**IN THE SUPREME COURT OF THE STATE OF NEVADA**

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| WYNN LAS VEGAS, LLC d/b/a WYNN LAS VEGAS,<br><br>*Appellant*,<br><br>vs.<br><br>YVONNE O'CONNELL, an individual,<br><br>*Respondent*. | Supreme Court Case No.: 70583(L)<br>*Consolidated with Case No.*: 71789<br><br>Eighth Jud. Dist. Ct.<br>Case No.: A-12-655992-C |
| YVONNE O'CONNELL, an individual,<br><br>*Appellant*,<br><br>vs.<br><br>WYNN LAS VEGAS, LLC d/b/a WYNN LAS VEGAS,<br><br>*Respondent*. | Supreme Court Case No.: 71789 |



**RESPONDENT/APPELLANT'S REPLY APPENDIX ("RA")**
**Vol. 3; 1 RA 401-600**

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DATED this 4th day of January, 2018.

NETTLES LAW FIRM

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## CERTIFICATE OF SERVICE

I certify that on the 4th day of January, 2018, I electronically filed **RESPONDENT/APPELLANT'S REPLY APPENDIX** with the Supreme Court of Nevada by using the Court's eFlex electronic filing system to the following parties.

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coin in and coin out?

A It does.

Q Can you identify that for the jury, please?

A 67.50 in, and 76.05 out.

Q How many games did she play?

A 15.

Q And how much time did she play?

A 2 minutes and 54 seconds.

Q In this particular column, did Ms. O'Connell use free credit during her session?

A Yes.

Q How much free credit did she use?

A $30.

Q And the coin in, coin out -- well, let's talk about the coin in for a minute. Does that mean that Ms. O'Connell necessarily put in $67 and 50 cents?

A No, it's total play.

MR. SEMENZA: One moment, Your Honor. No further questions.

THE COURT: Cross?

MR. SEMENZA: Thank you, Ms. Matthieu.

CROSS-EXAMINATION

BY MS. MORRIS:

Q All right, so I just want to understand this a little bit better here. This is page 3 of the exhibit.

A Um-hum.
Q The green is the time in; is that correct?
A No, that's out.
Q Time out? Okay. And then the white is time in; is that right?
A No, these are two different plays.
Q Okay. So, we've got this sheet you have here, Exhibit 3. So, the first line, the green line, that's the first play that you said she made, right?
A Correct.
Q Okay. And then the second one -- I can't tell if the first one's green or white, but the second one's definitely green.
A The one that's blue?
Q Yes, the one that's blue. Is that green or -- should that be green or white?
A That would be white. That's just for ease of reading, so it's white, green, white, green.
Q Oh, okay. So, you're saying that she took out $1,000 -- $1,050 and put it in the machine; is that my understanding of your testimony?
A No.
Q Did she use her card?
A Yes.
Q Okay.

A If she didn't use the red card, it wouldn't have registered here.

Q So, did she have those points on her card?

A Yes, that would have been on the card. The $30 would have been points on the card. When you're talking -- when -- can you ask the question again, please?

Q Sure. I'm just trying to understand your testimony. She put her card into the machine; is that correct?

A Correct, both times.

Q Okay. She didn't actually pull money out of her pocket and put it in the machine; is that accurate?

A No.

Q That's not accurate?

A No.

Q Are you saying that she put $1,050 into a machine?

MR. SEMENZA: Asked and answered, Your Honor.

MS. MORRIS: I'm sorry, I'm just trying to clarify.

THE COURT: Overruled.

THE WITNESS: If you go back to the first one where she first played, it will show 1,050 in and 1,105 out. So, when you asked me on the second machine if she put $1,105 in, no, she won a small amount there between -- the difference between the two.

When she went over to the next machine, I don't know if she put some of the money in her pocket. You know,

sometimes people decide to hold back some of their winnings, they put it in. Then she went to the next machine and she played $67.50, and then she kept playing, and she used $30 in credit, when she finally cashed out at 76.05. The difference between 67.50 and 76.05 is what she won from that machine.

BY MS. MORRIS:

Q Okay, I just want to be clear, how many machines are you saying she played?

A Two.

Q Okay, you're saying she only played two machines, and the first machine, how much did she gamble?

A 1,050, and then she won, lost, won, lost, won, lost, and so it ended with 1,105, so the difference between the two is how much money she won.

Q And you're saying that she was playing a penny machine that she put the $1,050 into?

A Correct, but when it's a penny machine, it's not just a penny. Most people play max bet. It could be several dollars per hand.

Q What is the max bet on a -- on a penny machine?

A This particular one goes back five years. I don't know what the max bet at that particular time was. It could be --

Q Did you say --

A -- two to three dollars --

Q Okay, so --
A -- or more.
Q And how long did you say she sat at that machine?
A Over 47 minutes.
Q So, mathematically, if she was max betting on that machine, how many spins per minute is she playing; do you know?
A I --
Q It would be about ten spins per minute, if I have the math right.
A I'm sorry, I don't know how many spins she was playing per minute. I have no way of knowing that.
Q Do -- and you also don't know if she actually inserted cash into that machine; is that correct?
A She would have had to have inserted cash, because there was no -- the first machine, there was no free credit, so she had to put cash in.
Q Okay, so she put -- that I think was my question earlier.
A Okay.
Q So, are you saying that she pulled out $1,050 and put it into a penny machine?
A I'm saying that while she was sitting there, she was putting money in the machine, and she played 1,050.
Q Okay, and when --

A During the time frame, she used no free credit, so she would have had to have used currency.

Q When did she leave that first machine?

A Can you go back? She left it at 4:27 P.M., and then was at the next machine at 4:30.

Q Okay, so when did she start playing that first machine?

A At 3:39 P.M.

Q And then, you said she cashed out at what time and left the casino?

A I don't know what time she left the casino.

Q Oh, okay. What's the last time -- what's the second time she cashed out?

A When she cashed out the last time? 4:33 P.M.

Q So, she cashed out twice, and the last time she cashed out was at 4:33?

A Yes.

Q And so, from 3:39 to 4:33, she gambled over $1,000; is that what you're saying?

A Yes.

Q I also want to look down here further on this sheet number 3. You've got some more numbers here printed out. Looks like on February -- or looking down to the February 11th, 2009 date, according to this paper, Yvonne gambled $9,525. Am I reading that correctly?

A It's difficult for me -- can you --

THE COURT: I'm sorry, what was the date you said?

MS. MORRIS: February 11th, 2009. It's midway down.

THE WITNESS: I would need to see the detail from another screen shot, which is what these other two are, for the time that she was there at this particular incident.

BY MS. MORRIS:

Q Why do you need to see a screen shot if you're relying on --

A Coin in and --

Q -- above it, it says 1,050, and that number's correct?

A I don't know if she had any credits.

Q So, she could have had credits that would get her up to $9,525?

A She could have a lot of credits. I don't know. Some people bank their credits for a really long time; they don't use them right away.

Q But Yvonne gambled twice on the day she fell, and she used her credits on that day; is that right?

A On the second machine, yes, she used credits.

Q Looks like you also have her gambling $6,055 on January 21st, 2010. Am I reading that correctly?

A Ms. O'Connell was a loyal Wynn customer, it appears.

Q What do you mean by that?

A Looks like she was here frequently, that she liked to play, and enjoyed her time at Wynn.

Q This is a printout of her visits; is that correct?

A That would be the printouts of the visits where she used her red card.

Q Okay. So, on average, it looks like she's at your casino maybe five times a year; would that be fair? Maybe more than that; ten times a year?

A I think it depends on the year, it varies a little bit there, but she has visited with us.

Q And so, sometimes she'll come and she'll gamble $45, and then other times, she'll come and gamble $9,525?

A I don't know if she was involved in any tournaments or not. I don't know what she was involved in or what she was gambling. So, if you're asking me about her gambling habits, I'm sorry, I'm not aware of what -- how many times she gambled, or, you know, how long she was there, or what machine -- I mean, I'd have to see a lot of detail if you're going to get into asking me a lot more questions about her past visits.

Q Then why did you call her a loyal customer?

A Because she's here frequently. Going by this, we would consider this a loyal Wynn customer; someone who enjoys coming to Wynn. In comparison, there are times when people have a red card; it's one time, they've never been back. So, they've come to visit us one time, and not been back. This is

someone who's been here several times. Anyone can see that she's been here several times and has gamed with us.

Q And can you tell from this what type of machine she's playing?

A Not -- I can tell they're all slot machines, but not on what types of slot machines.

Q So, the first slot machine you have her at for the $1,050 gamble is a penny machine; is that right?

A Yes.

Q And then, what was the second machine?

A That was the nickel, a five cent machine.

Q And do you know where those machines were that she was gambling at in the casino; where they're located?

A They have location codes on them, but I don't know where those locations were, because those are just numbers. I'm not familiar with that.

Q And do you deal with this Patron system often?

A Yes.

Q Patron Management?

A Yes.

Q And how do you interact with this? What do you use it for?

A A variety of different things. In the guest claims department, sometimes what we do is we offer our guest comps, things like that. So, sometimes, we'll look to see if someone

has been a regular guest of ours, and maybe a small mishap has happened, something that we want to do something for them. A lot of times, if someone is a very loyal customer that has a lot of comps, when we look at the Patron account, we might see that they're already considered what's called RFB; room, food and beverage. They already get all of that comped, so that would be something that we might need to look at something -- doing something different for them.

Q Now, you are the manager now in the claims department; is that correct?

A I'm the director.

Q The director? Okay. And tell me what your job duties are as the director.

A I oversee both the guest claims and the work comp departments.

Q Are you in charge of the budget for your department?

A No.

Q Do you receive any bonuses if you keep the department in a good budget?

MR. SEMENZA: Your Honor, I'm going to object. Outside the scope and not relevant.

THE COURT: Overruled.

THE WITNESS: No, no.

BY MS. MORRIS:

Q Nothing?

A Nothing, no. That would be impossible.
Q Why would it be impossible?
A You could never figure out how much a claim is going to cost every year. You have no idea what's going to happen.
Q So, there's no budget?
A Not that I'm aware of. It would be impossible to figure out every year how many people are going to have an incident that's going to cost money, and how much money that's going to cost.
Q Now, you were -- remind me what your position was back in 2010. I'm sorry.
A Manager.
Q Okay.
A Of the claims -- guest claims department.
Q And as the manager of the guest claims department, what were your duties back then?
A Taking a look at the incident reports that happened with security, assigning them to the claims representatives in the department, and then working closely with them to manage the day to day operations of the claims. So, that might entail speaking with guests. If a guest wants to speak to a manager or someone else other than the claims representative, it would involve looking at the files, reviewing the files, following up with guests, things like that.
Q Now, so you reviewed Yvonne's claim?

A Quite a while ago, yes.
Q Were you in charge of the investigation of her claim?
A Not at that time. I believe it happened before I got there. I got there in June of 2010, so it would have been after that. And I do remember reviewing the file on more than one occasion and working with the claims representative that was on the file.
Q Okay. Who was the claims representative on the file?
A The very first one was a woman by the name of Nickey Olson. She hasn't been with the company -- it was shortly after that that she was no longer with the company. And --
MR. SEMENZA: Go ahead.
THE WITNESS: And then Kristen Steinbach.
MR. SEMENZA: Your Honor, may I approach?
THE COURT: Yes.
(Off-record bench conference)
THE COURT: All right. Overruled to the extent we discussed at the bench.
BY MS. MORRIS:
Q I'm sorry, you were saying that the people that you had worked with on the file were Nickey Olson; is that correct?
A That was the original claims representative, yes.

Q And then, who's the other person?
A Kristen Steinbach.
Q And you said that you've worked on this file as well; is that correct?
A As the manager, it's not unusual for me to be involved in a lot of the files. And on that particular one, yes, I did do some work on it. And, yes, I worked with a claims representative.
Q When did you get involved in Yvonne's claim?
A Very early on from my initial start date. I don't remember the exact date.
Q When was your initial start date?
A June of 2010.
Q And when you came on in June of 2010, what involvement did you have in Yvonne's claim?
A Just the initial overall review of it, making sure that everything was in the file, taking a look at it. I know that there -- I seem to remember that we didn't have a phone number for Ms. O'Connell. And we had sent a letter, we didn't have a response. So, I was reviewing, like the fact that she never contacted. I think -- I don't remember exactly. It's been a long time.
Q You don't know if Yvonne ever contacted the Wynn, do you?
A From my recollection, she never did.

Q What investigation, if you know, was done into Yvonne's claim?

A There was a check with the horticulture department. PAD, public area department. The --

Q And -- oh, sorry.

A Go --

Q Sorry, go on.

A The security report was in there. Photos of the scene.

Q Who was contacted in the horticulture department?

A I don't remember the exact person's name. I'm sorry, it's been five years.

Q What information did the horticulture department provide to the file, if any?

A That we don't use any green liquid. There's nothing green liquid that we use in the watering. And that the time frame that we watered did not coincide with anything that could have possibly been wet in the area where she fell at the time that she fell. So, therefore, whatever it was that she fell on, could not possibly have been caused by the plants.

Q Did you bring the claims file with you? Do you know if I have a copy of the claims file?

A I don't know what you have.

Q And so, you're saying this is documented in a claims file on Yvonne somewhere; is that correct?

A It would probably be in our electronic notes much, much afterwards. The original file, that the security report took would not have been in there. It would have been phone conversations with horticulture, and PAD, and that type of thing.

Q And you talked to someone in PAD; public area department?

A Public area department.

Q Who did you --

A And that was just verifying the normal procedure, that we're constantly cleaning, that we're going through on a normal basis, that the -- that area, they go back and forth in quite a bit, and just constantly cleaning.

MR. SEMENZA: Your Honor, may we approach again?

THE COURT: Yes.

(Off-record bench conference)

THE COURT: All right, sustained. It's outside the scope of direct examination at this point.

BY MS. MORRIS:

Q You've reviewed the file in this case; is that correct?

MR. SEMENZA: Objection, Your Honor. We've been there.

MS. MORRIS: I'm moving onto a new question.

THE COURT: All right, we'll see.

BY MS. MORRIS:

Q Was the porter assigned to the area interviewed in this matter?

MR. SEMENZA: Objection, Your Honor, exceeds the scope.

THE COURT: Sustained.

BY MS. MORRIS:

Q Do you know the identify of the porter --

MR. SEMENZA: Objection --

MS. MORRIS: -- assigned to the area?

THE COURT: Sustained. This is all outside the scope if you're talking about her review of the file at this point.

BY MS. MORRIS:

Q You've stated it's your policy and procedure to continuously sweep and keep the floors clean; is that correct?

MR. SEMENZA: Objection, misstates testimony.

MS. MORRIS: Does it? Maybe it does.

THE COURT: Well, I don't think that was -- I think her testimony was that, yeah, that they do continually clean, so, overruled.

THE WITNESS: Our PAD department is tasked with consistently, every day, all day long, all night long, 24/7 going through the areas and maintaining them, keeping them properly cleaned.

BY MS. MORRIS:

Q And in every area that they are -- in every area of the casino, there is a casino porter assigned; is that correct?

MR. SEMENZA: Objection, exceeds the scope. Lacks personal knowledge.

THE COURT: Sustained.

BY MS. MORRIS:

Q You've stated it's your policy and procedure to keep those floors clean. How do you do it?

A I'm not -- I do apologize. I don't work for PAD. I don't know exactly what they do as far as -- you'd be better ask -- I can tell you that I constantly see them, and that they use a dry mop in sweeping, they use wet when necessary, there's big scrubbing units that go through. I've been in the hotel at 4:00 A.M. before, and they have these great big pieces of equipment that go through and they clean the carpets, so spick-and-span is very important.

Q Would it be fair to say that because guest safety is such a high priority, that if something happens with a guest, a full investigation's conducted?

MR. SEMENZA: Objection, vague.

MS. MORRIS: This is cross.

THE COURT: Well, I don't know that it's vague, so on that basis, it's overruled.

THE WITNESS: I'll answer to the best of my ability. An investigation takes place when there's a bodily injury.

BY MS. MORRIS:

Q Okay, and is there an investigation into the cause of the bodily injury?

A To the best of our ability, yes.

Q And you said that photographs are sometimes taken, but not always; is that correct?

A Correct.

Q Are you aware of the testimony of Yanet Elias who said that they never move anything until the security can get there and take pictures of the photograph (sic)?

MR. SEMENZA: Objection, misstates testimony.

THE COURT: Well, yeah. Sustained.

BY MS. MORRIS:

Q Are you aware that Yanet Elias -- well, in her deposition and at trial, because we talked about it, said that -- that they never clean until security gets there?

A I'm not aware of that, and that really surprises me. I don't know if maybe she misunderstood, because the most important thing is to maintain a safe environment, and we would clean something up if there was a hazard present. We wouldn't have to wait until security got there. Guest safety is more important than that.

Q Now, there's a couple things to do, is that correct,

when there's a spill? You can either put cones up around it or clean; is that correct?

MR. SEMENZA: Objection to the extent it exceeds her knowledge.

THE COURT: Sustained. Is the objection foundation?

MR. SEMENZA: Yes, Your Honor.

BY MS. MORRIS:

Q Have you ever, yourself, responded to a guest injury?

A As -- not as it's happened, no. There's too much going on. They're trying to take care of the guest, they're trying to take care of the area, do the report. No, that would -- that would not be proper.

Q Why wouldn't it be proper?

A If you have a guest that just experienced an injury, and the first thing that you do is go over there and send a claims person to say, you know, hi, I'm here, I represent the claims department, it's just not the five-star service. The proper thing to do is to just make sure that that guest's medical needs are taken care of first. We can follow up afterwards.

They need to be taken care of, the area needs to be secured, the area needs to be taken care of, the officer needs an opportunity to see if there's camera coverage. There's a lot of things that take place. But if a guest wanted to meet

with me in person, of course, I'm more than happy to. If they needed someone to speak to them before they departed property, I've done that, you know, the next day followed up with someone; I've met with them. I've done that quite frequently.

Q But you've seen spills and people falling on video surveillance; is that correct?

A Yes.

Q And have you seen situations where they have not cleaned it up, but simply put up cones around the area?

A I'm sorry, I'm trying to remember. I want to make sure that I'm as truthful as I can be. I've seen where they've secured the scene, but it's all very fast. So, if you're talking about cones like sitting there forever, waiting for security to arrive, no, I have never seen that.

Q I'm sorry, say that again. Cones --

A If you're -- you were talking about cones. Maybe I'm misunderstanding you.

Q No, I just -- you said, cones sitting there forever until security arrives?

A Yeah.

Q Okay.

A If I understood the question, it sounded like you were asking me if I've seen on camera coverage that cones are securing a scene, waiting for security to get there, that they're standing there for a long time. I've never seen that.

I've seen cones and employees securing a scene, and very quickly, the scene is cleaned up. It's not waiting for security ever.

Q So, in your experience, that -- in responding to a guest injury, it's the proper five-star response to ensure that the guest is first and foremost --

A And that it's a --

Q -- okay; is that right?

A -- safe area. Safety and our guest experience.

Q And photographs are taken of the guest; is that correct?

A Sometimes, yes.

Q And photographs of their footwear are taken; is that correct?

A Sometimes.

Q And the purpose of taking the photographs of the footwear is to ascertain what might have contributed to the fall; is that right?

A It can help sometimes. It depends upon the situation. We're a hotel, and a nightclub environment, and things -- you know, unfortunately, we've seen situations where someone maybe wearing wedges, or really high heels, and they've mis-stepped or things like that, and sometimes, the shoes have contributed to incidents.

Q And that's important for your analysis in the claims

department; is that right?

A It's a piece of the puzzle, but it's not the determining factor.

Q So, in evaluating the claim in the claims department, a piece of the puzzle is photographs of their footwear, but there's other factors?

MR. SEMENZA: I'm going to object as to outside the scope.

THE COURT: Sustained. It's still beyond the scope of direct exam.

BY MS. MORRIS:

Q Have you been in the atrium area where Yvonne fell?

A Yes.

Q And how many times have you been there do you think approximately?

A Oh, I couldn't even count. It's -- it's a main thoroughfare where we walk through that frequently. It's a main area.

Q And aren't there in fact multiple security cameras at the ceiling of the atrium area?

A There are multiple cameras in the area, but that doesn't necessarily mean that they're facing the atrium.

Q Now, you said earlier that you try, if possible, to get clips of 30 minutes before the fall, and 30 minutes after; is that correct?

A Of the location that it happens, where the fall happens, yes.

Q And you also make sure -- or try and get photographs of the guest themselves; isn't that right? Their face?

A No, I never said that. I said they sometimes do that, but not necessarily, no.

Q Well, they sometimes do it. Do you know why they sometimes do it?

A I can give you a pretty good example. If a guest had an incident and they didn't report it at the time, like maybe they had a small slip, didn't fall completely, and just departed, they were embarrassed, they didn't want to tell us, and they just left. And they didn't remember exactly like the time frame; I don't know, I think I fell at such and such time, and they come back to property and they tell us, or maybe they're a registered guest, and they stop by the front desk or call security the next day.

And then they're telling the officer, well, I was in the casino, and I was walking through, I was headed towards the buffet, and I fell kind of in that general area. The officer might take a photo because it could help the people doing the camera coverage to try to find that guest and try to track the incident, especially if we're looking -- people lose track of time. They don't know if it's 2:00 o'clock in the afternoon or if it's 4:00, especially if it's an international

guest and their time clock is off anyway. So, it can assist our surveillance team.

Q So, the photograph of the guest can be used to try and locate them in the casino; is that fair?

A Yes.

MS. MORRIS: Thank you.

THE COURT: Redirect?

MR. SEMENZA: I'll just be brief, Your Honor. I want to go back to Y1.

REDIRECT EXAMINATION

BY MR. SEMENZA:

Q Now, is it your testimony that Ms. O'Connell put in $1,050 when she sat at the table, or at the slot machine?

A No, I said that's the total amount gamed.

Q Okay. So, does that mean that each bet that Ms. O'Connell made over the course of that session would then add up to the coin in?

A Correct.

Q Okay, and the same with the coin out?

A Correct. So, the difference between the two is what she won.

Q Okay. So, we don't know how much money she actually put into the machine at that point in time?

A No, but I -- all I can tell you is it had to be currency.

Q But the betting, the 525 games that she played during that session, that betting added up to the coin in?

A Correct, and it was during 47 minutes and 51 seconds.

Q And that would be consistent with a penny machine; a small denomination machine?

A It just varies. You know, some people bet more than others; some people push the button more frequently than others.

MR. SEMENZA: Thank you. Nothing further.

MS. MORRIS: Just a follow up question.

THE COURT: All right.

RECROSS-EXAMINATION

BY MS. MORRIS:

Q I actually think I might understand better based on what was just said. So, she could have put in $40 and gambled that, winning and losing, all the way up and out. You're not saying she actually put in $1,050; is that correct?

A Correct.

MS. MORRIS: Thank you.

FURTHER REDIRECT EXAMINATION

BY MR. SEMENZA:

Q Ms. Morris had showed you a previous chart that identified other play that Ms. O'Connell had?

A Um-hum.

Q And she gave you one example of where Ms. O'Connell had $9,000 of play?

A Correct.

Q That would be the coin in, the multiple betting, as opposed to her playing or putting $9,000 into a machine?

A Correct, along with any credits she had.

MR. SEMENZA: Thank you.

THE COURT: Any questions from the jury?

(Off-record bench conference)

THE COURT: All right, question from the jury. So, can you tell from the document that's been admitted as Exhibit Y how quick her play was?

THE WITNESS: I -- I can't tell how quick it was. I can tell you that it was averaging about $21 a minute, and that during 47 minutes and 51 seconds, she played a total of 525 games. So, I don't know if that helps at all or not.

THE COURT: Okay. So, 500 and 20 --

THE WITNESS: In other words, she pushed the button 525 times.

THE COURT: Okay. And you had previously said this was a Wheel of Fortune machine. Is that a poker machine, or is that a --

THE WITNESS: No, it's not. It's the one that when you're walking by, it says, "Wheel of Fortune," and it's got the great big wheel at the top. And one of the bonuses, if

you hit the bonus on it, the wheel at the top spins around, and then you can earn extra -- so.

THE COURT: Okay. But it's not a poker machine?

THE WITNESS: It is not a poker machine.

THE COURT: So, it's not hands; it's just number of games? And is it --

THE WITNESS: Correct.

THE COURT: -- every time you press the button, that's a new game?

THE WITNESS: Correct.

THE COURT: Okay. Any questions then as a result of that?

MR. SEMENZA: No, Your Honor.

THE COURT: All right. May this witness be excused?

MS. MORRIS: Yes.

MR. SEMENZA: Yes, Your Honor.

THE COURT: Thank you very much for your testimony.

THE WITNESS: Thank you.

THE COURT: All right. Counsel approach.

(Off-record bench conference)

THE COURT: All right. Ladies and gentlemen, we have another witness, a doctor, who will be here at 2:00 P.M. So, I'm going to give you lunch until 2:00 P.M., and then we'll resume. So, you'll have a longer lunch break, so you can leave the building if you like.

And during this recess, of course, it is your duty not to converse among yourselves or with anyone else on any subject connected with the trial, or to read, watch, or listen to any report of or commentary on the trial by any person connected with the trial, or by any medium of information, including, without limitation, newspaper, television, radio, or internet, and you are not to form or express an opinion on any subject connected with this case until it's finally submitted to you.

So, we'll be -- you know, we'll need you back at 2:00 o'clock. Thank you.

THE MARSHAL: All rise for the jury, please.

(Outside the presence of the jury)

THE COURT: And the record will reflect the jury has departed the courtroom. So, I want to have counsel back at quarter to 2:00, and we'll see where we are on -- I'll in the meantime read the defendant's bench brief and cases cited before we come back, and we'll discuss it again when we come back at quarter to 2:00.

MR. SEMENZA: Thank you, Your Honor.

THE COURT: Thank you.

MS. MORRIS: Thank you.

(Court recessed at 12:20 P.M. until 1:46 P.M.)

(Outside the presence of the jury)

MR. SEMENZA: Good afternoon, Your Honor.

(Pause in the proceedings)

THE COURT: All right. We are back on the record in case number A-12-655992, Yvonne O'Connell vs. Wynn Las Vegas. We're outside the presence of the jury.

I read the defendant's bench brief regarding expert medical testimony to apportion damages, as well as the Schwartz case, which I'd read before, and reading it a second time refreshed my recollection. But I also went back and re-read the Nevada case, which again refreshed my recollection that I've had this case cited to me for the holding -- or the -- I should say the one part of the case, the Schwartz case, where it says, "In a case where a plaintiff has a preexisting condition and later sustains an injury to that area, the plaintiff bears the burden of apportioning the injuries, treatment, and damages between the preexisting condition and the subsequent accident," and that's -- then they cite Kleitz vs. Raskin, the 103 Nevada 325 case, as well as the -- which, in turn, also relied on Restatement Second Torts.

The problem is that the Klietz case doesn't say that. Nowhere in that case does it say that. And that's -- I don't -- you know, obviously, this case never went anyplace for a higher court to review what was said there, but Kleitz, as well as the Restatement Second of Torts, as well as all the Washington cases that are cited, are cases where you have two accidents, two separate tortfeasors, and then -- so there's

some argument being made as to whose burden it is to apportion damages.

Kleitz said when you have two accidents, that what happens is, it's the plaintiff's burden to prove that, in the second accident, the plaintiff was injured. If the plaintiff does that, then the burden shifts to the defense to apportion the damages between those two accidents. There's -- and of course, the Restatement of Second Torts talks about that, which is why the court cited the Restatement, says that makes sense, because vis-a-vis joint -- vis-a-vis two separate tortfeasors, it should be their burden to fight among themselves as to how the damages for the single injury should be apportioned between the two of them, and not -- the -- the burden should not be on the plaintiff.

And I realize that the federal court -- trial court in this bench case cited that case for that proposition. The problem is, the case doesn't say that. The Nevada case does not say that, and no one's ever cited me to any Nevada authority that says anything close to that.

So, what we have here is we have -- we have two doctors, and two -- you know, we have Dr. Dunn saying that plaintiff had a preexisting degenerative condition in her neck, which he believes was asymptomatic based upon the plaintiff's reports that she had no pain in the neck until she fell. This is his basis for saying that the fall caused the

condition in her neck to become symptomatic; i.e, resulting in pain.

And that, as -- so therefore, he believes she needs this surgery, a three-level anterior fusion, that -- to address her pain complaints that he believes were asymptomatic based upon her reports -- subjective reports of pain, and that she didn't have any pain prior to the accident. So, he -- you know, he causally connects it, saying, basically, she's the eggshell plaintiff.

Dr. Tingey has -- is looking at two different knees. He says, on the one hand, the left knee clearly has degenerative changes with medial meniscus tears on both sides, and that -- that is not related to the fall, so we don't even need to -- there's no causal connection, so there's nothing there.

He says the right knee looks like an acute injury, consistent with her report of a fall, and that he based his opinion that it was causally connected to the fall based upon, again, the plaintiff reporting that she -- the only fall she reported, and that she, you know, had this pain in her knee after that fall, and he didn't -- he wasn't told about any other kind of -- any other fall.

MR. SEMENZA: Um-hum.

THE COURT: And so, based on that, he causally connects it. But I don't think this is an apportionment issue

between two separate accidents.

And I know you like to -- because this is not the first time this Schwartz case has been brought out, you know, for the proposition. It says right in there, but when you look at the case they're citing, it doesn't say that in the case.

MR. SEMENZA: And, Your Honor, I think with regard to Dr. Dunn, we've got a situation where we've had a prior back injury in 1989. Dr. Dunn acknowledges that there was degenerative changes in her cervical and lumbar spine beforehand, and the only thing that has changed between that time is the plaintiff's subjective complaints of pain.

THE COURT: Well, I know in your brief that you say that, "The uncontroverted evidence at trial proves the plaintiff suffers from additional preexisting health issues and conditions, such as fibromyalgia, IBS, anxiety, depression, Ehlers-Danlos, and Marfan syndrome.

Well, first of all, I don't think that the plaintiff -- that the uncontroverted evidence does prove that she suffers, frankly, from any of those conditions. I mean, you can't -- you can't say, okay, well, we're going to believe her as to some of it, but not all of it, you know? She also --

MR. SEMENZA: Well, this is what --

THE COURT: She also reports that she --

MR. SEMENZA: -- she self-reported.

THE COURT: -- you know, suffers from heart palpitations, and all these other things. But more importantly, both doctors, right, Dr. Dunn and Dr. Tingey both said that fibromyalgia, even if they assume she has it, that it would not -- as for her neck pain -- because remember, Dr. Dunn says, as far as her lower back, he doesn't think, you know, that's surgical. And his -- his opinion -- I mean, nobody has connected up her complaints of back pain, so there's nothing as to lower back. There's just no causal connection regarding lower back.

Dunn only talks about her neck, because that's all he looked -- he's -- you know, he's opining, is that she needs a surgery to her neck, because she's got this stenosis, and he -- that was, by her report, asymptomatic until the fall.

Otherwise, you know, his testimony basically was, well, if you don't have pain, you could have this condition and not have any pain, and then you wouldn't have any surgery, because the only purpose for the surgery is to relieve pain. It's not -- there's no other reason to do it.

So, I just -- you know, I don't think that this Schwartz case stand -- well, it does stand for the proposition for what you've cited it, except it's just wrong. I mean, the cases it cites do not say what it says here. I mean, they -- the Court in the Schwartz case makes a specific statement immediately followed by a citation to a case. It does not say

what the statement says. So --

MR. SEMENZA: I mean, if -- and I understand Your Honor's point in this, but I think it goes to -- frankly, the broader issue in this particular case is you have doctors who are opining on causation of pain which is purely subjective in nature, which I think is improper. I mean, that information -- I don't think that --

THE COURT: Well, I disagree with that. And I thought we'd already addressed that issue once before earlier in the case.

MR. SEMENZA: I think we did talk about that, yeah.

THE COURT: Yeah, because that was -- you tried to keep it out for that -- keep them from testifying for that reason, and I told you that I disagreed with that premise. Doctors do have to rely on plaintiffs' complaints, and sometimes, they will -- they may causally connect something, while admitting at the same time, if the report is false, well, it's false. But it's up to the jury to decide whether the plaintiff is credible about her complaints, and when they occurred, and what caused them, as far as that goes.

MR. SEMENZA: And I understand Your Honor's point. I guess my concern is that you overemphasize the -- the importance of what the doctors are testifying to by virtue of allowing that evidence in, because all -- you're basically taking the plaintiff's complaint that says, I'm in pain, the

plaintiff is telling that to a doctor, and the doctor is then basically saying, that's the basis for the causal connection.

And I don't think that it would be proper in that setting, and frankly, I don't think that assists the trier of fact in this particular case, because it's ultimately her word as far as the pain she's experiencing. And it certainly doesn't have any impact upon what the doctor's opinion necessarily is, because he's saying, look, she reported she's in pain. I have no objective way -- with the cervical neck; let's take that for example -- I have no objective way in order to verify that that pain is the result of this fall, other than taking the plaintiff's word for it.

And so, I think in allowing the doctor to testify, and allowing that evidence to go to the jury, you overemphasize that. And I don't think it assists the trier of fact, because ultimately, if you come back to the point, it's just her statement, and that's it.

THE COURT: Well, he says she has objective findings in the neck, right? And sometimes, those objective findings will also come with the patient saying, I have pain; sometimes, they don't.

MR. SEMENZA: Sure.

THE COURT: Okay. So, pain can -- is always subjective, no matter what. And so, a doctor's not going to recommend surgery if -- if a patient, even though they have

some findings on MRI or plain films, they're not going to suggest surgery if they say, I don't -- I -- I don't have any pain. There would be no reason.

So, doctors always have to make their diagnosis, in part, based up on the subjective complaints from their patients. That's the only way they can.

MR. SEMENZA: And I understand that, Your Honor, but -- and I'm not going to --

THE COURT: There are going to be times, certainly, when there are no objective findings, and someone is saying, I -- my neck hurts, my neck hurts, and plain films and MRI shows there's nothing there, there's absolutely nothing there, but that's not what we have here.

MR. SEMENZA: But that is what we have in this particular case, because of the objective findings that Dr. Dunn talked about were preexisting conditions. So, it's not like a situation where a patient walks into the doctor's office and says, I have all this pain, and he can't find anything related. There's no -- nothing objective in that setting.

And in this particular case, what we have is the patient walking in and saying, I have all this pain, and Dr. Dunn says, well, you do have a preexisting degenerative condition in your back. So, in that sense, there's even less of a causal connection, because there is preexisting issues

that predate the fall in this particular case that would then impact the determination of whether she's experiencing pain or not.

THE COURT: I know that, but I think that's for the jury to decide whether they believe the plaintiff or not, because -- because no one -- Dr. Dunn can't feel her pain, and he doesn't -- so it's really a question of her credibility on the totality of the evidence as to whether they believe that truly she had no pain before, and that now she did, or that it was -- you know, Dr. Dunn doesn't even see her for five years after the accident.

And so, whether they believe that she was truthful with him, or forthcoming with him, that's really for the jury to decide. All he can do -- and he has been very candid about what he based his opinion on. And if -- and so, I think it's pretty clear from his testimony that, you know, he's laid all that out, that --

MR. SEMENZA: Right, and I understand that. I mean, and I think you kind of summarized it well. It's based upon the believability of the plaintiff. And so, my issue is, then Dr. Dunn's testimony doesn't assist the trier of fact in making that determination. I mean --

THE COURT: Well, yeah, it does, because -- because she does have these objective findings that show she has -- you know, she has a condition, that she's not -- that she has

a degenerative condition. And he said that, as people age, and, you know, they all will get degenerative disc disease. In fact, he said on cross that everyone will get it. You know, there's no one that escapes.

Some people like Sal, here's a good example, bounds off the stand and runs out of the courtroom at 79, and clearly is fine. I'm sure that if you took an x-ray or films of his spine, he would have some degenerative findings, but obviously, they're not bothering him.

And so, it does -- the explanation of what you have with a person who is potentially an eggshell plaintiff is -- does assist the trier of fact, that she has some objective findings. She's not -- she's not completely making this up. The same thing with the right knee, you know? I mean, Dr. Tingey says the right knee has evidence of an acute tear. So, that is some corroboration that she actually has something wrong in her right knee that would -- and that his testimony was also that the pain that she reports is consistent with -- with a medial meniscus tear like he sees on the findings from the MRI that was in 2014.

Now, when -- when it happened, okay, that goes back to the other evidence, right? So, he -- and he's not saying, I can say I know -- I can date from looking at the objective films. I'm, again, relying on her being truthful. Now, it's up to the jury to decide whether they think she is or not.

MR. SEMENZA: I understand, Your Honor. I've made the record, so that's fine.

THE COURT: All right.

MS. MORRIS: I have one issue I'd like to address, Your Honor.

THE COURT: Okay.

MS. MORRIS: Now that we know Dr. Klausner is going to be called, I would like to be able to question him on one issue that he stated in his report. He indicated that she has something called symptom magnification syndrome. And symptom magnification syndrome can only be diagnosed by doing a very specific clinical interview with a patient in order to establish -- and he relied on this report. I printed it out from the basis of his reports.

And what I'd like to do is, before he takes the stand and says she has symptom magnification syndrome, I'd like to be able to establish whether or not he's actually done appropriate testing to be able to testify as to that diagnosis.

THE COURT: So, you want to voir dire him to see if he has the foundation. And I think I -- I ruled before -- I usually rule this way on this, is if the -- if you can lay the foundation with the doctor that he has the qualifications to testify about that area, or any area, really, then you can ask him about it, so.

MR. SEMENZA: That's fine. Let's do that outside the presence of the jury, and make everyone comfortable.

THE COURT: Okay. All right, so he's here?

MR. SEMENZA: I will go check and see.

THE COURT: Okay.

MR. SEMENZA: I do not know the answer to that question. Let me check my phone. Your Honor, may I step out a moment?

THE COURT: Sure. Is the jury right out there?

THE MARSHAL: We have two in the restroom.

THE COURT: Okay, so be careful about where you go.

(Court recessed at 2:06 P.M. until 2:09 P.M.)

(Outside the presence of the jury)

THE COURT: All right. We're back on the record, still outside the presence of the jury.

MS. MORRIS: Thank you, Your Honor. Your Honor, during the deposition of Trish Matthieu, she testified that there is, in fact, a claims file in this matter, and that there are certain notes in a claims file regarding conversations as to the investigation of this incident, and comments about speaking with the horticulture department person, and questioning whether there was a green liquid -- or green liquid was used.

We certainly requested in our first Request for Production of Documents any and all claims file investigation

that was done in this matter. The claims file was never disclosed, certainly no comments regarding speaking with a horticulture employee regarding green liquid, and no privilege log was ever disclosed. And so, what I'd like to do is address that issue and talk about the non-disclosure of that information and an adverse inference.

MR. SEMENZA: They've closed their case. This issue is now -- I mean, we're in trial, so.

THE COURT: Yeah, I -- I mean, we don't know now whether there is a claim file. I mean --

MS. MORRIS: Well, she testified there was a claim file.

THE COURT: I thought you just said -- you said she testified in her deposition, is what you just said.

MS. MORRIS: So, I took the deposition of her as a 30(b)(6) deponent, and it was regarding the investigation of this matter. And at no time did she say that there was a claims file that was kept that she had looked through, and that there was any type of comment in there regarding horticulture. And so --

THE COURT: You asked her those questions?

MS. MORRIS: I asked her about -- I think there were certain topics in the 30(b)(6) that she was designated for, and I did not designate the claims file adjuster; they just brought her. And it was regarding video surveillance, so it

wasn't a 30(b)(6) regarding it. But I did request in Request for Production of Documents any and all investigations, claims, files, questions, anything regarding the case. I have the Request for Production here, and no such document was disclosed, nor was there any redacted privilege log.

Now, I asked for it. I don't know that it exists, unless they tell me it exists, and either they don't give it to me, or they -- you know, they choose -- they choose to give it to me. However, in this case, neither of those things were done. And obviously, that's relevant information as to what could have potentially caused the slip and fall from Yvonne O'Connell.

THE COURT: All right. So, first of all, when -- was something disclosed? Was something produced?

MS. MORRIS: No claims file was produced at all. The only things that were produced relating to what they did is what we have as joint exhibits, is essentially the Incident Reports --

THE COURT: Did they tell you no claims file existed?

MS. MORRIS: They said they had disclosed all relevant information in their response to Request for Production of Documents, and listed the information we have as our joint exhibit, but certainly not saying there's a claims file, we're not turning it over, nothing like that.

THE COURT: All right. Well, it just seems to me that that's something you should have addressed long ago with the Discovery Commissioner, and not --

MR. SEMENZA: Correct.

THE COURT: -- at the time of trial.

MS. MORRIS: Which I agree, if I had known there was something existing that I didn't have, I certainly would have gone after it, but if they answer the question, and give me incident reports and photographs, I am not to assume that they are withholding information, that there is more out there that they haven't given me. There was no indication that I should be looking for something such as a comment about checking with horticulture and green liquid, and I find it at this point in time in the trial where it's incredibly prejudicial that that information just happens to come out that they have it, they've had it --

THE COURT: Well, okay, but --

MS. MORRIS: -- and never disclosed it.

THE COURT: The thing was, as I recall, it came out because you solicited it on cross-examination.

MS. MORRIS: Yes.

THE COURT: So, if it was prejudicial, it was self-inflicted.

MS. MORRIS: It's prejudicial that now we are just getting that information, and there's been an illusion that it

exists when there is no proof that it exists, and if it did exist, it should have been produced as relevant evidence in the litigation of this case.

THE COURT: All right. Well, and then, when you didn't get a claims file, which a claims file isn't photographs that were taken by security. You knew that the photographs were all taken by security and the -- the statements were taken by security. You didn't get anything that looked like a claims file.

MS. MORRIS: Correct. I'm assuming they didn't have one. I didn't know I was supposed to go --

THE COURT: All right. Well, okay.

MS. MORRIS: -- demand that they create something.

THE COURT: So --

MR. SEMENZA: Your Honor, they didn't even send out written discovery. Former counsel -- prior counsel sent out written discovery. There has been no discovery dispute, there has been no 2.34, there's been nothing. I mean, that discovery was responded to in 2000 and -- June of 2014, so they didn't do anything in regard to it. We did make objection. I don't have the information -- the specifics in hand. We did object to producing some things. A claims file was never specifically asked for, so it hasn't been produced, if it exists.

MS. MORRIS: I specifically have the Request for

Production, which asks for, any documents and such files including, but not limited to reports, incident reports, correspondence, writing, photographs, log entries, emails, notes, internal memos, Post-Its, evaluations, diagrams, and investigations. All of that was requested.

THE COURT: All right. So, if you didn't -- you didn't get anything more then -- so, to me, it's pretty obvious when you don't get anything besides what security did that you ask for more than that, especially when you've got somebody that's a claims -- claims person that ends up getting designated. You took her deposition. You had the opportunity to ask at the time you took her deposition, was there a claims file.

MS. MORRIS: In fact, I didn't. I was limited to the categories in the 30(b)(6).

THE COURT: All right. Well, to me, this is too little, too late. And for me to say, well, now you get an adverse instruction, well, that's for spoliation; not as a -- you know, a discovery sanction. I mean, this is like way too late. You've rested your case, and now, no.

MR. SEMENZA: Thank you, Your Honor.

MS. MORRIS: And just so I can preserve it for the record; in this case, spoliation of evidence is either destruction or not disclosing relevant information. And having a case where there is an allegation that there was a

green liquid that could have come from the garden area, and Wynn did an investigation, and contacted the horticulture department, and spoke with someone that they absolutely didn't know, and noted it somewhere in a claims file which they've had in their possession since 2010, and didn't disclose it at all in the litigation or in response to Request for Production of Documents, to me, rises to the level of spoliation of evidence and withholding it, which creates --

THE COURT: Well --

MS. MORRIS: -- a prejudice in this case, because testimony has come out now that was never previously disclosed, although asked for, and now, it sits out there, and there is no verification of that information.

THE COURT: But her testimony was that some note indicates that they checked and there was no information.

MS. MORRIS: No, they --

THE COURT: So that there was an absence of information.

MS. MORRIS: No, they don't use green liquid in the horticulture department. That was what the quote was.

THE COURT: All right, but we have testimony regarding that from somebody who -- who knows who testified today.

MS. MORRIS: I'd like to know what else is in that claims file, what other kind of comments, because it certainly

would have been relevant in the litigation.

THE COURT: Okay. So, to me, it's that you didn't do an adequate discovery. And to bring up what amounts to a discovery motion in the middle of trial --

MS. MORRIS: We shouldn't have to. I agree.

THE COURT: Well --

MS. MORRIS: But, I mean, in this case, I asked for the --

THE COURT: If what you're asking for is an adverse inference instruction based upon this, there's not enough for me to do that.

MS. MORRIS: So, I asked for the information from Wynn in a written document in which they had the opportunity to respond to that.

THE COURT: Okay. Is there --

MS. MORRIS: They did not disclose --

THE COURT: Is there --

MS. MORRIS: -- that information.

THE COURT: Okay. You've already said that.

MS. MORRIS: Correct, but --

THE COURT: I mean, do you think I'm not understanding --

MS. MORRIS: No, no, I just --

THE COURT: -- the words that are coming out of your mouth?

MS. MORRIS: I would like to -- I would just -- I would like to understand clearly what the Court's decision is, is that --

THE COURT: The Court's decision is --

MS. MORRIS: -- I didn't do enough in asking that question.

THE COURT: The Court's decision is, yes, this is -- basically, you've -- what you've said is you're asking the Court to give an adverse inference instruction, which is based upon a finding that there has been spoliation of evidence. And there has been nothing given to me that indicates that any evidence has been spoliated.

You're saying, well, they should have given me something more out of the claims file. I don't know if that exists or not, but that is something that you could have discovered during the -- the lengthy discovery period. I mean, I don't know when the final discovery cut-off was, but this case is old. This case is really old.

MS. MORRIS: And we did learn today that there is a claims file. I mean, that was stated under oath.

THE COURT: Okay, but you could have asked somebody before this time. So -- so I'm -- what you asked for is an adverse inference instruction.

MS. MORRIS: Correct.

THE COURT: That's denied.

MS. MORRIS: Okay. And if I could request an instruction that the jury may conclude that there -- it's not a must -- it's not a must instruction, but they may conclude, because that claims file was never produced, the information that was just testified about, it that had been withheld could be -- it's to get an adverse inference, but that was not truthful testimony.

MR. SEMENZA: No.

MS. MORRIS: Or --

THE COURT: That's -- that's --

MS. MORRIS: They can infer that maybe the claims file doesn't exist with the information in it that it says, since it was never disclosed.

THE COURT: That's denied.

MS. MORRIS: Okay.

MR. SEMENZA: Thank you. Just a moment, Your Honor. I believe Dr. Klausner is here.

THE COURT: Let's bring our jury in.

MR. SEMENZA: I think we're going to voir dire him outside the presence.

THE COURT: Oh, that's right. I'm sorry. Yeah.

THE MARSHAL: Face the court clerk, remain standing, raise your right hand, please.

DR. VICTOR KLAUSNER, DEFENSE'S WITNESS, SWORN

THE CLERK: Please be seated, and then please state

and spell your first and last name for the record.

THE WITNESS: Victor B. Klausner. V-i-c-t-o-r. Middle name, Benjamin. Last name, Klausner, K-l-a-u-s-n-e-r.

THE COURT: You may proceed.

MS. MORRIS: Thank you.

(Testimony outside the presence of the jury)

DIRECT EXAMINATION

BY MS. MORRIS:

Q Dr. Klausner, can you tell us what type of doctor you are?

A I'm board certified in family practice and sports medicine, and I've practiced occupational medicine in the State of Nevada for the past 15 years.

Q Do you have any education in psychology?

A When you say education in psychology, I have education in terms of my training as a family practice physician, so part of that is, you know, a diverse background in basic psychology.

Q In this case, you reviewed some medical records of Yvonne O'Connell's; is that right?

A Yes, I did.

Q And you created a report as a result?

A Yes, I did.

Q And in that report, you had an opinion as to symptom magnification syndrome; is that correct?

A Yes.

Q And did you diagnose Yvonne O'Connell with having symptom magnification syndrome?

A So, diagnose of that syndrome is basically exactly what it is. It's a syndrome that's based on observation of a person's behavior and access of the medical system, and there's multiple findings which can be extracted from the medical record.

I did not actually meet the claimant, nor did I do an examination on the claimant. But based on my medical review of the records, I extracted information out of the records from multiple -- it wasn't one particular instance, but it was a pattern of multiple medical providers that were making observations in the medical record that would lead me to believe that this claimant was manifesting symptom magnification.

Q Isn't it true that in order to diagnose symptom magnification, you have to actually meet with the claimant and go through a clinical interview with them?

A Well, it's exactly what it is. It's a syndrome. So, you're making -- it's basically something that's been published in the medical records by not just psychologists, but originally developed out of orthopedic surgery; observation of certain individuals that did very poorly with medical intervention.

And so, there was certain signs based on physical examination that could be identified, and then an identification of a person's specific social situation within the medical -- the medical interaction with the system and how they're doing with their medical treatment, and how they're interacting with the system.

So, in terms of what you're saying, yes, there has to be a thorough evaluation and observation of the individual that has the syndrome. So, you're asking me, do I personally have to meet with the individual to make that diagnosis. And in this particular situation, I used other medical providers, because it was multiple medical providers from multiple specialities that made similar observations, and I used their observations, their clinical examinations, and I identified a pattern, and based on that pattern, I came to the conclusion that I did.

Q Now, there's a Leonard Matheson who wrote on the symptom magnification syndrome; is that correct?

A Yes.

Q And you relied on -- you rely on his literature?

A Yes.

Q Now, he says --

A Oh, not just on his literature. I mean, I relied on him as something that I referenced as like a basic definition of symptom magnification syndrome. But I'm relying on, you

know, physical examination points that have been identified in the medical literature in the past. And I think I referenced the Waddell literature that talks about, you know, things on examination that would lead to this particular observation. And I also rely on my own clinical expertise dealing with people who are recovering from injury, and that's what I do for a living. I deal, and treat, and diagnose people that are recovering from traumatic injury, and I've been doing it for the past 16 years.

Q Now, in order to diagnose this symptom magnification syndrome, isn't it true there has to be a structured interview that takes place in a room on a one-on-one basis after the Cornell Medical Index, Beck Depression Inventory, and other measures of general health and psychological distress have been completed by the patient, the rapport is established with the patient and the interviewer, then proceed -- then you proceed through 14 items in this -- this evaluation, and then the test is scored, and that's how you determine whether or not they have symptom magnification syndrome; is that correct?

A That's -- the article that I actually referenced states that from a psychological perspective. This is somebody who did groundbreaking work. I don't have the reference in front of me. I think it's here on my review of when this article was published. I believe it was in the 80s. Let me see exactly. 1991.

And so, this was basically a syndrome that was identified by orthopedic surgeons from the late 60s, and the syndrome was being kind of identified in utilizing certain physical exam signs. And what I did is I referenced an article in an occupational journal about occupational claimants that basically are manifesting this syndrome.

So, the syndrome itself isn't specifically defined by what this particular psychologist writes in his article, although he's trying to develop his own recommendations to the medical community about one way that a person -- a practitioner or medical provider can assess a claimant or an individual as having symptom magnification syndrome. So, he's writing a journal article about his own work.

Does a medical provider absolutely have to use the particular psychological inventories and have the lengthy interview to come to a conclusion of symptom magnification syndrome? No, absolutely not. It's a diagnosis that's based on observation of a person's behavior, an analysis of how they're interacting with the medical system, a thorough physical examination that can identify multiple points, and based on this, it's like any other medical diagnosis.

There's certain diagnosis -- diagnoses and medical syndromes that have no, quote/unquote, "objective medical findings" that you can kind of point to, but it's basically a input of multiple pieces of information that bring you to a

conclusion.

Q So, this structured interview, this is really the only structured testing that there is for this syndrome; is that correct?

A No.

Q Okay. Did you cite any other information as to any other structured process that you can go to in order to determine someone has symptom magnification syndrome?

A Yeah, there's physical examination findings that indicate a predilection of the person to develop any findings on an exam, like a physical exam, that would make a practitioner believe that there's inconsistencies in the person's physical presentation in terms of pain.

It's all revolving around pain and a person's perception of pain, and how they manifest their response to pain when a practitioner does an examination, or when a person is involved with performing some sort of physical task or physical process.

So, the -- to answer your question, it's a two-faced thing. One aspect of it is there's certainly -- in the community of medicine, there certainly has been an identification that people who manifest symptom magnification syndrome have some sort of psychological abnormality. It doesn't have to be severe, but they're manifesting some sort of psychological abnormality that makes them experience pain

at a much higher level than the average person. Or they may have a secondary gain issue that makes them report pain at a higher level than the average person would in a physical exam or a medical setting. So, that's the psychological aspect.

There's a very physical aspect of the diagnosis, too, and that's -- there's structured examination findings that lead a practitioner to believe that this person has a higher degree of probability that they're manifesting symptom magnification, and the classic example are these Waddell signs that I identified in --

Q Now, you've never actually done a physical examination of Yvonne; is that correct?

A Correct.

Q And you've never observed her behavior; is that correct?

A Correct.

Q You've read through some of her medical records; isn't that correct?

A Yeah. I read through every piece of medical record that was given to me. I don't know if that was a complete set of medical records, but I analyzed it very carefully.

Q And you never actually performed the Waddell test on Yvonne; is that correct?

A No, I did not.

Q And there were multiple other doctors that did;

isn't that correct?

A Yes.

Q And in 2010, she was tested three times for the Waddell factors by her pain management doctor, and those came out negative; isn't that correct?

A Which pain management -- is that Dr. Erkulvrawatr?

Q Correct.

A Is that what you're talking about?

Q Yes.

A Yes. So, I am going to answer your question, but I have to comment on that as well, and that is, in order to elicit Waddell signs, a doctor has to basically take time and do a very thorough examination of a claimant, and it has to go beyond a normal orthopedic examination.

So, I'm going to tell you the reality of the situation, and that is, first of all, Dr. Erkulvrawatr recorded a certain level of degree of pain that was to -- basically, out of proportion with what the, you know, objective imaging showed, but he documented on his paperwork that there were no Waddell signs.

Now, the reality is, is that doctors frequent -- and I can't -- I'm speculating, but I can't say for sure, but Erkulvrawatr -- many doctors use templates for their medical record reporting. So, he has it documented that the Waddell signs are negative.

I don't know if you put Dr. Erkulvrawatr on the stand and asked him specifically whether he did those tests or didn't do those tests. But in order for a doctor to actually elicit the Waddell signs, you have to observe a person very carefully. You have to spend time with them, you have to interview them, you have to basically do a very thorough examination, and it has to be over a period of time and multiple areas of testing.

So, in the medical community, most of the practitioners that truly identify symptom magnification are physical therapists. Why? Because physical therapists are the ones that spend most of the time with an injured person that's trying to rehabilitate, and a lot of the time, doctors rely on physical therapists to come up with these diagnoses, and there's specific examinations called functional capacity exams that we rely on to really give us a true essence if a person has, symptoms that are out of proportion with the medical findings.

And these functional capacity exams have the questionnaires and the pain questionnaires that you're talking about, and the inventories, and they do physical testing on a person. Those exams usually take two to three hours to complete.

So, if you're asking me, did Dr. Erkulvrawatr actually have a really strong concept of whether this person

was -- has Waddell signs, I think you'd have to talk to Dr. Erkulvrawatr himself, because he'd have to tell you how much time he spent with that patient, exactly what Waddell tests he did to elicit it, because you have to be really looking carefully to make those observations. And that's why physical therapists and doctors that do lengthy exams are the ones that really can make the diagnosis clearly.

Q So, you can't comment one way or another on whether Yvonne had, I think you said in your report, criteria for four out of five Waddell signs?

A I elicited that primarily from many pieces of information from her medical record. I could go through that with you if you want. And a lot of that information was primarily extracted from her physical therapists that were seeing her multiple times, and observing her over, and over, and over again, and seeing how she reacted to certain functional exercise, and functional testing, and strength testing, and sensory testing, and multiple tests that physical therapists do.

And you -- I identified two separate physical therapists that are very well respected in the community that have identified this very clearly in the medical record. And not only that, I would tell you that -- because I deal with physical therapists a lot. I mean, that's just what I do. I rehabilitate people. I'm interacting with physical therapists

on a daily basis.

The amount of times that I see a physical therapist document symptom magnification in the medical record is very infrequent, I would say maybe 1 in 100 actually like injured individuals that I deal with that are going through physical therapy. I would estimate maybe 1 in 100.

So, for someone -- for a physical therapist to come out and document it outwardly in a medical record, that's something substantial. And it wasn't just the physical therapist; there were other doctors that had made the same observation, that --

Q You can't comment on the veracity of each one of these medical providers because you don't know how it was conducted; isn't that correct?

A Explain the term veracity, because I'm not --

Q You said Dr. Erkulvrawatr might have said no, but he could get on the stand and say something different, and the truth is, Waddell's facts or signs have to be tested personally by the doctor, right, in order to make a determination?

A Doctor, physical therapist, occupational therapist, you know, nurse practitioner, physician assistant, whoever, yes, it has to be documented by each individual medical practitioner. And I would say that it requires a very lengthy exam and a lot of medical criteria to make those observations.

So, I know how the medical system works, and I know how doctors like myself are very busy. And a lot of times, we're seeing a claimant -- a patient that's injured, and we're moving through an orthopedic exam very quickly, and we make very superficial notes. And we have -- a lot of times -- I'm not -- like I said, I can't say this for sure, but a lot of times, doctors have templated notes, so something like Waddell signs just goes as a template.

We don't know for sure -- I don't know if Dr. Erkulvrawatr has been put under oath and said for sure, but we don't know for sure that he did those tests or not, or whether it was just on his medical record.

Q And so, we don't know for sure whether those physical therapists did it either, if that's -- if we're --

A Yes, we do, because they -- they definitely documented that they did do those things. You know, Matt Smith and Scott Pensivy very clearly said that they did multiple tests on this individual, and there was multiple inconsistencies involved.

Q So, you're --

A And I'll also -- there was an orthopedic surgeon as well, Dr. Trainor, that had made the same conclusion. But he diagnosed her with chronic regional pain syndrome, and I made very clear in my record why I didn't think this claimant, Ms. O'Connell, why I felt she didn't have chronic regional pain

syndrome, but.

Q What training do you have in chronic regional pain syndrome?

A I've trained with a lot of the best physiatrists in this country; in Chicago, in this town. I deal with neurologists. I see injured individuals and claimants like every day of my life for the past 16 years, other than weekends, treating injured workers. And I have seen multiple people with chronic regional pain syndrome, and it's a very clear diagnosis. And the -- and it used to be called reflex sympathetic dystrophy, used to be the old name for it, and then they changed it to chronic regional pain syndrome.

There's very clear criteria for it. And the criteria indicates that there has to be observable neuropathic changes on an examination. So, those changes involve neuropathic and vascular findings that involve nerve injury. And it's typically post-surgical, or post nerve injury, or if -- if an individual has like a very severe untreated radiculopathy from the spine, that nerve injury creates an autonomic response in the body that creates pain, vasodilation, erythema, skin changes, you know, hair loss.

You know, these are things that are very observable. And this situation didn't fit that picture because there was no evidence that this individual had any neuropathic injury or autonomic signs in any of the examinations that were done.

Q But again --

A And also, the EMG nerve testing was completely normal.

Q Again, in order to diagnose this chronic regional pain syndrome, you have to do a physical examination of the patient like Dr. Trainor did; is that correct?

A Correct, and he -- he didn't document that there was any neuropathic findings. He -- what he documented is that this claimant had regional pain in un -- like non-neuromyotomal region. So, like when a person has regional tenderness, and regional weakness, and diffuse pain, and diffuse tenderness in multiple regions, that's one thing. But to diagnose neuropathic injury and autonomic findings on an exam, it wasn't in his notes.

So, he diagnosed it and he did an exam. I can't speak for Dr. Trainor either. You'd have to put him under oath and talk to him about why he came up with that diagnosis, but I clearly felt that, you know, based on the reasons I just told you why neuropath -- chronic regional pain syndrome was an inappropriate diagnosis in this case, and that -- I'm sorry, I just want to turn off my phone.

You know, I can -- again, I did a very thorough medical record review, and I took Dr. Trainor's notes, and I did the best I could with them. And I understood why he came up with the diagnosis he did, because this claimant, if you

look at the medical record, she was reporting total body pain, you know, pain across her whole back, across her whole neck, across her legs, and her knees. And he was specifically examining her knees only, but he saw a person that was suffering with like total body pain.

And so, he said, I don't see anything focal. I can't do anything for this individual as an orthopedic surgeon. I recommend physical therapy. Now, he made a diagnosis. As a doctor, my opinion, that diagnosis was inaccurate.

Q Your training is in family medicine; is that correct?

A It's much more than family medicine.

Q And you also work in occupational medicine; is that right?

A Sport -- I'm board certified in sports medicine, I'm an osteopathic physician, and I -- I utilize that education as a high -- very high, thorough understanding of anatomy and physiology of the human body. And I've been practicing occupational medicine for 16 years.

And not only that, I believe I've earned a high respect in the community in Las Vegas and Southern Nevada to actually deal with multiple issues of injured human beings that aren't getting better in the medical system.

So, actually, my job that I do on a regular basis

involves rehabilitation medicine. And a lot of the insurance companies in Southern Nevada that deal with a lot of injured workers utilize me as a physiatrist. I'm not board certified in physiatry, but I -- I basically fit that role as a rehabilitation specialist.

Q And that's in the occupational, getting people back to work; is that correct?

A No, it's getting people healthy that have been injured.

Q What portion of your practice is in occupational?

A 90 percent.

Q So, if I understand correctly, the only way -- or only information you used to diagnose her with symptom magnification syndrome was what you saw in the medical records that you were provided; is that correct?

A Correct.

Q And you never actually physically performed the Waddell test on Yvonne O'Connell?

A Correct.

MS. MORRIS: May we approach, or?

MR. SEMENZA: Sure.

THE COURT: Is there -- well, I guess you can. Sure.

MS. MORRIS: Sorry.

THE COURT: We're outside the presence, but.

(Off-record bench conference)

BY MS. MORRIS:

Q All right, we're going to back up a little bit, Dr. Klausner.

A Yes.

Q Where did you attend medical school?

A Can I just give you a copy of my CV, or do you want me to go through everything?

Q I'd like to go through it.

A Okay. I went to Chicago College of Osteopathic Medicine.

Q All right. And when did you graduate from there?

A 1995.

Q And did you get any education past the Chicago college?

A Yes. I did a general medical internship at the Chicago Osteopathic Hospital, that was 1995 to 1996. And then I went on to complete my family practice residency at Olympia Fields Osteopathic Hospital from 1996 to 1998. And then I completed a sports medicine fellowship from 1998 to 1999, and passed those certification examinations, and continue to hold board certification in family practice and sports medicine.

Q And what training have you received in how to diagnose symptom magnification syndrome?

A So, in terms of my sports medicine training, I

certainly have learned to do very thorough medical evaluations and orthopedic evaluations on individuals that have suffered traumatic and musculoskeletal injury. And so, part of that training in orthopedic literature involves understanding how different people manifest pain and pain syndromes.

During that fellowship, as I said, I was trained in physiatry clinics, and clinics with doctors who excel in the research and identification of chronic regional pain syndrome, and dealing with myofascial pain syndrome and musculoskeletal injuries that are sometimes very difficult to treat in rehabilitation medicine.

So, part of my training did involve understanding pain syndromes, Waddell signs, orthopedic exams, how to identify these different syndromes. But I would have to tell you that I've been practicing occupational medicine since I was a family practice resident in Chicago.

So, in terms of occupational medicine itself, my experience probably ranges to about 17 years of being employed as an occupational physician. And this is one of the specific arenas of the healthcare system where it's crucial that a doctor has to understand mechanism of injury, thorough examination, correct diagnosis, how to interpret medical testing, imaging, electrodiagnostic studies, and putting all those pieces of information together to come up with an accurate diagnosis, rehabilitate a person, help them to get

well enough to resume their normal life.

And as you said, part of that equation means getting back to their job. And then, if there's a claim dealing with the legal issues to help the claim come to a conclusion and help everything come to, you know, a final medical legal conclusion, as I said.

So, this experience in occupational medicine is essential to my knowledge as a doctor. I've been doing it for 17 years.

So, Counselor, my cousin in Pittsburgh, she's a lawyer that negotiates union contracts for coal miners. Now, if I was to ask you what your knowledge of negotiating unions, and coal miners, and dealing with issues with, you know, disputes for the coal miners, and medical issues for coal miners, I'm sure your level of expertise might be little, but it's not as much as hers. And the same thing for me as a doctor.

I've been practicing occupational medicine for 17 years. I -- I pride myself in my knowledge of human behavior from people that get injured, the psychological aspects of disability, what happens to a person when they become injured and how they manifest pain, and how that disrupts their life. And what it takes to have a person move forward to try to get that conclusion where they can resume a normal life. So, it -- it's more than just what you see on the paper. It requires

a lot of expertise and experience.

So, if you ask me what my experience is in this, I've dealt with human beings, actual human beings. It's not just learning in a classroom. I've dealt with human beings that have been injured that have manifested pain that's out of proportion with what the medical testing shows, and I have a very clear understanding in many cases of why human beings develop this syndrome called symptom magnification syndrome.

I deal with physical therapists that test for it. I'm very observant. I know how to interpret medical records, and I believe that I'm extremely qualified to make the judgment regarding the diagnosis of symptom magnification syndrome, just based on my experience.

Q Have you received any training in how to diagnose symptom magnification specifically?

A Yes.

Q What was that?

A Well, let me take you back. I've worked with some of the best physiatrists or rehabilitation physicians during my training in sports medicine. And, if you want, I could tell you where and who they were that trained me.

And these -- and my own preceptor in sports medicine was a doctor at Olympia Fields Osteopathic Hospital, who also did a lot of occupational medicine. And he taught me as a young physician to observe and to identify when somebody's

having problems like moving through the medical system, and when somebody's developing psychological issues with pain that are out of proportion with the objective medical testing, and that's the crux of the diagnosis of symptom magnification syndrome.

And I've been taught it formally. I've, like I told you, practiced it, and I've helped people to deal with it, and I believe that I'm very qualified.

Q Now, you referenced that article in 1991 by Leonard Matheson?

A Yes.

Q And that's -- in beginning to diagnose symptom magnification syndrome, there is a one-on-one interview that is conducted; isn't that correct?

A Of course.

Q And in this case, you did not conduct any --

THE COURT: All right, we've gone --

MS. MORRIS: -- one on one interview?

MR. SEMENZA: We've been there.

THE COURT: We've done that. All right, so you've been voir diring him for almost an hour. I'm satisfied that he's qualified to testify in this area. I'm not going to exclude him from testifying regarding symptom magnification. However, Doctor --

THE WITNESS: Yes.

THE COURT: -- speculating about what another doctor did or didn't do --

THE WITNESS: I understand.

THE COURT: I don't want to hear that come out of your mouth.

THE WITNESS: Okay.

THE COURT: Okay. All right.

THE MARSHAL: All rise for the jury, please.

(In the presence of the jury)

THE MARSHAL: Jurors are all present.

THE COURT: Thank you. Please be seated. The record will reflect we've been rejoined by all eight members of the jury, as well as the alternate.

Ladies and gentlemen, I apologize that we kept you waiting for the past hour. I do want you to know that we have not been having a party; we've been working ever since 2:00 o'clock.

And so, we try not to keep the jury waiting, but sometimes it's required, and it was in this case, and so I apologize that we had to keep you waiting. We've been pretty prompt throughout the trial in getting started with you right on time, but there are times when we can't, and this was one of them. My apologies, again.

So, now we're going to have the doctor sworn. If you'll please stand.

THE CLERK: Can you please stand and raise your right hand?

DR. VICTOR KLAUSNER, DEFENSE'S WITNESS, RESWORN

THE CLERK: Please be seated, and then please state and spell your first and last name for the record.

THE WITNESS: Victor Klausner. V-i-c-t-o-r. Last name, K-l-a-u-s-n-e-r.

THE COURT: You may proceed.

MR. SEMENZA: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. SEMENZA:

Q Good afternoon, Dr. Klausner.

A Good afternoon.

Q Could you tell us a little bit about your education, please?

A I graduated from Chicago College of Osteopathic Medicine in 1995. I went on to do a family practice residency in Olympia Fields Osteopathic Hospital 1996 to 1998. I finished a fellowship in sports medicine from 1998 to 1999. I'm board certified in family practice and sports medicine. And for the past 15 years, I've been practicing primarily occupational medicine and rehabilitation medicine in Southern Nevada.

Q Where did you attend undergrad?

A I have a bachelor's degree in genetics from the

University of Illinois Champagne Urbana, 1996, and Elmhurst College, a bachelor's degree in chemistry, 1990.

Q And where are you currently licensed to practice medicine?

A I have an active license in the State of Nevada, and that's been since 1999. And then I have an inactive license in California.

Q Okay. And you are a doctor of osteopathic medicine; is that correct?

A Correct.

Q And what is the difference between your certification and an MD, medical doctor?

A So, osteopathic medicine is a fully licensed medical -- recognized medical practice in the United States in which an osteopathic doctor has the same rights of practice as a medical doctor.

So, an osteopathic physician has the same board certification and licensing practice that an M.D. has. The difference actually lies in the medical training, so where an MD or a medical doctor spends a lot of their undergraduate work dealing with like physiology, experimentation, and certain like, you know, pharmacological experimentation and things like that, osteopathic doctors spend time in a lab learning anatomy, and physiology, and human motion and physiology patterns as a manner of healing.

So, as a layperson, you might be familiar with chiropractic. So, like a chiropractic physician, they're licensed to primarily do physical medicine and heal a person through the means of a physical medicine practice.

So, an osteopathic doctor has similar education that a chiropractor would have, like learning like human anatomy very well, human physiology, the musculoskeletal system extremely well, and putting that to practice, helping a person to heal more holistically, but we're also licensed to prescribe medicine to do surgery to do anything that an M.D. does.

So, I like to say that an osteopathic physician is the best of both worlds, because an osteopathic physician has the same credentialing, and should have the same background of scientific knowledge that a medical doctor has, but they also have a more holistic approach, understanding the human body physiologically to help them heal in a more natural way.

Q Thank you for that. And are -- what are -- are you certified in anything? What are your certifications?

A My board certification?

Q Yes.

A In family practice and sports medicine.

Q Can you tell us about your employment history, please?

A So, since I graduated from medical school, I did

moonlighting in Chicago for an occupational medicine practice that was out of the hospital in Olympia Fields for two years. And then, when I came to Southern Nevada, I originally was hired by an occupational medicine clinic run by Southwest Medical Associates, and it was a two-doctor practice. I worked with a physiatrist in the practice, and myself, and we did pretty much full-time occupational medicine. It was 100 percent occupational medicine in the clinic, and I worked at Southwest Medical Associates for four years.

By the third year, I actually took over the clinic myself. They actually promoted me to be the medical director of that clinic. But in 2005, Southwest Medical Associates made the decision that they didn't want to be involved in that business of occupational medicine anymore, so they folded the clinic, and then I opened my own practice in 2005, which is the Center for Occupational Medicine.

Q And that's where you currently work?

A Yes, the Center for Occupational Health and Wellness.

Q And have you undertaken any teaching activities during your career?

A Yes, I have.

Q Can you tell us a little bit about those?

A Well, when I was being trained as a family practice physician and sports medicine fellow, I was very involved with

the teaching and the -- of the osteopathic medicine department at Chicago College of Osteopathic Medicine. And I developed multiple curriculums for these areas, teaching medical students and family practice residents techniques and understanding of osteopathic medicine.

When I came here to Southern Nevada, I was also involved in teaching interns at Lake Mead Hospital when it was Lake Mead. It's North Vista now. But Lake Mead had a family practice residency, and I was involved with teaching them sports medicine topics.

I had a journal club with fellow doctors here in Southern Nevada to do like a rehabilitation journal club, where we would get together once a month, and share articles, and have discussions about orthopedics, you know, physiatry, sports medicine, you know, different topics about -- that were pertinent to our treatment at the time.

I also was involved with the American Osteopathic Association lecturing on back pain syndromes, which was a national lecture that was held here in Las Vegas, and I've lectured on back pain multiple times in the community to a lot of occupational medicine organizations. I'm trying to think if there was anything else that I can think of. Yeah, yeah, I think that covers it.

Q One question, before I forget. What is a physiatrist?

A It's a doctor that specializes in physical medicine and rehabilitation. So that's otherwise known as PM&R, physical medicine and rehabilitation. So, it's doctors that treat musculoskeletal injury and rehabilitation.

And you find a lot of physiatrists that treat people in rehabilitation facilities. Like, so if a person has surgery, or an orthopedic surgery, and they have to go to a rehab facility, a lot of times the physiatrist will oversee their care and deal with physical therapists with rehabilitation. And physiatrists are also specialists in rehabilitating musculoskeletal injury.

Q And before we move on, have you had any publications?

A Yes.

Q Can you tell us just briefly about those?

A I published an article when I was a family practice resident in 1998, regarding nutritional medicine and impact on coronary artery disease. It was called, "Nutritional Impact of Lipid Oxidation in Coronary Artery Disease."

And then, during my family practice -- I'm sorry, my sports medicine fellowship, I published an article in a journal called, "The Physician and Sportsmedicine." It's regarding an ankle syndrome called the sinus tarsi syndrome, which is a syndrome of the ankle that's commonly seen in athletes or people that injure their ankle.

Q Okay. And did you perform any tasks in relation to this particular case?

A Yes.

Q Can you tell us what you did?

A Yes. I was asked to do a medical record review. I submitted this review, it was approximately three months ago, and -- I'm sorry, no, it was longer than that. This was seven months ago. I did it in April 2015.

And I reviewed all of the medical records up until that point of April 2015 and rendered my opinion regarding the medical treatment, the diagnosis of what I felt was the -- the picture of what the medical treatment provided, and the claimant herself, what the diagnosis that we were dealing with at the time -- I mean, in the medical record.

Q So, from -- what was the earliest medical record that you reviewed relating to Ms. O'Connell?

A It was February 8th, 2010.

Q And then, the latest records that you reviewed were through which date, or approximate?

A Okay, so the -- my written opinion, the last record that I reviewed was January 14th, 2014. Subsequently, I reviewed other records that were rendered more recently, but I don't have a written opinion of that.

Q Okay. And did you review the medical records for Ms. O'Connell from a number of different medical providers?

A Yes, I did.

Q Can you identify some of those medical providers?

A Well, I -- there's a lot. I can summarize. Ms. O'Connell was seen multiple times by a primary care physician at UMC Quick Care at multiple locations. The UMC Quick Care physicians had referred her for treatment with multiple cardiologists. I also mentioned that I reviewed one record from a primary care physician that had treated her previously named Dr. Prabhu at Ascent Primary Care.

There were other referrals in the medical record, including gastroenterologists, orthopedic hand surgeon. There was an orthopedic spine surgeon, a orthopedic sports medicine physician, physical therapists at two separate locations, a pediatrist at a foot and ankle clinic, a pain management doctor at Southern Nevada Pain Center, and then there was also imaging studies that I reviewed as well.

Q Okay.

A There was also a neurologist that did neurodiagnostic testing. And one last -- there was an ear, nose, and throat doctor; an otolaryngologist in the medical record as well.

Q Did you actually examine Ms. O'Connell?

A No, I did not.

Q And you've rendered opinions based upon the medical records that you've reviewed?

A Yes, I did.
Q And those medical records cover a number of years?
A The medical records were from February 8th, 2010, and that went all the way to January 14th, 2014, so it was almost four years.
Q And based upon your review of the medical records, do you have certain opinions relating to Ms. O'Connell's medical condition?
A That's a broad question.
Q It is.
A So, you know, I think that I can try to summarize, if you'd like, and that --
Q Well, let's walk through them.
A Do you want to walk me through, or do you want me to walk you through?
Q Why don't you walk me through?
A Okay. So, I -- the best way I can maybe approach this is tell you how, as a physician, I would look at the medical record and interpret the data.
Q That's fine.
A So, I had a report from security personnel from Wynn Hotel that there was a slip and fall incident. And the claimant slipped on some sort of liquid on the floor and fell to the ground. And there was documentation of -- from photographs that were taken with three areas of ecchymosis or

bruising on the right buttocks of the individual, Ms. O'Connell. And the guest -- the security personnel documented that the guest refused medical treatment.

The first encounter medically that was evaluated was at UMC Quick Care. And at UMC Quick Care, it was very well documented there was a slip and fall, and the claimant, Ms. O'Connell, described bilateral low back pain with contusions to her right buttocks and hip, and she said there was pain radiating into her right buttocks and right leg. There were x-rays of the lumbar spine performed at UMC Quick Care, and there was a diagnosis of contusions of the lumbar spine and sacral spine.

There was documentation by the physician at UMC Quick Care that it was an examination of the cervical spine and chest, and these examinations were normal. And the x-rays that were done identified disc -- degenerative findings of the lumbar spine, so there was narrowing of the disc spaces, calcifications, and so chronic findings of arthritis and disc degeneration, and Ms. O'Connell received medication.

So, this is very important. I went through that very, very carefully. And the reason why is, like I said, as a physician in the practice of occupational medicine, my job is really primarily to understand pathophysiology of an injured human being.

And that is very complex, because it involves like

understanding the actual trauma that occurred, how that individual accessed medical care, what the diagnostic studies were done, what the examination was that identified that, and the manifestations of a person's symptoms, and experience of pain and symptomotology, and how that plays out for any human being that's involved with trauma and is injured.

So, as doctors, we tend to try to identify what we call mechanism of injury, and then identify an injured body part, how a person manifests injury, and physiologically what would be normal for a human being manifesting following an injury. That's my speciality, because I see people that are injured all day long. I practice occupational medicine, and I see people that get injured on the job every day.

So, I went through this very carefully, and the reason why is because that first encounter is extremely important. This individual, Ms. O'Connell, was seen -- first of all, fell, and refused medical treatment. So, that's very indicative in one respect, and that respect is that if a person is seriously injured to the point where they're having major medical problems, there's an assumption that they're going to access medical treatment quickly, within let's say 24 hours. She was seen at a Quick Care two days after the date of injury.

So, the next thing is that I have a general rule of thumb as a doctor, because I see people that are injured all

the time, And there's something that's called like delayed onset of symptomotology. And especially with the spine, very commonly, sometimes we see delayed onset of symptoms, but those symptoms physiologically, based on human anatomy, human neurophysiology, and how a person normally manifests pain, there will always, always, always be some level of manifestation of injury within 48 hours, always. I've never seen a legitimate situation in my career as a doctor where a person that manifests delayed onset of pain more than 48 hours.

Now, not to say that a person can't experience pain, but there has to be typically other reasons for it that usually have other medical conditions that may not be associated specifically with the mechanism of injury per se. So, that's a medical truth, and that is that a person within 48 hours will manifest some sort of level of pain based on the mechanism of injury.

So, right here, we see that Ms. O'Connell documented her pain in her low back, radiating into her right buttocks and right leg. So, if I'm going to be like very objective about this, I'm going to tell you that this is the extent of her injuries wouldn't be involving her low back, right buttocks, right leg, and then we'll move forward. Then we can move forward in the medical record.

Q And let me stop you there for just --

A Yeah.

Q -- a moment. Was there any indication that Ms. O'Connell during this visit had injured her right knee?

A There was no documentation of that. I mean, the documentation was more radiating pain down the right leg.

Q Okay. Go ahead.

A Then, the next access of medical treatment was a month later with Ms. O'Connell's primary care physician, Dr. Prabhu. And Dr. Prabhu had known this individual, Ms. O'Connell, well based on his previous treatment of her, and he diagnosed her with lumbago, which is a generic term for back pain.

So, just -- when you see lumbago, it's just back pain. Chronic fatigue syndrome, Ehlers-Danlos syndrome, which is a connective tissue disorder. And then he basically took a history that she had generalized pain. She has a history of multiple issues of generalized pain, and it was after this trip and fall a month previous.

And he said -- he specifically stated, "Her back still hurts and she has a history of fibromyalgia, Ehlers-Danlos syndrome, irritable bowel syndrome, and depression." So, this is significant in the fact that now we're already a month out from the injury. And if -- this is a doctor that's been treating this individual before, has a rapport with Ms. O'Connell, and she's specifically focusing on

her back and generalized pain after the fall, but there's no specific mention of knee, there's no specific mention of neck, there's no specific mention of shoulder, there's no specific mention of specific identification of localized pain.

And in this record as well, we get a sense that Ms. O'Connell has had issues with pain before. She's had issues with fibromyalgia, which is a generalized pain syndrome, over the -- throughout the whole body, and she has a connective tissue disorder, Ehlers-Danlos syndrome.

And she has stomach issues, which the term here is irritable bowel syndrome, which means that a person has an autonomic problem with just -- problems with potentially constipation, diarrhea, stomach pain. And then there's identification of psychological problems, that she has depression.

So, I think that that's very telling, because this just wasn't an urgent care. This is somebody -- a doctor that had a rapport with this individual, and there's clear documentation that she was focusing on her back after a trip and fall a month after the date of injury.

So, he did lab work on her to make sure that she wasn't having any kind of flare-up of her rheumatologic disorders, because there's identification that she has Marfan syndrome and this Ehlers-Danlos syndrome. So, he did rheumatologic markers and a sed rate, which were normal, to

make sure that her pain wasn't coming from those specific syndromes. So, the -- can I move on?

Q Yes, please.

A So, the next entry was March 18th, 2010, which was about six weeks after the date of injury, and here's where things all the sudden changed in the medical record.

"The claimant, six weeks after the date of injury, is complaining of pain over her entire right side of the body after a slip and fall. Weakness, fainting, chills, trouble sleeping, blurred vision, lump on the back of her neck, dizziness, headaches, chest pain, cough, shortness of breath, nausea, change in appetite, severe constipation, heartburn, abdominal pain, neck pain, frequent urination, sexual dysfunction, depression, anxiety, pain and stiffness in her hands and wrists, pain in her elbows, pain in her shoulders, pain in her neck, pain in her back, pain in her hips, pain in her knees, pain in her toes, pain in her feet, and pain in her jaw. She describes a history of a fall in 1989" -- "that she developed chronic pain after a fall in 1989, which led to a diagnosis of multiple medical problems."

She developed irritable bowel syndrome, remember, like constipation and stomach problems, which can frequently arise in individuals that are over-treated by the medical system with medication, because medication can cause a lot of autonomic problems, and stomach issues, and things like that.

She also said that she developed anxiety, stress disorder, fibromyalgia, and medication dependance with severe constipation and abdominal pain.

So, there's -- this encounter also is very important. Why? Because all the sudden, six weeks after a person was injured, which seemed like a very localized low back pain situation, all the sudden become total body involvement where there were multiple systems, multiple orthopedic and musculoskeletal complaints. And there was an identification of multiple preexisting psychological problems, and medication dependance problems, and functional problems; i.e., like fibromyalgia and irritable bowel syndrome.

These are like functional medical conditions that are caused by people who have chronic pain, meaning that they're not able to cope with their pain, they develop stomach issues, constipation, functional problems that need specific attention.

So, that was very important in the medical record. She was referred for x-rays of her neck, her chest, her right knee, her right hip, and she was referred to a gastroenterologist and an orthopedic surgeon based on her complaints.

Q Okay.

A So, then, just real quick, the next day, she went for medical imaging at Steinberg Diagnostic. The x-rays of

her hip and knee were read as normal, which is important, to make sure she didn't fracture anything when she fell.

I mean, she had traumatic injury. So those issues of lumbar spine, hip, and right knee were taken care of right then and there in terms of ruling out like fracture, or obvious like serious traumatic problems.

The orthopedic surgeon that she saw was Dr. Cash, who's an orthopedic spine surgeon, and that was on March 23rd, 2010. So, at this point, I thought that he did a good -- Dr. Cash saw the claimant at about seven weeks post-accident, and he described her falling on her right side and left hand, which wasn't in the original record. And he said she describes pain over her right buttocks, right leg, right arm, and bilateral wrist. He said she has neck pain ranging to two to eight on a ten-point scale, and back pain from three to eight on a ten-point scale.

And I want you to pay attention to that, because even at this point, this was about seven weeks after the date of the accident, she was describing a range of pain that was somewhat reasonable. Like, maybe when she's resting, she's not in so much pain, but when she's active, maybe her pain escalates to a higher degree which, I would say, would be a normal physiologic response to somebody who's in pain. I'm not even saying that -- related or not related, it's just a normal human physiologic response to pain.

Q And at some point later in her treatment, did those numbers change?

A Yes, they did. You know, I would say specifically when she started accessing more medical treatment and going to physical therapy, this was April 28th, 2010, so that was basically two-and-a-half months, she was describing pain severity at ten out of ten all the time, and that, subsequent to that, if you look at the pain diagrams in the notes -- and a lot of times -- you know, I went through this medical record really thoroughly, and the pain diagrams, the things she was entering into the record.

She was writing pain diagrams like the whole body. Like her back, her neck, her legs, her feet, her hands. Complete pain over her whole body at a level of ten out of ten repetitively over, and over, and over, and over again.

And this was also documented by the pain management doctor that saw her. Dr. Erkulvrawatr saw her. He's a pain management physician. He saw her April 9th, 2010.

So, this was exactly five months following a date of injury, which you would suspect, just with time and physical therapy, there would be a progression of healing, a progression of trying to return to a normal activity level, to a normal state of function.

Dr. Erkulvrawatr described a subjective interview with the claimant that said she had bilateral neck and upper

extremity pain at a level of ten out of ten, worse in the neck with movement, and she also states she worsened with physical therapy, bilateral low back pain radiating into her right leg, with numbness and weakness in her leg with a severity of ten out of ten, worse with walking.

So, now, as a physician, you'd say, wow, this is serious, right? Because her pain is like escalating instead of getting better. So, as a physician, we're trained to really try to focus on like objective findings, you know, objective medical evidence.

And in this day and age, we're lucky. We're -- doctors are kind of spoiled, and I would say a lot of doctors over-utilize medical technology, because, as I said, you know, a good physician that analyzes an injured individual, you have to do a very good interview, get a sense for a person's experience of pain, behavior, so on and so forth, what their other stress factors are in their life. You have to do a thorough medical examination, and then rely on imaging and other testing that's done.

So, the testing is very objective, meaning, it doesn't mean Dr. Cash did it, or Dr. Erkulvrawatr did it, or Dr. Dunn, or whoever was seeing the patient. It's -- the MRI testing -- or -- is very objective. It is what it is. It tells a very, very clear story about physiologic injury. Why? Because an MRI can show a fracture, even a bruise. An MRI can

show a bruise in a bone, it could show whether there's traumatic damage to soft tissue, it could show nerve injury, it could show ligament injury, it could show tendon injury, it could show the chronicity of things based on the appearance of cartilage, the appearance of calcification in certain areas of the body.

So, like I said, in this day and age, in medical -- the medical environment, doctors are very spoiled, because we have this MRI technology that helps us. And it helps us to get a very clear picture of what possibly can be causing a person's pain, right?

So, that's why, you know, physicians -- and even in a medical legal arena, there's a heavy weight on MRI technology, because it tells us structurally, and functionally, physiologically what the source of a person's pain and disability is coming from.

And so, a lot of times, it doesn't mean a person wasn't injured, but a lot of times, it just gives us information where we can rule out bad things, and we come to a conclusion of why a person's in pain.

And so, I wanted really to pay attention at -- because Dr. Cash ordered MRI imaging of the claimant's cervical and lumbar spine, and the MRI of the lumbar spine was performed April 8th, 2010.

Q Okay.

A And it was done at Steinberg Imaging. And what those images showed was basically that the claimant had multiple levels of -- in the spine, the vertebrae of the bone, and in between the bone, there's little cushions called discs, which are ligament material filled with fluid. So, those discs are -- surround the spinal canal, and then you have the nerves that exit the spine behind the disc.

And the MRI showed no evidence of traumatic fracture or subluxation of the joints in the spine, which is very important. After a person falls, that's one of the first things you want to do. You want to make sure there's no translation of the vertebrae from traumatic subluxation.

The MRI showed that the discs in her spine from the bottom, which is L5-S1, then L4-L5, and then up to the middle disc at L2-L3, they were all desiccated, meaning, they lost -- were losing moisture, bulging, and calcified. There was calcification of the discs, which show a pattern of chronic disc degeneration. The disc at L2-L3 showed a left paracentral bulge, meaning that disc was kind of deformed more to the left than to the right, and it caused a tiny bit -- we see mild narrowing of -- across the nerve, which is physiologically insignificant.

So, if this individual is having all right-sided symptoms down the leg with burning, and weakness, and pain down the right leg, you -- what we're looking for on the MRI

is a disrupted disc, a disc that's torn, a disc that has an annular disruption, a deformity of the disc that is moving towards the right, impinging on a nerve that exit into the person's leg. This was absolutely not there.

Q Okay.

A It was -- it was specifically documented that she had these very mild central disc bulges at multiple levels. And then the -- this left paracentral disc bulge at L3-L4 was the only one that actually lateralized.

And aside from that, her soft tissue was normal. There was no mass, or edema, or swelling in the soft tissue, there was no fracture of the sacrum. And so, from this conclusion, when Dr. Cash interpreted this MRI, he very specifically recommended that the claimant required a pain management consult and physical therapy.

Q Okay.

A So --

Q And did she --

A There was an MRI of the cervical spine that was performed also at Steinberg on May 8th, 2010, and that was evaluated by Dr. Erkulvrawatr, along with the lumbar MRI. And his interpretation -- so this -- there was a radiologist that interpreted that MRI, and also Dr. Erkulvrawatr, and he said she had multi-level disc degeneration at C3-C4, C5-C6, C6-C7, so three lower discs in her neck had degenerative disc process

without any acute injury or disc herniation.

Q Okay.

A And then, he interpreted the MRI of the lumbar spine exactly the same way that I just kind of reviewed it. And what his exam showed, Dr. Erkulvrawatr said that she had complete regional tenderness of her whole cervical spine and her whole lumbar spine, she had limited range of motion, normal neurological exam, normal strength. So --

Q What does that tell you?

A So, what that tells you is Dr. Erkulvrawatr concluded that this woman had cervical disc degeneration and lumbar disc degeneration, and he made a note of lumbar radiculopathy.

Later on, the way you can confirm lumbar radiculopathy is through nerve testing, like diagnostic nerve testing, and the diagnostic nerve testing was subsequently done by a neurologist on March 6th, 2012, Dr. Milford, and that was approximately two years after the date of injury.

And Dr. Milford said that her upper extremity EMG and nerve conduction testing showed changes in the nerve velocity, consistent with bilateral carpal tunnel syndrome; no evidence of lower extremity abnormality; no evidence of upper extremity radiculopathy coming from the neck; no evidence of radiculopathy coming from the lumbar spine.

So, that's why this gets very complex, but you put

that together and you come to the conclusion that there was no MRI evidence of acute injury of the cervical or lumbar spine. There was nothing there that could be identified as being an acute damage to the spine.

Q Okay.

A The -- that was the specific analysis of the spine from orthopedic surgery perspective when she was seen by Dr. Cash, and then also her pain management doctor, Dr. Erkulvrawatr. She was seen by -- I'm sorry, I skipped this over. I apologize, I have to go back.

She was seen sooner than that by a neurologist, Dr. Germin, a clinical neurology specialist, sooner. This was June 10th, 2010. And he did upper and lower extremity neurodiagnostic testing, and his conclusion was that the symptoms that she was displaying was neck pain, headaches, blurred vision, chest pain, difficulty breathing, pain in her arms, difficulty walking, stomach pain, nausea, frequent urination, back pain, joint pain, muscle spasm, and decreased sensation in her hands and feet with trembling. This was four months after the date of injury.

His neurodiagnostic studies, EMG testing, and nerve conduction testing in the upper and lower extremities, he said no neurodiagnostic evidence of lower extremity radiculopathy, peripheral neuropathy, or demyelinating neurologic disease. So, again, that's two separate neurologists that confirmed

that there was no evidence of lower extremity neuropathic disease; no radiculopathy coming from the spine.

Q And radiculopathy is what?

A Radiculopathy is when there's a process in the spine that causes impingement on a nerve, or layman's terms would be a pinched nerve. So, it could be a chronic process or an acute process that causes lack of blood flow to a nerve, so the nerve starts becoming pathologic, and you can get pain, and weakness, and loss of reflexes in an extremity from a process happening in the spine. And so, the term for that is radiculopathy.

Q Okay.

A So, I want to just go backwards, and go back to the -- her -- the claimant's first physical therapy assessment.

Q Okay.

A And this was ordered by Dr. Cash for her to go to physical therapy. And she was evaluated by Matthew Smith, who was actually the owner of Matt Smith Physical Therapy. And I -- I just want you to know, I know and work with a lot of these people in this medical record, and I have very high respect for all of these medical practitioners.

Q Understood.

A You know. So, the initial evaluation from the physical therapist was April 28th, 2010. So, this was two-and-a-half months following the date of injury, or

basically, two months, three weeks. He said she had a slip and fall, landing on her right low back and right buttocks on February 8th, 2010; pain over the lumbosacral area on the right greater than the left at a level of ten out of ten. Again, in the record, everything is -- at this point, was escalating.

His assessment was that she was weight-bearing with a walker, so she was using a rolling walker. She had lower extremity strength of three-plus out of five, which is -- basically, if a person has full strength, that's five out of five. If a person has like mild weakness, so if you're trying to test strength and they're kind of giving away, that's kind of four out of five. If a person basically has like very little strength against gravity, so if they can barely move against gravity, that's three out of five.

And so, he said her strength in her lower extremities was three-plus out of five, and he commented that she was manifesting Waddell signs. He said that -- specifically, that she was not giving full effort with strength testing. And we see that -- remember what I said. Dr. Erkulvrawatr saw this claimant relatively the same period of time, and he tested her and said she had five out of five strength, and here at the physical therapist, she's manifesting three-plus out of five. That's a significant difference.

He said she had diffuse tenderness over her whole lumbar spine in her gluteal region, the same thing Dr. Erkulvrawatr documented. Diffuse regional tenderness, meaning it's not pinpoint; it's like the whole spine. He documented tenderness in her gluteal region, and her range of motion was extremely limited.

So, if a person is trying to kind of bend at the waist, if they can go to a perpendicular level, that's 90 degrees. So, he documented that she only could go 20 degrees, basically, like that. And he documented that she can extend her spine basically five degrees, like barely moving into extension, which is extremely limited. He said that she had no nerve tension signs.

And so, he documented what he thought were Waddell signs, meaning that -- a Waddell sign, I have to clarify that, is basically, there was a surgeon -- orthopedic surgeon famous in the late 60s and 70s, and he was an orthopedic spine surgeon. And Dr. Waddell observed that there was many individuals that were not recovering normally from surgery. Like, he identified a problem, he did surgery, and he noticed they weren't recovering normally.

And he identified there were certain things on exam that a doctor should look for. They're called -- now it's very famous -- they're called Waddell signs, and there's five findings on exam that you look for that would identify

basically what we would call functional overlay, meaning, there's something psychologically going on that's making a person manifest pain that's not normal.

Q Okay.

A And so, that's what Dr. Matt Smith was identifying at that time. And he -- on reevaluation in May, basically, he noticed that her symptoms were not improving. He said she had inconsistent resistence when he did a strength testing, similar range of motion. She had the same complaints, and he wanted to continue treating her.

I believe on the discharge summary, she completed 24 sessions of physical therapy from Matt Smith, and she completed it November 1st, 2010, and that is nine months after the date of the slip and fall. So, nine months later, after 24 sessions with a very well-known, good physical therapist, she described continued lumbosacral pain on the right greater than the left at a level of eight out of ten. Her neck pain was radiating into her bilateral upper extremity with weakness and tingling in her hands.

She was still walking with a walker. Her upper extremity strength was still inconsistent and measured from three to four out of five. She had lumbar flexion that didn't change at all, just barely moving. And he just -- he suggested discharge from physical therapy.

And then there was -- I want to stick with the

orthopedic side of this. There's other issues with other doctors, specifically, cardiologists that she --

Q Why don't you briefly just address that real quickly?

A Okay. So, one of the main issues that was coming up when she was following up with UMC Quick Care, as I mentioned before, she had multiple symptoms of dysfunction, and multiple complaints of pain. And one of the big ones that doctors always tune into real quick is chest pain, and she was complaining of a lot of chest pain. And her primary care physician at UMC Quick Care had recommended she go see a cardiologist.

So, she was evaluated. And she also saw a gastroenterologist. The gastroenterologist was treating her for constipation, and he diagnosed her with predominant irritable bowel syndrome and constipation.

She saw the primary care cardiologist March 29th, 2010, and he diagnosed Ms. O'Connell with atypical chest pain. Testing was normal. And she followed up in the clinic at Nevada Heart and Vascular Clinic with Dr. Wesley May 3rd, 2010, which was three months following the fall.

The discussion that he documented -- or the subjective information that Dr. Wesley documented was a 58-year-old Caucasian female, highly anxious, with a history of irritable bowel syndrome, gastroesophageal reflex disease,

and atypical chest pain. However, now, she stated that the pain is radiating from her chest to her back. She has a history of possible Marfan syndrome and hypertension, which is well controlled.

He did an echocardiogram, which showed normal heart function and normal valvular function. He said she most likely has atypical chest pain from gastroesophageal reflex disease, however, he suggested because of this possible issue with Marfan syndrome, which is -- it's a connective tissue disorder that's genetic, and patients with Marfan syndrome can have valvular abnormalities. And the arteries, especially the aorta, can cause like big dilations.

Q Okay.

A And so, he wanted to be very careful about that. He asked her to get a CT scan of the chest to look at her thoracic aorta, and she was reluctant to do that and she wanted to follow up with her gastroenterologist, so he recommended that she come back.

Q Okay.

A So, when she followed up with Dr. Wesley --

Q Was that May 7th of 2012?

A Yeah, that's what I'm looking for here. Okay, yes. So, she followed up actually April 9th, 2012.

Q Okay.

A She -- the recommendation was for a full cardiac

work-up, because at this point, now you're two years after the date of injury. She had atypical chest pain radiating to her back, shortness of breath, palpitations, like -- we call it presyncopal episode, which means you're getting week and feeling like you're going to pass out, and dyspnea on exertion, which is shortness of breath on like walking up a flight of stairs or on exertion.

So, he recommended full cardiac work-ups, stress test, CT angiogram of her chest, echocardiogram, Holter monitor, which are multiple cardiac tests to check the electrophysiology of her heart, the structure of her heart, and looking at her whole chest to make sure there wasn't any issues of an aneurysm in the aorta.

She followed up with Dr. Wesley after a lot of the testing was done on May 7th, 2012. He said, Evaluation for chest pain with normal CT of the chest, normal cardiac Holter monitor, which looks for arrhythmia, and normal echocardiogram. And he said, this concludes an extensive cardiovascular work-up with no objective medical findings to explain her symptoms, which clearly appears to be functional overlay of chronic anxiety. He said she has a final diagnosis of reflex disease, anxiety, and heart palpitations, which are not physiologic.

And that in and of itself, a very well respected cardiologist to do full cardiac work-up and to make that

statement in a medical chart is saying, this woman has problems that's functional. She has anxiety; she's developing symptoms that a doctor can't explain.

She felt she wanted a second opinion. She went to another cardiologist. This was September 7th, 2012. Dr. Fotedar is a cardiologist from the Heart Center of Nevada. He did a second -- he -- he knew what his role was. He said, I'm a second opinion cardiac consultation after a slip and fall two years prior with person describing severe chest pain radiating to her back, shortness of breath, and heart palpitations.

Quote from his chart. He said, "This is a 61-year-old female with a history of a fall a couple of years ago that has since had multiple cardiac symptoms, including palpitations, chest pain, and shortness of breath. She has had a work-up done with a Holter monitor, echocardiogram, CT of the chest, which are all unremarkable. I had a long discussion with the patient, and basically tried to assure her that everything's normal, that her echocardiogram was normal with physiologic findings.

"The patient was not very happy with my conclusion and thought that I wasn't paying attention to her echocardiogram. I spent more than 30 minutes with this individual trying to explain to her that she does not have a significant valvular heart disease based on the echocardiogram

and the clinical examination, and maybe her symptoms cannot be explained by these tests. I did recommend that she should have a stress test in the future. At this time, she has not -- the patient said I'm not ready to do a stress test at this time."

So, here's a second cardiologist that said, I can't explain this woman's symptoms. She is very adamant that she has physical problems. He can't explain it, and he said he tried to be patient and explain to her maybe what's going on.

And so, this is a classic type of situation where a person's dealing with functional symptoms, but there's no medical explanation for it.

Q Okay.

A And then, I wanted to go back to the orthopedic --

Q Okay.

A And that is, she saw a second physical therapist, because prior to this cardiac situation, she was evaluated by an orthopedic surgeon who's an orthopedic sports med surgeon, Dr. Trainor, and he saw her on February 10th, 2012. So, that was exactly two years following the slip and fall.

And it's -- basically, he said this is a 60-year-old female who injured herself two years ago when she fell on a curb. She states that she never fully healed. She complains of pain along the entire right lateral side of her body, from her buttocks, radiating down the right side of her leg, to her

right knee. She describes constant pain.

His physical examination showed tenderness to palpation in the upper and lower extremities bilaterally. So, she had tenderness all over the place in bilateral upper and lower extremities. No specific joint tenderness that could show like a localized physiologic exam.

There was nothing that he could extract from his exam that was localized on the joint line of her knees, and she -- he said she had no hip pain when he was moving her. But she was complaining of a lot of right-sided hip pain, but when he was moving her on her on the table, she didn't develop or experience hip pain in certain motions that he was doing during his exam.

So, he diagnosed her with two conditions; one which we already discussed, fibromyalgia, which is a chronic functional pain syndrome, and complex regional pain syndrome with no obvious organic problems of the hip or knee.

So, I want to clarify something. The diagnosis of chronic regional pain syndrome is an organic problem, because the doctors that have actually researched chronic regional pain syndrome have identified that there's an autonomic neurological dysfunction that occurs in a limb when a person has neurologic injury.

So, like we talked about, if a person has a pinched nerve or neuropathy -- a lot of people know what carpal tunnel

syndrome is, right? It's when the median nerve in your wrist gets compressed from certain diseases like diabetes, or sometimes if a person has trauma to the wrist, or repetitive use, combined with physiologic problems, you develop like peripheral neuropathy, or if a person has a pinched nerve in the spine, or if a person has injury from surgery or trauma, a person can develop neurologic and neuropathic pain that's called chronic regional pain syndrome.

So, it's actually a physically organic identifiable syndrome that you can diagnose not just by like imaging to diagnose that there's nerve impingement, but neurodiagnostically. We talked about these neurodiagnostic findings that the claimant four years after -- or I'm sorry, this was three years after the fall, she developed carpal tunnel syndrome, bilaterally. But he was diagnosing it in her lower extremity for her knees. He said she had chronic regional pain syndrome, but we know, based on the neurodiagnostic studies, that she didn't have any neuropathic findings.

Not only that, the diagnosis of chronic regional pain syndrome has identifiable factors on exam. You can get redness, or the skin starts changing colors, or you can get the skin that kind of gets purple and white, and then you lose hair, and you develop like physical findings that are associated with neuropathic disease and circulatory disease.

And, clearly, that's not the case here.

You know, Dr. Trainor didn't identify any neurologic problems, nor did any of the other doctors on the examinations that they did.

So, I felt that Dr. Trainor was using a term that may not have been appropriate for this situation. So he diagnosed her with a pain syndrome that I felt was not demonstrated by the medical testing that was done.

Again, as doctors, we always go to the objective medical evidence. So, Dr. Trainor tried to make a diagnosis. Personally, my opinion, I felt he was off the mark, that she didn't fit the criteria for chronic regional pain syndrome. But he suggested she should try another physical therapist.

So, Dr. Trainor said, because he couldn't figure out anything that was localized or focal, he -- and he had ordered MRIs, as well, he sent her for physical therapy evaluation. She went to a separate physical therapist called Scott Pensivy, who has a smaller type clinic; it's kind of a private practice. He saw her September 18th, 2012.

Q Let me stop you for just a moment. Is that commonly known as SPORTS?

A Right, because --

Q Okay.

A Scott Pensivy Orthopedic Rehabilitation Therapy, I think. It's an acronym.

Q Okay. Go ahead.

A Right. So, Scott Pensivy was a physical therapist. And he was -- referred her regarding right hip pain, right knee pain, although the patient wished to treat her bilateral hand, as well. And bilateral foot pain, low back pain, thoracic pain, neck pain, and headaches.

So, out of a lot of the evaluations that were done in the medical record, I thought that this one was a very thorough evaluation and very well documented.

So, I'm going to go through my observation of his medical record. He said, the patient has been seen by different physical therapists for 24 separate visits previously. She describes her symptoms as worsening, as the other therapists were possibly too aggressive. He observed that the patient at this time appears to be moderately anxious and seems to be passing out as she talks a lot about her injuries.

She has -- difficult for him to ask appropriate questions because she had -- it seems, the way he was saying it, she didn't have a good attention span to what he was saying. He said that he attempted to shake the patient's hand, and the patient refused to shake his hand due to a perception of severe pain.

On his examination, he said that she had hypersensitive reaction to palpation over her whole body.

Every body region he tested, he couldn't find anywhere that didn't have tenderness to palpation.

He said, unfortunately, it's difficult to assess joint function secondary to the patient having severe apprehension of pain throughout passive range of motion; meaning, if he wants to just tell her, okay, relax, relax, I'm just going to move your arm back and forth like this, it's passive range of motion, meaning, she's not contracting any kind of musculature or trying to do any work, he's passively moving her. And he said that she had severe apprehension throughout passive range of motion of her lower extremities.

Every motion hurt with the exam, and he said it was difficult for him to assess strength secondary to patient's complaint of pain and apprehension throughout the entire exam. However, we notice multiple other practitioners -- the physical therapist multiple times said he tested her strength, Dr. Erkulvrawatr tested her strength, and they all said that she had some level of resistance or effort on the exam, but he -- he basically said she had no effort on the exam.

He said it's difficult to assess her strength due to her complaints of pain and apprehension throughout the exam. Poor functional status with laboring on every mobility of her body. Sensation with decreased -- I'm sorry, the sensation in her dermatomes were decreased without a specific dermatomal pattern.

So, we know in the body the nerves innervate a certain region. So, for instance, in the hand, we know like this is the C6 dermatome, this is the C7 dermatome, this is the C5 dermatome here. You know, we know that the certain areas when you test sensation, you're going to test like specific localized nerve patterns and how those patterns can develop into, you know, following an injury. And he said she had decreased sensation completely throughout -- with hypersensitivity in both of her lower extremities.

So, we're not even talking carpal tunnel syndrome, which was diagnosed on this individual, which, frankly, is -- like I said, carpal tunnel syndrome is a progressive degenerative disorder of a peripheral nerve in the wrist that occurs with age, it occurs with metabolic problems, especially people that have disorders such as Ehlers-Danlos syndrome, or things that cause connective tissue disorders, because a person can get problems with blood flow to their extremities. So, he's saying this was specifically in her lower extremities; had nothing to do with carpal tunnel syndrome.

So, at this time -- his conclusion was, at this time, the patient has several pathologies she's complaining of, which includes her entire body. She was diagnosed with chronic regional pain syndrome, as we discussed earlier. At this time, the patient is in such severe pain that physical -- this physical therapist feels he is unable to help her. The

patient has expressed that other therapists have hurt her with exercise, and this physical therapist is concerned that this may be the wrong type setting to start rehabilitation.

The patient complains of too much pain with all motions, and the physical therapist was unable to assess the area of concern with any type of consistency during testing and objective values. He had no objective value to give her an appropriate plan of care.

So, I thought that that is a very good description of somebody that was coming to him that had a significant level of pain, to the point where she couldn't even passively move, and she had very diffuse symptoms throughout her whole body. And so, a lot of these findings helped me come to a conclusion. You know, I'm not sure if we want to discuss any other specific doctor notes.

Q Why don't you touch on the --

THE COURT: Could we --

MR. SEMENZA: Yes.

THE COURT: I'm sorry to interrupt.

THE WITNESS: To the conclusion?

THE COURT: Judge --

MR. SEMENZA: No, no.

THE COURT: Judge needs a restroom break. I'm sorry.

THE WITNESS: Yeah, all right.

THE COURT: I drank coffee at noon, and so --

THE WITNESS: I could take a deep breath.

THE COURT: So, ladies and gentlemen, we're going to take a ten-minute recess.

And during this recess, it is your duty not to converse among yourselves or with anyone else on any subject connected with the case, or to read, watch, or listen to any report of or commentary on the trial by any person connected with the trial, or by any medium of information, including, without limitation, newspaper, television, radio, or internet, and you are not to form or express an opinion on any subject connected with this case until it's finally submitted to you.

We'll be back at 4:15. Thank you.

THE MARSHAL: All rise for the jury, please.

(Court recessed at 4:06 P.M. until 4:18 P.M.)

(In the presence of the jury)

THE MARSHAL: Jury's all present, Your Honor.

THE COURT: Thank you, and please be seated. The record will reflect we're back within the presence of all eight members of the jury, as well as the alternate. And you may continue.

MR. SEMENZA: Thank you, Your Honor.

BY MR. SEMENZA:

Q When we left off, we were walking through some of the history that you had looked at. Just very briefly, I

would like you to address any -- the medical records relating to the Nevada Eye and Ear, just briefly.

A Oh, okay. So, Ms. O'Connell had mentioned complaints of visual changes, and also like congestion, jaw pain, facial pain, and -- okay. So, I believe there was an initial consultation at Nevada Eye and Ear. Okay, yeah, here it was. May 9th, 2011.

A CT scan was done by Dr. Manthei, who's an otolaryngologist. CT scan of the sinuses were reviewed. He said there's no evidence of sinus disease, polyps. He said she had a mild deviated septum to the right. He recommended conservative treatment with medication for her sinus pain, and he said, maybe in the future, if it continues, consider septoplasty surgery. She saw an ophthalmologist, Dr. Carr, 2011. She had mild cataracts and dry eye syndrome, and he said she should get corrective lenses and drops for her eyes.

And the subsequent follow up at Nevada Eye and Ear was September 24th, 2012. That's about two-and-a-half years following the fall. He said she had left-sided facial pain and drooping of her left eyelid on and off for one year. On exam, she continues to have no significant findings, other than a deviated septum. "I do not appreciate any drooping of her left eyelid; however, she is adamant that her eyebrows do not match. There's no evidence of facial nerve weakness."

And he said he diagnosed her with atypical facial

pain, and he recommended an MRI to rule out trigeminal neuralgia, which is a neurologic impingement of a nerve in the face.

Q Based upon the records that you reviewed, did Ms. O'Connell have anything -- and this will be in layman's terms, but were her retinas detaching?

A No.

Q Are you aware of any ocularly injuries that can take place --

A Well --

Q Well, hold on. With regard to MRIs that are performed?

A No. Unless a person has a metal foreign body in their eye -- they screen patients for metal before an MRI, and unless she had metal in her eye, there's no way an MRI can cause ocular injury.

Q Okay. And then, based upon --

A She was evaluated by an ophthalmologist in August of 2011, that was a year-and-a-half after the fall, and he did a thorough exam and said she had mild chronic cataracts and dry eye syndrome.

Q But that was it?

A That was it.

Q Okay. And based upon your review of the records, can you tell us what your opinions in this particular --

A All right, yeah --

Q -- matter are?

A I know that we've well decided -- this is getting long, so I want to like cut to the chase and really kind of summarize everything.

But I really feel the medical record is important, because these are doctors that documented things, and those things that those doctors documented tell a picture or story. It's information that's basically medical information; medical evidence. And if you pay attention to the medical evidence, there's certain conclusions that can be drawn.

So, I -- I basically had three conclusions, and I touched on some of that already. And the first conclusion I draw is, obviously, there was an incident that occurred. This incident occurred on February 8th, 2010. There was a slip and fall at the Wynn Hotel. The claimant objectively suffered minor contusions to her buttocks, which there was visual photographic evidence of that.

And the initial treatment that was given to her two days following the date of injury, she was diagnosed with a lumbosacral contusion. Examination of her cervical spine and her neck was done, and it was normal at that time, two days after the date of injury.

So, as a doctor that deals with mechanism of injury, there's a term called, causation, and this is something that's

very important. Medical causation. So, if a person says that they have a symptom, can a doctor causally relate A caused B, causing symptoms that are developing in a human being? So, that's called medical causation. And I -- and that's something -- like I said, this is my speciality. I deal with traumatic injury and medical legal causation all the time.

I said that there -- based on the medical evidence that was in the chart and her evaluation at the UMC Quick Care two days after the date of injury, the diagnosis that was made, her symptoms that were occurring, the causal relationship of the mechanism of injury would lead us to believe that those symptoms that she was experiencing show she had injured body parts, including her lumbosacral spine, her back, her tailbone, her hip, her buttocks -- her right buttocks --

Q That would --

A -- that there was contusion injury.

Q Okay, that wouldn't include the neck area --

A No.

Q -- or the cervical area?

A No.

Q Okay.

A That's it.

Q Okay.

A What was documented, that's in the medical record.

Lumbosacral contusion, right buttocks, right hip contusion.

Q Okay.

A That's conclusion number 1.

Q And is that to a reasonable degree of medical probability?

A Yes.

Q Thank you.

A Taking into account everything that we've discussed up until now, you know, don't have to go into it again. So, the second thing that I want to pay attention to is the pattern of the symptoms. This claimant -- and I want to say straight out, I never met the claimant, Ms. O'Connell. I never examined the patient -- the claimant, Ms. O'Connell. I don't know who she is. I wish her the best. I have nothing against her; I'm just doing a medical evaluation and trying to give my best medical opinion.

I wanted initially -- and we went through this already. I wanted everybody to look at the pattern of the symptomotology. There was a specific point in time, specifically, two months -- no, I'm sorry. Six weeks after the slip and fall, it was March 18th, 2010, she went to the UMC Quick Care, and all the sudden, there were multiple complaints. I mean, it went from back pain, and pain into the hip and the thigh to multiple complaints.

And I'll remind you what that inventory was. Pain

over the right -- whole right side of the body, weakness, fainting, chills, trouble sleeping, blurred vision, lump on her neck, neck pain, dizziness, headaches, chest pain, cough, shortness of breath, nausea, change in appetite, severe constipation, heartburn, abdominal pain, neck pain, frequent urination, sexual dysfunction, depression, anxiety, pain and stiffness of her hands, wrists, elbows, shoulders, neck, back, hips, knees, feet, and jaw.

So, my conclusion was that this is not normal human behavior. There may be explanations for why she was experiencing these things. Those explanations may be psychological, those explanations may be from preexisting pathology that was bothering the individual for some other reason, but to a reasonable degree of medical probability, all of those complaints have nothing to do with the slip and fall.

Q Okay.

A No causal relationship, no medical causation, no objective medical information at all that would lead anyone to believe that those complaints were related to the slip and fall, for the reasons I mentioned already, because when a person falls, there's a physiologic development of injury of a normal response to pain that would develop within 48 hours.

Q Okay.

A So these symptoms are six weeks after the slip and fall.

Q Okay.

A So, that was conclusion number 2. Then, number 3 is that I focused on the non-orthopedic issues of functional preexisting problems.

So, in the medical record, we clearly see that Ms. O'Connell documented a prior injury in 1989 with chronic back pain. So, even the injured body part, there was preexisting pathology of chronic back pain with diagnosis of fibromyalgia, irritable bowel syndrome, reflux disease, constipation, anxiety, stress. And then there was a mention of medication dependance with severe constipation and abdominal pain, and a possible diagnosis of Marfan syndrome.

So, I want -- basically, I want to understand, the reason why this is important is because this individual has had issues with chronic functional pain before.

Q Okay.

A This isn't new. This is something that she's dealt with before in terms of what I'm seeing in the medical record with multiple functional diagnoses. When I mean functional diagnoses, meaning, that a doctor -- when a doctor evaluates somebody, in order to get paid, we have to come up with a diagnosis. Are you familiar with that?

That if you just say -- you know, you can't write on the chart, this person has pain, you know, and I'm going to -- I have to come up with a diagnosis, so I have to come up with

either a sprained back, a contusion, reflux disease, gastritis. Whatever it is, a doctor has to come up with a diagnosis to bill it so you get paid.

So, a lot of times, in medical records, you see doctors giving diagnoses based on the symptoms, and that's what we call functional diagnosis. There's no objective medical testing that shows there's a pathologic problem, but we have to define the person's symptoms.

So, for instance, a person that has stomach pain that comes and goes, and gets nausea and constipation, but a doctor like Dr. Shaposhnikov, you know, did testing, and imaging, and colonoscopy on this individual, and he didn't find anything pathologic, the diagnosis is irritable bowel syndrome with constipation. That's a functional diagnosis, meaning, I'm going to define this person's symptoms as irritable bowel syndrome because I can't find anything else to explain it. And these syndromes can be treated.

So, she had -- another one is fibromyalgia. Fibromyalgia is frequently used as a diagnosis of regional body pain, meaning, a person may have pain problems in their neck, and their back, and their shoulders, and their elbows, and their hands, and their feet, and their knees. And people that frequently develop pain that is unexplainable by medical -- objective medical testing, they get this label of fibromyalgia. That's a functional diagnosis given by where

the person's manifesting the pain.

And so, she has these diagnoses. And I wanted to just bring that out into the open that she is dealing with multiple functional problems.

Dr. Shaposhnikov saw the claimant on March 24th, so that was six weeks after the injury, and he explained that she was having multiple complaints; nausea, constipation, heartburn, abdominal pain. Obviously, we mentioned atypical chest pain, facial pain, jaw pain, dizziness, chest pain, shortness of breath.

These are all what we call functional constitutional symptoms that are preexisting and was -- she already had these diagnoses preexisting in her chart. I'm not giving her the diagnoses; these were diagnoses that were in her chart. So, I'm just bringing it out into the forefront what was documented in the chart.

Q Okay.

A And these conditions are in no way related to the slip and fall.

Q Did you also have occasion to render conclusions about whether Ms. O'Connell had something called pain magnification --

A Okay, right.

Q -- syndrome?

A So, that was the last conclusion. I want to save

that for the last thing. And then, the last conclusion I came to is, why would it that a person would have like focal pain that was reported for six weeks in her back and her hip, all the sudden six weeks after the fact turn into total body pain?

So, in the orthopedic field, there is a syndrome called symptom magnification syndrome. And there's a couple of classic articles that I referenced in my report. I'm sure, you know, the jury and the attorneys all have reference to my notes, so you can read over it there. But the first one that I referenced is the definition of symptom magnification syndrome.

So, I used a journal article that was kind of a groundbreaking journal article in 1991 of a doctor that was trying to explain why a person might develop symptoms of pain, or other symptoms. It doesn't have to be pain. It could be -- like we said, it could be nausea, it could be shortness of breath, weakness, other things. Why would a person develop symptoms that are out of proportion with what we would normally expect a human being to experience? So, why would this happen? It's typically identified as a psychological problem, and the psychological problem is defined by this journal article, and the journal article defines symptom magnification syndrome as a self-destructive socially reinforced behavioral response pattern consisting of displays of symptoms which function to control the life and

circumstances of the sufferer, meaning, that a person is going to respond with behavior that's controlled by circumstances in their life, or psychological circumstances, and there's three types.

The type 3 of the symptom magnification syndrome is what we call the identified patient. This is a person whose symptoms try to ensure survival, or a person develops a role. They take on a role. So, if a person basically has personality issues, psychological issues, and they're getting a lot of attention in a certain arena that helps to reinforce their importance, a lot of times, they'll gravitate towards the attention.

And this commonly happens in medicine. It just happens. When a person goes to a doctor, and a doctor pays a lot of attention to them, they feel like they're the center of attention. They feel like they're getting a lot of attention from the physician or the medical professional, and they kind of gravitate towards that arena.

And then, the second part of this is -- the identified patient is secondary gain. It's classically pathognomonically defined by secondary gain, meaning, a person's going to get some sort of gain out of manifesting symptoms. So, it could be attention, it could be a sense of self-worth, it could be financial gain. There could be some other issue there, and these are things that cause a person to

manifest this symptom magnification syndrome.

Now -- and this article was written by a psychologist. He developed pain profiles that a person can take like a survey, and you can -- the person -- the survey will basically say, you know, what levels of pain do you have when you get up out of bed? Can you brush your teeth in the morning? Can you do this? Are you depressed? Do you have anxiety? Does -- you know, what's aggravating your pain?

And these pain profiles basically get scored, and a -- there's a normal response to pain that will kind of show up in these profiles, and then there's pain that's out of proportion with normal functional activity that will also show up on these profiles.

Obviously, the claimant didn't take these profiles, but the main criteria that I use to come up with a conclusion of chronic -- I'm sorry, of symptom magnification syndrome, is the idea of what we were talking about; that multiple medical professionals in the medical record were identifying symptoms, one, that were not explained by objective medical evidence; symptoms that were out of proportion with the objective medical findings; symptoms that were basically extreme pain.

So, if you look in the medical record, the last three entries in the medical record were from UMC Quick Care. Every single time -- this was June of 2013, September of 2013, and January of 2014, four years after the date of injury. Her

complaint going to the Quick Care was pain over her whole body at a level of ten out of ten. That's pain that's not normal. That's pain that's out of proportion with normal physiologic understanding of the human body.

So, this in and of itself negates the need for the psychological profiles because it's in the medical record. I mean, the pain is out of proportion with normal human behavior and human response to traumatic injury.

And not only that, but out of proportion with the diagnoses that she has. A person even with fibromyalgia, or atypical chest pain, or irritable bowel syndrome, or other diagnoses she has shouldn't be walking into a doctor -- and I'm not blaming her. I'm not castigating the claimant. I'm just saying, that's not normal to walk into a doctor's office three visits in a row and say, I have pain over my whole body, and it's ten out of ten. That's abnormal behavior.

And then, there's other criteria that were set up by orthopedic surgeons called Waddell signs. And so, these Waddell signs -- I identified a journal article by Dr. Waddell that identifies these five characteristics of things you'll see on a physical examination that will identify a person that is manifesting symptom magnification, or the other term for it is functional overlay, meaning, it's psychological overlay on the actual physiologic injury.

And so, these five characteristics is, one,

superficial, widespread, tenderness, meaning, wide regions of the body, and non-anatomic tenderness, meaning that if a person has a knee injury, you'd suspect there would be certain areas that are tender, or where a person falls, there would be certain areas that are tender, and not like wide, non-anatomical areas to light touch.

So, we've already gone through the medical record. You can understand all the doctors that saw her that identified that she had wide ranges of widespread, whole body, whole spine tenderness, whole limb tenderness from the -- specifically, Dr. Trainor, Dr. Erkulvrawatr, the pain management doctor, and both physical therapists documented this in the medical record, one out of five.

Two, regional weakness or poor effort or strength. This was clearly documented by both physical therapists. As I mentioned before very specifically, Matt Smith and Scott Pensivy, they both said this woman had very poor effort and regional weakness that wasn't explained by the diagnostic findings. So, two, regional weakness or poor effort on strength testing.

Three, distracted straight leg raise testing. This test, I couldn't identify. There was a spine surgeon that said it was negative, so that one, she passed. She didn't display straight leg raise testing or axial rotation.

Q Okay.

A Four, non-anatomic sensory changes. This was very well documented by the neurologist, Dr. Germin, that saw her, both physical therapists, and it was -- as we discussed before, sensory changes in derma -- in non-anatomic and non-dermatomal patterns, like the whole limb, and the legs, and the feet, and the arms have sensory changes that aren't explained by the neurodiagnostic tests, objective medical evidence. She had neurodiagnostic testing. That was normal. But these therapists that were treating her and orthopedic surgeons were seeing that she had non-dermatomal sensory changes. That's three.

The last one -- the last Waddell sign is overreaction to pain out of proportion with exam. So, I really focused on Scott Pensivy's notes, because he really laid that one out very clearly, like, I couldn't even touch this woman she was in so much pain.

And there were other mentions of it in the record on that one. Let me just look specifically. I think the orthopedic hand surgeon had mentioned that as well.

Okay. So, what we see just from the medical record observing other doctors' notes and conclusions, we see four out of these five Waddell signs. So, in the orthopedic knowledge, we say, if a person is three out of the five, there's a high likelihood that they have symptom magnification on exam and functional overlay.

So, based on this, clearly, the claimant has pain out of proportion with normal physiologic response to injury; pain that can't be explained by the objective medical findings.

The conclusion clearly is symptom magnification syndrome. That's definitely outlined in the medical record. And this is highly associated with psychological issues. So, we noted that the claimant had prior anxiety, prior depression, prior chronic pain, prior issues with medication, prior utilization of the medical system.

So, this all comes to a conclusion. I mean, it's a big picture, and it takes experience to see it, to tease out all these details, but it's very clear.

And you know, we talked about the other things besides pain. There was issues with the cardiologist. The cardiologist tried to talk to the claimant about her symptoms of chest pain and symptoms of shortness of breath, and said that that couldn't be explained by his testing.

And also, we talked about the ENT doctor, Dr. Manthei, that explained to the patient that she had no identifiable symptoms for facial pain or -- so, I think that that is a good conclusion to -- and like I said, to me, there's a high degree of certainty in my mind that I'm coming to an accurate conclusion with this.

Q Okay. And is your conclusion that Ms. O'Connell has

symptom magnification syndrome to a reasonable degree of medical probability?

A Yes.

Q And does your diagnosis that Ms. O'Connell has symptom magnification syndrome -- is that in any way causally related to the fall that she suffered on February 8th, 2010?

A No.

Q Thank you.

THE COURT: Cross?

MS. MORRIS: Thank you.

CROSS-EXAMINATION

BY MS. MORRIS:

Q Dr. Klausner?

A Yes.

Q You said that you did a very thorough review of the medical records; is that right?

A Yes.

Q And it's very, very important to you to see when there's onset of pain; is that right?

A Yes.

Q Because that helps you know what's related to this fall; is that correct?

A Yes.

Q And so, if I understand correctly, the sooner in time those symptoms manifest, the more likely it is in your

mind that they would be related to the fall; is that fair?

A Sooner, like I said, I mean, I personally make a very fine distinction of 48 hours.

Q So, you need it to develop in 48 hours, or to you, it's not related?

A Yeah. I think that there's always a reason why things happen. So, for me, 48 hours -- in my experience, I'm a doctor that sees traumatic injury, like I told you, here in Southern Nevada. Fifteen years, I've been dealing with people for traumatic injury. There is no reason why a physiologic injury to the human body should delay pain more than 48 hours. I understand sometimes pain progresses, so sometimes, it might be subtle and progressive, but it should be there within 48 hours.

Q And that's -- it doesn't matter about the age of the person, the type of injury. As long as it's a trauma, it needs to be there in 48 hours for you --

A Correct.

Q -- is that correct?

A Correct.

Q Now, you said that she went to UMC two days after?

A Yes.

Q And that she had reported pain in her butt and in her back; is that correct? Radiating down her right leg; is that correct?

A Correct.

Q Now, she -- you said that she didn't report pain in her right knee; is that correct?

A Correct.

Q I'd like you to, if you could, turn to the binder -- do you have the joint proposed binder in front of you? Great. If you could turn to B00062 in that binder.

THE COURT: Looking at the wrong --

MR. SEMENZA: Yeah.

THE COURT: -- binder.

MS. MORRIS: Oh, do we not have the joint --

THE WITNESS: Oh, wait.

MS. MORRIS: -- proposed up there?

THE WITNESS: It's on this side. Oh, it's way --

THE COURT: It's the --

THE WITNESS: -- forward. Okay.

THE COURT: It's the black one.

MR. SEMENZA: Christian, are you asking defendant's proposed exhibits, or --

MS. MORRIS: It's defendant's proposed exhibits.

MR. SEMENZA: Okay.

THE COURT: Oh, okay.

THE WITNESS: I just --

THE COURT: Not the joint?

MS. MORRIS: Yes.

THE WITNESS: -- have to move backwards. B0006. Okay, yeah.

BY MS. MORRIS:

Q All right, and do you -- did you look at this medical record in preparation for your testimony today and your review of Ms. O'Connell?

A There were a lot of records, so I can't tell you specifically that I saw this piece of paper. I definitely had records from UMC Quick Care on that date.

Q And this is her visit --

A So, I should --

Q I'm --

A I should --

Q Okay.

A -- have this, yeah.

Q This is from her visit on February 10th, 2010; isn't that correct?

MR. SEMENZA: B006?

THE WITNESS: No, I don't -- I don't --

MS. MORRIS: B0062.

BY MS. MORRIS:

Q Isn't this the medical --

MR. SEMENZA: Oh, 62.

MS. MORRIS: -- record you reviewed?

THE WITNESS: Yeah, no, this says November 5th,

2012.

THE COURT: 62.

MS. MORRIS: So, B0062. Maybe I could assist you. May I approach?

THE WITNESS: Wait, 0062. Is that this?

MS. MORRIS: There you go.

THE WITNESS: Okay.

MS. MORRIS: Okay.

THE WITNESS: There it is. Okay.

MS. MORRIS: Yes.

BY MS. MORRIS:

Q If you could read the complaint that Ms. O'Connell had upon arriving there.

A Okay. So, she said, fell last Monday, complaining of pain, right knee down to feet. Hurts to sit.

Q Okay, so she did complain of pain in her right knee; isn't that correct?

A Yes, correct.

Q Now, did you go out and gather Ms. O'Connell's medical records, or were they provided to you?

A They were provided to me.

Q And did you rely on defense counsel to provide you all the relevant records that you would need?

A Yes.

Q Now, you have a list of all the medical records that

you reviewed, and I've looked at that list. It looks like the next visit you have for her is a March 8th, 2010 visit with a Dr. Prabhu.

A Yes.

Q Would that be accurate?

A Correct.

Q I'd like you to, if you could, turn to R00001.

A Yeah.

Q And I'd like you to look at it and tell me if you've ever seen that medical record before.

A Nope. I have not.

Q Okay, and what's the date on that medical record?

A February 17th.

Q So, that's now nine days after she's fallen; is that correct?

A Yes.

Q And you haven't had an opportunity to review this medical record, have you?

A No.

Q And can you see the areas of pain that Yvonne is complaining of on that date?

A Yeah, I see it.

Q Okay. And can you tell me what parts of her body she's complaining of?

A She's complaining of -- let me just look at this

whole thing.

MS. MORRIS: I'd actually like to put it up, but I'm missing R001 for some purpose. Could I borrow someone's R001?

THE CLERK: R?

MS. MORRIS: Yes.

THE CLERK: Of defendant's exhibits?

MS. MORRIS: Yes. It's just the first page of that.

MR. SEMENZA: All right. Well, this is a clean copy, if you want --

THE WITNESS: So --

MS. MORRIS: And let me just --

THE WITNESS: So, first of all --

MS. MORRIS: Oh, sorry.

THE WITNESS: -- I think it's fair to me to tell me like --

MS. MORRIS: Doctor, let me just --

THE WITNESS: -- where this comes from.

MS. MORRIS: -- ask a question. I'm sorry. If you don't mind.

BY MS. MORRIS:

Q Okay, so this is a medical record that we've all seen before.

A Okay.

Q But it's clear, this is the first time you are seeing it; is that correct?

A Yes, correct.

Q Okay. And this is nine days after the accident, and Yvonne's got reported pain to her neck, her back, her right arm, down her right leg specifically, referencing her knee, too; isn't that correct?

A Yes.

Q Now, you were provided certain medical records, but you don't know if you were provided all the medical records; isn't that correct?

A Correct.

Q Specifically, when you were testifying, you mentioned that there was no finding of a traumatic injury in her cervical spine or her lumbar spine; is that correct?

A Repeat the question.

Q Sorry. When you were testifying, you said that there was no evidence of any kind of traumatic injury to her lumbar or her cervical spine?

A Based on the MR -- imaging evidence. That's what I said.

Q Okay. Now, you also said that you reviewed medical records --

A Well, let me put it this way. I said that I came to a conclusion that there was a lumbar contusion, but I said, beyond that, there was no objective medical evidence of lumbar spine or cervical spine injury.

Q Now, you reviewed Dr Cash's medical records, too; isn't that correct?
A Yes, I did.
Q I'd like you to turn to P0015, please.
A I -- I want to bring you to attention to your own medical record here. It says that, "My back was badly injured in --
Q Doctor.
A -- 1989, and I learned how to keep it healthy. I cannot be manipulated" --
Q Doctor, I'm sorry. I've just asked a question and I'd like to move on to it.
A You don't want to know about your own medical record?
Q We've actually already --
A Okay.
Q -- read them.
A Did you? Okay, okay.
Q We had those medical records, and the jury has seen them.
A Okay.
MR. SEMENZA: Which page, Christian?
MS. MORRIS: We are at P00015.
THE COURT: 15?
MS. MORRIS: 15.

THE WITNESS: Got it.
BY MS. MORRIS:
Q All right, now this is a medical record from Dr. Cash; isn't that correct?
A Um-hum, yes.
Q And it's an appointment that she had with this orthopedic surgeon on May 18th, 2010.
A Correct.
Q And according to my review of your medical records, you've never seen this record either?
A Nope, didn't have it. I had the MRI, but I didn't have his note.
Q And in the recommendations, Dr. Cash says that she has traumatic lumbar radiculopathy, as well as traumatic cervical radiculopathy with positive MRI findings; isn't that correct?
A That's what he says, but it's not necessarily true.
Q Okay. So, while you don't think Dr. Cash's record is true, it's also true that you never saw this medical record before --
A Correct.
Q -- isn't that correct?
A Yes.
Q And you said that the review of the medical record was incredibly important to your diagnosis of Yvonne, because

it's really the only thing you've done; isn't that correct?
A That's -- that's exactly true.
Q So, in order to come to a determination and diagnose a patient, with never seeing them, never touching them, never evaluating them in person, it's important that you have all of her medical records in order to come to a conclusion; isn't that fair?
A It's fair to say that I would request to have everything, but if I don't have everything, it doesn't necessarily change my conclusion.
Q I want to go back and talk to you about the testimony you said about Dr. Prabhu.
A Yes.
Q Now, that was that visit she had at Ascent Primary Care on March 8th, 2010.
A Um-hum.
Q And you made indications that Dr. Prabhu had known her for quite some time. Do you recall that testimony?
A Yes.
Q Okay. Now, Dr. Prabhu has only seen Yvonne once, so I'm concerned --
A I see.
Q -- or I'm interested in where you got that information.
MR. SEMENZA: Objection --

THE WITNESS: Well --

MR. SEMENZA: Hold on. Objection, Ms. Morris is testifying. She's making a representation.

THE COURT: All right. Sustained, and the jury will disregard the comments of the lawyers. When lawyers make statements, they're not allowed to be witnesses, and you can't -- you know, what -- their questions aren't evidence, and what they say like that, a gratuitous comment, not evidence, so you'll disregard that. Next question.

BY MS. MORRIS:

Q Dr. Prabhu only has one medical record; is that fair?

A Yes, correct.

Q Okay. So, in that one medical record from Dr. Prabhu, what about it made you think that he knew her well?

A He -- he basically documented her history very well of her chronic preexisting issues.

Q Is it solely based on the fact that he had a good documentation of her history that you thought he had seen her before?

A Yeah, I think it was the way he documented the record, because, exactly right, you know, he had documented that he had known about this history of multiple issues.

Q But you've seen Yvonne's medical records, and she documents her history pretty well to a lot of people; wouldn't

that be fair?
A Correct, yes.
Q And there's some indication you said of a medication dependancy?
A Um-hum.
Q What medication was she dependant upon?
A Yeah, I don't have that information. I just was documenting things that were mentioned by doctors in the medical record.
Q So, did you just assume, because she has IBS and constipation, she had a medication dependancy?
A No, it's in the medical record.
Q What medical record says she has a medication dependancy?
A Okay. I will tell you. It basically was UMC Quick Care March 18th, 2010.
Q Okay.
A She described history of back and hand injury in 1989, which led to a diagnosis of irritable bowel syndrome, GERD, anxiety, stress disorder, Marfan syndrome, fibromyalgia, medication dependance with severe constipation and abdominal pain.
Q What medication was she dependant upon?
A I don't know.
Q So, are you assuming it was a pain medication?

A I -- I don't make any assumptions. I just --
Q You don't make any assumptions?
A I just documented what's in the medical record.
Q Okay. So, looking a little more closely at what you've evaluated here, you've evaluated medical records from Yvonne after the fall; isn't that correct?
A Yes.
Q Now, you do a lot of these medical record reviews, you said; is that correct?
A I maybe do a medical record review maybe once every six months.
Q Isn't it important when you do a medical record review to get any kind of documentation, medical records of preexisting --
A Um-hum.
Q -- conditions to the patient?
A Um-hum. Absolutely, it's very important.
Q And in this case, did you request to get any medical documentation of her preexisting conditions?
A I felt it was documented in the records, so I didn't necessarily need more. And I didn't know if it was available, so I didn't ask.
Q So, you didn't ask to see if there was any prior medical records?
A No.

Q Generally, when you are given medical records in a med-legal situation --

A Yeah.

Q -- if there are preexisting medical records, are you provided with those?

A Well, I would tell you that when I'm actually in a situation where I'm actually seeing a patient, and I am asked to make conclusions based on medical records, and to do an evaluation of somebody, like a second opinion or an independent medical examination, absolutely, I'm going to want to come to have -- at that appointment, I'm going to want to have preexisting imaging, preexisting records from other doctors. If there's an injury, if the person's seeing a pain management doctor or an orthopedic surgeon, I'm going to want those notes. So, you're right, it's very helpful. But in this situation, I was given what I was given. I didn't ask for more.

Q Now, you were given what you were given --

A Um-hum.

Q -- and you said you relied on what was in those medical records to talk about what she previously had; isn't that right?

A I -- yes, I used the medical records to document diagnoses that were documented by the doctors that were seeing her for preexisting problems.

Q But all the issues of preexisting conditions came from Yvonne, right? The one that you said, we can't rely on what she's saying?

A I don't know why the -- how the doctors got their information. I'm assuming UMC Quick Care maybe has records on Yvonne that they were using to make diagnoses. So, I would say that Yvonne gave a history, but I'm -- you know, again, I'm in the dark, so I don't know where that information came from. It may come from Yvonne, it may come from medical records that show that there's other issues.

Q So, if you -- if I were to tell you, well, this is Yvonne's first visit at UMC Quick Care that day that she went on February 10th, 2010 --

A Was it? I don't know. I don't know.

Q Okay, that's fair. So, you are assuming that there are medical records out there that you didn't need, and didn't want, and --

A I didn't say that.

Q Okay. Tell me what -- tell me what you said then.

A I said I didn't have the records, and I didn't ask for the records.

Q But your -- you have diagnosed --

A I didn't say I didn't need them, or didn't want them, or couldn't have used them. I'm happy to review anything you give me. Give me the records. Obviously, you

don't want to see what's in other records that you showed me. I'm happy to discuss any of them.

Q Not that I don't want to see it, sir, but we had already looked at it.

A Oh, okay.

Q Okay? Now, you have diagnosed her with chronic regional pain syndrome; is that right?

A No.

MR. SEMENZA: Objection, misstates testimony.

THE COURT: Sustained.

MS. MORRIS: Okay.

THE WITNESS: I didn't diagnose her with chronic regional pain syndrome.

BY MS. MORRIS:

Q Do you think she has it?

A No.

Q Okay. What's your opinion about her chronic -- the chronic regional pain syndrome that you spoke -- oh, you're right. Dr. Trainor did that.

A Trainor.

Q Okay.

A That's right.

Q And you don't think that's accurate?

A No, I do not.

Q Okay. You don't think it's accurate because you

think she has symptom magnification syndrome?

MR. SEMENZA: Your Honor, I'm going to object. May we approach?

THE COURT: Yes.

(Off-record bench conference)

THE COURT: Objection, argumentative, sustained. Go ahead.

MS. MORRIS: Okay. I apologize.

BY MS. MORRIS:

Q You said, chronic regional -- I'm sorry, you said symptom magnification --

A Symptom --

Q Okay.

A Syndrome.

Q Syndrome.

A Um-hum.

Q And you cited some articles in support of that; isn't that right?

A Yes.

Q Okay. And the articles that you supported, the one that you talked about was that 1991 article; is that right?

A Yes.

Q That was -- I referenced it. I referenced the article to show the definition of the -- of -- and this was a definition. Obviously, there can be multiple definitions.

This was one psychologist's definition of what symptom magnification syndrome --

Q Okay.

A -- represents, and he --

Q Yes.

A -- classified it. So, based on his model -- and that's what it is. It's a psychological model of a pain syndrome. So, I used the model to show how a person might fit into that model, yes.

Q And Leonard Matheson was the author of it. He's a clinical psychologist and counselor; is that correct?

A Correct.

Q Okay. And Leonard Matheson says one of the steps to diagnosing this symptom magnification syndrome is it's a clinical interview that's performed in a structured environment, where you have an interviewee who forms a rapport with this person, and after multiple other testing, they go down through 14 different issue areas; is that correct?

A Again, this is his model, so that's not necessary to make the diagnosis. That's his model for doing research, and he came up with -- like I explained to you, pain inventories and interview tactics to try to understand why a person has symptom magnification syndrome.

The diagnosis of symptom magnification syndrome is basically made by the fact that's displayed by multiple areas.

Interview with the patient, could be having pain inventory showing that there's pain out of proportion with the objective medical findings, or just pain that it's experienced psychologically out of proportion with normal behavior. That's what he's getting at. There's pain inventories, a psychological understanding of why a person's experiencing pain.

So, you can do that without pain inventories. You just have to show that there's a pattern of pain that's out of proportion with normal behavior and physical observation of what we call functional overlay, or pain that doesn't make sense based on a physical examination, and pain that's not supported by objective medical findings. So, those three things have to be there.

Q Okay. So, you have to have observation of their pain behavior; is that correct?

A Yes.

Q You have to conduct a physical exam of them; is that correct?

A Correct.

Q And then you have to do this structured interview with them; is that correct?

A An interview. It doesn't have to meet -- be the way that this psychologist defines the interview with his pain inventories. It just has to -- an interview where you can get

a sense that a person is experiencing pain that's not normal. It's out of proportion with normal behavior.

Q And it's fair to say you did not conduct any of those three prongs in order to diagnose her with this symptom magnification syndrome?

A Correct. I used other doctors' clinical notes to show the pattern of what was happening.

Q So, you read through some of Yvonne's medical records and made a clinical diagnosis of her of having symptom magnification syndrome without completing any of the steps required to do so?

A I just told you that your steps are from that article, and that article doesn't -- it's not the defining way to diagnose symptom magnification syndrome. It has to have those three criteria.

Q And to be fair, you gave me this article, right?

A I gave it to you, yeah.

Q Okay. And so, I didn't go out and find it; you provided me with it --

A I provided it --

Q -- in your report?

A -- to show a definition psychologically of how a person and why a person might develop this syndrome of symptom magnification syndrome.

Q Now --

A As a tool. Doesn't say that this is the Bible; it has to fit exactly this person's model. Symptom magnification syndrome, like, can be made by a physical therapist.

Q A physical therapist could?

A A physical therapist can made that diagnosis.

Q So, a physical therapist could diagnose someone with symptom magnification syndrome?

A Yes, they can. And as a matter of fact, it's very recognized as standard of care in the medical community and in the legal community that if a claimant has signs of symptom magnification syndrome, that it can be proven with a test called a functional capacity examination that's done by a physical therapist. They do the interview, they give a person the -- the pain inventories, they do the physical testing, they evaluate the medical records, and then they try to get some information based on the person's functional capacity and how they're manifesting pain.

Q And in this case, no one performed a functional capacity examination on Yvonne?

A I said that's a tool that's recognized in the community. A doctor can make the diagnosis if they have the criteria to make it. I saw the criteria in this medical record very clearly.

Q So, you think it's clear from the medical records without doing any of the other testing that she has --

A There was --

Q -- symptom magnification syndrome?

A There was a lot of testing done. I outlined specific -- and most of -- most of the time, symptom magnification isn't seen very frequently in doctors' notes. Most of the time, it's observed by physical therapists, because the physical therapists are the ones that are observing the patients, talking to the patients, observing their functional behavior, observing them doing a functional capacity exercise, and seeing how they're responding, and if the therapist is seeing something that's not normal, he's going to document it. And you have two separate physical therapists that identified it.

Q And you -- you focused on those, about the two physical therapists that identified it, but isn't it true that Dr. Erkulvrawatr back in 2010 tested her three times for Waddell, and they all came back negative?

A Yes, and that --

Q Thank you.

A Yes. At the same time, he -- there were signs that I pointed out on Dr. Erkulvrawatr's notes that showed that she had regional tenderness to palpation, which is one Waddell sign. So, he documented that in his notes, but he said she had zero out of five Waddell sign. So, I understand what he was saying. He didn't get the overall impression that there

were Waddell signs, but at the same time, he did document that there were abnormalities on his exam that didn't make sense.

Q Now, the documents that you looked at, you reviewed them and you came to a conclusion, and that conclusion is -- is that she has symptom magnification syndrome, and there's certain motivations that come with it; is that fair?

A Well, there can be motivations, and they could be subconscious or conscious, but they're psychological issues.

Q Did you make a determination on what motivations Yvonne has?

A No.

Q You listed a few of them though; is that correct? You said one of them was secondary gain, financial?

A I said -- when I was defining this type 3 symptom magnification syndrome, it's -- I'll read it to you. It says, "The identified patient who is a person whose symptoms ensure survival and maintenance of their role as a patient." And I said, in other words, the person manifests symptoms in order to receive some kind of secondary gain, whether it's avoidance of responsibility, attention, or financial gain. It's a statement of fact about that category of symptom magnification. I'm not making any statement about the claimant's motivations.

Q So, you're just stating that she has the syndrome, and you're not sure what motivations come with it?

MR. SEMENZA: Objection, argumentative.

THE COURT: Overruled.

THE WITNESS: I'm stating what the definition of this category of symptom magnification is. If you want to ask me directly my opinion, it's an opinion, you know? I didn't put it in the record because I didn't want to give opinions; I wanted to give medical fact in my determination here. But I've --

MS. MORRIS: Well, I --

THE WITNESS: I've dealt with many people that manifest symptom magnification syndrome --

MS. MORRIS: Okay.

THE WITNESS: -- and I, at times, get a very good sense of why a person behaves the way they behave. So I've --

MS. MORRIS: So --

THE WITNESS: I've evaluated these records, and if you want to ask my opinion, I can give it to you.

BY MS. MORRIS:

Q Yes, what is your opinion?

A Okay. My opinion is that there is an individual -- and I don't know her personally, but there's an individual that's involved in a medical legal claim. And that there was obviously an access of care, there was -- two days after the date of the fall -- slip and fall. There was clear medical records of the body parts involved in that claim. So, you're

saying that the right knee was involved. There was a little part that she said -- so, okay, I'll accept that, that her right knee was involved on the second day.

Q So, are you going to give me the right knee? Is that what you're saying? I mean --

A I'm happy to give you the right knee.

Q Okay.

A So, I can --

Q Let's add a body part.

A -- agree that the right knee was involved. And then, for some reason, following a reasonable period of time where a person would experience symptoms, her symptoms exploded out of proportion. So, you showed me a note; I believe it was a chiropractor. You showed me a note that said that she had pain all the way up and down the right side of her body, and her limbs, and all the sudden, her symptoms were all over the place, and I believe that note was seven days after the date of injury.

Q Nine.

A Nine days after the date of injury. And if you ask my opinion, she probably had an encounter with an attorney between the date of UMC Quick Care and that chiropractor note, because that's how it always goes with personal injury claims.

Q Okay.

A And that somebody's sent to a chiropractor, and the

chiropractor elicits a lot of information to help them to manifest a legal case against -- and so, I don't know the chiropractor that saw the claimant. I don't know -- like I said, I don't know the claimant. But there was also -- on that same record, there was also the patient's claim that she has problems getting manipulations, because she's had manipulations in the past, and she's had severe neck problems from the manipulations. It was right there in the record.

So, clearly, even the record you showed me showed this patient had serious preexisting problems, and now her symptoms are exploding because she's involved in a claim. So, she's getting attention. There may be financial gain issues. This individual that slipped and fell, like I said, may have felt a sense of attention. There may have been a feeling like that she's getting reinforcement from going to the doctor frequently and listing symptoms. And like I said, it could be subconscious. I don't know. It doesn't have to be conscious.

This is -- let me be very clear. It doesn't mean that Ms. O'Connell's manipulating the situation. Could be -- because once a person's given that role of being the victim, the victim role perpetuates itself, so.

Q So, I'm a little confused on what you just said, because you don't think that she's necessarily manipulating the system, but you said you think probably between the 10th and the 17th, she went out and hired an attorney, and that's

why she had all these pain complaints on the 17th? Did I misunderstand you?

A No.

MR. SEMENZA: Objection, argumentative.

THE COURT: Overruled.

THE WITNESS: Yeah. So, I'm basically saying that if you're asking my opinion, that I'm making a guess she was sent to a chiropractor probably by an attorney, and that's a supposition. I don't know that as a fact, you know. Don't know. Probably you know, maybe. Why don't you tell me?

MS. MORRIS: I actually couldn't.

THE WITNESS: Okay.

BY MS. MORRIS:

Q So, let's talk about why you think that after she might have seen an attorney, she went back and had all kinds -- as you say, all kinds --

A I don't know.

Q -- of pain complaints.

A I really don't know. I mean, like I said, there's preexisting problems that are clearly there. So she -- and I'm not saying Ms. O'Connell didn't experience pain. Don't get me wrong. I believe this woman may be suffering terribly. I don't know.

Q So, you think --

A But the whole process -- you don't understand. The

whole process of this medical legal system that we're in creates people to develop this kind of situation.

Q Do you think that the fact that she has litigation has caused her to develop symptom magnification --

A No.

Q -- syndrome?

A I didn't say -- I didn't say that.

Q You said that she might be suffering terribly; you --

A Yeah.

Q -- don't know?

A I don't.

Q I'd like to talk to you a little bit about the work that you do.

A Yes.

Q Now, you -- you do a lot of work with -- and I'm probably saying it wrong. Is it -- it's workers' compensation, occupational injuries; is that fair to say?

A I see a lot of occupational injuries.

Q And that's about 90 percent of your practice --

A Yes.

Q -- is that correct?

A Well, occupational medicine is 90 percent of my practice, so I do a lot of occupational medicine. So, I do pre-employment examinations, I do fit-for-duty examinations, I

do routine maintenance -- health maintenance examinations, I -- you know, I'm a medical review officer. I do a lot of things that are occupationally related to help people stay healthy in the workplace, and I also treat occupational injury.

Q Now, I didn't see this on your resume, but I think you're on the board of directors for the Nevada Disability Prevention Coalition; is that fair?

A Yes.

Q Okay, and that the mission statement for that is to benefit managers, employers, work comp adjusters, risk managers, insurance brokers, and doctors; is that fair?

A No, that's totally not the definition of that organization. The definition of that organization is basically to help the system of medical treatment, and interface with employees in many facets; FMLA, injuries that have nothing to do with work, injuries that do have to do with work, drug abuse, you know, substance abuse issues. Help people to interface with their employers to keep them employed and not let people become disabled. That's the mission of that organization.

Q Now, to be fair, I just went to the website.

A Okay.

Q The mission statement on top is what I was reading.

A I don't know about the -- I didn't make the mission

statement, but I know very well what that organization does.

Q I think also --

A You may have just took a piece of it. I don't know.

Q I can show it to you. It's right at the top, if you'd like to see it.

A Oh, I'd love to see it, because --

Q Don't read my notes --

A -- maybe I have to talk to somebody about that. Right. So, again, let's read the whole thing. To be fair, let's read the whole thing. "Nevada Disability Prevention Coalition is an organization that brings awareness to the community about the prevention of needless work disability, and the importance of stay at work and return to work programs. We provide education regarding topics to benefit managers, employers, work comp adjusters, risk managers, insurance brokers, doctors, and others."

So, I think that's a statement about helping people to stay at work. I think it's a very noble goal. And it's not necessarily to benefit insurance companies. It -- and I do a lot of work with this organization, and I see a lot of abuses by insurance companies, a lot of abuses, and claim adjusters that are really unfair to people.

And the goal of that organization is to make a fair playing field between insurance companies, people that are injured, and potentially can become very seriously disrupted

in their life because of the system. That's what I'm saying. I know the system very well, and I try to help people to navigate the system to get healthy and to get well, and that's the name of the game.

Q Do you have a good reputation with your patients?

A I do.

Q Have you ever read reviews of your work online?

A Of course. And I think it comes with the business, you know, for doctors that basically practice medicine involved in the occupational field. Of course, my opinions aren't going to always be popular. My opinions aren't popular with you, and you probably would love to go write a review on me online, too. But I'm just -- I'm a very honest person. I'm honest, I'm ethical, I'm straightforward, I'm right down the line, and I tell it like it is. That's it.

I take the medical information, and I deal with it, and I help people to kind of move past all of the drama that occurs around the system. And I'm very honest about it, and I help people to get well. And I believe I'm a very good doctor and I help a lot of people. Although the people that go online and write reviews, you know, the two percent of people that are disgruntled about me are the ones that are going to be the most vocal.

I constantly have to deal with people going to the medical board saying that I -- and I shouldn't say constantly.

I would probably say twice a year, I have to go to the medical board and deal with people that go, because they lost a hearing on a workers' comp claim or something because I gave an opinion, and they're going to run to the medical board saying I'm unethical. I've never, ever, ever had anybody that had a substantial complaint about me with the medical board, ever.

Q Now, I mean in your work, you think it's important for people to get back to work; is that fair?

A It's essential.

Q And I think -- I looked at this -- this thing that you're the board of, this Nevada Disability Prevention Coalition. It says, "Job dissatisfaction has been shown to be one of the highest, strongest statistical predictors of disability." Do you agree with that?

A No. I -- what -- and I don't know what -- again, this is maybe out of -- taken out of context. I really don't know where that comes from, but it's a statistic. That's a statistic, because we -- as somebody that deals with injury and recovery from injury, as a good doctor, I have to look at the human being in front of me and get an understanding with them, and I -- I see it all the time. That's a statistic, and it's a very true statistic.

A person that has a difficult job, and a person that's kind of burned out with a job and they have an injury,

it's very difficult for them to be able to get back to that job, because emotionally, they're not giving their emotional 100 percent effort to be back into the workplace to keep them employed, keep -- so, we're human beings, so when we deal with human beings, we have to deal with the big picture. It's not just an injury, and MRIs, and, you know, tests and things like that.

There's human beings with emotions, and psychological makeup, and motivations, motivational factors, and to help a person, you have to get a good understanding of that.

Q I agree.

A Um-hum.

Q And in this case, you never met Yvonne O'Connell, did you?

A No. But again, the person's motivations and emotional factors have no bearing on what the medical records show. So, again, like I made a conclusion that said this person, to a high degree of medical probability, is manifesting symptom magnification syndrome, I have no reason -- I have no clear explanation why, because like you said, I don't know her, I don't know her motivations, I don't know all the details about what's going on; I could just see the pattern.

And when it comes down to it, like I said before, I

have nothing against Ms. O'Connell. I'm sure she's a wonderful person. It's just there's a medical reality, and the medical reality has to be dealt with.

And a lot of times, when the medical system tries to fix things that aren't broken and find answers for things that aren't there, it just turns into a huge spiral that goes nowhere. And here, we're talking four years after this person was injured.

Q I just want to be clear. You keep saying that you're not talking about her motivations, but you stated that her symptoms increased between February 10th to February 17th based on your belief she went out and hired an attorney.

A It's a gut feeling, because I'm a doctor that have a gestalt, and I look at the records. And I told you -- that's speculation. Excuse me, Your Honor. I'm sorry that I speculated.

THE COURT: No speculation.

THE WITNESS: I know, I'm sorry. But you asked me, and I basically just told you my gut feeling. Is it right? I don't know. You asked me my opinion, and I just told you.

BY MS. MORRIS:

Q Isn't it possible that her pain had just become more realized as the time had gone on, and she was feeling that pain when she went to the doctor and she told them about it?

A No.

Q Why not?
A Because when she went to UMC Quick Care, she was there to deal with the slip and fall, and she's -- when she's there to deal with the slip and fall, she's going to tell the doctor all of her symptoms. Very clearly, as we can see in the medical records, she has no problem telling doctors what's wrong with her.
Q Exactly.
A And so --
Q I agree with you.
A Okay.
Q We can agree on that.
A Okay.
Q Now, you looked at these medical records earlier this year; is that right?
A Yes.
Q And you came to a determination that she had suffered a slip and fall, and that she had suffered injury to her butt and her low back; is that fair?
A Yes. I said I think hip, buttocks, low back.
Q And then, today, you think that maybe her knee, too, based on what I showed you?
A Yeah, it's fair. It's in there. She mentioned it.
Q I've gone through the medical records, and there's quite a few that I -- that I don't see that you have

reviewed.

MR. SEMENZA: Objection --

MS. MORRIS: I'd like to look -- I'd like to kind of walk through it.

MR. SEMENZA: Okay. Objection, argumentative.

THE COURT: Okay. Well, again, you know, just, yeah, direct him to that. Don't -- don't testify.

MS. MORRIS: Okay.

THE COURT: Okay? So.

BY MS. MORRIS:

Q Do you have your review in front of you?

A Yes.

Q Okay. So, I know we've discussed the medical appointment on 2/17 that you hadn't seen; is that correct?

A The chiropractor note? Yes, I haven't seen that.

Q I also have a visit she had to Quest Diagnostic on March 23rd, 2011. Did you see that record?

A No.

Q I also have a visit to UMC Primary Care on August 13th, 2012. Have you seen that record?

A No.

Q I have --

A August 12th? Oh, no, I'm sorry. I'm in the wrong year. You're way ahead of me.

Q I can go back -- you know what, and I should go back

to '11, because there's an October 18th, 2011 visit that I also didn't see in your review.

A Right. Nope.

Q And then, that's just for UMC. I've got another one, August 13th, 2012, and that's specifically UMC.

A Okay. You know, those records from UMC, they all look alike, so some of those papers may have been missing, you know? I'm not sure, because they're handwritten notes.

Q Then there's a Steinberg Diagnostic visit it looks like on February 22nd, 2010?

A Was that the MRI for cervical spine?

Q No, you have that from 4/8/2010.

A So, I don't know what it is. What was done at Steinberg?

Q So, she had multiple imaging done at Steinberg. She had it to her back, her hip, her right knee --

A X-rays?

Q Yes.

A Oh, yeah. I -- I identified the back and the hip.

Q Okay.

A And --

Q Did you see the right knee one?

A No, I did not. But I believe it was mentioned in the record by the orthopedic surgeon, so -- but I didn't have it in the record.

Q We've talked about Dr. Cash's visit on May 18th, 2010.

A Yes.

Q But there's also a visit to him on June 22nd, 2010. Are you in possession of that record?

A No. I think you showed it to me, didn't you?

Q That was the May 18th --

A Oh.

Q -- 2010 one.

A Yeah, I didn't have the subsequent -- after that first evaluation, I didn't have his subsequent records.

Q And now, I know you said you have -- there's also Edwin Suarez, physical therapist. She saw him looks like February 21st and February 24th. I didn't see that in your medical record review. Do you have that?

A 21st -- February 21st of?

Q 2012. Sorry.

A 2012. So, no, I didn't have that.

Q And it looks like she had -- and I don't know if you had the OpenSided MRI that she had on May 8th, 2010 either.

A MRI of?

Q Let's see. I think that was her cervical spine.

A Yeah, that's -- I -- I basically identified the results of that from Dr. Cash's note and Dr. Erkulvrawatr's notes. So, I saw the results of it, but I didn't actually

have that OpenSided MRI document in front of me. I -- yeah. I have some subsequent records that I got afterwards, so I do have it actually in front of me right now. Well, you know what --

Q Are those maybe Dr. Dunn and Dr. Tingey's records?

A Yeah, you know what, these were -- yeah, these were 2014. Never mind, I don't have that. Yeah.

Q Have you ever actually seen the MRI images from Yvonne's neck or back?

A There was no way for anyone to get those to me. I haven't seen them.

Q Did you ever see any of the -- the actual MRI film of her right knee?

A The MRI of her right knee. When was it done?

Q She had multiple ones done.

A I see. Okay. I -- I did not see that, but I saw the report after the fact; after I did this review. You know, some of those reports got to me after the fact.

Q But they didn't change your opinion?

A Oh, absolutely not.

Q So, your fee schedule you also provided me with when you gave the report, and it looks like you charge $500 an hour paid in advance to review records; is that right?

A Yes.

Q And it looks like, for legal reports, you charge 500

payable in advance and require an authorized -- a signed authorization for release of information. Is that like a HIPAA release? Do you require that?

A Yeah.

Q And -- and is that so you can go out and gather medical records if you'd like?

A No, it's just to give me permission to look at the records.

Q And you also get a statement of specific questions that you need to address; is that right?

A I don't require that, and a lot of times, I don't really give that much weight. I basically kind of get a sense of what the issues are and try to answer the medical questions.

Q And how much have you been paid so far?

A I don't know. I mean, the money goes to my office manager. I'm a doctor, you know, I'm not an accountant.

Q Okay. So, you have no idea how much you've been paid so far?

A No. Is it relevant?

Q Excuse me?

A Is it relevant?

Q You know, it is.

A It is?

Q It is relevant, because I think that motivations

that we've been talking about right now --

THE COURT: Okay, stop.

THE WITNESS: I mean, you charge for your time.

THE COURT: Wait. Okay, stop, stop. Here we go. Okay, you don't get to ask her questions, and --

THE WITNESS: Okay, I'm sorry, I'm sorry.

THE COURT: -- you don't get to argue with him --

THE WITNESS: Okay.

THE COURT: -- and testify, okay? And I make the decision about what's relevant in this court, okay? Both of you.

THE WITNESS: Okay. I'm sorry, Your Honor.

THE COURT: Let's go.

BY MS. MORRIS:

Q Now, I want to talk about Dr. Dunn and Dr. Tingey. You have some of their medical records; is that right?

A Yes, I do.

Q And you have reviewed them?

A Yes.

Q Okay. So, Dr. Dunn and Dr. Tingey have both come in here and provided sworn testimony under oath. Are you aware of that?

A Yes.

Q And are you aware of the substance of their testimony?

A No.
Q You could have come in and watched their testimony, correct?
A I'm busy. I have a business to run, so I have patients to see. I couldn't -- I couldn't be here. I'm sorry.
Q Do you know Dr. Dunn in the -- in the medical community?
A Yes, I've met him. I have a high respect for him.
Q And Dr. Dunn is an orthopedic surgeon; is that correct?
A Orthopedic spine surgeon.
Q And you don't have any basis for disagreeing with Dr. Dunn's opinion, do you?
MR. SEMENZA: I'm going to object. Foundation, yeah.
THE COURT: Sustained.
BY MS. MORRIS:
Q You've read through Dr. Dunn's medical records; is that correct?
A Yes.
Q And you know that he has recommended that Yvonne undergo a three-level cervical fusion; is that correct?
A I believe I did see that in his record.
Q And you're not saying --

A Maybe you might want to direct me to which date that -- that visit when he gave his recommendations for cervical fusion. Do you know which date that was --

Q I can probably find it for you. It was sometime last year.

A Wait, let me see here. Okay, yeah, here. Let's see. This was 10/13/2014, so this was like a year ago -- about a year ago.

Q And Dr. Dunn has said that he believes that Yvonne needs to have this three-level cervical fusion.

A Yes, and I totally disagree, completely.

Q So, do you believe that Dr. Dunn is performing a medically unnecessary procedure?

A No, I --

MR. SEMENZA: Objection.

THE WITNESS: I didn't say he --

THE COURT: Wait, wait, wait. There's an --

THE WITNESS: Okay.

THE COURT: -- objection, but it hasn't been fully stated. What's the legal objection -- the basis -- legal basis?

MR. SEMENZA: I think it's a misrepresentation as to performing an unnecessary surgery. There's never been a surgery performed.

THE COURT: Okay, sustained.

BY MS. MORRIS:

Q Do you believe that if Dr. Dunn performed this three-level cervical fusion, he would be performing a medically unnecessary procedure?

A So, unnecessary is kind of not the terminology I would use. Ill-advised, how about that? Because spine surgeons have criteria by which that they do surgery. So in this situation, the MRI that he even evaluated himself basically shows that there's no significant central canal or -- there's no central canal stenosis at multiple levels. And so, she has one level in -- or, I'm sorry, two levels in her spine that show severe neural foraminal stenosis. So, those two levels clearly are a result of chronic disc degeneration and arthritis.

So, as a person ages, first of all, you have to look at many factors. We're not talking about, you know, Dr. Dunn going in with like an arthroscope and cleaning up something a little bit with a little incision. We're talking about a huge procedure with plates, pedicle screws, and major disability following the procedure, and long-term pain medication and rehabilitation.

So, it's very standard of care for a doctor that recommends this surgery to understand clearly whether that claimant is physically capable of undergoing this huge massive surgery that's going to fuse three levels in her spine, number

one.

Number two, have clear understanding of the psychological framework of this individual and have a very thorough neuro-psych evaluation to make sure she's psychologically ready for a surgery like this, and that there isn't other issues of functional overlay like we're talking about.

So, does Dr. Dunn have those -- that information? I didn't see it. So, I think he better walk on eggshells before he walks into this. I've seen many surgeries destroy people's lives and cause serious pain that's real pain beyond what they were experiencing before. And it can -- if surgery's done unnecessarily or not thought about carefully.

So, she is in pain. I get it. Is the surgery -- does it have enough predictable outcome -- a good predictable outcome that he can assure her that her pain is going to get better after the surgery? I would say, no, and I'll tell you why, because her neurodiagnostic studies of her upper extremities showed carpal tunnel syndrome, and that's it. It didn't show any radiculopathy, and it didn't show that she has any nerve root problems in the spine.

Yes, there's stenosis. It's caused by arthritis. And a human being, as they age, there's a lot of people that have severe stenosis in their spine, and they're not running out and getting fusions. A lot of times, doctors make

decisions because a person's in such severe pain that they're at the end of their rope, and it's not good practice to do spine surgery for somebody who's at the end of their rope, because bad things can happen.

And for this person, Ms. O'Connell's own benefit, I would say, be very careful. And from what I could see, she's got to do a lot more testing, and a lot more effort to help this person psychologically and physically to get healthier physically and psychologically before he even considers anything.

Q So, you disagree with Dr. Dunn that Yvonne should have --

A I strongly -- I strongly disagree.

MR. SEMENZA: Objection, argumentative.

THE COURT: Sustained, and -- sustained.

BY MS. MORRIS:

Q Do you agree with --

A Strongly -- I'd strongly disagree, because -- not because of anything that has to do with legally --

MR. SEMENZA: I don't think there's a question posed.

THE COURT: Yeah, there's no question pending.

THE WITNESS: Okay.

BY MS. MORRIS:

Q Do you think Dr. Dunn would be committing

malpractice by performing --

A No.

Q -- this three-level cervical fusion?

A No, that's what he does. He does surgery. So, she's in pain, he can do the surgery. It's not malpractice. It's just -- sometimes, it's just making the right medical decision. And that's all I'm saying here is that there's pain issues that aren't explained by the objective medical information or the objective medical evidence.

There's a lot of ways you could help a person with pain, and it's not always the end of the line surgery, got to fuse three levels. That's not always the medically responsible thing to do. It's not malpractice. And I have these conversations with spine surgeons all the time. He knows me, I know him, I talk to him a lot, and I've cared for a lot of his patients after he's done surgery.

Q Would you defer the decision on whether Yvonne O'Connell needs surgery to Dr. Dunn?

A No. I would say that there should probably be multiple opinions, because it's very standard of care for somebody that has a fusion surgery, and there's other issues going on, especially in a medical/legal arena, that there's second opinions, and there's neuro-psych testing, and a very, very clear idea of what this person's getting into. She has to be informed of the whole situation, she has to have other

opinions, and get multiple medical opinions. Obviously, my opinion is one opinion. Dr. Dunn's opinion's his opinion.

Q And Dr. Dunn --

A Ms. O'Connell's opinion's her opinion. But all I'm saying is the number one oath I took as a doctor is do no harm, and it should be very, very serious for any doctor that does anything like a procedure like that. Do no harm.

Q But Dr. Dunn's actually treated Yvonne. He's actually seen her in person and diagnosed her. You would not defer to her treating physician who's physically evaluated her?

A She's seen other spine surgeons, and -- or I should say one that I saw in the record, Dr. Cash. He didn't say he wanted to do fusion surgery, and he saw her closer to the slip and fall. He evaluated her within months of her slip and fall, and he said, send her for injections and physical therapy.

Q And you're aware that Dr. Cash referred Yvonne to Dr. Dunn, correct?

A Yeah, I saw that Dr. Dunn stated that Dr. Cash referred her, but doctors have many reasons for referring patients. Maybe he didn't want to take the medical legal risk of dealing with it. Maybe he wanted --

Q Are you speculating again?

A I said maybe.

Q What about Dr. Tingey? You -- you're aware that Dr. Tingey has testified in this case; is that correct?
A Yes, yes.
Q Do you know Dr. Tingey in the legal --
A I do.
Q -- in the medical community?
A Yes, I do.
Q Do you have a good respect for him --
A Yeah, I have a good --
Q -- in the medical community?
A -- rapport and a good respect for Dr. Tingey.
Q And Dr. Tingey has testified that Yvonne needs surgery to her --
A Yes.
Q -- right knee. You're aware of that?
A Yes.
THE COURT: Do you have an objection?
MR. SEMENZA: I do, but it's fine. I'll let it go.
THE COURT: You're withdrawing.
MR. SEMENZA: Thank you.
THE COURT: Okay, go ahead.
BY MS. MORRIS:
Q Do you disagree that Dr. Tingey should be performing this right knee repair for -- for Yvonne?
A Is he requesting an arthroscopic meniscectomy --

partial meniscectomy? Is that the procedure that he's doing?

Q Were you provided with his medical records?

A Well, you said repair. I don't know what that means, but let me -- let me kind of look closer. We'll get the real records out, right? Because you've seen these more than I have, yes?

Q Yes.

A Okay, so this was May 11th, 2015. And he basically said, "After discussion with the patient, I've recommended bilateral knee arthroscopy with partial medial meniscectomy of the right knee, and partial median lateral meniscectomy of the left knee. The surgery is not a guarantee of cure of her symptoms, specifically cannot cure arthritis."

Q Dr. Tingey has testified that she needs the -- what did you call it, meniscectomy? To her right knee.

A Right. So --

Q Do you disagree with Dr. Tingey's opinion that she needs this repair?

MR. SEMENZA: Objection, Ms. Morris is testifying.

THE COURT: Overruled.

THE WITNESS: So, I want to share an article with you. You can take this, you can put it into your list of -- that's a medical research study that was recently done. I don't have it to read from, but there's a research study done that shows in patients over the age of 50 with arthritis in

their knee, a horizontal medial -- degenerative medial meniscal tear probably will not have a decent outcome with arthroscopic surgery.

So, there's evidence to show that when you're dealing with somebody that has an arthritic knee that's of an older age, over the age of 50, and you have a horizontal degenerative tear, that arthroscopic surgery is a questionable procedure in terms of it's efficacy. Evidence based medicine. Not Dr. Tingey's opinion; evidence based medicine.

Q So, Dr. Tingey testified he would expect her to have a complete recovery to her right knee. You disagree with that?

A I don't know. I mean, again, he's -- he doesn't have a crystal ball. He's done a lot of surgeries that haven't necessarily gotten people better. That's the nature of arthroscopic surgery, especially in patients with arthritis. That's why doctors have to be very careful when a patient has knee arthritis to do -- to do arthroscopic surgery, because when they start -- they don't have a magic wand to give a person new cartilage in the knee.

You have to understand, what they do is they go in with a tool that shaves the meniscus, and what they're trying to do is make a better contour for the meniscus. And I deal with a lot of orthopedic surgeons, and not all orthopedic surgeons are so cavalier to go in and do surgery on patients

over the age of 50 with arthritis.

And the reason why is because if they start shaving cartilage, it can accelerate the arthritic changes in the knee, and then the person can go from having some pain in their knee to severe end-stage arthritis, and then they need a knee replacement.

So, you've got to be very careful, you know? I mean, these procedures aren't like curative processes. They're basically trying to clean up the joint surface to make the knee -- the joint mechanically more efficient and more functional.

Q So, she has a tear in her knee, and Dr. Tingey --

A She has a horizontal degenerative meniscal tear in the posterior horn of her medial meniscus.

Q So, it's your opinion that it's degenerative?

A Well, I -- I think that if you look at the MRI -- let me look at it here. It says there's subchondral changes with chondromalacia, there's marginal osteophyte formation which is with the patella that's related to arthritis.

THE COURT: Which knee are we looking at?

THE WITNESS: The right knee.

THE COURT: Okay.

THE WITNESS: This was Las Vegas Radiology, August 29th, 2014. Signal is identified within the posterior one-third of the medial meniscus which extends to the surface

and is consistent with a tear. The lateral meniscus demonstrates one signal within the anterior one-third and PCL.

So, the -- the way that this is defined is that the signal is within the meniscus. That's basically an intrasubstance tear of the posterior horn of the medial meniscus, and it communicates to the surface. So, yes. So, what -- the real way to define this would be an intrasubstance degeneration of the meniscus with a radial tear that communicates with the surface.

So, I understand. And I've had a lot of discussions with doctors and orthopedic surgeons about the appropriateness of arthroscopic surgery in this scenario, and they will make the decision based on mechanical symptoms. So, is the person's knee locking? Is the person's knee buckling? Are there mechanical symptoms in the knee? Are there certain findings on exam? And so, the -- the key thing isn't so much what the MRI is showing; it's basically the whole picture.

Right, and again, like I said, I can't make the -- I didn't do the exam on Ms. O'Connell. I'm just reading an MRI. But I'm just explaining to you, medicine is not an exact thing. Not every person with this finding on MRI even has symptoms. There's plenty of people walking around with an asymptomatic meniscal tear at the age of 65.

And we're talking about this four years after the date of this slip and fall. Ms. -- Ms. O'Connell could have

been doing -- doing laundry, and bending down and getting laundry out of the dryer, and twisted her knee and suffered a meniscal tear. There was a lot of time.

So, in reality, I think that the whole conversation is kind of a moot point, because there's no way you could take this MRI four years after the fact, this was done 2014, basically four years after the fact, and tell me that that meniscal tear is related to the slip and fall. Impossible, can't do it, no way.

Q So, Dr. Tingey testified that it was related to the fall, and you --

A How does he know?

Q -- disagree with him?

A Does he have a crystal ball?

Q He looked at the actual MRI imaging and actually --

A I think a more --

Q -- treated Yvonne.

A -- accurate would be to say there's not enough evidence to suggest that, because, again, he -- when did he first evaluate the claimant?

Q So, if I --

A He evaluated the claimant years after the slip and fall. So, he's not a magician. He doesn't have a crystal ball. He doesn't -- and I'm -- I'm being very honest. There's no way to -- there's no way you can causally relate

it. Medically, legally, there's no way to causally relate it.

Q So, you think it wasn't the fall at the Wynn; it was maybe when she was getting laundry out of a dryer?

A I didn't say that. I said, could happen. There's many ways that people can develop a meniscal tear, and it doesn't even have to be traumatic. A person can turn to the left with a planted foot, and their knee twists, and they develop -- their meniscus tears. I see things medically, and I know how things can go. And I'm just telling you, because I do have expertise in medical causation. You cannot causally -- medically causally relate this to a high degree of certainty to what happened four years prior.

Q So, if I -- if I understand correctly, earlier, you gave me the knee, and you just took it back?

A No. She may have injured her knee. I didn't say she had -- you have notes in the medical record from a board certified sports medicine orthopedic surgeon, Dr. Trainor, that said this person has no localizable symptoms to her -- to that right knee. He evaluated her knee. He said, her pain's all over the place, there's no way that this is localized, and I'm not going to treat it. He also said, I'm not going to do surgery.

Q And Dr. Trainor never looked at an MRI of her knee, did he?

A I don't know, because obviously, I didn't see it,

so.

Q Thank you.

A Okay.

MR. SEMENZA: Nothing further.

THE COURT: Thank you very much for your testimony, Doctor. You're excused.

MR. SEMENZA: And --

THE COURT: Oh, wait, wait. I'm sorry.

MR. SEMENZA: Your Honor --

THE COURT: I'm sorry.

MR. SEMENZA: Your Honor, I -- may I approach?

THE COURT: Oh, yes. Just a minute. We've got a jury question.

(Off-record bench conference)

THE COURT: Request from counsel for a restroom break.

THE WITNESS: Oh.

THE COURT: So, you can write your questions out. We'll take a five -- well, actually, we can just go off the record and wait for Mr. Semenza to come back, unless anyone else needs to.

THE WITNESS: How come the counsel doesn't get a, everyone rise? No? No?

THE COURT: Just the jury.

THE WITNESS: Oh, no respect, huh? Not even the

doctor --

(Off the record at 5:51 P.M. until 5:54 P.M.)

(In the presence of the jury)

(Pause in the proceedings)

THE COURT: All right. Doctor, questions from the jury. Okay. First, did Dr. Dunn in his medical record write what options she had going for her?

THE WITNESS: He said she failed non-surgical treatment. He ordered an MRI of the lumbar spine and cervical spine with contrast. And then he immediately said after that, "If she remains symptomatic, I may consider surgery and injection." And then she followed up after the MRI, at which time he reviewed it, and he said that, "She has degenerative disc disease of the cervical spine with cervical radiculopathy, and lumbar disc disease and sciatica, with bilateral carpal tunnel syndrome history." He prescribed her medication and he wanted to refer her for evaluation of her knee to his colleague.

And then the third encounter, we do know the identification of the medication is Lovaza, which is a long acting narcotic medication. And so that was one option he offered her is pain medication.

And then, the third encounter, he said, "I reviewed the MRI, explanation of reinsurance was provided. I discussed the treatment plan in detail. The patient's questions were

answered. I discussed all the treatment options, including non-surgical and surgical intervention."

So, he said he had given her treatment options of non-surgical and -- but that's not listed. He said, I've recommended anterior cervical decompression at three levels, with fusion and allograph. I've offered non-operative options consisting of physical therapy, pain management injection, epidural steroid injection. So, there's -- he offered her those options of physical therapy and pain management injection.

THE COURT: Okay. Next question. In your review of the medical records, did any of the doctors mention that a preexisting condition of loss of strength in her hands had caused her to stop being a dental hygienist?

THE WITNESS: Yeah, I didn't see that in the medical record.

THE COURT: Okay. All right. Okay. Is there any difference physically or mentally if a doctor prescribes a cane and the patient uses a walker instead?

THE WITNESS: No. You know, a lot of times, an individual is going to try to -- if they have an unsteady gait or an issue with pain, and they may feel like there's weakness or pain that can make their gait unsteady or unstable, a lot of times, if they're not confident with a walker, they'll go out and buy, or ask for -- I'm sorry, if they're unsteady with

a cane, a lot of times, they'll ask for like a walker, or something that can give them more stability that they could hold on with both hands.

So -- and it also a lot of times has to do with issues in the shoulder, because a lot of times, if a person has like very severe shoulder pain in their dominant hand, crutches or a cane in that hand is very ineffective, so they need kind of more to use both hands. So, I think there's multiple reasons why a patient asks for an assistive device, and I'm not really sure in this case why it is that she chose a walker. Maybe because she was having, you know, pain in her upper extremities. I don't know.

THE COURT: All right.

MR. SEMENZA: I do have one follow up question to that.

THE COURT: Okay.

REDIRECT EXAMINATION

BY MR. SEMENZA:

Q Dr. Klausner --

A Yes.

Q -- you had mentioned Lovaza?

A That was the medication that Dr. Dunn prescribed.

Q Is that fish oil, or is that a --

A Oh. Oh, Lovaza, right. Yeah, I was thinking of -- that's exactly right. Lovaza is fish oil. Thanks for

correcting me.

Q Okay.

A I stand corrected.

MR. SEMENZA: Thank you.

THE WITNESS: I was thinking of a different medication. I'm sorry.

THE COURT: No further from you?

MS. MORRIS: I have no questions.

THE COURT: Okay. Thank you very much for your testimony, Doctor.

THE WITNESS: All right.

THE COURT: You're excused.

THE WITNESS: Yes.

THE COURT: Counsel, approach on scheduling for tomorrow.

THE WITNESS: Okay.

THE COURT: We're almost there.

(Off-record bench conference)

THE COURT: All right. Does the defense have any further witnesses in the case?

MR. SEMENZA: No, Your Honor, the defense rests.

THE COURT: All right. Ladies and gentlemen, the next step in the process is to instruct you on the law in this case, and then the lawyers will do their closing arguments. So, I have to meet with the lawyers to settle the

instructions. That's not done with the jury, because it can be lengthy, and there's no role of the jury in that.

So, we're not going to have you come in tomorrow until 1:00 o'clock. This will help counterbalance our having run you ragged today. And so, relax, and you don't need to be here until tomorrow at 1:00 o'clock, and I hope that we will be ready for you at 1:00 o'clock.

Ladies and gentlemen, during this overnight recess, it is your duty not to converse among yourselves or with anyone else on any subject connected with the trial, or to read, watch, or listen to any report of or commentary on the trial by any person connected with the trial, or by any medium of information, including, without limitation, newspaper, television, radio, or internet, and you are not to form or express an opinion on any subject connected with this case until it's finally submitted to you.

I'll see you tomorrow at 1:00.

THE MARSHAL: All rise for the jury, please.

(Outside the presence of the jury)

THE COURT: All right. Have you met and conferred -- now the jury has departed the courtroom, have you met and conferred about the jury instructions yet?

MR. SEMENZA: No, Your Honor.

THE COURT: Okay.

MS. MORRIS: We have a list of everything that we

have issues with, then we're going to kind of work those issues out. But we have gone through, and they have our full packet, and what we'd like added and what we'd like modified, btu we do need to come to a consent on it.

THE COURT: Okay. So, what time do you want to come and see me? I mean, you should have met and conferred so you know what you're agreeing about and what you're not agreeing about, and then -- so that I know.

MR. SEMENZA: So we're not wasting your time.

THE COURT: Yes, that would be nice.

MS. MORRIS: I mean, we --

MR. SEMENZA: How --

MS. MORRIS: We can meet in the morning, and then meet with you after at maybe 10:30 or 11:00, if you think that will be enough time.

MR. SEMENZA: I don't think that will be enough time in order to modify the instructions and then get them presented. Maybe 10:00 o'clock, 10:30.

THE COURT: All right. You know, be at my chambers at 10:00 o'clock. And if you have -- bring with you -- so I'm not spending my time sitting at my computer, looking up on Westlaw the cases, so bring me copies of any cases you want to cite so I can look at them then, okay?

MR. SEMENZA: And Your Honor, I am going to -- just so you know, I will renew my Rule 50 Motion. And so, to give

me enough time, and the Court enough time to address that issue.

THE COURT: Okay. Well, remember, the rule got changed, so you get to renew your motion. If for any reason the Court does not grant a motion at the close of all the evidence, the Court is considered to have submitted the action to the jury, subject to the Court's later deciding the legal questions.

MR. SEMENZA: Right.

THE COURT: So, you've -- you chose to make the motion at the close of the plaintiff's case, so basically, at this point, I would let it go to the jury.

MR. SEMENZA: Understood, Your Honor.

THE COURT: And you would have the ability to renew that motion ten days after service of the written Notice of Entry of Judgment.

MR. SEMENZA: Understood.

THE COURT: Okay? All right.

MR. SEMENZA: Thank you.

THE COURT: You're welcome.

MR. SEMENZA: We'll see you tomorrow at 10:00.

THE COURT: All right.

(Court recessed at 6:07 p.m. until Friday, November 13, 2015, at 1:44 p.m.)

* * * * *

## CERTIFICATION

I CERTIFY THAT THE FOREGOING IS A CORRECT TRANSCRIPT FROM THE AUDIO-VISUAL RECORDING OF THE PROCEEDINGS IN THE ABOVE-ENTITLED MATTER.

## AFFIRMATION

I AFFIRM THAT THIS TRANSCRIPT DOES NOT CONTAIN THE SOCIAL SECURITY OR TAX IDENTIFICATION NUMBER OF ANY PERSON OR ENTITY.

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# Forensic Fee Schedule 2015

**Tax ID # 88-0132897**

| | |
|---|---|
| Independent Medical Examination | 1500-prepayment (up to 1 inches of records)<br>125- per 1/4 hour |
| IME or Deposition No Show<br>or cancellation (w/o 10 days notice) | 300- |
| IME Administrative Record Review | 40- per hour |
| Record Review | 300- prepayment<br>125- per ¼ hour<br>Report will be released after payment for balance is received. |
| Deposition | 1500-per hour for the 1st hour<br>(must be paid PRIOR to the depo)<br>250- per ¼ hour over the 1st hour (will bill for this time)<br>deposition cancellation 25% |
| Arbitration Preparation<br>Arbitration | 500 - minimum - payment (1 hour)<br>1500-prepayment/250- per ¼ hour over the 1st hour<br>25% of agreed fee will be charged if the Arbitration is cancelled in less than<br>48 hrs of the schedule appearance /<br>72 hrs out of town |
| Trial Preparation | 1000- minimum -prepayment ( 2 hours ) |
| Testimony | 4000-Half-day Minimum<br>8000-Full-day |

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# Forensic Fee Schedule 2015

**Tax ID # 88-0132897**

| | |
|---|---|
| Short Trial Preparation | 750- minimum -prepayment (1 hour) |
| Short Trial Testimony | 2500 - 1 hour |
| Out of town Testimony | 8000 full day minimum<br>Airfare<br>Hotel Accommodations<br>Airport Transfers |
| Trial Cancellation | 25% of agreed fee will be charged if the court appearance is cancelled in less than 48 hrs of the schedule appearance local / 72 hrs out of town |

# Curriculum Vitae
# of
# Anthony B. Serfustini

**Address:** 501 South Rancho Drive, Suite I-65
Las Vegas, NV 89106
(702)733-7855

**Birthplace:** Thomaston, GA
September 29, 1940

**Licensure:** Nevada (1974) #2851

**Education:** Troy High School 1954-1956
Troy, Alabama

Kenmore High School 1956-1958
Kenmore, New York

University of Buffalo 1958-1961
Buffalo, New York Major: Biology/Anthropology

State University of New York 1961-1966
Buffalo, New York
Medical School Degree: M.D.

**Training:** University of Utah
Salt Lake City, Utah

| | |
|---|---|
| Internship (Med-Surg) | 1966-1967 |
| Residency (Orthopaedics) | 1970-1973 |
| Chief Resident (Ortho) | 1973-1974 |

**Board Certification:** American Board of Orthopaedic Surgery 1975

**Teaching Responsibilities:** University of Nevada School of Medicine

| | |
|---|---|
| Clinical Assistant Professor of Surgery | 1980-1984 |
| Clinical Associate Professor of Surgery | 1985-1991 |
| Director, Orthopaedic Trauma Conference | 1980 - present |
| Professor of Surgery | June 1991 - present |
| Clinical Professor, Western University of Health Sciences, PA Program | 1998 - pr |

**Military:** United States Navy, Capt., Medical Corps

| | |
|---|---|
| Flight Surgeon Training, NAS Medical Institute Pensacola, FL | 1967-1968 |
| Flight Surgeon, V.A. 225, Squadron A-6 Vietnam | 1968-1969 |
| Surgical Consultant | 1969-1970 |
| Naval Hospital Danang, Vietnam | |
| German Hospital Ship, Helgoland | |
| Cherry Point Naval Hospital | |
| Civilian Commendation German Red Cross | 1969 |
| Bronze Star - with combat "V" VIETNAM | 1970 |
| United States Navy, | 1991 |
| Recalled to Active Duty in support of Desert Storm. Assigned to 1st Medical Battalion, 1st FSSG in support of the 1st Marine Division USMC Feb.- March, 1991. | |
| Resumed private practice in Las Vegas April 3, 1991 | |
| American Defense Ribbon (2nd Award) | 1991 |
| United States Naval Reserve | |
| Operation Distant Runner, East Africa | 1994 |
| Orthopaedic surgeon, Alpha Co 4th Med BN 4th FSSG | 1993-1995 |
| 1 MACE Surgeon | 1995-1997 |
| 4 MAW Surgeon | 1 Nov 97-1 Sep 2000 |
| 1AP 4th Med BN FMF | 1 Sep 2000-1Nov2001 |
| 1MACE Surgeon MCBCP | 2 Nov 2001-1Jan 2003 |
| Recalled to active duty in support of Operation Iraqi Freedom | 27JAN 2003 |
| Subject matter expert-far forward combat casualty care | USNR-Mar95-Dec05 |
| Senior Orthopaedic Consultant US Navy Forward Resuscitation Surgical System(FRSS TEAMS 1-6) | Jun 2002-Dec05 |
| SURGEON GENERAL'S(US NAVY) RESERVE SPECIALTY LEADER-OPERATIONAL MEDICINE | Jun 03-Dec05 |
| 1MACE SURGEON/MCBCP (CURRENT ASSIGNMENT) | JUN-03 - Dec05 |

*Further military information by request

**Memberships:**

| | |
|---|---|
| American Medical Association (AMA) | 1974 - present |
| Clark County Medical Society (CCMS) | 1974 - present |
| American Board of Orthopaedic Surgery (ABOS) | 1975 - present |
| American Academy of Orthopaedic Surgeons (AAOS) | 1978 - present |
| Western Orthopaedic Association (WOA) | 1979 - present |
| Nevada State Medical Association (NSMA) | 1979 - present |
| American College of Surgeons (ACS) | 1980 - present |
| Society of Military Orthopaedic Surgeons (SOMOS) | 1993 - present |
| Nevada Orthopaedic Society | 1998 - present |

**Appointments:**

| | |
|---|---|
| Active Staff - Las Vegas, Nevada Facilities: | |
| University Medical Center of Southern Nevada | 1974 - present |
| Director Orthopaedic Surgical Services/UMC | 1994 - Sep 2002 |
| Director Pediatric and Adult Orthopaedic Clinics/UMC | 1994-present |
| Courtesy Staff: | |
| Desert Springs Hospital | 1974 - 2005 |
| Sunrise Hospital | 1974 - 2005 |
| Valley Hospital Medical Center | 1974 - 2005 |
| Lake Mead Hospital | 1992 - 2005 |
| Rehab Hospital | 1993 – 2005 |
| Emeritus Staff: | |
| Desert Springs Hospital | 2005 |
| Other: | |
| Chairman Department of Orthopaedics | |
| University Medical Center, Las Vegas, NV | 1984 - 2003 |
| Consultant Air Force One | |
| (In case of personal injury to the President) | 1989 - 1992 |
| Consulting Team Physician | |
| University of Nevada, Las Vegas | 1983 - 1990 |
| Team Physician | |
| Las Vegas Americans Professional Soccer Team | 1984 - 1986 |
| Team Physician, Rodeo Team | |
| University of Nevada, Las Vegas | 1986 - 1990 |
| Associate Medical Director | |
| Professional Rodeo Cowboys Association | |
| National Finals Rodeo Las Vegas, Nevada | 1985 - present |
| Founding Director Medical Advisory Board | |
| Nevada Donor Organ Referral Service | 1985 |
| Chief Proctor American Board of Orthopaedic Surgery | |
| Examination Las Vegas, NV | 1986 |
| Trustee Clark County Medical Society | 2005 |

**Other Certifications:**

| | | |
|---|---|---|
| Advanced Trauma Life Support | | 1993 |
| Recertified | | 1997 |

**Hospital Committees:**

| | | |
|---|---|---|
| Quality Assurance | DSH | 1979 - 1982 |
| Surgery Committee | DSH | 1979 - 1982 |
| Executive Committee | DSH | 1979 - 1982 |
| Medical Care Evaluation Comm. | DSH | 1979 - 1982 |
| Division Heads Committee | DSH | 1979 - 1982 |
| Executive Committee | UMC | 1982 - 2003 |
| Surgery Committee | UMC | 1984 - 1990 |
| Medical Audit & Records Comm. | UMC | 1984 - 2000 |
| Quality Assurance | UMC | 1986 - 2003 |
| Medical Records Committee | UMC | 1985 - 1989 |
| Trauma Committee | UMC | 1990 - 2003 |
| Steering Committee | UMC | 1995 - 2003 |

**Community, County and State Level Committees:**

| | |
|---|---|
| Peer Review, Clark County Medical Society | 1980 - 1985 |
| Physician's State Review Organization | 1980 - 1984 |
| Medical/Legal Committee, Clark County | 1980 - 1984 |
| Nevada Physician's Review Organization | |
| Board of Directors | 1984 - 1986 |
| Consultant | 1986 - 1995 |
| State Rep. On Emergency Services Comm. | |
| AAOS Annual Meeting 1985 | 1984 |
| Local Transportation Committee | |
| AAOS Annual Meeting 1985 | 1984 |
| Regional Admissions Comm. #15 AAOS | 1985 - 1991 |
| Americare of Nevada | |
| Medical Advisory Committee | 1986 |
| Utilization Review | 1986 |
| Quality Assurance | 1986 |
| Health Insight (Physician PEER Review) | 1995 - present |
| Clark County Medical - Legal Screening Panel | 1996 - 2003 |

**National Level Committees:**

| | |
|---|---|
| AAOS National Committee | 1981 |
| American Medical Political Action Comm. | 1982 |
| AAOS Exhibit Committee | 1984 |
| National Board of Medical Examiners | 1986 |
| AAOS Annual Meeting Press Relations Comm. | 1989 |

**International Level Activities:**

| | | |
|---|---|---|
| Director: First Annual Cuban/North American Trauma Seminar, Havana, Cuba | | 6/92 |
| Orthopaedic Consultant to Hospital Ortopedico Docente "Frank Pais" Havana, Cuba | | 1992 - present |

**Elected Hospital Positions:**

| | | |
|---|---|---|
| Member at Large | DSH | 1977 - 1978 |
| Vice Chief of Staff | DSH | 1979 - 1982 |
| Chief of Orthopaedics | UMC | 1982 - 2003 |
| Vice Chief of Staff | UMC | 1984 - 1986 |
| Member at Large | UMC | 1986 - 1988 |
| Vice Chairman Trauma Department | UMC | 2002-2003 |

**Elected Positions:** Nevada Chapter

| | | |
|---|---|---|
| Western Orthopaedic Association | Pres. Elect | 1987 - 1988 |
| Western Orthopaedic Association | President | 1989 - 1990 |

**Clinical Areas of Special Interest:**

Management of Severe Trauma
Indications and Usage of External Fixation
Management of Pelvic Fractures
Circular Ring Fixation (Ilizarov Method)
Combat Casualty Care & Research
Diagnostic and Operative Arthroscopy of the Knee

**Allied Health Professional Responsibilities:**

| | |
|---|---|
| Advisor, Orthopaedic Nurses Association, SNC | 1976 - 1979 |
| On Site Evaluator, American Physical Therapy Association, University Division | 1977 - 1985 |
| Orthopaedic Consultant, U.S. Gymnast Association | 1975 |
| Advisor and Clinical Instructor Clark County EMT and Paramedic Training Clark County Community College | 1975 |
| Clinical Preceptor, Orthopaedic Surgery NAVHOS OPEN DET519 | 1993 - 1995 |
| Chairman, American Academy of Orthopaedics Surgeons "Update for Orthopaedic Physician Assistants" Las Vegas, NV | 1995 |
| Clinical Preceptor, Western University of Health Sciences | 1999-present |