16 17/18 17/24 20/25 21/17 24/9 24/10 24/15 26/5 26/22 27/12 27/19 30/13 31/3 35/6 35/17 37/3 37/3 38/6 40/15 40/25 43/3 43/16 43/18 44/11 44/12 44/14 45/16 46/24 50/4 50/23 53/4 54/13 55/17 55/17 56/4 58/3 58/6 58/16 58/19 58/22 60/23 64/9 65/16 67/4 67/8 68/1 68/18 68/21 69/6 69/19 69/20 73/2 73/6 73/7 74/6 74/17 74/17 75/1 75/2 75/8 75/14 77/3 81/19 81/20 82/4 82/11 82/11 83/3 83/25 84/5 86/7 91/6 91/9 93/4 98/24 101/2 102/9 104/5 106/13 106/15 107/2 109/11 110/1 111/10 112/4 113/8 113/9 113/10 114/9 114/11 115/1 115/4 116/10 116/20 117/22 120/22 125/3 126/20 128/1 128/9 130/24

K

K-H-O-U-R-Y [1] 3/7
Kaffcan [10] 43/19 43/23 44/20 83/4 87/15 89/20 93/21 93/24 95/4 114/2
Kahn [1] 63/8
keep [4] 5/4 36/18 45/6 60/11
KHOURY [9] 1/10 2/8 3/7 3/13 3/15 8/18 52/6 52/7 52/12
kind [8] 27/14 31/2 38/25 41/23 47/22 56/13 73/11 130/2
kinds [3] 88/10 90/25 91/3
knocked [2] 48/14 129/2
knocking [1] 128/16
know [208]
knowing [2] 42/13 66/9
knowledge [3] 28/22 94/10 94/11
known [1] 128/5
knows [4] 18/16 65/24 66/1 88/4

L

lack [2] 64/11 82/4
lacking [1] 130/1
lacks [1] 129/5
lady [4] 13/24 60/19 63/21 66/11
language [1] 96/22
lapse [1] 130/12
large [2] 42/3 48/23
larger [1] 98/14
LAS [4] 2/5 2/11 3/1 125/5
Las Vegas [1] 125/5
last [5] 12/25 71/22 80/8 95/22 114/12
later [6] 20/4 48/22 102/17 114/5 114/7 128/18
law [9] 2/3 13/22 23/19 24/5 24/7 24/12 25/25 67/23 103/20
LAWHJC.COM [1] 2/13
lawsuit [6] 65/2 66/12 66/15 66/22 67/1 67/21
lawsuits [1] 67/3
lawyer [1] 90/17
lay [4] 68/25 79/7 115/6 118/16
leap [1] 51/14
learned [1] 128/13
least [4] 30/14 49/23 62/16 120/14
leave [1] 23/21
leaves [1] 102/4
left [4] 20/9 67/3 104/11 107/6
less [9] 34/10 34/12 56/7 58/18 104/8 118/24 122/15 122/24 122/25
lesser [2] 102/19 106/20
lessons [2] 124/22 124/23
let [20] 4/2 28/19 51/7 63/3 63/4 67/13 68/19 75/10 79/6 79/11 89/22 90/14 98/24 101/22 109/1 114/6 115/4 116/17 120/14 131/25
let's [20] 9/20 9/23 13/14 13/15 43/17 43/19 47/3 68/8 68/8 75/10 77/3 90/17 93/21 101/10 105/4 107/4 109/3 109/4 109/8 122/7
letter [1] 48/6
liability [2] 29/1 29/24
liar [1] 76/4
lien [17] 50/2 50/3 50/8 98/10 98/16 101/3 102/17 102/19 102/24 103/1 103/2 105/14 105/14 106/15 121/25 122/4 122/16
liens [18] 49/22 49/23 49/23 49/24 50/22 97/11 97/16 98/1 98/2 98/5 98/22 100/11 100/16 100/17 100/19 121/21 121/22 122/3
life [22] 55/2 55/4 55/6 55/16 55/22 56/3 56/16 56/21 57/8 57/12 57/18 57/21 58/2 58/7 58/9 58/20 58/25 59/17 59/19 86/7 126/4 128/9
light [1] 52/11
like [52] 5/4 5/11 5/17 22/10 22/11 27/12 27/13 30/15 30/16 30/17 30/17 34/15 35/1 35/14 38/2 38/6 47/20 48/15 50/10 57/7 57/9 60/4 64/8 64/15 67/25 70/3 84/24 85/21 87/11 87/13 95/24 97/2 97/19 98/1 98/22 99/24 100/14 100/16 104/10 113/15 113/20 114/20 114/21 120/13 120/18 120/22 121/2 121/13 121/25 122/4 125/18 131/7
liked [1] 16/6
likelihood [3] 51/20 53/16 53/19
likely [2] 98/12 98/15
likes [2] 67/10 129/18
limb [1] 129/9
limine [14] 1/17 4/3 4/4 4/10 13/21 15/9 80/1 85/3 101/12 107/1 107/8 117/9 117/12 132/11
limit [9] 26/23 48/12 76/24 80/1 82/19 85/6 86/14 100/3 101/12
limitation [1] 16/14
limitations [2] 81/15 125/22
limited [5] 26/13 35/21 84/8 84/12 103/8
limiting [1] 81/24
line [10] 48/23 64/1 81/19 82/3 87/18 89/5 90/2 95/13 95/22 95/24
lines [5] 12/10 21/11 21/13 85/1 110/7
listen [3] 42/19 57/2 61/11
listened [1] 16/24
Literally [1] 20/7
literature [3] 28/23 53/14 56/3
litigant [2] 75/20 75/25
litigation [9] 4/14 19/9 19/12 21/21 22/12 23/1 24/15 24/20 90/21
litigious [2] 66/14 67/2
little [2] 35/7 76/18
live [3] 14/23 56/6 58/18
lives [1] 65/11
living [1] 61/20
LLP [1] 2/9
Lobata [1] 100/16
Lobato [3] 99/18 100/2 100/21
local [1] 32/25
lock [1] 128/6
log [1] 114/9
logical [1] 51/14
long [9] 12/3 16/14 35/23 36/9 61/20 84/13 97/14 120/24 123/13
longer [1] 110/18

L

look [19] 17/6 28/20 40/1 40/3 40/3 40/10 49/24 55/19 60/15 60/24 72/11 73/5 84/6 103/20 120/18 121/2 131/11 131/25 132/7
looked [3] 72/22 72/23 72/24
looking [6] 13/20 42/4 61/21 67/19 78/21 80/17
looks [1] 121/13
loss [3] 16/8 125/2 125/12
loss of [1] 16/8
lot [8] 3/25 32/15 47/5 53/18 67/9 97/20 128/22 132/21
love [3] 34/21 35/4 111/1
low [9] 56/5 58/17 63/16 63/19 64/11 69/16 69/17 72/16 72/17
low-impact [1] 63/16
lower [1] 51/20
luck [1] 87/19
lumbar [2] 86/3 123/17
lunch [1] 132/19
lying [1] 20/17

M

made [12] 12/8 18/11 24/3 65/3 94/6 94/22 95/3 103/12 110/1 113/22 127/22 129/18
make [35] 3/8 4/19 7/25 18/23 19/25 22/22 23/16 23/21 23/22 24/10 26/18 26/25 29/19 38/14 41/1 50/23 51/12 51/14 51/22 54/11 54/13 55/24 55/24 58/13 59/4 88/3 89/18 97/11 98/9 99/10 99/11 108/11 111/7 117/2 132/22
makes [5] 71/10 85/21 87/5 103/4 103/19
making [2] 40/14 68/14
Male [1] 53/18
malingerer [1] 76/20
malingering [4] 74/2 74/6 75/16 75/18
management [2] 22/4 79/7
manual [1] 74/13
many [7] 12/7 26/1 31/22 32/6 36/14 36/16 124/9
MARGARET [3] 1/7 2/2 3/6
Margie [9] 20/19 51/6 51/25 51/25 53/13 72/21 73/18 74/18 127/1
Margie's [4] 19/15 25/11 65/1 77/18
Marjorie [1] 84/25
marks [2] 63/20 64/11
matter [3] 68/24 114/22 134/6
may [36] 6/19 9/11 14/9 14/20 15/24 16/4 16/17 16/18 17/23 28/21 33/3 36/2 46/16 46/16 55/1 55/6 55/9 58/7 58/10 68/21 70/22 76/15 78/7 81/7 89/4 95/16 96/19 104/16 110/23 114/23 122/1 122/10 122/19 129/20 129/25 130/11
maybe [14] 4/7 43/18 43/22 49/5 62/5 65/25 70/10 84/14 84/25 86/24 88/20 105/14 113/23 131/12
me [48] 4/2 4/5 22/10 28/19 36/22 39/1 41/20 47/1 48/21 49/19 51/7 57/19 63/2 63/22 64/13 65/6 67/13 68/18 72/24 73/8 73/14 75/11 77/4 78/4 90/14 91/13 91/17 92/20 95/9 98/24 99/21 101/22 103/9 109/1 109/11 110/15 111/1 113/11 114/6 115/1 115/4 116/17 117/19 127/19 131/11 131/23 131/25 132/6
mean [74] 5/17 6/19 7/1 8/2 10/1 10/11 17/17 20/1 20/17 21/2 23/7 24/2 25/3 25/21 30/13 32/3 36/7 39/2 40/17 40/19 40/20 40/22 42/11 48/7 51/17 53/8 53/13 55/20 56/8 56/14 56/18 56/18 57/6 57/10 60/13 62/5 66/23 67/21 69/17 73/6 75/1 75/2 75/9 76/25 77/24 78/8 78/23 78/25 79/2 79/6 79/14 80/23 81/8 81/18 82/2 83/3 83/12 83/16 85/6 91/16 92/8 92/20 92/23 96/8 96/13 105/24 111/19 113/8 113/12 113/21 115/23 119/11 131/1 131/4
means [7] 24/15 29/19 40/15 42/19 47/19 56/6 75/21
median [2] 125/4 125/13
medical [46] 5/3 5/8 5/16 7/6 11/24 14/3 18/21 19/9 19/14 19/16 21/13 21/21 21/23 22/7 22/12 22/24 24/20 34/25 35/2 54/18 54/22 59/10 59/12 60/21 68/13 72/3 76/12 76/13 78/6 84/7 84/9 92/3 94/9 94/9 94/10 94/11 97/11 97/16 101/13 102/1 102/3 102/11 106/22 122/5 127/12 127/14
medical-buildup [1] 19/9
medically [3] 13/25 22/3 23/5
medication [3] 27/7 28/4 28/5
medications [2] 27/11 27/19
meds [1] 27/17
memory [1] 95/8
merely [1] 91/25
merits [1] 58/6
met [1] 127/20
methodology [1] 58/15
middle [1] 110/16
might [9] 3/21 11/23 17/10 17/11 18/21 85/23 98/4 99/23 127/25
million [21] 31/22 32/15 32/15 32/16 32/17 32/17 32/17 33/4 33/4 33/4 33/15 33/16 35/10 35/11 36/13 36/16 36/18 37/1 37/2 37/2 125/9
mind [4] 25/4 79/3 89/15 105/25
minds [4] 7/10 7/18 60/18 82/1
minimal [1] 63/21
minimized [1] 76/6
minor [12] 51/15 68/14 68/19 69/3 69/11 70/9 70/21 71/1 71/5 71/7 71/13 71/16
minute [5] 32/11 32/19 46/2 68/18 109/11
miscarriage [1] 56/15
miscarriages [2] 55/21 57/7
mislead [1] 8/18
mistrial [1] 88/9
models [1] 119/1
money [5] 32/15 32/16 34/9 98/13 99/15
months [11] 14/1 18/3 82/21 93/6 124/9 124/9 128/8 128/14 128/18 129/2 131/18
morbidities [8] 54/24 55/5 55/15 55/15 57/21 58/8 58/21 59/1
more [30] 5/23 17/10 17/24 20/3 24/8 30/15 31/21 34/22 34/25 35/2 35/4 36/13 36/16 49/9 53/16 65/23 67/8 68/1 84/15 84/15 95/16 98/12 98/15 99/7 99/15 103/21 103/23 106/23 113/12 114/19
morning [1] 3/11
most [2] 111/23 129/18
motion [56] 4/10 5/2 5/7 6/2 8/10 10/15 12/1 13/8 13/22 18/20 21/19 21/19 21/24 23/15 24/18 25/5 26/10 27/9 27/10 28/11 31/5 38/5 41/19 41/22 42/1 45/5 45/22 47/9 47/12 49/9 49/23 51/7 52/3 52/3 52/23 59/9 59/18 80/1 85/3 87/2 88/13 88/15 90/8 95/20 97/5 101/12 106/21 106/24 107/1 107/8 117/9 117/11 121/20 123/7 123/25 124/1
motions [18] 1/17 3/22 4/3 4/4 5/10 13/13 13/21 15/9 20/3 42/2 45/8 45/23 49/23 50/22 50/22 88/20 107/6 132/10
motive [2] 75/22 75/25
move [2] 48/11 107/4
Mr [3] 15/12 34/23 37/21
Mr. [64] 8/18 9/18 12/1 12/7 12/11 15/7 17/24 23/19 25/25 27/10 33/3 35/6 35/14 37/12 39/1 40/5 43/16 47/15 47/23 51/9 52/6 52/7 52/12 55/23 61/4 63/2 63/4 66/17 67/15 68/11 76/24 83/23 84/11 85/2 85/7 88/1 90/14 93/9 93/15 94/24 95/19 109/1 109/22 110/25 111/18 112/12 112/16 113/10 114/17 114/25 115/12 117/23 120/14 123/11 123/20 124/6 125/3 126/16 126/19 126/21 127/4 127/18 128/1 129/19
Mr. Busby [2] 66/17 67/15
Mr. Busby's [1] 68/11
Mr. Cloward [24] 9/18 12/1

M

Mr. Cloward... [22] 17/24 23/19 27/10 33/3 35/6 35/14 39/1 47/15 51/9 76/24 88/1 90/14 94/24 109/22 110/25 111/18 112/12 112/16 114/17 114/25 117/23 120/14
Mr. Cloward's [1] 15/7
Mr. Dineen [8] 123/11 123/20 124/6 125/3 126/16 126/19 126/21 127/18
Mr. Dineen's [1] 127/4
Mr. Jaffe [19] 12/7 25/25 37/12 40/5 43/16 47/23 61/4 63/2 83/23 84/11 85/2 85/7 93/15 95/19 109/1 113/10 115/12 128/1 129/19
Mr. Jaffe's [2] 55/23 93/9
Mr. Khoury [4] 8/18 52/6 52/7 52/12
Mr. Smith [1] 63/4
Mr. So-and-so [1] 12/11
Ms [1] 113/23
Ms. [7] 8/6 12/21 58/19 61/1 75/17 84/25 86/2
Ms. Frasier [1] 58/19
Ms. Marjorie [1] 84/25
Ms. Seastrand [5] 8/6 12/21 61/1 75/17 86/2
much [21] 10/17 10/18 11/2 11/5 15/7 27/25 32/15 34/15 35/14 42/11 53/15 57/13 57/15 57/16 80/4 98/7 98/8 98/9 99/1 99/2 132/13
much -- as [1] 57/15
Muir [30] 39/19 39/21 40/1 43/17 43/18 43/19 43/21 44/6 44/8 44/15 44/19 44/25 44/25 83/4 89/20 92/10 92/10 92/15 92/19 92/20 93/4 93/6 93/8 93/12 93/17 93/21 93/23 94/2 95/4 114/2
Muir's [2] 92/14 92/22
multiple [1] 100/13
must [6] 7/19 26/13 51/16 69/3 111/15 126/16
my [66] 4/2 4/6 5/15 10/12 14/2 18/4 18/5 21/14 25/4 31/11 34/17 36/5 36/6 36/7 37/9 38/6 45/10 54/3 57/2 61/12 63/17 70/13 70/20 70/20 70/21 70/22 71/5 71/7 72/21 72/25 72/25 73/9 73/9 74/7 79/3 103/15 104/15 104/16 105/25 107/20 107/22 107/23 107/25 108/2 108/6 108/17 108/22 111/4 112/9 112/9 112/10 114/7 114/15 115/3 115/20 121/16 126/22 126/23 126/25 127/12 127/20 131/18 134/9 134/11 134/14 134/14
myself [1] 80/8

N

nail [1] 8/13
name [6] 89/8 90/13 91/5 95/5 110/14 134/14
naming [1] 89/10
narcotic [4] 27/7 27/11 28/4 28/5
narrowed [1] 100/5
nasty [1] 120/25
nature [9] 26/2 56/18 65/20 65/23 67/1 67/25 80/21 81/16 119/16
necessarily [16] 14/9 24/14 49/8 53/4 54/20 57/15 58/4 62/11 64/6 70/1 78/8 97/1 102/1 102/14 116/11 120/10
necessary [19] 22/15 64/7 78/2 79/5 79/10 79/17 85/15 94/19 102/2 102/23 104/22 105/1 105/4 105/6 105/8 105/12 106/12 117/5 131/22
necessity [1] 81/15
neck [13] 6/5 6/5 6/6 6/9 6/10 6/11 6/17 10/10 16/25 17/3 18/5 20/21 43/19
need [32] 4/9 13/19 27/18 29/10 34/12 43/13 47/1 52/9 55/13 57/11 57/24 57/24 58/13 59/3 59/4 66/10 66/17 86/10 87/24 98/22 107/17 109/15 109/19 114/4 123/16 123/17 127/17 131/9 131/11 131/13 131/17 132/7
needed [1] 77/25
needle [1] 120/1
needless [1] 115/11
needs [21] 16/3 17/18 26/17 34/5 51/24 74/2 74/14 84/16 85/8 85/9 85/22 86/2 86/3 89/13 97/16 98/17 101/9 108/16 110/8 113/13 129/12
negative [2] 47/7 49/14
negligent [5] 105/20 105/25 106/2 106/7 106/7
neighbor [8] 65/11 65/24 66/1 67/5 67/5 67/9 67/10 68/3
neighbors [2] 66/8 67/9
neither [1] 121/10
NEVADA [8] 1/5 3/1 40/22 99/19 102/10 104/19 134/2 134/15
never [15] 14/5 14/10 14/12 15/13 33/21 34/9 34/11 78/15 86/18 96/6 97/19 116/9 118/9 124/6 124/7
new [14] 42/24 80/19 81/13 81/17 81/25 83/24 84/20 84/21 84/21 96/2 126/6 128/7 128/12 131/18
newly [3] 128/12 128/12 128/13
next [7] 27/2 46/25 47/4 90/2 101/11 107/4 107/7
night [1] 80/8
nine [3] 48/14 48/14 49/6
Ninth [2] 39/4 39/6
NJA [1] 39/11
no [71] 1/1 3/6 6/6 6/13 7/2 7/11 7/16 7/16 7/22 10/8 11/22 12/3 12/25 14/14 16/12 16/12 21/3 21/4 21/8 25/18 27/2 27/21 28/9 29/20 29/25 30/1 30/7 30/18 34/4 35/15 35/18 35/20 57/14 60/1 60/21 61/24 64/18 72/2 72/8 72/13 72/16 72/17 74/16 74/18 77/11 77/17 83/9 83/10 83/11 85/15 91/12 95/18 103/11 105/3 106/16 110/7 110/18 112/19 113/1 117/18 117/25 119/6 123/1 124/13 125/14 125/15 126/12 129/1 129/3 129/8 129/11
No. [34] 19/7 24/22 25/9 26/12 27/3 27/4 27/6 28/15 31/7 38/9 47/5 48/1 48/2 49/17 51/3 51/4 64/19 68/13 80/1 88/15 88/21 91/14 97/5 97/9 97/10 101/12 107/1 107/8 112/14 117/9 117/11 121/20 123/7 123/8
No. 1 [4] 48/1 80/1 91/14 112/14
No. 10 [1] 38/9
No. 11 [1] 47/5
No. 12 [2] 49/17 51/3
No. 13 [1] 51/4
No. 16 [1] 64/19
No. 18 [1] 68/13
No. 2 [3] 48/2 88/15 97/5
No. 3 [3] 19/7 97/9 97/10
No. 4 [3] 24/22 101/12 107/1
No. 5 [4] 25/9 88/21 107/8 117/9
No. 6 [4] 26/12 27/3 27/4 117/11
No. 7 [3] 27/6 121/20 123/7
No. 8 [2] 28/15 123/8
No. 9 [1] 31/7
nobody [9] 15/14 15/18 15/22 16/4 16/10 18/15 51/15 88/9 88/9
non [4] 19/16 40/7 40/15 51/5
non-expert [1] 40/15
non-indicated [1] 19/16
non-injuries [1] 51/5
non-resolution [1] 40/7
none [11] 11/25 18/22 21/4 21/14 27/8 32/5 54/3 60/13 60/14 61/1 100/9
nonexistent [3] 5/7 9/5 9/5
nonsensical [1] 113/11
nor [1] 121/10
not [226]
note [9] 21/10 22/16 24/4 24/7 24/11 24/25 80/7 91/23 106/13
NOTES [1] 134/8
nothing [9] 13/22 17/3 34/21 35/4 53/22 56/16 68/25 117/24 120/20
notice [3] 43/1 81/22 83/13
now [54] 12/1 12/15 13/24 14/4 14/21 18/9 23/7 27/9 31/9 32/9 45/23 48/4 48/16 48/17 52/6 64/4 65/19 66/14 71/13 76/2 77/4 81/12 81/16 81/20 81/21 81/25 82/1 87/20 89/7 90/5 93/15 93/22 95/1 98/6 98/11 100/9 103/3 105/11 106/2 107/5 114/7 121/9 124/4 124/5 124/14

N

now... [9] 124/17 125/24 126/3 126/6 126/8 126/12 127/8 128/7 128/11
NRS [1] 115/10
number [15] 31/21 33/13 33/15 33/16 35/11 36/19 36/19 36/20 37/4 79/25 88/15 104/4 104/5 106/5 125/13
number Use [1] 36/19
numbers [8] 33/5 33/19 34/2 37/3 104/25 128/9 130/9 130/12
numerous [2] 37/21 92/24
NV [2] 2/5 2/11

O

o'clock [1] 121/16
object [2] 5/20 85/2
objected [2] 109/22 112/16
objection [2] 5/20 87/5
obligation [9] 12/21 17/7 17/14 33/24 82/25 83/1 96/16 96/17 96/20
observation [2] 63/17 63/18
observations [4] 63/9 63/10 63/11 64/1
observe [2] 63/13 64/2
observed [3] 62/2 76/12 119/18
observing [1] 63/23
obtain [2] 13/1 15/13
obviously [9] 20/10 25/21 25/23 29/24 51/18 57/11 62/22 78/5 127/23
odd [1] 58/7
of -- the [1] 17/5
off [9] 34/23 43/7 84/13 86/1 94/7 105/15 105/24 110/6 125/17
offended [2] 36/14 36/17
offends [1] 36/22
offer [2] 96/25 100/10
offered [2] 14/21 15/7
offering [4] 13/8 71/1 73/17 77/18
offers [1] 44/24
OFFICE [1] 134/14
officer [8] 61/24 62/1 62/14 63/8 68/23 69/16 70/2 70/8
officer's [1] 62/4
officers [3] 62/15 64/7 70/2
often [1] 25/25
oftentimes [1] 12/6
oh [9] 7/18 14/23 50/16 66/13 82/1 82/20 88/22 114/5 116/19
okay [64] 3/18 3/20 4/5 5/6 6/23 8/11 10/9 11/10 11/15 11/18 11/21 13/6 18/8 18/13 18/16 22/21 23/15 23/16 24/17 25/20 26/21 27/23 28/11 31/24 34/5 36/12 37/1 37/6 37/8 41/2 45/4 45/8 45/9 45/18 45/21 46/11 46/15 46/23 52/1 56/11 57/6 63/12 68/8 71/9 71/13 71/20 72/9 88/11 88/18 92/15 94/7 100/18 101/10 101/16 106/13 106/25 112/11 114/12 117/8 121/18 123/6 123/10 132/3 132/8
old [1] 51/19
omnibus [4] 3/19 13/21 47/9 47/11
on [172]
once [4] 37/16 93/10 115/13 115/23
one [56] 4/23 5/2 10/22 16/22 17/23 18/3 27/2 28/20 30/15 36/19 36/20 36/20 37/3 37/4 41/24 42/1 45/10 46/5 46/23 46/25 47/4 48/8 48/10 48/16 49/19 49/23 50/13 60/9 61/9 61/14 61/23 63/5 74/4 79/13 80/5 80/16 88/24 90/1 93/23 94/18 94/23 95/16 98/7 99/19 101/11 101/21 107/7 112/2 113/2 115/15 116/14 123/22 123/23 126/20 127/22 131/16
ones [4] 48/13 54/22 81/11 83/12
ongoing [6] 9/22 60/15 83/8 87/16 87/22 127/6
only [28] 12/5 12/10 12/15 13/1 27/16 39/3 39/15 48/17 49/7 52/4 55/12 61/20 68/3 84/13 90/10 99/20 99/21 100/7 105/10 110/24 111/2 115/15 115/16 115/23 115/25 116/14 116/15 126/19
open [6] 23/21 24/9 32/19 81/19 102/4 104/11
opening [6] 26/22 26/23 118/5 120/24 130/10 130/16
opens [3] 37/18 96/3 96/23
opine [1] 91/25
opinion [48] 22/14 23/3 39/18 42/7 42/14 44/24 46/13 46/14 46/18 46/19 57/4 64/10 64/15 68/25 69/4 69/6 69/20 71/1 71/7 72/25 73/1 73/25 81/8 85/4 85/14 89/6 89/8 89/11 89/13 90/4 90/6 90/13 95/13 107/16 108/3 123/20 123/22 126/1 126/22 126/23 127/17 127/21 128/3 128/10 128/20 129/3 129/4 129/23
opinions [70] 18/6 21/25 22/8 22/23 22/25 23/2 23/4 40/18 41/5 41/13 41/13 42/21 42/24 44/2 46/9 58/14 60/22 61/25 62/4 62/10 62/14 62/16 70/14 70/16 70/24 75/7 76/21 80/1 80/9 80/20 81/3 81/14 81/14 82/12 83/25 84/9 85/10 86/15 89/1 90/1 91/2 91/9 92/22 92/22 93/13 93/18 93/24 94/3 94/8 95/2 95/23 96/7 96/25 96/25 107/17 107/17 108/23 113/14 113/16 114/3 115/19 124/12 124/18 124/20 125/22 126/10 129/21 129/24 130/3 130/6
opportunity [10] 42/16 48/21 93/7 107/23 108/1 108/2 108/8 108/21 108/25 119/22
oppose [1] 25/1
opposed [6] 14/11 58/5 102/20 105/9 117/6 129/19
opposition [5] 5/8 8/14 21/22 27/25 111/19
option [1] 105/2
or [210]
order [15] 3/17 18/13 39/7 40/12 40/13 52/9 77/6 84/8 87/12 104/20 109/16 114/24 115/7 115/8 117/4
orders [2] 81/23 132/23
ordinarily [1] 31/10
original [2] 102/21 131/24
originally [1] 124/24
other [52] 5/10 10/12 13/3 17/11 25/11 31/16 35/19 43/2 44/16 45/6 45/23 45/25 47/15 47/18 48/22 49/20 50/14 51/6 55/5 55/19 55/25 58/19 66/9 67/9 70/14 79/11 84/11 84/17 85/23 91/8 92/8 95/7 96/21 102/4 105/18 110/11 110/13 111/2 113/12 118/23 120/5 120/14 120/19 121/3 122/1 123/23 126/4 127/22 129/15 130/25 130/25 131/3
otherwise [13] 8/4 22/19 37/15 40/24 55/17 56/21 78/4 82/4 106/11 107/19 108/21 114/25 115/6
our [27] 6/7 8/14 8/17 21/22 21/25 22/7 22/22 27/24 39/7 42/12 42/15 43/11 47/4 50/21 54/11 55/12 61/6 66/23 98/19 99/14 99/15 101/3 102/9 106/16 106/24 109/20 118/13
out [54] 4/17 13/3 14/5 15/16 16/19 16/23 17/10 17/11 17/20 18/15 20/17 20/21 29/11 32/11 33/25 37/7 37/17 48/15 48/19 58/20 60/12 61/22 72/11 73/5 74/12 83/14 85/7 87/13 96/1 97/20 97/21 109/9 109/15 109/16 110/9 111/7 112/25 113/7 113/13 114/21 114/24 115/6 115/21 123/13 123/23 124/4 124/14 124/25 126/3 128/16 128/21 129/2 129/7 130/13
outrageous [1] 86/18
outs [1] 39/5
outside [13] 39/17 40/1 40/10 74/3 75/11 76/18 77/5 77/13 77/15 85/24 87/13 88/4 92/3
outweighs [1] 100/23
over [6] 12/19 17/7 29/20 34/5 78/6 89/9
overarching [1] 113/2
overburdensome [1] 113/4
overcome [1] 66/19
overlap [2] 3/24 3/25

O

overlook [1] 60/25
own [9] 38/6 39/18 78/17 78/18 93/25 94/21 94/21 108/3 124/15
owns [1] 124/21

P

page [2] 28/21 127/3
paid [21] 50/6 50/7 99/1 99/2 99/12 101/6 101/14 101/25 102/15 102/20 102/24 103/9 103/14 103/25 104/7 104/8 105/13 106/19 106/20 106/20 125/20
pain [19] 17/4 20/20 20/21 20/22 20/23 22/4 27/7 27/11 27/17 28/4 28/5 30/16 35/1 57/18 63/22 79/7 87/16 87/22 119/14
paint [1] 18/2
painted [2] 15/9 71/3
panel [2] 37/18 37/19
parameters [1] 90/10
paramount [2] 114/14 114/15
Pardon [2] 41/20 73/14
part [22] 4/18 9/2 10/16 10/16 15/18 25/14 27/11 33/25 40/9 45/18 46/8 46/13 59/14 59/15 62/6 68/9 68/9 73/10 73/10 75/18 92/2 119/13
particular [1] 29/21
particularly [3] 97/25 102/16 103/17
parties [3] 27/5 33/24 121/6
parts [4] 5/12 5/17 8/15 9/4
party [3] 102/18 104/9 122/4
pass [1] 126/12
past [2] 74/9 101/13
pasted [1] 74/12
pat [1] 107/18
patient [12] 39/23 40/5 45/14 45/19 46/8 46/14 46/19 80/12 81/9 82/22 83/8 90/20
patient's [1] 92/1
patients [2] 46/10 80/14
pause [1] 47/2
pay [2] 103/10 103/13
payer [2] 122/15 122/19
payment [4] 101/7 106/15 106/16 106/18
payments [1] 101/25
PEGGY [3] 1/24 134/4 134/17
penalty [1] 12/23
people [19] 30/18 32/20 36/14 37/11 37/25 48/19 51/8 51/18 52/18 53/15 58/23 70/25 72/4 74/16 75/8 78/12 107/14 114/24 117/3
per [1] 102/10
percent [5] 43/16 45/1 127/5 127/13 127/21
perfect [1] 13/19
performed [3] 19/15 92/19 119/9
period [1] 34/25
perjury [1] 12/23
permanency [1] 55/3
permit [1] 38/9
permitting [1] 46/5
person [4] 51/19 51/21 93/18 118/16
personal [6] 78/18 97/17 101/21 110/19 125/1 126/25
pertinent [1] 14/3
petitioned [1] 39/9
photograph [2] 69/2 69/3
photographs [4] 71/17 117/25 119/1 119/7
phrased [2] 16/16 28/12
physical [4] 39/24 39/25 40/3 85/1
physician [11] 19/15 39/14 44/2 44/25 88/16 91/24 98/10 98/21 99/25 99/25 116/18
physicians [7] 25/11 38/10 38/15 40/13 44/7 80/1 99/11
picture [1] 120/23
pie [1] 38/2
pissed [1] 34/23
place [6] 29/20 43/13 81/24 103/22 112/15 134/7
plaintiff [58] 3/10 6/6 10/3 11/22 12/14 12/16 12/17 14/14 19/10 19/13 24/22 24/24 25/9 26/12 28/21 34/5 36/12 41/8 42/4 47/16 65/9 66/13 67/20 71/9 82/16 89/15 97/15 97/22 98/13 101/14 102/6 102/9 102/12 103/3 103/5 103/22 103/23 105/21 105/22 105/23 106/4 106/9 107/19 108/4 109/5 112/7 118/21 119/14 119/17 119/20 119/24 120/6 122/2 123/12 123/14 123/16 124/21 130/9
Plaintiff — why [1] 97/15
plaintiff's [27] 3/19 5/2 6/9 14/10 16/10 18/12 19/14 24/23 25/5 25/10 26/5 60/1 61/10 77/23 79/19 79/20 79/22 80/16 98/21 101/12 107/8 108/18 109/17 117/13 123/8 124/15 130/16
plaintiffs [7] 1/8 25/24 34/9 77/23 98/6 109/18 114/11
plaintiffs' [1] 90/17
plan [5] 86/7 90/25 91/9 109/5 126/4
planning [3] 48/7 118/2 118/3
plans [1] 109/5
playing [1] 99/4
plays [2] 37/7 61/22
plenty [1] 37/20
point [27] 13/19 14/5 15/16 16/19 16/22 17/24 22/4 29/11 31/17 33/8 38/14 57/2 57/15 81/18 82/3 83/11 95/3 103/15 103/18 105/2 118/9 118/13 127/10 127/22 129/14 129/17 131/22
pointed [2] 58/19 113/13
poison [2] 37/17 37/25
police [6] 68/23 69/16 70/1 70/2 70/8 72/22
politically [1] 29/16
politically-charged [1] 29/16
politicize [3] 29/18 29/24 30/3
politicized [1] 29/15
politicizing [1] 31/1
politics [1] 31/3
population [1] 58/25
portion [2] 126/20 130/24
position [8] 63/17 70/9 101/3 102/9 103/23 104/1 106/16 112/10
possibility [1] 102/25
possible [3] 82/7 83/19 123/24
possibly [2] 83/14 113/22
potential [2] 30/15 65/10
potentially [2] 37/17 55/6
pound [2] 72/16 100/12
pounding [1] 73/9
practice [2] 73/3 78/16
praiser [1] 107/10
precaution [1] 82/8
preclude [21] 18/20 19/7 21/19 21/20 21/24 24/22 25/10 49/21 50/5 52/4 52/23 62/17 64/22 88/15 93/12 100/8 107/8 117/12 120/13 121/11 123/8
precluded [5] 22/8 28/2 53/1 64/10 76/11
precludes [1] 32/2
precluding [11] 19/10 47/7 49/17 51/4 59/24 61/24 62/13 65/1 68/13 73/17 77/17
preclusion [1] 100/24
preconceived [2] 34/1 38/1
predicated [1] 123/12
predict [1] 8/23
preexisted [1] 14/20
preexisting [1] 89/11
preference [2] 10/13 31/11
prejudice [6] 50/10 66/11 66/12 66/19 66/21 67/20
prejudices [2] 34/1 34/2
prejudicial [5] 8/5 52/11 61/1 118/15 120/9
prejudicing [1] 107/25
prepare [1] 82/6
prepared [1] 83/15
prescient [1] 95/9
prescribed [3] 27/11 28/3 28/5
presence [7] 74/3 75/11 76/19 77/5 77/15 87/14 88/5
present [6] 26/24 26/25 108/22 111/4 129/5 129/6
presentation [1] 101/13
presented [10] 4/5 4/11 26/14 26/18 74/24 107/18 108/20 111/15 112/24 126/15
pressure [5] 55/7 56/6 56/17 57/22 58/18
pretrial [1] 130/5

P

pretty [3] 27/25 54/19 80/4
prevail [1] 49/10
prevails [2] 103/5 103/7
prevent [8] 5/22 8/10 13/5 15/5 17/2 17/6 27/22 34/20
previously [4] 49/6 67/15 68/4 68/11
primarily [2] 60/5 95/21
principles [1] 113/2
prior [48] 5/9 5/11 6/6 6/11 6/17 6/17 7/7 7/10 8/7 8/14 8/19 8/20 9/4 9/4 9/5 9/7 9/20 9/24 9/25 11/24 13/25 14/1 15/14 15/17 16/23 17/3 18/21 22/3 23/6 28/4 38/7 54/17 54/21 59/9 59/11 59/25 60/2 60/19 61/7 65/2 65/19 67/21 76/7 77/15 90/19 97/2 121/7 121/8
private [2] 122/15 122/19
probability [6] 7/6 7/12 7/16 7/23 8/4 124/3
probably [20] 5/20 6/21 7/3 10/16 29/5 30/10 37/14 53/2 53/20 59/13 59/19 64/14 70/8 96/13 98/25 99/3 115/13 115/22 115/24 120/25
probate [1] 67/23
problem [17] 9/2 13/24 31/22 32/6 32/18 33/6 34/15 37/16 39/4 71/21 80/23 82/18 107/21 110/7 111/2 128/4 130/8
problems [3] 87/17 87/23 107/20
procedure [2] 13/16 119/16
procedures [5] 19/16 117/13 119/8 120/4 120/5
proceedings [4] 47/2 133/4 134/6 134/12
process [8] 4/14 4/15 42/13 43/11 108/7 112/18 112/25 119/4
processes [1] 118/22
Proctor [6] 50/18 50/19 100/20 100/25 105/17 106/14
procured [1] 63/15
produce [1] 20/7
producers [1] 125/4
producing [1] 125/8
prognosis [3] 38/11 46/7 92/1
prognostications [2] 42/22 80/20
progressed [1] 86/4
progresses [1] 86/12
prohibit [1] 33/1
proper [2] 122/20 122/20
property [3] 68/15 72/23 73/5
propose [1] 3/16
prospective [1] 30/11
proven [1] 55/16
provide [2] 88/16 116/17
provided [10] 12/11 12/15 13/2 14/11 16/18 16/19 17/12 39/22 124/6 124/7
provider [3] 9/14 102/3 122/2
providers [1] 40/21
provides [1] 124/22
providing [4] 61/25 62/14 92/4 130/23
psychiatrist [2] 73/20 75/7
psychologist [1] 73/20
publish [1] 37/25
pull [1] 71/22
purchase [1] 121/21
purchased [3] 102/19 121/22 122/1
purchaser [2] 102/18 104/9
purely [1] 117/19
purpose [5] 28/24 83/16 105/19 113/1 118/20
purposes [2] 80/13 125/19
pursuant [1] 40/23
pushing [1] 36/18
put [17] 6/2 25/17 35/11 43/3 56/19 57/11 58/5 59/4 60/23 71/6 75/3 87/12 103/25 104/20 109/19 119/23 130/9
putting [4] 32/11 55/2 74/7 74/8

Q

qualification [2] 56/1 58/12
qualified [1] 77/20
qualifying [1] 85/21
quarter [2] 79/24 107/5
question [36] 6/22 7/8 7/9 8/20 9/20 9/23 10/2 12/13 12/14 23/13 28/22 29/6 30/25 32/1 32/4 36/6 37/11 37/13 46/17 54/6 59/6 67/1 68/10 68/17 85/13 86/24 90/15 96/14 100/13 104/23 112/14 112/14 112/23 114/14 114/16 127/5
questioning [5] 28/15 28/24 30/23 31/7 122/21
questions [23] 5/3 5/16 5/18 5/22 6/14 7/20 8/17 10/18 10/19 11/3 11/6 11/14 14/25 28/18 30/22 31/2 32/7 35/22 54/6 56/10 76/16 85/12 91/1
quick [3] 76/18 98/25 113/3
quite [3] 4/18 95/9 132/21
quote [1] 91/23
quoting [1] 127/2

R

raise [2] 96/5 122/14
raised [1] 87/4
raises [1] 25/13
raising [2] 8/5 56/9
rather [5] 13/23 56/4 115/2 124/7 128/20
RAYMOND [5] 1/10 2/8 3/7 3/12 3/15
rays [1] 118/25
read [5] 4/7 37/21 42/11 84/8 130/24
readdress [1] 4/10
reading [3] 5/10 27/9 42/17
ready [2] 121/15 124/1
real [3] 90/18 98/25 120/7
reality [2] 7/22 60/20
realize [1] 92/25
realizes [1] 84/12
really [20] 18/10 20/18 21/2 27/18 28/13 29/18 35/7 37/9 53/2 71/16 72/15 97/6 105/9 112/24 113/9 113/10 114/11 115/2 126/7 127/19
really -- I [1] 113/9
realm [1] 79/2
rear [2] 53/14 53/15
rear-end [2] 53/14 53/15
reason [15] 29/25 30/7 68/5 80/24 80/25 97/22 98/22 101/1 110/23 115/4 115/5 121/3 122/24 126/16 126/23
reasonable [25] 7/6 57/20 58/14 78/9 78/24 79/1 79/5 79/10 79/16 84/10 86/16 87/4 87/12 87/17 87/21 102/13 104/22 105/1 105/4 105/6 105/7 105/12 106/11 106/22 122/17
reasonably [4] 53/1 78/19 87/8 126/14
reasons [3] 97/15 100/10 100/10
rebut [6] 42/16 90/12 91/9 93/23 95/2 98/3
rebuttal [26] 45/7 45/25 88/20 88/23 95/3 96/18 107/17 107/18 108/1 108/14 108/15 108/23 111/15 111/15 112/3 113/15 113/25 115/7 115/8 115/16 115/24 115/25 116/3 116/8 116/11 116/12
rebutting [10] 41/16 88/17 89/8 89/12 94/19 107/9 107/16 108/5 108/19 115/20
recall [2] 10/5 107/13
received [3] 22/2 23/5 23/6
recent [3] 29/11 38/22 74/4
recently [2] 39/3 74/6
recognition [1] 124/15
recognized [1] 101/9
recollection [1] 15/23
recommendations [1] 125/23
reconstruction [1] 70/7
reconstructionist [2] 69/13 70/10
reconstructionists [1] 63/1
record [8] 25/17 47/4 50/25 82/25 91/23 97/12 101/2 134/11
records [44] 11/24 12/3 12/11 12/15 12/25 13/2 13/3 14/3 14/6 14/7 14/11 14/12 14/13 14/21 14/22 15/1 15/12 15/13 15/15 15/18 16/16 17/11 17/16 18/6 18/14 18/15 18/21 18/23 18/25 22/9 41/14 44/20 44/20 45/16 45/18 76/13 80/2 80/10 80/12 84/7 84/9 86/15 127/12 127/15
records -- you [1] 18/14
recover [1] 102/11
recovery [1] 123/1
red [2] 8/5 60/23
reduce [1] 58/2
reduced [4] 103/1 103/1

R

reduced... [2] 105/23 106/9
reduction [7] 55/16 56/2 58/5 102/17 103/2 103/12 128/9
refer [6] 21/23 22/5 22/6 22/11 24/1 68/19
reference [11] 5/24 18/11 24/22 25/10 49/17 49/21 52/5 52/17 59/24 60/11 68/15
referenced [1] 17/25
references [1] 21/20
referencing [2] 51/5 107/9
referral [2] 23/18 26/3
referrals [1] 26/4
referred [9] 23/19 23/19 24/5 24/9 24/12 24/16 78/13 78/14 78/15
referring [2] 19/8 68/14
reflect [3] 128/10 128/20 132/23
reform [10] 28/16 28/23 29/5 29/16 29/23 29/25 30/2 30/6 30/12 30/24
regard [3] 5/16 76/17 114/2
regarding [12] 15/23 28/16 30/23 31/8 40/18 65/3 73/18 77/18 80/9 81/15 100/23 126/1
relate [3] 6/18 8/15 9/9
related [12] 8/25 11/24 18/21 41/5 54/23 59/14 59/16 79/5 80/20 104/22 124/24 126/5
relates [14] 31/4 45/5 45/10 45/13 45/24 46/5 59/16 59/19 62/13 64/17 68/10 70/1 93/24 126/2
relating [1] 69/11
relationship [7] 60/3 65/14 65/15 65/18 65/21 65/23 66/4
relationships [1] 26/3
relevance [3] 53/5 65/5 65/7
relevancy [1] 65/13
relevant [13] 7/7 10/12 26/7 50/11 53/7 54/8 56/22 59/13 61/5 65/20 100/14 105/19 122/7
relied [8] 126/19 126/24 127/24 128/2 128/24 130/25 131/3 131/6
relief [2] 48/22 90/9
relies [2] 101/17 128/25
rely [7] 17/8 70/14 70/23 73/15 86/11 102/6 128/23
relying [3] 70/17 71/18 126/14
remainder [1] 55/4
remained [1] 125/2
remains [1] 48/4
remember [2] 73/11 127/23
remind [1] 77/4
removed [1] 126/3
rendered [4] 18/5 40/25 44/3 95/12
rendering [1] 70/16
Reno [1] 124/10
repeatedly [1] 100/12
repetitive [1] 100/8
reply [3] 127/3 127/3 131/2
report [48] 19/21 38/12 39/15 41/6 42/6 46/16 62/6 70/21 72/23 74/7 74/8 74/14 75/3 81/1 88/17 89/14 94/14 94/18 94/25 96/18 115/24 116/2 116/3 116/5 116/7 116/8 116/21 123/15 123/22 124/12 124/16 126/6 126/9 126/13 126/19 126/20 127/24 128/7 128/12 129/15 129/22 129/22 129/23 131/1 131/5 131/18 131/24 131/25
REPORTED [1] 1/24
REPORTER [1] 134/4
REPORTER'S [2] 1/15 134/1
reports [19] 20/2 20/6 38/14 43/12 46/15 71/17 74/23 80/3 86/15 90/24 91/2 95/10 115/20 116/10 123/12 125/22 128/25 128/25 132/1
represent [1] 66/3
representations [1] 48/20
representative [1] 131/19
represented [2] 65/8 66/18
request [2] 76/25 77/2
requesting [1] 11/22
require [1] 116/15
required [2] 38/15 40/8
requirement [1] 104/19
requires [1] 102/22
reserve [3] 61/14 75/10 77/3
reserved [5] 64/20 64/21 64/23 64/24 69/12
resolution [1] 40/7
resolve [2] 3/22 102/2
respect [5] 4/19 8/21 113/10 119/10 123/11
respond [1] 21/17
responding [2] 61/24 62/13
response [2] 13/10 80/15
rest [1] 25/19
restrict [1] 35/24
restrictions [2] 99/20 99/21
resulting [1] 9/23
results [1] 104/3
retain [1] 67/6
retained [10] 24/24 25/5 41/16 67/15 68/2 91/24 98/8 98/20 99/14 99/15
retake [1] 82/10
retention [2] 24/23 25/4
review [2] 13/4 93/7
reviewed [6] 22/9 71/10 71/11 71/11 93/7 126/21
reviews [2] 92/3 92/13
revisit [1] 131/8
RICHARDHARRISLAW.COM [1] 2/6
right [55] 3/16 4/14 5/1 6/24 8/19 9/7 11/7 12/11 12/12 13/12 15/2 16/11 17/5 18/18 19/20 38/8 38/23 41/9 41/12 44/13 47/3 47/4 56/13 59/8 60/6 62/20 62/21 63/6 64/4 65/7 66/5 67/3 68/19 76/15 79/23 79/25 81/5 83/21 88/13 89/1 94/2 97/13 98/25 101/10 104/15 107/4 110/4 113/3 115/1 115/9 117/2 117/11 127/8 127/15 132/20
rights [10] 42/13 43/11 108/7 112/8 112/9 113/6 114/15 114/15 114/19 115/12
risk [2] 53/17 123/1
RMR [2] 1/24 134/17
road [1] 23/22
Roesler [2] 93/21 93/25
roof [1] 114/10
rounds [1] 72/9
routinely [2] 25/24 78/11
rule [37] 31/15 31/17 31/25 32/1 32/24 33/1 33/9 33/14 34/16 34/19 35/5 35/13 35/19 38/23 39/13 41/3 41/17 42/17 42/17 43/9 44/1 44/4 45/3 49/20 91/19 92/6 95/22 96/10 96/17 96/18 96/21 96/22 96/23 97/3 97/7 102/3 106/17
rule -- I'm [1] 96/22
ruled [1] 80/15
rules [10] 13/14 13/15 39/8 39/8 42/10 43/8 43/25 91/15 113/5 115/6
ruling [5] 4/3 4/4 17/22 45/11 64/20
rulings [1] 132/23
run [1] 64/2
running [1] 97/14

S

said [38] 6/4 9/6 10/25 13/10 17/15 18/16 19/22 21/10 24/12 43/16 47/19 57/7 58/1 61/13 62/25 67/18 69/2 71/13 71/16 72/2 75/23 77/11 84/16 86/17 87/5 87/9 97/19 99/24 109/4 110/20 110/25 123/23 125/3 125/11 125/14 126/22 131/1 134/7
sake [1] 109/3
same [18] 8/15 15/17 20/6 28/2 32/3 52/19 59/14 63/14 67/14 69/5 69/15 74/11 74/15 99/4 100/13 111/10 113/21 116/1
San [1] 115/21
sanitize [1] 14/4
saw [4] 14/6 14/12 15/18 62/2
say [111] 6/19 8/24 8/24 9/20 9/23 10/16 14/4 14/10 15/11 19/17 19/21 21/22 23/8 29/12 30/15 32/21 33/2 33/3 34/8 34/22 35/7 36/22 40/4 41/7 41/10 42/7 42/10 42/14 43/2 43/3 43/18 43/19 44/7 44/12 44/16 44/21 46/18 47/16 48/17 49/1 51/9 57/17 57/19 57/25 57/25 58/16 59/5 60/14 61/9 64/18 68/9 69/11 71/9 71/10 73/4 74/22 74/22 74/25 75/4 75/9 76/2 76/3 76/19 76/22 79/4 80/18 81/4 81/7 81/20 81/21

S

say... [41] 81/21 82/1 82/2 82/2 82/20 84/6 84/23 85/17 86/10 86/13 86/14 87/21 89/2 89/24 90/2 90/17 90/25 91/3 92/9 92/10 93/17 93/21 94/13 100/25 102/6 105/4 105/18 108/11 109/4 110/8 112/8 112/11 113/4 114/5 115/2 115/24 122/7 122/9 123/3 126/18 131/17
saying [25] 13/14 14/11 20/12 20/19 37/1 38/14 48/6 54/10 56/5 58/4 60/24 62/18 63/19 69/16 69/20 71/6 72/19 89/21 112/17 113/16 115/1 122/17 123/15 125/12 127/17
says [67] 5/9 14/13 19/13 19/22 20/12 20/13 22/17 23/18 24/5 24/7 24/7 25/13 26/13 27/10 27/25 28/21 31/11 33/12 34/3 34/11 34/16 35/13 36/12 36/15 36/21 39/20 44/5 44/8 44/13 45/3 52/3 52/4 53/14 56/20 59/9 61/5 62/6 71/6 74/5 74/13 74/15 75/1 76/4 78/24 80/8 85/15 85/16 87/16 89/10 91/23 91/24 92/14 95/22 99/20 100/2 100/7 102/8 105/3 105/7 106/14 106/18 113/18 122/8 127/4 127/18 130/2 131/6
scared [1] 23/7
scenario [2] 94/23 96/3
scene [1] 20/9
schedule [2] 110/16 110/22
scheduled [2] 110/17 114/21
Schifini [30] 19/22 19/24 20/1 20/4 20/12 22/1 39/20 40/5 41/10 44/8 44/12 44/24 71/23 72/20 73/17 73/24 75/6 75/15 75/17 75/19 76/11 77/17 79/9 89/3 90/3 94/5 94/13 113/17 114/6 116/21
school [1] 72/3
scientific [4] 56/8 58/15 69/20 74/19
scope [2] 38/18 85/24
screwed [1] 35/8
seasoned [1] 12/7
SEASTRAND [10] 1/7 2/2 3/7 8/6 12/21 61/1 62/18 75/17 86/2 127/1
second [10] 109/6 109/10 109/15 110/3 110/13 116/3 116/8 123/22 123/22 124/4
secondary [12] 25/1 25/3 73/18 73/21 74/2 74/11 75/22 75/25 76/14 76/21 76/23 76/25
Secondly [1] 98/5
section [1] 95/22
see [26] 10/1 14/5 14/14 14/14 16/11 28/17 28/19 35/14 37/7 51/7 59/20 61/15 61/22 65/4 65/13 69/2 69/2 95/10 101/15 111/3 113/22 120/13 120/15 122/5 129/15 130/2
seeing [2] 64/3 118/16
seek [1] 48/22
seeking [2] 21/19 27/16
seeks [2] 21/20 52/23
seem [2] 63/22 73/12
seeming [1] 16/16
seems [6] 17/19 71/3 86/1 113/9 113/9 129/17
seen [25] 12/8 14/3 14/23 16/4 16/6 16/17 16/18 21/9 23/3 31/15 33/21 37/5 67/12 70/20 71/16 71/17 71/17 71/18 118/9 118/11 119/11 120/11 120/12 121/1 121/10
select [1] 58/22
selected [1] 66/2
selection [1] 29/15
self [1] 69/21
self-serving [1] 69/21
sell [2] 122/13 122/25
sells [1] 122/3
sense [4] 7/25 15/8 41/1 80/24
sent [1] 48/6
served [1] 68/4
serves [1] 95/9
serving [1] 69/21
set [1] 42/2
setting [2] 101/20 101/21
settlement [2] 121/14 132/18
several [4] 51/8 60/19 125/6 125/9
Severity [1] 53/10
shackle [1] 44/6
share [2] 22/23 52/10
sharing [2] 21/25 22/8
she [66] 9/25 12/24 13/2 17/2 17/7 17/8 17/13 20/9 20/10 20/10 20/16 21/4 21/5 21/6 21/6 22/2 27/17 28/3 28/5 51/16 53/21 56/5 57/10 60/3 66/2 66/22 67/2 67/5 67/6 67/10 67/18 68/2 68/3 68/4 75/20 76/6 76/9 76/9 77/25 84/16 86/2 89/11 94/17 95/1 95/2 97/22 97/23 97/23 97/25 97/25 103/7 104/1 104/4 113/24 113/25 115/24 116/20 116/22 116/22 119/18 119/19 119/20 124/21 127/15 127/17 127/20
she's [29] 8/16 20/15 20/15 27/14 27/16 27/17 27/18 27/19 53/19 55/19 56/6 57/20 58/17 58/18 60/15 66/14 67/3 75/23 75/24 76/4 76/4 76/19 86/4 87/17 87/22 103/8 103/11 116/24 119/21
sheet [1] 105/1
shocking [1] 118/19
shoe [1] 92/8
SHORTHAND [1] 134/4
shot [1] 124/18
should [37] 7/8 25/15 25/15 28/23 28/24 29/22 29/23 30/10 30/18 30/19 34/24 35/15 38/17 52/19 52/19 53/1 59/6 63/3 67/12 69/12 77/22 84/4 84/8 86/23 86/24 87/3 87/7 89/6 94/2 99/23 100/7 100/17 105/9 106/8 113/18 117/6 122/14
shouldn't [9] 30/7 33/10 44/9 69/10 80/19 92/16 92/16 92/17 105/25
show [7] 8/19 65/20 65/22 98/5 99/22 112/15 119/14
showed [1] 63/15
showing [3] 66/11 119/6 120/6
shown [1] 55/16
shows [8] 28/3 65/14 66/4 86/8 100/1 100/6 100/15 125/8
sick [1] 35/7
side [12] 26/5 26/5 34/7 42/5 43/2 47/15 50/13 79/11 91/8 100/25 108/17 120/14
sides [6] 9/19 26/8 26/16 30/21 30/25 70/15
Siegler [1] 19/24
significantly [1] 21/18
similar [5] 5/12 5/16 59/15 117/20 118/11
Similarly [2] 63/19 112/9
simple [1] 131/4
simplify [1] 43/15
simply [6] 43/5 58/6 67/14 78/6 108/11 120/12
since [5] 60/15 70/15 82/23 95/8 123/13
singing [1] 124/22
single [14] 9/13 20/6 20/14 40/21 40/23 48/16 72/13 74/14 74/15 85/11 92/25 93/23 94/3 116/22
sir [15] 3/20 4/22 11/20 26/9 32/10 38/24 46/3 46/22 47/6 51/2 61/17 79/13 81/11 109/2 111/14
sit [13] 14/9 15/11 34/22 38/3 43/3 44/11 89/25 94/13 95/4 95/6 110/8 112/8 121/19
sitting [2] 129/7 129/9
situation [4] 31/19 33/21 98/2 112/15
situations [2] 10/22 104/7
six [3] 82/21 128/8 131/18
SJAFFE [1] 2/13
skid [1] 63/20
slightly [1] 88/24
slip [1] 17/20
slippery [4] 32/13 32/21 33/6 35/17
slope [4] 32/13 32/22 33/7 35/17
small [1] 124/21
SMITH [3] 2/10 3/14 63/4
smoker [1] 57/10
smoking [2] 57/12 58/1
so [159]
society [1] 66/24
soft [1] 89/12
solely [2] 116/3 127/24
some [56] 3/24 4/15 4/18 4/20 5/10 7/10 8/7 14/2

S

some... [48] 14/3 15/23 16/1 17/10 17/11 22/1 22/16 27/11 27/14 30/17 43/1 48/4 52/17 55/20 56/8 56/9 56/12 58/7 60/20 67/16 68/5 74/12 76/8 76/9 78/12 78/14 78/17 81/3 81/18 81/21 82/3 82/25 83/13 85/21 93/1 93/1 97/23 97/24 102/17 103/4 103/12 116/17 120/6 121/3 121/11 121/24 127/25 130/8
somebody [29] 19/23 24/12 34/3 36/21 42/13 49/2 50/2 51/10 51/10 51/17 56/20 57/4 61/4 65/16 66/2 67/4 67/5 72/10 73/4 82/18 83/24 86/9 90/5 104/21 105/3 105/7 112/1 114/20 114/21
somehow [3] 16/10 23/12 61/5
someone [2] 53/17 71/25
something [37] 4/9 5/24 7/16 8/8 12/9 13/20 13/23 21/10 21/12 26/16 29/20 39/3 47/19 47/21 48/15 62/11 81/13 81/16 81/25 82/6 83/2 84/24 85/1 86/17 86/22 87/3 87/4 87/7 87/8 87/25 88/1 98/17 106/19 110/6 119/18 119/19 120/23
sometimes [6] 10/11 28/17 28/18 33/19 84/12 97/20
somewhat [1] 62/15
somewhere [5] 22/17 24/4 96/15 96/16 125/22
sorry [6] 93/10 99/21 103/5 103/24 123/7 132/18
sort [6] 41/25 51/22 74/1 102/17 103/4 103/12
sought [1] 19/11
sound [1] 58/14
sounds [2] 22/10 22/10
source [15] 49/24 50/14 50/17 99/20 100/19 101/4 101/15 101/17 102/3 104/11 106/17 107/2 122/4 122/22 123/4
sources [10] 49/18 49/22 100/24 101/1 105/16 105/19 105/25 106/9 106/14 106/18
SOUTH [1] 2/4
speak [1] 108/9
speaking [1] 119/12
special [2] 101/13 102/11
specific [16] 9/3 13/20 13/23 31/13 32/1 32/8 33/13 35/22 36/10 36/11 45/7 51/24 51/24 53/23 53/23 79/2
specifical [1] 35/23
specifically [15] 35/21 40/11 44/1 44/15 52/4 68/22 71/24 73/23 91/20 91/22 100/2 100/5 102/8 103/18 106/18
specifics [2] 17/24 68/12
speculative [2] 69/21 100/9
speedy [1] 113/3
spending [2] 111/23 112/5
spinal [2] 78/12 124/5
spine [17] 77/19 77/21 77/21 77/22 77/25 78/2 78/7 78/9 78/23 78/24 78/25 79/2 79/3 79/4 79/6 79/10 79/12
split [1] 31/10
squishy [1] 38/25
stack [1] 45/15
stand [6] 57/16 71/6 76/3 81/7 87/15 99/11
standard [1] 125/20
standing [1] 124/11
stands [1] 99/10
start [13] 30/3 32/11 32/12 33/19 36/25 41/15 42/23 95/5 95/7 95/12 121/4 130/7 130/15
started [1] 86/1
starts [3] 32/14 34/17 130/21
state [6] 7/17 7/23 8/8 42/14 134/2 134/14
stated [9] 41/13 42/18 42/22 42/24 80/2 90/5 90/11 124/2 128/10
statement [3] 85/21 130/10 130/16
statements [4] 19/10 26/23 26/23 118/5
states [4] 40/11 44/1 101/24 103/21
STENOTYPE [2] 134/5 134/8
step [1] 90/2
steps [1] 83/18
STEVEN [2] 2/9 3/11
stick [1] 104/4
still [15] 33/4 47/11 82/17 83/8 102/25 121/15 122/22 123/4 124/8 124/11 126/7 126/11 128/18 128/19 130/13
stimulater [1] 87/18
stipulated [2] 123/13 124/25
stipulating [1] 22/11
stipulation [3] 121/6 124/4 124/17
stood [1] 129/7
stopped [1] 74/7
story [2] 110/10 115/6
STREET [1] 2/4
stricken [2] 126/17 129/12
strike [1] 129/14
strip [1] 125/9
stroke [4] 13/9 13/22 15/10 71/4
studies [1] 37/20
study [1] 125/5
stuff [6] 17/10 26/19 62/2 62/2 73/16 120/18
subject [5] 11/24 18/21 28/6 56/1 58/12
subjective [2] 20/16 21/5
SUBSCRIBED [1] 134/13
subsequent [1] 106/24
success [1] 40/7
successful [1] 39/23
such [18] 13/8 14/16 14/17 14/17 15/10 28/24 29/16 29/25 51/15 55/7 55/7 55/8 55/8 56/15 56/17 57/6 57/21 87/12
sudden [1] 128/7
sue [1] 66/13
suffered [2] 60/3 89/12
suffering [3] 30/16 35/1 57/18
suggest [3] 18/15 35/15 76/15
suggested [1] 96/3
suggesting [4] 11/23 16/12 18/20 27/7
suggestion [2] 13/1 20/18
SUITE [1] 2/11
suits [1] 125/19
sum [1] 99/12
sun [1] 44/19
supersede [2] 112/9 112/10
SUPERVISION [1] 134/9
supplement [1] 83/1
supplemental [5] 115/20 116/10 124/16 131/4 131/24
supplemented [1] 127/16
supplements [1] 86/6
support [3] 89/1 89/25 129/8
Suppose [2] 6/4 6/6
supposed [1] 117/4
Supreme [7] 29/12 29/14 30/4 39/8 40/12 95/25 95/25
sure [26] 6/15 9/12 10/4 10/14 11/4 18/1 22/22 23/22 24/10 26/25 36/4 50/24 56/15 58/13 61/22 67/17 70/5 88/3 88/12 89/18 90/16 91/4 91/7 109/12 114/13 132/22
surgeon [5] 78/7 78/23 79/2 79/3 79/12
surgeries [19] 22/2 23/4 77/19 77/21 77/22 78/13 78/15 86/1 117/15 123/13 123/23 124/5 124/13 126/2 126/3 126/5 127/18 128/17 128/21
surgery [23] 39/20 39/21 40/8 77/25 78/2 78/9 78/24 78/25 79/4 79/6 79/8 79/10 79/16 86/2 86/3 92/16 117/21 118/18 118/22 119/21 122/6 122/7 124/4
surgical [7] 78/13 78/20 78/20 117/13 117/18 119/3 125/23
surprise [6] 80/22 81/12 81/17 83/3 84/22 85/5
surrounding [1] 53/23
susceptible [1] 53/16
sustain [3] 5/20 52/7 52/8
sustained [4] 8/22 28/6 68/15 75/21
symptoms [2] 40/8 60/15
system [2] 34/23 114/10

T

table [2] 55/3 58/20
tables [2] 58/23 58/25
take [15] 8/25 44/12 51/14 51/17 58/21 58/23 58/25 69/7 70/19 81/10 81/24 125/7 125/24 128/6 131/25
taken [5] 82/7 82/10 83/18

T

taken... [2] 90/23 128/21
takes [2] 76/20 90/21
taking [5] 81/23 85/7 123/22 124/4 130/17
talk [44] 17/16 18/14 19/1 19/2 19/2 22/13 24/20 29/6 39/14 39/15 39/16 41/4 41/5 41/12 42/20 44/10 44/18 45/1 45/19 47/1 50/1 50/6 50/13 52/13 54/21 54/22 56/12 61/8 70/9 73/20 73/22 77/20 78/1 79/9 79/15 79/15 80/13 87/6 88/4 92/21 94/5 95/1 95/21 131/13
talked [2] 10/22 85/3
talking [19] 15/12 18/4 33/19 50/5 60/5 61/6 62/5 66/7 67/20 71/5 75/15 78/11 95/5 95/12 117/14 117/15 117/16 117/19 118/10
talks [4] 38/19 40/13 115/10 130/8
TAR [4] 64/5 64/5 70/6 70/6
teach [2] 64/6 64/6
tell [23] 4/3 6/9 9/25 12/23 20/20 20/24 30/13 31/10 36/23 40/24 45/16 47/24 48/24 54/14 63/2 84/1 84/18 91/8 91/13 92/20 97/7 109/13 114/7
telling [3] 57/5 107/20 107/21
tells [1] 127/11
temper [1] 84/6
tempered [4] 55/13 74/20 85/9 85/9
ten [1] 48/14
tend [5] 69/25 70/11 78/1 85/16 129/25
Terrance [5] 123/9 124/7 124/8 124/19 130/12
terror [1] 119/25
test [1] 126/13
testified [13] 9/14 21/6 26/1 45/13 52/8 60/14 61/2 61/15 63/8 75/17 75/19 114/6 128/24
testifies [7] 48/25 75/12 76/17 77/1 88/3 104/24 115/3
testify [36] 7/5 7/5 7/12 8/4 38/10 38/18 45/11 45/17 46/6 52/21 76/23 77/22 77/24 78/8 78/19 80/9 81/1 82/20 90/10 99/12 104/21 108/10 108/12 109/10 110/3 110/8 110/17 110/24 111/3 112/25 115/13 115/23 116/15 116/24 117/3 118/25
testifying [9] 64/10 65/19 76/12 84/20 89/17 108/18 110/2 123/9 130/21
testimony [25] 38/20 60/21 73/18 74/2 75/18 76/1 77/16 77/18 84/7 95/14 99/23 100/1 100/23 107/11 108/3 108/19 110/20 111/4 111/15 112/2 113/7 118/3 122/20 124/1 129/16
testing [1] 69/15
tests [1] 69/17
than [36] 4/7 13/23 15/8 23/20 23/24 31/21 33/15 33/16 34/10 34/12 34/22 34/25 35/2 35/4 35/19 36/13 36/16 51/6 51/21 53/17 56/4 63/11 65/23 67/8 68/1 68/25 70/25 99/7 101/20 103/23 103/24 104/1 104/8 114/19 129/15 130/25
thank [15] 4/22 16/21 26/9 26/20 38/4 49/11 51/2 59/23 61/17 88/7 96/12 132/9 132/12 132/14 132/16
Thanks [5] 64/16 132/15 132/24 132/25 133/1
that [941]
that's [194]
the -- our [1] 39/7
the -- the -- he [1] 63/14
theft [1] 65/4
their [135]
their -- their [1] 127/2
them [72] 10/9 11/16 13/4 13/11 13/13 14/8 14/8 14/14 14/15 15/22 16/4 16/7 16/11 19/1 19/2 19/2 20/7 20/7 23/13 35/6 35/10 40/14 40/22 41/7 41/9 41/12 45/19 48/6 48/16 49/6 49/7 50/3 50/3 50/6 50/13 51/9 57/25 60/14 61/9 65/15 66/7 66/8 66/9 69/20 76/24 79/11 79/14 81/20 84/22 87/13 90/10 91/3 91/9 91/16 95/7 95/11 95/20 96/14 96/16 108/5 111/3 112/2 112/3 113/7 113/8 114/4 115/13 115/14 119/11 119/20 122/16 131/25
theme [1] 72/16
themselves [1] 107/24
then [77] 7/7 7/13 13/1 14/23 16/19 17/18 32/13 35/2 36/2 36/21 36/22 37/18 38/21 40/1 40/20 41/15 48/3 49/7 53/11 56/3 59/4 60/16 63/13 64/9 68/8 71/9 76/6 76/20 76/21 81/25 82/25 85/16 85/16 87/12 89/10 89/22 90/23 92/13 94/6 94/13 96/4 98/1 98/21 99/18 100/2 100/7 100/7 101/17 102/19 105/10 106/3 106/4 106/7 106/22 107/17 108/8 108/15 109/13 110/2 110/2 111/4 112/3 115/5 115/14 115/20 116/1 116/2 116/7 122/3 123/2 123/18 123/21 127/15 129/25 130/4 131/8 131/12
theories [1] 84/21
therapy [4] 39/24 39/25 40/3 85/1
there [107] 4/1 5/8 5/9 6/4 6/13 6/16 6/16 8/14 11/23 11/25 12/3 12/18 12/25 13/3 13/3 14/2 14/9 14/19 15/23 17/5 17/10 17/10 17/11 17/11 18/15 18/15 18/20 18/22 18/25 20/23 21/10 21/10 23/1 23/20 27/7 29/11 30/1 32/11 33/10 34/22 35/15 39/12 43/1 44/11 45/1 48/2 49/20 54/24 56/2 56/3 56/4 57/9 58/8 58/16 62/7 62/8 62/10 63/25 65/15 66/4 66/10 67/8 69/2 69/3 71/15 72/6 74/2 75/4 75/25 76/5 84/15 85/22 85/22 88/20 89/25 93/1 93/23 94/3 95/11 99/16 101/8 102/17 104/4 106/15 110/6 112/8 112/19 112/21 114/20 118/23 119/3 122/9 122/25 123/3 124/2 124/24 126/11 127/15 127/22 127/25 129/8 129/9 129/20 129/22 129/25 130/13 132/21
there's [84] 3/25 7/10 7/19 8/6 17/20 20/3 21/3 21/4 21/8 21/14 22/16 23/17 23/18 23/18 24/4 24/7 24/11 24/19 27/21 29/25 30/7 30/14 34/4 35/18 37/20 47/5 49/22 52/20 53/14 53/18 60/1 60/4 60/21 63/20 63/25 66/3 66/21 67/8 69/19 74/18 75/21 76/6 76/8 76/9 78/5 81/17 81/18 82/3 82/4 83/16 85/6 85/14 87/2 87/2 88/19 96/15 96/17 96/20 97/15 99/16 101/8 102/16 102/25 103/6 103/11 104/24 105/18 106/21 110/13 111/6 113/22 113/23 115/4 118/25 119/1 120/4 123/1 123/10 126/9 128/22 129/3 129/11 129/15 131/7
THEREAFTER [1] 134/7
therefore [2] 51/14 102/15
therefrom [2] 84/10 86/16
these [56] 3/17 4/20 5/4 5/9 5/11 13/12 13/21 14/6 14/6 14/11 14/12 15/13 15/17 15/18 15/25 19/5 28/17 31/1 35/8 47/5 49/6 55/14 55/19 55/20 58/21 60/2 60/5 60/15 60/19 60/25 63/9 72/24 75/6 75/8 77/2 82/17 83/7 88/19 91/1 91/2 91/9 95/21 96/21 100/9 107/20 113/4 113/6 117/3 118/14 118/18 118/21 119/7 119/15 120/8 122/5 127/17
they [166]
they'll [1] 36/23
they're [62] 5/18 6/18 6/21 7/18 9/2 18/2 18/2 19/21 20/11 20/11 23/7 24/19 32/8 38/16 42/8 47/24 48/16 48/24 49/1 52/21 54/10 54/13 55/2 55/14 56/1 57/5 57/16 61/5 68/23 70/16 72/12 72/14 72/18 76/2 78/19 81/4 83/12 84/13 84/13 89/25 91/6 98/12 98/18 99/6 99/11 103/6 104/6 105/3 105/3 107/15 112/4 113/13 113/15 113/16

T

they're... [8] 119/7 119/13 120/20 122/8 122/16 122/18 127/3 130/17
they're -- they're [2] 18/2 20/11
they've [11] 14/23 22/9 49/4 82/25 83/1 83/2 83/18 89/22 95/8 108/5 120/4
thing [29] 9/13 9/18 16/22 17/6 20/6 33/20 33/22 47/22 54/4 58/19 61/9 62/24 69/15 71/3 74/11 74/15 84/11 85/25 88/25 90/1 91/20 92/7 95/17 99/4 113/12 113/21 116/22 130/16 131/17
things [40] 5/17 26/1 27/13 28/13 37/17 39/14 39/16 40/1 44/16 48/8 50/10 56/12 56/14 56/17 56/17 57/6 57/9 57/10 64/8 70/3 72/24 75/8 80/21 81/15 87/24 88/10 91/16 93/9 94/9 95/21 105/15 110/5 111/5 112/13 117/4 123/10 128/2 128/23 130/25 131/3
think [184]
think -- I [1] 33/17
think -- what [1] 62/17
thinking [2] 7/18 70/12
third [3] 102/18 104/8 122/4
this [211]
thoroughly [2] 96/1 119/2
those [60] 6/14 6/18 8/20 8/24 9/14 9/21 10/19 10/22 12/3 12/9 15/15 21/12 28/13 30/20 30/22 30/22 32/7 32/22 32/23 34/2 35/10 39/14 41/15 41/24 45/7 46/1 46/9 48/19 55/1 55/15 55/21 56/9 56/12 56/15 57/8 59/6 60/12 61/7 64/2 76/9 81/24 85/1 86/4 87/24 88/10 93/24 95/1 96/7 102/13 105/15 105/24 110/6 111/5 119/10 126/5 128/21 129/2 130/10 130/11 130/12
though [12] 6/18 47/16 53/8 54/25 56/21 71/1 81/8 82/22 96/19 107/2 124/9 131/17
thought [3] 60/18 86/19 96/1
thoughtful [1] 72/19
thoughts [4] 36/23 70/13 104/15 104/17
thousand [1] 125/10
three [1] 48/18
through [13] 3/23 4/14 56/25 57/3 59/21 72/18 81/20 94/11 94/21 97/21 114/10 124/16 124/16
Thursday [2] 109/10 109/19
time [32] 9/8 10/1 16/7 20/6 24/2 28/2 36/20 37/3 45/18 49/7 50/21 50/25 58/5 61/20 63/14 71/23 72/13 74/24 81/24 84/15 84/15 85/22 86/4 91/1 92/21 104/14 111/17 115/11 124/9 131/12 132/13 134/7
times [5] 26/1 75/16 93/1 100/14 111/23
TIMOTHY [1] 1/19
tire [2] 63/20 64/11
to -- I [1] 16/3
to -- it's [1] 50/12
today [5] 4/4 4/16 4/20 120/13 132/11
together [2] 60/12 64/2
told [6] 21/11 31/20 36/15 46/24 49/4 76/9
too [2] 32/15 54/19
took [7] 11/9 46/12 94/17 112/15 124/10 124/11 134/5
top [4] 99/10 99/11 124/19 125/21
topic [4] 55/11 55/11 59/7 108/9
tort [10] 28/16 28/23 29/5 29/16 29/22 29/25 30/2 30/6 30/12 30/23
totally [2] 25/3 29/2
track [1] 5/4
traction [1] 127/25
traffic [1] 70/7
trained [1] 62/16
training [3] 70/2 94/9 94/12
traipsing [1] 81/20
TRANSCRIBED [1] 134/8
transcript [3] 1/15 71/22 134/10
trauma [1] 71/8
treat [5] 50/2 75/7 78/12 90/20 90/20
treated [5] 12/24 50/2 50/3 93/18 98/1
treating [46] 13/25 15/24 25/11 38/9 38/15 39/14 40/13 40/21 42/8 43/6 43/6 44/2 44/7 44/25 45/11 45/15 45/19 45/20 45/24 46/6 47/18 50/8 74/16 80/9 80/25 82/17 82/22 83/6 83/6 83/8 88/16 90/19 90/24 91/6 91/24 94/17 94/22 98/10 98/10 98/21 99/3 99/10 99/25 116/4 116/18 116/25
treatment [68] 9/15 12/18 16/23 17/2 19/11 19/17 22/2 22/14 23/6 27/12 27/17 27/20 38/11 38/18 39/16 39/17 40/2 40/2 40/6 40/6 40/6 40/18 40/25 41/5 41/6 42/21 44/3 44/9 44/11 44/17 45/3 45/14 45/17 46/7 46/8 46/10 46/19 54/18 54/22 59/10 59/12 80/12 80/14 81/9 82/19 84/17 84/17 84/20 85/15 86/9 86/12 90/1 90/6 92/4 92/5 92/18 93/13 93/25 94/4 97/23 97/24 100/11 105/12 113/14 114/3 114/7 122/2 123/18
treatments [1] 85/23
tree [1] 129/9
Tri [5] 101/18 101/19 101/24 103/18 104/11
Tri-County [5] 101/18 101/19 101/24 103/18 104/11
trial [51] 4/6 4/9 4/11 4/14 4/17 14/4 26/14 26/18 26/25 27/1 29/21 29/22 29/23 30/11 30/14 31/21 45/16 48/25 49/7 75/10 77/4 82/11 83/20 83/25 84/19 85/5 85/16 86/20 91/1 91/11 91/19 92/21 93/4 93/16 96/23 97/2 97/20 99/12 100/5 101/13 109/4 110/12 110/16 110/16 110/18 113/2 115/7 120/15 121/4 130/7 130/21
trials [4] 17/20 31/1 31/16 118/12
tricky [1] 90/18
trier [1] 54/7
trouble [2] 15/8 35/17
true [9] 14/10 14/12 20/23 44/14 58/20 113/15 113/25 116/1 134/10
truly [1] 14/19
trust [1] 67/23
trusts [1] 67/6
truth [1] 12/23
try [5] 21/7 64/4 83/20 119/23 120/21
trying [26] 5/21 14/4 15/5 17/1 17/6 18/2 20/11 20/25 27/22 28/7 29/18 29/19 30/3 47/21 55/17 55/18 59/21 67/2 67/3 72/14 72/15 72/18 73/7 76/2 93/9 119/13
TUESDAY [2] 1/22 3/1
turn [5] 17/7 45/20 101/22 112/25 113/7
turnaround [1] 122/13
turned [1] 12/19
turns [1] 122/3
twelve [2] 47/17 47/18
twice [2] 108/12 117/3
two [17] 29/12 43/19 48/8 49/23 50/22 74/4 78/11 86/1 93/9 109/4 110/5 111/2 123/10 123/11 124/12 126/5 127/17
two-week [1] 109/4
type [11] 10/24 15/9 17/5 17/5 23/24 53/15 55/13 74/21 91/20 118/18 118/18
types [3] 56/9 62/8 75/6
TYPEWRITING [1] 134/8
typically [1] 94/12

U

Uh [1] 8/1
Uh-huh [1] 8/1
ultimately [1] 104/12
Um [5] 109/7 109/21 109/24 111/21 111/25
Um-hum [5] 109/7 109/21 109/24 111/21 111/25
unavailable [1] 97/24
unbiased [1] 108/17
under [14] 12/23 35/5 44/19 50/3 78/9 79/1 79/17 94/22 96/16 96/18 96/20 100/16 119/17 134/9
undergoing [1] 120/1
undergone [3] 118/23 120/4

U

undergone... [1] 120/6
underpinning [1] 21/8
understand [22] 5/10 6/1 12/1 30/25 47/14 50/9 51/7 53/5 57/14 60/4 61/19 62/1 62/15 85/8 88/25 99/17 106/25 109/16 109/18 115/12 117/3 131/20
understandable [1] 16/2
understanding [1] 21/14
underwent [1] 119/15
unduly [2] 52/11 107/25
unfair [16] 43/8 43/9 43/24 73/3 80/22 81/12 81/17 83/3 85/5 86/19 93/11 93/11 93/16 94/1 108/16 114/11
unfairly [2] 118/14 120/9
unfairness [2] 82/15 93/2
unfettered [1] 108/17
unflinching [1] 113/5
unfortunately [1] 17/9
unless [1] 69/19
unlikely [1] 71/8
unnecessary [1] 19/15
unqualified [3] 69/21 73/24 75/6
unrelated [6] 25/11 54/17 54/21 59/10 59/12 59/13
unringing [1] 87/19
unrung [1] 130/13
unscientific [1] 69/5
until [3] 74/6 109/19 128/18
unwarranted [2] 19/16 19/18
up [68] 4/11 6/19 9/19 10/1 14/9 18/23 21/1 23/12 26/19 30/1 30/7 30/8 32/19 35/11 36/7 36/24 36/25 37/18 37/23 39/5 42/23 43/3 44/18 45/1 49/5 50/23 54/25 55/5 56/4 57/11 58/5 58/16 59/4 60/23 69/1 71/22 72/5 75/3 75/16 77/21 81/16 83/24 87/6 87/20 89/9 89/21 89/23 89/25 93/23 94/3 95/6 95/11 96/3 96/23 103/19 104/4 104/20 110/14 111/18 112/5 112/16 119/3 119/23 122/9 123/3 124/10 125/24 130/10
updates [1] 86/7
upon [24] 4/5 7/2 23/5 26/17 31/13 31/18 31/19 32/4 32/8 32/12 34/2 35/22 36/10 44/13 48/21 62/4 70/14 76/25 89/16 109/25 123/20 124/12 125/5 129/21
ups [3] 33/7 34/18 36/9
upset [2] 34/24 86/1
us [18] 4/13 6/9 9/3 9/6 12/11 13/20 16/7 17/8 19/7 30/4 82/25 83/2 94/14 96/3 96/23 103/7 106/22 127/11
use [13] 28/1 29/6 29/7 35/23 35/25 36/19 37/14 37/15 53/12 119/1 119/2 120/21 122/12
used [5] 27/13 78/25 118/16 121/2 121/3
using [4] 118/2 118/3 127/5 127/13
usual [1] 122/10
usually [4] 62/5 62/9 62/10 62/15

V

vague [1] 100/8
valid [2] 29/5 96/14
value [3] 100/22 102/13 106/22
variety [1] 126/24
VEGAS [4] 2/5 2/11 3/1 125/5
vehicle [1] 72/11
vehicles [2] 64/12 68/16
veiled [1] 18/11
verbiage [1] 122/11
verdict [7] 31/8 31/12 37/11 98/14 98/14 99/15 106/4
verify [1] 82/12
version [1] 96/2
versus [10] 3/7 30/5 50/18 50/19 51/19 53/18 100/20 104/18 105/17 106/14
versus -- in [1] 30/5
very [25] 4/14 13/13 15/24 23/23 52/23 55/9 58/8 63/21 66/25 70/22 71/4 71/7 71/7 72/19 89/4 97/13 110/23 112/6 112/7 114/23 119/2 122/11 122/19 124/19 132/12
video [5] 117/12 117/15 118/10 120/7 121/12
videos [4] 117/18 117/20 118/11 120/18
videotape [4] 110/20 111/4 111/5 118/19
views [1] 31/3
Villablanca [2] 19/25 41/10
violate [1] 33/13
violated [1] 112/18
violates [1] 43/11
violation [4] 35/19 42/12 112/24 113/5
visit [2] 105/5 105/10
voice [1] 38/7
voir [12] 28/15 28/25 30/5 30/23 31/7 74/3 75/11 76/18 77/1 77/5 77/13 77/14
vote [1] 35/12

W

wage [1] 125/4
wages [1] 124/24
want [64] 9/6 9/7 11/6 15/12 16/22 18/22 19/7 20/8 21/24 22/7 22/13 22/22 23/7 23/11 23/21 23/22 24/6 24/6 24/10 25/17 27/6 27/12 28/18 28/19 29/12 29/15 30/4 30/21 30/21 32/9 35/11 38/9 42/8 44/6 44/7 44/21 44/21 44/22 45/16 47/15 51/9 52/13 53/25 54/14 54/20 54/22 54/25 57/17 60/11 62/17 71/4 74/22 75/4 84/23 89/17 97/12 100/10 107/13 112/11 113/9 129/14 132/3 132/5 132/22
wanted [1] 23/16
wants [17] 24/22 25/9 26/12 27/19 35/6 43/4 43/4 43/4 43/5 43/5 59/1 62/22 88/9 88/10 102/6 118/21 119/20
warranted [4] 78/3 78/9 79/1 79/17
was [141]
was -- he [1] 116/9
WASHINGTON [1] 2/10
wasn't [16] 21/4 22/14 50/7 51/10 52/14 52/16 54/12 54/14 62/9 85/4 85/4 86/24 112/14 112/19 116/12 128/17
wasn't -- there [1] 112/19
way [16] 10/19 16/15 25/22 30/3 31/2 31/15 34/4 66/16 72/20 73/2 74/17 76/20 84/4 84/7 96/24 97/3
ways [2] 110/13 120/5
we [144]
we -- I [1] 33/24
we'll [6] 37/7 42/19 46/1 77/3 77/6 110/20
we're [56] 5/21 13/17 17/1 17/6 18/7 20/25 21/22 22/5 22/6 22/19 23/8 23/23 24/10 27/22 27/25 29/4 33/3 33/14 33/15 36/13 36/15 42/11 45/4 47/11 48/17 58/22 59/20 60/4 61/15 61/21 67/1 67/3 68/9 68/11 75/5 75/15 77/5 78/21 79/13 80/17 83/15 84/18 84/19 84/21 87/6 87/9 89/18 90/9 97/14 100/11 102/8 117/4 117/19 118/10 121/7 121/15
we've [19] 15/16 15/17 42/2 61/6 66/13 80/5 81/14 81/22 81/23 83/4 83/13 83/13 86/6 118/8 121/23 124/25 125/6 125/16 125/21
wedding [1] 114/22
Wednesday [3] 109/10 109/20 110/25
weed [1] 33/25
week [14] 109/4 109/5 109/6 109/10 109/11 109/15 109/16 110/4 110/10 110/25 112/16 114/5 114/7 121/7
weekly [2] 65/12 82/23
weigh [4] 100/19 100/20 107/23 108/2
weight [4] 60/20 69/8 69/23 129/19
welcome [1] 121/19
well [90] 3/22 6/1 6/13 6/25 9/23 10/12 12/5 12/10 12/22 13/12 14/4 14/13 14/15 14/23 15/6 15/21 15/24 17/17 18/22 19/17 19/25 24/4 29/10 32/14 32/16 33/8 36/6 37/23 37/25 39/2 39/20 40/4 48/17 51/12 54/4 55/9 56/5 56/14 57/14 58/3 58/8 61/8 63/10 63/12 65/22 69/16 70/22 71/15 73/23 82/20 83/5 84/16 85/12 85/17 85/21 86/10 87/18 87/22 89/4 91/17 98/24 99/8 102/10 105/6

W

well... [26] 108/11 108/12 110/5 110/23 112/6 112/7 112/22 114/5 114/6 114/23 115/23 118/14 122/9 122/11 122/19 123/2 125/3 125/16 126/6 126/11 127/18 128/5 128/10 128/14 131/10 131/23
went [5] 39/5 40/5 48/15 48/19 124/10
were [44] 5/11 5/12 6/11 6/17 8/16 9/8 9/9 12/2 12/15 15/13 21/7 22/2 23/4 23/5 31/20 39/11 41/15 49/5 53/2 63/9 72/3 72/4 72/4 85/13 93/5 95/9 98/7 102/12 102/13 104/21 106/11 107/16 110/7 112/22 120/22 121/22 123/25 123/25 124/5 124/14 124/20 126/4 133/4 134/8
weren't [3] 17/12 18/16 116/11
WEST [1] 2/10
what [162]
what's [13] 17/13 43/2 47/10 47/23 50/16 64/13 69/9 73/8 105/12 105/13 105/13 105/14 114/14
whatever [23] 35/9 42/7 43/4 43/5 44/12 48/18 55/4 55/8 58/7 70/22 74/22 75/4 87/23 106/10 110/23 114/23 122/10 122/11 122/18 125/13 125/19 131/11 132/6
whatsoever [2] 35/16 124/13
when [47] 7/22 11/24 16/24 18/22 21/6 24/23 25/4 26/16 27/7 34/17 45/7 57/16 60/20 64/2 71/24 72/3 72/3 72/9 74/18 74/23 81/22 81/23 81/24 82/7 82/8 82/9 83/13 83/18 86/11 89/1 89/9 94/17 94/25 95/12 96/1 96/1 111/6 111/19 118/3 119/15 124/10 126/21 127/16 127/20 128/25 129/6 130/14
whenever [3] 4/3 43/4 84/5
where [42] 10/6 14/7 21/9 31/16 31/17 31/19 32/18 32/24 33/5 33/21 62/6 71/13 74/5 74/19 80/22 81/12 81/17 82/24 89/9 89/13 89/18 89/19 90/8 95/1 95/5 97/25 98/18 100/5 102/7 102/16 102/18 102/23 103/17 106/15 110/15 111/13 111/14 113/17 114/24 127/7 127/15 127/20
WHEREOF [1] 134/13
whether [27] 9/21 30/11 45/24 46/12 46/14 50/1 53/5 53/13 68/18 70/9 71/25 72/4 72/6 72/12 72/21 77/25 78/2 78/8 78/24 79/9 79/16 85/14 100/22 102/2 120/7 122/16 131/13
which [25] 14/19 15/9 15/25 19/22 21/25 29/5 29/23 32/1 39/5 53/21 58/20 80/11 99/4 99/18 99/22 100/1 100/10 102/14 102/15 104/5 106/9 115/10 121/22 124/21 125/20
while [4] 14/9 28/21 75/15 100/2
white [1] 44/4
who [42] 14/3 14/7 14/7 14/7 15/24 33/2 39/19 48/24 48/25 51/13 52/20 59/21 61/15 65/8 65/24 66/1 66/13 66/13 67/4 67/5 69/1 69/1 69/7 71/6 78/11 78/14 81/11 83/12 83/12 88/16 89/16 89/17 94/17 98/10 98/19 110/24 111/2 115/18 116/2 118/16 123/15 125/18
who's [7] 53/17 59/4 59/21 66/12 122/15 125/8 125/21
whoever [5] 43/5 44/20 89/4 89/20 94/6
whole [9] 4/14 38/13 53/12 83/16 83/24 99/7 105/13 124/17 128/16
whom [1] 78/12
whose [1] 69/23
why [37] 15/8 24/23 25/4 27/19 35/15 36/22 44/10 44/15 45/2 45/2 47/21 66/20 81/10 86/12 91/13 92/11 92/21 92/22 94/19 96/11 97/15 97/15 100/10 114/7 120/9 120/14 124/20 125/15 126/21 127/4 127/5 127/16 128/3 131/10 131/10 131/21 131/23
wide [1] 126/24
will [21] 4/3 4/16 4/17 19/13 57/6 65/17 67/22 77/8 91/21 91/25 92/7 92/8 96/4 97/18 99/1 103/1 106/21 106/23 111/10 114/17 126/15
WILLIAMS [1] 1/19
windfall [4] 103/4 103/6 103/11 104/3
withholding [1] 12/18
within [10] 12/24 13/25 14/1 29/21 41/13 41/17 42/22 42/24 78/16 84/9
without [13] 38/12 39/15 42/6 45/21 56/12 81/1 81/21 89/10 108/3 108/9 108/17 119/3 120/6
witness [9] 62/10 65/10 68/10 69/1 91/25 92/3 110/1 115/16 134/13
witness's [2] 99/23 100/1
witnessed [1] 69/1
witnesses [10] 19/1 47/8 47/17 47/25 48/5 48/8 48/25 49/6 49/15 62/5
woefully [1] 73/24
won [1] 38/3
won't [3] 77/8 77/11 91/18
word [7] 28/1 28/1 69/11 75/16 78/25 81/6 114/12
words [2] 27/12 122/1
work [5] 26/4 77/21 110/22 125/11 125/16
worked [2] 25/25 66/3
worker's [2] 101/20 101/25
working [1] 25/10
works [1] 43/13
workup [4] 22/4 77/24 78/2 79/15
worry [2] 106/3 106/5
worth [1] 57/17
would [102] 3/16 5/4 5/19 6/8 6/14 7/2 7/5 7/7 7/8 8/2 8/3 8/3 8/3 8/9 8/21 10/13 10/15 13/4 16/6 16/7 21/15 23/23 25/18 25/19 25/22 26/22 29/9 31/12 31/22 32/6 34/15 34/21 35/4 35/14 40/20 40/20 42/12 42/15 43/17 43/23 43/24 43/24 47/19 49/9 51/23 53/13 53/21 54/6 55/12 55/13 55/23 55/25 56/2 60/23 60/25 62/25 64/14 64/14 64/18 68/6 70/11 76/15 84/14 84/15 84/16 84/25 85/16 85/19 85/20 86/20 88/8 93/11 93/12 93/15 93/16 93/22 93/25 95/14 98/2 99/8 104/1 110/1 111/11 111/17 112/8 112/18 112/22 113/4 113/24 114/9 114/10 114/11 115/2 115/22 115/24 116/1 119/5 120/13 120/25 126/19 129/25 129/25
wouldn't [10] 24/9 37/14 41/1 55/21 79/6 79/11 91/14 91/17 110/2 110/3
Wow [1] 79/23
write [7] 20/22 41/6 43/12 96/14 96/16 105/24 130/14
writes [3] 62/7 94/25 128/7
writhing [1] 63/22
writing [2] 120/23 130/17
written [8] 12/22 42/6 82/9 96/6 97/3 102/1 104/5 105/14
written-down [1] 102/1
wrong [12] 41/10 41/11 45/2 73/8 88/20 90/3 90/4 90/5 92/15 92/22 94/14 107/22
wrote [10] 80/8 94/18 107/17 115/20 116/2 116/21 123/11 123/15 123/21 131/17

X

X,Y [1] 93/18
x-rays [1] 118/25

Y

yeah [24] 3/25 5/5 11/8 19/4 29/3 36/21 47/13 57/8 57/13 60/13 66/24 69/2 69/14 72/22 73/12 74/5 74/21 80/7 84/16 84/24 88/22 113/16 127/18 132/5
year [4] 51/19 93/5 125/10 125/13
years [25] 5/11 6/19 6/21 7/7 7/16 7/19 12/25 12/25 13/25 16/1 29/12 55/4 56/6 57/20 57/25 58/2 58/7 58/18 60/6 66/8 66/9 66/9 74/4 74/9 125/6
years' [1] 57/17
yes [18] 5/13 6/3 12/5 15/11 25/8 38/24 46/3 46/22

Y

yes... [10] 47/6 61/11
63/25 67/18 68/2 85/16
107/15 109/2 112/13 117/1
yet [6] 32/5 108/4 108/19
121/12 121/15 129/7
you [406]
You -- we [1] 130/14
you're [39] 7/15 10/19
13/20 14/25 16/9 19/20
20/25 22/11 22/11 26/16
26/24 26/25 29/17 31/25
32/12 40/19 48/7 55/17
55/18 56/11 56/19 57/23
67/19 77/4 78/11 87/5 89/19
91/2 92/23 92/25 98/25 99/2
105/6 106/5 111/23 112/17
113/20 121/19 122/11
you've [18] 20/19 20/20
20/20 20/21 20/22 20/23
43/18 61/19 74/8 82/7 82/8
82/8 82/9 82/22 107/19
110/1 121/1 129/18
your [128] 3/8 3/11 4/12
5/13 6/1 8/12 9/11 9/24
10/6 10/21 13/7 17/23 18/25
20/1 21/17 22/13 25/18
26/23 27/10 27/10 27/24
29/10 30/6 33/22 33/25 34/7
34/14 35/5 35/15 35/25 36/2
37/8 37/19 39/2 41/3 42/1
44/11 47/23 48/3 49/11
50/21 52/2 52/14 54/7 54/12
54/25 56/14 57/2 58/10 59/5
59/23 61/7 61/11 62/24 63/7
64/16 64/25 67/15 68/21
70/25 71/23 72/9 73/10
73/19 73/23 74/8 74/25 75/3
75/14 77/7 77/8 78/5 79/21
80/6 80/18 80/21 81/14
82/21 82/24 85/2 87/11 88/7
88/18 90/9 90/18 90/24 91/5
94/7 95/9 95/14 95/16 96/4
97/5 97/9 97/13 99/1 101/2
101/16 109/14 109/25 110/1
110/5 112/6 112/15 114/13
114/16 114/19 115/3 115/12
117/24 118/8 119/5 119/10
120/1 120/23 121/24 126/18
130/4 130/19 130/22 131/16
132/9 132/12 132/13 132/13
132/18 132/23 132/23

Z

zero [2] 32/4 32/6
Ziegler [6] 22/1 77/18 79/9
89/4 89/21 90/3

obtain, then any suggestion that they only have the records that she provided, creating the inference that there are other records out there but they just didn't have the chance to review them, would be inappropriate. And that's what that's designed to prevent.

THE COURT: Okay.

MR. JAFFE: Your Honor, I think that this is an improper motion to be offering with such a broad stroke because of the fact that --

THE COURT: You said that in response to all of them.

MR. JAFFE: Well, that's right, because these motions are very broad in general, and half of them are just basically saying, "Let's enforce the rules of evidence and let's enforce the rules of civil procedure."

THE COURT: We're going to do that.

MR. JAFFE: And I'm all in favor of that. That's perfect. But the point of this is you need to give us something specific, what you're looking for in these motions in limine. And this entire omnibus motion is nothing but a broad-stroke application of law rather than an attempt to exclude something specific.

Now, here's the problem, Judge: This lady was treating medically within the years prior to this

10:49:55 accident, within the months prior to this accident.
10:49:59 And it's my belief that there are some of her doctors
10:50:02 who have not seen some pertinent medical records. And
10:50:06 to sanitize this trial by now trying to say, "Well,
10:50:09 guess what, you can't point out that they never see
10:50:13 these -- saw these records, and if -- I don't know
10:50:16 who -- who got records from who. I don't know where
10:50:20 they got them. I don't know how they got them."
10:50:22 While I may not necessarily sit up there and
10:50:24 say, "Isn't it true that Plaintiff's counsel never
10:50:28 provided you with these records," as opposed to saying,
10:50:30 "Isn't it true that you never saw these records." And
10:50:32 if he says, "Well, if I got the records from the
10:50:34 plaintiff, and if I didn't see them no, I didn't see
10:50:36 them," well, that is appropriate.
10:50:39 That goes to issues such as causation. It
10:50:43 goes to issues such as damages. It goes to issues such
10:50:46 as apportionment. It goes to issues as to what
10:50:51 injuries are truly there and the extent to which they
10:50:55 may have preexisted.
10:50:56 Now, the records are going to be offered. The
10:50:58 records are going to be in the case. If doctors
10:51:00 haven't seen it, oh, well, then they've got to live
10:51:03 with that.
10:51:04 THE COURT: You're not going to ask questions

about doctors about records that you don't know about, right?

MR. JAFFE: Of course not.

THE COURT: I think -- I think that's what he's trying to prevent.

MR. JAFFE: Well, I hope that's what it is, but in Mr. Cloward's argument, he offered it in a much broader sense than that. And that's why I have trouble with motions in limine of this type, which are painted with such a broad stroke.

If he's going to sit here and say that, "Yes, the records I don't want Mr. Jaffe talking about are the records we were never able to obtain from these prior accidents that nobody has got," I agree with that. Because if I don't have those records -- but I think it's also fair to point out that we've got this prior accident, we've got these injuries to the same body part, and that nobody saw these records, and because that applies --

THE COURT: They don't exist anymore.

MR. JAFFE: Well, either they don't exist anymore or nobody was able to find them. I believe that there was some issues about recollection regarding who the treating doctors may very well have been, which, you know, given the fact that these accidents

happened 20 years before, that's to some extent understandable.

But to -- I think what needs to be -- the fair application is that nobody may have seen them. And with -- I think it's important for the jury to know that, that the doctors would have liked to have seen them. All of us would have. But given the time, and the loss of --

THE COURT: You're not going to imply that that's somehow the plaintiff's fault, that nobody gets to see them, right?

MR. JAFFE: No. No. I'm not suggesting --

THE COURT: That's what he's concerned about.

MR. JAFFE: As long as that's the limitation, that's fine. Because -- but if the way that argument was just phrased, was seeming to include records that we do have that doctors may not have seen or been provided, or that experts may not have seen or been provided, then that is fair game to point out.

THE COURT: I agree.

MR. JAFFE: Thank you.

MR. CLOWARD: One thing that I want to point out is that the discussion of the prior treatment almost created the inference -- and when I listened to it, it created the inference that it was for neck and

back issues. That's what -- exactly what we're trying to prevent from happening. The treatment that she had prior to the crash had nothing to do with her neck and back; had to do with chest pain.

So that right there is the type of -- the type of thing we're trying to prevent is that, "Hey, look, you know, she has an obligation to turn over documents." We have to rely on what she gives us. And unfortunately, you know, this is all we have. But, you know what, there might be some more stuff out there. There might be some other records out there that we weren't provided.

That's what's inappropriate. Because she has an obligation --

THE COURT: He already said he's not going to talk about records he doesn't know about.

MR. CLOWARD: Well, I mean, if -- and if he's not going to do that, then I -- I think that just needs to be clear that, you know -- because that seems to slip out in all the trials that I've had, that there's always the argument --

THE COURT: Here's going to be the ruling.

MR. JAFFE: Your Honor, may I clarify one point based on the more specifics that Mr. Cloward just referenced?

10:54:25 THE COURT: Sure.
10:54:26 MR. JAFFE: They're -- they're trying to paint
10:54:28 as one incident that happened a few months before this
10:54:32 incident as a heart issue. My experts are talking
10:54:35 about it as a neck issue. And my experts have rendered
10:54:40 opinions to that effect. It's in the records, and
10:54:43 we're not agreeing that it is a cardiac issue.
10:54:47 THE COURT: Okay.
10:54:48 MR. JAFFE: So that's now getting to the heart
10:54:50 of really what I was concerned about and I think what
10:54:54 was the veiled reference in the initial argument made
10:54:58 by Plaintiff's counsel.
10:55:00 THE COURT: Okay. So the order is going to be
10:55:01 this: You can't talk about records -- you can't
10:55:04 suggest that there are records out there that nobody
10:55:06 knows about. Okay. You said you weren't going to do
10:55:11 that anyway.
10:55:12 MR. JAFFE: Right.
10:55:19 THE COURT: And so, I guess, in that -- the
10:55:22 motion is to preclude suggesting to the jury that there
10:55:25 might be related medical records prior to the subject
10:55:28 crash, when there are none. Well, if -- I don't want
10:55:32 you to make up arguments about records that don't
10:55:34 exist.
10:55:35 If there are records that exist, and your

10:55:39 experts are going to talk about them, the witnesses are
10:55:41 going to talk about them, we talk about them.
10:55:44 MR. JAFFE: Fair enough.
10:55:45 MR. CLOWARD: I think that's fair. Yeah.
10:55:49 THE COURT: These are easy.
10:55:50 MR. JAFFE: I agree, Judge.
10:55:51 THE COURT: No. 3: You want us to preclude
10:55:54 Defendant from referring to the case as an
10:55:56 attorney-driven litigation or medical-buildup case and
10:56:00 precluding any statements insinuating that Plaintiff
10:56:03 sought treatment at the direction of the attorneys or
10:56:05 because of this litigation.
10:56:09 Plaintiff says it's anticipated Defendant will
10:56:11 argued that Plaintiff's attorneys directed the medical
10:56:14 care and that Margie's physician performed unnecessary,
10:56:18 unwarranted, and non-indicated medical procedures.
10:56:20 Well, that's what their experts say, that the treatment
10:56:24 was unwarranted and did didn't have anything to do with
10:56:26 this accident.
10:56:27 So I think you're right. I think that's what
10:56:29 they're going to say because they have an expert report
10:56:32 that says that, which is Schifini that said that or
10:56:35 somebody else?
10:56:36 MR. SMITH: Siegler and Schifini both I think
10:56:40 make -- and Villablanca as well.

10:56:45 MR. CLOWARD: I mean, your Honor, Schifini --
10:56:47 if you get his reports --
10:56:49 THE COURT: I know there's more motions about
10:56:50 Schifini later on.
10:56:51 MR. CLOWARD: I've got about, you know, 50 of
10:56:53 his reports, and it's the same thing every single time.
10:56:56 Literally. I've got them. I'll produce them, if you
10:56:59 want.
10:56:59 She left the scene of the crash in an
10:57:03 ambulance, so obviously she was -- she was injured.
10:57:09 You know, they're -- they're trying to hire a doctor
10:57:12 saying, "Hey" -- or their doctor, Schifini, says that
10:57:16 it's all attorney driven, and he says that in every
10:57:19 single case.
10:57:20 So either she's going to the doctors and she's
10:57:23 complaining of subjective complaints that she is flat
10:57:25 out lying at the direction of her attorney. I mean,
10:57:28 that's -- that's really what the suggestion is, is that
10:57:32 I'm saying to her, "Hey, Margie, you've got to go and
10:57:36 you've got to tell Dr. So-and-so that you've got pain,
10:57:39 5 out of 10. You've got a complaint of neck pain.
10:57:42 You've got to write on this diagram the pain here and
10:57:45 the pain there. Even if it's not true, you've got to
10:57:47 tell the doctors that. Because, you know, we know that
10:57:50 you're not hurt, but we're just trying to build this

10:57:52 case up."
10:57:53 I mean, that's really what -- what it boils
10:57:55 down to. There's no evidence of that. Absolutely
10:57:57 none. There's no evidence that she wasn't actually
10:58:01 injured, that she didn't have subjective complaints.
10:58:04 When she was deposed, she testified that -- what her
10:58:07 complaints were. And so to try and create that
10:58:10 argument, there's no factual underpinning.
10:58:12 I've had a case that I've seen where, you
10:58:16 know, there was a note in there that said something
10:58:19 along the lines, you know, attorney called and told the
10:58:22 client to do X, Y, and Z, or something along those
10:58:25 lines. That's evidence of attorney-driven medical
10:58:27 care. You know, my understanding is there's none of
10:58:29 that in this case, and so it would be inappropriate to
10:58:31 allow that in.
10:58:34 MR. SMITH: Just to respond to that, your
10:58:35 Honor. That -- that's significantly beyond what their
10:58:39 motion, you know, is seeking to preclude. Their motion
10:58:43 seeks to preclude all references to this as
10:58:46 attorney-driven litigation or medical buildup.
10:58:48 In our opposition, we say we're not going to
10:58:50 refer to this as medical buildup or attorney driven.
10:58:53 But what we don't want this motion to do is to preclude
10:58:55 our experts from sharing their opinions, which are,

according to Dr. Ziegler and Dr. Schifini, some of the treatment or the surgeries that she received were not medically indicated, based on the prior diagnostics and the pain management workup to that point.

So we're not going to refer to this as an attorney-driven case. We're not going to refer to the medical buildup. What we don't want is for our experts to be precluded from sharing their opinions based on the records and the information that they've reviewed.

THE COURT: So it sounds like -- sounds to me like you're stipulating you're not going to refer to it as attorney-driven litigation or medical buildup, but you want your doctors to be able to talk about the fact that their opinion is that the treatment wasn't necessary.

MR. SMITH: Correct. If there's some note somewhere that says, you know, an attorney was centered to this decision, you know, they certainly can comment on that. But otherwise we're not going to concoct that.

THE COURT: Okay.

MR. SMITH: But we want to make sure that our experts are able to share the opinions that, you know -- that they have based on the medical evidence.

THE COURT: And their opinions aren't that

there was attorney-driven litigation. Their opinions --

MR. SMITH: That's not an opinion I've seen. Their opinions are that the surgeries that were received were not medically indicated based upon the treatment received prior to that.

Now, if they want to -- I mean, they're scared that we're going to, you know, hop on that and say, you know, "So this was attorney driven."

You know, the jury can infer what, you know, they want to infer from the evidence. If the jury finds that that is somehow attorney driven, that's up to them. I'm not going to ask the question, you know, "Was this attorney driven?"

THE COURT: Okay. So motion is granted.

MR. CLOWARD: Okay. But I wanted to make the clarification that -- I think there's a difference. If there's -- if there's an attorney referral, if it says referred from Mr. Cloward or referred from Harris Law Firm, that's different than -- and I think that there, you know, they want to leave the door open to make this argument down the road, and I want to make sure that we're very clear going into it that that would be a different type of an argument than an actual attorney-driven argument.

11:01:04 Because attorneys refer clients to doctors all
11:01:07 the time. That doesn't mean that that -- that that's
11:01:11 attorney driven. And so, you know, they made the
11:01:15 caveat that, "Well, if there's a note somewhere that
11:01:18 says referred by, you know, Harris Law Firm, and we
11:01:22 want -- we want to be able to discuss that," I agree if
11:01:25 there's a note that says, "Hey, Harris Law Firm says to
11:01:29 do X, Y, and Z," that's more attorney driven. But if
11:01:32 it's just referred by, that wouldn't open the door.
11:01:36 I just want to make sure we're clear on that.
11:01:38 THE COURT: I think if there's a note that
11:01:39 said client was referred to somebody by Harris Law Firm
11:01:41 and they ask about that, I think they can ask about
11:01:44 that. I don't know that that necessarily implies
11:01:46 attorney-driven litigation either. Just means that the
11:01:53 client was referred by an attorney to a doctor.
11:01:55 MR. CLOWARD: Okay.
11:01:55 THE COURT: So the motion is granted because I
11:01:56 don't think there's an issue. They're not going to
11:02:00 talk about attorney-driven litigation or medical
11:02:03 buildup case, so it's granted. Easy.
11:02:07 No. 4: "Plaintiff wants to preclude reference
11:02:10 to Plaintiff's retention of counsel, when and why
11:02:14 Plaintiff retained counsel."
11:02:15 I have a note here: "Defendant does not

oppose, but this doesn't extend to all secondary gain arguments."

I mean, secondary gain is a totally different issue in my mind. So retention, when and why Plaintiff's counsel was retained, motion is granted.

Fair enough?

MR. SMITH: Fair enough.

MR. CLOWARD: Yes.

THE COURT: No. 5: "Plaintiff wants to preclude reference as to Plaintiff's counsel working with Margie's treating physicians on other unrelated cases. "

And I think the defense says that that raises an issue of bias on the part of the doctor so they should be able to allow that, they should be able to ask about that.

You want to argue it, put it on the record?

MR. CLOWARD: No, your Honor. We would -- we would rest on the brief.

THE COURT: Okay.

MR. CLOWARD: I mean, obviously, it's -- it would be a both-way argument, so.

MR. JAFFE: And I agree because obviously plaintiffs routinely ask experts hired by the defense "How often have you worked with Mr. Jaffe or his law

firm, how many times have you testified," things of that nature.

If doctors have referral relationships and have done work with referrals from attorneys on the plaintiff's side, I think it's just the flip side and it's equally fair game.

THE COURT: I think it's relevant on both sides.

MR. JAFFE: Thank you, sir.

THE COURT: Motion is denied.

MR. CLOWARD: Fair enough.

THE COURT: No. 6: Plaintiff wants to exclude closing -- it says "Closing arguments must be limited to evidence presented at trial."

I agree with that. I think it applies equally to both sides. When you're arguing something in closing, it definitely needs to be based upon the evidence that was presented at trial. You can't make stuff up.

MR. CLOWARD: Thank you.

THE COURT: Okay.

I would also just ask you, during opening statements, that you limit your opening statements, not to argument, but what you're going to present during trial and make sure you're actually going to present

that evidence during trial.

Next one is No. 7.

THE COURT CLERK: No. 6.

THE COURT: No. 6 is granted as to both parties.

No. 7. You want to exclude anything suggesting abuse of narcotic pain medication when there is none.

Now, I think from reading the motion that -- I think, Mr. Cloward, your motion says your client was prescribed some narcotic pain medications as part of her treatment. You just don't want words like "addiction" or things like that to be used to imply that she's some kind of a druggy.

MR. CLOWARD: Essentially, or that the inference be that, "Hey, she's only seeking this treatment because she's hooked on pain meds. She doesn't really need it, you know. She's, you know, just wants the medications. That's why she's doing the treatment."

There's no evidence of that. That's what we're trying to prevent.

THE COURT: Okay.

MR. SMITH: And, your Honor, I think our opposition says pretty much that. You know, we're not

11:05:41 going to use the "abuse" word or the "addiction" word.
11:05:46 But at the same time we can't be precluded from
11:05:50 introducing evidence that shows that she was prescribed
11:05:52 narcotic pain medication for prior injuries and that
11:05:54 she was prescribed narcotic pain medication for
11:05:58 injuries sustained in the subject accident.
11:06:01 THE COURT: I don't think he's trying to
11:06:02 exclude that.
11:06:02 MR. CLOWARD: No.
11:06:03 MR. SMITH: Fine.
11:06:04 THE COURT: Okay. So the motion as it's
11:06:05 phrased is going to be granted. I think you can get
11:06:11 into those things and that's not really going to be an
11:06:13 issue.
11:06:15 No. 8: "Allowing voir dire questioning
11:06:18 regarding tort reform exposures."
11:06:20 It's funny because sometimes you see these
11:06:26 questions that you want to allow that, sometimes you
11:06:27 don't want to allow that. Let me see.
11:06:35 The defendant's issue with this one, if I look
11:06:38 at page 12, says "While Plaintiff may be entitled to
11:06:44 question jurors to their exposure to and knowledge of
11:06:47 tort reform literature, the Court should also ensure
11:06:51 that such questioning should not go beyond the purpose
11:06:53 of voir dire and become an attempt to emphasize that

11:06:56 the defendants are covered by liability insurance."
11:06:58 I totally agree with that.
11:07:00 MR. CLOWARD: Yeah.
11:07:01 THE COURT: I think if we're going to ask
11:07:02 about tort reform, which I think is probably a valid
11:07:05 question of jurors, you can't use it to talk about
11:07:09 insurance, and you can't use it to imply that the
11:07:12 defendant has coverage.
11:07:13 MR. CLOWARD: We would absolutely agree.
11:07:15 MR. JAFFE: Well, your Honor, I also need to
11:07:16 point out, there was a fairly recent decision by the
11:07:19 Supreme Court, I want to say it was about two years
11:07:21 ago. I believe it's the Hardwick decision, and in that
11:07:24 the Supreme Court addressed generally that they do not
11:07:28 want jury selection to get into highly politicized and
11:07:34 politically-charged issues such as tort reform.
11:07:38 And that's the concern, is that what you're
11:07:42 really doing is trying to politicize the courtroom and
11:07:47 make general and broad charges as a means of trying to
11:07:53 impassion a jury over something that has no place
11:07:56 within this particular trial.
11:07:58 This is not a trial that should be about tort
11:08:01 reform. This is not a trial which should be about
11:08:05 insurance liability, obviously. But politicize the
11:08:09 issue such as tort reform have -- there's no reason to

bring it up. There is no basis for it because this is a car accident. This is not a tort reform issue. And to start trying to politicize it that way is exactly what the Supreme Court does not want us doing versus -- in voir dire.

So, your Honor, we believe that tort reform shouldn't even be brought up. There's no reason to bring it up in this case.

THE COURT: I think it's -- I think it's an issue that probably should be addressed in every jury trial, to determine whether or not a prospective juror has biases either for or against tort reform issues, if they think that -- I mean, I can tell you, in just about every jury trial I've done, there's been at least one or more potential jurors that say, "I don't like the issue. I don't like awarding pain and suffering. I don't like that idea. I don't like" -- or some people think that every case should have a cap or no case should have a cap.

I think -- I think those are issues that you guys want to know. I think both sides want to know those. So I'm going to allow those questions.

So voir dire questioning regarding tort reform, I think it's important and I think it's important for both sides. I understand the question

about politicizing trials and I think you can ask these kind of questions in a way that doesn't get into the politics. But just asks what the views are as it relates to certain issues.

So I'm going to allow it. Motion is granted.

No. 9: "Allowing voir dire questioning regarding verdict amounts."

Now, I think the judges here in the -- in this building are split on this. I'll tell you, ordinarily my preference is -- I think it's EDCR 7.70 says that you can't ask jurors about what their verdict would be based upon specific hypothetical facts.

And I agree with that. I'm going to enforce that rule. But the way that I've seen it happen in other trials where I think that it complies with the rule is where an attorney asks the jury, "At this point you don't know any facts, based upon the fact -- based upon the situation where you don't know any facts at all about this case, if we told you we were going to ask at the end of trial for a number more than $1 million, how many of you would have a problem with that?"

Okay. And the fact -- and I think that that complies with the rule because you're not basing that

question on specific hypothetical facts, which the rule precludes.

And equally, I mean, you can ask the same question with a zero, you know. "Based upon the fact that none of you know anything about this case yet, how many of you would have a problem with a zero."

I think those are appropriate questions because they're not based upon specific facts.

Now, if you want to argue contrary, go ahead.

MR. JAFFE: Certainly, sir. I think the minute you start putting any dollar figure out there, you're inviting jurors to start commenting upon dollar figures and then it becomes a slippery slope. Because if a juror starts to, "Well, you know, I agree that a million is a lot of money, but 5 million is too much money." It's inviting, "Well, how about 10 million, 20 million, 50, 200 million, 500 million?"

And that's where it becomes a problem. Because the minute you open up that door to allow a dollar figure, you don't know what the people in the box are going to say and it creates that slippery slope. And it's inviting those issues. And it's inviting those discussions.

And that's where Rule 7.70 becomes a big concern. And that's exactly what I believe that local

11:12:15 rule is designed to prohibit. And especially because,
11:12:19 you know, who is to say what that initial figure is.
11:12:23 Mr. Cloward may say, "We're going to ask for 5
11:12:25 million or 3 million or 10 million." It still invites
11:12:30 a discussion about numbers. And that's where I believe
11:12:33 it is a problem. Again, to get back -- it's a slippery
11:12:37 slope and invites follow-ups, and it invites
11:12:41 discussions. And it goes well beyond at that point
11:12:44 what Rule 7.70 allows.
11:12:47 So we believe that there shouldn't be any
11:12:49 discussion.
11:12:49 THE COURT: I think if an attorney says I'm
11:12:51 going to ask for a specific number, it does violate the
11:12:55 rule. But I think if an attorney asks, "We're going to
11:12:58 ask for a number greater than $1 million," or "We're
11:13:03 going to ask for a number greater than $100 million," I
11:13:08 think -- I don't know that that's bad.
11:13:13 I agree with you that it invites the jury to
11:13:15 start talking about numbers, and sometimes that's a
11:13:18 good thing.
11:13:19 MR. JAFFE: I've never seen a situation where
11:13:21 it's a good thing, your Honor.
11:13:22 THE COURT: I think it can be. Because I
11:13:24 think we -- I think both parties have an obligation on
11:13:28 the part of your clients to weed out the jurors that

11:13:31 have preconceived biases and prejudices, and even -- if
11:13:35 those biases and prejudices are based upon numbers and
11:13:39 you have somebody that says, you know, "I don't care
11:13:42 what the facts are, there's no way I'm going to award
11:13:45 anybody over $100,000," okay. Plaintiff needs to know
11:13:49 that.
11:13:50 And if you have -- equally on your side, if
11:13:52 you say "I don't care what the facts are, I think
11:13:56 Plaintiffs are entitled to money and I'm never going to
11:14:00 award anybody less than $10,000 because, you know, the
11:14:03 complaints says in excess of $10,000, I'm never going
11:14:06 to award anybody less than $10,000." You need to know
11:14:09 that.
11:14:10 MR. JAFFE: Your Honor, but I think the
11:14:11 problem is, as much as I would like to know it, I think
11:14:14 that's exactly what Rule 7.70 says we cannot know.
11:14:18 That's my concern. And especially when it starts
11:14:21 inviting the follow ups or the discussion. I think all
11:14:24 of that is exactly what Rule 7.70 is designed to
11:14:27 prevent.
11:14:28 And I agree with you. I would love nothing
11:14:30 more than to have a juror sit there and say, you know,
11:14:32 "Mr. Jaffe, I'm pissed off about this system. I'm
11:14:36 upset about this, and I don't think anybody should be
11:14:38 allowed more than their medical bills, period. I don't

like pain and suffering awards. And if it is $100,000 in medical bills, then I'm not going to award more than that."

I would love nothing more than to hear that. But, your Honor, under Rule 7.70, I'm not entitled to hear that. And just as Mr. Cloward wants to hear them say, "Boy, you know what, I'm really sick of the little guy getting screwed and these insurance companies are this and that and whatever," because it's inviting those discussions, "and give them a million bucks. Give him $5 million. You put up the number you want, and I'm going to vote for it."

That's exactly what Rule 7.70 says we can't have, as much as Mr. Cloward would like to see it. So that's why, your Honor, I suggest there should be no discussion whatsoever about any dollar figures, because it just invites trouble. And it's that slippery slope. And it -- there's no good that's going to come from it, other than to invite a violation of that rule.

THE COURT: No, I disagree.

I think 7.70 is specifically limited to questions based upon specific hypothetical facts. And as long as you don't use specifical hypothetical facts, I think 7.70 doesn't restrict that. And I think that that's important to allow you to use your challenge for

cause.

MR. JAFFE: Then, your Honor, may I ask for clarification --

THE COURT: Sure.

MR. JAFFE: -- because again my concern is not that -- well, my concern is the initial question. But my greater concern is the follow up. I mean, how far --

THE COURT: You can ask follow ups, as long as it's not based upon specific hypothetical facts or specific facts in this case.

MR. JAFFE: So if Plaintiff says, "Okay. We're going to be asking for more than $1 million at the end of the day. How many people are offended by that?" If he says, "What if I told you we're going to ask for more than $5 million, how many are going to be offended by that?"

And 10 million. And keep pushing that number Use one number.

MR. JAFFE: One number one time and that's it.

THE COURT: And then if somebody says, "Yeah, that offends me." Then you can say "Why?"

And they'll tell you what their thoughts are. You can follow-up on that but --

MR. JAFFE: But the follow-up can't be start

saying, "Okay. What if it was a half million or 2 million or 10 million?"

Just different numbers. Just the one time, one number.

THE COURT: That's how I've seen it.

MR. JAFFE: Okay. Because that's --

THE COURT: We'll see how it plays out.

MR. JAFFE: Okay. That's fine, your Honor. Because that's really -- that's my concern.

THE COURT: I think it's important to allow people to question about verdict amounts because honestly, Mr. Jaffe, I think it's going -- I think allowing that question is going to allow you to probably use challenges for cause that you wouldn't otherwise have been able to use.

MR. JAFFE: The problem is that once certain things are out, and it can potentially poison an entire jury panel, then what it opens up is a challenge to the entire panel, your Honor.

MR. CLOWARD: And there's plenty of studies. I've read Mr. Eglet's numerous briefs on the issue. That's --

THE COURT: Well, don't bring him up.

MR. CLOWARD: But that doesn't happen. You don't publish -- you don't poison the well. People

come in with their preconceived ideas, and if I don't like, you know, pie --

THE COURT: You already won. Sit down.

MR. CLOWARD: Thank you.

THE COURT: Motion is granted.

MR. CLOWARD: I just like to hear my own voice, Judge. You know that from prior cases.

THE COURT: All right.

No. 10. You want to permit treating physicians to testify as to causation, diagnosis, prognosis, future treatment, and extent of the disability without a formal expert report.

This is getting into the whole 16.1 changes. You make a point saying "Expert reports are not required by treating physicians." We know that.

And I think the defense's argument is they're not identified as experts, should not be able to testify beyond the scope of their clinical treatment. I think defense cites to 16.1(a)(2)(a), talks about disclosure of expert testimony.

And then you cite to Commissioner Beecroft and Commissioner Bulla's recent discussion about the amended rule. Right?

MR. JAFFE: Yes, sir.

THE COURT: This is kind of a squishy issue.

11:19:14 Go ahead, Mr. Cloward. Convince me.

11:19:16 MR. CLOWARD: Well, your Honor, I mean, this
11:19:18 is -- this is something that only recently became a
11:19:22 problem with the Ninth Circuit case. I believe it was
11:19:25 outs of the Arizona District, which went up to the
11:19:29 Ninth Circuit. And that was I believe a 2011 case.
11:19:33 Based on that case, in order to get the -- our
11:19:36 rules in harmony with the federal rules, the Supreme
11:19:40 Court was petitioned and 16.1(a)(2) was amended. And
11:19:46 the amendment was discussed by Commissioner Bulla,
11:19:48 Commissioner Beecroft at the NJA, I believe you were
11:19:53 there.
11:19:53 And the important addition to this rule is
11:19:58 that a treating physician can talk about those things
11:20:03 without a report. And not only can they talk about
11:20:07 their treatment, but they can also talk about things
11:20:10 outside of their treatment if it's in defense of their
11:20:13 own opinion.
11:20:14 So, for instance, if you have Dr. Muir who
11:20:17 does a surgery and Dr. Schifini says, "Well, you know
11:20:20 what, Dr. Muir, the surgery that you did or that you
11:20:23 provided was inappropriate because, you know, you
11:20:26 didn't have the patient do a successful course of
11:20:29 physical therapy. They didn't, you know -- they didn't
11:20:33 fail physical therapy."

Dr. Muir can then look at things outside of his treatment in defense of the treatment he did. He can look at the physical therapy. He can look at the chiropractic. He can say, "Well, actually I disagree, Mr. Jaffe, with Dr. Schifini because the patient went and did this treatment, this treatment, this treatment, didn't have any success. Based on the non-resolution of the symptoms, they required to have a surgery."

That's the important part of the -- of the additional amendment, is that doctors can look outside and that the amendment specifically states, and I brought the amendment, the order, the Supreme Court order. It talks about how treating physicians can, and the designation of, you know, making them an expert or a non-expert, that just means are they an expert as designated by 16.1 in the initial expert designation. That doesn't mean they can't come in and give their expert opinions regarding their care and treatment.

I mean, if you're to accept their argument, then that would mean that you would have to designate any and all treating providers in every single case in Nevada. I mean, you have to designate them as an expert pursuant to 16.1 in every single case. Otherwise, they don't get to come in and tell the jury about the treatment that they rendered. That just --

11:22:02 that wouldn't make any sense.
11:22:05 THE COURT: Okay.
11:22:07 MR. JAFFE: Your Honor, the change in the rule
11:22:10 is so that the doctors can come into court, talk about
11:22:14 their treatment, talk about their opinions related to
11:22:17 the treatment, and not have to write a report doing so.
11:22:20 It does not give them carte blanche to say anything and
11:22:24 everything about the case and about the plaintiff.
11:22:28 It doesn't give them the right to come in and
11:22:30 say Dr. Schifini is wrong about this. Dr. Villablanca
11:22:34 is wrong about this. Dr. So-and-so.
11:22:38 It gives them the right to talk about their
11:22:40 opinions and to defend their opinions as stated within
11:22:43 their clinical chart and in their records, and if they
11:22:45 were deposed in those depositions. But to then start
11:22:51 rebutting experts, that is -- the hired and retained
11:22:54 and designated experts, that is not within the rule.
11:22:58 THE COURT: That's actually a different
11:22:58 motion, isn't it?
11:22:59 MR. JAFFE: Pardon me?
11:23:00 THE COURT: I think that's actually a
11:23:01 different motion.
11:23:02 MR. JAFFE: And I think it kind of dovetails
11:23:04 in because -- and I think this is one of those that
11:23:06 sort of gets into that entire issue. And that is

another motion, your Honor, because that is one of the motions that we've set.

But I think that by and large, that's exactly what the plaintiff is looking for here, is the flip side, to allow their doctors to come in and have carte blanche without having written a report or given any opinion in advance to the defense to say whatever they want on the basis that they're a treating doctor. They don't have to do it, and that they have the carte blanche. And it's not what the Court rules say.

I mean, if we're going to read that much into it, that would be a complete violation of our due process rights, of not knowing what somebody was going to say, state with an expert opinion behind it in court, so that our experts and doctors would have had an opportunity to rebut it and address it. That is not a fair reading of that rule. And I have -- the rule is stated.

Listen: We'll abide by it, but what it means is that the doctors can come into court. They can talk about their opinions, and their treatment, and their prognostications as stated within their chart. But they can't go beyond that. They can't start coming up with new opinions that haven't been stated within their chart.

11:24:18 If -- because there has to be some fair notice
11:24:21 to the other side about what's going to say. You can't
11:24:23 sit here and just put a doctor up as an ambush to say
11:24:27 whatever he wants, however he wants, whenever he wants,
11:24:29 whatever he wants about whoever he wants simply because
11:24:34 he's a treating expert. He's a treating doctor. He's
11:24:37 hands off. You can't apply that.
11:24:38 That's an unfair extrapolation of the rules
11:24:41 and an unfair expansion of the rule, and it certainly
11:24:44 is not a fair interpretation. It does -- and it
11:24:47 violates our client's due process rights. The doctors
11:24:51 don't have to write reports because their clinical
11:24:54 chart works in that place. That's what they need to be
11:24:57 held to.
11:24:58 MR. CLOWARD: To simplify this, I agree with
11:25:01 99 percent of what Mr. Jaffe just said. I don't think
11:25:04 that it would be appropriate for Dr. Muir to -- let's
11:25:07 just say you've got Dr. Muir and, you know, maybe
11:25:11 two -- let's say Dr. Muir does the neck and Dr. Kaffcan
11:25:15 does the back.
11:25:16 I don't think it's appropriate for Dr. Muir to
11:25:18 come in and comment on maybe their expert's criticisms
11:25:24 of Dr. Kaffcan. That would be inappropriate. That
11:25:27 would be unfair. That would not be contemplated by the
11:25:31 rules.

However, the rule specifically states that a treating physician is allowed to discuss opinions in defense of the treatment that he rendered. That's the -- the rule is black and white. That's what it says.

So they want to shackle Dr. Muir or Dr. -- or the treating physicians in this case, they want to say, "Hey, Dr. Muir, you did X, Y, Z. Schifini says you shouldn't have done any of that treatment, but you know what, you don't get to talk about why you did it and defend your treatment. You just have to sit there and take it. You just have to say that whatever Schifini says is right, and you don't get to comment upon that."

That's just not true and that's not fair to Dr. Muir. And that's specifically why it was amended to say that they get to discuss other things in defense of their treatment. And I agree that it's not fair to allow a doctor to come up and talk about anything and everything under the sun, to give Dr. Muir all the records, or Dr. Kaffcan, whoever, all, the records and say, "Hey, I want you to criticize this guy. I want you to criticize this guy. I want you to criticize this guy."

But if Schifini offers an opinion in criticism of Dr. Muir as a treating physician, Dr. Muir

absolutely 100 percent gets to get up there and talk about why that's wrong and why he gets to defend his treatment. That's what the rule says.

THE COURT: Okay. Here's what we're going to do: As it relates to this motion, I'm going to -- I'm going to actually keep the comments about other experts in the rebuttal issue for when we get to those specific motions. Okay?

MR. CLOWARD: Okay.

THE COURT: As it relates to this one, my ruling has always been a treating doctor can testify about anything that's in his chart, anything that he testified in deposition to, anything as it relates to his care and treatment of the patient.

You can't give a treating doctor a stack of records just before trial and tell him you want him to testify about everybody else's care or treatment. Okay? If the records are part of his file at the time he was treating the patient, he can talk about them. But you can't turn a treating doctor into an expert without identifying him as an expert. Okay?

I think that addresses this motion.

Now, I know that we have other motions as it relates to whether or not the treating doctors can act as essentially a rebuttal expert to the other experts,

and I think we get to -- we'll get to those in a minute.

MR. JAFFE: Yes, sir.

THE COURT: Fair enough?

So this one, as it relates to permitting the treating doctors to testify as to causation, diagnosis, prognosis, future treatment, extent of disability, if that's part of their care and treatment of the patient, if those are opinions that they formed during the care and treatment of the patients, I'm going to allow that. Okay. That is going to be granted.

Because whether you took their depositions or not, if that was their opinion and that's part of their care of the patient, that's their opinion. Whether it's in their reports or not. Okay.

And it may not be in the report and you may not have asked the question during deposition. If they have the opinion and they say that they formed that opinion during their care and treatment of the patient, I'm going to allow it.

Fair enough?

MR. JAFFE: Yes, sir.

THE COURT: Okay. So that one is granted, consistent with what I just told you.

Before we go on to the next one, do we have

detectives here that need to talk to me?

(Brief pause in proceedings)

THE COURT: All right. Let's go back on the record. All right. So I think our next one is -- there's a lot of these. We at No. 11?

MR. JAFFE: Yes, sir.

THE COURT: "Precluding negative inference for failing to call cumulative witnesses."

THE COURT CLERK: Omnibus motion.

THE COURT: What's that?

THE COURT CLERK: We're still on the omnibus motion?

THE COURT: Yeah.

So basically, if I understand this correctly, Mr. Cloward, you don't want the other side to be able to say, "Even though the plaintiff called four of their twelve witnesses, the fact that they didn't call the other eight of their twelve treating doctors, that means that they would have said something different"?

MR. CLOWARD: Exactly. Like, you know, are they trying to hide something, why didn't they bring all their doctors, that kind of a thing.

THE COURT: What's your argument, Mr. Jaffe?

MR. JAFFE: If you tell the jury they're going to be calling certain witnesses and they don't, that's

fair game No. 1.

No. 2, there was an issue early on in this case, your Honor, that was a concern then, and it remains, I guess, to some extent a concern now. They had initially designated 70 before-and-after witnesses. And we sent them a letter basically saying, "Come on. I mean, if you're planning on calling 70 before-and-after witnesses, one of two things is going to happen. Either A, I'm going to depose all 70 and I'm going to ask for fees and costs for each one that you don't call. Or B, I'm going to have to move in front of the discovery commissioner to limit you to the ones."

They knocked it down to nine, nine or ten or eleven, something like that. We went out and deposed every single one of them. And now if they're going to, you know, say, "Well, now we're only going to call three or four, or whatever," given the fact that we went out and deposed all those people based on their representations, either that's going to have to be a fair opportunity for me to comment upon that, or I'm going to, you know, seek other relief later down the line. I guess, by and large, it's going to come down to who they tell the jury they're going to be calling as witnesses at trial and who actually testifies.

11:36:31 THE COURT: I think if they say that they're going to call somebody and they don't, I think that's a fair comment.

11:36:36 If the fact is they've told you that they anticipate that maybe they were going to call up to these nine witnesses previously so you deposed them and then they only call half of them at the time of trial, I don't know that that is necessarily fair comment to the jury. That would be more appropriate for a motion for costs afterwards if you prevail or not.

11:36:56 MR. JAFFE: Thank you, your Honor.

11:36:56 THE COURT: Is that fair?

11:36:57 MR. CLOWARD: That's fair.

11:37:01 THE COURT: So including the negative inference for failing to call witnesses, that's granted.

11:37:12 No. 12: "Precluding reference to collateral sources."

11:37:17 This one is actually easy for me, and I know that there are other judges that rule differently. But I'm going to preclude reference to all collateral sources, and I include liens. I know that there's a motion on liens, at least one or two motions on liens. I look at liens as a collateral source. So I don't allow that.

11:37:38 You can't talk about whether or not a doctor
11:37:40 treated somebody on a lien because if they didn't treat
11:37:43 them on a lien and they treated them under insurance,
11:37:45 we can't comment on that. So it's just -- it's not
11:37:48 fair to preclude a doctor from talking about the fact
11:37:53 that he is paid by insurance, but allow them to talk
11:37:56 about the fact that he wasn't paid because he was
11:38:01 treating on a lien.
11:38:03 I understand the counter-argument to that. It
11:38:07 does go to bias and prejudice and things like that.
11:38:09 And I think that that's a relevant issue, but I think
11:38:12 it's -- it's not fair to -- it's not fair to the
11:38:17 doctors to allow them to talk about one side and not
11:38:19 the other. And I think it is a collateral source
11:38:21 issue.
11:38:22 So based on the -- oh, what's the collateral
11:38:26 source case?
11:38:27 MR. CLOWARD: Proctor versus Castelletti.
11:38:30 THE COURT: Based on Proctor versus
11:38:31 Castelletti, I'm not going to allow it.
11:38:34 MR. JAFFE: Your Honor, at the time that our
11:38:35 two motions dealing with liens or a couple of motions
11:38:38 come up, can we just make a --
11:38:40 THE COURT: Sure.
11:38:40 MR. JAFFE: -- record at that time?

11:38:42 THE COURT: Absolutely.
11:38:43 MR. JAFFE: Thank you, sir.
11:38:44 THE COURT: But No. 12 is going to be granted.
11:38:50 No. 13: "Precluding Defendant from referencing injuries or non-injuries from any
11:38:53 11:38:56 individuals involved in the crash other than Margie."
11:39:08 Let me see if I understand this motion correctly. If you got several people in the accident,
11:39:09 11:39:12 Mr. Cloward, you don't want them to be able to say that somebody else was injured or that somebody else wasn't
11:39:17 11:39:20 injured.
11:39:21 MR. CLOWARD: Well, to make the argument that, "Hey, you know, the driver who hit her was not injured,
11:39:22 11:39:25 therefore, make the inference and take the logical leap that this was a -- such a minor impact that nobody
11:39:29 11:39:32 could be injured, so she must be faking."
11:39:38 I mean, I think to take somebody else, obviously people are built differently. If I'm in an
11:39:39 11:39:44 accident versus, you know, an 80-year-old person, I'm going to have a lower likelihood that, you know, I'm
11:39:48 11:39:52 going to be injured than that person. And so I think to make any sort of an argument based on another
11:39:55 11:39:59 individual not being injured would be inappropriate. I think it needs to be case specific, fact specific,
11:40:01 11:40:04 based on Margie and Margie alone.

11:40:07 THE COURT: Okay.

11:40:08 MR. SMITH: And, your Honor, that's different from what their motion says. Their motion doesn't specifically address arguments only. It says preclude any reference.

11:40:15 Now, Mr. Khoury was in the accident. Mr. Khoury didn't sustain any injuries, and he's testified in his deposition that he didn't sustain any injuries. In order to defend his case, we need to be able to share all of the evidence that has come to light, that you know, that is not unduly prejudicial.

11:40:33 Mr. Khoury --

11:40:34 THE COURT: So you want to be able to talk about the fact that your client wasn't hurt?

11:40:38 MR. SMITH: Exactly.

11:40:38 And the fact that he wasn't hurt doesn't automatically create some reference or inference that, you know, all people are created equal and the force should have impacted him the exact same as it should have impacted her. There's biomechanical experts who are going to testify in this case, and they're going to address all that.

11:40:57 But their motion seeks to preclude the very fact that he was involved in this injury -- in this incident and was not injured. And I think that goes

beyond what should be reasonably precluded.

THE COURT: Probably not really what you were asking for.

MR. CLOWARD: Not necessarily. I just don't understand the relevance at all to discuss whether or not he was injured or not.

THE COURT: I think it's relevant.

MR. CLOWARD: To what though? I mean, what does it go to?

THE COURT: Severity of the impact.

MR. CLOWARD: But then that cuts against the whole argument of not being allowed to use his injury as whether or not Margie would be injured. I mean, there's also literature that says that a rear-end impact, people in a rear-end type of collision are much more susceptible and have a higher likelihood of injury and risk than someone who's in a frontal impact.

So there's a lot of factors. Male versus female. So she's got higher likelihood, higher probably. So any discussion of "Hey, he's not injured so she can't be injured," which would be inappropriate or confuse the jury because it has nothing to do with her specific -- her specific -- the facts surrounding her injury.

If they want to get into it with their

biomechanics, that is fair game. But I don't think his injury, the defendant's injury, has anything to do with my client's injury. None at all.

THE COURT: Well, I -- here's the thing. Because of the fact that we allow jurors to ask questions, that's a question that I would ask if I was a trier of fact, is, "Was your client injured?" I think it's relevant. I think the jury is going to be curious about it.

Their -- the defense is saying they're not going to make the argument that, because our client wasn't injured, your client couldn't have been injured. They're not going to make that argument. They just want to tell the jury that their client wasn't injured. I think that's fair.

So 13 is denied.

14: "Excluding evidence of prior unrelated injuries, conditions, or medical treatment."

I actually think this is pretty easy, too, because I think the defense doesn't necessarily want to talk about prior, unrelated injury conditions or medical treatment. You want to talk about the ones you think are related.

MR. JAFFE: There are certain co-morbidities, though, that we do want to be able to bring up, your

11:43:23 Honor, because to the extent that any of those may deal
11:43:26 with life expectancy, if they're going to be putting in
11:43:29 a table and asking for a permanency award for the
11:43:32 remainder of her life, if it's 31.6 years or whatever,
11:43:35 I think I'm allowed to bring up other co-morbidities
11:43:41 that may exist that potentially do affect life
11:43:45 expectancy, such as blood pressure, such as diabetes,
11:43:49 such as heart conditions, such as cholesterol, whatever
11:43:53 it may very well be. And that's the case I believe
11:43:56 it's fair game for cross-examining doctors on that
11:43:59 topic and arguing on that topic.
11:44:01 MR. CLOWARD: Our only argument would be that
11:44:03 that would need to be tempered with a Hallmark type
11:44:06 analysis, that if they're going to discuss these
11:44:09 co-morbidities, that those co-morbidities actually be
11:44:12 proven and shown to cause a reduction in the life
11:44:15 expectancy. Otherwise, it's just -- you're just trying
11:44:17 to inflame -- you're trying to create an issue, "Hey,
11:44:19 look, Doctor, she's got these other issues."
11:44:21 I mean, some of these -- bunions,
11:44:24 miscarriages, hysterectomy. You know, those wouldn't
11:44:27 have anything to do with life expectancy, so I agree.
11:44:29 I think Mr. Jaffe's argument would be a good argument
11:44:32 to make. I think it's a fair argument to make.
11:44:35 But I think on the other hand, it would be

11:44:37 subject to a Hallmark qualification that if they're
11:44:42 going to argue that there would be a reduction in the
11:44:45 life expectancy, then there has got to be literature
11:44:48 rather than just Dr. So-and-so getting up there and
11:44:51 saying, "Well, you know what, she has got low blood
11:44:53 pressure so that means she's going to live five years
11:44:56 less."
11:44:57 I mean, you got to have some scientific basis,
11:44:59 some foundational argument behind raising those types
11:45:02 of questions to the doctors.
11:45:12 THE COURT: You okay with that? You're not
11:45:13 going to talk about any of those things without some
11:45:16 kind of foundation, right?
11:45:17 MR. JAFFE: Well, your Honor, I mean, things
11:45:19 such as bunion, miscarriage, sure, I agree that those
11:45:22 have nothing to do with the life expectancy. But
11:45:24 things such as cholesterol, blood pressure, things of
11:45:26 that nature, I mean, we don't know that. I mean --
11:45:29 THE COURT: You're going to have to put
11:45:30 somebody on that says what -- how that's going to
11:45:33 effect life expectancy though, or otherwise it's not
11:45:36 relevant.
11:45:36 MR. JAFFE: Can I cross-examine their doctors
11:45:38 in doing that?
11:45:39 THE COURT: If you can get it through their

doctors, I think that's fine.

MR. JAFFE: My point. Your Honor, listen.

THE COURT: You got to have it through somebody that has a foundation for their opinion or basis for what they're telling you.

MR. JAFFE: Okay. I will, I mean, things such as, like I said, of course, miscarriages and bunions, yeah, those don't effect life expectancy. I'm not going to go into things like that. But there are certain things. I mean, if she had been a smoker, obviously you don't need to put a doctor up. Jurors know that smoking effects life expectancy.

THE COURT: Yeah, but you don't know how much.

MR. JAFFE: Well, no. I understand that. But the point is it's not necessarily as a so much -- as a how much, or -- but when they're going to stand in front of the jury and say, "We want 32 years' worth of pain and suffering," because of her life expectancy, it's fair -- it's equally fair game for me to say it's not reasonable to award 32 years because she's got co-morbidities that effect life expectancy, such as cholesterol, blood pressure, et cetera.

THE COURT: I agree with you. But if you're going to do that, you need to have -- you need to be able to say it's not fair for them to say 32 years

because Dr. So-and-so said that smoking is going to reduce that life expectancy by four and a half years.

MR. JAFFE: Well, that's just it, Judge. I'm not necessarily saying that I have to -- I don't think I have to put up an actual time reduction as opposed to just simply arguing the merits of their argument, that life expectancy is 30-some-odd years or whatever it may very well be, if there are co-morbidities that do effect life expectancy.

MR. CLOWARD: Your Honor, if I may, I think he absolutely cannot do that. He absolutely cannot because that's subject to a Hallmark qualification. You as the gatekeeper need to make sure that the doctors are basing their opinions on reasonable sound, scientific methodology.

Doctors can't just get up there and say, "Hey, you know what, she's got low blood -- high blood pressure, so she's going to live five years less."

The other thing that Ms. Frasier just pointed out, which is true, is that the life expectancy table take into account all of these co-morbidities. They don't just select, "Hey, here's the -- here's -- we're basing the tables on healthy people." They take everybody into account. It's based on the general population, so the life expectancy tables already take

11:48:04 into account the co-morbidities that Counsel wants to
11:48:09 discuss.
11:48:09 MR. JAFFE: If that's an argument they need to
11:48:11 make, then they need to put up a doctor who's going to
11:48:14 say that, your Honor. Because if that's the case, I
11:48:15 should be able to question the doctor on those, on that
11:48:19 topic.
11:48:21 THE COURT: All right.
11:48:36 The motion says: "Excluding evidence of prior
11:48:38 unrelated injuries, conditions, or medical treatment."
11:48:42 I'm going to exclude evidence of prior
11:48:44 unrelated injuries, conditions, or medical treatment
11:48:49 because it's probably not relevant if it's unrelated.
11:48:53 It can be related if it's the same body part
11:48:57 or a similar body part that's in this accident, or I
11:48:59 think it could be arguably related if it relates to the
11:49:04 life expectancy issue.
11:49:05 So the motion is granted. I am going to
11:49:10 probably allow evidence as it relates to life
11:49:13 expectancy issue, but we're going to have to see how it
11:49:15 comes in and who's trying to bring it in through who.
11:49:18 MR. CLOWARD: Fair enough.
11:49:19 MR. JAFFE: Thank you, your Honor.
11:49:20 THE COURT: So 15 is "Precluding reference to
11:49:26 prior incidents."

11:49:27 Plaintiff's argument is that there's no
11:49:31 evidence that these prior incidents had any
11:49:33 relationship to the injuries that she suffered in this
11:49:36 accident. I understand there's, like, I think we're
11:49:44 primarily talking about these accidents that are 20
11:49:46 years ago. Right?
11:49:46 MR. CLOWARD: Correct.
11:49:47 THE COURT: And --
11:49:48 MR. CLOWARD: And one in 2004, '81, '85, and
11:49:53 2004.
11:50:01 THE COURT: And you want to keep any reference
11:50:03 to any of those accidents out all together?
11:50:06 MR. CLOWARD: Yeah. I mean, because none of
11:50:07 the doctors testified that -- none of them say, "Hey
11:50:10 look, you know, she's had these ongoing symptoms since
11:50:13 then."
11:50:13 So all that is going to do is create in the
11:50:15 minds of the jurors the thought that, "Hey, here's this
11:50:19 lady that has had these several prior incidents, so we
11:50:22 better give some weight to that." When, in reality,
11:50:25 there's absolutely no medical testimony or evidence or
11:50:28 opinions that they have any importance in the case, and
11:50:31 so it's just a red herring that Counsel would put up in
11:50:35 closing argument saying, "Hey, look, you know, you
11:50:38 can't overlook this -- these accidents," and that would

11:50:40 be prejudicial to Ms. Seastrand because none of the
11:50:45 doctors testified that they have anything to do with
11:50:47 anything.
11:50:48 THE COURT: Mr. Jaffe, do you have somebody
11:50:49 that says that they're relevant somehow.
11:50:52 MR. JAFFE: We've got our experts talking
11:50:53 about those prior accidents and injuries, your Honor.
11:50:55 THE COURT: Well, the fact that they talk
11:50:56 about them is one thing. Do they say that they have
11:50:59 any impact on the Plaintiff's condition?
11:51:02 MR. JAFFE: Yes. Listen, your Honor. In
11:51:09 fairness I'm not going to go beyond what my experts
11:51:12 have said.
11:51:12 THE COURT: I'm going to reserve this one.
11:51:14 We're going to see who testified to it and how it's
11:51:17 addressed.
11:51:26 MR. JAFFE: Thank you, sir.
11:51:26 THE COURT: I don't know how the evidence is
11:51:28 going to come in. You guys understand that you've been
11:51:30 living with this case for a long time and I only have
11:51:34 what I am looking at here. So we're going to have to
11:51:36 see how it plays out because I'm not sure about that
11:51:38 one.
11:51:39 No. 16: "Precluding the responding officer
11:51:42 from providing biomechanical opinions."

11:51:45 I understand the officer has -- did an
11:51:49 investigation and saw stuff, observed stuff. I think
11:51:55 that's admissible. What the doctors -- or what the
11:52:00 officer's conclusions are or his opinions based upon
11:52:05 maybe talking to the witnesses, I mean, usually the
11:52:10 part at the bottom of the accident report where it says
11:52:13 description of the accident and the cop writes in there
11:52:15 and or types in there how he believes the accident
11:52:18 happened, I usually exclude that because he wasn't
11:52:22 there to witness it usually. And I think his opinions
11:52:25 about what -- how something happened is not necessarily
11:52:29 helpful.
11:52:30 So as it relates to precluding the responding
11:52:34 officer from providing biomechanical opinions, I
11:52:38 understand that he -- officers are usually somewhat
11:52:41 trained, but their opinions, at least in this case, I
11:52:46 think -- what you -- what you want to preclude is him
11:52:51 saying injuries claimed by Seastrand are not consistent
11:52:55 with being caused during this collision.
11:52:57 MR. CLOWARD: Right.
11:52:58 THE COURT: Right?
11:52:58 And obviously the defense wants to get that
11:53:01 in.
11:53:09 MR. CLOWARD: Another thing, your Honor,
11:53:10 during his deposition, he said that he would defer to

accident reconstructionists.

THE COURT: Mr. Jaffe, tell me how come I should let that in.

MR. JAFFE: I'm going to let Mr. Smith convince you on this one.

THE COURT: All right.

MR. SMITH: Your Honor, the -- in his deposition, Officer Kahn, I believe, testified that these were his observations and impressions.

THE COURT: Well, observations are different than impressions. Observations, I'm going to allow.

MR. SMITH: Okay. Well, I guess, getting to that, then, he didn't observe the accident itself. But at the same time, the evidence from the -- the -- he procured on his investigation showed to him that it was a low-impact collision. So is that an impression or is that an observation? My position is that that's an observation based on the evidence that he had.

Similarly, he's saying that this is a low impact. I don't have any tire or skid marks. There's very minimal damage to the cars, and this lady is writhing in pain. Her injuries to me don't seem consistent with what I'm observing was the accident itself.

So, yes, I agree that there is a -- there's a

11:54:23 fine line between observations and impressions, but
11:54:27 those run together when, you know, what he can observe
11:54:30 doesn't correspondence with what he's seeing.
11:54:36 THE COURT: All right. Good try. Now, I'm
11:54:38 not buying it. I think the TAR 1 and TAR 2 classes
11:54:43 don't teach biomechanics. They don't necessarily teach
11:54:48 officers what forces are necessary for injury and
11:54:50 things like that, so.
11:54:52 MR. SMITH: Just to clarify, then, is he
11:54:54 precluded from testifying that in his opinion it was a
11:54:57 low impact based on the lack of tire marks and the
11:55:01 damage to the vehicles?
11:55:04 THE COURT: It's not what's before me, but I
11:55:05 would -- I would probably be inclined to allow an
11:55:11 opinion like that.
11:55:12 MR. SMITH: Fair enough. Thanks. Your Honor.
11:55:14 THE COURT: But as it relates to injury, I
11:55:15 would say no.
11:55:16 So No. 16 is granted.
11:55:20 THE COURT CLERK: 15 is ruling reserved?
11:55:24 THE COURT: 15 was reserved. 16 is granted.
11:55:27 17: "Preclude --"
11:55:30 MR. SMITH: 15 was reserved. 16 -- did I --
11:55:34 MR. JAFFE: 15 reserved; 16, granted.
11:55:39 MR. SMITH: I apologize, your Honor.

11:55:39 THE COURT: 17 is "Precluding of Margie's
11:55:42 prior civil lawsuit."
11:55:43 This is regarding an insurance claim made
11:55:48 after a theft at her business. I don't see any
11:55:52 relevance, so you guys are going to have to convince
11:55:56 me.
11:55:56 MR. SMITH: All right. The relevance is that
11:55:58 Jerry Busby is the attorney who represented her in that
11:56:00 case, and he's been identified as a plaintiff as a
11:56:03 potential before-and-after witness in this case. He
11:56:05 lives by her. He's her neighbor, interacts with her on
11:56:09 a weekly basis at church and what have you.
11:56:11 The relevancy that we see is this colors their
11:56:14 relationship. This shows the jury that, you know,
11:56:15 there is an existing relationship between them that
11:56:18 extends beyond just, you know, somebody I go to church
11:56:22 with. The jury can infer from that what they will, but
11:56:24 the fact that that relationship existed and that he's
11:56:27 her prior counsel testifying now on her behalf, we
11:56:31 believe is relevant to show his bias and the nature of
11:56:34 their relationship.
11:56:36 THE COURT: Well, how does that show bias and
11:56:40 the nature of their relationship more than the fact
11:56:43 that he's a neighbor and who knows her?
11:56:46 MR. SMITH: Maybe it doesn't. But he is both.

He's a neighbor who knows her, and he was their attorney. He was somebody that she selected to represent him and he worked on her behalf. There's a relationship there that shows a bias.

THE COURT: All right.

MR. CLOWARD: The danger is that they get -- they get the bias about talking about them being neighbors for 20 years, them being friends for 20 years, them knowing each other for 20 years. They get the bias there. They don't need to bring in the prejudice by showing the jury that here's this lady who's filed another lawsuit, because the prejudice is, "Oh, here we've got a plaintiff who is sue happy, who is litigious and, you know, now she's filing another lawsuit."

So they get the bias in another way. They don't need to bring in the fact that Mr. Busby represented her, because all that brings with it is that is the prejudice. And we can't overcome that.

And that's why it's inappropriate.

THE COURT: You think that there's a prejudice that comes from the fact that she filed a lawsuit?

MR. CLOWARD: Absolutely. I mean, I think our society, yeah.

MR. SMITH: That's very easily clarified with

11:57:52 the question about the nature of the lawsuit. We're
11:57:53 not trying to imply that she is litigious and that
11:57:57 she's filing lawsuits left and right. We're trying to
11:57:59 expose the fact that this isn't just somebody who is a
11:58:02 neighbor. This is somebody who is a neighbor that she
11:58:04 trusts enough and that she confides in enough to retain
11:58:08 as her counsel.
11:58:08 There's more of a bias there than just being a
11:58:11 neighbor. A lot of neighbors hate each other. You
11:58:13 know, certainly this is a neighbor that she likes, but
11:58:16 it goes beyond that. We think that that is the bias
11:58:18 that should be seen.
11:58:20 THE COURT: Let me ask this: Could you get
11:58:20 the same information by simply asking her, "Haven't you
11:58:24 also retained Mr. Busby previously as your attorney for
11:58:28 some issue?"
11:58:28 MR. SMITH: Sure.
11:58:31 THE COURT: If she said yes, that establishes
11:58:33 the bias I think that you're looking for, but it
11:58:36 doesn't prejudice the plaintiff by talking about a
11:58:37 prior civil lawsuit. I mean, the jury could infer that
11:58:41 that was a -- that, you know, had to do with a will or
11:58:46 a trust or probate issue, or family law case.
11:58:50 MR. SMITH: Absolutely. We don't think the
11:58:51 nature of their -- you know, the case or anything like

that goes to the bias any more than just the fact that she retained him as her counsel, so yes.

THE COURT: So not only is she a neighbor, but she previously served as his attorney -- as her attorney for some reason.

MR. CLOWARD: We think that would be a fair compromise.

THE COURT: Okay. Let's do that then. Let's say it's granted in part, denied in part. We're going to allow a question of the witness as it relates to Mr. Busby's previously being her attorney, but we're not going to go into the specifics.

No. 18: "Precluding Defendant's medical experts from referring to the crash as minor or making reference to the property damage sustained by the vehicles."

I guess this gets back to that question that you asked me just a minute ago about whether or not I was going to let the cop refer to it as minor, right?

MR. CLOWARD: Correct.

I guess, your Honor, if I just may, the danger in allowing comments specifically by a doctor or a police officer that they're going to get a heightened credibility by the jury, but the fact of the matter is, is that their opinion is nothing different than a lay

witness who witnessed it or who came up on it after and said, "Yeah, I see the photograph there. I see the photograph there. It must be a minor impact."

The analysis and the opinion is exactly the same. It's unscientific. It's not based on any credible information. It's just an opinion, but because of who is giving it, the jurors take, you know, they have a -- give it a higher weight. And that's what's inappropriate.

THE COURT: So you think doctors shouldn't be able to say the word "minor" as relating to the accident, that should be reserved for an accident reconstructionist?

MR. CLOWARD: Yeah. Because they don't know. They didn't do any testing. The same thing with the police officer saying it's low impact. Well, what do you mean by low, and what tests did you do to determine that?

I feel it's just unless there's actually a scientific basis for them saying, it's just an opinion that's unqualified, speculative, and self-serving, and -- but it's going -- the danger is that the jury is going to give it a higher weight based on whose giving it.

THE COURT: I tend to agree with you as it

relates to doctors, but not necessarily the police officer. Police officers do have training in determining forces of impact and things like that. They do the --

MR. CLOWARD: Sure.

THE COURT: -- TAR 1 and TAR 2 courses, dealing with traffic accident reconstruction and forces of impact. So I think a police officer probably is in as good a position to talk about whether it was a minor accident or not as maybe an accident reconstructionist would be. But the doctors, I tend to agree with you.

What are you thinking?

MR. JAFFE: Here's my thoughts, Judge. Experts are allowed to rely upon the opinions of other experts, and since doctors on the defense sides are going to be rendering causation opinions, if they're relying on the characterization of the accident from the forces and the analysis done by the biomechanical engineer, they are allowed to take that into account. And if my experts have seen my biomechanical engineer's report that my biomechanical engineer calls it minor or bump or insignificant, whatever it may very well be, my experts are allowed to rely on that in helping to form their causation opinions.

THE COURT: That's different than your people

12:02:31 offering the opinion that it's minor, though.
12:02:34 MR. JAFFE: I -- I guess I agree with that,
12:02:41 but the thing is, this seems to have been painted again
12:02:44 with a very broad stroke that they don't even want
12:02:47 doctors talking about it as minor. But if my doctor is
12:02:49 saying -- if I put a doctor on the stand who says,
12:02:51 "This is a very -- my opinion is this was a very minor
12:02:54 accident unlikely to have caused this trauma that the
12:02:57 plaintiff alleges," and then I go back and say, "Okay,
12:02:59 what makes you say -- what have you reviewed?"
12:03:01 "This is what I've reviewed. I've reviewed
12:03:04 this, this, this, and this."
12:03:05 "Okay. Now, you said it was minor. Where did
12:03:07 you get that from?"
12:03:08 "Well, there was a biomechanical analysis that
12:03:11 said it was really a minor accident. I've seen the
12:03:13 reports. I've seen the photographs. I've seen the
12:03:15 analysis. I've seen this and that. I'm relying on
12:03:17 that."
12:03:19 THE COURT: Okay.
12:03:20 MR. CLOWARD: Judge, here's the problem. I've
12:03:22 actually -- I'll pull up the transcript from the last
12:03:24 time a judge -- or Dr. Schifini was in your courtroom.
12:03:28 And I asked him specifically, "Hey, when you determine
12:03:32 whether someone is injured, do you consult with the

biomedical engineer?"

And he said, "No."

"When you were in medical school, when you were determining causation, whether people were injured, did you call up a biomechanical engineer to determine whether there was enough forces or impact to cause injury?"

"No."

"Okay. When you do your rounds at the hospital, do you ever -- if somebody comes in, do you have to go out and look at the vehicle to determine whether or not they're injured?"

The answer is no every single time. So they're trying to backdoor the information in and it's really inappropriate, because all that it's trying to do is to pound home the theme low impact, no injury. Low impact, no injury.

And they're trying to backdoor it in through the doctors by saying -- by creating a very thoughtful way to get it in that, "Hey, I'm Dr. Schifini, and in my analysis of determining whether or not Margie was injured, yeah, you know what, I looked at the police report and I looked at the property damage, and I looked at these things, and it was important for me and my opinion. It was a foundational element of my

12:04:37 opinion."

12:04:38 But that's just a creative way to get it in.
12:04:41 It's unfair. They don't do that in practice. They
12:04:43 don't -- if somebody comes to him and say, "Hey, I'm
12:04:46 injured," they don't go out and look at the property
12:04:48 damage. I mean, that's just not what they do. And
12:04:51 it's just trying to get it in the back door.

12:04:55 MR. JAFFE: I don't know what's wrong with me
12:04:56 pounding my argument, if that's my argument. That's
12:04:58 what the part -- that's part of advocacy, your Honor.
12:05:01 I kind of remember that in Advocacy 101.

12:05:04 THE COURT: Yeah. Doesn't seem fair, but I
12:05:10 think they can do it.

12:05:13 MR. JAFFE: Pardon me.

12:05:13 THE COURT: I think an expert can rely on that
12:05:16 stuff. I'm going to allow it. 18 is denied.

12:05:20 19: "Precluding Dr. Schifini from offering
12:05:26 testimony regarding alleged secondary gain by Margie."

12:05:30 Your argument is because he's not a
12:05:33 psychologist or psychiatrist, he can't talk about
12:05:35 secondary gain.

12:05:37 Don't all doctors talk about this?

12:05:38 MR. CLOWARD: Well, your Honor, specifically
12:05:41 with Dr. Schifini, he's woefully unqualified to give
12:05:46 this opinion. I have deposition after deposition, I

12:05:49 think before he's allowed to give any sort of a
12:05:53 testimony on malingering or secondary gain, there needs
12:05:56 to be voir dire outside the presence of the jury.
12:06:01 Because I have depositions recent of one or two years
12:06:05 ago where he says, "Yeah, I didn't -- I didn't know
12:06:07 until just recently what the definition of malingering
12:06:10 was. So I stopped putting it in my report."
12:06:13 "So you've been putting it in your report for
12:06:15 the past five years and you didn't even know the
12:06:18 definition?"
12:06:18 And it's the same thing with the secondary
12:06:20 gain. He's cut and pasted some information out of -- I
12:06:24 believe it's the DSM manual. And he basically says
12:06:28 that everybody needs -- I've got every single report.
12:06:31 He says the exact same thing in every single case. He
12:06:34 has no experience treating people for this.
12:06:36 And it's just -- it's just a way for him to
12:06:38 attack the credibility of Margie when there's no
12:06:42 scientific basis for him to do that. And that's where
12:06:44 it's inappropriate, is everything has to be tempered by
12:06:46 a Hallmark-type analysis. And, yeah, the doctors can
12:06:51 say that, but doctors can say whatever they want in
12:06:54 their depositions, in their reports, but when it comes
12:06:56 time to allowing that information to be presented to a
12:06:58 jury, that's what your Honor is for, to say, "Hey, you

know what, just because a doctor says it, doesn't mean that that gets to the jury. Doesn't mean that just because you put that in your report you get to get up there and say that, you know, whatever you want."

And that's what we're asking for, is that Dr. Schifini is unqualified to give these types of opinions. He's not a psychiatrist. He doesn't treat people for these things. And, you know, just because he's a doctor doesn't mean he gets to say it.

THE COURT: Let's reserve it for trial. Let me voir dire the doctor outside the presence before he testifies.

MR. CLOWARD: That's fair.

MR. SMITH: Your Honor, just to address this while we're talking about it. Dr. Schifini -- first of all, the word "malingering" came up a couple of times. Dr. Schifini has not testified that Ms. Seastrand is malingering. That's not part of his testimony.

Dr. Schifini has testified that by definition the fact this she is a litigant in a case involving injuries sustained in this accident means that there's a secondary gain motive. He's not -- he didn't expound on -- you know, he even said, "I don't think she's doing it intentionally, but by definition, if she's a litigant, you know, there is a secondary gain motive."

That's his testimony.

Now they're trying to extrapolate that and say he's going to come on the stand and he's going to say, "She's a faker and she's a liar." But he says, "By definition, that's there."

And then there's the fact that she minimized her prior injury complaint to her doctors after the accident. You know, there's some of her doctors that she told those to, there's some of her doctors that she didn't.

So I don't think Dr. Schifini can be precluded from testifying as to what he observed in the medical records and what are accepted medical definitions of secondary gain.

THE COURT: You may be right. I would suggest that you know exactly what questions are going to be asked of him in this regard before he testifies so we can do a quick little voir dire of him outside the presence. And if he's not going to say that she's a malingerer, then that takes way that issue.

Then if his opinions as far as secondary gain are what you say they are, and that's all he's going to testify to as far as secondary gain, it's going to limit Mr. Cloward to what he can ask them about secondary gain. But, I mean, based upon his request to

be able to voir dire him before he testifies about these issues, I think that's a fair request.

And so let's -- we'll just reserve that for now. You're going to have to remind me during trial that we're going to voir dire him outside the presence.

MR. SMITH: We'll include it in the order, your Honor.

MR. CLOWARD: We will, your Honor. I won't forget.

THE COURT: I'll forget.

MR. CLOWARD: No. I said I won't forget, Judge.

THE COURT CLERK: Voir dire outside.

THE COURT: We are going to voir dire him outside the presence of the jury prior to his testimony.

No. 20: "Precluding Dr. Schifini and Dr. Ziegler from offering testimony regarding Margie's spine surgeries."

Argument is that they are qualified to talk about spine, the work up to spine surgeries so they should be able to testify about the spine surgeries. Plaintiffs argue -- Plaintiff's argument is the fact that they do workup doesn't mean that he can testify about whether or not she needed spine surgery or not.

12:10:25 I tend to agree that they can talk about their
12:10:28 workup, but whether or not spine surgery was necessary
12:10:33 or warranted, I don't think that's their expertise.
12:10:38 Convince me otherwise.
12:10:40 MR. JAFFE: Your Honor, obviously there's a
12:10:41 cross-over between medical disciplines. And simply
12:10:45 because a doctor may not be a spine surgeon does not
12:10:49 necessarily mean that they cannot testify as to whether
12:10:52 a spine surgery is reasonable or warranted under the
12:10:57 circumstances.
12:10:58 You're talking about two doctors who routinely
12:11:01 treat people with spinal injuries, some of whom get
12:11:04 referred for surgical consultations and surgeries, and
12:11:07 some of who get referred for consultations don't get
12:11:11 surgeries or never even get referred for consultations.
12:11:15 I think within their practice, their experience, and
12:11:17 certainly their own I -- I guess to some extent it's,
12:11:23 you know, their own personal anecdotal experiences,
12:11:27 they're entitled to testify as to what they reasonably
12:11:31 expect to be surgical and not surgical conditions. And
12:11:36 I think that's what we're basically looking for here.
12:11:42 THE COURT: I don't know. I'm not convinced.
12:11:44 I mean, I think you got to have a spine surgeon that
12:11:47 says whether or not spine surgery was reasonable.
12:11:50 I mean, you even used the word spine surgery

12:11:53 reasonable or warranted under the circumstances. I
12:11:55 mean, that that's the specific realm of a spine surgeon
12:12:00 in my mind. If they didn't have a spine surgeon that
12:12:03 was going to come in and say that spine surgery was
12:12:07 reasonable and necessary and related to this accident,
12:12:11 I wouldn't let the spine surgery in. I mean, they
12:12:14 can't bring a pain management guy to lay the foundation
12:12:17 for that surgery, so I'm -- I can't allow -- I can't
12:12:23 allow Ziegler and Schifini to talk about whether or not
12:12:27 the spine surgery was reasonable and necessary because
12:12:29 I wouldn't let them do it on the other side.
12:12:32 Do you have a spine surgeon?
12:12:34 MR. JAFFE: Not -- we're not calling one, sir.
12:12:41 THE COURT: I can't allow them to. I mean,
12:12:42 they can talk about their workup. But they can't talk
12:12:45 about whether or not the surgery itself was reasonable
12:12:48 or necessary or warranted under the circumstances.
12:12:52 So 20 is granted.
12:13:05 MR. SMITH: That's the end of Plaintiff's.
12:13:06 MR. JAFFE: That's the end of Plaintiff's,
12:13:07 your Honor.
12:13:08 THE COURT: That's the end of Plaintiff's.
12:13:14 Wow. All right.
12:13:17 Quarter after 12:00.
12:13:20 All right. Number -- I guess it's Defendant's

12:13:26 Motion in Limine No. 1 to limit physicians to opinions
12:13:29 stated in their clinical records, depositions, and/or
12:13:32 expert reports, if any.
12:13:37 MR. JAFFE: I think this pretty much dovetails
12:13:39 with the argument, the one that we've already argued,
12:13:41 your Honor.
12:13:41 THE COURT: Yeah. The note that I have on
12:13:43 here that I wrote to myself last night says "Allow the
12:13:46 treating doctors to testify regarding their opinions
12:13:48 and conclusions that are in their records and their
12:13:51 depositions and which they formed during their care and
12:13:53 treatment of the patient. Records that are included in
12:13:56 their charts, they can talk about for purposes of their
12:13:59 treatment of the patients."
12:14:02 I think I already ruled on that in response to
12:14:04 one of the plaintiff's.
12:14:05 MR. JAFFE: And I guess what we're looking for
12:14:07 is to say that's fine, your Honor, but that they
12:14:10 shouldn't be allowed to go beyond that, even with new
12:14:13 opinions that related to care, future prognostications,
12:14:17 things of that nature that are not included in your
12:14:20 chart. That's where the unfair surprise comes in.
12:14:23 THE COURT: The problem is, I mean, I agree
12:14:27 with you in a sense because I think the reason that we
12:14:32 allow experts, the reason that we allow treating

12:14:35 doctors to testify as experts without a report is
12:14:37 because they do have charts. And based on their
12:14:42 charts, we have some indication of what their opinions
12:14:44 are and what they're going to say.
12:14:46 MR. JAFFE: Right.
12:14:46 THE COURT: The fact that not every word that
12:14:49 they may say on the stand is included in their chart,
12:14:52 though, doesn't mean that they didn't form that opinion
12:14:54 during their care and treatment of the patient.
12:14:58 MR. JAFFE: And that's why we take their
12:14:59 depositions, sir, and the ones who we have deposed,
12:15:01 that's where it becomes an unfair surprise if they now
12:15:04 come in with something new. Because if we ask what are
12:15:07 your opinions, if we've asked do you have any opinions
12:15:11 regarding future care, necessity, limitations, things
12:15:14 of that nature, and they now come up with something
12:15:17 new, that is where there's an unfair surprise.
12:15:19 And at some point, Judge, I mean, there's got
12:15:21 to be a line drawn. It just can't be an open field for
12:15:24 them to just go traipsing through and say now I'm going
12:15:28 to say this, now I'm going to say that without some
12:15:31 advanced notice. Because when we've gone to the cost
12:15:33 of taking the deposition and when we've got orders in
12:15:37 place limiting the time when we can take those
12:15:39 depositions, and then if something new now comes to

12:15:42 their minds and say, "Oh, now I'm going to come in and
12:15:44 say this or I'm going to come in and say that," I mean,
12:15:47 at some point there's got to be a line drawn because
12:15:49 otherwise there's just a lack of fairness to the
12:15:52 defense.
12:15:52 You can't prepare for something that you don't
12:15:55 know is coming in when you've taken every possible
12:16:00 precaution. When you've gotten their chart, you've
12:16:02 gotten written answers to discovery, and when you've
12:16:05 taken their deposition. I can't go back and retake
12:16:08 every doctor's deposition again just before trial just
12:16:11 to verify that they haven't changed their opinions, and
12:16:13 that's --
12:16:15 THE COURT: If --
12:16:15 MR. JAFFE: -- an unfairness.
12:16:17 THE COURT: I don't know if the plaintiff is
12:16:18 still treating with any of these doctors or not. The
12:16:22 problem that you have is with somebody that continues
12:16:25 treatment. Because we can't -- we can't limit a doctor
12:16:28 and say, "Oh, well you can't testify about anything
12:16:31 that happened after your deposition six months ago,
12:16:34 even though you've been treating this patient on a
12:16:36 weekly basis since."
12:16:38 MR. JAFFE: And, your Honor, that's where
12:16:39 they've got an obligation to then give us some record.

12:16:42 They've got an obligation to supplement an answer to an
12:16:45 interrogatory. They've got to give us something so
12:16:47 it's just not an unfair surprise. Because, I mean,
12:16:51 we've deposed in this case Dr. Muir, Dr. Kaffcan,
12:16:56 Dr. Belsky, Dr. -- well, Gross was an expert -- a
12:16:59 treating -- an expert, not a treating.
12:17:01 THE COURT: Are these -- are the doctors all
12:17:02 still treating the patient on an ongoing basis?
12:17:05 MR. JAFFE: No.
12:17:05 MR. CLOWARD: No.
12:17:06 MR. JAFFE: No. But that's the point. The
12:17:08 ones who are, who have been deposed, I mean, they're --
12:17:12 we've got to have some notice when we've done
12:17:17 everything that we can possibly do to find out so that
12:17:20 we're prepared and not blindsided. And that's the
12:17:24 whole purpose of this, Judge, is that, I mean, there's
12:17:27 got to be a fundamental fairness to the defense in this
12:17:30 when they've taken the affirmative steps to do
12:17:33 everything possible.
12:17:34 THE COURT: We try to avoid trial by ambush.
12:17:37 MR. JAFFE: Right.
12:17:37 THE COURT: So I'm inclined to agree with
12:17:40 Mr. Jaffe to an extent, because I don't think it's fair
12:17:43 to have somebody come up with a whole bunch of new
12:17:47 opinions, after their deposition just before trial,

that he's not going to know about and you didn't tell him about.

MR. CLOWARD: I completely agree. I actually agree. I think that's the way that it should be. Whenever this issue comes before a judge, I always just say, "Hey, look. As a temper to the deposition testimony and the medical records, the way that the order should read is that the doctors are limited to the opinions contained within the medical records and depositions or reasonable inference therefrom."

Because the other thing is that Mr. Jaffe realizes that sometimes depositions are limited. They're only a hour long. And they're cut off. And so, you know, maybe the doctor, if he would have had more time, if there would have been more time to depose him, he would have said, "Well, yeah, she needs this treatment, that treatment, or the other."

But I can tell you we're not going to get to trial and we're not going to have the doctors testifying to a bunch of new treatment and a bunch of new theories and a bunch of new -- you know, we're not going to surprise them.

But I also don't want to have the doctors say something like, for instance, "Yeah, you know, I think Ms. Marjorie would maybe benefit for another course of

physical therapy," or something along those lines and have Mr. Jaffe "Object, Your Honor. This is exactly what we talked about during the motion in limine. This wasn't in his opinion. This wasn't in his deposition. So this is unfair surprise, trial by ambush."

I mean, I agree there's got to be a limit. If Mr. Jaffe is diligent in going out and taking the depositions, I understand that. But that needs to be tempered. That needs to be tempered with the fact that -- that not all opinions are expressed during every single deposition --

THE COURT: Well, depends on what questions were asked. Because if he asked a question about "Do you have an opinion as to whether or not there's any future treatment necessary," and the doctor says no and then comes into trial and then says yes, I would tend to say, you know, "Well, he's going to be held to his deposition."

MR. CLOWARD: And I would disagree with that. And I would agree with that. But I think if the doctor makes some qualifying statement like, "Well, at this time I think there needs to be X, Y, and Z, but there might be other treatments," I don't think that that's, you know, outside the scope.

And, you know, here's the thing: Counsel

12:20:05 seems upset, but we started off with two surgeries.
12:20:08 Ms. Seastrand needs to have a cervical surgery. She
12:20:11 needs to have a lumbar surgery, in addition to what
12:20:13 she's already had. As time has progressed those have
12:20:16 been dismissed.
12:20:17 And, you know, we've done supplements and
12:20:21 updates to the -- to the life care plan, and that just
12:20:24 shows the dynamic changing fluid doctor or fluid care
12:20:29 that somebody has as they continue to have treatment.
12:20:32 So he can't say, "Well, you know, we need to be able to
12:20:35 rely on the depositions," when the human body and
12:20:40 treatment continues and it progresses. That's why I
12:20:42 say I'm fine with that.
12:20:43 I think that that's fair to say limit it to
12:20:46 their opinions, in their records, their reports, their
12:20:50 deposition, and reasonable inferences therefrom. So if
12:20:53 the doctor said something that is completely
12:20:57 outrageous, that has never been discussed or even
12:21:00 thought about or complained, that is -- that is unfair.
12:21:03 That's trial by ambush. I agree that would not be
12:21:07 allowed.
12:21:08 But if it is something that's been
12:21:09 contemplated or should have been contemplated that
12:21:12 maybe the exact question wasn't asked, that should be
12:21:16 allowed.

EXHIBIT "D"

Comprehensive Injury Institute
Complete Care from Diagnosis to Treatment

Office of: **Jeffrey D. Gross, M.D.**
Spine Fellowship Trained Neurological Surgeon
Diplomate, American Board of Neurological Surgery

August 28, 2012

PATIENT NAME:	**SEASTRAND, MARGARET**
DATE OF BIRTH:	12/27/1961
DATE OF INJURY:	03/13/09
DATE OF EXAMINATION:	08/28/12

NEUROSURGICAL EXPERT CONSULTATION (SUPPLEMENTING THE CASE REVIEW)

To Whom It May Concern:

I saw Ms. Margaret Seastrand for neurosurgical consultation concerning a motor vehicle collision related injury on the above-referenced date. This consultation is supplementary to my Neurosurgical Case Review dated 8/7/12.

Ms. Seastrand is a 50-year-old, right-handed woman.

HISTORY OF INJURY:

She reports that she was stopped as the driver of a 2002 Honda Odyssey minivan with her seatbelt on. She was at a red light at a surface street, when she was rear ended by an SUV without warning. She did not hear a screech. She thinks she was looking left at that time. There was no secondary impact. Her air bags did not deploy. She was jerked forward at some point. She was stunned. She felt pain in her neck and shoulders immediately, which was worse with turning. There was low back pain. Police came to the scene and made a report. She was taken by ambulance to Mountain View Hospital. Her car was towed.

She was treated in the emergency room predominantly for neck and shoulder pain. Medications were given and films were taken. She was released. She was instructed to follow-up with her physician and to take it easy. She missed some work at her business (child theatre). She had trouble with the narcotics (they made her loopy, nauseated, and constipated).

She sought care with Dr. Lurie within a week for worsening neck and right shoulder area. She continued to have low back pain and headaches. She also saw a medical doctor. Her initial treatment was cautious due to pain. Neck and back MRIs were obtained. She had developed leg and arm symptoms. She was referred to Dr. Belsky. A combined low back injection was given for increasing low back pain, but it did not help her in a lasting way. She may have had multiple injections. She was referred to Dr. Muir. She continued chiropractic care. A cervical injection was done at some point which helped her neck and shoulder area.

She took off work for the fall of that year, since she was struggling with her pain symptoms, and noted memory loss. Her husband, employees, and partners knew of this. She thought (and hoped) the memory problems were related to medication use. She also noticed slowness of calculation. She started having depression due to pain and was recommended to have a testosterone implant, but it had to be removed due to an allergic reaction.

In September of 2009, she had a lumbar discogram and a two level plasma disc decompression, L4 to S1. She felt worse and had severe spasms. She had increased right leg numbness and painful tingling. She received another injection from Dr. Belsky with temporary benefit. She was referred to Dr. Shah, who found her to have nerve problems in her cervical region. She was irritable and depressed. This was really hard for her. Her injuries affected her relationships with her husband and children. She could not fully function as a wife and mother. She became teary eyed when discussing this with me.

She also had a lumbar EMG that was positive. She was advised by Dr. Muir to have cervical surgery. This was performed by Dr. Muir. She had significantly reduced neck pain and right shoulder pain and reduced right arm tingling. She sought a second opinion from a pain physician in Dr. Bakersfield. She sought neurosurgical care with Dr. Khavkin, who performed an anterior L4-5 and L5-S1 fusion procedure. She had improvement in her legs. A few months later, she was back to work (with limitations). She bent down to attend to a child and strained her back and felt more low back pain. A CT scan was obtained. Posterior surgery was contemplated. She and Dr. Khavkin were trying everything they could to avoid additional surgery. She purposefully lost weight to help her low back. She did low back strengthening. She avoided lifting. Her low back has slowly improved and is now better before her flare-up she had after surgery.

CURRENT COMPLAINTS:

Her low back area is still the worst area. There is residual pain on the sacrum on a constant basis. The pain is tolerable unless she bends or does repetitive acts with her back. She feels best after a good night's sleep. There is mild right lateral thigh from the buttock to the lateral right leg to the outside of the right foot. There is also numbness at the same time, worse with lying on the right leg. There can be right low back pain when the leg is giving her trouble. She sometimes limps, but not often. Her distance is limited due to increasing low back pain (more than two laps around her cul-de-sac).

She reports urinary leakage mainly with coughing and sneezing. She did not have these symptoms prior to her injury or low back surgery. She has low back pain with intimacy. Her positional repertoire is limited due to her injuries or treatments.

She has limited low back motion with twisting and turning.

The neck area has limited motion. There is intermittent mild discomfort in the right trapezial and lower neck area. This is worse with sitting at a computer. Her headaches are very uncommon. There is no right arm pain, but she notes worsening right ulnar distribution numbness and bilateral hand pain.

There is some continued slow swallowing.

She continues to have issues with memory and calculations. She has to compensate by writing things down. She takes half of a valium from time to time due to stress. She had to be hospitalized three weeks ago. She uncommonly takes pain medications.

Household chores are limited and met with more symptoms.

She has residual depression but is managing as best as she can.

PREVIOUS INJURIES:

She sought chiropractic in college since her mother suggested it for maintenance.

In 2004, she bumped her head on the car trunk and had a brief concussion. A few months later, she bumped her head while cleaning the church bathroom, and had four hours of memory loss and was taken to the hospital. She made a full recovery, although she had a headache for a year.

She was in an accident at age 5-6 without injury.

She was in a traffic collision without injury at age 16

She was in a rollover accident in college (1981) and had neck pain and right knee pain. She was seen at a hospital. She received a colonic by a naturalist. Her pain resolved within a few weeks.

In 1985, she was in another accident and had neck pain. She had physical therapy. Her pain resolved.

She was in an accident without injury when her son was driving about eight years ago.

She denies work injuries or other childhood injuries. She denies work injuries.

She denies any other episodes of neck or back pain aside an occasional stiff neck.

She had one episode of anxiety in the 1990s.

PAST MEDICAL HISTORY:

Past history includes low blood pressure and PCOS.

PAST SURGICAL HISTORY:

The patient has had two D&Cs, hysterectomy, cyst ablation, four foot surgeries with hardware, back surgery, one neck surgery, and one plasma disc decompression.

MEDICATIONS:

Medications include Women to Women, Juice Plus, and occasional Valium.

ALLERGIES:

No known drug allergies.

FAMILY HISTORY:

Family history is positive for heart disease, diabetes, and back problems.

SOCIAL HISTORY:

The patient does not drink or smoke.

REVIEW OF SYSTEMS:

The following list was supplied to the patient for review with me:

General/Constitutional: Fevers, chills, nausea, vomiting, lethargy, fast or slow heartbeat, lapses of consciousness or memory.

Skin/Breast: Rashes, lumps under the skin, easy bruising, easy bleeding.

Eyes/Ears/Nose/Mouth/Throat: Sore throat, difficultly swallowing or getting food down, stuffed nose or sinuses, hoarseness.

Cardiovascular: Chest pain, skipped or irregular heartbeats.

Respiratory: Trouble breathing, frequent coughing, production of sputum, blood in sputum.

Gastrointestinal: Bloating, abdominal pain, pain after eating, trouble with bowel movements.

Genitourinary: Trouble starting or stopping urine flow, leakage of urine, impotence, incontinence, blood in the urine or burning on urination.

Musculoskeletal: Pain in the joints, limitation of range of motion, cramping in the muscles.

Neurologic/Psychiatric: Problem controlling mood, loss of appetite or sleepiness, sleeping too much, trouble with balance or walking, problems with vision, hearing, taste and /or smell.

Allergic/Immunologic/Lymphatic/Endocrine: Swollen lymph glands, frequent infections or illness, milk from breasts.

From this list, the patient chose difficulty with swallowing or getting food down sometimes, stress related chest pain, leakage of urine, pain in the joints, limitation of range of motion, loss of appetite, insomnia at times, trouble with balance or walking, and trouble with vision.

NEUROSURGICAL PHYSICAL EXAMINATION:

General: The patient shifts position often and sat with a pillow behind her. She cried while telling me how her family was affected by her injury.

Cervical Spine:

Appearance: Well healed cervical surgery just to right of center.

Palpation: No tenderness over the spinous process, or paraspinal musculature

Range of Motion:	Right	Left
Forward flexion:	Mildly reduced	
Reverse extension:	Mildly reduced	
Lateral bending:	Mildly reduced	Mildly reduced
Lateral twisting:	Mildly reduced	Mildly reduced

Provocative Testing: Spurling's maneuver was negative.

Upper extremities:

Arm Muscular appearance: Normal bulk and tone, with symmetry. No scapular winging.

Strength:	Right	Left
Grip	5/5	5/5

Interossei	5/5	5/5
Wrist flexion	5/5	5/5
Wrist extension	5/5	5/5
Brachioradialii	5/5	5/5
Biceps	5/5	5/5
Triceps	5/5	5/5
Deltoids	5/5	5/5
Trapezeii	5/5	5/5

Sensory Testing: Reduced pin prick right hypothenar area and right pinky.

Reflexes:	Right	Left
Brachioradialii	2	2
Biceps	2	2
Triceps	2	2
Knees:	2	2
Ankles:	2	2
Toes:	Downgoing	Downgoing
Clonus:	None	None
Hoffman's sign	No	No

Pathologic Reflexes: None

Gait: Heel, toe and tandem gait are normal.

Joint Range of Motion:	Right	Left
Shoulder	Mildly reduced	Mildly reduced
Elbow	Normal	Normal
Wrist	Normal	Normal

Joint Palpation:	Right	Left
Shoulder	Normal	Normal
Elbow	Normal	Normal
Wrist	Normal	Normal

Provocative Testing:	Right	Left
Impingement	Negative	Negative

Signs of Peripheral Nerve Entrapment	Right	Left
Median Tinel's	None	None
Ulnar Tinel's	None	None
Supraclavicular Tinel's	None	None
Phalen's Test	Negative	Negative

Lumbar Spine:

Appearance: Well healed left hypogastric scar. Scars on both large toes and both heels.

Palpation:

	Right	Left
Lumbar spine:		
Spinous Processes:	Nontender	Nontender
Facet Joints:	Nontender	Nontender
Paraspinal musculature:	Nontender	Nontender
Sacroiliac joints:	Nontender	Nontender
Sciatic notch:	Nontender	Nontender
Paraspinal bulk:	Reduced	Reduced
Paraspinal tone:	Normal	Normal

Range of Motion:	Right	Left
Flexion:	Mildly reduced	
Extension:	Mod. reduced extension	
Lateral Rotation:	*	*
Lateral flexion:	*	*

* = mild-to-moderately reduced

Lower extremities:

Leg Muscular appearance: Normal bulk and tone with symmetry.

Strength:	Right	Left
Plantar Flexion:	5/5	5/5
Dorsiflexion:	5/5	5/5
Extensor Hallucis longus	5/5	5/5
Knee Flexion:	5/5	5/5
Knee Extension:	5/5	5/5
Hip Abduction:	5/5	5/5
Hip Adduction:	5/5	5/5
Hip Flexion:	5/5	5/5

Sensory Testing: Reduced pin prick right lateral foot and lateral leg.

Joint Range of Motion:	Right	Left
Hip	Full	Full
Knee	Full	Full
Ankle	Full	Full

Provocative Testing:	Right	Left
Straight leg raise sign:	Negative	Negative
Sacroiliac Stress test:	Not performed	Not performed
Lateral Hip Tenderness	Negative	Negative
FABER sign	Negative	Negative
Crossed Abduction	Negative	Negative

Reflexes:	Right	Left
Knees:	2	2
Ankles:	2	2
Toes:	Downgoing	Downgoing
Clonus:	None	None

Gait: Heel, toe and tandem gait are normal.

Other Neurologic:
Romberg's test: Negative.

DIAGNOSTIC IMAGING:

I reviewed the following films personally as documented in my 7/3/12 Neurosurgical case review:

10/13/09 MRI Lumbar spine shows protrusions and mild loss of T2 signal at L4-5 and L5-S1. There is bilateral foraminal narrowing at L4-5. There is right more than left L4-5 inflammatory facet joint fluid.

9/23/10 Lumbar CT shows a ventral L4-S1 fusion construct with interbody spacers. The plate is elevated and there are some screw halos, mainly L4 and S1. The L5 screw does not look fully seated to the plate. The grafts are not incorporated.

11/2/11 Lumbar CT contains no reconstructed images. I cannot evaluate the fusion status well. The scout view does not show evidence of fusion and does show halos around the screws. The full study will be requested again.

SUMMARY OF TREATMENT FOR THIS INJURY:

Therapy:	Chiropractic treatment, 03/20/09 through 07/22/09.
Performed by:	Dr. Benjamin Lurie and Dr. Matthew Olmstead.
Result:	Temporary benefits.
Injections:	Transforaminal epidural at L4-5 and L5-S1 bilaterally and L4-5 bilateral facet injections, 05/20/09.
Performed by:	Dr. Marjorie Belsky.
Result:	Initial improvement but then had increased pain in the legs and back.
Injections:	Transforaminal epidural injection at C5-6 on the right, 08/26/09.
Performed by:	Dr. Marjorie Belsky.

Result:	Improvement with pain down from 7-10/10 to 5/10. Helped neck and shoulder area.
Injections:	Lumbar caudal epidural, 10/21/09.
Performed by:	Dr. Marjorie Belsky.
Result:	Temporary benefit.
Injections:	Lumbar caudal epidural, 12/09/09.
Performed by:	Dr. Marjorie Belsky.
Result:	Temporary relief. Had a lot of hot flushes since the injection.
Surgeries:	Plasma disc decompression L4 to S1, 09/16/09.
Performed by:	Dr. William Muir.
Result:	No benefit. Had increased symptoms.
Surgeries:	Anterior approach to the cervical spine, decompression discectomy C5-6, anterior cage placement C5-6, anterior fusion and plating C5-6, 01/25/10.
Performed by:	Dr. William Muir.
Result:	Significantly reduced neck pain and right shoulder pain and reduced right arm tingling. This is followed by subsequent tingling as noted above.
Surgeries:	Anterior lumbar approach for L4-5 and L5-S1 discectomy with placement of the interbody cage device by Stryker at the L4-5 and L5-S1 levels with an L4-5 interbody fusion using Vitoss and BMP followed by the placement of anterior lumbar instrumentation from L4 to SI using a Stryker Thor plate, 05/12/10.
Performed by:	Dr. Yevgeniy Khavkin.
Result:	Improvement in legs, strained back a few months later and had more low back pain, followed by slow and meaningful improvement.

REVIEW OF RECORDS AFTER CLINICAL VISIT:

I received and reviewed additional records:

1. 12/09/09 *Marjorie Belsky, MD of Surgery Center of Southern Nevada* – Operative report. The preoperative and postoperative diagnoses were ***"Lumbar disc bulge and lumbar radiculopathy."*** The procedure performed was **lumbar caudal epidural with dye study and fluoroscopic guidance**. There were no complications and the patient was advised to follow-up in one week.

2. 09/23/10 *Lawrence Bogle, MD of Las Vegas Radiology* – Report of CT of the lumbar spine, unenhanced with CT reconstructions. The study was compared to the prior MRI of 10/13/09. The findings revealed normal lordosis and no significant listhesis. The paraspinous soft tissues were normal. From T12 to L5, there was normal height without compression fracture. Anterior fixation of L4, L5 and S1 vertebral bodies were noted. At T12-L1 and L1-2, AP dimension of the central canal measured 15 mm. At L2-3, AP dimension of the central canal measured 14.2 mm. At L3-4, there was a diffuse disc bulge and AP dimension of the central canal measured 13.7 mm. There was mild stenosis of the bilateral neural foramen due to disc bulge. At L4-5, postoperative changes were noted in the anterior portion of the disc. There was 10.5 mm central canal stenosis due to 4.5 mm diffuse disc bulge. There was moderate stenosis of the bilateral neural foramen due to disc bulge and facet joint arthrosis. At L5-S1, postoperative changes were noted in the anterior portion of the disc. There was a 3 mm diffuse disc bulge. AP dimension of the central canal measured 12.2 mm. There was mild stenosis of the bilateral neural foramen due to disc bulge and facet joint arthrosis. The impressions of the study were ***"Interval anterior fixation of L4, L5, and S1 vertebral bodies, postoperative changes at L4-5 and L5-S1 intervertebral discs. L3-L4 – 2 mm diffuse disc bulge causing mild bilateral neural foraminal stenosis. L4-L5 – 10.5 mm central canal stenosis due to 4.5 mm diffuse disc bulge. There is moderate bilateral neural foraminal stenosis. L5-S1 – 3 mm diffuse disc bulge causing mild bilateral neural foraminal stenosis."***

3. 09/23/10 *Lawrence Bogle, MD of Las Vegas Radiology* – Report of bilateral screening mammogram. The findings revealed moderately dense parenchymal patterns bilaterally. No suspicious clusters of microcalcifications were seen. No asymmetric densities were identified to suggest the presence of malignant change. Several scattered benign-appearing calcifications were seen bilaterally. The impression of the study was ***"Bilateral mammography reveals no evidence of malignant change. Recommend annual screening."***

I reviewed my findings in detail with this patient. Questions were asked and answered satisfactorily.

NEUROSURGICAL IMPRESSION

Motor vehicle collision related injury resulting in:

1. Discogenic cervical pain with discogenic headaches and right upper extremity radiculopathy, improved after C5-6 anterior cervical discectomy with fusion and plating. There are mild residual symptoms, which are typical.

2. Low back pain, improved after L4-S1 anterior fusion with slow incorporation. There is improvement in the right leg radiculopathy with some residual right S1 numbness and tingling.

3. Mild post fusion right sacroiliitis.

4. Possible right ulnar neuropathy.

5. Secondary aggravated depression and anxiety.

6. Mild traumatic brain injury.

RECOMMENDATIONS:

1. Continue self-guided rehabilitation and weight loss.

2. Continue cognitive compensation.

3. Based upon her interval improvement and slow fusion incorporation in the lumbar spine, I will reasonably remove my prior recommendation for posterior lumbar fusion procedure from my life care plan, including medical clearance, and any other factors related to that surgery.

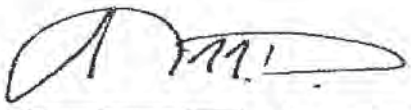
FOLLOW-UP:

Follow-up as needed.

DISCUSSION:

It appears clear based on my own history taken directly from the above named patient, a physical examination as performed by me, review of diagnostic tests listed, review of relevant medical records supplied, and taking into consideration the mechanism of injury, that the above listed diagnoses and the need for further work-up and treatment are directly related to the stated injury. My opinion is based upon the traditional application of constructive medical logic. There is no information to detract from this opinion. I would make myself available to review any additional medical records or clarification of my opinion as would be appropriate.

Sincerely,



JEFFREY D. GROSS, M.D.
Spine Fellowship Trained Neurosurgeon
Diplomate, American Board of Neurological Surgery

EXHIBIT "E"

Comprehensive Injury Institute
Complete Care from Diagnosis to Treatment

Office of: **Jeffrey D. Gross, M.D.**
Spine Fellowship Trained Neurological Surgeon
Diplomate, American Board of Neurological Surgery

September 29, 2012

PATIENT NAME: **SEASTRAND, MARGARET**
DATE OF BIRTH: **12/27/1961**
DATE OF INJURY: **03/13/09**
DATE OF REVIEW: **09/29/12**

NEUROSURGICAL SUPPLEMENTAL REPORT

To Whom It May Concern:

I received and reviewed the following reports:

1. 12/08/04 *Lisa Underwood, MD* – Report. The patient complained of **"left lower quadrant pain, burns, improved with eating, radiates down leg, onset eight years ago, now pain is worse six weeks – daily – better with lying flat."** She was doing Weight Watchers since two weeks. She had a concussion on labor day weekend, and had headaches for three weeks, CT normal. She had menstrual migraines, and IBS. Past surgical history included D&C, left ovarian cyst rupture in 1997, endometriosis, LLQ pain, colon adherent to sidewall 2002, and LAH-BSO in 2003. She had severe PMS. Family history and social history were reviewed. The assessment was ***"Menopausal syndrome. Hormone imbalance. LLQ pain, history of endometriosis, history of adhesions. Rule out hernia, ? constipation. Chronic insomnia. PMS, moody, migraines. IBS."*** Lab studies and diagnostic studies were ordered. Prescriptions were provided for medications and the patient was advised to follow-up in four to six weeks.

2. 12/08/04 *Lisa Underwood, MD* – Report. The patient had had a **near syncopal episode** (history of headaches for three weeks, recent concussion, MRI within normal limits). She used **melatonin** and last used **Sarafem** in the AM. The plan was to obtain an MRI of the head and observe the patient for 24 hours and to give consideration for EEG/neuro consult.

3. 12/08/04 *Robert S. Pretto, MD of West Valley Imaging* – Report of whole body percentage fat composition. Using a GE DEXA scanner, whole body images were performed and analysis for total body fat was performed. The total body fat was calculated at 44.0 %, placing the patient in the 92nd percentile. No other abnormalities were seen. Whole body, DEXA scan calculation for bone mineralization put the patient in a T score of +2.0, placing her with normal bone mineralization for age. The impression was ***"Total body fat of 44.0%."***

4. 12/09/04 *Sunrise Hospital Laboratory* – Laboratory report. Comprehensive metabolic panel showed high chlorine at 108 and low albumin/globulin ratio at 1.5 and low SGPT/ALT at 12. PT with INR and PTT was normal. CBC was within normal limits.

5. 12/09/04 *Quest Diagnostics* – Laboratory report. PAP smear were negative for intraepithelial lesion or malignancy. Pregnenolone was normal at 18. TSH was within normal limits. Estradiol was reduced to 87. Testosterone, free testosterone, and percent testosterone and AM cortisol were normal. CBC with differential and platelets was within normal limits. DHEA sulfate was normal at 247.5. Cardio CRP was at 2.2. Cardiovascular homocysteine was high as 12.3. Free T4 was normal at 1.1. Insulin was low as 4.8. Lipid panel showed high HDL as 76. Glycohemoglobin A1c was 5.4. Free T3 was normal at 308 and TSH was normal at 2.0.

6. 12/10/04 *Simon J. Farrow, MD of Sunrise Hospital and Medical Center* – Report of electroencephalogram. The electroencephalogram which was recorded at the patient's bedside was so extensively contaminated with electromyographic and maintenance frequency activity as that it was mostly un-interpretable. ***There did not appear to be any prominent focal or paroxysmal slowing. Background rhythm at about 10 cycles per second was symmetrical and reactive to eye opening. Contamination was primarily anterior.*** Dr. Farrow commented that if there was any question of epileptic activity, and if the purpose of the recording was to look for irritative foci, spikes, etc, a repeat recording would be clinically appropriate.

7. 12/10/04 *Lindsey C. Blake MD of Sunrise Hospital/Med Center* – Report of intracranial MR angiogram without contrast. The findings showed normal intracranial arteries in caliber. Hyperplasia of the left P1 segment was an anatomic variant. There was no stenosis or major branch occlusion. There was no vertebral basilar stenosis or no aneurysm or AVM. The impression was ***"Negative."***

8. 12/10/04 *Lindsey C. Blake MD of Sunrise Hospital/Med Center* – Report of an MRI of the brain without and with contrast. The findings showed normal midline brain structures. The sella and suprasellar cistern and optic chiasm were unremarkable. The brain, cerebral ventricles, and extra-axial CSF spaces were within normal limits. There was no mass or abnormal intracranial enhancement. In the superficial lobe of the left parotid gland there was a 4 mm focus of increased signal. Images were not completely obtained through this lesion. The impression was ***"Appearance of the brain is within normal limits, left parotid 4 mm nodule in the superficial lobe. This may represent a lymph node. A tumor cannot entirely be excluded."*** Follow up was suggested.

9. 12/10/04 *Anil Fotedar, MD of Sunrise Hospital and Medical Center* – 2-D and Doppler echocardiography. The impression was ***"Normal left ventricular size and systolic function. Estimated ejection fraction 60%. Redundant mitral valve without evidence of mitral valve prolapse. Normal chamber size. No pericardial effusion, intracardiac thrombus, or vegetation. No mitral regurgitation."***

10. 12/11/04 *Sunrise Hospital Laboratory* – Laboratory report. Basic metabolic panel was within normal limits.

11. 12/14/04 *Lisa Underwood, MD* – Report. Message. The patient called to say that the doctors found nothing when she was admitted for testing on 12/08/04. The patient was to pursue the recommendations of the last office visit – clear out her bowels.

12. 01/13/05 *Lisa Underwood, MD* – Visit report. The patient had a history of left lower quadrant pain, used two enemas, now no pain. She had a trial of **Sarafem** with improvement in mood, decreased migraines and normal sleep. Results of labs studies and DEXA study were reviewed. She still had dizziness. The assessment was ***"history of near syncopal episodes, hospitalized for three days, history of concussion, increased homocysteine, and vaginitis".*** The patient was recommended to follow-up with Dr. Diaz. Labs were ordered and medication prescriptions provided. The patient was advised to follow-up in six weeks.

13. 01/19/05 *Thomas Lambert, MD of Cardiology Specialists of Nevada* – Initial office evaluation. The patient reported that she hit her head back in September on the back of a hatchback. About three days later, she had a **headache** and was hospitalized. Head CT was negative and she was diagnosed with a **concussion**. In December, she hit her head on a towel rack. A few days later she had quite a bit of blood drawn by her general practitioner. She became **dizzy and developed double vision**. She felt that she **blacked out** and her **vision dimmed**. Her husband reported that she talked

throughout the next four hours but she had no recollection of this. Evidently MRI scan, carotid ultrasound, and echocardiogram were normal at Sunrise Hospital. She had chronic low blood pressure. She had been trying to lose weight over this time with Weight Watchers. She had been diagnosed with **low progesterone levels**. She did have **fluid retention with salt**. She would drink large amounts of water throughout the day. She did have some **dizziness with walking two days ago**. Current medications were **Estrogen, Sarafem, melatonin, and ibuprofen**. Past medical history was positive for **acid reflux**. On examination, blood pressure supine was 100/64 and heart rate 58. Standing blood pressure was 96/62 and heart rate increased to 73. EKG showed normal sinus rhythm. The diagnoses were ***"Post concussion syndrome with persistent headache. Chronic low blood pressure with orthostatic changes. Syncope times one and near syncope, probably secondary to increased vagal tone with the concussion."*** The patient was recommended to push salt and continue **ibuprofen** at least six tablets per day. She was started on **Elavil** and was asked to return in two to three weeks for follow up. The records from Sunrise Hospital were requested for review.

14. 01/24/05 *Thomas Lambert, MD of Cardiology Specialists of Nevada* – Follow up visit. The patient returned for follow up and reported over the weekend she had **blood pressure drop in the 70's with severe headache and lightheadedness**. She slept for 14 hours. She had been taking **Elavil** and overall her symptoms had been better than previous. On examination, supine blood pressure was 118/62 and heart rate 62 and standing BP was 118/88 and heart rate 84. Heart showed normal S1, S2 with a very soft mild systolic murmur at the apex. The impression was ***"Recurrent episodes of hypotension, probably related to blood pressure drops from higher vagal tone with the postconcussive syndrome."*** The patient was started on **Florinef** and was recommended an echocardiogram in one to two weeks and office visit in three to four weeks. She was to check chemistry prior to next visit.

15. 02/16/05 *Thomas Lambert, MD of Cardiology Specialists of Nevada* – Report of echo/Doppler. The impression was ***"Mild mitral valve prolapse with mild mitral regurgitation, suggest antibiotic prophylaxis."***

16. 03/11/05 *Thomas Lambert, MD of Cardiology Specialists of Nevada* – Follow up visit. The patient reported that every time she had a **headache, she would become vagal and drop her blood pressure.** She had several **fainting episodes**. She felt very well with **Florinef** as regards to her periods of hypotension, but she started to have swelling and then increasing headache. She had since discontinued this. She continued to use **Advil** about six to eight per day. On examination, BP was 124/80 and pulse 105. The diagnosis was ***"Postconcussive syndrome with recurrent near***

syncope from neurogenic cause." **Advil** was discontinued. She was started on **Naprosyn** and recommended continuing **off Florinef**. **ProAmatine** was to be considered if she had continued symptoms. The patient was asked to return in four to five weeks and recommended antibiotic prophylaxis for dental work.

17. 03/15/05 *Luis Diaz, MD of Summerlin Medical Center* – Consultation. The patient presented for consultation with the history of two separate incidents in which she experienced **head trauma**. The first one was on 09/04/04, when she hit her head in the occipital area against the hatchback of her car. She did not lose consciousness, but she became somewhat **dizzy** and the next day she **developed a severe headache** that lasted for one-month. The patient had a CAT scan of the head done through the emergency room, which was negative. She actually had resolution of the headaches after one month. **She did well and she was asymptomatic until 12/04/04, when she also suffered again, another incident of head trauma in the occipital region**. This was against a tall dispenser when she was in the restroom cleaning it at her children's school. This time, the patient did not lose consciousness either; however, she developed a **headache** immediately that had been present till date. This headache was now described as being present in the **left hemicranium** and associated with feelings of **nausea** and **lightheadedness** without any other symptoms. Her headaches were constant, 24-hours per day seven days per week. The episodes of lightheadedness were only present when the severity of the pain intensified to a great degree. Four days after the incident in December, the patient became confused for about four hours at home. She was taken to Sunrise Hospital where she remained for several days. Records from that hospitalization were unavailable for review. The patient, however stated that her neurologic workup was completely negative including MRIs, EEGs, and blood work. She was only found to have a mitral valve prolapse. She had extensive evaluation with a cardiologist. She had episodes of hypotension as low as 75/37, but always related to severe headaches. Apparently, the patient was never evaluated with a Tilt-tablet test. The ongoing medications were **naproxen, Elavil** since 01/19/05, **hormonal replacement therapy, melatonin, and Sarafem.** On examination, vitals showed blood pressure as 120/80 and pulse of 80. The patient had no orthostatic hypotension. Neurological examination was unremarkable except for decreased vibration distally. The impressions were ***"History of posttraumatic headaches."*** Dr. Diaz felt that the description of the headaches fitted a vascular origin. He noted the episodes of lightheadedness with documented hypotension but the patient had no signs of autonomic neurosystem disease. Her blood work had ruled out thyroid disease and only found an elevated homocysteine level. Due to persistent severe headaches, the patient was started on **Topamax**. She was recommended to continue the other medications but

discontinue **Elavil** as she had no benefit from it. Further recommendations or work up was pending review of the records and MRI films from Sunrise Hospital.

18. 05/15/05 *Thomas Lambert, MD of Mountainview Hospital and Medical Center* – Echocardiogram. The impression was ***"Technically adequate study. Normal left ventricular size and systolic function. Normal left atrial, right atrial, and right ventricular size. Redundant anterior leaflet of the mitral valve without mitral valve prolapse. Trace mitral regurgitation present. No other regurgitant or stenotic lesions seen by Doppler. No pericardial effusion, masses, or vegetations seen."***

19. 05/16/05 *Thomas Lambert, MD of Mountainview Hospital and Medical Center* – Adenosine Stress Test. The initial heart rate was 62 and initial blood pressure was 135/79. Maximal heart rate was and minimal blood pressure was 126/74. Resting EKG showed normal sinus rhythm. Stress EKG showed 0.5 mm of inferolateral upsloping ST segment depression with adenosine. The impression was ***"Adequate heart rate. Mild blood pressure response to adenosine. Clinically with chest heaviness. Electrocardiogram with mild to moderate changes, not diagnostic ischemia."***

20. 06/23/05 *Thomas Lambert, MD of Cardiology Specialists of Nevada* – Follow up visit. The patient had prolonged recurrent **headache and periods of vasovagal syncope and near syncope.** She had been off **Florinef and off Naprosyn.** She found that the **Seraphim** was giving her a headache and this had been discontinued. She was still having very **rare fainting spells, which were neurogenic in origin**. She had not had any fully syncope lately. Vitals showed blood pressure 112/72 and heart rate 70 without significant orthostatic changes. The impression was ***"Neurogenic near syncope, which is significantly improved."*** The patient needed to continue to be well hydrated and should not be on a salt restriction. She was asked to return to Weight Watchers and return in three months.

21. 01/19/06 *Thomas Lambert, MD of Cardiology Specialists of Nevada* – Follow up visit. The patient was previously seen for postconcussive syndrome. She was having recurrence that was bringing on vasovagal syndrome. She still had **periods of zoning out and lightheadedness, sometimes associated with blood pressure drops in the 70's.** She had been off her **Florinef** for several months now. She had been pushing salt and felt much better with this. The **lightheaded spells were much less frequent**, might be once a month. She had, over the last six weeks, had **increasing palpitations**, however. These were isolated episodes of ectopy, nothing sustained. There was no associated syncope or near syncope or chest discomfort with the palpitations. She denied any peripheral edema although she felt a little

fluid retention with her extra salt. Physical examination showed blood pressure 128/82 and heart rate 81. The impression was ***"New onset isolated palpitations. History of neurogenic syncope. Occasional blood pressure drops which are probably neurogenic in origin and unrelated to the mitral valve prolapse but the patient usually has lower blood pressure than seen today."*** Salt loading was continued and she was recommended Holter monitoring. Dr. Lambert discussed with her potential to go back on the **Florinef** to alleviate the near syncopal spells completely but she was asked just to push the salt at that point in time. The patient was having some periodic headaches as a residual of the postconcussive symptoms but she was blocking these with **Advil** on the first onset and this was helping to avoid hypotensive episodes that had previously occurred with the headaches and secondary vagal symptoms. Beta blocker was to be considered in the future if her blood pressure remained elevated.

22. 02/21/06 *Thomas Lambert, MD of Cardiology Specialists of Nevada* – Holter ECG summary report. The conclusions were ***"The average heart rate was 71, with a minimum of 46 and a maximum of 132. Ventricular ectopic beats totaled three, with 0 VE Pairs and a 0 V-Runs. Supraventricular ectopics totaled 1, with 0 SV-Runs. Pauses in excess of 2.5 seconds totaled 0. The number of minutes of analyzed ECG data was 1423. ST episode minutes totaled 0."***

23. 03/20/06 *Lisa Underwood, MD* – Visit report. The patient stated that she had a terrible year. She had **two concussions, was hospitalized thrice, now had low blood pressure with pain and syncope**. She had had a 10 lb weight loss, was feeling great otherwise. She was following up with Dr. Lamber for her cardiac issues. Her medications included melatonin, Sarafem, pregnenolone, Vivelle, and Estradiol. Assessment was ***"menopause, new onset syncope, history of recurrent episodes, seen by neuro, vaginitis."*** Labs were ordered.

24. 03/22/06 *Thomas Lambert, MD of Cardiology Specialists of Nevada* – Follow up visit. The patient was seen for previous postconcussive syndrome. She was having **recurrent headache** that was bringing on **vasovagal syndrome**. She previously had been having periods of lightheadedness, sometimes associated with blood pressure drops. She had changed her diet and was eating a lower carbohydrate diet and was feeling much better. At the last visit she was having isolated palpitations. Holter monitor showed just three PVC's for the day and one PAC with no significant arrhythmias. She continued salt loading. She was feeling much better. On physical examination, blood pressure was 118/76 and heart rate was 74. The impression was ***"Isolated palpitations but only rare PVC's seen. History of neurogenic syncope associated with postconcussive syndrome.***

Previous drops in the blood pressure that are probably neurogenic in origin that are improved currently. History of underlying mitral valve prolapse." The treatment plan was to continue off beta blockers since the patient was asymptomatic. She was to return in six months for follow-up.

25. 10/19/07 *Behzad Karmani, MD of Paseo Medical Center* – Office visit/regular check up. The patient was evaluated for **bilateral ankle pain,** especially in the morning. She stated she always had **low blood pressure**. She had a closed head injury in 2004, and had had **loss of consciousness**. Review of systems was positive for **headaches**. Examination showed enlarged thyroid nodule. The assessment was ***"Musculoskeletal pain in the ankles, chronic baseline hypotension with negative workup, headache with chronic history of the same, thyromegaly with nodules, MVA per history with back pain though quite infrequent flare ups, hysterectomy per history, breast lumps per history, anxiety, and probable mitral valve prolapse."*** For pain in the ankles, the recommendation was to obtain x-rays and place the patient on NSAIDs. It was felt that this pain was likely an inflammatory process. Early degenerative entities needed to be ruled out. The patient was placed on **naproxen** 500 mg with GI precautions and followup. The patient was utilizing beta blockers for headaches and at times that would drop her blood pressure. She was under the care of a different physician for that matter. The patient reported that at times she would phase out though she heard people, she would not respond for a while. She reported that she had checked out of seizures, but did not have seizures. Records on that were ordered for review. For thyromegaly, Dr. Kermani ordered labs and ultrasound. The patient was to follow up with her gynecologist. Anxiety issues were to be checked subsequent to thyroid evaluation. She was recommended obtaining an echocardiogram for possible mitral valve prolapse and was to return in two months for reevaluation.

26. 10/19/07 *Clement Herred, MD of West Valley Imaging* – Report of x-rays of the right ankle, two views. The impression was ***"No acute radiographic changes. There is a large plantar calcaneal spur. Otherwise radiographically normal with intact osseous structures and normal joint relationship."***

27. 10/19/07 *Clement Herred, MD of West Valley Imaging* – Report of x-rays of the left ankle, two views. The impression was ***"No acute radiographic changes. There is a large plantar calcaneal spur. Otherwise radiographically normal with intact osseous structures and normal joint relationship."***

28. 10/19/07 *Clement Herred, MD of West Valley Imaging* – Report of x-rays of the chest, PA and lateral. The findings showed normal heart size and vascular

pattern. Lungs were clear. The osseous structures were intact. The impression was ***"Normal chest."***

29. 11/07/07 *Terry Leavitt, DPM of Affiliated Podiatry* – Initial podiatry exam. The patient complained of **bilateral heel spurs that were painful. The pain was mostly on the medial side of the bilateral feet with painful bumps**. Ongoing medications were **naproxen and estrogen**. The past surgical history was positive for two D&C, two cyst ablation, and hysterectomy. Review of systems was positive for **headaches, low back pain, and mitral valve prolapse**. On examination, there was hallux valgus bilaterally. The assessment was ***"Pain in heels bilaterally-first step pain, x-rays revealing calcaneal spurring, and hallux valgus bilaterally."*** The condition was explained to the patient. No treatment was given at this visit. The patient was prescribed **Celebrex** and was scheduled for surgery.

30. 02/12/08 *Terry Leavitt, DPM of Affiliated Podiatry* – Office visit. The patient was evaluated for heel spurs. She wanted surgery. She complained of **pain in the heels** and due to hallux valgus she wanted to schedule for surgery. The procedure was explained to the patient.

31. 02/19/08 *Quest Diagnostics* – Laboratory report. Liver profile, random glucose, and CBC with differential and platelets were within normal limits. HIV was non reactive.

32. 02/21/08 *Terry Leavitt, DPM of Parkway Surgery Center*– Operative report. Preoperative and postoperative diagnosis was ***"Hallux valgus with bunion deformity bilateral and plantar calcaneal exostosis bilaterally."*** The procedure was **Excision of plantar calcaneal exostosis and Austin bunionectomy with osteotomy and screw fixation bilaterally.** Following the procedure, the patient was taken to the recovery with stable vitals and in satisfactory condition.

33. 03/03/08 *Terry Leavitt, DPM of Affiliated Podiatry* – Office visit, first postoperative follow up. On examination, the incision was clear and dry and progress was satisfactory. The assessment was ***"Satisfactory progress."*** The sutures were removed.

34. 04/14/08 *Terry Leavitt, DPM of Affiliated Podiatry* – Office visit. The patient complained of **swollen left foot, sore both feet**, mainly left. She could not place the left foot on the floor. She complained of pain in the **left hallux**. She bumped her foot and developed pain at the osteotomy site. She was given a prescription for **ibuprofen.**

35. 10/27/08 *Behzad Kermani, MD of Paseo Medical Center* – Office visit. The patient was evaluated for **chest pains** over the last few days. She had been

having **left chest wall pain associated with numbness and tingling bilaterally in both arms. The pain would shoot down her left arm**; however, she had no numbness bilaterally. She denied any shortness of breath. She recently had bilateral foot surgery and just recently exercising again. The exercise actually would take her chest pain away; thus her **pain was not exertional**. She had been having quite a bit of **stress from her job**. No significant findings were noted on exam. The assessment was ***"Atypical chest pain, numbness, and anxiety."*** Dr. Kermani recommended noninvasive workup, cervical spine and chest x-rays, and EKG. He placed the patient on NSAIDs. The patient was referred to cardiology for echocardiogram and stress test. He recommended that the patient be placed on **anxiolytics, Ativan** or **Xanax** for anxiety. She was recommended GYN update. Based on the history of possible thyroid nodule as indicated in the records, he recommended further evaluation for the same.

36. 10/27/08 *S. Robert Hurwitz, MD of Paseo Medical Center in Las Vegas, Nevada* – Report of chest x-rays. PA and lateral views of the chest showed unremarkable osseous structures, normal heart size, and no hilar or mediastinal adenopathy. The lungs were clear, without infiltrate, mass or volume loss. The impression was ***"Normal examination."***

37. 10/27/08 *S. Robert Hurwitz, MD of Paseo Medical Center in Las Vegas, Nevada* – Report of x-rays of the cervical spine, four views. The spine was mildly flexed to the right suggesting muscle spasm. The vertebral bodies were well maintained without fracture. There was mild disc space narrowing at C5-C6 with early interbody osteophytic spurring. There was early spondylitic encroachment by uncinate process spurring at C5-C6. The impression was ***"Mild rightward flexion of spine compatible with muscle spasm and spondylolytic [sic] changes of mild degree at C5-C6."***

38. 10/27/08 *Unknown physician* – Report of EKG. The impression was ***"Sinus rhythm. Incomplete right bundle branch block."***

39. 11/05/08 *Quest Diagnostics* – Laboratory report. CBC with differential, comprehensive metabolic panel and lipid panel were within normal limits. Urinalysis was unremarkable except for presence of few bacteria. Thyroid panel showed high TSH as 4.76.

40. 12/15/08 *Sohail Anjum, MD of Heart Center of Nevada* – Report of stress test. The test protocol was standard Bruce. Total exercise time was 09:50. Maximum heart rate was 149, % predicted MHR achieved 86%, peak BP measured was 134/76. Myoview injected at 146 bpm which was 84% of the predicted maximal heart rate. Resting EKG showed normal sinus rhythm at 75 bpm with an incomplete right bundle branch block and

nonspecific ST changes. The conclusion was ***"Positive exercise stress test for exercise induced myocardial ischemia. This was ST-T depression in the inferior lateral leads. The patient denied chest pain. Frequent premature ventricular and atrial contractions. Heart rate response was normal. Blood pressure response was normal. Separate myocardial perfusion report to follow."*** Recommendations were pending following perfusion imaging.

DATE OF PRESENT INJURY: 03/13/09

41. 01/07/10 *Drs. Diaz and Horan* – Billing statement. Total charges for the services provided on 03/15/05 were $250.00.

42. 03/15/11 *Affiliated Podiatry Group* – Billing statement. Total charges for the services provided from 12/07/07 through 04/14/08 were $5,060.00.

43. 03/16/11 *Lisa Underwood, MD* – Billing statement for services provided on 03/20/06. Total $490.00. Diagnoses ***"hormone imbalance, candidiasis vulva/vagina, insulin resistance."***

44. 03/16/11 *Lisa Underwood, MD* – Billing statement for services provided on 01/13/05. Total $270.00. Diagnoses ***"hormone imbalance, insulin resistance."***

45. 03/16/11 *Lisa Underwood, MD* – Billing statement for services provided on 12/08/04. Total $1,120.00. Diagnoses ***"pelvic pain, pre-menstrual tension syndrome, migraine, NOS not intractable."***

46. 03/30/11 *Thomas Lambert, MD* – Billing statement. Total charges for the services provided from 01/19/05 through 03/22/06 were $3658.00.

47. 07/12/12 *John Siegler, MD* – Letter to Mr. Steven Jaffe with opinions following review of records. Dr. Siegler notes his review of multiple records encompassing the time frame from 01/19/05 through January 2011. Records predating the subject incident allude to a diagnosis of postconcussive headache and low blood pressure in January 2005, evaluation for post-traumatic headaches in March 2005, mitral valve prolapse and neurogenic syncope treatment in March 2006, hallux valgus bilaterally treated in November 2007, bunion deformity and excision of exostosis in February 2008, chest pain and shortness of breath complaints in October and November 2008. He also documented his review of imaging studies following the subject accident. Billing charges from various facilities / clinicians were reviewed.

Based on the review, Dr. Siegler establishes the medical summary of the case. He notes that **the patient developed neck pain and headaches following the subject accident,** then underwent chiropractic treatment at which time she was noted to have **low back pain with radiation to both legs.** The patient had a lumbar discogram and then underwent plasma disc decompression. She had persistent symptoms and underwent cervical spine and lumbar spine injections and eventually a lumbar fusion by Dr. Grover. *[Reviewer' note: medical records and the patient's own history reflect that Dr. Khavkin performed the lumbar fusion surgery in May of 2010, not Dr. Grover.]* Dr. Siegler's accident related diagnoses were "***Exacerbation of cervical pain. Exacerbation of lumbar pain. Cervicogenic headache.***" *[Reviewer's note: Dr. Siegler's attempted "diagnoses" appear to blur any incidental pre-injury, but resolved symptoms, with new injuries from the present trauma. Such efforts to add vagueness to the details works against a logical and thoughtful analysis as to pre-injury and post-injury events, and render his "diagnoses" incomplete inaccurate. As stated in my 7/3/12 Neurosurgical Case Review, "a past history of neck and back pain and one prior concussion appear to have no significant factor in the need for treatment stemming from the present injury." In making that statement, I had reviewed all the prior and present records in an effort to determine and/or define any relationship between incidental past events and the present injury. Clearly, a history of neck pain and back pain was only mentioned in a single medical record in 2004, and for which no additional treatment or mention exists until the present injury. Thus, any such prior symptoms appeared to be nothing significant and any present treatment would not be required absent the present injury.]*

Dr. Siegler then notes that the patient had a documented history of cervical and lumbar pain. She had back pain with flare ups in 2007 and in 2008 was seen for numbness and tingling radiating to both arms and shooting pain into the left arm. *[Reviewer's note: Dr. Siegler appears to completely mis-represent the medical records (See above). There are only two mentions of low back pain, and one the one that deals with frequency specifically notes "quite infrequent flare-ups." In addition, he conveninently omits the fact that the records note that the episode of tingling to the upper extremities was related to chest pain and stress.]* He stated that the imaging studies did not indicate any acute pathology and given her previous history, it was likely that the disc findings were preexisting. *[Reviewer's note: no films exist to confirm Dr. Siegler's speculation. There is no basis to support a pre-injury discal abnormality or clinical ramifications thereof. Pre-existent spondylosis is expected.]* He was of the opinion that chiropractic treatment following the injury was appropriate. He questioned the diagnostic utility of the injections performed by Dr. Belsky on 05/20/09 as both epidural injections and facet

injections were done at the same time. He also voiced concern over the use of sedation during discography as it would have confounded the patient's ability to express and describe the pain when the discs were stimulated. *[Reviewer's note: I order all of my discograms with sedation since they are painful. The patient is briefly aroused for the provocative portion and then re-sedated. This is common practice in the pain community.]*

With regards to plasma disc decompression, he stated that this was indicated primarily for radicular pain occurring at one level. He thus questioned the performance of the plasma disc decompression based upon the discogram results, which was done to diagnose discogenic pain and not radicular pain. Furthermore, he was of the opinion that the discogram and plasma disc decompression were done prior to other conservative treatments being exhausted. *[Reviewer's note: Ms. Seastrand underwent and completed about 4 months of chiropractic therapy and underwent a number of pain injections prior to pursuing plasma disc decompression. That appears to be a reasonable and conservative course.]* He also was of the opinion that the lumbar fusion was not medically indicated as this was based upon the incorrect data from the discogram. *[Reviewer's note: There is no basis that the discogram was anything but confirmatory and diagnostic in the present matter. Ms. Seastrand's present condition is also testament to the need for fusion surgery. Thus, Dr. Siegler's opinion is not supported in regards to the need for fusion surgery.]*

48. 08/01/12 *J. Pablo Villablanca, MD* – Letter to Mr. Steven Jaffe and Mr. Jacob Smith. Dr. Villablanca reviewed medical records and imaging studies per the retention letter dated 04/25/12 with regard to the Khoury versus Seastrand case. He discussed the summary of the case stemming from the motor vehicle accident of 03/13/09. He notes that per the retention letter, both the vehicles had minimal damages with a small puncture defect in the rear bumper of Ms. Seastrand's vehicle and a small crack on the bumper of Mr. Khoury's vehicle, which was also confirmed by photographic evidence of both vehicles. Ms. Seastrand informed the officers at the scene that she had prior neck and back injuries caused by another accident years before the subject accident. The officer, Mr. Conn, had stated in his report that the injuries being claimed by Ms. Seastrand were not consistent with being caused by the collision. This, Dr. Villablanca, thought projected that the accident was of a trivial nature. *[Reviewer's note: as a physician who treats injuries, I have learned to treat patients, not vehicles. Vehicles are designed to withstand impact. The human body has not been afforded any re-design. It is illogical and inappropriate to measure the injuries to a person by virtue of the damage to vehicles involved. Furthermore, any prior symptoms as noted in the records appeared to have been significantly, if not completely mitigated prior to the present*

injury. Hypothetically, if any such anatomic changes were caused by any prior injury, such changes would have rendered Ms. Seastrand more susceptible to the present trauma. Dr. Villablanca omits and such discussion of susceptibility in his reliance on prior events, thus rendering his opinion incomplete and oversimplified.]

Dr. Villablanca further notes that Ms. Seastrand had had two prior automobile accidents of much greater severity than the subject accident. Following the subject accident, she had anterior decompression, discectomy and interbody fusion with cage and plate as a result of disc herniation at C5-6 and also underwent plasma disc decompression and subsequent lumbar fusion due to internal disc disruption of the lumbar spine at L4-5 and L5-S1 disc levels, with total medical costs to date being $400,000. She had a postoperative complication of displacement of the anterior fusion construct, which was thought to necessitate an additional future posterior fixation fusion at a cost of $122,200, per the opinions of Dr. Grover and Dr. Khavkin.

Dr. Villablanca then documented his review of imaging studies. He reviewed a chest x-ray of 10/27/08 revealing no significant findings. He was in agreement with Dr. Robert Hurwitz' interpretation of cervical spine x-rays from 10/27/08 as showing straightening of the cervical lordosis to suggest muscle spasm and mild narrowing of the C5-6 disc space with evidence of anterior and posterior vertebral body endplate osteophytes as well as neural foraminal narrowing due to uncovertebral joint osteophytes. Cervical spine x-rays from 03/13/09 were then reviewed and Dr. Villablanca's impressions were that these showed moderate disc space degeneration at the C5-6 disc level that had progressed since the prior study of 10/28/08. *[Reviewer's note: please refer to above mentioned absence of a discussion of susceptibility from any such anatomic changes.]* He thought that Dr. David Gorczyca who read the study had under interpreted it with respect to the degree of degeneration of the C5-6 disc and in absence of comparison films, Dr. Gorczyca could not have observed interval progression of disease at the C5-6 disc level. A brain MRI of 03/13/09 is then reviewed and interpreted as being a negative study.

Dr. Villablanca then reviewed a noncontrast cervical spine MRI from 04/03/09 and his impressions were that this showed mild reversal of the normal cervical lordosis centered at the C5-6 disc level that may be related to muscle spasm of indeterminate chronicity. There was essentially single level degenerative disc disease, consisting of moderate degenerative disc space height loss at C5-6, associated with mild anterior Modic type I degenerative discogenic endplate change, and circumferential disc osteophyte complex that was degenerative in nature and caused mild

spinal canal stenosis. There was mild neuroforaminal narrowing bilaterally due to degenerative uncovertebral joint osteophytes. There was no facet degeneration, no evidence of acute disc herniation, bony or soft tissue abnormality aside from possible paraspinal muscle spasm. The original study was interpreted by Dr. George Mulopulos and Dr. Villablanca generally concurred with his interpretation of the study. He, however, was in disagreement with Dr. Keith Lewis' interpretation of the same study and thought that this had been over interpreted. He stated that the mention of bone contusions without fractures at the C5-6 disc level was not supported by the remaining findings, including the absence of prevertebral soft tissue swelling or posterior paraspinous muscle edema that would be expected if the Modic type I discogenic endplate degenerative changes present in the anterior vertebral endplates had in fact been bone contusions. He also saw no evidence of torticollis or disc protrusion at C4-5 on either the sagittal or axial images. *[Reviewer's note: it appears that Dr. Villablanca is selectively referring to one reading of that MRI as over-read and another as under-read without discussion as to the complexity of susceptibility and without discussion of clinical correlation.]*

A noncontrast MRI of the lumbar spine from 04/03/09 was then reviewed. Dr. Villablanca again thought that the study was over interpreted by Dr. Keith Lewis. *[Reviewer's note: see review of films, below.]* He stated that there was no focal posterior disc abnormality at the L4-5 disc level but only a small right foraminal disc abnormality of indeterminate age, and moreover this was insignificant as it did not compromise the exiting right L4 or traversing right L5 nerves. He also stated that there was no disc herniation at L5-S1 but only circumferential disc bulging and disc desiccation that appeared degenerative in nature. There was also a prominent prevertebral venous plexus that mimicked a disc abnormality on the axial T2W images which was confirmed by the absence of any focal disc contour abnormality on the sagittal T1W or T2W sequences. He also saw no evidence of scoliosis to suggest muscle spasm.

Dr. Villablanca reviewed a noncontrast MRI of the lumbar spine dated 10/13/09. He interpreted this as showing facet joint degeneration at L4-5 and L5-S1 **that had progressed** from being moderate on 04/03/09 to moderately severe on the current study. *[Reviewer's note: Dr. Villablanca makes no mention as to that rapidity of such degeneration and its relationship to the present injury.]* At L4-5, the progressive facet joint degeneration was associated with joint space widening and increased fluid within the joint spaces, leading to minimal anterolisthesis of L4 on L5. The small right foraminal annular ligament defect was unchanged at the L4-5 disc level and did not impinge upon the exiting L4 or traversing right L5 nerves. The degeneration at L4-5 and L5-S1 were unchanged when

compared to the prior scan of 04/03/09. Dr. Villablanca was of the opinion that Dr. Sonny Patidar over interpreted the study with respect to neuroforaminal narrowing at L4-5 and the bulges and protrusion from L3-4 to L5-S1 and under interpreted it with respect to the severity of facet degeneration and hypertrophy at the L4-5 and L5-S1 disc levels.

Chest, frontal and lateral radiographs, of 01/22/10 were interpreted as being unremarkable. Cervical spine, frontal and lateral radiographs, of 01/25/10 demonstrated interval C5-6 anterior discectomy and anterior fusion via a C5-6 interbody graft and an anterior C5-6 vertebral plate and dual C5 and C6 vertebral body screws. Cervical alignment was preserved. The cervical column below the level of C6 was obscured by the shoulders and therefore not evaluated. The anteroposterior diameter of the bony cervical spinal canal appeared within normal limits. The posterior elements, including the facet joints, were normal in appearance. There was no prevertebral soft tissue swelling.

A noncontrast lumbar spine MRI from 09/23/10 was then reviewed. Dr. Villablanca thought that Dr. Lawrence Bogle had over interpreted as well as under interpreted the study. He disagreed with Dr. Bogle's interpretation of spinal stenosis due to disc bulges at L4-5 and L5-S1 disc and also disagreed that neural foraminal narrowing was present. He further stated that Dr. Bogle failed to note severe bilateral lumbar facet joint degeneration at the L4-5 disc level.

A noncontrast CT of the lumbar spine from 11/02/11 was stated to reveal interval L4-5 and L5-S1 anterior discectomy and fusion via anterior metallic plate and dual vertebral body screws. The interbody grafts and anterior metallic plate were anteriorly displaced relative to the lumbar column. There was no lucency about the vertebral body screws to suggest loosening or infection. The fusion appeared solid at L4-5 and likely solid at L5-S1. Lumbar alignment was anatomic.

Following this review, in his discussion section, Dr. Villablanca opined that the cervical study of 10/28/08 revealed typical degenerative changes at the C5-6 disc space and evidence of pre-existing bilateral C5-6 neural foraminal narrowing. The study of 03/13/09 showed progression of the degeneration and revealed no direct or indirect evidence of bony or soft tissue trauma. *[Reviewer's note: it should be known that MRIs only show such bony or other trauma in catastrophic cases and typically, findings of such are not seen on post-injury MRIs.]* With respect to the 04/13/09 study, he stated that it showed only the expected circumferential disc bulging that frequently accompanied a degenerated cervical disc, which only caused mild spinal canal stenosis and no evidence of cord compression. *[Reviewer's note: Dr. Villablanca did not comment on the*

pain that disc was found to be causing, as set forth in the records and outcome of treatment. This type of clinical correlation is crucial to a complete medical evaluation. Diagnostic films are only for correlation of clinical findings. Such a disc was apparently rendering Ms. Seastrand more susceptible to the present injury.] Specifically, there was no focal or acute disc herniation on this study and no evidence of subacute soft tissue, facet joint, or ligamentous injury attributable to the incident of 03/13/09. *[Reviewer's note: such focal findings are not always present and certainly not required for an injured patient to develop a post-traumatic painful disc and related symptoms. Dr. Villablanca omits that crucial clinical component.]* He stated that the bilateral C5-6 neuroforaminal narrowing identified on the studies of 10/28/08 and 04/13/09 were due to degenerative bony uncovertebral joint osteophytes, and not to an intraforaminal disc herniation which could not be attributed to the subject accident, as bony osteophytes required years to develop, and not three weeks. *[Reviewer's note: such elements render patients more susceptible to injury. Such MRI findings are also typically performed supine and do NOT demonstrate what relationship the pathological spinal elements have to neurological structure in other positions of the spine.]* Thus, Dr. Villablanca felt that imaging studies did not establish a causal connection between the disc pathology at the C5-6 disc level, the surgical procedure performed at that level, and the accident of 03/13/09. *[Reviewer's note: such studies are typically not helpful to make such links. Ultimately, the studies are used to correlate the clinical findings, and symptoms, for which an initial link, if it exists, is established. Thus, Dr. Villablanca's comment is not useful.]*

With regards to the lumbar spine, Dr. Villablanca commented that the small intraforaminal annular ligament defect at L4-5 on the right, as seen on the scan of 04/03/09, was of indeterminate age and remained unchanged on the study of 10/13/09. *[Reviewer's note: Dr. Villablanca omits any discussion as to the complexity of susceptibility, which is an ongoing theme in his opinions.]* Annular ligament defects **could** persist for years and **could** occur spontaneously and in the absence of trauma and **could** resolve completely. *[Dr. Villablanca's establishment of what could be happening does not establish a most probable medical opinion. Dr. Villablanca makes no mention as to the symptoms such a defect would be expected to cause. Thus, his opinion does nothing to help explain this patient's post-traumatic symptoms.]* This defect, moreover, was not touch the exiting right L4 or traversing right L5 nerves and in the absence of focal disc herniation was not expected to cause a right sided lumbar radiculopathy. *[Reviewer's note: Dr. Villablanca omits a relevant clinical discussion as to positional anatomic changes (see discussion in prior paragraph) and omits any discussion as to the commonplace concept of chemical radiculitis from such annular defects, once again rendering*

his opinion clinically irrelevant and incomplete.] He stated that the L5-S1 also showed no focal disc pathology and only showed early disc degeneration. The MRI of 10/13/09 only revealed evaluation of progression of degenerative changes and these **could** not be attributed to the accident of 03/13/09. Thus, there was no causal relationship between the accident of 03/13/09 and the IDET and fusion at L4-5, if these had done for internal disc disruption. *[Reviewer's notes: Dr. Villablanca's opinion ignore important analytical components including susceptibility, aggravation, and most importantly: clinical correlation. While ignoring these concepts, Dr. Villablanca has chosen an improbable conclusion.]*

Finally, with regard to the brain, Dr. Villablanca stated that there were no medical records of head trauma, altered sensation, or loss of consciousness, and the CT scan of the brain from 03/13/09 did not reveal any pathology. Thus, there were no indications for an accident related claim of head injury for Ms. Seastrand. *[Reviewer's note: the diagnosis of mild traumatic brain injury requires none of Dr. Villablanca's list. Thus, his conclusion is incorrect based upon medical definitions, and demonstrates only an oversimplified knowledge of head injury and its clinical ramifications.]*

[Reviewer's note: Dr. Villablanca appears to have disagreements with most of the radiologists who reviewed films as part of the treatment of Ms. Seastrand. It appears that there is a pattern of disagreement with most others who treated Ms. Seastrand, which makes evaluating his ultimate conclusions skeptical. It seems highly unlikely that everyone else is wrong except for Dr. Villablanca, who has created an island of opinions, separated from most others.]

49. 08/25/12 *Joseph Schifini, MD* – Letter to Mr. Steven Jaffe documenting opinions/conclusions following medical record review. Dr. Schifini notes that there was only one record predating the subject accident of 03/13/09, but overall the medical records identified multiple previous accidents involving Ms. Seastrand. These included a 1981 rollover accident with resultant neck and knee pain for which she received holistic care. She received treatment to her neck, low back, and shoulders as a result of another motor vehicle accident in 1985. Additionally, there was a history of two head injuries causing concussions in 2004. Records predating the incident included an unremarkable x-ray of the chest from October 2008 and cervical spine studies from the same time revealed mild rightward flexion of the spine compatible with muscle spasm and spondylolytic *[Reviewer's note: I don't think he meant to say "spondylolytic."]* changes of a mild degree at C5-6.

Based on his review of records following the subject accident until 09/23/10, Dr. Schifini discusses the medical chronology of the case. He, however, notes that he appeared to be missing records from the initial stages following the accident, including the ones from Mountain View Hospital, Dr. Benjamin Lurie, Dr. Olmstead and Dr. Koka as well as records from the later stages of Ms. Seastrand's care including those of Dr. Leo Langlois, Dr. Jorg Rosler, Dr. Yevgeniy Khavkin, and Dr. Jaswinder Grover. Following his review of records, Dr. Schifini provided his opinions and conclusions. He notes that the subject incident only caused minor damage to both vehicles. *[Reviewer's note: please see my above stated comments regarding Dr. Siegler. Dr. Schiffini and Dr. Siegler are apparently reliant on the damage to vehicles to determine injuries to patients. This is not a concept instructed in medical school or residencies and appears to be an opinion of convenience.]* He also makes note that Ms. Seastrand on an intake form from Nevada Imaging from 04/03/09 admitted to a 26-year history of back pain. Dr. Schifini thus opines that based on the mechanism of injury and the review of records, if at all injury was felt to have been caused by the 03/13/09, it would have been **limited to a temporary exacerbation of preexisting conditions or development of soft tissue injuries, and these would have resolved within four to eight weeks of the "minor" 03/13/09 motor vehicle accident.** *[Reviewer's note: minor injuries are often limited to short courses of treatment. Using that logic in the present matter, the ongoing need for treatments supports that the fact that the injury was greater than that as described by Dr. Schiffini. Additionally, he does not specify which soft tissues he is giving opinions regarding: discs?, nerves?, spinal cord?, ligaments, ?, etc. Grouping all of these different tissues together is not a useful clinical approach. Furthermore, use of the term "minor" applies only to the vehicle and not the patient. Dr. Schifini also completely omits any reference to the important medical analysis of susceptibility in discussing prior conditions. Thus, similar to the other physicians who rendered defense opinions as noted in my review herein, his opinions is incomplete and oversimplified. Dr. Schifini also discussed what "would" have occurred, and not which did occur. His opinion deals with expectations and statistics therefore, and not actual events. Thus, his opinion does not meet a medically probable standard.]* Thus, treatment beyond 05/13/09 was thought to be considered unrelated to the subject accident. *[Reviewer's note: Dr. Schifini's opinion is arbitrary. This would only be true had the patient returned to her baseline quality of life she enjoyed prior to the present injury, which has not occurred.]* He also expressed concerns for secondary gain based on his opinion that the patient's subjective complaints often outweighed the objective findings and medical records indicated "omissions or minimization" of her prior conditions. *[Reviewer's note: in meeting and examining Ms. Seastrand and reviewing her records, I found no evidence of any such psychological*

elements. If anything, this is a stoic patient who would have liked nothing more than to not have been injured. It is the physician's job to correlate the symptoms and findings. I found them to match reasonably in this matter, as have her other treatment physicians. Thus, there is no basis for Dr. Schifini's allegations.] Dr. Schifini then also commented on the diagnostic usefulness of the injections performed by Dr. Belsky in that the combination of multi-level and multi-site lumbar injections on 02/20/09 reduced the diagnostic value in addition to the non documentation of pre-procedure and post-procedure Visual Analog Pain Scale scores. He stated that the lumbar discography revealed a negative disc at L3-4, a likely indeterminate disc at L4-5, and either a concordant or indeterminate disc at L5-S1. With regard to plasma disc decompression performed after the discography, he stated that it was considered experimental by most insurers and considered non-standard in the Southern Nevada medical community. *[Reviewer's note: if Dr. Schifini defines the utility of treatments based upon who will or will not readily pay of the treatment, than his methods are non-medical, and only economically driven.]* Neurodiagnostic testing performed by Dr. Shah was felt to be likely unnecessary and demonstrated subacute findings, which Dr. Shah defined would have occurred three to nine months prior to the test, and thus the upper extremity and lower extremity findings were felt to be unrelated to the subject accident. *[Reviewer's note: Dr. Shah's electrodiagnostic testing was done about 9 months after the present injury. Subacute findings at that time could easily and readily be related to the post-traumatic symptoms. Further, there is no reasonable opinion to detract from the necessity of the evaluation by Dr. Shah. Ms. Seastrand's physicians were attempting to correlate the findings and symptoms that were still ongoing at that time. Such evaluation is the job of her treating physicians and is a typical and necessary part of the treatment of any patient with problems.]* Dr. Schifini questioned the medical logic of the cervical spine and lumbar spine surgery. *[Reviewer's note: no basis is provided for Dr. Schifini's questioning. There is no discussion of his "logic" to overcome the reasonableness of the approach of Ms. Seastrand Surgeons. Dr. Schifini is, in effect, calling her treating phsyciains: "illogical."]* He, however, had no records pertaining to the pending lumbar spine surgery. The injections performed by Dr. Belsky were performed under deep sedation using Versed, Fentanyl and Propofol thus again raising questions about the validity of the diagnosis. *[Reviewer's note: I prefer my patients to have pain injections under such sedation. The diagnostic component of an injection can be determined after the medication begins to take effect and the patient has woken up.]* He quoted from the ISIS guidelines to support his argument against the use of sedation. Dr. Schifini also included his opinions on the reasonableness of billing of various providers, though also added that this in no way meant that the billed charges were related to the subject accident.

Dr. Schifini concluded by stating that the patient's future was guarded. *[Reviewer's note: this is interesting since if Dr. Schifini felt that Ms. Seastrand should have had resolution of her injuries and symptoms in a few months, then why would he feel that she should still be guarded. Clearly, those opinions conflict and serve to underscore the inconsistencies in his approach.]* He reserved opinions on future needs pending his review of the latest records. He did not anticipate any decreased work life capacity or permanent impairment for Ms. Seastrand related to the subject accident. A record review section was included at the end of the report documenting his review of multiple records, as stated above.

DIAGNOSTICS:

I personally reviewed the following supplied images on CD:

4/3/09 Lumbar MRI shows a small L5-S1 and L4-5 discal protrusions. There is L4-5 inflammatory facet joint fluid and bilateral foraminal narrowing at L4-5. There is reduced T2 signal at L4-5 and L5-S1.

4/3/09 Cervical MRI shows straightening. There is a small C5-6 protrusion and mild kyphosis at C5-6. There is left C5-6 foraminal narrowing.

DISCUSSION:

In review of these additional records, I have identified areas of disagreement with defense participants. I have provided the reasons and basis for my disagreement, with my opinions being supported by the medical facts, medical knowledge, and applied clinical logic. My opinions are given within a reasonable degree of medical probability.

Sincerely,

JEFFREY D. GROSS, M.D.
Spine Fellowship Trained Neurosurgeon
Diplomate, American Board of Neurological Surgery

EXHIBIT "F"

Comprehensive Injury Institute
Complete Care from Diagnosis to Treatment

Office of: **Jeffrey D. Gross, M.D.**
Spine Fellowship Trained Neurological Surgeon
Diplomate, American Board of Neurological Surgery

May 13, 2013

PATIENT NAME: **SEASTRAND, MARGARET**
DATE OF BIRTH: 12/27/1961
DATE OF INJURY: 03/13/09

NEUROSURGICAL SUPPLEMENTAL REPORT: UPDATE OF MEDICAL LIFE CARE PLAN

To Whom It May Concern:

This report serves to update my previously submitted life care plan. Opinions expressed herein are also provided within a reasonable degree of medical probability. Reasons for medical life care plan modifications presented here are due to additional information obtained through my own examination of Ms. Seastrand.

1. Previous recommendations for posterior lumbar surgery are hereby withdrawn due to Ms. Seastrand's eventual improvement from her ventral surgery. Along with this modification would be a reasonable removal of a recommendation for a course of post-operative lumbar rehabilitative therapy. The future medical life care plan will therefore continue to maintain an average plan for therapy for flare-ups as previously noted. Similarly, lumbar x-rays can be withdrawn from the life care plan. Thus, future therapy costs would be $214,272.00. There will not be future diagnostic or surgical costs.

2. I will continue to exclude the possibility of sacroiliac joint treatments (there were mentioned, but not included in the original medical life care plan).

3. My future recommendations for the cervical spine remain unchanged.

4. Pain management visits for controlled substance oversight and prescription would be modified to twice a year ($150 per visit) for a total of $300 per year (average). The total would therefore be $9,900.00

5. I would remove the need for a spinal specialist and internal medicine physician due to her improvement.

6. Regarding medications, there is no need for the additional Lortabs for surgical recovery. She will continue to use Neurontin, Lortab, and Valium as needed, otherwise. That need is expected to be 1/3rd of the plan set forth in the original life care plan. The future total costs would be $60,140.16

7. Ms. Seastrand will not require the peri-operative durable medical equipment.

Thus, the current, modified total future medical life care plan for Ms. Seastrand, in relation to the present injury would reasonably be: $284,312.16

Please feel free to contact me if additional information is required.

Sincerely,

JEFFREY D. GROSS, M.D.
Spine Fellowship Trained Neurosurgeon
Diplomate, American Board of Neurological Surgery

EXHIBIT "G"

OFFICE VISIT (PASEO MEDICAL CENTER):

PATIENT: Margaret Scastrand
DATE OF VISIT: 10/27/08

SUBJECTIVE: Chest pains over the last a few days. The patient states that she has been having left chest wall pain associated with numbness and tingling bilaterally in both arms. The pain shoots down her left arm; however, she has **00:24** no numbness bilaterally. She denies any shortness of breath. She recently had bilateral foot surgery and just recently exercising again. Interestingly, she states that the exercise actually takes the chest pain away thus her pain is not exertional.

She adds that she has been having quite a bit of stress from her job. They recently had a business venture, which has been doing well but nevertheless has been quite stressful on her.

OBJECTIVE: VITAL SIGNS: Stable. HEART: Regular rate and rhythm. I hear no murmurs, gallops, or rubs. LUNGS: Clear to auscultation bilaterally. NEURO: Non-lateralizing. GU: Deferred. SKIN: Negative for any rashes or lesions.

ASSESSMENT/PLANS/DISCUSSION:

1. Atypical chest pain – noninvasive workup.
2. Numbness. We will obtain C-spine x-rays.
3. I placed the patient on NSAIDs. Obtain chest x-ray, EKG, and refer to cardiology for echocardiogram and stress test.
4. Anxiety. The patient would benefit from a small dose of anxiolytics (Ativan or Xanax).
5. GYN update.
6. Her records indicate that she has had history of possible thyroid nodule and this should be further evaluated as well in an update.

Behzad Kermani, M.D.
BK/aks

D: 10/27/08
T: 10/27/08
C: N 1027-426

Left message 9/17/11 g=a

EXHIBIT "H"

CASE NO. A-11-636515-C

DEPT. NO. 30

DOCKET U

DISTRICT COURT

CLARK COUNTY, NEVADA

* * * * *

MARGARET G. SEASTRAND,

Plaintiff,

vs.

RAYMOND RIAD KHOURY, DOES 1 through 10; and ROE ENTITIES 11 through 20, inclusive,

Defendants.

ROUGH DRAFT

REPORTER'S TRANSCRIPT

OF

JURY TRIAL

A.M. SESSION

BEFORE THE HONORABLE JERRY A. WIESE, II

DEPARTMENT XXX

DATED FRIDAY, JULY 19, 2013

REPORTED BY: KRISTY L. CLARK, RPR, NV CCR #708, CA CSR #13529

Q. Okay. What was the -- what was the first -- what was the cost that -- for the first plan that you created?

A. The complete medical future life-care plan, the total cost estimate was $606,325.02.

Q. Okay. And that was based on just your review of the records not your review of Ms. Seastrand.

A. The records and the films --

Q. Okay. Yes.

A. -- but not my examination and my own history of Ms. Seastrand.

Q. Okay. So 606 just based on the records?

A. Correct.

Q. And then you see Ms. Seastrand, and you actually reduce the number?

A. I do.

Q. Okay. What is -- what was the number reduced down to? We can get to the exact number in a moment.

A. Thank you. I have it. Just looking for it.

Q. Fair to say it was several hundred thousand dollars less?

A. Yeah, it was less than 300,000. I'm looking for the number.

Q. So I have a question: Margie told you that she was doing well when she saw you?

A. She was improving.

Q. She was improving. Now, you're aware that Dr. Schifini has suggested that Margie has something called secondary gain.

A. I saw that.

Q. Whereby, you know, that would suggest or imply that, you know, she is exaggerating her symptoms for financial gain in this lawsuit.

A. That's his idea.

Q. Okay. And let me ask a question: Would you expect someone with this term financial -- "secondary gain," you know, this exaggeration, would you expect them to report to you that they were doing better or improving?

MR. JAFFE: Objection, Your Honor. This is I believe an undisclosed opinion now.

MR. CLOWARD: I don't think it is, Judge.

MR. JAFFE: Let me double check.

THE COURT: Come up, guys.

(Whereupon a brief discussion was held at the bench.)

THE COURT: Objection's overruled.

Doctor, the question is: Let me ask you a question: Would you expect someone with this term "secondary gain," you know, this exaggeration, would

you expect them to report to you that they were doing better or improving?

THE WITNESS: The answer's no.

BY MR. CLOWARD:

Q. Why not?

A. People who exhibit secondary gain tend to amplify, exaggerate pain. Those patients complain of more pain or worsened pain. Ms. -- Ms. Seastrand complained of improvement. So the improvement doesn't go along with any support for the -- the doctor's opinion on secondary gain being in play here.

BY MR. CLOWARD:

Q. Okay. And, Doctor, can we talk about, you reviewed some medical records not only for -- not only for the treatment for the -- after the crash, but you also reviewed records that predated the automobile crash; is that correct?

A. Yes.

Q. In your review of the records from before the automobile crash, were there any records that suggested that Ms. Seastrand received treatment for the primary purpose, so her chief complaint is that she's going to the doctor for neck or low back pain or problems?

A. No.

Q. Now, I understand that -- or you're aware of

A. He did not.
Q. A neurospine surgeon.
A. He did not.
Q. Okay. Other than that one cervical X ray, that was the only -- the only thing related to the neck?
A. Correct.
Q. And there was nothing related to the lumbar?
A. Correct.
Q. If a patient presents with chest pain and numbness and tingling in the arms, why would a doctor even consider a cervical X ray, or why would -- or why would -- I think you said something about being careful?
A. Well, in the differential diagnosis, meaning the possibilities, arm tingling and numbness and pain even can arise of the neck. It can come from the neck. So an X ray would be a reasonable thing to rule out a neck problem.
Q. Okay. And, Doctor, can you explain to the jurors what the findings of that X ray were?
A. Yes. My recollection is it was normal. And may I take a quick look at my notes?
Q. Yes, please do.
A. There was some age-related change to the

spine to a mild degree at C5-6, which is one of the segments of the neck. And a mild rightward flexion of the spine, meaning the posture was slightly to the right, that the radiologist thought that was compatible with muscle spasm.

Q. Okay. Doctor, let me ask a question: So based on those findings of the X ray -- well, first off, are those findings abnormal for someone who at the time would have been Ms. Seastrand's age and her gender?

A. No, not at all.

Q. So let me ask a question: More probable that those findings were -- that the numbness and tingling was coming from the neck or more probable that it was from the heart event for which she had a positive stress test?

MR. JAFFE: Objection -- objection, Your Honor. Two areas. Number 1, this is an undisclosed opinion. Number 2, it's getting into an area beyond his expertise.

MR. CLOWARD: Judge, may we approach.

(Whereupon a brief discussion was held at the bench.)

THE COURT: All right. The objection's overruled. I'm going to reask the question. So it

says: Let me ask a question: Is it more probable those findings were -- of the numbness and tingling were coming from the neck or more probable it was from the heart event for which she had a positive stress test?

THE WITNESS: Thank you. It is more probable that the arm symptoms are unrelated to the neck and more likely related to the heart or anxiety or both.

MR. CLOWARD: Thank you.

THE COURT: All right. Folks, we're going to take a quick break. It's about 10:30. We'll give you a little break this morning.

JUROR: Yes. Thank you.

THE COURT: During our break, you're instructed not to talk with each other or with anyone else, about any subject or issue connected with this trial. You are not to read, watch, or listen to any report of or commentary on the trial by any person connected with this case or by any medium of information, including, without limitation, newspapers, television, the Internet, or radio. You are not to conduct any research on your own, which means you cannot talk with others, Tweet others, text others, Google issues, or conduct any other kind of book or computer research with regard to any issue, party,

witness, or attorney, involved in this case. You're not to form or express any opinion on any subject connected with this trial until the case is finally submitted to you.

Take about 15 minutes.

THE BAILIFF: All rise.

(Whereupon jury exited the courtroom.)

THE COURT: I'm going to excuse you too, Doctor.

All right. We're outside the presence of the jury. Mr. Jaffe, go ahead.

MR. JAFFE: Your Honor, at this time, I would like to make a record regarding the three issues that have been discussed at sidebar this morning. Most prominently, the most recent one where Dr. Gross just before this break was allowed to express an opinion as to the cause of the plaintiff's symptoms and treatment in October through December 2008. My opinion is twofold: No. 1, it is an undisclosed opinion; no. 2, it goes into areas beyond his expertise.

With respect to the expertise issue, he just testified that it related to the heart, and he's not here as a cardiologist. He has not been offered as a cardiologist. He is not testifying as a cardiologist. He's not an expert in cardiology. He's not trained as

a cardiologist. He has no background or experience in cardiology. And I believe it's entirely inappropriate for him to give what was now undeniably a cardiologic opinion.

Second, he just was allowed to testify regarding the causation for treatment in late 2008 that has never been disclosed. And, Your Honor, I would like leave to make court -- as Court exhibits all three of Dr. Gross's records -- or reports rather from August 7, 2012, August 28th, 2012, and the third from September 29, 2012.

THE COURT: You can make them Court exhibits. That's fine.

MR. JAFFE: I'm going to have clean copies brought in, because the only copy I've got is one that I've got marked up.

In his third report, the -- the September 2012 report, that is the first time he saw these October and December 2008 records. He had already rendered a causation opinion regarding this accident. But at no time did he ever render a causation opinion, even in that third report, regarding the need for the plaintiff to have been seen for that treatment to exclude it as an issue related to the 2009 motor vehicle accident.

All he said in that report by way of his opinions was, Discussion. I review -- in review of these additional records, I have identified areas of disagreement with defense participants. I have provided the reasons and basis for my disagreement and my opinions being supported by the medical facts, medical knowledge, and applied clinical logic. My opinions are given within a reasonable degree of medical probability.

In that report, he does not discuss the causation for why the plaintiff was seen in late 2008. It is different for him to defend his opinion than to go beyond that and give an affirmative opinion in a completely new medical area, that is, that late 2008 treatment.

My experts did address it in their reports. My experts did put it in their opinions. Dr. Gross did not. And he was now allowed to give a completely new opinion simply because Mr. Cloward saw that I'm making a point of this in my opening, and he's got no expert who's discussed it. His experts have never seen this report or these records other than Dr. Gross having seen it in time for his third report, and now he was allowed to give a new opinion. I believe that was entirely improper.

second supplement, or his third supplement. The defense points out that somehow Dr. Gross is making a cardiological opinion. However, the reverse analysis for his experts would be the exact same. They ruled out that this had anything to do with the neck or with the heart and say that it dealt with her neck.

In fact, Mr. Jaffe, in opening statement, represented to the jurors -- which was inaccurate, represented to the jurors that this heart issue turned out to be a neck issue. There's no evidence of that. None.

The fact that Dr. Gross reviewed this record, he says that his opinions -- it's unchanged. He was offered for causation. He reviewed the record. It didn't change his opinions. So it's not a new opinion. It's not an unfair surprise.

What were the other two things? What were the other two issues, Mr. Jaffe?

THE COURT: Discussion regarding discrepancy in the records, and Dr. Schifini's secondary gain issue.

MR. CLOWARD: Yeah. Dr. Schifini's report was referenced in Dr. Gross's third supplement. As a rendered -- as a -- an expert who is rendering a -- a -- an opinion on causation, Dr. Gross himself would

EXHIBIT "I"

CASE NO. A-11-636515-C

DEPT. NO. 30

DOCKET U

DISTRICT COURT

CLARK COUNTY, NEVADA

* * * * *

MARGARET G. SEASTRAND,

Plaintiff,

vs.

RAYMOND RIAD KHOURY, DOES 1 through 10; and ROE ENTITIES 11 through 20, inclusive,

Defendants.

REPORTER'S PARTIAL TRANSCRIPT

OF

JURY TRIAL

P.M. SESSION

BEFORE THE HONORABLE JERRY A. WIESE, II

DEPARTMENT XXX

DATED THURSDAY, JULY 18, 2013

REPORTED BY: KRISTY L. CLARK, RPR, NV CCR #708, CA CSR #13529

kicks in in a few days, if a patient gets at least 50 percent reduction of their symptoms for at least two weeks, that is additional indication that this is the patient's major pain generator. And that occurred both when Dr. Belsky injected the 4-5 and 5-1 level to look at those disks and the C5-6 level in the neck.

Q. Thank you, Dr. Muir.

Now, is there also another -- other than diagnostic, are there other reasons to do injections?

A. What you're hoping to do with injections, besides help figure out where the problem is, is give the patient some relief. Some patients will have two to three months relief from the steroid injection. Some will have those repeated. And maybe by the time the steroid has worn off, the medicine after a couple of injections, maybe the body has healed itself. And you can treat the problem in a less aggressive way or maybe it won't require any treatment after a period of time.

Q. So it's fair to say that the therapeutic benefit is also a reason to do an injection?

A. Yes.

Q. Okay. Now, there was a criticism that Dr. Belsky doing the facet joint in addition to the transforaminal epidural injections would be

inappropriate.

Do you have any feelings --

MR. JAFFE: Objection, Your Honor. May we approach?

THE COURT: Sure.

(Whereupon a brief discussion was held at the bench.)

THE COURT: Objection's overruled.

BY MR. CLOWARD:

Q. Dr. Muir, No. 1, do you feel that there was an adequate workup of the patient prior to getting to you?

A. Yes.

Q. Okay. And you made your decisions as to your course of treatment based on --

MR. JAFFE: Objection. Leading.

BY MR. CLOWARD:

Q. Did you --

THE COURT: Sustained.

BY MR. CLOWARD:

Q. Did you rely -- did you rely on the course of treatment of other providers in making your diagnosis and treatment plan?

A. I took that into consideration, though I did not see the actual chiropractic notes. Dr. Belsky

Internet, or radio. You are not to conduct any research on your own, which means you cannot talk with others, Tweet others, text others, Google issues, or conduct any other kind of book or computer research with regard to any issue, party, witness, or attorney, involved in this case. You're not to form or express any opinion on any subject connected with this trial until the case is finally submitted to you.

Go ahead and take about ten minutes.

THE BAILIFF: All rise.

THE COURT: Actually, I think we need to make a record on something, so take 15 minutes.

(Whereupon jury exited the courtroom.)

THE COURT: Okay. We're off the -- or we're on the record outside the presence of the jury.

Mr. Jaffe, you wanted to make a record on the objection that I overruled?

MR. JAFFE: Yes, Your Honor. I believe it's inappropriate for Dr. Muir to be commenting upon propriety of treatment rendered by other doctors. He is not here as a -- as an expert, and he was never disclosed as an expert on those topics. He never issued a report, but those were topics addressed by two defense experts. So I believe it was inappropriate to allow him comment upon the propriety of treatment

rendered by Dr. Belsky. And that was the basis of that objection.

In addition, Your Honor, we were concerned that for the second time there was now a violation of an in limine order regarding insurance when Dr. Muir responded to a question by saying that he would do examinations for companies or that companies would hire him after he had just finished talking about workers' compensation. And it was very clear that he was talking about insurance, and it was implying again insurance to this jury. It's the second time in -- in a day's worth of actual court dealings with this case, between the openings yesterday afternoon and this afternoon that we've now had that.

Yesterday, Your Honor overruled an objection from this trial. I'm afraid I have to make another one now simply because I have to protect my record. And I know that Your Honor admonished Dr. Muir by handing him a note telling him he should not make such references and that it was allowed -- not allowed. But I mean, when is this going to stop?

And I believe that, you know, Mr. Cloward has an obligation to advise his witnesses about the court orders so that we have assurance that they're going to be obeyed.

MR. CLOWARD: May I respond?

THE COURT: Sure.

MR. CLOWARD: I'll go in reverse order. Regarding the — Dr. Muir's comment, I don't think there was anything inappropriate about the comment using the word "company." I'm sure that Dr. Muir is hired by defendant companies. You know, if a company has a truck, you know, an air-conditioning company, and they rear end somebody and Dr. Muir's hired for them, the company could also be a defendant, No. 1. Number 2, there's nothing nefarious about the use of the word company that would suggest or imply insurance. So I think that's an inappropriate characterization. That's on that issue.

On the second issue, or the first issue that Dr. or Mr. Jaffe talked about, the -- what was it?

THE COURT: You were talking about Dr. Belsky.

MR. CLOWARD: Oh, yeah, Dr. Belsky's care. Very importantly, the transcript that was cited to at the bench, the transcript very specifically and -- and Your Honor ferreted out the issue exactly. The transcript talked about -- and this is what -- the transcript we talked about earlier when you ruled on it earlier was it's inappropriate for Dr. Muir to

criticize his experts, because Dr. Muir didn't do a report. Okay? But that's not to say that Dr. Muir cannot talk about criticisms of himself. So if -- if they're criticizing him, he can talk about that.

However, if Dr. Muir is -- or I mean, if, you know, Dr. Schifini is criticizing, you know, Dr. Duke or I mean Dr. Belsky or Dr. Khavkin or Dr. Grover, it wouldn't be appropriate for Dr. Muir to talk about that. But in this specific case, Dr. Schifini indicated that Dr. Grover's workup was un-- unsound.

MR. JAFFE: Dr. Grover's?

MR. CLOWARD: I mean, Dr. Muir's workup was unsound. He said that Dr. Muir rushed into the surgery. He didn't lay an appropriate foundation. And he -- you know, the workup was too quick. So it's appropriate for him to talk about the things that Dr. Belsky did because that's what he relied on to do the surgery. And obviously, he -- he didn't do it too quick because she had a 90 percent reduction of pain and she's been pain free pretty much since. So it's clear that Dr. Muir knew exactly what he was and did a great job.

MR. JAFFE: Well, the outcome has no bearing on the admissibility of comments that counsel through an expert testimony, No. 1. And No. 2, just because

Dr. Muir wants to go to bat for Dr. Belsky doesn't mean that it gives him the right in this courtroom to come in and comment upon her work and give what is effectively an undisclosed expert opinion on that topic.

THE COURT: All right. As far as the first issue dealing with the reference to the word company, I didn't think that there was really any discussion regarding insurance. I don't think that it implied insurance to the jurors. But out of an abundance of caution, while you were at the bench, I did hand the doctor a note, just on a sticky note that says, Please avoid comments regarding insurance claims, companies that hire you to do IMEs, et cetera. I think both of you said that that note was acceptable. Doctor read it and handed -- got the note back. I don't think there was any other comments regarding companies or insurance, and I don't think there's any discussion regarding insurance anyway, but he stayed away from that issue. I don't think that that was really a problem.

The other issue with regard to Dr. Belsky, the record will show that the objection was at approximately 1359 hours. I just wrote some notes here to myself that Dr. Muir talked about the injections of

EXHIBIT "J"

CASE NO. A636515
DOCKET U
DEPT 16

DISTRICT COURT

CLARK COUNTY, NEVADA

* * * * *

MARGARET SEASTRAND,

PLAINTIFFS,

VS.

RAYMOND KHOURY.

DEFENDANTS,

REPORTER'S TRANSCRIPT

OF

MOTIONS IN LIMINE

BEFORE THE HONORABLE JUDGE TIMOTHY C. WILLIAMS

DISTRICT COURT JUDGE

DATED TUESDAY, JUNE 11, 2013

REPORTED BY: PEGGY ISOM, RMR, CCR 541

APPEARANCES:

For MARGARET SEASTRAND:

HARRIS LAW FIRM
BY: BENJAMIN CLOWARD, ESQ.
BY: ALISON BRASIER, ESQ.
801 SOUTH FOURTH STREET
LAS VEGAS, NV 89101
(702) 444-4444
(702) 444-4455
BENJAMIN@RICHARDHARRISLAW.COM

For RAYMOND KHOURY:

HALL, JAFFE & CLAYTON, LLP
BY: STEVEN T. JAFFE, ESQ.
BY: JACOB SMITH, ESQ.
7455 WEST WASHINGTON AVENUE
SUITE 460
LAS VEGAS, NV 89128
(702) 316-4111
(702) 316-4114 Fax
SJAFFE@LAWHJC.COM

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LAS VEGAS, NEVADA; TUESDAY, JUNE 11, 2013

10:38 A.M.

P R O C E E D I N G S

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THE COURT: This is case No. 636515. Margaret Seastrand versus Raymond Khoury, K-H-O-U-R-Y. Go ahead and make your appearances.

MR. CLOWARD: Ben Cloward and Alison Brasier for the plaintiff --

MR. JAFFE: Good morning, your Honor. Steven Jaffe, Hall Jaffe and Clayton, for Defendant Raymond Khoury.

MR. SMITH: Also Jacob Smith from Hall Jaffe and Clayton for Defendant Raymond Khoury.

THE COURT: All right. I would propose that we do these in the order that they are in the book, if you guys are okay with that.

So we do Plaintiff's omnibus first.

MR. JAFFE: Okay, sir.

THE COURT: I think that actually might resolve a couple of the defendant's motions as well as we go through.

MR. JAFFE: Certainly some overlap.

MR. SMITH: Yeah, there's a lot of overlap in

10:39:07 there.

10:39:13 THE COURT: Let me just give you my --
10:39:14 whenever I'm ruling on motions in limine, I will tell
10:39:20 you that -- I'm ruling on the motions in limine today
10:39:23 based upon what was presented to me. Okay.

10:39:31 My experience is that during trial, evidence
10:39:33 comes in different than maybe how I read it or how I
10:39:37 anticipate it coming in. So if, during the course of
10:39:39 trial, something happens and you think I need to
10:39:41 readdress a motion in limine because of how the
10:39:43 evidence was presented, just bring it up in trial.

10:39:46 MR. JAFFE: Your Honor, I do appreciate that
10:39:47 because I think, you know, all of us know that the
10:39:50 whole litigation process right through trial is a very
10:39:53 fluid and dynamic process. And I think some issues
10:39:56 that we are going to be arguing about today will be
10:40:00 impacted by the evidence that will come out in trial.
10:40:02 So -- and quite candidly that was part of some
10:40:08 arguments that we did intend to make with respect to
10:40:11 some of these issues today.

10:40:13 THE COURT: I know.

10:40:13 MR. JAFFE: So thank you, sir.

10:40:14 THE COURT: I'm one of the judges that have
10:40:15 actually done this before.

10:40:17 MR. JAFFE: We appreciate that.

10:40:18 THE COURT: All right.

10:40:19 First one, Plaintiff's motion to exclude
10:40:22 hypothetical medical questions designed to confuse the
10:40:25 jury. We would like to keep track of these.

10:40:30 THE COURT CLERK: Yeah.

10:40:31 THE COURT: You got it? Okay.

10:40:34 The motion basically is about nonexistent
10:40:38 medical conditions, but in the opposition there, the
10:40:44 defense says, "There are these prior accidents," and I
10:40:47 understand from reading some of the other motions, that
10:40:50 these prior accidents were like 20 years ago, but they
10:40:53 were to similar body parts.

10:40:56 MR. CLOWARD: Yes, your Honor. That's
10:40:57 correct.

10:41:02 THE COURT: My inclination is to allow
10:41:05 hypothetical medical questions with regard to similar
10:41:09 body parts, things like that. I mean, I don't think
10:41:12 that they're going to intentionally ask questions to
10:41:15 confuse the jury. If they do, I would expect you to
10:41:19 object and I'll probably sustain the objection.

10:41:21 MR. CLOWARD: I guess the -- what we're trying
10:41:22 to prevent here are questions that are not based on any
10:41:26 fact, but are designed more to elicit an improper --
10:41:31 improper reference by the jury of something that does
10:41:38 not exist.

10:41:40 THE COURT: Well, I understand that in your
10:41:41 motion you put actually an example.
10:41:43 MR. CLOWARD: Yes.
10:41:44 THE COURT: And you said, "Suppose there is a
10:41:45 neck. This is a neck injury accident, happened in
10:41:50 2010. Suppose the plaintiff had no neck injuries prior
10:41:52 to our crash."
10:41:53 An impermissible hypothetical would be to ask
10:41:55 a doctor, "Tell us how the plaintiff's neck injury in
10:41:59 2003 affects her alleged neck injury from this case."
10:42:03 Or, "Doctor, were you aware of a prior neck
10:42:06 injury from 2003?"
10:42:08 Well, I agree that if there was no injury in
10:42:11 2003, those would be improper questions.
10:42:13 MR. CLOWARD: Sure.
10:42:13 THE COURT: The fact that there was or there
10:42:15 were prior accidents with allegedly prior neck
10:42:18 injuries, if they relate to those, even though they're
10:42:20 20 years ago, I mean, the doctors may get up and say it
10:42:23 doesn't have anything to do with it because it's 20
10:42:25 years ago. But I think that they're probably allowed
10:42:27 to ask that question.
10:42:30 MR. CLOWARD: Okay.
10:42:30 THE COURT: Right?
10:42:31 MR. CLOWARD: Well --

10:42:33 THE COURT: I mean, if it's a hypothetical
10:42:35 based upon no fact, I would agree with you. It's
10:42:37 probably improper.
10:42:40 MR. CLOWARD: But I guess that if the doctors
10:42:43 can testify -- if the doctors would testify that, to a
10:42:47 reasonable degree of medical probability, that the
10:42:48 accident 20 years prior would be relevant, then the
10:42:51 question should come in and would be allowed.
10:42:54 However, if the question is designed to create
10:42:58 in the minds of the jurors that there's some prior
10:43:00 accident that's important, but the doctor has no
10:43:04 ability to testify to a probability, that it has
10:43:07 anything to do with it, then I think it's
10:43:10 inappropriate.
10:43:10 Because you're allowing the doctor to discuss
10:43:13 something 20 years ago that has no -- no probability of
10:43:18 impacting the current state of her condition, but in
10:43:21 the minds of the jurors, they're thinking, "Oh, boy,
10:43:24 there's this accident 20 years ago. Boy, that must be
10:43:27 important if the doctor is being asked questions about
10:43:29 it."
10:43:29 When, in all reality, it -- the doctor has no
10:43:32 ability to state to a probability that it has an
10:43:36 effect.
10:43:37 Does that make sense?

10:43:38 THE COURT: Uh-huh.

10:43:39 MR. CLOWARD: I mean, so I would agree, it would be -- it would be allowed if the doctors would testify to a probability. But otherwise, it's just -- it's just raising a red flag that's prejudicial to Ms. Seastrand by creating the inference that there's some, you know, prior accident, that it is important that has something to do with her current state. And due to that, I think it would be inappropriate. And that's what the motion is designed to prevent.

10:44:08 THE COURT: Okay.

10:44:08 MR. SMITH: Your Honor, I think you hit the nail on the head.

10:44:12 Our opposition is essentially there are prior incidents in this that relate to the same body parts that she's alleged were injured in this accident. It's not our intent to ask questions that are going to confuse or mislead the jury. But we feel Mr. Khoury has a right to show the jury the prior accidents and to question the doctors what, if any, impact those prior injuries would have had with respect to her injuries sustained in this accident.

10:44:40 We can't -- I can't predict what the doctor is going to say. And the doctor can certainly say those aren't related at all, and the jury can take that into

their consideration.

Part of the problem here is that they're not giving us specific examples of what they don't -- you know, what prior injuries or what prior body parts that are not nonexistent or what nonexistent prior injuries they don't want us asking about. All we said is we want the right to ask about prior injuries that, you know, are existing or were existing at the time and relate to the body injuries that were injured in this accident.

MR. CLOWARD: Your Honor, if I may.

THE COURT: Sure.

MR. CLOWARD: Here's the thing: Not a single expert or provider has testified that those have anything to do with the current treatment.

THE COURT: Here's --

MR. CLOWARD: So.

THE COURT: -- the thing, Mr. Cloward, and I know that this is going to come up for both sides, but let's say that the question about the prior accidents is not asked to determine whether or not those injuries affected the ongoing complaints or the complaints resulting in this case. Well, let's say the question about the prior accidents is asked because your client didn't tell her doctors that she had prior accidents.

10:45:57 And, I mean, I see that come up all the time
10:46:00 in cases to question, you know, the credibility of the
10:46:03 plaintiff, or her --
10:46:05 MR. CLOWARD: Sure.
10:46:05 THE COURT: -- her ability to recall her
10:46:08 history. Isn't this a case where your client is
10:46:11 claiming a head injury?
10:46:12 MR. CLOWARD: No.
10:46:13 THE COURT: Okay. I get them confused.
10:46:15 MR. CLOWARD: Neck and back.
10:46:16 THE COURT: So, I mean, sometimes it's
10:46:18 relevant for other issues as well. I think what my
10:46:21 preference would be in this case --
10:46:22 MR. CLOWARD: Sure.
10:46:23 THE COURT: -- is on this motion, I would
10:46:25 probably say that it's granted in part, denied in part.
10:46:27 It's granted in as much as I'm going to allow
10:46:31 hypothetical questions, but it's denied in as much as
10:46:36 you're asking those hypothetical questions in a way
10:46:39 that's going to confuse the jury.
10:46:41 MR. SMITH: Fair enough, your Honor. I think
10:46:42 this is one of those fluid situations that we talked
10:46:44 about to address, you know, that it's going to depend
10:46:47 on, you know, what type of --
10:46:48 THE COURT: Actually I said that backwards.

10:46:50 Hold on.

10:46:51 It's denied in as much as I'm going to allow
10:46:54 the hypothetical questions.

10:46:55 MR. CLOWARD: Sure.

10:46:56 THE COURT: But granted in as much as I don't
10:46:57 want the hypothetical questions to confuse the jury.
10:46:59 Right?

10:47:00 MR. SMITH: Yeah, I think that's correct.

10:47:02 MR. JAFFE: And that's how we took it.

10:47:03 THE COURT: Okay.

10:47:04 THE COURT CLERK: So granted as allowing or
10:47:05 denied as allowing the hypothetical?

10:47:07 THE COURT: I'm going to allow hypothetical
10:47:09 questions.

10:47:09 THE COURT CLERK: Okay.

10:47:11 THE COURT: I'm not going to allow them to
10:47:13 confuse the jury.

10:47:15 THE COURT CLERK: Okay.

10:47:17 THE COURT: Fair enough?

10:47:17 MR. CLOWARD: Fair enough, sir.

10:47:20 THE COURT: Okay.

10:47:20 No. 2: "Plaintiff is requesting that we
10:47:25 exclude suggesting to the jury that there might be
10:47:28 related medical records prior to the subject crash when
10:47:32 there are none. "

10:47:33 Now, if I understand this motion, Mr. Cloward,
10:47:36 this is because of the fact that the accidents were so
10:47:39 long ago that there are no records from those
10:47:44 accidents.
10:47:45 MR. CLOWARD: Yes. And well, not only that,
10:47:47 but oftentimes, I've had this in a couple of cases, I
10:47:50 don't have as many, I'm not as seasoned as Mr. Jaffe,
10:47:55 but I've seen defense arguments made in closing or, you
10:47:59 know, in cross-examination or something along those
10:48:01 lines of, "Well, you know, you -- we only have the
10:48:05 records that you provided us, right, Mr. So-and-so, or
10:48:10 right, you know, Doctor."
10:48:11 You know, it can be a question to the
10:48:13 plaintiff or it could be a question to the doctor.
10:48:15 "Now, Doctor, you were only provided records
10:48:18 that the plaintiff identified, correct."
10:48:19 And so the inference is, is that the plaintiff
10:48:22 is withholding information and that there is treatment
10:48:26 that exists but that it's not being turned over.
10:48:29 That's the inference that's created, and it's improper.
10:48:33 Ms. Seastrand has a duty and an obligation in
10:48:36 her written discovery as well as in her deposition to
10:48:40 tell the truth. It's done under penalty of perjury.
10:48:42 If she identifies as not treated within the
10:48:45 last 10 years or 5 years, and there are no records to

IN THE SUPREME COURT OF THE STATE OF NEVADA

RAYMOND RIAD KHOURY, Appellant, vs. MARGARET SEASTRAND, Respondent.	Supreme Court Case No. 64702 Supreme Court Case No. 65907 Supreme Court Case No. 65172

APPEAL

from the Eighth Judicial District Court, Clark County

The HONORABLE JERRY WEISE, District Court Judge

District Court Case No. A-11-636515-C

APPELLANT'S APPENDIX

VOLUME XX

STEVEN T. JAFFE, ESQ.
Nevada Bar No. 007035
JACOB S. SMITH, ESQ.
Nevada Bar No. 010231
HALL JAFFE & CLAYTON, LLP
7425 Peak Drive
Las Vegas, Nevada 89128
Attorneys for Appellant Raymond Riad Khoury

VOLUME XX

Exhibit 48	Exhibits "D" – "J" to Defendant's Motion For New Trial	JA 3661-3881