

IN THE SUPREME COURT OF THE STATE OF NEVADA

BARRY JAMES RIVES, M.D.; and
LAPAROSCOPIC SURGERY OF NEVADA,
LLC,

Appellants/Cross-Respondents,

vs.

TITINA FARRIS and PATRICK FARRIS,

Respondents/Cross-Appellants.

BARRY JAMES RIVES, M.D.; and
LAPAROSCOPIC SURGERY OF NEVADA,
LLC,

Appellants,

vs.

TITINA FARRIS and PATRICK FARRIS,

Respondents.

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APPELLANTS' APPENDIX
VOLUME 1

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	<u>Exhibit C</u> : Medical Records (Dr. Chaney) re Titina Farris		10	1977-2088
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	<u>Exhibit A</u> : Partial Transcript of Video Deposition of Michael Hurwitz, M.D.	10/18/19	10	2092-2097
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	<u>Exhibit C</u> : Transcript of Video Transcript of Brian E. Juell, M.D.	6/12/19	11	2272-2314
54.	Offer of Proof re Sarah Larsen	11/1/19	11	2315-2317
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83.	<i>Jury Trial Transcript</i> — Day 8 (Wednesday)	10/23/19	23	4939-5121
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88.	<i>Jury Trial Transcript</i> — Day 13 (Thursday)	10/31/19	28 29	6068-6293 6294-6336
89.	<i>Jury Trial Transcript</i> — Day 14 (Friday)	11/1/19	29	6337-6493

ADDITIONAL DOCUMENTS¹

91.	Defendants Barry Rives, M.D. and Laparoscopic Surgery of, LLC's Supplemental Opposition to Plaintiffs' Motion for Sanctions Under Rule 37 for Defendants' Intentional Concealment of Defendant Rives' History of Negligence and Litigation And Motion for Leave to Amend Complaint to Add Claim for Punitive Damages on Order Shortening Time	10/4/19	30	6494-6503
92.	Declaration of Thomas J. Doyle in Support of Supplemental Opposition to Plaintiffs' Motion for Sanctions Under Rule 37 for Defendants' Intentional Concealment of Defendant Rives' History of Negligence and litigation and Motion for Leave to Amend Complaint to Add Claim for Punitive Damages on Order Shortening Time	10/4/19	30	6504-6505

¹ These additional documents were added after the first 29 volumes of the appendix were complete and already numbered (6,493 pages).

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93.	<i>Partial Transcript re: Trial by Jury – Day 4 Testimony of Justin Willer, M.D. (Filed 11/20/19)</i>	10/17/19	30	6514-6618
94.	Jury Instructions	11/1/19	30	6619-6664
95.	Notice of Appeal	12/18/19	30	6665-6666
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96.	Notice of Cross-Appeal	12/30/19	30	6673-6675
	<u>Exhibit “1”</u> : Notice of Entry Judgment	11/19/19	30	6676-6682
97.	<i>Transcript of Proceedings Re: Pending Motions</i>	1/7/20	31	6683-6786
98.	<i>Transcript of Hearing Re: Defendants Barry J. Rives, M.D.’s and Laparoscopic Surgery of Nevada, LLC’s Motion to Re-Tax and Settle Plaintiffs’ Costs</i>	2/11/20	31	6787-6801
99.	Order on Plaintiffs’ Motion for Fees and Costs and Defendants’ Motion to Re-Tax and Settle Plaintiffs’ Costs	3/30/20	31	6802-6815
100.	Notice of Entry Order on Plaintiffs’ Motion for Fees and Costs and Defendants’ Motion to Re-Tax and Settle Plaintiffs’ Costs	3/31/20	31	6816-6819
	<u>Exhibit “A”</u> : Order on Plaintiffs’ Motion for Fees and Costs and Defendants’ Motion to Re-Tax and Settle Plaintiffs’ Costs	3/30/20	31	6820-6834
101.	Supplemental and/or Amended Notice of Appeal	4/13/20	31	6835-6836
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(Cont. 101)	<u>Exhibit 2</u> : Order on Plaintiffs' Motion for Fees and Costs and Defendants' Motion to Re-Tax and Settle Plaintiffs' Costs	3/30/20	31	6842-6857


CLERK OF THE COURT

COMP

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Attorneys for Plaintiffs
TITINA FARRIS and PATRICK FARRIS

DISTRICT COURT
CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS,
Plaintiffs,

vs.

BARRY RIVES, M.D., LAPAROSCOPIC
SURGERY OF NEVADA LLC; DOES I-V,
inclusive; and ROE CORPORATIONS I-V,
inclusive,

Defendants.

Case No.: A- 16 - 739464 - C

Dept No.: XX I I

COMPLAINT

Arbitration Exemption Claimed:
MEDICAL MALPRACTICE

Plaintiffs, TITINA FARRIS and PATRICK FARRIS, by and through their attorneys,
George F. Hand, Esq. and Michael E. Bowman, Esq. of Hand & Sullivan, LLC, complains of
Defendants, and each of them, and alleges as follows:

JURISDICTION AND VENUE

1. This Court has subject matter jurisdiction pursuant to NRS 4.370 and Nevada
Constitution, Art. VI, § 6.

2. This Court is the proper venue pursuant to NRS 13.040.

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4 4. Plaintiff TITINA FARRIS is and was at all times relevant hereto a resident of the
5 County of Clark, State of Nevada.

6 5. Plaintiff, PATRICK FARRIS, is and was at all times relevant hereto a resident of
7 the County of Clark, State of Nevada.

8 6. That TITINA FARRIS and PATRICK FARRIS are, and at all times relevant herein
9 were, duly married and living together in the County of Clark, State of Nevada.

7. Defendant BARRY RIVES, M.D. (hereinafter sometimes referred to as ("DR. RIVES")), is and was at all relevant times a physician licensed to practice medicine within the State of Nevada, as defined by N.R.S. Chapter 630, et seq.

8. Upon information and belief, it is alleged that at all times relevant hereto Defendant LAPAROSCOPIC SURGERY OF NEVADA LLC was, and still is, a domestic Limited Liability Company regularly doing business in the County of Clark, State of Nevada.

9. The true names and capacities, whether individual, corporate, associate, or otherwise, of Defendants DOES I through V, inclusive, and ROE CORPORATIONS I through V, inclusive, are unknown to the Plaintiff, who therefore sues these Defendants by such fictitious names. Plaintiff is informed and believes and thereon alleges that each of the Defendants designated herein as a Does I through V, inclusive, and/or Roe Corporations I through V, inclusive, is responsible in some manner for the events and happenings herein referred to and caused injury and damages proximately thereby to Plaintiff as herein alleged, and Plaintiff will ask leave of this Court to amend this Complaint to insert the true names and capacities of Defendants DOE and/or ROE CORPORATION when the same have been ascertained by Plaintiff, together with appropriate charging allegations, and adjoin such Defendants in this action.

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1 18. In support of the allegations contained within this Complaint, Plaintiff has attached
2 as Exhibit 1 the *Affidavit of Vincent E. Pesiri, M.D.* and as Exhibit 2, his *Curriculum Vitae*. Dr.
3 Pesiri was at the time of the events alleged herein, and still is, Board Certified in Surgery. Dr.
4 Pesiri has reviewed the relevant medical records. Based upon his training, background, knowledge
5 and experience, he is familiar with the applicable standards of care for the treatment of individuals
6 demonstrating the symptoms and conditions presented by Plaintiff TITINA FARRIS. Further, he is
7 qualified on the basis of his training, background, knowledge, and experience to offer an expert
8 medical opinion regarding those accepted standards of medical care, the breaches thereof in this
9 case, and any resulting injuries and damages arising therefrom.

10 19. Dr. Pesiri has opined in the attached Exhibit 1 that, to a reasonable degree of
11 medical probability, Defendants fell below the accepted standard of care in their treatment of
12 Plaintiff. On July 3, 2015, Barry Rives, M.D. of Laparoscopic Surgery of Nevada performed a
13 laparoscopic reduction and repair of incarcerated incisional hernia on Titina Farris at St. Rose
14 Dominican Hospital – San Martin Campus. Post-operatively, the patient, Titina Farris became
15 septic as a result of a perforated colon. Dr. Pesiri opined that Dr. Rives deviated from the accepted
16 standard of care in his treatment of Titina Farris. The records indicate Titina Farris was a type 2
17 diabetic, obese and had a history of c-sections. On August 7, 2014, Dr. Rives performed an
18 excision of abdominal wall lipoma with repair of ventral hernia with mesh on Titina Farris. After
19 the August, 2014 surgery, Titina Farris indicated that she thought there was a recurrence of the
20 hernia. After a CT scan in June, 2015, it was determined by Dr. Rives that there was a recurrent
21 abdominal wall hernia. Dr. Rives recommended laparoscopic ventral hernia repair with mesh.

22 20. On July 3, 2015, Dr. Rives performed “1. Laparoscopic reduction and repair of
23 incarcerated incisional hernia with mesh; and 2. Colonorrhaphy x2.” on Titina Farris, a 52 year old
24 female. The operative report of Dr. Rives indicates that the transverse colon was severely stuck
25 and adhered to prior mesh repair. The mesh would not come free from the skin. A small tear was
26 created in the colon using a Endo-GIA blue load. Dr. Rives stapled across the small colotomy. A
27 second small colotomy was also noticeable and was repaired. Dr. Rives noted that after successive
28 firings, the staple lines appeared to be intact. He noted no further serosal or full-thickness injuries

1 to the colon. A piece of mesh was placed in the intrabdominal cavity. The colon was noted to be
2 healthy, viable with no further injuries or tears. The patient was extubated in the OR and noted to
3 be in stable condition.

4 21. After the July 3, 2015 surgery, Titina Farris was noted to have an extremely high
5 WBC. Titina Farris was transferred to the ICU on July 4, 2015. Titina Farris continued to
6 deteriorate. She was noted to have respiratory failure, atrial fibrillation, fever, leukocytosis and
7 ileus. There was evidence of sepsis. Dr. Rives did not determine the cause of the infection post-
8 operatively and Titina Farris did not improve. Titina Farris was placed on a ventilator and received
9 a tracheostomy. Dr. Elizabeth Hamilton was called in for a second opinion.

10 22. On July 16, 2015, Dr. Hamilton operated on Titina Farris. The procedure performed
11 was: 1. Exploratory laparotomy; 2. Removal of prosthetic mesh and washout of abdomen; 3.
12 Partial colectomy and right ascending colon end ileostomy; 4. Extensive lysis of adhesions over 30
13 minutes; 5. Retention suture placement; 6. Decompression of the stool from the right colon into
14 the ostomy; The postoperative diagnosis was: 1. Perforated viscus with free intra-abdominal air;
15 2. Sepsis; 3. Respiratory failure; 4. Anasarca; 5. Fever; 6. Leukocytosis; 7. Fecal disimpaction
16 of the rectum. Of significance, the operative report states: "Decision was made that she had
17 evidence of perforation and likely perforation of the colon from the previous colon injuries. A
18 decision was made that it would be in her best interest to take her to the operating room to evaluate
19 this and try to get rid of the source of continued sepsis in this patient, who is failing". The
20 transverse colon was visualized and there was an approximately quarter-size or 2.5 to 3 cm hole.
21 Around it was an active leak of green feculent material and free air. Feculent material was noted
22 on the mesh with 3 cm colotomy in the transverse colon at the staple line. Titina Farris currently
23 has bilateral foot drop as well as a colostomy. Dr. Pesiri opined that Dr. Rives fell beneath the
24 accepted standard of care as follows: a. Intraoperative technique; b. Failure to adequately repair
25 bowel perforations at the time of July 3, 2015 surgery; c. Poor post-operative management of
26 perforated bowel and resultant sepsis.

24. That as a direct and proximate result of the medical negligence and failures to meet the standard of care by Defendants, Dr. Pesiri has further opined that Plaintiff FARRIS suffered injury and damage to within a reasonable degree of medical probability (Exhibit 1), all to Plaintiff's damages in an amount in excess of TEN THOUSAND DOLLARS (\$10,000.00).

25. That as a direct and proximate result of the medical negligence and failures to meet the standard of care by Defendants, it has been necessary for Plaintiff to retain the law firm of HAND & SULLIVAN, LLC, to prosecute this action, and Plaintiff is therefore entitled to recover reasonable attorney's fees and costs.

(Corporate Negligence/Vicarious Liability)

15 26. Plaintiffs incorporate by reference the above paragraphs as though set forth fully
16 hereunder.

27. Defendant LAPAROSCOPIC SURGERY OF NEVADA LLC's employees, agents, residents and/or servants were acting in the scope of their employment, under BARRY RIVES, M.D.'s control, and in furtherance of LAPAROSCOPIC SURGERY OF NEVADA LLC's interest at the time their actions caused injuries to TITINA FARRIS.

21 28. Defendant LAPAROSCOPIC SURGERY OF NEVADA LLC is vicariously liable
22 for damages resulting from its agents and/or employees and/or servants regarding the injuries to
23 TITINA FARRIS.

24 29. As a result of these breaches, TITINA FARRIS sustained permanent injuries
25 through the employees' and/or agents' negligence and was the proximate cause of injuries.

26 30. As a direct result of these actions/or omissions, TITINA FARRIS sustained
27 permanent injuries resulting in continuing medical treatment and disability.

28 |||

1 31. As a proximate result of these actions and/or omissions, TITINA FARRIS has had
2 to endure extreme pain and suffering.

3 32. As a proximate result of these actions and/or omissions, TITINA FARRIS will incur
4 future medical and other special expense, in an amount to be determined at trial.

5 33. As a result of these actions and/or omissions, TITINA FARRIS is entitled to be
6 compensated in an amount to be determined at the time of trial of this matter, but which is in excess
7 of TEN THOUSAND DOLLARS (\$10,000.00).

8 34. That as a direct result of these actions and/or omissions, TITINA FARRIS
9 was required to retain the services of an attorney and seeks reimbursement for attorney's fees and
10 costs.

11 **THIRD CAUSE OF ACTION**

12 **(Loss of Consortium)**

13 35. Plaintiff incorporates by reference the above paragraphs as though set forth fully
14 hereunder.

15 36. That TITINA FARRIS suffered injuries as a direct result of Defendants actions as
16 alleged herein.

17 37. At the time of the events complained of in the Plaintiffs' Complaint, the Plaintiffs
18 were married and that the Plaintiffs continue to be married.

19 38. That as a result of the wrongful and negligent acts of the Defendants, and each of
20 them, the Plaintiffs were caused to suffer, and will continue to suffer in the future, loss of
21 consortium, loss of society, affection, assistance, and conjugal fellowship, all to the detriment of
22 their marital relationship.

23 39. That all the aforesaid injuries and damages were caused solely and proximately by
24 the negligence of the Defendants.

25 WHEREFORE, Plaintiffs prays for judgment against the Defendants, and each of them, as
26 follows:

27 1. For general damages and loss in an amount in excess of TEN THOUSAND
28 DOLLARS (\$10,000);

2. For special damages in an amount to be determined at time of trial;
3. For reasonable attorneys fees, pre and post-judgment interest, and costs of suit; and
4. For such other and further relief as the Court may deem just and proper.

Dated: July / , 2016

HAND & SULLIVAN, LLC

By: 

George F. Hand, Esq.
Nevada State Bar No. 8483
Michael E. Bowman, Esq.
Nevada State Bar No. 13833
3442 North Buffalo Drive
Las Vegas, Nevada 89129
Attorneys for Plaintiffs
TITINA FARRIS and PATRICK
FARRIS

EXHIBIT 1

AFFIDAVIT OF VINCENT E. PESIRI, M.D.

STATE OF NEW YORK)
) SS.:
COUNTY OF NASSAU)

Vincent E. Pesiri, M.D. being duly sworn, deposes and says:

1. Affiant is over the age of 18, has personal knowledge of the facts set forth herein, and is competent to testify thereto, except as to those matters stated upon information and belief, and as to those matters, I believe them to be true.
2. I am a Board Certified Surgeon. A copy of my curriculum vitae is attached hereto. I am qualified on the basis of my training, background, knowledge and experience to offer expert medical opinions in this matter.
3. I have reviewed the relevant medical records of Titina Farris and my opinions are to a reasonable degree of medical probability.
4. During the course of my career, I have performed a significant amount of hernia surgeries, including repairs of incisional hernias.
5. On July 3, 2015, Barry Rives, M.D. of Laparoscopic Surgery of Nevada performed a laparoscopic reduction and repair of incarcerated incisional hernia on Titina Farris at St. Rose Dominican Hospital - San Martin Campus. Post-operatively, the patient, Titina Farris became septic as a result of a perforated colon.
6. It is my professional opinion, to a reasonable degree of medical probability, that Dr. Rives deviated from the accepted standard of care in his treatment of Titina Farris.
7. The records indicate Titina Farris was a type 2 diabetic, obese and had a history of c-sections. On August 7, 2014, Dr. Rives performed an excision of abdominal wall lipoma with repair of ventral hernia with mesh on Titina Farris. After the August, 2014 surgery, Titina Farris indicated that she thought there was a recurrence of the hernia.
8. After a CT scan in June, 2015, it was determined by Dr. Rives that there was a recurrent abdominal wall hernia. Dr. Rives recommended laparoscopic ventral hernia repair with mesh.

9. On July 3, 2015, Dr. Rives performed "1. Laparoscopic reduction and repair of incarcerated incisional hernia with mesh; and 2. Colonorrhaphy x2." on Titina Farris, a 52 year old female.

10. The operative report of Dr. Rives indicates that the transverse colon was severely stuck and adhered to prior mesh repair. The mesh would not come free from the skin. A small tear was created in the colon using a Endo-GIA blue load. Dr. Rives stapled across the small colotomy. A second small colotomy was also noticeable and was repaired. Dr. Rives noted that after successive firings, the staple lines appeared to be intact. He noted no further serosal or full-thickness injuries to the colon. A piece of mesh was placed in the intrabdominal cavity. The colon was noted to be healthy, viable with no further injuries or tears. The patient was extubated in the OR and noted to be in stable condition.

11. After the July 3, 2015 surgery, Titina Farris was noted to have an extremely high WBC. Titina Farris was transferred to the ICU on July 4, 2015. Titina Farris continued to deteriorate. She was noted to have respiratory failure, atrial fibrillation, fever, leukocytosis and ileus. There was evidence of sepsis. Dr. Rives did not determine the cause of the infection post-operatively and Titina Farris did not improve. Titina Farris was placed on a ventilator and received a tracheostomy.

12. Dr. Elizabeth Hamilton was called in for a second opinion.

13. On July 16, 2015, Dr. Hamilton operated on Titina Farris. The procedure performed was: 1. Exploratory laparotomy; 2. Removal of prosthetic mesh and washout of abdomen; 3. Partial colectomy and right ascending colon end ileostomy; 4. Extensive lysis of adhesions over 30 minutes; 5. Retention suture placement; 6. Decompression of the stool from the right colon into the ostomy; The postoperative diagnosis was: 1. Perforated viscus with free intra-abdominal air; 2. Sepsis; 3. Respiratory failure; 4. Anasarca; 5. Fever; 6. Leukocytosis; 7. Fecal disimpaction of the rectum.

14. Of significance, the operative report states: "Decision was made that she had evidence of perforation and likely perforation of the colon from the previous colon injuries. A

decision was made that it would be in her best interest to take her to the operating room to evaluate this and try to get rid of the source of continued sepsis in this patient, who is failing". The transverse colon was visualized and there was an approximately quarter-size or 2.5 to 3 cm hole. Around it was an active leak of green feculent material and free air. Feculent material was noted on the mesh with 3 cm colotomy in the transverse colon at the staple line.

15. Titina Farris currently has bilateral foot drop as well as a colostomy.

16. In this case, to a reasonable degree of medical probability, Dr. Rives fell beneath the accepted standard of care as follows:

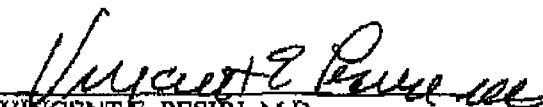
- a. Intraoperative technique;
- b. Failure to adequately repair bowel perforations at the time of July 3, 2015 surgery;

c. Poor post-operative management of perforated bowel and resultant sepsis.

17. It is my opinion to a reasonable degree of medical probability that the aforesaid breaches of the standard of care by Dr. Rives caused damage to the Plaintiff resulting in the injuries noted above.

18. I declare that the foregoing is true and correct to the best of my knowledge, that all opinions are stated to a reasonable degree of medical probability, and that this declaration was executed by me. My opinion may be supplemented as more information becomes available.

FURTHER, Affiant sayeth naught.


VINCENT E. PESIRI, M.D.

SUBSCRIBED AND SWORN to before me
this 1st day of July, 2016.


NOTARY PUBLIC



EXHIBIT 2

VINCENT E. PESIRI, MD

93 Fordham Street
Williston Park, NY 11596

Direct: 516-976-4465

Email: DRUMED18@gmail.com

EDUCATION:

Fellowship:	Vascular Surgery, State University of New York Lutheran Medical Center, Brooklyn, New York	1983 - 1984
Chief Resident Surgery:	State University of New York, Downstate Medical Center, Kings County Hospital Center	1982 - 1983
Resident Surgery:	State University of New York, Downstate Medical Center, Kings County Hospital Center	1979 - 1982
Internship:	State University of New York, Downstate Medical Center, King County Hospital Center	1978 - 1979
Medical Doctor:	State University of New York, Downstate Medical Center, Brooklyn, New York	1974 - 1978
B.S.	St. John's University, Queens, New York	1971 - 1974

STATE LICENSES: New York and Michigan

**BOARD
CERTIFICATIONS:** AMERICAN BOARD OF SURGERY
AMERICAN BOARD OF QUALITY ASSURANCE
CWS: CERTIFIED WOUND CARE SPECIALIST
CERTIFIED HYPERBARIC MEDICINE

**PROFESSIONAL
SOCIETIES:** FELLOW OF THE AMERICAN COLLEGE OF SURGEONS, AMERICAN
COLLEGE OF HYPERBARIC MEDICINE, UNDERSEAS HYPERBARIC
SOCIETY, STATE OF MICHIGAN MEDICAL SOCIETY, JACKSON
SOCIETY

EMPLOYMENT:	MOBILE HYPERBARICS, Binghamton, NY and Jackson, MI	08/11 - 09/14
	NORTH SHORE L.I. WOUND CARE CENTER Lake Success, NY	01/01 - 05/11
	DR. VINCENT PESIRI, PRIVATE SURGICAL PRACTICE Glen Cove, NY	1986 - 07/09

VINCENT E. PESIRI, MD

CV Pg. 2

HOSPITAL AFFILIATIONS:

North Shore University Hospital, Glen Cove, NY	1986 - 2009
Woodhull Medical Center, Brooklyn, NY	1984 - 1987

HOSPITAL POSITIONS AND ACTIVITIES HELD:

(All North Shore University Hospital, Glen Cove, NY)	
Vice President of Medical Board	2008 - 2009
Secretary - Treasurer of Medical Board	2007 - 2008
Chairman of Tissue Committee	2005 - 2009
Member of Tissue Committee	1992 - 2005
Member of House Staff Committee	1986 - 1992
Member of Nurse-Physician Liaison Committee	1991 - 2009
Member of Ambulatory Care Committee	1990 - 1996
Member of Ambulatory Care Committee	1990 - 1996
Member of Utilization Review Committee	1986 - 2009
Quality Assurance Reviewer of Surgery	1986 - 2009
Secretary of Surgery Department	1986 - 1991

AWARDS:

Outstanding Surgical Teacher in Family Practice Residency	06/2005
Outstanding Surgical Teacher in Family Practice Residency	06/2001
Outstanding Surgical Teacher in Family Practice Residency	06/1988

POST GRADUATE COURSES:

Advanced Cardiac Life Support	06/2010
Primary - Hyperbaric Medicine NBS	09/2010
SWAC	04/2010
Advanced Hernia	10/2008
Sentinel Lymph node Dissection	01/2000
Laparoscopic Surgery	05/1997
Laparoscopic Hernia Repair	09/1994
Advance Laparoscopic Surgery	10/1993
KTP-YAG Laser Surgery	09/1990
F.A.C.S.	10/1989
American College of Surgeons Post Graduate Vascular Surgery	01/1989

1 **IAFD**
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 2 Nevada State Bar No. 8483
ghand@handsullivan.com
 3 Michael E. Bowman, Esq.
 Nevada State Bar No. 13833
 4 **HAND & SULLIVAN, LLC**
hsadmin@handsullivan.com
 5 3442 North Buffalo Drive
 Las Vegas, Nevada 89129
 6 Telephone: (702) 656-5814
 Facsimile: (702) 656-9820
 7
 Attorneys for Plaintiffs
 8 TITINA FARRIS and PATRICK FARRIS

9
 10 **DISTRICT COURT**
 11 **CLARK COUNTY, NEVADA**

12 TITINA FARRIS and PATRICK FARRIS,	}	Case No.:
13 Plaintiffs,		Dept No.:
14 vs.		INITIAL APPEARANCE FEE
15 BARRY RIVES, M.D., LAPAROSCOPIC		DISCLOSURE (NRS CHAPTER 19)
16 SURGERY OF NEVADA LLC; DOES I-V,		
17 inclusive; and ROE CORPORATIONS I-V,		
18 Defendants.		

19 Pursuant to NRS Chapter 19, as amended by Senate Bill 106, filing fees were previously
 20 submitted for parties appearing in the above entitled action as indicated below:

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27 ///

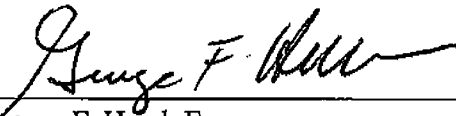
28

1	Plaintiffs, Titina Farris and Patrick Farris	\$270.00
2		
3	TOTAL REMITTED:	\$270.00

4
5 Dated: July 1, 2016

HAND & SULLIVAN, LLC

6
7
8 By:



George F. Hand, Esq.
Nevada State Bar No. 8483
Michael E. Bowman, Esq.
Nevada State Bar No. 13833
3442 North Buffalo Drive
Las Vegas, Nevada 89129
Attorneys for Plaintiffs
TITINA FARRIS and PATRICK
FARRIS


CLERK OF THE COURT

[ANS]
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KIM MANDELBAUM
Nevada Bar No. 318
MANDELBAUM ELLERTON & ASSOCIATES
2012 Hamilton Lane
Las Vegas, Nevada 89106
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Attorneys for Defendants BARRY RIVES, M.D.;
LAPAROSCOPIC SURGERY OF NEVADA, LLC

DISTRICT COURT
CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS,	)	CASE NO. A-16-739464-C
	)	DEPT. NO. 22
Plaintiffs,)	
	)	ANSWER TO COMPLAINT
vs.)	
)	
BARRY RIVES, M.D.; LAPAROSCOPIC	)	<i>Arbitration Exempt</i>
SURGERY OF NEVADA, LLC, et al.,	)	<i>Medical Malpractice</i>
)	
Defendants.)	

COME NOW Defendants, BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLP by and through their attorneys of record, Schuering Zimmerman & Doyle, LLP, and for their answer to the complaint of Plaintiffs on file herein, admit, deny and allege as follows:

JURISDICTION AND VENUE

1. Answering paragraph 1-2, of Plaintiffs' Complaint, Defendants Barry Rives,

1 M.D. and Laparoscopic Surgery of Nevada, LLC, admit each and every allegation
2 contained therein.

3 2. Answering paragraph 3, of Plaintiffs' Complaint, Defendants Barry Rives, M.D.
4 and Laparoscopic Surgery of Nevada, LLC, state that they do not have sufficient
5 knowledge or information upon which to base a belief as to the truth of the allegations
6 therein and, upon said ground, deny each and every allegation contained therein.

7 PARTIES

8 3. Answering paragraphs 4-6 of Plaintiffs' Complaint, Defendants Barry Rives,
9 M.D. and Laparoscopic Surgery of Nevada, LLC, state that they do not have sufficient
10 knowledge or information upon which to base a belief as to the truth of the allegations
11 therein and, upon said ground, deny each and every allegation contained therein.
12 deny each and every allegation contained therein.

13 4. Answering paragraphs 7-8, of Plaintiffs' Complaint, Defendants Barry Rives,
14 M.D. and Laparoscopic Surgery of Nevada, LLC, admit each and every allegation
15 contained therein.

16 5. Answering paragraph 9 of Plaintiffs' Complaint, Defendants Barry Rives, M.D.
17 and Laparoscopic Surgery of Nevada, LLC, state that they do not have sufficient
18 knowledge or information upon which to base a belief as to the truth of the allegations
19 therein and, upon said ground, deny each and every allegation contained therein.
20 deny each and every allegation contained therein.

21 6. Answering paragraph 10, of Plaintiffs' Complaint, Defendants Barry Rives,
22 M.D. and Laparoscopic Surgery of Nevada, LLC, deny each and every allegation contained
23 therein.

24 GENERAL ALLEGATIONS

25 7. Defendants Barry Rives, M.D. and Laparoscopic Surgery of Nevada, LLC,
26 hereby restate their answer to paragraphs 1 through 10 of Plaintiffs' Complaint, and

1 incorporate the same herein by reference as though fully set out herein at length.

2 8. Answering paragraph 12 of Plaintiffs' Complaint, Defendants Barry Rives,
3 M.D. and Laparoscopic Surgery of Nevada, LLC, state that they do not have sufficient
4 knowledge or information upon which to base a belief as to the truth of the allegations
5 therein and, upon said ground, deny each and every allegation contained therein.
6 deny each and every allegation contained therein.

7 9. Answering paragraph 13 of Plaintiffs' Complaint, Defendants Barry Rives,
8 M.D. and Laparoscopic Surgery of Nevada, LLC, admit the Defendants represented
9 themselves to be competent to perform all professional services, treatments and tests
10 that were to be rendered to the Plaintiff. Defendants state they do not have sufficient
11 knowledge or information upon which to base a belief as to the truth of the allegations
12 contained in the remainder of the paragraph and, upon said ground, deny each and every
13 allegation contained in the remainder of the paragraph.

14 10. Answering paragraph 14 of Plaintiffs' Complaint, Defendants Barry Rives,
15 M.D. and Laparoscopic Surgery of Nevada, LLC, admit each and every allegation
16 contained therein.

17 FIRST CAUSE OF ACTION

18 (Medical Malpractice)

19 11. Defendants Barry Rives, M.D. and Laparoscopic Surgery of Nevada, LLC,
20 hereby restate their answer to paragraphs 1 through 14 of Plaintiffs' Complaint, and
21 incorporate the same herein by reference as though fully set out herein at length.

22 12. Answering paragraph 16 of Plaintiffs' First Cause of Action, Defendants Barry
23 Rives, M.D. and Laparoscopic Surgery of Nevada, LLC, admit that at all times pertinent
24 hereto, Defendants had a duty to adequately and properly evaluate, diagnose and/or
25 otherwise provide competent medical care within the accepted standard of care to
26 TITINA FARRIS. Defendants state they do not have sufficient knowledge or information

1 upon which to base a belief as to the truth of the allegations contained in the remainder
2 of the paragraph and, upon said ground, deny each and every allegation contained in the
3 remainder of the paragraph.

4 13. Answering paragraph 17, of Plaintiffs' First Cause of Action, Defendants Barry
5 Rives, M.D. and Laparoscopic Surgery of Nevada, LLC, deny each and every allegation
6 contained therein.

7 14. Answering paragraphs 18-22 of Plaintiffs' First Cause of Action, Defendants
8 Barry Rives, M.D. and Laparoscopic Surgery of Nevada, LLC, state that they do not have
9 sufficient knowledge or information upon which to base a belief as to the truth of the
10 allegations therein and, upon said ground, deny each and every allegation contained
11 therein.

12 15. Answering paragraphs 23-25, of Plaintiffs' First Cause of Action, Defendants
13 Barry Rives, M.D. and Laparoscopic Surgery of Nevada, LLC, deny each and every
14 allegation contained therein.

15 SECOND CAUSE OF ACTION

16 (Corporation Negligence/Vicarious Liability)

17 16. Defendants Barry Rives, M.D. and Laparoscopic Surgery of Nevada, LLC,
18 hereby restate their answer to paragraphs 1 through 25 of Plaintiffs' Complaint, and
19 incorporate the same herein by reference as though fully set out herein at length.

20 17. Answering paragraph 27, of Plaintiffs' Second Cause of Action, Defendants
21 Barry Rives, M.D. and Laparoscopic Surgery of Nevada, LLC, state that they do not have
22 sufficient knowledge or information upon which to base a belief as to the truth of the
23 allegations therein and, upon said ground, deny each and every allegation contained
24 therein.

25 18. Answering paragraphs 28-34 of Plaintiffs' Second Cause of Action,
26 Defendants Barry Rives, M.D. and Laparoscopic Surgery of Nevada, LLC, deny each and

1 every allegation contained therein.

2 THIRD CAUSE OF ACTION

3 (Loss of Consortium)

4 19. Defendants Barry Rives, M.D. and Laparoscopic Surgery of Nevada, LLC,
5 hereby restate their answer to paragraphs 1 through 34 of Plaintiffs' Complaint, and
6 incorporate the same herein by reference as though fully set out herein at length.

7 20. Answering paragraphs 36, 38-39 of Plaintiffs' Third Cause of Action,
8 Defendants Barry Rives, M.D. and Laparoscopic Surgery of Nevada, LLC, deny each and
9 every allegation contained therein.

10 21. Answering paragraph 37, of Plaintiffs' Third Cause of Action, Defendants
11 Barry Rives, M.D. and Laparoscopic Surgery of Nevada, LLC, state that they do not have
12 sufficient knowledge or information upon which to base a belief as to the truth of the
13 allegations therein and, upon said ground, deny each and every allegation contained
14 therein.

15 FIRST AFFIRMATIVE DEFENSE

16 Plaintiffs fail to state causes of action upon which relief can be granted.

17 SECOND AFFIRMATIVE DEFENSE

18 Plaintiffs' causes of action are barred by the doctrines of laches, waiver and
19 estoppel.

20 THIRD AFFIRMATIVE DEFENSE

21 Plaintiffs failed to use ordinary care for the safety of their person and property, were
22 negligent and careless concerning the matters set forth in this action, and any damages
23 suffered by them proximately resulted therefrom.

24 FOURTH AFFIRMATIVE DEFENSE

25 At all times and places alleged in Plaintiffs' complaint, the negligence, misconduct
26 and fault of Plaintiffs exceeded that of these Defendants and/or all Defendants, if any, and

1 Plaintiffs are therefore barred from any recovery.

2 FIFTH AFFIRMATIVE DEFENSE

3 Plaintiffs are barred from asserting any causes of action against Defendants
4 because the alleged damages were the result of the intervening and/or superseding
5 conduct of others.

6 SIXTH AFFIRMATIVE DEFENSE

7 Plaintiffs' causes of action against Defendants are barred by the applicable statutes
8 of limitations in NRS. 41A or any other applicable statutes of limitations.

9 SEVENTH AFFIRMATIVE DEFENSE

10 In all of the treatment provided to Plaintiff TITINA FARRIS by Defendants, she was
11 fully informed of the risks inherent in such medical treatment and the risks inherent in her
12 own failure to comply with medical instructions, and did voluntarily assume all attendant
13 risks.

14 EIGHTH AFFIRMATIVE DEFENSE

15 Defendants reserve the right to introduce evidence of any amounts paid or to be
16 paid as a benefit for Plaintiffs pursuant to NRS 42.021, and claims the protection of NRS
17 41A.035.

18 NINTH AFFIRMATIVE DEFENSE

19 Defendants may elect to have future damages, if any, paid in whole or in part
20 pursuant to NRS 42.021.

21 TENTH AFFIRMATIVE DEFENSE

22 Defendants are immune from liability pursuant to NRS 41.500, NRS 41.503 and NRS
23 41.505.

24 ELEVENTH AFFIRMATIVE DEFENSE

25 Plaintiffs claim damages have been suffered, but Plaintiffs failed, neglected and
26 refused to exercise efforts to mitigate said damages.

Defendants would be severally liable for only the portion of Plaintiffs' damages that represent the percentage of negligence, if any, attributed to them.

Defendants reserve the right to amend this answer to raise additional affirmative defenses pursuant to NRCP 11.

WHEREFORE, Defendants Barry Rives, M.D. and Laparoscopic Surgery of Nevada, LLC, pray that Plaintiffs take nothing by reason of the complaint on file herein and that Defendants Barry Rives, M.D. and Laparoscopic Surgery of Nevada, LLC, be awarded attorney's fees and costs incurred in the defense of this action.

Dated: September 12, 2016

SCHUERING ZIMMERMAN & DOYLE, LLP

By /s/ Thomas J. Doyle
THOMAS J. DOYLE
Nevada Bar No. 1120
400 University Avenue
Sacramento, CA 95825-6502
(916) 567-0400
Attorneys for Defendants BARRY RIVES,
M.D.; LAPAROSCOPIC SURGERY OF
NEVADA, LLC

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 14th day of September , 2016, service of a true and correct copy of the foregoing:

ANSWER TO COMPLAINT

was served as indicated below:

☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);

Attorney

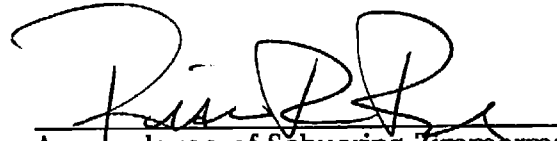
Representing

Phone/Fax/E-Mail

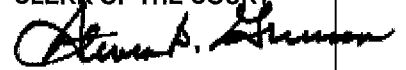
George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129

Plaintiff

702/656-5814
Fax: 702/656-9820
hsadmin@handsullivan.com



An employee of Schuering Zimmerman
& Doyle
1737-10881



1 NOAC
2 KIMBALL JONES, ESQ.
3 Nevada Bar No.: 12982
4 JACOB G. LEAVITT, ESQ.
5 Nevada Bar No.: 12608
6 **BIGHORN LAW**
7 716 S. Jones Blvd.
8 Las Vegas, Nevada 89107
9 Phone: (702) 333-1111
10 Email: Kimball@BighornLaw.com
11 Jacob@BighornLaw.com
12 Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

10 TITINA FARRIS and PATRICK FARRIS,
11
12 Plaintiffs,
13 vs.

CASE NO: A-16-739464-C
DEPT. NO: XXXI

13 BARRY RIVES, M.D.; LAPAROSCOPIC
14 SURGERY OF NEVADA, LLC et al.,
15 Defendants.

NOTICE OF ASSOCIATION OF COUNSEL

18 TO: ALL PARTIES TO THE ABOVE-ENTITLED ACTION.

19 PLEASE TAKE NOTICE that KIMBALL JONES, ESQ. and JACOB G. LEAVITT, ESQ., with
20 the Law Offices of **BIGHORN LAW**, hereby associate as co-counsel for Plaintiffs TITINA FARRIS and
21 PATRICK FARRIS, in the above-entitled matter.

22 KIMBALL JONES, ESQ. and JACOB G. LEAVITT, ESQ., will serve as said co-counsel together

23 ///

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1 with present counsel, GEORGE HAND, ESQ. Please forward copies of all future correspondence, pleadings,
2 and discovery regarding this case to the attention of the undersigned, as well as to GEORGE HAND, ESQ.

3 DATED this 15th day of July, 2019.

4 **BIGHORN LAW**

5 By: /s/ Kimball Jones

6 **KIMBALL JONES, ESQ.**

7 Nevada Bar No.: 12982

8 **JACOB G. LEAVITT, ESQ.**

9 716 S. Jones Blvd.

10 Las Vegas, Nevada 89107

11 *Attorneys for Plaintiffs*

CERTIFICATE OF SERVICE

Pursuant to NRCP 5, NEFCR 9 and EDCR 8.05, I hereby certify that I am an employee of **BIGHORN LAW**, and on the 15th day of July, 2019, I served the foregoing **NOTICE OF ASSOCIATION OF COUNSEL** as follows:

☒ Electronic Service – By serving a copy thereof through the Court’s electronic service system; and/or

☐ U.S. Mail—By depositing a true copy thereof in the U.S. mail, first class postage prepaid and addressed as listed below; and/or

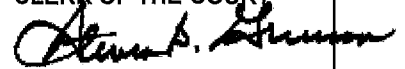
☐ Facsimile—By facsimile transmission pursuant to EDCR 7.26 to the facsimile number(s) shown below and in the confirmation sheet filed herewith. Consent to service under NRCP 5(b)(2)(D) shall be assumed unless an objection to service by facsimile transmission is made in writing and sent to the sender via facsimile within 24 hours of receipt of this Certificate of Service.

George Hand, Esq.
HAND & SULLIVAN, LLC
3442 N. Buffalo Drive
Las Vegas, Nevada 89129
Attorneys for Plaintiffs

Kim Mandelbaum, Esq.
MANDELBAUM ELLERTON & ASSOCIATES
2012 Hamilton Lane
Las Vegas, Nevada 89106
&
Thomas J. Doyle, Esq.
Chad C. Couchot, Esq.
SCHUERING ZIMMERMAN & DOYLE, LLP
400 University Avenue
Sacramento, California 95825
Attorneys for Defendants

/s/ Erickson Finch
An employee of **BIGHORN LAW**

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Steven D. Grierson
CLERK OF THE COURT



[MCOM]
THOMAS J. DOYLE
Nevada Bar No. 1120
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(916) 567-0400
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2012 Hamilton Lane
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(702) 367-1234
Email: filing@memlaw.net

Attorneys for Defendants BARRY RIVES, M.D.; and
LAPAROSCOPIC SURGERY OF NEVADA, LLC

DISTRICT COURT

CLARK COUNTY, NEVADA

<p>TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al., Defendants.</p>	<p>) CASE NO. A-16-739464-C) DEPT. NO. 31)) DEFENDANTS BARRY RIVES, M.D.'S AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S MOTION TO COMPEL THE DEPOSITION OF GREGG RIPPLINGER, M.D. AND EXTEND THE CLOSE OF DISCOVERY (9TH REQUEST) ON AN ORDER SHORTENING TIME))) <u>HEARING REQUESTED</u></p>
--	--

Defendants BARRY J. RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC
("Defendants") hereby move this Court for an Order compelling the deposition of plaintiff
TITINA FARRIS' treating physician Dr. Gregg Ripplinger and to extend the close of
discovery deadline to September 19, 2019, to complete the deposition of Dr. Ripplinger
and the deposition of plaintiff's general surgery expert witness Dr. Michael Hurwitz.

1 Defendants are entitled to an Order compelling the deposition of Dr. Ripplinger and
2 extending the close of discovery deadline under NRCP 26(b)(4)(A) because Defendants'
3 failure to take the depositions of Dr. Ripplinger and Dr. Hurwitz during the currently set
4 discovery deadline was based on the parties' mutual plan to continue the trial date, which
5 was denied on September 5, 2019, and Plaintiffs' counsel previously agreed to the
6 depositions of Dr. Ripplinger and Dr. Hurwitz, but withdrew such agreement as to
7 Dr. Ripplinger on September 12, 2019. Defendants' reasonable reliance on the mutual
8 plan of the parties to obtain a trial continuance and the reasonable reliance on the
9 representations of Plaintiffs' counsel associated with the deposition of Dr. Ripplinger are
10 good cause to support an Order compelling the deposition of Dr. Ripplinger and extending
11 the discovery deadline to September 19, 2019 to allow for the depositions of Dr. Ripplinger
12 and Dr. Hurwitz.

13 Additionally, Defendants request this Motion be heard on an Order shortening time
14 in light of the October 14, 2019, trial date, and the currently scheduled depositions of
15 Dr. Hurwitz and Dr. Ripplinger for September 18, 2019, and September 19, 2019,
16 respectively. Defendants' Motion cannot be heard as a regularly noticed motion with
17 sufficient time to allow for the depositions of Dr. Hurwitz and Dr. Ripplinger and counsel's
18 use of that deposition testimony in preparation for trial commencing on October 14, 2019.

19 Defendants' Motion is made and based on the Declaration of Chad C. Couchot, Esq.
20 and the documents attached thereto, the Declaration of Thomas J. Doyle, the Points and

21 ///

22 ///

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1 Authorities that follow thereafter, and any oral or documentary evidence that the Court
2 may hear at the time this motion is heard.

3 Dated: September 13, 2019

4 **SCHUERING ZIMMERMAN & DOYLE, LLP**

5
6 By /s/ Aimee Clark Newberry
7 AIMEE CLARK NEWBERRY
8 Nevada Bar No. 11084
9 400 University Avenue
10 Sacramento, CA 95825-6502
11 (916) 567-0400
12 Attorneys for Defendants BARRY RIVES,
13 M.D. and LAPAROSCOPIC SURGERY OF
14 NEVADA, LLC
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ORDER SHORTENING TIME

It appearing to the satisfaction of the Court, and good cause appearing therefore, IT IS HEREBY ORDERED that the foregoing DEFENDANTS' MOTION TO COMPEL THE DEPOSITIONS OF GREGG RIPPLINGER, M.D. AND MICHAEL HURWITZ, M.D. (9TH REQUEST) shall be heard on the _____ day of September, 2019, at the time of _____, in Department 31 of the above-entitled Court.

DISTRICT JUDGE

Respectfully submitted this 13th day of September, 2019, by:

SCHUERING ZIMMERMAN & DOYLE, LLP

By: /s/ Aimee Clark Newberry
AIMEE CLARK NEWBERRY, ESQ.
Nevada Bar No. 11084
400 University Avenue
Sacramento, California 95825
(916) 567-0400
Attorneys for Defendants
BARRY RIVES, M.D.; and
LAPAROSCOPIC SURGERY OF NEVADA, LLC

DECLARATION OF CHAD C. COUCHOT, ESQ.

I, CHAD C. COUCHOT, declare as follows:

1. I am an attorney at law licensed to practice in the State of Nevada, and I am a partner of the law firm of Schuering Zimmerman & Doyle, LLP, attorneys of record for Defendants.

2. I am making this declaration of support of Defendants' Motion to Compel the Deposition of Dr. Ripplinger and Motion to Extend the Close of Discovery Deadline on an Order Shortening Time (9th Request.)

3. I am making this declaration based upon my personal knowledge and if called to testify, I could and would do so competently.

4. Defendants initially noticed the deposition of Dr. Hurwitz for February 20, 2019. Attached hereto as **Exhibit 1** is a true and correct copy of the deposition notice for the deposition of Dr. Hurwitz for February 20, 2019.

5. Defendants then, at the agreement of Plaintiffs, re-noticed the deposition of Dr. Hurwitz for August 2, 2019. Attached hereto as **Exhibit 2** is a true and correct copy of the deposition notice for the deposition of Dr. Hurwitz for August 2, 2019.

6. On July 16, 2019, the parties appeared before the Honorable Joanna Kishner to request a continuance of trial at the scheduled status check conference. The parties both agreed to continue trial. The parties went back and forth in an attempt to formalize the continuance with the Court. An extension of the discovery deadlines was discussed amongst the parties. The parties agreed the depositions of Dr. Ripplinger and Dr. Hurwitz could be accomplished within an extended discovery period to be established once the Court officially continued trial.

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1 7. After the Court advised that the trial continuance would not be granted,
2 Defendants re-noticed the deposition of Dr. Hurwitz for September 18, 2019. Attached
3 hereto as **Exhibit 3** is a true and correct copy of the deposition notice for the deposition
4 of Dr. Hurwitz for September 18, 2019.

5 8. The deposition of Dr. Ripplinger was initially noticed for August 2, 2019.
6 Counsel for Dr. Ripplinger requested the date move to a date convenient to Dr. Ripplinger
7 and we agreed to the continuance. Attached hereto as **Exhibit 4** is a true and correct
8 copy of the deposition notice for the deposition of Dr. Ripplinger set for August 2, 2019.

9 9. Counsel for Dr. Ripplinger provided our office with dates for the deposition
10 of Dr. Ripplinger, and we planned to take the deposition of Dr. Ripplinger in the
11 anticipated extended discovery period after the Court finalized the trial continuance
12 requested at the July 16, 2019 status check conference.

13 10. After the Court advised that the trial continuance would not be granted,
14 Defendants re-noticed the deposition of Dr. Ripplinger for September 19, 2019. Attached
15 hereto as **Exhibit 5** is a true and correct copy of the deposition notice for the deposition
16 of Dr. Ripplinger for September 19, 2019.

17 11. Trial is currently scheduled to commence on October 14, 2019.

18 12. Defendants seek to have their Motion heard on an Order Shortening Time,
19 because the Motion cannot be heard as a regularly noticed motion with sufficient time,
20 prior to the September 18, 2019, deposition of Dr. Hurwitz, the September 19, 2019,
21 deposition of Dr. Ripplinger and the October 14, 2019, trial date, to allow for the deposition
22 of Dr. Hurwitz and the deposition of Dr. Ripplinger to be completed and to allow

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1 Defendants the opportunity to meaningfully use the depositions for purposes of their trial
2 preparation.

3 I declare under penalty of perjury under the laws of the State of Nevada that the
4 foregoing is true and correct, and if called to testify, I could competently do so.

5 Executed this 13th day of September, 2019, at Sacramento, California.

6
7
8 /s/ Chad C. Couchot

9 CHAD C. COUCHOT, ESQ.
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DECLARATION OF THOMAS J. DOYLE, ESQ.

I, THOMAS J. DOYLE, declare as follows:

1. I am an attorney at law licensed to practice in the State of Nevada, and I am a partner of the law firm of Schuering Zimmerman & Doyle, LLP, attorneys of record for Defendants.

2. I am making this declaration of support of Defendants' Motion to Compel the Deposition of Dr. Ripplinger and Motion to Extend the Close of Discovery Deadline on an Order Shortening Time (9th Request.)

3. I am making this declaration based upon my personal knowledge and if called to testify, I could and would do so competently.

4. Plaintiffs requested a trial continuance because of scheduling conflicts. The week of July 15, 2019, I traveled to New York with counsel for Plaintiffs, George F. Hand, to complete the depositions of two expert witnesses in this case. At that time, we agreed to a continuance of the October 14, 2019, trial date, and we reasonably anticipated that a trial continuance would be granted. While we were traveling in connection with the July 2019 New York depositions, Mr. Hand and I had a conversation regarding the depositions of Dr. Ripplinger and Dr. Hurwitz. We agreed that the depositions would occur at some future date, once trial was continued and discovery extended. Mr. Hand did not have an objection to our taking of either deposition. We further agreed that Dr. Ripplinger's deposition should occur first to allow for Dr. Hurwitz to potentially author a supplemental report. Our failure to take the depositions of Dr. Hurwitz and Dr. Ripplinger as originally set in July and August 2019, was due to our reasonable reliance on our agreement with Plaintiffs' counsel regarding the depositions of Dr. Hurwitz and Dr. Ripplinger and our reasonable expectation that the trial of this case would be continued.

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6. Pursuant to EDCR 2.34, after learning the October 14, 2019, trial date would not be continued, I have met and conferred with Plaintiffs' counsel regarding the need for the depositions of Dr. Ripplinger and Dr. Hurwitz, now outside of the discovery deadline.

I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct, and if called to testify, I could competently do so.

/s/ Thomas J. Doyle

THOMAS J. DOYLE, ESQ.

1 **MEMORANDUM OF POINTS AND AUTHORITIES**

2 **I.**

3 **BACKGROUND**

4 This medical malpractice action arises from the surgical care and treatment
5 provided to Tatina Farris. The depositions at issue are for Plaintiffs' general surgery expert
6 witness Dr. Hurwitz, and a treating general surgeon Dr. Ripplinger.

7 The parties were diligent in initially setting the depositions of Dr. Hurwitz and
8 Dr. Ripplinger. Defendants initially noticed the deposition of Dr. Hurwitz for February 20,
9 2019. Exhibit 1. Defendants then, at the agreement of Plaintiffs, re-noticed the deposition
10 of Dr. Hurwitz for August 2, 2019. Exhibit 2. The deposition of Dr. Ripplinger was also
11 noticed for August 2, 2019. Exhibit 4.

12 The parties stipulated to continue trial in July 2019, and requested a trial
13 continuance. Declaration of Chad Couchot, ¶ 6. The parties reasonably anticipated trial
14 would be continued and accordingly, the parties planned to take the depositions of
15 Dr. Hurwitz and Dr. Ripplinger once a new discovery deadline was set in connection with
16 the trial continuance. Declaration of Chad Couchot, ¶ 6.

17 In fact, in connection with a series of expert witness depositions in July 2019,
18 Plaintiffs' and Defendants' counsel made agreements regarding the depositions of
19 Dr. Ripplinger and Dr. Hurwitz. Declaration of Thomas J. Doyle, ¶ 4. The parties agreed
20 the depositions of Dr. Ripplinger and Dr. Hurwitz would occur at some future date, once
21 trial was continued and discovery extended. Declaration of Thomas J. Doyle, ¶ 4. There
22 was no objection by Plaintiffs' counsel at that time to the depositions of Dr. Ripplinger or
23 Dr. Hurwitz. Declaration of Thomas J. Doyle, ¶ 4. The parties further agreed that
24 Dr. Ripplinger's deposition should occur first to allow for Dr. Hurwitz to potentially author
25 a supplemental report. Declaration of Thomas J. Doyle, ¶ 4.

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1 On September 5, 2019, the parties learned that the October 14, 2019, trial date
2 would not be continued. Declaration of Thomas J. Doyle, ¶ 5. After the Court advised that
3 the trial continuance would not be granted, Defendants re-noticed the deposition of
4 Dr. Hurwitz for September 18, 2019, and the deposition of Dr. Ripplinger for
5 September 19, 2019. Exhibit 3, Exhibit 5.

6 As of September 12, 2019, Plaintiffs do not object to the September 18, 2019,
7 deposition of Dr. Hurwitz. Plaintiffs do, however, object to the September 19, 2019,
8 deposition of Dr. Ripplinger.

9 **II.**

10 **DISCOVERY COMPLETED TO DATE AND**
11 **REASON OUTSTANDING DISCOVERY NOT COMPLETED**

12 All other depositions and discovery in this case have been completed to date.
13 Dr. Hurwitz' and Dr. Ripplinger's depositions are the only outstanding depositions that
14 need to be completed. Dr. Hurwitz' and Dr. Ripplinger's depositions were not completed
15 within the deadline for discovery because the parties reasonably anticipated their
16 stipulated trial continuance made in July 2019 would be granted and the parties would
17 be able to accomplish the then-agreed upon depositions within the time frame of an
18 extended discovery period associated with the new trial date. After learning on
19 September 5, 2019, that the trial continuance was denied, Defendants re-noticed the
20 depositions of Dr. Hurwitz and Dr. Ripplinger. Plaintiffs do not object to the deposition of
21 Dr. Hurwitz. Plaintiffs have withdrawn their agreement as to the deposition of
22 Dr. Ripplinger.

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III.

ARGUMENT

A. Deposition of Dr. Hurwitz.

A party may depose any person who had been identified as an expert witness, whether retained or non-retained, whose opinions may be presented at trial. NRCp 26(b)(4)(A). If a report from the expert is required, the deposition shall not be conducted until after the report is provided to the opposing party. *Id.*

Here, Plaintiffs disclosed Dr. Hurwitz, as an expert witness to testify at trial that Dr. Barry Rives breached the standard of care with respect to his surgical care of Mrs. Farris. Dr. Hurwitz is expected to provide the only standard of care criticisms of Dr. Rives' care at the time of trial.

While Plaintiffs do not object to the deposition of Dr. Hurwitz, the currently set deposition on September 18, 2019, is outside the close of discovery and the parties therefore require an extension of the discovery deadline to accommodate Dr. Hurwitz' important deposition. Defendants' ability to take the deposition of Dr. Hurwitz, the sole standard of care expert for Plaintiffs at trial, is essential to Defendants' preparation for trial and their preparation of a defense to Plaintiffs' allegation Dr. Rives breached the standard of care in this medical malpractice action.

Defendants' inability to take the deposition of Dr. Hurwitz was not created by Defendants' conduct. Instead, Defendants properly noticed the deposition of Dr. Hurwitz within the confines of the discovery deadlines, but then agreed to re-notice it at a later date, based upon the parties' reasonable and mutual expectation that the October 14, 2019, trial date would be continued. Accordingly, Defendants are entitled to an Order extending the discovery deadline to allow for the agreed upon deposition of Dr. Hurwitz occurring on September 18, 2019.

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1 **B. Deposition of Dr. Ripplinger.**

2 A party may depose any person who had been identified as an expert witness,
3 whether retained or non-retained, whose opinions may be presented at trial.
4 NRCp 26(b)(4)(A). If a report from the expert is required, the deposition shall not be
5 conducted until after the report is provided to the opposing party. *Id.*

6 Here, Dr. Ripplinger is a treating general surgeon who provided care to Mrs. Farris
7 immediately following the surgical care by Dr. Rives that is at issue in this case.
8 Dr. Ripplinger is expected to provide essential testimony regarding the condition of
9 Ms. Farris during the time period at issue.

10 Plaintiffs initially agreed to the continuance of the deposition of Dr. Ripplinger,
11 when the parties reasonably anticipated the October 14, 2019, trial date would be
12 continued. Defendants relied on Plaintiffs' agreement as to the deposition of Dr. Ripplinger
13 in not taking the deposition as originally set at an earlier time. Plaintiffs have subsequently
14 withdrawn their agreement to the deposition of Dr. Ripplinger.

15 The deposition of Dr. Ripplinger is now set for September 19, 2019. As his
16 anticipated testimony is essential to the parties' understanding of Mrs. Farris' physical
17 condition at the time period at issue, his deposition testimony is necessary for Defendants'
18 preparation for trial. Defendants are therefore entitled to an Order compelling his
19 deposition.

20 Additionally, Defendants require the close of discovery deadline be moved to
21 include the September 19, 2019, deposition of Dr. Ripplinger to allow for Defendants to
22 obtain this necessary deposition testimony.

23 Defendants' inability to take the deposition of Dr. Ripplinger was not created by
24 Defendants' conduct. Instead, Defendants properly noticed the deposition of
25 Dr. Ripplinger within the confines of the discovery deadlines, but then agreed to re-notice
26 it at a later date, based upon the parties' reasonable and mutual expectation that the

October 14, 2019, trial date would be continued. Accordingly, Defendants are entitled to an Order extending the discovery deadline to allow for the agreed upon deposition of Dr. Ripplinger occurring on September 19, 2019, and compelling his deposition on that date.

IV.

PROPOSED NEW DISCOVERY SCHEDULE

- | | |
|-----------------------------------|--------------------|
| 1. Last Day to Amend Pleadings | Closed |
| 2. Disclosure of Experts | Closed |
| 3. Disclosure of Rebuttal Experts | Closed |
| 4. Discovery Cut-Off | September 19, 2019 |
| 5. Dispositive Motions Deadline | Closed |

V.

CURRENT TRIAL DATE

The current Trial date is set for October 14, 2019. The proposed amendment to the discovery deadlines will not impact the trial date.

VI.

CONCLUSION

For the reasons stated in more detail above, Defendants are entitled to an Order compelling the deposition of Dr. Ripplinger and extending the close of discovery deadline under NRCP 26(b)(4)(A) because Defendants' failure to take the depositions of Dr. Ripplinger and Dr. Hurwitz during the currently set discovery deadline was based on the parties' mutual plan to continue the trial date, which was denied on September 5, 2019, and Plaintiffs' counsel previously agreed to the depositions of Dr. Ripplinger and Dr. Hurwitz, but withdrew such agreement as to Dr. Ripplinger on September 11, 2019.

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1 Accordingly, Defendants respectfully request an Order compelling the deposition of
2 Dr. Ripplinger on September 19, 2019, and extending discovery to September 19, 2019.

3 Dated: September 13, 2019

4 **SCHUERING ZIMMERMAN & DOYLE, LLP**

5
6 By /s/ Aimee Clark Newberry

7 AIMEE CLARK NEWBERRY

8 Nevada Bar No. 11084

9 400 University Avenue

10 Sacramento, CA 95825-6502

11 (916) 567-0400

12 Attorneys for Defendants BARRY RIVES,
13 M.D. and LAPAROSCOPIC SURGERY OF
14 NEVADA, LLC
15
16
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CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 13th day of September, 2019, service of a true and correct copy of the foregoing:

DEFENDANTS BARRY RIVES, M.D.'S AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S MOTION TO COMPEL THE DEPOSITION OF GREGG RIPPLINGER, M.D. AND EXTEND THE CLOSE OF DISCOVERY (9TH REQUEST) ON AN ORDER SHORTENING TIME

was served as indicated below:

- ☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);
- ☐ served on all parties electronically pursuant to mandatory NEFCR 4(b) , exhibits to follow by U.S. Mail;
- ☐ by depositing in the United States Mail, first-class postage prepaid, enclosed ;
- ☐ by facsimile transmission; or
- ☐ by personal service as indicated.

Attorney

Representing

Phone/Fax/E-Mail

George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129

Plaintiff

702/656-5814
Fax: 702/656-9820
hsadmin@handsullivan.com

/s/ Jodie Chalmers
an employee of Schuering Zimmerman &
Doyle, LLP
1737-10881

EXHIBIT 1

1 THOMAS J. DOYLE
Nevada Bar No. 1120
2 CHAD C. COUCHOT
Nevada Bar No. 12946
3 SCHUERING ZIMMERMAN & DOYLE, LLP
400 University Avenue
4 Sacramento, California 95825-6502
(916) 567-0400
5 Fax: 568-0400
Email: calendar@szs.com

6 KIM MANDELBAUM
Nevada Bar No. 318
7 MANDELBAUM ELLERTON & ASSOCIATES
2012 Hamilton Lane
8 Las Vegas, Nevada 89106
(702) 367-1234
9 Email: filing@memlaw.net

10 Attorneys for Defendants BARRY RIVES, M.D.;
11 LAPAROSCOPIC SURGERY OF NEVADA, LLC

12 DISTRICT COURT

13 CLARK COUNTY, NEVADA

14	TITINA FARRIS and PATRICK FARRIS,	)	CASE NO. A-16-739464-C
15		)	DEPT. NO. 31
16	Plaintiffs,)	
17	vs.	)	NOTICE OF TAKING DEPOSITION OF
18	BARRY RIVES, M.D.; LAPAROSCOPIC	)	DR. MICHAEL HURWITZ
19	SURGERY OF NEVADA, LLC, et al.,)	
20	Defendants.)	

21 TO: ALL PARTIES ABOVE NAMED AND THEIR ATTORNEYS OF RECORD:

22 PLEASE TAKE NOTICE that on Wednesday, February 20, 2019, at 10:00 a.m.,
23 attorneys for Defendants will take the deposition of Dr. Michael Hurwitz.

24 Said deposition will be taken at 510 Superior Avenue, Suite 200G, Newport Beach,
25 California, upon oral examination pursuant to N.R.C.P., Rule 30, before a Notary Public,
26 or before some other officer authorized to administer oaths, and said depositions will

1 continue from day to day until completed.

2 The deponent has been disclosed as an expert in this matter and is required to
3 produce at the deposition the following documentation. Electronic data shall be
4 produced in paper form or in TIFF format on CDs.:

- 5 1. His current curriculum vitae.
- 6 2. Text chapters or journal articles referenced in his curriculum vitae that are
7 relevant to any of the issues in this action.
- 8 3. His complete written file concerning this action.
- 9 4. His complete e-mail or electronic file or records concerning this action,
10 including but not limited to, e-mails to or from plaintiff's counsel.
- 11 5. His billing records.
- 12 6. All scientific, technical or professional texts, treatises, journals or similar
13 publications referred to, considered or relied upon in arriving at or forming any of his
14 opinions.
- 15 7. All scientific, technical or professional texts, treatises, journals or similar
16 publications that he believes are a learned treatise and he plans to refer to or comment
17 on at trial.
- 18 8. All written or electronic general information files maintained by him that are
19 relevant to any of the issues in this action.
- 20 9. His records concerning all other medical malpractice actions in which he
21 has been retained as a expert witness and given a deposition.
- 22 10. His list of cases prepared pursuant to Federal Rule of Civil Procedure 26 or
23 a state statute or for any other reason.
- 24 11. His retainer, fee or other agreements with any expert witness service
25 through which he was retained in this case, together with all documents,
26 correspondence, e-mail, memoranda or other writings received by him from the service

1 or sent by him to the service, including all instructions, internal memoranda and policy
2 statements from the service and all billing statements generated by the service for his
3 work on this case.

4 You are invited to attend and cross examine.

5 Dated: February 6, 2019

6 **SCHUERING ZIMMERMAN & DOYLE, LLP**

7
8 By  _____

9 CHAD C. COUCHOT
10 Nevada Bar No. 12946
11 400 University Avenue
12 Sacramento, CA 95825-6502
13 (916) 567-0400
14 Attorneys for Defendants BARRY RIVES,
15 M.D.; LAPAROSCOPIC SURGERY OF
16 NEVADA, LLC
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CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 6th day of February, 2019, service of a true and correct copy of the foregoing:

NOTICE OF TAKING DEPOSITION OF DR. MICHAEL HURWITZ
was served as indicated below:

- ☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);
- ☐ served on all parties electronically pursuant to mandatory NEFCR 4(b), exhibits to follow by U.S. Mail;
- ☐ by depositing in the United States Mail, first-class postage prepaid, enclosed ;
- ☐ by facsimile transmission; or
- ☐ by personal service as indicated.

Attorney

Representing

Phone/Fax/E-Mail

George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129

Plaintiff

702/656-5814
Fax: 702/656-9820
hsadmin@handsullivan.co
m



An employee of Schuering Zimmerman &
Doyle, LLP
1737-10881

EXHIBIT 2

1 THOMAS J. DOYLE
 Nevada Bar No. 1120
 2 SCHUERING ZIMMERMAN & DOYLE, LLP
 400 University Avenue
 3 Sacramento, California 95825-6502
 (916) 567-0400
 4 Fax: 568-0400
 Email: calendar@szs.com

5 KIM MANDELBAUM
 Nevada Bar No. 318
 6 MANDELBAUM ELLERTON & ASSOCIATES
 2012 Hamilton Lane
 7 Las Vegas, Nevada 89106
 (702) 367-1234
 8 Email: filing@memlaw.net

9
 10 Attorneys for Defendants BARRY RIVES, M.D.;
 LAPAROSCOPIC SURGERY OF NEVADA, LLC

11
 12 DISTRICT COURT
 13 CLARK COUNTY, NEVADA

14	TITINA FARRIS and PATRICK FARRIS,	)	CASE NO. A-16-739464-C
		)	DEPT. NO. 31
15	Plaintiffs,)	
		)	AMENDED NOTICE OF TAKING
16	vs.	)	DEPOSITION OF DR. MICHAEL
		)	HURWITZ
17	BARRY RIVES, M.D.; LAPAROSCOPIC)	
	SURGERY OF NEVADA, LLC, et al.,)	
18)	
	Defendants.)	
19)	

20 TO: ALL PARTIES ABOVE NAMED AND THEIR ATTORNEYS OF RECORD:

21 PLEASE TAKE NOTICE that on Friday, August 2, 2019, at 2:00 p.m., attorneys for
 22 Defendants will take the deposition of Dr. Michael Hurwitz.

23 Said deposition will be taken at Litigation Services, 400 N. Tustin Avenue, Ste.
 24 350, Santa Ana, California, 92705 upon oral examination pursuant to N.R.C.P., Rule 30,
 25 before a Notary Public, or before some other officer authorized to administer oaths,
 26 and said depositions will continue from day to day until completed.

1 The deponent has been disclosed as an expert in this matter and is required to
2 produce at the deposition the following documentation. Electronic data shall be
3 produced in paper form or in TIFF format on CDs.:

- 4 1. His current curriculum vitae.
- 5 2. Text chapters or journal articles referenced in his curriculum vitae that
6 are relevant to any of the issues in this action.
- 7 3. His complete written file concerning this action.
- 8 4. His complete e-mail or electronic file or records concerning this action,
9 including but not limited to, e-mails to or from plaintiff's counsel.
- 10 5. His billing records.
- 11 6. All scientific, technical or professional texts, treatises, journals or similar
12 publications referred to, considered or relied upon in arriving at or forming any of his
13 opinions.
- 14 7. All scientific, technical or professional texts, treatises, journals or similar
15 publications that he believes are a learned treatise and he plans to refer to or
16 comment on at trial.
- 17 8. All written or electronic general information files maintained by him that
18 are relevant to any of the issues in this action.
- 19 9. His records concerning all other medical malpractice actions in which he
20 has been retained as a expert witness and given a deposition.
- 21 10. His list of cases prepared pursuant to Federal Rule of Civil Procedure 26
22 or a state statute or for any other reason.
- 23 11. His retainer, fee or other agreements with any expert witness service
24 through which he was retained in this case, together with all documents,
25 correspondence, e-mail, memoranda or other writings received by him from the
26 service or sent by him to the service, including all instructions, internal memoranda

1 and policy statements from the service and all billing statements generated by the
2 service for his work on this case.

3 You are invited to attend and cross examine.

4 Dated: July 16, 2019

5 **SCHUERING ZIMMERMAN & DOYLE, LLP**

6
7 By /s/ Thomas J. Doyle
8 THOMAS J. DOYLE
9 Nevada Bar No. 1120
400 University Avenue
10 Sacramento, CA 95825-6502
(916) 567-0400
11 Attorneys for Defendants BARRY RIVES,
M.D.; LAPAROSCOPIC SURGERY OF
NEVADA, LLC
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CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 16th day of July, 2019, service of a true and correct copy of the foregoing:

AMENDED NOTICE OF TAKING DEPOSITION OF DR. MICHAEL HURWITZ
was served as indicated below:

- ☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);
☐ served on all parties electronically pursuant to mandatory NEFCR 4(b) , exhibits to follow by U.S. Mail;

Attorney

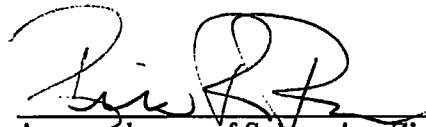
George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129

Representing

Plaintiff

Phone/Fax/E-Mail

702/656-5814
Fax: 702/656-9820
hsadmin@handsullivan.com


An employee of Schuering Zimmerman
& Doyle, LLP
1737-10881

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 6 MANDELBAUM ELLERTON & ASSOCIATES
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 7 Las Vegas, Nevada 89106
 (702) 367-1234
 8 Email: filing@memlaw.net

9
 10 Attorneys for Defendants BARRY RIVES, M.D.;
 LAPAROSCOPIC SURGERY OF NEVADA, LLC
 11

12 DISTRICT COURT

13 CLARK COUNTY, NEVADA

14	TITINA FARRIS and PATRICK FARRIS,	)	CASE NO. A-16-739464-C
		)	DEPT. NO. 31
15	Plaintiffs,)	
		)	SECOND AMENDED NOTICE OF TAKING
16	vs.	)	DEPOSITION OF DR. MICHAEL
		)	HURWITZ
17	BARRY RIVES, M.D.; LAPAROSCOPIC	)	(Location change only)
	SURGERY OF NEVADA, LLC, et al.,)	
18)	
	Defendants.)	
19)	

20 TO: ALL PARTIES ABOVE NAMED AND THEIR ATTORNEYS OF RECORD:

21 PLEASE TAKE NOTICE that on Friday, August 2, 2019, at 2:00 p.m., attorneys for
 22 Defendants will take the deposition of Dr. Michael Hurwitz.

23 Said deposition will be taken at 510 Superior Ave., Ste. 200G, Newport Beach,
 24 California, 92663 upon oral examination pursuant to N.R.C.P., Rule 30, before a Notary
 25 Public, or before some other officer authorized to administer oaths, and said
 26 depositions will continue from day to day until completed.

1 The deponent has been disclosed as an expert in this matter and is required to
2 produce at the deposition the following documentation. Electronic data shall be
3 produced in paper form or in TIFF format on CDs.:

- 4 1. His current curriculum vitae.
- 5 2. Text chapters or journal articles referenced in his curriculum vitae that
6 are relevant to any of the issues in this action.
- 7 3. His complete written file concerning this action.
- 8 4. His complete e-mail or electronic file or records concerning this action,
9 including but not limited to, e-mails to or from plaintiff's counsel.
- 10 5. His billing records.
- 11 6. All scientific, technical or professional texts, treatises, journals or similar
12 publications referred to, considered or relied upon in arriving at or forming any of his
13 opinions.
- 14 7. All scientific, technical or professional texts, treatises, journals or similar
15 publications that he believes are a learned treatise and he plans to refer to or
16 comment on at trial.
- 17 8. All written or electronic general information files maintained by him that
18 are relevant to any of the issues in this action.
- 19 9. His records concerning all other medical malpractice actions in which he
20 has been retained as a expert witness and given a deposition.
- 21 10. His list of cases prepared pursuant to Federal Rule of Civil Procedure 26
22 or a state statute or for any other reason.
- 23 11. His retainer, fee or other agreements with any expert witness service
24 through which he was retained in this case, together with all documents,
25 correspondence, e-mail, memoranda or other writings received by him from the
26 service or sent by him to the service, including all instructions, internal memoranda

1 and policy statements from the service and all billing statements generated by the
2 service for his work on this case.

3 You are invited to attend and cross examine.

4 Dated: July 25, 2019

5 **SCHUERING ZIMMERMAN & DOYLE, LLP**

6
7 By /s/ Thomas J. Doyle
8 THOMAS J. DOYLE
9 Nevada Bar No. 1120
400 University Avenue
Sacramento, CA 95825-6502
(916) 567-0400
10 Attorneys for Defendants BARRY RIVES,
11 M.D.; LAPAROSCOPIC SURGERY OF
NEVADA, LLC
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 25th day of July, 2019, service of a true and correct copy of the foregoing:

SECOND AMENDED NOTICE OF TAKING DEPOSITION OF DR. MICHAEL HURWITZ
was served as indicated below:

- ☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);
☐ served on all parties electronically pursuant to mandatory NEFCR 4(b) , exhibits to follow by U.S. Mail;

Attorney

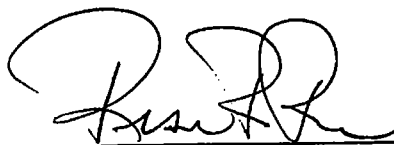
George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129

Representing

Plaintiff

Phone/Fax/E-Mail

702/656-5814
Fax: 702/656-9820
hsadmin@handsullivan.com



An employee of Schuering Zimmerman
& Doyle, LLP
1737-10881

EXHIBIT 3

1 THOMAS J. DOYLE
Nevada Bar No. 1120
2 SCHUERING ZIMMERMAN & DOYLE, LLP
400 University Avenue
3 Sacramento, California 95825-6502
(916) 567-0400
4 Fax: 568-0400
Email: calendar@szs.com

5 KIM MANDELBAUM
Nevada Bar No. 318
6 MANDELBAUM ELLERTON & ASSOCIATES
2012 Hamilton Lane
7 Las Vegas, Nevada 89106
(702) 367-1234
8 Email: filing@memlaw.net

9
10 Attorneys for Defendants BARRY RIVES, M.D.;
LAPAROSCOPIC SURGERY OF NEVADA, LLC
11

12 DISTRICT COURT

13 CLARK COUNTY, NEVADA

14	TITINA FARRIS and PATRICK FARRIS,	)	CASE NO. A-16-739464-C
15	Plaintiffs,	)	DEPT. NO. 31
16	vs.	)	THIRD AMENDED NOTICE OF TAKING
17	BARRY RIVES, M.D.; LAPAROSCOPIC	)	DEPOSITION OF DR. MICHAEL
18	SURGERY OF NEVADA, LLC, et al.,	)	HURWITZ
19	Defendants.)	

20 TO: ALL PARTIES ABOVE NAMED AND THEIR ATTORNEYS OF RECORD:

21 PLEASE TAKE NOTICE that on Wednesday, September 18, 2019, at 2:00 p.m.,
22 attorneys for Defendants will take the deposition of Dr. Michael Hurwitz.

23 Said deposition will be taken at 510 Superior Ave., Ste. 200G, Newport Beach,
24 California, 92663 upon oral examination pursuant to N.R.C.P., Rule 30, before a Notary
25 Public, or before some other officer authorized to administer oaths, and said
26 depositions will continue from day to day until completed.

1 The deponent has been disclosed as an expert in this matter and is required to
2 produce at the deposition the following documentation. Electronic data shall be
3 produced in paper form or in TIFF format on CDs.:

- 4 1. His current curriculum vitae.
- 5 2. Text chapters or journal articles referenced in his curriculum vitae that
6 are relevant to any of the issues in this action.
- 7 3. His complete written file concerning this action.
- 8 4. His complete e-mail or electronic file or records concerning this action,
9 including but not limited to, e-mails to or from plaintiff's counsel.
- 10 5. His billing records.
- 11 6. All scientific, technical or professional texts, treatises, journals or similar
12 publications referred to, considered or relied upon in arriving at or forming any of his
13 opinions.
- 14 7. All scientific, technical or professional texts, treatises, journals or similar
15 publications that he believes are a learned treatise and he plans to refer to or
16 comment on at trial.
- 17 8. All written or electronic general information files maintained by him that
18 are relevant to any of the issues in this action.
- 19 9. His records concerning all other medical malpractice actions in which he
20 has been retained as a expert witness and given a deposition.
- 21 10. His list of cases prepared pursuant to Federal Rule of Civil Procedure 26
22 or a state statute or for any other reason.
- 23 11. His retainer, fee or other agreements with any expert witness service
24 through which he was retained in this case, together with all documents,
25 correspondence, e-mail, memoranda or other writings received by him from the
26 service or sent by him to the service, including all instructions, internal memoranda

1 and policy statements from the service and all billing statements generated by the
2 service for his work on this case.

3 You are invited to attend and cross examine.

4 Dated: September 11, 2019

5 **SCHUERING ZIMMERMAN & DOYLE, LLP**

6
7 By /s/ Thomas J. Doyle
8 THOMAS J. DOYLE
9 Nevada Bar No. 1120
400 University Avenue
Sacramento, CA 95825-6502
(916) 567-0400
Attorneys for Defendants BARRY RIVES,
10 M.D.; LAPAROSCOPIC SURGERY OF
11 NEVADA, LLC
12
13
14
15
16
17
18
19
20
21
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26

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 11th day of September, 2019, service of a true and correct copy of the foregoing:

THIRD AMENDED NOTICE OF TAKING DEPOSITION OF DR. MICHAEL HURWITZ

was served as indicated below:

☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);

Attorney

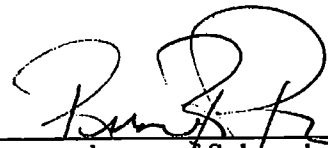
Representing

Phone/Fax/E-Mail

George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129

Plaintiff

702/656-5814
Fax: 702/656-9820
hsadmin@handsullivan.com



An employee of Schuering Zimmerman
& Doyle, LLP
1737-10881

EXHIBIT 4

1 THOMAS J. DOYLE
Nevada Bar No. 1120
2 SCHUERER ZIMMERMAN & DOYLE, LLP
400 University Avenue
3 Sacramento, California 95825-6502
(916) 567-0400
4 Fax: 568-0400
Email: calendar@szs.com

5 KIM MANDELBAUM
Nevada Bar No. 318
6 MANDELBAUM ELLERTON & ASSOCIATES
2012 Hamilton Lane
7 Las Vegas, Nevada 89106
(702) 367-1234
8 Email: filing@memlaw.net

9 Attorneys for Defendants BARRY RIVES, M.D.;
10 LAPAROSCOPIC SURGERY OF NEVADA, LLC

11 DISTRICT COURT

12 CLARK COUNTY, NEVADA

13	TITINA FARRIS and PATRICK FARRIS,	)	CASE NO. A-16-739464-C
14		)	DEPT. NO. 31
15	Plaintiffs,)	
16		)	SUBPOENA - CIVIL
17	vs.)	
18	BARRY RIVES, M.D.; LAPAROSCOPIC)	
19	SURGERY OF NEVADA, LLC, et al.,)	
20	Defendants.)	

21 THE STATE OF NEVADA SENDS GREETINGS TO:

22 **DR. GREGG RIPLINGER**
10001 S. Eastern Avenue #200
Henderson, NV 8052
23 (702) 914-2420

24 WE COMMAND YOU, that all and singular business and excuses being set aside,
25 to appear at 10:00 a.m., on the 2nd day of August, 2019, at Litigation Services located at
26 3770 Howard Hughes Parkway, Suite 300, Las Vegas, Nevada, for the purpose of


1 deposition testimony, pursuant to Rule 45(d) of the Nevada Rules of Civil Procedure.

2 FOR FAILURE TO ATTEND you will be deemed guilty of contempt of Court and
3 liable to pay all losses and damages sustained thereby to the parties aggrieved and forfeit
4 One Hundred Dollars (\$100.00) in addition thereto.

5 Dated: July 16, 2019

6 **SCHUERING ZIMMERMAN & DOYLE, LLP**

7
8 By



CHAD C. COUCHOT
Nevada Bar No. 12946
400 University Avenue
Sacramento, CA 95825-6502
(916) 567-0400
Attorneys for Defendants BARRY RIVES,
M.D.; LAPAROSCOPIC SURGERY OF
NEVADA, LLC

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 10th day of July, 2019, service of a true and correct copy of the foregoing:

SUBPOENA - CIVIL

was served as indicated below:

- ☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);
- ☐ served on all parties electronically pursuant to mandatory NEFCR 4(b) , exhibits to follow by U.S. Mail;
- ☐ by depositing in the United States Mail, first-class postage prepaid, enclosed ;
- ☐ by facsimile transmission; or
- ☐ by personal service as indicated.

Attorney

Representing

Phone/Fax/E-Mail

George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129

Plaintiff

702/656-5814
Fax: 702/656-9820
hsadmin@handsullivan.co
m

Schuerer

An employee of Schuerer Zimmerman &
Doyle, LLP
1737-10881

1 THOMAS J. DOYLE
Nevada Bar No. 1120
2 CHAD C. COUCHOT
Nevada Bar No. 12946
3 SCHUERING ZIMMERMAN & DOYLE, LLP
400 University Avenue
4 Sacramento, California 95825-6502
(916) 567-0400
5 Fax: 568-0400
Email: calendar@szs.com

6 KIM MANDELBAUM
Nevada Bar No. 318
7 MANDELBAUM ELLERTON & ASSOCIATES
2012 Hamilton Lane
8 Las Vegas, Nevada 89106
(702) 367-1234
9 Email: filing@memlaw.net

10 Attorneys for Defendants BARRY RIVES, M.D.;
11 LAPAROSCOPIC SURGERY OF NEVADA, LLC

12 DISTRICT COURT

13 CLARK COUNTY, NEVADA

14	TITINA FARRIS and PATRICK FARRIS,	)	CASE NO. A-16-739464-C
15		)	DEPT. NO. 31
16	Plaintiffs,)	
17	vs.	)	NOTICE OF TAKING DEPOSITION OF
18	BARRY RIVES, M.D.; LAPAROSCOPIC	)	DR. GREGG RIPLINGER
19	SURGERY OF NEVADA, LLC, et al.,)	
20	Defendants.)	

21 TO: ALL PARTIES ABOVE NAMED AND THEIR ATTORNEYS OF RECORD:

22 PLEASE TAKE NOTICE that on Friday, August 2, 2019, at 10:00 a.m., attorneys for
23 Defendants will take the deposition of Dr. Gregg Ripplinger.

24 Said deposition will be taken at Litigation Services located at 3770 Howard Hughes
25 Parkway, Suite 300, Las Vegas, Nevada, upon oral examination pursuant to N.R.C.P., Rule
26 30, before a Notary Public, or before some other officer authorized to administer oaths,


1 and said depositions will continue from day to day until completed.

2 You are invited to attend and cross examine.

3 Dated: July 16, 2019

4 **SCHUERING ZIMMERMAN & DOYLE, LLP**

5
6 By


CHAD C. COUCHOT

Nevada Bar No. 12946

400 University Avenue

Sacramento, CA 95825-6502

(916) 567-0400

Attorneys for Defendants BARRY RIVES,
M.D.; LAPAROSCOPIC SURGERY OF
NEVADA, LLC

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 10th day of July, 2019, service of a true and correct copy of the foregoing:

NOTICE OF TAKING DEPOSITION OF DR. GREGG RIPPLINGER
was served as indicated below:

- ☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);
- ☐ served on all parties electronically pursuant to mandatory NEFCR 4(b), exhibits to follow by U.S. Mail;
- ☐ by depositing in the United States Mail, first-class postage prepaid, enclosed ;
- ☐ by facsimile transmission; or
- ☐ by personal service as indicated.

Attorney

Representing

Phone/Fax/E-Mail

George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129

Plaintiff

702/656-5814
Fax: 702/656-9820
hsadmin@handsullivan.co
m

Chiquita

An employee of Schuering Zimmerman &
Doyle, LLP
1737-10881

EXHIBIT 5

1 THOMAS J. DOYLE
 Nevada Bar No. 1120
 2 CHAD C. COUCHOT
 Nevada Bar No. 12946
 3 SCHUERING ZIMMERMAN & DOYLE, LLP
 400 University Avenue
 4 Sacramento, California 95825-6502
 (916) 567-0400
 5 Fax: 568-0400
 Email: calendar@szs.com

6 KIM MANDELBAUM
 Nevada Bar No. 318
 7 MANDELBAUM ELLERTON & ASSOCIATES
 2012 Hamilton Lane
 8 Las Vegas, Nevada 89106
 (702) 367-1234
 9 Email: filing@memlaw.net

10 Attorneys for Defendants BARRY RIVES, M.D.;
 11 LAPAROSCOPIC SURGERY OF NEVADA, LLC

12 DISTRICT COURT
 13 CLARK COUNTY, NEVADA

14	TITINA FARRIS and PATRICK FARRIS,	)	CASE NO. A-16-739464-C
15		)	DEPT. NO. 31
16	Plaintiffs,)	
17	vs.	)	AMENDED NOTICE OF TAKING
18	BARRY RIVES, M.D.; LAPAROSCOPIC	)	DEPOSITION OF DR. GREGG
19	SURGERY OF NEVADA, LLC, et al.,	)	RIPPLINGER
20	Defendants.)	

21 TO: ALL PARTIES ABOVE NAMED AND THEIR ATTORNEYS OF RECORD:

22 PLEASE TAKE NOTICE that on Thursday, September 19, 2019, at 9:00 a.m.,
 23 attorneys for Defendants will take the deposition of Dr. Gregg Ripplinger.

24 Said deposition will be taken at Litigation Services located at 3770 Howard Hughes
 25 Parkway, Suite 300, Las Vegas, Nevada, upon oral examination pursuant to N.R.C.P., Rule
 26 30, before a Notary Public, or before some other officer authorized to administer oaths,

1 and said depositions will continue from day to day until completed.

2 You are invited to attend and cross examine.

3 Dated: September 11, 2019

4 **SCHUERING ZIMMERMAN & DOYLE, LLP**

5
6 By /s/ Chad C. Couchot
7 CHAD C. COUCHOT
8 Nevada Bar No. 12946
9 400 University Avenue
10 Sacramento, CA 95825-6502
11 (916) 567-0400
12 Attorneys for Defendants BARRY RIVES,
13 M.D.; LAPAROSCOPIC SURGERY OF
14 NEVADA, LLC
15
16
17
18
19
20
21
22
23
24
25
26

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 11th day of September , 2019, service of a true and correct copy of the foregoing:

AMENDED NOTICE OF TAKING DEPOSITION OF DR. GREGG RIPPLINGER was served as indicated below:

- ☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);
- ☐ served on all parties electronically pursuant to mandatory NEFCR 4(b) , exhibits to follow by U.S. Mail;
- ☐ by depositing in the United States Mail, first-class postage prepaid, enclosed ;
- ☐ by facsimile transmission; or
- ☐ by personal service as indicated.

Attorney

Representing

Phone/Fax/E-Mail

George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129

Plaintiff

702/656-5814
Fax: 702/656-9820
hsadmin@handsullivan.co
m

/s/ C.Perrault

An employee of Schuering Zimmerman &
Doyle, LLP
1737-10881



[PTD]
 THOMAS J. DOYLE
 Nevada Bar No. 1120
 CHAD C. COUCHOT
 Nevada Bar No. 12946
 SCHUERING ZIMMERMAN & DOYLE, LLP
 400 University Avenue
 Sacramento, California 95825-6502
 (916) 567-0400
 Fax: 568-0400
 Email: calendar@szs.com

KIM MANDELBAUM
 Nevada Bar No. 318
 MANDELBAUM ELLERTON & ASSOCIATES
 2012 Hamilton Lane
 Las Vegas, Nevada 89106
 (702) 367-1234
 Email: filing@memlaw.net

Attorneys for Defendants BARRY RIVES, M.D.;
 LAPAROSCOPIC SURGERY OF NEVADA, LLC

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS,

Plaintiffs,

vs.

BARRY RIVES, M.D.; LAPAROSCOPIC
 SURGERY OF NEVADA, LLC, et al.,

Defendants.

CASE NO. A-16-739464-C
 DEPT. NO. 31

**DEFENDANTS BARRY RIVES, M.D.;
 LAPAROSCOPIC SURGERY OF NEVADA,
 LLC'S NRCP 16.1(A)(3) PRETRIAL
 DISCLOSURE**

Under authority of Rule 16.1(a)(1) of the Nevada Rules of Civil Procedure,
 Defendants BARRY RIVES, M.D. AND LAPAROSCOPIC SURGERY OF NEVADA,
 LLC(Defendants), produces the following pretrial disclosure of witnesses and documents
 pursuant to NRCP 16.1(a)(3).

///

I.**WITNESSES/PARTIES DEFENDANT EXPECTS TO PRESENT AT TRIAL**

1. Barry Rives, M.D.
c/o Thomas J. Doyle
Schuering Zimmerman & Doyle, LLP
400 University Avenue
Sacramento, CA 95825
2. Person Most Knowledgeable
Laparoscopic Surgery of Nevada
c/o Schuering Zimmerman & Doyle, LLP
400 University Avenue
Sacramento, California 95825-6502
3. Bart Carter, M.D., P.C.
2240 West 16th Street
Safford, AZ 85546
4. Brian E. Juell, M.D.
6554 S. McCarran Blvd., Suite B
Reno, Nevada 89509
5. Lance Stone, D.O.
484 Lake Park Avenue
Oakland, CA 94610
6. Sarah Larsen, RN
Olzack Healthcare Consulting
2092 Peace Court
Atwater, CA 95301
7. Bruce Adornato, M.D.
177 Bovet Road, Suite 600
San Mateo, CA 94402
8. Kim Erlich, M.D.
1501 Trousdale Drive, Room 0130
Burlingame, CA 94010
9. Scott Kush, M.D.
101 Jefferson Drive
Menlo Park, CA 94025
10. Erik Volk
1155 Alpine Road
Walnut Creek, CA 94596
11. Naomi Chaney, M.D.
5380 South Rainbow Blvd.
Las Vegas, NV 89118

12. Gregg Ripplinger M.D.
10001 S Eastern Ave #201
Henderson, NV 89052
13. Steven Y. Chinn, M.D.
6950 W. Desert Inn Rd., #110
Las Vegas, NV 89117

II.**WITNESSES/PARTIES DEFENDANT MAY PRESENT AT TRIAL**

1. Titina Farris
c/o George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129
2. Patrick Farris
c/o George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129
3. Thomas Gebhard, M.D.
2400 S Cimarron Rd Ste 100
Las Vegas, NV 89117
4. Matthew Treinen D.O.
5495 S Rainbow Blvd Ste 203
Las Vegas , NV 89118
5. Ravishankar Konchada M.D.
5495 S Rainbow Blvd, Suite 101
Las Vegas, NV, 89118
6. Tanveer Akbar M.D.
520 Fremont Street
Las Vegas, NV 89101
7. Kenneth Mooney M.D.
10001 S Eastern Avenue, Suite 203
Henderson, NV 89052
8. Alka Rebentish M.D.
6088 S Durango Drive 100
Las Vegas, NV 89113
9. Arvin Gupta M.D.
6970 W Patrick Lane, Suite 140
Las Vegas, NV 89113

10. Ali Nauroz M.D.
657 N Town Center Drive
Las Vegas, NV 89144
11. Syed Zaidi M.D.
9280 W Sunset Road, Suite 320
Las Vegas, NV 89148
12. Ashraf Osman M.D.
5380 S Rainbow Blvd, Suite 110
Las Vegas, NV 89118
13. Charles McPherson M.D.
3121 Maryland Pkwy #502
Las Vegas, NV 89109
14. Teena Tandon M.D.
6970 W Patrick Lane, Suite 140
Las Vegas, NV 89113
15. Farooq Shaikh M.D.
3880 S Jones Blvd
Las Vegas, NV 89103
16. Howard Broder M.D.
2865 Siena Heights Drive, Suite 331
Henderson, NV 89052
17. Doreen Kibby PAC
2865 Siena Heights Drive, Suite 331
Henderson, NV 89052
18. Herbert Cordero-Yordan M.D.
2300 Corporate Circle, # 100
Henderson, NV 89074
19. Darren Wheeler, M.D.
4230 Burnham Avenue
Las Vegas, NV 89119

III.

WITNESSES SUBPOENAED FOR TRIAL

At this time, no witnesses have been subpoenaed for trial.

Defendants reserve the right to call any witness listed by any other party to this

case.

///

IV.**DESIGNATION OF WITNESSES WHOSE TESTIMONY MAY BE PRESENTED
BY MEANS OF A DEPOSITION**

1. At this time, Defendants do not anticipate presenting testimony by means of a deposition.

V.**DOCUMENTS DEFENDANT EXPECTS TO PRESENT AT TRIAL**

1. Medical records from Laparoscopic Surgery of Nevada, excluding the note regarding the telephone call dated November 17, 2015.
2. Medical records from St. Rose Dominican Hospital - San Martin Campus.
3. Medical records from Southern Nevada Pain Center.
4. Medical records from Spring Valley Internal Medicine (Dr. Noami Chaney).
5. Imaging studies from St. Rose Dominican Hospital - San Martin Campus.
6. Plaintiffs' responses to written discovery
7. Medical illustrations.

VI.**DOCUMENTS DEFENDANT MAY USE AT TRIAL**

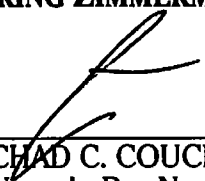
1. Deposition transcript of Plaintiff Titina Farris, including exhibits.
2. Deposition transcript of Plaintiff Patrick Farris, including exhibits.
3. Deposition transcript of Dr. Barry Rives, including exhibits.
4. Deposition transcript of Dr. Noami Chaney, including exhibits.
5. Deposition transcript of Dr. Justin Willer, including exhibits.
6. Deposition transcript of Dr. Alan Stein, including exhibits.
7. Deposition transcript of Dawn Cook, including exhibits.
8. Deposition transcript of Terrence Clauretie, including exhibits.
9. Deposition transcript of Dr. Alex Barchuk, including exhibits.
10. Deposition transcript of Dr. Michael Hurwitz, including exhibits.

11. Report(s) by expert Dr. Brian Juell.
12. Report(s) by expert Dr. Bart Carter.
13. Report(s) by expert Dr. Lance Stone.
14. Report(s) by expert Erik Volk.
15. Report(s) by expert Dr. Bruce Adornato.
16. Report(s) by expert Dr. Kim Erlich.
17. Report(s) by plaintiffs' expert Dr. Barchuk.
18. Report(s) by plaintiffs' expert Ms. Cook.
19. Report(s) by plaintiffs' expert Dr. Willer.
20. Report(s) by plaintiffs' expert Dr. Stein.
21. Report(s) by plaintiffs' expert Mr. Claurette.
22. Report(s) by plaintiffs' expert Dr. Hurwitz.

Dated: September 13, 2019

SCHUERING ZIMMERMAN & DOYLE, LLP

By



CHAD C. COUCHOT
Nevada Bar No. 12946
400 University Avenue
Sacramento, CA 95825-6502
(916) 567-0400
Attorneys for Defendants BARRY RIVES,
M.D.; LAPAROSCOPIC SURGERY OF
NEVADA, LLC

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 13th day of September, 2019, service of a true and correct copy of the foregoing:

**DEFENDANTS BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC'S
NRCP 16.1(A)(3) PRETRIAL DISCLOSURE**

was served as indicated below:

- ☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);
- ☐ served on all parties electronically pursuant to mandatory NEFCR 4(b), exhibits to follow by U.S. Mail;
- ☐ by depositing in the United States Mail, first-class postage prepaid, enclosed ;
- ☐ by facsimile transmission; or
- ☐ by personal service as indicated.

Attorney

Representing

Phone/Fax/E-Mail

George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129

Plaintiff

702/656-5814
Fax: 702/656-9820
hsadmin@handsullivan.co
m



An employee of Schuering Zimmerman &
Doyle, LLP
1737-10881

A.App.82

1 aside, you appear and attend on Monday, October 14, 2019, at the hour of 10:00 a.m., and
2 thereafter from day to day until completed, in Department 31 of the Eighth Judicial District
3 Court, Clark County, Las Vegas, Nevada. The address where you are required to appear
4 is the Regional Justice Center, 200 Lewis Avenue, Courtroom 12B, Las Vegas, Nevada.
5 Your attendance is required to give testimony and/or produce and permit inspection and
6 copy of designated books, documents or tangible things in your possession, custody or
7 control, or to permit inspection of premises. If you fail to attend, you may be deemed
8 guilty of contempt of Court and liable to pay all losses and damages caused by your failure
9 to appear.

10 Please see Exhibit A attached hereto for information regarding the rights of the
11 person subject to this subpoena.

12 **ITEMS TO BE PRODUCED:**

13 Your entire medical chart of TITINA FARRIS.

14 Dated: September 16, 2019

15 **SCHUERING ZIMMERMAN & DOYLE, LLP**

16
17 By _____

18 CHAD C. COUCHOT

19 Nevada Bar No. 12946

20 400 University Avenue

21 Sacramento, CA 95825-6502

22 (916) 567-0400

23 Attorneys for Defendants BARRY RIVES,
24 M.D. and LAPAROSCOPIC SURGERY OF
25 NEVADA, LLC
26

EXHIBIT "A"

NEVADA RULES OF CIVIL PROCEDURE

RULE 45

(c) Protection of Persons Subject to Subpoena.

(1) A party or an attorney responsible for the issuance and service of a subpoena shall take reasonable steps to avoid imposing undue burden or expense on a person subject to that subpoena. The court on behalf of which the subpoena was issued shall enforce this duty and impose upon the party or attorney in breach of this duty an appropriate sanction, which may include, but is not limited to, lost earnings and a reasonable attorney's fee.

(2) (A) A person commanded to produce and permit inspection and copying of designated books, papers, documents or tangible things, or inspection of premises need not appear in person at the place of production or inspection unless commanded to appear for deposition, hearing or trial.

(B) Subject to paragraph (d)(2) of this rule, a person commanded to produce and permit inspection and copying may, within 14 days after service of the subpoena or before the time specified for compliance if such time is less than 14 days after service, serve upon the party or attorney designated in the subpoena written objection to inspection or copying of any or all of the designated materials or of the premises. If objection is made, the party serving the subpoena shall not be entitled to inspect and copy the materials or inspect the premises except pursuant to an order of the court by which the subpoena was issued. If objection has been made, the party serving the subpoena may, upon notice to the person commanded to produce, move at any time for an order to compel the production. Such an order to compel production shall protect any person who is not a party or an officer of a party from significant expense resulting from the inspection and copying commanded.

(3) (A) On timely motion, the court by which a subpoena was issued shall quash or modify the subpoena if it:

- (i) fails to allow reasonable time for compliance;
- (ii) requires a person who is not a party or an officer of a party to travel to a place more than 100 miles from the place where that person resides, is employed or regularly transacts business in person, except that such a person may in order to attend trial be commanded to travel from any such place within the state in which the trial is held, or
- (iii) requires disclosure of privileged or other protected matter and no exception or waiver applies, or
- (iv) subjects a person to undue burden.

(B) If a subpoena

- (i) requires disclosure of a trade secret or other confidential research, development, or commercial information, or

- 1 (ii) requires disclosure of an unretained expert's opinion or
2 information not describing specific events or occurrences in
3 dispute and resulting from the expert's study made not at the
4 request of any party, the court may, to protect a person
5 subject to or affected by the subpoena, quash or modify the
6 subpoena or, if the party in whose behalf the subpoena is
issued shows a substantial need for the testimony or material
that cannot be otherwise met without undue hardship and
assures that the person to whom the subpoena is addressed
will be reasonably compensated, the court may order
appearance or production only upon specified conditions.

7 **(d) Duties in Responding to Subpoena.**

8 (1) A person responding to a subpoena to produce documents shall produce
9 them as they are kept in the usual course of business or shall organize and label them to
correspond with the categories in the demand.

10 (2) When information subject to a subpoena is withheld on a claim that it is
11 privileged or subject to protection as trial preparation materials, the claim shall be made
12 expressly and shall be supported by a description of the nature of the documents,
communications, or things not produced that is sufficient to enable the demanding party
to contest the claim.

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 16th day of September, 2019, service of a true and correct copy of the foregoing:

TRIAL SUBPOENA - CIVIL REGULAR

was served as indicated below:

- ☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);
- ☐ served on all parties electronically pursuant to mandatory NEFCR 4(b), exhibits to follow by U.S. Mail;
- ☐ by depositing in the United States Mail, first-class postage prepaid, enclosed;
- ☐ by facsimile transmission; or
- ☐ by personal service as indicated.

Attorney**Representing****Phone/Fax/E-Mail**

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HAND & SULLIVAN, LLC
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Las Vegas, NV 89129

Plaintiffs

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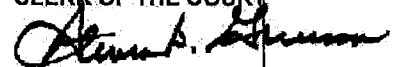
Plaintiffs

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An employee of Schuering Zimmerman &
Doyle, LLP
1737-10881

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CLERK OF THE COURT



1 MOTN

2 KIMBALL JONES, ESQ.

3 Nevada Bar No.: 12982

4 JACOB G. LEAVITT, ESQ.

5 Nevada Bar No.: 12608

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17 Phone: (702) 656-5814

18 Email: GHand@HandSullivan.com

19 Attorneys for Plaintiffs

DEPARTMENT XXXI

NOTICE OF HEARING

DATE 9/26/19 TIME 10:00 am

APPROVED BY [Signature]

DISTRICT COURT

CLARK COUNTY, NEVADA

15 TITINA FARRIS and PATRICK FARRIS,

16 Plaintiffs,

17 vs.

18 BARRY RIVES, M.D.; LAPAROSCOPIC
19 SURGERY OF NEVADA, LLC et al.,

20 Defendants.

CASE NO.: A-16-739464-C

DEPT. NO.: XXXI

HEARING DATE REQUESTED

**PLAINTIFFS' MOTION FOR SANCTIONS UNDER RULE 37 FOR DEFENDANTS'
INTENTIONAL CONCEALMENT OF DEFENDANT RIVES' HISTORY OF
NEGLIGENCE AND LITIGATION AND MOTION FOR LEAVE TO AMEND
COMPLAINT TO ADD CLAIM FOR PUNITIVE DAMAGES ON ORDER SHORTENING
TIME**

21 COMES NOW Plaintiffs PATRICK FARRIS and TITINA FARRIS, by and through their
22 attorneys of record, KIMBALL JONES, ESQ. and JACOB G. LEAVITT, ESQ., with the Law Offices
23 of **BIGHORN LAW** and GEORGE F. HAND, ESQ., with the Law Offices of **HAND &**
24

1 SULLIVAN, LLC, and hereby submit this Motion for Sanctions and for Leave to Amend Complaint
2 to Add a Claim for Punitive Damages on Order Shortening Time ("Motion").

3 This Motion is made and based upon all of the pleadings and papers on file herein and the
4 attached Memorandum of Points and Authorities.

5 DATED this 16th day of September, 2019.

6 **BIGHORN LAW**

7 By: /s/ Kimball Jones

8 **KIMBALL JONES, ESQ.**

9 Nevada Bar.: 12982

10 **JACOB G. LEAVITT, ESQ.**

11 Nevada Bar No.: 12608

12 716 S. Jones Blvd.

13 Las Vegas, Nevada 89107

14 **GEORGE F. HAND, ESQ.**

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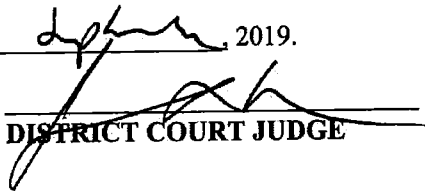
19 *Attorneys for Plaintiffs*

NOTICE OF HEARING

TO: ALL INTERESTED PARTIES, AND THEIR ATTORNEYS OF RECORD

It appearing to the satisfaction of the Court, and good cause appearing therefore, IT IS
 HEREBY ORDERED that the foregoing **MOTION** shall be heard on the 26th day of
September, 2019, at the hour of 10:00 a.m., in the above-noted Courtroom.

DATED this 18 day of September, 2019.


 DISTRICT COURT JUDGE

Respectfully submitted by:

BIGHORN LAW

By: /s/ Kimball Jones

KIMBALL JONES, ESQ.

Nevada Bar.: 12982

JACOB G. LEAVITT, ESQ.

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Nevada Bar No.: 8483

HAND & SULLIVAN, LLC

3442 N. Buffalo Drive

Las Vegas, Nevada 89129

Attorneys for Plaintiffs

Personally 9/19/19 @ 10:00am
 Motion must be filed/served by:

Opposition must be filed/served by: 9/24/19 @ 12pm

Reply must be filed/served by: 9/25/19 @ 12pm

Please provide courtesy copies to Chambers upon filing.

AFFIDAVIT OF KIMBALL JONES, ESQ. IN SUPPORT OF PLAINTIFF'S MOTION AND IN COMPLIANCE WITH EDCR 2.34 AND NRCP 37

STATE OF NEVADA)
) ss
COUNTY OF CLARK)

KIMBALL JONES, ESQ., being first duly sworn, under oath deposes and says:

1. I am an attorney duly licensed to practice law in the State of Nevada and a partner with the Law Offices of Bighorn Law.
2. I am personally familiar with the facts and circumstances surrounding this matter and am competent to testify hereto.
3. On April 17, 2017 Defendant Rives responded to Plaintiffs' request for him to disclose all prior medical malpractice lawsuits.
4. Although in active litigation at the time on the matter, Rives concealed from Plaintiffs the Center case, A-16-731390-C, which occurred only a few months before the subject incident, and which is extraordinarily similar to the case at bar.
5. Like the instant case, the Center case involves a botched hernia repair surgery by Rives wherein Rives negligently punctured a patient's vital organ, failed to correct the error during surgery, failed to properly diagnose the obvious cause of the ensuing sepsis, and ultimately caused his patient's legs to be destroyed for life by failing to timely correct his error while leaving her in a prolonged critical, septic state.
6. Later, at deposition, Rives was again asked about his malpractice history and Rives again failed to note the Center case.
7. During the summer of 2019, I checked the Odyssey database. It became apparent that Defendant Rives had withheld information on the Center case. Nevertheless, I did not know much about the case at that time and provided the name in the deposition was incorrect I had to do more research.

1 8. In August 2019, I obtained information regarding Rives deposition in the Center case, and
 2 on September 10, 2019, I had the opportunity to read Rives deposition testimony in the
 3 Center case for the first time.


4 9. In reading this testimony it became apparent that Rives was untruthful at least, and likely
 5 perjured himself, both in this matter and in the Center matter. Moreover, it demonstrated
 6 that Rives had clear knowledge of the likely permanent consequences to Titina Farris by
 7 his delay tactics, since his prior client—caused by almost identical neglect—had her legs
 8 amputated shortly before he operated on Titina.

10 10. It is clear that though Plaintiffs attempted numerous times to obtain information regarding
 11 Rives history, knowledge, habits and credibility, Defendant concealed pertinent
 12 information, most of which is still unknown by Plaintiffs at the present.

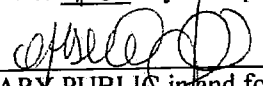
13 11. That there is not adequate time now to cure the prejudice caused by Defendant's
 14 obfuscation of this material evidence absent court involvement.

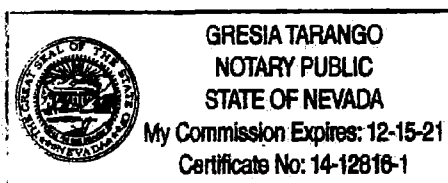
15 12. This Affidavit is made in good faith, and not for the purposes of delay.

16 FURTHER YOUR AFFIANT SAYETH NAUGHT.

17
 18 
 19 KIMBALL JONES, ESQ.

20 SUBSCRIBED AND SWORN to before
 21 me on this 10 day of September, 2019.

22 
 23 NOTARY PUBLIC in and for
 24 CLARK COUNTY, NEVADA



1 **MEMORANDUM OF POINTS AND AUTHORITIES**

2 **I. STATEMENT OF RELEVANT FACTS**

3 Plaintiff Titina Farris was a patient of Defendant Rives. Rives, while performing surgery on
4 Plaintiff, negligently cut her colon in at least two, and possibly three, places. Thereafter, Rives failed
5 to adequately repair the colon and/or sanitize the abdominal cavity. With feces actively in her
6 abdomen, Plaintiff predictably went into septic shock and was transferred to the ICU. Nevertheless,
7 Rives still failed to recommend any surgery to repair the punctured colon for eleven (11) days, during
8 which time Plaintiff's organs began shutting down and her extremities suffered permanent impairment.
9 Ultimately, Plaintiff developed critical care neuropathy, destroying all nerve function in her lower legs
10 and feet, commonly referred to as bilateral drop foot.
11

12 On April 17, 2017, Defendant Rives made sworn responses to Plaintiff Titina's Interrogatory
13 Requests. See Defendant Rives' Interrogatory Responses, attached hereto as **Exhibit "1."** Plaintiff
14 Titina asked if Defendant Rives had ever "been named as a defendant in a lawsuit arising from alleged
15 malpractice or professional negligence? If so, state the court/jurisdiction, the caption and the case
16 number for each lawsuit." *Id.* at No. 3.
17

18 Defendant responded only noting six (6) cases, one (1) of which is the subject action. See Id.
19 It is noteworthy that Defendant failed to mention Vickie Center v. Rives, A-16-731390-C, which was
20 actively in litigation at the time he fraudulently answered the Interrogatory.
21

22 On October 24, 2018, Plaintiff deposed Defendant Rives and asked him the same question.
23 Defendant failed again to admit the existence of the Center case. Then, in an act of improperly
24 coaching the witness, Defendant's attorney stepped in to assist in answering the question:
25

26 MR. COUCHOT: Sinner is not on there?

27 THE WITNESS: Mm-hmm?

28 MR. COUCHOT: Sinner is not on there? Just to be compete, when I prepared this he
 had not been deposed in the Sinner case so that is not listed there. So that would be
 responsive to that question. MR. HAND: What was the name of that case?

 THE WITNESS: Sinner versus Rives.

1 BY MR. HAND: Is it on here? It's not listed here

2 MR. COUCHOT: It's subsequent.

3 BY MR. HAND: Q Can you tell me what that case involved.

4 A Patient had a diaphragmatic hernia tear laparoscopically. She aspirated and became
5 septic. Q Is that still ongoing?

6 A That's pending.

7 Q And you gave a deposition in that case?

8 A Yes.

9 Q Is that a case in Las Vegas?

10 A Yes.

11 *See Deposition of Rives in Farris Case*, attached hereto as **Exhibit "2,"** at Page 13:15-14:11.

12 Defendant failed to note the Center case in his Interrogatory answer. Furthermore, Counsel's
13 argument that the case was "subsequent" is erroneous, as Center v. Rives was open and ongoing when
14 Plaintiff requested to know all medical malpractice cases wherein Rives was a named Defendant.
15 Further, while in many instances such an omission could appear accidental, the omission here appears
16 a coordinated effort to avoid admitting Rives' habit of committing the same medical errors, which
17 have led to similar, life-destroying outcomes for his unfortunate patients.

18 It is noteworthy that the proper name "Center" was not provided and that the incorrect name,
19 "Sinner" was used instead. Moreover, Rives' description of "Sinner" is an entirely erroneous
20 description of the events that took place, assuming "Sinner" was referring to the Center matter. For
21 example, in Center there is no evidence Center developed sepsis through aspiration. Rather, the
22 concept that sepsis developed through aspiration was entirely ruled out in that matter, on post-op day
23 two (2), and it was abundantly clear sepsis developed, not through at least one (1) hole that Rives
24 negligently cut in Center's stomach, but possibly two (2) holes. Rives' false description—one that
25 made the case seem very different from the case at bar—was seemingly not an accident. For, in
26 deposition of the Center case, Defendant also lied to Plaintiff's Counsel regarding the existence of the
27 subject case, and when finally confronted with the fact that Counsel was aware of the Farris matter,
28 lied again about the relevant facts. First, Rives failed to provide any information about the Farris case
when the call of the question required the same. Next, Rives dodged questions about "any other case"

1 by asking clarifying questions, without noting the Farris case. Then, Rives claimed he had no
2 recollection of "any other case" after being specifically asked no less than three (3) times:

3 Q. · Do you recall any other cases in which you were a defendant in a medical
4 malpractice case or it was alleged that you had committed medical practice?

A. · At jury trial or in general?

5 Q. · No, sir. Where a complaint was filed, you had to retain counsel, the matter was
6 either dismissed or settled?

A. · Yes.

7 Q. · Can you just review those for me?

8 A. · The first one was in regards to a patient who had a ductal Luschka leak after a
9 laparoscopic cholecystectomy and was dismissed.

10 Q. · I'm going to take them one at a time, if I could. I apologize for interrupting. It's
11 my interruptions, my failure. When you say that case was dismissed, was there a
12 settlement in that case or was it dismissed?

A. · Dismissed before trial. No payment.

13 Q. · Okay. And I do apologize for interrupting you. What is the next case that you
14 remember that you were a defendant in a medical malpractice case?

15 A. · There was a case where a patient had an anterior/posterior spine fusion, had a
16 colonic perforation from that procedure. Was transferred to Spring Valley where I had
17 to take her emergently to the OR, perform a life-saving surgery, an ostomy. The patient
18 actually did well. I had to reverse her ostomy. But because the lawyer named
19 everybody in the suit, I was named in that suit. And I was dismissed about two or three
20 months after being named in the suit.

Q. · And that was without payment?

A. · That was without payment, yes.

17 Q. · Can you remember any other lawsuit in which you were a defendant in a
18 medical malpractice case?

A. · Those two and the ones that I went to trial.

19 Q. · Okay. Do you -- do you recall whether or not you were a defendant in any
20 other medical malpractice case in this jurisdiction or anywhere else?

A. · No.

21 See Deposition of Rives in Center Case, attached hereto as Exhibit "3," at Page 8:8-10:3.

22 Finally, after Plaintiff's counsel in the Center case presented Rives with evidence of the Farris
23 case—despite Rives' failure to disclose the same—Rives lied about the facts of the matter.

24 Q. · With regards to the next case, Farris versus Rives, is that case still ongoing?

25 A. · Yes

26 Q. · And in ten words or less, can you -- you don't have to do it in ten words or less, but
27 can you just give us a brief description of what that -- the allegations are in that case?

28 A. · Patient had a laparoscopic hernia repair and resulted in a colocutaneous fistula
postoperatively that required subsequent surgery.

See Id. at Page 18:3-12.

1 As the Court is well aware, this was an erroneous description of the facts of the case at bar. In
2 the instant matter, Plaintiff Titina's colon was punctured and Defendant Rives failed to sanitize
3 Plaintiff's colon, and then failed to recommend surgery for eleven (11) days afterwards. There was no
4 fistula complication at all. Furthermore, Rives failed to take note of sepsis and failed to recommend
5 surgery. As a result, Plaintiff Titina suffered complete nerve destruction in her lower legs and feet and
6 is now unable to walk without assistance, facts that certainly would have been of interest in a case
7 where virtually identical neglect took place and a similar injury resulted, with Ms. Center's feet
8 ultimately amputated.

10 It is apparent that Defendant Rives has sought to hide the existence of Farris from Center, and
11 to hide the existence of Center from Farris, going so far as to give false deposition testimony and fail
12 to give proper interrogatory answers.

14 The Center case, which Defendant Rives sought to hide from Plaintiff, involved remarkably
15 similar factual circumstances. Center went to Dr. Rives to be treated for a revision hernia surgery, like
16 Plaintiff Titina in the instant case. See Exhibit 3, at 10:21-25. In Center, Rives punctured Ms. Center's
17 stomach, as opposed to Plaintiff Titina's colon. *Id.* at 14:8-10. Ms. Center developed sepsis the first
18 day after surgery, including septic shock, as did Plaintiff Titina. *Id.* at 11:5-8. Rives then waited eleven
19 (11) days to recommend a second surgery in both cases, even though the source of the sepsis was
20 obvious; all while his patient lay septic with her organs and extremities dying. *Id.* at 69:16-25

22 As a result of Dr. Rives' negligence, complications related to sepsis destroyed Ms. Farris'
23 nerves in her lower legs and feet completely, making them somewhat less useful than prosthetics,
24 while continuing to be susceptible to injury and require care and treatment; similarly, the sepsis slowed
25 the blood flow to Ms. Center's feet to the point that they had to be amputated.

27 Rives has lied to both Center and Farris under oath about the existence of the other incident,
28 and later on the nature of the injuries the other person sustained. This deliberate obfuscation prevented

1 Plaintiffs from inquiring into the notice which Defendant Rives necessarily would have had of the
2 dangers of perforating organs, sepsis setting in, and failing to immediately recommend surgery in order
3 to correct the damage.

4 The long-incubating sepsis caused catastrophic damage to Plaintiff Titina's feet and resulted
5 in an inability to walk without assistance. Defendant Rives would have known of this danger as he
6 was intimately put on notice of it by his actions in the Center case—a case in which long-incubating
7 sepsis led to catastrophic damage to Center's feet, causing their amputation.

8
9 Defendant Rives' actions, his lies under oath and his failure to correct these omissions, are
10 incredibly prejudicial. Plaintiffs only found out about the Center case by a search through Odyssey.
11 Defendant Rives' explanation of the case, that Ms. Center aspirated, was noted to by wholly
12 incorrect—something he knew for a fact when he was deposed by Plaintiff's Counsel in the Center
13 case:
14

15 Q. · All right. · You've opined today that at the time of your treatment of Ms. Center that
16 you believe that the cause of her sepsis was -- and I will say it wrong again -- but
aspiration · pneumonitis?

17 A. · That is correct.

18 Q. · Okay. · I'm learning. · Now, this bronchoscopy -- I won't go through the entire report
19 · because it's here and it's not your report. · But the last line of the first page, on page 10
of the document, it says, "The most likely etiology of the sepsis is extrapulmonary." ·
Do you see that?

20 A. · Yes, I do.

21 Q. · What does that mean in laymen's terms?

22 A. · It means Dr. Lin felt that the etiology of sepsis was not within her lungs.

23 See Exhibit 3, at Page 126:12-127:2.

24 As such, it is clear that at the time of his deposition in this instant matter, Rives knew that Ms.
25 Center did not aspirate—and certainly that the medical testing rejected such a theory. Yet, he described
26 the nature of the sepsis in that case as being one of aspiration, unrelated to the hole(s) he inadvertently
27 cut into her stomach. No note is made of Ms. Center's ensuing complications with her feet. No note
28

1 of waiting eleven (11) days to recommend surgery was made. Clearly, this was Defendant Rives' and
 2 Defense Counsel's deliberate attempt to hide the nature of the case.

3 Furthermore, the just-discovered evidence of Rives' actions in Center v. Rives properly results
 4 in a finding of punitive damages against Defendant Rives. He had knowledge of the extremely
 5 dangerous nature of his actions as they had resulted in catastrophic injury mere months before Plaintiff
 6 Titina's own injuries in this matter. As such, Leave should be Granted to allow Plaintiffs to bring a
 7 Claim for Punitive Damages against Defendant Rives.
 8

9 **II. LEGAL ARGUMENT AND ANALYSIS**

10 **A. Legal Authority.**

11 Pursuant to NRCP 16.1(a)(1), a party must, without awaiting a discovery request, provide to
 12 other parties:
 13

14 (A) The name and, if known, the address and telephone number of each
 15 individual likely to have information discoverable under Rule 26(b),
 16 including for impeachment or rebuttal, identifying the subjects of the
 17 information;

18 (B) A copy of, or a description by category and location of, all
 19 documents, data compilations, and tangible things that are in the
 20 possession, custody, or control of the party and which are discoverable
 21 under Rule 26(b);

22 ...

23 These disclosures must be made at or within 14 days after the Rule
 24 16.1(b)... A party must make its initial disclosures based on the
 25 information then reasonably available to it and is not excused from
 26 making its disclosures because it has not fully completed its
 27 investigation of the case or because it challenges the sufficiency of
 28 another party's disclosures or because another party has not made its
 disclosures.

NRCP 37(c)(1) states that if a party that fails to comply with Rule 16.1 or 26(e)(1), or to amend
 a prior response to discovery as required by the rules, it is not permitted to use the undisclosed evidence
 at a trial, at a hearing, or on a motion. In addition to or in lieu of this sanction, the Court may impose
 other appropriate sanctions. *Id.* In addition to requiring payment of reasonable expenses, including

1 attorney's fees, these sanctions may include any of the actions authorized under Rule 37(c) and may
 2 include informing the jury of the failure to make the disclosure. The Ninth Circuit has analyzed the
 3 Federal Rule 37 enforcement provision--which mirrors NRCP 37--and noted that it is intended as a
 4 "broadening of the sanctioning power," creating an "automatic sanction" and "provid[ing] a strong
 5 inducement for disclosure of material." *Yeti by Molly, Ltd. v. Deckers Outdoor Corp.*, 259 F.3d 1101,
 6 1106 (9th Cir. 2001).

8 NRCP 37(c) authorize case-dispositive sanctions for a party who deliberately lies and who fails
 9 to augment incomplete discovery responses.

10 **(2) Sanctions—Party.** If a party or an officer, director, or managing agent
 11 of a party or a person designated under Rule 30(b)(6) or 31(a) to testify on
 12 behalf of a party fails to obey an order to provide or permit discovery,
 13 including an order made under subdivision (a) of this rule or Rule 35, or if
 14 a party fails to obey an order entered under Rules 16, 16.1, and 16.2, the
 court in which the action is pending may make such orders in regard to the
 failure as are just, and among others the following:

15 (A) An order that the matters regarding which the order was made or any
 16 other designated facts shall be taken to be established for the purposes of
 the action in accordance with the claim of the party obtaining the order;

17 (B) An order refusing to allow the disobedient party to support or oppose
 18 designated claims or defenses, or prohibiting that party from introducing
 designated matters in evidence;

19 (C) An order striking out pleadings or parts thereof, or staying further
 20 proceedings until the order is obeyed, or dismissing the action or
 proceeding or any part thereof, or rendering a judgment by default against
 the disobedient party[.]

21 As sanctions for Defendant Rives' failure to augment his discovery responses, and more
 22 damningly, his decision to lie under oath in depositions with Plaintiff, and with Ms. Center—as well
 23 as in his interrogatory answers, Plaintiffs respectfully request that this Court Order a "case terminating
 24 sanction" and exercise its discretion to Strike Defendant Rives' Answer in this matter.

26 The Court has the power to apply whatever Sanction it finds necessary or reasonable with
 27 respect to litigation abuses by a party, including terminating sanctions. *See Skeen v. Valley Bank of*
 28 *Nevada*, 89 Nev. 301, 303, 511 P.2d 1053, 1054 (Nev. 1973) (holding a "[d]efault judgment will be

1 upheld where the normal adversary process has been halted due to an unresponsive party, because
2 diligent parties are entitled to be protected against interminable delay and uncertainty as to their legal
3 rights"); see also *Schalz v Devitte*, 75 Nev. 124, 126, 335 P.2d 783, 784 (Nev. 1959) (upholding order
4 to strike defendant's answer for failure to appear at a deposition.)
5

6 Defendant Rives' actions are far more vile than the actions of a party that fails to attend a
7 deposition. Defendant Rives repeatedly withheld important information and lied to multiple parties in
8 an attempt to hide from each party the fact that he has at least a history, and more likely a habit, of
9 negligence and that he made similar mistakes in each case. This information, at least, demonstrates
10 the clear objective and subjective foreseeability Defendant Rives had of the damages he was about to
11 cause when he failed to properly care for Plaintiff Titina in this case. Moreover, it demonstrates a
12 pattern of bad behavior and likely is evidence that Defendant Rives habitually engages in negligence
13 under similar circumstances. However, because Defendant Rives omitted and then lied about this
14 information, Plaintiffs had no reasonable opportunity to further investigate this critical and admissible
15 information.
16

17 Other cases note the propriety of ordering case terminating sanctions for spoliation of evidence.
18 Further, in the instant matter, Defendant Rives' actions are tantamount to spoliation. In hiding this
19 evidence, Defendant Rives took from Plaintiffs the opportunity to investigate the matter and/or to
20 question him on the notice he was under and of the danger in which Plaintiff Titina was facing. See
21 *Baglio v. St. John's Queens Hosp.*, 303 A.D.2d 341, 755 N.Y.S.2d 427 (2d Dept. 2003) (Striking an
22 answer is an appropriate remedy where spoliation prevents the other party from proving their case),
23 *Nat'l Ass'n of Radiation Survivors v. Turnage*, 115 F.R.D. 543, 557 (N.D. Cal. 1987) (Where one
24 party wrongfully denies another the evidence necessary to establish a fact in dispute, the court must
25 draw the strongest allowable inferences in favor of the aggrieved party.)
26
27

28 ///

1 In the alternative to a "case terminating sanction", an order finding liability against Defendant
2 Rives would serve to cure some of the prejudice caused by Defendant Rives' actions.

3 At a minimum, should this Court decline to order to above-noted sanction of striking Defendant
4 Rives' Answer, Plaintiffs requests that this Court strike Rives' affirmative defenses and/or, at a
5 minimum, provide an Order noting that Dr. Rives has a pattern of behavior, as noted in both his
6 treatment of Plaintiff Titina and Ms. Center and that the injury he caused Plaintiff Titina was
7 foreseeable and a specifically known consequence of delayed care in this matter. Such will serve in a
8 small way to fight the prejudice which Defendant Rives' actions have caused.
9

10 **B. Striking of Defendant Rives' Answer is Appropriate Due to his Willful Obfuscation of**
11 **Material Evidence, Under NRCP 37.**

12 As noted above, mere months before Defendant Rives endangered Plaintiff Titina, he had made
13 the same surgical mistakes on Ms. Center. In both cases he botched a hernia repair; punctured a vital
14 organ; failed to clean the wound; caused the organ become infected, causing sepsis by post-op day one
15 (1); failed to recommend surgery for eleven (11) days; and destroyed his patients' use of their feet for
16 life, among other damages.
17

18 It is impossible that Defendant Rives was unaware of the nature of Plaintiff Titina's injuries
19 when he spoke to Ms. Center's attorney. Nor is it possible that he was unaware of the nature of Ms.
20 Center's injuries when he spoke to Plaintiffs' attorneys in this matter. Yet, Rives first concealed the
21 reality of the subject event in each case, and he later lied to both parties as to the nature of the other's
22 injuries when questioned.
23

24 Had either party been put on notice of the true nature of the others' injuries, examination of
25 Defendant Rives' notice and specific foreseeability of the probable consequences of his behavior could
26 have been assessed. Defendant Rives' willful lies, under oath, have cost Plaintiffs the opportunity to
27 fully prove this aspect of their case.
28

1 As this opportunity has been lost, Plaintiffs seek herein for an appropriate Sanction. Discovery
2 is closed and trial begins in one (1) month. Thus, options are now limited. Yet, the Striking of
3 Defendant Rives' Answer is an appropriate remedy, which will cure the prejudice which Defendant
4 Rives' subterfuge has caused. As the Court noted in *Skeen* and *Schulz*, disruptive practices properly
5 result in case terminating sanctions. Defendant Rives' actions were far more vile than mere
6 disruption—they were calculated to conceal and distract from pertinent evidence and hide the depth
7 of evidence which lay against Defendant Rives regarding his negligent habits and his specific
8 knowledge of the probable consequences of his negligence in this case. As such, Striking of
9 Defendant's Answer is warranted.
10

11 **C. In the Alternative, this Court should Find Defendant Liable as a Matter of Law.**
12

13 Should this Court wish to not issue a case dispositive Sanction, this Court should Strike
14 Defendant Rives' affirmative defenses and find that Defendant Rives is liable for Plaintiff Titina's
15 injuries. Certainly the elements of liability are met—Rives had a duty to Plaintiffs, he breached those
16 duties, and he caused Plaintiff Titina's horrific injuries. The fact that Rives was keenly aware of the
17 likelihood of sepsis; its appearance; and the need to timely perform surgery to avoid destroying his
18 patient's extremities, properly results in a finding of liability in this matter.
19

20 **D. At a Minimum, a Jury Instruction that Defendant Rives has a Pattern of Behavior is**
21 **Warranted.**

22 Finally, should this Court not find adequate rationale in Defendant Rives' numerous, untrue,
23 sworn statements, a jury instruction noting that Defendant Rives has a pattern of failing to note sepsis
24 in his patients, and that he has lied under oath, should be given. Such an instruction will ultimately not
25 cure the prejudice to Plaintiffs' case in this matter caused by Defendant Rives' lies, but will serve to
26 put the jury on notice as to Defendant Rives' actions.
27

28 ///

///

E. Leave is Properly Granted to Amend Plaintiffs' Complaint to Add a Claim for Punitive Damages.

Leave to Amend shall be freely given when justice so requires. NRCP 15(a). The court should only deny a request to amend when the moving party has demonstrated undue delay, bad faith or dilatory motive or where the amendment would unduly prejudice the opposing party. See *Foman v. Davis*, 371 U.S. 178 (1962). A party must generally seek leave to amend before the deadlines imposed in the discovery scheduling order, or must demonstrate good cause exists for the amendment. See *Nutton v. Sunset Station, Inc.*, 131 Nev. Adv. Rep. 34 (Nev. Ct. App. June 11, 2015). Here, the deadline to amend pleadings or add parties was September 4, 2018. Furthermore, good cause exists to allow Plaintiffs to amend their Complaint based upon Defendant Rives' impeachment in his sworn deposition testimony, which was only fully known to Plaintiffs on September 10, 2019. Obstructing discovery is not permitted under NRCP 37. Defendant Rives and his attorney knew who the Plaintiff was in the other case, neither clarified. This information that was hidden from Plaintiffs is damning to Defendants and for this purpose was hidden. Defendant Rives further failed to clarify in his Interrogatories, as required by the Nevada Rules of Civil Procedure. This cannot be simply dismissed, rather NRCP 37 provides specific remedies.

The Sanction for hiding evidence must be equal to its damaging effect. For hiding evidence, the least Sanction must be finding liability against Defendant Rives. Plaintiffs have not hidden evidence, rather have provided Defendants with a level playing field, Defendants has not, rather Defendant Rives has intentionally hidden evidence, because he knows it will damn him in trial. Defendant Rives cannot point to any nefarious acts by Plaintiffs in discovery. Thus, this Court must even the field and move the needle of prejudice by Sanctioning Defendant Rives appropriately.

Likewise, "Punitive damages are designed to punish and deter a defendant's culpable conduct and act as a means for the community to express outrage and distaste for such conduct." *Countrywide Home Loans, Inc. v. Thitchener*, 124 Nev. 725, 739, 192 P.3d 243 252 (2008); see also *Republic Ins.*

1 v. *Hires*, 107 Nev. 317, 320, 810 P.2d 790, 792 (1991). In the instant matter, punitive damages are
2 properly claimed against Defendant Rives. He had clear knowledge of the specific dangers of
3 perforating organs and of the probable consequence of leaving his patient in a septic state for more
4 than ten (10) days without surgery—yet he failed to do so. Rives' behavior has demonstrated a
5 reckless disregard for the safety and welfare of Plaintiff Titina, amounting to no less than implied
6 malice. As such, Leave is properly Granted to allow Plaintiffs to amend their complaint and bring
7 punitive damages against Defendant Rives.
8

9 **III. CONCLUSION**

10 For the foregoing reasons, Plaintiffs respectfully requests that this Court GRANT Plaintiffs'
11 Motion for Sanctions and Grant Leave to Amend Plaintiffs' Complaint.
12

13 DATED this 16th day of September, 2019.

BIGHORN LAW

14 By: /s/ Kimball Jones

15 **KIMBALL JONES, ESQ.**

16 Nevada Bar.: 12982

JACOB G. LEAVITT, ESQ.

17 Nevada Bar No.: 12608

18 716 S. Jones Blvd.

Las Vegas, Nevada 89107

19 **GEORGE F. HAND, ESQ.**

20 Nevada Bar No.: 8483

HAND & SULLIVAN, LLC

21 3442 N. Buffalo Drive

22 Las Vegas, Nevada 89129

23 *Attorneys for Plaintiffs*
24
25
26
27
28

CERTIFICATE OF SERVICE

Pursuant to NRCP 5, NEFCR 9 and EDCR 8.05, I hereby certify that I am an employee of **BIGHORN LAW**, and on the ____ day of September, 2019, I served the foregoing ***PLAINTIFFS'*** ***MOTION FOR SANCTIONS UNDER RULE 37 FOR DEFENDANTS' INTENTIONAL CONCEALMENT OF DEFENDANT RIVES' HISTORY OF NEGLIGENCE AND LITIGATION AND MOTION FOR LEAVE TO AMEND COMPLAINT TO ADD CLAIM FOR PUNITIVE DAMAGES ON ORDER SHORTENING TIME*** as follows:

☒ Electronic Service – By serving a copy thereof through the Court's electronic service system; and/or

☐ U.S. Mail—By depositing a true copy thereof in the U.S. mail, first class postage prepaid and addressed as listed below:

Kim Mandelbaum, Esq.
MANDELBAUM ELLERTON & ASSOCIATES
2012 Hamilton Lane
Las Vegas, Nevada 89106
&
Thomas J. Doyle, Esq.
Chad C. Couchot, Esq.
SCHUERING ZIMMERMAN & DOYLE, LLP
400 University Avenue
Sacramento, California 95825
Attorneys for Defendants

An employee of **BIGHORN LAW**

EXHIBIT "1"

ELECTRONICALLY SERVED
04/17/2017 01:20:37 PM

[RSPN]
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Email: filing@memlaw.net

Attorneys for Defendants BARRY RIVES, M.D.;
LAPAROSCOPIC SURGERY OF NEVADA, LLC

DISTRICT COURT

CLARK COUNTY, NEVADA

14	TITINA FARRIS and PATRICK FARRIS,	)	CASE NO. A-16-739464-C
15	Plaintiffs,	)	DEPT. NO. 22
16	vs.	)	DEFENDANT DR. BARRY RIVES'
17	BARRY RIVES, M.D.; LAPAROSCOPIC	)	RESPONSE TO PLAINTIFF TITINA
18	SURGERY OF NEVADA, LLC, et al.,	)	FARRIS' FIRST SET OF
19	Defendants.	)	INTERROGATORIES

TO: George F. Hand, Esq., attorney for Plaintiff Titina Farris:

Under authority of Rule 33 of the Nevada Rules of Civil Procedure, Defendant Barry Rives, M.D. hereby respond in writing and under oath to interrogatories directed to him by Plaintiff Titina Farris as follows:

INTERROGATORY NO. 1:

State your full name, professional address and attach a current copy of your

1 curriculum vitae (CV). In the event you do not have a CV, state in detail your professional
2 qualifications, including your education by identifying schools from which you graduated
3 and the degrees granted and dates thereof, your medical internships and residencies,
4 fellowships and a bibliography of your professional writing(s).

5 **RESPONSE TO NO. 1:**

6 Barry James Rives. 10001 S. Eastern Avenue #309, Henderson, NV 89052. A copy
7 of Dr. Rives' curriculum vitae is attached.

8 **INTERROGATORY NO. 2:**

9 State whether you have held any position on a committee or with an administrative
10 body at any hospital, clinic or other similar health care facility. If so, state when you held
11 such position(s) and the duties and responsibilities involved in such position(s).

12 **RESPONSE TO NO. 2:**

13 Not applicable.

14 **INTERROGATORY NO. 3:**

15 Have you every been named as a defendant in a lawsuit arising from alleged
16 malpractice or professional negligence? If so, state the court/jurisdiction, the caption and
17 the case number for each lawsuit.

18 **RESPONSE TO NO. 3:**

19 Objection: irrelevant and not reasonably calculated to lead to the discovery of
20 admissible evidence; constitutional right to privacy; compound; and overbroad and
21 burdensome. Without waiving these objections, Dr. Rives and/or Laparoscopic Surgery
22 of Nevada, to the best of Dr. Rives' recollection, have been named as a defendant in the
23 following actions: Brown v. Rives; Eighth District Court, Clark County Nevada;
24 A-15-718937-C; Farris v. Rives; Eighth District Court, Clark County Nevada; A-16-739464-C;
25 Lang v. Rives; Eighth District Court, Clark County Nevada; A10-618207-C; Doucette v.
26 Garcia; Eighth District Court, Clark County Nevada; A552664; Schorle vs. Southern Hills

1 Hospital; Eighth District Court, Clark County Nevada; A-12-672833-C; and Tucker v. Rives;
2 Eighth District Court, Clark County Nevada; A576148.

3 **INTERROGATORY NO. 4:**

4 Since the institution of this action, have you been asked to appear before or attend
5 any meeting of a medical committee or official board of any medical society or other
6 entity for the purpose of discussing this case? If so, state the date(s) of each such meeting
7 and the name and address of the committee, society or other entity conducting each
8 meeting.

9 **RESPONSE TO NO. 4:**

10 Objection: This interrogatory seeks information protected by the peer review
11 privileges under NRS 49.119 and 49.265. Without waiving these objections: no.

12 **INTERROGATORY NO. 5:**

13 Have you ever testified in court or at deposition in a medical malpractice case in
14 any capacity (e.g., defendant, witness, etc.)? if so, state the court, the caption and the
15 case number of each such case, the approximate date of your testimony, whether you
16 testified as a treating physician or expert and whether you testified on your own behalf
17 or on behalf of the defendant or the plaintiff.

18 **RESPONSE TO NO. 5:**

19 Objection: irrelevant and not reasonably calculated to lead to the discovery of
20 admissible evidence; constitutional right to privacy; compound; and overbroad and
21 burdensome. Without waiving these objections, Dr. Rives has testified in depositions and
22 during trial in the matters of Lang v. Rives; Eighth District Court, Clark County Nevada;
23 A10-618207-C; and Doucette v. Garcia; Eighth District Court, Clark County Nevada;
24 A552664. He gave a deposition in the matter of Tucker v. Rives; Eighth District Court,
25 Clark County Nevada; A576148.

26 ///

1 **INTERROGATORY NO. 6:**

2 If you have authored any professional or scholarly articles, such as medical journal
3 articles, etc., identify the writing in a matter sufficient to enable it to be obtained.

4 **RESPONSE TO NO. 6:**

5 Not applicable.

6 **INTERROGATORY NO. 7:**

7 Has your license to practice medicine ever been suspended or has any disciplinary
8 action ever been taken against you in reference to your license? If so, state the specific
9 disciplinary action taken, the date of the disciplinary action, the reason for the disciplinary
10 action, the period of time for which the disciplinary action was effective and the name
11 and address of the disciplinary entity taking the action.

12 **RESPONSE TO NO. 7:**

13 Not applicable.

14 **INTERROGATORY NO. 8:**

15 State the exact date(s), place(s) and time(s) at which you saw or otherwise
16 rendered treatment or medical advise to the Plaintiff TITINA FARRIS from and including
17 July 3, 2015 to July 16, 2015.

18 **RESPONSE TO NO. 8:**

19 Pursuant to NRCP 33(d), see Titina Farris' medical records from St. Rose
20 Dominican Hospital-San Martin Campus.

21 **INTERROGATORY NO. 9:**

22 Regarding the above times you rendered care or treatment to Plaintiff TITINA
23 FARRIS, what was your assessment, diagnosis and treatment plan for TITINA FARRIS?

24 **RESPONSE TO NO. 9:**

25 Pursuant to NRCP 33(d), see Titina Farris' medical records from St. Rose
26 Dominican Hospital-San Martin Campus.

INTERROGATORY NO. 10:

State the name, author, publisher, title, date of publication and specific provision of all medical texts, books, journals, or other medical literature which you or your attorney intend to use as authority or reference in defending any of the allegations set forth in the Complaint.

RESPONSE TO NO. 10:

Objection: this Interrogatory calls for an expert opinion and seeks information about the disclosure of expert witnesses and the deadline for such disclosure has not yet arrived. As such, this Interrogatory constitutes a premature contention Interrogatory and is subject to supplementation in accordance with the governing discovery deadlines. *Racine v. PHW Las Vegas, LLC*, 2012 U.S. Dist. LEXIS 172632 (D. Nev. Nov. 4, 2012).

INTERROGATORY NO. 11:

Were you named or covered under any policy or policies of liability insurance at the time of the care and treatment alleged in the Complaint? If so, state for each policy:

- a. The name of the insurance company;
- b. The policy number;
- c. The effective policy period;
- d. The maximum liability limits for each person and each occurrence, including umbrella and excess liability coverage; and
- e. The named insured(s) under the policy.

RESPONSE TO NO. 11:

Dr. Barry Rives and Laparoscopic Surgery of Nevada maintained professional liability insurance through ProAssurance Casualty Company. The policy limits were \$1,000,000/\$3,000,000. The policy is attached to Laparoscopic Surgery of Nevada's Response to Plaintiff's Request for Production of Documents.

///

INTERROGATORY NO. 12:

Are you incorporated as a professional corporation or limited liability company (LLC)? If so, state the legal name of your corporation or LLC and the name(s) and address(es) for all shareholders and/or members.

RESPONSE TO NO. 12:

Yes. Laparoscopic Surgery of Nevada LLC; Barry Rives M.D.; 10001 S Eastern Ave # 309, Henderson, NV 89052.

INTERROGATORY NO. 13:

If you are not incorporated as a professional corporation or a member of an LLC, state whether you were affiliated with a corporate medical practice or partnership in any manner on the date of the occurrence alleged in the Complaint. If so, state the name of the corporate medical practice or partnership, the nature of your affiliation and the dates of your affiliation.

RESPONSE TO NO. 13:

Not applicable.

INTERROGATORY NO. 14:

Were you at any time a employee, agent, servant, shareholder or partner of LAPAROSCOPIC SURGERY OF NEVADA LLC? If so, state the date(s) and nature of your relationship.

RESPONSE TO NO. 14:

Yes. Managing Member since May 10, 2007.

INTERROGATORY NO. 15:

At the times of treatment alleged in Plaintiffs' Complaint, were you acting within the course and scope of your employment with LAPAROSCOPIC SURGERY OF NEVADA LLC? If not, were you acting within the course and scope of your employment with any other entity and what was that entity?

RESPONSE TO NO. 15:

Dr. Rives' care of Mrs. Farris was within the course and scope of his employment with Laparoscopic Surgery of Nevada LLC.

INTERROGATORY NO. 16:

State the names, addresses and title(s) of any and all employees of you and/or LAPAROSCOPIC SURGERY OF NEVADA LLC on or about July 3, 2015.

RESPONSE TO NO. 16:

Barry Rives M.D.; 10001 S Eastern Ave # 309, Henderson, NV 89052.

INTERROGATORY NO. 17:

Were any photographs, movies and/or videos taken of the Plaintiff TITINA FARRIS? If so, state the date(s) on which such photographs, movies and/or videotapes were taken, who is displayed therein, who now has custody of them, and the name, address, occupation and employer of the person taking them.

RESPONSE TO NO. 17:

Not applicable.

INTERROGATORY NO. 18:

Do you know any statements, written or oral, made by any person relating to the care and treatment or the damages described in the Complaint? If so, give the name and address of each such witness and the date of the statement, and state whether such statement was written or oral and if written the present location of each such statement.

RESPONSE TO NO. 18:

None other than those documented in Mrs. Farris' medical records.

INTERROGATORY NO. 19:

Have you (or has anyone acting on your behalf) had any conversations with any person at any time with regard to the manner in which the care and treatment described in the Complaint was provided, or have you overheard any statement made by any person

1 at any time with regard to the injuries complained of by the Plaintiff's mother or Plaintiff
 2 or in the manner in which the care and treatment described in the Complaint was
 3 provided? If so, state the following:

- 4 a. The date or dates of such conversation(s) and/or statement(s);
- 5 b. The place of such conversation(s) and/or statement(s);
- 6 c. All persons present for the conversation(s) and/or statement(s);
- 7 d. The matters and things stated by the person in the conversation(s) and/or
 8 statement(s);
- 9 e. Whether the conversation(s) was oral, written and/or recorded; and
- 10 f. Who has possession of the statement(s) if written and/or recorded.

11 **RESPONSE TO NO. 19:**

12 None other than those documented in Mrs. Farris' medical records.

13 **INTERROGATORY NO. 20:**

14 Provide the name and address of each witness who will testify at trial to your
 15 knowledge and state the subject of each witness' testimony.

16 **RESPONSE TO NO. 20:**

17 Objection: vague and ambiguous; and overbroad and burdensome. Further, this
 18 Interrogatory seeks information about the disclosure of expert witnesses and the deadline
 19 for such disclosure has not yet arrived. Without waiving these objections, the witnesses
 20 currently known to Dr. Rives have been identified in his NRCP 16.1 disclosure.

21 **INTERROGATORY NO. 21:**

22 Identify any statements, information and/or documents known to you and
 23 requested by any of the foregoing interrogatories which you claim to be work product or
 24 subject to any common law or statutory privilege, and with respect to each interrogatory,
 25 specify the legal basis for the claim of privilege.

26 ///

RESPONSE TO NO. 21:

Objection: vague and ambiguous. Further, this Interrogatory may seek information about the disclosure of expert witnesses and the deadline for such disclosure has not yet arrived. Without waiving these objections, not applicable.

INTERROGATORY NO. 22:

List the name and addresses of all persons (other than yourself) who have knowledge of the facts regarding the dare and treatment complained of in the Complaint filed herein and/or of the injuries claimed to have resulted therefrom.

RESPONSE TO NO. 22:

Objection: vague and ambiguous; and overbroad and burdensome. Further, this Interrogatory seeks information about the disclosure of expert witnesses and the deadline for such disclosure has not yet arrived. Without waiving these objections, pursuant to NRCP 33(d), see Titina Farris' medical records from St. Rose Dominican Hospital-San Martin Campus. Further, the witnesses currently known to Dr. Rives have been identified in his NRCP 16.1 disclosure.

INTERROGATORY NO. 23:

In your opinion, did the treatment rendered to Plaintiff TITINA FARRIS by any health care provider which forms the basis of her complaint fall below the standard of care? If so, what actions or inactions were below the standard of care, what health care provider's treatment fell beneath the standard of care and what should have been done and when for Plaintiff for the treatment to be within the standard of care?

RESPONSE TO NO. 23:

Objection: this Interrogatory calls for an expert opinion and seeks information about the disclosure of expert witnesses and the deadline for such disclosure has not yet arrived. As such, this Interrogatory constitutes a premature contention Interrogatory and is subject to supplementation in accordance with the governing discovery deadlines.

1 *Racine v. PHW Las Vegas, LLC*, 2012 U.S. Dist. LEXIS 172632 (D. Nev. Nov. 4, 2012).
2 Without waiving these objections, Dr. Rives believes his care of Mrs. Farris was
3 appropriate and within the standard of care.

4 **INTERROGATORY NO. 24:**

5 Do you intend at trial to introduce any evidence of any amount payable as a benefit
6 to the Plaintiff as a result of the injury or death pursuant to United States Social Security
7 Act, any state or federal income disability or worker's compensation act, any health,
8 sickness or income disability insurance, accident insurance that provides health benefits
9 or income disability coverage, and any contract or agreement of any group, organization,
10 partnership or corporation to provide, pay for or reimburse the cost of medical, hospital,
11 dental or other health care services? If so, what is the nature of the evidence you intend
12 to present and for what amount?

13 **RESPONSE TO NO. 24:**

14 Yes. Pursuant to NRS 41.021 defendants in a medical malpractice case may elect
15 to introduce evidence of collateral source payments. The source(s) and amount(s) of
16 such payments are unknown at this time.

17 **INTERROGATORY NO. 25:**

18 Are you aware of any evidence relevant to this case which is now destroyed or
19 otherwise unavailable or not under your control? If so, identify the evidence and its
20 relevance to this case, the last time you saw the evidence and, to your knowledge, the
21 person or entity in control of the evidence.

22 **RESPONSE TO NO. 25:**

23 No.

24 **INTERROGATORY NO. 26:**

25 State the name, address and title of each and every person involved in the care and
26 treatment of TITINA FARRIS from July 3, 2015 to July 16, 2015 at St. Rose Dominican

1 Hospital, San Martin Campus.

2 **RESPONSE TO NO. 26:**

3 Pursuant to NRCP 33(d), see Titina Farris' medical records from St. Rose
4 Dominican Hospital-San Martin Campus. Further, the witnesses currently known to Dr.
5 Rives have been identified in his NRCP 16.1 disclosure.

6 Dated: April 17, 2017

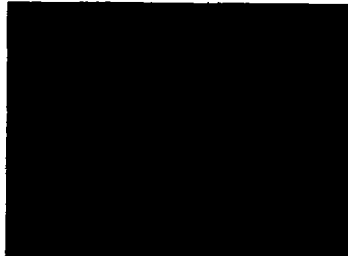
7 **SCHUERING ZIMMERMAN & DOYLE, LLP**

8
9 By 

10 CHAD C. COUCHOT
11 Nevada Bar No. 12946
12 400 University Avenue
13 Sacramento, CA 95825-6502
14 (916) 567-0400
15 Attorneys for Defendants BARRY RIVES,
16 M.D.; LAPAROSCOPIC SURGERY OF
17 NEVADA, LLC
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Curriculum Vitae

Barry J. Rives, M.D.



State Licensure and Insurance

Nevada 10642 Issued 09/03 expire 06/17

California 69943 Issues 10/99 expire 08/17

Nevada pharmacy CS12028 expire 10/17

DEA BR6901361 expire 04/18

NPI 1295751352

Malpractice PIC Wisconsin/ProAssurance policy 67482 retro 01/04 expire 01/18

Societies and Associations

American College of Surgeons

Society of Laparoendoscopic Surgeons

Society of American Gastrointestinal and Endoscopic Surgeons

Hospital Affiliations

St. Rose Siena and De Lima campuses – active

St. Rose San Martin – active

Southern Hills Medical Center - active

Spring Valley Hospital – active

Voluntary resignation from Sunrise Hospital, Summerlin Hospital, Mountainview Hospital, Desert

Springs Hospital, and University Medical Center

Hospital Appointments

Chief of Surgery St. Rose San Martin 2012 – current

Vice Chief of Surgery Southern Hills Hospital and Division Head of General Surgery 2005-2007

Surgical Quality Representative at Southern Hills Hospital, St Rose Hospital all campuses, Sunrise Hospital and Mountainview Hospital various years and timeframes

Surgical Employment

Laparoscopic Surgery of Nevada LLC – 2007 to current, sole owner and manager

8285 W. Arby Ave, Suite ³¹⁰165 Las Vegas NV 89113 phone (702) 253-9644 fax (702) 270-4062

MountainWest Surgical Kevin Rayls PC Las Vegas NV 01/2004-02/2007

Education

Surgical Residency Kern Medical Center Bakersfield CA 07/99-06/03 Chief of Surgery 02/03

Surgical Internship Kern Medical Center Bakersfield CA 07/98-06/99

Doctorate in Medicine Hahnemann University School of Medicine Philadelphia PA 08/94-05/98

Masters of Science in Pharmacology Hahnemann University Graduate School 08/90-05/93

Bachelor of Arts University of California San Diego 08/84-12/88

Major Animal Physiology Minors English Literature and Philosophy

Research

Appendix study for Kern Medical Center – postoperative use of antibiotics 02-03

Research Associate: active member in team comparing the effectiveness of Tenex in children with ADHD

who no longer respond to Ritalin. Responsibilities included implementation of hyperkinesis score, literature search, and clinical evaluation of patients for side effects 08/96-09/97

Thesis Research: "Laser Doppler Flow Studies Associated with CGRP and Serotonin Modulation of Parotid Secretion in Rats" research involved producing protocol, writing and securing grants, developing novel methodology, and organizing data synthesis and analysis. 05/91-05/93

Research Presentation Mid-Atlantic Pharmacological Society Annual Meeting -5/93

Research Presentation Hahnemann University Graduate School Research Day – 04/93

Research Papers

Laparoscopic Inguinal Hernia Repair – KMC Experience 05-02

Acute Intermittent Porphyria and Acute Abdomen – 05/02

Squamous Cell Metaplasia of Urachal Fistula – 04/01

Technical Paper for Transonics Systems Inc " Methodology for P1 Probe Placement and Blood Flow Analysis In Glandular Rat Tissue" 05/09

Technical Paper for Transonics Systems Inc. "Calibration, Time Constraints, and Digital to Analog Output Flow Data – Consideration and Adjustments in High Flow States" 05/93

"Laser Doppler Blood Flow Studies Associated with CGRP and Serotonin Modulation of Acetylcholine Mediated Parotid Secretion in Rats" unpublished 04/93

Honors

Society of Laparoendoscopic Surgeons Outstanding Surgical Resident Award 05/03

Honors Award for Outstanding Academic Achievement Dept of Pharmacology 05/93

Non-Surgical Employment

Owner and Manager of Health Beat INC A Cholesterol Caring Corporation San Diego CA

Organized company to test clients for cholesterol ,triglycerides, glucose, HDL ,and hemoglobin levels using Reflotron and Ektachem analysis. Advised clients about recommended levels, appropriate non-pharmacological reducing plans, and overall health maintenance. Eventually developed management/technical trainees, sold off as franchise. 01/89-05-90

Other Experiences

Volunteer MANNA Philadelphia PA - prepared and delivered lunches and dinners for shut-in victims of AIDS. Also provided information on health maintenance and drug trials. 5/93 – 04/96

Counselor and Instructor ASAP Hahnemann University - counseled and instructed high-risk teens

**in Adolescent Substance Abuse Program about biological and physiological basis for addiction
and the harmful effects of addictive substance on the body and mind. 08/94-05/95**

Mentor and Advanced Biology Instructor HUMRAP Hahnemann University Instructed - high school

**students in Hahnemann University Minority Research and Apprenticeship Program advanced
biology as well as served as research mentor. HUMRAP was designed to prepare minority students
for college basic science curriculums and to support career choices in science 93/94**

Volunteer, Homeless Project, Hahnemann University – assisted physicans and residents in the treatment

and care of the homeless population of Philadelphia. 09/90-06/93

Personal Interests

Former certified instructor rock climbing, archery, and riflery as well as water safety instructor.

Hobbies include volleyball, cycling, soccer, culinary arts, and piano.

VERIFICATION TO FOLLOW

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 17th day of April, 2017, service of a true and correct copy of the foregoing:

DEFENDANT DR. BARRY RIVES' RESPONSE TO PLAINTIFF TITINA FARRIS' FIRST SET OF INTERROGATORIES

was served as indicated below:

- ☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);
- ☐ served on all parties electronically pursuant to mandatory NEFCR 4(b), exhibits to follow by U.S. Mail;
- ☐ by depositing in the United States Mail, first-class postage prepaid, enclosed ;
- ☐ by facsimile transmission; or
- ☐ by personal service as indicated.

Attorney

Representing

Phone/Fax/E-Mail

George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129

Plaintiff

702/656-5814
Fax: 702/656-9820
hsadmin@handsullivan.co
m

Chenault
An employee of Schuering Zimmerman &
Doyle, LLP
1737-10881

EXHIBIT “2”

1 DISTRICT COURT
2 CLARK COUNTY, NEVADA
3
4
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TITINA FARRIS and PATRICK FARRIS,
Plaintiffs,
vs.
BARRY RIVES, M.D.,
LAPAROSCOPIC SURGERY @
NEVADA, LLC, et al,
Defendants.

CASE NO A-16-739484-C
DEPT NO 22

DEPOSITION OF BARRY RIVES, M.D.
Taken on October 24, 2018
At 10:07 a.m.
At Veritex Las Vegas
2250 South Rancho Drive, Suite 193
Las Vegas, Nevada 89102

Yvette Rodriguez, CCR NO. 860

LAS VEGAS REPORTING
scheduling@lvreporting.com
702.803.9363

1 APPEARANCES:
2
3 For the Plaintiffs:
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Las Vegas, NV 89129
702-656-5814
ghandshandsullivan.com
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1 LAS VEGAS, NEVADA, OCTOBER 24, 2018
2 10:07 a.m.
3 -000-
4 (In an off-the-record discussion
5 hold prior to the commencement
6 of the deposition proceedings,
7 counsel agreed to waive the
8 court reporter requirements
9 under Rule 30(b)(4) of the
10 Nevada Rules of Civil
11 Procedure.)
12 -000-
13 Whereupon,
14 BARRY RIVES, M.D.,
15 having been first duly sworn to testify to the
16 truth, the whole truth and nothing but the truth,
17 was examined and testified as follows:
18 -000-
19 MR. HAND: We're premarking certain
20 records as exhibits in this deposition. I will
21 just read what we have premarked: Exhibit 1,
22 Dr. Rives' office records. Exhibit 2,
23 Dr. Rives' progress notes. Exhibit 3,
24 operative report of July 3, 2015. Exhibit 4,
25 operative report of August 7, 2014. Exhibit 5,

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1 Interrogatories responses of Dr. Rivas.
 2 Exhibit 6, Dr. Ripplinger consult of July 9,
 3 2015. Exhibit 7, pathology reports from
 4 Dr. Hamilton's surgery. Exhibit 8, June 12,
 5 2015, CT of abdomen. It's a report.
 6 Exhibit 9, July 5, 2015, CT report. Exhibit
 7 10, July 9, 2015 CT report. July 15, CT
 8 reports is Exhibit 11. Exhibit 12, July 12,
 9 2015, X-ray report. Exhibit 13, Dr. Hamilton,
 10 operative report. And 14 is basically the
 11 consultations and progress notes from July 4th
 12 up until July 16 th. So that is Exhibit 14.

13 --oOo--

14 (Whereupon, Exhibits No. 1
 15 through 14 were marked for
 16 identification.)

17 --oOo--

18 EXAMINATION

19 --oOo--

20 BY MR. HAND:

21 Q Good morning. Can you state your full
 22 name for the record, please.

23 A Barry Rivas, R-I-V-E-S.

24 Q Good morning, Dr. Rivas. My name is
 25 George Hand. I'm one of the attorneys representing

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1 the Titina Farris and Patrick Farris. I'm here
 2 today to take your deposition. My questions are
 3 going to be directed towards your treatment of
 4 Titina Farris back in July 2015.

Well, before I start, have you ever
 6 had your deposition taken before?

7 A Yes.

8 Q About how many times?

9 A Five or seven.

10 Q In what -- under what circumstances were
 11 those taken?

12 A Mostly medical malpractice suits, as
 13 defendant and as witness.

14 Q So you were given, I guess, the usually
 15 admonitions in those cases. Do I need to go through
 16 those with you or do you --

17 A I don't think so. I think I'm fine.

18 Q The one thing is that sometimes the lawyer
 19 and the witness have a tendency to talk over each
 20 other so I just ask you to let me finish my question
 21 so the reporter can get down the question and answer
 22 fully; is that acceptable?

23 A Yes.

24 Q Okay. So are you licensed to practice
 25 medicine in the State of Nevada?

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1 A Yes, I am.

2 Q And when were you licensed?

3 A I got my license in 2003.

4 Q Do you have any specialty?

5 A General surgery.

6 Q Where do you currently have hospital
 7 privileges?

8 A I currently have hospital privileges at
 9 St. Rose Dominican, St. Rose Dilemma, St. Rose San
 10 Martin, Southern Hills Hospital, and Spring Valley
 11 Hospital.

12 Q What medical school did you attend?

13 A Hahnemann University in Philadelphia, PA.

14 Q And did you do any residencies at a
 15 different facility or at that facility?

16 A I did my surgical residency at Kern
 17 Medical Center in Bakersfield, California.

18 Q What years did you do the residency?

19 A 1998 to 2003.

20 Q When did you come to Nevada?

21 A 2003.

22 Q Did you ever practice medicine in any
 23 other state?

24 A No, I have not.

25 Q Do you have any fellowships in any field?

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1 A No, I do not.

2 Q Or are you board certified in any field?

3 A No, I do not.

4 Q Have you taken any board certification
 5 exams?

6 A Yes, I have.

7 Q What have you taken?

8 A American Board of Surgery. Written tests
 9 and oral test.

10 Q When did you take that?

11 A The written test would have been in around
 12 2004 or 2005, and the oral exam would have been a
 13 couple years later, 2007, 2008.

14 Q Did you pass those tests?

15 A I passed the written test. I failed the
 16 oral test. I reapplied to take the test again, but
 17 my time elapsed before I could redo it.

18 Q Are you planning on applying again for
 19 that certification?

20 A I actually have considered that, yes.

21 Q So you took it one time and then

22 A Yes.

23 Q Do you have any special training in
 24 laparoscopic procedures?

25 A I did during my fourth and fifth year of

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1 residency, focused my training on laparoscopic
2 techniques. That included what I was doing at the
3 hospital, as well as going to USC for extra
4 training.

5 Q Prior to July 2015, could you give me an
6 estimate of how many laparoscopic hernia repairs you
7 performed?

8 A All laparoscopic hernias?

9 A Yes. Prior to July 2015?

10 A Well over five hundred.

11 Q Have you written or published any
12 literature involving laparoscopic surgeries?

13 A When I was a resident, I was part of a
14 research paper involving laparoscopic appendectomy
15 and the use of post-operative antibiotics, yes.

16 Q We have marked interrogatory answers you
17 gave. And I believe it has a copy of your CV. And
18 that's Exhibit 5.

19 Dr. Rives, I'm going to show what has
20 been marked as an exhibit. I'll represent it's
21 interrogatory answers, as well as your CV. I just
22 ask you to take a look at that.

23 A You want me to look just at the CV part?

24 Q Yes, for now.

25 A Okay.

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Q Anything on that CV that has to be added
or deleted in any way?

3 A No. Except for the -- maybe the operation
4 dates of my licenses and stuff.

5 Q Can I see those interrogatories again for
6 a second? Thank you.

7 (The report of Dr. Rives was put into
8 practice?)

9 A My solo practice, yes.

10 Q Is that Laparoscopic Surgery of Nevada,
11 LLC?

12 A That is correct.

13 Q How long has that been in existence?

14 A It started in May of 2007. So that's
15 about 11 years.

16 Q And has there ever been any other members
17 of that practice who are physicians?

18 A No.

19 Q Are there any other employees of that
20 practice?

21 A No.

22 Q Where is your office located?

23 A 1110 West Sahara Avenue, Suite 110, Las Vegas,
24 Nevada 89113.

25 Q If I could direct you to Response No.

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11

and the question is if you had ever been named as a
2 defendant in a case arising from alleged malpractice
3 or negligence. So I'm just going to go over these
4 with you. We're on Page 2. There is a case, Brown
5 versus Rives, Eighth District Court. Is that case
6 resolved or still ongoing; do you know?

7 A It is still pending.

8 Q Can you tell me briefly just what the
9 allegations of the case are.

10 A The patient had to have a peritoneal
11 dialysis catheter removed. She had a incisional
12 hernia at the same time. She was very sick. And I
13 made it clear we were just to take care of the PD
14 catheter for infection reasons. She later had to
15 have surgery to repair the incisional hernia and a
16 piece of the peritoneal dialysis catheter was
17 involved in the hernia sac.

18 Q And we have of Lang versus Rives. Can you
19 tell me what the allegations in that case were?

20 A That was a defense verdict. It was a
21 delay in recognizing a enterocutaneous fistula.

22 Q And we have Doucette versus Garcia. Can
23 you tell me what the allegations in that case were.

24 A Again, defense verdict. It was a patient
25 with a perforated colon who was not treated properly.

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1 And I guess the allegation was delay in diagnosis of
2 the lymphoma.

3 Q And there is Schorle versus Southern Hills
4 Hospital. Can you tell me what the allegations in
5 that case were.

6 A The case was a patient who had spinal
7 surgery, had a colon perforation. I ended up doing
8 surgery to repair the colon, gave her an ostomy,
9 ended up reversing the patient's ostomy, but
10 because of the lawsuit, every doctor on chart was
11 named. And I was quickly dropped thereafter.

12 Q And we have a case, Tucker v. Rives. Can
13 you tell me the allegations in that case.

14 A Mr. Tucker had a duct of Luschka leak
15 post-operatively after a laparoscopic colon
16 dissection. I guess it would be complications from
17 surgery.

18 Q Is that case resolved or ongoing?

19 A It was dismissed.

20 Q And looking at Response No. 3, there is
21 notes of depositions you gave in some of these cases
22 we just talked about. Are there any other
23 depositions that you given, such as an expert for
24 patient or for defendant doctor in any cases?

25 A I've testified as a participant in care.

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1 Q What case was that?

2 A There have been a few. One involved a

3 patient who was misdiagnosed with perforated

4 appendicitis, delay in treatment, presented to the

5 OR in distress. I was the surgeon on the case. And

6 the suit was against the internal medicine doctor.

7 There was another suit involving

8 delay in diagnosis of a patient that was treated by

9 a rehab facility, transferred to a hospital. And

10 basically, was not doing well on arrival and there

11 was nothing we could do surgically for her.

12 Q That's it, that you recall?

13 A Those are the two that I can recall at

14 this time.

15 MR. COUCHOT: Sinner is not on there?

16 THE WITNESS: He-hum?

17 MR. COUCHOT: Sinner is not on there?

18 Just to be complete, when I prepared this

19 he had not been deposed in the Sinner case so

20 that is not listed there. So that would be

21 responsive to that question.

22 MR. RAND: What was the name of that case?

23 THE WITNESS: Sinner versus Rivas.

24 BY MR. RAND:

25 Q Is it on here? It's not listed here --

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1 MR. COUCHOT: It's subsequent.

2 BY MR. RAND:

3 Q Can you tell me what that case involved.

4 A Patient had a diaphragmatic hernia tear

5 laparoscopically. She aspirated and became septic.

6 Q Is that still ongoing?

7 A That's pending.

8 Q And you gave a deposition in that case?

9 A Yes.

10 Q Is that a case in Las Vegas?

11 A Yes.

12 Q Have you given any lectures involving

13 hernia repair?

14 A Other than to medical students or

15 residents, no.

16 Q Prior to coming here today, what did you

17 review, if anything?

18 A I reviewed my office notes, progress

19 notes. My progress notes and my operative notes, I

20 think I reviewed some of the radiology findings.

21 Q Did you review any other operative

22 reports?

23 A No.

24 Q Is there anything that you would like to

25 review that you haven't looked at in this case?

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1 A Not in particular.

2 Q Do you have any teaching or academic

3 appointments currently?

4 A No, I do not.

5 Q Have you ever had any teaching or academic

6 appointments?

7 A No.

8 Q In your practice, can you give me just a

9 general description of the kind of cases you handle

10 surgically.

11 A Well, I'm a general surgeon. I handle

12 mostly about 80, 85 percent of my cases are all

13 laparoscopic. All involving the abdomen. That

14 could be anything from diaphragmatic hernia repairs,

15 surgery of foregut, including the esophagus, the

16 stomach, gallbladder, abdominal wall hernias,

17 gastric cancers, colon cancers, bowel obstructions.

18 Pretty much anything inside the abdomen.

19 Q Have you ever had any of your hospital

20 privileges suspended or revoked?

21 A No.

22 Q Have you reviewed any medical literature

23 prior to the deposition?

24 A Ever?

25 Q In preparation for this?

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1 A Oh, as preparation, no.

2 Q I've marked as Exhibit 1, your office

3 chart. I mean -- yes, Exhibit 1. You can take a

4 look at that.

5 Dr. Rivas, can you tell me the first

6 time you saw Titina Farris as a patient?

7 A According to my office record, it was

8 July 31, 2014.

9 Q How did she come to you as a patient?

10 A She was referred to me by Dr. Chaney.

11 Q And Dr. Chaney, is she an internist?

12 A She is a primary care doctor.

13 Q And for what reason was she referred to

14 you?

15 A She was referred to me for a swelling or

16 mass in her upper abdomen.

17 Q And what was your -- did you see Titina

18 and exam her?

19 A Yes, I did.

20 Q And what history did you take from her?

21 A Medical history of hyperlipidemia,

22 hypertension -- excuse me, diabetes,

23 anxiety/depression disorder NOS. Family history of

24 diabetes. Patient was never a smoker and denied the

25 use of alcohol. Reviewed her medications. And she

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1 had no known drug allergies.

2 Q And at some point, did you make a

3 diagnosis as to what her condition was?

4 A I made a diagnosis of lipoma of the skin

5 and subcutaneous tissue.

6 Q What is a lipoma?

7 A Lipoma is a fatty tumor. And by tumor, we

8 just mean mass. The majority of these are benign.

9 They are almost never cancerous.

10 Q Where was it located?

11 A It was located in her upper abdomen along

12 the midline.

13 Q At some point did you schedule a surgery?

14 A Yes, I did.

15 Q And I'll show you -- well, I think you

16 have the operative report in your notes, but I have

17 marked it, the August 7, 2014, operative report. I

18 have it as Exhibit 3.

19 A I have it.

20 Q On that report, was there a statement that

21 you had a hernia?

22 A Yes, that is correct.

23 Q And was that a preperitoneal

24 hernia?

25 A Yes, that was correct.

26 Q And then, was that the procedure

27 performed?

28 A Yes, that was correct.

29 Q And then, was that the procedure

30 performed?

31 A Yes, that was correct.

32 Q And then, was that the procedure

33 performed?

34 A Yes, that was correct.

35 Q And then, was that the procedure

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37 A Yes, that was correct.

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100 A Yes, that was correct.

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1 by the open method?

2 A Well, lipoma is a subcutaneous tumor. You

3 would not do a laparoscopic approach to that. It

4 requires an incision of the skin to remove the

5 tumor.

6 Q So looking at your report -- I'm going to

7 ask you where it says technique.

8 A Yes.

9 Q See where I'm referring to?

10 "Note that there was an incarcerated

11 ventral hernia?"

12 A Correct.

13 Q Before I get into these. Do you have an

14 independent recollection of Mrs. Farria or do you

15 need these records to refresh your memory?

16 A I have some independent recollection, yes.

17 Q What do you remember about her, if you can

18 tell me?

19 A From her first meeting, she was rather

20 short, a little bit on the obese side. She had a

21 shorter abdominal habitus than most people do.

22 Probably a smaller chest cavity than most people do.

23 She was pleasant, fairly forthright, and easy to get

24 along with.

25 Q And then, was that the procedure

26 performed?

27 A Yes, that was correct.

28 Q And then, was that the procedure

29 performed?

30 A Yes, that was correct.

31 Q And then, was that the procedure

32 performed?

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1 coming to the lipoma, there was an area that was

2 distinctly different from the lipoma itself and it

3 appeared to be a incarcerated ventral hernia. Can

4 you tell what a incarcerated ventral hernia is.

5 A A ventral hernia is any abdominal wall

6 defect on anterior abdominal wall. The incarcerated

7 part means that inside the hernia sac is usually

8 something intraabdominal that is quote/unquote

9 "stuck", for lack of a better term.

10 Q So going to Page 2, you state, "The sac

11 contained omentum".

12 Which sac are you referring to, the

13 hernia sac?

14 A Correct.

15 Q And then, was that the procedure

16 performed?

17 A Yes, that was correct.

18 Q And then, was that the procedure

19 performed?

20 A Yes, that was correct.

21 Q And then, was that the procedure

22 performed?

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104 A Yes, that was correct.

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1 hernia. It was a 1.5 cm x 1.5 cm hernia.

2 primary sutures. The recurrence rate of closing it

3 with primary sutures is much higher without mesh.

4 So bridge mesh, for lack of a better term, was

5 necessary.

6 Q Where specifically in the preperitoneal

7 space did you place the mesh?

8 A In the pre -- well, part of it is in the

9 preperitoneal space, but obviously where the defect

10 is gone there is no preperitone. There is no

11 peritoneum at all.

12 Q Do you know how big the piece of mesh was?

13 A I would have to refer to the operative

14 notes by nursing. They usually have that in there.

15 I don't recall off the top of my head.

16 Q How was the mesh inserted? How was it

17 secured?

18 A I secured it to the fascia with Prolene

19 sutures in an interrupted fashion. Then I over

20 sewed the fascia together using Ethibond sutures in

21 an interrupted fashion.

22 Q Then you go down -- and going down further

23 in your report you state, "We closed the

24 subcutaneous layer with 2.0 Vicryl sutures.

25 Numerous sutures were not able to hold despite there

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being very little tension. The tissue was very friable and had been compressed and stretched from the lipoma and from the hernia".

Q And then you go on, you were able to get the subcutaneous layer closed. Were there any complications after the surgery when you closed the patient?

A When I closed the patient, and we went to the PACU, there were no complications.

Q Then did Mrs. Farris come back to see you in June of '15? Does your chart reflect that for a recurrence of a hernia?

A It looks like it was April 30, 2015.

Q Can you read me that note as to her return to your office.

A "History of present illness, postoperatively: Patient says she was doing well after surgery and did not feel the need to come in post-op from surgery in August. Over the last few months, patient says her lipoma has returned and has increased in size. She went to see Dr. Chaney who referred her back to me for evaluation of hematomas/lipoma. Patient says this feels different than prior to her surgery. It is more uncomfortable and occasionally tender to touch. Patient says she

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1 has no nausea or vomiting, no diarrhea or
2 constipation. No signs or symptoms of obstruction.
3 Patient has had no fever and chills. Patient says
4 it is altering her daily activities of living".

Q Did you make a diagnosis as to what her condition was at that appointment?

A At that time, I felt that she had a recurrent ventral hernia. Part of the hernia on physical exam felt slightly different. It wasn't completely reducible. So my plan was to order a CT scan to further evaluate exactly what had gone on post-surgically here.

Q Did you get a CT scan on June 12, 2015? I have it here if you --

A On June 12, 2015 she did get a CT scan of the abdomen and pelvis.

Q What medical significance if any did you attach to this CT scan?

A The impression was that she had a weakening/hernia of the right paracentral anterior abdomen opening, measuring 5.8 cm. The herniated portion measures 7.7 x 0.9. Contains large bowel. There was no obstruction. The significance was that she had recurrence, that she had a large bowel that was inside the hernia, but not strangulated and not

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23

1 obstructed.

Q Was there a treatment plan formulated after you got the CAT scan?

A The treatment plan was for Mrs. Farris to come back in the office to see me to discuss her surgery options.

Q Did you discuss the options with her?

A Yes.

Q Can you tell me, is there anything noted in your chart about the discussions?

A We reviewed how her symptoms were going and discussed the findings on the CT scan. At that time, she said she felt like it was getting bigger. She didn't have signs or symptoms of obstruction. She did say that this was making her nervous regarding her activity level. I re-examined her at that time. And I noted no significant changes from the prior exam, reviewed the CT findings with her. Recurrent abdominal wall hernia. Likely slipped around the prior mesh repair and that large bowel is in the hernia but does not appear to be obstructed and shows no ischemic changes. There is no recurrence of lipoma, which she was concerned about. I recommended laparoscopic ventral hernia repair with mesh. Explained to her all the risks,

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1 benefits, and alternatives in my customary fashion,
2 including possible conversion to open.

3 She wished to proceed. I asked her
4 if she had any questions. And all of her questions
5 were answered to her satisfaction. As she had just
6 recently had surgery, had no changes in her
7 medications or history, I didn't feel like she
8 needed any further a cardiac evaluation before
9 surgery.

Q Why did you recommend laparoscopic approach versus open repair for this procedure?

A Patients recover better from laparoscopic hernia repair than open repair. It has decreased down time for their activity. And especially in somebody who was concerned about being active and getting back to her normal daily activities of living. Also, as you approach a hernia laparoscopically from inside the abdomen, you will get a better appreciation for the anatomy going up inside the defect versus making an incision and coming down on top of it. Especially if there is bowel involved.

Q And was Titina Farris taken to surgery on July 3, 2015?

A Yes.

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1 Q Do you have that report in your chart?

2 A Yeah.

3 Q Looking at this report, would you go to

4 where it states findings.

5 In your report you state,

6 "Visualization of the abdomen revealed an

7 incarcerated incisional hernia with a transverse

8 colon inside the hernia sac". Can you explain what

9 that means.

10 A That's under technique.

11 Q Sorry. You're right. That's under

12 technique, yeah.

13 A So after you obtain pneumoperitoneum, you

14 put a trocar in and you put a camera in. And the

15 camera allows you to visualize the abdomen and

16 allows you to assess the hernia defect and what is

17 inside of it. And visualizing her abdomen, I can

18 see that she had a recurrence of the hernia and that

19 the transverse colon was incarcerated inside that

20 hernia defect.

21 Q That was the same hernia from the surgery

22 in 2014?

23 A That is correct.

24 Q Now, going down on your technique, you

25 talked about reducing the hernia, taking down the

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1 momentum and the transverse colon was severely stuck

2 and adhered to the prior mesh repair.

3 Can you describe what you saw in

4 regard to the transverse colon being severely stuck

5 to the prior mesh.

6 A The transverse colon was adhered and stuck

7 to the prior mesh repair. Sometimes, even a union

8 mesh or a separate mesh or a dual mesh, the tissues

9 will grow into the mesh underneath. So there are

10 not easily to remove from that mesh. You either

11 have to excise part of the mesh with the colon and

12 leave it there, which can cause serious

13 complications down the line or you have to do what

14 you can to remove the mesh entirely from the colon

15 itself.

16 Q And you chose here to approach it in what

17 fashion?

18 A To remove the mesh entirely from the

19 colon.

20 Q So you removed the prior mesh, the whole

21 piece of mesh?

22 A I don't have an independent recollection

23 how much of the mesh I removed according to the mesh

24 that was adhered to the transverse colon.

25 Q Not all of the original mesh, just part of

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1 it?

2 A Let me read my notes real quick. I don't

3 state specifically whether I took all the prior mesh

4 out or not. If the -- in my customary fashion, if

5 the mesh is not causing an obstruction or problem

6 and I can close the defect with the other mesh prior

7 intact, then I will not take the entire mesh out.

8 If you take unnecessary mesh out, you

9 cause more hernia defects and factual defects

10 because you are removing a fair amount of the

11 abdominal wall tissue.

12 Q Do you know the size of the mesh that you

13 inserted in the 2014 surgery?

14 A The 2014?

15 Q When you placed the mesh the first time.

16 A No, I do not recall.

17 Q Is there any note in here of the size of

18 the mesh?

19 A That I placed in 2014 or 2015?

20 Q When you went in the '15, is there any

21 notations as to the size of the mesh?

22 A Yes.

23 Q Where is that?

24 A On the second page. Turning our attention

25 towards the repair of the incisional hernia, 7x9 --

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1 which should say ventralized with Echo. Piece of

2 mesh was placed into the intra abdominal cavity.

3 Q What does it mean, with Echo?

4 A Echo is a insufflation device that is

5 attached to the mesh. And when you put the mesh

6 into the intraabdominal cavity, you grab a little

7 tube and you exteriorize it. And you insufflate

8 air. An Echo device flattens the mesh out so that

9 way when pull it up, it stays flat against the

10 abdominal wall. And that way you can start doing

11 your approximations without the mesh flipping around

12 and making it much more difficult for you to

13 approximate. And that part is obviously excised and

14 taken out later.

15 Q So was mesh removed during this surgery of

16 July 3, 2015?

17 A I don't know if any mesh was removed in

18 relation to the removal from the colon itself. It

19 might have been, yes.

20 Q Was there any pathology sent from this

21 operation, do you know?

22 A I do not recall.

23 Q Have you seen any pathology reports

24 regarding this surgery --

25 A I don't recall --

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Q -- In reviewing the records?

A I don't recall.

Q So what I'm asking you: There is no specific notes that you removed any mesh that was placed in the August '14 surgery?

A No.

Q Going to your report, under technique, where you state, "We began by reducing the hernia, taking down the omentum. The transverse colon is severely stuck and adhered to the prior mesh repair", do you recall how much of the bowel was stuck to the -- or the transverse colon stuck to the prior mesh repair?

A I know it was stuck in at least two places.

Q And you state, "Taking this down, we had used the LigaSure device to extract it from the mesh as the mesh would not come free from the skin".

What is the LigaSure device?

A The LigaSure is a sealing and cutting device. So it will function by, first, sealing the tissue for coagulation purposes. And then it has an associated blade for cutting.

Q Does it have thermal energy attached to it?

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A It has some thermal energy, yes.

Q Did you consider using scissors or a nonthermal device to free the bowel or the colon from the mesh?

A When I assessed what instruments to use, it all depends on what the tissue looks like and what the mesh looks like. In some cases if the adhesions are a little less dense and that I can get away from using scissors, I'll do that. But if the tissue is fairly ingrained, I want to make sure that the tissues coagulate so you don't end up with a lot of bleeding. You just cut native tissue.

I hadn't used the harmonic scalpel in at least five or seven years because of the heat distribution from that particular instrument.

Q Thin you state, "The mesh would not come free from the skin". Can you tell me what you meant by that? What skin were you referring to --

A Well, it is actually referring to the mesh.

Q And you state, "In doing so, this created a small tear in the colon using Endo-GIA blue load".

What is a Endo-GIA blue load?

A An Endo-GIA is a laparoscopic stapling device. Again, it staples in two lines and then it

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has a blade that divides. So that it will remove the tissue from the staple line.

Q Clarify this note. Did the small tear in the colon come from trying to get the mesh out of the -- I mean, getting the colon out of the mesh or was it created with the stapler? I don't understand.

A No. The colectomy was made by getting the colon off of the mesh. Once you have a hole in the colon, there is various ways to repair it. One of the ways is you use a stapling device to close the defect.

Q Did Mrs. Ferris have bowel prep prior to this procedure?

A No, she did not.

Q Did you recommend that?

A No.

Q Why not?

A I don't do val preps for any of my colon or bowel surgeries. It causes an inflammatory cascade. Nowadays, with enhance recovery after surgery, bowel preps are probably about -- most people don't do them 70 percent of the time. Some people are still doing them 30 percent of the time.

Q So do you recall the size of the tear in

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the colon?

A I believe it was about 1 cm, to the best of my recollection.

Q Just to clarify this. You say you placed a 7x0 Venture light. Would that go -- the 7x9 is -- what measurement are you using for that?

A 7x9 inches.

Q So you then state that there was a second small colectomy. What is a colectomy?

A Hole in the colon.

Q Was this through the complete wall of the colon, these holes?

A Full thickness, yeah.

Q Both were full thickness?

A Yes.

Q So the second one, do you know the size of that one?

A It was also around 1 cm.

Q And how did you see these holes?

A Through the laparoscope, yes.

Q How far apart were those holes?

A It's kind of hard to say from an independent recollection. I -- I -- when you have -- it's not like you have the colon straightened out and you can make an exact

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3 measurement. The colon is kind of angulated. So
4 it's kind of hard to say how far one part is away
5 from the other.

6 They were both within -- yeah, I
7 would be guessing. I cannot say for sure.

8 Q When you say "in the colon", what part of
9 colon are you referring to in this report?

10 A Transverse colon.

11 Q And then you state, "The second colotomy
12 was repaired with the Endo-GIA 45 tissue load".
13 Repairing the first one, could you tell me how
14 that -- how you did that. The first colotomy.

15 Q Well, both colotomies were repaired in the
16 same way. First, you look at the tissue, then you
17 decide if it is healthy tissue, will it take a
18 stapling or does it need to be sewed. You look to
19 see if there is excessive stool.

20 If you have a colotomy and all of a
21 sudden there is stool everywhere, then you probably
22 wouldn't want to use a stapling device. So you have
23 to assess the tissue in how well you would do that.
24 Then you basically pinch the tissue so that you're
25 holding the hole closed. You then place the
stapling device below that. And then you apply the

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1 much it takes to close the defect. And then you
2 remove the little tag of tissue behind it. You
3 examine it, look at it, and make sure that it looks
4 closed.

5 Q Did you see any fecal content from either
6 of these colotomies?

7 A No.

8 Q Did you see any stool in the colon?

9 A Yes, but it was not in the colon. It was
10 in the time that you had the colotomy. At the time
11 I was there, I saw stool in the colon. It was the
12 stool that I could see was fairly hard and inside
13 the colon. It was not liquefied or oozing out
14 anywhere.

15 After I repaired the colon and when I
16 repaired the hernia and then re-examined everything
17 again to make sure that there is no stool or soil
18 anywhere else in the abdomen to suggest either, A, a
19 leak I missed or that the staple line hadn't take
20 properly.

21 Q Are you able to run the whole bowel
22 laparoscopically to check if there is any
23 perforations?

24 A You run the bowel that's involved in the
25 area of the surgery, yes. There is no need to run

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1 quote/unquote, "the entire bowel" that was not
2 involved because you're more likely to cause a
3 complication in the tear or somewhere else.

4 Q Was there any washout done of the area
5 where the colotomies were?

6 A Yes. Irrigate drain.

7 Q Where does it say you did that in the
8 report?

9 A It's my customary fashion. I'm not sure
10 whether it says it in the report, but once I do the
11 staple line, I use the -- there is a irrigation
12 device and you can both suction on the staple line
13 to suck off any material, make sure there is
14 nothing. You can irrigate with it as well. You can
15 wash away any debris so that way you have a nice
16 visualization of what you're looking at. And I do
17 that routinely for all my hernia repairs.

18 Q So you repaired both of these with the
19 stapler? You were able to visualize that?

20 A Yes.

21 Q Did you use the Endo-GIA 45 staples you used
22 on the first colotomy?

23 A Yes.

24 Q Did you use the Endo-GIA 45 staples you used
25 on the second colotomy?

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1 A Yes. It looked quite healthy.

2 The second colotomy, did it have any
3 ragged edges?

4 A Yes, but it was not ragged.

5 Q Did you use the Endo-GIA 45 staples you used
6 the second colotomy?

7 A I do not.

8 Q At any time did you consider converting
9 this to an open procedure?

10 A Sure.

11 Q Did you use the Endo-GIA 45 staples you used

12 the second colotomy?

13 A Yes, but it was not ragged.

14 Q Did you use the Endo-GIA 45 staples you used

15 the second colotomy?

16 A Correct.

17 Q And why was that?

18 A Because I saw that the tissue looked
19 healthy. By the time I finished the surgery,
20 everything looked good. There was no evidence of
21 any fecal drainage or soilage. So I was happy with
22 the repairs.

23 If there was was something about the
24 tissue that was tenuous or inflammatory or that it
25 was still leaking, then, of course, I will do
open and convert that to an open procedure.

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1 everything looked healthy, create an anastomosis.
 Q So one of the reasons to go open is if
 3 there is issues with the integrity of the bowel, is
 4 that a fair statement?
 A Yes.
 Q So you didn't feel it was necessary?
 A Correct.
 Q How did you determine if the staple or the
 9 staple repair is satisfactory?
 A First, you look at the staple line to make
 11 sure it's gone. Not just to cover the defect, but a
 12 little bit more on each side of the defect. Then
 13 you look at the overall viability of the tissue
 14 around it. And then you can squeeze the colon with
 15 a clamp and see if any air bubbles come up or if
 16 perforation develops.
 Q Is there an alternative way to repair a
 16 colostomy in the colon other than using a stapler?
 A There is many ways.
 Q Sutures can be used?
 A Sutures can be used, yes.
 Q Assuming a patient is converted to a
 23 laparotomy, can you still use staplers if you choose
 24 or would you use sutures or some other method?
 A You could -- depending on what the bowel

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1 looks like inside the defect, you can suture close,
 you can staple close or you can resect the entire
 3 fecal bowel and do a new anastomosis, if necessary.
 Q Are there advantages to using a stapler
 5 over a suture?
 A No, not really.
 Q Okay. Can you suture a colostomy such as
 the colostomy sutures that Mrs. Rives (sic) had
 9 laparoscopically and maybe suturing or stapling?
 A Mrs. Farris?
 Q Yes.
 A Yes, you could.
 Q You can suture?
 A Yes.
 Q You decided not to suture this but to use
 15 the stapler that you talked about, was healthy and
 16 had a satisfactory closure of the colostomy?
 A It had to do with the size of the defect,
 19 the size of the colon, and the tissue you have. So
 20 if the hole comes together nice and easily without
 21 causing a stricture of the colon with the stapling
 22 device, that is quicker and easier and reduces the
 23 anesthesia time.
 If the hole is a little wider and you
 24 are worried about causing a stricture or a
 25

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constriction by closing it, then I would use sutures
 2 or, if necessary, a laparotomy and resect the bowel.
 Q So you didn't notice any thermal injury to
 the colon or bowel during this procedure?
 A No.
 Q Can you see such a thermal injury,
 7 normally?
 A Sometimes with small bowels, you will be
 9 be able to see branching of the tissue. I noticed
 10 that occasionally when I have used a harmonic
 11 scalpel, using a ligature device, I don't think I
 12 have ever seen that thermal effect.
 Q Then you state, "After success" -- I'm
 14 looking at page -- it's the second page of the
 15 report -- you state, "After successive firings".
 16 What do you mean by firings?
 Explain to me how that works.
 A That means more than one firing of the
 19 stapler. So that means there was at least a minimum
 20 of two firings.
 Q And you state, "The staple lines appear to
 be intact".
 Do you know how many staples you used
 24 in this first colostomy repair?
 A I do not.

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1 Q Do you recall how many staples you used in
 2 the second colostomy repair?
 A I do not.
 Q When you fire the stapler, how many
 5 staples come out per firing?
 A I would have to look at the manufacturer's
 7 list. It's a staple line consistent of multiple
 8 titanium staples. Depending upon the color of the
 9 load, a blue load is a typical tissue load. A green
 10 load is a thick tissue load. It does not change the
 11 number of staples. It changes the staple size. I
 12 do not recall the exact measurements off the top of
 13 my head.
 Q We discussed already the hernia with the
 15 piece of mesh. And specifically, where was that
 16 mesh placed?
 A Into the abdominal cavity.
 Q Do you recall specifically where it was
 19 placed in abdominal cavity?
 A You mean, how did I introduce it?
 Q No. No. Where was it within the cavity.
 A When you first place it in the intra
 23 abdominal cavity, you pull it up against the
 24 abdominal wall, and then you do an approximation and
 25 pack it into place.

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1 Q What was used to pack it into place?
 2 A Secure strap device.
 3 Q Do you know the manufacturer?
 4 A I think it's Ethicon, but I'm not sure.
 5 Q Do you know the color of the straps that
 6 you used?
 7 A It they're kind of a pinkish or purple
 8 color.
 9 Q Explain to me how that is done, how you
 10 mechanically place the mesh and secure it.
 11 A The secure strap device is a laparoscopic
 12 instrument that, as you deploy it, it fires a
 13 bioabsorbable cap that goes through the mesh. So
 14 you start circumferentially as far out as you can,
 15 cause that's where the fascia -- so you make a
 16 circumferential row all the way around.
 17 At that point, you remove the echo
 18 device so that the echo device is not in the way of
 19 doing further approximations. And then, I
 20 typically, or in my customary fashion, continue
 21 doing circumferential rows until I'm satisfied that
 22 the mesh is in place and there is coverage at least
 23 by 2 centimeters around the entire area.
 24 Q And you state, "A small incision was made
 25 at the midline grasping the insufflation tubing".

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1 Can you explain what that was.
 2 A The insufflation tubing is part of the
 3 echo device that I mentioned earlier.
 4 Q Then you state, "It was exteriorized from
 5 the abdomen".
 6 Can you explain that.
 7 A You use is a little grasping device and
 8 you put it through the incision, you grab the
 9 insufflation tube and you pull it up through the
 10 abdominal wall so that it is now on the outside of
 11 the abdomen. You can attach the syringe to it, put
 12 air into it, insufflating the echo device, put a
 13 hemostat on the abdominal wall on top of the
 14 insufflation device where it will hold the pressure.
 15 Q Yeah, you state, "The insufflation device
 16 was deployed and held against the abdominal wall
 17 with a hemostat clamp".
 18 What is a hemostat clamp?
 19 A It's a metal clamp.
 20 Q And then you state, Using you Secure Strap
 21 device, you approximated the mesh circumferentially
 22 around the hernia defect. And going doing further,
 23 you state, "Returning to the abdomen, we continued
 24 further approximation of the SecureStrap device
 25 making sure that we had inner circumferential layer

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1 near the hernia defect in extreme outer
 2 circumferential row and then inner circumferential
 3 rows".
 4 Can you explain what that means.
 5 A You make a circumferential row all the way
 6 round the hernia defect with the SecureStrap device.
 7 When I'm happy that the complete outer ring is
 8 complete, then I do a inner ring. Same thing,
 9 circumferential all the way around. If necessary, I
 10 will do even the third row, if needed.
 11 Q One than you state, "Once it was
 12 adequately approximated covering the hernia defect
 13 by 3-5 cm in all directions, we visualize the
 14 omentum. There was no further evidence of
 15 bleeding".
 16 Okay. Was there bleeding during
 17 there procedure?
 18 A Yes. Some.
 19 Q Where was the bleeding originally from?
 20 A Taking down the omentum out of the
 21 hernia sac.
 22 Q Do you know how much bleeding there was?
 23 A Minimal.
 24 Q And you state, "The colon appeared to be
 25 healthy, viable, no further injuries or tears".

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1 So did you inspect the colon at that
 2 point?
 3 A I inspected it at that point, as well
 4 during, yes.
 5 Q And if there injury or tear, would you
 6 examine that and you would be visualize that before
 7 closing the patient?
 8 A Yes.
 9 Q Were you able to visualize the complete
 10 colon, the whole circumference of the colon during
 11 this procedure?
 12 A Well, the entire circumference of the
 13 colon is not visual anyways so you won't see that
 14 part of the colon. So the part that is visible,
 15 yes.
 16 Q Then you state, "The 12 mm trocar sites
 17 were closed at the fascia level with an 0 Vicryl
 18 stitch in a figure-of-eight fashion". Then later
 19 on, you state, "The patient was extubated in the OR
 20 and transferred to the PACU in stable condition.
 21 She tolerated the procedure well without
 22 complications".
 23 According to this report then, there
 24 were no complications, she was in good condition
 25 with the surgery?

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1 A Yes.

2 Q I have marked your progress notes. I'm

3 referring to Exhibit 2. Will you take a look at

4 those. Do you have a recollection or notes as to

5 the next time you saw the patient after the surgery?

6 A I saw her briefly in the recovery room.

7 And I don't recall when I saw her next, except to

8 what I refer to as in the notes.

9 Q Prior to the surgery, did you meet with

10 the patient to discuss the surgery in the hospital?

11 A Yes, we met in the preoperative holding

12 area.

13 Q Do you recall what was said between you

14 and the patient?

15 A Yes. My customary fashion, I reviewed the

16 indications for surgery. Again, risk, benefits,

17 alternatives, if she had any conditions that had

18 changed since I saw her last, and any other

19 questions regarding the surgery. I usually go over

20 the postoperative instructions at that time.

21 Especially, if there is family there because a lot

22 of times the patient won't remember and I want them

23 to hear it from me because sometimes the nurses tell

24 them stuff that I do not necessarily put down in the

25 orders.

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1 Q Okay. Do you recall meeting Mrs. Farris'

2 husband, Patrick?

3 A I remember meeting him and talking to him,

4 yes.

5 Q Do you remember him being in the pre-op

6 area? Was he present for the discussion?

7 A I do not recall.

8 Q Going to your progress note of July 4th,

9 it looks like it was done 12:22 in the afternoon.

10 And do you see what I'm referring to, Doctor?

11 A Yes, I do.

12 Q It says, "Subjective, patient complaint,

13 patient with abdominal pain and bloating while

14 drinking a SoBe beverage but no emesis, possible

15 subjective F/C"

16 What is F/C?

17 A Fever and chills.

18 Q "Patient feels short of breath."

19 A Correct.

20 Q "Positive flatus, no issues with

21 urination. Patient states there is no change".

22 So do you recall what time the

23 surgery was done on the 3rd?

24 A I believe it was some time in the morning.

25 Q And reading your note from the first -- I

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1 guess, going down to the end, where it says plan.

2 Go all the way down to the lower left, it says Page

3 No. 2231, you have --

4 A 23 or 22?

5 Q If you look at the bottom --

6 MR. COUCHRO: Yeah, he misspoke --

7 BY MR. HAND:

8 Q Yeah, 2231.

9 A Okay.

10 Q In the impression of plan, diagnosis,

11 course, plan. So can I ask you, how would these

12 notes be entered? Is there like a workstation that

13 is on the floor or in the room or how is it done?

14 A There's computer stations. There is some,

15 if you wanted to, there are some in the room. Most

16 of them are outside of the room. Sometimes, I

17 finish my note immediately as I walk out.

18 Sometimes, I will see a couple of patients and then

19 I will do them in the doctor's lounge where there is

20 some access.

21 Q Do you have any records regarding the

22 patient that are not in the hospital record or in

23 your office chart that we have gone through?

24 A No.

25 Q So if we can going to that date, it says,

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1 "Impression and plan, diagnosis, incarcerated

2 incisional hernia. Course, worsening".

3 What did you mean by worsening?

4 A Her heart rate and blood sugars were

5 according to my plan were unstable. Her abdomen was

6 fairly extended and I felt that she needed NGT to

7 decompress the GI tract. I would have to check my

8 postoperative orders, but I was pretty sure that she

9 was NPO after the surgery. And instead she was

10 drinking these beverages. And it looked like she

11 was not tolerating them well. I was concerned that

12 the bloating and the distention would make it a

13 higher risk for her to aspirate or have further

14 complications where we repaired the colon.

15 Q The distention of the abdomen, you

16 attribute it to the not drinking liquid?

17 A No. It's probably multifactorial. It's

18 due to the anesthesia. It can be due to the extent

19 of the surgery. It could be due to colon repairs,

20 her response to narcotic medication. It's

21 multifactorial.

22 Q Do you know how much the abdomen was

23 distended?

24 A We don't really measure it in terms of a

25 quantitative. We just figure out in our own heads,

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1 moderate, mild or severe. Sometimes we will notice
2 whether the abdomen is dull percussion versus
3 tympanic percussion as a way.
4 Q How did you characterize this distention?
5 A I put it as slightly firm and distended in
6 tympanic. So I would say that was moderate to
7 severely distended.
8 Q Tympanic, what does that mean?
9 A Tympanic means when you touch the
10 abdomen it sounds like a hollow drum.
11 Q Is there any medical significance to this,
12 it sounds like a hollow drum?
13 A It usually means that the bowel is
14 distended, full of air, and not working well. So
15 either, most likely, it represents an ileus and that
16 the bowel is not functioning properly.
17 Q Now, we go to another note of July 5th,
18 progress note, looks like it was done at 11:02. It
19 is on Page 2212. Do you see where I'm referring to
20 there?
21 A Yes, I do.
22 Q Post-op. Is there a note that her white
23 blood count was 23.3? Going down to Page 2214.
24 A Correct.
25 Q Okay. What is a normal white blood count?

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1 A For this hospital, I think the upper range
2 in normal is around 12,000.
3 Q Did you attach any medical significance to
4 that blood count, 23.3?
5 A By itself, no but in relationship to all
6 of clinical factors, yes.
7 Q Can you explain that to me.
8 A Well, sometimes patients will have a
9 leukocytosis after surgery just from the stress of
10 surgery. However, if the abdomen is distended,
11 bloated, not working well, she went into respiratory
12 distress, had to be intubated. Then we had to
13 figure out a possible source for that leukocytosis.
14 Q And what were you considering, if any, as
15 the source of the leukocytosis?
16 A Pretty much every differential diagnosis
17 from aspiration pneumonia to complications from
18 surgery.
19 Q Were there any part of her vitals on that
20 page, were there any other abnormal vital signs?
21 A For the objective part, she has a -- well,
22 at one point she has a high or a T max of 38.2. Her
23 heart rate is elevated. Her blood pressure is
24 fairly -- there is low blood and there is very high
25 blood pressure, but that is over a 24 hour period.

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1 Her saturations appear normal at that time.
2 Part of this considers that she
3 was -- before she was intubated and afterwards
4 because she was 80 percent and it mentions the
5 mandatory modes.
6 Q If you go down to Page 2216, the last page
7 of that note. Impression of plan, diagnosis,
8 incarcerated incisional hernia. Course, worsening.
9 What did you mean by "course, worsening"?
10 A Well, the day before, she was breathing on
11 her own. And now, she's had an event that has caused
12 her to be intubated. Her heart rate was sky high.
13 They had to do put her on a dobutamine drip and they
14 put her on a heparin drip as well. During the
15 course of these events, from one day to the other,
16 she got significantly worse, but then they
17 resuscitated her and she was at least somewhat more
18 stable, it appears.
19 Q And your note from that date states,
20 "Patient more stable now while intubated and
21 sedated. Glucose still not well controlled.
22 Patient with SVT" -- what is SVT.
23 A Supraventricular tachycardia.
24 Q So she had a rapid heart rate?
25 A Correct.

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1 Q And did you come to a conclusion what may
2 be causing that?
3 A No, I did not.
4 Q Then it states she was on the drip and you
5 said, "We will await the results of the CT scan,
6 chest, abdomen, pelvis. Will consider exploratory
7 laparotomy, depending on results of CT and patient's
8 clinical progression."
9 So you were considering laparotomy on
10 July 5th?
11 A As one of possibilities of going forward,
12 yes.
13 Q Why were you considering that?
14 A Well, because my intraoperative findings
15 were that I had two colon holes that I repaired
16 laparoscopically. And my first concern was whether
17 those holes had opened up and possibly created leak.
18 Q So you wanted to see what a CAT Scan
19 showed?
20 A Correct.
21 Q What would the signs be of a leak?
22 A On a CT scan?
23 Q No. Just clinically, what would the signs
24 be?
25 A Clinically, signs of a leak are very vague

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1 and nonspecific. I have seen patients with a leak
2 with fairly normal vital signs. And I have seen
3 patients with leaks with tachycardia and high
4 fevers. The abdomen itself, if there is a fresh
5 leak with fresh incisions, usually enteric contents
6 can come up to those incisions because they're brand
7 new and not healed and any enteric contents is under
8 pressure, like an abscess, will just go right up
9 through those. So you use the vital signs and the
10 physical exam of the abdomen and the incisions.

11 Q So the white blood count on July 7th was
12 26.7 and then 22.6. And then if we go to the 9th,
13 it was 22.9. Let me ask you to look at your note on
14 the 9th. That is page at this bottom it says page
15 19 zero flierchits correct.

16 Q It looks like it was done on 15:42 PDT.
17 It was now postoperative day six. At this point
18 she's in the intensive care unit, is that right?

19 A Yes.

20 Q Looking at the -- if you go to the Page
21 1911, the vital signs, white blood count, 22.9. Is
22 that an elevated white blood count?

23 A Well, first of all, white blood is not a
24 vital sign.

25 Q All right. White blood count, 22.9, is

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1 that elevated?

2 A It's consistent with the range she's been
3 in for the last five or six days."

4 Q If she has changes in her clinical course,
5 then we would consider if we reoperate. What would
6 be the ramification if we reoperate on her, which
7 would be most likely resection of her colon,
8 ostectomy, other parts of the bowel. Just from
9 other operation standpoints.

10 Q So at this point, did she have --

11 A It does not look like it based upon the CT
12 scan.

13 A What would you expect to see on the CT
14 scan that indicates there is infectious process?

15 A It's not what is on the CT. It's on the
16 readings.

17 Q What is on the prior CT scan?"

18 A If this CT scan all of a sudden showed
19 increased incompetent that paraaortic air, showed
20 increased fluid, showed increased bowel edema,
21 showed gross soilage. So if she has a hole in her
22 colon, she could.

23 Q And that contrast on that CT Scan shows
24 would be in line of a possible leak.

25 Q Was Mrs. Ferris conscious or conscious, do

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1 you have any recollection.

2 A It's hard to answer that because their
3 trying when the excavator, and at various times
4 they're taking her off sedation. And when she was
5 off sedation, she was fairly agitated. I can tell
6 that because there is a comment from my note that
7 they switched propofol to Fentanyl, trying to get
8 her to be more relaxed when she they were giving
9 her, what we call, a sedation vacation.

10 Q So at this time point, did you have an
11 expectation or a idea when she would be able to be
12 discharged from the hospital?

13 A I was not making a discharge plan at that
14 level -- at that stage of the game, so to speak.
15 It's about getting her exacerbated, which had been
16 the problem for many, many days and had been
17 delaying her progression. And now, she is -- her
18 bowels are next of my concern to get them
19 functioning better as she has got a load of rectal
20 contrast up in there that most likely is delaying
21 her bowel or returned bowel activity. And I want to
22 get her either on enteral feeding, if we could or
23 extubated and eating.

24 Q At this point, what, in your opinion, was
25 she septic?

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1 A That's hard to say based upon my limited
2 notes here.

3 Q So at this point, did you have any concern
4 for a leakage from the bowel?

5 A I was also concerned about leakage from
6 the bowel.

7 Q We go to the note.

8 MR. HAND: Let's go off of the record.
9 (Off the record.)

10 BY MR. HAND:

11 Q Okay. Looking at 13, it looks like her
12 white blood count is 17.9 on that day. Any medical
13 significance to that?

14 A It's a little lower than it's been over
15 the last couple of days but in and of itself, no.

16 Q And we go to, it says, "Course,
17 progressing as expected. Plan, patient tolerating
18 sedation protocol better today. White blood count
19 basically unchanged. Patient now afebrile with
20 normal lactic acid and no acute issues on array.
21 During this period of of time was there any
22 distention in the abdomen?

23 A She had various degrees of distention the
24 entire time.

25 Q Then you state -- well, the distention,

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1 was that - did it remain at the same level, going
2 down, going up, do you know?

3 A It's hard to say in a patient that has
4 anasarca because the edema of the abdominal wall
5 interferes with a good examination from a distant
6 standpoint. So when the abdominal wall is doing
7 better from the anasarca standpoint, that is more
8 indicative that we're getting rid of the excess
9 fluid. Hopefully, it's getting off her lungs.
10 Hopefully, it will help her breathe better.
11 Hopefully, her bowels start to function.

12 Q And you state, "Agree with ICU team after
13 patient only lasted four minutes on CPAP that she
14 will likely need tracheostomy. Will consult with CT
15 surgery. Discussed all of the above with husband
16 who seems encouraged".

17 So do you remember speaking to the
18 husband that day?

19 A I don't remember the conversation, but
20 according to the note, I did.

21 Q So at this point, on the 13th, was she
22 septic at this time?

23 A It does not appear so.

24 Q And the signs of sepsis would be what, if
25 she was?

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1 A Worsening or lowering blood pressure,
2 higher tachycardia, worsening renal function.
3 Worsening pulmonary functions. And she didn't have
4 any of those things.

5 Q If we go to the note on the 14th. That's
6 at 8:43. That's page 1800. Her white blood count
7 on that date was 21.10. Any significance to that
8 finding?

9 A Again, in and of itself, no.

10 Q And then you state, "Patient with new run
11 fevers and white blood count has trended back up and
12 abdominal exam as gotten a bit worse in terms of
13 being firm. Also, no response to fleets and no
14 bowel activity. Will await trach today and likely
15 get repeat CT scan of the abdomen tomorrow looking
16 for any increase in free fluid/abscess or
17 development of" -- it should be bowel obstruction, I
18 assume.

19 A Correct.

20 Q "Or free air. Discussed with ICU team."

21 So at this point, what is your
22 assessment of the patient?

23 A That she's clinically getting worse.

24 Q Based on what factors?

25 A New running fevers, increased white cell

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1 count, worsening in the abdominal exam, no return of
2 bowel function, and no response to fleet or
3 suppositories.

4 Q So at this time, is there infectious
5 process in the peritoneal cavity?

6 A Possibly.

7 Q So at this point, what was your plan in
8 terms of the next step you were going to take?

9 Meaning, you were going to get a Cat scan?

10 A I was going to wait until they did the
11 tracheostomy and then get a repeat CT scan of the
12 abdomen and see if there was any change from the
13 prior CAT scans.

14 Q Now, we're going to the 14th. And that is
15 Page 1497. And I'm reading your note. It states:
16 "Reviewed patient's CAT Scan concerning for new
17 developments of abscess fluid and free air where
18 there was none prior, still no extravasation of
19 contrast but very concerning for possible leak and
20 or abscess either of which requires surgical
21 intervention given patient's increasing fevers over
22 the last 48 hours and increased leukocytosis
23 over the last 48 hours. No improvement in abdominal
24 exam".

25 So at this point, what is your

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1 assessment of the patient in terms of her? Is she
2 septic now?

3 Q Again, depends on your definition of
4 septic, but you don't have to be septic to take the
5 patient back to the OR. She had signs and symptoms
6 that are consistent with a possible leak from the
7 colon or some other etiology.

8 Q Were there any signs or symptoms of a leak
9 from the colon prior to July 15, 2015?

10 A In the continuum of her clinical
11 evaluation, no.

12 Q Then you go down and state -- sorry.
13 Withdraw that question.

14 And the basis for that statement is
15 what? Can you explain the basis for that.

16 A Again, if you look at the patient in the
17 continuum of their day to day improvement and
18 clinical situation. If a patient has a hole on day
19 one, they're not going to continue to get improved
20 and show signs of improvement day by day by day.
21 They're going to show signs of getting worse
22 immediately. So in a patient is even smoldering
23 along and doing better and better, even if it's just
24 step-wise, then your suspicion is still there but
25 it's kind of in the back of your head.

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1 If a patient all of a sudden takes a
2 change clinically, in which case, these last 48
3 hours, now she has not just had -- now, she's had a
4 spike in her fever. Now, it's up there and staying
5 up there. And it's not 101. It's 103. Now, the
6 white count which was trending down slightly is now
7 trending all the way up.

8 Her abdominal exam is worse. I
9 repeated the CAT Scan, which is clearly different
10 from the one prior. So if you look at the changes,
11 with all these factors on the patient on a
12 day-to-day basis, it is not one little single item
13 points to this versus the other.

14 Q You further state, "Spoke to the husband
15 regarding the findings and the patient's overall
16 condition, patient's spike in fever is 103 now.
17 Recommend exploratory laparotomy with explantation
18 of mesh, abdominal wash out, thorough inspection of
19 entire small and large bowel, possible colonic
20 lavage to remove inspissated contrast, possible bowel
21 resection, explained further the risks,
22 complications or sepsis and he indicated he wanted
23 to think about it further and decide tomorrow based
24 upon how she does. I notified ICU team of husband's
25 decision".

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1 So you spoke to the husband and
2 indicated it was time to bring her back to the
3 operating room on the 15th?
4 A Correct.
5 Q Was that the first recommendation for her
6 to be taken back to the operating room at that point
7 on the 15th?

8 A That I can remember, yes.

9 Q And you state that your concerns for
10 further complications or sepsis. What did you mean
11 by "or sepsis"?

12 A That she can develop sepsis and
13 multi-organ failure and die.

14 Q So if we go to the next day, you note at
15 11:39, "After discussion with Dr. Mono, family would
16 be more comfortable with having Dr. Ripplinger
17 taking over as surgical consultant going forward. I
18 will continue to be available if Dr. Ripplinger or
19 family has any further questions or I can assist in
20 any way. Otherwise, I will effectively sign-off for
21 now".

22 Who is Dr. Mono?

23 A Gary Mono is a general surgeon, who at
24 that time, he was either chief medical officer or
25 vice-chief medical officer of San Marlin, I believe.

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1 I don't know his exact title at that time.

2 Q Prior to July 16th, did you ever discuss
3 the patient with this Dr. Ripplinger?

4 A Dr. Ripplinger was consulted as a second
5 opinion earlier in the patient's clinical course.
6 He was the one that wanted the CAT Scan specifically
7 with rectal contrast. I don't recall having an
8 independent conversation with Dr. Ripplinger at all.

9 Q Was there a meeting at the hospital of
10 some kind about Mrs. Farris with the husband, you
11 and some of the administration people, do you recall
12 that?

13 A I thin Dr. Mono, when we spoke, mentioned
14 that.

15 Q Was there a meeting with family and
16 hospital personnel that you attended?

17 A I don't recall whether I attended or not.

18 Q How did you -- well, Dr. Mono, did you
19 have a discussion with him about this patient in
20 that time frame, on July 16th?

21 A In regards to?

22 Q Mrs. Farris and her -- about her
23 generally. Did you speak --

24 A Dr. Mono and I discussed that the family
25 would be more comfortable with having Dr. Ripplinger

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1 take over as surgical consultant going forward.

2 Q What do you remember about that discussion
3 with Dr. Mono, as far as where did it take place?

4 A I don't recall.

5 Q Do you recall the substance of the
6 conversation?

7 A The substance was that the family was
8 uncomfortable with me continuing as surgical
9 consultant on the case. They didn't want me to be
10 be the surgeon doing the reoperationoperation.

11 Q Was the family present for any discussions
12 between you and Dr. Mono?

13 A I don't recall.

14 Q So on the 16th, is that the last day that
15 you were involved with the treatment of Mrs. Farris?

16 A Yes.

17 Q So when were you planning to take her back
18 to the operating room?

19 A The night prior.

20 Q The night of the 15th?

21 A Correct.

22 MR. HAND: Can we go off for second.

(Off the record.)

24 BY MR. HAND:

25 Q We are going to Exhibit 6. It is a

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1 consultation by Dr. Ripplinger on July 9, 2015. Can
2 you take a look at that.

3 A Okay.

4 Q Have you seen this note prior to today?

5 A I'm sure some time during her clinical
6 course, I reviewed it, yes.

7 Q Are you able to review on the work
8 station, the notes entered by other doctors or
9 nurses or personnel?

10 A Yes.

11 Q So looking at his note, do you know who
12 requested this consult?

13 Q I think it was the family, but I'm not
14 sure.

15 Q So Dr. McPherson, do you know him?

16 A Dr. McPherson is an ICU doctor.

17 Q It seems like he is the one that requested
18 it.

19 A Where does it say that?

20 Q It says referring to the - I don't know
21 who requested it but, he's in there. So it just
22 says second surgical opinion?

23 A Yes.

24 Q And looking at his notes, it states,
25 "Postoperatively, the patient began to do poorly on

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1 her first postoperative day July 4, 2015, and was
2 first transferred to IMC and then to Intensive Care
3 Unit when she was intubated later on postoperative
4 day 1. And she has consistently had a relatively
5 elevated white blood cell count".

6 Do you agree with that note?

7 A For what you read, yes.

8 Q "Her very first white blood count, which
9 was done on July 4, 2015 was 21.7. It has remained
10 fairly consistent in the greater than 20,000 and was
11 as high as 26,000 on couple of occasions".

12 Do you agree with that note?

13 A I have no reason to argue with it.

14 Q All right. Then, "She has been on
15 ventilator since the evening of her first
16 postoperative day". And it says, "She has not had
17 significantly elevated temperature recently. She
18 has been tachycardic".

19 Do you agree with that statement?

20 A To the best of my recollection, yes.

21 Q We're down to the physical examination on
22 the next page. It states, "Maximum temperature over
23 the last 24 hours was 37.2 degrees centigrade,
24 maximum pulse rate is 123. Her blood pressure
25 mostly recently is 126/73. The temperature of 37.2,

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1 is that normal temperature, low or high or something
2 else?

3 A Normal.

4 Q Maximum pulse rate is 123. Is that
5 normal, low or high?

6 A For a person who is not sick it would be
7 high.

8 Q And the blood pressure is 126/73, is that
9 normal blood pressure?

10 A Normal.

11 Q And then he states, "Abdomen, obese and
12 quite distended. She has some fluctuance in the
13 area of her incisional hernia, which I believe is
14 fluid or air between the mesh and skin. Her wounds
15 are healing nonerythematous and there is no
16 drainage."

17 He discusses the CT Scan of the
18 abdomen that was done four days ago on July 5th. It
19 states, "The abdomen and pelvis showed some air and
20 fluid above the mesh".

21 Do you agree with that note?

22 A I would have to refer to the radiology
23 report, but I don't have any reason to except it
24 other than that.

25 Q Assuming that the CT showed air fluid

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1 above the mesh, is there any medical significance to
2 that on July 5th?

3 A No. After a laparoscopic repair, there is
4 typically air and fluid above the mesh.

5 Q So in impression and plan, it states,
6 "Obese female, who is status post repair of an
7 incisional hernia with placement of mesh, who is on
8 a ventilator with an elevated white blood cell
9 count". He states, "I think there is a reason to be
10 concerned for possible leak from one of the two
11 colon repairs or an early aggressive infection of the
12 mesh causing some of the patient's problems".

13 Do you agree with that note?

14 A Yes.

15 Q Then he states, "I would recommend a
16 repeat CT scan of the abdomen and pelvis done with
17 intravenous oral contrast and to help rule out leak
18 from the colon". He states, "I think there should
19 be a fairly low threshold for at least a diagnostic
20 laparoscopy or even laparotomy if there are any
21 significant abnormalities noted on the CT scan.
22 Especially, if there is increase in free fluid in
23 the abdomen. I would be concerned for possible
24 bowel leak".

25 Do you agree with that assessment that

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1 he states?

2 A Basically, yes.

3 Q So you don't remember if you discussed

4 this with him? You don't think you did?

5 A I don't think we did.

6 Q Now, I'm going to show you what I have

7 marked as Exhibit 13, which is an operative report

8 from July 16th by a Dr. Elizabeth Hamilton. Do you

9 know Dr. Hamilton?

10 A Yes, I did.

11 Q Is she a general surgeon?

12 A Yes, she is.

13 Q Can you take a look at that. Date of

14 operation done on July 16, 2015. Have you seen that

15 operative report prior to today?

16 A I don't believe I have.

17 Q Preoperative diagnoses, perforated

18 viscus -- well, if you want, let me give you a few

19 minutes to read through it if you have not seen it

20 yet. Would you like that?

21 A I don't think it's going to make a

22 difference.

23 Q All right. She does -- her preoperative

24 diagnoses: perforated viscus with free

25 intraabdominal air. Sepsis, respiratory failure,

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1 anasarca, fever, leukocytosis, recent incisional

2 hernia repair with prosthatic mesh, previous

3 incisions hernia repair, and then overweight.

4 And she -- her postoperative

5 diagnoses appears to be the same. And her procedure

6 performed; exploratory laparotomy, removal of

7 prosthetic mesh and washout of abdomen, partial

8 colectomy and right ascending colon and ileostomy,

9 extensive lysis of adhesions over 30 minutes,

10 retention suture placement, decompression of the

11 stool from the right colon into the ostomy, fecal

12 disimpaction of the rectum. Dr. Ripplinger was the

13 assistant surgeon.

14 Going down on Page 44,

15 "Dr. Ripplinger had been called for a second opinion

16 for this patient who is not improving in the

17 postoperative period".

18 Do you agree with that note or

19 disagree or something else, that she was not

20 improving in the postoperative period from the 3rd

21 to the 9th?

22 A Specifically, the sentence, "My partner,

23 Dr. Ripplinger has been called on 7/9/2015 for a

24 second opinion for this patient who is not improving

25 in the postoperative period, I don't know what she

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1 means by not improving.

2 Q She goes on to state, "Patient was

3 observed on ventilator and received a tracheostomy.

4 She continued to have evidence of sepsis with fever

5 and leukocytosis". And then, "Repeat CT Scan done

6 on the 15th which demonstrated significant free air

7 as well as some free fluid and concern for

8 perforated viscus". And then Dr. Hamilton states,

9 "Dr. Rivas by report on the 16th notified the

10 patient that a repeat trip to the operating room was

11 in order".

12 Anything you disagree with that note

13 that I just read?

14 A It depends upon when she felt that the

15 patient had evidence of sepsis and fever. I assume

16 it was the couple of days that I referred to

17 previously. Other than that, no.

18 MR. COUCHOT: The other thing you

19 talked -- the timing, she has wrong. You

20 already testified you recommended surgery

21 surgery on the 15th; not the 16th but it is

22 kind of a minor point.

23 THE WITNESS: Well she is referring that

24 it was reported on the 16th.

25

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1 MR. COUCHOT: "By report on the 16th

2 notified the patient that a return trip was in

3 order", that actually occurred on the 15th.

4 THE WITNESS: Well, that -- that part is

5 true. Well, it depends on how you mean by

6 report. I didn't speak to her about it, so she

7 is maybe getting that from the nurse. I don't

8 know.

9 BY MR. HAKD:

10 Q Going down, Dr. Hamilton says, "The

11 patient had severe anasarca. Her abdomen was

12 incredibly taut to the point where it was tympanic

13 and literally look like you could balance a quarter

14 off of it. She said she had discomfort. She had

15 evidence of peritonitis and she had a midline

16 wound that was just to the right of midline".

17 Going down further, she states, "She

18 was febrile, her pulse was only in the 80s. She had

19 a leukocytosis of about 20,000. I reviewed the CT

20 Scan personally". And then she goes down to state,

21 "Decision was made that she had perforation and

22 likely perforation of the colon from the previous

23 colon injuries".

24 And then they decided to take her

25 back to the operating room. And she states that

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1 they were tried to get rid of the source of
2 continued sepsis in the patient who is failing.

3 Now, going down to the actual
4 procedure, which is on the next page, she states,
5 "Her abdomen was distended out like a tiny mountain.
6 It was very abnormal appearing. In addition, she
7 had severe anasarca. I decided to approach the area
8 of abnormality from the highest yield area". And
9 then she states when she opened the incision she got
10 a rush of air.

11 Add further, she states, "The
12 peritoneum was extremely thickened and it almost
13 seemed to be cavity in there". You see where I'm
14 reading, Dr. Rives?

15 A Yes.

16 Q I am doing this in detail because I don't
17 know if you saw it. It just want to put it into
18 context. So there was no clear feculent spilling
19 out of the skin once mesh the vertical incision was
20 opened, but I could see a feculent sitting on the
21 mesh and purulence in feculent sitting within the
22 cavity of the level of the mesh.

23 Do you have any indication how long
24 that feculent would be sitting on the mesh prior to
25 her operating on the 15th?

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1 MR. COUCHROT: I'm just going to object.
2 Calls for speculation.

3 If you know it, you can answer.

4 THE WITNESS: There is no way for me to
5 answer that.

6 BY MR. HAND:

7 Q And she goes on to state, "The mesh was
8 not well incorporated. I could see the purple
9 plastic tackers."

10 Do you have an opinion as to why,
11 assuming this is correct, the mesh was not well
12 incorporated when she operated on the 15th?

13 MR. COUCHROT: Objection. Calls for
14 speculation. Lacks foundation. Calls for
15 expert opinion.

16 THE WITNESS: Basically, it's too early
17 for the mesh to incorporate postoperatively.

18 BY MR. HAND:

19 Q And she states, "I can see purple plastic
20 tackers". Is that something that would be an
21 unusual finding in opening a patient laparotomy?

22 A No. I use the SecureStrap device and
23 those are the purple tackers for that device.

24 Q Further down, it says, "Underlying this
25 was what appeared to be the transverse colon with

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1 about a quarter size or about a 2.5 to 3 cm hole
2 with small chronic appearing edges. Around it, there
3 was active leak of green feculent material and free
4 air".

5 Do you have an opinion as to when
6 that hole appeared that I'm referring to, 2.5 to 3
7 centimeter hole?

8 MR. COUCHROT: Objection. Calls for
9 speculation. Seeks expert opinion.

10 I'm not going to let him give a retrospect
11 of the analysis. If he had thoughts about what
12 he was doing at the time, I mean, I think
13 you're entitled to that.

14 But as far as what he now thinks, I think
15 that's kind of within the purview of our
16 experts. I'm not going to be disclosing him as
17 an expert. He won't be offering such opinions
18 of that at trial.

19 MR. HAND: He's not going to be — but the
20 thing is under, you know, via, he is an expert.
21 He's operating on people. And I think I'm
22 entitled to expert opinions, whether you
23 disclose him as such or not because, you know,
24 he is, by all indications, he is an expert. He
25 is a surgeon. He does the surgery. And I

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1 think I'm entitled to ask him, you know, his
2 opinions on, you know, what the result of this
3 was. You can object, but I have to bring
4 people back for deposition and stuff like that.

5 MR. COUCHROT: Well, two thoughts: One,
6 first, let's find out if he does. And then we
7 can figure out if we're going to fight over it.
8 And then secondly, we just have been down this
9 similar road in the Sinner case and, you know,
10 every judge is different but essentially the
11 outcome that we got in that case was, no
12 present opinions but you can give opinions that
13 you formulated at the time.

14 And the thought process that we argued,
15 and Judge Smith agreed with, was essentially,
16 you know, at this point we have had it
17 reviewed, we have spoken with him, our experts
18 have come up with a information. And to the
19 extent we're basing information on his opinions
20 are based on those things, that's

21 attorney-client privilege, work-product stuff.
22 So first, do you have an opinion in that
23 regard?

24 THE WITNESS: I'll be honest with you, I'm
25 lost about what you guys are asking asking.

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1 What are you talk about?

2 THE WITNESS: Can you repeat the question

3 and then we will see if he has an opinion and

4 then we will --

5 (Record read.)

6 THE WITNESS: I don't think I can make an

7 opinion about that without severe speculation.

8 BY MR. HAND:

9 Q Okay. Do you see later then, "she had a

10 colostomy?"

11 A Yes, I do.

12 Q Okay. Do you see later then, "she had a

13 colostomy?"

14 A Yes, I do.

15 Q Okay. Do you see later then, "she had a

16 colostomy?"

17 A Yes, I do.

18 Q Okay. Do you see later then, "she had a

19 colostomy?"

20 A Yes, I do.

21 Q Okay. Do you see later then, "she had a

22 colostomy?"

23 A Yes, I do.

24 Q Okay. Do you see later then, "she had a

25 colostomy?"

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1 A Wait. Well, that's confusing because she

2 writes, "Which this morning is pink and viable and

3 actually is already functioning."

4 C I think she said after the colostomy.

5 A It sounds like she's incorporating her

6 postoperative note with her operative note.

7 Q Do you have an opinion as to timeframe

8 where the reoperation would have avoided a colostomy

9 the patient?

10 MR. COUCHNOT: Objection. Lacks

11 foundation. Calls for an expert opinion.

12 THE WITNESS: Yes.

13 A Yes, I do.

14 Q Okay. Do you see later then, "she had a

15 colostomy?"

16 A Yes, I do.

17 Q Okay. Do you see later then, "she had a

18 colostomy?"

19 A Yes, I do.

20 Q Okay. Do you see later then, "she had a

21 colostomy?"

22 A Yes, I do.

23 Q Okay. Do you see later then, "she had a

24 colostomy?"

25 A Yes, I do.

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1 Did you read the whole -- or review

2 the whole chart from her admission record from the

3 surgery from July 15 onward?

4 A Her entire medical record?

5 A No, I did not.

6 Q Are you aware of what her condition was

7 when she was discharged?

8 A No, I do not.

9 Q I want go through this. I'm just going --

10 this has been marked as Exhibit 14. It is basically

11 the consultation progress notes from July 4th up

12 until the date of her admission to the hospital.

13 A Yes, I do.

14 Q Okay. Do you see later then, "she had a

15 colostomy?"

16 A Yes, I do.

17 Q Okay. Do you see later then, "she had a

18 colostomy?"

19 A Yes, I do.

20 Q Okay. Do you see later then, "she had a

21 colostomy?"

22 A Yes, I do.

23 Q Okay. Do you see later then, "she had a

24 colostomy?"

25 A Yes, I do.

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1 Q Do you see where he makes a note, white

2 blood count -- well, on 2237, he says, "white blood

3 count, 21.7. And then on 2239, he makes a note,

4 "probable sepsis".

5 Did you ever discuss this patient

6 with Dr. Akbar?

7 A I did, but I don't have any recollection.

8 Q If you did discuss it, would that be

9 something in your tradition -- you know, normally it

10 will be in the notes you do, right?

11 A Yes, I do.

12 Q Okay. Do you see later then, "she had a

13 colostomy?"

14 A Yes, I do.

15 Q Okay. Do you see later then, "she had a

16 colostomy?"

17 A Yes, I do.

18 Q Okay. Do you see later then, "she had a

19 colostomy?"

20 A Yes, I do.

21 Q Okay. Do you see later then, "she had a

22 colostomy?"

23 A Yes, I do.

24 Q Okay. Do you see later then, "she had a

25 colostomy?"

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note by Dr. Mooney on Page 40.

A Which page?

Q If you look at Page 40. It's down at the bottom there.

A 2240?

Q No. No. 40.

A Just 40? They're not in order. That's okay. I got it. Electronically signed by Mooney, Kenneth.

Q Yeah. Do you ever recall discussing this patient with Dr. Mooney?

A I probably did, but I don't have an independent recollection.

Q He states at that point, "Patient aware of on guarded prognosis". Do you see that note on Page 40?

A Oh, on top. "Patient aware of guarded prognosis".

Q And if we go to Page 31 -- it's somewhere in there, but Dr. Shaikh. Is Dr. Shaikh an infectious disease physician?

A There is a couple Dr. Shaikhs.

Q Farooq Shaikh?

A I would have to see the note. I went all the way to 34.

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Q Page 31.

A Yeah, I don't -- let's see. Here it is. Infectious disease consultation?

Q Right.

And do you know know Dr. Farooq Shaikh?

A Yes.

Q Do you recall discussing this patient with Dr. Shaikh on July 4th?

A I don't have an independent recollection of that.

Q And Dr. Shaikh states -- if you go to Page 32, assessment and plan. "Status post reduction of incarcerated incisional hernia, operative nick to the colon and repair. Now with postoperative abdominal pain, distention, nausea, leukocytosis, and fever. This can represent fecal peritonitis".

Did you review that note during that timeframe?

A I don't recall.

Q Would that cause you any concern if an infectious disease doctor is making a note that it could be fecal peritonitis?

A No, because I was considering the same thing already.

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Q What is fecal peritonitis?

A Basically, it's saying a leak in the colon.

Q So from July 4th up until July 15th, when you were not treating the patient anymore during that time period, how did you rule out fecal peritonitis?

A It's not that it was ever ruled out. It was always a consideration. It was a matter of the patient's clinical course, what her abdominal exam looks like, what her lab results were like, what her blood pressure, heart rate, ventilatory status, what the CT Scan showed, what the radiology of the report showed. It's a combination of all those factors. Nothing is ever ruled out completely until the patient is out of the hospital, eating, and eliminating.

Q Then if we go to -- there is a note from Dr. Shaikh on -- let me go back for a second. Also, on the 4th, there is a note from a Dr. Syed Zaidi. Do you know Dr. Zaidi?

Q He is a cardiologist, it looks like.

A There has to be an easier way for me to find these out. There are not in any record whatsoever. I mean, you have them labeled such,

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but.

MR. COUCHOT: I found that particular one.

THE WITNESS: Is in that okay?

MR. HAND: Sure. Whatever is easier.

THE WITNESS: Yeah.

BY MR. HAND:

Q He makes a note of acidosis. What is acidosis?

Q Acidosis is a general term meaning that the -- from a cardiac standpoint, a renal standpoint, the patient's situation is more acidotic than it is alkaline and not back to homeostasis. Acidosis can be caused by -- there is a long list of diagnoses.

Q Yeah. If we go to the note of Dr. Shaikh, the infectious disease doctor on the 5th. Are you able to pull it out there?

MR. COUCHOT: What is the Bates stamp?

MR. HAND: The Bates stamp on that is 2194.

THE WITNESS: I've got that.

BY MR. HAND:

Q Page 2195, he states, "Course worsening". And again says, "This can represent fecal peritonitis". This is on the 5th that we're

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1 talking now. And then, "She's also developing
2 respiratory failure, intubated, ICU, abnormal
3 distention". And recommends abdominal imaging and
4 CT Scan.

5 If we go down, there is another
6 doctor involved, Dr. Tanveer Akbar.

7 A He is a hospitalist.

8 Q Okay. On the 5th, he mentions an acute
9 kidney injury. AKI, does that mean acute kidney
10 injury?

11 A That's correct. Page 2210.

12 Electronically signed by Akbar, Tanveer, 7/5/15.

13 Q Yes. An acute kidney injury, is that
14 something that is within the realm of expected
15 complications after the surgery?

16 A Yes.

17 Q Why is that?

18 A Any hypoglycemic state would cause a
19 patient to have acute kidney injury.

20 Q And we go to Page 2118. This is also on
21 the -- it's on the 5th. I'm sorry. Dr. Ali, what
22 kind of doctor is Dr. Kauroz Ali?

23 A I don't recognize the name.

24 Q I believe he's an internist, hospitalist.
25 And then on Page 2147, it's down quite a bit. So he

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1 makes a note, impression and plan, diagnosis, July
2 5th. This is a later note. Does he state sepsis?

3 A He actually added on to the note and
4 repopulated it.

5 Q Right. And then on July 5th, he says
6 sepsis. Do you recall reviewing this note during
the course of treatment of the patient?

8 A I have no independent recollection of
reviewing this note.

10 Q If you reviewed it, would that give you
11 any concern that she was a septic patient?

12 A No, because I thought she was in sepsis on
13 the 5th anyways.

14 Q Okay? You felt she was septic on the 5th?

15 A The day after surgery?

16 Q Yeah?

17 A Well, let's see. The day of surgery was
18 the 3rd. So the 4th and 5th, yeah, you can say she
19 was in sepsis at that point.

20 Q So at that point, did you determine what
21 the source of the sepsis was?

22 A No.

23 Q How come you didn't determine the source?

24 A Because there are consideration for the
25 source.

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1 Q Such as?

2 A Aspiration, cardiac, postoperative or
3 intraoperative complications. Those are just a few.

4 Q Did you consider hierarchy of the cause of
the sepsis as to which is more likely, and which is
6 less likely?

7 A When dealing with sepsis, we're not so
8 much concerned with what is the source as is, like I
9 said before, treating the sepsis and getting ahead
10 of the sepsis so the patient does not go into
11 multi-organ failure. So at that point, we have
12 kidney, renal, pulmonary, ID, everybody on board to
13 try to get a hold of how to treat the sepsis.

14 Identifying the what is exactly
15 causing the sepsis is sort of secondary at that
16 point. My concern was related to the abdomen more
17 than anything else as the possible source. In other
18 words, it was not my scope of practice to figure out
19 whether it was cardiac, pulmonary, etc.

20 Q As a general proposition, will sepsis
21 resolve without source control?

22 A Yes, it can.

23 Q Can you explain how that can happen.

24 A I will give you an example of people who
25 develop appendicitis, develop sepsis, don't have

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1 surgery, and it heals up on its own and the patient
2 recovers. The the same thing happens
3 microperforation diverticulitis. We don't operate
4 on those much anymore. We give them IV,
5 antibiotics. The body heals itself up. We don't do
any quote/unquote "source control" in those cases.
7 And they resolve spontaneously.

8 Q And if we go to the same day, Page 2149.
9 Dr. McPherson's notes. It's July 5th. And Page
10 2149, does he state -- make a note also of sepsis?

11 A He makes a diagnosis of sepsis, yes.

12 Q And do you agree with that diagnosis?

13 A On the 5th, I don't recall whether I
14 agreed with it or not. I would have to review my
15 notes again. But if you notice, most of the notes,
16 they continue the same diagnosis throughout the
17 entire length of stay. They rarely change those.

18 Q In terms of sepsis?

19 A In regards to any of the diagnoses.

20 Q Is there a reason why or is that standard?

21 A Without editorializing? I think it's a
22 lazy physician, quite honestly. I have had notes
23 say, "pending surgery", and now the patient is 10
24 days post-operative.

25 They don't change a lot of them in

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1 the progress note on the computer. They kind of add
2 to it. If that make sense.

3 Q If we go to the Page 2033, it's a note by
4 Dr. Shaikh, the infectious disease doctor on the
5 7th.

6 A Repeat that page number for me, please.

7 Q 2033.

8 A Dr. Shaikh, 7/7/2015?

9 Q Right. Again, like you mentioned before,
10 he repeats -- the first note, he says "52-year old
11 female, status post-reduction of incarcerated
12 incisional hernia, operative nick to the colon and
13 repair, now with postoperative abdominal pain,
14 distention, sepsis, leukocytosis, and fever. This
15 could represent fecal peritonitis".

16 And if you go Page 2034, he states,
17 "Course worsening". Now, we're on the 7th. Do you
18 agree with that assessment, "Course worsening"?

19 A No.

20 Q Why is that?

21 A Well, I don't know his reasoning for why
22 he thought the patient was worsening. I never spoke
23 to him about it, as far as I can remember. And my
24 recollection of what we reviewed from my progress
25 notes, that the patient was slightly improving at

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1 that point.

2 Q And then if you go to Page 2037, Dr.
3 McPhearson's notes, continues to say -- make a note
4 that the patient is septic on -- that's the 7th. Do
5 you see where I'm referring to?

6 A Yes.

7 Q Do you agree with that assessment, that
8 she's septic on that day?

9 A No.

10 Q And why is that?

11 A Because pulmonary-wise, she was improving,
12 her kidney function was improving. And her heart
13 rate, I think was controlled. Her blood pressure
14 was more stable.

15 Q Now, if we go to -- there is a note by
16 Dr. Shaikh, infectious disease, on July 8th on
17 Page 1974. It starts -- he repeats the assessment
18 and plan from previous. And he makes a note that
19 the patient is developing acute renal insufficiency.
20 Any medical significance to that note?

21 A In and of itself, none.

22 Q On Page 1975, he says, "Abdomen remains
23 distended, silent and surgical". Any medical
24 significance to that note?

25 A From a non-surgeon, none.

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1 Q Why is that?

2 A Because it's not his job to exam abdomens
3 that are surgical.

4 Q So on this date, the 8th, Dr. Shaikh,
5 infectious disease doctor, note that the patient
6 is septic. Do you agree with that note?

7 A From my standpoint, I don't know how to
8 answer it. From my recollection of my progress
9 notes, I don't know what he means by septic. I
10 didn't speak to him. I don't have an independent
11 recollection of it. I cannot answer that.

12 Q And Page 1981, it's a note from July 9th
13 of Dr. Shaikh. On that note, he repeats, "Abdomen
14 remains distended, silent, and surgical". And there
15 is no change on that note.

16 Going to July 10th, Page 1829. Dr.
17 Howard Broder. Do you know who Dr. Howard is?

18 A The name sounds familiar. And I don't
19 know if it is Dr. Broder or his PA. But go ahead.
20 He is cardiology.

21 Q He makes a note on Page 1829, diagnosis,
22 sepsis. Do you agree with that diagnosis on that
23 date?

24 A On the 10th?

25 Q Yes.

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1 A I don't recall.

2 Q And if we go to Dr. Shaikh's note on Page
3 1867. States no change and the the course says
4 worsening. Do you see where I'm referring to?

5 A No.

6 Q You're on Page 1867?

7 A Yes.

8 Q It is actually page 1862. He says,
9 course, worsening. Do you see that, Dr. Rives?

10 A Yes.

11 Q As of that date, did you agree with that
12 assessment by Dr. Shaikh?

13 A I did not speak to Dr. Shaikh about these
14 assessments, as far as I can recollect.

15 Q On July 10th, was her course worsening?

16 A From my progress notes, I don't believe
17 so.

18 Q And there's is a note. This is is Page
19 1830. Her name is Kibby, Doreen Dobby? Do you know
20 her, Doctor?

21 A It doesn't sound familiar at all.

22 Q On that note on Page 1830, there is a
23 diagnosis of sepsis. Do you see that?

24 A I do.

25 Q Do you agree with that note of the

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1 diagnosis of sepsis on that date
 2 A I have no idea of what she made that
 3 diagnosis of sepsis on or whether she made
 4 diagnosis. I did not speak to her, and I don't have
 5 a recollection of it.
 6 Q Then we go to Page 1766, July 11th.
 7 Again, he states, "No change. Abdomen remains
 8 distended and surgical".
 9 Do you see that?
 10 A Is that the date of the 7/7 on his notes?
 11 Q Right. And then as a continuation, where
 12 7/11, he states, "Fever 39.1 to 39.4. No change in
 13 abdomen, no focus yet. CX chest and abdomen".
 14 Do you see what I'm referring to?
 15 A Yes.
 16 Q Okay. Do you agree with what he says, no
 17 change on July 11th?
 18 A In her abdomen? Or his exam?
 19 Q Yes.
 20 A I didn't examine it with with him. I have
 21 no idea. From my exam, I think she was starting to
 22 have changes. I would have to review my progress
 23 notes.
 24 Q If you go to July 12, Dr. Sheikh,
 25 Page 1758, "Fever remains, no presser, no focus,

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1 micor pending from yesterday".
 2 Do you agree with that note?
 3 A Well, let me withdraw that.
 4 Q Later on, it says course worsening on that
 5 page. Do you agree with that assessment?
 6 A Again, I don't know what he's referring
 7 to, case worsening. I didn't speak with him. I
 8 don't have an independent recollection about that.
 9 Q Go to Page 1590. Dr. Mooney on the 14th
 10 of July.
 11 A 15, what?
 12 Q Page 1590, Dr. Mooney.
 13 A Okay.
 14 Q On Page 1591, he notes the white blood
 15 count --
 16 A -- on Page 51
 17 Q -- he notes the white blood count is 110.
 18 And 1591, "Husband aware of guarded prognosis and
 19 need for trach".
 20 On that day, was her prognosis
 21 guarded at that time?
 22 A What date?
 23 Q On the 14th of July.
 24 A Well, A, I didn't discuss on what he meant
 25 by guarded, as far as I can recollect. From my

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1 standpoint, having reviewed my own progress notes,
 2 guess, maybe guarded may be appropriate.
 3 Q On Page 1573. This is a note from
 4 Dr. Saidi.
 5 A I cannot find that one.
 6 Q Okay.
 7 A 1573?
 8 Q Yes.
 9 A Yeah.
 10 Q Let me go to Page 1581 then.
 11 A Alke Rebentish.
 12 Q Is she an infectious disease doctor?
 13 A Yes.
 14 Q Does she make a note of postoperative,
 15 abdominal distention, sepsis, leukocytosis, and
 16 fever, question mark, fecal peritonitis?
 17 A Yes.
 18 Q Did you agree with that assessment by that
 19 doctor on that date?
 20 A I didn't speak to Dr. Rebentish, as far as
 21 I can remember. I don't recall whether I reviewed
 22 this note with her or not.
 23 Q Then we go to Page 1498. This is is a
 24 note by Dr. Mooney. Goes to Page 1507. Do you have
 25 that, Dr. Rives?

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1 A Correct.
 2 Q On that page, does he make a note that the
 3 patient's in critical condition?
 4 A Yes.
 5 Q Do you agree with that assessment on that
 6 date?
 7 A If I remember correctly, having reviewed
 8 my progress notes, that was the date that I felt
 9 that she needed to go back to the OR. So I would
 10 say yes.
 11 (Off the record.)
 12 BY MR. HAND:
 13 Q Dr. Rives, what is your understanding of
 14 the standard of care applicable to the treatment of
 15 this patient.
 16 MR. COUCHOT: Well, I am going to object.
 17 It calls for an expert opinion --
 18 MR. HAND: Well let me chain it.
 19 BY MR. HAND:
 20 Q Would it be a reasonable physician under
 21 the circumstances? Does that sound --
 22 A It sounds vaguely like that. There are
 23 some parts regarding the community, bahrain, et
 24 cetera, et cetera. Vague.
 25 Q So do you feel or have the opinion that

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1 you met the standard of care in your treatment of
2 Mrs. Ferris?

3 DURBGS: I'm going to object. Again,
4 we're not going to disclose him as an expert
5 opinion. I will let you answer that narrow
6 question, though, as to whether you believe you
7 reached the standard of care -- or whether you
8 were within the standard of care.

9 THE WITNESS: Yes, I was within the
10 standard of care.

11 BY MR. HAND:

12 Q And why was that the basis for that
13 statement?

14 A Because that is what is reasonable and
15 expected of a properly trained surgeon.

16 Q Okay. I want to show this exhibit.
17 Pathology reports from the Hamilton surgery of July
18 16th.

19 A Surgical pathology report?

20 Q Yes. Have you seen that prior to today?

21 A It's in my office notes, I believe. So I
22 probably looked at it at some point.

23 Q Could you look at the -- if we look at
24 the -- it starts at Page 8502. And I believe there
25 were -- it's Dr. Darren Wheeler, under gross

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1 submitted, found three defects in the colon. Do you
2 see where I'm referring to?

3 A "Three foci of colonic ulceration with
4 transmural acute inflammation and perforation. See
5 comment".

6 Q All right. It says, "First defect is
7 located roughly within the mid aspect, measures 2.0
8 x 1.6 cm and the borders are inked orange".

9 A Wait. You're on the next page?

10 Q Yeah. Page 8503.

11 A And approximately where on the page?

12 Q In the middle.

13 A Colon, serosa -- which?

14 Q Yes. Where it starts serosa.

15 A Serosa, okay.

16 Q It states: "The first defect it located
17 roughly within the mid aspect, measures 2.0 x 1.6
18 cm, borders are inked orange."

19 A Correct.

20 Q Okay. And then there is a second defect
21 located, measuring 3.7 x 3.5 cm. And then there is
22 a third defect, located 1.9 cm from the green
23 inked margin. So my understanding reading this,
24 there were three holes in the bowel.

25 A That's what the pathologist found,

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1 apparently.

2 Q Do you have any opinion as to the cause of
3 these holes in the bowel?

4 MR. COUCHOT: Objection. Calls for an
5 expert opinion. I'm not going to let you
6 answer if -- but do you have an opinion?

7 THE WITNESS: It's hard to say without
8 speculation. He mentions ulceration. And his
9 differential includes ischemia, rare
10 diverticulitis and/or prior procedures of
11 surgery. Other than that, I can't comment.

12 BY MR. HAND:

13 Q Where is that Hamilton report?

14 Looking at Dr. Hamilton's report, if
15 you can look at that again, Doctor, real quick. Do
16 you see, we are at Page 4242, findings No. 3, that
17 Dr. Hamilton found a quarter size or 3 centimeter
18 hole in the transverse colon anteriorly associated
19 with staples in the colon wall. Is that an
20 indication that the staples didn't hold that were
21 put in during the surgery of July 3rd?

22 MR. HAND: Objection. Lacks foundation.
23 Calls for an expert opinion.

24 THE WITNESS: Yes, I have no idea to know
25 that without speculation.

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1 BY MR. HAND:

2 Q Would you have any opinion or knowledge as
3 to when the staple line gave way?

4 A Based upon her clinical course and
5 condition, I would quastimate at some time
6 postoperative day maybe six or seven, some time
7 around there.

8 Q What is the basis for that?

9 A That her earlier course improved, that her
10 CT scans, the first two sucessfully showed
11 improvement, that she didn't have an alteration in
12 course until about the, I think, it was the 11th or
13 12th, we discussed when she started having fever, a
14 higher white count, a change in her clinical course.
15 So I would suppose that's when it occurred.

16 Q Is there any action or precaution that
17 could have been taken before July 16th that would
18 have prevented holes in the bowel?

19 MR. COUCHOT: Objection. Calls for
20 speculation. Lacks foundation. Calls for an
21 expert opinion.

22 THE WITNESS: Again, I cannot make an
23 opinion without speculation.

24 MR. HAND: All right. Thank you, Dr.
25 Rives. I have nothing else.

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1	MR. COUCHOT: Thank you.
2	(Whereupon, Exhibit No. 15
3	marked for identification.)
4	-cDo-
5	(Whereupon, the deposition
6	concluded at 2:11 p.m.)
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1	CERTIFICATE OF DEPOSITION			
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20	I, BARRY RIVES, M.D., deponent herein, do			
21	hereby certify and declare the within and foregoing			
22	transcription to be my deposition in said action;			
23	under penalty of perjury; that I have read,			
24	corrected, and do hereby affix my signature to said			
25	deposition.			
	BARRY RIVES, M.D., Deponent Date:			

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1	CERTIFICATE OF REPORTER	
2	STATE OF NEVADA)
3	COUNTY OF CLARK) ss:
4	I, Yvette Rodriguez, a duly commissioned	
5	Notary Public, Clark County, State of Nevada do	
6	hereby certify:	
7	That I reported the deposition of	
8	BARRY RIVES, M.D., commencing on October 24,	
9	2018 at 10:17 a.m.	
10	That prior to being deposed, the witness	
11	was duly sworn by me to testify to the truth;	
12	that I thereafter transcribed my said shorthand	
13	notes into typewriting; and that the	
14	typewritten transcript is a complete, true, and	
15	accurate transcription of my said shorthand	
16	notes.	
17	I further certify that I am not a relative	
18	or employee of counsel or any of the parties	
19	nor a relative or employee of the parties	
20	involved in said action, nor a person	
21	financially interested in the action.	
22	IN WITNESS WHEREOF, I have set my hand in	
23	my office in the County of Clark, State of	
24	Nevada, this 30th day of October, 2018.	
25	YVETTE RODRIGUEZ, CSR NO. 850	

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EXHIBIT “3”

1

DISTRICT COURT

2

CLARK COUNTY, NEVADA

3

4

VICKIE CENTER; THOMAS CENTER,)
individually, and as the Husband)
to VICKIE CENTER,)

6

Plaintiffs,

7

vs.

8

) CASE NO.
) A-16-731390-C
)

9

BARRY JAMES RIVES, M.D.;)
LAPAROSCOPIC SURGERY OF NEVADA)
LLC, A Nevada Limited-Liability)
Company; ABDUL-SAMI SIDDIQUI,)
M.D.; A.S.F. SIDDIQUI, M.D. LTD;)
YANN-BOR LIN, M.D.; WESTERN)
CRITICAL CARE ASSOCIATES)
(WANTANABE), LTD.; MIR MOHAMMAD,)
M.D.; ANTONIO FLORES ERAZO, M.D.,)
DOES 1-45; and ROE CORPORATIONS)
1-45; inclusive)

15

Defendants.

16

17

18

VIDEO DEPOSITION OF BARRY JAMES RIVES, M.D.

19

20

Taken at the Law Offices of Brenske & Andreevski
3800 Howard Hughes Parkway
Suite 500

21

Las Vegas, Nevada 89169

22

Tuesday, April 17, 2018
10:59 a.m.

23

24

Job Number: 451742

25

Reported by: Angela Campagna, CCR #495

BARRY JAMES RIVES, M.D. - 04/17/2018

Page 2			Page 4		
1	APPEARANCES:		1	VIDEO DEPOSITION OF BARRY JAMES RIVES, M.D.	
2	For the Plaintiffs:	WILLIAM R. BRENSKE, ESQ.	2	April 17, 2018	
3		Brenske & Andreevski	3	THE VIDEOGRAPHER: This is the beginning of	
4		3800 Howard Hughes Parkway	4	media number one in the deposition of Barry James	
5		Suite 500	5	Rives, MD, in the matter of Center versus Barry	
6		Las Vegas, Nevada 89169	6	James Rives, MD, held at Brenske, Andreevski, Clark	
7		Wbrenske@hotmail.com	7	Hill. Today's date is April 17, 2018. The time on	
8			8	the monitor is 10:59 a.m. The court reporter is	
9			9	Angela Campagna. And I am Marc Zamora, the	
10	For Defendants Abdul-Sami Siddiqui, M.D., and A.S.F. Siddiqui, M.D., Ltd.		10	videographer, an employee of Litigation Services.	
11		PATRICIA EGAN DAHNKE, ESQ.	11	This deposition is being videotaped at all times	
12		Daehnke Stevens, LLP	12	unless specified to go off the video record.	
13		2300 West Sahara Avenue	13	Would all present please identify	
14		Suite 600	14	themselves, beginning with the witness.	
15		Box 32	15	THE WITNESS: Barry J. Rives, MD.	
16		Las Vegas, Nevada 89102	16	MR. DOYLE: Tom Doyle for Dr. Rives and	
17		Pdaehnke@daehnkestevens.com	17	Laparoscopic Surgery of Nevada, LLC.	
18	For Defendants Western Critical Care Associates (WANZANABE), Ltd. Yann-Bor Lin, M.D., and Antonio Flores Erazo, M.D.:		18	MS. KIDDOO: Rochelle Kiddoo with ProAssurance	
19		MICHAEL D. NAVRATIL, ESQ.	19	for Dr. Rives.	
20		John H. Cotton & Associates	20	MR. KELLY: Sean Kelly for Dr. Mohammad.	
21		7900 West Sahara Avenue	21	MR. NAVRATIL: Michael Navratil for Western	
22		Suite 200	22	Critical Care Associates, Dr. Lin and Dr. Erazo.	
23		Las Vegas, Nevada 89117	23	MS. DAHNKE: Patricia Daehnke for	
24		Mnavratil@cottonlaw.com	24	Dr. Siddiqui.	
25			25	MR. BRENSKE: And this is attorney William	
1		SEAN M. KELLY, ESQ.			
2		Carroll, Kelly, Trotter,			
3		Franzen, McKenna & Peabody			
4		8329 West Sunset Road			
5		Suite 260			
6		Las Vegas, Nevada 89113			
7		Smkelly@cktfmlaw.com			
8	For Defendants Barry James Rives, M.D., and Laparoscopic Surgery of Nevada, LLC:				
9		THOMAS J. DOYLE, ESQ.			
10		Schuerling Zimmerman & Doyle			
11		400 University Avenue			
12		Sacramento, CA 95825			
13		Tjd@sza.com			
14	Also Present:	Rochelle Kiddoo			
15		ProAssurance			
16					
17		Marc Zamora			
18		Videographer			
19					
20					
21					
22					
23					
24					
25					
Page 3			Page 5		
1	INDEX TO EXHIBITS		1	Brenske on behalf of Vickie and Thomas Center.	
2	BARRY JAMES RIVES, M.D.		2	I would make note for the record	
3	Tuesday, April 17, 2018		3	that everyone in here is an attorney except for the	
4	Angela Campagna, OCR No. 495		4	young lady representing ProAssurance, I'm assuming.	
5	EXAMINATION		5	MS. KIDDOO: I'm sorry?	
6	By Mr. Brenske: 5		6	MR. BRENSKE: You're not a lawyer.	
7			7	MS. KIDDOO: Correct.	
8	MARKED DESCRIPTION PAGE		8	THE VIDEOGRAPHER: And will the court reporter	
9	Exhibit 1 - Plaintiff's Second Amended	5	9	please swear in the witness.	
10	Notice to Videotape and Take		10	BARRY JAMES RIVES, M.D.,	
11	Deposition of Defendant Of		11	having been first duly sworn, testified as follows:	
12	Barry James Rives, M.D.		12	(Exhibit 1 marked.)	
13	Exhibit 2 - Defendant Dr. Barry Rives'	15	13	EXAMINATION	
14	Response to Plaintiff Vickie		14	BY MR. BRENSKE:	
15	Center's First Set of		15	Q. Doctor, I'm going to show you for	
16	Interrogatories		16	identification as Plaintiffs' Second Amended Notice	
17	Exhibit 3 - Answer to Complaint	22	17	of a videotape to take deposition of Defendant Barry	
18	Exhibit 4 - LSN 000001 through 86	26	18	James Rives, MD. Have you had a chance to review	
19	Exhibit 5 - anatomical drawing	45	19	that document prior to sitting here today?	
20	Exhibit 6 - anatomical drawing	48	20	A. Yes, I have.	
21	Exhibit 7 - anatomical drawing	89	21	Q. All right. And the reason you're here	
22	Exhibit 8 - Progress Notes Nursing	96	22	today is because your deposition has been noticed	
23	Exhibit 9 - Emergency Documentation	119	23	yet a second time in this case. Fair statement?	
24	Exhibit 10 - Operative/Procedure Reports	123	24	A. That is correct.	
25			25	Q. Okay. Dr. Rives, can you explain to	

BARRY JAMES RIVES, M.D. - 04/17/2018

<p style="text-align: right;">Page 6</p> <p>1 this jury what documents you've reviewed in 2 preparation for this particular deposition? 3 A. I reviewed my progress notes and 4 operative notes from the EMR at Dignity Health and 5 my office notes. 6 Q. Did you review any of the chart of the 7 hospital that Ms. Center was having the surgery in? 8 A. Yes. 9 Q. Okay. What of those records or charts 10 did you review? 11 A. Progress notes by other physicians, 12 some lab results, and some radiology results. 13 Q. Did you review any nurse progress 14 notes? 15 A. I don't recall. 16 Q. Okay. Are there any other notes that 17 you recall that you reviewed in preparation for 18 either your first deposition or your deposition 19 today? 20 A. Not that I'm aware of. 21 Q. Did you review your interrogatory 22 responses prior to either deposition? 23 A. I reviewed them when they were 24 initially sent to me. I didn't review them in 25 preparation for this.</p>	<p style="text-align: right;">Page 8</p> <p>1 A. That is correct. 2 Q. The other jury trials that you have 3 been in -- let me withdraw that. 4 How many trials have you attended 5 where you were a defendant in a medical malpractice 6 case? 7 A. Two. 8 Q. Do you recall any other cases in which 9 you were a defendant in a medical malpractice case 10 or it was alleged that you had committed medical 11 practice? 12 A. At jury trial or in general? 13 Q. No, sir. Where a complaint was filed, 14 you had to retain counsel, the matter was either 15 dismissed or settled? 16 A. Yes. 17 Q. Can you just review those for me? 18 A. The first one was in regards to a 19 patient who had a ductal Luschka leak after a 20 laparoscopic cholecystectomy and was dismissed. 21 Q. I'm going to take them one at a time, 22 if I could. I apologize for interrupting. It's my 23 interruptions, my failure. 24 When you say that case was 25 dismissed, was there a settlement in that case or</p>
<p style="text-align: right;">Page 7</p> <p>1 Q. Okay. With regards to the original 2 complaint that was filed against you, did you ever 3 review that? 4 A. The original summons? 5 Q. Yes, sir. 6 A. That I received? 7 Q. Yes, sir. 8 A. Yes. 9 Q. And now the answer that was -- that was 10 filed in this case is normally filed by your 11 attorney and not you. It's normally not a verified 12 response or answer. Do you recall whether you 13 reviewed the answer that was filed on your behalf in 14 this case? 15 A. Yes. 16 Q. Okay. I'm going to jump around a 17 little bit. That's what I do and I apologize for 18 that. The most important thing today, obviously, is 19 to tell the truth. And I'm sure you are aware that 20 you're under oath and you will tell the truth, and 21 your failure to do so would subject you to penalty 22 of perjury. Do you understand that? 23 A. Yes. 24 Q. And in fact, you have been in at least 25 two jury trials where you were a defendant?</p>	<p style="text-align: right;">Page 9</p> <p>1 was it dismissed? 2 A. Dismissed before trial. No payment. 3 Q. Okay. And I do apologize for 4 interrupting you. What is the next case that you 5 remember that you were a defendant in a medical 6 malpractice case? 7 A. There was a case where a patient had an 8 anterior/posterior spine fusion, had a colonic 9 perforation from that procedure. Was transferred to 10 Spring Valley where I had to take her emergently to 11 the OR, perform a life-saving surgery, an ostomy. 12 The patient actually did well. I had to reverse her 13 ostomy. But because the lawyer named everybody in 14 the suit, I was named in that suit. And I was 15 dismissed about two or three months after being 16 named in the suit. 17 Q. And that was without payment? 18 A. That was without payment, yes. 19 Q. Can you remember any other lawsuit in 20 which you were a defendant in a medical malpractice 21 case? 22 A. Those two and the ones that I went to 23 trial. 24 Q. Okay. Do you -- do you recall whether 25 or not you were a defendant in any other medical</p>

BARRY JAMES RIVES, M.D. - 04/17/2018

<p style="text-align: right;">Page 10</p> <p>1 malpractice case in this jurisdiction or anywhere 2 else? 3 A. No. 4 Q. You've done very well answering my 5 questions today and I appreciate that. There will 6 come a time or times today when I ask you a question 7 and it will be either unintelligible or difficult to 8 understand. If you do not understand that question, 9 please ask me to rephrase that question. And I will 10 rephrase it. Is that fair? 11 A. Yes. 12 Q. Okay. And if you do not understand 13 what -- strike that. 14 If you answer a question that I 15 ask, I can assume you understood it. Fair? 16 A. That's fair. 17 Q. Now -- and I do bounce around. I 18 assume that you do remember the patient Vickie 19 Center? 20 A. Yes. 21 Q. What type of surgery did you -- what 22 was the surgery you originally performed upon 23 Vickie? 24 A. A laparoscopic diaphragmatic hernia 25 repair and Nissen fundoplication.</p>	<p style="text-align: right;">Page 12</p> <p>1 to -- take your time. 2 A. I don't think you can really associate 3 a time frame with it. 4 Q. Okay. At any time do you recall her 5 suffering from pneumonia? 6 A. Well, aspiration pneumonitis, normally 7 we use the term kind of intermixed, so... 8 Q. So at the time that you were treating 9 Ms. Center, it was your understanding that there had 10 -- there may have been many causes, but aspiration 11 pneumonitis was the number one culprit in your mind? 12 A. Correct. 13 Q. Did you have a differential diagnosis 14 at that time for the cause of the sepsis? 15 A. When she initially started to go into 16 sepsis, we had a large possibility, including 17 pulmonary embolism, cardiogenic, the pneumonitis or 18 -- pneumonitis or issue, and we whittled it down one 19 by one. 20 Q. So it was your opinion at that time 21 that the sepsis was aspiration pneumonitis? 22 A. By the time things got sorted out, yes. 23 Q. When you performed the second surgical 24 procedure on Ms. Center, I believe, on the 17th of 25 February, what did you find in that surgical</p>
<p style="text-align: right;">Page 11</p> <p>1 Q. Now, was any part of Vickie Center's 2 stomach or surrounding organs injured 3 perioperatively as a result of that surgery? 4 A. No. 5 Q. And Ms. Center had suffered from sepsis 6 one day postop after that first surgery. Fair 7 statement? 8 A. That is correct. 9 Q. And at the time, what was your 10 understanding of the cause of the sepsis? 11 A. At the time that it happened, between 12 myself and the other consultants, there was talk 13 about multiple possible reasons. The most likely 14 being aspiration pneumonitis. 15 Q. Do you remember a bronchoscopy being 16 done? 17 A. I believe there was a bronchoscopy done 18 the next day or two, sometime afterwards. 19 Q. What were the results of that 20 bronchoscopy? 21 A. I don't recall them off the top of my 22 head. 23 Q. Okay. How long did you believe that 24 the source of that sepsis was from the lungs? If 25 you don't understand the question, it's a good time</p>	<p style="text-align: right;">Page 13</p> <p>1 procedure? 2 A. I started the case laparoscopically, 3 and when I got in I could see that there was 4 brackish-looking fluid consistent with possible 5 perforation of the stomach. I irrigated and cleaned 6 all that up so I could visualize the stomach, and I 7 could see that the NG tube was up in the 8 fundoplication wrap. And so I needed to take the 9 wrap down to evaluate the stomach adequately to make 10 sure there wasn't any injury to it. 11 When I did that, taking down one 12 of the sutures, I created a small hole in the 13 stomach by cutting it out. And when everything was 14 completely unwrapped, I could see that the NG tube 15 had caused a perforation in another section of the 16 stomach. It vaguely looked like it had been from a 17 necrosis or pressure by the NG tube. 18 Q. So the second surgical procedure that 19 you performed, I think, was on the 17th of February 20 2015. You found a perforation of the stomach and 21 you determined the cause of that perforation was the 22 NG tube? 23 A. It appeared to be, yes. 24 Q. And then you did a third surgery on 25 Ms. Center in the same general area, at least to a</p>

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<p style="text-align: right;">Page 14</p> <p>1 layperson. What did you find in that particular 2 surgery?</p> <p>3 A. I did that surgery in combination with 4 Dr. Wiencek. And he's a cardiothoracic surgeon, he 5 was doing the EGD part of the case. And with the 6 scope inside the stomach retroflex looking up, he 7 could see a perforated gastric ulcer.</p> <p>8 Q. All right. So is that a perforation of 9 the stomach?</p> <p>10 A. Yes.</p> <p>11 Q. So you have three surgeries thus far, 12 one on the 6th of February, one on the 17th of 13 February, and one in March. I wish I knew the day.</p> <p>14 MR. DOYLE: March 19th.</p> <p>15 BY MR. BRENSKE:</p> <p>16 Q. Let's go with your counsel's date of 17 March 19th. There is a lot of other stuff going on 18 here, so...</p> <p>19 All right. So the first surgery 20 was uncomplicated, had sepsis, thought it was an 21 aspiration pneumonitis. You went back in ten or 22 eleven days later, found perforation of the stomach, 23 you indicated it was caused by the NG tube. And 24 then on the third surgery there was perforation of 25 the stomach and you determined it to be an ulcer?</p>	<p style="text-align: right;">Page 16</p> <p>1 Q. Then I have -- go to interrogatory 2 No. 4. It asks if you're board certified in any 3 specialty, the date you became board certified, the 4 date you qualified to take the board certification, 5 and date and number of times you took the oral 6 written examinations. Your response to 7 interrogatory No. 4 is that you are not board-fied. 8 Is that true?</p> <p>9 A. That's true.</p> <p>10 Q. Did you ever sit for any boards?</p> <p>11 A. Yes.</p> <p>12 Q. When did you first sit for a board?</p> <p>13 You know, let me withdraw that question because it's 14 too broad.</p> <p>15 What boards, if any, have you sat 16 for?</p> <p>17 A. American College of Surgeons.</p> <p>18 Q. When did you -- now, is that a written 19 and oral exam?</p> <p>20 A. There is two parts. There's a written 21 part and an oral part.</p> <p>22 Q. When did you first sit for the written 23 part, if you can remember?</p> <p>24 A. It would be 2004 or '05, I believe.</p> <p>25 Q. And did you pass that written exam?</p>
<p style="text-align: right;">Page 15</p> <p>1 A. Correct.</p> <p>2 MR. BRENSKE: Mark that as Plaintiffs' 3 Proposed Exhibit No. 2, please. 4 (Exhibit 2 marked.)</p> <p>5 BY MR. BRENSKE:</p> <p>6 Q. Doctor, if you could just hand me that 7 Exhibit 2 so I know what I gave you is what I wanted 8 to give you.</p> <p>9 All right. So, Doctor, we're 10 handing you what is described as Defendant Dr. Barry 11 Rives' response to Vickie -- Plaintiff Vickie 12 Center's first set of interrogatories. This would 13 be the Center interrogatories that -- that you 14 reviewed prior to verifying. Is that a fair 15 statement?</p> <p>16 A. Yes.</p> <p>17 Q. I don't have a lot of questions about 18 it, but just a few. Interrogatory No. 2 gives your 19 medical education. That you obtained your medical 20 degree from Hahnemann Medical College in 21 Philadelphia, Pennsylvania in 1988. You completed a 22 general surgery residency at Kern Medical Center in 23 Bakersfield, California in 2003. Did you receive 24 any other formal training in medicine?</p> <p>25 A. No.</p>	<p style="text-align: right;">Page 17</p> <p>1 A. Yes.</p> <p>2 Q. When, if ever, did you sit for the oral 3 exam?</p> <p>4 A. To the best of my knowledge, it would 5 be 2006 or '07.</p> <p>6 Q. And did you pass that oral exam?</p> <p>7 A. That one, no.</p> <p>8 Q. Did you ever again sit for the written 9 or oral exam?</p> <p>10 A. No.</p> <p>11 Q. If you could go to interrogatory No. 13 12 for me. I know I had asked you this question a bit 13 earlier today, but I want to be fair to you 14 concerning my questions. I've asked you about 15 medical malpractice cases that you are a defendant 16 in, and this is a written listing of them. So you 17 may have missed a couple. I don't know that. But 18 for completeness purposes, I thought we'd look over 19 this. Brown versus Rives, are you currently a 20 defendant in that case?</p> <p>21 A. Yes.</p> <p>22 Q. What -- in ten words or less -- are the 23 allegations against you in that case?</p> <p>24 A. The patient had a peritoneal dialysis 25 catheter removed. There was a small segment that</p>

BARRY JAMES RIVES, M.D. - 04/17/2018

<p style="text-align: right;">Page 18</p> <p>1 was left behind in a hernia sac, and the patient</p> <p>2 later had to have surgery to remove it.</p> <p>3 Q. With regards to the next case, Farris</p> <p>4 versus Rives, is that case still ongoing?</p> <p>5 A. Yes.</p> <p>6 Q. And in ten words or less, can you --</p> <p>7 you don't have to do it in ten words or less, but</p> <p>8 can you just give us a brief description of what</p> <p>9 that -- the allegations are in that case?</p> <p>10 A. Patient had a laparoscopic hernia</p> <p>11 repair and resulted in a colocutaneous fistula</p> <p>12 postoperatively that required subsequent surgery.</p> <p>13 Q. Did you perform that subsequent</p> <p>14 surgery?</p> <p>15 A. No.</p> <p>16 Q. Do you remember who did?</p> <p>17 A. I know the group. I don't remember</p> <p>18 which member of the group did it.</p> <p>19 Q. Who is the group?</p> <p>20 A. Southern Nevada Surgery. I think it</p> <p>21 was Dr. Hamilton or Dr. Ripplinger.</p> <p>22 Q. As you sit here today, do you have a</p> <p>23 recollection of why you did not do the surgical</p> <p>24 repair?</p> <p>25 A. The family asked for a second opinion.</p>	<p style="text-align: right;">Page 20</p> <p>1 path report that said there was lymphoma?</p> <p>2 A. Correct.</p> <p>3 Q. Is that something you got?</p> <p>4 A. It's something -- yeah -- well,</p> <p>5 eventually, yeah.</p> <p>6 Q. Did someone get it long before you?</p> <p>7 A. Well, there was questions about who got</p> <p>8 the pathology first and whether the pathologist</p> <p>9 should have notified everybody. There were some</p> <p>10 nuances to that.</p> <p>11 Q. Was anyone found at fault in trial on</p> <p>12 this case?</p> <p>13 A. At trial, no.</p> <p>14 Q. Now, Schorle versus Southern Hills</p> <p>15 Hospital. This case looks like a 2012 case, just</p> <p>16 says motion to dismiss granted. Can you just tell</p> <p>17 me what the allegations were in that case?</p> <p>18 A. This is the spinal case that I</p> <p>19 mentioned where I did an exploratory laparotomy, did</p> <p>20 a diverting ostomy for a patient's perforated colon</p> <p>21 from her spinal approach.</p> <p>22 Q. It just says motion to dismiss granted.</p> <p>23 Do you know if any money -- that case was ever</p> <p>24 settled?</p> <p>25 A. By me?</p>
<p style="text-align: right;">Page 19</p> <p>1 Q. Okay. Now, Lang versus Rives, this</p> <p>2 indicates that you went to trial on this particular</p> <p>3 case?</p> <p>4 A. That is correct.</p> <p>5 Q. And can you tell me what the alleged</p> <p>6 improper management of the ventral hernia -- what</p> <p>7 the allegation was?</p> <p>8 A. The patient developed a enterocutaneous</p> <p>9 fistula after surgery and was not timely diagnosed</p> <p>10 or managed.</p> <p>11 Q. Did you go back in and repair that?</p> <p>12 A. Yes.</p> <p>13 Q. How many days was it, to your</p> <p>14 recollection, did you go back in and repair that?</p> <p>15 A. From the time the patient presented</p> <p>16 with it, we went in within 24 hours.</p> <p>17 Q. The Doucette versus Garcia case. This</p> <p>18 shows that you had a defense verdict in that case.</p> <p>19 What were the allegations in that case?</p> <p>20 A. Patient presented with a perforated</p> <p>21 colon. The pathology came back as metastatic B-cell</p> <p>22 lymphoma. So the allegation was delay in diagnosis</p> <p>23 and treatment.</p> <p>24 Q. I don't want to get into these cases in</p> <p>25 detail, because I don't need to do that. There's a</p>	<p style="text-align: right;">Page 21</p> <p>1 Q. Yes, sir.</p> <p>2 A. No. No money.</p> <p>3 Q. Okay. The one after it says Tucker</p> <p>4 versus Rives, and that says dismissed without</p> <p>5 payment. Do you see that one?</p> <p>6 A. Yes.</p> <p>7 Q. I just want to know -- I wanted to know</p> <p>8 why there was a difference in language in Schorle</p> <p>9 versus Southern Hills and Tucker versus Rives. But</p> <p>10 in neither case no money was paid on your behalf?</p> <p>11 A. Correct.</p> <p>12 Q. Can you tell me what hospitals that you</p> <p>13 currently have privileges in?</p> <p>14 A. I have courtesy privilege at Spring</p> <p>15 Valley Hospital. I have active privileges at</p> <p>16 Southern Hills Hospital. Then I have active</p> <p>17 privileges at Dignity Health, St. Rose, San Martin</p> <p>18 Siena, and De Lima campuses.</p> <p>19 Q. So you've got active privileges at</p> <p>20 Southern Hills and Dignity Health hospitals?</p> <p>21 A. Correct.</p> <p>22 Q. What is courtesy privilege?</p> <p>23 A. It's a designation of basically how</p> <p>24 many cases you do at a hospital. You have to have</p> <p>25 so many cases or so much activity to be considered</p>

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<p style="text-align: right;">Page 22</p> <p>1 active staff. Courtesy is just a designation, you 2 still have full privileges at the hospital.</p> <p>3 Q. Does that mean you just don't use it as 4 much?</p> <p>5 A. Basically, yes.</p> <p>6 Q. At any time, at any hospital, have you 7 had your privileges revoked or suspended for any 8 period of time?</p> <p>9 A. No.</p> <p>10 Q. Doctors sometimes get their privileges 11 suspended for days because they -- late in doing 12 their paperwork. Has that sort of thing ever 13 happened to you?</p> <p>14 A. No.</p> <p>15 Q. We're done with that.</p> <p>16 MR. BRENSKE: Mark that as next Plaintiffs' 17 exhibit in order.</p> <p>18 (Exhibit 3 marked.)</p> <p>19 BY MR. BRENSKE:</p> <p>20 Q. Dr. Rives, you have been provided with 21 marked -- with what's been marked as Plaintiffs' 22 Proposed Exhibit No. 3. It is entitled Answer to 23 Complaint. This is a complaint by Vickie and Thomas 24 Center that your lawyer answered for you. It was 25 electronically filed on June 6 of 2016. Is this the</p>	<p style="text-align: right;">Page 24</p> <p>1 Q. Then the fourth affirmative defense, it 2 says in part that, "the negligence, misconduct and 3 fault of plaintiffs exceeded that of these 4 defendants."</p> <p>5 Are you aware of any information 6 that Tom or Vickie Center were negligent or 7 performed any misconduct with regards to the 8 allegations contained in this case?</p> <p>9 A. Not to my knowledge.</p> <p>10 Q. And I can only ask you to your 11 knowledge, so that's a perfectly acceptable answer 12 to me.</p> <p>13 Now, the fifth affirmative defense 14 is a little interesting, so I want to go over it 15 with you carefully. The entire fifth affirmative 16 defense says, "Plaintiffs are barred from asserting 17 any causes of action against defendants because the 18 alleged damages were the result of the intervening 19 and/or superseding conduct of others."</p> <p>20 Now, in English, that means to me 21 that someone else caused these damages, not you. 22 And that person's conduct intervened between your 23 conduct. Do you follow me?</p> <p>24 A. Yes.</p> <p>25 Q. Okay. Do you have any information from</p>
<p style="text-align: right;">Page 23</p> <p>1 answer that you indicated that you have reviewed in 2 this case?</p> <p>3 A. Yes.</p> <p>4 Q. This answer is not verified, in other 5 words, it's not answered under oath. But I do want 6 to ask you questions about it, if I may. If you 7 could go to page 6 of your answer.</p> <p>8 Now, I know you've had some 9 experience in court, but I want to make it clear to 10 you that when an answer is filed, lawyers provide I 11 think what we call affirmative defenses, and they 12 are pled in the answer at the beginning of the case. 13 Some of them may be applicable, some of them may not 14 be applicable. But as the defendant in this case, I 15 need to ask you about some of these. Okay?</p> <p>16 A. Sure.</p> <p>17 Q. Now, the third affirmative defense 18 says, "Plaintiffs failed to use ordinary care for 19 the safety of their person." Do you see that?</p> <p>20 A. Yes.</p> <p>21 Q. Do you have any information yourself 22 that would support that affirmative defense, that 23 Tom and Vickie failed to use ordinary care for the 24 safety of their person?</p> <p>25 A. I am not aware of any, no.</p>	<p style="text-align: right;">Page 25</p> <p>1 any source that you're aware of, that the damages 2 were the result of the intervening or superseding 3 conduct of others?</p> <p>4 MR. DOYLE: I'll just -- if I can inject that 5 that's not my understanding of that defense.</p> <p>6 But you go ahead and based upon 7 the question posed to you.</p> <p>8 THE WITNESS: From my limited review of 9 everything, I don't see anything that agrees with 10 that.</p> <p>11 BY MR. BRENSKE:</p> <p>12 Q. Okay. Then the seventh affirmative 13 defense, it states, "In all of the treatment 14 provided to Plaintiff Vickie Center by defendants, 15 she was fully informed of the risks inherent of such 16 medical treatment and the risks inherent in her own 17 failure to comply with medical instructions, and did 18 voluntarily assume all attendant risks."</p> <p>19 Do you see that?</p> <p>20 A. Yes.</p> <p>21 Q. Do you have any information from any 22 source that Vickie Center failed to comply with 23 medical instructions from you?</p> <p>24 A. No.</p> <p>25 Q. Now, we're going to the eleventh</p>

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<p style="text-align: right;">Page 26</p> <p>1 affirmative defense. It says, "Plaintiffs claim 2 damages have been suffered, but plaintiffs failed, 3 neglected and refused to exercise efforts to 4 mitigate said damages." 5 Do you have any information that 6 you're aware of that Tom or Vickie failed, neglected 7 or refused to exercise efforts to mitigate their 8 damages? 9 A. I'm not aware of any. 10 Q. We're done with that one. Let's see if 11 I can find it. 12 MR. BRENSKE: Ms. Court Reporter, can you mark 13 this as the next exhibit in order. 14 (Exhibit 4 marked.) 15 BY MR. BRENSKE: 16 Q. Doctor, I'm showing you what's been 17 marked for identification purposes as Plaintiffs' 18 Proposed Exhibit No. 4. It is -- on the front page 19 it is Bates stamped LSN 000001 through 86. It has 20 on the top Barry J. Rives, MD, Laparoscopic Surgery 21 of Nevada, 8285 West Arby Avenue, Suite 165, Las 22 Vegas, Nevada. Do you see that before you, sir? 23 A. Yes, I do. 24 Q. And if you could look through this to 25 see if this is a copy of your chart that's been</p>	<p style="text-align: right;">Page 28</p> <p>1 is just -- this is an information sheet filled by 2 the patient? 3 A. Correct. 4 Q. And page 7 would be that also? 5 A. Yes. 6 Q. Then page 8 is the consent for care, 7 authorization for release of medical records, 8 financial agreement, the record of disclosures and 9 compliance of medical treatment. That would be a 10 document that your office provides that has to be 11 initialed by the patient? 12 A. And signed, correct. 13 Q. The next page is an authorization. It 14 says, "I hereby authorize Jessica Lucero, primary 15 fission -- primary physician, to get medical 16 records." Do you know who Jessica Lucero is? 17 A. Supposedly the patient's primary 18 physician. 19 Q. Do you remember who the physician was 20 that referred Ms. Center to you? 21 A. I think it was Desha Frankel. 22 Q. And then the next thing is a two-page 23 document. It's entitled Progress Note. The 24 provider is Barry Rives, MD. It's dated January 25 22nd, 2005. And the last two numbers of the Bates</p>
<p style="text-align: right;">Page 27</p> <p>1 provided to our office. 2 A. Yes. 3 Q. By the way, Doctor, if there is some 4 question that I ask you that later on in the 5 deposition it reminds you of a more complete answer, 6 please do so. Okay? 7 A. Sure. 8 Q. All right. Now, this chart starts with 9 -- it looks like the patient information sheet. Is 10 this something that is filled out by the patient on 11 the top half and then -- well, stop that. What is 12 this? 13 A. It's a demographic sheet filled out by 14 the patient. 15 Q. Okay. And the second page, third page 16 -- second page, third page are front and back of a 17 license. The fourth page is Blue Cross Blue Shield. 18 Fifth is the back page of Blue Cross Blue Shield. 19 Page 6 -- when I say the pages, they are all Bates 20 stamped pages on the bottom. I put everything in -- 21 I'm just the exact opposite of a doctor, I put 22 everything oldest first and newest last, as opposed 23 to a chart that you want to see the most recent 24 stuff. So that's why I do this. 25 Now, the Bates stamp page 8, this</p>	<p style="text-align: right;">Page 29</p> <p>1 stamp are number ten. Are you at that page, Doctor? 2 A. Yes. 3 Q. Is this -- is this a document, this 4 two-page document, something that you would prepare? 5 A. I prepare most of this, yes. 6 Q. Okay. You would have prepared it on 7 January 22nd, 2015? 8 A. Correct. 9 Q. So you've got a chief complaint, it 10 says referred by Dr. Frankel for a para -- say that 11 for me again. 12 A. Paraesophageal. 13 Q. Paraesophageal hernia repair. So that 14 was the complaint that she came to you with, that 15 she had a paraesophageal hernia and you were to work 16 her up to see if you could help repair that? 17 A. That is correct. 18 Q. All right. Now, it's got the history 19 and physical. You talk about her being referred for 20 a moderate to large-size hernia, what her problems 21 were. And then it shows EGD showing antrum 22 gastritis and large -- that word "hernia." What is 23 an EGD -- what is an EGD? 24 A. Esophagogastroduodenoscopy. 25 Q. And that report is in here somewhere,</p>

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<p style="text-align: right;">Page 30</p> <p>1 is it not?</p> <p>2 A. I believe it is.</p> <p>3 Q. And we'll get to that. And then there</p> <p>4 is a HIDA with RX normal. What is that?</p> <p>5 A. HI-SCAN is a radiology test that looks</p> <p>6 at the function of the gallbladder.</p> <p>7 Q. And then UTZ?</p> <p>8 A. Ultrasound.</p> <p>9 Q. And a CT, would this be a CT of the</p> <p>10 abdomen?</p> <p>11 A. Yes.</p> <p>12 Q. And then a UGI -- excuse me. Could you</p> <p>13 help me understand what UGI means?</p> <p>14 A. Upper GI study. It's a barium test</p> <p>15 where the patient swallows barium, they watch for</p> <p>16 the esophageal motility, and it clarifies the</p> <p>17 anatomy of the stomach as it relates to the chest</p> <p>18 and diagram. As well as whether it's obstructed or</p> <p>19 whether it's clear.</p> <p>20 Q. All right. And the reason that you</p> <p>21 have the patient undergo the EGD -- the HIDA, the</p> <p>22 EGD, the CT, and the UGI is to get a picture of the</p> <p>23 patient's condition prior to surgery?</p> <p>24 A. Correct.</p> <p>25 Q. And then the next page. You show the</p>	<p style="text-align: right;">Page 32</p> <p>1 Q. Okay. So as a general rule when you</p> <p>2 chart in your own office, you don't sign the chart,</p> <p>3 you just --</p> <p>4 A. Well, it's an electronic signature.</p> <p>5 Q. Okay.</p> <p>6 A. There is no written chart to actually</p> <p>7 sign. So when we print it out, it goes off as being</p> <p>8 signed at that time.</p> <p>9 Q. Okay. The next thing I have is a</p> <p>10 telephone encounter. It says answered by Rives,</p> <p>11 Barry J. Does that mean that you actually spoke</p> <p>12 with someone?</p> <p>13 A. Not necessarily. That just means I'm</p> <p>14 the provider for that patient.</p> <p>15 Q. Then page 13, dated January 29, 2015.</p> <p>16 Although it says answered by Barry Rives, comma,</p> <p>17 Barry J., this may be something actually done by</p> <p>18 someone other than you? Although this looks pretty</p> <p>19 technical, so --</p> <p>20 A. So it says action taken, and you'll see</p> <p>21 my name by that. So that's where I put in the</p> <p>22 sentence that follows. And that was a direction to</p> <p>23 Azaria, my medical assistant at the time.</p> <p>24 Q. All right. So this -- I think I have</p> <p>25 this understood. This is what you're advising your</p>
<p style="text-align: right;">Page 31</p> <p>1 vitals, you do a general examination, then you do an</p> <p>2 assessment, and then you do a plan. And I'm looking</p> <p>3 at the plan here. Looks like what you did is had to</p> <p>4 go through all these different tests and explain to</p> <p>5 her that she's a candidate for this type of surgery?</p> <p>6 MR. DOYLE: Let me just belatedly object that</p> <p>7 it mischaracterizes the evidence.</p> <p>8 MR. BRENSKE: I would be more than happy to</p> <p>9 correct anything that you think I mischaracterized.</p> <p>10 MR. DOYLE: I believe most, if not all, of</p> <p>11 these tests were performed before the referral</p> <p>12 rather than him having ordered them.</p> <p>13 BY MR. BRENSKE:</p> <p>14 Q. Okay. But the tests -- just so that</p> <p>15 we're clear, so the jury understands. The tests</p> <p>16 that are listed in your chart, those tests' reports</p> <p>17 are in your chart?</p> <p>18 A. I believe they are, yes.</p> <p>19 Q. All right. And then we do the plan, I</p> <p>20 think it was under plan. And it shows that all this</p> <p>21 was done on the 22nd of January 2015. It states</p> <p>22 electronically signed by Barry Rives, MD, on</p> <p>23 06-09-16 at 2:34 p.m. PDT, is that when we</p> <p>24 requested these records? Do you have any idea?</p> <p>25 A. Yeah. When they get printed out.</p>	<p style="text-align: right;">Page 33</p> <p>1 people to get ready for?</p> <p>2 A. Correct.</p> <p>3 Q. Then the next thing I have is dated</p> <p>4 June 6 -- excuse me, June 11 of 2015. It says</p> <p>5 follow up on surgery. The history and physical</p> <p>6 states postop. I don't want to get into all that.</p> <p>7 It looks like the patient is somewhat better but</p> <p>8 tired? I don't want to put words in your mouth or</p> <p>9 overly condense it, just...</p> <p>10 A. I say, "Still quite fatigued and tires</p> <p>11 easily."</p> <p>12 Q. Then under surgical history you talk</p> <p>13 about Vickie's past history of a bladder sling in</p> <p>14 2009. Bilateral carpal tunnel in 2010 and '11.</p> <p>15 Hysterectomy and no sequela or anesthesia in January</p> <p>16 2013. Then a paraesophageal hernia repair with</p> <p>17 repeat -- what does DX scope mean?</p> <p>18 A. Diagnostic laparoscopy.</p> <p>19 Q. As well as perforation of the gastric</p> <p>20 ulcer. Then it says hospitalization, major</p> <p>21 diagnostic procedure. You say the hernia repair</p> <p>22 with a postop sepsis -- excuse me -- sepsis 2015.</p> <p>23 February 2015. And your thought process at the time</p> <p>24 was the sepsis was a lung infection due to</p> <p>25 aspiration?</p>

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<p style="text-align: right;">Page 34</p> <p>1 A. At the time of this office visit?</p> <p>2 Yeah.</p> <p>3 Q. Okay. Has that changed?</p> <p>4 A. No.</p> <p>5 Q. I'm going to go to page 19 of the</p> <p>6 document. It's the lab report. Labs. This is</p> <p>7 something that you would request that the patient</p> <p>8 get prior to undergoing the hernia repair surgery.</p> <p>9 Is that a fair statement?</p> <p>10 A. I either would have requested it or</p> <p>11 that some other doctor had already done the labs for</p> <p>12 me, yes.</p> <p>13 Q. Was there anything contained in this</p> <p>14 document that was concerning to you with regards to</p> <p>15 going forward with your surgical procedure?</p> <p>16 A. No.</p> <p>17 Q. Then on page 22 to 23, this is an upper</p> <p>18 endoscopy report done November 5th, 2014. And this</p> <p>19 -- just tell the jury what an upper endoscopy report</p> <p>20 -- no. What does an upper endoscopy do?</p> <p>21 A. The gastroenterologist takes a</p> <p>22 gastroscope, places it through the oropharynx while</p> <p>23 the patient is under modern anesthetic care to</p> <p>24 evaluate the oropharynx, the esophagus, the stomach,</p> <p>25 as well as the duodenum.</p>	<p style="text-align: right;">Page 36</p> <p>1 A. Yes.</p> <p>2 Q. That was dated in September of 2014.</p> <p>3 And the gallbladder ultrasound indicated to you that</p> <p>4 she had a normal gallbladder. No evidence of</p> <p>5 gallstones or sludge?</p> <p>6 A. Correct.</p> <p>7 Q. Then there was CT abdomen of the pelvis</p> <p>8 without contrast dated May 24. This is in April of</p> <p>9 2014, about ten months before the surgery. What's</p> <p>10 the purpose of doing the CT abdomen/pelvis without</p> <p>11 contrast?</p> <p>12 A. I didn't order the test. It was</p> <p>13 ordered by Dr. Torres. So I'm not sure what his</p> <p>14 indication for ordering the test was.</p> <p>15 Q. What did this test tell you about</p> <p>16 Vickie's condition?</p> <p>17 A. It didn't really contribute much to my</p> <p>18 thought process.</p> <p>19 Q. Then the next page, 25, it's an upper</p> <p>20 GI that was done December of 2014. This is</p> <p>21 something you had ordered or was it ordered previous</p> <p>22 to the patient seeing you?</p> <p>23 A. It was ordered by Dr. Frankel.</p> <p>24 Q. What did this report, if anything, tell</p> <p>25 you about Vickie Center's condition in regards to</p>
<p style="text-align: right;">Page 35</p> <p>1 Q. All right. And this is report is to</p> <p>2 provided to you to help you understand the</p> <p>3 situation?</p> <p>4 A. That is correct.</p> <p>5 Q. So the -- it says the esophagus was</p> <p>6 examined and no abnormalities were being seen;</p> <p>7 correct? Under findings?</p> <p>8 A. Yes.</p> <p>9 Q. And then the stomach was examined and</p> <p>10 no abnormalities were seen?</p> <p>11 A. Correct.</p> <p>12 Q. And then -- give me that word, duo --</p> <p>13 A. Duodenum.</p> <p>14 Q. The duodenum was examined and no</p> <p>15 abnormalities were seen, but there was a large</p> <p>16 hiatal hernia and mild erosive gastritis; correct?</p> <p>17 A. In the antrum, yes.</p> <p>18 Q. Where is the antrum?</p> <p>19 A. The body of the stomach.</p> <p>20 Q. So what this would tell you is that</p> <p>21 she's a candidate for the hernia surgery?</p> <p>22 A. It's one of the factors that go into</p> <p>23 it, yes.</p> <p>24 Q. Then you were given the report, the</p> <p>25 gallbladder ultrasound?</p>	<p style="text-align: right;">Page 37</p> <p>1 you operating on her in February of 2015?</p> <p>2 A. The no demonstration of</p> <p>3 gastroesophageal reflux disease was one of the</p> <p>4 considerations. That's it.</p> <p>5 Q. Okay. There is another -- excuse me --</p> <p>6 report that's in your chart. I think this is a HIDA</p> <p>7 scan, but they call it A&M radionuclide</p> <p>8 hepatobiliary scan with Ensure Plus?</p> <p>9 A. Correct.</p> <p>10 Q. Okay. What did this report tell you</p> <p>11 with regards to Vickie's condition?</p> <p>12 A. That her pain and symptoms were not</p> <p>13 related to her gallbladder.</p> <p>14 Q. Then the next page, pages I'm looking</p> <p>15 at are simply four pages of records from January 15</p> <p>16 of 2015 from Dr. Frankel. These are not your</p> <p>17 records, obviously, but they are part of your chart.</p> <p>18 Fair statement?</p> <p>19 A. Correct.</p> <p>20 Q. And on the fourth page where it says</p> <p>21 32, synopsis, Dr. Rives, general surgeon,</p> <p>22 consultation for consideration for hiatal hernia</p> <p>23 repair either electrically or chest pain or</p> <p>24 dysphagia if worsen in the future. Do you see that?</p> <p>25 A. Yes.</p>

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<p style="text-align: right;">Page 38</p> <p>1 Q. Dysphagia is difficulty swallowing?</p> <p>2 A. Yes.</p> <p>3 Q. Okay. So this document basically is</p> <p>4 Dr. Frankel recommending Ms. Center see you?</p> <p>5 A. Rephrase that.</p> <p>6 Q. Sure. This document is a</p> <p>7 recommendation of Dr. Frankel to see you?</p> <p>8 A. Yes.</p> <p>9 Q. Then the next page, 33, there is</p> <p>10 several things on here. This is where Jessica</p> <p>11 Lucero shows up in your records. And the -- there</p> <p>12 is a statement, "Patient is low risk for cardiac and</p> <p>13 pulmonary complications related to the surgery." Do</p> <p>14 you see that?</p> <p>15 A. Yes.</p> <p>16 Q. Now, is that something that was</p> <p>17 provided to you by Ms. Lucero?</p> <p>18 A. By the -- by their office, yes.</p> <p>19 Q. By their office. All right. Then</p> <p>20 you've got more labs. Anything in these labs give</p> <p>21 you cause?</p> <p>22 A. No.</p> <p>23 Q. Excuse me. Then I've got page 36.</p> <p>24 Take a wild guess and say this is some sort of</p> <p>25 cardiac thing to show that her heart is working.</p>	<p style="text-align: right;">Page 40</p> <p>1 MR. DOYLE: I'm sorry. What page?</p> <p>2 MR. BRENSKE: Page 39. Just trying to help</p> <p>3 you fall asleep.</p> <p>4 MR. DOYLE: It's working.</p> <p>5 MR. BRENSKE: It is. I thought it would.</p> <p>6 BY MR. BRENSKE:</p> <p>7 Q. So I'm looking at page 39, and it's the</p> <p>8 -- it's -- it looks like -- well, what is an x-ray</p> <p>9 of the unilateral ribs?</p> <p>10 A. It's a -- well, this is actually ribs</p> <p>11 with a PA chest. So it looks like it's a plain film</p> <p>12 x-ray taken either for rib pain, seeing if there is</p> <p>13 a fracture of the ribs, as well as a view of the</p> <p>14 chest.</p> <p>15 Q. Okay. This is just something that is</p> <p>16 part of your chart or did you order it?</p> <p>17 A. No. Lucero ordered it. So it came</p> <p>18 from their records.</p> <p>19 Q. Now, the next document I've got is a</p> <p>20 faxed document dated February 7th of 2015 at 1:14</p> <p>21 p.m. -- a.m. I don't know if that's correct or not.</p> <p>22 And it's from St. Rose Dominican-San Martin to you.</p> <p>23 And then the next three pages are your operative</p> <p>24 report of February 6, 2015. Do you see that?</p> <p>25 A. Yes.</p>
<p style="text-align: right;">Page 39</p> <p>1 Okay?</p> <p>2 A. Basically, yes.</p> <p>3 Q. Okay. That was a shot. I wasn't sure</p> <p>4 of that.</p> <p>5 All right. And then the next page</p> <p>6 that's signed by you, what is this document?</p> <p>7 A. This is the patient's preoperative</p> <p>8 orders.</p> <p>9 Q. And what are the preoperative orders</p> <p>10 with regards to this patient made by you?</p> <p>11 A. They include the diagnosis, the</p> <p>12 consent, the patient's information, the antibiotics</p> <p>13 to give preoperatively. That sequential compression</p> <p>14 devices are to be placed on the patient in the</p> <p>15 operating room.</p> <p>16 Q. Now, it's got your signature and then</p> <p>17 something to the right. Can you tell me what that</p> <p>18 is?</p> <p>19 A. That is my signature to the right.</p> <p>20 It's signed Barry J. Rives. Below it says Rives</p> <p>21 10642, which is my Nevada medical license number,</p> <p>22 the date and time.</p> <p>23 Q. Thank you. The next thing I have in</p> <p>24 your chart is a September 8, 2014, XR unilateral</p> <p>25 ribs with PA chest. Just says --</p>	<p style="text-align: right;">Page 41</p> <p>1 Q. So is that standard procedure when you</p> <p>2 do a surgery at St. Rose Dominican, they fax you</p> <p>3 your operative report?</p> <p>4 A. They fax me my operative reports and my</p> <p>5 consultation reports, yes.</p> <p>6 Q. Okay. Is that automatic?</p> <p>7 A. Yes.</p> <p>8 Q. Okay.</p> <p>9 MR. BRENSKE: Now, we're going to take about a</p> <p>10 five-minute break, if that's all right with</p> <p>11 everybody, because I want to go over this operative</p> <p>12 report. And in order for me to understand what</p> <p>13 you're doing, I've got pictures that might help me</p> <p>14 figure out what you're doing. So you're going to</p> <p>15 have to give me five minutes.</p> <p>16 THE VIDEOGRAPHER: We are off the record at</p> <p>17 11:58 a.m.</p> <p>18 (Off the record.)</p> <p>19 THE VIDEOGRAPHER: We're back on the record at</p> <p>20 12:09 p.m.</p> <p>21 BY MR. BRENSKE:</p> <p>22 Q. I always jump the gun.</p> <p>23 All right. Doctor, you're looking</p> <p>24 in your chart and we're at the surgical procedure</p> <p>25 you performed on Vickie Center on February 6 of</p>

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<p style="text-align: right;">Page 42</p> <p>1 2015. That surgical procedure, the periesopha --</p> <p>2 the hernia repair, how does that -- how long would</p> <p>3 you expect that operation to take?</p> <p>4 A. It takes me anywhere from an hour and a</p> <p>5 half to well over two and a half hours sometimes.</p> <p>6 Q. Do you recall any specific difficulty</p> <p>7 you may have had with this surgical procedure?</p> <p>8 A. Off the top of my head, no.</p> <p>9 Q. With regards to the surgical procedure</p> <p>10 of February 6 of 2015, when would you have expected</p> <p>11 Ms. Center to be released from the hospital?</p> <p>12 A. While I was performing the surgery or</p> <p>13 afterwards or preoperatively?</p> <p>14 Q. The surgical procedure that you</p> <p>15 performed on Vickie Center, the surgical procedure</p> <p>16 itself was February 6 of 2015. So I'm going to</p> <p>17 assume that's when she went to the hospital?</p> <p>18 A. Correct.</p> <p>19 Q. Okay. And what day would you have</p> <p>20 expected her to leave the hospital?</p> <p>21 A. When I completed the surgery, she was</p> <p>22 to be admitted overnight. My expectation she would</p> <p>23 go home the next day.</p> <p>24 Q. Do you remember when Ms. Center</p> <p>25 actually left the hospital?</p>	<p style="text-align: right;">Page 44</p> <p>1 Q. And the hospitalist would have been the</p> <p>2 person in charge. Is that a fair statement?</p> <p>3 MR. DOYLE: Object. The question is vague.</p> <p>4 But go ahead.</p> <p>5 MS. DAEHNKE: Join.</p> <p>6 THE WITNESS: Okay.</p> <p>7 BY MR. BRENSKE:</p> <p>8 Q. Just ignore them and answer me.</p> <p>9 A. Okay. Sorry.</p> <p>10 Q. That's all right.</p> <p>11 A. Basically, yes.</p> <p>12 Q. All right. So let's go through this</p> <p>13 sort of procedure. Now, I've got some pictures</p> <p>14 here. We don't have to mark them as exhibits, I'm</p> <p>15 not going to use them at trial. I'm -- this is for</p> <p>16 my own edification, so I'm not going to take this</p> <p>17 and say, hey, you marked on this in your deposition</p> <p>18 and you marked over here in your trial. Just so</p> <p>19 Mr. Doyle has an understanding of what I want to do</p> <p>20 here. This is to educate me.</p> <p>21 MR. DOYLE: But if he's -- if you're going to</p> <p>22 ask him to write on them or mark them, then I would</p> <p>23 want to make them exhibits.</p> <p>24 MR. BRENSKE: Then we can.</p> <p>25 MR. DOYLE: Okay.</p>
<p style="text-align: right;">Page 43</p> <p>1 A. I don't recall the exact date, no.</p> <p>2 Q. When Ms. Center left the hospital, did</p> <p>3 she go home or did you refer her to any</p> <p>4 rehabilitation hospital?</p> <p>5 A. I believe the hospitalist would have</p> <p>6 referred her to a rehabilitation center.</p> <p>7 Q. With regards to Ms. Center, were you</p> <p>8 the admitting physician?</p> <p>9 A. No.</p> <p>10 Q. Who was the admitting physician?</p> <p>11 A. Dr. Siddiqui was.</p> <p>12 Q. While Mrs. Center was in the hospital,</p> <p>13 were you her primary care physician?</p> <p>14 A. No. I was not.</p> <p>15 Q. Who was her primary care physician?</p> <p>16 A. It's not a correct term to really use</p> <p>17 primary care physician. There is a hospitalist who</p> <p>18 is the admitting physician who will oversee the care</p> <p>19 of the patient, and then everybody else is</p> <p>20 considered a consultant to the case.</p> <p>21 Q. So you would have been -- while --</p> <p>22 while Ms. Center was in the hospital at St. Rose</p> <p>23 Dominican-San Martin Campus, you would have been</p> <p>24 considered one of the consultants?</p> <p>25 A. Correct.</p>	<p style="text-align: right;">Page 45</p> <p>1 MR. BRENSKE: That's not a problem whatsoever.</p> <p>2 Next in order.</p> <p>3 (Exhibit 5 marked.)</p> <p>4 BY MR. BRENSKE:</p> <p>5 Q. Dr. Rives, I'm showing you what's been</p> <p>6 marked for identification purposes as Plaintiffs'</p> <p>7 Proposed Exhibit No. 5, I believe. It's simply an</p> <p>8 anatomical drawing that I took to give me a simple</p> <p>9 understanding of the structures that are in the</p> <p>10 general area of your surgical procedure. How did I</p> <p>11 do?</p> <p>12 A. Fair.</p> <p>13 Q. Fair. All right. I'm sure there is a</p> <p>14 lot more going on there, but only so much I can</p> <p>15 handle. So obviously this shows the esophagus, it</p> <p>16 shows the liver that overlies the stomach and the</p> <p>17 top of the stomach, correct?</p> <p>18 A. From this point of view, yes.</p> <p>19 Q. And when you performed your surgical</p> <p>20 procedure, the patient's in the supine position or</p> <p>21 on her back?</p> <p>22 A. Correct.</p> <p>23 Q. So you're going from -- you're going</p> <p>24 from the front in?</p> <p>25 A. Yes.</p>

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<p style="text-align: right;">Page 46</p> <p>1 Q. The anterior right there. Now, what is 2 the purpose of a laparoscopic Nissen fundoplication 3 surgery? 4 A. There's a couple goals to the surgery 5 when you repair somebody's hiatal hernia, 6 diaphragmatic hernia. The first is to get the 7 stomach or other -- out of the hernia, which is 8 basically inside the patient's chest, bring it back 9 down inside the abdomen where it belongs. Then you 10 close the diaphragmatic hernia repair so that it 11 won't slide up there again. 12 And then the fundoplication part 13 is where you wrap the stomach around itself to 14 support reflux if it happens after diaphragmatic 15 repair. It also holds the esophagus partially 16 within the abdomen, keeping it from falling back up 17 into the chest. 18 Q. What is the definition of hernia that I 19 could understand? 20 A. Hernia is a hole in the abdominal wall. 21 Q. When you say hole, that means there is 22 a frank hole in the -- or is there a weakness? 23 A. In the case of the diaphragm, there is 24 already an existing hole called the hiatus. And as 25 that expands and gets larger, it becomes a hernia</p>	<p style="text-align: right;">Page 48</p> <p>1 BY MR. BRENSKE: 2 Q. Now, six is just a diagram that says 3 Laparoscopic Nissen Fundoplication Surgery, using 4 laparoscopic instruments. Fair statement? 5 A. Correct. 6 Q. All right. Now, getting back to 7 Exhibit 5, what structures are you either 8 retracting, moving, up against when you performed 9 the surgery that you performed on Vickie Center? 10 A. We have to retract the left lobe of the 11 liver. We then are operating on the stomach. Which 12 is attached to the spleen by short gastrics. And 13 then operating through the hiatus of the diaphragm, 14 where there is the esophagus, the vagal nerves, the 15 heart, and both lobes or both sides of the lung. 16 The aorta and IVC are also within that area. 17 Q. What does IVC mean? 18 A. Inferior vena cava. 19 Q. Got it. On Exhibit 5 can you see the 20 left lobe of the liver? 21 A. Yes. 22 Q. And can you see the stomach? 23 A. Yes. 24 Q. What other structures that you just 25 discussed can you see on Exhibit 5?</p>
<p style="text-align: right;">Page 47</p> <p>1 hole. If it happens anywhere in your abdominal 2 wall, it's actually a hole or tear of the abdominal 3 wall, whereas a weakness would be considered a 4 diastasis. 5 Q. All right. In Vickie Center's case, 6 what was her condition when you went in to look at 7 her? 8 A. She had a significant size 9 diaphragmatic hernia, with about a third to half of 10 her stomach up in her chest. 11 Q. And your job was to do what? 12 A. Get the stomach out of the hernia, 13 reduce the hernia sac, close the diaphragmatic 14 hernia repair, and then perform a Nissen 15 fundoplication. 16 Q. Okay. So let's start with your -- so 17 looking at Exhibit 5, what area of the body are you 18 dealing with? With what structures? 19 A. This is a poor representation to 20 explain where we are operating. 21 Q. Okay. 22 MR. BRENSKE: Let's mark this as 6 and maybe 23 we'll get better. 24 (Exhibit 6 marked.) 25 / / / /</p>	<p style="text-align: right;">Page 49</p> <p>1 A. The esophagus, that's it. 2 Q. Okay. Just circle them for me so I 3 have something. 4 What instruments do you use in 5 this type of surgery? 6 A. We access the abdomen, via a Veress 7 needle to cause insufflation of the abdomen. We 8 then use trocars, which are sleeves, for lack of a 9 better word, to pass instruments in and out of the 10 abdomen. We use a liver retractor to move the left 11 lobe of the liver out of the way of dissection. 12 Then we use various instrumentations to grasp and 13 handle the organs. 14 Q. What instrumentations are those? 15 A. There is a variety of grasping 16 instruments. They're all laparoscopic. Then we'll 17 use a coagulation device to control bleeding. 18 Q. Modern science. All right. So a 19 coagulation device, what is -- is that -- is that a 20 heated device? 21 A. In this case I was using a harmonic 22 scalpel, which works on an ultrasonic vibratory wave 23 to control bleeding. 24 Q. But the harmonic scalpel is to cut 25 things away?</p>

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<p style="text-align: right;">Page 50</p> <p>1 A. It's effectively to burn and cut things 2 away, yes. 3 Q. All right. So let's go to your 4 operative report. And we're just going to have to 5 go through it, but you're going to have to explain 6 it in laymen's terms as to what you're doing and 7 what devices you're doing, okay? Can you do that 8 for me? 9 A. Sure. 10 Q. All right. So it says you've got the 11 informed consent -- oh, in this surgical procedure 12 who did you have, if anyone, to assist you? 13 A. There is a scrub tech that's helping me 14 with the procedure. There was no other surgeons 15 involved in the case. 16 Q. All right. So if anybody is using a 17 trocar or a harmonic scalpel, that's going to be 18 you? 19 A. I'm the only one manipulating tissue, 20 yes. 21 Q. All right. Much better answer than the 22 question. 23 All right. So let's go through 24 this. You begin with a small incision in the left 25 upper quadrant, inserting a Veress needle. So the</p>	<p style="text-align: right;">Page 52</p> <p>1 A. Place a five-millimeter trocar into the 2 abdomen and then visualize the anatomy. 3 Q. Okay. And the trocar is a sleeve. It 4 allows you to pass instruments through to look at 5 the anatomy? 6 A. Correct. 7 Q. And that's what you did in this case? 8 A. Yes. 9 Q. And then visualization. Now, this 10 visualization is done how? 11 A. With a videoscope. 12 Q. All right. So you've got a videoscope, 13 you go in there and you look at the abdomen. And 14 that's where you saw the incarcerated paraesophageal 15 hernia? 16 A. Correct. 17 Q. What did you do next? 18 A. I noticed that there were no adhesions 19 in the abdomen. 20 Q. What does that mean in regular folks' 21 terms? 22 A. That there was no scar tissue in the 23 way of the surgery. 24 Q. That's a good thing? 25 A. It is.</p>
<p style="text-align: right;">Page 51</p> <p>1 small incision in the left upper quadrant is used -- 2 are you using a -- what device are you using? Using 3 a scalpel? 4 A. Scalpel. 5 Q. All right. And then what's a Veress 6 needle? 7 A. It's a little needle that has a 8 pressure point such that as you press down, the 9 needle is, in effect, going through the abdomen 10 wall. When it reaches a negative pressure, it 11 automatically retracts. We then hook up the 12 insufflation to the Veress needle and we insufflate 13 the abdomen. 14 Q. In laymen's terms, you take a needle, 15 you puncture the abdomen, you fill it full of air? 16 MR. DOYLE: Let me just object. It 17 mischaracterizes the testimony. 18 Go ahead. 19 THE WITNESS: CO2. 20 BY MR. BRENSKE: 21 Q. CO2. All right. So you balloon up the 22 -- you balloon up the abdomen? 23 A. Basically, yes. 24 Q. All right. What is the next thing you 25 do?</p>	<p style="text-align: right;">Page 53</p> <p>1 Q. All right. 2 A. Then I placed another five-millimeter 3 trocar in the right subxiphoid area to use as a 4 working board for the liver retractor. 5 Q. Okay. Can you in any way, shape or 6 form give us an idea on either Exhibit 5 or Exhibit 7 6 what we're talking about? 8 A. On Exhibit 6 it would be this trocar 9 site here. 10 Q. What's that called? 11 A. Subxiphoid, right side. 12 Q. If you could just write -- you should 13 write whatever word was in your operative report. 14 When I'm looking at that, can look at that and know 15 what's going on. And keep that handy. 16 Okay. Is there any way to show on 17 Exhibit 5 the general area that... 18 A. (Witness indicates.) 19 Q. All right. So we did the right 20 subxiphoid area; correct? 21 A. Correct. 22 Q. All right. What did you do next? 23 A. The liver was -- liver retractor was 24 placed in the abdomen, placed under the left lobe of 25 the liver, retracting it superiorly and medially.</p>

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<p style="text-align: right;">Page 54</p> <p>1 Meaning upwards and towards the midline.</p> <p>2 Q. So explain to the jury what a retractor</p> <p>3 is.</p> <p>4 A. It's a thin, blunt metal instrument</p> <p>5 that you twist on the end, and it will go from a</p> <p>6 straight piece of metal to a triangular formation</p> <p>7 such that you can hold a retract -- hold the liver</p> <p>8 up and out of the way of the dissecting area. It's</p> <p>9 an atraumatic device.</p> <p>10 Q. So you're making a space? You're</p> <p>11 moving the liver out of the way?</p> <p>12 A. That's a better way of saying it, yes.</p> <p>13 Q. All right. Then what did you do? I</p> <p>14 think you took a ten-millimeter trocar?</p> <p>15 A. Yeah. And at that point I placed the</p> <p>16 ten-millimeter trocar, again under direct</p> <p>17 visualization, atraumatically just above the belly</p> <p>18 button. That was going to be my main camera view.</p> <p>19 And then I placed another five-millimeter trocar,</p> <p>20 again under direct visualization, in the subcostal</p> <p>21 region on the left side for another working port.</p> <p>22 Q. All right. So on Exhibit 5 you've</p> <p>23 shown -- if you could show where those are on five,</p> <p>24 that would be great?</p> <p>25 A. Six would probably be easier.</p>	<p style="text-align: right;">Page 56</p> <p>1 causing a strangulation.</p> <p>2 Q. So volvulus is bad?</p> <p>3 A. Yes.</p> <p>4 Q. No volvulus is good?</p> <p>5 A. Yes.</p> <p>6 Q. Okay. When you say it was</p> <p>7 incarcerated, I think you explained that. But just</p> <p>8 do that one more time.</p> <p>9 A. Incarcerated is when an organ goes up</p> <p>10 into a hernia and is attached to the underlying sac.</p> <p>11 In this case when I'm pulling, tugging on the</p> <p>12 stomach, sometimes it will reduce fairly easily,</p> <p>13 meaning it would be a reducible diaphragmatic</p> <p>14 hernia. Or in this case it's pulled back up because</p> <p>15 it's tethered to the sac, in which case it would be</p> <p>16 called incarcerated.</p> <p>17 Q. So this one was incarcerated?</p> <p>18 A. Correct.</p> <p>19 Q. All right. So what did you do next?</p> <p>20 A. The next part was to start mobilizing</p> <p>21 the stomach so that we can reduce it out of the</p> <p>22 chest. I started by taking down the short gastrics</p> <p>23 where the stomach is, in effect, tethered by the</p> <p>24 spleen. That allows me access to the greater</p> <p>25 curvature of the stomach. The left side of the</p>
<p style="text-align: right;">Page 55</p> <p>1 Q. I'm not going to tell you no.</p> <p>2 A. (Witness indicates.)</p> <p>3 Q. Okay. And is there any way you can</p> <p>4 help me on five?</p> <p>5 A. (Witness indicates.)</p> <p>6 Q. All right. That would be the placement</p> <p>7 of all the trocars?</p> <p>8 A. Up to that point, yes.</p> <p>9 Q. Okay. You indicate that -- well, let's</p> <p>10 see, what is the next point? I don't want to get</p> <p>11 lost here. What did you do next?</p> <p>12 A. After the trocar is replaced, then --</p> <p>13 and the liver retractor is in place, I can visually</p> <p>14 inspect the stomach to see the anatomy, how much of</p> <p>15 the stomach is up into the chest and if there is</p> <p>16 going to be any problems with the dissection.</p> <p>17 Q. Okay. Do you see any -- when you</p> <p>18 visualized the stomach, what did you see?</p> <p>19 A. It was not twisted.</p> <p>20 Q. That's a good thing?</p> <p>21 A. Yes. There was no volvulus.</p> <p>22 Q. And what is that?</p> <p>23 A. A volvulus is where the stomach twists</p> <p>24 upon itself causing an obstruction, or it can twist</p> <p>25 on itself causing compromise to its blood flow and</p>	<p style="text-align: right;">Page 57</p> <p>1 diaphragm and the left crus of the diaphragm.</p> <p>2 Q. When you say taking down, what's the --</p> <p>3 what are you actually doing in laymen's terms?</p> <p>4 A. I'm cauterizing and cutting those</p> <p>5 arteries.</p> <p>6 Q. And those are attached to what, those</p> <p>7 arteries?</p> <p>8 A. To the greater curvature of the stomach</p> <p>9 and towards the spleen.</p> <p>10 Q. Okay. So when you're done cutting or</p> <p>11 taking down the short gastrics, what do you do next?</p> <p>12 A. After I was able to see the left crus</p> <p>13 of the diaphragm, now I could dissect the hernia sac</p> <p>14 away from the left crus of the diaphragm, in effect,</p> <p>15 releasing the stomach. And I carried that</p> <p>16 posteriorly, in other words, behind the esophagus</p> <p>17 and behind the stomach; and then anteriorly, on top</p> <p>18 of the stomach and the esophagus.</p> <p>19 Q. All right. And that's all used with a</p> <p>20 harmonic scalpel?</p> <p>21 A. Correct.</p> <p>22 Q. What did you do next?</p> <p>23 A. Once that was reduced and sat fairly</p> <p>24 easy in the abdomen, I then had to work on the other</p> <p>25 side of the stomach, also known as the lesser</p>

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<p style="text-align: right;">Page 58</p> <p>1 curvature.</p> <p>2 Q. And what did you do with regards to</p> <p>3 that part of the stomach?</p> <p>4 A. Released the adhesions and hernia sac</p> <p>5 on the right side of the stomach until I could see</p> <p>6 the right crus of the diaphragm.</p> <p>7 Q. That would have been done with the</p> <p>8 harmonic scalpel?</p> <p>9 A. Mostly, yes.</p> <p>10 Q. What other instruments would you</p> <p>11 normally use to do that?</p> <p>12 A. I could use scissors or sometimes</p> <p>13 bluntly they'll dissect out.</p> <p>14 Q. Okay. In this particular operative</p> <p>15 report, can you tell what you did?</p> <p>16 A. Well, I don't dictate every last little</p> <p>17 move that I make. So if I use a blunt instrument</p> <p>18 for two little moves, I wouldn't necessarily dictate</p> <p>19 that. So I don't have an instant recollection of</p> <p>20 how many times I used the scissors or I used a blunt</p> <p>21 instrument.</p> <p>22 Q. Okay. So you would normally use a</p> <p>23 harmonic scalpel, a blunt instrument, and scissors?</p> <p>24 A. Yes.</p> <p>25 Q. Okay. Please tell us what you did</p>	<p style="text-align: right;">Page 60</p> <p>1 either a harmonic scalpel, scissors or a blunt</p> <p>2 instrument?</p> <p>3 A. Correct.</p> <p>4 Q. What did you do next? This is easy for</p> <p>5 me. I just say what did you do next and you've got</p> <p>6 to tell me.</p> <p>7 A. By the time -- at that point I had two</p> <p>8 to three centimeters of esophagus that was stained</p> <p>9 within the abdomen, the hernia sac was reduced. The</p> <p>10 stomach wasn't falling into the hernia, so we</p> <p>11 effectively had everything reduced. There was no</p> <p>12 incarceration anymore. I then placed a Penrose</p> <p>13 drain around the esophagus and retracted it</p> <p>14 laterally.</p> <p>15 Q. What is the purpose of the Penrose</p> <p>16 drain?</p> <p>17 A. The Penrose drain is a way to</p> <p>18 manipulate the esophagus so that the esophagus</p> <p>19 doesn't tear and cause a perforation.</p> <p>20 Q. What did you do next?</p> <p>21 A. With everything reduced, the object now</p> <p>22 was to close the diaphragmatic fundus repair. And I</p> <p>23 did that with figure-eight stitches of 2-0 Vicryl</p> <p>24 suture. Approximately four were placed.</p> <p>25 Q. Where exactly were they placed?</p>
<p style="text-align: right;">Page 59</p> <p>1 next.</p> <p>2 A. Right crus was then dissected away from</p> <p>3 the hernia sac and from the esophagus. At that</p> <p>4 point we cleaned up the right side and now I have to</p> <p>5 create a posterior window behind the esophagus, A,</p> <p>6 to make sure that it's clear from the hernia sac and</p> <p>7 that it won't pull back into the chest. This is</p> <p>8 also going to be the window I use to bring the</p> <p>9 stomach from one side of the abdomen to the other to</p> <p>10 create my Nissen fundoplication.</p> <p>11 Q. All right. What is a crus?</p> <p>12 A. The crus are where the leaf of the</p> <p>13 diaphragm come together in this hiatus. They are</p> <p>14 basically musculature. There is no real cartilage</p> <p>15 to them. There is no real structural support to</p> <p>16 them. They are thicker than the rest of the</p> <p>17 diaphragm, but they are basically muscle.</p> <p>18 Q. Okay. So what did you do next?</p> <p>19 A. We then -- or I then start to dissect</p> <p>20 the remaining hernia sac out of the mediastinum. So</p> <p>21 that way the esophagus would be free and that way I</p> <p>22 can keep part of the esophagus in the abdominal</p> <p>23 cavity, rather than having it pulling back up into</p> <p>24 the chest.</p> <p>25 Q. And that dissection would be done using</p>	<p style="text-align: right;">Page 61</p> <p>1 A. You're closing the left crus of the</p> <p>2 diaphragm to the right crus of the diaphragm.</p> <p>3 Basically you're tightening up the hiatus of the</p> <p>4 diaphragm.</p> <p>5 Q. What did you do next?</p> <p>6 A. I made sure that there was adequate</p> <p>7 mobilization of the esophagus so that my closure</p> <p>8 didn't create any tension. It didn't require any</p> <p>9 mesh implantation. And then I went on to do the</p> <p>10 Nissen fundoplication.</p> <p>11 Q. And just in general terms, what is a</p> <p>12 Nissen fundoplication?</p> <p>13 A. Nissen fundoplication is where you take</p> <p>14 the greater curvature of the stomach. You wrap it</p> <p>15 around to the anterior part of the stomach, creating</p> <p>16 fundoplication or taco or whatever term you want to</p> <p>17 use, wrapping the stomach.</p> <p>18 Q. If you look at Exhibit 6, is that an</p> <p>19 example?</p> <p>20 A. Yes, it is.</p> <p>21 Q. What did you do next?</p> <p>22 A. Secured the fundoplication.</p> <p>23 Q. How do you do that?</p> <p>24 A. In this case I used the 2-0 Vicryl</p> <p>25 suture on the initial closure to attach it briefly</p>

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<p style="text-align: right;">Page 62</p> <p>1 to the esophagus. And then I used Ethibond sutures</p> <p>2 above and below that, that are stomach to stomach.</p> <p>3 Q. All right. I don't want to</p> <p>4 oversimplify, but you stitched it together?</p> <p>5 A. Yes.</p> <p>6 Q. That's pretty much you're done? What</p> <p>7 did you do next?</p> <p>8 A. No.</p> <p>9 Q. No?</p> <p>10 A. You have to assess whether the wrap is</p> <p>11 too tight. I put an instrumentation underneath</p> <p>12 there to make sure that the wrap is what we kind of</p> <p>13 call floppy. In the old days they were always too</p> <p>14 tight and caused esophageal problems for patients.</p> <p>15 We've since learned that that's a big thing to</p> <p>16 avoid. So we make sure that we do what's called a</p> <p>17 floppy closure. And then at that point, reevaluate</p> <p>18 the crura to make sure that the closure I did was</p> <p>19 still intact. I inspected the liver to make sure</p> <p>20 there is no injury to the liver. There was no</p> <p>21 capsular tears. I then watch the retractor be</p> <p>22 removed safely. I visualized the short gastrics to</p> <p>23 make sure there was no bleeding in that area. And</p> <p>24 then there's no bleed from the stomach or the</p> <p>25 spleen.</p>	<p style="text-align: right;">Page 64</p> <p>1 that referring physician is Dr. Siddiqui. That</p> <p>2 would be the hospitalist?</p> <p>3 A. That's correct.</p> <p>4 Q. Okay. Prior to the 2D echo with</p> <p>5 Doppler, did you have any discussions with</p> <p>6 Dr. Siddiqui concerning the need for this test?</p> <p>7 A. No.</p> <p>8 Q. What is your understanding of the</p> <p>9 purpose for this test?</p> <p>10 A. At this time when she was going into</p> <p>11 sepsis, one of the differential diagnosis between</p> <p>12 Dr. Siddiqui, intensivists, and other consultants</p> <p>13 would be whether she was having a cardiogenic</p> <p>14 episode that would be causing her signs and</p> <p>15 symptoms. One of the ways to rule that out would be</p> <p>16 to do a 2D echo to look at the ejection fraction of</p> <p>17 the heart, to look at the wall motion of the heart,</p> <p>18 and to hopefully access the valves of the heart.</p> <p>19 Q. What did this test result tell you</p> <p>20 about the heart?</p> <p>21 A. Well, I don't interpret these, so...</p> <p>22 Q. All right. And I apologize, I didn't</p> <p>23 -- you don't read those -- you don't -- I apologize.</p> <p>24 When you say you don't interpret these, does that</p> <p>25 mean you don't look at the document itself or you</p>
<p style="text-align: right;">Page 63</p> <p>1 At that point we opened up the</p> <p>2 trocar to let all the CO2 that we can out of the</p> <p>3 abdomen, and we removed the trocars and close the</p> <p>4 incisions. The larger trocars have to be closed at</p> <p>5 the fascial level because they have a risk of</p> <p>6 herniation. The five millimeters do not. Then we</p> <p>7 use local injection for pain control and suture the</p> <p>8 skin closed. At that point they put on sterile dry</p> <p>9 dressings. The patient is extubated and transferred</p> <p>10 to the recovery.</p> <p>11 Q. If at any time you had caused an injury</p> <p>12 to the abdomen or any other structures that you're</p> <p>13 working in, it would have been your responsibility</p> <p>14 to repair those structures. Fair statement?</p> <p>15 A. That is correct.</p> <p>16 Q. In this particular surgery you did not</p> <p>17 see any injuries to any of the structures, therefore</p> <p>18 you did not have to make any repairs of any. Fair</p> <p>19 statement?</p> <p>20 A. That is correct.</p> <p>21 Q. Going to -- we're just continuing on in</p> <p>22 your chart. And I'm looking at page 45 and 46, a 2D</p> <p>23 echo with Doppler. Can you tell us what that is?</p> <p>24 A. This is an echo exam of the heart.</p> <p>25 Q. All right. Did you order -- this shows</p>	<p style="text-align: right;">Page 65</p> <p>1 don't look at the report? What don't you do?</p> <p>2 A. If I have an echo come to me in a</p> <p>3 preoperative setting from a cardiologist, I will</p> <p>4 scan it to look for anything grossly abnormal that</p> <p>5 may catch my eye. In the context of when this was</p> <p>6 performed, the intensivist and Dr. Siddiqui would</p> <p>7 have been responsible for this. This comes to my</p> <p>8 office back from the hospital subsequent to how</p> <p>9 things were proceeding.</p> <p>10 Q. All right. So you would not be made</p> <p>11 aware of the results at the time the results came</p> <p>12 in?</p> <p>13 A. Only if one of the hospitalists or</p> <p>14 intensivists brought it to my attention.</p> <p>15 Q. Okay. As part of your practice, do you</p> <p>16 look at the reports themselves?</p> <p>17 A. Sometimes, yes.</p> <p>18 Q. Are you able as a doctor to look at a</p> <p>19 report and -- strike that.</p> <p>20 What does this report tell you?</p> <p>21 A. The report says the patient had an</p> <p>22 elevated heart rate during the study. It says that</p> <p>23 the ventricular systolic function appears to be</p> <p>24 normal, between 50 and 55. The remaining heart</p> <p>25 appears to be normal in terms of its atrial size,</p>

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<p style="text-align: right;">Page 66</p> <p>1 it's aortic root diameter, mitral valve function, 2 right ventricular function. There is no clot in the 3 heart. And there is no effusion or fluid around the 4 heart. There is a pericardium around the heart, and 5 sometimes if there is a fluid there it will crush 6 the heart, causing blood pressure changes. 7 Q. When, if ever, were you aware that this 8 procedure was going to be done on your patient? 9 A. I was vaguely aware of that happening 10 on Saturday night. 11 Q. Was that post -- 12 A. Postop. 13 Q. Postop one day? 14 A. Postop day one. 15 Q. All right. And page 2 shows a CC to 16 you, but you don't know when it was CC'd to you? I 17 mean, there is a -- there is a fax. The first page 18 says 02-09 at 3:14 a.m. and it just says CC to 19 you -- let me rephrase my question. 20 It would have gotten to your 21 chart, assuming the fax is correct, the morning of 22 the 9th? 23 A. It looks like it was performed on the 24 7th, the note was dictated on the 8th. It was 25 transcribed on the 9th. And the best interpretation</p>	<p style="text-align: right;">Page 68</p> <p>1 office dated the 9th? 2 A. I assume that, yes. 3 Q. Okay. Now, you -- did you have an 4 opportunity to read this report on the 9th? 5 A. I probably actually read this report in 6 the hospital EMR before I ever read my office chart. 7 Q. Okay. Would that be the same as the 8 Doppler document? 9 A. In the hospital I probably didn't 10 review the Doppler, the TD-echo. 11 Q. But you would have been in the hospital 12 -- strike that. 13 Your best recollection is you 14 would have reviewed Dr. Yordan's consult at the 15 hospital prior to this document getting to your 16 office? 17 A. Most likely, yes. 18 Q. Okay. What did this document tell you, 19 other than she has sepsis? 20 A. That Dr. Cordero felt she was in DIC, 21 which is disseminated intravascular coagulopathy, 22 that she had renal failure or that her kidneys were 23 failing, and she had respiratory failure. Cultures 24 were pending, but she was being treated with 25 broad-spectrum and IV antibiotics. And he notes</p>
<p style="text-align: right;">Page 67</p> <p>1 I would have is that it would have gotten to me 2 sometime thereafter. 3 Q. All right. So if you look in your 4 chart -- 5 A. I would say on the 9th, based upon 6 the -- 7 Q. The fax? 8 A. -- cover sheet. 9 Q. Okay. All right. The next thing I 10 have that's in your chart is a fax from the hospital 11 to you dated the 9th at 12:49 a.m. It's four pages. 12 It says the referring physician is Barry Rives, MD, 13 the referring doctor is Dr. Siddiqui, and the 14 consultation is for sepsis. Sepsis. Do you know 15 who -- or are you familiar with Dr. Herbert 16 Cordero-Yordan? 17 A. Yes. 18 Q. What is your understanding as to why 19 Dr. Yordan saw your patient? 20 A. He was the cardiology specialist 21 consulted on her case when she went into sepsis. 22 Q. When you reviewed his report dated the 23 8th of February -- strike that. 24 I'm assuming that you would have 25 gotten this on the 9th, based upon the fax to your</p>	<p style="text-align: right;">Page 69</p> <p>1 that the 2D echo shows preserved left ventricular 2 systolic function. 3 Q. And in regular folks' terms, what does 4 that mean? 5 A. It appears that she's not having a 6 heart attack. 7 Q. When the patient coded, were you in the 8 hospital at the time? 9 A. I don't remember. 10 Q. All right. So let's go to the next 11 part of your chart. And it's the fax of 02-18, 8:20 12 a.m., it's to you from St. Rose. It's four pages 13 and it includes your three-page operative report. 14 Do you have that in front of you, sir? 15 A. Yes. 16 Q. All right. So we're now -- this 17 operative report indicates that you took Ms. Center 18 back to surgery on the 17th of February; correct? 19 A. Correct. 20 Q. Okay. So the original surgery happened 21 on 02-06, you took her back on 02-17. Just taking 22 all the time you wish, could you explain to the jury 23 why you waited 11 days to take her back to surgery? 24 MR. DOYLE: I'll object. It's argumentative. 25 But go ahead.</p>

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1 THE WITNESS: After her initial septic shock
 2 episode, she was recovering and doing well. She had
 3 one episode where she threw up some material. So a
 4 nasogastric tube was placed by a radiologist. She
 5 continued to improve. We started to place her on
 6 two feeds. And in a 24 or 48-hour period, she all
 7 of a sudden began to deteriorate with a significant
 8 change in status. I ordered a CT scan which showed
 9 some fluid and air that was not on the previous CAT
 10 scan on the 9th, I believe. So at that point I was
 11 concerned that she had a perforation. I ordered an
 12 upper GI study which confirmed there was a
 13 perforation of the stomach. I spoke to her and the
 14 family and recommended surgery.
 15 Q. So let's go over the surgical
 16 procedure, if we could.
 17 MR. BRENSKE: I need to take another
 18 five-minute break. Sorry.
 19 THE VIDEOGRAPHER: Okay. We are off the
 20 record at 12:54 p.m.
 21 (Short break.)
 22 THE VIDEOGRAPHER: We are back on the record
 23 at 1:06 p.m.
 24 BY MR. BRENSKE:
 25 Q. Doctor, just before we took a break,

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1 you mentioned that the -- I think you had a CT done
 2 shortly postop that you believe did not show any
 3 abnormalities?
 4 A. Which CT are you referring to?
 5 Q. The first one.
 6 A. The first one on postoperative day 2
 7 showed findings consistent with postoperative
 8 changes.
 9 Q. And the CT, did you review the actual
 10 CT itself or just a report?
 11 A. I do not recall.
 12 Q. So you may have looked at the CT
 13 itself, you may not have. You may have looked at
 14 the report, you may not have, but you would have
 15 looked at one of them?
 16 A. I definitely looked at all the reports
 17 for the CAT scans. Sometimes I review the films
 18 either on the PAC system, or sometimes I'll review
 19 them with the radiologist if I have a question about
 20 the anatomy or whatever is going on with the
 21 patient, or sometimes the report is clear enough and
 22 I don't need to.
 23 Q. Well, I would assume this is a pretty
 24 rare event that you would perform the hernia surgery
 25 and the patient is sepsis postop day 1?

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1 MR. DOYLE: Well, hold on. It's argumentative.
 2 But go ahead.
 3 THE WITNESS: Yes.
 4 BY MR. BRENSKE:
 5 Q. How many hernia surgeries have you
 6 performed?
 7 A. Diaphragmatic hernias or all hernias?
 8 Q. Let's go with all.
 9 A. Well over 500.
 10 Q. Of those well over 500 hernia surgeries
 11 you performed, how many of your patients have gone
 12 -- had sepsis postop day 1, other than Vickie
 13 Center?
 14 A. I can't recall any that come to mind.
 15 Q. I understand that there may be
 16 something. But as you sit here today, you don't
 17 remember one. Fair statement?
 18 A. That's fair.
 19 Q. All right. So I would also assume that
 20 if your patient gets sepsis postop day 1, you're
 21 looking for answers?
 22 A. That's correct.
 23 Q. And in this case it's your
 24 understanding, at least at the time you were
 25 treating the patient, that her sepsis was caused by

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1 -- I want to say aspiration pneumonia, but that is
 2 probably not the right term. What is the right
 3 term?
 4 A. They use both terms, but the actual
 5 correct term is aspiration pneumonitis. It's an
 6 inflammation of the lungs.
 7 Q. But this -- this infection becomes
 8 systemic and causes organ shutdown?
 9 A. It doesn't have to be an infection of
 10 the lungs. It's an inflammation of the lungs. You
 11 can have inflammation of the organ without it being
 12 grossly affected.
 13 Q. But if you have an inflammation of the
 14 lung, is that going to create sepsis?
 15 A. Yes, it can.
 16 Q. Is it -- was it your understanding at
 17 the time this was going on that the patient Vickie
 18 Center was having inflammation of the lung -- lung,
 19 which caused her sepsis and ultimate coding? Coding
 20 is c-o-d-i-n-g.
 21 A. That was what myself, the other
 22 consultants, the ICU intensivists all were working
 23 on.
 24 Q. Did it come to mind to you at any time
 25 the first ten days postop that you may have cut

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<p style="text-align: right;">Page 74</p> <p>1 something, burned something, caused some injury</p> <p>2 during your surgical procedure that resulted in the</p> <p>3 sepsis?</p> <p>4 A. Anytime a patient has an unexpected</p> <p>5 complication after surgery, my job is to make sure</p> <p>6 that it's not related to the surgery.</p> <p>7 Q. Had the CT of the abdomen -- strike</p> <p>8 that.</p> <p>9 You went back in to surgery</p> <p>10 because there was a CT of the abdomen that showed</p> <p>11 abnormality?</p> <p>12 A. Not entirely. The upper GI was the</p> <p>13 definitive study, plus the patient's clinical</p> <p>14 condition that made a surgery a secondary time</p> <p>15 necessary.</p> <p>16 Q. When would you have ordered a CT of the</p> <p>17 abdomen on this patient given her condition one day</p> <p>18 postop?</p> <p>19 A. When the patient is transferred to the</p> <p>20 IDU, the ICU intensivist becomes the attending</p> <p>21 physician, and they will tend to order almost all</p> <p>22 radiology tests and evaluations. If I feel a test</p> <p>23 is indicated that they haven't done, then that would</p> <p>24 be a case where I would order the test. I don't</p> <p>25 recall whether I ordered the CT scan for</p>	<p style="text-align: right;">Page 76</p> <p>1 of the Nissen fundoplication and closure of</p> <p>2 gastrostomy." Gastrostomy is a -- is that a fancy</p> <p>3 way of saying there's a hole in the stomach?</p> <p>4 A. Yes. Closure of gastrostomy times two.</p> <p>5 Q. Okay. So why don't you tell me what</p> <p>6 the findings -- so tell me what your findings are.</p> <p>7 I can read what this says, but maybe you can explain</p> <p>8 it in more simple terms that I can understand.</p> <p>9 A. So with the stomach wrapped upon</p> <p>10 itself, the NG tube could slide up inside the wrap</p> <p>11 causing it to be obstructed. In this case, when we</p> <p>12 took her to the OR and we had the NG tube hooked up</p> <p>13 to suction, they -- let's see. About three and a</p> <p>14 half to four liters of gastric contents was</p> <p>15 aspirated. At that point I had a concern that if</p> <p>16 you damage the vagal nerves during the surgery, you</p> <p>17 get what is called gastric outlet obstruction. So I</p> <p>18 went out and spoke with the family to make sure they</p> <p>19 are aware that this may be a possibility and would</p> <p>20 change the way that the surgery went.</p> <p>21 As I got in there, the first thing</p> <p>22 I did was clean out the area of concern of any</p> <p>23 debris, any scar tissue, so that I could adequately</p> <p>24 evaluate the anatomy. At that point I can see that</p> <p>25 the duodenum and the distal end of the stomach was</p>
<p style="text-align: right;">Page 75</p> <p>1 postoperative day 2 or whether the intensivist had</p> <p>2 already ordered it.</p> <p>3 Q. I do not want to put words in your</p> <p>4 mouth. What you're telling me is the ICU</p> <p>5 intensivist is the person that orders testing. If</p> <p>6 it is your patient that is sent to the ICU and</p> <p>7 you're reviewing the chart, if you see a test that</p> <p>8 should be done, you can order it.</p> <p>9 A. That's correct.</p> <p>10 Q. All right. I think -- all right. So</p> <p>11 now we're at -- on your chart concerning your second</p> <p>12 surgery of Ms. Rivers [sic] on the 17th of February,</p> <p>13 beginning on page 52 and ending on page 54. Are you</p> <p>14 there?</p> <p>15 A. Yes.</p> <p>16 Q. I think we haven't really discussed</p> <p>17 this yet. It shows that the preoperative diagnosis</p> <p>18 is gastric perforation, and that's -- is that a</p> <p>19 fancy way to say there is a hole in the stomach?</p> <p>20 A. Yes.</p> <p>21 Q. Okay. And what operation -- you did a</p> <p>22 diagnostic laparoscopy. That means you went in and</p> <p>23 looked around?</p> <p>24 A. That is correct.</p> <p>25 Q. Okay. And then you say "with revision</p>	<p style="text-align: right;">Page 77</p> <p>1 intact. There was no perforation. It did not look</p> <p>2 like she had gastric outlet obstruction. As I</p> <p>3 looked at the Nissen wrap, I could see that it was</p> <p>4 twisted, anatomically being pushed by the NG tube.</p> <p>5 And there was no way to assess that without taking</p> <p>6 those three sutures out that I placed prior. And as</p> <p>7 I did that, one of the sutures was deep. And the</p> <p>8 only way to get it was by making an actual hole in</p> <p>9 that part of the stomach to release it. And then as</p> <p>10 the stomach flopped back into its normal anatomical</p> <p>11 position, I could see that the NG tube was coiled up</p> <p>12 towards an area where there was about a</p> <p>13 one-and-a-half-inch defect or hole in the stomach.</p> <p>14 Q. Okay. First you just kind of -- you</p> <p>15 took between three and a half and four liters of</p> <p>16 gastric contents that was out of the stomach?</p> <p>17 A. Correct.</p> <p>18 Q. Or was it -- so that was contained in</p> <p>19 the stomach itself?</p> <p>20 A. Correct.</p> <p>21 Q. Okay. And when you -- when you</p> <p>22 released the NG tube from the -- let's take a look</p> <p>23 at six. So I'm looking at -- and you can help me</p> <p>24 with it, I hope. So I'm looking at the -- I'm just</p> <p>25 going to call it the Nissen, okay? Sounds like a</p>

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<p style="text-align: right;">Page 78</p> <p>1 car and I don't mean to do that.</p> <p>2 But we're looking at the Nissen,</p> <p>3 and the NG tube is somehow wrapped around this</p> <p>4 Nissen so that you've got to remove -- you separate</p> <p>5 those parts of the stomach. Am I right?</p> <p>6 A. Correct.</p> <p>7 Q. Okay. And when you separated those</p> <p>8 parts of the stomach, you found an inch-and-a-half</p> <p>9 hole in the stomach?</p> <p>10 A. Correct. And there was a hole that I</p> <p>11 created by taking out the suture as well.</p> <p>12 Q. Right. So you found an inch-and-a-half</p> <p>13 hole in the stomach and you had to make a hole in</p> <p>14 the stomach to get the suture out. And you repaired</p> <p>15 that?</p> <p>16 A. Two different holes.</p> <p>17 Q. So you repaired the two different</p> <p>18 holes. There is a lot of words here and I'm trying</p> <p>19 to get us out within a couple of days.</p> <p>20 Once you separated the Nissen and</p> <p>21 you fixed the inch-and-a-half hole in the stomach</p> <p>22 and you repaired the hole that you created in order</p> <p>23 to undo the Nissen, did you do any other repairs?</p> <p>24 Take your time and look at it.</p> <p>25 A. So after repairing the two holes in the</p>	<p style="text-align: right;">Page 80</p> <p>1 contrast?</p> <p>2 A. I would have to see the --</p> <p>3 Q. And if you don't know, that's fine.</p> <p>4 A. Yeah. I don't recall off the top of my</p> <p>5 head.</p> <p>6 Q. If there had been an injury, an</p> <p>7 unintended injury by yourself perioperatively in</p> <p>8 your first surgery and an IV -- or CT with IV</p> <p>9 contrast of the abdomen had taken place, would that</p> <p>10 probably show that defect or injury?</p> <p>11 MR. DOYLE: Just for clarification. By</p> <p>12 perioperative, that can be a wide range of things.</p> <p>13 Did you mean to say within the operation itself or</p> <p>14 are you intending to include before and after?</p> <p>15 MR. BRENSKE: Well, we can do it both ways.</p> <p>16 MR. DOYLE: I mean, it's --</p> <p>17 MR. BRENSKE: That's fine.</p> <p>18 THE WITNESS: Perioperative, to me, means</p> <p>19 during the operative course. Postoperative means</p> <p>20 anytime after the surgery.</p> <p>21 BY MR. BRENSKE:</p> <p>22 Q. So if there had been -- with those</p> <p>23 definitions in mind, if there had been an unattended</p> <p>24 injury to a portion of the abdomen or other</p> <p>25 structures that you were working with causing it to</p>
<p style="text-align: right;">Page 79</p> <p>1 stomach, we continued with installation -- or</p> <p>2 installation of methylene blue into the stomach</p> <p>3 under pressure. Not too much pressure. That way we</p> <p>4 can see if there is an active leak from anywhere in</p> <p>5 the stomach.</p> <p>6 Also, I was able to evaluate that,</p> <p>7 given the little bit of time that the stomach was</p> <p>8 spontaneously draining into the duodenum, and I</p> <p>9 wasn't concerned for a gastric outlet obstruction</p> <p>10 like I was preoperatively after the NG tube had such</p> <p>11 high output. I evaluated the remaining structures</p> <p>12 in the area. I cleaned out any other debris or</p> <p>13 possible abscess cavity areas. I inspected the rest</p> <p>14 of the hollow viscus or large bowel and small bowel</p> <p>15 for any other possible sites of perforation. And</p> <p>16 then closed up the incisions after removing the CO2.</p> <p>17 Q. Did -- was -- was a CT of the abdomen</p> <p>18 with contrast done at any time prior to your second</p> <p>19 surgery?</p> <p>20 A. Depends what you mean by contrast.</p> <p>21 Either IV or oral. There were two CTs done, as we</p> <p>22 mentioned prior. One was on postoperative day 2.</p> <p>23 And there was another one done one or two days</p> <p>24 before this surgery.</p> <p>25 Q. Were either of them done with IV</p>	<p style="text-align: right;">Page 81</p> <p>1 leak, would a CT of the abdomen using IV contrast be</p> <p>2 able to identify that?</p> <p>3 A. Possibly.</p> <p>4 Q. I want to go over a couple more things</p> <p>5 here. I don't -- when you say the omentum caked to</p> <p>6 the left lateral quadrant in the lower abdomen, can</p> <p>7 you tell me what that means?</p> <p>8 A. It means the omentum was stuck to the</p> <p>9 left side of the abdomen.</p> <p>10 Q. And you indicated you had to remove</p> <p>11 some debris?</p> <p>12 A. I suction irrigated fluid, debris,</p> <p>13 inflammatory tissue.</p> <p>14 Q. None of that being good, I would</p> <p>15 assume?</p> <p>16 A. It's just reactionary fluid from a --</p> <p>17 from the perforation.</p> <p>18 Q. Going on in your chart to the -- let me</p> <p>19 make sure I'm not getting lost here.</p> <p>20 All right. So the next part of</p> <p>21 your chart is a fax on 03-19-2015. 000055. And the</p> <p>22 next three pages after that, under operative notes</p> <p>23 from your operation on Vickie Center of March 18,</p> <p>24 2015. Do you have that in front of you, Doctor?</p> <p>25 A. Yes, I do.</p>

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<p style="text-align: right;">Page 82</p> <p>1 Q. All right. So --</p> <p>2 MR. DOYLE: Just for clarification, I think</p> <p>3 it's the 18th. Not the 19th.</p> <p>4 MR. BRENSKE: The fax is the 19th, the surgery</p> <p>5 is the 18th.</p> <p>6 MR. DOYLE: Got it. Got it. Okay. I</p> <p>7 misunderstood you.</p> <p>8 MR. BRENSKE: Well, I'm easily misunderstood.</p> <p>9 BY MR. BRENSKE:</p> <p>10 Q. We're looking at the surgical procedure</p> <p>11 of March 18, 2015, where your preoperative diagnosis</p> <p>12 is perforated viscus. Can you just tell me from</p> <p>13 your recollection why you needed to go back in on</p> <p>14 the 18th of March of 2015?</p> <p>15 A. The patient was doing fairly well</p> <p>16 tolerating some oral diet. However, there was</p> <p>17 concern that she was developing a leak from her</p> <p>18 stomach to her abdominal wall. We, at some point</p> <p>19 prior to this, had done a CT scan and had</p> <p>20 interventional radiology place a drain into the</p> <p>21 area. As -- a lot of times these leaks, if they are</p> <p>22 suspected, will dry up on their own. We had given</p> <p>23 what I felt was ample enough time for that to</p> <p>24 happen. I consulted Dr. Wiencek, the cardiothoracic</p> <p>25 surgeon. Discussed the case with him since he had</p>	<p style="text-align: right;">Page 84</p> <p>1 A. I don't recall whether it was done by</p> <p>2 Dr. Wiencek or an interventional radiologist.</p> <p>3 Q. And we've got it in here, so we'll find</p> <p>4 out. All right. So you go in with Dr. Wiencek as</p> <p>5 your second surgeon. Tell me what you did.</p> <p>6 A. The first thing I did was cleared the</p> <p>7 packing from her abdominal wounds, and then we</p> <p>8 prepped and draped the patient in standard surgical</p> <p>9 fashion. I started by making a small incision in</p> <p>10 the right middle quadrant where we had not operated</p> <p>11 before. So that way I can insert a Veress needle</p> <p>12 such that it wouldn't interfere with any possible</p> <p>13 adhesions from the prior surgery. I wasn't able to</p> <p>14 get any insufflation from that. And then I made an</p> <p>15 incision from one of her prior trocars, and I opened</p> <p>16 that up under direct visualization so I could put my</p> <p>17 finger inside the abdomen to see if I could get</p> <p>18 insufflation. And I could not get any insufflation.</p> <p>19 Q. Now, if you can't get insufflation,</p> <p>20 does that just mean the CO2 gas that you're putting</p> <p>21 in there is going -- it's not -- it's like there's a</p> <p>22 -- you're blowing up a balloon and there's just a</p> <p>23 hole in the balloon so you can't blow it up?</p> <p>24 A. No. It means that something is keeping</p> <p>25 the abdomen from being free and pliable to expand to</p>
<p style="text-align: right;">Page 83</p> <p>1 been on prior when she went into the ICU with sepsis</p> <p>2 back in the beginning. And discussed it with the</p> <p>3 family that we both felt that there was a need to</p> <p>4 take her back to the surgery -- to take her back to</p> <p>5 the OR and evaluate her esophagus for a possible</p> <p>6 leak, her stomach for a possible leak or any hollow</p> <p>7 viscus for a possible leak.</p> <p>8 Q. So this particular surgery you were</p> <p>9 assisted by Dr. Wiencek?</p> <p>10 A. Yes.</p> <p>11 Q. And this had been -- I didn't -- and it</p> <p>12 may be in your chart. But this was after Dr. -- I</p> <p>13 don't remember which doctor it was, but aspirated</p> <p>14 fluid from Vickie Center?</p> <p>15 A. I don't know what you're referring to.</p> <p>16 Q. Because, I mean, I don't know what I'm</p> <p>17 talking about. So that works.</p> <p>18 Prior to this, I recall there</p> <p>19 being a cardiothoracic doctor coming in and removing</p> <p>20 or draining some part of Vickie. Does that ring a</p> <p>21 bell?</p> <p>22 A. Yes. She had a right chest tube</p> <p>23 thoracostomy placed to drain fluid out of her right</p> <p>24 chest.</p> <p>25 Q. Do you remember which doctor did that?</p>	<p style="text-align: right;">Page 85</p> <p>1 accommodate the pressure.</p> <p>2 Q. All right. So that could be from some</p> <p>3 -- pressure from some other area then?</p> <p>4 A. Correct.</p> <p>5 Q. Okay. Did you ever determine why you</p> <p>6 couldn't get insufflation?</p> <p>7 A. Indirectly when I opened up her</p> <p>8 abdomen, she had a fair amount of inflammatory</p> <p>9 tissue and adhesions. So that would be the reason</p> <p>10 why I couldn't get insufflation with the Veress</p> <p>11 needle.</p> <p>12 Q. Okay. I'm sorry. Continue, what did</p> <p>13 you do next?</p> <p>14 A. I then created an upper midline</p> <p>15 incision and opened peritoneum bluntly between the</p> <p>16 subxiphoid and the belly button basically. The area</p> <p>17 was fairly stuck with inflammatory tissue. It was</p> <p>18 friable. I mean, you touch it, it would bleed. You</p> <p>19 couldn't delineate what was stomach, what was colon.</p> <p>20 So it was not a very safe area to operate on. So I</p> <p>21 went down below her belly button where there was no</p> <p>22 prior surgery by myself, and I was able to get</p> <p>23 access to the abdomen where there was, lack of a</p> <p>24 better term, what we call virgin territory. In</p> <p>25 other words, there is no adhesions, there's no</p>

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<p style="text-align: right;">Page 86</p> <p>1 inflammation. And then I started working my way up 2 towards the abdomen, taking down the small bowel, 3 the large bowel, so that I could identify everything 4 fairly routinely at that point.</p> <p>5 Q. What did you do next?</p> <p>6 A. Once I had everything freed up from the 7 small bowel and the large bowel, I had the incision 8 completely freed up, the stomach and transverse 9 colon were scarred to one another.</p> <p>10 MR. DOYLE: Slow down just for a little bit. 11 For the court reporter.</p> <p>12 THE WITNESS: Sorry. You okay?</p> <p>13 I then dissect over towards the 14 left side of the abdomen where I was concerned about 15 a fistula, so that I could follow the fluid back 16 towards where the origin would be.</p> <p>17 BY MR. BRENSKE:</p> <p>18 Q. Now, before you go any further. A 19 fistula, explain to the jury what that is.</p> <p>20 A. A fistula is a connection between any 21 hollow viscus and the skin.</p> <p>22 Q. And is a fistula created as a means to 23 get -- well, let me just -- why would the body form 24 a fistula?</p> <p>25 A. The body can form a fistula due to a</p>	<p style="text-align: right;">Page 88</p> <p>1 no evidence of perforation there. At that point NG 2 tube was inserted. And we began to insufflate the 3 area, and again used methylene blue to see if there 4 was an appreciable leak. At that point there was 5 actually no methylene blue and no air coming out. 6 So Dr. Wiencek and I thought the next best step, 7 since there is no way to see a perforation from 8 those maneuvers, was for him to do an EGD. Where he 9 puts a scope down through the esophagus into the 10 stomach, and he can look from the inside and see if 11 there is anything that would suggest to him an area 12 that could cause a leak.</p> <p>13 When he did that and he started to 14 insufflate the stomach, I could hear a whistling 15 sound, indicating that there was an air leak 16 somewhere. So with him looking down the scope at 17 the inside of the stomach and me inside the abdomen 18 palpating the stomach, I could locate where the hole 19 was. And he could see that there was a gastric 20 ulcer in that area and I was able to stitch the hole 21 closed. Basically until the whistling stopped.</p> <p>22 Q. Where was the gastric ulcer located?</p> <p>23 A. It was on the left side of the stomach, 24 up near the GE junction.</p> <p>25 Q. Can we use this horrible Exhibit 5?</p>
<p style="text-align: right;">Page 87</p> <p>1 number of issues. Basically if you have an 2 obstruction, an injury, chemotherapy, radiation such 3 that a hollow part of the anatomy is weak, it can 4 blow out through that area and the body finds a way 5 to get that fluid out. It's usually directly 6 through the skin.</p> <p>7 Q. Thank you. Where are we next?</p> <p>8 A. At that point I started to visualize 9 the lesser curvature of the stomach and looked at 10 the right crus where the repair was. I didn't see 11 any evidence of a leak. I didn't see any evidence 12 of a perforation. Nor did I see any material in 13 that area to suggest that would be the site of the 14 perforation. Then I started to mobilize what we 15 call the gastroduodenal ligament, which is the distal 16 end where the stomach is adhere to the transverse 17 colon. So that way I can fully look at the end of 18 the stomach, the duodenum, look at the underneath 19 side of the stomach, again, to evaluate if there was 20 any sort of perforation in that area.</p> <p>21 The greater curvature had already 22 been taken down from the prior surgery and I 23 inspected the staple line. There was no 24 perforations at the staple line. I then followed 25 this up towards the left crus to make sure there was</p>	<p style="text-align: right;">Page 89</p> <p>1 A. No. Well --</p> <p>2 Q. We -- well, no is a pretty rough term, 3 but --</p> <p>4 A. The problem is the stomach is in 3D. 5 Q. Of course it is. 6 A. And this is in 2D and it doesn't give 7 you a true sense. So looking at your diagram, this 8 ulcer would be behind -- here, I'll mark, as long as 9 you understand. It would be in this general area 10 but behind the stomach.</p> <p>11 Q. So posterior?</p> <p>12 A. On the back side of the stomach, 13 correct.</p> <p>14 Q. Okay. Just write down whatever you 15 want to write down as to what that is.</p> <p>16 A. (Witness complies.)</p> <p>17 Q. And we'll mark it as exhibit next in 18 order?</p> <p>19 A. Sure. (Exhibit 7 marked.)</p> <p>21 MR. BRENSKE: I know we wrote all over five. 22 MR. DOYLE: That will be seven then; correct? 23 MR. BRENSKE: Yes. I think so.</p> <p>24 BY MR. BRENSKE:</p> <p>25 Q. Is there anything on six that would be</p>

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<p style="text-align: right;">Page 90</p> <p>1 easier for you to show?</p> <p>2 A. No.</p> <p>3 Q. Okay. I didn't think so. I was just</p> <p>4 reading. It said, "Eventually able to -- eventually</p> <p>5 able to visualize the air bubbles were leaking out</p> <p>6 from the very far upper left corner of the stomach."</p> <p>7 A. I filled the abdomen at that point with</p> <p>8 water. And that way with the air bubbles you kind</p> <p>9 of see the air bubbles coming from that general</p> <p>10 area.</p> <p>11 Q. I see. All right. So you sutured that</p> <p>12 general area until there was no more bubbles?</p> <p>13 A. Yeah. Dr. Wiencek could see from the</p> <p>14 inside on the scope that it had been closed. The</p> <p>15 insufflation had stopped, the whistling had stopped,</p> <p>16 there were no more air bubbles coming up from the --</p> <p>17 from the abdominal cavity.</p> <p>18 Q. What did you do next?</p> <p>19 A. We placed the NG tube to decompress the</p> <p>20 stomach of the fluid and air that we put into it. I</p> <p>21 then went ahead and irrigated and drained the entire</p> <p>22 abdomen, clearing out any abscess fluid, debriding</p> <p>23 any necrotic tissue, especially in the left upper</p> <p>24 quadrant. I placed two drains into the abdomen.</p> <p>25 One was in the greater curvature or the left side of</p>	<p style="text-align: right;">Page 92</p> <p>1 a reaction to that. Kind of like on your skin it's</p> <p>2 a scab. On the inside of your abdomen it forms this</p> <p>3 little kind of like a scab. So that's the type of</p> <p>4 stuff that I was debriding out of there.</p> <p>5 Q. The next part of your chart is a fax</p> <p>6 from the hospital to you concerning a two-page</p> <p>7 operative report by Dr. Wiencek. Can you tell us --</p> <p>8 this isn't your operation, you were not at this</p> <p>9 particular surgery, I'm assuming?</p> <p>10 A. I was not.</p> <p>11 Q. And I don't want you to go through all</p> <p>12 of the details of someone else's surgery. But if</p> <p>13 you can tell me what he did, in laymen's terms, that</p> <p>14 was faxed to your chart.</p> <p>15 A. Basically Dr. Wiencek did a videoscopic</p> <p>16 procedure to free up the right lung from any</p> <p>17 inflammatory tissue on that side.</p> <p>18 Q. Can you tell me what you believe caused</p> <p>19 the empyema of the chest?</p> <p>20 A. Empyema.</p> <p>21 Q. Empyema.</p> <p>22 MR. DOYLE: I assume you want to ask him if he</p> <p>23 had that thought back then, given the court's</p> <p>24 ruling.</p> <p>25 MR. BRENSKE: I get to ask both times, but I'm</p>
<p style="text-align: right;">Page 91</p> <p>1 the stomach, but behind the stomach where the ulcer</p> <p>2 had been repaired. So that way if there was any</p> <p>3 fluid coming out of there, we'd know where a</p> <p>4 possible source would be. And then another one was</p> <p>5 placed, what we call the paracolic gutter, on the</p> <p>6 left later side where fluid from the surgery would</p> <p>7 accumulate so we could draw it off.</p> <p>8 Q. What is necrotic tissue? Is that dead</p> <p>9 tissue?</p> <p>10 A. Dead tissue.</p> <p>11 Q. Where did you clear the dead tissue</p> <p>12 from?</p> <p>13 A. Well, there was necrotic tissue on the</p> <p>14 omentum. There were little spots of it -- not part</p> <p>15 of the bowel, but glammed onto the bowel in various</p> <p>16 parts.</p> <p>17 Q. That necrotic tissue came from what</p> <p>18 source?</p> <p>19 A. The inflammatory process of the</p> <p>20 perforation.</p> <p>21 Q. I mean, was it part of the stomach?</p> <p>22 A. It's not -- it's not part of the</p> <p>23 stomach. It's a reaction to the -- to the</p> <p>24 perforation. So when you have a cut or laceration</p> <p>25 or perforation, just like your skin, your body makes</p>	<p style="text-align: right;">Page 93</p> <p>1 asking --</p> <p>2 MR. DOYLE: Well, why don't we find out first</p> <p>3 if he had an opinion then.</p> <p>4 MR. BRENSKE: Yeah. I thought I did, but</p> <p>5 that's okay.</p> <p>6 MR. DOYLE: You asked present tense.</p> <p>7 THE WITNESS: Can you restate the question?</p> <p>8 BY MR. BRENSKE:</p> <p>9 Q. Sure. We'll do it this way. Was</p> <p>10 Vickie Center your patient on March 25th of 2015?</p> <p>11 A. Yes.</p> <p>12 Q. Okay. And what's your understanding of</p> <p>13 why Dr. Wiencek had to do a right empyema?</p> <p>14 A. Empyema.</p> <p>15 Q. I'll never get it, but thanks very much</p> <p>16 for trying.</p> <p>17 A. So if the lung has any inflammatory</p> <p>18 tissue trapping it, you can't get good ventilation</p> <p>19 through that side of the lung. So a cardiothoracic</p> <p>20 surgeon would go into the chest, free the lung up</p> <p>21 from any inflammatory tissue holding it, so that way</p> <p>22 they would have better ventilation. Remove some</p> <p>23 potential abscess cavity or fluid to control</p> <p>24 infection.</p> <p>25 Q. What was your understanding at the time</p>

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<p style="text-align: right;">Page 94</p> <p>1 as to why there was that inflammation?</p> <p>2 A. It would be from her -- it would</p> <p>3 probably be from her gastric perforation.</p> <p>4 Q. From the hole in her stomach?</p> <p>5 A. From the ulcer, yes.</p> <p>6 Q. Then the next document is page 62.</p> <p>7 This looks like your referral to -- what is it?</p> <p>8 A. It's a referral to Dr. Dominic</p> <p>9 Ricciardi at the wound care center, for him to</p> <p>10 evaluate Vickie for her ischemia to her feet.</p> <p>11 Q. Okay. Looking at the next pages, I'm</p> <p>12 going to -- they seem to be multiple requests from</p> <p>13 Vickie's daughter to allow you to fill out forms to</p> <p>14 indicate that she's unable to return to work?</p> <p>15 A. Yes. For Katie.</p> <p>16 Q. For Katie?</p> <p>17 A. For Katie, correct.</p> <p>18 Q. All right. So if I go to page 68, it</p> <p>19 says, "Katie's mom underwent surgery 02-06-15 and</p> <p>20 had serious complications resulting in her admission</p> <p>21 to the ICU and intubated. Katie has been caring for</p> <p>22 her father and family during this most difficult</p> <p>23 time." And I go to page 70, and I'm assuming that's</p> <p>24 your signature?</p> <p>25 A. Yes, it is.</p>	<p style="text-align: right;">Page 96</p> <p>1 co-pays and deductibles and all sorts of things.</p> <p>2 Q. All right. And then the next page is a</p> <p>3 bill for an office visit, with payments and</p> <p>4 adjustments?</p> <p>5 A. Yes.</p> <p>6 Q. And then if you can tell me what this</p> <p>7 last page is, I would be really impressed.</p> <p>8 A. This is basically all of the billed</p> <p>9 services, as far as what we billed out. These are</p> <p>10 the charges and the payments made by the insurance,</p> <p>11 any adjustments and anything else withheld.</p> <p>12 Q. Okay. I think that ends your chart.</p> <p>13 MR. BRENSKE: All right. Another five-minute</p> <p>14 break, if that's okay. Court reporter needs a break</p> <p>15 too.</p> <p>16 THE VIDEOGRAPHER: All right. We're off the</p> <p>17 record at 1:48 p.m.</p> <p>18 (Short break.)</p> <p>19 (Exhibit 8 marked.)</p> <p>20 THE VIDEOGRAPHER: We're back on the record at</p> <p>21 2:00 p.m.</p> <p>22 BY MR. BRENSKE:</p> <p>23 Q. Doctor, if I could see that document,</p> <p>24 please, just to make sure you've got what I've got.</p> <p>25 Excuse me. Doctor, I'm going to hand you what's</p>
<p style="text-align: right;">Page 95</p> <p>1 Q. And then she's just asking a couple</p> <p>2 more times to do that and you have complied with her</p> <p>3 request? I mean, there is a lot of pages here, but</p> <p>4 they look like all the same thing.</p> <p>5 A. Yes.</p> <p>6 Q. Then I'm looking at your chart starting</p> <p>7 at page 84. This looks like 84 is your initial</p> <p>8 billing statement?</p> <p>9 A. This is a synopsis --</p> <p>10 Q. Okay.</p> <p>11 A. -- of a billing statement, for lack of</p> <p>12 a better term.</p> <p>13 Q. That's fine. So it's got all these</p> <p>14 different numbers in them. It looks like -- just</p> <p>15 follow me along. Follow along here. The numbers on</p> <p>16 the left-hand side are the original, say -- the</p> <p>17 original charges, and then payments and adjustments</p> <p>18 in the middle, and then third column is what is owed</p> <p>19 now?</p> <p>20 A. The left side is the date of service.</p> <p>21 The middle is the description of the services. Then</p> <p>22 that next column would be what is billed. The</p> <p>23 middle column would be what is accepted or paid by</p> <p>24 the insurance company. And then the remainder would</p> <p>25 be potentially billed to the patient depending upon</p>	<p style="text-align: right;">Page 97</p> <p>1 been marked for identification purposes as</p> <p>2 Plaintiffs' Proposed Exhibit No. 8. It is the</p> <p>3 progress notes from nursing. It has nursing notes,</p> <p>4 Bates stamp 00001 through 00019. Have you had a</p> <p>5 chance to review those notes prior to your</p> <p>6 deposition today?</p> <p>7 A. I have not reviewed all of these notes.</p> <p>8 I may have reviewed some of these notes.</p> <p>9 Q. Okay. Do you remember the last time</p> <p>10 you looked at them?</p> <p>11 A. No.</p> <p>12 Q. Okay. I put them in order oldest first</p> <p>13 to last. So they may not be in an order that you</p> <p>14 have reviewed them. So I will try to be clear and</p> <p>15 not be confusing.</p> <p>16 The first progress note is dated</p> <p>17 -- or Bates stamped nursing notes and then there's a</p> <p>18 one. And it's -- the first note is at 12:10,</p> <p>19 received patient from PACU. PACU is the patient</p> <p>20 anesthesia care unit.</p> <p>21 A. Post-anesthetic care unit.</p> <p>22 Q. I can never get it right.</p> <p>23 So once the surgical procedure has</p> <p>24 been performed in the operating room, the patient is</p> <p>25 sent to the PACU to recover from the anesthesia.</p>

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<p style="text-align: right;">Page 98</p> <p>1 Fair statement?</p> <p>2 A. Correct.</p> <p>3 Q. Also one of the reasons the patient</p> <p>4 goes to the PACU is so that there is something --</p> <p>5 some complication or something that needs to be</p> <p>6 addressed, the doctor can address it there as</p> <p>7 opposed to going to the hospital. Fair statement?</p> <p>8 A. One of them, yes.</p> <p>9 Q. So I don't have your operative report</p> <p>10 in front of me, but this says at 12:10. So you</p> <p>11 would have performed the surgery, the original</p> <p>12 hernia surgery that -- early that day?</p> <p>13 A. Correct.</p> <p>14 Q. So at 12:10 it says "received patient</p> <p>15 from PACU, patient's fully awake times three. No SS</p> <p>16 of distress noted." Do you know what SS means?</p> <p>17 A. Signs or symptoms.</p> <p>18 Q. Okay. On oxygen. Can you decipher</p> <p>19 what that says?</p> <p>20 A. Two liters nasal cannula, vital signs</p> <p>21 stable.</p> <p>22 Q. What is abdominal lap sites with</p> <p>23 steri-strips?</p> <p>24 A. The dressing on the incisions.</p> <p>25 Q. So you've got five -- you did five</p>	<p style="text-align: right;">Page 100</p> <p>1 A. The nurse advised me just as this is</p> <p>2 documented. I told her that's expected after a</p> <p>3 laparoscopic -- actually any laparoscopic surgery.</p> <p>4 Especially where you work on the diaphragm, the</p> <p>5 patients tend to have pain radiating through the</p> <p>6 chest up to their shoulder. It's called Kehr's</p> <p>7 sign, K-e-h-r, apostrophe S, and it's a known sign</p> <p>8 or symptom after laparoscopic surgery.</p> <p>9 Q. Is this something that you would have</p> <p>10 advised Vickie Center as being something she is</p> <p>11 going to experience after the surgery?</p> <p>12 A. I usually do, yes.</p> <p>13 Q. It says placed SCDS.?</p> <p>14 A. Sequential compressive devices.</p> <p>15 Q. Okay. And continue v/s fall?</p> <p>16 A. And continue vital signs, fall</p> <p>17 precautions initiated.</p> <p>18 Q. And it says, "Instructed patient to</p> <p>19 call for assistance, call and reach. Cont to</p> <p>20 monitor." I don't know what cont means.</p> <p>21 A. Continue.</p> <p>22 Q. So at 14:00 it looks like she's in no</p> <p>23 acute distress. Then at 15:30 Dr. Siddiqui sees the</p> <p>24 patient, made aware that -- the nurse made him aware</p> <p>25 of the chest tightness. And it says, "Per MD it's</p>
<p style="text-align: right;">Page 99</p> <p>1 laparoscopic sites?</p> <p>2 A. I think there were four.</p> <p>3 Q. Okay. Let's go with four. So the --</p> <p>4 what does "CDL pain" mean?</p> <p>5 A. The steri-strips are clean, dry and</p> <p>6 intact.</p> <p>7 Q. Pain control per patient at this time;</p> <p>8 is that right?</p> <p>9 A. That's what it says, yes.</p> <p>10 Q. And then denied NV, what is NV?</p> <p>11 A. Nausea and vomiting.</p> <p>12 Q. And it says, "Patient is having chest</p> <p>13 tightness since in the PACU." Then it says, "Per</p> <p>14 page RN, Dr. Rives was notified, and per MD it's</p> <p>15 expected after lap. Incarcerated periesophageal</p> <p>16 hernia repair."</p> <p>17 Did I decipher that right?</p> <p>18 A. Correct.</p> <p>19 Q. All right. Do you recall being called</p> <p>20 by the nurse, either in the PACU or received the</p> <p>21 patient from the PACU, contacting you concerning</p> <p>22 Vickie Center having any unusual pain?</p> <p>23 A. Yes.</p> <p>24 Q. What do you recall the nurse advising</p> <p>25 you at that time?</p>	<p style="text-align: right;">Page 101</p> <p>1 related to surgery. No order received."</p> <p>2 Did you have any discussions with</p> <p>3 Dr. Siddiqui on the 7th -- excuse me, on the 6th,</p> <p>4 that the pain the patient's encountering is not</p> <p>5 unusual for this type of surgery?</p> <p>6 A. I don't recall.</p> <p>7 Q. Okay. So you may have spoken to</p> <p>8 Dr. Siddiqui, you may not have. You don't remember?</p> <p>9 A. Correct.</p> <p>10 Q. Then 15:41, patient complains of</p> <p>11 abdominal pain, medicated with as-need pain meds.</p> <p>12 And then at 6:30 there is another note, "pain is</p> <p>13 well controlled." And then we go to the next page.</p> <p>14 MR. DOYLE: Are we going to read all the</p> <p>15 notes?</p> <p>16 MR. BRENSKE: We are. Dr. Rives is in almost</p> <p>17 all of them.</p> <p>18 MR. DOYLE: All right. Well, these aren't his</p> <p>19 notes, but I guess if that's what you want to do.</p> <p>20 MR. BRENSKE: It is.</p> <p>21 BY MR. BRENSKE:</p> <p>22 Q. Looking at this document, Doctor --</p> <p>23 MS. DAEHNKE: I'm so sorry. Not to get your</p> <p>24 flow off, but -- so are we going to eat or are we</p> <p>25 not going to eat? We're just going to take</p>

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<p style="text-align: right;">Page 102</p> <p>1 five-minute breaks? I'm just asking.</p> <p>2 MR. BRENSKE: Well, I don't know how long the</p> <p>3 doctor can -- I mean, I want to get through as much</p> <p>4 as I can.</p> <p>5 MR. DOYLE: Well, we want to finish today.</p> <p>6 MR. BRENSKE: We want to finish today. I</p> <p>7 don't know if the court reporter needs a breaks or</p> <p>8 not, it would be up to the court reporter. If we</p> <p>9 take an hour break today, we'll never get done</p> <p>10 today.</p> <p>11 MS. DAEHNKE: Well, we can take a 20-minute</p> <p>12 break and run down and get some protein or you could</p> <p>13 -- we could call in something. I mean, I don't</p> <p>14 think the doctor --</p> <p>15 MR. BRENSKE: We can do all of that.</p> <p>16 MS. DAEHNKE: Okay. I'm sorry. I just don't</p> <p>17 --- endurance test for everyone. Little hard boiled</p> <p>18 eggs or something?</p> <p>19 MR. BRENSKE: Let me get through these nurses</p> <p>20 notes.</p> <p>21 MS. DAEHNKE: Okay.</p> <p>22 MR. BRENSKE: And then we'll discuss it.</p> <p>23 THE WITNESS: The doctor does not need a</p> <p>24 break, for the record.</p> <p>25 MS. DAEHNKE: Well, that's --</p>	<p style="text-align: right;">Page 104</p> <p>1 Q. Then the next is 19:40, that's 7:40</p> <p>2 p.m. The patient complains of abdominal and</p> <p>3 shoulder pain. Administered Zofran and Dilaudid.</p> <p>4 What is Zofran?</p> <p>5 A. Zofran is as antiemetic, and Dilaudid</p> <p>6 is an analgesic.</p> <p>7 Q. After that, it looks like patient</p> <p>8 denied any chest pain. Then at 20:10, that's at</p> <p>9 8:10 p.m., it indicates patient still complains of</p> <p>10 ten out of ten pain after Dilaudid. What does ten</p> <p>11 out of ten mean?</p> <p>12 A. It's a subjective scale. You ask the</p> <p>13 patient from one to ten, ten being the worst pain</p> <p>14 ever, what is your reference number for how severe</p> <p>15 your pain is?</p> <p>16 Q. I see. So would it be unusual for</p> <p>17 someone such as Vickie Center, who has undergone the</p> <p>18 type of surgery that you did, to have a ten out of</p> <p>19 ten pain after receiving Dilaudid?</p> <p>20 A. Not necessarily.</p> <p>21 Q. Then at 8:25, that's 15 minutes later,</p> <p>22 It says, "Page Dr. Siddiqui regards to patient's</p> <p>23 pain level after Dilaudid."</p> <p>24 Do you recall on this day being</p> <p>25 paged by any of the nursing staff concerning Vickie</p>
<p style="text-align: right;">Page 103</p> <p>1 MR. BRENSKE: Doctors generally don't, because</p> <p>2 you guys can work ten or twelve hours standing up.</p> <p>3 You guys are insane.</p> <p>4 MS. DAEHNKE: Right. You're a surgeon. We</p> <p>5 just do God's work in a different way. Okay.</p> <p>6 BY MR. BRENSKE:</p> <p>7 Q. All right. If I could continue. And,</p> <p>8 Doctor, these nurses notes, the reason I'm going</p> <p>9 over them is because I need to find out what you</p> <p>10 recollect as being provided to you and what you</p> <p>11 provided to the nursing staff and to Dr. Siddiqui.</p> <p>12 The next -- the next report, if</p> <p>13 you look at the progress note, it is a little</p> <p>14 different. You have to start at 19:30, which is</p> <p>15 halfway down the page.</p> <p>16 A. Yes.</p> <p>17 Q. In there indicates that patient did</p> <p>18 have some chest pain and tightness of the chest</p> <p>19 today. Both MDs are aware, Dr. Siddiqui and</p> <p>20 Dr. Rives, and per report state it was normal with</p> <p>21 type of surgery patient had.</p> <p>22 So do you remember telling a nurse</p> <p>23 that the pain that this patient is encountering is</p> <p>24 not unusual?</p> <p>25 A. Correct.</p>	<p style="text-align: right;">Page 105</p> <p>1 Center's pain?</p> <p>2 A. Other than the previously mentioned</p> <p>3 one?</p> <p>4 Q. Yes, sir.</p> <p>5 A. I do not have an independent</p> <p>6 recollection.</p> <p>7 Q. All right. At 8:36 p.m., notified</p> <p>8 Dr. Siddiqui of patient's pain, ten out of ten in</p> <p>9 abdomen and left side. Patient crying. Medications</p> <p>10 already given.</p> <p>11 And then it goes to 8:45 that</p> <p>12 Dilaudid one milligram, IV administered. Can you</p> <p>13 tell the jury if that's a lot a little?</p> <p>14 MR. DOYLE: Question is vague.</p> <p>15 But go ahead.</p> <p>16 THE WITNESS: It's a normal dose for the</p> <p>17 medication.</p> <p>18 BY MR. BRENSKE:</p> <p>19 Q. Okay. One milligram IV administered,</p> <p>20 okay. Then at 21:20 it says, "Patient states pain</p> <p>21 is still a ten out of ten and no change after the</p> <p>22 additional dose of Dilaudid."</p> <p>23 Is that something that you would</p> <p>24 expect to have that kind of pain after getting</p> <p>25 another dose of Dilaudid?</p>

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<p style="text-align: right;">Page 106</p> <p>1 A. Possibly, yes.</p> <p>2 Q. Then we go to 21:37, which is halfway</p> <p>3 down the page of the addendums -- the addendums go</p> <p>4 up. The addendum by Carey, comma, Erin, RN, 20:15,</p> <p>5 21:37, paged Dr. Siddiqui. Then there is another</p> <p>6 addendum at 21:44, that notified</p> <p>7 Dr. Siddiqui regarding patient's pain level still</p> <p>8 ten out of ten. Patient is very upset.</p> <p>9 Dr. Siddiqui stated to notify Dr. Rives regarding</p> <p>10 patient's pain. Attempting to page Dr. Rives at</p> <p>11 this time.</p> <p>12 MR. DOYLE: It's Dr. Rives, Counsel.</p> <p>13 MR. BRENSKE: Rives. I didn't mean to be</p> <p>14 disrespectful, Doctor.</p> <p>15 THE WITNESS: It's okay.</p> <p>16 MR. BRENSKE: But thank you for the</p> <p>17 correction, Counsel.</p> <p>18 BY MR. BRENSKE:</p> <p>19 Q. Then the next addendum is 21:54 where</p> <p>20 they -- they re-paged you again. And then at 22:07</p> <p>21 it looks like they notified you, Doctor, of the</p> <p>22 patient's pain level. The patient's medication is</p> <p>23 already given. Where the pain is located, left side</p> <p>24 of abdomen radiating into shoulders. It looks like</p> <p>25 order received for Morco, PRN, and encourage</p>	<p style="text-align: right;">Page 108</p> <p>1 call him back. He states no. To continue with</p> <p>2 medications as ordered and have her walk and deep</p> <p>3 breathe."</p> <p>4 Do you recall telling the nurses</p> <p>5 that were taking care of Vickie Center the night of</p> <p>6 February 6 to not call you back?</p> <p>7 A. I don't have a recollection of that.</p> <p>8 But I would typically tell them in the case a</p> <p>9 patient after laparoscopy to get up, walk around, to</p> <p>10 relieve the pain in the left shoulder.</p> <p>11 Q. So is it possible the nurse that night</p> <p>12 of the surgery asked you if this pain continues ten</p> <p>13 out of ten, do you want them to call them back and</p> <p>14 you say no?</p> <p>15 MR. DOYLE: Objection. Calls for speculation.</p> <p>16 BY MR. BRENSKE:</p> <p>17 Q. You have to answer the question,</p> <p>18 please.</p> <p>19 A. Okay. It's no with a comma, get her</p> <p>20 up, walk around, move around and do these modalities</p> <p>21 first.</p> <p>22 Q. Okay. So let me just ask, do you have</p> <p>23 an independent recollection of this telephone call</p> <p>24 from the nurse?</p> <p>25 A. No.</p>
<p style="text-align: right;">Page 107</p> <p>1 ambulation and deep breathing.</p> <p>2 Is that something that you would</p> <p>3 have ordered, the Morco?</p> <p>4 A. I don't typically order an oral</p> <p>5 medication in this situation postoperatively.</p> <p>6 However, if one had been ordered by another</p> <p>7 physician, I may have said it was okay to take the</p> <p>8 Morco. I would have to review the orders on the</p> <p>9 chart to see who actually ordered it.</p> <p>10 Q. All right. What is Morco?</p> <p>11 A. It's an analgesic oral medication.</p> <p>12 Q. What does it do?</p> <p>13 A. Relieve pain.</p> <p>14 Q. Okay. Then it says, "Dr. Rives states</p> <p>15 the pain is due to the air on the diaphragm."</p> <p>16 Do you recall indicating that</p> <p>17 information to a nurse on this -- this is at 10:07</p> <p>18 p.m. that first night, it would be the same night?</p> <p>19 A. I don't have a recollection of the</p> <p>20 exact conversation. I'm going with the nurses notes</p> <p>21 here.</p> <p>22 Q. It indicates from the nurse, "Dr. Rives</p> <p>23 states the pain is due to the air under diaphragm.</p> <p>24 Ask Dr. Rives if pain continues to be ten out of ten</p> <p>25 after additional medications given if he wants to</p>	<p style="text-align: right;">Page 109</p> <p>1 Q. All right. Then there is another</p> <p>2 addendum at 22:12 on the evening of the 6th. And</p> <p>3 that's, "Notified patient of new orders received</p> <p>4 from Dr. Rives."</p> <p>5 I know these are not your notes</p> <p>6 and it's speculative, but I'm assuming that what you</p> <p>7 did in this case is when they're having the pain,</p> <p>8 you want them to get up and walk around and breathe</p> <p>9 deeply?</p> <p>10 A. Correct.</p> <p>11 Q. Now, if you go to page 3 of this</p> <p>12 progress note -- I'll try to move quickly on this.</p> <p>13 This is the same nurse at three -- at midnight. It</p> <p>14 looks like the pain level is unacceptable.</p> <p>15 MR. DOYLE: I see acceptable.</p> <p>16 MR. BRENSKE: It is acceptable. That's why we</p> <p>17 have you.</p> <p>18 MR. DOYLE: I thought you said unacceptable.</p> <p>19 MR. BRENSKE: I did. I made a mistake.</p> <p>20 MR. DOYLE: Okay.</p> <p>21 THE WITNESS: Pain level is acceptable, yeah.</p> <p>22 BY MR. BRENSKE:</p> <p>23 Q. The next one is -- now we're at the --</p> <p>24 6:48, the following morning of the surgery. So</p> <p>25 we're about 18 hours out, I guess. It states,</p>

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<p style="text-align: right;">Page 110</p> <p>1 "Encourage patient to use incentive spirometer and 2 perform deep breathing as per orders from Dr. Rives 3 to assist in passing gas." 4 Can you explain to me the use of 5 the spirometer? 6 A. The incentive spirometer is something 7 that I order for all my postoperative patients. It 8 is a device to encourage deep breathing to expand 9 the lungs, to avoid pneumonia and effusions, and aid 10 in respiration. 11 Q. Now, I'm going to go to page 5, and 12 we're still -- all of these are the nursing progress 13 notes. By 9:17 the following morning, it says BP is 14 low, 76 over 54, and heart rate is 112. Standing 15 order, NS 500 cc bolus for -- what is SPB? 16 A. Systolic blood pressure. 17 Q. Less than 90 start. So I take it there 18 is a standing order when the blood pressure goes 19 down to a certain level that, one, administers 20 bolus? 21 A. That's correct. 22 Q. And what is a bolus? 23 A. Instead of giving 500 cc's as a drip, 24 as in a rate of 50 cc's an or 100 cc's an hour, you 25 open it and let it flow in freely.</p>	<p style="text-align: right;">Page 112</p> <p>1 Q. The next blood pressure at 10:02 in the 2 morning is 102 over 507. Next order I have is at 3 10:00 a.m. Dr. Siddiqui called back and new order 4 for CT of abdomen. Do you see that? 5 A. Yes. 6 Q. Why did you discontinue that order? 7 A. Because it wasn't indicated. 8 Q. So CT of the abdomen would be a picture 9 of the general area of where you performed your 10 surgery? 11 A. Correct. 12 Q. Now, at 11:13 is when you were in the 13 room to see the patient and you discontinued the CT 14 of the abdomen. And you had a new order for -- what 15 is NS 1 L bolus? 16 A. Normal saline, one liter. 17 Q. All right. So obviously it was your 18 opinion -- not obviously. It was your opinion at 19 the time on the 7th of February there was no reason 20 for there to be a CT or picture of Ms. Center's 21 abdomen? 22 A. They wanted the CT scan to rule out 23 bleeding, and a CT scan is not a good study to rule 24 out bleeding. 25 Q. Would a CT scan -- I think we had this,</p>
<p style="text-align: right;">Page 111</p> <p>1 Q. And what is that supposed to do, 2 increase blood pressure? 3 A. Well, if the patient's volume is 4 depleted from the surgery or from not eating or not 5 drinking enough, et cetera, you give fluids to 6 support the blood pressure. 7 Q. Well, this is less than -- well, less 8 than 24 hours from surgery. Is it unusual to have a 9 bolus provided? 10 A. No. 11 Q. Do you recall in your operative report 12 how much blood was lost as a result of your surgery 13 on the 6th? 14 A. It would be in my operative note. 15 Q. What is the usual? 16 A. The usual would be less than 50 cc's. 17 Q. 20 cc's would be -- is that something 18 that -- 19 A. Normal. 20 Q. Normal. Now, the blood pressure at 21 9:19 in the morning is 86 over 53 and Dr. Siddiqui 22 paged. Do you remember if and when you were paged 23 next with regards to the care for Ms. Center? 24 A. I think at that point I actually saw 25 the patient in the hospital.</p>	<p style="text-align: right;">Page 113</p> <p>1 so just to go over it. A CT scan of the abdomen 2 with IV contrast would indicate -- would give you 3 potentiality of finding any leak or injury in the 4 surgical area. Fair statement? 5 A. It's possible, yes. But it doesn't 6 rule it out. 7 Q. When did you rule out any possible nick 8 or cut or injury to the -- Vickie Center's abdomen 9 from your February 7th surgery? 10 MR. DOYLE: I'll object. It lacks foundation. 11 But go ahead. 12 THE WITNESS: This morning when I -- the 13 morning that I rounded on her? 14 BY MR. BRENSKE: 15 Q. No, sir. I apologize. I'll rephrase 16 it. We'll allow the objection to go through. So it 17 won't, you know, be interrupted. 18 At what point in time during your 19 treatment of Vickie Center did you rule out the 20 possibility that you had injured or cut the stomach 21 or any surrounding area, causing further injury to 22 Vickie Center? 23 MR. DOYLE: Again, it lacks foundation. 24 THE WITNESS: I think the only time that I 25 finally had ruled that out would be at her second</p>

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<p style="text-align: right;">Page 114</p> <p>1 surgery.</p> <p>2 BY MR. BRENSKE:</p> <p>3 Q. Okay. So that would have been 11 days</p> <p>4 later?</p> <p>5 A. Correct.</p> <p>6 Q. All right. Let's go to -- now, at 11</p> <p>7 -- excuse me, at 11:30 in the morning on the 7th the</p> <p>8 Foley was discontinued. Do you know whose order</p> <p>9 that was?</p> <p>10 A. I don't know. But it probably would be</p> <p>11 mine.</p> <p>12 Q. Then by 2:00 p.m. you indicate that</p> <p>13 Vickie was back to bed due to shortness of breath.</p> <p>14 It says "placed O2 and is 92 percent on two liters."</p> <p>15 What does that mean in regular folks' terms?</p> <p>16 A. She walked around the hall, felt that</p> <p>17 she was short of breath. They put her back on some</p> <p>18 supplemental oxygen, two liters, which is the</p> <p>19 minimum, and her pulse oximetry was acceptable at 92</p> <p>20 percent.</p> <p>21 Q. And then by 4:00 p.m. it looks like the</p> <p>22 CNA called the nurse in because of a low O2 SAT and</p> <p>23 low BP. What is that in normal folks' terms?</p> <p>24 A. Her blood pressure was low. But more</p> <p>25 importantly, just note her oxygen saturation was</p>	<p style="text-align: right;">Page 116</p> <p>1 to the ICU.</p> <p>2 MR. BRENSKE: Well, Counsel, if that was my</p> <p>3 question, it would be a valid objection. I asked</p> <p>4 this doctor why he would transfer someone to an ICU.</p> <p>5 I think he's required to answer that question.</p> <p>6 MR. DOYLE: I will instruct him not to answer</p> <p>7 that. That it calls for an expert opinion based</p> <p>8 upon a foundation that you have not laid.</p> <p>9 MR. BRENSKE: So are you telling me that I'm</p> <p>10 not allowed to ask this doctor why he would transfer</p> <p>11 a patient to ICU?</p> <p>12 MR. DOYLE: What does that -- it's not his</p> <p>13 order.</p> <p>14 MR. BRENSKE: I'm not asking if this is his</p> <p>15 order.</p> <p>16 MR. DOYLE: So how is that his percipient</p> <p>17 testimony?</p> <p>18 MR. BRENSKE: Fine.</p> <p>19 BY MR. BRENSKE:</p> <p>20 Q. When did you first learn that your</p> <p>21 patient was transferred to ICU?</p> <p>22 A. Sometime that evening.</p> <p>23 Q. Okay. Were you given the reasons why</p> <p>24 the patient was transferred to ICU?</p> <p>25 A. I was given some general instructions,</p>
<p style="text-align: right;">Page 115</p> <p>1 dropping while on supplemental oxygen. Meaning she</p> <p>2 was having a respiratory issue.</p> <p>3 Q. When it says her oxygen is 87 percent</p> <p>4 on 5 L's, what does that tell you?</p> <p>5 A. That tells me she's having serious</p> <p>6 respiratory complications.</p> <p>7 Q. It indicates Dr. Siddiqui paged and he</p> <p>8 walked into the room, ordered transferred the</p> <p>9 patient received, and MS 1 L bolus started as</p> <p>10 ordered. That would have been ordered by him then?</p> <p>11 I know we have the order somewhere, I'm just trying</p> <p>12 to --</p> <p>13 A. It looks like it, yes.</p> <p>14 Q. Patient transferred to ICU. Why would</p> <p>15 you transfer a patient to ICU?</p> <p>16 MR. DOYLE: Well, you're asking him to comment</p> <p>17 on the care provided by someone else. That is</p> <p>18 clearly expert opinion.</p> <p>19 MR. BRENSKE: I'm asking this doctor why he</p> <p>20 would have a patient transferred to ICU.</p> <p>21 MR. DOYLE: He did -- if you can lay the</p> <p>22 foundation that he in fact gave that order and made</p> <p>23 the transfer, I'll let him answer the question. But</p> <p>24 he's not going to be an expert witness and comment</p> <p>25 on why someone else may have transferred the patient</p>	<p style="text-align: right;">Page 117</p> <p>1 yes.</p> <p>2 Q. Did you have any disagreement with the</p> <p>3 patient being transferred to ICU?</p> <p>4 A. No.</p> <p>5 Q. Okay. What did -- questions did you</p> <p>6 ask of anyone concerning why this patient was sent</p> <p>7 to ICU?</p> <p>8 A. I don't recall the exact questions I</p> <p>9 asked the providers.</p> <p>10 Q. Okay. Did -- you countermanded the</p> <p>11 order for the CT of the abdomen, why didn't you</p> <p>12 countermand the order for the patient being</p> <p>13 transferred to ICU?</p> <p>14 MR. DOYLE: I'll object. It's argumentative.</p> <p>15 THE WITNESS: I countermanded the CT scan</p> <p>16 because I was there observing the patient directly</p> <p>17 and had clinical knowledge about the patient.</p> <p>18 Patients having some distress that I'm not there to</p> <p>19 see -- evaluate, so I have to rely on my colleagues</p> <p>20 to do their best clinical judgment.</p> <p>21 BY MR. BRENSKE:</p> <p>22 Q. Okay. When you saw the patient at</p> <p>23 11:13 on February 7th, did you examine the patient?</p> <p>24 A. Yes.</p> <p>25 Q. Did you examine the feet of the</p>

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<p>Page 118</p> <p>1 patient?</p> <p>2 A. I do not recall.</p> <p>3 Q. Okay. The next nurses notes on page 6,</p> <p>4 it just says something about the feet -- both feet</p> <p>5 of the patient getting purplish in color before</p> <p>6 patient was brought to ICU. Do you have any</p> <p>7 recollection of examining the patient's feet prior</p> <p>8 to her being -- while you were examining her at</p> <p>9 11:13 that day?</p> <p>10 A. You mean regarding this progress note</p> <p>11 from 02-09?</p> <p>12 Q. Well, yes. The progress note from</p> <p>13 02-09 indicates that someone saw her feet, purplish</p> <p>14 color, before the patient was brought to ICU. And</p> <p>15 you saw her on the 7th, and I wanted to know if you</p> <p>16 had -- if you had examined them, yes or no; if you</p> <p>17 hadn't, then you wouldn't know.</p> <p>18 A. I don't have an independent</p> <p>19 recollection.</p> <p>20 Q. Okay.</p> <p>21 MR. BRENSKE: If we could mark this next in</p> <p>22 order.</p> <p>23 (Exhibit 9 marked.)</p> <p>24 BY MR. BRENSKE:</p> <p>25 Q. Doctor, I'm showing you what's been</p>	<p>Page 120</p> <p>1 Q. All right. Do you have a recollection</p> <p>2 of Ms. Vickie Center undergoing a code blue on the</p> <p>3 7th of February?</p> <p>4 A. Based upon the documentation, yes.</p> <p>5 Q. Okay. Now, this document says that she</p> <p>6 had code blue at 19:39 p.m. That's 7:39 p.m.</p> <p>7 Assuming that's correct, that is how many hours</p> <p>8 after you last saw the patient? You have to go to</p> <p>9 the exhibit. I don't want you to juggle, but there</p> <p>10 is no other way around it. If you can answer the</p> <p>11 question.</p> <p>12 A. About eight or nine hours.</p> <p>13 Q. Okay. It's your understanding with the</p> <p>14 time of my client undergoing a code blue, you</p> <p>15 believed it to be resulting from -- I apologize,</p> <p>16 Doctor, you're better -- I want to say aspiration of</p> <p>17 pneumonia, but do you have a more definitive term</p> <p>18 for it?</p> <p>19 A. Aspiration pneumonitis.</p> <p>20 Q. What does it mean when the patient is</p> <p>21 in cardiac arrest?</p> <p>22 A. Without looking at the rhythm strips, I</p> <p>23 would -- I'd have to know what exact cardiac arrest</p> <p>24 means.</p> <p>25 Q. All right.</p>
<p>Page 119</p> <p>1 marked for identification purposes Plaintiffs'</p> <p>2 Proposed Exhibit No. 9. It is -- if I could see it</p> <p>3 real quick. It's entitled Coding 01 through 4.</p> <p>4 Okay. This is an emergency document. It's dated</p> <p>5 February the 7th, 2015, at 19:39 p.m. So that would</p> <p>6 be 7:39 p.m. The date of service is 02-07-15. And</p> <p>7 it is by a Logan Sondrup, MD. Have you seen this</p> <p>8 document before?</p> <p>9 A. I may have.</p> <p>10 Q. Okay. So do you know who Logan Sondrup</p> <p>11 is?</p> <p>12 A. Yes, I do.</p> <p>13 Q. Who is Logan Sondrup?</p> <p>14 A. He is the ER director -- well, he's the</p> <p>15 ER director now at St. Rose-San Martin. He's an ER</p> <p>16 physician.</p> <p>17 Q. Okay. So I know you're not the author</p> <p>18 of this document, but I want to ask a few questions</p> <p>19 about it. This is -- it says you've responded to</p> <p>20 the ICU for a code blue call. What is a code blue</p> <p>21 call?</p> <p>22 A. Code blue in this hospital is a patient</p> <p>23 in distress. When it happens, various members or</p> <p>24 team members throughout the hospital respond to the</p> <p>25 call.</p>	<p>Page 121</p> <p>1 A. That could be arrhythmia, that can be</p> <p>2 asystole, that could be a number of cardiac</p> <p>3 arrhythmic disorders.</p> <p>4 Q. As a treating physician for this</p> <p>5 patient Vickie Center, what was your understanding</p> <p>6 upon reading the emergency document report where it</p> <p>7 says the patient is in cardiac -- patient is in</p> <p>8 cardiac arrest?</p> <p>9 A. As a surgical consultant on this case,</p> <p>10 I would have no bearing on this document whatsoever.</p> <p>11 This would be managed by the ICU team and the</p> <p>12 intensivists.</p> <p>13 Q. What is -- what is PCP?</p> <p>14 A. Primary care physician.</p> <p>15 Q. Can you tell me why you're listed as</p> <p>16 the primary care physician on this document?</p> <p>17 A. No, I cannot.</p> <p>18 Q. As a consulting physician, you</p> <p>19 discontinued the order for CT of the abdomen earlier</p> <p>20 that very day?</p> <p>21 A. Earlier that morning, yes.</p> <p>22 Q. All right. I get lost. Sorry. And I</p> <p>23 apologize, Doctor, do you have a recollection of</p> <p>24 when you were informed that Ms. Center coded?</p> <p>25 A. Sometime that evening.</p>

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<p style="text-align: right;">Page 122</p> <p>1 Q. When did you next see her?</p> <p>2 A. I don't recall whether I went in the</p> <p>3 hospital that night, but the next documented visit</p> <p>4 was the next day, I believe.</p> <p>5 Q. Do you remember what your diagnosis of</p> <p>6 her condition would have been at that time?</p> <p>7 A. On postoperative day 2 in the morning,</p> <p>8 based upon looking at the patient, reviewing the</p> <p>9 chart, it looks like she had aspiration pneumonia</p> <p>10 causing sepsis.</p> <p>11 Q. Okay. When was the bronchoscopy done?</p> <p>12 A. I would have to refer to the notes for</p> <p>13 that.</p> <p>14 Q. Do you recall whether a bronchoscopy</p> <p>15 was done to rule out that diagnosis?</p> <p>16 A. I know a bronchoscopy was done.</p> <p>17 Q. Do you -- do you recall whether or not</p> <p>18 -- we'll get to that. Just trying to shorten this a</p> <p>19 little bit. What does obtunded mean,</p> <p>20 o-b-t-u-n-d-e-d?</p> <p>21 A. Obtunded is when a patient is</p> <p>22 neurologically not very responsive.</p> <p>23 Q. There is a nursing note on page 15 of</p> <p>24 that exhibit. I apologize, we switched exhibits.</p> <p>25 That's not very nice of me.</p>	<p style="text-align: right;">Page 124</p> <p>1 like you have --</p> <p>2 MR. KELLY: Did you say page 10?</p> <p>3 MR. BRENSKE: Yeah. Okay. So I am doing</p> <p>4 something wrong.</p> <p>5 MR. DOYLE: We'll figure it out.</p> <p>6 MR. BRENSKE: Let's see what we did wrong</p> <p>7 here.</p> <p>8 MR. DOYLE: What are you trying to find?</p> <p>9 MR. BRENSKE: Well, see, my original is</p> <p>10 different than these copies. Other than a competent</p> <p>11 copier --</p> <p>12 MR. DOYLE: Is it a particular op note or</p> <p>13 something?</p> <p>14 MR. BRENSKE: Yeah. I'm looking for the --</p> <p>15 what scares me is -- what did they do to me here?</p> <p>16 MR. DOYLE: I will leave you. We'll let you</p> <p>17 figure that out.</p> <p>18 MR. BRENSKE: Well, let's take a moment.</p> <p>19 MR. DOYLE: Okay.</p> <p>20 MR. BRENSKE: Thanks.</p> <p>21 MS. DAHNKE: And off the record.</p> <p>22 MR. DOYLE: Are we going off?</p> <p>23 MR. BRENSKE: Yes.</p> <p>24 THE VIDEOGRAPHER: We are off the record at</p> <p>25 2:49 p.m.</p>
<p style="text-align: right;">Page 123</p> <p>1 MR. DOYLE: This would be Exhibit 8, I</p> <p>2 believe.</p> <p>3 MR. BRENSKE: You know, I don't know. It's on</p> <p>4 the front of the exhibit, so...</p> <p>5 THE WITNESS: Eight. "Okay to restart tube</p> <p>6 feeds per Dr. Rives"?</p> <p>7 BY MR. BRENSKE:</p> <p>8 Q. Yes. I just want to know what that</p> <p>9 mean. Tube, what is that?</p> <p>10 A. It says, "Okay to restart tube feeds</p> <p>11 per Dr. Rives."</p> <p>12 Q. Is that a feeding tube?</p> <p>13 A. If -- I'd have to put this in</p> <p>14 chronological order because we're hopping all over</p> <p>15 the place. But it usually means we're feeding the</p> <p>16 patient through an NG tube.</p> <p>17 Q. Okay. There is a lot of stuff here.</p> <p>18 Okay.</p> <p>19 (Exhibit 10 marked.)</p> <p>20 BY MR. BRENSKE:</p> <p>21 Q. All right. Doctor, I'm showing you</p> <p>22 what's been marked for identification purposes</p> <p>23 Plaintiffs' Proposed Exhibit No. 10. It is entitled</p> <p>24 Op Reports. 000001 through 23. If you go to --</p> <p>25 page 10, do you have that before you? Doesn't look</p>	<p style="text-align: right;">Page 125</p> <p>1 (Lunch break.)</p> <p>2 THE VIDEOGRAPHER: All right. We are back on</p> <p>3 the record at 3:23 p.m.</p> <p>4 MR. DOYLE: That was our lunch break.</p> <p>5 BY MR. BRENSKE:</p> <p>6 Q. Doctor, I've marked what -- for</p> <p>7 identification purposes as a new Exhibit 10, because</p> <p>8 it has more pages in it and more of a complete</p> <p>9 record. It's Bates stamped 1 -- I mean, 000001</p> <p>10 through 27, Op Report. I wanted to go to page 10,</p> <p>11 if you all recall, of the document. This is the</p> <p>12 operative procedure report of Dr. Yamm-Bor Lin. Did</p> <p>13 I ask you if you were familiar with Dr. Bor Lin?</p> <p>14 A. In what way? I know of him. I know</p> <p>15 he's an intensivist. I'm familiar with his work.</p> <p>16 Q. Okay. This procedure performed on 2008</p> <p>17 -- excuse me, February 8 of 2015 is -- can you</p> <p>18 recall whether or not this bronchoscopy was ordered</p> <p>19 by you or Dr. Siddiqui or do you know?</p> <p>20 A. It would have been done by Dr. Lin.</p> <p>21 Q. Did you consult Dr. Lin at any time in</p> <p>22 this case?</p> <p>23 A. At this point Dr. Lin is the</p> <p>24 intensivist managing the patient in the ICU.</p> <p>25 Q. All right. So in this document it</p>

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<p style="text-align: right;">Page 126</p> <p>1 shows that the PCP is Dr. Rives?</p> <p>2 A. That's what it says on there.</p> <p>3 Q. Would this be a document that you would</p> <p>4 have available to you once the bronchoscopy report</p> <p>5 had been done?</p> <p>6 A. In the EMR of the hospital, yes.</p> <p>7 Q. Okay. Do you recall whether or not you</p> <p>8 reviewed this bronchoscopy report at or around the</p> <p>9 time that the report came out?</p> <p>10 A. I know that I've reviewed it. I can't</p> <p>11 say as to the exact time and date.</p> <p>12 Q. All right. You've opined today that at</p> <p>13 the time of your treatment of Ms. Center that you</p> <p>14 believe that the cause of her sepsis was -- and I</p> <p>15 will say it wrong again -- but aspiration</p> <p>16 pneumonitis?</p> <p>17 A. That is correct.</p> <p>18 Q. Okay. I'm learning. Now, this</p> <p>19 bronchoscopy -- I won't go through the entire report</p> <p>20 because it's here and it's not your report. But the</p> <p>21 last line of the first page, on page 10 of the</p> <p>22 document, it says, "The most likely etiology of the</p> <p>23 sepsis is extrapulmonary." Do you see that?</p> <p>24 A. Yes, I do.</p> <p>25 Q. What does that mean in laymen's terms?</p>	<p style="text-align: right;">Page 128</p> <p>1 etiology mean in laymen's terms?</p> <p>2 A. Source or cause.</p> <p>3 Q. So the likely cause of the sepsis is</p> <p>4 extrapulmonary. What does extrapulmonary mean in</p> <p>5 laymen's terms?</p> <p>6 A. Outside of the lungs.</p> <p>7 Q. That opinion is in contravention to</p> <p>8 your opinion at the time that the source of the</p> <p>9 sepsis was pulmonary. Fair statement?</p> <p>10 A. Again, I disagree with that.</p> <p>11 Q. Okay.</p> <p>12 A. His limited evaluation of the lungs can</p> <p>13 show one thing, does not necessarily contraindicate</p> <p>14 or contradict what my impression was based upon them</p> <p>15 finding a large amount of vomitus in the oropharynx</p> <p>16 when they intubated the patient, for instance.</p> <p>17 Q. Okay. So what did you -- when you</p> <p>18 contacted Dr. Lin, did you discuss with him your</p> <p>19 opinion as opposed to his opinion?</p> <p>20 A. I never contacted Dr. Lin.</p> <p>21 Q. The large amount of vomitus, that would</p> <p>22 have been when?</p> <p>23 A. The note you referenced earlier by</p> <p>24 Dr. Sondrup.</p> <p>25 Q. On the 7th?</p>
<p style="text-align: right;">Page 127</p> <p>1 A. It means Dr. Lin felt that the etiology</p> <p>2 of sepsis was not within her lungs.</p> <p>3 Q. And that -- that would be in</p> <p>4 contradiction to your opinion. Fair statement?</p> <p>5 A. I would say it's his interpretation. I</p> <p>6 wouldn't say it's in direct contraindication to it,</p> <p>7 or contradiction.</p> <p>8 Q. All right. At least we would have a</p> <p>9 day as the deposition. But at least according to</p> <p>10 this, Dr. Lin is explaining to you or any other</p> <p>11 reader that it's his opinion that the sepsis that</p> <p>12 Vickie Center is suffering from on the 8th of</p> <p>13 February 2015 is -- the source of that sepsis is not</p> <p>14 in the lungs. Fair statement?</p> <p>15 MR. NAVRATIL: Foundation objection.</p> <p>16 THE WITNESS: He's basing his opinion on</p> <p>17 his --</p> <p>18 MS. DAHNKE: Join.</p> <p>19 THE WITNESS: -- bronchoscopy.</p> <p>20 BY MR. BRENSKE:</p> <p>21 Q. I understand what he's basing -- let me</p> <p>22 rephrase it so that we're clear. I'm looking at</p> <p>23 Dr. Lin's report, after he did a bronchoscopy, after</p> <p>24 he looked at the lungs, wrote down his findings and</p> <p>25 indicates that the likely etiology -- what does</p>	<p style="text-align: right;">Page 129</p> <p>1 A. At the code blue, when he was assisting</p> <p>2 Dr. Lin in the intubation of Ms. Center.</p> <p>3 Q. So the bronchoscopy would have been</p> <p>4 after that?</p> <p>5 A. The bronchoscopy was the day afterwards</p> <p>6 it looks like. Based upon his note.</p> <p>7 Q. Now, let's go to page 6 of Exhibit 10.</p> <p>8 A. Exhibit --</p> <p>9 Q. I apologize. Page 6 of Exhibit 10,</p> <p>10 page 000006. Have you got that in front of you,</p> <p>11 Doctor?</p> <p>12 A. Central line placement by Dr. Lin.</p> <p>13 Q. Yeah. Can you just tell the jury what</p> <p>14 a central line placement is?</p> <p>15 A. A central line is when we access a</p> <p>16 larger vein with a larger catheter to give fluids,</p> <p>17 antibiotics and other treatments more quickly.</p> <p>18 Q. Okay. And then if we can go to page 8.</p> <p>19 That's the hemodialysis cannula insertion. Can you</p> <p>20 tell me what that is?</p> <p>21 A. Dr. Lin put in a type of catheter that</p> <p>22 has more than one port so that the patient can</p> <p>23 receive dialysis through it.</p> <p>24 Q. Okay. According to this, preoperative</p> <p>25 diagnosis says acute renal failure. Do you see</p>

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<p style="text-align: right;">Page 130</p> <p>1 that?</p> <p>2 A. Yes.</p> <p>3 Q. From your review -- from your review of</p> <p>4 the records, did Ms. Center have acute renal</p> <p>5 failure?</p> <p>6 A. Yes.</p> <p>7 Q. Is it -- was it your opinion at that</p> <p>8 time that the acute renal failure was a result of</p> <p>9 the aspiration pneumonitis?</p> <p>10 A. It was due to her sepsis.</p> <p>11 Q. Which was due to the aspiration --</p> <p>12 aspiration pneumonitis?</p> <p>13 A. That was the presumed diagnosis at the</p> <p>14 time, yes.</p> <p>15 Q. That's still your opinion today, is it</p> <p>16 not?</p> <p>17 A. Yes.</p> <p>18 Q. We discussed earlier -- I'm sorry. If</p> <p>19 you could go to page 21. I do bounce around, so I</p> <p>20 apologize. But this says -- another word that I</p> <p>21 cannot pronounce -- empyema?</p> <p>22 A. Empyema.</p> <p>23 Q. I think I was correct again that I</p> <p>24 don't know how to pronounce it. Empyema. Again,</p> <p>25 what is empyema?</p>	<p style="text-align: right;">Page 132</p> <p>1 BY MR. BRENSKE:</p> <p>2 Q. Doesn't mean I remembered to ask him</p> <p>3 the question. Okay. So we were -- I think we were</p> <p>4 at page 25, were we not? With regards to --</p> <p>5 A. No.</p> <p>6 Q. We're at page 25 now. Surgeon, Sean</p> <p>7 Byron Dow.</p> <p>8 A. Yes.</p> <p>9 Q. Okay. All right. What is a</p> <p>10 right-sided ultrasound-guided chest tube?</p> <p>11 A. Looks like Dr. Dow, under ultrasound</p> <p>12 guidance, placed a tube into the right chest of</p> <p>13 Ms. Center.</p> <p>14 Q. And I don't -- do you have an</p> <p>15 understanding why there was the need to remove this</p> <p>16 purulent material?</p> <p>17 A. I do not have a direct knowledge base</p> <p>18 of that.</p> <p>19 Q. On page 26, is this the -- you did talk</p> <p>20 about -- page 26, we did talk about Dr. Wiencek and</p> <p>21 his right-sided video-assisted thorascopic surgery</p> <p>22 with decortication; correct?</p> <p>23 A. You questioned me about that earlier,</p> <p>24 yes.</p> <p>25 Q. And the purpose of this was to remove</p>
<p style="text-align: right;">Page 131</p> <p>1 A. Empyema is when there is an abscess in</p> <p>2 the thorax.</p> <p>3 Q. When you say abscess, what does that</p> <p>4 mean in laymen's terms?</p> <p>5 A. Infected fluid.</p> <p>6 Q. Do you recall the different specialists</p> <p>7 that were called in as consultants to help heal</p> <p>8 Vickie Center while you were her physician at</p> <p>9 St. Rose Dominican?</p> <p>10 A. While I was a surgical consultant at</p> <p>11 St. Rose?</p> <p>12 Q. Yes.</p> <p>13 A. The entire length of the stay?</p> <p>14 Q. Yes, sir.</p> <p>15 A. I would have to review the chart to</p> <p>16 give you the entire list.</p> <p>17 Q. Once -- once Ms. Center got out of the</p> <p>18 ICU, were you -- what was your relationship? Were</p> <p>19 you still a consultant physician?</p> <p>20 A. Yes.</p> <p>21 Q. Can you explain why you're listed as a</p> <p>22 primary care physician throughout the records?</p> <p>23 MR. DOYLE: Asked and answered.</p> <p>24 THE WITNESS: No idea.</p> <p>25 / / /</p>	<p style="text-align: right;">Page 133</p> <p>1 more purulent material?</p> <p>2 A. It was to free up the lung, yes.</p> <p>3 Q. Just bouncing around here. It</p> <p>4 indicates -- in the second page, which is on page</p> <p>5 27, about a third of the way down -- "of interest,</p> <p>6 the abscess did track down to the esophageal</p> <p>7 hiatus." Where is the esophageal hiatus?</p> <p>8 A. The esophageal hiatus is the area that</p> <p>9 we discussed earlier, where the esophagus goes</p> <p>10 through the diaphragm and joins the stomach.</p> <p>11 Q. Would that be the general surgery that</p> <p>12 you did February 7th of 2015?</p> <p>13 A. Yes.</p> <p>14 Q. When you received this, what did --</p> <p>15 what, if anything, did it tell you?</p> <p>16 A. I don't know what you mean by received.</p> <p>17 Q. That's okay. When you reviewed this</p> <p>18 operative procedure report, what effect -- well,</p> <p>19 strike that.</p> <p>20 You would have gotten a copy of</p> <p>21 this?</p> <p>22 A. I would have reviewed it at some point,</p> <p>23 yes.</p> <p>24 Q. It says CC Barry Rives, so I figure you</p> <p>25 got it. Did that in any way assist you in</p>

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1 confirming your opinions concerning the cause of the
2 sepsis?

3 A. Well, let me clarify something first.
4 CC means it may have gone to my office. The
5 majority of what we're talked about I'm reviewing
6 actively in the EMR of the hospital. So in doing my
7 rounds on Ms. Center, I would have read
8 Dr. Wiencek's note. That's how that comes around.

9 Q. Okay. And how -- I didn't mean to
10 interrupt you. Go ahead.

11 A. What Dr. Wiencek did, his procedure did
12 not change my management of the patient.

13 Q. Do you recall Dr. Shadrou's involvement
14 in this case? When I say "the case," the case of
15 taking care of Vickie Center.

16 A. He's a renal doctor, kidney specialist.

17 Q. Okay. Do you recall what Dr. Mir
18 Mohammad's -- strike that.

19 Are you familiar with Dr. Mir
20 Mohammad?

21 A. He's an infectious disease specialist.

22 Q. Did you consult with him in the care
23 and treatment of Vickie Center?

24 A. We never spoke.

25 Q. Dr. Antonio Flores Erazo, are you

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1 familiar with that doctor?

2 A. I believe he's an intensivist.

3 Q. What, if anything, did you discuss with
4 Dr. Erazo concerning your care and treatment of
5 Vickie Center?

6 A. I don't recall our exact conversations.

7 Q. Do you recall in general subject matter
8 of the conversations?

9 A. Well, she was in the ICU for an
10 extended length of time. I spoke to a lot of the
11 consultants on and off. Just about her general
12 condition, how their -- how she's progressing from
13 their standpoint.

14 Q. Okay. Did any of the physicians, Dr.
15 Siddiqui, Dr. Yan-Bor Lin, Dr. Mir Mohammad,
16 Dr. Antonio Flores Erazo, did you discuss with any
17 of them the possibility of there being a --
18 something occurring during the surgery itself to
19 have led to the sepsis?

20 A. I discussed with them the possibility
21 of surgical complications causing sepsis, yes.

22 Q. Did you discuss with them the
23 possibility of the surgical complication with regard
24 to the actual surgery causing injury to Ms. Center
25 that caused sepsis?

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1 A. As a possibility, yes.

2 Q. So was that within your differential
3 diagnosis at any time?

4 A. As I mentioned earlier, it's always in
5 my postoperative differential, yes.

6 Q. And you indicated a CT of the abdomen
7 ruled that out?

8 A. No. I did not indicate that.

9 Q. Okay. What ruled out the differential
10 diagnosis?

11 A. A CT scan --

12 MR. DOYLE: Hold on. Let him --

13 BY MR. BRENSKE:

14 Q. What -- in your mind, what ruled out
15 the possibility that you had injured some part of
16 the anatomy of Vickie Center causing the sepsis?

17 A. The only time that I ruled that out was
18 when I did her second surgery and I could see that
19 the gastric perforation was related to the NG tube,
20 and there were no other anatomical defects caused by
21 the surgery.

22 Q. Was the NG tube placed before or after
23 the code?

24 A. After.

25 Q. So if I recollect correctly, it was

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1 your opinion that Ms. Center suffered sepsis as a
2 result of the aspiration pneumonitis. She was
3 recovering from that. Then she suffered a hole in
4 her stomach from the NG tube, you fixed that. And
5 then she had another hole in her stomach from -- I
6 don't want to say -- gastric ulcer.

7 A. That's correct.

8 Q. Did you review any test prior to the
9 surgery that would have indicated whether or not
10 Ms. Center suffered from any gastric ulcers?

11 A. Which surgery?

12 Q. The first surgery.

13 A. The only test that that would be
14 relative to would be Dr. Frankel's EGD, which showed
15 agile gastritis.

16 Q. Did that indicate gastric ulcers?

17 A. It indicated she had irritation of her
18 stomach, which would be prone to ulcers, yes.

19 Q. So the gastric ulcer that Vickie Center
20 suffered from would have occurred after her
21 hospitalization on the -- after the hospitalization
22 began February 6 of 2015?

23 A. We're talking about two different types
24 of ulcer. There is an ulcer when somebody is -- as
25 we all are sitting here today -- stress related,

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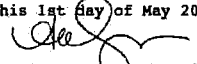
1 et cetera. There is a second type of ulcer that
 2 happens in the acute care setting, a higher level of
 3 stress-induced ulcer that can happen after surgery
 4 or sepsis.
 5 Q. So is the kind of ulcer that you had to
 6 repair in the hospital that second type of ulcer?
 7 A. The one that's -- the one that's
 8 consistent with an acute stress item like sepsis,
 9 yes.
 10 Q. Okay. So it would be your opinion at
 11 the time and today that the gastric ulcer that you
 12 repaired was a -- I don't know if the right word is
 13 consequence of the acute sickness that she had while
 14 she was in the hospital?
 15 A. Yes, that's accurate.
 16 Q. I get it right sometimes.
 17 MR. BRENSKE: Okay. I'm going to pass the
 18 witness before I look at any more documents.
 19 MS. DAHNKE: I don't have any questions.
 20 MR. NAVRATIL: I don't have any questions.
 21 MR. KELLY: No questions.
 22 MR. DOYLE: I don't have anything.
 23 MR. BRENSKE: Well, I don't think I'm allowed
 24 to have any more. So I think you're allowed to go.
 25 THE VIDEOGRAPHER: We're off the record at

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1 3:47 p.m.
 2 MR. DOYLE: I assume you'll do color copies.
 3 And would you -- at least for me anyway, would you
 4 put all the exhibits in a separate cover. Are you
 5 with Litigation?
 6 THE REPORTER: Yes.
 7 MR. DOYLE: So you have my standing order?
 8 THE REPORTER: Yes.
 9 Does anybody want a copy of it? I
 10 know you do, an e-trans.
 11 MS. DAHNKE: I do, please. Mini e-trans.
 12 (Whereupon the deposition was
 13 concluded at 3:47 p.m.)
 14
 15
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REPORTER'S CERTIFICATE

1
 2
 3 STATE OF NEVADA)
 4) ss.
 5 COUNTY OF CLARK)
 6
 7 I, Angela Campagna, a certified court
 8 reporter in Clark County, State of Nevada, do hereby
 9 certify:
 10 That I reported the taking of the
 11 video deposition of the witness, BARRY JAMES RIVES,
 12 M.D., on Tuesday, April 17, 2018, commencing at the
 13 hour of 10:59 a.m.
 14 That prior to being examined, the
 15 witness was by me first duly sworn to testify to the
 16 truth, the whole truth, and nothing but the truth.
 17 That I thereafter transcribed my
 18 said shorthand notes into typewriting and that the
 19 typewritten transcript of said deposition is a
 20 complete, true, and accurate transcription of
 21 shorthand notes taken down at said time.
 22 I further certify that I am not a
 23 relative or employee of an attorney or counsel of
 24 any of the parties, nor a relative or employee of
 25 any attorney or counsel involved in said action, nor
 a person financially interested in said action.
 IN WITNESS WHEREOF, I have
 hereunto set my hand in my office in the County of
 Clark, State of Nevada, this 1st day of May 2018.

 ANGELA CAMPAGNA, CCR #495

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ERRATA SHEET

1
 2
 3
 4
 5 I declare under penalty of perjury that I have read the
 6 foregoing _____ pages of my testimony, taken
 7 on _____ (date) at
 8 _____ (city), _____ (state),
 9
 10 and that the same is a true record of the testimony given
 11 by me at the time and place herein
 12 above set forth, with the following exceptions:
 13
 14 Page Line Should read: Reason for Change:
 15
 16 _____
 17 _____
 18 _____
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ERRATA SHEET		Page 142	
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1 **ORDR**2 **DISTRICT COURT**
3 **CLARK COUNTY, NEVADA**4
5
6 **TITINA FARRIS and PATRICK FARRIS**

Case No.: A-16-739464-C

7 **Plaintiffs,**

Dept. No.: XXXI

8 **vs.**9
10 **BARRY RIVES, M.D.; LAPAROSCOPIC**
11 **SURGERY OF NEVADA, LLC.****ORDER DENYING STIPULATION
REGARDING MOTIONS IN LIMINE
AND ORDER SETTING HEARING
FOR SEPTEMBER 26, 2019, AT 10:00
AM, TO ADDRESS COUNSEL
SUBMITTING MULTIPLE
IMPERMISSABLE DOCUMENTS
THAT ARE NOT COMPLIANT WITH
THE RULES/ORDER(S)**12 **Defendants.**
13
1415
16 **I. FACTUAL BACKGROUND**17
18 The Court is in receipt of the parties' attached purported Stipulation and
19 Order Regarding Motions in Limine. The Court not only needs to Deny the
20 requested impermissible Stipulation due to its *per se* non-compliance with
21 various rules/Order(s), but the Court also unfortunately must set this matter for
22 hearing due to the ongoing conduct of counsel. As counsel is aware, they have
23 continued to submit impermissible documents/requests to the Court which *per se*
24 cannot be granted by the Court as they run afoul of various rules/orders which
25 the parties' counsel have disregarded. This has continued to occur in some
26 cases such as the present one even after the Court has already informed the
27
28

1 parties that they have failed to comply with the rule/standards at issue.
 2 Unfortunately, the conduct of counsel has not only multiplied the proceedings,
 3 but has resulted in the Court spending numerous unnecessary hours responding
 4 to these impermissible documents/requests despite the fact the Court has
 5 already granted the parties seven prior extensions of discovery and/or trial; had
 6 its staff, within legal and ethical bounds, contact counsel (and their staff) to
 7 attempt to remedy issues in the documents/requests; has provided counsel
 8 (verbally and in writing), within legal and ethical bounds, notice of the NRS,
 9 NRCP, EDCR's, and Trial Order provisions at issue; and has even set a
 10 mandatory in-person hearing when counsel would not respond to the Court to try
 11 and gain compliance, all to no avail.

12
 13 With respect to the instant Stipulation and Order Regarding Motions in
 14 Limine, the Court unfortunately cannot sign the proposed Stipulation and Order
 15 for several reasons including, *inter alia*, that it is contrary to the Amended Trial
 16 Order dated January 22, 2019. While the parties have the Order and it is
 17 available online, the Court has provided part of the relevant provisions below:
 18
 19

20 **E. Pre-Trial Memorandum** - The Pre-Trial Memorandum
 21 must be filed no later than **4:00 p.m., on SEPTEMBER**
 22 **30, 2019,** with a courtesy copy delivered to Department
 23 XXXI. All parties, (attorneys and parties in proper person)
MUST comply with **ALL REQUIREMENTS** of E.D.C.R.
 2.67, 2.68 and 2.69.

24 Counsel should include in the Memorandum **an identification**
 25 **of orders on all Motions in Limine** or Motions for Partial
 26 Summary Judgment previously made, a summary of any
 27 anticipated legal issues remaining, a brief summary of the
 28 opinions to be offered by any witness to be called to offer

1 opinion testimony as well as any objections to the opinion
2 testimony.

3 **F. Motions in Limine** - All Motions in Limine, must be
4 in writing and filed no later than eight (8) weeks before
5 the first day of the Trial stack date. Orders shortening
6 time will not be signed except in extreme emergencies.

7 Amended Trial Order January 22, 2019, Pg. 2 (emphasis added in part)

8 As counsel is aware, the proposed Stipulation and Order provided does
9 not cite any emergency. Indeed, there is no reason given at all for why the
10 parties waited until either late in the evening of September 18th or the morning of
11 September 19th to submit to the Court a Stipulation to file Motions in Limine¹
12 when they would have been aware since the original Trial Order in February
13 2017 that Motions in Limine are due eight weeks prior to the trial date.

14 Further, if the Court were to look at the dates proposed by the parties,
15 they would disrupt the ability of the parties to comply with their EDCR 2.67, 2.68,
16 and 2.69 obligations, and would preclude the Court and parties from conducting
17 a productive Calendar Call which is set for October 8th pursuant to the Trial
18 Order. That, in turn, would violate provisions of the 2019 version of NRCP.

19 Specifically, as set forth in Section E of the Amended Trial Order, the Joint
20 Pre-Trial Memorandum is due on September 30, 2019; and in that Memorandum,
21 the parties are to set forth the Orders on any Motion in Limine. That allows the
22 Court to be fully prepared for any issues that may arise at the Calendar Call
23 where the parties are to bring their exhibits, jury instructions, etc., as well as to
24
25

26
27 ¹ The Stipulation and Order was logged in the morning of September 19, 2019, which means that
28 it either arrived in the Department incoming drop box after hours on September 18th or the
morning of September 19th.

1 discuss any outstanding trial issues that need to be resolved prior to the trial
 2 commencing the following week. Based on the parties' requested Stipulation,
 3 their Motions would not even be heard until after the Calendar Call date in order
 4 for the hearing to be compliant with the NRCP which would further unnecessarily
 5 multiply proceedings and risk the parties not being prepared for trial which
 6 commences on October 14th.

8 Second, the proposed Stipulation and Order is non-compliant with EDCR
 9 2.25. As the section in bold sets forth, requests such as the present one which
 10 are made after the expiration of the specified period, "shall not be granted
 11 unless the moving party, attorney or other person demonstrates that the
 12 failure to act was the result of excusable neglect...." As noted above, there
 13 was no explanation or any reason provided in the document. The Stipulation
 14 provides a recitation of counsel and then it says, "that the following consolidated
 15 briefing schedule be issued in this matter regarding Motions in Limine" ² The
 16 deadline to file Motions in Limine has clearly passed. Thus, as counsel chose
 17 not to provide any demonstration of excusable neglect, the Court is precluded
 18 from granting their request.³

20 **Rule 2.25. Extending time.**

21 (a) Every motion or stipulation to extend time shall inform
 22 the court of any previous extensions granted and state the
 23 reasons for the extension requested. **A request for**
extension made after the expiration of the specified

24 ² The language is quoted directly from the Stipulation and Order as the word "that" immediately
 25 follows the word "Associates".

26 ³ The Court notes this is at least the third time the parties have provided a purported Stipulation
 27 after a deadline has expired and have failed to set forth the necessary information required per
 28 the EDCR. Although the Court has previously informed counsel of the issue, unfortunately as
 with the prior occasions, the Court again has to comply with the NRCP and EDCR, and based on
 the express language of the applicable rules cannot grant the parties' request.

1 **period shall not be granted unless the moving party,**
2 **attorney or other person demonstrates that the failure to**
3 **act was the result of excusable neglect.** Immediately below
4 the title of such motion or stipulation there shall also be
5 included a statement indicating whether it is the first second,
6 third, etc., requested extension.

7 (b) Ex parte motions for extension of time will not
8 ordinarily be granted. When, however, a certificate of counsel
9 shows good cause for the extension and a satisfactory
10 explanation why the extension could not be obtained by
11 stipulation or on notice, the court may grant, ex parte, an
12 emergency extension for only such a limited period as may be
13 necessary to enable the moving party to apply for a further
14 extension by stipulation or upon notice, with the time for
15 hearing shortened by the court. [Amended; effective
16 October 13, 2005.]

17 Third, as counsel who were present at the mandatory in-person hearing
18 on September 5, 2019, recall, the Court, on at least two occasions (at
19 approximately 10:39 am and 10:45 am) reminded counsel that due to counsel's
20 non-compliance with several of the rules, the Court was precluded by the
21 provisions of those rules and statute(s) from granting the proposed Stipulation for
22 Extension of Discovery and Trial which meant that the dispositive motion filing
23 deadline, and the Motion in Limine filing deadline which required Motions to be
24 filed eight weeks prior to Trial, remained as set forth in the Amended Trial Order
25 of January 2019. The Pre-Trial Conference date, the Calendar Call date, and the
26 Trial date of October 14, 2019, also remained as set forth in that Order. The
27 Court then again reminded the parties a few moments later that to the extent they
28 had an agreement among themselves regarding experts, depositions, and things
29 that did not impact the court-scheduled dates listed above, nothing precluded
30 them from completing the things that they agreed-upon as long as those items
31 did not impact the Motions in Limine filing deadlines which remained as set by
32 the Court - eight weeks before the start of trial. Thus, it is unclear why the parties

1 disregarded the Court's specific instructions; and instead, about two weeks later
2 submitted the Proposed Stipulation.

3
4 The Court, however, need not even address the parties' disregard of its
5 instruction at the hearing on September 5, 2019, as the EDCR's language
6 specifically precludes the Court from granting the parties' request. In addition,
7 the Trial Order presents an additional obstacle as the parties chose not to
8 provide any reasoning for their request. Additionally, given the parties waited
9 approximately three and a half weeks before trial to even submit a proposed
10 Stipulation to file Motions in Limine, and provided a timetable which would not
11 have the Motions heard until a few days before trial, counsel have effectively
12 precluded themselves from being able to comply with their other pre-trial
13 obligations and would not give the Court time to address any other issues that
14 may arise regarding the trial. These additional factors provide independent
15 reasons for the Court to deny the request particularly in light of the fact counsel
16 have not provided any assurances that they would comply with their other
17 obligations. Accordingly, the Court must DENY signing the proposed Stipulation
18 and Order. For the reasons stated herein, the Court must also address counsels'
19 continued non-compliance on September 26, 2019 at 10:00 am.

20 Dated this 19th day of September, 2019.


21
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23 
24 HON. JOANNA S. KISHNER
25 DISTRICT COURT JUDGE
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CERTIFICATE OF SERVICE

I hereby certify that on or about the date filed, a copy of this Order was served via Electronic Service to all counsel/registered parties, pursuant to the Nevada Electronic Filing Rules, and/or served via in one or more of the following manners: fax, U.S. mail, or a copy of this Order was placed in the attorney's file located at the Regional Justice Center:

ALL COUNSEL SERVED VIA E-SERVICE


TRACY L. CORDOBA-WHEELER
Judicial Executive Assistant

12

RUN # 211 (M-F, PM)
 FIRM Hand & Sullivan, LLC
 ADDR 3442 North Buffalo Drive, Las Vegas, NV 89129
 PH # (702) 666-5814

LegalWings
 PILB #388
 1118 Fremont Street
 Las Vegas, NV 89101
 Ph 384-0305 Fax 384-8638

1000116009
 ATTN: Anna Grigoryan DATE: 09/18/2019
 DD/EXT:

Case # A-16-739484-C
 CASE NAME Famil vs. Rives, et al. NO. A-16-739484-C
 DOCUMENTS Stipulation & Order, CK # \$
 REF # 6618.280 Limit of Liability: \$100.00 per form

☐ Return Copy ☒ Return Original ☐ No Documents Uploaded
 Pick-up Location 3442 North Buffalo Drive, Las Vegas, NV 89129 DM 9/18/19

1. Please pick up the original Stipulation and Order Regarding Motions in Limine from our office.
2. Please deliver the original Stipulation and Order Regarding Motions in Limine to Dept. 31.
3. Please obtain the Hon. Judge's signature on the Stipulation and Order Regarding Motions in Limine.
4. Please return back the executed/signed Stipulation and Order Regarding Motions in Limine to our office. Thank you.

☒ DISTRICT
☐ DISCOVERY
☐ ARB
☐ FAMILY
☐ JUSTICE
☐ MUNI CT.
☒ RECORDER
☒ FEDERAL
☐ BANKRUPTCY
☐ SECRETARY OF STATE
☐ HEARING OFFICER
☐ APPEALS OFFICER

☒ NEXT SCHED DAY ☐ SPECIAL (4HRS) ☐ EXPEDITED (2HRS)

Statute Expires: _____
 May be subject to an additional charge.

Received by (31) 9/18
 Date _____ Time _____
☐ NOT COMPLETE DUE TO _____

LAST DATE 9/18/19 5pm
 RETURN DATE _____ 5pm

9/18/2019, 12:12:49 PM

1 **SAO**2 **KIMBALL JONES, ESQ.**

3 Nevada Bar No.: 12982

4 **JACOB G. LEAVITT, ESQ.**

5 Nevada Bar No.: 12608

6 **BIGHORN LAW**

7 716 S. Jones Blvd.

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9 Phone: (702) 333-1111

10 Email: Kimball@BighornLaw.com11 Jacob@BighornLaw.com12 **GEORGE F. HAND, ESQ.**

13 Nevada Bar No.: 8483

14 **HAND & SULLIVAN, LLC**

15 3442 N. Buffalo Drive

16 Las Vegas, Nevada 89129

17 Phone: (702) 656-5814

18 Email: GHand@HandSullivan.com19 *Attorneys for Plaintiffs*20 **DISTRICT COURT**21 **CLARK COUNTY, NEVADA**22 **TITINA FARRIS and PATRICK FARRIS,**23 **Plaintiffs,**24 **vs.**25 **BARRY RIVES, M.D.; LAPAROSCOPIC**
26 **SURGERY OF NEVADA, LLC et al.,**27 **Defendants.**

CASE NO.: A-16-739464-C

DEPT. NO.: XXXI

28 **STIPULATION AND ORDER**
REGARDING MOTIONS IN LIMINE

IT IS HEREBY STIPULATED AND AGREED TO by Plaintiffs PATRICK FARRIS and TITINA FARRIS, by and through their attorneys of record, KIMBALL JONES, ESQ. and JACOB G. LEAVITT, ESQ., with the Law Offices of **BIGHORN LAW** and GEORGE F. HAND, ESQ., with the Law Offices of **HAND & SULLIVAN, LLC**, and Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC, by and through their attorneys, THOMAS J. DOYLE, ESQ., CHAD C. COUCHOT,

Stipulation and Order Regarding Motions in Limine

Patrick Farris et al. vs. Barry Rives, M.D. et al. – Case No.: A-16-739464-C

Page 1 of 3

ESQ., and AIMEE CLARK NEWBERRY, ESQ., with the Law Offices of **SCHUERING ZIMMERMAN & DOYLE, LLP** and KIM MANDELBAUM, ESQ., with the Law Offices of **MANDELBAUM ELLERTON & ASSOCIATES**, that the following consolidated briefing schedule be issued in this matter regarding Motions in Limine:

Deadline for E.D.C.R. 2.47 Conference	:	September 18, 2019
Deadline to File Motions in Limine	:	September 23, 2019
Deadline to File Oppositions to Motions in Limine	:	September 30, 2019
Deadline to File Replies to Motions in Limine	:	October 2, 2019

Dated this 18th day of September, 2019.

BIGHORN LAW


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KIM MANDELBAUM, ESQ.

Nevada Bar No.: 0318

MANDELBAUM ELLERTON & ASSOCIATES

2012 Hamilton Lane
Las Vegas, Nevada 89106

Attorneys for Defendants

IT IS SO ORDERED that the filing and briefing schedule for the parties' motions in limine be set as follows:

Deadline for E.D.C.R. 2.47 Conference	:	September 18, 2019
Deadline to File Motions in Limine	:	September 23, 2019
Deadline to File Oppositions to Motions in Limine	:	September 30, 2019

Stipulation and Order Regarding Motions in Limine

Patrick Farris et al. vs. Barry Rives, M.D. et al. – Case No.: A-16-739464-C

IT IS SO FURTHER ORDERED that the Hearing on the parties Motions in Limine is set for

DISTRICT COURT JUDGE

BIGHORN LAW

By:

KIMBALL JONES, ESQ.

Nevada Bar No.: 12982

Stipulation and Order Regarding Motions in Limine

Patrick Farris et al. vs. Barry Rives, M.D. et al. – Case No.: A-16-739464-C

ORIGINAL

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Electronically Filed
9/19/2019 1:14 PM
Steven D. Grierson
CLERK OF THE COURT

Steven D. Grierson

MOTN
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Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

9/25/19
9:30am

TITINA FARRIS and PATRICK FARRIS,

Plaintiffs,

vs.

BARRY RIVES, M.D.; LAPAROSCOPIC
SURGERY OF NEVADA, LLC et al.,

Defendants.

CASE NO.: A-16-739464-C

DEPT. NO.: XXXI

HEARING DATE REQUESTED

*To Be Heard Before the Discovery
Commissioner*

**PLAINTIFFS' MOTION TO STRIKE DEFENDANTS' REBUTTAL WITNESSES SARAH
LARSEN, R.N., BRUCE ADORNATO, M.D. AND SCOTT KUSH, M.D., AND TO LIMIT
THE TESTIMONY OF LANCE STONE, D.O. AND KIM ERLICH, M.D., FOR GIVING
IMPROPER "REBUTTAL" OPINIONS, ON ORDER SHORTENING TIME**

COMES NOW Plaintiffs PATRICK FARRIS and TITINA FARRIS, by and through their
attorney of record, KIMBALL JONES, ESQ. and JACOB G. LEAVITT, ESQ., with the Law Offices
of **BIGHORN LAW** and GEORGE F. HAND, ESQ., with the Law Offices of **HAND &**

1 **SULLIVAN, LLC**, and hereby submit this Motion to Strike and Limit Defendants' Rebuttal Experts
2 on Order Shortening Time ("Motion").

3 This Motion is made and based upon all of the pleadings and papers on file herein and the
4 attached Memorandum of Points and Authorities.

5 DATED this 16th day of September, 2019.

6 **BIGHORN LAW**

7 By: /s/ Kimball Jones

8 **KIMBALL JONES, ESQ.**

9 Nevada Bar.: 12982

10 **JACOB G. LEAVITT, ESQ.**

11 Nevada Bar No.: 12608

12 716 S. Jones Blvd.

13 Las Vegas, Nevada 89107

14 **GEORGE F. HAND, ESQ.**

15 Nevada Bar No.: 8483

16 **HAND & SULLIVAN, LLC**

17 3442 N. Buffalo Drive

18 Las Vegas, Nevada 89129

19 *Attorneys for Plaintiffs*

NOTICE OF MOTION ON ORDER SHORTENING TIME

TO: ALL INTERESTED PARTIES, AND THEIR ATTORNEYS OF RECORD

It appearing to the satisfaction of the Court, and good cause appearing therefore, IT IS
HEREBY ORDERED that the foregoing **MOTION** shall be heard on the 25th day of
September, 2019 at the hour of 9:30 a.m.

DATED this 18th day of September, 2019.


DISCOVERY COMMISSIONER

Respectfully submitted by:

BIGHORN LAW

By: /s/ Kimball Jones

KIMBALL JONES, ESQ.

Nevada Bar.: 12982

JACOB G. LEAVITT, ESQ.

Nevada Bar No.: 12608

716 S. Jones Blvd.

Las Vegas, Nevada 89107

GEORGE F. HAND, ESQ.

Nevada Bar No.: 8483

HAND & SULLIVAN, LLC

3442 N. Buffalo Drive

Las Vegas, Nevada 89129

Attorneys for Plaintiffs

**AFFIDAVIT OF KIMBALL JONES, ESQ. IN COMPLIANCE WITH EDCR 2.34 AND IN
SUPPORT OF PLAINTIFF'S MOTION ON ORDER SHORTENING TIME**

STATE OF NEVADA)
) ss
COUNTY OF CLARK)

KIMBALL JONES, ESQ., being first duly sworn, under oath deposes and says:

1. I am an attorney duly licensed to practice law in the State of Nevada and an attorney with the Law Offices of BIGHORN LAW.
2. I am personally familiar with the facts and circumstances surrounding this matter and am competent to testify hereto.
3. That the reason this Motion must be heard on an Order Shortening Time is because discovery is closed in this matter and trial is imminent.
4. That on September 11, 2019, I met with Defense Counsel and spoke with him about my concerns as to Defendant's improperly called rebuttal experts, as well as to the testimony of rebuttal experts which veered into purely initial expert territory, dealing with issues of causation and standard of care opinions.
5. That Defense Counsel refused to stipulate to not call the witnesses and otherwise limit their testimony.
6. As trial is beginning October 14, 2019, and as discovery is closed, it is imperative that this issue be heard prior to trial. As such, Order Shortening Time is warranted.

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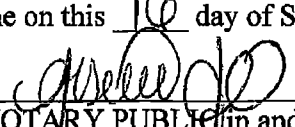
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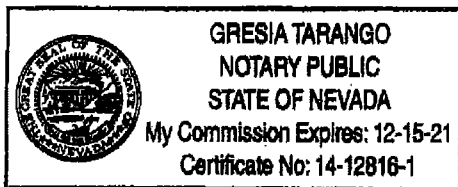
1 7. This Affidavit is made in good faith, and not for the purposes of delay.

2 FURTHER YOUR AFFIANT SAYETH NAUGHT

3
4 
KIMBALL JONES, ESQ.

5 SUBSCRIBED AND SWORN to before
6 me on this 16 day of September, 2019.

7 
8 NOTARY PUBLIC in and for
CLARK COUNTY, NEVADA



1 **MEMORANDUM OF POINTS AND AUTHORITIES**

2 **I. STATEMENT OF RELEVANT FACTS**

3 Plaintiff Titina Farris was a patient of Defendant Rives. Rives, while performing surgery on
4 Plaintiff, negligently cut her colon in at least two (2), and possibly three (3), places. Thereafter, Rives
5 failed to adequately repair the colon and/or sanitize the abdominal cavity. With feces actively in her
6 abdomen, Plaintiff predictably went into septic shock and was transferred to the ICU. Nevertheless,
7 Rives still failed to recommend any surgery to repair the punctured colon for eleven (11) days, during
8 which time Plaintiff's organs began shutting down and her extremities suffered permanent
9 impairment. Ultimately, Plaintiff developed critical care neuropathy, destroying all nerve function in
10 her lower legs and feet, commonly referred to as bilateral drop foot.
11

12 On December 19, 2018, Defendants disclosed eight (8) Rebuttal experts: Dr. Bart Carter, Dr.
13 Brian Juell, Dr. Lance Stone, Nurse Sarah Larsen, Dr. Bruce Adornato, Dr. Kim Erlich, Dr. Scott
14 Kush, and Erik Volk. See Rebuttal Expert Disclosure, attached hereto as Exhibit "1."
15

16 Defendants noted that Larsen, Adornato, and Kush are all "rebuttal witnesses and that their
17 reports are being produced to "rebut" a report from Plaintiffs' initial experts:
18

19 Ms. Larsen is an life care planner. Ms. Larsen is a rebuttal witness. She will provide
20 opinions rebutting the opinions of plaintiffs' expert, Dawn Cook.
21 See Id. at Page 3:1-3.

22 Dr. Adornato is a neurologist. Dr. Adornato is a rebuttal witness. He will provide
23 opinions rebutting the opinions of plaintiffs' expert, Dr. Justin Willer.
24 See Id. at Page 3:7-8.

25 Dr. Kush is a life expectancy expert. Dr. Kush is a rebuttal witness. He will provide
26 opinions rebutting the opinions of plaintiffs' expert, Dr. Alex Barchuk, as they pertain
27 to life expectancy.
28 See Id. at Page 3:19-21.

 However, despite the description which Defendants provided to these three (3) witnesses, they
are not, in fact, rebuttal witnesses. All three (3) of these reports are, in fact, Initial reports masquerading
as Rebuttal reports.

1 The reports from Larsen and Kush never once addressed the reports they claim to be rebutting.
2 Larsen's report notes, "Pursuant to your request, I have prepared a Life Care Plan Report in connection
3 with the above entitled matter based on my review of the expert reports, depositions and medical
4 records provided, and upon the recommendations of Lance Stone, M.D. The life Care Plan Report has
5 been prepared in accordance with Federal Rules of Civil Procedure- Rule 26 and is attached." See
6 *Larsen Report*, attached hereto as **Exhibit "2."**

8 Kush's report notes, "My analyses and opinion of Ms. Titina Farris' life expectancy is based
9 on (1) a review of the materials provided including her medical records, a report, depositions, and other
10 documents, (2) a review of a relevant body of medical and scientific literature, (3) the standard
11 scientific methods for calculating life expectancy, (4) my education, training, experience and
12 expertise." See *Kush Report*, attached hereto as **Exhibit "3."**

14 These reports, as will be more fully outlined below, not only fail to address Plaintiffs' experts'
15 reports, but they are entirely created to combat long-known aspects of Plaintiffs' case in chief. These
16 are initial expert reports, disclosed after the deadline and after Plaintiffs' chance to rebut these claims
17 had passed.

19 This same issue is inherent in Dr. Bruce Adornato's report. Adornato at least as the decency to
20 name-drop Dr. Willer—who he is supposedly rebutting—yet, Adornato's report is nothing but initial
21 expert opinions, which are addressing the long-known aspects of Plaintiffs' case-in-chief. See
22 *Adornato Report*, attached hereto as **Exhibit "4."** As such, Defendants' "Rebuttal" experts, Adornato,
23 Larsen, and Kush are properly Stricken from Trial.

25 Other named witnesses: Carter, Juell, Stone and Erlich, all delve into standard of care opinions
26 or causation opinions. Neither is appropriate from a "Rebuttal" witness. As such, these aspects of their
27 testimony are properly limited.

28 ///

1 **II. LEGAL ARGUMENT AND ANALYSIS**

2 Rebuttal evidence is “intended solely to contradict or rebut evidence on the same subject
3 **matter** identified by another party.” *NRCP 16.1(a)(2)(C)(ii)*. For this reason, rebuttal witnesses are
4 disclosed after initial witness disclosures. *Id.* This later disclosure deadline does not apply to any
5 party’s witness whose purpose is to contradict a portion of another party’s case in chief **that should**
6 **have been expected and anticipated by the disclosing party, or to present any opinions outside**
7 **of the scope of another party’s disclosure.** *Id.* (emphasis added).

9 Nevada’s Federal Courts have repeatedly made persuasive decisions on the propriety of
10 utilizing rebuttal experts to present new theories. These courts have declared that rebuttal expert
11 reports are not the proper venue for presenting new arguments. Instead, rebuttal expert opinions should
12 only address new, unforeseen issues upon which the opposing party’s initial experts have opined.
13 *Nunez v. Harper*, 2014 WL 979933, *1 (D. Nev. Mar. 11, 2014) (citing *R&O Constr. Co.*, 2011 WL
14 2923703 at *2). “If the purpose of expert testimony is to contradict an expected and anticipated portion
15 of the other party’s case-in-chief, then the witness is not a rebuttal witness or anything analogous to
16 one.” *Id.* Presenting a new, alternative theory of causation is not a rebuttal opinion; rather, it is an
17 expected and anticipated portion of a party’s case-in-chief. *See Amos v. Makita U.S.A., Inc.*, 2011 WL
18 43092, *2 (D. Nev. Jan. 6, 2011).

21 Finally, a party cannot abuse the rebuttal date and use it as “an extension of the deadline by
22 which a party must deliver the lion’s share of its expert information.” *Amos*, 2011 WL 43092 at *2
23 (citing *Sierra Club, Lone Star Chapter v. Cedar Point Oil Co., Inc.*, 73 F.3d 546, 571 (5th Cir. 1996).

24 In *R&O Constr. Co. v. Rox Pro Int’l Group, Ltd.*, 2011 U.S. Dist. LEXIS 78032 (D. Nev. July
25 18, 2011) the District Court of Nevada addressed a similar situation to that in the case at bar in which
26 an expert who was offered by the defense to address an expected and anticipated portion of the
27 plaintiff’s case in chief was improperly disclosed as a rebuttal expert.
28

1 The court explained that:

2 Fed. R. Civ. P. 26(a)(2)(C)(ii) permits the admission of rebuttal expert testimony that is
 3 "intended solely to contradict or rebut evidence on the same subject matter identified"
 4 by an initial expert witness. *TC Sys. Inc. v. Town of Colonie*, NY, 213 F.Supp.2d 171,
 5 179 (N.D.N.Y. 2002). Rebuttal expert reports "necessitate 'a showing of facts supporting
 6 the opposite conclusion' of those at which the opposing party's experts arrived in their
 7 responsive reports." *Bone Care Int'l, LLC v. Pentech Pharmaceuticals, Inc.*, 2010 U.S.
 8 Dist. LEXIS 104549, 2010 WL 389444 (N.D. Ill. Sep. 30, 2010) (quoting *ABB Air*
Preheater, Inc. v. Regenerative Environmental Equip., Inc., 167 F.R.D. 668, 669 (D.N.J.
 9 1996). Rebuttal expert reports are proper if they contradict or rebut the subject matter of
 10 the affirmative expert report. *Lindner v. Meadow Gold Dairies, Inc.*, 249 F.R.D. 625,
 11 636 (D. Haw. 2008). They are not, however, the proper place for presenting new
 12 arguments. *1-800 Contacts, Inc. v. Lens.com, Inc.*, 755 F.Supp.2d 1151, 1167 (D. Utah
 13 2010); see *LaFlamme v. Safeway, Inc.*, 2010 U.S. Dist. LEXIS 98815, 2010 WL
 14 3522378 (D. Nev. Sep. 2, 2010); cf. *Marmo v. Tyson Fresh Meats*, 457 F.3d 748, 759
 15 (8th Cir. 2006) ("The function of rebuttal testimony is to explain, repel, counteract or
 16 disprove evidence of the adverse party.") (citation omitted). **"If the purpose of expert
 17 testimony is to 'contradict an expected and anticipated portion of the other party's
 18 case-in-chief, then the witness is not a rebuttal witness or anything analogous to
 19 one'"** *Amos v. Makita U.S.A.*, 2011 WL 43092 at *2 (D. Nev. Jan. 6, 2011) (quoting *In*
re Apex Oil Co., 958 F.2d 243, 245 (8th Cir. 1992)); see also *Morgan v. Commercial*
Union Assur. Cos., 606 F.2d 554, 556 (5th Cir. 1979); *LaFlamme*, 2010 U.S. Dist.
 LEXIS 98815, 2010 WL 3522378 at *3. Rather, **rebuttal expert testimony "is limited
 to 'new unforeseen facts brought out in the other side's case.'" *In re President's*
Casinos, Inc., 2007 Bankr. LEXIS 4804, 2007 WL 7232932 at * 2 (E.D. Mo. May 16,
 2007) (quoting *Cates v. Sears, Roebuck & Co.*, 928 F.2d 679, 685 (5th Cir. 1991)).
 (Emphasis added).**

18 The bright line authority in this jurisdiction is that rebuttal expert testimony "is limited to 'new
 19 unforeseen facts brought out in the other side's case.'" In this case it is undisputed that the causation
 20 of Plaintiffs' injuries and the future care they would require were anticipated parts of their case in
 21 chief and therefore any experts designated by the Defendants regarding the Plaintiffs' loss of earnings,
 22 should have been designated by the Initial Expert Disclosure Deadline.

24 The court in *R&O Constr. Co. v. Rox Pro Int'l Group, Ltd.*, 2011 U.S. Dist. LEXIS 78032 (D.
 25 Nev. July 18, 2011) explained that because the "rebuttal experts" in that case were not true rebuttal
 26 experts they were improperly disclosed. The court explained:

27 While both McMullin's and Hoff's reports address the same general subject matter of
 28 the case, Hoff's report does not directly address the findings, i.e. "the same subject
 matter," of McMullin's report. Therefore it is not a rebuttal expert report within the

1 meaning of Rule 26(a)(2)(C)(ii). See *Vu v. McNeil-PPC, Inc.*, 2010 U.S. Dist. LEXIS
 2 53639, 2010 WL 2179882 at *3 (C.D. Cal. May 7, 2010) (finding that such a broad
 3 meaning would all but nullify the distinction between an initial “affirmative expert” and
 4 a “rebuttal expert.”); see *International Business Machines Corp. v. Fasco Indus., Inc.*,
 5 1995 U.S. Dist. LEXIS 22533, 1995 WL 115421 (N.D. Cal. Mar.15, 1995) (“rebuttal
 6 experts cannot put forth their own theories; they must restrict their testimony to
 7 attacking the theories offered by the adversary’s experts.”). McMullin’s report offers
 8 opinions and conclusions regarding the structural insufficiency of the design for the
 9 installation of a stone veneer on the project, the requirement that the stone veneer
 10 installation be accomplished with an anchored system and the resulting irrelevance of
 11 the bond between stone and mortar, and R&O’s role in bringing potential design
 12 deficiencies to the attention of WD Partners. By comparison, Hoff’s report details
 13 theories regarding the failure of the stone and mortar, and makes observations regarding
 14 the “responsibilities” of the various players — general contractor/subcontractor and
 architect — with regard to installation. **The report’s findings do not speak to “new
 unforeseen facts” brought out in McMullin’s report**, see *In re President’s Casinos,
 Inc.*, 2007 Bankr. LEXIS 4804, 2007 WL 7232932 at * 2; rather, they set forth an
 alternate theory, viz., that the stone failure is related to installation and mortar errors.
 Although causation may be demonstrated in various ways, “simply because one method
 fails, the other does not become “rebuttal.”” See *Morgan v. Commercial Union Assur.
 Cos.*, 606 F.2d at 555. Nor is a rebuttal expert report the proper place for presenting new
 arguments. *1-800 Contacts, Inc. v. Lens.com, Inc.*, 755 F.Supp.2d at 1167.
 (Emphasis added).

15 Because the report is not a rebuttal report, it is untimely and must be stricken unless
 16 Real Stone can show that the untimely disclosure was substantially justified or harmless.
 17 See *Rule 37(c)(1)*. Here, Real Stone’s late disclosure is not substantially justified.
 18 Notably, it had named Hoff as an expert and provided his curricula vitae within the time
 19 limit set for the disclosure of initial experts, but it did not produce a report. Despite the
 relevant inspections having been performed on February 11 and 16, 2009, prior to the
 filing of the lawsuit, Real Stone does not justify its failure to timely disclose the report.

20 As to the issue of harm, the Hoff report was not disclosed until nearly nine weeks after
 21 the initial expert cutoff date of November 10, 2010. Discovery cutoff has already been
 22 extended three times in this case, and the latest cutoff date has passed. Although no trial
 23 date has yet been set, the dispositive motion deadline was April 8, 2011. Accordingly,
 24 R&O is prejudiced by the Hoff report, because the time to designate rebuttal experts has
 25 passed, as well as the discovery cutoff and dispositive motion deadlines. A scheduling
 26 order “shall not be modified except upon a showing of good cause and by leave of . . .
 a magistrate judge.” *Fed.R.Civ.P. 16(b)*. Real Stone did not seek an extension of the
 deadline to disclose initial experts, nor has it shown good cause for the failure to do so.
 Accordingly, Hoff’s report must be stricken. See e.g. *Yeti by Molly*, 259 F.3d at 1107.
 (Emphasis added).

27 The facts in the *R&O Construction* case are very similar to the facts in the subject case. Larsen,
 28 Adornato, and Kush were not disclosed as initial experts and their reports were not made to the

1 Plaintiffs until a month after the initial expert disclosure deadline. This designation was improper and
2 untimely and this Court should follow the reasoning of the *R&O Construction* case and Strike the
3 untimely and improper expert designation of these three “rebuttal” experts.

4
5 In the instant case, Defendants negligently failed to care for Plaintiff Titina before and after
6 she developed sepsis. The effect this damage had on her health and her future are catastrophic. This—
7 liability and damages, including future damages—was the entire sum and substance of Plaintiffs’
8 initial complaint and Defendants’ subsequent answer. Plaintiffs’ initial Complaint spelled out with
9 laser precision that they believed that Defendants were liable for Plaintiffs’ injuries and for the damage
10 caused by Defendants’ negligence. That causation was an expected and central component to the case
11 precludes any rebuttal witnesses from offering faux-rebuttal testimony which opines on alternative
12 causation opinions in their rebuttal reports:

13
14 Rebuttal experts are not allowed to put forth their own theories; instead, **“they must**
15 **restrict their testimony to attacking the theories offered by the adversary’s**
16 **experts.”**

17 *Downs v. River City Grp., LLC*, No. 3:11-CV-00885-LRH, 2014 WL 814303, at *5 (D.
18 Nev. Feb. 28, 2014) (Emphasis added).

19 Even if it is not outside that scope, the subject of the causation of the fire is an expected
20 and anticipated portion of Defendant's case-in-chief, and therefore Hyde cannot be a
21 rebuttal expert or anything analogous to a rebuttal expert. *Apex Oil*, 985 F.2d at 245.

22 Allowing Hyde to testify as more than a rebuttal expert would allow Makita to use the
23 30 day deadline for disclosure of rebuttal experts as an extension of time for disclosing
24 the lion's share of its expert information. See *Sierra Club*, 73 F.3d at 571. Causation of
25 the fire is the central issue of this entire litigation. Makita knew that long before the
26 expert disclosure deadlines.

27 *Amos v. Makita U.S.A., Inc.*, No. 2:09-CV-01304-GMN, 2011 WL 43092, at *2 (D. Nev.
28 Jan. 6, 2011).

Furthermore, Plaintiffs quickly identified and disclosed their initial expert witnesses, in their
disclosure of initial experts. Indeed, Defendants had every reason to anticipate, expect and prepare for

1 their side of the adversarial process. Defendants' preparation for their case in chief did just that—as
2 they timely disclosed their own initial Medical Providers.

3 Despite clearly understanding that reasonableness of medical care, causation, and damages,
4 including future life care, was part of the Plaintiffs' case-in-chief, Defendants are now abusing the
5 disclosure process by attempting to ambush Plaintiffs by sneaking in *additional* medical experts and
6 life care experts to give entirely new alternate theories of causation for Plaintiffs' injuries when it is
7 no longer possible for Plaintiffs to hire experts to rebut these new opinions. Defendants added these
8 new voices a month after the deadline for initial experts had passed.

10 Furthermore, these "Rebuttal" expert reports provided do not appropriately address or rebut
11 Plaintiffs' initial expert opinions, but instead seek to introduce new opinions—including reports which
12 fail to even reference Plaintiffs' initial expert reports, which they are supposedly rebutting.

14 This masquerade will confuse the jury and significantly prejudice the Plaintiffs, who have
15 appropriately followed Nevada Rules of Civil Procedure and the Court's process for disclosures, in a
16 timely and respectful manner. Therefore, this Court should Strike Defendants' rebuttal experts'
17 testimony, and allow Defendants to make their arguments through their initial experts.

18
19 **A. The Opinions of Larsen, Adornato, and Kush Address Issues That Were Long-**
20 **Anticipated Portions of Plaintiffs' Case in Chief; As Such, They Are Properly Stricken.**

21 Nevada Rules of Civil Procedure state in plain language what qualifies as rebuttal testimony,
22 stating definitively that rebuttal deadlines are not created to give counsel a second chance to argue
23 what "should have been expected and anticipated by the disclosing party." *NRCP 16.1(a)(2)(C)(ii)*.
24 Furthermore, Nevada Courts, as addressed above, have declared the impropriety of subverting process
25 by utilizing rebuttal experts to present a new case-in-chief or to present new theories after the period
26 for disclosing initial expert witnesses has passed.

27 Defendants should easily have expected and anticipated that Plaintiffs would make one of their
28 core causes of action against Defendants for their negligence in causing Plaintiff Titina to undergo

1 substantial medical treatment and damages, that the treatment provided after the subject incident was
2 reasonable, and that Plaintiff Titina would require care in the future. Defendants had every reason to
3 expect, anticipate and prepare for that debate in their disclosure of initial experts.

4 Plaintiffs were again circumspect about this goal to prove that Defendants' behavior led to the
5 medical care sought by Plaintiffs, and that such subsequent care was reasonable in light of Plaintiff
6 Titina's injuries. Plaintiffs disclosed their initial experts and noted that they would be testifying as to
7 the reasonableness of Plaintiff Titina's medical care. In their reports, Plaintiffs' initial experts testified
8 to the nature of Plaintiffs' injuries, how they were caused by Defendants' negligence and how the
9 subsequent care, and cost thereof, was reasonable.
10

11 Nevertheless, more than a month after the deadline to disclose initial expert witnesses,
12 Defendants disclosed eight (8) experts as "rebuttal experts," including Jensen, Kush, and Adornato.
13 While Plaintiffs take issue with each of these witnesses, Adornato most blatantly fails to conform to
14 those restrictions required for rebuttal disclosure.
15

16 Adornato Report Deficiencies:

17 Dr. Adornato's report mentions Dr. Willer's initial report. However, each and every one of his
18 opinions critiques a long-known portion of Plaintiffs' case-in-chief, and could only be properly
19 disclosed through an initial expert disclosure, if at all. See Exhibit 4.
20

21 Adornato attacks Plaintiffs' long-known causation opinions, which were outlined in Plaintiffs'
22 Complaint from the beginning of the case. Moreover, these opinions were found within the medical
23 records Plaintiffs disclosed early on. Adornato takes issue with elements of Plaintiff Titina's medical
24 records, which were available to Defendants – for years. Adornato does not comment on anything new
25 or novel; he simply fills the role of an additional initial expert, though he is disclosed as "rebuttal"
26 only.
27

28 ///

1 In addition, Adornato gives a new, novel theory that was never addressed by Dr. Willer—and
2 one that is a direct causation opinion, which is inappropriate in a rebuttal report:

3 Based on my education, training, and experience and review of the pertinent documents,
4 I have reached the opinion that Ms. Farris suffered from a significant painful diabetic
5 neuropathy prior to the events of August 2015 and that this was in part due to her poorly
6 controlled diabetes, which continues to the present time.

7 See Exhibit 4, at Page 2.

8 This causation opinion is couched as one Dr. Willer failed to consider—yet, if this was
9 Defendants' belief as to the causation of Plaintiff Titina's injuries, it may only enter from an initial
10 expert. This is true for numerous reasons. First, expert medical causation opinions are always initial.
11 Second, Dr. Willer's opinion that Adornato departs from was not new, but was rather a well-known
12 opinion in Plaintiffs' case-in-chief from the commencement of the case, requiring Defendants to
13 contradict it, if at all, in their initial expert disclosure. Third, Adornato's opinion is entirely formed
14 from medical records in Defendants' possession – for years.

15 As this is the sum of Adornato's testimony, it is properly Stricken. As Adornato does not have
16 a single appropriate rebuttal opinion in this matter, but has instead offered initial opinion only, he must
17 be Stricken in this matter to avoid further prejudice to Plaintiffs and abuse by Defendants.

18 This resolution is strengthened by the Court's finding in *R&O*—which notes that Rebuttal
19 Testimony is exclusively limited to “unforeseen” facts:

20 **[R]ebuttal expert testimony "is limited to 'new unforeseen facts brought out in the**
21 **other side's case.'"** *In re President's Casinos, Inc.*, 2007 Bankr. LEXIS 4804, 2007 WL
22 7232932 at * 2 (E.D. Mo. May 16, 2007) (quoting *Cates v. Sears, Roebuck & Co.*, 928
23 F.2d 679, 685 (5th Cir. 1991)).

24 *R&O Constr. Co. v. Rox Pro Int'l Group, Ltd.*, 2011 U.S. Dist. LEXIS 78032 (D. Nev.
25 July 18, 2011). (Emphasis added).

26 The bright line authority in this jurisdiction is that rebuttal expert testimony “is limited to ‘**new**
27 **unforeseen facts brought out in the other side's case.**” In this case it is undisputed that the causation
28 of Plaintiffs' injuries and the future care they would require were anticipated parts of their case in

1 chief and therefore any experts designated by the Defendants regarding the Plaintiffs' loss of earnings,
2 should have been designated by the initial expert disclosure deadline. Everyone was aware of Plaintiff
3 Titina's diabetes even prior to her surgery, and certainly long before the lawsuit was filed. Moreover,
4 the fact that Defendants' initial experts both note the role of diabetes in their analysis makes it clear
5 that Defendants were aware of the matter long before rebuttal disclosures.
6

7 Adornato's report is inappropriate because he is not addressing "new" "unforeseen" facts
8 elicited by Dr. Willer—he is simply creating new, novel theories based on the medical records that
9 Willer (and all of Defendants' initial experts) already relied upon. These facts have been known by
10 Defendants – for years, prior to Dr. Willer's reports.
11

12 Larsen Report Deficiencies:

13 Nurse Larsen's report consists of twenty-two (22) pages of new, novel theories for Plaintiff
14 Titina's life care plan—testimony which should have been part of Defendants' case in chief. Larsen
15 notes that she based her report on Defendants' own "rebuttal" expert of Dr. Stone, and not as any
16 rebuttal to Plaintiffs' initial expert reports:

17 My opinions, which are set forth in the Life Care Plan Report for Ms. Farris, are based upon
18 the review of expert reports, my 19 years of experience in nursing, academia and life care
19 planning, and the current costs associated from the Las Vegas and Henderson, Nevada areas
20 for the outlined recommendations for medical care, treatment and supplies. I have consulted
21 with Dr. Stone regarding his opinions of future care needs for Ms. Farris. I have outlined the
22 recommendations of Dr. Stone in the Life Care Plan Report. I reserve the right to modify my
23 report in the event additional information is provided.

24 See Exhibit 2, at Page 2.

25 This opinion is inappropriate from a "rebuttal" witness. Plaintiffs' future medical needs are an
26 anticipated part of their case in chief, particularly in a case where it is well known by all parties that
27 Plaintiff Titina lost her ability to walk independently as a result of the subject incident. Defendants
28 failed to present these wholly initial expert opinions until a month after they were required to be
submitted. Larsen is not contradicting or pointing out deficiencies in any initial report by Plaintiffs'

1 experts—she is merely delving into new opinions which are inappropriate coming from a rebuttal
2 expert. It is crystal clear that this is a causation opinion which is being shoe-horned into a rebuttal
3 report.

4 Further, it is telling that, in a report where Larsen is supposed to be rebutting Cook, she is
5 instead quoting from Defendants’ “rebuttal” expert, Dr. Stone, to prove her initial opinions. Larsen
6 does not even discuss or note the opinions of Plaintiffs’ experts in her report, neither does she
7 incorporate or consider their opinions. Rather, Larsen simply creates a new set of novel opinions about
8 Plaintiff Titina’s future care needs based on nothing more than the information that was readily
9 available from the commencement of the case, combined with the other opinions offered by
10 Defendants’ “rebuttal” expert Dr. Stone. There was nothing new in Plaintiffs’ initial expert disclosure
11 that surprised Defendants, or that Larsen needed for the opinions formed here. Defendants’ attempt to
12 circumvent the discovery deadlines in this matter disqualifies them from presenting this opinion.
13 Therefore, Larsen should be Stricken as a witness in this matter.
14

15
16 Kush Report Deficiencies:

17 Likewise, Dr. Kush’s report is wholly an initial expert report. As noted above, Dr. Kush fails
18 to address Plaintiffs’ experts’ reports in any regard, never once referring to them in his reports—aside
19 from a one-line claim, that he reviewed them. Its contents, however, are never addressed.
20

21 Kush, after noting Plaintiff Titina had diabetes then concludes:

22 **To a reasonable degree of scientific certainty, I have calculated Ms. Titina Farris’**
23 **life expectancy, as of the date of this report, to be 21.5 additional years.**

24 See Exhibit 3 (Emphasis in original).

25 Dr. Kush’s report is another initial report. Kush provides opinions about Plaintiff Titina’s
26 physical condition both before and after the subject incident. Kush provides opinions about how long
27 Plaintiff Titina will live. These opinions should have come from an initial expert—one that Plaintiffs
28 could have rebutted. Instead, Defendants have snuck this initial opinion in from their rebuttal

1 witness—making a rebuttal impossible in this matter. Defendants had the opportunity to calculate
 2 Plaintiff Titina’s lifespan in the initial stages of litigation in this matter—yet they chose not to do so.
 3 Instead they are violating this Court’s scheduling order by presenting initial opinions in the guise of
 4 rebuttal opinions. As such, Dr. Kush’s initial testimony, couched as rebuttal, must be Stricken.

5
 6 **i. Additional Support in Striking these “Rebuttal” Reports.**

7 Both Kush and Larsen’s report exemplify the type of inappropriate “rebuttal” report noted by
 8 the Federal District Court:

9 “Courts have repeatedly held that an expert is improperly designated as a rebuttal expert
 10 when he has failed to review the initial expert report, or otherwise failed to indicate that
 11 he was aware of the opinions offered by the initial expert.” *See, e.g., Clear-View Techs.,*
 12 *Inc. v. Rasnick*, 2015 WL 3509384, at *4 (N.D. Cal. June 3, 2015) (internal quotations
 13 and alterations omitted) (citing *Houle v. Jubilee Fisheries, Inc.*, 2006 WL 27204, at *3
 14 & n.4 (W.D. Wash. Jan. 5, 2006) and *Amos*, 2011 WL 43092, at *1). Quite simply, “an
 15 expert cannot be said to ‘rebut’ testimony he or she has never seen or reviewed.” *Clear-*
 16 *View Technologies*, 2015 WL 3509384, at *4.

17 *Felix v. CSAA Gen. Ins. Co.*, No. 215CV02498APGNJK, 2017 WL 1159724, at *3 (D.
 18 Nev. Mar. 28, 2017).

19 These three (3) experts, Adornato, Larsen and Kush, were improperly utilized and violate the
 20 Nevada Rules of Civil Procedure, because any issues that Defendants thought would pertain to
 21 causation of damages and reasonableness of care must have been included in their initial expert
 22 disclosure. This is obvious since damages, reasonable care and causation are essential to Plaintiffs’
 23 case in chief and were a well-known portion of Plaintiffs’ case from the commencement of this
 24 litigation. Defendants chose to ignore the proper role and scope of rebuttal experts in order to stack
 25 the deck against Plaintiffs and compensate for the oversights of their initial experts’ reports. This
 26 prejudices the entire testimonial process and leaves Plaintiffs without recourse to the luxuries of time
 27 and lavish testimony that Defendants enjoy as a result of their strategy.

28 The ultimate result, of course, is that Plaintiffs are now ambushed by Defendants’ false-rebuttal
 disclosure, with no way to offset this unfair advantage, since all expert deadlines are now passed.

1 Commissioner Beecroft in this jurisdiction came to the same conclusion as the Federal Courts
2 did in *Nunez* and *Amos*—that rebuttal experts are not to be used to establish a new case-in-chief.
3 Commissioner Beecroft gave this opinion in a decision on an automobile crash case, *Mangus v. Abram*,
4 A-11-634090-C, (8th Judicial District Court January 7, 2013). In *Mangus*, Defendant disclosed a
5 biomechanical accident reconstructionist as an initial expert, and plaintiff scrambled to rebut, seeking
6 permission to examine defendant's vehicle in order to disclose a rebuttal expert. Defendant refused,
7 arguing that plaintiff knew prior to the initial expert disclosure deadline that defendant would enlist a
8 biomechanical expert because defendant requested permission for his expert to inspect plaintiff's
9 vehicle. *Id.* As a result of this disclosure, plaintiff could anticipate that the biomechanical expert would
10 be part of defendant's case in chief and should have disclosed her *own* initial biomechanical expert
11 instead of abusing the rebuttal process to compensate for her oversight. Commissioner Beecroft not
12 only denied plaintiff's motion to compel inspection of defendant's vehicle, but went further, striking
13 plaintiff's biomechanical rebuttal expert altogether on the grounds that plaintiff should have disclosed
14 said expert as initial. *Id.*

17 In the instant case, Defendants have had ample reason to acknowledge and anticipate Plaintiffs'
18 damages, including reasonableness of care, future life care and medical causation, all central to
19 Plaintiffs' case. Importantly, Defendants did attack these positions through the use of their initial
20 experts – proving Defendants' knew of these elements in Plaintiffs' claimed damages. Therefore,
21 Defendants should not be allowed to abuse rebuttal disclosures, which by their very nature are limited
22 in scope, to further bolster initial expert opinions. Like Plaintiffs, Defendants should have prepared
23 their best case in line with the law, and debated damages, causation, and reasonableness on an even
24 playing field, disclosing all initial expert opinions on the deadline to do so, as Ordered by this Court.
25 To do otherwise prejudices the judicial process and rewards the Defendants' circumvention of this
26 Court's Rules and Processes. Therefore, this Court must Strike Defendants' rebuttal experts, Adornato,
27
28

1 Larsen, and Kush, and focus on the debate between the properly retained initial and rebuttal expert
2 witnesses.

3 **B. The Opinions of Stone and Erlich must be Limited to Preclude Testimony on Standard**
4 **of Care and Causation.**

5 As noted above, the bright line authority in this jurisdiction is that rebuttal expert testimony
6 "is limited to 'new unforeseen facts brought out in the other side's case.'" As the standard of care
7 (including breaches of the same) and medical causation are always part of Plaintiffs' case-in-chief,
8 these are areas that can only be addressed by initial experts, rather than by rebuttal experts. Yet,
9 Defendants' Rebuttal experts delve into declaring that Rives' actions were within the standard of care,
10 and gave opinions on causation.

12 Dr. Stone opines on Causation:

13 Based upon my independent review of Ms. Farris medical records I agree in general
14 with Dr. Barchuck's diagnosis. However, the medical records I reviewed support my
15 conclusions that several medical problems were preexisting or unrelated to surgery.

16 See Stone Report, attached hereto as Exhibit "5."

17 Whether Plaintiffs' injuries were actually preexisting is a new and novel theory, and one which
18 is not based on new evidence. Stone admits that his opinion is coming from a record review, not from
19 Barchuck's report. This opinion may properly be made by an initial expert, but cannot be made by Dr.
20 Stone, who is exclusively a rebuttal expert. As such, Plaintiffs request that Dr. Stone's testimony be
21 limited to pure rebuttal opinions and that he be precluded from offering any opinions regarding the
22 standard of care of medical causation of injury, which issues are exclusively initial in nature.
23

24 Similarly, Dr. Erlich presents improper standard of care opinions:

25 It is my opinion that, from an Infectious Diseases standpoint, Dr. Rives met the standard
26 of care in his evaluation and management of Ms. Farris.

27 See Erlich Report, attached hereto as Exhibit "6."

28 ///

1 All of the information regarding infectious disease was known by Defendants – for years. The
2 primary source of infectious disease analysis comes from Plaintiff Titina’s treatment from July 3 – 15,
3 2015. To permit Dr. Erlich to provide opinions regarding the standard of care, as a purely “rebuttal”
4 expert, would prejudice Plaintiffs and reward Defendants for violating Nevada rule.

5
6 Dr. Erlich also states:

7 The abnormalities seen on July 15, 2015 had not been present on the CT scan which was
8 performed on July 9, 2015, and therefore the patient did not have a bowel perforation at
9 that time. It is my opinion that the bowel perforation was a relatively recent event and
occurred sometime between the July 9, 2015 and July 15, 2015 CT scans.

10 *Id.*

11 From the commencement of the case, the issue of how/when Plaintiff Titina developed a bowel
12 leak, was questioned. This was such a central issue of the case, from the beginning, that Defendants
13 produced two (2) initial experts in this case to comment on it. Both provided the same opinion outlined
14 here by Dr. Erlich. Clearly, this was not a new issue and is not the province of rebuttal experts. As
15 such, Dr. Erlich must be precluded from offering opinions about when Plaintiff Titina developed an
16 active and ongoing bowel leak, as this has been a central point of the case from the beginning, has
17 already been addressed by Defendants’ initial experts, is now an improper “rebuttal” opinion and is
18 clearly Defendants attempt to gang up against Plaintiffs through expert numerosity.

19
20 Therefore, the Opinions of Stone and Erlich must be Limited to Preclude Testimony on
21 Standard of Care and Causation.

22 23 III.

24 CONCLUSION

25 Clearly, all of the information opined about by these “rebuttal” experts was well known by all
26 parties – long before the initial expert disclosure deadline. As such, any expert opinions about this
27 information were required to be produced, if at all, no later than the initial expert disclosure deadline.
28

1 Giving Defendants carte blanche to untimely interject new theories and arguments is severely
2 prejudicial to Plaintiffs and will confuse the basic issues of the case. It also allows a dangerous
3 precedent of abusing rebuttal disclosures to gain unfair adversarial advantage. Therefore, this Court
4 should Strike Defendants' rebuttal experts Adornato, Larsen, and Kush, while precluding Defendants'
5 other rebuttal experts from offering any opinions as to standard of care or medical causation, as such
6 topics are well known portions of Plaintiffs' case-in-chief and are reserved for initial experts.
7

8 Again, Defendants' Rebuttal Experts Larsen, Adornato, and Kush have given exclusively
9 inappropriate testimony that should have been (and certainly was) anticipated as part of Plaintiffs'
10 case in chief. Therefore, based on the foregoing law, facts, and analysis, Plaintiffs respectfully requests
11 their Motion to Strike Defendants' Rebuttal Experts be Granted.
12

13 DATED this 16th day of September, 2019.

BIGHORN LAW

14 By: /s/ Kimball Jones

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23 *Attorneys for Plaintiffs*
24
25
26
27
28

CERTIFICATE OF SERVICE

Pursuant to NRCP 5, NEFCR 9 and EDCR 8.05, I hereby certify that I am an employee of BIGHORN LAW, and on the 19th day of September, 2019, I served the foregoing ***PLAINTIFFS' MOTION TO STRIKE DEFENDANTS' REBUTTAL WITNESSES SARAH LARSEN, R.N., BRUCE ADORNATO, M.D. AND SCOTT KUSH, M.D., AND TO LIMIT THE TESTIMONY OF LANCE STONE, D.O. AND KIM ERLICH, M.D., FOR GIVING IMPROPER "REBUTTAL" OPINIONS, ON ORDER SHORTENING TIME*** as follows:

☒ Electronic Service – By serving a copy thereof through the Court's electronic service system; and/or

☐ U.S. Mail—By depositing a true copy thereof in the U.S. mail, first class postage prepaid and addressed as listed below:

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EXHIBIT “1”

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20 LAPAROSCOPIC SURGERY OF NEVADA, LLC

21 DISTRICT COURT

22 CLARK COUNTY, NEVADA

23	TITINA FARRIS and PATRICK FARRIS,	)	CASE NO. A-16-739464-C
24		)	DEPT. NO. 31
25	Plaintiffs,)	
26		)	DEFENDANTS BARRY J. RIVES, M.D.
27	vs.	)	AND LAPAROSCOPIC SURGERY OF
28		)	NEVADA, LLC'S REBUTTAL
29	BARRY RIVES, M.D.; LAPAROSCOPIC	)	DISCLOSURE OF EXPERT WITNESSES
30	SURGERY OF NEVADA, LLC, et al.,	)	AND REPORTS
31)	
32	Defendants.)	

33 Defendants BARRY J. RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC
34 ("Defendants") hereby disclose pursuant to Nevada Rules of Civil Procedure Rule 26 and
35 16.1 the name of their rebuttal expert witnesses who may be called at trial.

36 ///

37 ///

RETAINED EXPERTS

1. Bart Carter, M.D., P.C.
2240 West 16th Street
Safford, AZ 85546

Dr. Carter is a general surgeon and will testify as to the issues relating to the standard of care, causation and damages, if any. Dr. Carter's initial report, curriculum vitae including publication history, fee schedule and testimony history were previously disclosed. His rebuttal report is attached hereto as Exhibit A.

2. Brian E. Juell, M.D.
6554 S. McCarran Blvd., Suite B
Reno, Nevada 89509

Dr. Juell is a general surgeon and will testify as to the issues relating to the standard of care, causation and damages, if any. Dr. Juell's initial report, curriculum vitae including publication history, fee schedule and testimony history were previously disclosed. His rebuttal report is attached hereto as Exhibit B.

3. Lance Stone, D.O.
484 Lake Park Avenue
Oakland, CA 94610

Dr. Stone is a physician medicine and rehabilitation specialist. Dr. Stone is a rebuttal witness. He will provide opinions rebutting the opinions of plaintiffs' experts, Dr. Alex Barchuk and Dawn Cook. His opinions are described in his attached report and the life care plan prepared by Sarah Larsen. Dr. Stone's report, curriculum vitae including publication history, and fee schedule are attached hereto as Exhibit C. Dr. Stone was asked to identify the matters he has testified in during the prior four years. Dr. Stone indicated he does not maintain a list of testimony. He recalled having given approximately five depositions during the past four years. The only matter in which he could recall the name of the case was *Baxter v. Dignity Health*.

4. Sarah Larsen, RN
Olzack Healthcare Consulting
2092 Peace Court
Atwater, CA 95301

1 Ms. Larsen is an life care planner. Ms. Larsen is a rebuttal witness. She will provide
2 opinions rebutting the opinions of plaintiffs' expert, Dawn Cook. Ms. Larsen's report,
3 curriculum vitae including publication history and list of deposition/trial testimony and fee
4 schedule are attached hereto as Exhibit D.

5 5. Bruce Adornato, M.D.
177 Bovet Road, Suite 600
6 San Mateo, CA 94402

7 Dr. Adornato is a neurologist. Dr. Adornato is a rebuttal witness. He will provide
8 opinions rebutting the opinions of plaintiffs' expert, Dr. Justin Willer. Dr. Adornato's
9 report, Curriculum Vitae including publication history, list of deposition/trial testimony and
10 fee schedule are attached hereto as Exhibit E.

11 6. Kim Erlich, M.D.
1501 Trousdale Drive, Room 0130
12 Burlingame, CA 94010

13 Dr. Erlich is an infectious disease expert. Dr. Erlich is a rebuttal witness. He will
14 provide opinions rebutting the opinions of plaintiffs' expert, Dr. Alan Stein. Dr. Erlich's
15 report, Curriculum Vitae including publication history, list of deposition/trial testimony,
16 and fee schedule are attached hereto as Exhibit F.

17 7. Scott Kush, M.D.
101 Jefferson Drive
18 Menlo Park, CA 94025

19 Dr. Kush is a life expectancy expert. Dr. Kush is a rebuttal witness. He will provide
20 opinions rebutting the opinions of plaintiffs' expert, Dr. Alex Barchuk, as they pertain to
21 life expectancy. Dr. Kush's report, Curriculum Vitae including publication history, list of
22 deposition/trial testimony and fee schedule are attached hereto as Exhibit G.

23 8. Erik Volk
1155 Alpine Road
24 Walnut Creek, CA 94596

25 Mr. Volk is an economist. Mr. Volk is a rebuttal witness. He will provide opinions
26 rebutting the opinions of plaintiffs' expert, Dr. Terrence Clairitie. Mr. Volk's report,

1 curriculum vitae including publication history, list of deposition/trial testimony and fee
2 schedule are attached hereto as Exhibit H.

3 **NON-RETAINED EXPERTS**

4 1. See NRCP 16.1 disclosures.

5 Defendants reserve the right to call any experts identified by any other party to this
6 action.

7 The above expert witnesses may not be the only ones called by defendants to
8 testify. Defendants reserve the right to later name other expert witnesses prior to trial.
9 Defendants also reserve the right to call to testify at trial expert witnesses not named
10 whose testimony is needed to aid in the trial of this action and/or to refute and rebut the
11 contentions and testimony of plaintiff's expert witnesses.

12 Dated: December 19, 2018

13 **SCHUERING ZIMMERMAN & DOYLE, LLP**

14
15 By 

16 CHAD C. COUCHOT

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19 Sacramento, CA 95825-6502

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24
25
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