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. 7 PART 2

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THE COURT: Thank you.

You guys can be seated. Thank you.

All right, we will be back on the record. We are going to continue on with the defendant's case in chief and the testimony of Dr. Rimoldi.

Dr. Rimoldi, I will remind you that you are still under oath, okay?

THE WITNESS: Yes, sir.

THE COURT: All right. Mr. Prince.

MR. PRINCE: Okay, thanks.

CROSS-EXAMINATION

BY MR. PRINCE:

Q Dr. Rimoldi, good afternoon.

A Good afternoon.

Q You and I know each other, right?

A Yes, we've met before.

Q I've taken your deposition many times, right?

A More than a dozen, I think.

Q Yeah. And I just to just establish a few things up front. You're obviously charging for your professional time to be here, correct?

A That's correct.

Q And according to your fee schedule, your -- you charge for -- $12,000 for a full day of testimony for being out of your office, correct?

A I believe that charge is $14,000.

Q Oh, it's -- okay -- oh, I'm a little light. Okay. And then a half day, it was 6,000. Is it higher now?

A Seven thousand dollars.

Q Okay. And that's -- so if Dr. Cash charged a comparable amount to be here for a full day, that would be what a usual and customary charge would be for a surgeon like yourself coming to have to testify?

A I think that's reasonable.

Q And this isn't cheap, is it?

A I'm sorry?

Q This isn't inexpensive, is it?

A No.

Q And when you do a defense medical examination, you charge for the exam and reviewing one inch of records -- well, it was $2,300. Is it more now?

A I believe it's $2,500.

Q Right. And for every inch of additional records, it was a thousand dollars. Is it more than that now?

A I think it's the same.

Q Okay. So in this case, we have binders full of information, you would have reviewed, you know, initially $2,500 -- or $2,300 for the initial exam and one inch of records and a thousand bucks for every inch after that.

A That's a fair statement.

Q Okay. And you were initially retained by counsel, the former lawyers for Dr. Capanna, to perform a medical evaluation for the defense side of this case, correct?

A That's correct.

Q You weren't appointed by the Court to serve as an independent physician to conduct an examination of Beau Orth, correct?

A Not to my knowledge.

Q And your -- you only saw Beau Orth one time, on July 17th, 2013, correct?

A That's correct.

Q You've not examined him any time since then.

A No, I haven't.

Q You've not taken a history, nor performed a physical examination any time after July 17th, 2013, correct?

A That's a correct statement.

Q And you know Dr. Capanna, correct?

A Yes, I do.

Q And you operated probably in some of the same hospitals over the years, haven't you?

A Yes, sir.

Q So even though he's a neurosurgeon, you would consider him a colleague of sorts?

A Yes, I would.

Q Okay. And when you're -- when you review this case, you agree it's your responsibility to be open minded, fair, and objective, correct?

A That's correct.

Q You shouldn't be an advocate, correct?

A That's correct.

Q You shouldn't be biased towards Dr. Capanna in favor -- against my client, Beau Orth, correct?

A That's correct.

Q And you shouldn't selectively review information which only benefits Dr.

Capanna and doesn't benefit Beau Orth, correct, and --

A That's a fair state --

Q And vice versa?

A I'm sorry.

Q And, I'm sorry. And vice versa, you shouldn't do something that only favors Beau to the detriment of Dr. Capanna.

A Those are fair statements.

Q Now, you agree that in this case, you are serving not in the role of a treating physician, correct?

A That's correct.

Q I think you outlined that for the jury earlier, right?

A Yes, in describing the independent medical evaluation, yes, sir.

Q And from time to time, you have patients who undergo medical evaluations, correct?

A Certainly.

Q I mean, they're in litigation and the defense hires someone like yourself to conduct an examination and review records, correct?

A Yes.

Q And at times, the reviewing physician will disagree with your opinions, your treatment recommendations, correct?

A At times, that's correct.

Q Doesn't necessarily make you wrong or them right, it just means you have a difference of opinion, correct?

A That's a fair statement.

Q And also, you understand that sometimes your patients will go for a

second opinion, whether in Las Vegas or elsewhere, before they agree to undergo an operative procedure, correct?

A Yes, they do.

Q And sometimes the second -- you know, the second opinion physician may disagree with your course of treatment, as well as recommendations for treatment, correct?

A At times.

Q Doesn't necessarily make him right and you wrong, it just means you have a difference of professional opinion, correct?

A I think that's a fair statement.

Q And don't you agree that it's always -- it's reasonable for Beau to follow the advice and recommendations of his treating physicians, including Dr. Cash?

A Yes.

Q You're not critical of Beau Orth in any way, are you, in this matter?

A No.

Q And you're not here saying that he doesn't have the symptoms that he's complaining of to both Drs. Cash and Dr. Ruggeroli, correct?

A That’s correct.

Q And -- okay. Now, what I know is, it's your opinion that Dr. Capanna operated at a -- the incorrect level, L4-5 instead of L5-S1, correct?

A Yes, sir.

Q And it's your opinion, based upon your review of the records, that Dr. Capanna opened up, dissected, and decompressed the disc at L4-5 as opposed to L5-S1.

A Yes, sir.

Q Okay. And you agree that that caused Beau -- that -- strike that. You agree that as a result of that, you know, dissection and decompression of L4-5, that caused Beau to herniate at that level, L4-5, correct?

A I am -- I'm not clear on that. I'm not stating that, or can't recall opining that because of that operation, that that caused a hernia at that level.

Q A herniation.

A A herniation at that level.

Q All right. You agree that by dissecting and decompressing an otherwise normal, healthy disc, that that increased the potential, at least, for L4-5 to herniate.

A I can't state that to a reasonable degree of medical probability.

Q All right. And you're aware that before -- excuse me, before September 17th, 2010, all imaging studies demonstrated that Beau Orth had normal anatomy, a normal, healthy disc at L4-5, correct?

A To the best of my knowledge, yes.

Q Because your knowledge is based on a direct review of all of the MRI imaging studies that took place before September 17th, 2010, correct?

A That's correct.

Q On every one of those, the only abnormality ever seen before September 17th, 2010 was a small left-sided paracentral disc protrusion.

A I believe that to be the case, yes, sir.

Q And based upon your review of the MRI imaging, was it your belief that the L5-S1 disc protrusion was a contained disc protrusion?

A Yes.

Q Meaning that there was no fragment outside of the L5-S1 disc space, correct?

A That's what the scan appeared to denote, yes.

Q And you agree that Beau Orth did not have any significant degenerative disc disease at any level above L5-S1, correct?

A I can't recall that he did.

Q Okay. And you agree that there's no information in the record that you saw that Beau was symptomatic at the L4-5 disc level before Dr. Capanna's surgery on September 17th, 2010, correct?

A I can't recall specifically where there were notes stating he was symptomatic from that level.

Q In fact, the opposite is true; that it appeared, based upon your review of the records, as well as the deposition of Dr. Capanna, that Beau Orth had classic S1 symptoms, meaning sciatica-type symptoms.

A Well, I'm not going to say he had classic S1 symptoms, but based on everything that I reviewed, it appeared that the left side of the L5-S1 disc was the problem.

Q Okay. Causing him to have radicular -- radiating symptoms down the back of his left leg, correct?

A That's correct.

Q In an S1 distribution.

A Yes.

Q All right. Now, you agree that following the September 17th, 2010 surgery by Dr. Capanna that there wasn't fact evidence that Beau had a -- suffered or experienced a herniation at the L4-5 level, correct?

A Can you restate that question?

Q Sure. After the surgery of September 17th, 2010, you agree the

imaging studies show that Beau suffered from a L4-5 disc herniation?

A No, I think he had a protrusion at that level.

Q A protrusion at that level that did not exist before.

A Certainly, there were changes there that didn't exist before, yes.

Q And you agree that by operating on a normal, healthy disc, that that affected the structural integrity of the L4-5 disc.

A Certainly, it did.

Q Right. And as a result of Dr. Capanna's surgery, since he -- according to your testimony, he dissected and decompressed an otherwise normal disc, he would have been removing disc material from an otherwise healthy disc, correct?

A Yes.

Q And that, would you agree, caused -- that affected the structural integrity of that L4-5 disc, correct?

A Yes, it wasn't like it was before.

Q All right. And you agree that based upon your review of the October 6, 2010 MRI scan, that the -- it showed a left-sided L4-5 laminotomy, correct?

A That's correct.

Q And you agree that the October 6, 2010 MRI scan showed that there was no laminotomy on the left side at L5-S1, correct?

A That's what it appeared to be on my review of that scan, yes.

Q In your practice, Dr. Rimoldi, I understand that you review MRI imaging of the spine, whether cervical or lumbar, frequently, correct?

A Yes, sir.

Q On the order -- you said, I think, in your deposition, approximately 200 scans a week.

A That's an estimate and that sounds about right.

Q Right. And so probably more than 500 a month, correct?

A That's a fair statement.

Q And so you're obviously -- based upon your education, training, and experience, you have a lot of familiarity with reviewing MRI images of the lumbar spine, correct?

A Yes, sir.

Q You don't rely on radiology reports to make surgical decisions or recommendations, do you?

A Not surgical decisions, absolutely not.

Q You review the films yourself and make recommendations and perform surgery accordingly to your review.

A That’s correct.

Q And you agree -- you did review plain X-ray images taken by Dr. Cash at his office, correct?

A Yes, I did.

Q And you reviewed an X-ray of October the 12th, 2010, it was taken about 10 days before Dr. Cash's surgery, that showed changes consistent with an L4-5 laminotomy, based upon your review of that imaging study, correct?

A I'd have to look at that image that you're referring to. I mean, I'm not doubting what you say, but I would have to look at that image. I can't recall that as I'm sitting here today.

Q Okay. Why don't you look at your report, page 5. I think you commented --

A Fair enough.

Q -- on it there.

A And you're talking about my July 17, 2015 report?

Q Yes, sir.

A Is there a specific dates that you're referring to?

Q Yes, October 12th, 2010, on page 5. It says 10/12/10, X-rays of the lumbar spine show changes consistent with an L4-5 laminotomy

A Yes, I see that.

Q Okay. So that have been based upon your direct review of the October 12th, 2010 imaging by Dr. -- from Dr. Cash's office that showed left-sided L4-5 laminotomy on plain imaging.

A Yes.

Q Okay. Now, you agree that based upon the medical records, there was a significant change in Beau's clinical status about two weeks after the surgery by Dr. Capanna.

A From a subjective standpoint, yes.

Q Well, and an objective standpoint, right?

A I don't know what you're referring to there.

MR. PRINCE: If we can look at Exhibit Number 3, Bate number 137. Let's look at the history, the data and the history.

Q You've seen this record from Dr. Cash, correct?

A Yes.

Q It says a 21-year-old male that is a UNLV football player. It talks -- he had surgery by Dr. Capanna. Says the patient had good relief for a week and then felt back pain and recurrent left leg pain. Back disability index is 94 percent with pain 6 out of -- you know, between 6 and 10 out of 10 on an analog scale. Don't you

agree that that presentation was significantly different than how he was initially postoperatively?

A Yeah, from a subjective standpoint.

Q Right. Well, pain is always subjective, correct?

A Yeah, you can't measure it. Pain is subjective.

Q Right. I mean, you treat patients with pain every day.

A Certainly if they didn't have paid, I guess I probably wouldn't be treating them.

Q Right, or they -- yeah, right. I mean, they're -- all of your patients have some pain or discomfort, right? Some symptoms.

A Yes, that's a fair statement.

Q Otherwise, they wouldn't be coming to see you, in all likelihood.

A I would --

Q And so --

A That's a correct statement.

Q You have no reason to believe that Beau was (sic) accurately describing his pain level to Dr. Cash that day, do you?

A None whatsoever.

MR. PRINCE: And if you go down to the physical examination.

Q And it says on physical examination, the patient has a painful stance. He lists to the right standing, he has an antalgic gait, and is unable to walk very well. Do you see that?

A Yes.

Q That's a significant change in his clinical condition from not only before surgery, but also immediately postoperatively.

A I'm not certain what his gait exam showed prior to surgery.

Q Okay. Well, do you want to look at that? Would that help you? According to Dr. Capanna's records, he had no problem with his gait, had no difficulty walking, did not have a painful stance. But if would --

A Is that --

Q Does that comport with your recollection?

A Well, that was after surgery, correct?

Q Before surgery, I'm talking about.

A But for that initial period of time after surgery, he was doing well.

Q Yeah, for about a week, right?

A Yes.

Q But I mean --

A So I -- I'm -- just to be clear, I'm not certain that this is an objective finding that's significantly different.

Q Well, you're not suggesting --

A It could be --

Q I'm sorry?

A It could be a subjective finding. He was complaining of pain and walking --

Q You don't --

A -- with an antalgic gait. That's the only --

Q Well, you're not saying just because it may be subjective that there's anything wrong with that, right?

A No. I'm just clarifying. I -- you asked me a question and I said subjective. And, I mean, the next thing that you did was you pulled this record to -- I

guess you were looking for objectivity, and I'm just giving my point that the record speaks for itself, and I --

THE COURT: Will you --

THE WITNESS: -- stated that that is subjective.

THE COURT: Can I interrupt you for just a second? Will you explain to the jury what you -- when you guys talk subjective and objective findings --

THE WITNESS: Yes.

THE COURT: -- from a physician's standpoint?

THE WITNESS: That's a good point. Subjectivity is something that you rely on a patient to tell you. We talked about the concept of pain. Pain is not something I can see on a scan or an X-ray. I rely on the patient to describe that. We try to assess scales, but they're still subjective scales. Zero to 10 scale, we talk about, where the pain's a 6 or it's a 2. Patients respond to pain differently and so that's still, I consider, subjective.

Objective findings are things that I can see on an X-ray or a scan or things that I can clearly measure on a physical exam that can't be controlled by the patient. For example, range of motion, one could say, well, you know, that's subjective because when he bent over, you know, he didn't bend over as far as a normal person would. But a patient can still control that; maybe they stop because of pain. So I consider that subjective as well. I'm not really sure that I can measure that.

True muscle weakness, certainly things that I see on an MRI scan, things that I see on X-ray and I can see those things, those are objective findings. So objectivity is something that you can see on a scan. If the patient wasn't in the room, you could still identify those things on X-rays, MRIs, where subjective things,

you rely on the patient to communicate those things to you. You can't measure them on an X-ray, you can't measure them specifically on those types of tests.

BY MR. PRINCE:

Q Any time a patient comes to you and tells you what their symptoms are, pain, numbness, tingling, other limitations, that's always going to be subjective, correct?

A Yes. Pain, limitations, numbness, tingling, yeah, those are all subjective things, that's correct.

Q Right. And you agree that a history is vital to reaching a diagnosis and coming up with a treatment plan, correct?

A Absolutely.

Q In fact, it's the cornerstone of everything that you do. The patient is telling their problem and they're almost describing for you what their diagnosis is, right?

A That's a fair statement, yes, sir.

Q All right. So the mere fact that it's subjective doesn't mean that the fellow is doing anything wrong, it just means it's just subjective, you can't look on an MRI scan and say that that person has pain or doesn't have pain.

A That's a correct statement.

Q All right. And so -- but now, you know, you agree that postoperatively, it's a significant change if he now has an antalgic gait and was unable to walk very well and was walking with a limp, right?

A Yes, that's what that says.

Q All right. And it says he has weakened toe-and-heel walking. To you, as an orthopedic spine surgeon, weakness is a significant change in condition,

correct? You're looking for it.

A Certainly. If it's a new onset weakness, absolutely.

Q Right. That could mean that something more significant is going on and you should investigate further, correct?

A That's correct.

Q Which may include having to do another surgery, correct?

A Could.

Q Right, because if you don't address the weakness soon enough, you could develop, for example, a drop foot.

A That's possible.

Q And it says he has diminished left Achilles reflex, he has numbness down the lateral aspect of his leg and thigh. You agree that the numbness down the lateral aspect of his leg and thigh, that's a new report by Beau of a condition in his leg, correct?

A I'm not doubting what you're saying.

Q Okay.

A He did have leg symptoms prior, too.

Q Yeah, down the back of the leg.

A Well, I can't recall the records per memory, but I'm not doubting what you're saying.

Q Okay, fair.

A But he did have leg pain before.

Q And don't you agree that based upon that presentation, that Beau required a second surgical procedure by Dr. Cash since the original surgery was done at the wrong level?

A Yes.

Q The surgery by Dr. Cash to not only correct the issue of what was seen at L4-5, but also perform the surgery that was indicated at L5-S1?

A That's what he did, two levels, yes.

Q And you agree that after the surgery, Beau did remain symptomatic, correct?

A You're talking after Dr. Cash's surgery?

Q Yes, I am.

A Yes.

Q I'm sorry, yes, right. He never returned to being pain free, correct?

A No.

Q He never returned back to playing football, correct?

A Not to my knowledge.

Q And unlike maybe some of the -- you know, those studies that you talked about with Mr. Lauria, Mr. -- Beau didn't just have two levels done, two microdiscectomies at two different levels, he actually had two microdiscectomies at one level, L4-5, correct?

A That was part of the total surgery that he had.

Q Right. And so when Dr. Cash went into correct the problem at L4-5, he had to remove additional disc material within the L4-5 disc space, correct?

A I'm not certain if he removed a protrusion or he removed more nuclear material that was well contained still within the L4-5 disc.

Q Right. He -- I think he -- Dr. Cash testified that he actually had to -- you know, he removed the fragment, which is the extruded part of it, and then he went in there, had to remove additional fragment with -- inside the L4-5 disc space. You

have no reason to disagree with that, right? If that's what he said he did?

A Well, I guess I would just wonder why he would remove more nuclear material that was inside the disc if it wasn't causing any pressure on the nerve. But no, I don't -- I'm not in disagreement with that.

Q Right. And you agree, Dr. Rimoldi, that, you know, as a spine surgeon, when you're performing a microdiscectomy, you know, through a microscope, you can visualize, you know, a motion -- spine motion segment with much more clarity than you can get with an MRI image, correct?

A I disagree with that statement.

Q So you think you can see the disc better through an MRI than you can on the microscope?

A Well, on the microscope, you're looking at one portion of the disc. You can't see the entire disc. You can't see in the center of the nucleus. You can't see the anterior annulus --

Q Right.

A -- or the lateral annulus, so that's a false statement that you made.

Q Well, you can -- Dr. Cash certainly said he visualized a disc fragment as well as the epidural fibrosis outside of the L4-5 disc space, correct?

A Yes.

Q All right. He could certainly visualize that with a microscope better than you could visualize that same portion of the anatomy through an MRI, correct?

A Yes, I would indicate that that's a correct statement, yes, sir.

Q All right. And when Dr. Cash indicates that he found a box cut in the L4-5 disc, you'd have no reason to disagree with that finding either, correct?

A No.

Q All right. And that would be consistent with your opinion that Dr. Capanna dissected and then decompressed L4-5, correct?

A That would be consistent, yes, sir.

Q All right. If Dr. Cash said he had to go in and remove additional disc material -- additional disc fragment from the L4-5 space, that would be further loss of some of the structural integrity of the L4-5 disc itself, correct?

A If he had to do that, yes.

Q Now, when Dr. Cash had to -- assuming he did that, obviously that disc is no longer a healthy, normal L5 -- L4-5 disc, correct?

A Well, what do you mean by healthy?

Q It was a normal, healthy disc before the surgery by Dr. Capanna, correct?

A Yes.

Q And there was no indication that L4-5 at any time before Dr. Capanna's surgery was symptomatic, correct?

A Nothing that I could see.

MR. PRINCE: Let's look at slide 7, demonstrative slide 7.

Q I'm showing you two images, Dr. Rimoldi, one from February 3rd, 2009, and one from September 2nd, 2010. It's -- September 2nd, 2010 is image 7 of 11; the other one is 15 of 18. Anyway, you agree that on both of these images, L4-5 is a normal, healthy-looking disc, correct?

A It looks a little different in that September 2nd scan. The --

Q Actually, probably more hydrated, right?

A The hydration looks about the same.

Q Okay. Does the height appear to be better on the September 2nd,

2010 scan?

A Well, the height is different at all the levels up and down the spine. In fact, when you look at this, you can see that the dimensions of the vertebrae are different. I mean, the vertebrae look like they are almost taller here than they are wide, and here they're wider than they are tall. So this is probably unfair to compare these in detail.

Q Yeah, I guess I'm not -- I don't want to -- I'm doing that, I'm not comparing them in detail. I'm just showing them to you, that the L4-5 disc is a normal, healthy disc in both images.

A Yes, based on these two images, that disc appears healthy.

Q Right. And on the September 2nd one, that was actually a flexion-extension, so he was actually sitting up at that point. He was laying down on the -- I don't know if it would make a difference in terms of the vertebral height.

A No, it wouldn't.

Q Okay. But the point I'm making is it's -- they're -- it's normal, healthy preoperatively, right? L4-5 is, I'm talking about.

A Yes.

Q Okay. And you agree that postoperatively, that there is degenerative change at L4-5, correct?

A Yes.

MR. PRINCE: Let's look at demonstrative slide 12.

Q And I'm showing you a sagittal T2 image of the lumbar spine, of Beau's lumbar spine. And don't you agree that the L4-5 disc, it has significantly desiccated, correct?

A Yes. The signal is different.

Q Right. And it's no longer normal, healthy with -- you know, like with the white like in the other discs above that level, correct?

A No, it doesn't appear like the disc above.

Q And you agree that that L4-5 disc, as a result of microdiscectomies at that level caused that disc to degenerate, correct?

A Well, it caused those desiccative changes which you also see in degenerative discs, yes.

Q Right. That's -- L4-5 is now a degenerative disc, isn't it?

A Yes.

Q Okay. And that's not how you would normally see the -- an L4-5 of a normal, healthy 22-year-old; it wouldn't normally expect to look like that, correct?

A Not normally.

Q All right. And you agree it's the two microdiscectomies at L4-5, the one done by Dr. Capanna and the one done by Dr. Cash, that caused that disc to degenerate like that, correct?

A Yes, to give that appearance, yes, sir.

Q And don't you agree, Dr. Capanna (sic), based upon the imaging studies, that the L4-5 disc condition has suffered accelerated degenerative cascade secondary to the two microdiscectomy surgeries?

A The degeneration there has been accelerated.

Q Okay. More so than the normal aging process, correct?

A Yes, given what that disc looked like prior, yes, sir.

Q Okay. And it -- once the degenerative process starts, it doesn't stop, does it?

A No, it usually does not reverse itself.

Q Right. It will continue to typically get worse with time, correct?

A That's a fair statement, as --

Q And --

A As in everybody.

Q As -- right. And now after undergoing two microdiscectomies at the L4-5 level, Beau does not have much left of any of the disc material that was once in that disc space, correct?

A No, I --

Q It's been removed.

A I disagree with that.

Q He's got significant disc material?

A Yes.

Q Okay. It no longer functions in the same way that it did before when it was a normal, healthy disc, correct?

A No, it's not functioning the same because some of the nucleus has been removed from it.

Q Right. And when that happened, the shock-absorption of the L4-5 disc has now been compromised as a result of those two microdiscectomies, correct?

A Biomechanically, yes.

Q And that alters the motion at the L4-5 segment, doesn't it?

A I disagree with that statement.

Q Okay. That's -- so that will have the same motion as any of the other segments?

A Yes. There's no fusion at that level.

Q Okay. Now, initially when Beau went back to Dr. Cash, he had good

relief immediately following the surgery, correct?

A Yes.

Q And that improved his symptoms, wouldn't you agree?

A Yes.

Q And Mr. Lauria asked you about whether, you know, there was any discussion of fusion surgery with Dr. Cash in any of the records. Do you remember that?

A Yes.

Q Actually, Dr. Cash discussed potential for fusion at L4-5 at the time of the initial consultation, correct?

A I can't recall that.

Q All right. If it's in the records, do you have any reason to disagree with that?

A You'd have to show it to me in the record.

Q Okay.

MR. PRINCE: Let's look at 137, Exhibit 3, recommendations.

Q One said the patient appears to be crippled at this time from the recurrent disc herniation and I would recommend surgical intervention. The patient realizes a second operation most likely will yield a successful result. The patient also recognizes if this is a recurrent herniation at L4-5 and he has another injury at this level, he most likely will require fusion surgery. Do you see that?

A Yes, I see that.

Q So fusion surgery was discussed in -- at the beginning of the treatment on October the 12th, 2010, the very first day he sees Beau?

A I think that's part of the informed consent process, that you discuss rare

risks of surgery. But that doesn't imply to me that that's a statement that would be stated or taken as a -- to a reasonable degree of medical certainty that he's going to require that.

Q Right. It's certainly Dr. Cash telling a patient about what the potentials are for the future for a disc that's now going to be operated on for the second time in about a month.

A I'm sorry, I didn't understand your question. Was that a statement?

Q Let me re-ask it, then.

A Yes.

Q Don't you agree that by Dr. Cash telling Beau that there is a potential for a fusion at L4-5 at some point in the future because now you're going to have a second surgery at the L4-5 disc level in about a month?

A I'm sorry, I'm not understanding --

THE COURT: It's still not a question.

A -- your question.

MR. PRINCE: Still not a question, okay. Maybe I'm a little -- thanks for reminding me of that.

BY MR. PRINCE:

Q Do you -- now that statement there, obviously Dr. Cash is having some discussion with the patient regarding at least the potential for fusion at L4-5, correct?

A Yes.

Q It would be reasonable for him to have that discussion since Dr. Cash is going to go in and operate for the second time in one month at the L4-5 disc level which was previously normal and healthy, correct?

A It would be reasonable to mention that --

Q In order to --

A -- in discussion -- I'm sorry?

Q I'm sorry, I didn't mean to interrupt you. In order to set expectations for the patient and what they may -- you know, be think -- what could happen long term, right?

A That's reasonable.

Q All right. Now, you agree that Beau Orth suffers from chronic mechanical low back pain, correct? Based upon your review of the records.

A Yes.

Q And you agree that even though you saw him for a single encounter in July of 2013, he's had a longstanding relationship with Dr. Cash, almost for five years now.

A That's a fair statement.

Q And when you have a longstanding relationship as a physician, you really get to know your patient over that period of time, don't you?

A Yes.

Q You kind of get to know how they describe their pain, you're more familiar with their pain, their complaints, their -- any change in their symptoms, right?

A That's a fair statement.

Q And you treat patients long term, many patients long term, correct?

A That’s correct.

Q And so while not everything may have -- given the fact that you see them, you see your patients, you're, you know, seeing them on -- no, not too -- not necessarily every month, but periodically, you may have a discussion, a verbal discussion between the two of you, meaning between yourself and the patient, that

may not always land itself in your daily dictation for your office note, correct?

A Yes, there's some things I discuss that may not appear in the record. Certainly, if they were pertinent, they would be in the record.

Q And now Dr. Cash testified here under oath, in court, that he recommended to Beau that he not return back to playing football. If he -- assuming that that's what testified to, you wouldn't -- you're not critical of Dr. Cash recommending to Beau not to return back to playing football, are you?

A No.

Q Right, because he could have the potential risk of re-injury, correct, and making his condition worse?

A Certainly, those are factors that should be discussed, yes.

Q And while, you know, playing football was certainly -- you know, college football and maybe even going the next level may be an athlete's hope and dream, I guess long term they need to be thinking about their health and what that decision -- how that could affect, you know, their medical future, correct?

A That's a fair statement.

Q And you're not critical of Beau for following the recommendation of Dr. Cash for not returning back to playing football, correct?

A I'm not aware that he made that recommendation specifically, but no, I wouldn't be critical of that.

Q Right. I mean, that's a -- that would be a reasonable recommendation to make given Beau's condition and his status, correct?

A Certainly.

Q Assuming he made it, right?

A Yes, sir.

MR. PRINCE: If we could go to page 59 of Beau's deposition. Get Beau's deposition, 59. Okay, starting at lines 3, we're probably going to go through line 23.

Q Do you remember Mr. Lauria was asking you questions about Beau and his decision making and about being done with football and --

A Yes.

Q -- going to go to school?

A Yes.

Q Okay. I want to show you something else. This is from page 59 of his deposition, line -- starting at line 3: Okay, but after you have the surgery, I think you said that coaches didn't come see you or weren't talking to you or weren't really involved.

Answer: Yeah, I didn't receive any -- receive calls from any of the training staff, really none of the coaches or my position coach or anybody.

All right. So you were kind of done with football at that point?

The answer: No, I wasn't done with football. I was just concentrating on my and trying to get my degree at that time.

Okay.

There was always other options outside of playing college football and I honestly had -- I had more years of eligibility. I still to this day have years of eligibility. I just can't play. So there was always more -- so I was not done with football, no sir.

But I mean, you were done at this point with playing for UNLV? You were done trying to play this next year at UNLV.

I was just trying to get healthy.

Did I read that correctly?

A Yes.

Q Okay. Mr. Lauria, he didn't show you that part of the deposition, correct?

A No.

Q All right. And you're not critical of Beau for concentrating on his own personal health, his own condition, keeping himself strong so he could avoid any risk of recurrence of any herniation, either at L4-5 or L5-S1, correct?

A Not at all.

Q And you agree that football is a very -- is a violent sport?

A Yes.

Q You're a sports medicine guy, right?

A Yes.

Q And, I mean, obviously as a defensive back and, you know, with the kind of hits those guys take and give, there is a strong -- a significant potential, given his status of having two microdiscectomies at L4-5 and another one at L5-S1 within a month, that he could suffer a significant injury to his spine as a result of that weakened condition.

A I guess in someone with a normal spine, but yes.

Q And Dr. -- or Mr. Lauria was asking you questions about various articles. Remember that?

A Yes.

Q None of those articles or even the abstracts have as part of their patient population someone like Beau who had two microdiscectomies within a three-week period of time and then a third surgery at L5-S1, correct? None of them -- there's nobody that fit that profile.

A Well, certainly there were similar patients that had a multi-level surgical procedure, but I'm certain if it was within that time frame.

Q Well, I'm not just talking about multi-level, you know, meaning two levels. I'm talking about two procedures at one level and one at the second level. There was no patient that fit that profile in the study.

A There were similar patients that had two-level surgical procedures.

Q I understand two-level. But what about two microdiscectomies at one level? In that patient population.

A I can't recall the specifics on that.

Q Okay. So you can't point to any article where there was a wrong-level surgery, a surgeon had to go in and correct a level -- correct the problem and then go in and do a second level?

A No, I don't think there's any paper out there one way or the other that states outcome with regard to that. I have to rely on the literature that has the most similar patients, but I don't believe there's any controlled study that's -- looks at that scenario that you're talking about.

Q Right. I mean, there's not one article that you can think of that would fit Beau's kind of condition and his history, correct?

A No, that's incorrect. The articles that I can think of are the articles that I reviewed. They're the most common. There's no controlled study that has a patient population that's had wrong-level surgery at one level and then two decompressions at another level. There is no -- I don't know of any controlled study that looks at that specifically. I don't know where you get a patient population large enough to suffice looking at that specific scenario that Beau has.

Q Okay. And the -- I guess the patient population that you've seen in

those studies is either a single-level properly performed or a multi-level properly performed discectomy --

A Yeah.

Q -- and how they do.

A Yeah, that's a fair statement.

Q Right.

A And the probability states that they won't need a fusion.

Q Right. Now, you were -- you saw that in Dr. Cash's records that, you know, after the surgery, you know, Beau underwent physical therapy, correct?

A Yes.

Q He went to Keith Kleven physical therapy and completed about six to eight months worth of physical therapy.

A I recall that.

Q From your review of the records, Beau was a compliant patient, correct?

A As far as I could tell, absolutely.

Q Never acted, you know, contrary to his doctor -- or his physician's recommendations, correct?

A Not that I was aware of.

Q And you saw that Beau continued to work out in order to keep his core strong, correct?

A Yes, sir.

Q That's a good thing to do, isn't it?

A Yes, sir.

Q That's one way you, as a patient, can protect yourself from any further

injury and can potentially minimize your symptoms, correct?

A Right.

Q And when you saw Beau in July of 2013, at that point he seemed to be doing reasonably well?

A Yes.

Q All right. And you knew that he had degeneration -- you know, the accelerated degeneration at L4-5 secondary to the two microdiscectomies at L4-5, correct?

A Yes, sir.

Q And you knew that that process was going to continue to worsen with time, not improve, correct?

A It would progress.

Q Correct. And you -- based upon your review of the medical records, obviously Beau's condition changed after he saw you and went back to Dr. Cash in March of 2014, correct?

A From a subjective standpoint.

Q Right. When you say subjective standpoint, I guess pain -- if a patient says I've got increased pain, I guess that's always going to be subjective.

A Yes, I just want --

Q That doesn't mean they're lying?

A I didn't say that.

Q Okay. No, I know. Oh, so you -- okay, I just want to make sure that you're not saying Beau is overstating his symptoms or magnifying his symptoms, anything like that?

A You asked me a question. I just made a comment just to clarify for the

jury.

Q Okay. And you have no reason to disagree that Beau, at least subjectively, he -- his condition started to change in March of 2014; he now has increased pain.

A Yes, sir.

Q And it was reasonable for him to go back to Dr. Cash to be evaluated because he had increased pain and symptoms down his left leg.

A Yes, sir, that's a fair statement.

Q And that -- with that change in presentation, obviously Dr. Cash, you know, he was -- it was reasonable for him to order an updated MRI image of the lumbar spine, correct?

A Yes, sir.

Q And that's something that you do as a orthopedic spine surgeon if patients come back to you, you know, with complaints of pain. You haven't seen them for a while, you'll re-scan them or re-image them?

A That's one avenue, absolutely. It seems like a reasonable avenue.

Q Right. And you agree that when Beau came back and was complaining of, you know, back pain, you know, 3 to 9 out of 10, and talking about limitations he was having, that that's a change in his clinical condition, correct?

A From a subjective standpoint.

Q Right. And he was now also complaining of some new -- like sensory deficits that he didn't complain of before then, correct?

A Yes, sir.

Q He was complaining of, you know, numbness and tingling radiating to the lateral left thigh and leg, correct?

A Yes, sir.

Q Which is consistent with an L -- potentially an L5 problem, correct?

A Could be.

Q Right. From a dermatome standpoint, it's at least in that dermatomal pattern, correct? That subjective description.

A That's hard to say. There's crossover between dermatomes. You're talking about a dermatome proximal to the knee, above the knee. They're much more inconsistent there, but --

Q Well -- okay.

A So I wouldn't use the word classic or that means specifically S1.

Q But it -- well, let me ask it this way. You agree that pain, numbness, and tingling radiating to the lateral left thigh and leg, that's consistent with an L5 problem?

A Could very well be, yes, sir.

Q Now, Dr. Cash ordered another -- and updated image that we talked about. And the radiologist indicated --

MR. PRINCE: If we can go to like 228 of Exhibit 5, please. Okay, the impression. Okay.

Q And at number 2, it says disc desiccation at L5-S1. The radiologist also noted disc desiccation up in the findings at L4-5, he just didn't put it in the impression section, correct?

A No, I'm not certain what the radiologist was noting at that time.

Q Okay.

MR. PRINCE: Here, Peter, go grab L4-5 under the findings and bring it down to the end.

Q You see it, L4-5 there --

A Yeah.

Q -- on the findings, says disc desiccation. You agree with that finding --

A Yes.

Q -- right?

A Yes.

Q We've talked about that.

A Yes.

Q That's the secondary -- accelerated degenerative change secondary to the two microdiscectomies, correct?

A Yes.

Q All right. Now, it says -- at L5-S1, it says correlate for potential left S1 radiculopathy. Do you see that?

THE COURT: At the bottom of the --

THE WITNESS: You're talking about --

MR. PRINCE: At the bottom under number --

THE WITNESS: -- under the impression. Yes, I see that.

BY MR. PRINCE:

Q Right. And that's one of the ways that a radiologist communicates with say a treating spine surgeon, it's like, you know, clinical correlation or tells you, hey, go correlate whether this finding is causing any symptoms in a patient, correct?

A Yes. The radiologist doesn't have the advantage of examining the patient.

Q Right. That's the clinician's job, the surgeon's job to do that, right?

A Yes.

Q And so what you're -- what he's trying to suggest to you is like compare, you know, this radiology finding of an L5-S1, you know, disc bulge with a central protrusion to determine whether or not that is potentially a cause of the patient's symptoms, correct?

A Yes.

Q All right. Now, you can do that by, you know, taking a detailed history, physical examination, but you also can order certain types of diagnostic injections to assist you as a surgeon to determine whether or not L -- the left S1 is a primary source of the problem, correct?

A You can get information one way or the other, yes. I don't think you can use any of those specifically and state that, hey, will all certainty, this is the issue. They are aids that should be put together in total.

Q And what we're talking about is various pieces of the puzzle, right, Dr. Rimoldi?

A That's a fair statement, yes, sir.

Q Right. We're talking about taking a history, that's a critical piece of the puzzle, correct?

A Yes.

Q Physical examination findings, that's a critical piece of the puzzle, correct?

A Absolutely.

Q Radiology findings such as an X-ray, MRI, or CT scan, correct?

A Yes, sir.

Q And pain management injections, that's another piece of the puzzle that helps you kind of complete the diagnostic picture for a patient, correct?

A That's a fair statement, yes, sir.

Q And in this case, you know that Beau underwent a -- in March of 2014, a left-sided L5-S1 transforaminal epidural steroid injection, correct?

A Yes.

Q And you agree there is not only a therapeutic component and hopefully it will maybe, you know, help -- lessen some of those symptoms, but there's also a diagnostic component to that to assist you as the surgeon to determine, hey, is that at least a portion of the problem or a -- the problem itself?

A Depending on how it's done, yes.

MR. PRINCE: And let's look at Bate number 281.

Q Okay. You know Dr. Ruggeroli, correct?

A Yes.

Q And he's a competent, well-known, respected pain management specialist in our town, correct?

A Yes.

Q Okay. And under --

MR. PRINCE: Kind of go to the procedure, please, Peter. And then go down to medications also. All right.

Q And so the preoperative diagnosis was lumbar disc herniation, protrusion, slash, bulge, and then he described a left L5-S1 transforaminal epidural steroid injection, which we've been talking about, correct?

A Yes.

Q And then he also did a left S1 transforaminal epidural steroid injection, correct?

A Yes.

Q So he did two things, right? Injected two places.

A Yes.

Q And the lidocaine, that's the anesthetic, that can give you the immediate diagnostic information as a surgeon, right, depending on what the pre-pain score was -- the pre -- strike that. The pain score before the procedure and then comparing to the pain score after the procedure.

A As you discussed, one piece of the puzzle, yes.

Q Right. And I want to, just while we're here, talk about what it means to inject those levels.

MR. PRINCE: And if we can go to 38, demonstrative 38.

Q Because when -- Dr. Rimoldi, what I'm showing is a diagram of a spine model and where the certain nerves exit, you know, the foramen as well as what nerves kind of go below the various disc levels, right?

A Yes.

Q Okay. And so when Dr. Ruggeroli says he's injecting the L5-S1 nerve, he's injecting in this area right here, correct? Kind of up here near the foramen, up in that area?

A Well, he's injecting between these two pedicles, between this S1 pedicle --

Q Okay.

A -- and between this L5 pedicle. So that's where he's placing the medicine.

Q That's the first one, right?

A Yeah.

Q Here, can you draw a circle around that for me? Okay. And then

where is he injecting -- he said he did a left-sided S1 injection Show me where he did that.

A Well, I'm not certain. He could have done the S1 injection through the same portal here as that's the traversing nerve root, or he could have placed the needle between then S1 and S2 pedicle here and done it.

Q And that's what he says he did, right?

A I don't know. I'd have to look at that report in detail.

Q Okay. And so let's -- well, let's look at it then because I think that's --

A Yes, sir.

Q -- what he did. Well, if he says here -- I'm going to read it for you -- that he injected, you know, at the L5-S1 segment and then the left S1 dorsal foramen, where's the left S1 dorsal foramen?

A The dorsal foramen here would be in this area right here.

Q Okay. And let's -- I want you to verify this. Let's look at --

MR. PRINCE: Go back to 281. And go to the -- right there, the last paragraph, Peter.

Q Okay, there's lots of words here. And then it says here -- says -- next he says with 22 gauge needles were used to penetrate the skin and were advanced one towards the caud -- should be cauded -- says be caudal aspect of the L5-S1 foramen. That's what you just -- that's the first circle you drew, correct --

A Yes.

Q -- in yellow?

A Yes, sir.

Q And then it says with the other needle directed towards the lateral aspect of the left S1 dorsal foramen. That's the one that was below, correct?

A Yes.

Q Okay.

MR. PRINCE: Could we put that back -- that image back up? that's 38.

Q So draw where he injected the first needle.

A L5-S1.

Q Yes, L5-S1. Okay. And where did he inject the next?

He's actually affecting two nerves at that point, correct?

A Well, it's not all that clear, though. He could be affecting two nerves at the first point because you can see the S1 nerve root traverses --

Q True.

A -- here. So if he injects the medicine and he's looking at an X-ray to localize the needle, that medicine diffuses out and he could be affecting L5 and S1 at this level, you know, without the added benefit of S1. I'm not certain I would place too much value in the S1 injection because conceivably both nerve roots could have been injected during the first process.

Q Right. So I guess what you're saying is when you do the first injection where you wrote the yellow, it's going to obviously affect L5 -- the L5 nerve root and potentially the S1 root.

A That's correct.

Q And so he went further down and he went to the foramen for S1 and he injected there, too. So you've got to agree that S1 is probably -- he completely blocked that one, right, with those two injections?

A I'm not certain if he completely blocked it.

Q Well, that would be the goal --

A If he completely blocked it, the patient may not be able to leave the

hospital for --

Q Well --

A -- or the surgery center for a period of time because he couldn't plantar flex his foot, so --

Q Well, assuming he didn't block it at that level, I mean --

A At what level?

Q To the point where the patient can't walk. There's no indication of that, that he couldn't walk out of --

A Well, then he --

Q -- surgery center.

A Then your previous statement that he completely blocked the S1 nerve root would be incorrect.

Q So then -- but he did inject it to the point where hopefully you gain some diagnostic information of whether there is pain coming from the S1 root -- the S1 nerve, rather.

A Well, the way the injection was described, I don't know if you can infer that because if he blocked L5 and S1 from the first injection, if all the pain was coming from L5, you wouldn't really be able to differentiate that --

Q Okay.

A -- if he got a good block at S1 as well at that level. So you can't tell by the process that he describes specifically and state, well, the pain is coming from L5 or S1.

Q Okay.

A I would say that the injection process, if he was better after the injection, would indicate that one of those nerve roots, in the method that Dr.

Ruggeroli described, was producing some of his pain.

Q Okay.

A You can infer that piece of the puzzle from the process, but you can't infer any more than that. You can't say, well, since he blocked S1 in two places, one further down the line, that it's an S1 problem, we can say that for certain. You can't state that.

Q Okay. So then let's look at what the -- what happened.

MR. PRINCE: If we can go to Bate number 406.

Q And I want to look at the -- that's from this -- this is the pain management procedure record from that injection. Okay, Doctor?

A Yes, sir.

Q Okay.

MR. PRINCE: Peter, the top left box.

Q And so you understand that typically they'll record the pain score immediately before the procedure, correct?

A Yes, that's --

Q That's a typical --

A -- what they --

Q Typical practice?

A Yes, it's a reasonable thing to do.

Q Right, because to you as a surgeon, you not only want to know how the patient responded to it, but you're also looking for this kind of diagnostic information, did the pain level -- did the pain score go down immediately following the procedure, correct?

A Yes, that's an important piece of the puzzle.

Q All right. If we go --

MR. PRINCE: Go to 407 now, Peter.

MR. HELLMAN: What slide?

MR. PRINCE: 407. Next page.

BY MR. PRINCE:

Q And the pain score remained a 6, correct?

A That's what that states.

Q And so it doesn't appear that L5 or S1, at least based upon this, is the primary source of the pain, at least according to this, correct?

A Yeah, if you're just going to take this partial piece of that document out and understand that he had the injection on that day, yeah, they both say 6 out of 10. So --

Q Right.

A -- that piece of the puzzle doesn't tell you too much.

Q Right. So it tells you, however, this, don't you agree, Doctor, that based upon this diagnostic injection, it does support that L5-S1 is not the primary pain generator in Beau's case?

A I'm not certain you can infer that based just on this document. That specific piece of the puzzle, yeah, that would indicate that L5-S1 isn't causing any pain.

Q Right. And I didn't say it wasn't causing any. I said it's not the primary pain generator in Beau's case --

A Well --

Q -- L5 -- based upon this study, you know, taken in --

A Yeah, I --

Q -- consideration with all the other data --

A You were talking about this study and it would indicate to me, just based on this study, that L5-S1 wasn't causing any of his pain.

Q Okay.

A That portion of the puzzle that you're looking at.

Q Oh, okay. And with regard to the radiofrequency treatment, if Beau wasn't -- didn't get any significant relief from that, then you're not critical of him for not continuing to undergo the radiofrequency ablations, correct?

A No, that wouldn't be something that I'd recommend. If other healthcare providers recommended it -- no, I think that -- in my opinion, everything that's been discussed is disc pathology, disc degeneration --

Q Right.

A -- disc, disc. And now you're talking about some new portion of the anatomy, I guess, the facet. So --

Q Right.

A -- I mean, if you're going to give radiofrequency ablations, then I guess you're going to say nothing -- or there is no pain coming from the disc because he's going to get all these radiofrequency ablations.

Q Well, obviously the -- he had one at the recommendation of Dr. Ruggeroli. His testimony is it didn't work. So, therefore, you're not critical of him for continuing to not undergo those procedures if they're not beneficial to him, right?

A I guess, just like I wouldn't make the recommendation for repeated radiofrequency ablations for the rest of his life.

Q Now, I want to -- I probably didn't kind of tie this in, but I want to go back to the MRI image of March 13th, 2014, you know, the one -- that's 228. I kind of

want to tie in the pain management procedure at L5-S1 to what, you know, this clinical correlation statement means. And you agreed -- you know, we just looked at this a moment ago, the radiologist suggested, you know, to correlate for the potential for a left S1 radiculopathy, correct?

A That's what the radiologist states there.

Q And Dr. Cash, he attempted to correlate that by sending Beau for an L5-S1 transforaminal epidural steroid injection. That's one way to do it, correct?

A It's a piece of the puzzle

Q Right. And the L5-S1 injection did not correlate with that finding on the MRI, correct, based on what we just talked about?

A That’s correct.

Q Suggesting that Beau has some other source of pain that is not primarily coming from L5-S1, correct?

A Yes. But if you look at the other piece of the puzzle, he had an absent reflex there, which would suggest S1. So you have to take the -- everything together. It gets confusing when you're relying on one part of one document and inferring principles, medical principles.

Q Well, I'm not necessarily -- I'm saying it's just one piece of the puzzle, right?

A That's correct. I just want to make sure that the jury understands that.

Q Understood that. And, therefore, you agree -- you -- L4-5 is an all likelihood, based upon all the pieces of the puzzle, a pain generator in Beau's case?

A I believe that some of his ongoing symptoms are emanating from that area.

Q Okay. Including the radiculitis or symptoms that are going down his leg,

correct?

A I can't state that. It's difficult to discern whether that's coming part or parcel from L4-5 or L5-S1.

Q His symptoms that he describes going down the lateral part of his leg and down -- down his thigh and into his leg, you agree that's consistent with an L4-5 problem, correct?

A It would be consistent with a L5-S1 problem.

Q And you have patient who have -- you treated who are -- have painful degenerative discs, correct?

A Yes.

Q And when they don't respond to conservative treatment, one of the things that you offer them as a potential option is a reconstruction -- reconstructive fusion surgery, correct?

A On rare occasions.

Q Right. That's an option for patients who have ongoing mechanical low-back pain, significant disc degeneration, as well as pain that radiates down their leg. That's one potential surgical option to treat that patient, correct?

A An elective surgical option that the patient would have to choose, absolutely.

Q Right. And just -- it would depend upon the severity of their symptoms, correct?

A That's one factor.

Q I mean, you agree that Beau is no longer a candidate for microdiscectomy surgery at L4-5, right? He doesn't need that.

A As we sit here today?

Q Yeah.

A Yeah. I agree with that.

Q Right. And you know that Beau is going to continue to worsen over time at the L4-5 level, correct?

A No, I'm not certain of that.

Q Well, you know radiographically he's going to worsen over time, correct?

A Just like my discs without surgery are worsening over time and so are yours.

Q Yeah, but he's 25 and he --

A That's correct.

Q And he -- that's -- you agree, that's a significant degenerative condition for a 25-year-old healthy male?

A Certainly, it's significant.

Q Yeah. All right. Now, you agree that if -- when -- if you perform spinal -- a spinal reconstructive fusion surgery -- let's say you did it at two levels, okay? You agree that that would put adjacent level stress on the levels above those two levels that are fused, correct?

A That's correct.

Q And when you fuse two levels, so let's say L4-5 and L5-S1, that prevents those two segments of the spine from really having any motion permanently, correct?

A That's correct.

Q And if it had -- there was any facet component, it would theoretically deal with that, correct? Fusion.

A Yeah, depending on the fusion taking and assuming it heals, certainly.

Q Right, because once you, you know, fuse the motion segment, there's not going to any -- there's not going to be any movement of the facet joint either, correct?

A That's correct.

Q So if there's a minor component of facet pain, it will be resolved with the fusion surgery typically, right?

A When you say -- when you're talking about pain being resolved with a fusion, I have to be clear on this, that there is no guarantee of that. In fact, I rarely tell -- in fact, I'm going to say never tell my patients that are going to undergo a fusion, whether it be for a disc problem, a facet problem, an instability problem, a tumor problem, that they're going to be pain free. That's not going to happen.

Q Right. And the best you can do as an orthopedic spine surgeon when you fuse a segment or multiple segments of the spine is hopefully you're going to provide some relief of symptoms, correct, and improve the quality of life.

A That's the key, right. You're going to take -- if their pain is up here somewhere, you know, where this is let's say a pain of 10 out of 10 and no pain is down here, maybe you get them down to here, a 4 or a 5 out of 10. You're not going to relieve all their pain with a fusion. Nobody can do that.

Q And you agree that if you fuse two segments of the spine in a 30-year-old male at the L4-5, L5-S1, more likely than not there's going to be an adjacent segment breakdown at L3-4 during that person's lifetime, correct?

A There will be an adjacent level breakdown that is like the situation we're looking at here, maybe a progression of degenerative changes.

Q Right, because when you fuse -- for example, if you fuse L4-5 and

L5-S1, that's going to cause L3-4 to degenerate at a faster rate, correct?

A Your -- there's more stresses placed through L3-4.

Q Right.

A And there are reports that the segment above a two-level fusion will degenerate faster than we manifest degenerative changes on our own as part of the aging process, yes, sir.

Q Right. It will degenerate at a faster rate than the normal aging process I think is what you're saying, correct?

A That's correct.

Q And in a -- when you do a fusion surgery on someone who's say only 30 years old, there is a significant likelihood, meaning more probable than not, that there's going to be an adjacent segment breakdown at L3-4, which requires fusion in the future?

A No, I won't -- I disagree with that, where you indicate that it requires fusion. There will be a breakdown, there's no question about that. It will be in a -- accelerated over the normal aging process. Some patients will experience symptoms that may necessitate fusion. Usually that's because of accompanying stenosis or tightness around the nerves. But many patients won't require surgery.

Q Well, you agree that a patient undergoes a two-level fusion at L4-5 and L5-1 (sic) is at an increased risk of a fusion at L3-4 due to adjacent segment breakdown?

A Yes, but it's not probable. It's not like 50 out of -- 51 out of 100 that have this two-level fusion are going to need this surgery.

Q And --

A More of them will not require the surgery.

Q And are you familiar with the literature that people who undergo a lumbar fusion, that the adjacent level will break down at a rate of approximately 3 percent per year?

A Yes, yes. That's a fair statement.

Q And that's cumulative, right?

A Yes.

Q Okay. So if you live 10 years, about a 30 percent increased chance you're going to need a, you know -- strike that. If you life an additional 10 years after your fusion surgery, there's about a 30 percent likelihood you may require a fusion surgery due to an L3-4 breakdown?

A There's no -- no, I disagree with that.

Q Okay.

A It's not 30 percent that would require a fusion.

Q Well, you agree that before Dr. Capanna did his surgery, Beau was not at any risk, based upon what you know of his condition at that time, of an L4-5 fusion at any time in his lifetime, correct?

A No, I can't speculate on that, at any time in his lifetime.

Q You agree that Beau did not have any risk to have an L3-4 fusion when he underwent surgery with Dr. Capanna?

A At that point in time, yes, but I can't speculate that, you know, when --

Q I guess you --

A -- he reaches his fifth or sixth decade of life that he won't require a fusion for some degenerative instability or something.

Q You agree that the surgery performed by Dr. Cash was as a result of the wrong-level surgery performed by Dr. Capanna?

A Yes --

Q Okay.

A -- that was the reason that Dr. Cash did the second surgery, yes, sir.

Q And don't you agree, Doctor, in some ways, once you start performing surgeries on the spine, it kind of creates -- I'm not going to call it a domino effect, but it kind of creates a cascade of events that can -- you know, once you addressed one level, you may have to start addressing another level and continue on for some period of time with that?

A That's why the option of continued conservative care should strongly be considered in somebody who has a pain level in 2 out of 10, yes, sir.

Q Right.

A Because you want to avoid situations --

Q Right.

A -- with multi-level lumbar spine fusions in patients that down the road say, geez, I'm -- wish I would have never done that.

Q Right. And it creates this whole cascade -- once you start down the fusion path, it creates a whole nother level of potential risk for that patient, right?

A Are you talking about me or --

Q In general.

A -- a health care --

Q In general.

A Yes, it can.

MR. PRINCE: Let me check my notes, Your Honor.

BY MR. PRINCE:

Q And you're not critical of Beau because he doesn't take significant

amounts of narcotic pain medication, correct?

A No, not at all.

Q I mean, some patient elect -- are more stoic, have a higher pain threshold and, therefore, they may not take much pain medication, but may have a very high level of pain.

A Yes.

Q Right. And just because Beau can work does not mean that he does not have pain or limitation, correct?

A That's correct.

Q And just because Beau continues to, you know, I guess be as active as he can but pay for it, you're not critical in any way of that, correct?

A I'm not certain what you mean by pay for it.

Q Meaning if, for example, he go -- he likes to go golfing and then they all go golfing and then, you know, for the next two or three days, he's going to have some pain.

A I'm sorry, I see. That -- yes, that's reasonable.

Q Right. I mean, he's still got to try to live. He's only 25 years old, right?

A Yes, sir.

Q And you encourage your patients, you know, who are maybe the same age bracket as Beau, have similar issues, I mean, just try to stay as active as they can and stay within their limits, right?

A That's a fair statement.

Q Sometimes it's best to leave the limits up to the patients themselves, they know their body the best.

A That's reasonable.

Q Just because there's no formal lifting, bending, or twisting restriction doesn't mean that Beau doesn't have ongoing pain limitation every day, correct?

A That's a fair statement.

MR. PRINCE: I'm almost done, Judge.

[Colloquy between counsel]

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

THE WITNESS: Thank you, sir.

THE COURT: Mr. Lauria.

MR. LAURIA: Thank you.

REDIRECT EXAMINATION

BY MR. LAURIA:

Q We spent about 20 minutes with the diagram of the nerve roots and the injections and the epidural steroid injections, so I just want to clear this up, hopefully once and for all if we can. I want to look at --

MR. LAURIA: Can you put me on -- thank you.

THE COURT RECORDER: I'm sorry.

MR. LAURIA: That's all right.

BY MR. LAURIA:

Q Let's make this clear --

MR. CARDINALE: Oh, the --

MR. LAURIA: Yeah --

MR. CARDINALE: The ELMO.

THE COURT RECORDER: Sorry.

BY MR. LAURIA:

Q 3/26/2014. You went through this report with Mr. Prince, 3/26/2014. It was a left L5-S1 transforaminal epidural steroid injection and a left S1 transforaminal epidural steroid injection.

A Yeah.

Q It shows the medications he used, IV conscious sedation, fluoroscopic needle localization, correct?

A Yes.

Q All right. And we -- Dr. Ruggeroli, after this transforaminal epidural steroid injection, found the patient got no relief, right?

A Yes.

Q All right. And Mr. Prince's assertion to you was doesn't that indicate that he's not having an L5-S1 problem, right?

A That's correct.

MR. PRINCE: Objection. That's not -- wasn't my question. So it --

THE COURT: Well --

MR. PRINCE: -- misstates my question.

BY MR. LAURIA:

Q Wasn't he --

THE COURT: Overruled.

MR. PRINCE: I said primary generator.

BY MR. LAURIA:

Q Wasn't he suggesting to you, Doctor, that the L5-S1 area was not a generator of pain or a primary generator of pain in Mr. Orth?

A Based on that injection, yes.

Q Okay. Well, based on that injection, I mean, he did L5 and S1 and

there's no relief, right? So that must mean that it's not a pain generator, right?

A If you're going to rely completely on that.

Q Well, I'm going to look at -- I want to look at another study. I think Dr. Cash, when I asked him about it, said it may not have been in the same procedure, but I think it was exactly the same procedure, and let's look at page 326, which is 8/13/20 (sic), Dr. Ruggeroli doing the procedure. Do you agree, Doctor, that the primary pain generator in Mr. Orth in 8/13/2010 was L5-S1?

A Yes.

Q Has anybody disagreed with that opinion?

A I don't believe so.

Q All right. Everybody agrees that 8/13/10 was L5-S1 was causing Mr. Orth's pain. Dr. Ruggeroli described doing a left L5-S1 transforaminal epidural steroid injection, a left S1 transforaminal steroid injection, IV conscious sedation, fluoroscopic needle, exactly the same medications, true?

A Yes.

Q He did exactly the same procedure in 2010 that he did in 2014, right?

A Yes.

Q And that was just prior to seeing Dr. Capanna five days later.

A Yes.

Q And everybody agrees that his problem at that time was L5-S1, right?

A That's correct.

Q I'm going to put up page 325 and we'll see what Dr. Ruggeroli says about that injection. Too big, but -- status post-left L5-S1 transforaminal epidural steroid injections, no significant relief. Pain in lower extremity is still impairing performance. So he got no relief from that one either, did he?

A That's what that note says.

Q Does that mean that in fact that L5-S1 which everybody thought was the pain generator wasn't the pain generator?

A No.

Q All right. Well, does it mean, then, as was suggested, that just because he didn't get relief on 3/26/14 that L5-S1 is not the pain generator?

A No.

Q All right. Did precisely the same procedure before the surgery and didn't get relief, and precisely the same one later, true?

A That's correct.

Q And you would assume that he injected in exactly the same spots that you were drawing up there in 2010 as in 2014 in all of the stuff that we saw, true?

A He describes the same procedure, so I would expect those things, yes, sir.

Q All right. Mr. Prince has said do you know if the studies have someone who has the specific timing and characteristics of the surgeries on Mr. Orth. Do you know whether they have a specific factual scenario like him?

A No.

Q Does that make them any less reliable in the medical community as a basis for opinions on what future care is?

A No.

Q All right. There are patient in there who have single-level discectomies.

A Yes, sir.

Q There are patients in there who have had multi-level discectomies.

A Yes, sir.

Q There are patients who have had repeat discectomies like Mr. Orth had that is a --

MR. PRINCE: Objection; leading, Judge. He's just -- it's on some -- leading. All the questions are leading. Every one of them are leading.

THE COURT: For the whole week and a half?

MR. PRINCE: For a whole week and a half.

MR. LAURIA: There were a couple that weren't, Judge, probably a couple.

THE COURT: Just clarifying.

MR. LAURIA: Sure.

THE COURT: I will sustain the objection as leading.

BY MR. LAURIA:

Q Are there reports in the studies, Doctor, that cover patients who've had discectomies and re-herniated and had a repeat discectomy?

A Yes.

Q All right. That's the equivalent of Mr. Orth's condition; he had a --

MR. PRINCE: No.

Q -- discectomy, and had a herniation, had a repeat procedure done, true?

A If you're focusing on that one level, yes.

Q All right. And there are multi-level patients in there, too.

A That's correct.

Q In your opinion, to a reasonable medical probability, are the studies that are done at Harvard or Johns Hopkins or Stanford, are they as applicable to Mr. Orth as they are to other patients who have undergone these types of procedures?

A Certainly.

Q And do some of those studies measure the number of patients who've had re-herniations, required a second discectomy, and then the percentage of those that have gone on to require a fusion surgery?

A Can you state that again? I'm sorry, I lost my --

Q Do any of --

A -- train of thought.

Q Sorry. That's okay. Do any of those studies talk about the patients who have had a discectomy, had a re-herniation, and had a second discectomy, the percentage of those that have gone on to require fusion?

A Yes.

Q All right.

A They do talk about that

Q And were the percentages still in the 20, 30 percent range at best?

A Yes. It was not probable that they would go on to require a fusion.

Q There was a lot of discussion with Mr. Prince about the L4-5 disc and degeneration of the disc. Would you agree that Mr. Orth had -- at L5-S1 had a degenerative disc before he even saw Dr. Capanna?

A Yes. There were some degenerative changes noted at L5-S1.

Q And you would agree that the L5-S1 disc was going to continue to degenerate following a microdiscectomy?

A Yes.

Q All right. So Mr. Orth was going to continue to have L5-S1 disc problem regardless of what occurred at Dr. Capanna's surgery, do you agree with that?

A Yes.

Q Counsel has asked about, again, Dr. Cash indicating that -- telling Mr.

Orth he should not return to football or don't return to football. Did you see anywhere in the records where he actually said that, where he recorded that?

A No.

Q All right. Is that something that you, in your experience, is generally recorded by other spine surgeons if they're giving a recommendation like that to a patient?

A Yes.

Q All right. So you would expect to see something like don't go back to heavy labor, right? You do it on people that are lifting all the time; or don't return to a certain activity?

A Yes.

Q Going back to April of 2011, patient is taking next season off to complete school. Nowhere in the records of Dr. Cash did you find any mention of I'm telling him he shouldn't play football or it shouldn't be done?

A No, I didn't see that.

Q All right. But you said something, you were asked by counsel about there's a significant risk to returning to football with a -- after having this two-level microdiscectomy.

A Yes.

Q Is there a significant risk, in your opinion, to returning to a contact sport like football with a single-level microdiscectomy?

A Yes.

Q And what are the risks of returning to football if you have a single-level microdiscectomy?

A I would -- as far as I know, the risks are the same if you have a two-

level microdiscectomy.

Q Risk is you could re-injure your disc, you would re-herniate, require further surgery?

A Yes, sir.

Q All right. There was -- Mr. Prince brought out in the first note by Dr. Cash of October 12th, 2010 which --

MR. LAURIA: Is that it? It's the first visit. Here we go.

BY MR. LAURIA:

Q Again, saying that there was a discussion of fusion surgery. Do you recall that testimony? That's on October 12th, 2010.

A Yes.

Q I'm going to represent to you that Dr. Cash has testified in this case that he told Mr. Orth on his very first visit that because he'd had a microdiscectomy, he was going to require two fusion surgeries.

MR. PRINCE: No, objection, Your Honor; beyond the scope of my cross-examination. That did not -- was not covered by me, nor was it covered by Mr. Lauria during his original direct exam.

THE COURT: It's technically correct, but I want very badly for Dr. Rimoldi not to have to come back. So I'll let you ask the question and then you can go back into on --

MR. LAURIA: Thanks.

THE COURT: -- recross if you need to.

BY MR. LAURIA:

Q The -- Doctor, I just want to clarify. You -- this record -- well, when you read this record, is it telling the patient that, Mr. Orth, you are going to require, to a

reasonable medical probability, a fusion in the future?

A No.

Q What is he saying by this statement?

A He's discussing additional surgery and potential risks of the surgery. He talks about recurrent disc herniation and the spinal fusion. So in my -- when I reviewed this record, it's -- he's going through the informed consent process with him.

Q Is he essentially telling the patient look, if you have yet another herniation at this level, then you may need a fusion sometime in the future?

A No, he doesn't say that, but --

Q Well, if he says --

A -- you know, he --

Q I'm sorry.

THE COURT: You can --

Q Patient recognized if this is a recurrent herniation at L4-5 and he has another injury at this level, then he will most likely require a fusion --

A Yes.

Q -- (indiscernible) I'm sorry.

A Yes, that statement does state that. I think that's part of his informed consent process as he's planning on performing an additional surgery.

Q So he's saying in the event you herniate this disc again in the future, you may need a fusion.

A Right.

Q Okay. Not that you're going to need a fusion. And I think we've covered it, but when you reviewed his records, other than this statement, did you

see any mention of a fusion before two months ago?

A No.

Q Oh, so the images were put up, but I can't ask them to put them up again, but you noted that there was some abnormality in the comparison films that they put up from 9/2/2010 and 2/3/09. Do you recall that?

A Certainly. If I didn't see the -- his name on the top, I would have suggested it was a different patient. The dimensions of the vertebral bodies were completely different.

Q In one of them, they're kind of more elongated and in of them, they're very block and square; is that your interpretation?

A Right. One was more rectangular with the width of the bodies being much greater than the height, and the next view, they were about equal in dimension, equal width, equal height.

Q Can you explain why that is?

A Different technique in the scan.

Q All right. Do you believe those scans or those images can be readily compared?

A I wouldn't.

Q When you were asked a question about the disc fragment at L -- sorry -- the fragment at L5-S1, Mr. Prince used the word contained. And I think you said contained within the L5-S1 disc space. Is that different than being contained within the nucleus or the annulus?

A Certainly if it's --

Q Let me ask it again, that's a poor question. Is there a difference between being contained within an L4-51 (sic) disc space and being contained

entirely within the annulus?

A Certainly.

Q Okay. So when the term contained is used in regard to the L5-S1 disc space, that doesn't mean that some portion hasn't extruded out of the annulus or the annulus hasn't opened, agree?

A That's correct.

Q All right. I wanted to ask you about the images --

MR. LAURIA: I want -- put up the plain films -- this one first. Put up this one first. And now I need you to switch me, if you would. Thank you.

Q Doctor, this is an image that was made by Dr. Cash, post-op X-ray after his surgery of 11/3/2010, except the little diagram next to it. But what do you see --

MR. PRINCE: Objection, beyond the scope of the cross, Judge. We didn't -- I didn't ask one thing about post-Cash-operative X-ray.

THE COURT: Mr. Lauria?

MR. LAURIA: He asked about the laminotomy at L4-5 and so I'm giving --

MR. PRINCE: Pre-Dr. Cash.

MR. LAURIA: Excuse me, can I finish?

THE COURT: Hold on, hold on. Let him -- let Mr. Lauria finish, please.

MR. LAURIA: So I'm entitled to show him for a comparison view, Judge, the before and after so he can make a comparison.

THE COURT: You can go ahead.

MR. LAURIA: Thank you.

BY MR. LAURIA:

Q This is the postoperative X-ray taken after Dr. Cash's surgery. Can you see that?

A Yes.

Q And what do you see in regard to any abnormality in the lumbar spine in the areas of L4 and L5?

A What I see is on the -- and I'm assuming this to be the left side. There's a defect in the bone. It looks like the entire lamina of L5 has been removed and a portion of the lamina of L4 on the left side. That's what I see, postoperative changes. That's all I see.

Q Okay. So --

THE COURT: And just so I can be clear, you're assuming this is the left side, correct? Is that what you're saying?

THE WITNESS: Yes.

THE COURT: Okay.

THE WITNESS: Yes.

THE COURT: Just making sure.

MR. LAURIA: And -- I wish I could make little marks.

BY MR. LAURIA:

Q And then where we see --

THE COURT: I haven't given you privilege to do that yet.

MR. LAURIA: I'm trying, Judge.

BY MR. LAURIA:

Q Where we see the space or the lines going across, that's where the disc space is essentially?

A Yes. This being L4-5 here.

Q Okay.

A And this being L5-S1 here.

Q So up above that last red mark that you made, that's indication of a laminotomy at L4, and it's a laminotomy because he only took a portion of the bone, not the entire lamina as down here at L5. Is that fair?

A That's a fair statement.

Q Let's go to the one that's October 12th, 2010. That's a pre-op Dr. Cash. That's after Dr. Capanna's surgery. Are you able to say with any reasonable certainty in looking at this film that in fact there was a laminotomy performed?

A No, I can't.

Q Okay. Very different appearance in the bone before Dr. Cash's surgery and after?

A Yes.

Q One more thing.

MR. LAURIA: Can you go back to that -- back to the testimony if we had it --

MR. CARDINALE: Oh, yeah. Cash?

MR. LAURIA: Yes.

BY MR. LAURIA:

Q Just for review, I want to ask you about the testimony of Dr. Cash in this case. Question --

MR. PRINCE: Your Honor, object to being definitely beyond the scope. I never talked about any deposition or the testimony of Dr. Cash. You ruled on this previously.

MR. LAURIA: This is the trial testimony.

THE COURT: Well, why don't --

MR. PRINCE: You ruled upon --

MR. LAURIA: It's the trial testimony.

THE COURT: Well, let's approach. Let's approach. Let's approach the bench, please.

MR. PRINCE: Are you going to have him take that down --

MR. LAURIA: It's trial.

MR. PRINCE: -- before you rule?

[Bench conference begins at 3:07 p.m.]

MR. PRINCE: I'm asking to take it down until you rule.

THE COURT: Who's got it up?

MR. PRINCE: Yeah, you --

THE COURT: Paul?

MR. LAURIA: Well, she'd have to turn it off. So --

MR. PRINCE: No, you're --

THE COURT: Okay.

MR. PRINCE: -- you're -- you can turn it --

THE COURT: Thank you. Okay.

MR. PRINCE: Thank you.

THE COURT: All right. What are we --

MR. LAURIA: It's trial testimony, it's not a depo.

MR. PRINCE: I didn't ask about trial testimony.

THE COURT: Well, just because you didn't ask about trial testimony doesn't make the issue ripe for somebody to ask about it, assuming you asked some questions about it. I'm just trying to make sure it's an issue that's been gone into. I generally try and give people some leeway because I don't want to say okay, well I'll just recall him again in case in chief, but I don't want to keep going, going and going and beyond. So what is this issue --

MR. LAURIA: All this --

THE COURT: -- that you were going ask him about?

MR. LAURIA: What it goes to is what Dr. Cash says was on that 8/31/12 (sic throughout) film that he asked him about what the postoperative changes (indiscernible) the postoperative changes were at the L4-5 level.

THE COURT: Okay. All right.

MR. PRINCE: And what level?

MR. LAURIA: L4-5.

MR. PRINCE: What film?

THE COURT: The 8/30 --

MR. LAURIA: 8/31/12.

THE COURT: -- '12

MR. PRINCE: There's no 8/31/12.

THE COURT: Or 8/13/12.

MR. LAURIA: 8/13/12, excuse me.

THE COURT: Not 8/31. Today's the 31st.

MR. LAURIA: Feels like the 10th.

THE COURT: I know.

[Bench conference ends at 3:08 p.m.]

THE COURT: All right. You can go ahead.

MR. LAURIA: Thank you.

THE COURT: You can put it back up.

MR. LAURIA: Can we go back to that? Thank you. There we go.

BY MR. LAURIA:

Q I'm showing you the testimony talking about is there any more

cushioning based on your review of the MRI image of August 31st, 2012 at L4-5 disc space. No, the cushion has been taken out through two surgeries.

Do you have an opinion, Doctor, based upon your review of the MRIs and as we went through the reports of the radiologist as to whether all of the cushion has been taken out of the L4-5 disc?

A No, that's absolutely a false statement.

Q All right.

MR. LAURIA: Let's scroll down, please, Paul. Let's -- you can stop there.

Q And then we talked about L5-S1 on that same film of 8/31/12 where there's a little bit of disc protrusion, you don't have the axial, just a little bit of disc. The disc has no more jelly. It's not going to have a big protrusion obliterating the nerve. It's collapsed. It's going to lead to bone on bone. It's almost there. This is the most symptomatic level. Doctor, do you have an opinion to a reasonable medical probability, based on your review of the films and what the radiologists say whether or not the films of 8/31/12 show a lack of jelly in any disc space or any disc space being bone on bone?

A No, there's no space that's bone on bone.

Q Is it even close?

A No.

Q Come down again. Now, he's asking about the L4-5 disc space, and Dr. Cash testifies, this has lost all of it's shock absorption capacity essentially, let's say a great majority of it, maybe 80, 90 percent. This is flat. This is not a shock absorber anymore and it's less mobile. Do you have an opinion to a reasonable medical probability whether Dr. Cash's statements regarding 80 to 90 percent loss of its capacity is accurate or inaccurate?

A That is inaccurate.

Q And do the radiologists who interpreted this study concur with your opinion?

MR. PRINCE: Objection for foundation, speculation.

BY MR. LAURIA:

Q You've reviewed the --

THE COURT: Thank you.

Q -- radiology reports for this procedure, correct?

A Yes.

Q Do they indicate anywhere that there is an 80 to 90 percent loss of this disc height or absorption or anything like that?

A No.

Q We put up when I was first questioning you the report of the procedure two years after that in March of 2014, and they describe some mild desiccation, true?

A That's correct.

Q All right. They don't describe any significant loss of disc height?

A No, they don't.

Q Thank you, Doctor. Appreciate it.

A You're welcome.

MR. PRINCE: You done?

MR. LAURIA: I'm done.

MR. PRINCE: Okay.

RECROSS EXAMINATION

BY MR. PRINCE:

Q Just have a few questions, Doctor.

A Yes, sir.

Q Okay.

MR. PRINCE: I just need control of the monitor.

Q Mr. Lauria asked you a moment ago about some questions about, you know, before Dr. Capanna performed surgery, about Dr. Ruggeroli's transforaminal epidural steroid injections. Remember those questions?

A Yes, I do.

Q And your testimony was, well, he performed the exact same one at -- in August of 2010 as he did in March of 2014, right?

A Based on that descriptive report, yes.

Q Right. And that there was no relief following the August of 2010 procedure, correct?

A Yes.

Q Remember that?

A That's what that showed in that note.

Q Well, we've got to be careful how we use the word relief, correct? Because there's a steroid component and that could be long-term relief because of providing the patient any lasting benefit because of the steroid, correct?

A Yes, that's where you're looking at therapeutic benefit.

Q Right. And then there's the diagnostic part of it, that's when you inject like the anesthetic at the level and that provides like the immediate diagnostic information that you would use as a surgeon, correct?

A That's one piece of the puzzle --

Q Right.

A -- as we talked about before, yes.

Q One piece of the puzzle, right. And so in -- so when Dr. Ruggeroli says, you know, he didn't receive any -- you know, any significant benefit, typically from a patient's standpoint he goes, yeah, I got better for a few days and then after that -- after about a week, I just kind of went back to normal, right?

MR. LAURIA: Objection to --

MR. PRINCE: That's what the therapeutic aspect of it would be.

MR. LAURIA: -- compound question.

THE COURT: Well, I'll agree. Please break it up a little bit.

BY MR. PRINCE:

Q Typically, after a patient undergoes a transforaminal epidural steroid injection, they'll go back to the doctor, right?

A Yes.

Q The pain physician.

A Yes.

Q And the pain physician will say, how are you feeling, did you improve, how did you do following the injection?

A Yes.

Q The patient will say, oh, I've done fantastic and either -- or I've gotten no benefit, or somewhere in between, right?

A That's a fair statement, yes, sir.

Q All right. And so if a -- just because a patient says, hey, I didn't get much benefit from that, that doesn't mean that -- diagnostically speaking, that L5-S1 is not a problem, it just means they didn't receive any therapeutic benefit from the steroid injection, correct?

A Well, if they said they didn't get any benefit, yeah, obviously they didn't get benefit.

Q Right. But we -- diagnostically, you need to look at how are -- what was the pain score just before the procedure and then how is it just after the procedure, correct?

A You can rely on that as one piece of the puzzle.

Q Right, because typically the steroid doesn't kick in for, you know, hours or even maybe a day or two, correct?

A That's a fair statement.

Q So -- all right. And let's look at -- we're going to go to the February, 2010 L5-S1 injection. Okay? We're going to go to the pain management record.

MR. PRINCE: Please put up 438 of Exhibit Number 9.

Q This is again from February, 2010. The pre-procedure pain score was a 5. Okay?

A Yes.

Q And if we go to the next page, 439, it shows that the post-procedure pain score was zero, correct?

A Yes.

Q So it had significant benefit to Beau at that time, correct?

A Looking at this one document.

Q Now, I want to show you the 8/26/2010 (sic) report. Remember, Mr. Lauria said that he got -- there was no relief after that injection, correct?

A I'm sorry, what injection are you talking about?

Q The 8/26/10 injection. Remember that? The one just before Dr. Capanna's surgery.

A I thought we were talking about August 13, 2010.

Q Oh, I'm sorry. August -- it is August 13, 2010. What -- I'm sorry, if I used the wrong date, then that's my fault. I'm sorry.

A No worries. I just want to be clear.

Q No, thank you for clarifying that. And so I want to look at the pain score, the pre-procedure pain score from that. That's Bate number 425. And it's a 7, correct? Do you see that?

A That's what this one states, 7 out of 10, yes.

Q Okay. And if we go to 426, pain score went down to 4 and a half. So there was some reduction in pain following the administration of the anesthetic, correct?

A I'll just state that I'm not sure that's 4 and a half. It could be 4 to 5, I don't know.

Q Oh, okay. I see what you're saying. Anyway --

A But there was a mild to modest reduction, I guess.

Q Okay, and so -- all right. And so from a -- diagnostically speaking, this suggests that L5-S1 is a potential -- a pain generator for Beau in August -- on August 13th, 2010.

A Okay, this -- I just wanted to make sure. This goes with that August 13th --

Q Yes, it does.

A -- 2010.

Q And if you want to see the --

A No, no.

Q -- record, I'll show it to you.

A No, I just wanted to be clear for the jury.

Q Yes, it does.

A Okay.

Q It goes with that.

A It would tell me that after that injection, based on this one document, that he had a mild to modest reduction.

Q Right. Okay. So there -- diagnostically speaking, there was information available to a surgeon which should that, hey, that L5-S1, based upon this mild to modest pain reduction immediately post-procedure would suggest that that is the source of Beau's problem?

A If you're just going to rely on that, and I would suggest a healthcare provider doesn't, yes.

Q It's one piece of the puzzle.

A That's correct.

Q Along with the history, physical exam, and MRI findings.

A That's correct.

Q Right. You put it all together, it looks like Beau had a problem at L5-S1 before his surgery with Dr. Capanna, correct?

A Yes.

Q All right. And then put it -- go back to March of 2014, and where Beau got no pain relief of any kind, diagnostically it doesn't -- looking at the total picture, it does not appear that L5-S1 was a primary pain generator as of March of 2014?

A If you're going to look at that document as one piece of the puzzle.

Q Along with all the other pieces, correct?

A Well, no, you can't -- that would imply that you're indicating that I'm

saying that all the pieces of the puzzle show that, and that's not true.

Q Okay.

A I just want to be clear. If you look at all the pieces of puzzle, he's had a reasonable post-op course after his two-level discectomy that was done by Dr. Cash. But if you look at that piece of the puzzle in and of itself, the statement that you say is correct, that it would suggest that L5-S1 wasn't the primary pain generator --

Q Okay.

A -- in March of 2014.

Q Okay. And when we were talking -- you were talking about comparing the scans from February, 2009 to August of 20 -- 2010, I didn't ask you to conduct a direct comparison. We were just looking at, you know, images just to show kind of the condition of both L4-5 and L5-S1, not a direct comparison, right?

A Well, you were showing two scans and you were asking me questions about both scans.

Q Well, I didn't ask you to compare them. I just said -- because they're different scans, right?

A Yeah.

Q Different equipment?

A Well, it's different dimensions. I mean, you can't --

Q Right.

A -- infer anything one way or the other from --

Q Either way, L4-5 was normal in both scans, no matter what you looked at, right?

A Yeah, it looked as a normal disc to me based on those two studies that

you showed.

Q And there was a small L5-S1 disc protrusion based on both -- either scan, correct?

A Yes.

Q They were consistent with each other?

A Yes.

Q Okay. Thank you, Doctor.

MR. PRINCE: No additional questions.

THE COURT: Mr. Lauria, anything further?

FURTHER REDIRECT EXAMINATION

BY MR. LAURIA:

Q The only thing is, Doctor, have all the opinions you've expressed today been to a reasonable medical probability?

A They have.

Q All right. Thank you, Doctor.

A Thank you.

THE COURT: Anything from our jurors? Yes? Joel.

We're getting close, Doctor.

[Bench conference begins at 3:20 p.m.]

THE COURT: Mr. Ostrow.

MR. PRINCE: Huh?

THE COURT: Mr. Ostrow formed some good questions that time.

MR. LAURIA: I don't think he can answer that --

THE COURT: What I don't know is whether he opined about any of that in his --

MR. LAURIA: He hasn't in standard of care so he --

THE COURT: -- in his reports or anything.

MR. LAURIA: -- really can't talk as to (indiscernible) --

MR. PRINCE: I'm okay with it.

THE COURT: But are these things that he's offered opinions on before?

MR. LAURIA: Yeah --

MR. PRINCE: Yeah.

MR. LAURIA: -- I don't think he can answer that because it's -- he's not (indiscernible) standard of care expert so he hasn't opined on standard of care or those procedures.

MS. TARMU: Well, but at least some of them aren't standard of care.

MR. PRINCE: But -- no, no, Mr. --

THE COURT: Look --

MR. PRINCE: -- Tony's asked --

THE COURT: -- I think these are very good --

MR. PRINCE: -- all kind --

THE COURT: -- questions --

MR. PRINCE: -- all kinds of -- he's asked all kinds of witnesses about, you know, well you've done wrong levels (indiscernible) he didn't do that with this particular doctor.

THE COURT: Well, look I think they're good questions, but my worry is if the guy hasn't offered an opinion at them and nobody's deposed him or read a report --

MR. PRINCE: True, that's true.

THE COURT: -- where he's offered opinions about that, then we get some kind of answer and you guys are like oh now we need to --

MR. LAURIA: And we need four more --

THE COURT: Yeah.

MR. LAURIA: hours with him.

THE COURT: Yeah.

MR. PRINCE: Okay.

THE COURT: So -- okay. Thank you.

[Bench conference ends at 3:22 p.m.]

THE COURT: All right. Dr. Rimoldi, I can't imagine that getting off a plane and from -- returning home, you wanted to come to court for five hours, but nonetheless, I very much appreciate your time. You are excused, sir.

THE WITNESS: Thank you.

THE COURT: Thank you.

THE WITNESS: Appreciate it. Thank you.

MR. LAURIA: Thank you, Doctor.

THE WITNESS: You're welcome.

THE COURT: Mr. Lauria, do you all have any further witnesses?

MR. LAURIA: No, Your Honor, subject to admitting the documentary evidence --

THE COURT: Okay.

MR. LAURIA: -- we would rest.

THE COURT: And Mr. Prince, are you all going to have any rebuttal witnesses?

MR. PRINCE: Yeah, I do. Beau. One witness. It will be like less than five minutes.

THE COURT: Okay. Is that famous last words?

MR. PRINCE: No.

THE COURT: All right. Mr. Orth, if you would raise your right hand again for me, please, sir.

BEAU ORTH

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

THE CLERK: Thank you. You may be seated.

THE COURT: All right. And you previously spelled your name, so don't worry about that.

Mr. Prince, you can go ahead.

DIRECT EXAMINATION OF BEAU ORTH

BY MR. PRINCE:

Q Beau, you heard the questioning of Mr. Lauria of Dr. Rimoldi about you not returning to football. Do you recall that?

A Yes, sir.

Q Tell the jury why you didn't return to playing football?

A I returned to football because Dr. Cash --

Q Why you did not return to football.

A I did not return to football because Dr. Cash said that I couldn't.

Q Is there any other reason why you didn't other than your doctor told you not -- recommended you not to?

A Well, the doctor recommended me not to and my future -- I mean, the future damage that I could cause just wasn't worth it.

Q If it was any reasonable option, Beau, for you to return back to playing football, would you have?

A Absolutely.

Q Would you have ever given it up if it was a reasonable option for you to go back and pursue?

A No, sir.

Q Thank you.

MR. PRINCE: No additional questions.

THE COURT: Mr. Lauria?

MR. LAURIA: I don't have any further questions, Judge.

THE COURT: Any from our jurors? No?

Mr. Orth, thank you again for your time. You can go ahead and step down.

Plaintiff going to have any further rebuttal witnesses?

MR. PRINCE: Nothing, Your Honor.

THE COURT: Mr. Lauria, any surrebuttal to that?

MR. LAURIA: No, Your Honor.

THE COURT: All right. Ladies and gentlemen, that brings us to the conclusion of witnesses and evidence in this case.

MR. TAYLOR: Hallelujah.

THE COURT: There you go, Mr. Taylor. Those are famous last words. But, as you can imagine, look it's 3:30 in the afternoon. There's no way we're going to get around to arguing this case today. I still have to -- some jury instructions we can't finalize until all the evidence is presented because of the nature of some of them, so I've got to finish that with the attorneys now. And then I've got to get them typed and corrected and in an order for you, and it's going to take several hours, I'm sure, to argue the case anyway. So we're going to have to do that tomorrow.

I've moved backwards my criminal calendar, so I'm planning on starting our trial at 10:00, and then my plan would be to go for -- I don't know as I sit here right now and I'll have to talk to the attorneys a little further, I don't know that we can get all the arguments done before we would take a lunch break. I think that's probably unrealistic. But what I would plan on doing is just buying you lunch anyway so you don't have to leave. We'll -- if we have to take a break during the arguments and let you eat lunch, we'll do that. And as soon as you're done with lunch, we'll get you back in, finish up the arguments so you can start your deliberations.

So there's two things that I can usually get really quickly when we're buying you lunch. That is pizza, which includes salads, things like that, or Capriotti's from downstairs, a sandwich shop. So just kind of think about that and chat with Joel when you go outside about what you want for lunch tomorrow and we will have that available for you, okay?

And with that, I'll see you tomorrow at 10:00. During the recess, you are admonished not to talk or converse among yourselves or with anyone else on any subject connected with the trial; or read or watch or listen to any report of or commentary on the trial by any medium of information, including and without limitation no newspapers, no television, no internet; and you cannot form or express any opinions on any subject connected with the case until it's submitted to your for your deliberations tomorrow. Okay. Have a good evening.

[Jury out at 3:26 p.m.]

THE COURT: Okay. And just real quickly for the record, with regard to the last questions, I know originally the questions that were posed by the juror, plaintiff was okay with me asking. I think though from my last comment at the bench -- Mr. Prince, I just want to make sure though that you thereafter agreed with not asking

them.

MR. PRINCE: I did.

THE COURT: Okay, because they were questions that I thought were good questions and they were put together in a good way by the juror, but they were asking Dr. Rimoldi to express an opinion on something that he had never been asked to opine on, wasn't deposed on, hadn't offered any opinions in his reports. And my worry was we were going to end up going off into something that was going to cause --

MR. PRINCE: Right.

THE COURT: -- some problems. Okay. We'll take a break for a second while you guys --

MR. PRINCE: Yeah, I have --

THE COURT: -- use the restroom --

MR. PRINCE: -- a 50(a) motion myself, so --

THE COURT: Okay. Use the restroom whatnot, and then we'll start up with jury instructions. Okay. We are -- hold on, before you --

[Off the record at 3:27 p.m.]

[Proceedings resumed at 3:44 p.m.]

THE COURT: Joel, could you hand them each a copy of that.

THE MARSHAL: Okay.

THE COURT: These are just the most recent set of instructions that Danielle had sent over, but in an order --

MS. TARMU: Yeah. I had --

THE COURT: -- that I put them in. Okay. That's kind of how we'll look at them here.

[Colloquy between counsel]

THE COURT: For the first thing that we had is --

[Colloquy between counsel]

THE COURT: Okay. So Mr. Lauria, you had some questions about some of the language that's in some of the instructions, correct?

MR. LAURIA: I believe so, Your Honor.

THE COURT: Okay. First paragraph of your email was talking about the rebuttable presumption instruction, page -- that's going to be back a little ways. It's about two-thirds of the way through there. I didn't number them right now. So --

MR. LAURIA: The issue I have, Your Honor -- I'm down -- I'm there now.

THE COURT: You got it?

MR. LAURIA: Thanks. You want me to address it?

THE COURT: Yeah. Plaintiffs, you guys got it?

MR. PRINCE: Yes.

THE COURT: Okay. Go ahead.

MR. LAURIA: The issue I have is that the burden of proof would then shift to the defendant to prove by a preponderance of the evidence that personal injury was not --

THE COURT: Well actually, let me do this. Let me give you a copy of one that I was kind of typing on while we were in court so you guys can look at this as well because --

MR. LAURIA: I'll pass it along.

THE COURT: -- in addition to what you were talking about saying, I think it should say standard of care, I realize that we didn't put the last part of it in there from the standard instructions which is the if you don't find the rebuttable

presumption then plaintiff still carries their burden.

MR. PRINCE: Okay.

MR. LAURIA: And Your Honor, I apologize. I do not have the actual pattern instruction in front of me.

THE COURT: Yeah, the pattern instruction goes over the course of two pages and the instruction that I typed up just -- and what we were talking about the other day was really just -- toward the end of the first page. The second page has the last paragraph, which is what I've now added on at the bottom of the instruction that says, if on the other hand you do not find by a preponderance of the evidence that the defendant performed a surgical procedure on the wrong organ, blah, blah, blah, then the burden of proving that any personal injury was caused by medical negligence remains with the plaintiff, okay?

So that I think needs to be in there. That's part of the pattern instruction. I know that's not really what your objection is to, but nonetheless I added that because I think that needs to be in there. Okay, go ahead.

MR. LAURIA: Well, my -- one, I'm a little confused and I suggested violated the standard of care as opposed --

THE COURT: Okay.

MR. LAURIA: -- to negligence. And my concern is this, Your Honor, it doesn't remove the entire burden of proof from the plaintiff. They still have to prove that any damages they claim were clearly caused by the violation of the standard of care. So you know, it doesn't eliminate a causation proof for the plaintiffs by giving this instruction. But as it's worded, I think it can be confusing in that regard.

THE COURT: Well, wait, what --

MR. PRINCE: You --

THE COURT: Okay, what do you mean? Now you've confused me. I mean it doesn't relieve them of their burden to prove an injury.

MR. LAURIA: Right.

THE COURT: But it absolutely -- I mean it presumes that the injury was caused by negligence.

MR. LAURIA: So --

THE COURT: That's what that statute stands for.

MR. PRINCE: And medical negligence is a defined term. It's a separate --

THE COURT: No.

MR. PRINCE: -- instruction so it -- which is the standard of care issue.

THE COURT: I know.

MR. LAURIA: So the injury --

THE COURT: Right.

MR. LAURIA: Right. The confusion is when you start using that term. The injury is to the L4-5 disc, right, if there's an injury?

THE COURT: Okay.

MR. LAURIA: But that's not the same as damages, right?

THE COURT: Right.

MR. LAURIA: That's not the same as proving that damages occurred. And I think that the way this is written, as I interpret it, it can be confusing to saying well okay, well, we have to disprove everything they claim. That's my concern here.

MR. PRINCE: No.

THE COURT: Well no, I disagree with that. I mean, look, there are three levels of this. There is establishing the standard of care. There's establishing that there was a violation of the standard of care. And there's establishing what the

damages were that flowed from that violation of the standard of care. Okay. I mean, that's just the basic proving negligence, right? Okay. So what the pattern instruction talks about is, if you prove by a preponderance of the evidence that somebody operated on the wrong part of somebody's body, then you've essentially presumed -- it's presumed that you violated the standard of care.

MR. LAURIA: Right.

THE COURT: You were negligent.

MR. LAURIA: Right.

THE COURT: That doesn't say that they don't have to prove any of their damages.

MR. LAURIA: Well, what --

THE COURT: They still have to prove the damages and there's, you know, the instruction packet is replete with other instructions that talk about that.

MR. LAURIA: And my only concern is again, you -- I think you've correctly identified it. If they -- if you find that they've proven he's operated at the wrong level, you find a violation of the standard of care, right? I mean, that's the --

THE COURT: Okay.

MR. LAURIA: -- rebuttable presumption that we would then have to prove no it wasn't within the standard of care. But this talks about, rebuttable presumption, that there was an injury caused by negligence and suggests that we have --

THE COURT: No. No, no, no --

MR. LAURIA: Okay.

THE COURT: No, no, no. Well, I mean, read the paragraph that starts with except. Except that such evidence as described above is not required in a rebuttable presumption that a personal injury was caused by negligence arises. So

it's saying that the injury -- whatever the injury is, the rebuttable presumption is that the injury was caused by the negligence. Not that there was an injury, just that the injury was caused by the negligence. That's exactly what the statute speaks to. The -- or excuse -- and the pattern jury instruction. The law provides for a rebuttable presumption that a personal injury was caused by negligence where the personal injury occurred under the following circumstances.

MR. LAURIA: So what is the remaining burden of proof as you interpret the law under this instruction?

THE COURT: Well, plaintiff still has the burden of proof of showing that they were injured, and showing that -- what the damages were, and what their monetary damages are from that injury. But if the -- if -- and they have the burden of showing to the jury that there was an operation on the wrong part of the body under this part that we're talking about.

MR. LAURIA: Sure.

THE COURT: And once they've done that, there's a rebuttable presumption that it was negligent.

MR. LAURIA: I understand that, and I don't have a problem with that.

THE COURT: Okay.

MR. LAURIA: What I'm concerned is, I -- because if I don't understand it, Judge, I mean -- and I'm not the sharpest knife in the drawer by any means, but -- you've probably figured that out over the last 10 days. As I read this, it's confusing to me, and I can't tell exactly what -- so what burden do they still have? Maybe we need to -- I mean, we need to have some specificity as this does not relieve the plaintiff of all their burdens.

MR. PRINCE: It's not even saying that.

THE COURT: Well, but you got to consider all the instructions together.

MR. PRINCE: Read them together, correct.

THE COURT: There are instructions -- I mean, for instance, let's see, when we get to the instruction on damages. Whether any of these elements of damage have been proven by the evidence is for you to determine. Neither sympathy, et cetera, et cetera. It is only required that plaintiff prove each item of damage by a preponderance of the evidence. So we tell them that plaintiff has the burden of proof on proving their damages.

We tell them, you know, a little earlier in the instructions that the plaintiff has the burden of proof on proving negligence. We tell them that they have the burden of proof of proving negligence through the use of expert testimony. And then this instruction just seeks to tell them that if they prove that there was an operation under this circumstance, that it's presumed that the negligence occurred. That's all that instruction speaks to. I mean, in my mind, in Egdatar (phonetic) I think that's what was outlined and I think the pattern instruction which this is almost verbatim of, that's all it's really speaking to. It's just saying all that's being presumed here is that the injury, whatever the injury was, was caused by negligence.

MR. LAURIA: So --

THE COURT: If there was any injury -- I mean, if there was an injury.

MR. LAURIA: Well, that's -- but I mean this kind of presumes there was an injury, right, by the --

THE COURT: Well, essentially yeah.

MR. LAURIA: So I mean are we taking away -- of the -- you know, the standard burden of proof instruction? Are we taking away the first three elements and now they only have to prove the fourth?

THE COURT: No. I mean, the instruction may presuppose that there was an injury, but the case -- there's nothing in here that says you're mandated to find that an injury occurred.

MR. LAURIA: Okay.

THE COURT: The instruction's just saying that if there was a -- that there's a rebuttable presumption that an injury was a result of medical negligence if you operated on the wrong part of the body.

MR. LAURIA: Okay. I -- Judge, I will just -- I mean, I'll --

THE COURT: Well, in any event, so I think that's -- that one's okay. And I don't agree that the language should be a violation of the standard of care. I think what it is, is it's a negligence instruction, and in this case medical negligence. And just as the pattern uses the terminology negligence, I think the instruction should use that as well.

The next one that you were talking about the language of was -- one, two -- if you flip back about six instructions, it's the damages for pain and suffering.

MR. LAURIA: Toward the back or toward the front? I'm sorry, I was --

THE COURT: Oh, go -- keep going back.

MR. LAURIA: Okay.

THE COURT: I'm sorry. Back another six instructions or so. The one that begins the damages for pain and suffering.

MR. PRINCE: Yeah.

THE COURT: Okay. And I agree. I don't know that there's any need to have on the other hand. I don't think the on the other hand is that big of a deal, but I think

it's more appropriate just to say damages for pain and suffering compensate damages for loss of enjoyment of life compensate.

MR. PRINCE: Well, the only issue I had was, with that, Judge, is just to ensure that they're -- there's differentiation. And I think that was the point of the instruction. On the other hand, that's kind of like well, that's one type of damage. This is another type of damage.

THE COURT: Yeah, I don't think the instruction, even with on the other hand, can be read in my mind to create separate categories for them to make an award on in terms of -- and the verdict form doesn't ask them to do that. But I don't think it's inappropriate to define both of those things for them. I just don't think you really need on the other hand.

MR. LAURIA: And I think it does kind of suggest it's a separate --

THE COURT: Okay.

MR. LAURIA: -- category which I think is best left out. So --

THE COURT: Anyway, so in anticipation of that, I changed one of the instructions. So I'll give you copies of that one --

MR. LAURIA: Thank you.

THE COURT: -- as well. You can kind of stick that into your packet for that one.

MR. LAURIA: Thank you.

THE COURT: There's two of those. Okay. And then I'll just tell you that I changed your read backs instruction to be a play backs instruction.

MR. PRINCE: Okay.

THE COURT: So that's -- but I've already replaced it in your packet so don't worry about that.

And then the next thing we have is, Mr. Lauria, you all were going to propose something regarding punitive damages, and we have to talk about our 42.021 issue.

MR. LAURIA: Correct, Your Honor. I just think it's appropriate since there have been all kinds of insinuations and allegations and claims that Dr. Capanna knew, but didn't tell the patient, and mislead the patient, and -- about what was on the X-ray, and that this jury be instructed that there is no claim for punitive damages. There's no action that would support a claim for punitive damages in this case. And so I think it is important that they be instructed that those are inappropriate. They're not to award damages based on a punishment if they think that the insinuations are accurate, but that their damages need to be awarded only on the elements that are recoverable in this case, and punitive damages are not recoverable.

So I think that clarification is necessary given all of the, again, kind of the argument, or the hounding, or the pointing, or the saying, you knew, you didn't tell him. You know, that kind of thing. If a juror believed that those occurred they may say well, let's cream the guy because, you know -- and they need to be told and instructed in the law. I mean clearly that's an appropriate --

MR. PRINCE: No.

MR. LAURIA: It's an accurate statement of law.

THE COURT: Well, just --

MR. PRINCE: I don't even know where -- I didn't have --

THE COURT: -- just out of curiosity --

MR. PRINCE: How do you give a punitive --

THE COURT: Where did it -- hold on. Where did this come from because I can't find it on CALJIC --

MR. LAURIA: It's a --

THE COURT: -- on the CACI.

MR. LAURIA: Yeah, it's CACI. It's a standard CACI -- In fact I've got the cite down there to it.

THE COURT: I know, but I looked --

MR. PRINCE: I don't even have a copy of it.

THE COURT: -- them up and they don't -- I was looking at the December 2014 California Civil Jury instructions and there is no 3924. So I can't find it.

MR. LAURIA: That -- Judge, maybe my book's a little bit -- you know, not December 2014, but --

THE COURT: Okay.

MR. LAURIA: -- or maybe they renumbered it. I don't know. But --

MR. PRINCE: How does it read even?

THE COURT: Pardon?

MR. LAURIA: I sent it to you.

MR. PRINCE: How does it even read? I haven't seen it.

MR. LAURIA: Oh, I sent it to you guys.

MS. TARMU: Hold on. Let me look.

MR. PRINCE: Danielle's looking.

MS. TARMU: Did you send it like in an email?

THE COURT: It says you must not include in your award any damages to punish or make an example of the defendant. Such damages would be punitive damages and they cannot be part of your verdict. You must award only the damages that fairly compensate plaintiff for his loss.

MR. PRINCE: Yeah. You've already instructed on the damage calculations.

And so -- I mean, we're not -- there's no item in there for punitive damages, there's -- you know, if they're following the jury instructions and carefully reading them -- we don't have it, apparently, Danielle says. But any event, that's not a Nevada based instruction. You don't give a non-punitive damage instruction in these types of cases in Nevada. I don't know --

MR. LAURIA: Well, I have had them given in Nevada, Judge --

MR. PRINCE: Well --

MR. LAURIA: -- where -- just where they were --

MR. PRINCE: -- I haven't finished my argument?

MR. LAURIA: Sorry, I thought you were done, Dennis.

THE COURT: Hold on.

MR. PRINCE: I'm talking a little slow.

THE COURT: Hold on.

MR. PRINCE: And so anyway, nevertheless, you -- it -- you've instructed adequately on negligence. You've instructed adequately on the damages the jury may consider giving.

THE COURT: All right, Mr. --

MR. PRINCE: And there don't need to be any further instruction on that, particularly -- and interjecting that concept.

THE COURT: Mr. Lauria?

MR. LAURIA: Your Honor, they -- again, because of the nature of the allegations here. This isn't just a standard med-mal case, right, where they're claiming not only did he do it, but then he hid it and this -- and then what he said he did isn't what he did. The kinds of things that are done to inflame a jury's passion in a case like this. So all you're saying -- it's a correct statement of the law. You're not

telling them anything confusing or that's not accurate. You're just telling them look, even if you feel that way, because we tell them don't -- you know, don't use passion or prejudice.

THE COURT: Right.

MR. LAURIA: But all it says is, you know, you're -- in this case, you're not authorized to base a decision on punitive damages because that's not part of the case.

THE COURT: I know. But I got to tell you, I just never advocate instructing a jury on the things that aren't part of the case.

MR. PRINCE: Right.

THE COURT: I mean, because you're basically inserting something in there that isn't part of what they've been told about, or instructed about, or heard evidence about. And I just always think that you go down a dangerous path trying to now get people to think about something that has never even been mentioned to them and they have no reason to think about.

MR. LAURIA: Well --

THE COURT: Now, I'm not saying that necessarily means somebody's going to go hey, lightbulb, oh, yeah, let's punish --

MR. LAURIA: Well --

THE COURT: -- this guy. That's a good idea.

MR. LAURIA: Yeah, I don't --

THE COURT: But --

MR. LAURIA: -- think that's -- I think if they're inclined to go that way they're going to go that way anyway. And this just tells them as a matter of law, you can't. I mean -- and so it's a correct statement of the law that provides some protection

against them going in a direction they shouldn't be going. And given the facts and the presentation of this case, I just think it's appropriate and it's required to make sure that we don't have some element of that in the verdict.

THE COURT: Well, I'm not going to give that. I mean, I've given them instructions that very clearly define what the case is about, what the damages issue, how they're suppose to, you know -- what are proper considerations for the damages issue. I don't want to give them something that's inserting into their thought process something that isn't involved here. I mean for that matter you could, you know, go on and say give them the instructions about fraud saying fraud's not a part of the case, but because there's some issue with medical records that they may be thinking about that, it's just -- I -- no. I don't agree that that's necessary.

I've never given a non-punitive damages instruction in any personal injury case regardless of the nature of allegations against somebody. Twofold, number one, I don't think anybody's ever proposed it, but I don't think that I ever would give it just for the very reason that I'm stating. I don't really think it's a good idea to raise things that aren't part of a case.

Okay. And then the last thing is our 42.021 instruction. I did get the proposed one that you all had typed up. And I will tell you that, you know, in my searching through my fellow judges, I didn't get a whole lot of responses. The one response that I had that I thought might bare some fruit was Judge Kishner, and she said, you know, actually it looks like maybe we didn't give that instruction because we can't find it anywhere now. Judge Wiese said I found the statute unconstitutional so I've never given it, which, you know, that's the easy way out. Nobody else said that they had ever given such an instruction.

MR. PRINCE: Right.

THE COURT: And probably the one thing I got that helped me the most as to where I sit right now in my decision making was somebody that just asked me, why would you give that? And I was kind of, well what do you mean why would I give that? Do you think the statute is unconstitutional? And that judge said, no, no, no, I think the statute's very much constitutional. But why would you give them an instruction that pertains to a particular piece of evidence without other instructions that pertain to particular pieces of evidence? Which was very thought provoking for me. But let me hear what you guys have to say on the one that you propose.

MR. PRINCE: Like I said preliminarily I'm just renewing my motion on the constitutionality. I just think when -- now that you've had a chance to try to work an instruction to see how unworkable it -- the statute -- statutory scheme really, really is, once you start to really conceptually think about it and then implement it in a case like this because you have to have -- there's no other testimony that how can the jury then make a determination of what is a reasonable medical expenses solely based on the reimbursement amount on the record that's before them. They don't have -- for example, if they brought somebody else in, an expert of some type, to talk about the reasonable charge is what a reasonable physician would accept as a reimbursement for the service, that may be one way to accomplish it.

But on the evidence they have -- this jury has before it, there's no basis for the instruction. There's no basis for even -- unfortunately for the evidence to come in because there's -- then they're not going to be told -- given any guidance what to do with it. And it's very specific directed towards medical expense. And it allows the jury to speculate. It invites speculation. For example, what if a juror's thinking, well, they have health insurance. I wonder if they have to pay the health insurance back? You know what I mean? You know, then you're not telling them

the whole story. I mean, they're not being told that held -- the university nor the private insurance for the family has to be reimbursed back, because they don't have to be reimbursed that.

MR. LAURIA: We can add that on there. I'm okay with that.

MR. PRINCE: I'm not advocating any -- adding anything on there. I'm just saying to you that it invites speculation by the jury. There's not adequate guidance given to them. And I think this -- I think as you realized, trying to come up with what's a workable instruction, it's almost completely unworkable. And so therefore that lends credibility to the -- I mean, a lot of persuasiveness, I think, to the vagueness problem that it has.

THE COURT: All right.

MR. PRINCE: So anyway --

THE COURT: Mr. Lauria?

MR. LAURIA: Judge, I -- we've taken it right from the statute. It is again, a correct statement of the law. Plaintiff has requested, and you said you were going to give, an instruction that says they can't consider whether plaintiff has medical expenses -- I mean insurance to cover future medical expenses.

THE COURT: Right.

MR. LAURIA: So if you give them that one, and I think you're only giving that one because you were planning to give this one, as I understood your --

THE COURT: No, no, no. I'm giving that one because there's no guarantee of somebody having insurance in the future --

MR. LAURIA: Okay. But you don't --

THE COURT: -- that makes something payable to them.

MR. LAURIA: -- normally give that instruction, right?

THE COURT: No, normally you give an instruction that says you're not to consider whether somebody has insurance.

MR. LAURIA: Sure. So in this case -- again, I just think that you just need a basic -- what we tried to draft is something that is basically reflects the statute because you're telling them, you can't consider whether there's insurance in the future.

THE COURT: Right.

MR. LAURIA: So why aren't -- why are you not permitted to tell them -- because the statute clearly says, you are permitted to consider evidence that payments have been made.

THE COURT: And that evidence came in at trial.

MR. LAURIA: Right.

THE COURT: I mean, here's my thing. For instance, we don't give an -- you got to step back a little bit, and this kind of is what I started thinking through when the judge posed that question to me. If we give people jury instructions that talk about the generalities of the justice system and how they can -- how they deal with general concepts, you know, what's direct and circumstantial evidence? How do you use common sense? You know, how do you consider all the instructions as a whole, how you vote, things like that, how you elect a foreperson, if you need to hear evidence again. General concepts that apply in every kind of criminal trial. And then you give them special instructions that define the law surrounding the type of case that they have.

It is very, very rare that you give an instruction that pertains to particular pieces of evidence. The reason being that you always have an instruction, and we have it here, that says in considering any proposition in the case, you consider all

the evidence that you're given regardless of who produces it, okay? So we don't then go in and give a specific piece of evidence about that bill or that photograph or what have you. Sometimes you may do that because there's a particular tentative law that applies to how they can consider this evidence. For instance, in criminal -- well, it actually applies to civil cases as well. If you're going to introduce evidence of somebody's prior bad acts somehow because that pertains to deciding an issue in the case, then the Supreme Court has said that generally doesn't come in at a trial.

There are only specific ways that a jury should consider that. Not to infer that people are bad people, or that they have a propensity to do back things, but because it pertains to proving a particular item in a particular case. So we want to have a written jury instruction on that. We do not give instructions that say, you know, plaintiff has produced witnesses who say Mr. Orth is going to need two fusion surgeries in the future, and the defense has produced experts to say he's not going to need those surgeries, you can consider all that when you decide what, if any, award to give him.

MR. LAURIA: Of course. I mean --

THE COURT: Well, we don't do that because that's evidence and they know they consider the evidence. You give them instructions like we did here on insurance because generally speaking, insurance is off limits, and they need to know that they cannot give any kind of award with some kind of concern for Dr. Capanna's insurance. They cannot give an award with any kind of concern about Mr. Orth's future insurance. But in this case, they've been given evidence about insurance that's paid for things so far, and what Mr. Orth has paid in terms of procuring that insurance. So that's evidence that's in front of them. It's evidence that they can consider. So it's kind of a redundancy to say, in this case the

defendant introduced evidence of amounts paid by insurance, and plaintiff introduced amounts he paid for that insurance, you can consider that. I mean, if we're going to do that then why is it just about one piece of evidence versus another piece of evidence?

MR. LAURIA: Well, again, I just think it's confusing, Judge, without some instruction when we're saying, you know, you're not to consider insurance for the doctor, which I object to anyway, and you're not to consider whether there's future -- insurance to pay for future medical specials. And so all we're telling them is you can't consider insurance, you can't consider insurance. And then -- well, can they consider this or not? I mean, I --

THE COURT: Well, but you're basically -- and this is kind of at the end of the day what I -- as I was thinking through it decided. This is the kind of micro management instruction that I disagree with. I think people are always so worried that jurors just won't follow the instructions that they want to over instruct juries. And so this was one that basically presupposes -- well, they -- they're not going to read or understand an instruction that says you can't consider future insurance issues with the plaintiff. So because we're worried they won't read or understand that, we need to give them this one. We have to presume that the jury is going to follow the law that I give them, and that they're going to read that instruction and say, we can't consider anything related to whether Mr. Orth will have future insurance. That's the future.

We can consider it, and we were given evidence about the fact that there was insurance that made payments so far. So we can consider that because the judge told us in here, consider all the evidence that we were given no matter who it was that produced it in deciding, you know, what kind of an award to give. And then

we give them instructions on damages that tells them how to go about those things, and the cost of those things, and the methods of calculation are non-specific. And so I just, you know, going back through this I think, no, this isn't an appropriate one. You know, it's just like saying are we going to give them an instruction that says plaintiff introduced a life expectancy table. Defendant introduced experts to talk about factors that pertain to the plaintiff that might lead him to live a shorter life span, so you can consider all that.

Plaintiff introduced photographs and defense had somebody that introduced photographs. You can consider all of that. We can always do those things, but it -- you just have to presume that the jurors are going to do their job and they're going to follow the law that we give them. So I don't think my trouble in formulating this instruction originally gives me any pause to go back and say, oh, the statutes unconstitutional. I still think the statute, regardless of what I think about it personally, meets constitutional unless --

MR. PRINCE: Be bold, Judge, be bold. The citizenry of the State of Nevada --

THE COURT: Look --

MR. PRINCE: -- is counting on you.

THE COURT: Hey, I've been bold plenty of times before, but this one I just -- I still think it's constitutional. I just think in retrospect that this isn't an instruction that you need to try and formulate an instruction on because it's that one off thing where you're trying to talk about a particular piece of evidence, and it's not a piece of evidence that mandates anything under the law. So in any event, I'm not going to give that instruction.

Okay. And you -- plaintiffs didn't have any further instructions, right?

MR. PRINCE: No.

THE COURT: No? Okay.

MR. LAURIA: And Your Honor, the -- one more thing I just want to raise, again, for the record, because I understand the Court's position but I want to make sure that my rights are preserved. Normally in a case -- in a -- for future damages case, especially future medical specials, the instruction would be, and the verdict form would have -- reduce them to a net present value. To reduce them to a net present value though requires me to have some economic testimony --

THE COURT: Right.

MR. LAURIA: -- to show what that net present value was. It is my position, because of the timing of the disclosure of those future damages in this case --

THE COURT: Okay.

MR. LAURIA: -- that I was prevented from essentially having economic testimony to address the issue of the net present value of the case. So I just want to make a record that -- the timing of the disclosure of the future damages has prevented me from being able to present it as a net present value.

THE COURT: Okay. Mr. Prince?

MR. PRINCE: Your Honor, the future damage component was known at a minimum in May. They never asked for any additional relief in terms of hiring an economist to construct -- if that's what their desire was, a future -- you know, a present value. Those -- I mean, I had Dr. Cash testify as to the present value based upon his knowledge of medical costs and you know, now and how they grow. He says he's familiar with that. He does a survey of the various medical costs that we were talking about in the case. So at this point -- I mean, he -- the defense didn't offer that testimony. They had an opportunity to go out and get that had they wanted to, had they really felt they were that prejudiced by it. I think that's just one

additional add-on to this whole delay argument.

MR. LAURIA: Well, Your Honor --

THE COURT: Mr. Lauria?

MR. LAURIA: -- for the record, Dr. Cash did not talk about a net present value.

MR. PRINCE: Yes, he did.

MR. LAURIA: He just said here's what it cost today.

THE COURT: No, I don't think he talked about a net present value.

MR. PRINCE: I asked the question, the current value of those services.

MR. LAURIA: That's not the same as net present --

MR. PRINCE: Present -- the present value. Yeah, so I used those words. I for sure did.

MR. LAURIA: That's not the same as the net present value as we all know because that's based on a discount.

THE COURT: No, I agree that the questions were, what's the current cost of these proceeding things.

MR. LAURIA: And again --

THE COURT: But here's the thing. I know you -- when I made my rulings before trial, asked to stay the proceedings to take a writ because you disagreed with the ruling, but I don't recall there being any, I want to move to continue the trial so I can go hire an economist now --

MR. LAURIA: Well --

THE COURT: -- to address these issues. So I think that's --

MR. LAURIA: -- I did request a continuance to address the Ruggeroli issue, I believe, at the time. So -- and you said we're going forward, Judge, so -- and again, given the timeliness or the untimeliness of the presentation, I don't think it's fair to

place the obligation on the defendant to seek extraordinary relief. So it's for the record. I mean, it's --

THE COURT: Okay.

MR. LAURIA: -- out there.

THE COURT: Well, I just also want my record to be clear --

MR. LAURIA: I understand.

THE COURT: -- in two areas that I don't think you preserved that timely. And even if you preserved it timely as to Ruggeroli, which I'm not necessarily agreeing to, they aren't proceeding with any request for future damages for Ruggeroli. So that one's irrelevant.

MR. LAURIA: Well, okay.

THE COURT: Okay. All right. So let me number off our packet and we'll get you out of here. So page 1 is obviously number 1. Number 2 is going to be if in these instructions. Number 3, the masculine form. Number 4, the purpose of the trial. Number 5, your purpose as jurors. Number 6, you must decide. Number 7, the evidence which you are to consider. Number 8, in determining whether any proposition. Number 9, although you are to consider. Ten, if during this trial. Eleven, you must not -- it doesn't have a line on it.

MR. PRINCE: That's 11?

THE COURT: Yeah. I don't know why that doesn't have that on there. Anyway, I'll put instruction number at the top of that one. That's 11.

Twelve, credibility or believeability; 13, an attorney has a right to interview; 14, discrepancies; 15, a witness who has special knowledge; 16, an expert witness has testified; 17, a hypothetical question; 18, certain testimony has been read; 19, you are not to discuss plaintiff; 20, you are not to discuss defendant;

21, whenever in these instructions I state; 22, the preponderance; 23, the plaintiff seeks to establish; 24, medical negligence means; 25, plaintiff has the burden; 26, illegal cause; 27, you must determine; 28, in performing professional services; 29, it is the duty of a physician; 30, the standard of skill and care; 31, a physician is not necessarily negligent; 32, causation of injury; 33, in this case liability; 34, plaintiff has the right to rely; 35, more than one person; 36, a person who has a condition; 37, the law requires; 38, in determining the amount of losses; 39, damages for pain and suffering; 40, no definite standard; 41, whether any of these elements; 42, according to a table of mortality; 43, the Court has given you instructions; 44, it is your duty; 45, if during your deliberation; 46, when you retire; 47, now you'll listen to the arguments of counsel.

Plaintiff has a copy of those 47?

MR. PRINCE: I do, Judge.

THE COURT: Other than the objections that were raised on Friday or today, do you have any objections to any of those 47?

MR. PRINCE: No.

THE COURT: Do you have any others that you're proposing be given that you would like to have marked as court exhibits --

MR. PRINCE: One moment.

THE COURT: -- because the Court is not going to give them?

[Colloquy between counsel]

MR. PRINCE: No, at this point -- hang on a second.

THE COURT: Okay.

[Colloquy between counsel]

MR. PRINCE: I'm going to -- no, no additional instructions, Your Honor.

THE COURT: Okay. And you've got a copy of the verdict form?

MR. PRINCE: I do.

THE COURT: And you're in agreement with that as well?

MR. PRINCE: I am.

THE COURT: All right. And Mr. Lauria, you all have a copy of the 47?

MR. LAURIA: We do, Your Honor.

THE COURT: And other than the objections raised on Friday or earlier today, do you have any objections to any of the 47?

MR. LAURIA: I do not.

THE COURT: Okay. And do you have some that you want to have marked as court exhibits that are being proposed but not given?

MR. LAURIA: I do. I think that --

THE COURT: Okay.

MR. LAURIA: -- they are the ones that we presented two versions of the 42.021, and the version on not -- punitive damages not permitted.

THE COURT: Okay. Can you give Debbie clean copies of those because mine are all marked up?

MR. LAURIA: Sure.

THE COURT: Okay.

MR. LAURIA: Do you need them right now?

THE COURT: No, you can just bring them tomorrow, that's fine. And then do you have a copy of the verdict form as well?

MR. LAURIA: I'm looking.

THE COURT: It should be on the back of the packet that I gave you guys.

MR. LAURIA: Yes. And my only question, Judge, and I haven't seen it put this

way before, because I don't think we have any issues of related expenses. So the only evidence has been for medical expenses. So I don't know what related expenses means. And there's been no evidence of related expenses.

THE COURT: Well, that's a good question. I don't even think I noticed that actually.

MR. PRINCE: Well --

MR. LAURIA: So I think if it says past medical expenses, future medical expenses, I have no problem.

MR. PRINCE: I think related would be related to health care.

THE COURT: Well --

MR. PRINCE: I mean, there's various --

THE COURT: I tell you what, I'm going to change that because I like to make it, obviously, in line with the instruction that they're given which is the reasonable medical expenses they've incurred.

MR. PRINCE: Okay.

THE COURT: So -- I mean, I'll -- I want to just leave it as past medical expenses --

MR. PRINCE: Okay.

THE COURT: -- and future medical. So I'll -- I have it on my computer. I'll change it.

MR. PRINCE: So you're going to fix it?

THE COURT: Yeah. Other than that, any objections to the verdict form?

MR. LAURIA: No, Your Honor.

THE COURT: Okay. Then that is it. I will see you guys tomorrow 10:00.

MR. PRINCE: Oh, I have a motion.

THE COURT: Oh, I'm sorry.

MR. PRINCE: A 50(a) motion.

THE COURT: Okay.

MR. PRINCE: We're moving for the directed verdict at the conclusion of all of the testimony because, Your Honor, the only competent testimony that Dr. Capanna met the standard of care in this case was offered by Drs. Yoo and Dr. Cash. The only standard of care expert witness that was identified who testified on behalf of the plaintiff was Dr. Belzberg. And Dr. Belzberg barely testified in his -- in the trial testimony and I have the transcript here, that solely looking at the records and the MRI imaging he could not determine that Dr. Capanna met the applicable standard of care in treating Beau Orth.

Moreover, on 68 of his trial transcript he says I'm not the judge, I'm not a jury. I've read Dr. Capanna's deposition as to what he did at the time of the surgery. I listened to Dr. Cash this morning. He has a very different explanation of what happened at the surgery. If you believe what Dr. Capanna said, yes, he was within the standard of care with what he did. And again, a very unusual approach to 5-1, but it wouldn't be outside the standard of care. And no, if I believe Dr. Cash that Dr. Capanna was never at 5-1, and was only at 4-5, I would say that he was outside the standard of care.

And then there was some questions asked about, you know, can a surgeon be at the wrong level and be within the standard of care. And he answered yes, but that wasn't particularized to Dr. Capanna. It was only kind of in a hypothetical sense, and so there was no competent testimony that Dr. Capanna did in fact meet the standard of care.

And under *Morsicato* you have -- have to have to a reasonable degree of

medical probability that a defendant met the standard of care in order to meet the evidentiary requirements for expert witness testimony on the standard of care testimony. And they have to have that in order to defend them self. Just like we have the obligation to the burden to prove it.

THE COURT: So -- I'm sorry. What are you making of the testimony that said if you believe Dr. Capanna's version of what occurred then he did not violate the standard of care?

MR. PRINCE: Correct. Because it doesn't meet the requirements of expert opinion testimony on standard of care. It has to be more probable than not --

THE COURT: Okay.

MR. PRINCE: -- meaning a reasonable degree of medical probability. He's just saying, well, if you believe one version, it's this way. If you believe another version, it's that way.

THE COURT: Right.

MR. PRINCE: That's not an affirmative of an opinion that the doctor met the applicable standard of care. That's just some alternative that's being given. Typically -- I mean you can give alternative causation theories, but you can't give an alternative standard of care opinion.

THE COURT: Right.

MR. PRINCE: And so -- you know, using the Williams example. I mean, you might be able to get away with it in a causation issue on an injury issue, but not as it relates to standard of care. There needed to be affirmative testimony that he met the standard of care. We're already -- he's -- Dr. Belzberg acknowledged wrong level surgery. Dr. Rimoldi today confirmed wrong level surgery. Dr. Yoo confirmed wrong level surgery. Dr. Cash confirmed wrong level surgery. The evidence is

overwhelming that he was at the wrong level and therefore negligent in his care. And that -- kind of this alternative well if you believe this way, you know, Dr. Capanna, he met it. If you believe Cash, he didn't meet it. Kind of throwing your hands up in the air. I don't -- like for example, I don't know what to believe. That's kind of essentially what he's getting down to. That can never be the evidentiary threshold to meet -- you know, to state to a reasonable degree of medical probability under *Morsicato*.

THE COURT: Well, but you acknowledge that, you know, most medical malpractice cases, when they're talking about the standard of care, they're -- the debate is over whether a particular procedure was the right thing to do or not. Whether that met the standard of care as opposed to the allegation here being that the procedure, you know, doing a discectomy was fine. That his conduct in performing the discectomy was fine. It's just that he went to the wrong place, is the allegation, to do the discectomy. So what you're having to decide is did he go there, to the wrong place accidently, or did he go there intending to do what he described that he was intending to do.

That's not anything that Dr. Belzberg could affirmatively say, you have to believe Dr. Capanna, and therefore find that he did not violate the standard of care. I mean, it was -- I was kind of surprised the way he phrased it as well to be quite honest, but I think what he's saying, admittedly, to the jury is, if you believe him when he's describing why he was where he was, then he didn't violate the standard of care.

MR. LAURIA: And that's for reasonable medical probability.

THE COURT: Well, yeah. I mean, all --

MR. LAURIA: Right.

THE COURT: -- of these things --

MR. LAURIA: Right.

THE COURT: -- were to a reasonable degree of medical probability.

MR. PRINCE: Yeah, but I mean that --

THE COURT: I don't have an issue with that.

MR. PRINCE: -- kind of like -- that alternative like well, he -- he's not saying based on the evidence he's reviewed that it's his opinion based upon the state of the evidence that he met the standard of care. He's not saying that. And I'll read the -- read it again. I mean, it's just if you believe -- I'm not the judge and the jury. I've read Dr. Capanna's deposition as to what he did. When I listen to Dr. Cash he has a very different explanation. If you believe what Dr. Capanna said, yes, he was within the standard of care in what he did. If you -- that's not him saying I've objectively reviewed the information. I formulated an opinion based upon an adequate foundation of factual information and therefore competent to give opinion testimony to this jury. It does not meet that requirement.

MR. LAURIA: Can I address --

MR. PRINCE: So there -- well, hold on.

MR. LAURIA: I'm sorry. I thought -- I keep thinking your done, Dennis, because you pause.

THE COURT: It's okay. I think you guys have both done that during the trial.

MR. LAURIA: I think --

THE COURT: Like I said, you're an old married couple. Sometimes --

MR. PRINCE: No.

THE COURT: -- you pause --

MR. PRINCE: No.

THE COURT: -- and the other one --

MR. PRINCE: No.

THE COURT: -- thinks it's time --

MR. PRINCE: No.

THE COURT: -- to start talking.

MR. PRINCE: I'm -- please.

THE COURT: I know, you don't want to be married to each other but you are.

MR. PRINCE: I don't want to be married to him.

MR. LAURIA: Yeah, I'm not --

MR. PRINCE: There's no circumstance --

MR. LAURIA: -- married to you either so there.

MR. PRINCE: -- under which that -- so --

MR. LAURIA: Oh I'm hurt.

MR. PRINCE: -- nevertheless, I don't think that that is a sufficient evidentiary basis to state to a reasonable degree of medical probability that someone met their standard of care consistent with the requirements of *Morsicato*. And the purpose of that has to be some basis of reliability for the testimony and the way you accomplish that in these medical malpractice cases or in medical causation in non-medical malpractice cases, there has to be a sufficient basis to make it trustworthy, to make it reliable testimony. And here you don't have that with him.

And he even went to the next level of saying, just looking at the records I can't say it was looking at that. I -- you know, Dr. Capanna says one thing, and I guess if you believed it, all right, even though it was a non-traditional approach, maybe it was within the standard of care. So I don't think that record is enough for them, and therefore the only evidentiary -- the only evidence in the record would

therefore be our evidence, and therefore it would be required to give us a directed verdict on both the standard of care in injuring the disc as well as causation.

THE COURT: Mr. Lauria?

MR. LAURIA: Judge, it's a hypothetical as you get in every malpractice case. Because -- and a witness will give an opinion that somehow met the standard of care, and they're always relying on some certain aspects of evidence, right? And then you get the hypothetical and say well, if A, B, C, D and E, or if that evidence is incorrect, or if you interpret this film this way, then you agree he didn't meet the standard of care, right? And witnesses always have to go yes, you're right, if facts B, then he didn't. But in my opinion, I'm relying and I'm believing facts A, and then he did. Clearly before this section Dr. Belzberg had testified to his opinion to a reasonable medical probability Dr. Capanna met the standard of care.

When he is given the alternative hypothesis, if you assume X, well, then you know, I'm not the judge or jury that -- that's different. So I think we clearly met that standard. It is up to the jury to decide. You don't decide -- if an expert says just because yes, if you give me that hypothetical or you take that away, now he hasn't met the standard of care, that doesn't take away his testimony about first complying with them. So I think that's what he's saying here. He's saying, I've read Dr. Capanna's testimony. We now have Dr. Capanna's testimony also on the record in this trial, where he describes what he did and how he did it, which is just exactly in conformity with what Dr. Belzberg said he relied upon.

If the jury finds that evidence credible, and we have the testimony of Dr. Belzberg, then to a reasonable medical probability under Dr. Belzberg's standard, he's met the standard of care. He said I'm not going to be the judge or jury of the facts or not, but if the doctor as described what he did, that's appropriate within the

standard of care. So that is not a Rule 50(a) decision this Court can make. I think that's a matter for the judge -- the jury to decide factually, you know, what do they believe occurred? Do they believe he went to the wrong level and did a discectomy at L4-5 or do they believe his testimony that he was at L4-5 for a reason to do something else and inadvertently injured the disc at L4-5.

If they believe that by the testimony of Dr. Belzberg, that is not malpractice. To a reasonable medical probability, that is within the standard of care. So I think you've got that testimony. The questions for the jury to decide, factually, what scenario do they believe occurred?

MR. PRINCE: Well, I'm going to read the question. The question to what -- that answer -- I read you the answer without the question.

THE COURT: Right.

MR. PRINCE: I think I'm almost done. I'm going to try to get you to a reasonable degree of medical probability. Do you agree -- is it your opinion that Dr. Capanna complied with the standard of care of a neurosurgeon in his care of Mr. Orth. In listening, and again I'm not a judge, I'm not a jury, that whole sequence I just read to you --

THE COURT: Right.

MR. PRINCE: -- he's not giving an opinion to a reasonable degree of medical probability. He's saying I don't know. There's two potential scenarios. I'm not giving an opinion. If you believe one way, it's one way. If you believe one -- another way, it's another way. For example, let's assume you're doing a -- an abdominal surgery and you're removing a gallbladder and you injure the bile duct or you injure a ureter. I mean, is it below the standard of care to injure a ureter? No. I mean, I -- or you could say well, you didn't protect the ureter. You didn't identify it, so therefore

you're below the standard of care in not identifying it before you did the surgery, or you didn't take the necessary precautions for it. I mean, so there's usually a foundational basis to give an opinion, not just well, I don't know, sure -- well, I'm not sure what to believe. I don't really believe either so I'm leaving it to the jury to decide. I mean, that's not an adequate foundation for expert testimony --

THE COURT: Well --

MR. PRINCE: -- in a medical malpractice case.

THE COURT: Well, here's what I think. I'm going to deny the motion. I think in any situation a expert coming in to talk about standard of care could phrase an answer the way Dr. Belzberg did because you're -- and often times when you're talking about standard of care, allegations of violations of that, the allegation is the doctor didn't do these certain things during the treatment. And the doctor's saying, no, no, I did A, B. I prepared for the ureter. I identified it. I did these things. And unfortunately it got cut during the process of doing the abdominal surgery, and you know what, I feel bad but that was -- that's an acceptable risk of that. And the retained experts come in and say that is an acceptable risk, so he's within the standard of care.

They could always say, if you believe what he testified to or what he put in his records about how he identified it beforehand, then he's within the standard of care. They could always make that disclaimer. So I don't really think the disclaimer in and of itself says now he's not giving an opinion about that.

MR. PRINCE: Oh, okay, well --

THE COURT: And just like I said, I just -- it was an odd way to word it. I've never heard him say well if you believe the doctor.

MR. PRINCE: Well then let me go to the next question.

THE COURT: Okay.

MR. PRINCE: Right, okay, fine, the disclaimer -- I don't think the disclaimer gets there because under your hypothetical, the doctor was already given an opinion about -- based upon, you know, he adequate protection -- adequate identification of the ureter, did indigo carmine, indigo blue, whatever the case scenario would be, and he protected it, and you know, ureter injuries happen, known risk --

THE COURT: No, no, no, I'm not saying that they -- that in my example the doctor's already identified all those things. I'm just saying if somebody asks that doctor -- the expert doctor on the stand during that trial under the hypothetical scenario I just -- I've just proposed, did Dr. Jones violate the standard of care, they could always -- no matter what the situation is, they could always insert that disclaimer into their answer because part of their answer, obviously, presupposes that the doctor has adequately described what the doctor did during the procedure that's at issue in the trial.

MR. PRINCE: Well, this -- well, we know for a fact that Dr. Belzberg doesn't believe that Dr. Capanna did adequately describe it. We know the operative report is wrong.

THE COURT: I know. I know. I know.

MR. PRINCE: And so the next question was to him, on page 68 of the transcript: In your opinion, can a surgeon be at the wrong level be within the standard of care? Answer, yes. So that's in a hypothetical context, not particularized to Beau Orth's case. So therefore he never corrected the inadequate basis. Anyway, that's my position.

THE COURT: All right. Look, I don't disagree with a lot of what you say about what the other testimony was, but I think that there's enough evidence for the

defendant's to ward off a Rule 50 request and be able to move forward with their defense in the case. So I don't think it's appropriate to enter any directed verdicts on that issue.

MR. LAURIA: Thank you, Your Honor.

THE COURT: All right.

MR. LAURIA: Moving additional evidence in, when do you want us to do that?

THE COURT: What's that?

MR. LAURIA: We need to have some documentary evidence I believe --

MR. PRINCE: Yeah, I need to know what you're doing --

THE COURT: Okay.

MR. PRINCE: -- because I don't know what you're doing.

THE COURT: You're just talking about replacing things that we have and --

MR. LAURIA: No, I think there are some that have marked but haven't been moved into evidence, so I --

THE COURT: Oh, okay.

MR. PRINCE: What is that?

MR. LAURIA: Well, we have the -- we've replaced Exhibit DD.

MR. PRINCE: Well, yeah, you never -- well, I have an issue with DD because --

MR. LAURIA: I took out the language --

MR. CARDINALE: And I gave it to him three days ago.

MR. LAURIA: We gave it to you three days ago.

MR. PRINCE: Understood. But you never established its relevancy. It never hit a witness's hands.

MR. LAURIA: Sure it did. We talked to --

MR. CARDINALE: Kyle.

MR. LAURIA: I'm sorry?

MR. CARDINALE: Kyle Wilson.

MR. PRINCE: Kyle Wilson.

MR. LAURIA: Well, we talked to Kyle Wilson about it. We talked about -- we've talked about his condition prior to seeing Dr. Capanna which included these records. So we've questioned witnesses on his condition as noted in the UNLV records and what it was and what his back pain was. So --

MR. PRINCE: No. Kyle Wilson, the record will be very clear, like I was listening for this, they never showed Mr. Wilson triple D ever.

THE COURT: Is it triple D or DD?

MR. CARDINALE: Double D.

MR. LAURIA: DD.

MR. PRINCE: DD, sorry.

THE COURT: DD. Okay.

MR. PRINCE: They never showed double D to Mr. Wilson, ever.

THE COURT: Okay.

MR. PRINCE: And it had a general description. And so therefore we never established the relevance. No expert they said relied upon those records. Dr. Rimoldi clearly didn't rely upon those records. Dr. Belzberg clearly didn't rely upon those records. So therefore they're not relevant. The testimony's the testimony, what it is, but those records haven't been -- there's no foundation for them, and there's -- they never established relevancy through any witness.

MR. LAURIA: Wait. I thought we weren't raising foundation objections here. So that was --

MR. PRINCE: Fine, that's authenticity. I don't have a problem they're authentic. I agree with that. I mean --

MR. LAURIA: I mean, we have them in the report of Dr. Cash, so they're part of his testimony and his evaluation in this case. So I think -- and at the beginning of the -- this case, Judge, we were -- he said I'll stipulate to move them in if you take out the references to things that aren't in the back. I mean, that was the stipulation on the record. We can go back and read it.

THE COURT: That's what I recall.

MR. LAURIA: Yeah. So --

MR. PRINCE: Okay.

THE COURT: Hold on.

[Colloquy between counsel]

MR. PRINCE: You know what? I think you are right. I -- and I did. I did stipulate if they redacted. That's true. I did it with Paul. So just let us --

THE COURT: I have --

MR. PRINCE: -- let's -- let me just have a look at them one more time to --

THE COURT: -- object to DD, EE through XX, UUU through N, I think. But I think that was -- DD was one of the ones that you said, but it's okay if it's just the back.

MR. PRINCE: Right, with the redacted, yes.

THE COURT: Yeah.

MR. LAURIA: Okay.

THE COURT: All right. So those will be admitted so long as they're redacted or removed things unrelated to the back.

[Defendant's Exhibit DD admitted]

MR. LAURIA: We have the new record --

MR. PRINCE: Well, the problem -- there's other -- well they're not completely redacted --

THE COURT: Okay.

MR. PRINCE: -- because --

THE COURT: Well, I have no idea if they are or not.

MR. PRINCE: I know, they're not, because there's certain like -- for example, on games missed or whatever like, that there's still things about concussion, finger, and a thumb.

MR. LAURIA: We've taken everything, Judge, I believe that doesn't talk about back we've taken out.

MR. PRINCE: Well no, it's not true.

THE COURT: Okay. Well --

MR. LAURIA: Well, you said you haven't looked at it.

THE COURT: Hold on. Hold on.

MR. PRINCE: I have looked at them. Oh, I have looked at them. I'm going to look at it one more time but I know that for a -- that one for a fact.

THE COURT: All right. Look at them again and we'll figure it out in the morning what if any more redactions. So what -- if you think there's other things that need to be redacted, you guys are going to need to be able to point those out to me so we can get it decided tomorrow morning.

MR. PRINCE: Fine.

MR. LAURIA: All right. Thanks, Judge. I'm going to work backwards from this point. We have five T's, TTTTT. We got -- this is -- yeah, crazy. How about numbers next time so --

MR. PRINCE: Well, I don't know why you don't do numbers. Just pick like a number range.

MR. LAURIA: This are the Southern Hills billing records. We needed an order from you to get --

THE COURT: Right.

MR. LAURIA: -- to show the actual amounts that were billed. We have an affidavit from the custodian of records as to the accuracy of the records and the amounts paid and accepted.

MR. PRINCE: Yeah, untimely disclosure.

THE COURT: I don't have TTTTT.

THE CLERK: You don't -- you wouldn't have it. They just gave it today --

THE COURT: Yeah, let me see.

MS. TARMU: Yeah, it needs to be redacted.

MR. PRINCE: Yeah and then the back where there's explanation of benefits. That's on -- this can't obviously be a hospital -- which are in the hospital records.

MR. LAURIA: Judge, I think I've got another copy here. I'll show you what it is.

THE COURT: Nope, they're in here.

MR. LAURIA: Again, this is one of those that I thought, when we were talking about these, we didn't have an objection to the billing records. And so we said -- we advised the Court we're having trouble getting them from this one hospital --

THE COURT: Right.

MR. LAURIA: -- because they're billing people are in Georgia or wherever Gwinnett County is, I guess, in Georgia. So we got the order from you to get the records so we could have the complete information. We now have an affidavit from this gentleman as to exactly what was paid and what was written off and -- so I

thought we had a stipulation on it.

MR. PRINCE: No, we don't. No.

MR. LAURIA: Okay. Well then -- so then I stipulated to admit his billing records on a false pretense because I would never --

MR. PRINCE: Well, I --

MR. LAURIA: Excuse me. I would never have stipulated if he was going to pull this and go I'm not stipulating now.

MR. PRINCE: No, no.

MR. LAURIA: I told him before the trial, I'll stipulate to your bills and you stipulate to mine that show the write offs. That was the agreement we had. So that's the only reason I agreed we didn't have to call all of these custodian of records people in this case. Otherwise if he's not going to stipulate I would have said, call them all Dennis. Bring them all in here and you have them say the bills and I'll tell them what the write offs are.

MR. PRINCE: I stipulated to what they had already produced. So -- and I -- I guess I wasn't clear that it wasn't the -- these bills.

THE COURT: All right. TTT -- let me start over. TTTTT, five T's, so that's going to be admitted.

[Defendant's Exhibit TTTTT admitted]

MR. LAURIA: Thank you, Your Honor.

MR. PRINCE: So what about the explanation of benefits in the back? All right, that's fine, just leave it all.

THE COURT: Well hold on. We can redact that out --

MR. PRINCE: That's -- no, it's okay. I want it in there.

THE COURT: All right.

MR. PRINCE: Leave it in there. It's part of the (indiscernible) so --

THE COURT: Okay. What's the next one?

MR. LAURIA: Next is PPPPP --

MR. PRINCE: What is that?

MR. LAURIA: -- PP.

MR. PRINCE: What is that?

MR. LAURIA: Five P's. It's Dr. Cash's report of 7/28 that you first sent to me -- or seven -- yeah, 7/28 report.

MR. PRINCE: No. Expert reports are inadmissible.

THE COURT: Yeah, generally I don't --

MR. LAURIA: It's not a report, it's a medical visit, Judge. It's not an expert report.

MR. PRINCE: Let me see it. I mean, I want to see the record.

MR. LAURIA: Well, go get it. I'm not your servant.

THE COURT: This is follow up, July 28th, 2015, and I would agree, it appears to be a medical record.

MR. PRINCE: Well, we obviously don't have all of your exhibits because we don't have it.

MR. LAURIA: I gave it to you this morning I believe or whenever we had it marked.

MS. TARMU: Well, we --

MR. PRINCE: Well we have --

MS. TARMU: -- we got one.

MR. PRINCE: -- the binder here -- we have your whole exhibit binders --

MS. TARMU: You only gave me one today. You gave me the five T's.

MR. PRINCE: Can I look at the P -- that one?

MR. CARDINALE: It wasn't today.

MR. LAURIA: It wasn't today. It was several days ago.

MR. CARDINALE: It was last week.

MR. PRINCE: Okay, then I don't have it. If you show it to me I'll -- let me look at it.

MR. LAURIA: I don't have it in front of me.

MR. PRINCE: Where's your exhibits then?

MR. LAURIA: They're probably in these boxes if you want to --

MS. TARMU: We have -- we've never gotten a complete set of exhibits from you guys. I mean, we've emailed --

THE COURT: Well, look, you're not -- you guys aren't disputing that Cash gave --

MR. PRINCE: No, I don't, but there was -- one of his records was obviously incomplete. It was like not even -- like the pain scores weren't completed. He's talking about cervical pain and so he had a revised record. I think --

MS. TARMU: It was July 28th.

MR. PRINCE: -- they're trying -- if it's -- they're both dated the same day. So there was a problem with -- there's a --

THE COURT: You just want to make -- here, come look at this --

MS. TARMU: The weird one was July 28th, 2015, I think.

MR. LAURIA: I agree, Judge, it's -- what is --

MR. PRINCE: Yeah. He's trying to use -- he's trying to -- like for example -- yeah. It's the patient comes in complaining of neck pain on an average pain level of something out of 10. It's like the blank -- something's wrong with the dictation --

MR. LAURIA: Right.

MR. PRINCE: -- and so there's all sorts of issues with it. We have the correct 7/28 --

THE COURT: You're not objecting to the document, just that it's the correct document?

MR. PRINCE: Yes, right, I am objecting to the document because it's incorrect. It's inaccurate.

THE COURT: Well, no. You're not objecting to the July 28th, 2015 actual medical report being introduced, just to make --

MR. PRINCE: Oh.

THE COURT: -- sure it's the correct one.

MR. PRINCE: Yes. I have -- we have that in there, but I object to this one because he wants to try to --

THE COURT: Okay.

MR. PRINCE: -- put a little smear job on -- again, on Dr. Cash, because he's under indictment.

THE COURT: All right. Mr. Lauria?

MR. LAURIA: Your Honor, what it is, it's the report that was served on me -- or the -- I'm sorry, medical record, let's be clear. The medical record that was served on me by counsel after -- again, after -- within the 30 days of trial in this case, showing a visit to Dr. Cash three weeks before he's going to come in and testify. The fact that they're rushing to get a document out or putting it together, and so Dr. Cash has already got his diagnosis before he's got any of his physical findings, is something that can be considered. There's no reason that's not admissible. They produced it.

THE COURT: Well -- yeah. I'm not going to admit this one. This is a template diagram. I mean, it's -- the patient comes in complaining of neck pain. On average the pain level is slash 10, so there's not even the pain level part in there. The worst pain level is blank slash 10. The pain -- period. The pain usually occurs while looking down, slash, looking up, slash, reading, slash, driving, slash, turning, period. Blank helps the pain feel -- it's obvious that nothing's been put in here yet that, you know, all --

MR. LAURIA: But it's already got a diagnosis and a treatment plan.

THE COURT: All medical offices, though, have all these kind of templates and they pump information in and then they print them out. But -- I mean, I'm -- no. I'm not going to admit this one. I mean if there's one that actually is reflective of the visit and has the information in there, then that's fine. I don't -- but I'm not --

MR. LAURIA: But they're offering that --

MR. PRINCE: We do.

MR. LAURIA: -- and I object to that, but that's all right.

THE COURT: All right. Well, I'll admit the corrected July 28th -- the accurate July 28th, 2015 medical record. Whoever has it, whoever's proposing it. But not this one.

THE COURT: All right, what's the next?

MR. LAURIA: We would move in the articles discussed by Dr. Rimoldi. They are Exhibits UUUU.

THE COURT: Okay, we got into the fours now, that's a good sign.

MR. LAURIA: Through four M's.

THE COURT: (Indiscernible) UUU. I go from four N's to five B's. So where are the --

MR. LAURIA: No, I -- sorry. Here's what I'm showing is the list. From UUUU, three U's --

THE COURT: No -- oh, UU -- no, you said four U's.

MR. LAURIA: No, I said three U's to four M's, I think.

THE COURT: So three U's.

MR. LAURIA: It's starts with the medical abstracts.

THE COURT: Okay. Microdiscectomy for the treatment of lumbar disc herniation?

MR. LAURIA: Yes.

THE COURT: Okay. Other than the objections you all raised about timeliness, is there any objection --

MR. LAURIA: Yes, it is. They're not admissible. And rule -- I mean instruction number 16 says that expert's reliance on books, treatises, articles, et cetera, have not been admitted into evidence. So those haven't been admitted into evidence. He didn't move for the admission of those during the testimony of Dr. Rimoldi. They're hearsay. They're not --

MS. TARMU: Form --

MR. PRINCE: -- ever admitted into evidence. You can cross-examine --

MR. LAURIA: That's --

MR. PRINCE: -- based upon then, but they don't come physically into evidence.

MR. LAURIA: You know what, Judge, he's totally wrong because if you read the Nevada statute it's different than the federal statute. He's right under the federal rules. Federal rules, you can read them but they don't come into evidence. Nevada statute is specific and says they're admissible into evidence, they come in.

MS. TARMU: Where? What rule?

MR. LAURIA: Fifty-two -- I can cite it for you. Let me find it.

MS. TARMU: I'm looking at it right here, 51.255.

THE COURT: I'll tell you, I've never admitted them, but I'll look at whatever you're proposing.

MR. LAURIA: I got to find the section now. I just had it last night. 51.255. He's right about the federal rule. They don't get admitted. But in Nevada it says you can. That's one of the distinctions.

MR. PRINCE: No.

MR. LAURIA: Not bad for a California lawyer.

MR. PRINCE: It says to the extent called to the attention of an expert witness upon cross-examination a statement contained in the, you know, periodical, pamphlet, or whatever, it's not inadmissible under the hearsay rule. It doesn't establish that the actual treatise comes into evidence, or the article or book. It's a mechanism by which you can cross examine certain witnesses either during direct and/or cross-examination. And therefore that -- so the evidence comes in in that format, but the articles themselves do not.

MR. LAURIA: That is incorrect. And if you look at --

MR. PRINCE: Rules of jury instruction 16.

MR. LAURIA: If you look at the scholar's articles in Nevada, it clearly states these are admissible.

THE COURT: No, no, no.

MR. LAURIA: They are an exception to the hearsay rule.

THE COURT: I don't disagree with the idea that things -- I think what the statute says is they're not inadmissible under the hearsay rule. So it's not that