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

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

VOL. 4

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DISTRICT COURT

CLARK COUNTY, NEVADA

BEAU R. ORTH,) Case No: A-11-648041-C

Plaintiff,) Dept. No.: III

vs.)

ALBERT H. CAPANNA, M.D.,)

DOES I through X; ROE BUSINESS)

ENTITIES I through X, inclusive,)

)

Defendants.)

______________________________________)

1 DISTRICT COURT
2 CLARK COUNTY, NEVADA
3
4
5 BEAU R. ORTH,) Case No: A-11-648041-C
6 Plaintiff,) Dept. No.: III
7 vs.)
8 ALBERT H. CAPANNA, M.D.,)
9 DOES I through X; ROE BUSINESS)
10 ENTITIES I through X, inclusive,)
11)
12 Defendants.)
13 ______________________________________)
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1 COURT: Jury is present.
2 JUDGE: Thank you. You all can be seated. We
3 will be back on the record. We are going to continue
4 on with our openings statements, moving on to the
5 defense and Mr. Laurie.
6 MR. LAURIE: Thank you. Thanks ladies and
7 gentlemen, I'm going to give you an opening statement
8 which is kind of what I think the evidence is going
9 to show what I believe it will show and a road map to
10 where this case is going. I believe that the road map
11 will lead in a very different direction than some of
12 the clips and bites that you've been shown so far. We
13 will present the entire picture to you. We will
14 present to you the rest of the story as it goes and
15 the bite. But I want to tell you I'm also excited to
16 represent Dr. Capanna in this case. Dr. Capanna
17 didn't start doing neurosurgery two days ago and
18 doesn't know how to get to a level and just figured
19 out where the lamina was. Dr. Capanna went to medical
20 school at the University of Texas, graduated in 1970
21 and then went to Wayne State University spent four
22 years studying medicine to receive a medical degree.
23 After that he did five years of residency in the
24 specialty of neurosurgery trained to do procedures
25 like this. After he completed that residency he

1 didn't need to have any more training. He could have
2 gone anywhere in the US and practiced as a
3 neurosurgeon. But Dr. Capanna wanted some more
4 training and some more experience and there were
5 certain areas that interested him, so he went to some
6 places outside the country. He was a Fellow at the
7 University of Zurich in Switzerland, and he studied
8 there under a Dr. Yasario who was the neurosurgeon of
9 the millennium and is incredibly well-known in
10 neurosurgery. He's in his 80s or 90s but still
11 affiliated with the University of Arkansas. He moved
12 after that. But Dr. Yasario was one of the pioneers
13 of developing microdiscectomy, and Dr. Capanna
14 trained under him during that time when he went to
15 Zurich and that became an area of his interest. One
16 of the things that Dr. Capanna did in regard to that
17 was actually do a study on performing microdiscectomy
18 in rect. As a new technique is coming on or you're
19 learning something in medical community you start by
20 doing it on animals, not on people. Dr. Capanna has a
21 study that was published in the medical literature
22 for other neurosurgeons, or spine surgeons to look at
23 on doing microdiscectomy very early on. Dr. Capanna
24 also went to the University of Paris and studied
25 additionally there on stereotactic surgery, a

1 different method of surgery and did an additional
2 fellowship at the hospital for sick children in
3 Canada. So even after he had completed four years of
4 medical school, five years of training as a
5 neurosurgeon, he went and spent additional time. He
6 didn't need to do a fellowship, because he had an
7 interest in those areas of medicine including
8 microdiscectomy. He's been practicing in this area
9 since the early to mid 90s practicing neurosurgery
10 for over 30 years. He has been a team physician for
11 the UNLV athletic department helping to take care of
12 athletes there in all sports for 25 years or so,
13 since the late 1990s. I want to tell you about some
14 of the other people that will be here and you will
15 hear testimony from in this case. They include Dr.
16 Mark Kay. Now, Dr. Mark Kay is a radiologist from
17 Florida, radiologist specialized in reading the MRIs
18 or the films that you were shown little bits of here.
19 I want to talk a little bit about MRI because an MRI
20 it's not like a plain X-ray. Even with a plain X-ray
21 you take one image and it's a stock film and that's
22 it, that's all you see. So if you took an X-ray of me
23 standing right here, you'd get that picture of me of
24 my bones. With an MRI if anybody has ever had one,
25 you go in and you're in the tube and it takes kind of

1 a continuous picture. So you can look from slice to
2 slice all the way across. The view that you're going
3 to get and what you're going to see depends on which
4 little slice you take, and it depends on how far,
5 sometimes you're five millimeters, sometimes not so
6 far, but the view you're going to see on an MRI is
7 going to depend on which slice you're going to look
8 at. So you can look at one area and it may appear a
9 certain way if you just take a little slice of it.
10 But if you look at the whole picture, if you look at
11 the slices next to it, and the slices next to those,
12 you may see a very different picture. You can also
13 change the, you can change the coloration with the
14 brightness of an MRI. So if you see a film that shows
15 a very dark disc, versus a film in comparison that
16 shows a very white disc, it doesn't necessarily mean
17 there's a change in the disc. You can just change the
18 brightness on the film. Dr. Kay will testify that he
19 has reviewed the MRI of October 6th 2010 after Dr.
20 Capanna's surgery, and he will tell you that yeah he
21 sees evidence of surgery in the L4-5 area. Nobody
22 denies that. Dr. Capanna has never denied that he did
23 some surgery in the area of L4-5. He did not do an
24 L4-5 discectomy. He did not go to the wrong level and
25 take out the wrong disc. He went to the level above

1 L5-S1 because of where this particular fragment or
2 protrusion was in the disc, and he felt that a better
3 way to get to it would be to remove a little lamina
4 there to allow him access to get to it. So there has
5 never been a dispute that he was in that area. Now,
6 Dr. Kay will say yeah there is evidence of surgery or
7 disruption of tissue at L4-5 and there is also
8 evidence of a change at that disc at L5-S1. The
9 evidence will show that there were three MRIs that
10 were done before Dr. Capanna's surgery, and in all
11 three of them the radiologist mentions this five
12 millimeter disc that's protruding and affecting the
13 nerve. On the MRI that was ordered after surgery,
14 we'll show you the report; the doctor doesn't mention
15 this protrusion on the S1 nervure at the L5-S1. What
16 he describes as changes at L4-5 and he says at L5-S1
17 it's a bulging disc. That's a very different
18 phenomena. A bulging disc is kind of like if you take
19 a water balloon and you push it down, it spreads out
20 around as opposed to protrusion if you had that same
21 balloon but poked it out in one particular spot. So
22 Dr. Crow, no affiliation with the case, who read that
23 forth MRI after Dr. Capanna's surgery, doesn't make
24 any mention of the thing that every other radiologist
25 before that has pointed out. Dr. Kay will say look if

1 you look at these views you can see evidence of a
2 surgical tract going to the L5-S1 area, and you can
3 see where there has been a change in the disc at L5-
4 S1. Dr. Capanna will tell you that he was at L5-S1
5 and he wrote it in his report and he said "I went to
6 the area of the disc and I could see where the disc
7 was impinging upon the nerve." Now, everybody agrees
8 there was no disc impinging on a nerve at L4-5 when
9 Dr. Capanna went to surgery. It wasn't there. So if
10 there was a disc impinging on a nerve, the only place
11 that could be was at L5-S1. Dr. Capanna will explain
12 to you what he did that he saw it, that he relieved
13 it. The radiology report confirms it. Dr. Kay will
14 confirm it. There are some other findings that will
15 confirm it that we'll explain to you. Mr. Prince has
16 talked about these deep tendon reflexes in the
17 dermatome. Remember the pictures with the lines that
18 go through? One of things that measures the function
19 of a nerve are the deep tendon reflexes, and so
20 doctors test those to see is a nerve affected, is it
21 impacted, has it changed. Before surgery Dr. Capanna
22 noted that the deep tendon reflexes...in fact Dr.
23 Rigarolli noted too that the deep tendon reflexes on
24 the left side of Mr. Orth in the area of his ankle
25 were abnormal. They were decreased. They weren't what

1 you would expect. After surgery when Dr. Capanna
2 tested it before there was any claims that he did
3 something wrong or a problem, Dr. Capanna noted deep
4 tendon reflexes are now symmetrical, they are equal,
5 they are both on the same sides. So there is more
6 than just a picture saying it was there. We had
7 actual changes in the function of the nerve. We also
8 know that not only Dr. Capanna in his records and
9 what he documented showed that for a period of seven,
10 ten, twelve days after the procedure Mr. Orth was
11 doing pretty well. He was doing fine. He wasn't
12 having leg pain. He wasn't having significant pain.
13 He wasn't having these neurologic symptoms that he'd
14 have the whole time that lead him there in the first
15 place. Those weren't present. In fact, even Dr. Cash
16 noted in his report when he first saw him he had done
17 well for a period of time after surgery. So something
18 resolved those symptoms, and we'll suggest to you and
19 the evidence will show it's because Dr. Capanna did
20 believe the protruding disc at L5-S1...Now, Dr.
21 Capanna...and again you've gotten bits and
22 pieces...will tell you and explain what this
23 testimony meant, so if you take a quote out of
24 context or take a bitten piece, it is what it is. But
25 Dr. Capanna will explain to you that yes I was up in

1 that area to take a little bit of bone off because of
2 where this disc was in my 30 years experience in
3 doing neurosurgery I felt this may give me a
4 reasonable access to get to this disc easier without
5 taking out more bone, because Dr. Capanna's
6 philosophy is do as much little damage as you can
7 removing bone in other structures. So he wanted to
8 minimalize the surgery. Dr. Capanna also said, will
9 tell you "I don't know exactly what caused the L4-5
10 creation later. Is it possible that when I was up
11 there doing that that an instrument injured or
12 touched or affected the L4-5." Yeah it's possible.
13 But you'll also hear from the experts that that's not
14 malpractice. That one of the risks that's discussed
15 in every surgery is that there's a risk that other
16 adjacent structures being injured. You're working in
17 a very tight space with very small clearances and one
18 of the risks of the procedure that nobody ever wants
19 to happen which is disclosed and discussed is the
20 inadvertent injury to the adjacent structure. So you
21 will hear that evidence and after hearing the
22 evidence you folks will decides whether if that
23 happened, if there was an inadvertent injury to L4-5
24 as a, which is a known risk and complication of the
25 procedure, is that malpractice, or is that part of

1 the risk of doing neurosurgery.
2 Now, I want to go back for a minute and I want
3 to talk a little bit about Mr. Orth because I think
4 there's been a partial picture given there too. Mr.
5 Orth was born on November 2nd, 1989. Do I have that
6 right Mr. Orth? Thank you. And he began having
7 problems with his lower back on August 25th,
8 2008...according to the records of the UNLV athletic
9 department, August 5th, 2008...And we'll have those
10 records, you'll have a chance to look at them. That
11 was on his third day of practice when he started at
12 UNLV, his back pain started. It went on about a week
13 but he is 18 years old at that time and he is having
14 problems with his back. October 18th, 2008 to October
15 23rd, to 2008 he was reporting pain in his lower back
16 during that time, since he was in practice and got
17 hit. So reporting pain again in October 2008...I'm
18 going to turn this so I don't have to walk back and
19 forth if that's okay. Seems to do okay for a while, a
20 couple of months later January 20th, 2009, increased
21 low back pain with weight lifting. This time it
22 doesn't go away within a couple of days as or within
23 a week or so as the others did. Now, since it doesn't
24 go away, since at that time he's having this pain and
25 numbness the doctors decide maybe we should get an

1 MRI and we should look at your back and make sure we
2 find out what's going on there, so they send both for
3 his first MRI and that is February 3rd ,2009. From
4 the very start that MRI describes what it calls a
5 very small, very small five millimeter protrusion or
6 herniation that's impinging on the left S1 nervure.
7 The evidence will show that it was displacing the
8 root at that time. Now, what's interesting about that
9 is there has been presented to you that Dr. Cash will
10 talk about how big the herniation was at L4-5. Dr.
11 Cash will show you and tell you that there was a very
12 large piece of disc or disc fragment at L4-5 when he
13 saw the patient in October of 2010. This very small
14 five millimeter is the language that the radiologist
15 who read the report used, 'very small'. Mr. Prince
16 put up some testimony by Dr. Capanna where he agreed
17 it was very small. And yet the disc that Dr. Cash or
18 the fragment Dr. Cash referred would say is very
19 large or very, very larger is actually foreknown. Now
20 let me just say some things about Dr. Cash. Dr. Cash
21 has been hired as an expert by Mr. Prince's firm in
22 the past. In this case Dr. Cash saw Mr. Orth up until
23 March of 2014 and then didn't see Mr. Orth again
24 until just a week or so before the trial, kind of
25 went in there. So he didn't see him for a year and a

1 half before this trial except that visit just a week
2 before. Dr. Cash last saw him in March of 2014, but
3 in April of 2015 was paid 10,000 dollars to prepare a
4 summary, a report of Mr. Orth's past medical records
5 that he has never seen before...10,000 dollars to
6 prepare a report. Then on May 15th for the first time
7 he prepares a report that said Mr. Orth is going to
8 need surgery at two levels of the spine and another
9 surgery in the future. First time, Dr. Cash writes
10 that down on a piece of paper anywhere is in May of
11 this year, three months before this trial. You'll
12 have his records, we'll show you his records. Going
13 back to 2010, and there's not a spot in there where
14 he says it's my prognosis that Mr. Orth is going to
15 need surgery on his spine. There is, at the time he
16 now provides this report in May of 2015, three months
17 before trial for the first time, he hadn't seen the
18 patient in 14 months. He hadn't evaluated him, didn't
19 know how he was doing. There was no change in the
20 information he had. In any event folks, you will hear
21 from Dr. Cash, and you will hear from Dr. Belsberg
22 who is a neurosurgeon at John Hopkins University and
23 teaches people how to do neurosurgery in John Hopkins
24 University in addition to practicing himself. Dr.
25 Belsberg will tell you that performing this surgery

1 as Dr. Capanna describes and going up to a level to
2 try and gain access is reasonable and not a violation
3 of the state of the care and that it's always a risk,
4 and a known complication that another structure can
5 get injured even when you do everything
6 appropriately. Dr. Kay will show you that there are
7 in fact indications on the MRI of surgery being done
8 at L5-S1, and he will point them out to you and show
9 it to you.
10 Back to Mr. Orth though, In 2/25/2009, so now
11 weeks later he still has pain, numbness and tingling
12 down his legs. Pain goes basically all the way
13 through March of 2009 and then gets better. He seems
14 to do pretty well for a while and then back in
15 October, 13th of 2009 we have another onset of pain,
16 and problems and numbness with his leg. The notes
17 from that visit that we'll show you show he had a
18 history of tingling in his left buttock from August 8
19 through March 2009, that his pain had been pretty
20 good since the end of March of 2009, but one week ago
21 it had come on again in that numbness and tingling.
22 The problem with a herniation or protrusion like that
23 on the nerve root is it can as you extend it or as
24 you stretch or as you do more to it, it cannot be
25 painful at a time and then ultimately it comes out

1 enough or protrudes enough or gets in a position
2 where it's just constantly painful and it's not going
3 away. March 23rd, 2010 he is seen by Dr. Ruggeroli.
4 Now, Dr. Ruggeroli is a pain management specialist.
5 He does some injections to try and relieve those pain
6 without surgery, and let's see how...show you how Dr.
7 Ruggeroli describes what went on with Mr. Orth. Can
8 you folks see that? Better? Interval history notable
9 of lumbar and calf pain since his freshman year. He's
10 modified his lists most of the pain consists during
11 drills lateral planting to the left, continued to
12 work with the trainers, lumbar spine, pain, numbness,
13 pins, needles, stabbing are the current pain. His leg
14 pain with pins, needles, numbness with a current rate
15 of 4. Spine is seven. Evidence will show that
16 sometimes doctors, and probably you have done it,
17 rate your level of pain from zero being no pain to
18 ten being the worst pain that you can imagine. This
19 is how Mr. Orth is rating his pain back when Dr.
20 Ruggeroli sees him on 2/23/2010. It is not just he
21 had pain occasionally. Its' not just had oh I had an
22 incident of pain and it went away. He's now
23 describing that at worst the pain, it's excruciating,
24 it's ten out of a zero to ten scale. Its lowest is
25 four out of ten. On average it's five out of ten. At

1 the current time it's six out of ten. At that point
2 they decide they need to do something to try and take
3 care of this level of pain. Dr. Ruggeroli does an
4 epidural steroid injection. So what he does is he
5 goes to the area where it appears that nerve root is
6 inflamed, where the problem is coming from where the
7 pain generation is and he actually injects into that
8 a steroid and then some anesthetic to try and kill
9 that pain. The steroid hopefully remove any
10 inflammation that's causing the swelling or causing
11 the pain to go on, and then some anesthetic to try
12 and provide pain relief. Dr. Ruggeroli does that, and
13 fortunately that is fairly successful for a while,
14 for a brief period of time. The notes by UNLV note
15 that by March 4th of 2010 the pain feels like it did
16 before the injection. So there was some very brief
17 and temporary relief but not a lot. He follows up
18 with Dr. Ruggeroli on March 9th and says I'm having
19 less pain but the pain is not gone. It's all because
20 we know he's got a disc that is not healthy. You will
21 hear that it is not normal, it is not customary, it
22 is not usual for someone who is 18 years old, that's
23 the time that the lower back pain started, and is 19
24 years old at the time of the MRI to have a disc
25 protrusion that's impinging upon a nerve root. That

1 is not the usual case for a 18 or 19 year old young
2 man. The other thing we will see is that the
3 treatment occurs often times during football season
4 because that's when we have notes from the people
5 that are taking care of him at the UNLV athletic
6 department, the trainers that are working there. He
7 practices in the spring, he'll work out in the
8 spring, and then there's football season when it
9 starts in the fall and you'll find and you'll see
10 that that's when the complaints are really heightened
11 when he's involved in doing the activities that he
12 wants to do. I understand, a young person wanting to
13 play a sport, loving a sport, anybody who's ever been
14 in sport and loved it can relate to that. But he's
15 got a small disc herniation and it's causing him pain
16 that sometimes is ten on ten long before he ever saw
17 Dr. Capanna. It had been going on at this point for
18 quite a while from 08' to 2010. Now, before a little
19 bit, August of 2010, he's again complaining of pain,
20 and tingling and numbness by August, that's again
21 when he's back to try and play football. That's back
22 when you're working out, he's doing the drills, and
23 he's getting ready for the season. I don't know the
24 exact date that you even called back for football
25 into practice, but probably around that time, and we

1 can find that out. So at that point they again send
2 him to Dr. Ruggeroli, and Dr. Ruggeroli sees him on
3 August 11th, 2010, and let's see what Dr. Ruggeroli
4 had to say on that visit...Interval history notable
5 for recent last few days of typical pain return. That
6 was described last time it was paining five, six out
7 of ten. Involving the left glute worst pain,
8 buttocks, radiation into the posterior thigh and
9 calf. Now, Mr. Prince made a big indication that
10 somehow the posterior thigh and calf pain showed,
11 that was the proof that showed that Dr. Capanna had
12 done surgery at L4-5, because remember on the
13 dermatome the only time it went to the posterior
14 outside the leg was when it came from L4-5. And yet,
15 before Dr. Capanna even touched this patient Dr.
16 Ruggeroli is noting radiation in the posterior thigh
17 and calf where the lower extremity has significant
18 numbness to it. Doing well since injection in
19 February, tolerating spring training, until recently.
20 I want to talk about his pain, that it wasn't just
21 there was a pain after a particular practice then
22 everything was fine. Dr. Ruggeroli asked him what's
23 your average pain since the last visit. The last
24 visit was back in February. Average pain since the
25 last visit is eight, according to the records of Dr.

1 Ruggeroli. One of the things that Dr. Ruggeroli notes
2 in August of 2011 is that left S1 diminished
3 sensation and he describes the deep tendon reflexes.
4 The evidence as I said will show that both Dr.
5 Ruggeroli as he noted there, and Dr. Capanna measured
6 the deep tendon reflexes that are related to the S1
7 dermatome Beau Orth before Dr. Capanna did surgery.
8 Dr. Ruggeroli notes they are decreased. When we show
9 you Dr. Capanna's records preoperatively, he notes it
10 its decreased also. And yet, when Dr. Capanna
11 evaluates him after surgery he notes that now they're
12 symmetrical, now they're normal. Sensation is sharp;
13 he is describing those dermatomes intact. Just one
14 little more note I want to show you from Dr.
15 Ruggeroli. Even at that time without the argument
16 that now the bones have degenerated because of
17 something Dr. Capanna did, range of motion is normal
18 but it causes him pain even back in 2010 he is having
19 pain increase. So the plan is to do another one of
20 the treatments he did before treating this known disc
21 protrusion at L5-S1. He's been trying the same thing,
22 do the epidural steroid injection and hope that it
23 works for Mr. Orth, but it doesn't. It doesn't help
24 him. He doesn't get any relief, and it's at that
25 point he has referred to Dr. Capanna.

1 Now, Dr. Capanna saw Mr. Orth on September 1st,
2 2010. He evaluated him and looked at the CT scans
3 that were done before. He considered what the options
4 were. Initially he was told that no blocks had been
5 done, but before surgery he was told that Dr.
6 Ruggeroli had done those, but it didn't really help
7 him pretty much. Dr. Capanna was in no rush to get
8 Mr. Orth into surgery. He saw him on September 1st
9 and the first thing he did is said okay you've had an
10 MRI in 2009. I think there was another MRI that was
11 done that showed essentially the same thing. And he
12 said I want to get an MRI that's more recent, because
13 the last one was six or seven or eight months old.
14 Can you get another MRI, I want to get one a little
15 bit different. I want to get one with you standing
16 instead of laying down on the table, because if I do
17 it standing with a little bit of flexion and
18 extension I could actually see if that little
19 fragment on that disc moves as you move. So I want to
20 get a different kind of a more specialized study so
21 we can make a decision here as to what's the best
22 course to treatment. He also says I want to confirm
23 before I go into a surgery on spine that in fact your
24 problems are coming from this disc at L5-S1 in the S1
25 nerve root. So he sends him for an EMG and nerve

1 conduction study to a neurologist. What they actually
2 do is they actually run current through the nerves
3 and see if the nerve...and measure the function of
4 the nerve. They can actually measure whether it's
5 functioning appropriately or not. That confirmed that
6 there's this small five millimeter protrusion was
7 impinging on that S1 nerve root that S1 nerve root
8 wasn't functioning appropriately and that was likely
9 the cause of his pain. Likely, because you can't be
10 sure exactly what it is in any of these
11 circumstances. Dr. Capanna wanted the EMG again to
12 try and confirm. And then he met with Mr. Orth and he
13 met with Mr. Orth's dad and they talked about what
14 were some of the options here. One of the options,
15 and it's got a typo in his records, so he never wrote
16 them. But it says he can continue to play and it says
17 but will probably not get worse. What he meant to
18 write was that if he continues to play without doing
19 anything about it, this is probably just going to get
20 worse and worse which makes sense. He also said look
21 another option is that we can go in and do a
22 different type of procedure, a different type of
23 discectomy where basically we just go in and we put a
24 needle in and just suck out a little bit of that
25 jelly, so we even lessen the incision we don't have

1 to go in and remove that piece off the disc. You just
2 suck out some of the filling so to speak, and then
3 maybe the bubble will protract itself. So if you take
4 a little water out of the balloon and you pull it
5 back in you can understand that the balloon or the
6 part that's sticking out is going to shrink. We'll
7 explain what that is, but because the study on Mr.
8 Orth did not show that the disc sticking out changed
9 with movement, he thought well even if we remove some
10 of the interior of the disc that it's unlikely that
11 that part that's pressing on the nerve sticking is
12 going to come back in. So he discussed with him that
13 what he thought was the best procedure was a
14 microdiscectomy and that that was likely to provide
15 the most successful result. It's been said that Dr.
16 Capanna said that this was simple, easy, that Mr.
17 Orth would be playing within a few weeks, but if we
18 look at the note, and you'll see the note in the
19 records of Dr. Capanna, he actually discusses that he
20 hopes it's going to be successful, that's right, he
21 wouldn't do it if he didn't think it was going to
22 improve this. But he actually says we discussed
23 redshirting...Now, we're in October of 2010...Excuse
24 me, September of 2010, football season has just
25 started. If he is discussing redshirting, he's

1 already talking about taking the whole rest of the
2 year off right. You've got several months left of
3 football season, so the discussion with Dr.
4 Capanna...Let me just make a couple of notes. So we
5 have Dr. Capanna sees on 9/1/10 for the first time
6 has this discussion on 9/15 or he discusses these
7 options with the patient, the recommendations for
8 surgery, and in that note he mentions...Look,
9 redshirt! The reason is because no surgeon can
10 guarantee, Dr. Capanna couldn't guarantee that he
11 would recover if at all. He hoped he would. He
12 thought it was likely he would, he probably would.
13 Couldn't guarantee that he would recover or when he
14 would recover. No one could. Dr. Cash I assume will
15 even tell you that, because that's undeniable. In
16 addition, there was discussion of the potential risks
17 and complications and things that can happen at
18 surgery. Dr. Capanna explained to Mr. Orth and to his
19 father that there are risks of this procedure as with
20 any other surgical procedure, that structures can be
21 injured, that you could have infection, hemorrhage,
22 bleeding, paralysis, other neurologic problems that
23 can be temporary or permanent, he could even die from
24 this simple, easy, no problem you're back playing in
25 two week procedure. Dr. Capanna will tell you look I

1 will never tell a patient they could be back playing
2 contact football in two weeks. What I might say is we
3 can get you back into starting to therapy so you're
4 working toward that goal within a couple of weeks.
5 It's reasonable for you to start...Maybe you can do
6 some light lifting of weights within a couple of
7 weeks. Just let that tissue heal, you can start
8 running or sprinting, but not full contact pad work
9 in a couple of weeks. But Dr. Capanna and Mr. Orth
10 and his father both signed this. They also noted that
11 any course of the operation unforeseen circumstances
12 might arise, making necessary to extend the operation
13 beyond the originally planned operation. In the
14 operation, attempts to relieve my problem new
15 complications may arise which may be worse than the
16 original problem. It may not be relieved...The
17 original problem may not be relieved and also may get
18 worse. There's absolutely no guarantee of the
19 surgery. Dr. Capanna in describing, in discussing
20 these things with the patient and obtaining his
21 consent made it clear to Mr. Orth and his parents
22 that look I can't guarantee how this is going to turn
23 out for him. I'll try my best, I think it's going to
24 be good, most of these work out really well, but
25 risks and things can happen. The argument will be

1 that he didn't have any consent to do anything at any
2 other area, and his consent was L5-S1. But it says
3 look it might make it necessary for me to go operate
4 or extend the operation to do what I'm trying to
5 accomplish here. Dr. Capanna went to a level above,
6 took off a little piece of bone to see if he could
7 reach the disc because he thought that would be the
8 best way to complete the operation. It turned out
9 that didn't work out too well. It's possible that
10 that L4-5 disc got injured during that, but that
11 doesn't mean he's negligent. It's a risk of the
12 procedure that a known complication can and does
13 occur. The evidence will show again that Dr. Capanna
14 performed the surgery, used fluoroscopy
15 appropriately. He will explain to you how it was
16 used. The actual fluoroscopy report only shows a
17 small number of seconds. That's because if you take a
18 film and you stop it, you don't want an X-ray running
19 for a super long period of time. So every time you
20 take a film you may get the view you wanted to take a
21 film. It takes only a fraction of a second to take
22 any particular film. So Dr. Capanna will explain to
23 you what he did, what he saw, why he did what he did,
24 why he believes it was reasonable, why he is as
25 disappointed as Mr. Orth that there was a

1 complication or a problem that occurred, but why he
2 doesn't believe that it was malpractice. Dr. Capanna
3 will explain that to you. He'll explain to you why he
4 believes he was at L5-S1, because he observed this
5 disc compressing the nerve. He describes it in his
6 operative report. He will explain to you why post
7 operatively the finding of the deep tendon reflexes
8 being back to normal now confirm what he sought. We
9 don't deny that Dr. Rimoldi says I don't see the
10 changes at L5-S1 surgically. It looks to me like it
11 was down at L4-5 based on the information he had. Dr.
12 Capanna is not trying to deny responsibility here.
13 Dr. Capanna has said all along when asked, no I was
14 up at the L4-5 level. He's not trying to hide
15 anything. He's not trying to pretend he wasn't there.
16 He says I was there but I don't believe it was
17 negligent, and I don't believe it was malpractice.
18 So the surgery started on September 17th, 2010.
19 September 28th UNLV notes he's back to class. He's
20 got some pain, stiffness when lying down. Another
21 note from UNLV notes at that time he was doing well.
22 Dr. Capanna sees him on September 29th, the next day,
23 he's better but he's got some back spasm, muscle
24 spasms if he lays down, but this pain and numbness in
25 the legs that he had preoperatively is gone. He's got

1 a little change but he’s definitely doing better. Dr.
2 Capanna measures the deep tendon reflexes on that day
3 and now they’re symmetrical...they’re equal, which
4 means they’re symmetrical. What Dr. Rimoldi described
5 previously as the ankle deep tendon reflex being
6 diminished is now back to normal. He’s seen from
7 October 1st to October 5th at UNLV they note some
8 muscle spasms and stiffness, some lower back pain,
9 but none of the numbness and the tingling that was
10 radiating down the leg that brought him to Dr.
11 Capanna and to Dr. Ruggeroli in the first place. Now,
12 there is an MRI when Mr. Orth calls on the night of
13 October 5th and there is an MRI done on October 6th
14 2010 in which Dr. Crow, the radiologist says I see
15 evidence of laminectomy at L4 and surgery at L4-5
16 level, and doesn’t describe anything at L5-S1. Dr.
17 Capanna disagrees somewhat with that interpretation.
18 That’s not unusual. Doctors disagree as they review
19 these films all the time. The radiologist said
20 there’s a non enhancing fragment and some scar
21 tissue, maybe disc, not certain but maybe disc. Dr.
22 Capanna said I reviewed the films, I’m not sure I
23 agree. I think this may be just some swelling going
24 on, some reaction may be the muscles that were re-
25 approximating or healing got torn, so why don’t we

1 just treat this conservatively, why don't we treat
2 this with some steroids or some anti inflammatory and
3 see if we can get that to heal without having to go
4 back in and do surgery. That was Dr. Capanna's
5 thought and opinion. Dr. Capanna didn't hide
6 anything. He told him what the radiologist said it
7 showed, but also said I'm not sure I concur. I think
8 we have to try to treat this conservatively. Dr.
9 Capanna never got the chance to try and treat this
10 conservatively; to see if that would have helped or
11 made the problem better, too see if steroids would
12 have improved him, because the patient left his cure
13 and went to Dr. Cash. So that was the last time when
14 the patient was seen. The plan was to treat him
15 conservatively, do some steroids, get the swelling
16 down, let's see if we really need to go into doing
17 surgery or not. The patient then went to Dr. Cash who
18 evaluated him, and Dr. Cash decided to take him to
19 surgery fairly quickly. Dr. Cash didn't do another
20 study, didn't pour a reflection, or MRI. He didn't
21 order an EMG or nerve conduction study to confirm
22 that in fact there was nerve dysfunction going on. He
23 took him to surgery, and interestingly before the
24 operation, we'll show you Dr. Cash's records and
25 we'll ask him about it, he doesn't make any mention

1 of seeing this protrusion at L5-S1. Dr. Cash's
2 records talk about what again has been described as
3 this very large fragment at L4-5 which is actually
4 smaller and what's described as a small fragment at
5 L5-S1. Dr. Cash doesn't mention seeing anything
6 abnormal at L5-S1 until his operative report is
7 dictated. His records don't mention it all. Nor, does
8 Dr. Crow mention that the L5-S1 protrusion on the
9 nerve root is still there.
10 Now, Dr. Cash I think some part of the records
11 that he also believed that he would get a good result
12 in Mr. Orth, because there was nothing that Dr.
13 Capanna did even if the L4-5 area had herniated. That
14 didn't mean that all of a sudden this was a disaster,
15 you're not going to get a good result with that. Dr.
16 Cash noted "Yeah I think we should get a good result
17 out of this. It shouldn't be too much of a problem."
18 Dr. Rimoldi who is an orthopedic spine surgeon who
19 does the same things that Dr. Cash and Dr. Capanna
20 do, although neurosurgeons do some different things,
21 but an orthopedic spine surgeon does exactly what Dr.
22 Cash does, has been doing it quite a bit longer will
23 tell you yeah okay you're right you had to do surgery
24 at another level if there's a disc fragment there.
25 But that doesn't really change much. That wouldn't

1 make it go from oh my god I was going to be fine and
2 playing in two weeks to I can never run or play
3 again. That's not how it works. If you have a disc
4 herniation at one level and you treat, and you have a
5 disc herniation at the other level and treat, it
6 doesn't significantly change what the outcome is
7 going to be. They do two level microdiscectomy as
8 part of their practice all the time, and it doesn't
9 really change how people do. Dr. Cash notes post
10 operatively after his surgery on October...Well, let
11 me go back. Dr. Cash does surgery October 22nd, 2010.
12 He describes finding some scar tissue in the area L4-
13 5. No questions. He agrees he was there. He says at
14 L5-S1 he describes a discectomy, but he doesn't
15 actually describe seeing the disc at L5-S1 impinging
16 on the nerve root. If you compare the operative
17 reports Dr. Capanna specifically says look I went in
18 there and I saw the S1 nerve root, and I saw the disc
19 compressing it. I removed that piece of disc and the
20 nerve was now free. Dr. Cash's report at L5-S1
21 doesn't describe seeing that same protrusion
22 compressing the nerve root at that level. It's not
23 reported. So is his operative report incomplete if
24 it's missing that information or is it something he
25 didn't see at the time?

1 Mr. Orth as expected after...by 11/3/2010 Dr.
2 Cash follows him up. Surgery is 10/22. So 11 days
3 later Dr. Cash notes he's only got mild pain. He is
4 not having to take any kind of pain medications.
5 Doing better. He was doing well after surgery as it
6 was predicted. He said he's doing better but he's not
7 completely relieved of the pain, and he says post
8 laminectomy syndrome is his diagnosis. Post
9 laminectomy syndrome, you will hear from the experts
10 it just means that the surgery didn't relieve
11 everything we hoped it would relieve, there's still
12 some problems or issues going on. There is still some
13 compression of nerves.
14 By December 9th, 2010, Mr. Orth starts physical
15 therapy. As he goes through physical therapy he had
16 some problems. He states his pain level was one to
17 two out of ten. Incision hurts but he's still got
18 some of the numbness and tingling in the left lower
19 extremities. He's still got some symptoms that are
20 related to a nerve compression. Although Dr. Cash has
21 said look I've treated both, I've relived both
22 nerves, but there is still some numbness and tingling
23 on the left side. Numbness and tingling is associated
24 again with that protrusion, with that disc piece
25 pushing on that nerve or in conjunction or being next

1 to that nerve. We know that later on down the road
2 that L5-S1 area had re-herniated, that protrusion had
3 recurred. We don't know whether it was this early or
4 later on, but we know that that happened. If you
5 listen to Dr. Cash and if you listen to the experts
6 on their side, if L5-S1 has re-herniated or re-
7 protruded for a better word. The only person who ever
8 touched L5-S1 under their theory is Dr. Cash.
9 According to their theory Dr. Capanna was never at
10 L5-S1. But Dr. Capanna couldn't have done something
11 that resulted in the re-herniation or the re-
12 protrusion of that disc. The statement was made that
13 the post later MRIs from 2013 and 2014 show that this
14 L4-5 disc is so bad, it's so bad now, and that L5-S1
15 is kind of okay. But I'll show you in a second, I
16 think the reports by the radiologists who reviewed
17 those films say exactly the opposite. They say we
18 don't' see any neurologic impingement at L4-5. We see
19 some disc height change. But at L5-S1 there is
20 protrusion causing nerve root.
21 Mr. Orth goes through physical therapy, by April
22 19th, 2011 he sees Dr. Cash. His pain is low; it's at
23 two to three out of ten. He has a dull pain in his
24 back. He has still got some of this numbness and
25 tingling in his buttock which is the S1 nerve root

1 that Dr. Cash had said he had dealt with, some pins
2 and needles impinging on the foot. He tells him to
3 return in three months, that's in April 2011. Mr.
4 Orth doesn't feel the need to return in three months.
5 He doesn't come back. Next note we have is September
6 15th, 2011. So from March of 2011 to November of 2011
7 there's no need to return. It's noted at that point
8 that he's doing really well. It's been almost a year
9 since he's required treatment. So September 15th,
10 2011 he's doing well. No treatment for a year. A year
11 later August 28th, 2012, he goes back to Dr. Cash and
12 he says look I've got pain that's a one to two level
13 that mild pain in my back morning and night, low
14 grade back ache but I've still got some numbness down
15 my leg. In the interim evidence will show that Mr.
16 Orth has been able to do a fair amount of things. The
17 evidence will show that Mr. Orth was not
18 significantly restricted in his activities. Although
19 I'm sure things caused him pain. I'm sure you know if
20 you did something too strenuous that was painful. But
21 he was snowboarding, he was playing flag football
22 with his friends, he was doing a lot of activities
23 that requires some things. In fact when I took his
24 deposition just in April of this year, I asked him
25 how are you doing. He said "You know, I've got some

1 pain but I do what I got to do, I go to the gym, I
2 work out four days a week and I've gone snowboarding
3 a few times. I'm able to do that. I've played some
4 flag football with my friends. Yeah I go golf, but if
5 I golf I kind of pay for it, my back hurts
6 afterwards. I don't like to take pain medications so
7 I don't take pain medications regularly." That was
8 his, what he told us his condition was in just a few
9 months ago. I don't know what Dr. Cash's record now
10 from just a couple of weeks before this trial will
11 say but from what I heard Mr. Prince say that we'll
12 now say his pain is six out of ten and he can't
13 function and he can't do any of the things that he'd
14 said he would do. So we have...He returns...I'm going
15 to go through this really quick folks, I just want
16 some of these time lines so we understand what's
17 happening. So he comes back, he returns and he has
18 got pain but it's the numbness so they get another
19 MRI at that point. That MRI shows a small left disc
20 protrusion at L5-S1 with a radial tear. That's at the
21 level we're recording now that Dr. Cash had done
22 surgery. There's a diffused bulge at L4-5 but no
23 compromise of the neurologic elements. It's not
24 pressing on the nerve root. It's not showing that
25 it's impinging anything, so it would cause indicative

1 symptoms.
2 Dr. Cash notes on 9/4/12 okay there's a small
3 disc bulge at L5-S1 with an annual tear. There's some
4 dehydration above the disc, follow up as needed. What
5 that means is I don't think your symptoms or your
6 problems require any real further intervention at
7 this time. We don't need to do surgery on you
8 certainly now, we don't need to send you to pain
9 management, I'm not going to prescribe you any pain
10 medication. I'll look, come back as you need to. If
11 something is really bad, come back and see me, and
12 we'll take care of it, we'll deal with it, we'll
13 treat you. He didn't return for 15 months. For 15
14 months from September of 2012 until March of 2013 Mr.
15 Orth didn't need any care for his back, wasn't seeing
16 any doctors, wasn't receiving any pain medications,
17 wasn't requiring any kind of treatment. Fifteen
18 months later he comes back to Dr. Cash in March of
19 2014, Dr. Cash doesn't say at that point I think you
20 need surgery, he says go see Dr. Ruggeroli again, Dr.
21 Ruggeroli does the epidural spine injection, doesn't
22 really do anything, does a different type of
23 treatment and ablation and then after the ablation
24 Mr. Orth never came back to him, that's in May of
25 2014.

1 We asked Mr. Orth in his deposition how did you
2 respond to the treatment by Dr. Ruggeroli, because
3 there is a mention or a claim that Mr. Orth would
4 require future pain management treatment going on for
5 the rest of his life that Mr. Orth has decided not to
6 do that. When we asked Mr. Orth did that help you at
7 all...He said well, "Maybe it helped a little bit,
8 but not really, didn't really do much for me. And yet
9 at the request of Mr. Prince, Dr. Ruggeroli wrote a
10 letter for this lawsuit that says Mr. Orth will need
11 20 years of those very treatments that Mr. Orth said
12 will not help at a cost of 160 to 320 thousand
13 dollars. He was asked to do that by Mr. Prince's
14 office even though after he gave that treatment, he
15 doesn't know how the patient did, Mr. Orth never came
16 back to him for treatment.
17 Now, when he came back in March of 2014 he said
18 that his pain...he'd been doing really well and that
19 three days ago he had an onset pain, didn't know why,
20 didn't know what had happened, he'd been doing fine
21 but now his pain was at six to eight out of ten,
22 although he had been doing pretty well for 15 months.
23 The last treatment that Mr. Orth has received or
24 anything having to do with his back or spine was on
25 May 14th, 2015. He said I don't take narcotic

1 medications. I haven't been to the doctor except a
2 week or so ago, hasn't had to go get any treatment of
3 any kind, hasn't had any physical therapy. The last
4 treatment he has received was...I'm sorry May 14th,
5 2014. You will hear from Dr. Yu who they've indicated
6 is a neurosurgeon from San Diego. Dr. Yu was hired by
7 the Prince firm in 2011 to testify as an expert in
8 this case. Dr. Yu initially issued a report in
9 September of 2011 and Dr. Yu was then re-disclosed as
10 an expert in 2014. The first time that Dr. Yu ever
11 made any mention that Mr. Orth would need some type
12 of future care or treatment or surgery was when I
13 went down to take his deposition and asked him
14 questions about this case. He was hired or wrote his
15 first report in September of 2011. No mention that
16 because of this terrible surgery, because he had had
17 to have this other level done, because now it's a two
18 level discectomy, we could just anticipate that he's
19 going to need all these future surgeries and he's
20 going to need all these future treatment and it's
21 going to be awful. Dr. You didn't say that. September
22 7th, 2011 nobody said that. On May 26th, 2015 when I
23 went down to ask Dr. Yu what's he going to say in
24 this case, what are his opinions, for the first time
25 Dr. Yu hands me a report saying look I've got a new

1 report, now I think he's going to need future
2 surgery. The testimony and the evidence will show Dr.
3 Yu didn't have any additional information that he
4 didn't have on September 11th of 2011. We know what
5 his additional information was because he wrote it on
6 the report itself. He said I relied on these items
7 which are all the things that he had before and then
8 the deposition of Dr. Capanna and the deposition of
9 Mr. Orth. And yet now he says now there is future
10 surgery. We'll go into it while I talk to Dr. Yu
11 about that and we'll go into it with Dr. Cash as to
12 why that was not noted earlier. But I asked Dr. Yu
13 about, "Doctor what percentage of patients who
14 undergo microdiscectomy, undergo the procedure that
15 Mr. Orth underwent, what percentage of those patients
16 at one or two levels actually go on to require a
17 fusion? I mean, how does that happen right? Because
18 we are trying to predict how people are in the
19 future. We are trying to make predictions in this
20 case for Mr. Orth 10 or 20 or 30 years down the road
21 if he's going to need surgery. I said, and I asked
22 Dr. Cash, I said Dr. Cash, the only way that you can
23 have a valid scientific opinion about what that's
24 going to be, what the future is going to hold, is to
25 look at how other patients who have had these types

1 of treatments or surgeries have done." Right? So you
2 look at some hundreds of patients who have had
3 microdiscectomy and you follow them or you get into
4 contact with them, ten or fifteen years you go...okay
5 let's look at this, this group we've got young
6 patients, this group we've got old patients, this
7 group we've got patients who got two levels, this
8 group is older, and you look what percentage of those
9 patients have actually required some additional
10 surgery like a fusion. Those studies are done in
11 universities and hospitals throughout the world
12 because they want to know, that's information that
13 neurosurgeons and spine surgeons rely on, that's
14 where they get the information. They can't do studies
15 in their own office. Dr. Yu and Dr. Cash haven't been
16 practicing long enough to do that. I think that they
17 are practicing since 2004 for one and 2005 to the
18 other, so they can't have any personal knowledge as
19 to what's going to happen in 10 or 15 years. The way
20 they get that knowledge is they read the studies that
21 are done at places like John Hopkins. We are going to
22 hear Dr. Belsberg talk about it. So they study those
23 patients populations different hospitals throughout
24 the world and they say let's look what percentage of
25 these patients in 10 or 15 years are going to need

1 surgery. The reality and you will hear testimony from
2 Dr. Rimoldi who has reviewed those will probably show
3 you some of the studies themselves, and even Dr. Yu
4 admits that while the consensus according to Dr. Yu
5 the consensus is about 20, only about 25 percent of
6 people who undergo microdiscectomy are going to
7 require a fusion and he said well it may be different
8 for Beau because he is young. I said well doctor you
9 know some of the studies include people that are
10 young right. They include people that are teenagers,
11 and he goes "Yeah that's true, it doesn't change the
12 consensus that its 25 percent. They haven't found
13 that it changed that." He said well you know he had
14 disc problems to start with. I said well "Dr. Yu
15 doesn't everybody who has spine surgery have disc
16 problems to start with? Isn't why they're have a
17 spine surgery?" He said yeah, but it's a part of the
18 picture, part of the whole picture here. I said what
19 are the factors, do you have to say that he is
20 outside of the norm of the consensus here. And he
21 said well he's at two level. I said doctor you'd
22 agree with me that some of the studies that reach
23 this consensus, a consensus of people who do spine
24 surgery... If you go to a meeting or a conference of
25 spine surgeons the consensus is about 25 percent of

1 people and I said you would agree that those same
2 studies include people who have had two level
3 microdiscectomy. “Well, yeah.” I said can you
4 identify any study anywhere that shows that anything
5 about Mr. Orth case changes what everybody else has
6 found throughout the world in doing these studies. He
7 said no I can’t name any off hand. He was asked that
8 question at his deposition on May 26th, 2015 and to
9 date we haven’t seen any study, no one has produced
10 one, no one has identified a study that takes him out
11 of that consensus position. You will hear from Dr.
12 Belsberg neurosurgeon, you will hear from Dr. Rimoldi
13 that will say Mr. Orth had two level microdiscectomy
14 that is true and he didn’t recover as well as
15 everybody hoped he would but it is not more likely
16 than not that he is going to need a fusion and is
17 certainly not more likely than not that he’s going to
18 need two fusions down the road. That’s not supported
19 by what we know in medicine, that’s not supported by
20 the studies that are done in medicine including some
21 of Dr. Belsberg’s own university John Hopkins. And
22 then we have Dr. Cash, and Dr. Cash’s opinion is
23 really interesting because I asked Dr. Cash about the
24 need for future surgery...in fact it’s written in his
25 report and we will show you the language. I’ll ask

1 him about it because I did ask him about at his
2 deposition. I said "Dr. Cash you tell all of your
3 patients, all your patients that if Beau came to you,
4 instead of going to Dr. Capanna for the first time,
5 you tell all your patients that you are doing a
6 microdiscectomy on, that they are probably more
7 likely than not they are going to need a fusion in 10
8 to 15 years. He said "Yup. I tell all of them. I tell
9 my patients that more probably than not everyone is
10 going to need a fusion in 10 to 15 years." So I said
11 "Well doctor are you telling me that in your opinion
12 that even if nothing had happened in L4-5, if
13 everything had been done just at L5-S1, if L4-5 had
14 never had a fragment, if L5-S1 was perfectly cured,
15 that it's your opinion that Mr. Orth still would have
16 required a fusion surgery?" Dr. Cash said yes it's my
17 opinion to a reasonable medical probability that even
18 if Dr. Capanna had done everything absolutely
19 appropriately, or the best surgeon in the world had
20 done everything appropriately Mr. Orth was still
21 going to require a future surgery. Dr. Cash also said
22 and even if this surgery had been done absolutely
23 perfectly he probably would have needed one fusion in
24 10 to 15 years and then the second fusion at the
25 adjacent level in 17 years. I don't know how he comes

1 up with 17 years specifically, but in 17 years at the
2 adjacent level. So according to Dr. Cash, they were
3 experts own testimony, their treating doctor's own
4 testimony in his opinion whether Dr. Capanna did
5 everything absolutely right or not doesn't make any
6 difference in the fact that Mr. Orth is going to
7 require fusion surgery in 10 to 15 years. He was
8 going to need it even if the surgery went perfectly.
9 Dr. Cash will say there are some differences because
10 I'd be doing two levels now so the charges might be a
11 little different because I have to do two levels, but
12 basically the same procedure, same physical therapy
13 time, same anesthesia, all of those kind of things.
14 Now, I believe the evidence will show that it
15 really isn't unlikely that Mr. Orth...It's not
16 reasonable, is not probable, that Mr. Orth is going
17 to need surgery in 5, 10, 15 years. I think the
18 evidence will show that it's unlikely and it's not
19 reasonable that he is going to need another fusion
20 surgery in 17 years but if you believe that he will
21 from Dr. Cash's testimony because that's the
22 one...He'll tell you that then you also have to
23 believe that he was going to need those two fusions
24 regardless of what Dr. Capanna did even if he did
25 everything perfectly, and would the need of a fusion

1 in ten years affect the ability to play in the NFL or
2 play football or do whatever the claim is here.
3 I am almost done so just let me get into my
4 notes. Dr. Cash as part of that hiring him and paying
5 him the $10,000 dollars to do this record review in
6 April of this year, Dr. Cash then set out and listed
7 these costs or went to the past medical cost or past
8 medical treatment of hundred something thousand
9 dollars which Mr. Prince put up there. The evidence
10 in this case will show that Mr. Orth hasn't paid a
11 penny of that, doesn't have to pay a penny of that,
12 will never have to pay a penny of that, that all of
13 that was paid by his health insurer. Anything that
14 was over charged they just wrote off and forgave and
15 if there was any co-pay or anything UNLV picked it.
16 So of a hundred and...
17 MR. LAURIE: Can we pause for a minute?
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DISTRICT COURT

CLARK COUNTY, NEVADA

BEAU R. ORTH,

Plaintiff,

vs.

ALBERT H. CAPANNA, M.D.; DOES I through X; ROE BUSINESS ENTITIES I through X, inclusive,

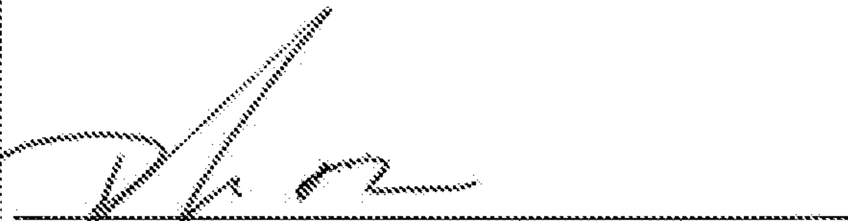
Defendants.

CASE NO. : A-11-648041-C
DEPT. NO. : III

ORDER REGARDING PLAINTIFF'S MOTION TO STRIKE UNTIMELY DISCLOSURES ON ORDER SHORTENING TIME

This matter having come on for hearing on the 14th day of August, 2015; Dennis M. Prince, Esq., and Danielle Tarmu, Esq. of Eglet Prince appearing on behalf of Plaintiff, Beau Orth; and Anthony D. Lauria, Esq. and Paul A. Cardinale, Esq. of Laura Tokunaga Gates & Linn, LLP, appearing on behalf of Defendant Albert H. Capanna, M.D. The Court, having read the moving papers and heard oral argument by counsel, and hereby **DENIES** Plaintiff's

1 Motion to Strike Untimely Disclosures on Order Shortening Time and Defendant's Counter-
2 Motion to Exclude Improper "Supplemental" Disclosures and Claims for Future Damages.
3 Dated this 20 day of August, 2015.
4
5

6 **DISTRICT COURT JUDGE**
7
8 DATED this 20th day of August, 2015.
9 Respectfully Submitted By:
10 **EGLET PRINCE**
11

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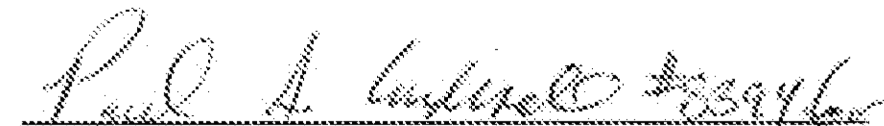
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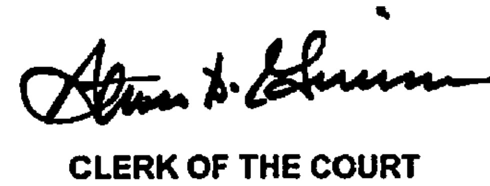

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DISTRICT COURT

CLARK COUNTY, NEVADA

BEAU R. ORTH, Plaintiff, vs. ALBERT H. CAPANNA, M.D.; DOES I through X; ROE BUSINESS ENTITIES I through X, inclusive, Defendants.	CASE NO. : A-11-648041-C DEPT. NO. : III **ORDER REGARDING PLAINTIFF'S MOTION TO DECLARE NRS 42.021 AND NRS 41A.035 UNCONSTITUTIONAL**

This matter having come on for hearing on the 14th day of August, 2015; Dennis M. Prince, Esq., and Danielle Tarmu, Esq. of Eglet Prince appearing on behalf of Plaintiff, Beau Orth; and Anthony D. Lauria, Esq. and Paul A. Cardinale, Esq. of Laura Tokunaga Gates & Linn, LLP, appearing on behalf of Defendant Albert H. Capanna, M.D. The Court, having read the moving papers and heard oral argument by counsel, and hereby **DENIES** Plaintiff's

1 Motion to Declare NRS 42.021 and NRS 41A.035 Unconstitutional. The statutes pass
2 constitutional scrutiny under rational basis test.
3 Dated this 20 day of August, 2015.
4
5
6
DISTRICT COURT JUDGE
7
8 DATED this 27 day of August, 2015.
9 Respectfully Submitted By:
10 **EGLET PRINCE**
11
12
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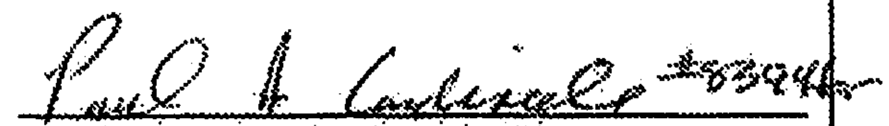
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TRAN

DISTRICT COURT

CLARK COUNTY, NEVADA

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

BEFORE THE HONORABLE DOUGLAS W. HERNDON,
DISTRICT COURT JUDGE

MONDAY, AUGUST 24, 2015

TRANSCRIPT OF PROCEEDINGS

JURY TRIAL - TESTIMONY OF DR. ALLAN BELZBERG

APPEARANCES:

For the Plaintiff: DENNIS M. PRINCE, ESQ.
TRACY A. EGLET, ESQ.

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

RECORDED BY: SARA RICHARDSON, COURT RECORDER

GAL FRIDAY REPORTING & TRANSCRIPTION
10180 W. Altadena Drive, Casa Grande, AZ 85194 (623) 293-0249

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1 Monday, August 24, 2015 at 1:08 p.m.
2
3 [Inside the presence of the jury]
4 THE COURT: And Mr. Lauria, you are going to call?
5 MR. LAURIA: Your Honor, I'm going to call Dr. Allan Belzberg.
6 THE COURT: Okay. Dr. Belzberg, if you could come on up here, sir.
7 Actually before I take this, are you guys going to use the exhibit book
8 with him as well?
9 MR. LAURIA: We probably will.
10 THE COURT: Okay. I'm going to leave that for you.
11 MR. LAURIA: We also need defendant's book that has -- thank you.
12 THE COURT: Feel free to set that wherever you want for right now.
13 THE WITNESS: That's fine.
14 [Colloquy between counsel and the Clerk]
15 THE COURT: Okay. And Doctor, if you just raise your right hand please, sir.
16 ALLAN BELZBERG
17 [having been called as a witness and being first duly sworn, testified as follows:]
18 THE CLERK: You may be seated. Will you please --
19 MR. LAURIA: May I approach?
20 THE COURT: You may, yeah.
21 THE CLERK: Will you please state and spell your name for the record?
22 THE WITNESS: Allan Joel Belzberg.
23 MR. LAURIA: Thank you.
24 THE COURT: Okay, Mr. Lauria.
25 MR. LAURIA: Thank you.

1 DIRECT EXAMINATION OF ALLAN BELZBERG

2 BY MR. LAURIA:

3 Q Dr. Belzberg, I'm going to give you what's been marked as Defendant's

4 Exhibit NN, and can you identify for this -- for us what that is?

5 A This is a copy of my curriculum vitae.

6 Q Curriculum vitae being a professional resume of your training,

7 background, accomplishments during the course of your career in neurosurgery?

8 A Yes.

9 Q Where do you practice as a neurosurgeon, Doctor?

10 A I'm at Johns Hopkins Hospital in Baltimore.

11 Q How long have you been practicing at Johns Hopkins in Baltimore?

12 A Approximately 25 years.

13 Q Can you give the -- well strike that. Currently you are a professor of

14 medicine at Johns Hopkins?

15 A Currently -- no, currently I am a associate professor of neurosurgery at

16 Johns Hopkins School of Medicine and at Johns Hopkins Hospital I'm the George

17 Heuer Professorship in neurosurgery at Johns Hopkins Hospital.

18 Q And what does that mean the George Heuer Professorship? Are you

19 the --

20 A You hold a chair. It's a position.

21 Q You're the head of the department of neurosurgery or?

22 A Henry Brem is the head.

23 Q Okay.

24 A This is a -- it's called a professorship or chair so you have a

25 professorship at the hospital.

1 Q Is your 25 years with Johns Hopkins University, have you been
2 teaching people about spine surgery, brain surgery and surgery related to nerves?
3 A Yes.
4 Q All right. Have you been teaching people that are fellows trying to learn
5 neurosurgery both in -- both orthopedists and neurosurgeons?
6 A Yes, we have fellows who rotate with us who are doing a spine
7 fellowship in neurosurgery. We also have fellows in the orthopedic department who
8 will come and do a spine fellowship, but they'll spend time with me as well.
9 Q Can you expand a little bit, Doctor? I know you don't like to overboard,
10 but can you tell the jury a little bit about you and your training and experience and
11 what you do at Johns Hopkins?
12 A Okay. So my current duties shall we say, I spend approximately 70 to
13 80 percent of my time in clinical practice performing neurosurgery. The bulk of my
14 practice is in what's called spine and peripheral nerve. So I do very little brain
15 surgery now; I've really concentrated on spine and peripheral nerve. And then about
16 20 to 30 percent of my time is actively doing research, and that includes both basic
17 science research as well as clinical research.
18 Part of my duties are teaching so I have 21 neurosurgery residents at
19 any one time who we are training. We have an additional three spine fellows who
20 we are training at any one time. And then I travel fairly extensively giving lectures,
21 visiting professorships and so on.
22 Q So let me just break that down for a minute. You have in your
23 department 21 residents in neurosurgery who are attempting to learn how to
24 become neurosurgeons, right?
25 A They spend seven years -- I think you heard some of that grueling part

1 about the five years for orthopedics. Neurosurgery is a seven-year program so they
2 spend seven years training in neurosurgery, and then they may or may not do extra
3 training afterwards.
4 Q So you have 21 of those people in your program.
5 A Yes.
6 Q And you also have you said I think three neurosurgery fellows?
7 A We have three fellows who are training specifically in spine who have
8 completed their neurosurgery training as residents and they come to us for extra
9 training later in spine.
10 Q And then you have you said two orthopedists who've done the
11 residency in orthopedic surgery but want to learn about spine and rotate through
12 your program?
13 A Yes.
14 Q And you actually teach people -- like Dr. Cash described going through
15 these programs, you teach people how to do this. You've been doing that for how
16 long?
17 A Well, so I've been doing this for 25 years at Johns Hopkins as a faculty
18 member.
19 Q All right. Have you personally yourself treated pro athletes?
20 A Yes.
21 Q Just once? Is it a one-time exam or how does that work?
22 A I routinely get referred patients who are professional athletes.
23 Q Have -- do you treat Supreme Court Justices of the United States when
24 they have a problem that is within your purview?
25 A I have operated on a Supreme Court Justice of the United States.

1 Q All right. Do you operate -- do people come from parts of the U.S. or
2 around the world to have you be the neurosurgeon who takes care of them?
3 A I have patients both national and international that come to Johns
4 Hopkins for me to look after them.
5 Q All right. Specifically for you?
6 A Yes.
7 Q Do you have people that want to be in your fellowship program to train
8 under you as a neurosurgeon that you just don't have room to take?
9 A Yes.
10 Q Frequently?
11 A Yes.
12 Q All right. Are you the director of any clinics or programs that are
13 research based in Johns Hopkins or affiliated with Johns Hopkins dealing with
14 issues related to this case such as pain or -- and spine? Or peripheral nerves?
15 A So the department of neurosurgery at Johns Hopkins has a separate
16 but part of institute called the Neurosurgery Pain Research Institute. That institute is
17 dedicated to doing research on decreasing -- understanding, decreasing and
18 managing pain as it relates to neurosurgical issues. Certainly spine pain would be
19 about the most predominant thing we have to deal with. That institute I'm the
20 co-director of. Two of us direct the institute. We've raised in private donations $75
21 million to fund that institute.
22 Q So there is an institute dealing specifically with pain and to study pain
23 and its treatment at Johns Hopkins and you're the co-director of that?
24 A Yes.
25 Q And you have raised $75 million in contributions from people to have

1 you and the people that are working under you and the other co-director study and
2 learn about how to treat -- take care of pain including spine pain like we're talking
3 about here?
4 A Yes.
5 Q Have you received any research grants from other places to study
6 things such -- related to spine or treatment of spine and spine pain?
7 A I have an active laboratory. We have number of grants that we work on
8 related to pain related to spine. One issue we're dealing with right now is certain
9 tumors that affect the spine. We do active research trying to understand why it
10 causes pain and how to decrease the pain associated with the spine from the tumor.
11 Q We've called you and counsel was nice enough to let me call you out of
12 order today because you actually have to catch a flight -- the last flight that will get
13 you back in time is at 4:50 back to Baltimore to Johns Hopkins University?
14 A Yes.
15 Q All right. And you have a surgery tomorrow you just told me a little bit
16 about. What are you having to do tomorrow?
17 A We have a young man from Central America who was operated on in
18 Central America once for a tumor and unfortunately they were unable to get the
19 tumor out. He has a very extensive tumor that involves the abdomen, the chest and
20 the spine, and we've put together a team of a cardiac surgeon, abdominal surgeon,
21 thoracic surgeon and myself, the neurosurgeon. I head the team and we're doing
22 this operation tomorrow.
23 Q All right. So you have three surgeons in addition to yourself that are
24 planning this surgery tomorrow. You have to be back.
25 A Yes.

1 Q All right. When you are training fellows in neurosurgery at Johns
2 Hopkins, are they the ones that primarily do the surgical procedure or does
3 someone else primarily do the surgical procedure?
4 A So during your training you're going to progress through your training
5 through your seven years in terms of responsibility at the time of surgery. You'll be
6 given more responsibility obviously as you get more mature and skillful in your set.
7 Basically the what we call the critical portions of any case is always performed by
8 the attending surgeon, someone such as myself, but how much you will perform of
9 the surgery outside of the critical portion will depend on your level of training and
10 basically how good you really are.
11 Q All right. So whenever someone is in a fellowship or a residency, if they
12 do any surgery, it is under the direct observation and direction typically of the
13 attending?
14 A It is under the supervision of an attending, yes.
15 Q Okay. And so the -- and the critical or central or core part of it is
16 typically has to be done by the attending; is that true?
17 A Yes.
18 Q All right. Is Johns Hopkins, I guess, for lack of a better term, a tertiary
19 referral system; that is, hospitals all around the East Coast area will refer the difficult
20 cases, the troubling cases that people in a community can't handle?
21 A So tertiary hospital has certain definitions. Johns --
22 Q Maybe I used the wrong term but --
23 A Johns Hopkins certainly gets referrals I wouldn't say from the East
24 Coast. We get referrals -- I personally get referrals including from Los Angeles. I've
25 had patients from Las Vegas. We get patients from all parts of the United States

1 and certainly from different parts of the world.

2 Q All right. Typically though, if there are difficult cases that the average

3 person out in practice is not kind of trained or equipped to handle, like this

4 gentleman coming from South America, they end up at a center like Johns Hopkins

5 or Stanford or --

6 A Yes.

7 Q -- a location similar to that, true?

8 A Yes.

9 Q All right. And that's the kind of cases that you see or deal with?

10 A Yes.

11 Q And you also deal with patients who have a disc herniation or a problem

12 like Mr. Orth?

13 A Yes. Every so often it's very nice to have a very straightforward case

14 rather than --

15 Q All right.

16 A -- have to do something very complicated.

17 Q How many -- Doctor, are you able to give me an estimate as to how

18 many, for example, pro athletes you've operated on in your career?

19 A I don't know. I don't really track it.

20 Q Okay. You heard Dr. Cash talk a lot about Dr. Watkins, right, and talk

21 about that program?

22 A Yes.

23 Q All right. Not to toot your own horn, but are you the Dr. Watkins kind of

24 person that somebody would study under, do their fellowship under to learn -- to

25 train how to do what you do?

1 A Yes.

2 Q All right. Have you published in the medical -- peer-reviewed medical
3 literature articles for other people doing spine work about how to do it, about
4 findings, those types of things?

5 A Yes.

6 Q Approximately how many articles have you published for other
7 physicians to learn and read about spine or peripheral nerves?

8 A I have over a hundred peer-reviewed publications in the topics of spine
9 and peripheral nerve.

10 Q All right. Over a hundred?

11 A Yes.

12 Q So when you say peer reviewed, that means that the study gets done,
13 you gather the data, right?

14 A Yes.

15 Q And then you put the data together and in an article format?

16 A Yes.

17 Q And the article includes what's called an abstract which is a -- kind of a
18 summary of what the article's findings are?

19 A Yes.

20 Q And all of that then goes to an editorial board at a particular journal or
21 peer-reviewed medical journal that physicians in that field then read, right?

22 A Would review. Yes.

23 Q And that editorial board then looks at the study, looks at the scientific
24 basis for the study, looks at the underlying information whether it's statistically
25 correct and determines whether this is an appropriate study to be published. Is that

1 an accurate kind of summation?

2 A It's a reasonable summation, yes.

3 Q All right. In fact you do that, Doctor, you review those types of articles

4 to determine whether they have valid scientific basis for publication, don't you?

5 A I regularly review publications, yes.

6 Q For -- okay.

7 A From number of journals.

8 Q And so you've got over a hundred of them in your 25 years that have

9 actually been published in peer review journals such as *Spine*?

10 A Yes.

11 Q And that is one of the highest rated journals on back surgery, the issues

12 we're talking about here?

13 A Yes.

14 Q All right. And there are others in your department of neurosurgery that

15 are also publishing articles. I think we looked or talked about one on specific issues

16 related to things in this case like microdiscectomy and how patient outcomes are,

17 those types of things?

18 A Our spine group of which I'm a member has probably over a thousand

19 peer review publications.

20 Q All right. Does your CV as Exhibit N (sic) accurately reflect your

21 training, qualifications, publications that -- in the field of neurosurgery?

22 A So I'm looking at the date and it says September 2014. So other than

23 being a year out of date where there'd be a number of more publications in it,

24 research articles, it's up -- it would be a accurate reflection.

25 Q Okay.

1 MR. LAURIA: I would move to admit Exhibit NN.

2 THE COURT: Any --

3 MR. PRINCE: I do, Your Honor. I think it's typically not admitted. He's

4 already outlined his qualifications and credentialing.

5 THE COURT: Well --

6 MR. PRINCE: It's typically a hearsay document.

7 THE COURT: -- I'll allow it to be admitted.

8 [Defendant's Exhibit NN admitted]

9 MR. LAURIA: Thank --

10 THE COURT: You said it was NN?

11 MR. LAURIA: NN.

12 THE COURT: Thank you.

13 MR. LAURIA: Double N.

14 THE COURT: Okay.

15 MR. LAURIA: Thank you.

16 BY MR. LAURIA:

17 Q Doctor, just again quickly, you -- I think you told me that you are going

18 to speak or do presentations to other physicians on issues of your knowledge in the

19 U.S. and throughout the world and you've got them planned in the next year or so?

20 A Yes.

21 Q Can you tell the jurors some of what those things are?

22 A My travel schedule can be hectic. I'll be in New Orleans shortly doing

23 presentations. Then I'm going to be visiting professor at the Mayo Clinic for doing

24 presentations in teaching. Then I have a teaching session set up in Baltimore where

25 we're bringing in a number of orthopedic and neurosurgical people for spine session.

1 Then there's the Christmas break, then I'm going to India to do a program where I'm
2 going to be lecturing and teaching. Then I'll be in Israel for a week and then I'll be in
3 Spain for a week doing presentations.
4 MR. LAURIA: Your Honor, I would submit Dr. Belzberg as a qualified expert
5 in the field of neurosurgery and spine surgery.
6 THE COURT: Any objection?
7 MR. PRINCE: No objection.
8 THE COURT: Okay. Ladies and gentlemen, Dr. Belzberg will also be found
9 to have the education, skill, training and experience necessary to qualify him to give
10 opinions in his fields of expertise.
11 BY MR. LAURIA:
12 Q Dr. Belzberg, you were -- what were you retained to do in this case?
13 A Review the medical file and provide expert opinion.
14 Q All right. Did -- when you were retained or when you were coming out
15 here, were you asked -- did I ask you to make any comments about anything about
16 Dr. Cash?
17 A No.
18 Q You were present during Dr. Cash's testimony up until the time you got
19 on the stand, correct?
20 A Yes.
21 Q And during the break did you indicate to me that there were some
22 things that Dr. Cash said that you disagreed with from a medical standpoint?
23 A Yes.
24 Q Let me -- one other question I want to ask you: Dr. Cash talked about
25 having -- being board certified and having to present to a board and answer

1 questions to these people. Do you do that, do you -- are you one of the reviewers of
2 people who say I want to be a board certified neurosurgeon? So you're one of the
3 people who questions them to make sure that the answers they give are in line with
4 earning that certification?
5 A Yes.
6 Q All right. And, Doctor, did you -- do you believe that some of the
7 answers or some of the statements that were made by Dr. Cash regarding medicine
8 and its aspect and anatomy earlier were misleading?
9 A Yes.
10 Q All right. Let's talk about the -- comparing the MRIs preoperatively and
11 postoperatively in this case and --
12 [Colloquy between counsel]
13 BY MR. LAURIA:
14 Q This I believe is the -- well, strike that. You can step over and look at
15 the MRI image.
16 THE COURT: Yeah, you may --
17 MR. LAURIA: Thank you.
18 THE COURT: -- certainly, Doctor. Thank you.
19 BY MR. LAURIA:
20 Q So this is the image from October 6th, 2010 and you heard -- strike that.
21 You saw the images that Dr. Cash had put up which included an image from
22 February 3rd, 2009 and then compared it with this image. Did you not?
23 A Yes.
24 Q In your mind, Doctor, as someone who trains fellows and residents and
25 sits on the board, what was the problem with comparing side by side the two images

1 that Dr. Cash put up there?

2 A So one wants to be as accurate as possible and provide objective

3 testimony. If you look at an MRI, an MRI consists of hundreds of slices often, so

4 hundreds of different images will make up this entire picture.

5 Q So when you say a slice, can you explain how that works or what that

6 means?

7 A So this is a static picture obviously and it's one slice through your body.

8 And it may be in the midline, may be off to one side or the other. But in the series of

9 MRI when the MRI is done, you move right across your area of interest with

10 numerous slices. Each slice you look at individually and you put it all together to get

11 three dimensional anatomy.

12 If you only see one slice, that obviously doesn't tell you what's doing

13 just beside it. And if you compare pre-op to post-op and you're looking at two slices,

14 you would expect those slices to be the same anatomy taken at the same place. If I

15 move a little bit to my left on one and a little bit to my right on the other and they're

16 not the same place in the body, then it's really not appropriate to compare and say

17 well this is the pre-op exactly how it looked and this is the postop exactly how it

18 looked.

19 When I saw the two images that were put up and somebody says -- and

20 Dr. Cash says yes, this is the pre-op/post-op same image and here's the difference,

21 in fact they're not the same image; they're clearly not the same anatomy. And it's

22 very obvious to me because this is what's called the spinal cord, and you see it very

23 clearly here this structure. And in one of the images you saw the spinal cord and in

24 the other image you didn't. You were off the midline so you couldn't see it so they

25 were clearly two different images.

1 Now, when I say that it's very important if somebody starts by saying I'm
2 going to compare these, I'm saying these are the same image pre and postop and
3 now I'm going to show you the differences, you're already starting by -- you know, by
4 that's just not true. They're not the same image. They're taken in a difference place
5 in the body so you -- either you say that up front and put a series of images so you
6 can compare or I believe that's misleading.
7 When I look at this particular image and we talk about the discs, I would
8 agree that this disc, which is the L4-5 disc, is probably a little bit compressed or a
9 little shrunk. But I heard stated that it's bone on bone. That is not bone on bone.
10 That's not even close to bone on bone. If all of this disc had completely collapsed
11 and this bone was literally touching that bone, sure we would call that bone on bone
12 which is very severe. That's severe degeneration. That's simply not what's here. I
13 think a lot of the verbiage used is simply inaccurate and misleading.
14 Q All right. So just so I understand, how wide are the slices typically
15 taken? How far apart are they?
16 A So it depends on the machine and depends on how the radiologists set
17 them up. They can be a few millimeters or more, really depends on how you set it.
18 Q So a few millimeters being that maybe four or five millimeters?
19 A So if we think of a centimeter three -- 2.54 centimeters in an inch and
20 you can work backwards from that.
21 Q Okay, I'm not good at that math but -- we're talking I mean these slices
22 are taken very close together?
23 A They're very close together, yes.
24 Q But it's important that you be in the same orientation as opposed to
25 trying to compare a slice that's taken in the center of your forehead versus a slice

1 taken over here, you're going to get very different views?

2 A You're looking at different anatomy.

3 Q All right. And so then to try to compare those if in teaching a fellow or a

4 resident or evaluating someone who is trying to become a board certified

5 neurosurgeon and they put up different images like that or different slices and

6 wanted to show a comparison, what would your opinion or response be?

7 A It's very reasonable to say that I'm going to compare a pre-op MRI with

8 a post-op MRI and look at the difference and see what's better, what's worse and so

9 on. It's an appropriate thing to do. The radiologist routinely does that and I would

10 agree that a spine surgeon should have some competency in looking at the MRI

11 themselves and also understanding the differences; what's different, what's the

12 same, what's progressed and so no. But when you take just one slice away and you

13 say here's all I'm going to let you look at is one slice over here and one slice over

14 here and they're not the same slice, then that's very misleading.

15 Q The fluoroscopic image that was put up that -- the last thing that Dr.

16 Cash had up there, that represented after the surgery was essentially over, correct?

17 Or at least the instrument was actually in the disc itself?

18 A When we heard the original testimony and what I commented to you at

19 that time was that they put up a fluoroscopic image and Dr. Cash stated that the

20 critical portion of this image, what was critical is that he puts an instrument on the

21 surface of the disc to identify the disc before he goes into the disc because it's

22 absolutely critical to only go into the disc if it's the right disc.

23 Q So his testimony at that time --

24 A As I understand it.

25 Q -- when he showed it was I do this to identify the level, I put it up to the

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1 disc?

2 A My understanding of what he was testifying at that point this morning

3 was this is a critical step. You have to have the instrument right on the disc because

4 once you violate the disc, game over if you've gone to the wrong level. I can't

5 remember the exact words, I apologize, but I think that was the summary of it. My

6 concern at the time was I'm looking at a fluoroscopic image that in fact the

7 instrument was not at the surface of the disc, the instrument was inside the disc.

8 You had already violated the disc. So I'm looking at an image that shows me an

9 instrument in the disc and I'm listening to testimony about how critical it is to put the

10 instrument on the surface of the disc before you violate it. So yes, I had trouble with

11 putting that together.

12 Q Okay, because clearly the disc had already been violated there?

13 A Yes.

14 Q And have they put -- have they shown you any images from Dr. Cash

15 where he did any of those pre-violation steps that he talked about where he had it

16 on the skin or through the skin or before he violated the disc? Have you seen any of

17 those?

18 A No.

19 Q All right. You have read Dr. Cash's records in this case?

20 A Yes.

21 Q And we'll put them back up there, but did you note that Dr. Cash

22 indicated before he did surgery or at the time he did surgery on this patient that he

23 anticipated that Mr. Orth was going to have a good result?

24 A Yes.

25 Q All right. And did you hear him testify this morning that now before he

1 did surgery he had decided he probably wasn't going to go back to playing football?
2 Did you hear that?
3 A Yes, I did.
4 Q All right. Doctor, in your opinion as a neurosurgeon who's been treating
5 people for 25 years, given the presentation that Dr. Cash had, do you think to a
6 reasonable likelihood or reasonable probability that your opinion would have been
7 more likely than not he's going to get back to play football?
8 A So it's -- going through that the initial presentation is that he has --
9 MR. PRINCE: Your Honor, object -- this is totally an undisclosed opinion by
10 this doctor and I want to approach --
11 THE COURT: Well approach --
12 MR. PRINCE: Yeah.
13 THE COURT: -- approach the bench.
14 [Bench conference at 1:34 p.m. - not transcribed]
15 THE COURT: All right. Ladies and gentlemen, we're going to take a break
16 for a minute. During the recess you're admonished not to talk or converse among
17 yourselves or with anyone else on any subject connected with the trial; read, watch
18 or listen to any report of or commentary on the trial by any medium of information,
19 including without limitation newspapers, television, internet or radio. Thank you.
20 Please step outside with Joel.
21 [Jury out at 1:38 p.m.]
22 THE COURT: Okay guys, where is it you need me to look?
23 MR. PRINCE: All right -- me just set up my objection. We -- and if obviously
24 that Dr. Belzberg is now going into something that's not contained his report
25 specifically --

1 THE COURT: Actually hold on. Dr. Belzberg, you can step down. You don't
2 need to stay up there. Thank you, sir.
3 THE WITNESS: Thank you.
4 MR. PRINCE: -- relating to outcome of surgery, being able to go back to
5 playing football. Dr. Belzberg prepared initially an undated report -- it's Exhibit 8 to
6 our trial brief, number one, which you have there in front of you.
7 THE COURT: Right.
8 MR. PRINCE: It's undated. Part of the materials he -- I described that he
9 reviewed was medical records from Dr. Cash and Southern Hills Hospital and if you
10 look at summary of events then regarding standard of care, he only talks -- he gives
11 under the standard of care section which is page 3 of his report --
12 THE COURT: Right.
13 MR. PRINCE: -- he talks about what he -- the anticipated testimony of Dr.
14 Capanna's going to be. He does not comment on not one singular record after Dr.
15 Cash's surgery, even though he has Dr. Cash's records in his possession. He
16 doesn't talk about going -- his prognosis, doesn't talk about going back to play
17 football, he doesn't talk about Dr. Cash's surgery in any respect, nothing.
18 THE COURT: Okay.
19 MR. PRINCE: What Dr. Cash's recommendations were -- fast forward even
20 to his report dated July 20th, 2015 -- he only has two reports. The only thing he
21 talks about in the July 20, 2015 is that in general, a microdiscectomy does not
22 change the natural history of the progression of degenerative disc disease. Other
23 than that, he has no other opinions. That's all he's articulated and as a 16.1(a)(2)
24 expert, he is required to set forth the basis for his opinions, everything he reviewed
25 and his actual opinions. He does not -- so it wasn't our job to go take his

1 depositions and ask hey, do you have any other opinions. He's required to set them
2 forth.
3 We're not even -- we don't even have to take a deposition of him if we
4 don't have to and that wouldn't even be a defense that hey, you didn't take a
5 deposition of the witness. The whole point of the rule requiring expert witness
6 reports is we're entitled to rely upon that's their basis, that's the records they
7 reviewed, that's the basis for their opinions and finally their opinions.
8 So now we're starting to get into other things regarding Dr. Cash's
9 surgery which he's never ever ever before expressed and I challenge the defense to
10 find one portion of the deposition transcript anywhere he comments on Dr. Cash's
11 surgery, critical of it, or Mr. Orth's prognosis or his ability to return back to football.
12 MR. LAURIA: Well I --
13 THE COURT: Well I think Mr. Lauria acknowledged when he was questioning
14 Dr. Belzberg early on that he wasn't asking him nor was he retained or hired to
15 comment on Dr. Cash's surgery.
16 MR. LAURIA: Correct.
17 THE COURT: Okay.
18 MR. LAURIA: He's not commenting on --
19 THE COURT: Okay.
20 MR. LAURIA: -- Dr. Cash's surgery.
21 MR. PRINCE: Well but he's just getting ready to --
22 THE COURT: I'm just talking about that aspect of what you said. The aspect
23 of what you said about his prognosis and predictions for his ability to continue on
24 playing football, I understand that's a concern as well so Mr. Lauria.
25 MR. LAURIA: Your Honor, I don't have those expert reports in front of me. I

1 don't know what their -- I can't tell you exactly what their -- what the complaint was
2 so --
3 THE COURT: Well but you got to know the answer to that. I mean when
4 objections come up at trial saying something was not contained within anybody's
5 reports, you all --
6 MR. LAURIA: In my --
7 THE COURT: -- you all know that I can't have an --
8 MR. LAURIA: Okay.
9 THE COURT: -- encyclopedic knowledge of all the experts --
10 MR. LAURIA: In my opinion to a reasonable medical probability --
11 THE COURT: Okay.
12 MR. LAURIA: -- Mr. Orth will not require lumbar fusion surgery in the future --
13 THE COURT: Okay.
14 MR. LAURIA: -- and a majority of patients with lumbar disc generation (sic)
15 such as Mr. Orth do not require future surgery. Clearly that means --
16 THE COURT: Okay.
17 MR. LAURIA: -- he's talking about Mr. Orth's condition postoperatively post
18 Dr. Cash's surgery. So --
19 THE COURT: In terms of the need for surgery.
20 MR. PRINCE: Post-op -- after Dr. Cash's surgery.
21 THE COURT: Understood.
22 MR. PRINCE: Yeah.
23 THE COURT: Understood.
24 MR. PRINCE: Because I'm looking at his deposition, Judge. Specifically --
25 MR. LAURIA: Well, can I --

1 MR. PRINCE: -- I'm on page 12 -- excuse me.
2 THE COURT: Hold on, hold on, let Mr. Lauria finish, please.
3 MR. LAURIA: So the argument -- the statement that Dr. -- that there was
4 nothing in Dr. Belzberg's report where he's going to talk about the future prognosis
5 is false because it's clearly in here and it's specific to Mr. Orth, not just in general.
6 THE COURT: Okay, well let's --
7 MR. LAURIA: It's specific to him so --
8 THE COURT: -- let's kind of -- I need to kind of rein you guys in. The focus is
9 a question about his ability to play football, not about whether he's going to have
10 surgery or not have surgery. I agree that aspect is in there. We talked about that
11 previously.
12 MR. PRINCE: Right. So Dr. Belzberg in his initial report does not comment
13 on any aspect of care after Dr. Cash's surgery, nothing.
14 THE COURT: Okay. All right.
15 MR. PRINCE: In his deposition -- I'm reading on page 12 of his deposition --
16 THE COURT: Right, but --
17 MR. PRINCE: -- he -- excuse me, he identifies --
18 THE COURT: -- but -- hold on, hold on, hold on. Okay. But we went through
19 this. You all moved to strike the supplemental disclosures. I denied that. So the
20 supplemental reports are fair game.
21 MR. PRINCE: I understand.
22 THE COURT: Okay, where -- and if his supplemental reports is talking about
23 future prognosis in terms of needs for surgery or not needs for surgery, that's fine.
24 I'm talking about the singular issue that the objection was raised to right now.
25 MR. PRINCE: I understand that.

1 THE COURT: Okay.

2 MR. PRINCE: Because he -- we talked about -- you said kind of if it's in a
3 deposition, if it's in the report, it's noticed and that's one way --

4 THE COURT: Yes.

5 MR. PRINCE: -- we're going to look at it.

6 THE COURT: Absolutely.

7 MR. PRINCE: So his initial report does not talk about prognosis, doesn't talk
8 about the propriety (phonetic) of Dr. Cash's original surgery, about Beau Orth being
9 able to return back to playing football, nothing.

10 THE COURT: Okay.

11 MR. PRINCE: We asked him in his deposition what materials have you
12 received. He then says on page 12, a letter from November 6, 2014 I received from
13 counsel on a CD, a -- you know, MRI from Desert Radiologist 2009, 2010, 2012,
14 Steinberg diagnostic MRI, ortho --

15 MR. LAURIA: Judge, I'll withdraw the question.

16 THE COURT: Hold on, please.

17 MR. PRINCE: And so then he goes on to but I -- because I want to be able to
18 establish some parameters about this. And he says he's never -- was never asked
19 to author a supplemental report. When you go to his supplemental report, the only
20 other report he generated, he does not comment on any postoperative film, not a
21 single postoperative film from Dr. Cash meaning 2012 or 2014. He doesn't
22 comment on anything concerning Beau's symptoms or his condition. He's only
23 talking about in general the progression of disc disease following microdiscectomy
24 and he does author -- express an opinion with respect to that. He does not go into
25 anything specific -- all he says is Mr. Orth will not require lumbar surgery in the

1 future.

2 THE COURT: Right.

3 MR. PRINCE: That's really what he says.

4 THE COURT: I understand that.

5 MR. PRINCE: Okay. Got it.

6 THE COURT: I understand that.

7 MR. PRINCE: He's not even talking about 4-5, he's only talking about 3-4.
8 And so -- and 5-1. So with regard to that, I understand that's in his report, but he
9 doesn't go on and talk about any of the other films, the 2012, 2010 film -- excuse
10 me, '14 film, any pain management injections --

11 THE COURT: Okay.

12 MR. PRINCE: -- nothing. Nothing --

13 THE COURT: Well let's try this -- let's reverse course and try this a different
14 way. For a proffer, what are you wanting to ask him about this issue?

15 MR. LAURIA: Judge, I'm so far past the issue I think we're now just spending
16 time. I've withdrawn the question because I -- he knows I got an expert that's got to
17 catch --

18 THE COURT: I know.

19 MR. LAURIA: -- a plane so --

20 THE COURT: All right.

21 MR. LAURIA: We're spending half an hour he's reading -- denying what's in
22 the report and we've got in the deposition he talks about seeing the other films, he
23 talks about seeing the other records, it's asked of him so I don't understand what
24 we're doing other than wasting time here so my doctor can't testify.

25 MR. PRINCE: Judge, I'm not wasting any time but I want to make sure we

1 have the scope of this down because --

2 THE COURT: Look I'll sustain the objection to the question that was asked in

3 regard to could he return to playing football since that wasn't in the initial, that wasn't

4 in the supplement any kind of an opinion about that. But I do find, and I found it

5 before and that's why I allowed the supplemental report to continue to go forward,

6 that he expresses opinion postoperatively post Dr. Cash operatively in the future this

7 is Dr. Belzberg's opinion about what he would not require. That they can ask him

8 about. Okay? I don't think that was really the question we got to before the

9 objection was raised, but I'm just prospectively telling you they can certainly ask him

10 questions about that.

11 MR. PRINCE: So --

12 MR. LAURIA: I'm sorry, which one can I ask --

13 MR. PRINCE: So when we --

14 MR. LAURIA: Now I'm --

15 THE COURT: The things that are in line with the supplemental report that he

16 gave that he doesn't expect that he should need lumbar fusion surgery in the future.

17 MR. LAURIA: And he talks about everything progressing from the L5-S1

18 herniation. I mean --

19 MR. PRINCE: No he doesn't, Judge.

20 MR. LAURIA: Excuse me. Can I finish please? He says Mr. Orth suffered a

21 disc herniation at L5-S1 and this is the cause of ongoing pain problems, not the fact

22 that two microdiscectomies were done.

23 THE COURT: Right.

24 MR. LAURIA: It covers the whole spectrum.

25 THE COURT: I agree.

1 MR. LAURIA: Thank you.
2 MR. PRINCE: That covers the whole spectrum? Because this is unfair,
3 Judge; let me say why. Let me say why. We asked him in his deposition -- so we
4 could flesh this out, we asked him about -- when we -- we went took his deposition
5 in May of 2015 --
6 THE COURT: The deposition was prior to the supplemental report.
7 MR. PRINCE: I understand but I want to tell you what he already knew at the
8 time of his deposition.
9 THE COURT: Okay.
10 MR. PRINCE: He already had those records I'm telling you about.
11 THE COURT: Okay.
12 MR. PRINCE: The question was if you have reviewed documents subsequent
13 to your report that challenged -- that challenge or change any of your opinions in
14 that report or made your opinions in that original report medically unsustainable,
15 would you have changed your report. I don't know that I would have changed my
16 report and in that I was not asked to address my report or do an addendum to my
17 report. Again I'm trying to answer your questions.
18 THE COURT: Understood.
19 MR. PRINCE: He never authored any opinions based upon any additional
20 medical records. He's got to be limited to just hey, the -- on the fusion issue, I
21 understand what your ruling is. You've already made clear what your ruling is. That
22 doesn't mean you get to draw this huge inference now and saying well everything
23 goes back to that, now I'm going to go through very specific records -- radiology
24 films that he never did before. He had them. He had the ability to comment on
25 them --

1 MR. LAURIA: Judge, can we cut this off?
2 MR. PRINCE: Excuse me.
3 THE COURT: Hold on. Just finish.
4 MR. PRINCE: He had the ability to do that. He elected not to, he -- he
5 prepared a very brief and very limited report only addressing future lumbar fusion
6 only. Not his ongoing condition, not his status, nothing more.
7 THE COURT: I don't think it's that narrow and obviously you can't allow in an
8 expert report that says he's not going to need this without saying here's why I think
9 he's not going to need this. Can't allow in an expert report that says he has
10 problems, all of his pain problems stem from the S5 -- the L5-S1 issue without
11 explaining why that is. So obviously it's not limited to just regurgitating a sentence
12 from the report, okay?
13 MR. PRINCE: Understood that. I agree.
14 THE COURT: But if there is an opinion of some sort that's outside of the
15 areas that he expresses in the report, then you can object to those things.
16 MR. PRINCE: Okay.
17 THE COURT: All right.
18 MR. PRINCE: That's what I'll do.
19 THE COURT: Joel, go ahead and get them back in, please.
20 [Colloquy between counsel]
21 THE COURT: The only report that was attached to the trial brief was the --
22 MR. PRINCE: The undated one, probably.
23 THE COURT: -- original report, right?
24 MR. PRINCE: Probably.
25 THE COURT: Yeah.

1 MR. PRINCE: At this point.

2 THE COURT: Because I don't have the other report sitting up here with me.

3 I don't know that I ever got that one.

4 Well let me correct myself, other than in the pleadings, but I'll get a copy

5 of it sent in.

6 [Jury in at 1:50 p.m.]

7 THE MARSHAL: Jury is present, Your Honor.

8 THE COURT: Thank you.

9 All right, we will be back on the record. We are going to continue on

10 with Dr. Belzberg's testimony. This is in the defense case in chief.

11 Dr. Belzberg, I'll remind you that you're still under oath, sir, okay?

12 Thank you.

13 THE WITNESS: Thank you.

14 MR. LAURIA: Thank you.

15 THE COURT: Mr. Lauria.

16 BY MR. LAURIA:

17 Q Doctor, again I'm going to move along here because I know you got to

18 catch that flight and go to your surgery. Dr. Cash said in his opinion that a dull

19 probe -- strike. You sat and you heard what he said that if you're using a probe in

20 the area of surgery, that that can't cause a penetration of the disc because of the

21 annulus, so if you're using something in a probe, that doesn't make sense, you have

22 to have a box cut or a sharp object. Did you hear that said, Doctor?

23 A Something along those lines, yes.

24 Q Okay. Do you believe that that is accurate or that is misleading?

25 A It depends on your definition I guess of the word probe. So I know what

1 we use in neurosurgery as a probe which is typically what's called a Penfield
2 number 4. That's a type of instrument. It is -- it has a dull tip to it and that's
3 commonly what you use to palpate when you're doing these types of procedures.
4 That probe, even though it does have a dull end, certainly could inadvertently enter
5 a disc. We've seen that -- I've done that myself where I've inadvertently entered a
6 disc with a Penfield 4 where I did not intend to.
7 Q So you yourself using the probe that's commonly used in neurosurgery,
8 by your probing around because you have to move tissue out of the way and to
9 observe what you're doing. Can you explain how that occurs? Just using an MRI
10 maybe?
11 A You would be -- you would be using the instrument and again, we wish
12 we had a perfect view. Even with the microscope and great surgery you don't
13 always see exactly what you need to see or everything that you need to see. So
14 you're using the probe to move tissues over and to gently palpate and trying to find
15 -- for example, you might be finding the junction of where the disc starts and where
16 the bone ends and you're sort of -- we call it palpating, you're tapping along. Now
17 unfortunately sometimes you're tapping and you're pushing and you're trying to
18 understand that anatomy and you can in advertently actually go into the disc space
19 with your probe.
20 Q Has that happened to you?
21 A Yes, it has.
22 Q All right. Has it happened to your colleagues in neurosurgery at Johns
23 Hopkins?
24 A Yes.
25 Q All right. So you disagree with the statement that a probe can't cause a

1 -- can't enter the disc space and cause a rent or a tear there?

2 A Oh you can actually -- absolutely cause a rent or a tear into the disc

3 with a Penfield 4 with an instrument like that.

4 Q Because you've done it?

5 A Yes.

6 Q All right. Do you believe, Doctor, that five weeks after a surgical

7 procedure such as was performed here and in an area with a significant amount of

8 scarring around the area of the disc that you would be able to identify the difference

9 between a rent or a perforation or an entry into the disc from a probe versus some

10 kind of cut or a circle?

11 A So one might expect that there -- and what Dr. Cash describes is scar

12 tissue. This would be scarred and at approximately four weeks you would have a

13 fairly dense scar present. It would be very, very difficult, if not impossible, to look at

14 that and say you know that this was done with a knife versus a probe and to say that

15 it's cut as a square or a box versus cut as a cruciate and so on. You would be --

16 probably be able to tell that if you got in within a week or less; there wouldn't be

17 sufficient scarring, but past a week the area's going to be scarred. You would not

18 know -- you would certainly know there'd been a rent. So you can tell that the disc

19 in that area either would still have a little bit of a hole in it or when you palpate it, it

20 would be soft. But I don't believe and certainly in my experience I would not be able

21 at a month going back on an operation tell you exactly how that hole was made,

22 what instrument was used and whether it was done as a cruciate single cut and so

23 on.

24 Q All right. So you in 25 years as a professor of neurosurgery wouldn't be

25 able to tell whether that was a palpation by a probe inadvertently or was cut

1 surgically at five weeks post-op?

2 A No, I would not be able to tell and certainly not to a reasonable degree

3 of medical probability.

4 Q All right. There was some discussion by Dr. Cash regarding the use of

5 an Anulex to close these discs. You heard that and how if you use that keeps the

6 disc closed so nothing comes out, true?

7 A Yes.

8 Q All right. Are you familiar with the -- and that Dr. Cash I think still uses

9 the Anulex or prefers the Anulex?

10 A I don't know what he currently does.

11 Q All right. You're familiar with the Anulex?

12 A Yes.

13 Q All right. And what is your experience in using the Anulex to try and

14 repair a disc?

15 MR. PRINCE: Objection; outside the scope of his designation and disclosure,

16 Judge.

17 THE COURT: Mr. Lauria?

18 MR. PRINCE: Not disclosed.

19 MR. LAURIA: I'll withdraw the question.

20 THE COURT: Okay.

21 BY MR. LAURIA:

22 Q Is the Anulex used at Johns Hopkins?

23 MR. PRINCE: Same objection, Judge. He didn't -- they never even raised

24 this issue about the use of Anulex.

25 THE COURT: Well I don't really perceive that to be an expert opinion. You

1 can answer the question.

2 THE WITNESS: No, we do not currently use it.

3 BY MR. LAURIA:

4 Q All right. And why isn't it used at Johns Hopkins?

5 A Because the research data suggests that it is actually not useful. The

6 data -- the most recent data and certainly the best data is published in the Journal of

7 Spine (sic) which is level one evidence, the best possible evidence. There's an

8 excellent paper that came out in 2013 showing that the Anulex does not make any

9 difference, the use of it, in terms of the re-herniation rate.

10 Q Doctor, one other thing and then I want to go into something else. You

11 -- can you -- do you recall what terms you heard describing this fragment of disc at

12 L4-5 that was found at surgery? How was that described by Dr. Cash to the jury

13 that you heard?

14 MR. PRINCE: Objection; outside the scope his disclosure, Judge. Never

15 commented on this in his report anywhere.

16 THE COURT: Well, overruled. I think he's asking him a question about a

17 description that Dr. Cash used earlier in his testimony so you can go ahead.

18 THE WITNESS: He used different words at different times. He described it a

19 number of different ways. I --

20 BY MR. LAURIA:

21 Q Did he use the terms large or huge, or I think at one point said there

22 was this colossal fragment?

23 A The last description which is what I made a note on was it was a

24 colossus or colossal disc herniation fragment.

25 Q I don't even know how to spell colossal but I'm going to try. Doctor,

1 what -- how big did the radiologist say that the disc fragment was?

2 A Four millimeters.

3 Q Is four millimeters in our opinion a colossal fragment?

4 A No.

5 Q That's smaller actually than the disc bulge that's described in the

6 preoperative MRIs at L5-S1, isn't it?

7 A Yes.

8 Q All right. What -- in your practice, what would you describe as a

9 colossal fragment that you've removed that's herniated out of a patient?

10 A So I think -- and again, to be complete and to -- full disclosure, the

11 actual size of a fragment does not necessarily correlate with how symptomatic

12 somebody may be. So you can have a very small fragment that's causing an

13 enormous amount of problems because of the way the fragment is pressing on a

14 nerve or deforming the nerves. You can have a very large fragment that actually is

15 asymptomatic and we've seen massive disc herniations that would be three or four

16 times the size of this one that's actually asymptomatic. So that's the starting point

17 so it's not a direct correlation. But I certainly wouldn't be calling a four millimeter

18 fragment colossal or something like that. When it gets to be a centimeter and a half,

19 two to three times that at least, that's when I'd be impressed.

20 Q All right. So is the use of the term huge or large or colossal as to this

21 fragment you believe from a medical standpoint that's misleading?

22 A Yes.

23 Q Were there any other instances that you can -- off the top of your head

24 as we sit here now, Doctor, that you heard testimony from Dr. Cash that from a

25 medical standpoint you believe did not make medical sense and was misleading to

1 the jury?

2 A I don't think because somebody has a discectomy that you know that

3 patient is going to require a spinal fusion down the road. As a matter of fact, the

4 published literature would suggest that for somebody who has had a

5 microdiscectomy, the likelihood that they will need a spinal fusion is clearly less than

6 50 percent and it's in the order of, depending on the paper that you read, anywhere

7 from 10 percent to as probably as high as 35 percent. So it is less likely not more

8 likely than not that based on just having had a discectomy that you will need a fusion

9 in the future.

10 Q So the testimony to -- by Dr. Cash that because patients have a

11 discectomy, more likely than not they're going to require a fusion is not in conformity

12 with what you teach your residents or fellows?

13 A No, I certainly would not be teaching that.

14 Q What do you teach your residents or fellows about what the likelihood is

15 of a need for a fusion after a discectomy?

16 A First thing is we don't know. That's the starting point. The literature is

17 controversial on it. We tell patients that once you've had some sort of spine

18 problem, not uncommon that you may have further spine problems in the future. We

19 coach them on trying to have good spine care so that you minimize any risks of

20 spine problems in the future, but I certainly would never tell a patient and I would be

21 very upset if one of my trainees told a patient that just because you're having a

22 discectomy, there is more likely than not and more importantly what was said is a

23 hundred percent assured that you're going to need a fusion in the future. Again the

24 published literature is clear that it is less than a 50 percent likelihood.

25 Q All right. And significantly less, maybe from the 10 to the 30 to 35

1 percent range at most given all of the studies that you're aware of or you've looked
2 at from around the world?
3 A Correct.
4 Q And the way that that's study and -- strike that. And that's again in
5 these peer review journals where somebody looks at data, scientifically studies it,
6 writes an article and it gets published by the editorial board approves it?
7 A This includes our own literature, meaning studies that we've put out of
8 Johns Hopkins on our own patients. Yes.
9 Q All right. So Johns Hopkins has conducted its own studies and haven't
10 come anything close to more than 50 percent of patients who have a discectomy are
11 going to require a fusion?
12 A Correct.
13 Q So you believe that testimony is misleading from a medical standpoint?
14 A Yes.
15 Q The way that I understand these studies, at least looking at this, would
16 be a retrospective analysis, true?
17 A The best studies are always prospective, meaning you study them in
18 the future, but virtually all of these studies are retrospective. You go back and look
19 at the data.
20 Q Because you're not going to cause a disc herniation in someone and
21 then say we're going to do a discectomy and see what happens to you in the future.
22 The way typically these studies are done is you go we're going to take patients that
23 have had discectomies in all different categories, some studies look at young
24 patients, some studies look at one level, some studies look at two levels, but you
25 take this group of patients who've had the procedure and then you look periods of

1 time down the road and say how many have had re-operation, how many have done
2 well, how many have done poorly, how many require a fusion. Is that a fair --
3 A It is. Sometimes you collect data and it gets into a little bit of the terms
4 how you want to use them. Sometimes you look back on your data, sometimes you
5 prospectively collect the data so you're -- as you go forward, you're collecting the
6 data. But these are not randomized studies, these are -- and again when we talk
7 about evidence, these would be level three evidence where you're simply collecting
8 the data and looking at it over time.
9 Q And do -- are there -- some of those studies include -- I mean I've seen
10 one that's from Korea where they studied 11,000 patients in the patient population
11 because of a national health system they can do that, right, and go back and look at
12 a whole year of all those patients?
13 A Yes.
14 Q Some had very large patient populations.
15 A Yes.
16 Q All right. Would you agree, Doctor, that typically any patient undergoing
17 a microdiscectomy that even in the best of hands, best of care, that there's a two to
18 three out of 10 of them are going to continue to have back pain after that's done?
19 A Yes, we quote our -- our patients are told that if you have a -- if you're
20 going to need a microdiscectomy and you have back pain and leg pain when you
21 present, there is a eight to nine out of 10 chance that you'll be very happy with the
22 surgery. Unfortunately, that also means there's a one to two out of 10 chance that
23 you will have persisting pain. If we look at the published data on this again and you
24 look at microdiscectomies long term how do patients do, it's probably as high as
25 about 30 to 40 percent of patients will have continuing back pain or leg pain.

1 Q In the studies looking at patients who go on to have fusion after
2 microdiscectomy, as I understand it, your review of those studies there's not a single
3 published peer-reviewed study that you're aware of that indicates the incidence is
4 greater than 50 percent or more probable than not; is that true?
5 A I have not taken a specific review to look at that. When I say that there
6 are over 20 to 30,000 published papers on the topic of spine. So I've not reviewed
7 every one of those papers specifically looking at this. But I certainly attend the
8 lectures, give lectures and so on, on spinal fusion and I've reviewed papers as they
9 come out. I have never seen a published paper that suggests a higher than 50
10 percent rate of fusion after discectomy.
11 Q Fact the highest one you've seen I think you said was about 35
12 percent?
13 A About 38 percent I believe.
14 Q All right. And most are well below that?
15 A Most are somewhere between 10 and 30 -- again, 10 to 35 percent.
16 Q And plaintiffs didn't question you during your deposition or identify for
17 you any study or peer review journal article or any type of scientific medical literature
18 that indicated that patients were likely to have fusions at a rate of greater than 50
19 percent?
20 A Not that I specifically recall.
21 Q Okay. You work with the orthopedic spine surgery department at Johns
22 Hopkins?
23 A Division, yes.
24 Q Division. I'm sorry. Okay. And so their residents come through some
25 of your spine training also?

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1 A Not so much their residents, their fellows.
2 Q Their fellows.
3 A So usually when you're in the -- if it's a resident, you tend not to do
4 much spine as an orthopedist. But if you're doing a spine fellowship, then I see
5 them, yes.
6 Q So -- wait a second, so when you're an orthopedic surgery resident,
7 your exposure to doing spine surgery, is it the same or different than a resident in
8 neurosurgery's exposure to doing spine surgery?
9 A It would be very, very different.
10 Q Can you explain that?
11 A In neurosurgery during your seven years of training, you're training to
12 do spine and brain surgery, and I would say almost equally, so you're probably
13 doing four to five hundred surgeries a year as a resident and it's -- depending on the
14 institution you're training in, it's about a 50/50 split between spine cases and
15 intracranial brain cases, and that goes on for seven years.
16 In orthopedics, the vast -- as we heard this morning, the vast bulk of
17 your training is on joints and things like that; broken bones and so on. You're not
18 training in spine. If you want to do spine as an orthopedist, then you would try to do
19 an extra training like a fellowship after you complete your residency. For the
20 neurosurgeons, you've already done seven years of that, and yet there still are
21 some residents who when they finish neurosurgery will do an extra years
22 sometimes.
23 Q Okay. Let's go a little bit through Mr. Orth's history and again, I don't
24 know where we are time wise --
25 MR. LAURIA: Do you know what times it is? I don't have a watch on --

1 THE COURT: Five after one.
2 MR. CARDINALE: Five after two.
3 THE COURT: After two, excuse me.
4 MR. LAURIA: Five after two. Thank you. All right.
5 BY MR. LAURIA:
6 Q Mr. Orth we know had an MRI for back and leg pain, numbness, tingling
7 in 2009 was the first MRI?
8 A Yes.
9 Q All right. And you've seen all his MRIs from 2009 up and through the
10 most recent ones in 2014 that we're aware of, right?
11 A Yes.
12 Q All right. You've seen all the records from Dr. Cash up through his visit
13 in March of 2014?
14 A Yes.
15 Q All right. Dr. Cash just -- okay. You've seen them for Dr. Ruggeroli?
16 MR. PRINCE: Your Honor, can we approach for a minute, please?
17 [Bench conference at 2:08 p.m. - not transcribed]
18 THE COURT: Mr. Lauria, you can continue.
19 MR. LAURIA: Thank you.
20 BY MR. LAURIA:
21 Q Doctor, you can answer the question now.
22 THE COURT: You remember that question?
23 THE WITNESS: No, I don't. Sorry.
24 THE COURT: That's kind of like what did you have for lunch last week, right?
25 MR. LAURIA: Yeah.

1 THE COURT: All right. Can we read the question back, please?

2 THE COURT RECORDER: It'll take a minute to find it.

3 MR. LAURIA: You know what, I'll ask -- I think I know --

4 THE COURT: Ask it again.

5 MR. LAURIA: -- what it was.

6 THE COURT: Okay.

7 BY MR. LAURIA:

8 Q You've seen the records from Dr. Cash through March of 2014, right?

9 A Yes.

10 Q And you've seen the records of Dr. Ruggeroli through May of 2014?

11 A Yes.

12 Q So an objection that you hadn't would be incorrect; you've seen them,

13 right? You indicated --

14 A I don't understand objections so I'm going to stay away from that.

15 Q Okay. All right. You reviewed them and it's your knowledge that up

16 until maybe just before this trial, that was the last time that this patient had been

17 seen by Dr. Cash, right?

18 A That was my understanding, yes.

19 Q All right. And based upon your review of all of those records,

20 everything that you know about neurosurgery up to the time of the records that

21 you've seen through May of 2014, was it your opinion to a reasonable medical

22 probability that Mr. Orth was going to require a fusion?

23 A My opinion to a reasonable degree of medical probability is that he

24 would not require a spinal fusion.

25 Q All right. And that includes reviewing the x-rays, reviewing the reports

1 of the physicians such as Dr. Cash up to that point, reviewing the reports of Dr.
2 Ruggeroli?
3 A Yes.
4 Q Can you give us just give the jury -- again, I know your time's limited so
5 can you give the jury an overview of what his course of treatment has been up to
6 that point?
7 A He had had two operations. He had been through therapy. He had had
8 injections. And he was I assume doing the best he could to be active.
9 Q Were there large gaps where he didn't seek any treatment or care?
10 A Yes.
11 Q Periods of a year, up to a year and a half where Mr. Orth didn't go to a
12 therapist or didn't go to Dr. Cash or didn't go to Dr. Ruggeroli, didn't go to anybody?
13 A The medical record that I reviewed has at least a year to a year and a
14 half where there was no medical care delivered for spinal issues.
15 Q All right. In fact, if the last record of May 14th by Dr. Ruggeroli until
16 most recently just before trial he goes in and sees Dr. Cash and Dr. Ruggeroli on
17 the same day, but up to that point that would have been a period of what, 14, 15
18 months just before this trial he hadn't sought any treatment, true?
19 A That's my understanding, yes.
20 Q Would you agree with me, Doctor, is -- well tell -- strike that. I'm rushing
21 because I'm trying to get you out of here. I apologize. In your opinion, Doctor,
22 through the records that you've seen up to that point, what is the primary or what
23 would be the primary cause of any complaints or problems the patient was having?
24 Was it something to do with L4-5 or was it something to do with L5-S1 or was it a
25 combination?

1 A Trying to understand the question so the -- what is the ideology or what
2 is the cause of the pain that he's -- or that the symptoms he's having at what point?
3 Q Sure. Let's take it from the time post Dr. Cash's procedure --
4 A Yes.
5 Q -- up until -- till March of 2014 when he's seen by Dr. Cash.
6 A And you want to know what's the cause of that?
7 Q In your opinion, yeah, to a reasonable medical probability.
8 A To a reasonable degree of medical probability he has problems that
9 relate to having a problem at both L4-5 and L5-S1, and I would say it's a
10 combination of both. It would be extremely difficult to parse out whether it's more of
11 a problem from L5 or more of a problem from S1. So his complaints are back and
12 leg pain. If you're very specific on where the leg pain goes in the foot, sometimes
13 you can tell whether it's more S1 or L5. In this particular case, up until 2014, it
14 wasn't that specific, so I would say it's just he had a bad back and was having pain
15 secondary to his bad back.
16 Q In 2014 was there an indication of which dermatome or which nerve
17 was not functioning appropriately or causing him pain or problems?
18 A There was no indication of weakness, so I can't say that -- as we had
19 heard this morning about inability to get up on your toes or your heels. There was
20 no indication that he was having weakness. There was indication of pain and the
21 pain was not specific enough in terms of its -- where he's feeling it for one to be able
22 to say that's clearly from 4-5 or from 5-1. I would say and I would have to say to
23 degree of medical probability it's probably from both.
24 Q Okay.
25 MR. LAURIA: Do you have that pain diagram from March 14th?

1 MR. CARDINALE: Oh. I got t find --

2 MR. LAURIA: Okay. I'll have him find that.

3 BY MR. LAURIA:

4 Q Well, Doctor, can you explain where the S1 dermatome in your opinion
5 goes to lower extremity or the leg? And we can put up the slide if you want, but in
6 the interest of time, can you explain to the jurors what's significant about what was
7 said and what your opinion is?

8 A So the issue comes when you're trying to sort out is this which of the
9 two nerves in question here. Is it that bottom one, S1, or is it the higher one, L5,
10 that he's complaining of. When he complained of pain that comes down the leg and
11 goes into the lateral aspect of the foot, goes to your little toe, pain that goes to the
12 little toe we assume is S1. Pain that goes on the top of the foot to the big toe is L5.
13 My understanding from looking at the diagrams and where he puts his own little
14 stars is it's on the lateral aspect of the foot or towards the little toe. That would
15 suggest that's an S1 distribution pain.

16 Q So the pain or problems he was having at that time -- let's show the --

17 [Colloquy between counsel]

18 MR. LAURIA: Plaintiff's 107? March 18th, 2014. Put that up so the jury
19 can --

20 BY MR. LAURIA:

21 Q This is a pain diagram drawn by Mr. Orth. Is that your understanding?

22 A Yes.

23 Q And that's in Dr. Cash's records?

24 A Yes.

25 Q All right. So can you -- you can step out, Doctor, so maybe you can

1 show the jury what you're referring to or talking about.

2 A So -- and it's from looking at the diagram as well as reading the notes.

3 The notes suggest that he was having pain in the heel and out to the lateral aspect

4 -- lateral three toes I believe is the way it was explained. So your outer three toes of

5 the foot and in the heel.

6 The other thing of interest here is it's on both feet as well. He was also

7 having pain in his right foot in a similar distribution, not as much pain. And that

8 would --

9 Q So --

10 A Sorry, that would suggest this distribution would be S1 which would

11 relate to the 5-1 disc problem, not the 4-5 problem.

12 Q Four-five would not cause the problem out here on the lateral toes.

13 That wouldn't be associated --

14 A The 4-5 problem one would anticipate pain coming down onto the top of

15 the foot and going to the first toe or big toe.

16 MR. LAURIA: I put my yellow pad down and I left it up here. Excuse me,

17 Your Honor. Sorry.

18 THE COURT: Oh.

19 BY MR. LAURIA:

20 Q So let's -- I started to go through the treatment here and I want to go

21 through it quickly. You would agree with me the records indicate that he started

22 having back in 2008?

23 A Yes.

24 Q All right. And that he started having back pain when he was playing the

25 football season in August of 2008?

1 A Yes.

2 Q And kind of waxed and waned, came and went?

3 A Yes --

4 Q Had some radicular symptoms that suggested that there was something

5 going on in the disc and his spine?

6 A Something that would suggest that nerves being compressed.

7 Q All right. And then in February of 2009, after the football season has

8 been over, he has an MRI that shows that there is a five millimeter disc protrusion

9 on the left side of L5-S1?

10 A Central to the left. Yes.

11 Q And it appears to be compressing or impinging on the S1 nerve root?

12 A The radiologist reads it as causing impingement upon the nerve root.

13 Yes.

14 Q And that would be consistent with the complaints that he had at that

15 time?

16 A Yes.

17 Q All right. And then he goes -- but he kind of recovers from that, is

18 relatively short lived, goes on for a month or so, true?

19 A Yes.

20 Q All right. And then starts playing football --

21 MR. PRINCE: Objection; leading, Judge. I know he's trying to hurry but he's

22 -- I want to ask question --

23 THE COURT: Well --

24 MR. PRINCE: -- correctly.

25 THE COURT: -- technically he's leading. I'll sustain the objection.

1 MR. LAURIA: Okay. Thanks. All right.
2 BY MR. LAURIA:
3 Q Did he have another MRI?
4 A Yes, he had a follow-up MRI.
5 Q All right. He had a follow-up MRI -- was that also during -- at or around
6 the time of football as you recall?
7 A Yes.
8 Q All right. Did it appear that most of Mr. Orth's problems or complaints
9 came when he tried to play football?
10 A I don't specifically recall that.
11 Q Okay. And again in -- well strike that. What led him to be referred to a
12 neurosurgeon, Dr. Capanna, for evaluation and treatment?
13 A Usually with back and leg pain and more common -- when it's more leg
14 pain than back pain, we would anticipate that 80 percent of people will get better if
15 you just leave them alone. So the natural history nature clears things up for about
16 80 to 90 percent of people. If you're in that 10 percent that wax and wane and don't
17 get better over time, then you get investigated and consideration is given to a
18 surgical intervention.
19 Q All right. So at the point that he's referred to Dr. Capanna in September
20 of 2010, he's been having pain problems now on and off for two plus years?
21 A Yes.
22 Q All right. He had pain management which had once worked and then
23 once didn't work; is that fair?
24 A Yeah. Yes.
25 Q All right.

1 A It had mixed results with it.

2 Q And the most recent was not successful? The most recent to Dr.

3 Capanna's visit?

4 A The 2015? You're talking about --

5 Q No, the 2010 --

6 A Oh, for Dr. Capanna.

7 Q -- August of 2010.

8 A Yes.

9 Q All right.

10 A That had not been successful.

11 Q All right. And so a recommendation at that point was made for surgical

12 consultation?

13 A Yes.

14 Q Certainly reasonable, right?

15 A Yes.

16 Q All right. Now, when he saw Dr. Capanna, did Dr. Capanna rush him

17 immediately in to do surgery at that time?

18 A No.

19 Q What did he have done?

20 A At that time he did the history, physical examination, he had further

21 imaging and he made a offer at one point that surgery was a reasonable option for

22 him.

23 Q He also ordered an EMG and nerve conduction study and --

24 A Yes, he did.

25 Q -- what did that show?

1 A The EMG nerve conduction study which is an electrical study that looks
2 at the function of the nerves showed a combination of things. It showed some S --
3 predominantly S1 problem, a little bit of an L5 problem -- much more so an S1
4 problem. But in the background it also showed something called peripheral
5 neuropathy. That's a more generalized problem showing that the nerves have a
6 little bit of an illness to them.
7 Q So what is that -- what is a peripheral nopathy (sic)? Can you explain --
8 MR. PRINCE: Move to strike, Judge. That is completely an undisclosed
9 opinion they -- no one's ever diagnosed him with that, including this doctor. No
10 report, nothing ever.
11 THE WITNESS: It's on the EMG report.
12 MR. PRINCE: Yeah, it's not --
13 THE COURT: Well --
14 MR. PRINCE: Yeah, but that doctor --
15 THE COURT: Okay. Hold on.
16 MR. PRINCE: -- didn't even diagnose --
17 THE COURT: Approach the bench. Approach the bench.
18 MR. PRINCE: -- S1 radiculopathy --
19 THE COURT: Approach -- okay, stop talking.
20 MR. PRINCE: He never talked about it.
21 THE COURT: Stop talking --
22 MR. LAURIA: It's in the record.
23 THE COURT: -- and approach the bench, both of you.
24 [Bench conference at 2:25 p.m. - not transcribed]
25 THE COURT: I'll sustain the objection. Let's move on.

1 MR. LAURIA: All right.
2 BY MR. LAURIA:
3 Q Did -- in your review, did it appear that any guarantees were made
4 about the outcomes of surgery by Dr. Capanna?
5 A Certainly not.
6 Q All right. We talked a little about -- earlier about your experience or
7 what you tell patients that depending on how they present to you, some percentage
8 of them, one to three out of every 10 people are going to continue to have problems
9 even if you do a microdiscectomy?
10 A Correct.
11 Q All right. And are you able to predict which ones those are going to be?
12 I mean could you have predicted that I would be -- I would do well and Mr. Cardinale
13 wouldn't?
14 A If I could predict it, then I'd know who to operate on and who not to and
15 we wouldn't have those rates. So no, you can't predict it.
16 Q All right. It's just for unknown medical reasons that we don't understand
17 some people do well and some don't?
18 A That's why we have a research institute. Hopefully we'll have an
19 answer.
20 Q That's one of the things you're studying?
21 A Yes.
22 Q All right. And how long have you been doing that?
23 A Number of years.
24 Q All right.
25 A Sorry, don't have an answer yet.

1 Q The -- what would be -- well strike that. Let me go back and let me just
2 time answering. What is your understanding based upon your review of the records,
3 the reading the deposition in this case as to what occurred most likely during the
4 operation to cause entry into the L4-5 disc so -- do you understand my question?
5 A I think so.
6 Q All right.
7 A So my understanding from everything that I've gleaned from this case
8 so far is that the surgeon, Dr. Capanna, was palpating around the L4-5 region, he
9 was at the L4-5 interspace, was probably using a -- I would suspect a Penfield 4 but
10 some sort of probe, and when he was palpating and tapping he violated the L4-5
11 disc space; he entered the disc space.
12 Q Can you show the jury -- if I put up a model or a diagram, could you
13 explain to the jury what Dr. -- what you understand Dr. Capanna's approach to be in
14 this case and how that could have occurred? Does that make sense?
15 A Yes.
16 Q All right.
17 THE WITNESS: Can I --
18 THE COURT: You may. Yes, absolutely.
19 THE WITNESS: So my understanding from -- especially from --
20 THE COURT: Hold on, Dr. Belzberg, I'm sorry. Mr. Lauria, the -- as far as the
21 screen's concerned, you can't see part of that diagram for the jurors.
22 MR. LAURIA: We're just using the part --
23 THE COURT: Oh.
24 MR. LAURIA: -- in the center.
25 THE COURT: Okay.

1 MR. LAURIA: I think that is the --

2 THE COURT: I'm sorry.

3 BY MR. LAURIA:

4 Q Is that the only part you wanted right there?

5 A Sure. That makes sense.

6 MR. LAURIA: Thank you, Judge.

7 THE WITNESS: So in reviewing trying to understand the operation that was
8 done the -- we're talking about the first operation. This would be a fair
9 representation. Again we're splitting the body in half looking in from the side, front,
10 back, top, bottom, and I fully agree with Dr. Cash he described this this morning.
11 This would be the 5-1 disc herniation between the fifth bone and the S1 bone. This
12 is the target that Dr. Capanna was going for. In his deposition and what he
13 describes, at one point he feels that going this way, which would be definitely the
14 traditional maneuver of getting into this area, he abandoned that for a period of time.
15 He moved above this bone and tried coming this way. And in his description he
16 says I nibbled a little bit of the L5 which would be this bone here. I nibbled a little bit
17 of this bone and tried to aim this way to get to that disc space. That's my
18 understanding of what he did.

19 Now when he was between these two bones in this area, he's
20 palpating, he's using that probe and I believe he probed and entered that disc. And
21 that's my understanding of what happened.

22 BY MR. LAURIA:

23 Q Doctor, is -- in your opinion, is it a recognized risk that when you're
24 doing a surgery and probing that there may be some inadvertent entry into another
25 structure?

1 A Yes. That would be a complication from surgery, yes.

2 Q And in your opinion would an inadvertent entry into the disc as you're

3 probing, would that be malpractice or below the standard of care?

4 A No, that would not be considered malpractice.

5 Q You have had an inadvertent entry into a disc yourself when probing?

6 A Yes, I have.

7 Q It's happened to your colleagues at Johns Hopkins?

8 A Yes, it has.

9 Q Doesn't mean you're being careless or not paying attention to what

10 you're doing?

11 A You certainly don't want it to happen and you're trying not to do

12 something like that, but I would not consider it malpractice just because it happened.

13 Q All right. Going on what Dr. Capanna has testified that he did and the

14 reason he went up there, do -- the reason he was trying that approach, is there a

15 cookbook or textbook that a surgeon in your opinion has to follow as to you can only

16 approach this way and that's the only appropriate way to do it?

17 A I think what you have to do is do what is -- what you're -- number one

18 what you're trained to do, what you're comfortable with, what is reasonable, and

19 what is reasonable is what would a prudent and reasonable surgeon do in a similar

20 circumstance. Surgery is never cookbook. There's always going to be little twists to

21 it. Just like when you're working on a car or doing something mechanical, it's never

22 a hundred percent the way the book is. So you have to be prepared to alter your

23 technique depending on what you're faced with and you do that in a responsible

24 manner.

25 My understanding in this case is that Dr. Capanna did the traditional

1 approach to 5-1 by going into the 5-1 interspace. He then moved up to 4-5 and tried
2 to come above the L5 lamina and angle into the space. That is certainly not the
3 traditional way to do a 5-1 disc. He has an explanation as to why he felt under the
4 circumstances that was something he had to try.

5 Now I heard this morning that it would be absolutely impossible to get to
6 the 5-1 disc coming above the lamina. Again this is not my diagram, this is just a
7 diagram. I think one can see that if you nibbled this corner and I take my straight
8 line and go like this, I certainly can get to the 5-1 disc coming above the L5 lamina.
9 It is not a traditional way of doing it, but if he felt under the circumstances that's what
10 he needed to do to try, that's what he needed to do.

11 Q So it is certainly not impossible to do it that way?

12 A It's not impossible to do it that way.

13 Q All right. And in your opinion does a surgeon who is attempting to
14 relieve a problem have -- are they allowed to exercise judgment in what they think is
15 best in taking care of the patient at the time?

16 A A surgeon's going to do during surgery what they believe in the -- is in
17 the patient's best interest.

18 Q Do you exercise judgment when you're performing a procedure as to
19 what's the best approach to do and it may be different this time than last time?

20 A When a patient consents for surgery, they're basically consenting
21 saying do what you believe is in my best interest and you're trusting your surgeon to
22 act in their best interest.

23 Q In this case the patient consented to an L5-S1 discectomy. If Dr.
24 Capanna attempted to approach it by taking off a bit of the top of the lamina of L5
25 and approaching it that way and so was up in the area L4-5, did that in your opinion

1 mean that to a reasonable medical probability he violated the informed consent?

2 A Again, I would not consider that a traditional way of doing a 5-1

3 discectomy. I wasn't there at the time of surgery. I can only go by what the surgeon

4 is saying in his deposition. He felt that he did not get the view that he needed going

5 at 5-1, the traditional manner, and he was trying the approach from above. If he felt

6 under those circumstances that was what he needed to do, that's what he felt he

7 needed to do.

8 Q Okay. And so that would not violate the consent to just do a certain

9 level?

10 A It doesn't violate the consent.

11 Q All right. Now, postoperatively some of the MRI films they show at least

12 one cut of the 10/6 MRI. You've looked at that MRI also, true?

13 A Yes.

14 Q All right. And in your experience and opinion, is -- are you less likely to

15 see evidence of a surgical track in the area of L5-S1 than you would in the L5 --

16 L4-5 area?

17 A In general terms when you do a microdiscectomy at 5-1 there's going to

18 be much less scarring than at 4-5, simply because the 5-1 interspace is easier to get

19 to in terms of removing ligament and not having to remove bone. So usually you

20 can get to 5-1 without removing any bone and there's therefore going to be less

21 scar.

22 Q All right. So there's going to be -- part of the reason that you see the

23 scarring in that area at L4-5 is because of the bone removal?

24 A In general terms the operation at 4-5 and as you move higher, 2-3 and

25 so on, there's more work you have to do to expose the disc. The 5-1 space in most

1 people is the easiest space to get to.

2 Q As Dr. Capanna explains, in his procedure he removed just a portion of

3 the top of that lamina to get down to the disc. But ultimately it didn't work. He went

4 and did another way and was able to accomplish it. Is that your understanding?

5 A That's what he says.

6 Q All right. When Dr. Cash did his procedure -- you've reviewed his

7 operative report?

8 A Yes.

9 Q All right. Were there any things that were in your opinion done in that

10 procedure but that Dr. Cash didn't report or record doing at that time?

11 MR. PRINCE: Objection; definitely beyond the scope of any opinions he's

12 ever expressed in this case. He doesn't even comment on that --

13 THE COURT: Mr. Lauria?

14 MR. PRINCE: -- ever.

15 MR. LAURIA: Judge, I don't know that that's an opinion. I mean the record

16 says what it says.

17 THE COURT: Well, approach the -- I'm going to sustain the objection.

18 MR. LAURIA: All right.

19 THE COURT: I don't want to --

20 BY MR. LAURIA:

21 Q Doctor, you were here when Dr. Cash said he did an -- he had to do a

22 partial laminectomy or a laminotomy at L4 to get to the L4-5 disc space, didn't he?

23 A He -- when he went for the fragment, he removed part of the L4. Yes.

24 Q All right. And he said that I think when he was sitting here testifying?

25 A That was not in his operative note. That was what he stated this

1 morning.

2 Q All right. So his operative report -- he stated this morning he did it, but

3 it's not in his operative report that he did it. Is that your understanding?

4 A Yes.

5 Q All right. What kind of postoperative changes might you expect if in fact

6 there is relief of a L5-S1 nerve root that's impinged by a disc?

7 A What type of post -- say that again, sorry?

8 Q Yeah. Yeah. What kind of things might you find -- for example,

9 changes that might occur -- if you've relieved some compression on a disc in the

10 immediate postoperative period?

11 A And you're talking about find on an MRI?

12 Q No, you might find clinically.

13 A Hopefully the patient's better. So if you've relieved the pressure on the

14 nerve, you would expect the patient's pain to be better.

15 Q All right. Any findings deep tendon reflexes those types of things?

16 A Those can lag behind. So if a patient has lost their deep tendon reflex

17 or it's down a little bit, sometimes it comes back quickly, sometimes it comes back

18 slowly and sometimes it doesn't come back at all.

19 Q Did Dr. Capanna note when he saw the patient postoperatively any --

20 before the patient returned with this big pain complaint of any change in his deep

21 tendon reflexes?

22 A Yes, he noted that it improved.

23 Q All right. And that would be a clinical sign as a neurosurgeon that there

24 had been some relief in some way on this compression?

25 A Yes.

1 Q All right. I want to talk about because -- what do you believe occurred,
2 Doctor, in your opinion that resulted in the patient calling Dr. Capanna on the night --
3 late night of October 5th, 2010 with a change in his condition?
4 MR. PRINCE: Objection; lacks foundation. Undisclosed opinion, Judge.
5 THE COURT: Mr. Lauria?
6 MR. LAURIA: Your Honor, I think it is -- again is all part of the patient's history
7 that leads to where he is and --
8 THE COURT: Well I'll let you follow up with a little more foundation in the
9 question if you would.
10 MR. LAURIA: Sure.
11 THE COURT: Right.
12 BY MR. LAURIA:
13 Q You have read Dr. Capanna's office chart and notes, right?
14 A Yes.
15 Q And you understand that he received the phone call the night hours
16 approximately October 5th late evening about a change in Mr. Orth's condition?
17 A Yes.
18 Q Dr. -- did Dr. Capanna ignore the patient at that time?
19 MR. PRINCE: Objection, Your Honor; outside the scope of his designation as
20 an expert, definitely an undisclosed opinion. I have his report right here. No --
21 comment any of this.
22 THE COURT: I don't -- it's not an expert opinion. You can answer the
23 question.
24 THE WITNESS: No, he did not ignore his patient.
25 BY MR. LAURIA:

1 Q All right. What did he do?

2 A He had the patient come in the next day so he could be evaluated.

3 Q And then he sent -- had him have an MRI done to see what was going

4 on?

5 A He did a history and physical examination on the patient and then he

6 ordered an MRI.

7 Q All right. Based upon everything you know about the patient's condition

8 in the immediate post-op period, that is the first follow-up visit with Dr. Capanna,

9 patient was doing pretty well, wasn't he?

10 A He was -- yes.

11 Q All right. And then we have an event on the evening of October 5th and

12 now the patient has fairly severe pain complaints?

13 A Correct.

14 Q All right. Based upon the information we know from the MRI, there was

15 a fragment that's at the --

16 A L4-5.

17 Q -- L4-5 disc space --

18 A Yes.

19 Q -- that's present on October 6th that wasn't there previously, true?

20 A Yes.

21 Q You -- what is your opinion as to what occurred -- how did that happen?

22 MR. PRINCE: Objection; outside the -- did not designate that opinion, Judge.

23 Did not disclose.

24 THE COURT: Mr. Lauria?

25 MR. LAURIA: Your Honor, again I believe it is part of the entire course of this

1 patient's --

2 MR. PRINCE: No.

3 MR. LAURIA: -- treatment and what's happened.

4 THE COURT: Well that I'm going to sustain the objection.

5 BY MR. LAURIA:

6 Q You believe that there was a change in his condition that occurred from

7 the first pre-op visit obviously until the MRI was done?

8 A Yes.

9 Q All right. You believe it's likely that that fragment that was noted on that

10 MRI had been there since the surgery 20 days before?

11 MR. PRINCE: Objection; undisclosed opinion, Judge. Same thing.

12 THE COURT: Sustained.

13 BY MR. LAURIA:

14 Q All right. Dr. Capanna -- after the MRI, did he make any

15 recommendations in treatment for the patient?

16 A Yes.

17 Q All right. What is your understanding, Doctor, of the recommendations

18 that Dr. Capanna made when Mr. Orth returned, had the MRI and the MRI findings?

19 A Was also on the -- based on his history and physical examination. So

20 at that time he felt the patient was having pain. He determined that the patient did

21 not have any deficits, he did not have any weakness, and he recommended

22 non-operative care. He recommended steroid therapy -- possibility of steroid

23 therapy and pain medication management.

24 Q All right. Given the fact that the patient did -- wasn't showing any signs

25 of weakness at that point, the patient was experiencing pain, based on the findings

1 of the MRI, was that a reasonable method to address this patient's complaints at
2 that time?
3 A So --
4 Q With non-surgical intervention?
5 A The indications -- the absolute indication for surgery in a patient who
6 has this presentation on MRI, a fragment, the absolute indication would be a
7 progressive -- progressing neurological deficit, bowel or bladder problems from
8 compression of the nerves or pain that can't be managed any other way. Those
9 would be the absolute indications. In this case, it would be very reasonable to offer
10 the patient surgery and it would be very reasonable to offer the patient
11 non-operative care, including medication management.
12 Q All right.
13 A Again approximately 80 percent of people -- even with a free fragment
14 like this, approximately 80 percent of people will get better and it will vanish so to
15 speak over time.
16 Q All right. So 80 percent of people will get better with treatment with
17 steroids or pain management?
18 A Basically the fragment you're hoping will shrink. It's full of water when it
19 first herniates. Over time it shrinks, so if you think of this like toothpaste that came
20 out of the -- out of your toothpaste container, it's a big blob in the morning on the
21 sink. But over time -- by nighttime it's shrunk down as the water's come out of it.
22 The body resorbs the water as well from that fragment. So over time it does shrink,
23 and we see patients who will have big disc herniations, fragments and so on who
24 over time they -- they'll get better.
25 Now again, there are certain times when you'll wait and there's certain

1 times when you don't wait in terms of offering surgery. That's a judgment call.
2 Q All right. So when Dr. Capanna follows up with this patient after the
3 MRI, in your opinion it was reasonable to make the recommendation he did for
4 conservative treatment?
5 A Yes.
6 Q And your understanding was there was no weakness at that time in the
7 examination or evaluation?
8 A He did not document any weakness.
9 Q All right. Little bit different picture when the patient presents days later
10 and sees Dr. Cash?
11 A He reported that there was weakness on toe stepping and heel.
12 Q All right.
13 A So having the toes come up and having the toes go down he reported
14 weakness.
15 Q All right. The patient's course in the months following the surgery by Dr.
16 Cash did -- would you have expected his recovery to be as it was?
17 A In general terms after a microdiscectomy that Dr. Cash did where there
18 was a fragment, he has clear pain related to the fragment and I would have
19 suspected that his pain was related to the fragment, there would be an eight to nine
20 out of 10 chance that he will do well with that surgery and have fairly good resolution
21 of his symptoms.
22 Q All right. That would have been your anticipation?
23 A That would be the data. Yes.
24 Q All right. Data based on scientific evidence what the studies show?
25 A Best on our based -- best review of the data, yes.

1 Q All right. And so -- and that's true -- even though he's had surgery at
2 L5-S1 and L4-5, you would anticipate that he would do well?
3 A I would anticipate in that scenario that he had with his presentation, he
4 has an eight to nine out of 10 chance that he will do well with that surgery.
5 Q All right. He ultimately continued to have complaints of back pain; do
6 you agree?
7 A Yes.
8 Q And he continued to have complains of the radicular pain like we talked
9 about in March 14, 2014?
10 A Yes.
11 Q The subsequent MRIs were taken by Dr. Cash or ordered by Dr. Cash
12 in 2012?
13 A Yes.
14 Q And then again in early 2014?
15 A Yes.
16 Q That's the most recent radiologic study you've seen, true?
17 A Yes.
18 Q All right. Did those study show that there was again some L5-S1 bulge
19 that may have been compressing the nerve root?
20 A Yes.
21 Q All right. That's what's reported by the radiologist?
22 A By the radiologist. Yes.
23 Q All right. And so that can happen, disc can bulge again or protrude
24 again or inflict a nerve root, true?
25 A Yes.

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1 Q All right. Based on the patient's complaints, his evaluations and those
2 studies, you believe that the primary source of his complaints at that time were
3 related to the L5-S1 space in the S1 nerve root?
4 A We're talking about 2014?
5 Q Talking about 2012 through 2014.
6 A Again I would say that I can't say for sure after his second operation
7 whether his complaints are due to L4-5 or L5-S1. Without a clear cut sensory
8 change that follows one root or the other, I don't believe I could say which level is
9 causing the pain.
10 Q Do you believe anybody -- any neurosurgeon, any spine surgeon could
11 be able to say his problems are because of L4-5 versus L5-S1? Do you think that's
12 possible?
13 A I don't think that you would be able to tell -- back pain especially even
14 more so than leg pain. You would not be able to tell whether the back pain is
15 coming from one level, both levels, which one.
16 Q Did this patient -- did Mr. Orth -- was he predisposed to have
17 degenerative changes at the L5-S1 level given that he had a two-year disc extrusion
18 before surgery was done?
19 A Trying to understand the question.
20 Q Sure.
21 A So he had a disc problem at L5-S1. Does that predispose him to
22 problems or is it the fact that he had that problem suggestive that he has a
23 degenerative disc problem? I'm trying to understand the question.
24 Q Okay. Does the fact that he has that problem suggest that there's some
25 degenerative disc problem?

1 A So you can't -- it's very difficult to know the natural history of spine
2 disease. Most people do not herniate discs at the end of the day at that young age.
3 Whether he is predisposed to it, very difficult to say. You would say at L5-S1 when
4 you look at his original films, there were some changes in the joints. He already had
5 some thickened joints or facet hypertrophy, a bulging disc. At that point you would
6 say he has early degenerative disc disease in his spine.
7 Q Would you anticipate as a neurosurgeon that that was going to
8 progress over time?
9 A Very difficult to predict what's going to happen in spine.
10 Q All right. Is that one of the reasons that you believe you cannot say to a
11 reasonable medical probability that he's going to require a fusion sometime in the
12 future?
13 A Again if I go to the data, it is -- what is published in the literature is that
14 approximately 30 to 40 percent of patients maximum when you know they have
15 degenerative disc disease can you predict that they will need a spinal fusion. So it's
16 more likely than not that he won't need a spinal fusion. Everybody has degenerative
17 disc disease; it's just a question of how bad, but as we age, all of our spines
18 degenerate and certainly all of us don't need spinal fusions.
19 Q If -- just a hypothetical question. If the patient has a spinal fusion,
20 would you -- does that provide relief of pain typically?
21 A So in general terms if we're talking specifically about degenerated --
22 degenerative disc disease, spine fusions for that indication, pain and degenerative
23 disc disease, has in general a six out of 10 success rate in terms of patient
24 satisfaction.
25 Q All right. Patients who have fusions are able to play sports, go skiing,

1 do all kinds of activities?

2 A Patients who have successful in terms if they're one of the six out of the

3 10, yes, they go back to very active lifestyles.

4 Q All right. You have patients that you've done fusions on that are

5 engaged in strenuous recreational sports?

6 A Yes.

7 Q Can you give me some examples of what they do that you're aware of?

8 A Waterskiing, jet skiing, snow skiing.

9 Q All right. Those are some of the most strenuous sports on the back?

10 A They're tough on spines.

11 Q All right. I think I'm almost done I'm going to try to get you -- to a

12 reasonable medical probability, do you agree that -- is it your opinion that Dr.

13 Capanna complied with the standard of care of a neurosurgeon in his care of Mr.

14 Orth?

15 A In listening and -- and again I -- I'm not a judge and I'm not a jury. I've

16 read Dr. Capanna's deposition as to what he did at the time of surgery. When I

17 listened to Dr. Cash this morning, he has a very different explanation of what

18 happened at that surgery. If I believe what Dr. Capanna said, yes, he was well

19 within the standard of care in what he did. Again a very unusual approach to 5-1,

20 but would it be outside the standard of care? No. If I believe Dr. Cash that Dr.

21 Capanna was never at 5-1, was only at 4-5, I would say that that was outside the

22 standard of care.

23 Q Can -- in your opinion, can a surgeon be at the wrong level and be

24 within the standard of care?

25 A Yes.

1 Q All right. Has it happened in your facility with your colleagues?
2 A Yes.
3 Q All right. And if there was an inadvertent entry by a probe into the disc
4 at L4-5, would that be below the standard of care?
5 A No, that would not be.
6 Q All right. Thank you, Doctor.
7 MR. CARDINALE: Tony, are all your -- all your opinions.
8 BY MR. LAURIA:
9 Q Oh. Have all your opinions in this case been stated to a reasonable
10 medical probability?
11 A Yes.
12 Q All right. Thank you.
13 THE COURT: Just so I know what -- how much time do we have for the
14 gentleman before we absolutely need to get him out of here and on his plane?
15 THE WITNESS: 4:50 flight. What time do I --
16 THE COURT: 4:50 flight? Okay.
17 MR. LAURIA: And we got the President in town I understand, Judge.
18 THE COURT: I know. You have a -- somebody --
19 MR. PRINCE: He's already here though and that's -- yeah.
20 THE COURT: Pardon?
21 MR. PRINCE: He's already here -- the President's already here. He's going
22 to be going to Henderson so --
23 THE COURT: Okay. Well I'm -- look I'm -- without getting into politics, I'm
24 more concerned --
25 MR. PRINCE: I know.

1 THE COURT: -- about Dr. Belzberg --
2 MR. PRINCE: I understand.
3 THE COURT: -- than I am --
4 MR. PRINCE: So I guess --
5 THE COURT: -- Obama.
6 MR. PRINCE: I'm saying he's south --
7 THE COURT: So --
8 MR. PRINCE: -- of the airport. He -- we're north of the airport so I'm --
9 THE COURT: I just want you all to tell me what -- I'm assuming you have
10 somebody available to take him right away just when --
11 MR. LAURIA: I got a car waiting down for him --
12 THE COURT: -- when you want to break.
13 MR. LAURIA: -- at 3:00 so --
14 THE COURT: Okay.
15 MR. LAURIA: He's got four other people --
16 MR. PRINCE: Okay.
17 THE COURT: No, I know. I know I -- I'm more concerned about that than I
18 am about --
19 MR. PRINCE: Okay.
20 THE COURT: -- finishing this up today so -- all right, Mr. Prince.
21 MR. PRINCE: Thank you, Judge.
22 CROSS-EXAMINATION
23 BY MR. PRINCE:
24 Q Good afternoon, Dr. Belzberg. How are you today?
25 A Good, thank you.

1 Q Have a few questions for you here today. I don't think we're going to be
2 a long time. Kind of depends upon your answers. You understand that today
3 there's going to be a permanent record of your testimony, correct?
4 A Yes.
5 Q And you understand that it would be available to -- for review by the,
6 you know, board of neurosurgery, if necessary, or your colleagues at Johns Hopkins
7 University, correct?
8 A No, would not be available to the board of neurosurgery, would
9 probably be available to the association of neurological surgeons.
10 Q And it could be available to the board. They could -- they review your
11 testimony, right?
12 A The board of neurosurgery?
13 Q Yeah, they have the ability to review testimony you give in medical legal
14 cases.
15 A I don't know that that's in the purview of the board but sure.
16 Q And you understand your role here is you're here to be -- serve as an
17 independent expert. Wouldn't you agree with that, that's your role?
18 A Yes.
19 Q You're not here to be an advocate?
20 A I'm here to be as an expert witness.
21 Q Right. And the one that's hired by the defense, correct? You're not
22 here asked by the Court to serve as an expert witness, correct?
23 A I was hired by the defense.
24 Q Right. And part of what you do at Johns Kopkins (sic) University in
25 addition to the things you also described is that you do medical legal work, correct?

1 A Yes.
2 Q In medical malpractice cases, correct?
3 A Yes.
4 Q And you spend about 90 percent of your time in medical legal work
5 involving medical malpractice matters, you're hired -- by the defense about 90
6 percent of the time to do work on behalf of neurosurgeons, right?
7 A I'd have to think about that. I'm not sure if it's on behalf of
8 neurosurgeons. Probably mostly on behalf of neurosurgeons. I know I've also been
9 asked to be involved where there's orthopedic surgeons, plastic surgeons,
10 neurologists. So it's not just neurosurgeons. And in terms of defense versus
11 plaintiff, I'm probably asked to review cases about equal and I end up being involved
12 in cases much more so on defense.
13 Q Right. And I think you said in your deposition 90 percent of the time
14 you spend in medical legal cases is on behalf of the defense, correct?
15 A Probably in adult. I'm not sure what it is in children. Yes, in adult.
16 Q Okay. And you -- I want to show you -- put on the screen for a moment
17 -- you've read Dr. Capanna's operative note, correct?
18 A Yes.
19 Q And -- a copy up here. It's Exhibit 1, page Bates number 57.
20 [Colloquy between counsel]
21 BY MR. PRINCE:
22 Q And Doctor, you agree that this operative note is not an accurate
23 reflection of the surgery performed by Dr. Capanna, correct?
24 A Yes.
25 Q And you agree that L4-5 was a normal disc before Dr. Capanna

1 performed surgery on September 17th, 2010, correct?

2 A Yes.

3 Q There's three imaging studies that show that that was a normal, healthy

4 disc before that surgery, correct?

5 A Yes.

6 Q After that surgery, L4-5 was no longer a normal, healthy appearing disc,

7 correct?

8 A Yes.

9 Q You agree that based upon your review of the MRI films

10 postoperatively, the -- specifically the August -- excuse me, the October 6, 2010

11 MRI, that there were significant postoperative changes at L4-5, correct?

12 A Yes.

13 MR. PRINCE: And I like you to put up slide number one, Peter.

14 Demonstrative slide one.

15 [Colloquy between counsel]

16 BY MR. PRINCE:

17 Q You have that there, Doctor?

18 A Yes.

19 Q Can you see it --

20 A Yes.

21 Q -- on the screen? I mean, I know you -- Mr. -- you're critical of Dr. Cash

22 for not putting up -- you know, comparing the same slides, you know, from February

23 of '09 to October 2010, correct?

24 A Yes.

25 Q And the slide that -- the cut that was put up at the beginning of part of

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1 your testimony, it didn't show the surgical track that I'm showing here in L4-5,
2 correct?
3 A I'm not sure. I would have to go back and look.
4 Q Right, you don't recall as we sit -- as you sit here that the image that Mr.
5 Lauria showed you didn't show this surgical track going to L4-5?
6 A Sorry, you're talking about before this operation before --
7 Q No.
8 A Which one are we talking about?
9 Q I'm talking Mr. Lauria --
10 A Right.
11 Q -- had you comment upon the one -- the one cut of the October 6, 2010
12 MRI. Do you recall that?
13 A Yes.
14 Q You recall that cut that you looked at, at the beginning of your testimony
15 with Mr. Lauria from October 6, 2010, it did not have the clear surgical track going
16 towards the L4-5 disc space, did it?
17 A It had surgical changes, and I can't recall specifically whether the track
18 was similar to what you're showing here. I'd be happy to look and compare.
19 Q All right. But I mean if you're -- so you weren't trying to mislead this jury
20 in any way by showing a cut from the MRI that didn't show that clear surgical track at
21 L4-5, were you?
22 A Can you repeat the question?
23 Q Sure. You weren't trying to mislead the jury by showing them a cut from
24 the October 6, 2010 MRI that did not show that clear surgical track going towards
25 L4-5?

1 A Despite double negatives, I would not try to mislead a jury and I don't
2 think there was any question when we were looking at a film about a track. I wasn't
3 talking about tracks, wasn't looking at tracks and wasn't referring to tracks. I'm not
4 sure --
5 Q You're looking --
6 A -- when you say was I misleading the jury, I never discussed anything
7 about surgical sites on that discussion.
8 Q Okay. Did you -- now, you agree that there is post-surgical scarring at
9 L4-5 consistent with a surgery at that level according to the October 6, 2010 MRI
10 film, correct?
11 A Yes.
12 Q You've reviewed every cut, both sagittal and axial which is the top down
13 cuts, correct?
14 A Yes.
15 Q And every one of them demonstrated that showed it, post-surgical
16 scarring at L4-5 consistent with a surgery being performed at the L4-5 level, correct?
17 A Yes.
18 Q And in your testimony as I understand it, there is clear evidence of a
19 surgical procedure at L4-5, correct?
20 A Yes.
21 Q And you agree that there is no postoperative changes at the L5-S1
22 level, correct?
23 A There are no postoperative changes that I saw deep to the spinous
24 process at L5 to suggest surgery at L5-S1 that I could see.
25 Q When you say deep to the spinous process, you're talking about as you

1 get towards the lamina and the ligament out -- as you get closer to the canal,
2 correct?
3 A Yes.
4 Q There you have like kind of this soft tissue kind of surgical track kind of
5 a -- right in that area. That's where you see -- seen some postoperative changes
6 following the incision, correct?
7 A Yes.
8 Q All right. Because you agree that looking at that, there is continuity of
9 the ligament and lamina at the L5-S1 level, correct?
10 A I did not when I -- again to be honest full disclosure, I did not look --
11 when I was looking at the MRIs, I do not specifically recall looking at the posterior
12 longitudinal ligament on every cut to see if the post -- what's called posterior
13 longitudinal ligament had been violated.
14 Q All right.
15 A I felt -- and again, I didn't look specifically for it, but I did not see any
16 changes that I could convince myself showed epidural within the canal changes at
17 the L5-S1.
18 Q When you say epidural, you're talking about that area between the
19 lamina -- this area right here. That's the epidural space, the spinal canal, correct,
20 right in there?
21 A Yes.
22 Q Okay. And you understood that this was a wrong level surgical case,
23 correct?
24 A You're talking about the court case when --
25 Q Yeah, the case, this case.

1 A Yes.

2 Q So obviously you as a trained neurosurgeon, you're going to be looking
3 for images which any way indicate was surgery performed at L5-S1 as indicated in
4 the report, correct?

5 A Yes.

6 Q All right. And you couldn't find any, could you?

7 A No, I could not.

8 Q And in your words you saw no clear evidence that surgery was
9 performed at L5-S1, correct?

10 A I saw no clear evidence deep to the -- again, deep to that level that
11 there was surgery at the L5-S1 level.

12 Q I'm sorry, I didn't hear your answer.

13 A Again, I'm saying deep to -- just so we're saying the same thing, on
14 some of the cuts once these changes to the level of the canal and I can't tell whether
15 those changes are there because of 4-5 or because of 5-1. I'm just saying there's
16 changes there, but I don't see any changes deep to that within the canal at L5-S1.

17 Q Right. And you saw no -- at the level of L5-S1, you saw no scarring at
18 L5-S1, only L4-5 consistent with a surgery at that level, correct?

19 A Yes.

20 Q And if you were just simply to -- if a patient came to you with these films
21 and said I had a microdiscectomy, I'm not sure what level, Dr. Belzberg, you would
22 -- looking at those films, you would believe that they had a surgery at L4-5 and not
23 L5-S1, correct?

24 A So that's a -- that's a different question. So the question -- and in trying
25 to answer that, do I have patients where I've seen -- even my own patients or other

1 patients where they've had an L5-S1 microdiscectomy and there's no obvious
2 scarring on the post-op film. I've had, and it's unusual but we've certainly seen it,
3 L5-S1 virtually, and I'm using the word virtually because there's usually something
4 that a radiologist can pick up, but virtually no scarring at 5-1 in a microdiscectomy in
5 the canal. Again, 5-1 you can get away with minimal scarring because there's
6 minimal dissection. In this case, I don't see any change within that space.
7 Q Okay.
8 MR. PRINCE: Do you have Dr. Belzberg's deposition, please?
9 Did we give him his deposition?
10 [Colloquy between the Court and the Clerk]
11 MR. PRINCE: Oh I'm sorry. I'd like to publish --
12 THE COURT: Okay.
13 MR. PRINCE: May I hand it to the witness, Your Honor?
14 THE COURT: You may.
15 MR. PRINCE: Okay.
16 BY MR. PRINCE:
17 Q Dr. Belzberg, I'm handing you a copy of your deposition.
18 THE COURT: And just for the record, that was May 29th of this year, correct?
19 MR. PRINCE: Yes.
20 THE COURT: Okay.
21 BY MR. PRINCE:
22 Q What I'd like you to do, Dr. Belzberg, is go to page 44 of your
23 deposition, starting at line 9.
24 MR. PRINCE: Ready? I'll tell you when, Peter.
25 Q Starting at line 9 and we're going to go to line 24. And you recall that

1 your deposition was taken by my law firm over the telephone in May of this year,
2 correct?
3 A Yes.
4 Q And you read your deposition for preparation for the trial testimony,
5 correct, obviously?
6 A Yes.
7 Q Something you would commonly do, correct?
8 A Yes.
9 Q And you took an oath just like you took an oath here today, correct?
10 A Yes.
11 Q Okay. And I'd like to have you start look at line 9 of page 44.
12 A Yes.
13 [Colloquy between counsel]
14 MR. PRINCE: One second.
15 MR. LAURIA: And Your Honor, just for clarification, I assume that we're going
16 to permit publication of testimony of witnesses for cross or --
17 THE COURT: Well we don't use depositions of nonparties for any purpose. I
18 -- are you just trying to ask him --
19 MR. LAURIA: Yeah, so he's got to be posted --
20 MR. PRINCE: Impeach him.
21 THE COURT: -- to refresh his memory or what?
22 MR. PRINCE: No, I'm trying to impeach him.
23 THE COURT: Why don't you take it off the screen for a second, please.
24 MR. PRINCE: Okay.
25 BY MR. PRINCE:

1 Q Well let me just ask you this: Doctor, do you --
2 THE COURT: I got it off. Let's keep going.
3 MR. LAURIA: Thank you.
4 THE COURT: I want to get the gentleman on his way --
5 BY MR. PRINCE:
6 Q Doctor, do you recall testifying -- being asked the question at the time of
7 your deposition that said: Absent any history, if you were to see -- without knowing
8 anything about the patient, if you were to see this MRI from October 6, 2010, what
9 would you as a neurosurgeon determine happened to the patient?
10 Your answer was so I understand your question, I'm looking strictly at
11 the MRI.
12 Question: Yes. The patient comes to you and says I had back surgery,
13 I don't know what level, here's my MRI, what would your conclusion be of where the
14 patient had surgery?
15 Answer: Lumbar spine, left side, L4-5 region.
16 Did I read that question and answer correctly? Did I?
17 A I don't know. I'm still stuck on the part you're trying to impeach me.
18 Q No, I'm just asking if I read the question and answer --
19 A I'm going back to the first comment.
20 Q No, I'm asking the -- if I read the question and answer correctly.
21 A The first part wasn't a question. It was just a combative statement --
22 THE COURT: Did he read that correctly, Doctor, or not?
23 THE WITNESS: Yes, he did.
24 THE COURT: Thank you.
25 MR. PRINCE: I was talking to the Judge.

1 THE COURT: Okay.

2 MR. PRINCE: Your Honor, please instruct the witness not to address me --

3 THE COURT: Let's just go ahead and ask another question now.

4 BY MR. PRINCE:

5 Q And it says here --

6 THE COURT: He answered the last one.

7 Q -- so it says -- then it goes on to say you wouldn't suspect that L5-S1

8 was operated on, correct, based on this MRI. What was your answer?

9 A Do you want me to read it?

10 Q Yes.

11 A Correct.

12 Q Okay. So if patient came to you with that MRI film, according to your

13 deposition testimony, and said Dr. Belzberg, I'm having problems, I had

14 microdiscectomy, I'm not sure what level, you would look at the film and determine

15 based upon your review of the radiographic study as a fellowship-trained

16 neurosurgeon, professor at Johns Hopkins that they had a left-sided L4-5 surgery,

17 correct?

18 A No.

19 Q You wouldn't conclude that?

20 A No, I wouldn't.

21 Q Well that's what you just said in your deposition.

22 A No, in fact it's not. Shall we read again? You asked me if a patient

23 came to see me and told me what they had had, I would do a history, a physical

24 examination and then I would review the MRI. And I said in that situation I would

25 make a determination on what I think the patient may or may not have had. If

1 isolated -- strictly isolated, you showed me that MRI and nothing else and said what
2 level has this patient been operated on, I would say L4-5.
3 Q Right. That's what I'm asking you about. If --
4 A No, you asked me --
5 THE COURT: Hold on. Hold on, Doctor.
6 A -- if a patient came to see me --
7 THE COURT: Hold on, Doctor.
8 A -- and --
9 THE COURT: Let him ask you another question now, okay?
10 THE WITNESS: Sure.
11 THE COURT: Thank you.
12 BY MR. PRINCE:
13 Q Okay. I'm going to read the question and answer again, because I want
14 to make sure we're clear on this point.
15 A Sure.
16 Q Question: The patient comes to you and says I had back surgery, I
17 don't know what level, here's my MRI, what would your conclusion be of where the
18 patient had surgery?
19 Answer: Lumbar spine, left side, L4-5 region.
20 Did I read that correctly?
21 A And once again so I --
22 Q Did I say -- that's a yes or no.
23 A No, it's not a yes or no then you didn't. It says so I understand your
24 question, if I'm looking strictly at the MRI. And I will agree looking strictly at the MRI
25 in this case, if I only have the MRI, I would suggest that patient had surgery at L4-5.

1 Q Okay. And you wouldn't suspect -- this is reading your deposition, page
2 -- line 22 of page 44: Okay, you wouldn't suspect that L5-S1 was operated on,
3 correct, based on this MRI? Your answer was correct.
4 A Yes, that's correct.
5 Q Now, as it relates to this case and your work in this case, you don't
6 recall when you're hired, correct?
7 A Correct.
8 Q You don't know what year it was, correct?
9 A Correct.
10 Q You don't know what year you even prepared your initial report,
11 correct?
12 A Correct.
13 Q You don't even know -- recall who hired you, right?
14 A Not specifically --
15 Q You don't even know if you've ever been hired in the state of Nevada --
16 in a case involving the state of -- in the state of Nevada before, correct?
17 A I don't track what medical legal review I've done in the past.
18 Q Right. You don't recall if you've ever given a deposition in a case
19 involving a Nevada patient?
20 A Again, I don't track that.
21 Q And in your -- the report you prepared, it does -- it is undated, correct?
22 A I don't know, I'd have to go back on that.
23 Q And at the time you gave your deposition in May of 2015, you had a
24 copy of Dr. Capanna's deposition but do not recall whether you had read it or not,
25 correct?

1 A Correct.

2 Q Now, I want to look -- do you have your report there available to you?

3 A Somebody will have to find it for me.

4 Q Okay. Now I just want to --

5 A There's a lot of folders in here.

6 Q I just want to talk about one aspect of it.

7 A Can --

8 Q Because don't you agree that initially --

9 A Excuse me.

10 THE COURT: Hold on. Hold on, let him --

11 THE WITNESS: I'm just looking for the report.

12 THE COURT: -- let him locate the report if you want to ask him about that.

13 MR. PRINCE: I don't think he has it. He said he didn't have it.

14 THE WITNESS: No.

15 MR. PRINCE: I didn't know if he brought it up there with him.

16 THE WITNESS: Excuse me, there's two huge binders. If my report is in here

17 somewhere, I'd like to look at it. So does --

18 BY MR. PRINCE:

19 Q I don't know if it's in there or not I -- in fairness, I don't know what -- I

20 don't know you have up there.

21 A Do you want me to look at the report or just listen to a question about

22 it? What would you like?

23 Q Yeah, I would like to go through --

24 MR. PRINCE: What exhibit -- what defense exhibit?

25 THE COURT: You asking about --

1 MS. EGLET: It's --

2 THE COURT: -- his original report?

3 MR. PRINCE: Yes.

4 THE COURT: Here's a copy of it, sir.

5 THE WITNESS: Thank you.

6 MR. LAURIA: Yeah, it's --

7 MS. EGLET: It's Defense Exhibit Double --

8 MR. LAURIA: I think it's Defense -- let me see if we can find it so we can

9 move along.

10 MS. EGLET: Double --

11 THE COURT: He's got a copy now. Go ahead.

12 MR. LAURIA: Okay. Thank you.

13 MR. PRINCE: Okay.

14 BY MR. PRINCE:

15 Q Okay, do you have it?

16 A Yes.

17 Q Okay. And you were asked -- not asked. You were asked to give an

18 opinion concerning standard of care, correct?

19 A Yes.

20 Q Regarding Dr. Capanna?

21 A Yes.

22 Q And that's the only opinion that you expressed in your original undated

23 report was just the opinion on standard of care, correct?

24 A Just looking at that. I have a summary here and then I have a standard

25 of care with a comment on it, yes --

1 Q Okay, so --

2 A -- and opinion.

3 Q Okay. And so your opinion -- you were asked to give an opinion
4 regarding Dr. Capanna's standard of care, correct?

5 A Yes.

6 Q And based upon just looking at the records and the MRI films
7 themselves -- okay, his operative report and the MRI, you couldn't state to a
8 reasonable degree of medical probability that Dr. Capanna met the standard of care,
9 correct? If you just looked at only those two items?

10 A Correct.

11 Q And so then you were asked to assume that certain testimony would be
12 true, correct?

13 A Yes.

14 MR. PRINCE: And let's put up slide 39.

15 BY MR. PRINCE:

16 Q I want to -- it's kind of a lengthy assumption that you were given. And it
17 says it's my understanding that Dr. Capanna's anticipated --

18 MR. LAURIA: Your Honor, again I'm not --

19 Q -- testimony --

20 MR. LAURIA: Excuse me. I'm not sure this is in evidence, so I'm not sure
21 why it's on the screen.

22 MR. PRINCE: Well I want to read the section of it -- they said it's Dr.
23 Capanna's testimony --

24 THE COURT: I understand what the purpose of this question is. You can go
25 ahead.

1 BY MR. PRINCE:
2 Q Said it's my understanding that Dr. Capanna's anticipated testimony will
3 acknowledge his operative report was dictated as a general template report and
4 omitted specific details explaining why he left a surgical footprint at the L4-L5 level.
5 Do you see that?
6 A Yes.
7 Q Because it's your practice and how you train surgeons at Johns
8 Hopkins and anywhere else in the world that you should accurately and in a very
9 detailed manner document your findings during surgery and the procedure you
10 perform, correct?
11 A Sorry, there was a lot in that. What was the actual question? You
12 should document in your surgery note? Is that what you're asking me about?
13 Q Yes.
14 A Surgery notes should be documented well. Yes.
15 Q And it should be documented well, it should be detailed and should be
16 accurate, correct?
17 A It should be accurate, yes.
18 Q Okay, and that's the --
19 A The detail is all over the place. Some people put a lot of detail, some
20 people put very little detail, but it should be accurate, yes.
21 Q Always accurate, correct?
22 A Yes.
23 Q And it should document any significant findings, correct?
24 A Significant findings is a judgement call, so I don't know what you mean
25 by that, but it should be accurate, yes.

1 Q Okay, which could include any significant findings concerning the
2 anatomy of the spine where you're operating?
3 A Again, operative notes are done very differently by different surgeons.
4 There -- some operative notes are pages long, some are a paragraph long. They
5 vary. I would agree that they should be accurate.
6 Q Okay. And it says it's my understanding that Dr. Capanna's anticipated
7 testimony will explain the following. Now, you've never had another case like this
8 where you're asked to assume that certain information is going to be true, that
9 someone's going to testify a certain way, correct?
10 A No, I have had that.
11 Q You have had that before?
12 A Yes.
13 Q Okay. I just haven't seen it before. And it says -- so this is a
14 description of what you -- Dr. Capanna's anticipated testimony is going to be
15 according to his original lawyers, correct?
16 A Yes.
17 Q And you never interviewed Dr. Capanna as part of your review of this
18 case, correct?
19 A Not when I prepared this report.
20 Q And it says during surgery, Mr. Orth's fascia and muscles were larger
21 and tighter than usual so Dr. Capanna made a small microlaminotomy in L5-S1. Do
22 you see that?
23 A Yes.
24 Q You agree that on the MRI imaging, there is no evidence of a
25 microlaminotomy at L5-S1?

1 A Yes.

2 Q So that -- even that assumed testimony, that part is inaccurate?

3 A No, that's not true.

4 Q That's not true?

5 A No, just because it's not on an MRI doesn't mean it's not there.

6 Q Okay. Well let me ask it this way. There is no finding on the October 6,
7 2010 MRI which showed a microlaminotomy at L5-S1 consistent with that alleged
8 statement by Dr. Capanna, correct?

9 A Yes.

10 Q Then it says laterally, where the disc would be was at an angle and he
11 could not reach the fragment. Now you agree that Dr. Capanna -- he did not
12 document that in his operative note that there was a lateral disc he needed to get
13 to?

14 A Correct.

15 Q In fact it was a paracentral disc, correct?

16 A Yes.

17 Q It was not a lateral disc, correct?

18 A This was not a lateral disc herniation.

19 Q And because you agree that at the L5-S1 level, it's the L5 nerve root
20 that exits out the L5-S1 level, correct?

21 A Yes.

22 Q If there is a disc herniation -- a paracentral disc herniation, that would
23 affect the S1 root, not the L5 root, correct?

24 A Most likely. Yes.

25 Q Also, it's only if you have a lateral disc herniation out to the side would

1 the L5 root be affected, correct?

2 A Most likely. Yes.

3 Q And you saw in your review of the MRI imaging preoperatively there

4 was no lateral disc herniation present, correct?

5 A I do not believe there was a far lateral disc herniation at L5-S1.

6 Q Okay. And then it says so Dr. Capanna went above the L5 lamina and

7 angled laterally to see if he could reach the disc space under the lamina or to take a

8 portion off. This necessitated extending the incision up the L4-5 interlaminar area to

9 angle down. Ultimately the small fragment was removed at L5-S1 without removing

10 intradiscal material. That's inconsistent with his operative report, right, because he

11 says he removes intradiscal material?

12 A It is not what's in the operative report.

13 Q Because he says he removes material in his operative report, correct?

14 A Yes.

15 Q So it directly contradicts his operative report?

16 A Yes.

17 Q And then it says the anatomy required Dr. Capanna to approach the

18 L5-S1 disc fragment from both below and above the L5 lamina. See that?

19 A Yes.

20 Q Now, there's no evidence -- there's no laminotomy on the bottom

21 portion or the inferior lamina -- L5 lamina, correct? That you saw.

22 A Sorry, there's no -- you mean in the post-op scan is what you're asking

23 me?

24 Q Yes.

25 A On the post-op scan I do not see evidence of a laminotomy at L -- the

1 inferior aspect of L5 --
2 Q And --
3 A -- the caudal aspect of L5.
4 Q Right. And when we say superior, that means towards the head and
5 inferior means towards the feet?
6 A Correct.
7 Q Okay. And so when it says Dr. Capanna was required to approach the
8 L5-S1 disc fragment from both below and above, there's no finding on the October
9 6th MRI imaging which would indicate that he did a laminotomy at the inferior portion
10 of the L5 lamina, correct?
11 A Correct.
12 Q So that assume statement that you were asked to assume, that is
13 inconsistent with the objective imaging in the case?
14 A That's not true.
15 Q Okay. Well you know there's no inferior L5 laminotomy, correct?
16 A That's not true. How do I know that?
17 Q You don't see it on the L5 imaging, correct?
18 A An MRI is not a way I would look for a laminotomy. If I'm looking for
19 laminotomy, I would do a CAT Scan to look at the bone.
20 Q Okay.
21 A So again, the fact that I don't see it on an MRI doesn't mean it's not
22 there. You could easily miss that.
23 Q And the only person who actually was in there at that disc space and
24 could visualize it through a microscope which would be the most sensitive would be
25 Dr. Cash, correct?

1 A Yes.
2 Q All right. And you have no reason to disagree with any of Dr. Cash's
3 findings or contradict Dr. Cash's findings that he made during his operation, correct?
4 A Correct.
5 Q You agree that patients are entitled to trust that their neurosurgeons are
6 going to do the surgery properly, correct?
7 A Yes.
8 Q They're entitled to trust that their surgeon is going to diligently locate the
9 correct level of the spine before performing the procedure, correct?
10 A Yes.
11 Q You agree that the neurosurgeon --
12 THE COURT: Two minutes. Go ahead.
13 Q -- is under an obligation to diligently locate and identify the correct disc
14 before performing the surgery itself, the discectomy?
15 A Yes.
16 Q And you agree that there -- a neurosurgeon is required to tell the patient
17 the whole truth about their condition even if there's complications and not hide that
18 from them?
19 A Yes.
20 Q You agree there's no evidence of a violation of the lamina or ligament at
21 L5-S1 in any way indicating that Dr. Capanna did any procedure at L5-S1, correct?
22 A Correct.
23 Q And you agree that Dr. Cash in his operative procedure, he noted that
24 there was a box cut in the L4-5 disc, correct?
25 A Yes.

1 Q And the term box cut, that is a term of art that is used by neurosurgeons
2 to describe a particular incision in a disc, correct?
3 A Used by spine surgeons, yes.
4 Q Okay, both neurosurgeons and orthopedic spine surgeons, correct?
5 A Yes.
6 Q And I know, you know, you're proud of your area of specialty, but I
7 mean there's a lot of well qualified, well trained and competent orthopedic spine
8 surgeons as well, correct?
9 A Absolutely.
10 Q And when Dr. Cash found a box cut at the L4-5 disc, that ends any
11 doubt that Dr. Capanna violated the L4-5 disc space during his procedure, correct?
12 A Again, I have trouble with the box cut. So I don't think there's any
13 question that there was a violation at L4-5 in the sense of the 4-5 disc space was
14 entered. I don't think there's any question of that. A box cut -- to say that there was
15 a box cut because you saw it a month later in a scarred area I think is a bit of a
16 stretch and I would say that that's -- I can't be so sure of that. But I don't think
17 there's any question that Dr. Cash saw evidence of an L4-5 disc space entry at L4-5.
18 Q Right. And --
19 THE COURT: All right, why don't you guys approach the bench.
20 MR. LAURIA: Yep.
21 [Bench conference at 3:20 p.m. -- not transcribed]
22 THE COURT: All right. First off, I'm going to let you go, Dr. Belzberg. Thank
23 you very much --
24 THE WITNESS: Thank you.
25 THE COURT: -- for your time. Good luck with your surgery tomorrow.

1 THE WITNESS: Thank you very much.
2 THE COURT: I appreciate you coming out here. It may be that we're going to
3 need to finish this up in some video type fashion, but your attorney will arrange that
4 with you, okay?
5 THE WITNESS: Thank you.
6 [Testimony of Dr. Belzberg concluded at 3:21 p.m.]
7 ATTEST: I hereby certify that I have truly and correctly transcribed the audio/visual
8 proceedings in the above-entitled case to the best of my ability.
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12 Tracy A. Gegenheimer, CER-282, CET-282
Court Recorder/Transcriber
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