IN THE SUPREME COURT OF THE STATE OF NEVADA

ALBERT H. CAPANNA, M.D., Appellant/Cross-Respondent, vs. BEAU R. ORTH, Respondent/Cross-Appellant.	Case No. 69935 District Court Case No. A648041
ALBERT H. CAPANNA, M.D., Appellant, vs. BEAU R. ORTH, Respondent.	Case No. 70227

APPENDIX TO RESPONDENT/CROSS-APPELLANT'S COMBINED OPENING AND ANSWERING BRIEF

VOL. 6 PART 1

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A Yeah, but I think eight shows something you didn't mention.

Q Okay.

A So why don't we look at that?

Q And -- now, even though there's clear defects shown on there, you only note in your note that there was significant edema, right? That's what you put in your note. That's what you see, right?

A No, that -- what you're calling a disc in my opinion is edema and early scar tissue forming. Enhancing tissues it's called.

Q Okay. And really the edema is kind of out in here, right? This is where the edema is where the swelling is. This is where like the -- this is where you made the -- the skin is up here and this is the muscle and the tissue and the fascia. That's where edema's at, right?

A No, it's all on the whole track. You just said if you make a surgical track and retract it, you'll have swelling on the whole track.

Q Right. The surgical track is only at L4-5, correct? Not at L5-S1, correct?

A I disagree.

Q Okay. And so you disagree with Dr. Belzberg who said there's -- the clear surgical track was a L4-5. You disagree with him, right?

A Yeah, there's a track there. Yes, I went there.

Q And you agree -- you disagree with Dr. Rimoldi, your own expert, that there is surgical track at L4-5, correct?

A No, I don't disagree with that --

MR. LAURIA: Objection; never said that, Your Honor.

THE COURT: Well, I'll sustain the objection.

MR. PRINCE: On what basis?

THE COURT: That's not what --

MR. PRINCE: What was the objection even?

THE COURT: That's not what was said. I think you phrased it wrong. You can rephrase the question, you can ask it a different way.

BY MR. PRINCE:

Q Now, with regard to L4-5, there's clear indication that you performed a operative procedure at L4-5, correct?

A Yes.

Q That was your approach. Right?

A We approach at L5-S1 and then went up to L4-5, yes.

Q No, the approach -- here's the approach. It starts here at L4-5, correct?

A Yes.

Q You had to remove the L4 lamina, correct? Had to.

A No. (Indiscernible) --

Q Then the -- well the -- there's no L4 lamina left, is there?

A You're not even looking at the lamina -- on the midline you can't see the lamina at all. It's not there.

Q Okay.

A You remove some ligament.

Q So when Dr. Rimoldi says that you did a laminotomy at L4-5 and removed ligament there, then are you disagreeing with him?

MR. LAURIA: That's not said --

Q Your expert?

MR. LAURIA: -- anywhere, Judge.

THE COURT: Well assuming --

MR. LAURIA: Misstates the testimony.

MR. PRINCE: Yes, it does.

THE COURT: -- assuming --

MR. PRINCE: Assuming he says that.

THE COURT: -- hypothetically that that's what Dr. Rimoldi testified --

BY MR. PRINCE:

Q If that's Rimoldi says in his report, then you disagree with that, correct?

A Now wait, it's already -- we already went over that. I did a little laminotomy at the top of the L5 and --

Q Right.

A -- little bit of ligament.

Q Right. Well, you also --

A (Indiscernible) --

Q -- had to remove ligament at L4-5, correct?

A I just said that.

Q Right, but you don't -- you never -- you denied a moment ago that you removed any ligament at L4-5. Did you remove ligament at L4-5? It's clearly shown, right?

A Yeah.

Q Okay. And when I asked you in your deposition, you know, why -- you know, what did you think happened to Beau, you indicated because he herniated his disc at L4-5 you -- following some intimate moments with his girlfriend, correct? That's what you said.

A I believe you asked me what possibly happened or something of that

nature, you know, late at night, and I just said that's a possibility, I don't know.

Q Okay.

A Don't know now.

Q And if we can go to page 110 of your deposition, please. And starting at line 22. My question of you was: Is there any activity that Beau engaged in that you think caused L4-5 to herniate in an otherwise healthy disc?

Answer: Well he called at 11:30 at night --

MR. PRINCE: Go on to page 111, lines 1 through -- 1 and 2. No, 111.

MR. LAURIA: And I ask we read --

MR. PRINCE: And he showed up --

MR. LAURIA: -- down to line 18, Your Honor?

MR. PRINCE: What?

THE COURT: What's that?

MR. LAURIA: I'd ask we read down to line 18.

MR. PRINCE: Your Honor --

THE COURT: You can follow up with your examination.

BY MR. PRINCE:

Q And starting at line 1, it says showed up the next day with his girlfriend, so he might have been having some intimate moments. Do you see that?

A Yes.

Q And so your belief that it was likely that he was having sex with his girlfriend and that's why he herniated at L4-5 in an otherwise healthy, normal disc in a 20-year-old young man?

A You asked me what I thought he might have been doing. I was just postulating, you know, it's a possibility.

THE COURT: Are we --

BY MR. PRINCE:

Q You have no evidence of anything --

THE COURT: Are we -- Mr. Prince, are we getting close to --

MR. PRINCE: No.

THE COURT: -- a place to stop?

MR. PRINCE: We -- oh, we can stop. Yeah, we can stop here.

THE COURT: Okay.

MR. PRINCE: Yeah, that's fine. We can stop for tonight.

THE COURT: All right, because it's 5:00 so -- I'd like to keep my promise to the jury at least one night.

MR. PRINCE: Oh, sure. No, that's fine. No, we can stop here.

THE COURT: So we're going to break at 5:00 finally.

All right, ladies and gentlemen, we're going to go ahead and take our evening recess. During the recess, you're admonished not to talk or converse among yourselves or with anyone else on any subject connected with the trial; or read, watch or listen to any report of or commentary on the trial by any medium of information, including without limitation newspapers, television, internet and radio; or form or express any opinion on any subject connected with the case until it is finally submitted to you. I'll see you at 10:30 tomorrow, okay? Have a good evening.

MR. RIETZ: So is that --

THE COURT: Thank you for today.

MR. RIETZ: -- 10:30?

THE COURT: Pardon?

MR. RIETZ: 10:30, you said?

THE COURT: 10:30, please.

Doctor, you can step down as well.

THE WITNESS: Thank you, Your Honor.

THE COURT: We'll get all the books out of your way, don't worry.

[Jury out at 5:03 p.m.]

THE COURT: Okay. First off, moving forward when you display depositions, I agree with Mr. Lauria that if you're wanting to ask the witness a question about something at the deposition, that's fine, and displaying it's fine, but if there are objections raised at the deposition, I don't want you displaying the objections. So either you got to -- you know --

MR. PRINCE: Okay.

THE COURT: -- when Peter's pulling it up, leave that --

MR. PRINCE: I'll redact --

MR. LAURIA: Well --

THE COURT: -- leave that part out --

MR. PRINCE: -- if that's necessary.

THE COURT: -- and know that if you're about to display something that was objected to, I need to rule on whether it was a proper question --

MR. PRINCE: Okay.

THE COURT: -- before you display it.

MR. PRINCE: That's what I'll do.

THE COURT: Okay.

MR. LAURIA: That's what I'm asking, Your Honor.

THE COURT: All right.

MR. LAURIA: Thank you.

MR. PRINCE: That's what I'll do.

MR. LAURIA: The only other question -- I'm just trying to figure out schedule for tomorrow. Do we know --

THE COURT: 10:30.

MR. PRINCE: Yeah, 10:30.

MR. LAURIA: And are we going back to Dr. --

MR. PRINCE: I've already told you -- I've already told you our witnesses.

MR. LAURIA: Well I'm trying to figure are we going back with Dr. Capanna or are we going to do Dr. Cash first? I just trying to get a schedule.

THE COURT: I thought Cash was afternoon, or am I wrong?

MR. PRINCE: You're right.

MR. LAURIA: Okay.

THE COURT: So we're going to try and finish up --

MR. PRINCE: I told Mr. Lauria every day --

THE COURT: Okay.

MR. PRINCE: -- and before we start every day --

MR. LAURIA: Dennis, I'm not accusing you --

MR. PRINCE: -- what the witnesses are.

MR. LAURIA: -- of not telling me.

MR. PRINCE: Every day it's the same drill.

MR. LAURIA: I'm just asking --

THE COURT: All right.

MR. LAURIA: -- so I know.

THE COURT: So we're going to try and finish Dr. Capanna or get as far along as we can. You have any idea of how much longer you have with him on direct?

MR. PRINCE: I don't know. I'm going to check my notes and --

THE COURT: Okay.

MR. PRINCE: -- 30 minutes?

THE COURT: All right. So what time do you have Dr. Cash coming?

MR. PRINCE: One or two. So we'll try to --

THE COURT: Okay.

MR. LAURIA: I -- because I've got -- I've got a couple hours with him myself, Judge.

THE COURT: Yeah, I didn't know if you were going to do Dr. Capanna cross now or just call him in your case.

MR. LAURIA: I haven't made up my mind. I was going to see how long he takes and where we go, so I --

THE COURT: Okay.

MR. LAURIA: -- haven't made that decision --

THE COURT: But you'll do at least some --

MR. LAURIA: Oh absolutely, I'll do at least some --

THE COURT: Okay.

MR. LAURIA: I'd be stupid if I didn't --

THE COURT: Okay. All right. Then I would probably --

MR. PRINCE: Well then we're going to --

THE COURT: -- I would probably tell Dr. Cash 1:30-ish then, because we can try and do Dr. Capanna. If we don't get him finished -- and go through lunch hour a little bit. If we don't get him finished up, then we'll start with Dr. Cash and get him finished.

MR. LAURIA: I mean I'm thinking if he's saying a half an hour, my follow up

for Dr. Capanna at that point -- I mean I just want to make sure I get Dr. Cash on while he's available, so --

THE COURT: No, I know.

MR. PRINCE: Oh yeah, we got --

MR. LAURIA: So I'd rather have him appear at 1:00 --

THE COURT: I agree.

MR. LAURIA: -- and we can go with him than --

THE COURT: I can't even remember where we are in Dr. Cash now.

MR. LAURIA: He was almost done, but he hadn't gotten to damages yet I think is where he was.

THE COURT: With direct, correct?

MR. LAURIA: Right, direct

THE COURT: Okay.

MR. LAURIA: So I haven't asked a question yet.

THE COURT: Okay.

MR. LAURIA: So --

MR. PRINCE: You haven't. He knows -- he knows that. He remembers that.

THE COURT: No, no, no, that's what I just said. I can't -- I was --

MR. PRINCE: No, I know, he -- but Tony's asking he -- he hasn't asked question -- I said you're aware of that. Everybody is aware of that --

MR. LAURIA: Well the Judge couldn't remember.

MR. PRINCE: -- that you're on direct still --

MR. LAURIA: That's why I said that.

THE COURT: No, no, no, no, I actually wasn't. I mean, I couldn't --

MR. PRINCE: He knew he was on direct still.

THE COURT: -- remember if we had started cross. Between him and Belzberg, I couldn't remember where we stopped on each of them, but I do now remember that you started cross on Belzberg, so -- yeah, I obviously want to get Dr. Cash on and finished up tomorrow.

MR. LAURIA: So if we could -- as a precaution, can -- if you said can he be here at one just to be sure we -- case we're going timewise?

MR. PRINCE: He's coming at two.

MR. LAURIA: So two.

MR. PRINCE: He can be here by two.

MR. LAURIA: Okay.

THE COURT: Okay.

MR. PRINCE: That's when he'll be --

THE COURT: Well, just tell him to get here as soon as he can.

MR. PRINCE: Totally -- he's --

THE COURT: From 1:00 forward, as soon as he gets here --

MR. PRINCE: I agree. I totally agree.

THE COURT: -- we'll stop and put him on.

MR. PRINCE: He said the earliest --

THE COURT: Okay.

MR. PRINCE: -- he could be here was two --

THE COURT: Okay.

MR. LAURIA: Okay.

MR. PRINCE: -- so -- he's coming out of an OR and so I'm going to --

THE COURT: Okay.

MR. PRINCE: -- do what I can do.

THE COURT: Okay.

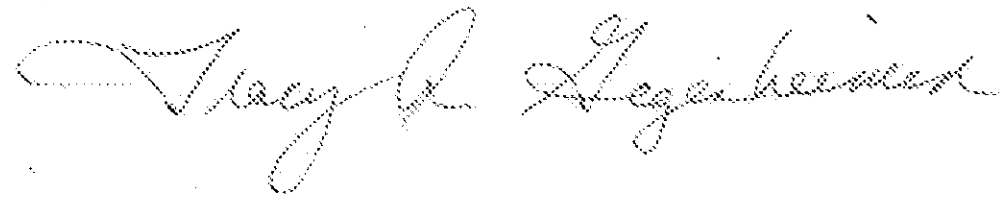
MR. LAURIA: All right.

THE COURT: All right, gentlemen, thank you.

MR. LAURIA: Thank you, Judge.

[Proceedings concluded at 5:06 p.m.]

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



Tracy A. Gegenheimer, CER-282, CET-282
Court Recorder/Transcriber

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TRAN

CLERK OF THE COURT

DISTRICT COURT

CLARK COUNTY, NEVADA

BEAU ORTH, Plaintiff, vs. ALBERT CAPANNA, MD, Defendant.	CASE NO. A-11-648041-C DEPT. III

BEFORE THE HONORABLE DOUGLAS W. HERNDON,
DISTRICT COURT JUDGE

THURSDAY, AUGUST 27, 2015

TRANSCRIPT OF PROCEEDINGS

JURY TRIAL - DAY 7

APPEARANCES:

For the Plaintiff: DENNIS M. PRINCE, ESQ.
DANIELLE A. TARMU, ESQ.

For the Defendant: ANTHONY D. LAURIA, ESQ.
PAUL A. CARDINALE, ESQ.

RECORDED BY: SARA RICHARDSON, COURT RECORDER

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FOR THE PLAINTIFF:

(None)

FOR THE DEFENDANT:

(None)

Thursday, August 27, 2015 at 11:11 a.m.

[Outside the presence of the jury]

THE COURT: All right, anything outside the presence?

MR. PRINCE: Nothing, Judge.

THE COURT: Okay.

MR. LAURIA: Judge, we have a -- we have one issue. We're trying to get the Spring Hill Hospital to give us the bills that have all the write-offs and everything --

THE COURT: Okay.

MR. LAURIA: -- and they're telling us now we need a HIPAA signed release or we need a court order, even though we've subpoenaed them.

THE COURT: Okay.

MR. LAURIA: And their person is in Georgia or something.

THE COURT: Okay.

MR. LAURIA: So do you have a --

THE COURT: I can give you -- I mean if you can prepare it, I'll sign a court order. I don't know how it's going to --

MR. PRINCE: How do you do that, Judge?

MR. LAURIA: It's prepared.

THE COURT: Pardon?

MR. PRINCE: Shouldn't they done that during the discovery phase of the case?

THE COURT: Well they should have, but I'm just talking about getting it right now.

MR. LAURIA: Yeah, we subpoenaed --

THE COURT: But I don't know that's -- I don't know that's going to get you anything in Georgia. Tell you that right now.

MR. LAURIA: No, they said -- they said they have -- they've prepared them, but they can't give it to us now without a HIPAA release, so --

THE COURT: Okay.

MR. LAURIA: Do you have a three hole punch? Thank you.

THE COURT: Here you go.

MR. LAURIA: Thank you.

MR. PRINCE: I mean Judge --

THE COURT: And then anything else?

MR. PRINCE: -- you're not making a ruling that they can any way use --

THE COURT: Just trying to get it right now.

MR. PRINCE: Okay.

MR. LAURIA: It's attached and you've already agreed to the admission of the bills from that --

THE COURT: Okay. Let's --

MR. LAURIA: That's part of the stipulation.

THE COURT: We got to move forward, guys, and just --

MR. LAURIA: Thank you.

THE COURT: -- just so you understand, this is the last time we're going to delay starting while you guys talk settlement. You want to talk settlement, talk about it on your own time, but we're wasting time missing out on witnesses and whatnot. I would love for you to settle your case, but we can't keep delaying 30, 45 minutes or more while you guys talk about settling it. Do it in the evening.

MR. PRINCE: I understand.

THE COURT: Okay.

MR. PRINCE: I've never been approached -- every time it's been in the morning.

THE COURT: I know.

MR. PRINCE: Every single time.

THE COURT: I know.

MR. PRINCE: And they brought a manager in today so anyway, I respect the Court's position.

THE COURT: I just -- I don't want you to --

MR. PRINCE: I agree.

THE COURT: -- continue to have a problem from a witness standpoint or finishing our trial, so --

MR. PRINCE: I -- thank you.

THE COURT: All right. Joel, you can go ahead and get them back in.

[Colloquy between counsel]

MR. LAURIA: And I don't remember, Your Honor, had he concluded with -- I thought he concluded with Dr. Capanna.

MR. PRINCE: Concluded who?

MR. LAURIA: With Dr. Capanna, or did you just break?

THE COURT: No.

MR. LAURIA: Okay.

MR. PRINCE: No, I didn't.

MR. LAURIA: Okay.

THE COURT: No, he wasn't done yet, I don't think.

All right. I don't -- you know what? You may be right, Tony, I'm sorry.

Were you done with direct, Dennis?

MR. PRINCE: No.

MR. LAURIA: Okay.

THE COURT: Okay.

[Jury in at 11:14 a.m.]

THE COURT: All right. You guys can be seated.

We're back on the record in 648041. We are going to continue on with the plaintiff's case in chief, and we're going to swear you back in, Doctor, so if you just stay -- remain standing for me, please.

ALBERT CAPANNA

[having been called as a witness and being first duly sworn, testified as follows:]

THE CLERK: Thank you. Please be seated.

THE COURT: Okay. We're going to continue on with the testimony of Dr. Capanna.

Mr. Prince, I think you were still on direct examination.

MR. PRINCE: I am. Thank you, Judge.

THE COURT: Okay.

MR. PRINCE: Do my housing over here. Apologize.

DIRECT EXAMINATION CONTINUED

BY MR. PRINCE:

Q Okay, Dr. Capanna. Good morning.

A Good morning, sir.

Q I have a few more questions for you today. I kind of want to summarize kind of where we were yesterday and kind of what we established before I finish my questions, okay, so we're all on the same page. Okay?

A Yes.

Q Okay. And --

MR. PRINCE: Peter, start at 42.

Q The -- you agree -- we -- you testified yesterday that you didn't do surgery at an incorrect level, correct?

MR. HELLMAN: Forty-two?

MR. PRINCE: Forty-two.

BY MR. PRINCE:

Q Remember testifying to that?

A Yes.

Q Okay. Hang on a second.

So the first point is you didn't do a surgery at an incorrect level. You said that yesterday, right?

A Yes.

Q And you indicated that you went above L5 lamina to get down to the L5-S1 disc space, correct?

A Yes, I tried to.

Q You agree that you explored the L4-5 area, correct?

A Yes, sir.

Q You agreed that you moved -- you now agree that you've moved things around at L4-5, correct?

A Yes.

Q You agree that you may have put a probe into the disc at L4-5, correct?

A Yes.

Q You agree that your surgery may have made his L4-5 disc weaker,

correct? You admit that.

A Yes.

Q You agree that your surgery contributed to an L4-5 disc herniation, correct?

A Yes.

Q You agree that your surgery made it more likely for L5 to even herniate, correct?

A Yes.

Q Okay. You -- so all those of things that I just put on that board you agree to, correct? Because we just -- I just had you agree to every one of those things.

A Yes.

Q Okay. You disagree --

MR. PRINCE: Go on to the next.

Q -- you disagree with the radiologist that there are no laminotomy findings at L5-S1, correct?

A Right.

Q That's what we said yesterday.

A Yes. They're so subtle you may not see them.

Q Right. So you disagree with the radiologist that there are no laminotomy findings at L5-S1 based upon the October 6, 2010 film, correct? His report.

A I disagree that there's laminotomy findings, I mean, I think there is and he doesn't think so, and --

Q So you disagree with that.

A -- there's a track there, basically. And he --

Q So you disagree with that.

A -- disagrees with -- yes.

Q Okay. You also disagree with your defense medical expert, Dr. Rimoldi, that there is no laminotomy at L5-S1, correct? You disagree with him, right?

A Yes. The same --

Q Do you --

A -- rationale.

Q You disagree with Dr. Rimoldi that you did surgery at the wrong level, L4-5 instead of L5-S1, correct?

A Yes.

Q And further -- we're going to be talking about this in a minute -- in your opinion you don't think Beau needed any additional surgery after yours, correct? That's your opinion.

A I think given the post-op scan that I ordered for him and the little fragment that he had there which hasn't been shown yet but it -- basically in my opinion we should have treated him conservatively for a while and then when the swelling went down he might have gotten better without surgery. He might have had to have more surgery.

Q Don't you agree -- don't you recall testifying in your deposition that had you been treating him he wouldn't have required any further surgery? Do you recall saying that in your deposition, sir? I can show it to you if you want me to.

A You don't have to show it to me. I can't guarantee that. I said I would have tried to not have --

Q Okay.

A -- to had --

Q So anyway --

A -- do more surgery on him.

Q -- so you all -- therefore, you disagree with Dr. Rimoldi that Beau required the second surgery by Dr. Cash, correct? You disagree with Dr. Rimoldi's opinions in that regard, right?

A We can have different opinions, yes.

Q Now -- and if you were to redo your operative note and had to rewrite it, you would add that you explored at L4-5 to see if you could come down to the L5-S1 disc space, correct? That's what you would add to it.

A Yes, sir.

Q All right. You'd also have to add that you did laminotomy in the inferior portion -- or excuse me -- the superior portion of L5, correct?

A Yes.

Q You'd have to add that you did laminotomy at L4 also, right?

A No, I didn't.

Q You didn't do -- you did no laminotomy at L4?

A No.

Q Okay. Now, I want to go back -- one second. Second -- that with regard to the -- remember the comparison? Remember the MRI image that we did the comparisons -- or, you know, there was questions about comparing, you know, the February of 2009 MRI to the October 2010 MRI?

A Yes.

Q Remember those? And we went through kind of like slide by slide the

October 6, 2010 MRI and you kind of pointed out the ones you thought were best representative, at least on a sagittal view, of Beau's spine? Do you remember that from yesterday?

A Yes.

Q We'll do the same thing for the February image.

[Colloquy between counsel]

BY MR. PRINCE:

Q Okay. And what I have on the screen there, Doctor, is -- hang on -- is the -- from February 2nd, 2009, the -- it's February 3rd, 2009 -- the MRI of Beau's spine. We're starting at slice 1 from the sagittal view. Do you agree that slice -- image 1 doesn't show very much clarity with regard to the spine, correct?

A Correct.

Q We're looking at now image number 2 of 15. That doesn't show much clarity of the spine yet either, correct?

A Correct.

Q Three doesn't show much clarity either, correct?

A I don't think you showed it yet, but --

Q Right there. I'm showing -- no, just this particular slide 3 --

A No.

Q -- doesn't show -- well, you can't really see the disc, the vertebral bodies.

A No. You can just see a couple of nerve roots and the foramina.

Q So --

A The beginning of it.

Q -- this one just doesn't give you a lot of information, correct?

A Correct.

Q We're starting now to see the vertebral bodies, starting to see the disc spaces, correct?

A Yes.

Q Start -- we can't see the spinal canal, correct?

A No.

Q So this one doesn't give you a really good idea of how, you know, what -- the condition of Beau's spine in February of 2009, right?

A Correct.

Q Starting to get a little more detail when you get to slide 5, correct?

A Yes.

Q Now we're starting -- we're now at slide 6. We're starting to get more detail. The vertebral bodies and the disc space are in clear view. The spinal canal is not quite open or patent yet, correct?

A Correct.

Q Now I'm showing you slide 7. Now the discs are in better view. You can -- the spinal canal is -- you know, you can now -- wider and more patent, correct? So this is getting more representative. Don't you agree?

A Yeah, and the radiologist is measuring a little bulge at 5-1.

Q Okay.

A That's what that --

Q So that one --

A -- means.

Q And so -- and now slide number 8. You agree that that gives us a good image of Beau's spine. You can see the L5-S1 disc and you can see the small

bulge at L5-S1, correct?

A Yes.

Q Okay. So if I've been showing that slide throughout the course of this trial you agree that that's fairly representative of Beau's spine in February of 2009, correct?

A Yes.

Q If I'm using that cut.

A Yes.

Q Now, let's just finish through them, because after this -- so 9's not bad, correct? Looks pretty good, right? In terms of the quality of what you can see in his spine.

A Yes.

Q All right. Now the quality starts to diminish once you get up to the -- you know, it's 10. It's not as clear as 8 or 9. Would you agree?

A Yes.

Q Would you agree then we start, you know, now the quality of the image starts to dissipate now that you're at 11, correct?

A Correct.

Q Same with 12, correct?

A Correct.

Q Same with 13.

A Yes.

Q Correct? Same with 14. That doesn't really show you anything, does it?

A Well, you can see a couple of nerve roots in the foramina lower and one

partially up above.

Q But that's not something that you would say is very representative of the condition of his spine, right?

A No.

Q Okay. And 15 obviously doesn't show you much at all.

A Correct.

Q Okay. So the best were 8 and 9, I guess, and the ones -- number 7 where the radiologist kind of marked the disc and measured it, right?

A Yes.

Q Okay. Now, you've looked at the records in this case, correct? All the records?

A I don't believe it's --

MR. LAURIA: Overbroad, Your Honor.

BY MR. PRINCE:

Q You've looked at the medical records in this case, haven't you?

MR. LAURIA: Overbroad.

THE COURT: Well, I'll sustain the objection. Why don't you just --

BY MR. PRINCE:

Q Have you looked at the medical records in this case?

MR. LAURIA: Objection --

THE COURT: Of?

MR. LAURIA: -- overbroad.

BY MR. PRINCE:

Q Oh, on -- oh, of Beau Orth, right, of Beau Orth after the --

THE COURT: Well, no, I know it --

Q -- postoperatively.

THE COURT: I know it's Beau Off -- Beau Orth, but are you talking about Dr. Cash or his own records or just everybody's?

MR. LAURIA: Dr. Ruggeroli or who?

BY MR. PRINCE:

Q Have you reviewed any of the records from Dr. Cash?

A Yes.

Q Have you -- you also reviewed Dr. Ruggeroli -- you reviewed Dr. Ruggeroli's records, correct?

A I read them for the first time when you gave it to me at deposition.

Q Okay. And you've also -- no, that was Rimoldi's depo -- report.

A Okay. I'm sorry.

Q Okay. So you've read your own expert report, Dr. Rimoldi, right?

A Yes. You gave it to me.

Q Yeah. And you've looked at the history that Beau gave to Dr. Cash and to Dr. Rimoldi, right?

A I believe so, yes.

Q Right? And you've even gone as far as to saying that Beau is not telling the truth in your opinion, that he's not telling the truth. You've said that about him, right?

A I think you're taking it out of context and saying something, what did you think of that.

Q Okay. Let's go to page number 147 of your deposition. Actually we'll go to page 146. We can -- we're going to start at line 20. At the end of the page. And the question is:

And he indicates he needed a second surgery performed by Dr. Cash after the first.

We're talking about Dr. Rimoldi's report.

Surgical procedure was done at the wrong level.

Do you disagree with that?

Answer: The patient also told me he never got any relief, which is not true from all the records. He --

And then it's going on to page 147, line 1.

-- he had complete relief.

MR. PRINCE: Going down -- all the way down to line 13. Go to 147 now.

THE WITNESS: That's 146, sir.

MR. PRINCE: No, I know. He -- he's --

THE WITNESS: Oh, I'm sorry.

MR. PRINCE: -- waiting for me to catch up. I want us to -- can we -- I want to go 146 and do it again, and then if we go to 147 so we have the question and answer correctly? Are you ready? Can you get -- just let me know when you're ready. I want to go to 146, then 147, 1 through 13, okay?

MR. HELLMAN: One forty-six is on the screen.

MR. PRINCE: I know, but I -- then I want you to be ready to go to 147 right after it. Are you ready?

MR. HELLMAN: Uh-huh.

MR. PRINCE: Tell me when you're ready.

MR. HELLMAN: I'm ready.

BY MR. PRINCE:

Q All right. So the question -- start on line 20 of page 146 your deposition

when we asked that and he says your -- going to your answer. Patient also told me he never got any relief which is not true from all the records. He, being Beau, had complete relief --

And question was complete relief?

Answer: Yeah, he was doing well. He took minimal pain meds after two weeks and that is not a correct statement that the patient told him for his evaluation.

Question: So you're saying Beau's history is wrong?

Answer: Beau is not telling the -- him the truth, in my opinion. My records are just the opposite of that.

My question was oh you're -- and you're telling the truth?

Answer: Why would I lie? There are the records.

Right. Why would you lie?

Answer: I wouldn't.

You wouldn't?

Answer: No.

So you did say that Beau is not telling the truth. You said that Beau wasn't telling the truth to Dr. Rimoldi, right? That's what you said.

A My records when I saw --

Q Did you say that -- those words? That's all I'm asking you, Dr. Capanna. Did you say those words in your deposition that Beau was not telling him the truth, yes or no?

A Yes.

Q Okay. And I asked you what do you want to tell the jury in terms of why you didn't document the procedure at L4-5, and here was your answer. Let's go to

page 147 of your deposition, still there, line 16 through 23.

Question by me: So what do you want to tell the jury in terms of why you didn't document the procedure at L4-5?

Answer: Because it was just a little addition to try and get to where I was trying to get to and I didn't remember to dictate it.

That's all? Question: You're not lying about it?

Answer: That's the truth. No.

I read that correctly?

A Yes.

Q Okay. And you want the jury to believe that you're telling the truth, correct?

A Yes.

Q Okay. Now --

MR. PRINCE: If I could -- where's the exhibits?

Q And just for -- so our record is complete, you never saw Beau again after October the 6th, 2010, correct?

A Correct. Well that's not true. I saw him several times.

Q In the office I'm talking about.

A No.

Q You never spoke to him, even if you saw him, right?

A I shook his hand once.

Q Where at?

A In the tunnel at the Rebels game.

Q When?

A It's in my notes.

Q I -- well, I'm telling you --

A My chart.

Q -- when it is -- you tell us when.

A 11/14/11. Saw at Rebels Reno game. We were in tunnel together. Shook his hand. He carried a Subway sign to the audience.

Q Okay. And -- but you never saw him back as a patient, you never evaluated him, never examined him, correct?

A Correct.

Q All right. And you learned through other sources that he actually had surgery done by Dr. Cash, correct?

A Yes, sir.

Q Right. Now, if we can -- Exhibit 2 to the trial exhibits is your billing record and it's --

MR. PRINCE: And I want to start at Bate number 97.

Q And for your services you billed --

MR. PRINCE: No, the -- well, you need to go down to the bottom so I can see all the -- yeah. There you go.

Q The total charges for your services were $12,480. Well, I guess that's the balance due. Yeah. Well, I guess that's the total amount of your charges, $12,480, right?

A Yes, sir.

Q Okay. And let me just ask you a question. Now, you agree that there's the medical expense. That's what your charge is, correct?

A Yes, sir.

Q And then how much a third party, whether it be insurance company,

State of Nevada or whoever, how much somebody reimburses you, that's a totally separate issue than whether your charge is -- you know, what a reasonable charge is. Don't you agree with that?

A Amen to that, yes.

Q Okay. And because -- you agree that different insurance companies have different reimbursement amounts, correct?

A Yes.

Q And let's say Aetna, Blue Cross Blue Shield, United Healthcare, Medicare, they all may -- they reimburse different amounts for different procedures, correct?

A Yes.

Q But -- and you -- as a physician, you understand that, you know, your charge -- you establish your charge based upon what you feel is usual and customary in the community, correct?

A No, actually we -- physicians are the only group that can't talk about their charges. It's still prohibited from the Sherman Clayton antitrust laws of the 1930s, only to apply to physicians, so we can't talk about what we charge because they're afraid we'll be price fixing, quote, unquote.

Q No, but I mean, you certainly -- there's certainly data available to determine how you come up with what a reasonable charge is for a service, right? Whether it be a -- through the government or elsewhere, there's way to do that, right?

A Yes. I believe the billing service does that, yes.

Q Okay. The billing service may do that, right. And so there's services that can determine what a reasonable charge is for a new patient evaluation, for a

microlumbar discectomy, office follow up, et cetera, right?

A Yes.

Q Right. And so the -- your charge of $12,480 represents the reasonable expense for the services you provided to Beau Orth, correct?

A Yes, sir.

Q How much you're reimbursed or any -- by an insurance company, that has no bearing on whether your charge of $12,480 is a reasonable charge for the service provided, correct?

A Correct.

Q Okay. If we're -- when you're talking about how much a physician charges for a service versus how much being reimbursed by an insurance company, those are apples and oranges, don't you agree?

A Yes. Quite different.

Q You can't look at what a -- what an insurance company's going to reimburse a physician for their service to say yeah, that's what establishes a reasonable medical expense. It's the charge itself established by the physician that is -- you -- reasonable and customary for the service provided. Wouldn't you agree?

A Yes.

Q Okay. All right. Look at Exhibit Number 18. Might be in the next book. Exhibit -- see if I can get it without having go to the book.

MR. PRINCE: Peter, can you put up Bate number 794? I'm going to go to 794 through 798. Without me having to go get the book, I'm just going to work off of the monitor.

Go the next page. Can you go the next page? Okay, next page. Can you go the next --

MR. HELLMAN: It is.

MR. PRINCE: Okay. Trying get to the -- I want to get to the end, Peter, of the billing. The --

MR. HELLMAN: The 798?

MR. PRINCE: That shows the total. Need to go the next one. All right. Here we go.

BY MR. PRINCE:

Q The total charges for UMC for Beau's surgery by you is $15,085.38. Do you see that?

A Yes.

Q That would be what UMC charged the -- the actual medical expense for the outpatient surgical procedure performed by you at UMC, correct?

A I've never seen it before but yes.

Q And --

A I assume so.

Q -- you agree that that you -- since you're on staff at UMC, you've been doing surgery there for a long time, you agree that the $15,085.38, that would be a reasonable charge for the outpatient surgery that day, correct?

A I assume so. I don't know the charges.

Q And you have no reason to believe it's not a reasonable and customary medical expense for that service, right?

A No.

Q And just like we talked about with you, hospitals, they negotiate separate rates with different insurance companies for how much they're going to be reimbursed, correct?

A Yes, but they can talk about their charges in amongst themselves, so it's a little different.

Q Yeah. I understand, but I'm talking about reimbursement rate only. I mean, it's the same -- they --

A Yeah, they --

Q -- they negotiate their own rates --

A Yes. Right.

Q -- with every insurance company it's different. Some are higher reimbursements, some are lower reimbursements.

A And some they don't even have contracts with.

MR. PRINCE: That's good, Peter. You can take that down.

Your Honor, I'm just checking my notes. I think I'm almost done with Dr. Capanna.

THE COURT: Okay.

[Colloquy between counsel]

MR. PRINCE: Okay. Doctor, I don't have any additional questions.

THE COURT: Thank you. Mr. Lauria?

MR. LAURIA: Thank you.

MR. PRINCE: Oh, and Your Honor, we do have Dr. Cash coming back at one. I made that arrangement for us.

THE COURT: Okay. Thank you.

MR. LAURIA: I'll let Mr. Prince clear off the table so --

THE WITNESS: Can you hear me, Peter? You were complaining. Okay. We're good today? Okay. Good. Sorry.

MR. LAURIA: Thank you.

CROSS-EXAMINATION

BY MR. LAURIA:

Q Dr. Capanna, they -- everybody -- a lot of people have been introduced in this case, but the jury hasn't heard anything about you other than reading bits and pieces out of your deposition, so I want to introduce you to the jury a little bit, let them know who you are, other than a snippet out of a deposition.

MR. PRINCE: Objection; move to strike the argumentative comments, Your Honor. The --

THE COURT: Well, I'll --

MR. PRINCE: -- the snippet comment.

THE COURT: -- I'll strike the last thing that was said.

MR. LAURIA: Thank you.

BY MR. LAURIA:

Q Dr. Capanna, what is your profession?

A Medicine.

Q All right. And what specialty in medicine do you practice?

A Neurosurgery.

Q How long have you been a neurosurgeon?

A Since 1979.

Q Let's go back through your education, training and background for a little bit. Where did you go do your undergraduate?

A University of Texas at Austin.

Q And what year were you at UT Austin?

A Let's see. '66 to '69, '70.

Q And what was your -- what did you study when you were doing your

undergraduate schooling?

A Chemistry, zoology and premed.

Q Did you then make a decision that you wanted to go to medical school?

A I made it before I started.

Q All right. That was something that you knew you wanted to do? What made you decide even before that that you wanted to go into medicine?

A I wanted to be my whole life a physician. And my father died when I was five, and I saw him die, and I think that might have had an influence on it, but I'm not sure.

Q So as long as you can remember kind of wanting to do something, it was to practice medicine?

A Yes, sir.

Q After you graduated, where did you go to medical school?

A Wayne State University in Michigan.

Q And how long did you spend at Wayne State in medical school?

A Three and a half years.

Q Once you completed medical school, did you -- were you required to go on and do additional study or if you wanted to practice as a family doctor, could you have gone out and done that?

A Yes.

Q What -- which is it?

A At that time you could just go practice. Now you have to do a -- there's a family medicine residency, so you have to do that.

Q All right. But back when you studied, if you wanted to go out and be a general practitioner, take care of people, you could have gone right after that three

and a half years, right?

A Yes.

Q You wouldn't have had to do any additional study or residency or any --

A You may have had to do for medicine an internship. I don't know to be honest with you.

Q Okay. Because that was never your direction? You weren't going to be a general practitioner?

A No.

Q What specialty did -- appealed to you? What did you want to do?

A Neurosurgery.

Q Why did you want to do neurosurgery?

A I -- like I said, I wanted to do that before I even was in medical school.

Q Well, what was it about --

A I was --

Q -- neurosurgery that made you want to follow that field? I mean, we've heard from Dr. Belzberg. There -- I mean, that's a seven-year residency.

A I've -- I -- as I said, I think I had a reason for it, and it was interesting, and it was always changing, and I think you really help people. The wins are really big. The losses are big too, but it's very satisfying.

Q And so in neurosurgery and in your practice of neurosurgery, what areas of the body are you dealing with on a daily basis?

A Well, in -- myself, neurosurgery in general has to deal with the brain, and the spine, and the peripheral nerves, and carotid arteries to your brain vessels. Most neurosurgeons, if they're in practice, do about 70 percent spine and 30 percent head or -- and some of them don't do any cranial stuff at all, so it varies with what

you're interested in or want to do.

Q And so where did you do your neurosurgery residency?

A At Wayne State, Michigan.

Q And when did you complete that?

A 1979.

Q Did you go right into practice then or did you do some additional training and study?

A No, I did three fellowships after that.

Q What -- you -- so after you completed the seven-year residency in neurosurgery, you did additional training and fellowship?

A Yes.

Q Where did you do additional training and fellowships?

A I was a fellow at the University of Zurich in Switzerland on microneurosurgery. I was a fellow at the University of Paris in France on what's called stereotactic neurosurgery. That's where you localize a spot in three planes, XYZ, just like a stereos tube but -- it was a highly specialized thing and they were doing a lot of it even back then. And then when I finished that, I went to The Hospital for Sick Children in Toronto, did pediatric neurosurgery.

Q And when did you come to Las Vegas and begin practicing here?

A I came to Las Vegas before that when I was a resident to work on microdiscectomy, and then I moved here in 1983 and have been here ever since.

Q So for 32 years you've been doing neurosurgery in Las Vegas?

A Yes, sir.

Q Are you married?

A Yes.

Q Do you have any kids?

A Yes.

Q How many kids do you have, Doctor?

A Ten.

Q You have 10 kids?

A Yes.

Q And what are the ages of your kids?

A The little one just turned 13 July 2nd, and the oldest one's 31.

Q Do you have any kids that are in high school now?

A Yes.

Q Do you have one that's actually a senior at Bishop Gorman? I think you told me this morning.

A Yes. He's a senior baseball player and his father has all the aspirations for him that Rob had for Beau. It's -- so I understand what he's saying.

Q You -- in addition to your private practice of neurosurgery, are you involved in other aspects of medicine? For example, you heard I think Dr. Cash mention about being a ring doctor or fights. What -- can you tell us -- the jury a little bit about what you do or what that involves?

A Well, a ringside physician is a special license in Nevada that you have to get every year and do CPR and all that kind of thing. But basically you're working for the Nevada Athletic Commission and they assign you to MMA or boxing matches, kickboxing, that kind of thing.

Q And how long you been doing that?

A Since I first got here.

Q What -- what's the last event or fight that you were a ringside doctor?

A Oh --

Q Or give me a -- are there some that have been recent that people would know about?

A Yes. I was at the Pacquiao/Mayweather fight.

Q And who did you end up with in that fight?

A Well, the commission called three days before and said which side do you want to work on and I initially said Pacquiao and then I said, no, wait, I did him last time and I switched to Mr. Mayweather.

Q So you had done fights with Pacquiao before the Mayweather fight and so this time you said you'd do Mayweather?

A I've done every one of Manny's fights since he started in Las Vegas. I like him. He's a nice man.

Q Now, one of the things that's been talked about in this case is that you are a team physician or -- for UNLV athletics, true?

A Yes. I'm the -- we -- we're physicians in the Department of Athletics.

Q You're not paid by UNLV, are you?

A No.

Q You're not an employee of UNLV?

A No.

Q UNLV has no oversight or responsibility for you, do they?

A No.

Q You do -- are you a volunteer?

A Yes.

Q This is something you do for free because you enjoy it?

A The way of sports medicine fellows, like Cash was talking about, he

was with Watkins, and we teach them and we have -- starting September -- every Monday night from six to eight we have didactic lectures on sports medicine and that kind of thing.

Q All right. But I mean, you're not affiliated with UNLV in any way, other than you volunteer to be a team neurosurgeon?

A Well, they have to want you to be one. They make you part of their athletic department.

Q Sure. But I mean, they don't pay you. They're not responsible for anything you do.

A No.

Q They're not involved in this case in any way, are they?

A No, sir.

Q All right. They have nothing to do with this, other than you happened to be treating a football player and you happened to be a team doctor and Beau was at UNLV. But other than that, it has nothing to do with UNLV, does it?

A No.

Q All right. And they're not named in this case, they're not defending you in this case, they have nothing to do with it, do they?

A No.

Q All right. There were some things that were talked about that you agreed with. You agree, Doctor, that -- well, strike that. You -- you're not saying, and you haven't been saying from the time that you were asked, that you may have inadvertently injured the L4-5 disc, true?

MR. PRINCE: Objection; leading and lacks foundation.

THE COURT: Objection -- I will sustain it as to leading. You can rephrase it.

BY MR. LAURIA:

Q Doctor, are you asserting or claiming that you didn't possibly inadvertently injure the L4-5 disc?

A No, I believe I did, and I'm sorry.

Q And are -- can you explain to the jury -- and if you need to use your model, you can -- how it was that this -- you believe you may have injured that disc?

A Yes.

MR. LAURIA: Can he get up and show the jury, Your Honor?

THE COURT: Are you talking about the spine model or the --

MR. LAURIA: Correct.

THE COURT: -- or a diagram model?

MR. LAURIA: Spine model.

THE COURT: Yeah. Yeah. Absolutely.

[Colloquy between counsel]

THE COURT: If you would just try and keep that -- maybe, Mr. Lauria, you can move that --

MR. LAURIA: Sure. We'll try and keep the microphone so they can hear you --

THE COURT: Okay.

MR. LAURIA: -- and you have a little bit of a soft --

THE COURT: Well, there's the stand-up one. I had -- I brought the --

MR. LAURIA: Oh.

THE COURT: -- remote one in so that you guys can move it wherever you need to.

MR. LAURIA: Thank you, Judge.

THE WITNESS: Okay, can you hear me? Everybody happy? Okay. All right, basically as you've seen several --

MR. PRINCE: Your Honor, can I reposition myself as well?

THE COURT: Oh, yeah. Yeah.

MR. PRINCE: Okay. Thank you.

THE COURT: You can move over there.

THE WITNESS: The objective with Beau was to go down and get the little disc off of the nerve root as you've heard already. Now, Beau had a spine like this one that's curved a little more than some people's. His lamina was a little smaller like this model is. And the objective was to go down --

BY MR. LAURIA:

Q Can you make sure that you --

A Yes. I'll walk around --

Q -- because these folks over here can't see, so --

A I'll walk around, I'm sorry. I'll be --

Q -- make sure as you --

A I'll be a good teacher. Okay.

Q -- point something out you show it to everyone, please.

A As you heard about taking the ligament off here, the objective was with the microdiscectomy you could do as little as possible, and the -- disrupting the normal anatomy, okay? That's why we developed the operation. That's why it's -- you get better quicker and all that kind of thing. So my objective was to go down here, and you can see the spine's curved a little bit here when a -- in a normal person, and to get to the disc space, which is at an angle with the sacrum or the tailbone. Now, we did all the X-ray that we've talked about, and probably ad

nauseam for you guys, but at any rate, to find out where you are because you're -- even though you're here, one of the experts said, you know, it's really up here where you start.

So we go through a whole routine to get the X-ray to tell us where we are, because if you just rely on touching things, you won't be accurate, okay, because sometimes some people have different musculature, okay? And Beau's came in here more, so he's more fibrous down here, and more muscular up here.

So, basically, I made a little incision up here, and it's about the size of a dime, up here, and went down here to try to get there, and the angle coming through was not good. So I went up over the lamina, and I didn't go up here, in spite of all the testimony, that's why I believed Dr. Cash had to extend the incision to get there. But the objective is to basically get there and not hurt anything, or do more than you have to with the normal anatomy. Okay? So I went up here, and I probed around, and I took a little bit of this off, and I took a little bite out of the top --

Q If you -- go ahead. Little bit of the top of --

A The superior part of the L5. This is the 5 lamina, okay? It's the lead --

MR. LAURIA: Can everybody see what he's showing? Or --

THE WITNESS: Can you see? I'm sorry. Okay, the L5 lamina, it's the one that was taken out eventually with Dr. Cash.

And I probed around here. I admit that freely. Okay, I did. (Indiscernible) why would I lie? This (indiscernible) true. And it wasn't going to be any better. So I abandoned that, came down here, got there without a great deal of difficulty. The nerve root was just like the pictures you saw before surgery underneath the little disc, so I had to take a little bit of the ligament out here to go further over here.

Beau has bigger joints because of all the weightlifting he's been doing. That's one of the things we argue with the coaches all the time they put too much pressure on, but at any rate -- so I could get in here without taking all the bone out. And then I got the little fragment out.

MR. PRINCE: Well I'm going to object right now. He's not saying where -- he's not identifying where, he's talking for the record --

THE WITNESS: Okay. I'm sorry.

MR. LAURIA: Well -- hold on.

THE COURT: Okay. Go ahead.

MR. PRINCE: -- just identify just so we're clear on what the record --

THE WITNESS: Okay.

MR. PRINCE: -- if you say here --

THE COURT: All right.

THE WITNESS: No, I told them L5-S1 to begin with. This is L5-S1. This is L5. This is sacrum 1 (indiscernible) --

BY MR. LAURIA:

Q Okay. And again, make sure everyone can see, please.

A Okay -- did I break the whole place? I think I just disconnected something here.

Q I'll get that. Go ahead.

A All right. Okay. Can you all see back there? Sorry. Okay. So this is the L5, this is 4, the 3, we've been through that. This is the sacrum. These are the coccyx or little tailbones. So I got down into here and then the disc actually came out pretty easily. It's been five years, as I recall, and then the little ones that were loose were taken out. And the objective with microdiscectomy is not to go in there

and take all the loose stuff out like he showed you, or somebody showed you here, because then you'd degenerate the disc more.

So you take out what's loose there, which I did, and that's what I dictated because that's what I did. And I didn't dictate that I went up here. And I should have, okay? No argument.

And then Beau was doing good. His reflexes were back, his pain was gone. In the office everything was okay. And then he called 11:30 at night or whatever the records have there. And I called him back, see what was going on --

MR. PRINCE: I'm going to object to this part --

THE COURT: Well --

BY MR. LAURIA:

Q Okay, we'll get there.

THE COURT: All right.

BY MR. LAURIA:

Q Yeah, we'll -- I'll get there.

A Okay.

THE COURT: All right. All right.

THE WITNESS: Okay.

BY MR. LAURIA:

Q I'll ask you about that.

A Okay.

THE COURT: I'll sustain that objection.

THE WITNESS: Okay. I'm sorry.

THE COURT: You're going off topic.

MR. LAURIA: So -- okay.

THE WITNESS: Okay.

MR. LAURIA: So --

THE WITNESS: So I finished doing this, okay? And then I hurt Beau. And I admit it, okay? And I'm very sorry, or we wouldn't all be here. Okay? I hurt the disc --

MR. PRINCE: I'm moving to strike that. He's never said that one time ever before.

THE COURT: All right.

MR. LAURIA: He's never --

MR. PRINCE: And this not even response --

MR. LAURIA: -- had a chance --

THE COURT: Hold on.

MR. LAURIA: -- to say it. Excuse me.

MR. PRINCE: -- to a question.

THE COURT: Hold on.

MR. PRINCE: He -- Beau was at his deposition --

THE COURT: I will sustain the objection. I mean we need to confine ourselves --

MR. LAURIA: Sure.

THE COURT: -- to answering the question that was asked --

MR. LAURIA: I agree.

THE COURT: -- which was just how -- how did you do your procedure.

THE WITNESS: So then this was closed up --

BY MR. LAURIA:

Q So hold on, let me ask you a question. All right.

A Yes.

Q So at the time that you did the surgery, were you aware that you had gone or entered the L4-5 disc? Not the space where you were probing, but were you aware that you'd actually entered the disc?

A No, sir.

Q All right. When did you first become aware that there may have been a problem with the L4-5 disc space?

A When we did the post-op scan when Beau was having all the problems --

THE COURT: Let me just ask do you need him to be using the model any more or can he sit back down?

THE WITNESS: I think it was 10/6 or 10/7 I believe it was.

MR. LAURIA: Okay. You can probably step back.

BY MR. LAURIA:

Q Doctor, as part of your decision making in how you were going to approach the L5-S1 level, did you use your best surgical judgment in the approach that you were going to use that you thought was going to be the most beneficial for this patient?

A I did that for his whole treatment, and at the time of surgery, I thought it might be easy. I've done it a couple of times. It's not common at all unless their lamina is angled a little bit more and thin like his was, and that's why I did it. I thought it'd be safer for him. And --

Q Did -- do you believe that in probing and having a structure surrounding the disc, that that's a recognized risk of doing surgery? Or recognized complication?

A Yes, unfortunately, yes.

Q You heard Dr. Yoo give testimony about even if you are -- were going to the wrong level. Do you recall Dr. Yoo talking about that?

A Yes.

Q And I believe Dr. Yoo -- Yoo's testimony was that basically everybody who's a spine surgeon at some point, even if you do all of the steps that you're trained to do, and the preoperative films and the fluoroscopy, that you still can end up at the wrong level and end up doing surgery. Do you recall that?

A Yeah, the incidence is about three percent to some others 10 percent, so yes, it's a known complication.

Q So even with fluoroscopy and using all the markers that you can, when you actually get in the spine, there is a percentage-- one, three or four, whatever, different studies have different incidents, but every surgeon has had that happen to them, hasn't -- haven't they?

MR. PRINCE: Objection; foundation, speculation.

BY MR. LAURIA:

Q That you're aware of.

THE COURT: Well, with that caveat you can answer the question.

BY MR. LAURIA:

Q Every spine surgeon that you're -- that you know or are aware of has had that happen to them in their career, haven't they?

A I don't know if everyone has, to be honest with you. I don't know that. But -- yeah.

Q You believe, Doctor, that you did surgery at L5-S1, correct?

A Yes, sir.

Q And you note -- and we'll go through your operative report. You actually

note going in and seeing the disc and the nerve root touching each other, correct?

A Yes, the --

Q So you --

A -- nerve root was angled.

Q -- you got to a level and saw the pathology or saw the abnormality that you were looking for.

MR. PRINCE: Objection; leading.

THE COURT: Well, sustained.

BY MR. LAURIA:

Q When you did surgery and you got to the disc level where you intended to be, what did you find?

A I think I already told that to the jury that the nerve root was angled and there was disc underneath it, and basically I had to dissect some more to get to be able to move it and not hurt the nerve.

Q Can we get your operative report?

MR. LAURIA: Paul, can you pull that out for me? And I don't know, do we need to switch over or --

THE CLERK: You have to plug the TV back in.

MR. PRINCE: The doctor unplugged the TV.

MR. LAURIA: Oh, okay. Sorry.

THE WITNESS: Sorry.

THE CLERK: Joel, can you help him?

THE WITNESS: I have it, Your Honor, if they want to use mine.

THE COURT: Well, I think he wants to put it on the monitor.

[Colloquy between counsel]

THE COURT: Did they break the prongs?

MR. LAURIA: I think --

THE MARSHAL: Yes.

MR. LAURIA: I think one of the prongs may have got screwed up when he stepped, Your Honor.

THE COURT: Oh my gosh.

MR. LAURIA: I can't tell. I can't see without my glasses so -- it's all a big blur to me.

Well should --

THE COURT: Well, I tell you what --

MR. LAURIA: Should we take a break for a minute while we --

THE COURT: -- we're going to go ahead and take our --

MR. LAURIA: Thank you.

THE COURT: -- lunch break then.

Ladies and gentlemen, we'll go ahead and break for lunch at this time. During the recess you're admonished not to talk or converse amongst yourselves or with anyone else on any subject connected with the trial; or read, watch or listen to any report of or commentary on the trial by any medium of information, including without limitation newspapers, television, the internet and radio; and you cannot form or express any opinion on any subject connected with the case until it's finally submitted to you. I'll see you back at 1:00. Thank you very much.

[Jury out at 11:59 a.m.]

THE COURT: Okay, guys, we'll be in recess.

And you said you have Dr. Cash coming at one?

MR. PRINCE: I sure do --

[Off the record at 11:59 a.m.]

[Proceedings resumed at 1:12 p.m.]

[Outside the presence of the jury]

THE COURT: Okay, guys. You got anything outside the presence?

MR. LAURIA: I don't think so.

THE COURT: No? Did we lose Mr. Prince? Anything outside the presence for plaintiffs?

MR. PRINCE: No.

THE COURT: No, okay.

MR. PRINCE: I mean, I guess we're ready to go. I think we've been -- I think we're close as a resolution. I don't know if it's within minutes, so I don't know if you want to give it a couple minutes. We're going -- but we can start but who knows. There's no -- I guess there's no guarantees until there's --

THE COURT: Well, the -- here's the reality of why I said what I said earlier. I mean, you all know as attorneys that obviously, you know, settling a case, you give up a little bit, but you get something as opposed to turning it over to the jury. I generally never have any problem when people say we need some time, we're close to settling the case. And I'll always talk to a jury afterwards if we're in a jury and explain to them why that happened and they always understand. My concern here was just getting this trial finished and all the --

MR. PRINCE: Right.

THE COURT: -- witnesses --

MR. PRINCE: Understood.

THE COURT: -- were giving up surgery time and all that to come in and testify. So if you think it's fruitful and you want a little time --

MR. PRINCE: Yeah, give us -- give us like five minutes -- five, 10 minutes and we'll just see --

THE COURT: Yep.

MR. PRINCE: -- how we do.

THE COURT: Okay.

MR. PRINCE: I think she's already talk to somebody, they're waiting to get approval. And so I doubt we'll put --

MR. LAURIA: I think --

MR. PRINCE: -- we'll load Dr. Cash up and --

MR. LAURIA: And I'm somewhat out of the loop, Judge. So I'm ready to go whenever we're ready to go. So --

MR. PRINCE: I mean, I'm fine --

THE COURT: Okay. This has nothing to do with you.

MR. LAURIA: I'm just the defense lawyer, Judge.

MR. CARDINALE: He doesn't have the checkbook.

MR. LAURIA: I --

THE COURT: All right.

MR. PRINCE: So --

THE COURT: All right. I will give you a few more minutes. Go ahead.

[Off the record at 1:14 p.m.]

[Proceedings resumed at 1:21 p.m.]

[Outside the presence of the jury]

THE COURT: Okay. You ready?

MR. PRINCE: Yeah.

THE COURT: All right, Joel, go ahead and get them in, please.

Dr. Cash, you can go ahead and come back up here.

THE WITNESS: Oh.

THE COURT: You're going to be our witness. Thank you. Thank you for coming back, by the way.

[Jury in at 1:22 p.m.]

THE COURT: All right. Everybody can be seated except Dr. Cash. Please just go ahead and raise your hand for me.

ANDREW CASH

[having been called as a witness and being first duly sworn, testified as follows:]

THE CLERK: Thank you. You may be seated. Will you please state and spell your name for the record?

THE COURT: That's okay. You've done that before.

THE WITNESS: Okay.

THE COURT: That's okay.

All right, ladies and gentlemen, we're still in plaintiff's case in chief. We're going to go back and resume the testimony of Dr. Cash who is still under direct examination of Mr. Prince.

DIRECT EXAMINATION CONTINUED

BY MR. PRINCE:

Q Yeah. And Dr. Cash, thanks for coming back this afternoon.

A My pleasure.

Q I want to talk about a microdiscectomy and kind of like how you perform a microdiscectomy like the one you did on Beau on October 22nd, 2010. I've created an operating table for you and here's a patient. And did you bring some surgical instruments so you can kind of demonstrate the things that you would

typically use as a spine surgeon in performing a microdiscectomy on somebody's spine?

A Yes.

Q All right. Would it help you in explaining the surgery if you came down and used the model to show the jury what you do?

A Absolutely, it'd also be helpful if you could put up a couple of the MRIs, maybe the sagittal 2 images just for review.

Q Okay. Would you -- which one would you like to see? Would the pre-op or the post-op be best?

A Post-op would be better.

Q Okay. Let's put up October 6th, 2010, that's the demonstrative one.

THE COURT: He should be fine there because there's a microphone right in front of him anyway.

THE COURT RECORDER: His voice is really low.

THE COURT: Pardon -- oh, go ahead --

THE COURT RECORDER: Yeah.

THE COURT: -- Joel.

THE COURT RECORDER: Thank you.

THE COURT: Okay. So this is October 6th, 2010, sagittal T2, 9 of 15.

MR. PRINCE: Correct.

THE WITNESS: Thank you. Okay. So essentially this would be the patient now. Unfortunately, we don't have a great model that really reenacts the surgery, so we have a skeletonized model. So you'll be able to see a lot of stuff I'd never be able to see in surgery, which is most of it. So if you could imagine I can't see anything from the side at all unless it's with an X-ray. And X-rays look pretty much

like that MRI, so pretend it's an X-ray when I'm talking. I can see from the side and I can only know which level I'm at with an X-ray. That's why I've got to do the confirmatory test, okay?

So coming from the top, I just see skin of the back like this, okay? So I can't tell you if 4 to 5 is here or it's here or it's anywhere, so I have to start with a needle, okay? So I'll put a needle down over to the side safely, not over the spine, but right about here, take an X-ray, see if that's -- I'm guessing that's probably 3-4, okay?

Now, that's 5-1, 3-4, 5 -- so I was right, okay? But often, if I'm putting through, if you look at -- I can always see with a centimeter, but you can see it's at two different levels. So you can't just put this down there and assume we're at the right level. You got to do an X-ray. What that would like -- and in this case it'd look like here's the skin. The needle would be right there in line with the track, so that was a good track to go, leads right to 4-5.

The next step is to make a scalpel incision. And then I only see the fat over here. I can't see any of the spine still, okay? Then you pull the fat to the side and there's this band of tissue, it looks really glistening, and I have to decide which side to operate on. I normally do the left, but I'm going to do the right side because you can see it better. So I take another instrument and I kind of scoop the muscle and push it over to the side where I'm looking right down at the interlaminar space. Then I take this instrument -- it's a retractor of sorts. It's one of the ones we use. Then I'll pull all the muscle and fascia and skin and fat to the one side so I can look directly at the inner space where the ligament is.

Now, at this point I've pulled muscle at -- you know, 5-1, 4-5, I've pulled a bunch of muscle over and it's retracted and that's why you're going to see a scar

at more than one level, even when you're doing a single level approach, okay? Now, I have an assistant hold this in place, but just remember this big piece of metal is pulling on that muscle this whole time, okay?

The next thing I'll do is because this level from a little hole, the ligament in the bone looks just like this one, which looks like that one. I've got to do a confirmatory X-ray in the interlaminar space to make sure I didn't go in the wrong place. Because I can have a needle in and it looks kind of similar to the angle I am here, then I make an incision and I go straight down and I'm right there.

So it's tricky. Needles to begin with helps me get the trajectory and the interlaminar space X-ray lets me get confirmation I'm in the right 4-5 area. So -- and I would have this picture, so I'm about to violate the ligament, okay?

Now, the next part of the procedure I take some other bigger instruments I didn't bring in, shave the bone as necessary, reflect the ligament and pull it off, okay?

BY MR. PRINCE:

Q While you're standing there, on that image do you see a portion of the L4-5 lamina removed?

A Yeah, that's this gap here.

MR. LAURIA: Objection; compound, vague, Your Honor.

THE COURT: Well, why don't you first show us where the L4 lamina would be on that diagram --

THE WITNESS: Sure.

THE COURT: -- if you would, Doctor.

THE WITNESS: Okay. So if everybody can see these black areas, that's a non-vascular ligament, okay? That's where the -- that's where the ligament is here.

A ligament is here. A ligament is here. This interruption, this black area here means the ligament is disrupted. And the lamina above and below connects to the ligament. So you may have to shave a sliver or a millimeter right off the bone to get the ligament out or you may have to take more, depending on your trajectory and where you're trying to look.

So this absence here, this little white patch with the track behind it indicates that approaching 4-5 and a ligament was removed and to some extent the bone was removed. And so now you're looking at the -- you can't see the disc yet. You're seeing a piece of nerve that through -- and a nerve right there, okay?

So the next step is to retract all the nerves over to the side --

MR. LAURIA: Can I move, Your Honor, so I can see?

THE COURT: Yeah.

MR. LAURIA: Thank you.

THE COURT: Absolutely.

THE WITNESS: So we're going to make a hole here and I can't see the disc yet because this is a big water-ballooned nerve. So I reach over this way and I pull it back. That instrument is a nerve root retractor. It looks like this, okay. So it comes in, hits the nerves, scoops them over, pulls them this way so I can look at a clear channel straight -- the microscope looks straight, not around corners. That's why this bayonetted like the rifles are bayonetted. If this were straight up, it'd be hard to like look straight down on that end, so it moves to the side so it has more visualization. So I can look straight down.

So now I'm looking at the disc. This -- so far no harm has been done to the patient if we're at the wrong level. If you just take out that ligament and piece of bone, it doesn't provide much stabilization, okay? The point of no return is the

violation of the disc. That's why no matter what you've done ahead of time, whether you've done the X-rays at this point or not, you must put something down, usually blunt like a Penfield 4 we've been talking about, pass the nerves.

You can't see in there. You scoot past the nerves, pull it over, see how the nerves move, pull it over. I'm looking at it. I get an X-ray with this in position. This is down here moving the nerves to the side. Put this right on the disc and take a picture.

That picture will look like this. I don't think it's necessary to save the initial the interlaminar space or this one because I know by taking an X-ray I'm at the right space. I can either take the X-ray here and save it and prove I was about to enter the right space or I can do the procedure, put the instrument in or leave it out here, wherever, but there's got to be some kind of X-ray proof that you're at the right space. That just covers myself from being in this position.

So at this point I take an X-ray before I violate this because once you violate it, it's open, it's popped out, it starts to preserve it's condition, okay? So we want to make sure it's the correct one.

So the next step is to take a sharp knife and cut the disc. We were talking Monday, I think it was, that you could put one of these in a disc and I think Dr. Belzberg said he's seen his partners do it. That may be true. It requires a bit of either effort to get this in a disc or it requires an incompetent disc, you know, a hole is already there maybe through a tear or something like that.

There was not a tear in Beau's disc. It was very strong. It was supporting a 200-pound football player for years. So for this to slip in and get pushed in, you've got to push it really hard or you'd have to mount. And it has to be the point of least resistance because things are going to go wherever it's easier for

them to go physically. So if you're pushing this way --

MR. LAURIA: Could we -- excuse me, could we get a question at some point?

MR. PRINCE: He's talking about how to do a microdiscectomy.

THE COURT: Well, under these circumstances, I'll let him continue on.

You can go ahead.

MR. LAURIA: Thank you.

THE WITNESS: So by pushing in, I mean the -- it's like a rubber tire. Now, it's not as hard as a tire. I'm not implying that at all, okay? Tires have to support big tons, you know, cars and trucks. But it is kind of like a tire for his body size. It's hard to enter, it feels like it's kind of rubbery.

So if you were slipping, you'd probably slip in some other direction, maybe hit a nerve. But to go actually in -- I mean, this is just an orange. So if you actually went it and you're stuck in, there'd be no mistaking it. It's sticking right out. Plus you have to clear about a centimeter of hard fibrous tissue, those cross-radial tire band.

BY MR. PRINCE:

Q Would there be any question if you actually stuck one in a normal healthy disc? Would there be any question that it was stuck in the disc itself?

A It'd be a shock and you'd be surprised and you'd be like, gasp, and then you would take an X-ray of this to see where you were, and it would stick out. So you wouldn't shed like a flake of a cell off there. And this is very thick fibrous tissue. So if you entered this same hole or put it through, it'd take a little force.

Now, the thing is with this instrument, the reason this is devised and the -- we're also talking about a probe. This is very similar to a probe. It just pushes

them in. You want to probe, which means feel around. You're probing for stuff, you're feeling very gently. And you don't want to use a sharp instrument. Probes are dull, they have to feel around. So it's not like you're feeling around with a knife where you're going to go. That's the last thing you want to do. You want to use something dull. So this is a very dull instrument and that's we use it very often. You're very gentle in your motions. It'd be hard to forcibly put this into a competent, strong disc gently, but not with direct pressure without slipping it somewhere else.

Q And when you're probing, I mean, what kind of force are you using while you're probing to make sure you're not injuring other tissue?

A There's not a lot of force. I mean, gently, you're trying to like say is this a nerve? Let me pull it to the side. Hmm, it moves like a nerve. You're doing something like this. You're just probing. It's not very forceful. These are delicate instruments, they're blunt, so I could hit this nerve many times and probably not cut it.

I'll show you this knife in a second. It looks like a razor blade. It'll cut right through it.

So you probe with dull stuff. It's almost like closing your eyes. If you're trying to probe around a corner you can't see, like you went to L4-5 and you probe down, it'd be with a very blunt instrument to avoid injuries because you can't even see what you're probing. So it's got to be dull, okay?

Additionally, when you're entering this space and you want to see the disc, you just move it to the side just directly under. If there were a lateral fragment -- remember there's no lateral fragment. If there were a lateral fragment in this case, you would go this way, you could look at it this way. Coming up here, you can't get the instrument around there, even if I nibble it off. Even if I did nibble it off, I couldn't

see this physically. Even if I did move the retractor, you just got to push, you got to make a new hole in the skin for -- to account for all that angle, further away the skin is.

So the account of going to 4-5, I don't question the doctor's judgment in wanting to go a level above to look if he feels like he could probe that way, but there was no lateral fragment. The fragment was contained. It didn't pop out and move north and certainly no visualization could have been performed, and the instrument couldn't have passed very well.

So with that, I will show a scalpel. It's a very sharp instrument.

MR. LAURIA: So, Your Honor, at some point, is there going to be a question that's responded to or --

THE COURT: You can continue.

THE WITNESS: So this would be the disc, a very sharp instrument, razor-fine with a point, and then it goes in the disc very easily. You have to keep and maintain a really strong control, holding it close. And that's a box cut. And that's a hole and that stays in the patient when you come out of surgery, even after you reach in, grab some material out, happened with your decompression, there's going to be a hole there. As soon as the patient sits up and weight is near it, he's got force and this material can come out.

Now, it may not come out right away, it may require bending over and picking up a pencil on the floor, it may require sitting up from a recliner, it may require something, but when you load with gravity, a plump disc like this that just have a little bit of discectomy and the force of gravity from standing in a forward flexing and then sitting pops out. This is what happens. Disc was in there and now it's popped out through a manmade hole, now it's a normal plump disc. This has

never been addressed surgically. There's no track there, only this one. There's a hole made in this disc and it's not surprising it popped back out within a few weeks.

BY MR. PRINCE:

Q Now, Doctor --

THE WITNESS: So the scar tissue wouldn't have formed to block that trap -- trapdoor -- to block that box cut. By the time it popped back out, by definition, that hole is still there, the disc popped out when he called -- made the call at 11:00 at night. So it wasn't a month or three weeks waiting something to scar in and it still would not scar that fast, but we're looking at the time it popped back out through an open hole to where I went back in for time to scar down.

By MR. PRINCE:

Q If it's scarred down, you wouldn't have -- this material couldn't escape in a manner like this, right?

A It couldn't. It has to have an open conduit. It came right back out of the hole, so it wouldn't have scarred down that fast. So the hole is the least patent when the re-herniation -- I call it re-herniation, when the herniation from the surgery happened.

Q Now, Dr. Cash, I mean, you kind of showed -- I'm preserving the box cut for the closing arguments. I'll use that later. But using -- you have another -- was it a lemon or -- was this a lemon?

A It's an orange.

Q Orange. That's a poor looking orange but all right. I don't -- and so no wonder you brought it with you. And so now --

A It's yours.

Q Thanks, I appreciate that.

MR. PRINCE: It's yours, Paul.

MR. CARDINALE: Oh.

BY MR. PRINCE:

Q And so can you mistake -- when you said you saw a box cut in the L4-5 disc, when you did your surgery, can you -- could that be mistaken for just simply a probe slipping in there or would it be distinctly different in terms of the way it looked?

A If a probe somehow defied gravity and didn't bend and went in there, it'd be known at the time of the incident. And it would be a small little dot like this and it would probably be close back reasonably well. I don't think a sizeable herniation would pop back through that pinhole. If a probe light instrument, like a Penfield number 4, it's very common to probe, slipped in -- I think we saw that a minute ago --

Q I'll give it back for a minute. I just don't want you to take this and eat it.

A I may have an extra one. Okay. So this is a bigger -- this is bigger than a probe, but we do use a probe. If it comes out, you can see the size of the hole there -- can you see it? Can you see any of those? You can see a box cut, okay? Because a probe that Penfield 4 make doesn't readily allow this to go in, okay? But a probe that -- a box cut hole does allow this to go in, okay? So three ways to make it. You make a slit, you make an X or you make a box cut.

Q Yeah, well, show us the other methods. We'll just go ahead and use that same orange.

A This is a slit, you can't see it. That's it. This is an X, can't see it. But you can't probably force --

Q Is that the same way on the disc that you can't really visualize it well?

A Well, I'm looking at a high-powered microscope, of course I can see it.

And I just made it and there's only a -- there's only a area about this big as I feel anyway, I know this is only that big. So you probably could just reach around and find the box cut, I'd be -- yeah, because I'd be looking at it. But this would get into an X. And if you couldn't successfully get in a slit or the X, then you make a smaller box cut and make it bigger and bigger as needed and this definitely would go in. But the bigger the hole, the bigger this material could pop back out.

Q And I want to ask you a question. The Mr. -- Dr. Capanna testified earlier, said he did not have to go in to make any incision into the L5-S1 disc because the disc material was -- the fragments were outside of the disc space. Based upon your review of this and the pre and postoperative MRIs, was this a contained disc protrusion?

A This disc protrusion was contained. It was contiguous and encapsulated by the ligaments usually behind. Most disc, paracentral, pop open and it's like a zip, you have to put a hole in it with a knife and the zip will go up through, and this material will come through and you'll reach back in, okay? But if it's extruded, that means it's popped through a ligament and it's free to move about the cabin, if you will; it can move north or south. If it had extruded and it popped and moved north up the spinal canal towards the head, I would anticipate that maybe you would have to make an incision at the level above and sort of reach in and grab it, but you would be looking at a moved fragment, sort of like a little pea, side here that's moved up.

For instance, this is popped out and moved like a little dot up the canal, you'd be able to grab it that way. But this is not -- it didn't move up -- it didn't -- first of all, it didn't extrude. Second of all, it didn't have a chance to move north because it didn't extrude. And finally, it wasn't lateral. So this is paracentral classic disc

herniation that hits the nerves as its traversing.

Q Now, when you -- when you were in there performing your surgery, Dr. Cash, at L5-S1, had that level, based upon your use of a high-powered microscope, ever been operated before October 6th -- or October 22nd, 2010?

A I was the first person to operate on L5-S1, interlaminary and at the disc.

Q When you -- did you exam the ligament, you know, which was behind the L4-5 disc space before proceeding?

A Yes.

Q Was there any removal of the ligament -- ligamentum flavum behind the L5-S1 disc space?

A Absolutely, you can see its absence on the MRI. It's confirmed with a high-powered microscope.

Q Let me -- let me -- I think I might have misspoke. Was there any ligament removed behind the L5-S1 disc --

A No.

Q -- before your surgery?

A No, it was unbothered.

Q Who is the person who removed any of the ligament to get to the L5-S1 disc?

A I did.

Q Okay. And when you visualized the L5-S1 disc during your operative procedure, using the microscope, was there any evidence that there had been attempt to remove the disc protrusion that we saw in all the preoperative MRI films?

A No.

Q Okay. What you called the virgin tissue?

A Correct.

Q Okay. Good. Is there anything else that you think would be helpful in demonstrating, you know, your surgery and what you saw when you were there at the time you did the surgery on Beau?

A No, other than you're looking through a hole here and you make a hole here and there's going to be scar tissue from the skin all the way down here.

MR. LAURIA: Your Honor, can I ask that we put this down because we can't see.

THE COURT: You mean this board?

MR. LAURIA: It's kind of blocking. If they're not using that --

THE COURT: Yeah, you can sit it down on the floor.

MR. LAURIA: Okay.

MR. PRINCE: Thank you. Maybe I'll just maybe move it back a little bit. Can you see?

MR. LAURIA: I can now, thank you.

MR. PRINCE: Okay.

THE WITNESS: So there will be scar tissue from adjacent levels. Perhaps your approach layering levels different, but there's going to be scar tissue more than just the one level perhaps. But when you come down and you violate the interlaminar area and the ligament, then you're going to have scar tissue there. You're not going to have it through here because you didn't go through here. So this was addressed -- it shows on the MRI clearly and then I confirmed it with direct visualization with a microscope, this was a surgical area and only the surgical area after the ligament and disc was removed and there was a non-violated canal.

MR. PRINCE: Can you -- Peter, can you put up the plain X-ray. It might be --

is it our demonstrative 42? Oh, there you go.

BY MR. PRINCE:

Q Can you show us on, you know, this plain X-ray, Doctor, that you took, where the laminectomy is in this case, what we see here?

A Okay. So --

MR. LAURIA: Can we have the date, please?

THE WITNESS: I don't see a date on there.

MR. LAURIA: We have two post-op, that's why I'm asking.

THE COURT: All right. Can you find the date for that one, please?

BY MR. PRINCE:

Q Doctor, would all -- in terms of --

A They look the same.

Q Will they look identical --

A Yeah.

Q -- no matter what the date? We'll get the date and we'll --

MR. LAURIA: Thanks.

Q -- state it in a minute.

A X-rays look at bone. I removed bone. It won't grow back. It won't resolve. It'll still look the same, every X-ray will look the same.

Q Okay.

A If it -- if it's clearly visualized.

Q Okay.

A So this is your pelvis. Hip bones, pelvis, this is the bottom of your spine, lumbar spine right here, okay? So if you look, you'll see that this is the 4-5 disc space, this is the 5-1 disc space, okay? So we have a little hole right over here

is where the ligament sits. That bridges this bone to this bone, this little piece of area. Now, if you look over here, this whole piece of area is much bigger. There's -- all the way up to here is a -- this piece of bone with the laminotomy at 4. If you look down here, this little area is where the ligament will sit, this is drilled out into the moved area, then take it all the way up to here, this whole area right there.

Q Where does the L5-S1 space?

A Right here, that's the ligament -- the space is here. That's the 4-5, there's 5-1. This is where the ligament sits, which is a mirror image.

MR. LAURIA: I'm going to sit this down.

THE COURT: Yeah, that's fine.

THE WITNESS: You can see this side of 3-4, it's not a mirror image of the same side. This should be like this and this should be like this and it was not. All this bone had to be removed for exposure of 5-1. All of this bone had to be removed for exposure of 4-5. So you can clearly see that when you perform the surgery that this -- that there was no -- this was still intact.

Now, if I could take -- I took out the 4-5 of this right in here and explored it, right went through this hole, but I knew I could not see at an angle underneath all this tissue. And the skin is way up here now, at an angle, I can't see the visualization. It's like going through a tunnel, you just can't get the angle for it, so I had to make a hole here to perform the initially complicated surgery at 5-1.

The reason I removed the remainder of this bone is because scar formation and this was travelling north and south and I had to connect it. I realized that he had had a surgery a few weeks earlier. He was having his second surgery, and third discectomy today, the day of the surgery, and the scars travelling out -- I couldn't take -- I didn't want to run the risk of not just visualizing the entire nerve as it

passes. It showed some sides of nerves, I needed to see the entire nerve because if a little -- this fragment was hiding underneath this bridge of bone, he's going to have his third surgery in six weeks instead of his second at two, so I had to connect the dots. But I had to put one dot here to address 4-5 now, I had to do one dot here to address 5-1, and I connected them because I didn't want to come back.

BY MR. PRINCE:

Q Okay. Now, in operative note, you indicated that there was disc material cephalad or north towards the head; is that correct, Dr. Cash?

A Yes, this was different between the two discs, primarily. One disc has let's just say compressed, eroded down over two years of playing football. It is symptomatic and it's got a protrusion that you can treat procedurally, but, you know, you tried this for a couple of years and decided to do surgery on it. So that stays trapped inside the zip, okay?

Now, this hole in 4-5 is manmade. It was ready for something to pop right back out, the big juicy disc is there hadn't been violated before, so it pops out of the hole. This one is in the zip, you have to pop it. This one is popped out of the hole already, so it's free to migrate. That's the difference in the extrusion. This is how it's extruded and it can travel -- travel north.

Q Okay. Did it -- was it above and below a little bit?

A Well, the disc material, I recall, was above a little bit, but the scar formation was completely engulfed in this area. A lot of scar formation from here because it was attacking that disc. This material is not supposed to be on here. The body sees it as abnormal, loss scar, reactive tissues come out. And it was encapsulating the nerve. I had to peel it off of the nerve delicately. And as it was coming here, I had to take more and more bone, so I finally just disconnected it so I

can visualize the whole nerve. Couldn't take a chance.

Q Okay. And -- all right. Now, with regard to the -- when you did the surgery at the L5-S1 disc --

MR. PRINCE: If we could go back to demonstrative 1.

Q In order to correct the -- this disc protrusion that we see here on this October 6th film, did you have to make an incision in the disc so that you could remove disc material?

A No, the incision had already been made. It was a box cut. I just put --

Q No, I meant at 5 --

A Oh, you said 5-1.

Q No, 5-1, 5-1.

A Yes, this has not been bothered yet. I had to make an incision. I made a longitudinal incision. I wanted to do the least invasive, so I made a longitudinal incision in hope to even do more and sew it back together, which I couldn't for technical difficulty.

Q Right, when you said you kind of have like a pimple or whatever, and that's -- and so -- and so you said you have to like put and then secrete an incision to release it out?

A It's under pressure, it's like a pimple and you make an incision, and many times it kind of just flows right out. It has to pass of least resistance, so I took it out of the disc that way. Well, this one had already escaped and it was free to migrate.

Q Yeah.

A This one has been looking like this for two years before his first surgery. It's not going anywhere, it's contained. This one popped out, it was free to move. It

moved a little bit north.

Q I guess the question was earlier with Dr. Capanna because he said he went in and did the 5-S1 disc. He said he did not have to make an incision into it to remove all the fragment. Did you have to make an incision in the L5-S1 disc, the one that's been there for two years, in order to remove and release the pressure and get some of the disc material out of there so it would stop compressing the nerve?

A Yeah, and making an incision was a great point. So if I didn't have to make an incision, I wouldn't have described it, I would have just pulled this down and there would have been a hole there. But there was no hole there. I had to make a hole with a slit incision through the disc material.

Q Okay. Doctor, is there anything else you think would be helpful to us or the jury to understand sort of what the surgery you did, the anatomy, and, you know -- in this?

A I'd be glad to answer any questions at the end of the session for the jury, but I think that's about it --

Q Okay. Good.

A -- for now.

Q Thank you. Now, there was lots of -- there'd been lots of discussion about if you do a successful and a properly done microdiscectomy at L5-S1 level, what is the potential risk for the need for a fusion surgery in the future, okay? Now, you indicated last week that, you know, it was your opinion based upon your training that in 10 to 15 years, there's a good likelihood that someone would go onto require a fusion even if properly done, right?

A Yes, I agree with that.

Q And, you know, we've had -- we've heard testimony since you've been

here that the statistics have been -- can go anywhere from 10 to almost 40 percent based upon the available studies that would have been discussed and, therefore, it's not a greater than 50 percent chance of that. One witness, even our witness --

MR. LAURIA: Well, object. Judge, can we get a question or are we going --

MR. PRINCE: I'm saying -- getting ready to give a question.

MR. LAURIA: Excuse me, excuse me.

THE COURT: Go ahead. Let me hear the question.

BY MR. PRINCE:

Q Nevertheless, there's been some discussion in court about your opinion versus what the studies have shown. I want you to assume, for the purposes of my question, Dr. Cash, you're wrong, okay?

A Okay.

Q That you're wrong, that your opinion is wrong and, therefore, I want us to just adopt the Defense's position that there is a -- not a greater than 50 percent chance of the need for a fusion surgery on a single level, properly done microdiscectomy, okay?

A Okay.

Q Now, assuming they're right and -- assuming they're right, how does that affect your opinions in this case regarding Beau's need for a fusion surgery as a result of the surgeries he underwent in this case?

A Well, because Beau was unique example, it does not -- Beau didn't have a single level microdiscectomy for a contained disc. He had three microdiscectomies for a combined two levels within three weeks as a 20-year-old, okay? All the other studies are -- would be very -- be very rare for the studies to contain somebody that's 20 years old. It would be extremely rare to have any study

with a group of cohort group of having three discectomies in two levels within three weeks as a 20-year-old. So, I mean, his spine looks like it's 60 years old already. So this is not a single level discectomy. And if you quote their literature that's saying 10 o 40, it's not applicable. This is a young man who's going to have another 50 years of life and he's got to walk around on a three level discectomy.

So if you look at his records specifically, you'll see that according to their data that Defense is trying to show that, you know, you do the surgery and everything is fine, no fusion, this gentleman has already gone under facet degeneration as a result of the three level discectomy. He's already been discectomized three times. He's wearing those discs out. They're like a flat tire. So there's no study that they produced or that I've ever seen that would show somebody 20 years old having three level -- three discectomies at two levels. The population isn't out there.

Q All right. And in your review of the literature that's been identified by the Defense in this case, was there any studies documenting or chronicling the effect of wrong level surgery on the spine and the long-term effect of that?

A No. Fortunately, wrong level surgery is not very common. And when it is performed or recognized, then that data is not readily shared and made available with the medical community. There's no author that would have so many wrong level surgeries they could provide a paper. They may have a case study. If they have a few, they may have a case series, but they certainly wouldn't be readily trying to send that into medical literature.

Q Now, when you say case study, what's a case study?

A Just one patient, just looking at one patient, no comparisons, no other controlled variables. Just looking at one patient, what happened to them and what

happened over time. The purpose of a case study is because we don't have a lot of institutions having a thousand wrong level surgeries and follow-ups on those patients, because we can't look at it going forward, it's not very common. And we can't look at it going backwards because nobody readily makes those available. And it's still a small number. You have to go even smaller to a case series.

So if you have a series of patients that have wrong level surgeries, you can compare them and see how they do. But like I said, those don't make themselves into literature very readily so they're undiscovered. So usually you have to look at a case study, which means this is a pretty unique situation that may have happened before, but nobody really knows -- as our whole -- the medical society doesn't really know how many times it's happened and tends to look at each individual one to compare.

So this is case study. This is a male who's 250 -- or 200 pounds. He's a collegiate athlete, starting strong safety as a 20-year-old that's had a worn down disc for two years, had the other level operated on, went back and had a total of three discectomies in three weeks. It may have happened before, but it may have been 20 years ago in Pennsylvania, who knows. So this is a unique situation.

Q Right.

A Now, obviously biomechanics and physics doesn't give any breaks because he's 20 years old. He's had three part -- one level was already protruding and now removed and the other level has had two microdiscectomies, so physically it's going to wear down. It's worn down. He's only mid-20s now, he's going live until he's 75, he's going to have a fusion for sure.

Q All right. And I guess the imaging that you've ordered over the period of time supports your conclusion that when you do the microdiscectomy at the two

level -- at least at the L4-5, significant rapid degeneration occurs, right?

A The -- if you look at his case study, look at the clinical records and the treatment he's required for pain meds with myself and you look at the MRIs, what I predicated is going to happen is coming to fruition. If you look at 5-1, it being a bad level for seven years now and having a discectomy doesn't look as bad as 4-5, which used to look normal. MRIs show it completely in 2014.

Q Yeah, Doctor, you said that Beau probably deserves a case study-type of an article himself. Do you agree with that?

A That's what I was just saying, absolutely.

Q All right. Have you thought -- have you considered doing a case study --

A No.

Q -- and submitting it?

A No, I have not because the implications of someone doing their own little surgery, I don't like to get involved in that.

Q Okay. And now, if Beau had had a successful L5-S1 microdiscectomy, do you have an opinion whether it was likely that he would return back to playing and completing his, you know, division 1 football career and potentially whatever he could achieve professionally?

A Yes, I disagree with the operative surgeon -- initial surgeon that said he would be back in six weeks on the field. I think that he would have been red-shirted the first year -- if he had the surgery in September, he would have been red-shirted because he wouldn't have been back playing for at least four to six months, but would have returned after a red shirt year and played either his senior year or his last two years eligibility and, perhaps, gone on further.

Q And, Doctor, if a -- Beau had undergone a successful L5-S1 microdiscectomy, would he have needed to have the updated MRI from 2010, 2012 or 2014 that had been ordered in this case?

A It's unlikely that they would have been ordered for any kind of symptomology similar to what he sustained, but they could have been ordered just to -- you know, when you're a collegiate athlete, they take MRIs just to follow the progression of things.

Q If Beau had underwent successful microdiscectomy surgery by Dr. Capanna, would your surgery of October 22nd, 2010 have been medically necessary?

A No.

Q Doctor, if Beau had underwent successful microdiscectomy surgery at L5-S1, would he have needed the pain management referral that you -- to Dr. Ruggeroli that you made in 2014?

A No, perhaps he would have had facet treatment much later on, but it's unlikely to have occurred at this point.

Q And if Beau had underwent successful microdiscectomy surgery at L5-S1, would he have required the lumbar injections that you referred for in 2014?

A It's unlikely.

Q Do you have -- if Beau had underwent a successful microdiscectomy surgery at L5-S1 by Dr. Capanna, would he have needed the facet injection as well as the ablation treatment in 2014?

A No, not that soon. That's not likely.

Q Do you believe that all of that treatment, the updated MRIs, referral for pain management, injections, and the ablation treatment was all as a result of this

wrong level surgery?

A Yes.

Q Is that your opinion to a reasonable degree medical probability?

A Yes.

Q Okay. We talked last time about the Beau -- the need for Beau to have a fusion at some point in the next five to 10 years and we talked about the fact that it's going to be a two-level fusion initially.

A That's right.

Q Do you have a model with you, Dr. Cash, kind of demonstrating, you know -- you know, the model of the spine with fusion hardware in place?

A Yes.

Q Okay.

MR. PRINCE: Your Honor, is it okay if Dr. Cash steps down and shows the model to the jury with the fusion hardware in place?

MR. LAURIA: Judge, could we just clarify that this is the fusion that he is recommending or say would be needed as opposed to -- there's lots of different types of fusions--

THE COURT: Understood.

MR. LAURIA: -- so I just want to make sure that if he's going to testify to it, it's the one he thinks is needed.

BY MR. PRINCE:

Q Dr. Cash, what type of fusion would you recommend for Beau based upon his current condition?

A I would recommend a two-level lumbar reconstruction or fusion at L4-5 and L5-S1. I'll show you a classic example of that through the anterior, through the

belly and through the back approach, but this is just a one-level hardware construct that only shows it at 3-4. So it's not the exact level and it's not the exact number. We'd actually perform a surgery twice as big and at these bottom two levels.

Q Okay.

MR. LAURIA: Is it the same hardware, Judge, that we're talking about?

THE COURT: Well, I'm satisfied at this point. You can go ahead and describe it. And you can follow up as need be with him.

THE WITNESS: So essentially we'd place the position belly up this time. And I'd have a vascular surgeon, somebody that's good at going through the abdomen making sure we don't injure the big vessels that carry blood. And you would make the incision in the abdomen, work around the muscles, pull all the abdominal contents including bowels, intestines, look through the tubes and make sure we have no injury in the contents of the abdomen. So it's a pretty risky surgery in that regard.

The next thing I would do is once we form a hole with even much bigger retractors than what we just had, just attached to the bed, I'll be able to look at this disc, it'll look like this. So just to preserve our model, I'm not going to cut here, but I would take a much bigger knife that's longer and reach down here. And I would saw -- again, we're using a very sharp instrument, not a blunt probe. It's got to be the size of a sharp instrument. You've got to make your cut at the bottom and top in a very big box because I'm not just sticking an instrument in this box, I'm actually putting this big piece of plastic in there. It looks like a leg of a plastic block. So I remove all the disc. I didn't bring the instrument --

BY MR. PRINCE:

Q When you say -- when you say you removed the disc, I mean, are you

removing the entire disc in its entirety?

A Pretty much.

Now, we're not removing the entire annulus, that circle that goes around, because we want to keep it on the side for stability and safety. You don't want to violate any vessels out this way. All we need to do is gain access through a hole big enough to put that block in. It doesn't need to be any bigger. So I try to size it where it's going to fit right to left and top to bottom very well. And I mallet, I actually scrape with like a very sharp spoon all the material and back corners and make sure this is a very wide open, so there's a big hole there. You can't -- you can't leave it like that because it'll be bone on bone immediately. So I put a block of plastic on a big piece of metal about this big and I take a mallet and I tap it in real hard so that this fits real snuggly in there, okay? That is going to reform the angle and the height of the disc to make it look better because it's all collapsed and had bone on bone. So we're going to restore the regular configuration, the curve and the height.

And then what you can't see inside this block, it looks like a donut, so it looks like this. It's got a hole on the side of it. So I fill that with cadaver bone and this grows from this bone to this bone and makes a fusion. Because he has painful motion, be removing the motion, we take the pain away from that area.

Q And what is a fusion?

A A fusion is making this bone grow to this bone. So instead of being two bones, it's one bone with no motion. It's kind of like a ling bone now. It's like a thigh or something, it's just connected bone. So it doesn't happen immediately, it doesn't happen during this surgery. It takes months for the bones to mend like they would if they were fractured.

So how do I hold this in place? Well, one way is I put a couple screws on a plate in front here so it doesn't pop out and flip the patient over, okay? That would be tragic and we'd have to go back in and redo it immediately. So I put a little plate there to buttress it in. Then we'd have the vascular surgeon close, make sure all the tubes are connected and nothing is leaking, suture and close.

Now we have to reposition it under the same anesthesia. And we're using those X-rays coming front and sideways during this procedure. We reposition him just like this. So it'd be the same kind of procedure, use the X-ray and make sure my marks are in position.

With him I already have an incision. I'll just use that, I'll carry it down. We'll open everything from the side, put this big metal retractors in. I'll look at the bones that I think are 4, 5 and 1 because I'll put screws in 4, 5 and 1 on both sides.

But before I drill the first hole, guess what? X-ray. Am I on the right level? No, I'm off by one. Okay, now I'm correct, so I'm using the X-ray a lot.

I'm going to drill a hole. I'm going to put these screws in with an X-ray so I know it's going not only in the right hole, but it's not going to medial towards the spinal cord. It's not going too lateral and missing the bone. It's not going too high and hitting this nerve, not going to low hitting this nerve, not going too deep hitting the abdomen and the blood vessels causing him to die. And it's going directly in the bone at the right angle so it doesn't go up this way and hit a disc up here.

So I'm using the X-ray a lot in this case as well, make sure everything is correct in the right levels. I'm going to put one screw in. I test to make sure it's strong, second and third.

Q You do it by hand or a power tool?

A I do it with a power tool because I feel like it's safer by --

Q Are you like a carpenter? What do you got going here?

A It's absolutely carpentry. That's almost like NASCAR, you're just drilling these things in. If you haven't seen it before and you're a surgeon, you freak out. But I was trained on it, so it's much safer because it gives you control. When you're pushing a screw down and you turn it, you've got to really push it down and you wobble a little bit. By definition, you can't make a perfect circle and you're pushing down with force. If you use a screwdriver, like a Black & Decker like you have in your garage and you just torque it, it will guide itself down under control. And it's very safe that way and it's a concentric circle so it doesn't make a big hole that a screw is sitting by your hand and just puts the screw in directly. Very concentric component and fluid.

Q Into the bone?

A Into the bone.

Q Okay.

A And I make sure it's solid. I check the X-rays in both directions, make sure it's in the right position in the bone, move on to the second one, repeat the procedure, repeat it for the third one. So there's three little heads popping up, not connected by a rod yet, three little heads. And I'm going to test them. I'm going to attach a little neuro monitoring tip to make sure that this is in bone and it's not touching a nerve, so we're making sure the patient is safe. The same way I hooked him up before to make sure I'm not violating nerves and hitting nerves, it's the same thing, but we test the screws. So it's safe, on the X-ray, direct visualization, and with the --

Q Now, here, are you looking through a microscope or through the loops?

A No, no, you can do it either way. You could do it either way.

Q Okay.

A The microscope is big and cumbersome for this. And instead of just pulling material out through a microscope looking through, and I got the drills and the screws and everything. And it's more than just a screw. I mean, I've got to put it all -- it looks like a medieval sharp spike and I've got to tap it into the right place with a mallet, pull it out. And I've got to put a pedicle finder in, which is kind of like a Penfield 4. And I'm digging in the soft cancellous bone inside avoiding a cortical breach and I pull it out.

Then I take a little probe. It's ball-tipped. I can't see down there, so it's safe, so it's blunt. So I reach and feel in there with that, checking the X-rays. Then I do a tap, which is like a 5.5 millimeter diameter and I put that through and I bring that back out, so I've got a pilot hole that's ready for just a little bit snugger fit with a 6.5 millimeter screw that's about 40 millimeters long and I put that down and I check it on X-ray and direct visualization.

MR. LAURIA: Your Honor, I don't mean to interrupt, but at some point can we -- I don't know how long this explanation is going to go, so --

MR. PRINCE: He's explaining a fusion surgery.

THE COURT: The nature --

MR. PRINCE: I guess it takes a minute.

THE COURT: -- of the question is to explain the surgical procedure like with the other one, so overruled. You can continue.

THE WITNESS: So now I have successfully put in three on one side. Then I connect it with a rod and I have a rod measure to make sure it's about, you know, 70 millimeters and we double check to make sure it's not too long. If it's too long, it's this set up here, causes problems. It's too low, you have to set it down there.

So I make sure it's perfectly sized and I lock it into place with a strong torque wrench and lock it in place there. So with that being done, I move to the other side and repeat the entire procedure again, okay?

And if the disc is collapsed so much that there's stenosis and pinched nerves, then I have to take some really barbaric instruments and pretty much rip and rip off this big metal piece and these pieces of bone back here were not touched before, and open this entire area up so that you can -- maybe the illustrations have that. I'd have to remove --

BY MR. PRINCE:

Q Does that one have it?

A I don't think it does, no. Well, with a much bigger instrument than that, I have to remove -- we removed this before, now we're removing all of that and making it two levels. And we make sure all the nerves are free and not compressed. It depends on what it looks like, you know, going in when you get to that part.

And then after we're done there, the patient is instrumented, meaning the metal is in for a fusion. We call them fused because essentially they are locked into place. But the fusion hasn't developed. So they have to go through a longer physical therapy course and they have to keep this real still. The only way to keep it still is with the metal.

So the post-op physical therapy is not for the fused area now because it's not moving. It's essentially instrumented and going to be fused in a few months. So the physical therapy protects what structures? The ones above it because now that this is fused, all the forces you used to go through everywhere is going through bottom and the top. So it wears it out faster. Physical therapy stabilizes it, teaches a patient to go from conscious stabilization of their hip and pelvic structures into a

subconscious, they can just do it automatically in any kind of position that's very ergonomic and protective. So that physical therapy is for the other level. And the forces will never go away at that level, so they're going to have to do physical therapy. And, you know, every other year, every year a certain amount. And they'll probably start needing injections at the next level as it starts wearing past the point of no return. Pretty similar to the treatment he's got to in now.

Q Now, while you're here, Doctor, and I just want to talk about this concept, now we have a -- you know, a fused level here and what would that be, the 6 -- L3-4?

A 3-4 in this case.

Q All right. And now, I mean, what happens now this level is fused and no longer function, it just locked place? What effect does it have on this disc as well as this disc, L4-5 and L2-3?

A Well, you can see that these are in motion like this, okay? But when you put it across those levels and you move it, a lot of motion goes to the level below. You can see this doesn't move so much and this moves quite a bit more because no force generates, no force concentrates here. It's pushed up and down. It usually goes down in this model. But his case, the bottom two will be fused, so it'll probably be the 3-4 that wears out next.

Q Okay. Why will wear out and at what rate would it wear out?

A Well, because you still have the force of your body, you still have mass, you still have weight, you still have cycles, and cycles in stepping and walking, whether it's running, whatever you do, pushing on that spine. So because the bottom two levels are fused now and don't see any stress, they just push it off like a rock and starts wearing this next level down usually at a rate of about three percent

per year and someone is going to need the next surgery.

So I mean, oh my gosh, three percent of people are going to have symptoms so bad they need that next level fuse in a year? Yeah, that's only three percent that first year. That's good because the next year it's them and the next three percent, so that's six.

So if three have to have surgery, almost 10 percent, nine percent of people need surgery for the next level because it's so bad and the stress. So if you calculate it out, I always say at 17 years is three times 17, 51, that's when you reach the legal threshold for more likely than not. And at 17 years after this two level fusion will the third level be required. And Beau has about 50 more years of life, so he's definitely going to need that third level.

Q And have you seen recent articles confirming the rate of adjacent segment breakdown, Dr. Cash?

A Absolutely, there's articles that go back over the last decade that indicate that around three percent is the number, some are 1.8, some are 2.8, it's an average of about three. And there's recent articles supporting that notion.

Q Okay. In what journal?

A I'd have to look, but it's Spine or Spine Journal or --

Q Okay. Is that something you looked at during the pendency of this case?

A It's definitely a peer related spine journal where other spine surgeons have to think that's it's worthy of being presented to the international societies.

Q Okay. Okay. You can sit back down. Do you have an opinion of whether Beau is going to suffer adjacent segment breakdown at L3-4 as a result of the two-level fusion that he'll need to have in the next five to 10 years?

A He's going to need the 2L fusion in the next 10 years and he's going to need the adjacent level 17 years after that fusion, so during his lifetime, yes.

Q Is that your opinion to a reasonable degree of medical probability?

A Yes.

Q Dr. Cash, what is the cost, in your opinion, in today's dollars, I know you can't, you know -- for a two-level fusion, approximately?

MR. LAURIA: Your Honor, may we approach please?

THE COURT: Yes.

MR. LAURIA: Thank you.

[Bench conference begins at 2:12 p.m.]

MR. LAURIA: For the reasons that I have previously stated, I want the record to reflect my objection to testimony by this witness about future damages and future costs of care that I believe were inappropriately reported and disclosed in this case.

THE COURT: Okay. All right.

MR. LAURIA: So I do not need to object anymore, it's on the record, correct, Your Honor?

THE COURT: And these are recorded as well.

MR. PRINCE: Yes.

MR. LAURIA: Standing objection at this point.

THE COURT: Okay.

MR. LAURIA: Thank you.

[Bench conference ends at 2:13 p.m.]

THE COURT: Okay. You can continue, Mr. Prince.

MR. PRINCE: Sure.

BY MR. PRINCE:

Q And, Dr. Cash, do you have an opinion as to what the cost -- the future -- you know, today's dollars, what the future costs would be of a two-level fusion at L4-5 and L5-S1, with all the related services?

A Absolutely. The -- specifically the penny amount is in my records. I could look specifically, but it's over a quarter million dollars, in the more $300,000 range.

Q Yeah. Yeah, and I have in your --

A I can refer to my reports, which I generated after talking to vendors and hospitals and whoever performs those services for the most accurate representation.

Q Okay. I'm going to show you your May 14th, 2015 report just to help refresh your recollection on costs. On the first page I think is the cost estimating for the two-level.

A Yes, so approximately $350,00 for a two-level surgery --

Q Okay.

A -- fusion.

Q And I know it's -- we're kind of looking into the future also, but we have to plan for Beau's needs now, Dr. Cash, with regard to his L3-4 fusion, at some point, you know, after he has his two-level fusion in the next five to 10 years, what is your opinion estimating, using today's dollars, the cost of a single-level fusion at L3-4?

A Well, this is more than just a single-level fusion. It's an extension, which requires an expiration of the previous fusion and more complications, have to bring a vascular surgeon in, you have to spend more time in -- time under anesthesia will be more. So these numbers will go up a little bit more than if this

was an native 3-4 fusion. But an adjacent level 3 fusion -- 3-4 fusion from a revision costs $342,000.

Q Okay. And did you do the research on that to -- you know, for all the various line items that would be associated with -- with that procedure?

A Yes, absolutely. For the facility, I would call one to three hospitals, usually I do it every year at the first of the year. And they are the three facilities that represent the three hospital systems. That'd be Spring Valley, San Martine, and Southern Hills and I could make an average. And then the surgeon's fees, my assistant fees. My vascular surgeon I have to call every year to see what their rates are, Anesthesia I have to get an estimate on what their units are per the time allowed. The bone stimulator, I have to call vendors. Postoperative bracing requires vendors. Home healthcare vendors. Postoperative therapy. And neuro monitoring vendors. So I call at least one and probably up to three venders for each one of those categories.

Q You typically do that at the beginning of each year?

A Typically, yes.

Q Are you -- from time to time, if you're involved in a patient's care and you're having to estimate the cost of, you know, future care needs, is that how you're familiar with these types of charges?

A No, I also do that in the days dollars. I mean, that -- yeah, last year didn't include the inflation for the next year, so usually these fees goes up. They're not required to. Potentially could go down, but they usually go up as a trend. So every year I think it's good to update the information and keeping in mind that it's probably going to escalate over the next decade or 20 years.

Q Okay. Now, have you reviewed the medical billing in this case for the