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.	Case No. 80271
BARRY JAMES RIVES, M.D.; and LAPAROSCOPIC SURGERY OF NEVADA, LLC, Appellants, vs. TITINA FARRIS and PATRICK FARRIS, Respondents.	Case No. 81052

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APPELLANTS' APPENDIX
VOLUME 1

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ATTORNEYS FOR APPELLANTS

CHRONOLOGICAL INDEX TO APPELLANTS' APPENDIX

[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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CLERK OF THE COURT

COMP
George F. Hand, Esq.
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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.: XXII **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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3. Where applicable, all matters set forth herein are incorporated by reference in the various causes of action which follow.

PARTIES

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

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

6. That TITINA FARRIS and PATRICK FARRIS are, and at all times relevant herein 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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10. At all relevant times, Defendants, and each of them, were the agents, ostensible agents, servants, employees, employers, partners, co-owners, and/or joint venturers of each other and of their co-defendants, and were acting within the color, purpose and scope of their employment, agency, ownership and/or joint ventures and by reason of such relationships the Defendants, and each of them, are vicariously and jointly and severally responsible and liable for the acts and/or omissions of their co-Defendants.

GENERAL ALLEGATIONS

11. Plaintiff incorporates by reference the above paragraphs as though set forth fully hereunder.

12. From on or about July 31, 2014 to July 16, 2015, Plaintiff was under the care of Defendants.

13. That the Defendants, their agents and/or employees, represented themselves to be competent to perform all professional services, treatments and tests that were to be rendered to the Plaintiff, .

14. That at all times herein mentioned, Defendant BARRY RIVES, M.D. was employed by co-defendant LAPAROSCOPIC SURGERY OF NEVADA LLC and acting within the scope of his employment.

FIRST CAUSE OF ACTION

(Medical Malpractice)

15. Plaintiff incorporates by reference the above paragraphs as though set forth fully hereunder.

16. That at all times pertinent hereto, Defendants had a duty to adequately and properly evaluate, diagnose and/or otherwise provide competent medical care within the accepted standard of care to TITINA FARRIS, as well as properly supervise, monitor, communicate with others, and otherwise ensure her health and safety while this patient was under their care.

17. Defendants, each individually, breached the standard of care they owed to Plaintiff TITINA FARRIS by failing to provide reasonable and competent medical treatment and monitoring.

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

19. Dr. Pesiri has opined in the attached Exhibit 1 that, to a reasonable degree of medical probability, Defendants fell below the accepted standard of care in their treatment of Plaintiff. 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. Dr. Pesiri opined that Dr. Rives deviated from the accepted standard of care in his treatment of Titina Farris. 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. 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.

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

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

22. 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. 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. Titina Farris currently has bilateral foot drop as well as a colostomy. Dr. Pesiri opined that 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.

23. The Defendants' breaches of the respective standards of care and the duty of care owed to Plaintiff TITINA FARRIS constituted a departure from the accepted standard of care or practice and constitutes medical malpractice as that term is defined in NRS 41A.009. (*See*, Exhibits "1" through "2").

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.

SECOND CAUSE OF ACTION

(Corporate Negligence/Vicarious Liability)

26. Plaintiffs incorporates by reference the above paragraphs as though set forth fully 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.

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

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

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

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

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

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

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

THIRD CAUSE OF ACTION

(Loss of Consortium)

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

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

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

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

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

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

1. For general damages and loss in an amount in excess of TEN THOUSAND 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 7, 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. Colonorraphy 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

VINCENT E. PESIRI, M.D.

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

Joseph W. Buffa

NOTARY PUBLIC

JOSEPH W BUFFA
Notary Public - State of New York
NO. 01BU6243613
Qualified in Nassau County
My Commission Expires Jun 20, 2019

EXHIBIT 2

VINCENT E. PESIRI, MD

93 Fordham Street
Williston Park, NY 11596
Direct: 516-976-4466
Email: DRVINCE01@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 LIJ WOUND CARE CENTER	
Lake Success, NY	01/01- 05/11
DR. VINCENT PESIRI, PRIVATE SURGICAL PRACTICE	
Glen Cove, NY	1986- 07/09

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

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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.: Dept No.: **INITIAL APPEARANCE FEE DISCLOSURE (NRS CHAPTER 19)**

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

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Plaintiffs, Titina Farris and Patrick Farris	$270.00
TOTAL REMITTED:	$270.00

Dated: July 1, 2016

HAND & SULLIVAN, LLC

By: George F. Hand

George F. Hand, Esq.
Nevada State Bar No. 8483
Michael E. Bowman, Esq.
Nevada State Bar No. 13833
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CLERK OF THE COURT

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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, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al., Defendants.	CASE NO. A-16-739464-C DEPT. NO. 22 **ANSWER TO COMPLAINT** *Arbitration Exempt* *Medical Malpractice*

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,

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

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

PARTIES

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

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

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

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

GENERAL ALLEGATIONS

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

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

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

deny each and every allegation contained therein.

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

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

FIRST CAUSE OF ACTION

(Medical Malpractice)

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

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

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

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

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

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

SECOND CAUSE OF ACTION

(Corporation Negligence/Vicarious Liability)

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

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

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

every allegation contained therein.

THIRD CAUSE OF ACTION

(Loss of Consortium)

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

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

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

FIRST AFFIRMATIVE DEFENSE

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

SECOND AFFIRMATIVE DEFENSE

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

THIRD AFFIRMATIVE DEFENSE

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

FOURTH AFFIRMATIVE DEFENSE

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

Plaintiffs are therefore barred from any recovery.

FIFTH AFFIRMATIVE DEFENSE

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

SIXTH AFFIRMATIVE DEFENSE

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

SEVENTH AFFIRMATIVE DEFENSE

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

EIGHTH AFFIRMATIVE DEFENSE

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

NINTH AFFIRMATIVE DEFENSE

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

TENTH AFFIRMATIVE DEFENSE

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

ELEVENTH AFFIRMATIVE DEFENSE

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

TWELFTH AFFIRMATIVE DEFENSE

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

THIRTEENTH AFFIRMATIVE DEFENSE

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

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Steven D. Grierson
CLERK OF THE COURT

NOAC
KIMBALL JONES, ESQ.
Nevada Bar No.: 12982
JACOB G. LEAVITT, ESQ.
Nevada Bar No.: 12608
BIGHORN LAW
716 S. Jones Blvd.
Las Vegas, Nevada 89107
Phone: (702) 333-1111
Email: Kimball@BighornLaw.com
Jacob@BighornLaw.com
Attorneys for Plaintiffs

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: XXXI

NOTICE OF ASSOCIATION OF COUNSEL

TO: ALL PARTIES TO THE ABOVE-ENTITLED ACTION.

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

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

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

DATED this 15th day of July, 2019.

BIGHORN LAW

By: */s/ Kimball Jones*
KIMBALL JONES, ESQ.
Nevada Bar No.: 12982
JACOB G. LEAVITT, ESQ.
716 S. Jones Blvd.
Las Vegas, Nevada 89107
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
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Attorneys for Defendants BARRY RIVES, M.D.; and 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.'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** **HEARING REQUESTED**

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.

Case Number: A-16-739464-C

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 12, 2019. Defendants' reasonable reliance on the mutual plan of the parties to obtain a trial continuance and the reasonable reliance on the representations of Plaintiffs' counsel associated with the deposition of Dr. Ripplinger are good cause to support an Order compelling the deposition of Dr. Ripplinger and extending the discovery deadline to September 19, 2019 to allow for the depositions of Dr. Ripplinger and Dr. Hurwitz.

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

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

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

Dated: September 13, 2019

SCHUERING ZIMMERMAN & DOYLE, LLP

By */s/ Aimee Clark Newberry*

AIMEE CLARK NEWBERRY
Nevada Bar No. 11084
400 University Avenue
Sacramento, CA 95825-6502
(916) 567-0400
Attorneys for Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC

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

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

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

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

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

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

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

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.

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

/s/ Chad C. Couchot

CHAD C. COUCHOT, ESQ.

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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5. On September 5, 2019, at a status check conference, Judge Kishner denied the request for a trial continuance and affirmed the October 14, 2019, trial date.

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.

7. On September 11, 2019, in connection with the EDCR 2.67 conference, Plaintiffs' new associated counsel advised that they would not agree to the depositions of Dr. Hurwitz and Dr. Ripplinger. Plaintiffs' counsel the next day agreed we could take the deposition of Dr. Hurwitz. We advised Plaintiffs' counsel on September 12, 2019, that we would therefore need to file a motion to compel the deposition of Dr. Ripplinger and to extend the discovery deadline to take his deposition and the deposition of Dr. Hurwitz. We further advised that we would file the motion on shortened time.

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.

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

/s/ Thomas J. Doyle

THOMAS J. DOYLE, ESQ.

MEMORANDUM OF POINTS AND AUTHORITIES

I.

BACKGROUND

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

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

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

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

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

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

II.

DISCOVERY COMPLETED TO DATE AND REASON OUTSTANDING DISCOVERY NOT COMPLETED

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

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

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

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

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

Defendants' inability to take the deposition of Dr. Ripplinger was not created by Defendants' conduct. Instead, Defendants properly noticed the deposition of Dr. Ripplinger 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. 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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Accordingly, Defendants respectfully request an Order compelling the deposition of Dr. Ripplinger on September 19, 2019, and extending discovery to September 19, 2019.

Dated: September 13, 2019

SCHUERING ZIMMERMAN & DOYLE, LLP

By */s/ Aimee Clark Newberry*
AIMEE CLARK NEWBERRY
Nevada Bar No. 11084
400 University Avenue
Sacramento, CA 95825-6502
(916) 567-0400
Attorneys for Defendants BARRY RIVES, M.D. and 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.'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

THOMAS J. DOYLE
Nevada Bar No. 1120
CHAD C. COUCHOT
Nevada Bar No. 12946
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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, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al., Defendants.	CASE NO. A-16-739464-C DEPT. NO. 31 **NOTICE OF TAKING DEPOSITION OF DR. MICHAEL HURWITZ**

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

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

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

Case Number: A-16-739464-C

continue from day to day until completed.

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

1. His current curriculum vitae.

2. Text chapters or journal articles referenced in his curriculum vitae that are relevant to any of the issues in this action.

3. His complete written file concerning this action.

4. His complete e-mail or electronic file or records concerning this action, including but not limited to, e-mails to or from plaintiff's counsel.

5. His billing records.

6. All scientific, technical or professional texts, treatises, journals or similar publications referred to, considered or relied upon in arriving at or forming any of his opinions.

7. All scientific, technical or professional texts, treatises, journals or similar publications that he believes are a learned treatise and he plans to refer to or comment on at trial.

8. All written or electronic general information files maintained by him that are relevant to any of the issues in this action.

9. His records concerning all other medical malpractice actions in which he has been retained as a expert witness and given a deposition.

10. His list of cases prepared pursuant to Federal Rule of Civil Procedure 26 or a state statute or for any other reason.

11. His retainer, fee or other agreements with any expert witness service through which he was retained in this case, together with all documents, correspondence, e-mail, memoranda or other writings received by him from the service

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

You are invited to attend and cross examine.

Dated: February 6, 2019

SCHUERING ZIMMERMAN & DOYLE, LLP

By _____

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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 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.com

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

EXHIBIT 2

THOMAS J. DOYLE
Nevada Bar No. 1120
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 **AMENDED NOTICE OF TAKING DEPOSITION OF DR. MICHAEL HURWITZ**

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

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

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

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

1. His current curriculum vitae.

2. Text chapters or journal articles referenced in his curriculum vitae that are relevant to any of the issues in this action.

3. His complete written file concerning this action.

4. His complete e-mail or electronic file or records concerning this action, including but not limited to, e-mails to or from plaintiff's counsel.

5. His billing records.

6. All scientific, technical or professional texts, treatises, journals or similar publications referred to, considered or relied upon in arriving at or forming any of his opinions.

7. All scientific, technical or professional texts, treatises, journals or similar publications that he believes are a learned treatise and he plans to refer to or comment on at trial.

8. All written or electronic general information files maintained by him that are relevant to any of the issues in this action.

9. His records concerning all other medical malpractice actions in which he has been retained as a expert witness and given a deposition.

10. His list of cases prepared pursuant to Federal Rule of Civil Procedure 26 or a state statute or for any other reason.

11. His retainer, fee or other agreements with any expert witness service through which he was retained in this case, together with all documents, correspondence, e-mail, memoranda or other writings received by him from the service or sent by him to the service, including all instructions, internal memoranda

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

You are invited to attend and cross examine.

Dated: July 16, 2019

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 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	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

THOMAS J. DOYLE
Nevada Bar No. 1120
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 **SECOND AMENDED NOTICE OF TAKING DEPOSITION OF DR. MICHAEL HURWITZ** **(Location change only)**

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

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

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

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

1. His current curriculum vitae.

2. Text chapters or journal articles referenced in his curriculum vitae that are relevant to any of the issues in this action.

3. His complete written file concerning this action.

4. His complete e-mail or electronic file or records concerning this action, including but not limited to, e-mails to or from plaintiff's counsel.

5. His billing records.

6. All scientific, technical or professional texts, treatises, journals or similar publications referred to, considered or relied upon in arriving at or forming any of his opinions.

7. All scientific, technical or professional texts, treatises, journals or similar publications that he believes are a learned treatise and he plans to refer to or comment on at trial.

8. All written or electronic general information files maintained by him that are relevant to any of the issues in this action.

9. His records concerning all other medical malpractice actions in which he has been retained as a expert witness and given a deposition.

10. His list of cases prepared pursuant to Federal Rule of Civil Procedure 26 or a state statute or for any other reason.

11. His retainer, fee or other agreements with any expert witness service through which he was retained in this case, together with all documents, correspondence, e-mail, memoranda or other writings received by him from the service or sent by him to the service, including all instructions, internal memoranda

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

You are invited to attend and cross examine.

Dated: July 25, 2019

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 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	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 3

THOMAS J. DOYLE
Nevada Bar No. 1120
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 **THIRD AMENDED NOTICE OF TAKING DEPOSITION OF DR. MICHAEL HURWITZ**

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

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

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

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

1. His current curriculum vitae.

2. Text chapters or journal articles referenced in his curriculum vitae that are relevant to any of the issues in this action.

3. His complete written file concerning this action.

4. His complete e-mail or electronic file or records concerning this action, including but not limited to, e-mails to or from plaintiff's counsel.

5. His billing records.

6. All scientific, technical or professional texts, treatises, journals or similar publications referred to, considered or relied upon in arriving at or forming any of his opinions.

7. All scientific, technical or professional texts, treatises, journals or similar publications that he believes are a learned treatise and he plans to refer to or comment on at trial.

8. All written or electronic general information files maintained by him that are relevant to any of the issues in this action.

9. His records concerning all other medical malpractice actions in which he has been retained as a expert witness and given a deposition.

10. His list of cases prepared pursuant to Federal Rule of Civil Procedure 26 or a state statute or for any other reason.

11. His retainer, fee or other agreements with any expert witness service through which he was retained in this case, together with all documents, correspondence, e-mail, memoranda or other writings received by him from the service or sent by him to the service, including all instructions, internal memoranda

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

You are invited to attend and cross examine.

Dated: September 11, 2019

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 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

THOMAS J. DOYLE
Nevada Bar No. 1120
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 SUBPOENA - CIVIL

THE STATE OF NEVADA SENDS GREETINGS TO:

DR. GREGG RIPPLINGER
10001 S. Eastern Avenue #200
Henderson, NV 8052
(702) 914-2420

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

Case Number: A-16-739464-C

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

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

Dated: July 16, 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 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.com

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

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 **NOTICE OF TAKING DEPOSITION OF DR. GREGG RIPPLINGER**

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

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

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

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

You are invited to attend and cross examine.

Dated: July 16, 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 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.com

Clwaust

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

EXHIBIT 5

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 **AMENDED NOTICE OF TAKING DEPOSITION OF DR. GREGG RIPPLINGER**

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

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

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

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

You are invited to attend and cross examine.

Dated: September 11, 2019

SCHUERING ZIMMERMAN & DOYLE, LLP

By */s/ Chad C. Couchot*

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 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.com

/s/ C.Perrault
An employee of Schuering Zimmerman & Doyle, LLP
1737-10881

Electronically Filed
9/13/2019 2:28 PM
Steven D. Grierson
CLERK OF THE COURT

[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).

///

Case Number: A-16-739464-C

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 Schuerng 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. Clauretie.

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.com

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

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Steven D. Grierson
CLERK OF THE COURT

[TSUB]

THOMAS J. DOYLE
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Attorneys for Defendants BARRY RIVES, M.D. and 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 **TRIAL SUBPOENA - CIVIL REGULAR**

THE STATE OF NEVADA SENDS GREETINGS TO:

DR. NAOMI CHANEY
5380 S. Rainbow Boulevard, #218
Las Vegas, NV 891 18
(702) 319-5900

YOU ARE HEREBY COMMANDED, that all and singular, business and excuses set

Case Number: A-16-739464-C

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

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

ITEMS TO BE PRODUCED:

Your entire medical chart of TITINA FARRIS.

Dated: September 16, 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. and LAPAROSCOPIC SURGERY OF NEVADA, LLC

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

(ii) requires disclosure of an unretained expert's opinion or information not describing specific events or occurrences in dispute and resulting from the expert's study made not at the request of any party, the court may, to protect a person subject to or affected by the subpoena, quash or modify the 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.

(d) Duties in Responding to Subpoena.

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

(2) When information subject to a subpoena is withheld on a claim that it is privileged or subject to protection as trial preparation materials, the claim shall be made 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
George F. Hand, Esq. HAND & SULLIVAN, LLC 3442 North Buffalo Drive Las Vegas, NV 89129	Plaintiffs	702/656-5814 Fax: 702/656-9820 hsadmin@handsullivan.com
Kimball Jones, Esq. Jacob G. Leavitt, Esq. BIGHORN LAW 716 S. Jones Boulevard Las Vegas, NV 89107	Plaintiffs	702/333-1111 Kimball@BighornLaw.com Jacob@BighornLaw.com

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

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MOTN
KIMBALL JONES, ESQ.
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Phone: (702) 656-5814
Email: GHand@HandSullivan.com
Attorneys for Plaintiffs

DEPARTMENT XXXI
NOTICE OF HEARING
DATE 9/26/19 TIME 10:00 am
APPROVED BY

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.: 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

COMES NOW 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 &**

SEP 18 '19 AM 08:18

TC31

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

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

DATED this 16th day of September, 2019.

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

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.
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

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

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

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

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

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

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

FURTHER YOUR AFFIANT SAYETH NAUGHT.

KIMBALL JONES, ESQ.

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

NOTARY PUBLIC in and for CLARK COUNTY, NEVADA

GRESIA TARANGO
NOTARY PUBLIC
STATE OF NEVADA
My Commission Expires: 12-15-21
Certificate No: 14-12816-1

MEMORANDUM OF POINTS AND AUTHORITIES

I. STATEMENT OF RELEVANT FACTS

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

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

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

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

> MR. COUCHOT: Sinner is not on there?
> THE WITNESS: Mm-hmm?
> 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.

BY MR. HAND: Is it on here? It's not listed here
MR. COUCHOT: It's subsequent.
BY MR. HAND: Q Can you tell me what that case involved.
A Patient had a diaphragmatic hernia tear laparoscopically. She aspirated and became septic. Q Is that still ongoing?
A That's pending.
Q And you gave a deposition in that case?
A Yes.
Q Is that a case in Las Vegas?
A Yes.

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

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

It is noteworthy that the proper name "Center" was not provided and that the incorrect name, "Sinner" was used instead. Moreover, Rives' description of "Sinner" is an entirely erroneous description of the events that took place, assuming "Sinner" was referring to the Center matter. For example, in Center there is no evidence Center developed sepsis through aspiration. Rather, the concept that sepsis developed through aspiration was entirely ruled out in that matter, on post-op day two (2), and it was abundantly clear sepsis developed, not through at least one (1) hole that Rives negligently cut in Center's stomach, but possibly two (2) holes. Rives' false description—one that made the case seem very different from the case at bar—was seemingly not an accident. For, in deposition of the Center case, Defendant also lied to Plaintiff's Counsel regarding the existence of the subject case, and when finally confronted with the fact that Counsel was aware of the Farris matter, 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"

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

> Q.· ·**Do you recall any other cases in which you were a defendant in a medical malpractice case or it was alleged that you had committed medical practice?**
> A.· ·At jury trial or in general?
> Q.· ·No, sir.· Where a complaint was filed, you had to retain counsel, the matter was either dismissed or settled?
> A.· ·Yes.
> Q.· ·Can you just review those for me?
> A.· ·The first one was in regards to a patient who had a ductal Luschka leak after a laparoscopic cholecystectomy and was dismissed.
> Q.· ·I'm going to take them one at a time, if I could.· I apologize for interrupting.· It's my interruptions, my failure. When you say that case was dismissed, was there a settlement in that case or was it dismissed?
> A.· ·Dismissed before trial.· No payment.
> Q.· ·Okay.· And I do apologize for interrupting you.· What is the next case that you remember that you were a defendant in a medical malpractice case?
> A.· ·There was a case where a patient had an anterior/posterior spine fusion, had a colonic perforation from that procedure.· Was transferred to Spring Valley where I had to take her emergently to the OR, perform a life-saving surgery, an ostomy. The patient actually did well.· I had to reverse her ostomy.· But because the lawyer named everybody in the suit, I was named in that suit.· And I was dismissed about two or three months after being named in the suit.
> Q.· ·And that was without payment?
> A.· ·That was without payment, yes.
> Q.· ·**Can you remember any other lawsuit in which you were a defendant in a medical malpractice case?**
> A.· ·Those two and the ones that I went to trial.
> Q.· ·Okay.· **Do you -- do you recall whether or not you were a defendant in any other medical malpractice case in this jurisdiction or anywhere else?**
> A.· ·**No.**

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

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

> Q.· ·With regards to the next case, Farris versus Rives, is that case still ongoing?
> A.· ·Yes
> Q.· ·And in ten words or less, can you -- you don't have to do it in ten words or less, but ·can you just give us a brief description of what that -- the allegations are in that case?
> 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.

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

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

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

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

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

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

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

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

> Q.· ·All right.· You've opined today that at the time of your treatment of Ms. Center that you believe that the cause of her sepsis was -- and I will say it wrong again -- but aspiration· ·pneumonitis?
> A.· ·That is correct.
> Q.· ·Okay.· I'm learning.· Now, this bronchoscopy -- I won't go through the entire report ·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?
> A.· ·Yes, I do.
> Q.· ·What does that mean in laymen's terms?
> A.· ·It means Dr. Lin felt that the etiology of sepsis was not within her lungs.
>
> See *Exhibit 3*, at Page 126:12-127:2.

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

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

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

II. LEGAL ARGUMENT AND ANALYSIS

A. Legal Authority.

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

> (A) The name and, if known, the address and telephone number of each individual likely to have information discoverable under Rule 26(b), including for impeachment or rebuttal, identifying the subjects of the information;
> (B) A copy of, or a description by category and location of, all documents, data compilations, and tangible things that are in the possession, custody, or control of the party and which are discoverable under Rule 26(b);
> . . .
>
> These disclosures must be made at or within 14 days after the Rule 16.1(b)... A party must make its initial disclosures based on the information then reasonably available to it and is not excused from making its disclosures because it has not fully completed its investigation of the case or because it challenges the sufficiency of 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 16.1or 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

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

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

> **(2) Sanctions—Party.** If a party or an officer, director, or managing agent of a party or a person designated under Rule 30(b)(6) or 31(a) to testify on behalf of a party fails to obey an order to provide or permit discovery, including an order made under subdivision (a) of this rule or Rule 35, or if 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:
>
> (A) An order that the matters regarding which the order was made or any 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;
> (B) An order refusing to allow the disobedient party to support or oppose designated claims or defenses, or prohibiting that party from introducing designated matters in evidence;
> (C) An order striking out pleadings or parts thereof, or staying further 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[.]

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

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

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

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

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

///

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

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

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

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

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

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

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

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

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

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

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

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///

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.*

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

III. CONCLUSION

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

DATED this 16th day of September, 2019.

BIGHORN LAW

By: */s/ Kimball Jones*
KIMBALL JONES, ESQ.
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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

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

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

RESPONSE TO NO. 1:

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

INTERROGATORY NO. 2:

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

RESPONSE TO NO. 2:

Not applicable.

INTERROGATORY NO. 3:

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

RESPONSE TO NO. 3:

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

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

INTERROGATORY NO. 4:

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

RESPONSE TO NO. 4:

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

INTERROGATORY NO. 5:

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

RESPONSE TO NO. 5:

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

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INTERROGATORY NO. 6:

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

RESPONSE TO NO. 6:

Not applicable.

INTERROGATORY NO. 7:

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

RESPONSE TO NO. 7:

Not applicable.

INTERROGATORY NO. 8:

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

RESPONSE TO NO. 8:

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

INTERROGATORY NO. 9:

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

RESPONSE TO NO. 9:

Pursuant to NRCP 33(d), see Titina Farris' medical records from St. Rose 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.

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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 our 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, moves 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

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

a. The date or dates of such conversation(s) and/or statement(s);

b. The place of such conversation(s) and/or statement(s);

c. All persons present for the conversation(s) and/or statement(s);

d. The matters and things stated by the person in the conversation(s) and/or statement(s);

e. Whether the conversation(s) was oral, written and/or recorded; and

f. Who has possession of the statement(s) if written and/or recorded.

RESPONSE TO NO. 19:

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

INTERROGATORY NO. 20:

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

RESPONSE TO NO. 20:

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, the witnesses currently known to Dr. Rives have been identified in his NRCP 16.1 disclosure.

INTERROGATORY NO. 21:

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

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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.

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

INTERROGATORY NO. 24:

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

RESPONSE TO NO. 24:

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

INTERROGATORY NO. 25:

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

RESPONSE TO NO. 25:

No.

INTERROGATORY NO. 26:

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

Hospital, San Martin Campus.

RESPONSE TO NO. 26:

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.

Dated: April 17, 2017

SCHUERING ZIMMERMAN & DOYLE, LLP

By _____

CHAD C. COUCHOT
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Sacramento, CA 95825-6502
(916) 567-0400
Attorneys for Defendants BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC

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 ~~165~~ 310 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 Instuctor 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.com

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

EXHIBIT "2"

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 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 195

Las Vegas, Nevada 89102

Reported By: Yvette Rodriguez, CCR NO. 860

APPEARANCES:

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I N D E X

WITNESS: BARRY RIVES, M.D.

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EXHIBITS

LAS VEGAS, NEVADA, OCTOBER 24, 2018

10:07 a.m.

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(In an off-the-record discussion held prior to the commencement of the deposition proceedings, counsel agreed to waive the court reporter requirements under Rule 30(b)(4) of the Nevada Rules of Civil Procedure.)

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Whereupon,

HARRY RIVES, M.D.,

having been first duly sworn to testify to the truth, the whole truth and nothing but the truth, was examined and testified as follows:

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MR. HAND: We're premarking certain records as exhibits in this deposition. I will just read what we have premarked: Exhibit 1, Dr. Rives' office records. Exhibit 2, Dr. Rives' progress notes. Exhibit 3, operative report of July 3, 2015. Exhibit [illegible], operative report of August 7, 2014. Exhibit 5,

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

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

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EXAMINATION

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BY MR. HAND:

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

A Barry Rives, R-I-V-E-S.

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

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

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

A Yes.

Q About how many times?

A Five or seven.

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

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

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

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

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

A Yes.

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

A Yes, I am.

Q And when were you licensed?

A I got my license in 2003.

Q Do you have any specialty?

A General surgery.

Q Where do you currently have hospital privileges?

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

Q What medical school did you attend?

A Hahnemann University in Philadelphia, PA.

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

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

Q What years did you do the residency?

A 1998 to 2003.

Q When did you come to Nevada?

A 2003.

Q Did you ever practice medicine in any other state?

A No, I have not.

Q Do you have any fellowships in any field?

A No, I do not.

Q Or are you board certified in any field?

A No, I do no.

Q Have you taken any board certification exams?

A Yes, I have.

Q What have you taken?

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

Q When did you take that?

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

Q Did you pass those tests?

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

Q Are you planning on applying again for that certification?

A I actually have considered that, yes.

Q So you took it one time and then

A Yes.

Q Do you have any special training in laparoscopic procedures?

A I did during my fourth and fifth year of

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

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

A All laparoscopic hernias?

Q Yes. Prior to July '15?

A Well over five hundred.

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

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

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

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

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

Q Yes, for now.

A Okay.

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

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

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

[illegible] practice?

A My solo practice, yes.

Q Is that Laparoscopic Surgery of Nevada, [illegible]

A That is correct.

[illegible] How long has that been in existence?

[illegible] It started in May of 2007. So that's about 11 years.

[illegible] And has there ever been any other members of that practice who are physicians?

A No.

[illegible] Are there any other employees of [illegible]

A No.

[illegible] Nevada 89113.

Q If I could direct you to Response No.

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

A It is still pending.

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

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

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

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

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

A Again, defense verdict. It was a patient [illegible]

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

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

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

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

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

[illegible] Is that case resolved or ongoing?

A It was dismissed.

Q And looking at Response No. 5, there is notes of depositions you gave in some of these cases we just talked about. Are there any other depositions that you given, such as an expert for patient or for defendant doctor in any cases?

A I've testified as a participant in care.

Q What case was that?
A There have been a few. One involved a patient who was misdiagnosed with perforated appendicitis, delay in treatment, presented to the OR in distress. I was the surgeon on the case. And the suit was against the internal medicine doctor.
There was another suit involving delay in diagnosis of a patient that was treated by a rehab facility, transferred to a hospital. And basically, was not doing well on arrival and there was nothing we could do surgically for her.
Q That's it, that you recall?
A Those are the two that I can recall at this time.
MR. COUCHOT: Sinner is not on there?
THE WITNESS: Mm-hmm?
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. RAND: What was the name of that case?
THE WITNESS: Sinner versus Rives.
BY MR. RAND:
Q Is it on here? It's not listed here --

MR. COUCHOT: It's subsequent.
BY MR. RAND:
Q Can you tell me what that case involved.
A Patient had a diaphragmatic hernia tear laparoscopically. She aspirated and became septic.
Q Is that still ongoing?
A That's pending.
Q And you gave a deposition in that case?
A Yes.
Q Is that a case in Las Vegas?
A Yes.
Q Have you given any lectures involving hernia repair?
A Other than to medical students or residents, no.
Q Prior to coming here today, what did you review, if anything?
A I reviewed my office notes, progress notes. My progress notes and my operative notes. I think I reviewed some of the radiology findings.
Q Did you review any other operative reports?
A No.
Q Is there anything that you would like to review that you haven't looked at in this case?

A Not in particular.
Q Do you have any teaching or academic appointments currently?
A No, I do not.
Q Have you ever had any teaching or academic appointments?
A No.
Q In your practice, can you give me just a general description of the kind of cases you handle surgically.
A Well, I'm a general surgeon. I handle mostly about 80, 85 percent of my cases are all laparoscopic. All involving the abdomen. That could be anything from diaphragmatic hernia repairs, surgery of foregut, including the esophagus, the stomach, gallbladder, abdominal wall hernias, gastric cancers, colon cancers, bowel obstructions. Pretty much anything inside the abdomen.
Q Have you ever had any of your hospital privileges suspended or revoked?
A No.
Q Have you reviewed any medical literature prior to the deposition?
A Ever?
Q In preparation for this?

A Oh, as preparation, no.
Q I've marked as Exhibit 1, your office chart. I mean -- yes, Exhibit 1. You can take a look at that.
Dr. Rives, can you tell me the first time you saw Titina Farris as a patient?
A According to my office record, it was July 31, 2014.
Q How did she come to you as a patient?
A She was referred to me by Dr. Chaney.
Q And Dr. Chaney, is she an internist?
A She is a primary care doctor.
Q And for what reason was she referred to you?
A She was referred to me for a swelling or a mass in her upper abdomen.
Q And what was your -- did you see Titina and exam her?
A Yes, I did.
Q And what history did you take from her?
A Medical history of hyperlipidemia, hypertension -- excuse me, diabetes, anxiety/depression disorder NOS. Family history of diabetes. Patient was never a smoker and denied the use of alcohol. Reviewed her medications. And she

had no known drug allergies.

Q And at some point, did you make a diagnosis as to what her condition was?

A I made a diagnosis of lipoma of the skin and subcutaneous tissue.

Q What is a lipoma?

A Lipoma is a fatty tumor. And by tumor, we just mean mass. The majority of these are benign. They are almost never cancerous.

Q Where was it located?

A It was located in her upper abdomen along the midline.

Q At some point did you schedule a surgery?

A Yes, I did.

Q And I'll show you -- well, I think you [illegible] operative report in your notes, but I have marked it, the August 7, 2014, operative report. I have it as Exhibit 3.

A I have it.

[illegible]

[illegible] procedure

by the open method?

A Well, lipoma is a subcutaneous tumor. You would not do a laparoscopic approach to that. It requires an incision of the skin to remove the tumor.

Q So looking at your report -- I'm going to ask you where it says technique.

A Yes.

Q See where I'm referring to?

"Note that there was an incarcerated ventral hernia"?

A Correct.

Q Before I get into these. Do you have an independent recollection of Mrs. Farris or do you need these records to refresh your memory?

A I have some independent recollection, yes.

Q What do you remember about her, if you can tell me?

A From her first meeting, she was rather short, a little bit on the obese side. She had a shorter abdominal habitus than most people do. Probably a smaller chest cavity than most people [illegible]. She was pleasant, fairly forthright, and easy to get along with.

[illegible]

coming to the lipoma, there was an area that was distinctly different from the lipoma itself and it appeared to be a incarcerated ventral hernia. Can you tell what a incarcerated ventral hernia is.

A A ventral hernia is any abdominal wall defect on anterior abdominal wall. The incarcerated part means that inside the hernia sac is usually something intraabdominal that is quote/unquote "stuck", for lack of a better term.

Q So going to Page 2, you state, "The sac contained omentum".

Which sac are you referring to, the hernia sac?

Correct.

[illegible]

preperitoneal space?

[illegible]

[illegible] primary sutures. The recurrence rate of closing it with primary sutures is much higher without mesh. So bridge mesh, for lack of a better term, was necessary.

Q Where specifically in the preperitoneal space did you place the mesh?

A In the pre -- well, part of it is in the preperitoneal space, but obviously where the defect is gone there is no preperitive. There is no peritoneum at all.

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

A I would have to refer to the operative notes by nursing. They usually have that in there. I don't recall off the top of my head.

Q How was the mesh inserted? How was it secured?

A I secured it to the fascia with Prolene sutures in an interrupted fashion. Then I over sewed the fascia together using Ethibond sutures in an interrupted fashion.

Q Then you go down -- and going down further in your report you state, "We closed the subcutaneous layer with 2.0 Vicryl sutures. Numerous sutures were not able to hold despite there

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

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 hematoma/lipoma. Patient says this feels different than prior to her surgery. It is more uncomfortable and occasionally tender to touch. Patient says she

has no nausea or vomiting, no diarrhea or constipation. No signs or symptoms of obstruction. Patient has had no fever and chills. Patient says 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

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,

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

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

Q Do you have that report in your chart?
A Yeah.
Q Looking at this report, would you go to where it states findings.
In your report you state, "Visualization of the abdomen revealed an incarcerated incisional hernia with a transverse colon inside the hernia sac". Can you explain what that means.
A That's under technique.
Q Sorry. You're right. That's under technique, yeah.
A So after you obtain pneumoperitoneum, you put a trocar in and you put a camera in. And the camera allows you to visualize the abdomen and allows you to assess the hernia defect and what is inside of it. And visualizing her abdomen, I can see that she had a recurrence of the hernia and that the transverse colon was incarcerated inside that hernia defect.
Q That was the same hernia from the surgery in 2014?
A That is correct.
Q Now, going down on your technique, you talked about reducing the hernia, taking down the

omentum and the transverse colon was severely stuck and adhered to the prior mesh repair.
Can you describe what you saw in regard to the transverse colon being severely stuck to the prior mesh.
A The transverse colon was adhered and stuck to the prior mesh repair. Sometimes, even a union mesh or a separate mesh or a dual mesh, the tissues will grow into the mesh underneath. So there are not easily to remove from that mesh. You either have to excise part of the mesh with the colon and leave it there, which can cause serious complications down the line or you have to do what you can to remove the mesh entirely from the colon itself.
Q And you chose here to approach it in what fashion?
A To remove the mesh entirely from the colon.
Q So you removed the prior mesh, the whole piece of mesh?
A I don't have an independent recollection how much of the mesh I removed according to the mesh that was adhered to the transverse colon.
Q Not all of the original mesh, just part of

it?
A Let me read my notes real quick. I don't state specifically whether I took all the prior mesh out or not. If the -- in my customary fashion, if the mesh is not causing an obstruction or problem and I can close the defect with the other mesh prior intact, then I will not take the entire mesh out.
If you take unnecessary mesh out, you cause more hernia defects and factual defects because you are removing a fair amount of the abdominal wall tissue.
Q Do you know the size of the mesh that you inserted in the 2014 surgery?
A The 2014?
Q When you placed the mesh the first time.
A No, I do not recall.
Q Is there any note in here of the size of the mesh?
A That I placed in 2014 or 2015?
Q When you went in the '15, is there any notations as to the size of the mesh?
A Yes.
Q Where is that?
A On the second page. Turning our attention towards the repair of the incisional hernia, 7x9 --

which should say ventralized with Echo. Piece of mesh was placed into the intra abdominal cavity.
Q What does it mean, with Echo?
A Echo is a insufflation device that is attached to the mesh. And when you put the mesh into the intraabdominal cavity, you grab a little tube and you exteriorize it. And you insufflate air. An Echo device flattens the mesh out so that way when pull it up, it stays flat against the abdominal wall. And that way you can start doing your approximations without the mesh flopping around and making it much more difficult for you to approximate. And that part is obviously excised and taken out later.
Q So was mesh removed during this surgery of July 3, 2015?
A I don't know if any mesh was removed in relation to the removal from the colon itself. It might have been, yes.
Q Was there any pathology sent from this operation, do you know?
A I do not recall.
Q Have you seen any pathology reports regarding this surgery --
A I don't recall --

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 bladed for cutting.
Q Does it have thermal energy attached to it?

A It has some thermal energy, yes.
Q Did you consider using sciasors or a nonthermal device to free the bowl 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 sciasors, 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

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 colotomy 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.
A 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 mel 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

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 colotomy. What is a colotomy?
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

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

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

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

A Transverse colon.

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

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

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

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

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

A No.

Q

A

stool that I could see was fairly hard and inside the colon. It was not liquefied or oozing out anywhere.

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

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

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

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

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

A Yes. Irrigate drain.

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

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

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

A

Q staples you used

A

A It looked quite healthy.

The second colotomy, did it have any ragged edges?

A

Q

the second colotomy?

A I do not.

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

A Sure.

Q

correct?

A Correct.

Q And why was that?

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

If there was was something about the tissue that was tenuous or inflammatory or that it was still leaking, then, of course, I will do

everything looked healthy, create an anastomosis.

Q So one of the reasons to go open is if there is issues with the integrity of the bowel; is 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 staple repair is satisfactory?

A First, you look at the staple line to make sure it's gone. Not just to cover the defect, but a little bit more on each side of the defect. Then you look at the overall viability of the tissue around it. And then you can squeeze the colon with a clamp and see if any air bubbles come up or if perforation develops.

Q Is there an alternative way to repair a colotomy 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 laparotomy, can you still use staplers if you choose or would you use sutures or some other method?

A You could -- depending on what the bowel

looks like inside the defect, you can suture close, you can staple close or you can resect the entire fecal bowel and do a new anastomosis, if necessary.

Q Are there advantages to using a stapler over a suture?

A No, not really.

Q Okay. Can you suture a colotomy such as the colotomy sutures that Mrs. Rives (sic) had laparoscopically and maybe suturing or stapling?

A Mrs. Farria?

Q Yes.

A Yes, you could.

Q You can suture?

A Yes.

Q You decided not to suture this but to use the stapler that you talked about, was healthy and had a satisfactory closure of the colotomy?

A It had to do with the size of the defect, the size of the colon, and the tissue you have. So if the hole comes together nice and easily without causing a stricture of the colon with the stapling device, that is quicker and easier and reduces the anesthesia time.

If the hole is a little wider and you are worried about causing a stricture or a

constriction by closing it, then I would use sutures 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, normally?

A Sometimes with small bowels, you will be be able to see branching of the tissue. I noticed that occasionally when I have used a harmonic scalpel, using a ligature device, I don't think I have ever seen that thermal effect.

Q Then you state, "After success" -- I'm looking at page -- it's the second page of the report -- you state, "After successive firings". What do you mean by firings?

Explain to me how that works.

A That means more than one firing of the stapler. So that means there was at least a minimum of two firings.

Q And you state, "The staple lines appear to be in tact".

Do you know how many staples you used in this first colotomy repair?

A I do not.

Q Do you recall how many staples you used in the second colotomy repair?

A I do not.

Q When you fire the stapler, how many staples come out per firing?

A I would have to look at the manufacturer's list. It's a staple line consistent of multiple titanous staples. Depending upon the color of the load; a blue load is a typical tissue load. A green load is a thick tissue load. It does not change the number of staples. It changes the staple size. I do not recall the exact measurements off the top of my head.

Q We discussed already the hernia with the piece of mesh. And specifically, where was that mesh placed?

A Into the abdominal cavity.

Q Do you recall specifically where it was 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 abdominal cavity, you pull it up against the abdominal wall, and then you do an approximation and pack it into place.

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

Can you explain what that was.
A The insufflation tubing is part of the echo device that I mentioned earlier.
Q Then you state, "It was exteriorized from the abdomen".
Can you explain that.
A You use is a little grasping device and you put it through the incision, you grab the insufflation tube and you pull it up through the abdominal wall so that it is now on the outside of the abdomen. You can attach the syringe to it, put air into it, insufflating the echo device, put a hemostat on the abdominal wall on top of the insufflation device where it will hold the pressure.
Q Yeah, you state, "The insufflation device was deployed and held against the abdominal wall with a hemostat clamp".
What is a hemostat clamp?
A It's a metal clamp.
Q And then you state, Using you Secure Strap device, you approximated the mesh circumferentially around the hernia defect. And going doing further, you state, "Returning to the abdomen, we continued further approximation of the SecureStrap device making sure that we had inner circumferential layer

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

So did you inspect the colon at that point?
A I inspected it at that point, as well during, yes.
Q And if there injury or tear, would you examine that and you would be visualize that before closing the patient?
A Yes.
Q Were you able to visualize the complete colon, the whole circumference of the colon during this procedure?
A Twell, the entire circumference of the colon is not visual anyways so you won't see that part of the colon. So the part that is visible, yes.
Q Then you state, "The 12 mm trocar sites were closed at the fascia level with an 0 Vicryl stitch in a figure-of-eight fashion". Then later on, you state, "The patient was extubated in the OR and transferred to the PACU in stable condition. She tolerated the procedure well without complications".
According to this report then, there were no complications, she was in good condition with the surgery?

A Yes.

Q I have marked your progress notes. I'm referring to Exhibit 2. Will you take a look at those. Do you have a recollection or notes as to the next time you saw the patient after the surgery?

A I saw her briefly in the recovery room. And I don't recall when I saw her next, except to what I refer to as in the notes.

Q Prior to the surgery, did you meet with the patient to discuss the surgery in the hospital?

A Yes, we met in the preoperative holding area.

Q Do you recall what was said between you and the patient?

A Yes. My customary fashion, I reviewed the indications for surgery. Again, risk, benefits, alternatives, if she had any ew conditions that had changed since I saw her last, and any other questions regarding the surgery. I usually go over the postoperative instructions at that time. Especially, if there is family there because a lot of times the patient won't remember and I want them to hear it from me because sometimes the nurses tell them stuff that I do not necessarily put down in the orders.

Q Okay. Do you recall meeting Mrs. Farris' husband, Patrick?

A I remember meeting him and talking to him, yes.

Q Do you remember him being in the pre-op area? Was he present for the discussion?

A I do not recall.

Q Going to your progress note of July 4th, it looks like it was done 12:22 in the afternoon. And do you see what I'm referring to, Doctor?

A Yes, I do.

Q It says, "Subjective, patient complaint, patient with abdominal pain and bloating while drinking a SoBe beverage but no emesis, possible subjective F/C"

What is F/C?

A Fever and chills.

Q "Patient feels short of breath."

A Correct.

Q "Positive flatus, no issues with urination. Patient states there is no change".

So do you recall what time the surgery was done on the 3rd?

A I believe it was some time in the morning.

Q And reading your note from the first — I

guess, going down to the end, where it says plan. Go all the way down to the lower left, it says Page No. 2231, you have --

A 23 or 22?

Q If you look at the bottom --

MR. COUCHOT: Yeah, he misspoke --

BY MR. HAMD:

Q Yeah, 2231.

A Okay.

Q In the impression of plan, diagnosis, course, plan. So can I ask you, how would these notes be entered? Is there like a workstation that is on the floor or in the room or how is it done?

A There's computer stations. There is some, if you wanted to, there are some in the room. Most of them are outside of the room. Sometimes, I finish my note immediately as I walk out. Sometimes, I will see a couple of patients and then I will do them in the doctor's lounge where there is some access.

Q Do you have any records regarding the patient that are not in the hospital record or in your office chart that we have gone through?

A No.

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

"Impression and plan, diagnosis, incarcerated incisional hernia. Course, worsening".

What did you mean by worsening?

A Her heart rate and blood sugars were according to my plan were unstable. Her abdomen was fairly extended and I felt that she needed NGT to decompress the GI tract. I would have to check my postoparative orders, but I was pretty sure that she was NPO after the surgery. And instead she was drinking these beverages. And it looked like she was not tolerating them well. I was concerned that the bloating and the distention would make it a higher risk for her to aspirate or have further complications where we repaired the colon.

Q The distention of the abdomen, you attribute it to the not drinking liquid?

A No. It's probably multifactorial. It's due to the anesthesia. It can be due to the extent of the surgery. It could be due to colon repairs, her response to narcotic medication. It's multifactorial.

Q Do you know how much the abdomen was distended?

A We don't really measure it in terms of a quantitative. We just figure out in our own heads,

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moderate, mild or severe. Sometimes we will notice whether the abdomen is dull percussion versus tympanitic percussion as a way.

Q How did you characterize this distention?

A I put it as slightly firm and distended in tympanitic. So I would say that was moderate to severely distended.

Q Tympanitic, what does that mean?

A Tympanitic means when you touch the abdomen it sounds like a hollow drum.

Q Is there any medical significance to this, it sounds like a hollow drum?

A It usually means that the bowel is distended, full of air, and not working well. So either, most likely, it represents an ileus and that the bowel is not functioning properly.

Q Now, we go to another note of July 5th, progress note, looks like it was done at 11:02. It is on Page 2212. Do you see where I'm referring to there?

A Yes, I do.

Q Post-op. Is there a note that her white blood count was 23.3? Going down do Page 2214.

A Correct.

Q Okay. What is a normal white blood count?

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A For this hospital, I think the upper range in normal is around 12,000.

Q Did you attach any medical significance to that blood count, 23.3?

A By itself, no but in relationship to all of clinical factors, yes.

Q Can you explain that to me.

A Well, sometimes patients will have a leukocytosis after surgery just from the stress of surgery. However, if the abdomen is distended, bloated, not working well, she went into respiratory distress, had to be intubated. Then we had to figure out a possible source for that leukocytosis.

Q And what were you considering, if any, as the source of the leukocytosis?

A Pretty much every differential diagnosis from aspiration pneumonitis to complications from surgery.

Q Were there any part of her vitals on that page, were there any other abnormal vital signs?

A For the objective part, she has a — well, at one point she has a high or a T max of 38.2. Her heart rate is elevated. Her blood pressure is fairly -- there is low blood and there is very high blood pressure, but that is over a 24 hour period.

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Her saturations appear normal at that time.

Part of this considers that she was -- before she was intubated and afterwards because she was 80 percent and it mentions the mandatory modes.

Q If you go down to Page 2216, the last page of that note. Impression of plan, diagnosis, incarcerated incisional hernia. Course, worsening. What did you mean by "course, worsening"?

A Well, the day before, she was breathing on her on. And now, she's had an event that has caused her to be intubated. Her heart rate was sky high. They had to do put her on a diltiazem drip and they put her on a heparin drip as well. During the course of these events, from one day to the other, she got significantly worse, but then they resuscitated her and she was at least somewhat more stable, it appears.

Q And your note from that date states, "Patient more stable now while intubated and sedated. Glucose still not well controlled. Patient with SVT" -- what is SVT.

A Supraventricular tachycardia.

Q So she had a rapid heart rate?

A Correct.

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Q And did you come to a conclusion what may be causing that?

A No, I did not.

Q Then it states she was on the drip and you said, "We will await the results of the CT scan, chest, abdomin, pelvis. Will consider exploratory laparotomy, depending on results of CT and patient's clinical progression."

So you were considering laparotomy on July 5th?

A As one my possibilities of going forward, yes.

Q Why were you considering that?

A Well, because my intraoperative findings were that I had two colon holes that I repaired laparoscopically. And my first concern was whether those holes had opened up and possibly created leak.

Q So you wanted to see what a CAT Scan showed?

A Correct.

Q What would the signs be of a leak?

A On a CT scan?

Q No. Just clinically, what would the signs be?

A Clinically, signs of a leak are very vague

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

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

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

A Yes.

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

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

Q All right. White blood count, 22.9, is

that elevated?

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

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

Q So at this point, did she have --

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

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

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

Q What is on the prior CT scan?"

A If this CT scan all of a sudden showed increased incompetant that parafeel air, showed increased fluid, showed increased bowel edema, showed gross soilage. So if she has a hole in her colon, she could.

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

Q Was Mrs. Ferris conscious or conscious, do

you have any recollection.

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

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

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

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

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

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

A I was also concerned about leakage from the bowel.

Q We go to the note.

MR. HAND: Let's go off of the record.

(Off the record.)

BY MR. HAND:

Q Okay. Looking at 13, it looks like her white blood count is 17.9 on that day. Any medical significance to that?

A It's a little lower than it's been over the last couple of days but in and of itself, no.

Q And we go to, it says, "Course, progressing as expected. Plan, patient tolerating sedation protocol bttor today. White blood count basically unchanged. Patient now afebrile with normal lactic acid and no acue issues on xray. During this period of of time was there any distention in the abdomen?

A She had various degrees of distention the entire time.

Q Then you state -- well, the distention,

was that - did it remain at the same level, going down, going up, do you know?

A It's hard to say in a patient that has anasarca because the edema of the abdominal wall interferes with a good examination from a distention standpoint. So when the abdominal wall is doing better from the anasarca standpoint, that is more indicative that we're getting rid of the excess fluid. Hopefully, it's getting off her lungs. Hopefully, it will help her breathe better. Hopefully, her bowels start to function.

Q And you state, "Agree with ICU team after patient only lasted four minutes on CPAP that she will likely need tracheostomy. Will consult with CT surgery. Discussed all of the above with husband who seems encouraged".

So do you remember speaking to the husband that day?

A I don't remember the conversation, but according to the note, I did.

Q So at this point, on the 13th, was she septic at this time?

A It does not appear so.

Q And the signs of sepsis would be what, if she was?

A Worsening or lowering blood pressure, higher tachycardia, worsening renal function. Worsening pulmonary functions. And she didn't have any of those things.

Q If we go to the note on the 14th. That's at 8:43. That's page 1600. Her white blood count on that date was 21.10. Any significance to that finding?

A Again, in and of itself, no.

Q And then you state, "Patient with new run fevers and white blood count has trended back up and abdominal exam as gotten a bit worse in terms of being firm. Also, no response to fleets and no bowel activity. Will await trach today and likely get repeat CT scan of the abdomen tomorrow looking for any increase in free fluid/abscess or development of" -- it should be bowel obstruction, I assume.

A Correct.

Q "Or free air. Discussed with ICU team."

So at this point, what is your assessment of the patient?

A That she's clinically getting worse.

Q Based on what factors?

A New running fevers, increased white cell

count, worsening in the abdominal exam, no return of bowel function, and no response to fleet or suppositories.

Q So at this time, is there infectious process in the peritoneal cavity?

A Possibly.

Q So at this point, what was your plan in terms of the next step you were going to take? Meaning, you were going to get a Cat scan?

A I was going to wait until they did the tracheostomy and then get a repeat CT scan of the abdomen and see if there was any change from the prior CAT scans.

Q Now, we're going to the 14th. And that is Page 1497. And I'm reading your note. It states: "Reviewed patient's CAT Scan concerning for new developments of abscess fluid and free air where there was none prior, still no extravasation of contrast but very concerning for possible leak and or abscess either of which requires surgical intervention given patient's increasing fevers over the last 48 eight hours and increased leukocytosis over the last 48 hours. No improvement in abdominal exam".

So at this point, what is your

assessment of the patient in terms of her? Is she septic now?

Q Again, depends on your definition of septic, but you don't have to be septic to take the patient back to the OR. She had signs and symptoms that are consistent with a possible leak from the colon or some other etiology.

Q Were there any signs or symptoms of a leak from the colon prior to July 15, 2015?

A In the continuum of her clinical evaluation, no.

Q Then you go down and state -- sorry. Withdraw that question.

And the basis for that statement is what? Can you explain the basis for that.

A Again, if you look at the patient in the continuum of their day to day improvement and clinical situation. If a patient has a hole on day one, they're not going to continue to get improved and show signs of improvement day by day by day. They're going to show signs of getting worse immediately. So in a patient is even smoldering along and doing better and better, even if it's just step-wise, then your suspicion is still there but it's kind of in the back of your head.

If a patient all of a sudden takes a change clinically, in which case, these last 48 hours, now she has not just had -- now, she's had a spike in her fever. Now, it's up there and staying up there. And it's not 101. It's 103. Now, the white count which was trending down slightly is now trending all the way up.

Her abdominal exam is worse. I repeated the CAT Scan, which is clearly different from the one prior. So if you look at the changes, with all these factors on the patient on a day-to-day basis, it is not one little single item points to this versus the other.

Q You further state, "Spoke to the husband regarding the findings and the patient's overall condition, patient's spike in fever is 103 now. Recommend exploratory laparotomy with explantation of mesh, abdominal wash out, thorough inspection of entire small and large bowel, possible colonic lavage to remove insippated contrast, possible bowel resection, explained further the risks, complications or sepsis and he indicated he wanted to think about it further and decide tomorrow based upon how she does. I notified ICU team of husband's decision".

So you spoke to the husband and indicated it was time to bring her back to the operating room on the 15th?

A Correct.

Q Was that the first recommendation for her to be taken back to the operating room at that point on the 15th?

A That I can remember, yes.

Q And you state that your concerns for further complications or sepsis. What did you mean by "or sepsis"?

A That she can develop sepsis and multi-organ failure and die.

Q So if we go to the next day, you note at 11:39, "After discussion with Dr. Mono, family would be more comfortable with having Dr. Ripplinger taking over as surgical consultant going forward. I will continue to be available if Dr. Ripplinger or family has any further questions or I can assist in any way. Otherwise, I will effectively sign-off for now".

Who is Dr. Mono?

A Gary Mono is a general surgeon, who at that time, he was either chief medical officer or vice-chief medical officer of San Martin, I believe.

I don't know his exact title at that time.

Q Prior to July 16th, did you ever discuss the patient with this Dr. Ripplinger?

A Dr. Ripplinger was consulted as a second opinion earlier in the patient's clinical course. He was the one that wanted the CAT Scan specifically with rectal contrast. I don't recall having an independent conversation with Dr. Ripplinger at all.

Q Was there a meeting at the hospital of some kind about Mrs. Farris with the husband, you and some of the administration people, do you recall that?

A I thin Dr. Mono, when we spoke, mentioned that.

Q Was there a meeting with family and hospital personnel that you attended?

A I don't recall whether I attended or not.

Q How did you -- well, Dr. Mono, did you have a discussion with him about this patient in that time frame, on July 16th?

A In regards to?

Q Mrs. Farris and her -- about her generally. Did you speak --

A Dr. Mono and I discussed that the family would be more comfortable with having Dr. Ripplinger

take over as surgical consultant going forward.

Q What do you remember about that discussion with Dr. Mono, as far as where did it take place?

A I don't recall.

Q Do you recall the substance of the conversation?

A The substance was that the family was uncomfortable with me continuing as surgical consultant on the case. They didn't want me to be be the surgeon doing the reoperationoperation.

Q Was the family present for any discussions between you and Dr. Mono?

A I don't recall.

Q So on the 16th, is that the last day that you were involved with the treatment of Mrs. Farris?

A Yes.

Q So when were you planning to take her back to the operating room?

A The night prior.

Q The night of the 15th?

A Correct.

MR. HAND: Can we go off for a second.

(Off the record.)

BY MR. HAND:

Q We are going to Exhibit 6. It is a

consultation by Dr. Ripplinger on July 9, 2015. Can you take a look at that.

A Okay.

Q Have you seen this note prior to today?

A I'm sure some time during her clinical course, I reviewed it, yes.

Q Are you able to review on the work station, the notes entered by other doctors or nurses or personnel?

A Yes.

Q So looking at his note, do you know who requested this consult?

Q I think it was the family, but I'm not sure.

Q So Dr. McPherson, do you know him?

A Dr. McPherson is an ICU doctor.

Q It seems like he is the one that requested it.

A Where does it say that?

Q It says refering to the - I don't know who requested it but, he's in there. So it just says second surgical opinion?

A Yes.

Q And looking at his notes, it states, "Postoperatively, the patient began to do poorlyy on

her first postoperative day July 4, 2015, and was first transferred to IMC and then to Intensive Care Unit when she was intubted later on postoperative day 1. And she has consistently had a relatively elevated white blood cell count".

Do you agree with that note?

A For what you read, yes.

Q "Her very first white blood could, which was done on July 4, 2015 was 21.7. It has remained fairy consistent in the greater than 20,000 and was as high as 26,000 on couple of occasions".

Do you agree with that note?

A I have no reason to argue with it.

Q All right. Then, "She has been on ventilator since the evening of her first postoperative day". And it says, "She has not had significantly elevated temperature recently. She has been tachycardic".

Do you agree with that statement?

A To the best of my recollection, yes.

Q We're down to the physical examination on the next page. It states, "Maximum temperature over the last 24 hours was 37.2 degrees centigrade, maximum pulse rate is 123. Her blood pressure mostly recently is 126/73. The temperature of 37.2,

is that normal temperature, low or high or something else?

A Normal.

Q Maximum pulse rate is 123. Is that normal, low or high?

A For a person who is not sick it would -- high.

Q And the blood pressure is 126/73, is that normal blood pressure?

A Normal.

Q And then he states, "Abdomen, obese and quite distended. She has some fluctuance in the area of her incisional hernia, which I believe is fluid or air between the mesh and skin. Her wounds are healing nonerythematous and there is no drainage."

He discusses the CT Scan of the abdomen that was done four days ago on July 5th. It states, "The abdomen and pelvis showed some air and fluid above the mesh".

Do you agree with that note?

A I would have to refer to the radiology report, but I don't have any reason to except it other than that.

Q Assuming that the CT showed air fluid

above the mesh, is there any medical significance to that on July 5th?

A No. After a laparoscopic repair, there is typically air and fluid above the mesh.

Q So in impression and plan, it states, "Obese female, who is status post repair of an incisional hernia with placement of mesh, who is on a ventilator with an elevated white blood cell count". He states, "I think there is a reason to be concerned for possible leak from one of the two colon repairs or an early agressive infection of the mesh causing some of the patient's problems".

Do you agree with that note?

A Yes.

Q Then he states, "I would recommend a repeat CT scan of the abdomen and pelvis done with intravenous oral contrast and to help rule out leak from the colon". He states, "I think there should be a fairly low threshold for at least a diagnostic laparoscopy or even laperotomy if there are any significant abnormalities noted on the CT scan. Especially, if there is increase in free fluid in the abdomen. I would be concerned for possible bowel leak".

Do you agree with that assessment that

he states?

A Basically, yes.

Q So you don't remember if you discussed this with him? You don't think you did?

A I don't think we did.

Q Now, I'm going to show you what I have marked as Exhibit 13, which is an operative report from July 16th by a Dr. Elizabeth Hamilton. Do you know Dr. Hamilton?

A Yes, I did.

Q Is she a general surgeon?

A Yes, she is.

Q Can you take a look at that. Date of operation done on July 16, 2015. Have you seen that operative report prior to today?

A I don't believe I have.

Q Preoperative diagnoses, perforated viscus -- well, if you want, let me give you a few minutes to read through it if you have not seen it yet. Would you like that?

A I don't think it's going to make a difference.

Q All right. She does -- her preoperative diagnoses: perforated viscus with free intraabdominal air. Sepis, respitory failure,

anasarca, fever, leukocytosis, recent incisional hernia repair with proathatic mash, previous incisions hernia repair, and then overweight.

And she -- her postoperative diagnoses appears to be the same. And her procedure performed; exploratory laparotomy, removal of prosthetic mesh and washout of abdomen, partial colectomy and right ascending colon and ileostomy, extensive lysis of adhesions over 30 minutes, retention suture placement, decompression of the stool from the right colon into the ostomy, fecal disimpaction of the rectum. Dr. Ripplinger was the assistnt surgeon.

Going down on Page 44, "Dr. Ripplinger had been called for a second opinion for this patient who is not improving in the postoperative period".

Do you agree with that note or disagree or something else, that she was not improving in the postoperative period from the 3rd to the 9th?

A Specifically, the sentence, "My partner, Dr. Ripplinger has been called on 7/9/2015 for a second opinion for this patient who is not improving in the postoperative period, I don't know what she

means by not improving.

Q She goes on to state, "Patient was observed on ventilator and received a tracheostomy. She continued to have evidence of sepsis with fever and leukocytosis". And then, "Repeat CT Scan done on the 15th which demonstrated significant free air as well as some free fluid and concern for perforated viscus". And then Dr. Hamiltonn states, "Dr. Rives by report on the 16th notified the patient that a repeat trip to the operating room was in order".

Anything you disagree with that note that I just read?

A It depends upon when she felt that the patient had evidence of sepsis and fever. I assume it was the couple of days that I referred to previously. Other than that, no.

MR. COUCHOT: The other thing you talked -- the timing, she has wrong. You already testified you recommended surgery surgery on the 15th; not the 16th but it is kind of a minor pont.

THE WITNESS: Well she is referring that it was reported on the 16th.

MR. COUCHOT: "By report on the 16th notified the patient that a return trip was in order", that actually occurred on the 15th.

THE WITNESS: Well, that -- that part is true. Well, it depends on how you mean by report. I didn't speak to her about it, so she is maybe getting that from the nurse. I don't know.

BY MR. EAKD:

Q Going down, Dr. Hamilton says, "The patient had severe anasarca. Her abdomen was incredibly taut to the point wher it was tympanitic and literally look like you coul balance a quarter off of it. She said she had discomfort. She had evidence of peritenonitis and she had a midline wound that was just to the right of midline".

Going down further, she states, "She was febrile, her pulse was only in the 80s. She had a leukocytosis of about 20,000. I reviewed the CT Scan personally". And then she goes down to state, "Decision was made that she had perforation and likely perforation of the colon from the previous colon injuries".

And then they decided to take her back to the operating room. And she states that

they were tried to get rid of the source of continued sepsis in the patient who is failing.

Now, going down to the actual procedure, which is on the next page, she states, "Her abdomen was distended out like a tiny mountain. It was very abnormal appearing. In addition, she had severe anasarca. I decided to approach the area of abnormality from the highest yield area". And then she states when she opened the incision she got a rush of air.

Add further, she states, "The peritoneum was extremely thickened and it almost seemed to be cavity in there". You see where I'm reading, Dr. Rives?

A Yes.

Q I am doing this in detail because I don't know if you saw it. It just want to put it into context. So there was no clear feculent spilling out of the skn once mesh the vertical incision was opened, but I could see a feculent sitting on the mesh and purulence in feculent sitting within the cavity of the level of the mesh.

Do you have any indication how long that feculant would be sitting on the mesh prior to her operating on the 15th?

MR. COUCHOT: I'm just going to object. Calls for speculation.

If you know it, you can answer.

THE WITNESS: There is no way for me to answer that.

BY MR. HAND:

Q And she goes on to state, "The mesh was not well incorporated. I could see the purple plastic tackers."

Do you have an opinion as to why, assuming this is correct, the mesh was not well incorporated when she operated on the 15th?

MR. COUCHOT: Objection. Calls for speculation. Lacks foundation. Calls for expert opinion.

THE WITNESS: Basically, it's too early for the mesh to incorporate postoperatively.

BY MR. HAND:

Q And she states, "I can see purple plastic tackers". Is that something that would be an unusual finding in opening a patient laparotomy?

A No. I use the SecureStrap device and those are the purple tackers for that device.

Q Further down, it says, "Underlying this was what appeared to be the transverse colon with

about a quarter size or about a 2.5 to 3 cm hole with semi chronic appearing edges. Around it, there was active leak of green feculent material and free air".

Do you have an opinion as to when that hole appeared that I'm referring to, 2.5 to 3 centimeter hole?

MR. COUCHOT: Objection. Calls for speculation. Seeks expert opinion.

I'm not going to let him give a retrospect of the analysis. If he had thoughts about what he was doing at the time, I mean, I think you're entitled to that.

But as far as what he now thinks, I think that's kind of within the purview of our experts. I'm not going to be disclosing him as an expert. He won't be offering such opinions of that at trial.

MR. HAND: He's not going to be -- but the thing is under, you know, 16A, he is an expert. He's operating on people. And I think I'm entitled to expert opinions, whether you disclose him as such or not because, you know, he is, by all indications, he is an expert. He is a surgeon. He does the surgery. And I

think I'm entitled to ask him, you know, his opinions on, you know, what the result of this was. You can object, but I gate to bring people back for deposition and stuff like that.

MR. COUCHOT: Well, two thoughts: One, first, let's find out if he does. And then we can figure out if we're going to fight over it. And then secondly, we just have been down this similar road in the Sinner case and, you know, every judge is different but essentially the outcome that we got in that case was, no present opinions but you can give opinions that you formulated at the time.

And the thought process that we argued, and Judge Smith agreed with, was essentially, you know, at this point we have had it reviewed, we have spoken with him, our experts have come up with a information. And to the extent we're basing information on his opinions are based on those things, that's attorney-client privilege, work-product stuff.

So first, do you have an opinion in that regard?

THE WITNESS: I'll be honest with you, I'm lost about what you guys are asking asking.

What are you talk about?

Can you repeat the question and then we will see if he has an opinion and then we will --

(Record read.)

THE WITNESS: I don't think I can make an opinion about that without severe speculation.

BY MR. MAND:

Q Okay. Do you see later then, "she had a colostomy?

[illegible]

[illegible] at? "She felt that a colostomy"?

Q Yes.

A Okay. I'm there.

Q All right. It says -- I'm at the last page which is 48. "We brought out an ascending colon colostomy, which this morning is pink and viable and actually is already functioning". You see where I'm referring to?

A [illegible] the Summary paragraph?

Q Right.

A Correct.

Q So --

A Wait. Well, that's confusing because she writes, "Which this morning is pink and viable and actually is already functioning."

Q I think she said after the colostomy.

A It sounds like she's incorporating her postoperative note with her operative note.

Q Do you have an opinion as to timeframe where the reoperation would have avoided a colostomy the patient?

MR. COUCHOT: Objection. Lacks foundation. Calls for an expert opinion.

THE WITNESS: [illegible]

[illegible]

A [illegible] would have been likely to have an ostotomy.

Q Why is that?

A Because if you try to repair a piece of bowelel initially and it fails, it usually fails for various reasons. If you try to just simply repair that, you're risking another leak and a whole other problem. So the more direct and safest route is to resect that and bring out an ostotomy.

Q Now, have you seen any records

[illegible]

Did you read the whole -- or review the whole chart from her admission record from the surgery from July 15 onward?

Her entire medical record?

[illegible]

A No, I did not.

Q Are you aware of what her condition was when she was discharged?

No, I do not.

Q I want go through this. I'm just going -- this has been marked as Exhibit 14. It is basically the consultation progress notes from July 4th up

[illegible]

A [illegible]

[illegible] do [illegible]

A He's a hospitalist.

Do you know him?

A Yes.

Q And do you see [illegible] 2239.

Okay.

Q Do you see where he makes a note, white blood count -- well, on 2237, he says, "white blood count, 21.7. And then on 2239, he makes a note, "probable sepsis".

Did you ever discuss this patient with Dr. Akbar?

I did, but I don't have any recollection.

Q If you did discuss it, would that be something in your tradition -- you know, normally it [illegible]

A [illegible]

[illegible] that day.

Q Are you able to review that note in your -- when you go see the patient?

A Yes.

Did you attach any medical significance to his [illegible] of probable sepsis?

[illegible]

Did it give any heightened sense of awareness as to the possible sepsis?

I don't know if I was aware that [illegible] mentioned sepsis or not. I don't have a recollection of it.

[illegible] is a

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 infectionous 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 36.

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, sepsis, 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 infectionous disease doctor is making a note that it could be fecal peritonitis?

A No, because I was considering the same thing already.

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. These are not in any record whatsoever. I mean, you have them labeled such,

but.

MR. COUCHOT: I found that particular one.

THE WITNESS: Is is 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 Akoline 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 peritenonitis". This is on the 5th that we're

talking now. And then, "She's also developing respiratory failure, intubated, TCU, abnormal distention". And recommends abdominal imaging and CT Scan.

If we go down, there is another doctor involved, Dr. Tanveer Akbar.

A He is a hospitalist.

Q Okay. On the 5th, he mentions an acute kidney injury, AKI, does that mean acute kidney injury?

A That's correct. Page 2210. Electronically signed by Akbar, Tanveer, 7/5/15.

Q Yes. An acute kidney injury, is that something that is within the realm of expected complications after the surgery?

A Yes.

Q Why is that?

A Any hypoglycemic state would cause a patient to have acute kidney injury.

Q And we go to Page 2118. This is also on the -- it's on the 6th. I'm sorry. Dr. Ali, what kind of doctor is Dr. Nauros Alis?

A I don't recognize the name.

Q I believe he's an internist, hospitalist. And then on Page 2147, it's down quite a bit. So he

makes a note, impression and plan, diagnosis, July 5th. This is a later note. Does he state sepsis?

A He actually added on to the note and repopulated it.

Q Right. And then on July 6th, he says sepsis. Do you recall reviewing this note during the course of treatment of the patient?

A I have no independent recollection of reviewing this note.

Q If you reviewed it, would that give you any concern that she was a septic patient?

A No, because I thought she was in sepsis on the 5th anyways.

Q Okay? You felt she was septic on the 5th?

A The day after surgery?

Q Yeah?

A Well, let's see. The day of surgery was the 3rd. So the 4th and 5th, yeah, you can say she was in sepsis at that point.

Q So at that point, did you determine what the source of the sepsis was?

A No.

Q How come you didn't determine the source?

A Because there are consideration for the source.

Q Such as?

A Aspiration, cardiac, postoperative or intraoperative complications. Those are just a few.

Q Did you consider hierarchy of the cause of the sepsis as to which is more likely, and which is less likely?

A When dealing with sepsis, we're not so much concerned with what is the source as is, like I said before, treating the sepsis and getting ahead of the sepsis so the patient does not go into multi-organ failure. So at that point, we have kidney, renal, pulmonary, ID, everybody on board to try to get a hold of how to treat the sepsis.

Identifying the what is exactly causing the sepsis is sort of secondary at that point. My concern was related to the abdomen more than anything else as the possible source. In other words, it was not my scope of practice to figure out whether it was cardiac, pulmonary, etc.

Q As a general proposition, will sepsis resolve without source control?

A Yes, it can.

Q Can you explain how that can happen.

A I will give you an example of people who develop appendicitis, develop sepsis, don't have

surgery, and it heals up on its own and the patient recovers. The the same thing happens microperforation diverticulitis. We don't operate on those much anymore. We give them IV, antibiotics. The body heals itself up. We don't do any quote/unquote "source control" in those cases. And they resolve spontaneously.

Q And if we go to the same day, Page 2149. Dr. McPhearson's notes. It's July 5th. And Page 2149, does he state -- make a note also of sepsis?

A He makes a diagnosis of sepsis, yes.

Q And do you agree with that diagnosis?

A On the 6th, I don't recall whether I agreed with it or not. I would have to review my notes again. But if you notice, most of the notes, they continue the same diagnosis throughout the entire leanght of stay. They rarely change those.

Q In terms of sepsis?

A In regards to any of the diagnoses.

Q Is there a reason why or is that standard?

A Without editorializing? I think it's a lazy physician, quite honestly. I have had notes say, "pending surgery", and now the patient is 10 days post-operative.

They don't change a lot of these in

the progress note on the computer. They kind of add to it. If that make sense.

Q If we go to the Page 2033, it's a note by Dr. Shaikh, the infectionous disease doctor on the 7th.

A Repeat that page number for me, please.

Q 2033.

A Dr. Shaikh, 7/7/2015?

Q Right. Again, like you mentioned before, he repeats -- the first note, he says "52-year old female, status post-reduction of incarcerated incisional hernia, operative nick to the colon and repair, now with postoperative abdominal pain, distention, sepsis, leukocytosis, and fenever. This could represent fecal peritonitis".

And if you go Page 2034, he states, "Course worsening". Now, we're on the 7th. Do you agree with that assessment, "Course worsening"?

A No.

Q Why is that?

A Well, I don't know his reasoning for why he thought the patient was worsening. I never spoke to him about it, as far as I can remember. And my recollection of what we reviewed from my progress notes, that the patient was slightly improving at

that point.

Q And then if you go to Page 2037, Dr. McPhearson's notes, continues to say -- make a note that the patient is septic on -- that's the 7th. Do you see where I'm referring to?

A Yes.

Q Do you agree with that assessment, that she's septic on that day?

A No.

Q And why is that?

A Because pulmonary-wise, she was improving, her kidney function was improving. And her heart rate, I think was controlled. Her blood pressure was more stable.

Q Now, if we go to -- there is a note by Dr. Shaikh, infectious disease, on July 8th on Page 1974. It starts -- he repeats the assessment and plan from previous. And he makes a note that the patient is developing acute renal insufficiency. Any medical significance to that note?

A In and of itself, none.

Q On Page 1975, he says, "Abdomen remains distended, silent and surgical". Any medical significance to that note?

A From a non-surgeon, none.

Q Why is that?

A Because it's not his job to exam abdomens that are surgical.

Q So on this date, the 8th, Dr. Shaikh, infectionous disease doctor, note that the patient is septic. Do you agree with that note?

A From my standpoint, I don't know how to answer it. From my recollection of my progress notes, I don't know what he means by septic. I didn't speak to him. I don't have an independent recollection of it. I cannot answer that.

Q And Page 1901, it's a note from July 9th of Dr. Shaikh. On that note, he repeats, "Abdomen remains distended, silent, and surgical". And there is no change on that note.

Going to July 10th, Page 1829. Dr. Howard Broder. Do you know who Dr. Howard is?

A The name sounds familiar. And I don't know if it is Dr. Brodar or his PA. But go ahead. He is cardiology.

Q He makes a note on Page 1829, diagnosis, sepsis. Do you agree with that diagnosis on that date?

A On the 10th?

Q Yes.

A I don't recall.

Q And if we go to Dr. Shaikh's note on Page 1867. States no change and the the course says worsening. Do you see where I'm referring to?

A No.

Q You're on Page 1867?

A Yes.

Q It is actually page 1862. He says, course, worsening. Do you see that, Dr. Rives?

A Yes.

Q As of that date, did you agree with that assessment by Dr. Shaikh?

A I did not speak to Dr. Shaikh about these assessments, as far as I can recollect.

Q On July 10th, was her course worsening?

A From my progress notes, I don't believe so.

Q And there's is a note. This is is Page 1830. Her name is Kibby, Doreen Dibby? Do you know her, Doctor?

A It doesn't sound familiar at all.

Q On that note on Page 1830, there is a diagnosis of sepsis. Do you see that?

A I do.

Q Do you agree with that note of the

diagnosis of sepsis on that date

A I have no idea of what she made that diagnosis of sepsis on or whether she made diagnosis. I did not speak to her, and I don't have a recollection of it.

Q Then we go to Page 1766, July 11th. Again, he states, "No change. Abdomen remains distended and surgical".

Do you see that?

A Is that the date of the 7/7 on his notes?

Q Right. And then as a continuation, where 7/11, he states, "Fever 39.1 to 39.4. No change in abdomen, no feces yet. CT chest and abdomen".

Do you see what I'm referring to?

A Yes.

Q Okay. Do you agree with what he says, no change on July 11th?

A In her abdomen? On his exam?

Q Yes.

A I didn't examine it with with him. I have no idea. From my exam, I think she was starting to have changes. I would have to review my progress notes.

Q If you go to July 12, Dr. Sheikh, Page 1758. "Fever remains, no prassar, no feces,

micor ponding from yesterday".

Do you agree with that note?

A Well, let me withdraw that.

Q Later on, it says course worsening on that page. Do you agree with that assessment?

A Again, I don't know what he's referring to, case worsening. I didn't speak with him. I don't have an independent recollection about that.

Q Go to Page 1590. Dr. Mooney on the 14th of July.

A 15, what?

Q Page 1590, Dr. Mooney.

A Okay.

Q On Page 1591, he notes the white blood count —

A — on Page 51

Q — he notes the white blood count is 110. And 1591, "Husband aware of guarded prognosis and need for trach".

On that day, was her prognosis guarded at that time?

A What date?

Q On the 14th of July.

A Well, A, I didn't discuss on what he meant by guarded, as far as I can recollect. From my

standpoint, having reviewed my own progress notes, I guess, maybe guarded may be appropriate.

Q On Page 1573. This is a note from Dr. Zaidi.

A I cannot find that one.

Q Okay.

A 1573?

Q Yes.

A Yeah.

Q Let me go to Page 1581 then.

A Alka Rebentish.

Q Is she an infectionous disease doctor?

A Yes.

Q Does she makes a note of postoporative, abdominal distention, sepsis, leukocytosis, and fever, question mark, fecal peritonitis?

A Yes.

Q Did you agree with that assessment by that doctor on that date?

A I didn't speak to Dr. Rebentish, as far as I can remember. I don't recall whether I reviewed this note with her or not.

Q Then we go to Page 1498. This is is a note by Dr. Mooney. Goes to Page 1507. Do you have that, Dr. Rives?

A Correct.

Q On that page, does he make a note that the patient's in critical condition?

A Yes.

Q Do you agree with that assessment on that date?

A If I remember correctly, having reviewed my progress notes, that was the date that I felt that she needed to go back to the OR. So I would say yes.

(Off the record.)

BY MR. HAND:

Q Dr. Rives, what is your understanding of the standard of care applicable to the treatment of this patient.

MR. COUTHOT: Well, I am going to object. It calls for an expert opinion —

MR. HAND: Well let me daine it.

BY MR. HAND:

Q Would it be a reasonable physician under the circumstances? Does that sound —

A It sounds vaguely like that. There are some parts regarding the community, berein, et cetera, et cetera. Vague.

Q So do you feel or have the opinion that

you met the standard of care in your treatment of Mrs. Ferris?

EURBGS: I'm going to object. Again, we're not going to disclose him as an expert opinion. I will let you answer that narrow question, though, as to whether you believe you reached the standard of care — or whether you were within the standard of care.

THE WITNESS: Yes, I was within the standard of care.

BY MR. HAND:

Q And why was that the basis for that statement?

A Because that is what is reasonable and expected of a properly trained surgeon.

Q Okay. I want to show this exhibit. Pathology reports from the Hamilton surgery of July 16th.

A Surgical pathology report?

Q Yes. Have you seen that prior to today?

A It's in my office notes, I believe. So I probably looked at it at some point.

Q Could you look at the -- if we look at the — it starts at Page 8502. And I believe there were -- it's Dr. Darren Wheeler, under gross

submitted, found three defects in the colon. Do you see where I'm referring to?

A "Three foci of colonic ulceration with transmural acute inflammation and perforation. See comment".

Q All right. It says, "First defect is located roughly within the mid aspect, measures 2.0 x 1.6 cm and the borders are inked orange".

A Wait. You're on the next page?

Q Yeah. Page 8503.

A And approximately where on the page?

Q In the middle.

A Colon, serosa -- which?

Q Yes. Where it starts serosa.

A Serosa, okay.

Q It states: "The first defect it located roughly within the mid aspect, measures 2.0 x 1.6 cm, borders are inked orange."

A Correct.

Q Okay. And then there is a second defect located, measuring 3.7 x 3.5 cm. And then there is a third deeffect, located 1.9 cm from the green inked margin. So my understanding reading this, there were three holes in the bowel.

A That's what the pathologist found,

apparently.

Q Do you have any opinion as to the cause of these holes in the bowel?

MR. COUCHOT: Objection. Calls for an expert opinion. I'm not going to let you answer if -- but do you have an opinion?

THE WITNESS: It's hard to say without speculation. He mentions ulceration. And his differential includes ischemia, rare diverticulitis and/or prior procedures of surgery. Other than that, I can't comment.

BY MR. HAND:

Q Where is that Hamilton report?

Looking at Dr. Hamilton's report, if you can look at that again, Doctor, real quick. Do you see, we are at Page 4242, findings No. 3, that Dr. Hamilton found a quarter size or 3 centimeter hole in the transverse colon anteriorly associated with staples in the colon wall. Is that an indication that the staples didn't hold that were put in during the surgery of July 3rd?

MR. HAND: Objection. Lacks foundation. Calls for an expert opinion.

THE WITNESS: Yes, I have no idea to know that without speculation.

BY MR. HAND:

Q Would you have any opinion or knowledge as to when the staple line gave way?

A Based upon her clinical course and condition, I would guesstimate at some time postoperative day maybe six or seven, some time around there.

Q What is the basis for that?

A That her earlier course improved, that her CT scans, the first two sucessfully showed improvement, that she didn't have an alteration in course until about the, I think, it was the 11th or 12th, we discussed when she started having fever, a higher white count, a change in her clinical course. So I would suppose that's when it occurred.

Q Is there any action or precaution that could have been taken before July 16th that would have prevented holes in the bowel?

MR. COUCHOT: Objection. Calls for speculation. Lacks foundation. Calls for an expert opinion.

THE WITNESS: Again, I cannot make an opinion without speculation.

MR. HAND: All right. Thank you, Dr. Rives. I have nothing else.

MR. COOCHOT: Thank you.

(Whereupon, Exhibit No. 15 marked for identification.)

-oOo-

(Whereupon, the deposition concluded at 2:13 p.m.)

CERTIFICATE OF DEPONENT

PAGE	LINE	CHANGE	REASON

* * * * *

I, BARRY RIVES, M.D., deponent herein, do hereby certify and declare the within and foregoing transcription to be my deposition in said action; under penalty of perjury; that I have read, corrected, and do hereby affix my signature to said deposition.

BARRY RIVES, M.D., Deponent Date

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CERTIFICATE OF REPORTER

STATE OF NEVADA)
) ss:
COUNTY OF CLARK)

I, Yvette Rodriguez, a duly commissioned Notary Public, Clark County, State of Nevada do hereby certify:

That I reported the deposition of BARRY RIVES, M.D., commencing on October 24, 2018 at 10:17 a.m.

That prior to being deposed, the witness was duly sworn by me to testify to the truth; that I thereafter transcribed my said shorthand notes into typewriting; and that the typewritten transcript is a complete, true, and accurate transcription of my said shorthand notes.

I further certify that I am not a relative or employee of counsel or any of the parties nor a relative or employee of the parties involved in said action, nor a person financially interested in the action.

IN WITNESS WHEREOF, I have set my hand in my office in the County of Clark, State of Nevada, this 30th day of October, 2018.

YVETTE RODRIGUEZ, CCR NO. 860

EXHIBIT "3"

DISTRICT COURT

CLARK COUNTY, NEVADA

VICKIE CENTER; THOMAS CENTER, individually, and as the Husband to VICKIE CENTER,	)	
Plaintiffs,	)	
vs.	)	CASE NO. A-16-731390-C
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	)	
Defendants.	)	

VIDEO DEPOSITION OF BARRY JAMES RIVES, M.D.

Taken at the Law Offices of Brenske & Andreevski
3800 Howard Hughes Parkway
Suite 500
Las Vegas, Nevada 89169

Tuesday, April 17, 2018
10:59 a.m.

Job Number: 451742

Reported by: Angela Campagna, CCR #495

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ProAssurance

Marc Zamora
Videographer

INDEX TO EXHIBITS
BARRY JAMES RIVES, M.D.
Tuesday, April 17, 2018
Angela Campagna, CCR No. 495

EXAMINATION

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VIDEO DEPOSITION OF BARRY JAMES RIVES, M.D.
April 17, 2018

THE VIDEOGRAPHER: This is the beginning of media number one in the deposition of Barry James Rives, MD, in the matter of Center versus Barry James Rives, MD, held at Brenske, Andreevski, Clark Hill. Today's date is April 17, 2018. The time on the monitor is 10:59 a.m. The court reporter is Angela Campagna. And I am Marc Zamora, the videographer, an employee of Litigation Services. This deposition is being videotaped at all times unless specified to go off the video record.

Would all present please identify themselves, beginning with the witness.

THE WITNESS: Barry J. Rives, MD.

MR. DOYLE: Tom Doyle for Dr. Rives and Laparoscopic Surgery of Nevada, LLC.

MS. KIDDOO: Rochelle Kiddoo with ProAssurance for Dr. Rives.

MR. KELLY: Sean Kelly for Dr. Mohammad.

MR. NAVRATIL: Michael Navratil for Western Critical Care Associates, Dr. Lin and Dr. Erazo.

MS. DAEHNKE: Patricia Daehnke for Dr. Siddiqui.

MR. BRENSKE: And this is attorney William

Brenske on behalf of Vickie and Thomas Center.

I would make note for the record that everyone in here is an attorney except for the young lady representing ProAssurance, I'm assuming.

MS. KIDDOO: I'm sorry?

MR. BRENSKE: You're not a lawyer.

MS. KIDDOO: Correct.

THE VIDEOGRAPHER: And will the court reporter please swear in the witness.

BARRY JAMES RIVES, M.D.,
having been first duly sworn, testified as follows:

(Exhibit 1 marked.)

EXAMINATION

BY MR. BRENSKE:

Q. Doctor, I'm going to show you for identification as Plaintiffs' Second Amended Notice of a videotape to take deposition of Defendant Barry James Rives, MD. Have you had a chance to review that document prior to sitting here today?

A. Yes, I have.

Q. All right. And the reason you're here today is because your deposition has been noticed yet a second time in this case. Fair statement?

A. That is correct.

Q. Okay. Dr. Rives, can you explain to

this jury what documents you've reviewed in preparation for this particular deposition?

A. I reviewed my progress notes and operative notes from the EMR at Dignity Health and my office notes.

Q. Did you review any of the chart of the hospital that Ms. Center was having the surgery in?

A. Yes.

Q. Okay. What of those records or charts did you review?

A. Progress notes by other physicians, some lab results, and some radiology results.

Q. Did you review any nurse progress notes?

A. I don't recall.

Q. Okay. Are there any other notes that you recall that you reviewed in preparation for either your first deposition or your deposition today?

A. Not that I'm aware of.

Q. Did you review your interrogatory responses prior to either deposition?

A. I reviewed them when they were initially sent to me. I didn't review them in preparation for this.

Q. Okay. With regards to the original complaint that was filed against you, did you ever review that?

A. The original summons?

Q. Yes, sir.

A. That I received?

Q. Yes, sir.

A. Yes.

Q. And now the answer that was -- that was filed in this case is normally filed by your attorney and not you. It's normally not a verified response or answer. Do you recall whether you reviewed the answer that was filed on your behalf in this case?

A. Yes.

Q. Okay. I'm going to jump around a little bit. That's what I do and I apologize for that. The most important thing today, obviously, is to tell the truth. And I'm sure you are aware that you're under oath and you will tell the truth, and your failure to do so would subject you to penalty of perjury. Do you understand that?

A. Yes.

Q. And in fact, you have been in at least two jury trials where you were a defendant?

A. That is correct.

Q. The other jury trials that you have been in -- let me withdraw that.

How many trials have you attended where you were a defendant in a medical malpractice case?

A. Two.

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

A. At jury trial or in general?

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

A. Yes.

Q. Can you just review those for me?

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

Q. I'm going to take them one at a time, if I could. I apologize for interrupting. It's my interruptions, my failure.

When you say that case was dismissed, was there a settlement in that case or

was it dismissed?

A. Dismissed before trial. No payment.

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

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

Q. And that was without payment?

A. That was without payment, yes.

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

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

Q. Okay. Do you -- do you recall whether or not you were a defendant in any other medical

malpractice case in this jurisdiction or anywhere else?

A. No.

Q. You've done very well answering my questions today and I appreciate that. There will come a time or times today when I ask you a question and it will be either unintelligible or difficult to understand. If you do not understand that question, please ask me to rephrase that question. And I will rephrase it. Is that fair?

A. Yes.

Q. Okay. And if you do not understand what — strike that.

If you answer a question that I ask, I can assume you understood it. Fair?

A. That's fair.

Q. Now — and I do bounce around. I assume that you do remember the patient Vickie Center?

A. Yes.

Q. What type of surgery did you — what was the surgery you originally performed upon Vickie?

A. A laparoscopic diaphragmatic hernia repair and Nissen fundoplication.

Q. Now, was any part of Vickie Center's stomach or surrounding organs injured perioperatively as a result of that surgery?

A. No.

Q. And Ms. Center had suffered from sepsis one day postop after that first surgery. Fair statement?

A. That is correct.

Q. And at the time, what was your understanding of the cause of the sepsis?

A. At the time that it happened, between myself and the other consultants, there was talk about multiple possible reasons. The most likely being aspiration pneumonitis.

Q. Do you remember a bronchoscopy being done?

A. I believe there was a bronchoscopy done the next day or two, sometime afterwards.

Q. What were the results of that bronchoscopy?

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

Q. Okay. How long did you believe that the source of that sepsis was from the lungs? If you don't understand the question, it's a good time to -- take your time.

A. I don't think you can really associate a time frame with it.

Q. Okay. At any time do you recall her suffering from pneumonia?

A. Well, aspiration pneumonitis, normally we use the term kind of intermixed, so...

Q. So at the time that you were treating Ms. Center, it was your understanding that there had -- there may have been many causes, but aspiration pneumonitis was the number one culprit in your mind?

A. Correct.

Q. Did you have a differential diagnosis at that time for the cause of the sepsis?

A. When she initially started to go into sepsis, we had a large possibility, including pulmonary embolism, cardiogenic, the pneumonitis or -- pneumonitis or issue, and we whittled it down one by one.

Q. So it was your opinion at that time that the sepsis was aspiration pneumonitis?

A. By the time things got sorted out, yes.

Q. When you performed the second surgical procedure on Ms. Center, I believe, on the 17th of February, what did you find in that surgical procedure?

A. I started the case laparoscopically, and when I got in I could see that there was brackish-looking fluid consistent with possible perforation of the stomach. I irrigated and cleaned all that up so I could visualize the stomach, and I could see that the NG tube was up in the fundoplication wrap. And so I needed to take the wrap down to evaluate the stomach adequately to make sure there wasn't any injury to it.

When I did that, taking down one of the sutures, I created a small hole in the stomach by cutting it out. And when everything was completely unwrapped, I could see that the NG tube had caused a perforation in another section of the stomach. It vaguely looked like it had been from a necrosis or pressure by the NG tube.

Q. So the second surgical procedure that you performed, I think, was on the 17th of February 2015. You found a perforation of the stomach and you determined the cause of that perforation was the NG tube?

A. It appeared to be, yes.

Q. And then you did a third surgery on Ms. Center in the same general area, at least to a

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layperson. What did you find in that particular surgery?
A. I did that surgery in combination with Dr. Wiencek. And he's a cardiothoracic surgeon, he was doing the EGD part of the case. And with the scope inside the stomach retroflex looking up, he could see a perforated gastric ulcer.
Q. All right. So is that a perforation of the stomach?
A. Yes.
Q. So you have three surgeries thus far, one on the 6th of February, one on the 17th of February, and one in March. I wish I knew the day.
MR. DOYLE: March 19th.
BY MR. BRENSKE:
Q. Let's go with your counsel's date of March 19th. There is a lot of other stuff going on here, so...
All right. So the first surgery was uncomplicated, had sepsis, thought it was an aspiration pneumonitis. You went back in ten or eleven days later, found perforation of the stomach, you indicated it was caused by the NG tube. And then on the third surgery there was perforation of the stomach and you determined it to be an ulcer?

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A. Correct.
MR. BRENSKE: Mark that as Plaintiffs' Proposed Exhibit No. 2, please.
(Exhibit 2 marked.)
BY MR. BRENSKE:
Q. Doctor, if you could just hand me that Exhibit 2 so I know what I gave you is what I wanted to give you.
All right. So, Doctor, we're handing you what is described as Defendant Dr. Barry Rives' response to Vickie -- Plaintiff Vickie Center's first set of interrogatories. This would be the Center interrogatories that -- that you reviewed prior to verifying. Is that a fair statement?
A. Yes.
Q. I don't have a lot of questions about it, but just a few. Interrogatory No. 2 gives your medical education. That you obtained your medical degree from Hahnemann Medical College in Philadelphia, Pennsylvania in 1988. You completed a general surgery residency at Kern Medical Center in Bakersfield, California in 2003. Did you receive any other formal training in medicine?
A. No.

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Q. Then I have -- go to interrogatory No. 4. It asks if you're board certified in any specialty, the date you became board certified, the date you qualified to take the board certification, and date and number of times you took the oral written examinations. Your response to interrogatory No. 4 is that you are not board-fied. Is that true?
A. That's true.
Q. Did you ever sit for any boards?
A. Yes.
Q. When did you first sit for a board? You know, let me withdraw that question because it's too broad.
What boards, if any, have you sat for?
A. American College of Surgeons.
Q. When did you -- now, is that a written and oral exam?
A. There is two parts. There's a written part and an oral part.
Q. When did you first sit for the written part, if you can remember?
A. It would be 2004 or '05, I believe.
Q. And did you pass that written exam?

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A. Yes.
Q. When, if ever, did you sit for the oral exam?
A. To the best of my knowledge, it would be 2006 or '07.
Q. And did you pass that oral exam?
A. That one, no.
Q. Did you ever again sit for the written or oral exam?
A. No.
Q. If you could go to interrogatory No. 13 for me. I know I had asked you this question a bit earlier today, but I want to be fair to you concerning my questions. I've asked you about medical malpractice cases that you are a defendant in, and this is a written listing of them. So you may have missed a couple. I don't know that. But for completeness purposes, I thought we'd look over this. Brown versus Rives, are you currently a defendant in that case?
A. Yes.
Q. What -- in ten words or less -- are the allegations against you in that case?
A. The patient had a peritoneal dialysis catheter removed. There was a small segment that

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was left behind in a hernia sac, and the patient later had to have surgery to remove it.

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

A. Yes.

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

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

Q. Did you perform that subsequent surgery?

A. No.

Q. Do you remember who did?

A. I know the group. I don't remember which member of the group did it.

Q. Who is the group?

A. Southern Nevada Surgery. I think it was Dr. Hamilton or Dr. Ripplinger.

Q. As you sit here today, do you have a recollection of why you did not do the surgical repair?

A. The family asked for a second opinion.

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Q. Okay. Now, Lang versus Rives, this indicates that you went to trial on this particular case?

A. That is correct.

Q. And can you tell me what the alleged improper management of the ventral hernia -- what the allegation was?

A. The patient developed a enterocutaneous fistula after surgery and was not timely diagnosed or managed.

Q. Did you go back in and repair that?

A. Yes.

Q. How many days was it, to your recollection, did you go back in and repair that?

A. From the time the patient presented with it, we went in within 24 hours.

Q. The Doucette versus Garcia case. This shows that you had a defense verdict in that case. What were the allegations in that case?

A. Patient presented with a perforated colon. The pathology came back as metastatic B-cell lymphoma. So the allegation was delay in diagnosis and treatment.

Q. I don't want to get into these cases in detail, because I don't need to do that. There's a path report that said there was lymphoma?

A. Correct.

Q. Is that something you got?

A. It's something -- yeah -- well, eventually, yeah.

Q. Did someone get it long before you?

A. Well, there was questions about who got the pathology first and whether the pathologist should have notified everybody. There were some nuances to that.

Q. Was anyone found at fault in trial on this case?

A. At trial, no.

Q. Now, Schorle versus Southern Hills Hospital. This case looks like a 2012 case, just says motion to dismiss granted. Can you just tell me what the allegations were in that case?

A. This is the spinal case that I mentioned where I did an exploratory laparotomy, did a diverting ostomy for a patient's perforated colon from her spinal approach.

Q. It just says motion to dismiss granted. Do you know if any money -- that case was ever settled?

A. By me?

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Q. Yes, sir.

A. No. No money.

Q. Okay. The one after it says Tucker versus Rives, and that says dismissed without payment. Do you see that one?

A. Yes.

Q. I just want to know -- I wanted to know why there was a difference in language in Schorle versus Southern Hills and Tucker versus Rives. But in neither case no money was paid on your behalf?

A. Correct.

Q. Can you tell me what hospitals that you currently have privileges in?

A. I have courtesy privilege at Spring Valley Hospital. I have active privileges at Southern Hills Hospital. Then I have active privileges at Dignity Health, St. Rose, San Martin Siena, and De Lima campuses.

Q. So you've got active privileges at Southern Hills and Dignity Health hospitals?

A. Correct.

Q. What is courtesy privilege?

A. It's a designation of basically how many cases you do at a hospital. You have to have so many cases or so much activity to be considered

active staff. Courtesy is just a designation, you still have full privileges at the hospital.

Q. Does that mean you just don't use it as much?

A. Basically, yes.

Q. At any time, at any hospital, have you had your privileges revoked or suspended for any period of time?

A. No.

Q. Doctors sometimes get their privileges suspended for days because they -- late in doing their paperwork. Has that sort of thing ever happened to you?

A. No.

Q. We're done with that.

MR. BRENSKE: Mark that as next Plaintiffs' exhibit in order.

(Exhibit 3 marked.)

BY MR. BRENSKE:

Q. Dr. Rives, you have been provided with marked -- with what's been marked as Plaintiffs' Proposed Exhibit No. 3. It is entitled Answer to Complaint. This is a complaint by Vickie and Thomas Center that your lawyer answered for you. It was electronically filed on June 6 of 2016. Is this the

answer that you indicated that you have reviewed in this case?

A. Yes.

Q. This answer is not verified, in other words, it's not answered under oath. But I do want to ask you questions about it, if I may. If you could go to page 6 of your answer.

Now, I know you've had some experience in court, but I want to make it clear to you that when an answer is filed, lawyers provide I think what we call affirmative defenses, and they are pled in the answer at the beginning of the case. Some of them may be applicable, some of them may not be applicable. But as the defendant in this case, I need to ask you about some of these. Okay?

A. Sure.

Q. Now, the third affirmative defense says, "Plaintiffs failed to use ordinary care for the safety of their person." Do you see that?

A. Yes.

Q. Do you have any information yourself that would support that affirmative defense, that Tom and Vickie failed to use ordinary case for the safety of their person?

A. I am not aware of any, no.

Q. Then the fourth affirmative defense, it says in part that, "the negligence, misconduct and fault of plaintiffs exceeded that of these defendants."

Are you aware of any information that Tom or Vickie Center were negligent or performed any misconduct with regards to the allegations contained in this case?

A. Not to my knowledge.

Q. And I can only ask you to your knowledge, so that's a perfectly acceptable answer to me.

Now, the fifth affirmative defense is a little interesting, so I want to go over it with you carefully. The entire fifth affirmative defense says, "Plaintiffs are barred from asserting any causes of action against defendants because the alleged damages were the result of the intervening and/or superseding conduct of others."

Now, in English, that means to me that someone else caused these damages, not you. And that person's conduct intervened between your conduct. Do you follow me?

A. Yes.

Q. Okay. Do you have any information from

any source that you're aware of, that the damages were the result of the intervening or superseding conduct of others?

MR. DOYLE: I'll just -- if I can inject that that's not my understanding of that defense.

But you go ahead and based upon the question posed to you.

THE WITNESS: From my limited review of everything, I don't see anything that agrees with that.

BY MR. BRENSKE:

Q. Okay. Then the seventh affirmative defense, it states, "In all of the treatment provided to Plaintiff Vickie Center by defendants, she was fully informed of the risks inherent of such medical treatment and the risks inherent in her own failure to comply with medical instructions, and did voluntarily assume all attendant risks."

Do you see that?

A. Yes.

Q. Do you have any information from any source that Vickie Center failed to comply with medical instructions from you?

A. No.

Q. Now, we're going to the eleventh

affirmative defense. It says, "Plaintiffs claim damages have been suffered, but plaintiffs failed, neglected and refused to exercise efforts to mitigate said damages."

Do you have any information that you're aware of that Tom or Vickie failed, neglected or refused to exercise efforts to mitigate their damages?

A. I'm not aware of any.

Q. We're done with that one. Let's see if I can find it.

MR. BRENSKE: Ms. Court Reporter, can you mark this as the next exhibit in order.

(Exhibit 4 marked.)

BY MR. BRENSKE:

Q. Doctor, I'm showing you what's been marked for identification purposes as Plaintiffs' Proposed Exhibit No. 4. It is -- on the front page it is Bates stamped LSN 000001 through 86. It has on the top Barry J. Rives, MD, Laparoscopic Surgery of Nevada, 8285 West Arby Avenue, Suite 165, Las Vegas, Nevada. Do you see that before you, sir?

A. Yes, I do.

Q. And if you could look through this to see if this is a copy of your chart that's been

provided to our office.

A. Yes.

Q. By the way, Doctor, if there is some question that I ask you that later on in the deposition it reminds you of a more complete answer, please do so. Okay?

A. Sure.

Q. All right. Now, this chart starts with -- it looks like the patient information sheet. Is this something that is filled out by the patient on the top half and then -- well, stop that. What is this?

A. It's a demographic sheet filled out by the patient.

Q. Okay. And the second page, third page -- second page, third page are front and back of a license. The fourth page is Blue Cross Blue Shield. Fifth is the back page of Blue Cross Blue Shield. Page 6 -- when I say the pages, they are all Bates stamped pages on the bottom. I put everything in -- I'm just the exact opposite of a doctor, I put everything oldest first and newest last, as opposed to a chart that you want to see the most recent stuff. So that's why I do this.

Now, the Bates stamp page 8, this

is just -- this is an information sheet filled by the patient?

A. Correct.

Q. And page 7 would be that also?

A. Yes.

Q. Then page 8 is the consent for care, authorization for release of medical records, financial agreement, the record of disclosures and compliance of medical treatment. That would be a document that your office provides that has to be initialed by the patient?

A. And signed, correct.

Q. The next page is an authorization. It says, "I hereby authorize Jessica Lucero, primary fission -- primary physician, to get medical records." Do you know who Jessica Lucero is?

A. Supposedly the patient's primary physician.

Q. Do you remember who the physician was that referred Ms. Center to you?

A. I think it was Desha Frankel.

Q. And then the next thing is a two-page document. It's entitled Progress Note. The provider is Barry Rives, MD. It's dated January 22nd, 2005. And the last two numbers of the Bates

stamp are number ten. Are you at that page, Doctor?

A. Yes.

Q. Is this -- is this a document, this two-page document, something that you would prepare?

A. I prepare most of this, yes.

Q. Okay. You would have prepared it on January 22nd, 2015?

A. Correct.

Q. So you've got a chief complaint, it says referred by Dr. Frankel for a para -- say that for me again.

A. Paraesophageal.

Q. Paraesophageal hernia repair. So that was the complaint that she came to you with, that she had a paraesophageal hernia and you were to work her up to see if you could help repair that?

A. That is correct.

Q. All right. Now, it's got the history and physical. You talk about her being referred for a moderate to large-size hernia, what her problems were. And then it shows EGD showing antrum gastritis and large -- that word "hernia." What is an EEG -- what is an EGD?

A. Esophagogastroduodenoscopy.

Q. And that report is in here somewhere,

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is it not?
A. I believe it is.
Q. And we'll get to that. And then there is a HIDA with RX normal. What is that?
A. HI-SCAN is a radiology test that looks at the function of the gallbladder.
Q. And then UTZ?
A. Ultrasound.
Q. And a CT, would this be a CT of the abdomen?
A. Yes.
Q. And then a UGI -- excuse me. Could you help me understand what UGI means?
A. Upper GI study. It's a barium test where the patient swallows barium, they watch for the esophageal motility, and it clarifies the anatomy of the stomach as it relates to the chest and diagram. As well as whether it's obstructed or whether it's clear.
Q. All right. And the reason that you have the patient undergo the EGD -- the HIDA, the EGD, the CT, and the UGI is to get a picture of the patient's condition prior to surgery?
A. Correct.
Q. And then the next page. You show the

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vitals, you do a general examination, then you do an assessment, and then you do a plan. And I'm looking at the plan here. Looks like what you did is had to go through all these different tests and explain to her that she's a candidate for this type of surgery?
MR. DOYLE: Let me just belatedly object that it mischaracterizes the evidence.
MR. BRENSKE: I would be more than happy to correct anything that you think I mischaracterized.
MR. DOYLE: I believe most, if not all, of these tests were performed before the referral rather than him having ordered them.
BY MR. BRENSKE:
Q. Okay. But the tests -- just so that we're clear, so the jury understands. The tests that are listed in your chart, those tests' reports are in your chart?
A. I believe they are, yes.
Q. All right. And then we do the plan, I think it was under plan. And it shows that all this was done on the 22nd of January 2015. It states electronically signed by Barry Rives, MD, on 06-09-16 at 2:34 p.m. PDT, is that when we requested these records? Do you have any idea?
A. Yeah. When they get printed out.

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Q. Okay. So as a general rule when you chart in your own office, you don't sign the chart, you just --
A. Well, it's an electronic signature.
Q. Okay.
A. There is no written chart to actually sign. So when we print it out, it goes off as being signed at that time.
Q. Okay. The next thing I have is a telephone encounter. It says answered by Rives, Barry J. Does that mean that you actually spoke with someone?
A. Not necessarily. That just means I'm the provider for that patient.
Q. Then page 13, dated January 29, 2015. Although it says answered by Barry Rives, comma, Barry J., this may be something actually done by someone other than you? Although this looks pretty technical, so --
A. So it says action taken, and you'll see my name by that. So that's where I put in the sentence that follows. And that was a direction to Azaria, my medical assistant at the time.
Q. All right. So this -- I think I have this understood. This is what you're advising your

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people to get ready for?
A. Correct.
Q. Then the next thing I have is dated June 6 -- excuse me, June 11 of 2015. It says follow up on surgery. The history and physical states postop. I don't want to get into all that. It looks like the patient is somewhat better but tired? I don't want to put words in your mouth or overly condense it, just...
A. I say, "Still quite fatigued and tires easily."
Q. Then under surgical history you talk about Vickie's past history of a bladder sling in 2009. Bilateral carpal tunnel in 2010 and '11. Hysterectomy and no sequela or anesthesia in January 2013. Then a paraesophageal hernia repair with repeat -- what does DX scope mean?
A. Diagnostic laparoscopy.
Q. As well as perforation of the gastric ulcer. Then it says hospitalization, major diagnostic procedure. You say the hernia repair with a postop sepsis -- excuse me -- sepsis 2015. February 2015. And your thought process at the time was the sepsis was a lung infection due to aspiration?

A. At the time of this office visit? Yeah.

Q. Okay. Has that changed?

A. No.

Q. I'm going to go to page 19 of the document. It's the lab report. Labs. This is something that you would request that the patient get prior to undergoing the hernia repair surgery. Is that a fair statement?

A. I either would have requested it or that some other doctor had already done the labs for me, yes.

Q. Was there anything contained in this document that was concerning to you with regards to going forward with your surgical procedure?

A. No.

Q. Then on page 22 to 23, this is an upper endoscopy report done November 5th, 2014. And this -- just tell the jury what an upper endoscopy report -- no. What does an upper endoscopy do?

A. The gastroenterologist takes a gastroscope, places it through the oropharynx while the patient is under modern anesthetic care to evaluate the oropharynx, the esophagus, the stomach, as well as the duodenum.

Q. All right. And this is report is to provided to you to help you understand the situation?

A. That is correct.

Q. So the -- it says the esophagus was examined and no abnormalities were being seen; correct? Under findings?

A. Yes.

Q. And then the stomach was examined and no abnormalities were seen?

A. Correct.

Q. And then -- give me that word, duo --

A. Duodenum.

Q. The duodenum was examined and no abnormalities were seen, but there was a large hiatal hernia and mild erosive gastritis; correct?

A. In the antrum, yes.

Q. Where is the antrum?

A. The body of the stomach.

Q. So what this would tell you is that she's a candidate for the hernia surgery?

A. It's one of the factors that go into it, yes.

Q. Then you were given the report, the gallbladder ultrasound?

A. Yes.

Q. That was dated in September of 2014. And the gallbladder ultrasound indicated to you that she had a normal gallbladder. No evidence of gallstones or sludge?

A. Correct.

Q. Then there was CT abdomen of the pelvis without contrast dated May 24. This is in April of 2014, about ten months before the surgery. What's the purpose of doing the CT abdomen/pelvis without contrast?

A. I didn't order the test. It was ordered by Dr. Torres. So I'm not sure what his indication for ordering the test was.

Q. What did this test tell you about Vickie's condition?

A. It didn't really contribute much to my thought process.

Q. Then the next page, 25, it's an upper GI that was done December of 2014. This is something you had ordered or was it ordered previous to the patient seeing you?

A. It was ordered by Dr. Frankel.

Q. What did this report, if anything, tell you about Vickie Center's condition in regards to

you operating on her in February of 2015?

A. The no demonstration of gastroesophageal reflux disease was one of the considerations. That's it.

Q. Okay. There is another -- excuse me -- report that's in your chart. I think this is a HIDA scan, but they call it A&M radionuclide hepatobiliary scan with Ensure Plus?

A. Correct.

Q. Okay. What did this report tell you with regards to Vickie's condition?

A. That her pain and symptoms were not related to her gallbladder.

Q. Then the next page, pages I'm looking at are simply four pages of records from January 15 of 2015 from Dr. Frankel. These are not your records, obviously, but they are part of your chart. Fair statement?

A. Correct.

Q. And on the fourth page where it says 32, synopsis, Dr. Rives, general surgeon, consultation for consideration for hiatal hernia repair either electrically or chest pain or dysphagia if worsen in the future. Do you see that?

A. Yes.

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Q. Dysphagia is difficulty swallowing?
A. Yes.
Q. Okay. So this document basically is Dr. Frankel recommending Ms. Center see you?
A. Rephrase that.
Q. Sure. This document is a recommendation of Dr. Frankel to see you?
A. Yes.
Q. Then the next page, 33, there is several things on here. This is where Jessica Lucero shows up in your records. And the -- there is a statement, "Patient is low risk for cardiac and pulmonary complications related to the surgery." Do you see that?
A. Yes.
Q. Now, is that something that was provided to you by Ms. Lucero?
A. By the -- by their office, yes.
Q. By their office. All right. Then you've got more labs. Anything in these labs give you cause?
A. No.
Q. Excuse me. Then I've got page 36. Take a wild guess and say this is some sort of cardiac thing to show that her heart is working.

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Okay?
A. Basically, yes.
Q. Okay. That was a shot. I wasn't sure of that.
All right. And then the next page that's signed by you, what is this document?
A. This is the patient's preoperative orders.
Q. And what are the preoperative orders with regards to this patient made by you?
A. They include the diagnosis, the consent, the patient's information, the antibiotics to give preoperatively. That sequential compression devices are to be placed on the patient in the operating room.
Q. Now, it's got your signature and then something to the right. Can you tell me what that is?
A. That is my signature to the right. It's signed Barry J. Rives. Below it says Rives 10642, which is my Nevada medical license number, the date and time.
Q. Thank you. The next thing I have in your chart is a September 8, 2014, XR unilateral ribs with PA chest. Just says --

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MR. DOYLE: I'm sorry. What page?
MR. BRENSKE: Page 39. Just trying to help you fall asleep.
MR. DOYLE: It's working.
MR. BRENSKE: It is. I thought it would.
BY MR. BRENSKE:
Q. So I'm looking at page 39, and it's the -- it's -- it looks like -- well, what is an x-ray of the unilateral ribs?
A. It's a -- well, this is actually ribs with a PA chest. So it looks like it's a plain film x-ray taken either for rib pain, seeing if there is a fracture of the ribs, as well as a view of the chest.
Q. Okay. This is just something that is part of your chart or did you order it?
A. No. Lucero ordered it. So it came from their records.
Q. Now, the next document I've got is a faxed document dated February 7th of 2015 at 1:14 p.m. -- a.m. I don't know if that's correct or not. And it's from St. Rose Dominican-San Martin to you. And then the next three pages are your operative report of February 6, 2015. Do you see that?
A. Yes.

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Q. So is that standard procedure when you do a surgery at St. Rose Dominican, they fax you your operative report?
A. They fax me my operative reports and my consultation reports, yes.
Q. Okay. Is that automatic?
A. Yes.
Q. Okay.
MR. BRENSKE: Now, we're going to take about a five-minute break, if that's all right with everybody, because I want to go over this operative report. And in order for me to understand what you're doing, I've got pictures that might help me figure out what you're doing. So you're going to have to give me five minutes.
THE VIDEOGRAPHER: We are off the record at 11:58 a.m.
(Off the record.)
THE VIDEOGRAPHER: We're back on the record at 12:09 p.m.
BY MR. BRENSKE:
Q. I always jump the gun.
All right. Doctor, you're looking in your chart and we're at the surgical procedure you performed on Vickie Center on February 6 of

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2015. That surgical procedure, the periesopha -- the hernia repair, how does that -- how long would you expect that operation to take?

A. It takes me anywhere from an hour and a half to well over two and a half hours sometimes.

Q. Do you recall any specific difficulty you may have had with this surgical procedure?

A. Off the top of my head, no.

Q. With regards to the surgical procedure of February 6 of 2015, when would you have expected Ms. Center to be released from the hospital?

A. While I was performing the surgery or afterwards or preoperatively?

Q. The surgical procedure that you performed on Vickie Center, the surgical procedure itself was February 6 of 2015. So I'm going to assume that's when she went to the hospital?

A. Correct.

Q. Okay. And what day would you have expected her to leave the hospital?

A. When I completed the surgery, she was to be admitted overnight. My expectation she would go home the next day.

Q. Do you remember when Ms. Center actually left the hospital?

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A. I don't recall the exact date, no.

Q. When Ms. Center left the hospital, did she go home or did you refer her to any rehabilitation hospital?

A. I believe the hospitalist would have referred her to a rehabilitation center.

Q. With regards to Ms. Center, were you the admitting physician?

A. No.

Q. Who was the admitting physician?

A. Dr. Siddiqui was.

Q. While Mrs. Center was in the hospital, were you her primary care physician?

A. No. I was not.

Q. Who was her primary care physician?

A. It's not a correct term to really use primary care physician. There is a hospitalist who is the admitting physician who will oversee the care of the patient, and then everybody else is considered a consultant to the case.

Q. So you would have been -- while -- while Ms. Center was in the hospital at St. Rose Dominican-San Martin Campus, you would have been considered one of the consultants?

A. Correct.

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Q. And the hospitalist would have been the person in charge. Is that a fair statement?

MR. DOYLE: Object. The question is vague. But go ahead.

MS. DAEHNKE: Join.

THE WITNESS: Okay.

BY MR. BRENSKE:

Q. Just ignore them and answer me.

A. Okay. Sorry.

Q. That's all right.

A. Basically, yes.

Q. All right. So let's go through this sort of procedure. Now, I've got some pictures here. We don't have to mark them as exhibits, I'm not going to use them at trial. I'm -- this is for my own edification, so I'm not going to take this and say, hey, you marked on this in your deposition and you marked over here in your trial. Just so Mr. Doyle has an understanding of what I want to do here. This is to educate me.

MR. DOYLE: But if he's -- if you're going to ask him to write on them or mark them, then I would want to make them exhibits.

MR. BRENSKE: Then we can.

MR. DOYLE: Okay.

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MR. BRENSKE: That's not a problem whatsoever. Next in order.

(Exhibit 5 marked.)

BY MR. BRENSKE:

Q. Dr. Rives, I'm showing you what's been marked for identification purposes as Plaintiffs' Proposed Exhibit No. 5, I believe. It's simply an anatomical drawing that I took to give me a simple understanding of the structures that are in the general area of your surgical procedure. How did I do?

A. Fair.

Q. Fair. All right. I'm sure there is a lot more going on there, but only so much I can handle. So obviously this shows the esophagus, it shows the liver that overlies the stomach and the top of the stomach; correct?

A. From this point of view, yes.

Q. And when you performed your surgical procedure, the patient's in the supine position or on her back?

A. Correct.

Q. So you're going from -- you're going from the front in?

A. Yes.

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Q. The anterior right there. Now, what is the purpose of a laparoscopic Nissen fundoplication surgery?

A. There's a couple goals to the surgery when you repair somebody's hiatal hernia, diaphragmatic hernia. The first is to get the stomach or other -- out of the hernia, which is basically inside the patient's chest, bring it back down inside the abdomen where it belongs. Then you close the diaphragmatic hernia repair so that it won't slide up there again.

And then the fundoplication part is where you wrap the stomach around itself to support reflux if it happens after diaphragmatic repair. It also holds the esophagus partially within the abdomen, keeping it from falling back up into the chest.

Q. What is the definition of hernia that I could understand?

A. Hernia is a hole in the abdominal wall.

Q. When you say hole, that means there is a frank hole in the -- or is there a weakness?

A. In the case of the diaphragm, there is already an existing hole called the hiatus. And as that expands and gets larger, it becomes a hernia

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hole. If it happens anywhere in your abdominal wall, it's actually a hole or tear of the abdominal wall, whereas a weakness would be considered a diastasis.

Q. All right. In Vickie Center's case, what was her condition when you went in to look at her?

A. She had a significant size diaphragmatic hernia, with about a third to half of her stomach up in her chest.

Q. And your job was to do what?

A. Get the stomach out of the hernia, reduce the hernia sac, close the diaphragmatic hernia repair, and then perform a Nissen fundoplication.

Q. Okay. So let's start with your -- so looking at Exhibit 5, what area of the body are you dealing with? With what structures?

A. This is a poor representation to explain where we are operating.

Q. Okay.

MR. BRENSKE: Let's mark this as 6 and maybe we'll get better.

(Exhibit 6 marked.)

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BY MR. BRENSKE:

Q. Now, six is just a diagram that says Laparoscopic Nissen Fundoplication Surgery, using laparoscopic instruments. Fair statement?

A. Correct.

Q. All right. Now, getting back to Exhibit 5, what structures are you either retracting, moving, up against when you performed the surgery that you performed on Vickie Center?

A. We have to retract the left lobe of the liver. We then are operating on the stomach. Which is attached to the spleen by short gastrics. And then operating through the hiatus of the diaphragm, where there is the esophagus, the vagal nerves, the heart, and both lobes or both sides of the lung. The aorta and IVC are also within that area.

Q. What does IVC mean?

A. Inferior vena cava.

Q. Got it. On Exhibit 5 can you see the left lobe of the liver?

A. Yes.

Q. And can you see the stomach?

A. Yes.

Q. What other structures that you just discussed can you see on Exhibit 5?

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A. The esophagus, that's it.

Q. Okay. Just circle them for me so I have something.

What instruments do you use in this type of surgery?

A. We access the abdomen, via a Veress needle to cause insufflation of the abdomen. We then use trocars, which are sleeves, for lack of a better word, to pass instruments in and out of the abdomen. We use a liver retractor to move the left lobe of the liver out of the way of dissection. Then we use various instrumentations to grasp and handle the organs.

Q. What instrumentations are those?

A. There is a variety of grasping instruments. They're all laparoscopic. Then we'll use a coagulation device to control bleeding.

Q. Modern science. All right. So a coagulation device, what is -- is that -- is that a heated device?

A. In this case I was using a harmonic scalpel, which works on an ultrasonic vibratory wave to control bleeding.

Q. But the harmonic scalpel is to cut things away?

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A. It's effectively to burn and cut things away, yes.

Q. All right. So let's go to your operative report. And we're just going to have to go through it, but you're going to have to explain it in laymen's terms as to what you're doing and what devices you're doing, okay? Can you do that for me?

A. Sure.

Q. All right. So it says you've got the informed consent -- oh, in this surgical procedure who did you have, if anyone, to assist you?

A. There is a scrub tech that's helping me with the procedure. There was no other surgeons involved in the case.

Q. All right. So if anybody is using a trocar or a harmonic scalpel, that's going to be you?

A. I'm the only one manipulating tissue, yes.

Q. All right. Much better answer than the question.

All right. So let's go through this. You begin with a small incision in the left upper quadrant, inserting a Veress needle. So the

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small incision in the left upper quadrant is used -- are you using a -- what device are you using? Using a scalpel?

A. Scalpel.

Q. All right. And then what's a Veress needle?

A. It's a little needle that has a pressure point such that as you press down, the needle is, in effect, going through the abdomen wall. When it reaches a negative pressure, it automatically retracts. We then hook up the insufflation to the Veress needle and we insufflate the abdomen.

Q. In laymen's terms, you take a needle, you puncture the abdomen, you fill it full of air?

MR. DOYLE: Let me just object. It mischaracterizes the testimony.

Go ahead.

THE WITNESS: CO2.

BY MR. BRENSKE:

Q. CO2. All right. So you balloon up the -- you balloon up the abdomen?

A. Basically, yes.

Q. All right. What is the next thing you do?

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A. Place a five-millimeter trocar into the abdomen and then visualize the anatomy.

Q. Okay. And the trocar is a sleeve. It allows you to pass instruments through to look at the anatomy?

A. Correct.

Q. And that's what you did in this case?

A. Yes.

Q. And then visualization. Now, this visualization is done how?

A. With a videoscope.

Q. All right. So you've got a videoscope, you go in there and you look at the abdomen. And that's where you saw the incarcerated paraesophageal hernia?

A. Correct.

Q. What did you do next?

A. I noticed that there were no adhesions in the abdomen.

Q. What does that mean in regular folks' terms?

A. That there was no scar tissue in the way of the surgery.

Q. That's a good thing?

A. It is.

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Q. All right.

A. Then I placed another five-millimeter trocar in the right subxiphoid area to use as a working board for the liver retractor.

Q. Okay. Can you in any way, shape or form give us an idea on either Exhibit 5 or Exhibit 6 what we're talking about?

A. On Exhibit 6 it would be this trocar site here.

Q. What's that called?

A. Subxiphoid, right side.

Q. If you could just write -- you should write whatever word was in your operative report. When I'm looking at that, can look at that and know what's going on. And keep that handy.

Okay. Is there any way to show on Exhibit 5 the general area that...

A. (Witness indicates.)

Q. All right. So we did the right subxiphoid area; correct?

A. Correct.

Q. All right. What did you do next?

A. The liver was -- liver retractor was placed in the abdomen, placed under the left lobe of the liver, retracting it superiorly and medially.

Meaning upwards and towards the midline.

Q. So explain to the jury what a retractor is.

A. It's a thin, blunt metal instrument that you twist on the end, and it will go from a straight piece of metal to a triangular formation such that you can hold a retract — hold the liver up and out of the way of the dissecting area. It's an atraumatic device.

Q. So you're making a space? You're moving the liver out of the way?

A. That's a better way of saying it, yes.

Q. All right. Then what did you do? I think you took a ten-millimeter trocar?

A. Yeah. And at that point I placed the ten-millimeter trocar, again under direct visualization, atraumatically just above the belly button. That was going to be my main camera view. And then I placed another five-millimeter trocar, again under direct visualization, in the subcostal region on the left side for another working port.

Q. All right. So on Exhibit 5 you've shown -- if you could show where those are on five, that would be great?

A. Six would probably be easier.

Q. I'm not going to tell you no.

A. (Witness indicates.)

Q. Okay. And is there any way you can help me on five?

A. (Witness indicates.)

Q. All right. That would be the placement of all the trocars?

A. Up to that point, yes.

Q. Okay. You indicate that -- well, let's see, what is the next point? I don't want to get lost here. What did you do next?

A. After the trocar is replaced, then — and the liver retractor is in place, I can visually inspect the stomach to see the anatomy, how much of the stomach is up into the chest and if there is going to be any problems with the dissection.

Q. Okay. Do you see any -- when you visualized the stomach, what did you see?

A. It was not twisted.

Q. That's a good thing?

A. Yes. There was no volvulus.

Q. And what is that?

A. A volvulus is where the stomach twists upon itself causing an obstruction, or it can twist on itself causing compromise to its blood flow and

causing a strangulation.

Q. So volvulus is bad?

A. Yes.

Q. No volvulus is good?

A. Yes.

Q. Okay. When you say it was incarcerated, I think you explained that. But just do that one more time.

A. Incarcerated is when an organ goes up into a hernia and is attached to the underlying sac. In this case when I'm pulling, tugging on the stomach, sometimes it will reduce fairly easily, meaning it would be a reducible diaphragmatic hernia. Or in this case it's pulled back up because it's tethered to the sac, in which case it would be called incarcerated.

Q. So this one was incarcerated?

A. Correct.

Q. All right. So what did you do next?

A. The next part was to start mobilizing the stomach so that we can reduce it out of the chest. I started by taking down the short gastrics where the stomach is, in effect, tethered by the spleen. That allows me access to the greater curvature of the stomach. The left side of the

diaphragm and the left crus of the diaphragm.

Q. When you say taking down, what's the -- what are you actually doing in laymen's terms?

A. I'm cauterizing and cutting those arteries.

Q. And those are attached to what, those arteries?

A. To the greater curvature of the stomach and towards the spleen.

Q. Okay. So when you're done cutting or taking down the short gastrics, what do you do next?

A. After I was able to see the left crus of the diaphragm, now I could dissect the hernia sac away from the left crus of the diagram, in effect, releasing the stomach. And I carried that posteriorly, in other words, behind the esophagus and behind the stomach; and then anteriorly, on top of the stomach and the esophagus.

Q. All right. And that's all used with a harmonic scalpel?

A. Correct.

Q. What did you do next?

A. Once that was reduced and sat fairly easy in the abdomen, I then had to work on the other side of the stomach, also known as the lesser

curvature.

Q. And what did you do with regards to that part of the stomach?

A. Released the adhesions and hernia sac on the right side of the stomach until I could see the right crus of the diaphragm.

Q. That would have been done with the harmonic scalpel?

A. Mostly, yes.

Q. What other instruments would you normally use to do that?

A. I could use scissors or sometimes bluntly they'll dissect out.

Q. Okay. In this particular operative report, can you tell what you did?

A. Well, I don't dictate every last little move that I make. So if I use a blunt instrument for two little moves, I wouldn't necessarily dictate that. So I don't have an instant recollection of how many times I used the scissors or I used a blunt instrument.

Q. Okay. So you would normally use a harmonic scalpel, a blunt instrument, and scissors?

A. Yes.

Q. Okay. Please tell us what you did

next.

A. Right crus was then dissected away from the hernia sac and from the esophagus. At that point we cleaned up the right side and now I have to create a posterior window behind the esophagus, A, to make sure that it's clear from the hernia sac and that it won't pull back into the chest. This is also going to be the window I use to bring the stomach from one side of the abdomen to the other to create my Nissen fundoplication.

Q. All right. What is a crus?

A. The crus are where the leaf of the diaphragm come together in this hiatus. They are basically musculature. There is no real cartilage to them. There is no real structural support to them. They are thicker than the rest of the diagram, but they are basically muscle.

Q. Okay. So what did you do next?

A. We then -- or I then start to dissect the remaining hernia sac out of the mediastinum. So that way the esophagus would be free and that way I can keep part of the esophagus in the abdominal cavity, rather than having it pulling back up into the chest.

Q. And that dissection would be done using

either a harmonic scalpel, scissors or a blunt instrument?

A. Correct.

Q. What did you do next? This is easy for me. I just say what did you do next and you've got to tell me.

A. By the time -- at that point I had two to three centimeters of esophagus that was stained within the abdomen, the hernia sac was reduced. The stomach wasn't falling into the hernia, so we effectively had everything reduced. There was no incarceration anymore. I then placed a Penrose drain around the esophagus and retracted it laterally.

Q. What is the purpose of the Penrose drain?

A. The Penrose drain is a way to manipulate the esophagus so that the esophagus doesn't tear and cause a perforation.

Q. What did you do next?

A. With everything reduced, the object now was to close the diaphragmatic fundo repair. And I did that with figure-eight stitches of 2-0 Vicryl suture. Approximately four were placed.

Q. Where exactly were they placed?

A. You're closing the left crus of the diaphragm to the right crus of the diaphragm. Basically you're tightening up the hiatus of the diaphragm.

Q. What did you do next?

A. I made sure that there was adequate mobilization of the esophagus so that my closure didn't create any tension. It didn't require any mesh implantation. And then I went on to do the Nissen fundoplication.

Q. And just in general terms, what is a Nissen fundoplication?

A. Nissen fundoplication is where you take the greater curvature of the stomach. You wrap it around to the anterior part of the stomach, creating fundoplication or taco or whatever term you want to use, wrapping the stomach.

Q. If you look at Exhibit 6, is that an example?

A. Yes, it is.

Q. What did you do next?

A. Secured the fundoplication.

Q. How do you do that?

A. In this case I used the 2-0 Vicryl suture on the initial closure to attach it briefly

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to the esophagus. And then I used Ethibond sutures above and below that, that are stomach to stomach.

Q. All right. I don't want to oversimplify, but you stitched it together?

A. Yes.

Q. That's pretty much you're done? What did you do next?

A. No.

Q. No?

A. You have to assess whether the wrap is too tight. I put an instrumentation underneath there to make sure that the wrap is what we kind of call floppy. In the old days they were always too tight and caused esophageal problems for patients. We've since learned that that's a big thing to avoid. So we make sure that we do what's called a floppy closure. And then at that point, revaluate the crura to make sure that the closure I did was still intact. I inspected the liver to make sure there is no injure to the liver. There was no capsular tears. I then watch the retractor be removed safely. I visualized the short gastrics to make sure there was no bleeding in that area. And then there's no bleed from the stomach or the spleen.

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At that point we opened up the trocar to let all the CO2 that we can out of the abdomen, and we removed the trocars and close the incisions. The larger trocars have to be closed at the fascial level because they have a risk of herniation. The five millimeters do not. Then we use local injection for pain control and suture the skin closed. At that point they put on sterile dry dressings. The patient is extubated and transferred to the recovery.

Q. If at any time you had caused an injury to the abdomen or any other structures that you're working in, it would have been your responsibility to repair those structures. Fair statement?

A. That is correct.

Q. In this particular surgery you did not see any injuries to any of the structures, therefore you did not have to make any repairs of any. Fair statement?

A. That is correct.

Q. Going to -- we're just continuing on in your chart. And I'm looking at page 45 and 46, a 2D echo with Doppler. Can you tell us what that is?

A. This is an echo exam of the heart.

Q. All right. Did you order -- this shows that referring physician is Dr. Siddiqui. That would be the hospitalist?

A. That's correct.

Q. Okay. Prior to the 2D echo with Doppler, did you have any discussions with Dr. Siddiqui concerning the need for this test?

A. No.

Q. What is your understanding of the purpose for this test?

A. At this time when she was going into sepsis, one of the differential diagnosis between Dr. Siddiqui, intensivists, and other consultants would be whether she was having a cardiogenic episode that would be causing her signs and symptoms. One of the ways to rule that out would be to do a 2D echo to look at the ejection fraction of the heart, to look at the wall motion of the heart, and to hopefully access the valves of the heart.

Q. What did this test result tell you about the heart?

A. Well, I don't interpret these, so...

Q. All right. And I apologize, I didn't -- you don't read those -- you don't -- I apologize. When you say you don't interpret these, does that mean you don't look at the document itself or you don't look at the report? What don't you do?

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A. If I have an echo come to me in a preoperative setting from a cardiologist, I will scan it to look for anything grossly abnormal that may catch my eye. In the context of when this was performed, the intensivist and Dr. Siddiqui would have been responsible for this. This comes to my office back from the hospital subsequent to how things were proceeding.

Q. All right. So you would not be made aware of the results at the time the results came in?

A. Only if one of the hospitalists or intensivists brought it to my attention.

Q. Okay. As part of your practice, do you look at the reports themselves?

A. Sometimes, yes.

Q. Are you able as a doctor to look at a report and -- strike that.

What does this report tell you?

A. The report says the patient had an elevated heart rate during the study. It says that the ventricular systolic function appears to be normal, between 50 and 55. The remaining heart appears to be normal in terms of its atrial size,

it's aortic root diameter, mitral valve function, right ventricular function. There is no clot in the heart. And there is no effusion or fluid around the heart. There is a pericardium around the heart, and sometimes if there is a fluid there it will crush the heart, causing blood pressure changes.

Q. When, if ever, were you aware that this procedure was going to be done on your patient?

A. I was vaguely aware of that happening on Saturday night.

Q. Was that post --

A. Postop.

Q. Postop one day?

A. Postop day one.

Q. All right. And page 2 shows a CC to you, but you don't know when it was CC'd to you? I mean, there is a -- there is a fax. The first page says 02-09 at 3:14 a.m. and it just says CC to you -- let me rephrase my question.

It would have gotten to your chart, assuming the fax is correct, the morning of the 9th?

A. It looks like it was performed on the 7th, the note was dictated on the 8th. It was transcribed on the 9th. And the best interpretation

I would have is that it would have gotten to me sometime thereafter.

Q. All right. So if you look in your chart --

A. I would say on the 9th, based upon the --

Q. The fax?

A. -- cover sheet.

Q. Okay. All right. The next thing I have that's in your chart is a fax from the hospital to you dated the 9th at 12:49 a.m. It's four pages. It says the referring physician is Barry Rives, MD, the referring doctor is Dr. Siddiqui, and the consultation is for sepsis. Sepsis. Do you know who -- or are you familiar with Dr. Herbert Cordero-Yordan?

A. Yes.

Q. What is your understanding as to why Dr. Yordan saw your patient?

A. He was the cardiology specialist consulted on her case when she went into sepsis.

Q. When you reviewed his report dated the 8th of February -- strike that.

I'm assuming that you would have gotten this on the 9th, based upon the fax to your

office dated the 9th?

A. I assume that, yes.

Q. Okay. Now, you -- did you have an opportunity to read this report on the 9th?

A. I probably actually read this report in the hospital EMR before I ever read my office chart.

Q. Okay. Would that be the same as the Doppler document?

A. In the hospital I probably didn't review the Doppler, the TD-echo.

Q. But you would have been in the hospital -- strike that.

Your best recollection is you would have reviewed Dr. Yordan's consult at the hospital prior to this document getting to your office?

A. Most likely, yes.

Q. Okay. What did this document tell you, other than she has sepsis?

A. That Dr. Cordero felt she was in DIC, which is disseminated intravascular coagulopathy, that she had renal failure or that her kidneys were failing, and she had respiratory failure. Cultures were pending, but she was being treated with broad-spectrum and IV antibiotics. And he notes

that the 2D echo shows preserved left ventricular systolic function.

Q. And in regular folks' terms, what does that mean?

A. It appears that she's not having a heart attack.

Q. When the patient coded, were you in the hospital at the time?

A. I don't remember.

Q. All right. So let's go to the next part of your chart. And it's the fax of 02-18, 8:20 a.m., it's to you from St. Rose. It's four pages and it includes your three-page operative report. Do you have that in front of you, sir?

A. Yes.

Q. All right. So we're now -- this operative report indicates that you took Ms. Center back to surgery on the 17th of February; correct?

A. Correct.

Q. Okay. So the original surgery happened on 02-06, you took her back on 02-17. Just taking all the time you wish, could you explain to the jury why you waited 11 days to take her back to surgery?

MR. DOYLE: I'll object. It's argumentive. But go ahead.

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THE WITNESS: After her initial septic shock episode, she was recovering and doing well. She had one episode where she threw up some material. So a nasogastric tube was placed by a radiologist. She continued to improve. We started to place her on two feeds. And in a 24 or 48-hour period, she all of a sudden began to deteriorate with a significant change in status. I ordered a CT scan which showed some fluid and air that was not on the previous CAT scan on the 9th, I believe. So at that point I was concerned that she had a perforation. I ordered an upper GI study which confirmed there was a perforation of the stomach. I spoke to her and the family and recommended surgery.

Q. So let's go over the surgical procedure, if we could.

MR. BRENSKE: I need to take another five-minute break. Sorry.

THE VIDEOGRAPHER: Okay. We are off the record at 12:54 p.m.

(Short break.)

THE VIDEOGRAPHER: We are back on the record at 1:06 p.m.

BY MR. BRENSKE:

Q. Doctor, just before we took a break,

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you mentioned that the -- I think you had a CT done shortly postop that you believe did not show any abnormalities?

A. Which CT are you referring to?

Q. The first one.

A. The first one on postoperative day 2 showed findings consistent with postoperative changes.

Q. And the CT, did you review the actual CT itself or just a report?

A. I do not recall.

Q. So you may have looked at the CT itself, you may not have. You may have looked at the report, you may not have, but you would have looked at one of them?

A. I definitely looked at all the reports for the CAT scans. Sometimes I review the films either on the PAC system, or sometimes I'll review them with the radiologist if I have a question about the anatomy or whatever is going on with the patient, or sometimes the report is clear enough and I don't need to.

Q. Well, I would assume this is a pretty rare event that you would perform the hernia surgery and the patient is sepsis postop day 1?

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MR. DOYLE: Well, hold on. It's argumentive. But go ahead.

THE WITNESS: Yes.

BY MR. BRENSKE:

Q. How many hernia surgeries have you performed?

A. Diaphragmatic hernias or all hernias?

Q. Let's go with all.

A. Well over 500.

Q. Of those well over 500 hernia surgeries you performed, how many of your patients have gone -- had sepsis postop day 1, other than Vickie Center?

A. I can't recall any that come to mind.

Q. I understand that there may be something. But as you sit here today, you don't remember one. Fair statement?

A. That's fair.

Q. All right. So I would also assume that if your patient gets sepsis postop day 1, you're looking for answers?

A. That's correct.

Q. And in this case it's your understanding, at least at the time you were treating the patient, that her sepsis was caused by

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-- I want to say aspiration pneumonia, but that is probably not the right term. What is the right term?

A. They use both terms, but the actual correct term is aspiration pneumonitis. It's an inflammation of the lungs.

Q. But this -- this infection becomes systemic and causes organ shutdown?

A. It doesn't have to be an infection of the lungs. It's an inflammation of the lungs. You can have inflammation of the organ without it being grossly affected.

Q. But if you have an inflammation of the lung, is that going to create sepsis?

A. Yes, it can.

Q. Is it -- was it your understanding at the time this was going on that the patient Vickie Center was having inflammation of the lung -- lung, which caused her sepsis and ultimate coding? Coding is c-o-d-i-n-g.

A. That was what myself, the other consultants, the ICU intensivists all were working on.

Q. Did it come to mind to you at any time the first ten days postop that you may have cut

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something, burned something, caused some injury during your surgical procedure that resulted in the sepsis?

A. Anytime a patient has an unexpected complication after surgery, my job is to make sure that it's not related to the surgery.

Q. Had the CT of the abdomen -- strike that.

You went back in to surgery because there was a CT of the abdomen that showed abnormality?

A. Not entirely. The upper GI was the definitive study, plus the patient's clinical condition that made a surgery a secondary time necessary.

Q. When would you have ordered a CT of the abdomen on this patient given her condition one day postop?

A. When the patient is transferred to the IDU, the ICU intensivist becomes the attending physician, and they will tend to order almost all radiology tests and evaluations. If I feel a test is indicated that they haven't done, then that would be a case where I would order the test. I don't recall whether I ordered the CT scan for

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postoperative day 2 or whether the intensivist had already ordered it.

Q. I do not want to put words in your mouth. What you're telling me is the ICU intensivist is the person that orders testing. If it is your patient that is sent to the ICU and you're reviewing the chart, if you see a test that should be done, you can order it.

A. That's correct.

Q. All right. I think -- all right. So now we're at -- on your chart concerning your second surgery of Ms. Rivers [sic] on the 17th of February, beginning on page 52 and ending on page 54. Are you there?

A. Yes.

Q. I think we haven't really discussed this yet. It shows that the preoperative diagnosis is gastric perforation, and that's -- is that a fancy way to say there is a hole in the stomach?

A. Yes.

Q. Okay. And what operation -- you did a diagnostic laparoscopy. That means you went in and looked around?

A. That is correct.

Q. Okay. And then you say "with revision

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of the Nissen fundoplication and closure of gastrostomy." Gastrotomy is a -- is that a fancy way of saying there's a hole in the stomach?

A. Yes. Closure of gastrostomy times two.

Q. Okay. So why don't you tell me what the findings -- so tell me what your findings are. I can read what this says, but maybe you can explain it in more simple terms that I can understand.

A. So with the stomach wrapped upon itself, the NG tube could slide up inside the wrap causing it to be obstructed. In this case, when we took her to the OR and we had the NG tube hooked up to suction, they -- let's see. About three and a half to four liters of gastric contents was aspirated. At that point I had a concern that if you damage the vagal nerves during the surgery, you get what is called gastric outlet obstruction. So I went out and spoke with the family to make sure they are aware that this may be a possibility and would change the way that the surgery went.

As I got in there, the first thing I did was clean out the area of concern of any debris, any scar tissue, so that I could adequately evaluate the anatomy. At that point I can see that the duodenum and the distal end of the stomach was

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intact. There was no perforation. It did not look like she had gastric outlet obstruction. As I looked at the Nissen wrap, I could see that it was twisted, anatomically being pushed by the NG tube. And there was no way to assess that without taking those three sutures out that I placed prior. And as I did that, one of the sutures was deep. And the only way to get it was by making an actual hole in that part of the stomach to release it. And then as the stomach flopped back into its normal anatomical position, I could see that the NG tube was coiled up towards an area where there was about a one-and-a-half-inch defect or hole in the stomach.

Q. Okay. First you just kind of -- you took between three and a half and four liters of gastric contents that was out of the stomach?

A. Correct.

Q. Or was it -- so that was contained in the stomach itself?

A. Correct.

Q. Okay. And when you -- when you released the NG tube from the -- let's take a look at six. So I'm looking at -- and you can help me with it, I hope. So I'm looking at the -- I'm just going to call it the Nissen, okay? Sounds like a

car and I don't mean to do that.

But we're looking at the Nissen, and the NG tube is somehow wrapped around this Nissen so that you've got to remove -- you separate those parts of the stomach. Am I right?

A. Correct.

Q. Okay. And when you separated those parts of the stomach, you found an inch-and-a-half hole in the stomach?

A. Correct. And there was a hole that I created by taking out the suture as well.

Q. Right. So you found an inch-and-a-half hole in the stomach and you had to make a hole in the stomach to get the suture out. And you repaired that?

A. Two different holes.

Q. So you repaired the two different holes. There is a lot of words here and I'm trying to get us out within a couple of days.

Once you separated the Nissen and you fixed the inch-and-a-half hole in the stomach and you repaired the hole that you created in order to undo the Nissen, did you do any other repairs? Take your time and look at it.

A. So after repairing the two holes in the

stomach, we continued with installation -- or installation of methylene blue into the stomach under pressure. Not too much pressure. That way we can see if there is an active leak from anywhere in the stomach.

Also, I was able to evaluate that, given the little bit of time that the stomach was spontaneously draining into the duodenum, and I wasn't concerned for a gastric outlet obstruction like I was preoperatively after the NG tube had such high output. I evaluated the remaining structures in the area. I cleaned out any other debris or possible abscess cavity areas. I inspected the rest of the hollow viscus or large bowel and small bowel for any other possible sites of perforation. And then closed up the incisions after removing the CO2.

Q. Did -- was -- was a CT of the abdomen with contrast done at any time prior to your second surgery?

A. Depends what you mean by contrast. Either IV or oral. There were two CTs done, as we mentioned prior. One was on postoperative day 2. And there was another one done one or two days before this surgery.

Q. Were either of them done with IV

contrast?

A. I would have to see the --

Q. And if you don't know, that's fine.

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

Q. If there had been an injury, an unintended injury by yourself perioperatively in your first surgery and an IV -- or CT with IV contrast of the abdomen had taken place, would that probably show that defect or injury?

MR. DOYLE: Just for clarification. By perioperative, that can be a wide range of things. Did you mean to say within the operation itself or are you intending to include before and after?

MR. BRENSKE: Well, we can do it both ways.

MR. DOYLE: I mean, it's --

MR. BRENSKE: That's fine.

THE WITNESS: Perioperative, to me, means during the operative course. Postoperative means anytime after the surgery.

BY MR. BRENSKE:

Q. So if there had been -- with those definitions in mind, if there had been an unattended injury to a portion of the abdomen or other structures that you were working with causing it to

leak, would a CT of the abdomen using IV contrast be able to identify that?

A. Possibly.

Q. I want to go over a couple more things here. I don't -- when you say the omentum caked to the left lateral quadrant in the lower abdomen, can you tell me what that means?

A. It means the omentum was stuck to the left side of the abdomen.

Q. And you indicated you had to remove some debris?

A. I suction irrigated fluid, debris, inflammatory tissue.

Q. None of that being good, I would assume?

A. It's just reactionary fluid from a -- from the perforation.

Q. Going on in your chart to the -- let me make sure I'm not getting lost here.

All right. So the next part of your chart is a fax on 03-19-2015. 000055. And the next three pages after that, under operative notes from your operation on Vickie Center of March 18, 2015. Do you have that in front of you, Doctor?

A. Yes, I do.

Q. All right. So --

MR. DOYLE: Just for clarification, I think it's the 18th. Not the 19th.

MR. BRENSKE: The fax is the 19th, the surgery is the 18th.

MR. DOYLE: Got it. Got it. Okay. I misunderstood you.

MR. BRENSKE: Well, I'm easily misunderstood.

BY MR. BRENSKE:

Q. We're looking at the surgical procedure of March 18, 2015, where your preoperative diagnosis is perforated viscus. Can you just tell me from your recollection why you needed to go back in on the 18th of March of 2015?

A. The patient was doing fairly well tolerating some oral diet. However, there was concern that she was developing a leak from her stomach to her abdominal wall. We, at some point prior to this, had done a CT scan and had interventional radiology place a drain into the area. As -- a lot of times these leaks, if they are suspected, will dry up on their own. We had given what I felt was ample enough time for that to happen. I consulted Dr. Wiencek, the cardiothoracic surgeon. Discussed the case with him since he had

been on prior when she went into the ICU with sepsis back in the beginning. And discussed it with the family that we both felt that there was a need to take her back to the surgery -- to take her back to the OR and evaluate her esophagus for a possible leak, her stomach for a possible leek or any hollow viscus for a possible leak.

Q. So this particular surgery you were assisted by Dr. Wiencek?

A. Yes.

Q. And this had been -- I didn't -- and it may be in your chart. But this was after Dr. -- I don't remember which doctor it was, but aspirated fluid from Vickie Center?

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

Q. Because, I mean, I don't know what I'm talking about. So that works.

Prior to this, I recall there being a cardiothoracic doctor coming in and removing or draining some part of Vickie. Does that ring a bell?

A. Yes. She had a right chest tube thoracostomy placed to drain fluid out of her right chest.

Q. Do you remember which doctor did that?

A. I don't recall whether it was done by Dr. Wiencek or an interventional radiologist.

Q. And we've got it in here, so we'll find out. All right. So you go in with Dr. Wiencek as your second surgeon. Tell me what you did.

A. The first thing I did was cleared the packing from her abdominal wounds, and then we prepped and draped the patient in standard surgical fashion. I started by making a small incision in the right middle quadrant where we had not operated before. So that way I can insert a Veress needle such that it wouldn't interfere with any possible adhesions from the prior surgery. I wasn't able to get any insufflation from that. And then I made an incision from one of her prior trocars, and I opened that up under direct visualization so I could put my finger inside the abdomen to see if I could get insufflation. And I could not get any insufflation.

Q. Now, if you can't get insufflation, does that just mean the CO2 gas that you're putting in there is going -- it's not -- it's like there's a -- you're blowing up a balloon and there's just a hole in the balloon so you can't blow it up?

A. No. It means that something is keeping the abdomen from being free and pliable to expand to

accommodate the pressure.

Q. All right. So that could be from some -- pressure from some other area then?

A. Correct.

Q. Okay. Did you ever determine why you couldn't get insufflation?

A. Indirectly when I opened up her abdomen, she had a fair amount of inflammatory tissue and adhesions. So that would be the reason why I couldn't get insufflation with the Veress needle.

Q. Okay. I'm sorry. Continue, what did you do next?

A. I then created an upper midline incision and opened peritoneum bluntly between the subxiphoid and the belly button basically. The area was fairly stuck with inflammatory tissue. It was friable. I mean, you touch it, it would bleed. You couldn't delineate what was stomach, what was colon. So it was not a very safe area to operate on. So I went down below her belly button where there was no prior surgery by myself, and I was able to get access to the abdomen where there was, lack of a better term, what we call virgin territory. In other words, there is no adhesions, there's no

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inflammation. And then I started working my way up towards the abdomen, taking down the small bowel, the large bowel, so that I could identify everything fairly routinely at that point.

Q. What did you do next?

A. Once I had everything freed up from the small bowel and the large bowel, I had the incision completely freed up, the stomach and transverse colon were scarred to one another.

MR. DOYLE: Slow down just for a little bit. For the court reporter.

THE WITNESS: Sorry. You okay?

I then dissect over towards the left side of the abdomen where I was concerned about a fistula, so that I could follow the fluid back towards where the origin would be.

BY MR. BRENSKE:

Q. Now, before you go any further. A fistula, explain to the jury what that is.

A. A fistula is a connection between any hollow viscus and the skin.

Q. And is a fistula created as a means to get -- well, let me just -- why would the body form a fistula?

A. The body can form a fistula due to a

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number of issues. Basically if you have an obstruction, an injury, chemotherapy, radiation such that a hollow part of the anatomy is weak, it can blow out through that area and the body finds a way to get that fluid out. It's usually directly through the skin.

Q. Thank you. Where are we next?

A. At that point I started to visualize the lesser curvature of the stomach and looked at the right crus where the repair was. I didn't see any evidence of a leak. I didn't see any evidence of a perforation. Nor did I see any material in that area to suggest that would be the site of the perforation. Then I started to mobilize what we call the gastrocolic ligament, which is the distal end where the stomach is adhere to the transverse colon. So that way I can fully look at the end of the stomach, the duodenum, look at the underneath side of the stomach, again, to evaluate if there was any sort of perforation in that area.

The greater curvature had already been taken down from the prior surgery and I inspected the staple line. There was no perforations at the staple line. I then followed this up towards the left crus to make sure there was

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no evidence of perforation there. At that point NG tube was inserted. And we began to insufflate the area, and again used methylene blue to see if there was an appreciable leak. At that point there was actually no methylene blue and no air coming out. So Dr. Wiencek and I thought the next best step, since there is no way to see a perforation from those maneuvers, was for him to do an EGD. Where he puts a scope down through the esophagus into the stomach, and he can look from the inside and see if there is anything that would suggest to him an area that could cause a leak.

When he did that and he started to insufflate the stomach, I could hear a whistling sound, indicating that there was an air leak somewhere. So with him looking down the scope at the inside of the stomach and me inside the abdomen palpating the stomach, I could locate where the hole was. And he could see that there was a gastric ulcer in that area and I was able to stitch the hole closed. Basically until the whistling stopped.

Q. Where was the gastric ulcer located?

A. It was on the left side of the stomach, up near the GE junction.

Q. Can we use this horrible Exhibit 5?

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A. No. Well --

Q. We -- well, no is a pretty rough term, but --

A. The problem is the stomach is in 3D.

Q. Of course it is.

A. And this is in 2D and it doesn't give you a true sense. So looking at your diagram, this ulcer would be behind -- here, I'll mark, as long as you understand. It would be in this general area but behind the stomach.

Q. So posterior?

A. On the back side of the stomach, correct.

Q. Okay. Just write down whatever you want to write down as to what that is.

A. (Witness complies.)

Q. And we'll mark it as exhibit next in order?

A. Sure.

(Exhibit 7 marked.)

MR. BRENSKE: I know we wrote all over five.

MR. DOYLE: That will be seven then; correct?

MR. BRENSKE: Yes. I think so.

BY MR. BRENSKE:

Q. Is there anything on six that would be

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easier for you to show?
A. No.
Q. Okay. I didn't think so. I was just reading. It said, "Eventually able to -- eventually able to visualize the air bubbles were leaking out from the very far upper left corner of the stomach."
A. I filled the abdomen at that point with water. And that way with the air bubbles you kind of see the air bubbles coming from that general area.
Q. I see. All right. So you sutured that general area until there was no more bubbles?
A. Yeah. Dr. Wiencek could see from the inside on the scope that it had been closed. The insufflation had stopped, the whistling had stopped, there were no more air bubbles coming up from the -- from the abdominal cavity.
Q. What did you do next?
A. We placed the NG tube to decompress the stomach of the fluid and air that we put into it. I then went ahead and irrigated and drained the entire abdomen, clearing out any abscess fluid, debriding any necrotic tissue, especially in the left upper quadrant. I placed two drains into the abdomen. One was in the greater curvature or the left side of

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the stomach, but behind the stomach where the ulcer had been repaired. So that way if there was any fluid coming out of there, we'd know where a possible source would be. And then another one was placed, what we call the paracolic gutter, on the left later side where fluid from the surgery would accumulate so we could draw it off.
Q. What is necrotic tissue? Is that dead tissue?
A. Dead tissue.
Q. Where did you clear the dead tissue from?
A. Well, there was necrotic tissue on the omentum. There were little spots of it -- not part of the bowel, but glommed onto the bowel in various parts.
Q. That necrotic tissue came from what source?
A. The inflammatory process of the perforation.
Q. I mean, was it part of the stomach?
A. It's not -- it's not part of the stomach. It's a reaction to the -- to the perforation. So when you have a cut or laceration or perforation, just like your skin, your body makes

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a reaction to that. Kind of like on your skin it's a scab. On the inside of your abdomen it forms this little kind of like a scab. So that's the type of stuff that I was debriding out of there.
Q. The next part of your chart is a fax from the hospital to you concerning a two-page operative report by Dr. Wiencek. Can you tell us -- this isn't your operation, you were not at this particular surgery, I'm assuming?
A. I was not.
Q. And I don't want you to go through all of the details of someone else's surgery. But if you can tell me what he did, in laymen's terms, that was faxed to your chart.
A. Basically Dr. Wiencek did a videoscopic procedure to free up the right lung from any inflammatory tissue on that side.
Q. Can you tell me what you believe caused the empyema of the chest?
A. Empyema.
Q. Empyema.
MR. DOYLE: I assume you want to ask him if he had that thought back then, given the court's ruling.
MR. BRENSKE: I get to ask both times, but I'm

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asking --
MR. DOYLE: Well, why don't we find out first if he had an opinion then.
MR. BRENSKE: Yeah. I thought I did, but that's okay.
MR. DOYLE: You asked present tense.
THE WITNESS: Can you restate the question?
BY MR. BRENSKE:
Q. Sure. We'll do it this way. Was Vickie Center your patient on March 25th of 2015?
A. Yes.
Q. Okay. And what's your understanding of why Dr. Wiencek had to do a right empyema?
A. Empyema.
Q. I'll never get it, but thanks very much for trying.
A. So if the lung has any inflammatory tissue trapping it, you can't get good ventilation through that side of the lung. So a cardiothoracic surgeon would go into the chest, free the lung up from any inflammatory tissue holding it, so that way they would have better ventilation. Remove some potential abscess cavity or fluid to control infection.
Q. What was your understanding at the time

as to why there was that inflammation?
A. It would be from her — it would probably be from her gastric perforation.
Q. From the hole in her stomach?
A. From the ulcer, yes.
Q. Then the next document is page 62. This looks like your referral to -- what is it?
A. It's a referral to Dr. Dominic Ricciardi at the wound care center, for him to evaluate Vickie for her ischemia to her feet.
Q. Okay. Looking at the next pages, I'm going to -- they seem to be multiple requests from Vickie's daughter to allow you to fill out forms to indicate that she's unable to return to work?
A. Yes. For Katie.
Q. For Katie?
A. For Katie, correct.
Q. All right. So if I go to page 68, it says, "Katie's mom underwent surgery 02-06-15 and had serious complications resulting in her admission to the ICU and intubated. Katie has been caring for her father and family during this most difficult time." And I go to page 70, and I'm assuming that's your signature?
A. Yes, it is.

Q. And then she's just asking a couple more times to do that and you have complied with her request? I mean, there is a lot of pages here, but they look like all the same thing.
A. Yes.
Q. Then I'm looking at your chart starting at page 84. This looks like 84 is your initial billing statement?
A. This is a synopsis --
Q. Okay.
A. -- of a billing statement, for lack of a better term.
Q. That's fine. So it's got all these different numbers in them. It looks like -- just follow me along. Follow along here. The numbers on the left-hand side are the original, say -- the original charges, and then payments and adjustments in the middle, and then third column is what is owed now?
A. The left side is the date of service. The middle is the description of the services. Then that next column would be what is billed. The middle column would be what is accepted or paid by the insurance company. And then the remainder would be potentially billed to the patient depending upon

co-pays and deductibles and all sorts of things.
Q. All right. And then the next page is a bill for an office visit, with payments and adjustments?
A. Yes.
Q. And then if you can tell me what this last page is, I would be really impressed.
A. This is basically all of the billed services, as far as what we billed out. These are the charges and the payments made by the insurance, any adjustments and anything else withheld.
Q. Okay. I think that ends your chart.
MR. BRENSKE: All right. Another five-minute break, if that's okay. Court reporter needs a break too.
THE VIDEOGRAPHER: All right. We're off the record at 1:48 p.m.
(Short break.)
(Exhibit 8 marked.)
THE VIDEOGRAPHER: We're back on the record at 2:00 p.m.
BY MR. BRENSKE:
Q. Doctor, if I could see that document, please, just to make sure you've got what I've got. Excuse me. Doctor, I'm going to hand you what's

been marked for identification purposes as Plaintiffs' Proposed Exhibit No. 8. It is the progress notes from nursing. It has nursing notes, Bates stamp 00001 through 000019. Have you had a chance to review those notes prior to your deposition today?
A. I have not reviewed all of these notes. I may have reviewed some of these notes.
Q. Okay. Do you remember the last time you looked at them?
A. No.
Q. Okay. I put them in order oldest first to last. So they may not be in an order that you have reviewed them. So I will try to be clear and not be confusing.
The first progress note is dated -- or Bates stamped nursing notes and then there's a one. And it's -- the first note is at 12:10, received patient from PACU. PACU is the patient anesthesia care unit.
A. Post-anesthetic care unit.
Q. I can never get it right.
So once the surgical procedure has been performed in the operating room, the patient is sent to the PACU to recover from the anesthesia.

Fair statement?
A. Correct.
Q. Also one of the reasons the patient goes to the PACU is so that there is something -- some complication or something that needs to be addressed, the doctor can address it there as opposed to going to the hospital. Fair statement?
A. One of them, yes.
Q. So I don't have your operative report in front of me, but this says at 12:10. So you would have performed the surgery, the original hernia surgery that -- early that day?
A. Correct.
Q. So at 12:10 it says "received patient from PACU, patient's fully awake times three. No SS of distress noted." Do you know what SS means?
A. Signs or symptoms.
Q. Okay. On oxygen. Can you decipher what that says?
A. Two liters nasal cannula, vital signs stable.
Q. What is abdominal lap sites with steri-strips?
A. The dressing on the incisions.
Q. So you've got five -- you did five

laparoscopic sites?
A. I think there were four.
Q. Okay. Let's go with four. So the -- what does "CDL pain" mean?
A. The steri-strips are clean, dry and intact.
Q. Pain control per patient at this time; is that right?
A. That's what it says, yes.
Q. And then denied NV, what is NV?
A. Nausea and vomiting.
Q. And it says, "Patient is having chest tightness since in the PACU." Then it says, "Per page RN, Dr. Rives was notified, and per MD it's expected after lap. Incarcerated periesophageal hernia repair."
Did I decipher that right?
A. Correct.
Q. All right. Do you recall being called by the nurse, either in the PACU or received the patient from the PACU, contacting you concerning Vickie Center having any unusual pain?
A. Yes.
Q. What do you recall the nurse advising you at that time?

A. The nurse advised me just as this is documented. I told her that's expected after a laparoscopic -- actually any laparoscopic surgery. Especially where you work on the diaphragm, the patients tend to have pain radiating through the chest up to their shoulder. It's called Kehr's sign, K-e-h-r, apostrophe S, and it's a known sign or symptom after laparoscopic surgery.
Q. Is this something that you would have advised Vickie Center as being something she is going to experience after the surgery?
A. I usually do, yes.
Q. It says placed SCDS.?
A. Sequential compressive devices.
Q. Okay. And continue v/s fall?
A. And continue vital signs, fall precautions initiated.
Q. And it says, "Instructed patient to call for assistance, call and reach. Cont to monitor." I don't know what cont means.
A. Continue.
Q. So at 14:00 it looks like she's in no acute distress. Then at 15:30 Dr. Siddiqui sees the patient, made aware that -- the nurse made him aware of the chest tightness. And it says, "Per MD it's

related to surgery. No order received."
Did you have any discussions with Dr. Siddiqui on the 7th -- excuse me, on the 6th, that the pain the patient's encountering is not unusual for this type of surgery?
A. I don't recall.
Q. Okay. So you may have spoken to Dr. Siddiqui, you may not have. You don't remember?
A. Correct.
Q. Then 15:41, patient complains of abdominal pain, medicated with as-need pain meds. And then at 6:30 there is another note, "pain is well controlled." And then we go to the next page.
MR. DOYLE: Are we going to read all the notes?
MR. BRENSKE: We are. Dr. Rives is in almost all of them.
MR. DOYLE: All right. Well, these aren't his notes, but I guess if that's what you want to do.
MR. BRENSKE: It is.
BY MR. BRENSKE:
Q. Looking at this document, Doctor --
MS. DAEHNKE: I'm so sorry. Not to get your flow off, but -- so are we going to eat or are we not going to eat? We're just going to take

five-minute breaks? I'm just asking.
MR. BRENSKE: Well, I don't know how long the doctor can -- I mean, I want to get through as much as I can.
MR. DOYLE: Well, we want to finish today.
MR. BRENSKE: We want to finish today. I don't know if the court reporter needs a breaks or not, it would be up to the court reporter. If we take an hour break today, we'll never get done today.
MS. DAEHNKE: Well, we can take a 20-minute break and run down and get some protein or you could -- we could call in something. I mean, I don't think the doctor --
MR. BRENSKE: We can do all of that.
MS. DAEHNKE: Okay. I'm sorry. I just don't --- endurance test for everyone. Little hard boiled eggs or something?
MR. BRENSKE: Let me get through these nurses notes.
MS. DAEHNKE: Okay.
MR. BRENSKE: And then we'll discuss it.
THE WITNESS: The doctor does not need a break, for the record.
MS. DAEHNKE: Well, that's --

MR. BRENSKE: Doctors generally don't, because you guys can work ten or twelve hours standing up. You guys are insane.
MS. DAEHNKE: Right. You're a surgeon. We just do God's work in a different way. Okay.
BY MR. BRENSKE:
Q. All right. If I could continue. And, Doctor, these nurses notes, the reason I'm going over them is because I need to find out what you recollect as being provided to you and what you provided to the nursing staff and to Dr. Siddiqui.
The next -- the next report, if you look at the progress note, it is a little different. You have to start at 19:30, which is halfway down the page.
A. Yes.
Q. In there indicates that patient did have some chest pain and tightness of the chest today. Both MDs are aware, Dr. Siddiqui and Dr. Rives, and per report state it was normal with type of surgery patient had.
So do you remember telling a nurse that the pain that this patient is encountering is not unusual?
A. Correct.

Q. Then the next is 19:40, that's 7:40 p.m. The patient complains of abdominal and shoulder pain. Administered Zofran and Dilaudid. What is Zofran?
A. Zofran is as antiemetic, and Dilaudid is an analgesic.
Q. After that, it looks like patient denied any chest pain. Then at 20:10, that's at 8:10 p.m., it indicates patient still complains of ten out of ten pain after Dilaudid. What does ten out of ten mean?
A. It's a subjective scale. You ask the patient from one to ten, ten being the worst pain ever, what is your reference number for how severe your pain is?
Q. I see. So would it be unusual for someone such as Vickie Center, who has undergone the type of surgery that you did, to have a ten out of ten pain after receiving Dilaudid?
A. Not necessarily.
Q. Then at 8:25, that's 15 minutes later, It says, "Page Dr. Siddiqui regards to patient's pain level after Dilaudid."
Do you recall on this day being paged by any of the nursing staff concerning Vickie

Center's pain?
A. Other than the previously mentioned one?
Q. Yes, sir.
A. I do not have an independent recollection.
Q. All right. At 8:36 p.m., notified Dr. Siddiqui of patient's pain, ten out of ten in abdomen and left side. Patient crying. Medications already given.
And then it goes to 8:45 that Dilaudid one milligram, IV administered. Can you tell the jury if that's a lot a little?
MR. DOYLE: Question is vague.
But go ahead.
THE WITNESS: It's a normal dose for the medication.
BY MR. BRENSKE:
Q. Okay. One milligram IV administered, okay. Then at 21:20 it says, "Patient states pain is still a ten out of ten and no change after the additional dose of Dilaudid."
Is that something that you would expect to have that kind of pain after getting another dose of Dilaudid?

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A. Possibly, yes.
Q. Then we go to 21:37, which is halfway down the page of the addendums -- the addendums go up. The addendum by Carey, comma, Erin, RN, 20:15, 21:37, paged Dr. Siddiqui. Then there is another addendum at 21:44, that notified Dr. Siddiqui regarding patient's pain level still ten out of ten. Patient is very upset. Dr. Siddiqui stated to notify Dr. Rives regarding patient's pain. Attempting to page Dr. Rives at this time.
MR. DOYLE: It's Dr. Rives, Counsel.
MR. BRENSKE: Rives. I didn't mean to be disrespectful, Doctor.
THE WITNESS: It's okay.
MR. BRENSKE: But thank you for the correction, Counsel.
BY MR. BRENSKE:
Q. Then the next addendum is 21:54 where they -- they re-paged you again. And then at 22:07 it looks like they notified you, Doctor, of the patient's pain level. The patient's medication is already given. Where the pain is located, left side of abdomen radiating into shoulders. It looks like order received for Norco, PRN, and encourage

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ambulation and deep breathing.
Is that something that you would have ordered, the Norco?
A. I don't typically order an oral medication in this situation postoperatively. However, if one had been ordered by another physician, I may have said it was okay to take the Norco. I would have to review the orders on the chart to see who actually ordered it.
Q. All right. What is Norco?
A. It's an analgesic oral medication.
Q. What does it do?
A. Relieve pain.
Q. Okay. Then it says, "Dr. Rives states the pain is due to the air on the diaphragm."
Do you recall indicating that information to a nurse on this -- this is at 10:07 p.m. that first night, it would be the same night?
A. I don't have a recollection of the exact conversation. I'm going with the nurses notes here.
Q. It indicates from the nurse, "Dr. Rives states the pain is due to the air under diaphragm. Ask Dr. Rives if pain continues to be ten out of ten after additional medications given if he wants to

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call him back. He states no. To continue with medications as ordered and have her walk and deep breathe."
Do you recall telling the nurses that were taking care of Vickie Center the night of February 6 to not call you back?
A. I don't have a recollection of that. But I would typically tell them in the case a patient after laparoscopy to get up, walk around, to relieve the pain in the left shoulder.
Q. So is it possible the nurse that night of the surgery asked you if this pain continues ten out of ten, do you want them to call them back and you say no?
MR. DOYLE: Objection. Calls for speculation.
BY MR. BRENSKE:
Q. You have to answer the question, please.
A. Okay. It's no with a comma, get her up, walk around, move around and do these modalities first.
Q. Okay. So let me just ask, do you have an independent recollection of this telephone call from the nurse?
A. No.

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Q. All right. Then there is another addendum at 22:12 on the evening of the 6th. And that's, "Notified patient of new orders received from Dr. Rives."
I know these are not your notes and it's speculative, but I'm assuming that what you did in this case is when they're having the pain, you want them to get up and walk around and breathe deeply?
A. Correct.
Q. Now, if you go to page 3 of this progress note -- I'll try to move quickly on this. This is the same nurse at three -- at midnight. It looks like the pain level is unacceptable.
MR. DOYLE: I see acceptable.
MR. BRENSKE: It is acceptable. That's why we have you.
MR. DOYLE: I thought you said unacceptable.
MR. BRENSKE: I did. I made a mistake.
MR. DOYLE: Okay.
THE WITNESS: Pain level is acceptable, yeah.
BY MR. BRENSKE:
Q. The next one is -- now we're at the -- 6:48, the following morning of the surgery. So we're about 18 hours out, I guess. It states,

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"Encourage patient to use incentive spirometer and perform deep breathing as per orders from Dr. Rives to assist in passing gas."

Can you explain to me the use of the spirometer?

A. The incentive spirometer is something that I order for all my postoperative patients. It is a device to encourage deep breathing to expand the lungs, to avoid pneumonia and effusions, and aid in respiration.

Q. Now, I'm going to go to page 5, and we're still -- all of these are the nursing progress notes. By 9:17 the following morning, it says BP is low, 76 over 54, and heart rate is 112. Standing order, NS 500 cc bolus for -- what is SPB?

A. Systolic blood pressure.

Q. Less than 90 start. So I take it there is a standing order when the blood pressure goes down to a certain level that, one, administers bolus?

A. That's correct.

Q. And what is a bolus?

A. Instead of giving 500 cc's as a drip, as in a rate of 50 cc's an or 100 cc's an hour, you open it and let it flow in freely.

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Q. And what is that supposed to do, increase blood pressure?

A. Well, if the patient's volume is depleted from the surgery or from not eating or not drinking enough, et cetera, you give fluids to support the blood pressure.

Q. Well, this is less than -- well, less than 24 hours from surgery. Is it unusual to have a bolus provided?

A. No.

Q. Do you recall in your operative report how much blood was lost as a result of your surgery on the 6th?

A. It would be in my operative note.

Q. What is the usual?

A. The usual would be less than 50 cc's.

Q. 20 cc's would be -- is that something that --

A. Normal.

Q. Normal. Now, the blood pressure at 9:19 in the morning is 86 over 53 and Dr. Siddiqui paged. Do you remember if and when you were paged next with regards to the care for Ms. Center?

A. I think at that point I actually saw the patient in the hospital.

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Q. The next blood pressure at 10:02 in the morning is 102 over 507. Next order I have is at 10:00 a.m. Dr. Siddiqui called back and new order for CT of abdomen. Do you see that?

A. Yes.

Q. Why did you discontinue that order?

A. Because it wasn't indicated.

Q. So CT of the abdomen would be a picture of the general area of where you performed your surgery?

A. Correct.

Q. Now, at 11:13 is when you were in the room to see the patient and you discontinued the CT of the abdomen. And you had a new order for -- what is NS 1 L bolus?

A. Normal saline, one liter.

Q. All right. So obviously it was your opinion -- not obviously. It was your opinion at the time on the 7th of February there was no reason for there to be a CT or picture of Ms. Center's abdomen?

A. They wanted the CT scan to rule out bleeding, and a CT scan is not a good study to rule out bleeding.

Q. Would a CT scan -- I think we had this,

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so just to go over it. A CT scan of the abdomen with IV contrast would indicate -- would give you potentiality of finding any leak or injury in the surgical area. Fair statement?

A. It's possible, yes. But it doesn't rule it out.

Q. When did you rule out any possible nick or cut or injury to the -- Vickie Center's abdomen from your February 7th surgery?

MR. DOYLE: I'll object. It lacks foundation. But go ahead.

THE WITNESS: This morning when I -- the morning that I rounded on her?

BY MR. BRENSKE:

Q. No, sir. I apologize. I'll rephrase it. We'll allow the objection to go through. So it won't, you know, be interrupted.

At what point in time during your treatment of Vickie Center did you rule out the possibility that you had injured or cut the stomach or any surrounding area, causing further injury to Vickie Center?

MR. DOYLE: Again, it lacks foundation.

THE WITNESS: I think the only time that I finally had ruled that out would be at her second

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surgery.
BY MR. BRENSKE:
Q. Okay. So that would have been 11 days later?
A. Correct.
Q. All right. Let's go to -- now, at 11 -- excuse me, at 11:30 in the morning on the 7th the Foley was discontinued. Do you know whose order that was?
A. I don't know. But it probably would be mine.
Q. Then by 2:00 p.m. you indicate that Vickie was back to bed due to shortness of breath. It says "placed O2 and is 92 percent on two liters." What does that mean in regular folks' terms?
A. She walked around the hall, felt that she was short of breath. They put her back on some supplemental oxygen, two liters, which is the minimum, and her pulse oximetry was acceptable at 92 percent.
Q. And then by 4:00 p.m. it looks like the CNA called the nurse in because of a low O2 SAT and low BP. What is that in normal folks' terms?
A. Her blood pressure was low. But more importantly, just note her oxygen saturation was

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dropping while on supplemental oxygen. Meaning she was having a respiratory issue.
Q. When it says her oxygen is 87 percent on 5 L's, what does that tell you?
A. That tells me she's having serious respiratory complications.
Q. It indicates Dr. Siddiqui paged and he walked into the room, ordered transferred the patient received, and NS 1 L bolus started as ordered. That would have been ordered by him then? I know we have the order somewhere, I'm just trying to --
A. It looks like it, yes.
Q. Patient transferred to ICU. Why would you transfer a patient to ICU?
MR. DOYLE: Well, you're asking him to comment on the care provided by someone else. That is clearly expert opinion.
MR. BRENSKE: I'm asking this doctor why he would have a patient transferred to ICU.
MR. DOYLE: He did -- if you can lay the foundation that he in fact gave that order and made the transfer, I'll let him answer the question. But he's not going to be an expert witness and comment on why someone else may have transferred the patient

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to the ICU.
MR. BRENSKE: Well, Counsel, if that was my question, it would be a valid objection. I asked this doctor why he would transfer someone to an ICU. I think he's required to answer that question.
MR. DOYLE: I will instruct him not to answer that. That it calls for an expert opinion based upon a foundation that you have not laid.
MR. BRENSKE: So are you telling me that I'm not allowed to ask this doctor why he would transfer a patient to ICU?
MR. DOYLE: What does that -- it's not his order.
MR. BRENSKE: I'm not asking if this is his order.
MR. DOYLE: So how is that his percipient testimony?
MR. BRENSKE: Fine.
BY MR. BRENSKE:
Q. When did you first learn that your patient was transferred to ICU?
A. Sometime that evening.
Q. Okay. Were you given the reasons why the patient was transferred to ICU?
A. I was given some general instructions,

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yes.
Q. Did you have any disagreement with the patient being transferred to ICU?
A. No.
Q. Okay. What did -- questions did you ask of anyone concerning why this patient was sent to ICU?
A. I don't recall the exact questions I asked the providers.
Q. Okay. Did -- you countermanded the order for the CT of the abdomen, why didn't you countermand the order for the patient being transferred to ICU?
MR. DOYLE: I'll object. It's argumentive.
THE WITNESS: I countermanded the CT scan because I was there observing the patient directly and had clinical knowledge about the patient. Patients having some distress that I'm not there to see -- evaluate, so I have to rely on my colleagues to do their best clinical judgment.
BY MR. BRENSKE:
Q. Okay. When you saw the patient at 11:13 on February 7th, did you examine the patient?
A. Yes.
Q. Did you examine the feet of the

patient?
A. I do not recall.
Q. Okay. The next nurses notes on page 6, it just says something about the feet -- both feet of the patient getting purplish in color before patient was brought to ICU. Do you have any recollection of examining the patient's feet prior to her being -- while you were examining her at 11:13 that day?
A. You mean regarding this progress note from 02-09?
Q. Well, yes. The progress note from 02-09 indicates that someone saw her feet, purplish color, before the patient was brought to ICU. And you saw her on the 7th, and I wanted to know if you had -- if you had examined them, yes or no; if you hadn't, then you wouldn't know.
A. I don't have an independent recollection.
Q. Okay.
MR. BRENSKE: If we could mark this next in order.
(Exhibit 9 marked.)
BY MR. BRENSKE:
Q. Doctor, I'm showing you what's been

marked for identification purposes Plaintiffs' Proposed Exhibit No. 9. It is — if I could see it real quick. It's entitled Coding 01 through 4. Okay. This is an emergency document. It's dated February the 7th, 2015, at 19:39 p.m. So that would be 7:39 p.m. The date of service is 02-07-15. And it is by a Logan Sondrup, MD. Have you seen this document before?
A. I may have.
Q. Okay. So do you know who Logan Sondrup is?
A. Yes, I do.
Q. Who is Logan Sondrup?
A. He is the ER director -- well, he's the ER director now at St. Rose-San Martin. He's an ER physician.
Q. Okay. So I know you're not the author of this document, but I want to ask a few questions about it. This is -- it says you've responded to the ICU for a code blue call. What is a code blue call?
A. Code blue in this hospital is a patient in distress. When it happens, various members or team members throughout the hospital respond to the call.

Q. All right. Do you have a recollection of Ms. Vickie Center undergoing a code blue on the 7th of February?
A. Based upon the documentation, yes.
Q. Okay. Now, this document says that she had code blue at 19:39 p.m. That's 7:39 p.m. Assuming that's correct, that is how many hours after you last saw the patient? You have to go to the exhibit. I don't want you to juggle, but there is no other way around it. If you can answer the question.
A. About eight or nine hours.
Q. Okay. It's your understanding with the time of my client undergoing a code blue, you believed it to be resulting from -- I apologize, Doctor, you're better -- I want to say aspiration of pneumonia, but do you have a more definitive term for it?
A. Aspiration pneumonitis.
Q. What does it mean when the patient is in cardiac arrest?
A. Without looking at the rhythm strips, I would -- I'd have to know what exact cardiac arrest means.
Q. All right.

A. That could be arrhythmia, that can be asystole, that could be a number of cardiac arrhythmic disorders.
Q. As a treating physician for this patient Vickie Center, what was your understanding upon reading the emergency document report where it says the patient is in cardiac — patient is in cardiac arrest?
A. As a surgical consultant on this case, I would have no bearing on this document whatsoever. This would be managed by the ICU team and the intensivists.
Q. What is -- what is PCP?
A. Primary care physician.
Q. Can you tell me why you're listed as the primary care physician on this document?
A. No, I cannot.
Q. As a consulting physician, you discontinued the order for CT of the abdomen earlier that very day?
A. Earlier that morning, yes.
Q. All right. I get lost. Sorry. And I apologize, Doctor, do you have a recollection of when you were informed that Ms. Center coded?
A. Sometime that evening.

Q. When did you next see her?
A. I don't recall whether I went in the hospital that night, but the next documented visit was the next day, I believe.
Q. Do you remember what your diagnosis of her condition would have been at that time?
A. On postoperative day 2 in the morning, based upon looking at the patient, reviewing the chart, it looks likes she had aspiration pneumonitis causing sepsis.
Q. Okay. When was the bronchoscopy done?
A. I would have to refer to the notes for that.
Q. Do you recall whether a bronchoscopy was done to rule out that diagnosis?
A. I know a bronchoscopy was done.
Q. Do you — do you recall whether or not — we'll get to that. Just trying to shorten this a little bit. What does obtunded mean, o-b-t-u-n-d-e-d?
A. Obtunded is when a patient is neurologically not very responsive.
Q. There is a nursing note on page 15 of that exhibit. I apologize, we switched exhibits. That's not very nice of me.

MR. DOYLE: This would be Exhibit 8, I believe.
MR. BRENSKE: You know, I don't know. It's on the front of the exhibit, so...
THE WITNESS: Eight. "Okay to restart tube feeds per Dr. Rives"?
BY MR. BRENSKE:
Q. Yes. I just want to know what that mean. Tube, what is that?
A. It says, "Okay to restart tube feeds per Dr. Rives."
Q. Is that a feeding tube?
A. If -- I'd have to put this in chronological order because we're hopping all over the place. But it usually means we're feeding the patient through an NG tube.
Q. Okay. There is a lot of stuff here. Okay.
(Exhibit 10 marked.)
BY MR. BRENSKE:
Q. All right. Doctor, I'm showing you what's been marked for identification purposes Plaintiffs' Proposed Exhibit No. 10. It is entitled Op Reports. 000001 through 23. If you go to -- page 10, do you have that before you? Doesn't look

like you have --
MR. KELLY: Did you say page 10?
MR. BRENSKE: Yeah. Okay. So I am doing something wrong.
MR. DOYLE: We'll figure it out.
MR. BRENSKE: Let's see what we did wrong here.
MR. DOYLE: What are you trying to find?
MR. BRENSKE: Well, see, my original is different than these copies. Other than a competent copier --
MR. DOYLE: Is it a particular op note or something?
MR. BRENSKE: Yeah. I'm looking for the -- what scares me is -- what did they do to me here?
MR. DOYLE: I will leave you. We'll let you figure that out.
MR. BRENSKE: Well, let's take a moment.
MR. DOYLE: Okay.
MR. BRENSKE: Thanks.
MS. DAEHNKE: And off the record.
MR. DOYLE: Are we going off?
MR. BRENSKE: Yes.
THE VIDEOGRAPHER: We are off the record at 2:49 p.m.

(Lunch break.)
THE VIDEOGRAPHER: All right. We are back on the record at 3:23 p.m.
MR. DOYLE: That was our lunch break.
BY MR. BRENSKE:
Q. Doctor, I've marked what -- for identification purposes as a new Exhibit 10, because it has more pages in it and more of a complete record. It's Bates stamped 1 -- I mean, 000001 through 27, Op Report. I wanted to go to page 10, if you all recall, of the document. This is the operative procedure report of Dr. Yann-Bor Lin. Did I ask you if you were familiar with Dr. Bor Lin?
A. In what way? I know of him. I know he's an intensivist. I'm familiar with his work.
Q. Okay. This procedure performed on 2008 -- excuse me, February 8 of 2015 is -- can you recall whether or not this bronchoscopy was ordered by you or Dr. Siddiqui or do you know?
A. It would have been done by Dr. Lin.
Q. Did you consult Dr. Lin at any time in this case?
A. At this point Dr. Lin is the intensivist managing the patient in the ICU.
Q. All right. So in this document it

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shows that the PCP is Dr. Rives?
A. That's what it says on there.
Q. Would this be a document that you would have available to you once the bronchoscopy report had been done?
A. In the EMR of the hospital, yes.
Q. Okay. Do you recall whether or not you reviewed this bronchoscopy report at or around the time that the report came out?
A. I know that I've reviewed it. I can't say as to the exact time and date.
Q. All right. You've opined today that at the time of your treatment of Ms. Center that you believe that the cause of her sepsis was — and I will say it wrong again — but aspiration pneumonitis?
A. That is correct.
Q. Okay. I'm learning. Now, this bronchoscopy — I won't go through the entire report 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?
A. Yes, I do.
Q. What does that mean in laymen's terms?

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A. It means Dr. Lin felt that the etiology of sepsis was not within her lungs.
Q. And that -- that would be in contradiction to your opinion. Fair statement?
A. I would say it's his interpretation. I wouldn't say it's in direct contraindication to it, or contradiction.
Q. All right. At least we would have a day as the deposition. But at least according to this, Dr. Lin is explaining to you or any other reader that it's his opinion that the sepsis that Vickie Center is suffering from on the 8th of February 2015 is — the source of that sepsis is not in the lungs. Fair statement?
MR. NAVRATIL: Foundation objection.
THE WITNESS: He's basing his opinion on his --
MS. DAEHNKE: Join.
THE WITNESS: -- bronchoscopy.
BY MR. BRENSKE:
Q. I understand what he's basing -- let me rephrase it so that we're clear. I'm looking at Dr. Lin's report, after he did a bronchoscopy, after he looked at the lungs, wrote down his findings and indicates that the likely etiology -- what does

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etiology mean in laymen's terms?
A. Source or cause.
Q. So the likely cause of the sepsis is extrapulmonary. What does extrapulmonary mean in laymen's terms?
A. Outside of the lungs.
Q. That opinion is in contravention to your opinion at the time that the source of the sepsis was pulmonary. Fair statement?
A. Again, I disagree with that.
Q. Okay.
A. His limited evaluation of the lungs can show one thing, does not necessarily contraindicate or contradict what my impression was based upon them finding a large amount of vomitus in the oropharynx when they intubated the patient, for instance.
Q. Okay. So what did you — when you contacted Dr. Lin, did you discuss with him your opinion as opposed to his opinion?
A. I never contacted Dr. Lin.
Q. The large amount of vomitus, that would have been when?
A. The note you referenced earlier by Dr. Sondrup.
Q. On the 7th?

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A. At the code blue, when he was assisting Dr. Lin in the intubation of Ms. Center.
Q. So the bronchoscopy would have been after that?
A. The bronchoscopy was the day afterwards it looks like. Based upon his note.
Q. Now, let's go to page 6 of Exhibit 10.
A. Exhibit --
Q. I apologize. Page 6 of Exhibit 10, page 000006. Have you got that in front of you, Doctor?
A. Central line placement by Dr. Lin.
Q. Yeah. Can you just tell the jury what a central line placement is?
A. A central line is when we access a larger vein with a larger catheter to give fluids, antibiotics and other treatments more quickly.
Q. Okay. And then if we can go to page 8. That's the hemodialysis cannula insertion. Can you tell me what that is?
A. Dr. Lin put in a type of catheter that has more than one port so that the patient can receive dialysis through it.
Q. Okay. According to this, preoperative diagnosis says acute renal failure. Do you see

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that?
A. Yes.
Q. From your review -- from your review of the records, did Ms. Center have acute renal failure?
A. Yes.
Q. Is it -- was it your opinion at that time that the acute renal failure was a result of the aspiration pneumonitis?
A. It was due to her sepsis.
Q. Which was due to the aspiration -- aspiration pneumonitis?
A. That was the presumed diagnosis at the time, yes.
Q. That's still your opinion today, is it not?
A. Yes.
Q. We discussed earlier -- I'm sorry. If you could go to page 21. I do bounce around, so I apologize. But this says -- another word that I cannot pronounce -- empyema?
A. Empyema.
Q. I think I was correct again that I don't know how to pronounce it. Empyema. Again, what is empyema?

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A. Empyema is when there is an abscess in the thorax.
Q. When you say abscess, what does that mean in laymen's terms?
A. Infected fluid.
Q. Do you recall the different specialists that were called in as consultants to help heal Vickie Center while you were her physician at St. Rose Dominican?
A. While I was a surgical consultant at St. Rose?
Q. Yes.
A. The entire length of the stay?
Q. Yes, sir.
A. I would have to review the chart to give you the entire list.
Q. Once -- once Ms. Center got out of the ICU, were you -- what was your relationship? Were you still a consultant physician?
A. Yes.
Q. Can you explain why you're listed as a primary care physician throughout the records?
MR. DOYLE: Asked and answered.
THE WITNESS: No idea.
////

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BY MR. BRENSKE:
Q. Doesn't mean I remembered to ask him the question. Okay. So we were -- I think we were at page 25, were we not? With regards to --
A. No.
Q. We're at page 25 now. Surgeon, Sean Byron Dow.
A. Yes.
Q. Okay. All right. What is a right-sided ultrasound-guided chest tube?
A. Looks like Dr. Dow, under ultrasound guidance, placed a tube into the right chest of Ms. Center.
Q. And I don't -- do you have an understanding why there was the need to remove this purulent material?
A. I do not have a direct knowledge base of that.
Q. On page 26, is this the -- you did talk about -- page 26, we did talk about Dr. Wiencek and his right-sided video-assisted thorascopic surgery with decortication; correct?
A. You questioned me about that earlier, yes.
Q. And the purpose of this was to remove

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more purulent material?
A. It was to free up the lung, yes.
Q. Just bouncing around here. It indicates -- in the second page, which is on page 27, about a third of the way down -- "of interest, the abscess did track down to the esophageal hiatus." Where is the esophageal hiatus?
A. The esophageal hiatus is the area that we discussed earlier, where the esophagus goes through the diaphragm and joins the stomach.
Q. Would that be the general surgery that you did February 7th of 2015?
A. Yes.
Q. When you received this, what did -- what, if anything, did it tell you?
A. I don't know what you mean by received.
Q. That's okay. When you reviewed this operative procedure report, what effect -- well, strike that.
You would have gotten a copy of this?
A. I would have reviewed it at some point, yes.
Q. It says CC Barry Rives, so I figure you got it. Did that in any way assist you in

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confirming your opinions concerning the cause of the sepsis?

A. Well, let me clarify something first. CC means it may have gone to my office. The majority of what we're talked about I'm reviewing actively in the EMR of the hospital. So in doing my rounds on Ms. Center, I would have read Dr. Wiencek's note. That's how that comes around.

Q. Okay. And how -- I didn't mean to interrupt you. Go ahead.

A. What Dr. Wiencek did, his procedure did not change my management of the patient.

Q. Do you recall Dr. Shadrou's involvement in this case? When I say "the case," the case of taking care of Vickie Center.

A. He's a renal doctor, kidney specialist.

Q. Okay. Do you recall what Dr. Mir Mohammad's -- strike that.

Are you familiar with Dr. Mir Mohammad?

A. He's an infectious disease specialist.

Q. Did you consult with him in the care and treatment of Vickie Center?

A. We never spoke.

Q. Dr. Antonio Flores Erazo, are you

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familiar with that doctor?

A. I believe he's an intensivist.

Q. What, if anything, did you discuss with Dr. Erazo concerning your care and treatment of Vickie Center?

A. I don't recall our exact conversations.

Q. Do you recall in general subject matter of the conversations?

A. Well, she was in the ICU for an extended length of time. I spoke to a lot of the consultants on and off. Just about her general condition, how their -- how she's progressing from their standpoint.

Q. Okay. Did any of the physicians, Dr. Siddiqui, Dr. Yan-Bor Lin, Dr. Mir Mohammad, Dr. Antonio Flores Erazo, did you discuss with any of them the possibility of there being a -- something occurring during the surgery itself to have led to the sepsis?

A. I discussed with them the possibility of surgical complications causing sepsis, yes.

Q. Did you discuss with them the possibility of the surgical complication with regard to the actual surgery causing injury to Ms. Center that caused sepsis?

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A. As a possibility, yes.

Q. So was that within your differential diagnosis at any time?

A. As I mentioned earlier, it's always in my postoperative differential, yes.

Q. And you indicated a CT of the abdomen ruled that out?

A. No. I did not indicate that.

Q. Okay. What ruled out the differential diagnosis?

A. A CT scan --

MR. DOYLE: Hold on. Let him --

BY MR. BRENSKE:

Q. What -- in your mind, what ruled out the possibility that you had injured some part of the anatomy of Vickie Center causing the sepsis?

A. The only time that I ruled that out was when I did her second surgery and I could see that the gastric perforation was related to the NG tube, and there were no other anatomical defects caused by the surgery.

Q. Was the NG tube placed before or after the code?

A. After.

Q. So if I recollect correctly, it was

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your opinion that Ms. Center suffered sepsis as a result of the aspiration pneumonitis. She was recovering from that. Then she suffered a hole in her stomach from the NG tube, you fixed that. And then she had another hole in her stomach from -- I don't want to say -- gastric ulcer.

A. That's correct.

Q. Did you review any test prior to the surgery that would have indicated whether or not Ms. Center suffered from any gastric ulcers?

A. Which surgery?

Q. The first surgery.

A. The only test that that would be relative to would be Dr. Frankel's EGD, which showed agile gastritis.

Q. Did that indicate gastric ulcers?

A. It indicated she had irritation of her stomach, which would be prone to ulcers, yes.

Q. So the gastric ulcer that Vickie Center suffered from would have occurred after her hospitalization on the -- after the hospitalization began February 6 of 2015?

A. We're talking about two different types of ulcer. There is an ulcer when somebody is -- as we all are sitting here today -- stress related,

et cetera. There is a second type of ulcer that happens in the acute care setting, a higher level of stress-induced ulcer that can happen after surgery or sepsis.

Q. So is the kind of ulcer that you had to repair in the hospital that second type of ulcer?

A. The one that's -- the one that's consistent with an acute stress item like sepsis, yes.

Q. Okay. So it would be your opinion at the time and today that the gastric ulcer that you repaired was a -- I don't know if the right word is consequence of the acute sickness that she had while she was in the hospital?

A. Yes, that's accurate.

Q. I get it right sometimes.

MR. BRENSKE: Okay. I'm going to pass the witness before I look at any more documents.

MS. DAEHNKE: I don't have any questions.

MR. NAVRATIL: I don't have any questions.

MR. KELLY: No questions.

MR. DOYLE: I don't have anything.

MR. BRENSKE: Well, I don't think I'm allowed to have any more. So I think you're allowed to go.

THE VIDEOGRAPHER: We're off the record at

3:47 p.m.

MR. DOYLE: I assume you'll do color copies. And would you -- at least for me anyway, would you put all the exhibits in a separate cover. Are you with Litigation?

THE REPORTER: Yes.

MR. DOYLE: So you have my standing order?

THE REPORTER: Yes.

Does anybody want a copy of it? I know you do, an e-trans.

MS. DAEHNKE: I do, please. Mini e-trans.

(Whereupon the deposition was concluded at 3:47 p.m.)

REPORTER'S CERTIFICATE

STATE OF NEVADA)
) ss.
COUNTY OF CLARK)

I, Angela Campagna, a certified court reporter in Clark County, State of Nevada, do hereby certify:

That I reported the taking of the video deposition of the witness, BARRY JAMES RIVES, M.D., on Tuesday, April 17, 2018, commencing at the hour of 10:59 a.m.

That prior to being examined, the witness was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth.

That I thereafter transcribed my said shorthand notes into typewriting and that the typewritten transcript of said deposition is a complete, true, and accurate transcription of shorthand notes taken down at said time.

I further certify that I am not a relative or employee of an attorney or counsel of any of the parties, nor a relative or employee of 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

ERRATA SHEET

I declare under penalty of perjury that I have read the foregoing _____ pages of my testimony, taken on _____ (date) at _____(city), _____(state), and that the same is a true record of the testimony given by me at the time and place herein above set forth, with the following exceptions:

Page	Line	Should read:	Reason for Change:

ERRATA SHEET

Page	Line	Should read:	Reason for Change:

Date: _____

_____
Signature of Witness

_____
Name Typed or Printed

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9/19/2019 3:48 PM
Steven D. Grierson
CLERK OF THE COURT

ORDR

DISTRICT COURT
CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC. Defendants.	Case No.: A-16-739464-C Dept. No.: XXXI **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)**

I. FACTUAL BACKGROUND

The Court is in receipt of the parties' attached purported Stipulation and Order Regarding Motions in Limine. The Court not only needs to Deny the requested impermissible Stipulation due to its *per se* non-compliance with various rules/Order(s), but the Court also unfortunately must set this matter for hearing due to the ongoing conduct of counsel. As counsel is aware, they have continued to submit impermissible documents/requests to the Court which *per se* cannot be granted by the Court as they run afoul of various rules/orders which the parties' counsel have disregarded. This has continued to occur in some cases such as the present one even after the Court has already informed the

JOANNA S. KISHNER
DISTRICT JUDGE
DEPARTMENT XXXI
LAS VEGAS, NEVADA 89155

Case Number: A-16-739464-C

parties that they have failed to comply with the rule/standards at issue. Unfortunately, the conduct of counsel has not only multiplied the proceedings, but has resulted in the Court spending numerous unnecessary hours responding to these impermissible documents/requests despite the fact the Court has already granted the parties seven prior extensions of discovery and/or trial; had its staff, within legal and ethical bounds, contact counsel (and their staff) to attempt to remedy issues in the documents/requests; has provided counsel (verbally and in writing), within legal and ethical bounds, notice of the NRS, NRCP, EDCR's, and Trial Order provisions at issue; and has even set a mandatory in-person hearing when counsel would not respond to the Court to try and gain compliance, all to no avail.

With respect to the instant Stipulation and Order Regarding Motions in Limine, the Court unfortunately cannot sign the proposed Stipulation and Order for several reasons including, *inter alia,* that it is contrary to the Amended Trial Order dated January 22, 2019. While the parties have the Order and it is available online, the Court has provided part of the relevant provisions below:

> **E. Pre-Trial Memorandum** - The Pre-Trial Memorandum must be filed no later than **4:00 p.m., on SEPTEMBER 30, 2019,** with a courtesy copy delivered to Department 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.
>
> Counsel should include in the Memorandum **an identification of orders on all Motions in Limine** or Motions for Partial Summary Judgment previously made, a summary of any anticipated legal issues remaining, a brief summary of the opinions to be offered by any witness to be called to offer

JOANNA S. KISHNER
DISTRICT JUDGE
DEPARTMENT XXXI
LAS VEGAS, NEVADA 89155

opinion testimony as well as any objections to the opinion testimony.

F. Motions in Limine - All Motions in Limine, must be in writing and filed no later than **eight (8) weeks before the first day of the Trial stack date. Orders shortening time will not be signed except in extreme emergencies.**

Amended Trial Order January 22, 2019, Pg. 2 (emphasis added in part)

As counsel is aware, the proposed Stipulation and Order provided does not cite any emergency. Indeed, there is no reason given at all for why the parties waited until either late in the evening of September 18th or the morning of September 19th to submit to the Court a Stipulation to file Motions in Limine[1] when they would have been aware since the original Trial Order in February 2017 that Motions in Limine are due eight weeks prior to the trial date.

Further, if the Court were to look at the dates proposed by the parties, they would disrupt the ability of the parties to comply with their EDCR 2.67, 2.68, and 2.69 obligations, and would preclude the Court and parties from conducting a productive Calendar Call which is set for October 8th pursuant to the Trial Order. That, in turn, would violate provisions of the 2019 version of NRCP.

Specifically, as set forth in Section E of the Amended Trial Order, the Joint Pre-Trial Memorandum is due on September 30, 2019; and in that Memorandum, the parties are to set forth the Orders on any Motion in Limine. That allows the Court to be fully prepared for any issues that may arise at the Calendar Call where the parties are to bring their exhibits, jury instructions, etc., as well as to

[1] The Stipulation and Order was logged in the morning of September 19, 2019, which means that it either arrived in the Department incoming drop box after hours on September 18th or the morning of September 19th.

JOANNA S. KISHNER
DISTRICT JUDGE
DEPARTMENT XXXI
LAS VEGAS, NEVADA 89155

discuss any outstanding trial issues that need to be resolved prior to the trial commencing the following week. Based on the parties' requested Stipulation, their Motions would not even be heard until after the Calendar Call date in order for the hearing to be compliant with the NRCP which would further unnecessarily multiply proceedings and risk the parties not being prepared for trial which commences on October 14th.

Second, the proposed Stipulation and Order is non-compliant with EDCR 2.25. As the section in bold sets forth, requests such as the present one which are made after the expiration of the specified period, "**shall not be granted unless the moving party, attorney or other person demonstrates that the failure to act was the result of excusable neglect...**." As noted above, there was no explanation or any reason provided in the document. The Stipulation provides a recitation of counsel and then it says, "that the following consolidated briefing schedule be issued in this matter regarding Motions in Limine" [2] The deadline to file Motions in Limine has clearly passed. Thus, as counsel chose not to provide any demonstration of excusable neglect, the Court is precluded from granting their request.[3]

> **Rule 2.25. Extending time.**
> (a) Every motion or stipulation to extend time shall inform the court of any previous extensions granted and state the reasons for the extension requested. **A request for extension made after the expiration of the specified**

---

[2] The language is quoted directly from the Stipulation and Order as the word "that" immediately follows the word "Associates".

[3] The Court notes this is at least the third time the parties have provided a purported Stipulation after a deadline has expired and have failed to set forth the necessary information required per 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.

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DISTRICT JUDGE
DEPARTMENT XXXI
LAS VEGAS, NEVADA 89155

> **period shall not be granted unless the moving party, attorney or other person demonstrates that the failure to act was the result of excusable neglect.** Immediately below the title of such motion or stipulation there shall also be included a statement indicating whether it is the first second, third, etc., requested extension.
>
> (b) Ex parte motions for extension of time will not ordinarily be granted. When, however, a certificate of counsel shows good cause for the extension and a satisfactory explanation why the extension could not be obtained by stipulation or on notice, the court may grant, ex parte, an emergency extension for only such a limited period as may be necessary to enable the moving party to apply for a further extension by stipulation or upon notice, with the time for hearing shortened by the court. [Amended; effective October 13, 2005.]

Third, as counsel who were present at the mandatory in-person hearing on September 5, 2019, recall, the Court, on at least two occasions (at approximately 10:39 am and 10:45 am) reminded counsel that due to counsel's non-compliance with several of the rules, the Court was precluded by the provisions of those rules and statute(s) from granting the proposed Stipulation for Extension of Discovery and Trial which meant that the dispositive motion filing deadline, and the Motion in Limine filing deadline which required Motions to be filed eight weeks prior to Trial, remained as set forth in the Amended Trial Order of January 2019. The Pre-Trial Conference date, the Calendar Call date, and the Trial date of October 14, 2019, also remained as set forth in that Order. The Court then again reminded the parties a few moments later that to the extent they had an agreement among themselves regarding experts, depositions, and things that did not impact the court-scheduled dates listed above, nothing precluded them from completing the things that they agreed-upon as long as those items did not impact the Motions in Limine filing deadlines which remained as set by the Court - eight weeks before the start of trial. Thus, it is unclear why the parties

JOANNA S. KISHNER
DISTRICT JUDGE
DEPARTMENT XXXI
LAS VEGAS, NEVADA 89155

disregarded the Court's specific instructions; and instead, about two weeks later submitted the Proposed Stipulation.

The Court, however, need not even address the parties' disregard of its instruction at the hearing on September 5, 2019, as the EDCR's language specifically precludes the Court from granting the parties' request. In addition, the Trial Order presents an additional obstacle as the parties chose not to provide any reasoning for their request. Additionally, given the parties waited approximately three and a half weeks before trial to even submit a proposed Stipulation to file Motions in Limine, and provided a timetable which would not have the Motions heard until a few days before trial, counsel have effectively precluded themselves from being able to comply with their other pre-trial obligations and would not give the Court time to address any other issues that may arise regarding the trial. These additional factors provide independent reasons for the Court to deny the request particularly in light of the fact counsel have not provided any assurances that they would comply with their other obligations. Accordingly, the Court must DENY signing the proposed Stipulation and Order. For the reasons stated herein, the Court must also address counsels' continued non-compliance on September 26, 2019 at 10:00 am.

Dated this 19th day of September, 2019.

HON. JOANNA S. KISHNER
DISTRICT COURT JUDGE

JOANNA S. KISHNER
DISTRICT JUDGE
DEPARTMENT XXXI
LAS VEGAS, NEVADA 89155

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

JOANNA S. KISHNER
DISTRICT JUDGE
DEPARTMENT XXXI
LAS VEGAS, NEVADA 89155

RUN # 211 (M-F, PM)
FIRM Hand & Sullivan, LLC
ADDR 3442 North Buffalo Drive, Las Vegas, NV 89129
PH # (702) 656-5814

PILB #389
1113 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 Farris vs. Rives, et al. NO. A-16-739484-C
DOCUMENTS Stipulation & Order, CK # $
REF # 6618.260 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

12

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
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☉ NEXT SCHED DAY ○ SPECIAL (4HRS) ○ EXPEDITED (2HRS)

Statute Expires

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LAST DATE 9/18/19 5pm
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SAO
KIMBALL JONES, ESQ.
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Attorneys for Plaintiffs

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.: XXXI **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,

SEP 19 19 AM 10:53*

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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	**SCHUERING ZIMMERMAN & DOYLE, LLP**
KIMBALL JONES, ESQ. Nevada Bar No.: 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*	**THOMAS J. DOYLE, ESQ.** Nevada Bar No.: 1120 **AIMEE CLARK NEWBERRY, ESQ.** Nevada Bar No.: 11084 400 University Avenue Sacramento, California 95825 **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

Deadline to File Replies to Motions in Limine : October 2, 2019

IT IS SO FURTHER ORDERED that the Hearing on the parties Motions in Limine is set for the ___ day of _____, 2019 at ___:____ a.m. / p.m.

_____
DISTRICT COURT JUDGE

Submitted by:

BIGHORN LAW

By: _____
KIMBALL JONES, ESQ.
Nevada Bar No.: 12982

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MOTN
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Attorneys for Plaintiffs

9/25/19
9:30am

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.: 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 &**

Case Number: A-16-739464-C

SULLIVAN, LLC, and hereby submit this Motion to Strike and Limit Defendants' Rebuttal Experts on Order Shortening Time ("Motion").

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

DATED this 16th day of September, 2019.

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

~~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.

Ann Lee Sullivan
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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7. This Affidavit is made in good faith, and not for the purposes of delay.

FURTHER YOUR AFFIANT SAYETH NAUGHT.

KIMBALL JONES, ESQ.

SUBSCRIBED AND SWORN to before me on this 16 day of September, 2019.

NOTARY PUBLIC in and for CLARK COUNTY, NEVADA

GRESIA TARANGO
NOTARY PUBLIC
STATE OF NEVADA
My Commission Expires: 12-15-21
Certificate No: 14-12816-1

MEMORANDUM OF POINTS AND AUTHORITIES

I. STATEMENT OF RELEVANT FACTS

Plaintiff Titina Farris was a patient of Defendant Rives. Rives, while performing surgery on Plaintiff, negligently cut her colon in at least two (2), and possibly three (3), places. Thereafter, Rives failed to adequately repair the colon and/or sanitize the abdominal cavity. With feces actively in her abdomen, Plaintiff predictably went into septic shock and was transferred to the ICU. Nevertheless, Rives still failed to recommend any surgery to repair the punctured colon for eleven (11) days, during which time Plaintiff's organs began shutting down and her extremities suffered permanent impairment. Ultimately, Plaintiff developed critical care neuropathy, destroying all nerve function in her lower legs and feet, commonly referred to as bilateral drop foot.

On December 19, 2018, Defendants disclosed eight (8) Rebuttal experts: Dr. Bart Carter, Dr. Brian Juell, Dr. Lance Stone, Nurse Sarah Larsen, Dr. Bruce Adornato, Dr. Kim Erlich, Dr. Scott Kush, and Erik Volk. See *Rebuttal Expert Disclosure*, attached hereto as **Exhibit "1."**

Defendants noted that Larsen, Adornato, and Kush are all "rebuttal witnesses and that their reports are being produced to "rebut" a report from Plaintiffs' initial experts:

> Ms. Larsen is an life care planner. Ms. Larsen is a rebuttal witness. She will provide opinions rebutting the opinions of plaintiffs' expert, Dawn Cook.
> See *Id.* at Page 3:1-3.

> Dr. Adornato is a neurologist. Dr. Adornato is a rebuttal witness. He will provide opinions rebutting the opinions of plaintiffs' expert, Dr. Justin Willer.
> See *Id.* at Page 3:7-8.

> Dr. Kush is a life expectancy expert. Dr. Kush is a rebuttal witness. He will provide opinions rebutting the opinions of plaintiffs' expert, Dr. Alex Barchuk, as they pertain to life expectancy.
> 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.

The reports from Larsen and Kush never once addressed the reports they claim to be rebutting. Larsen's report notes, "Pursuant to your request, I have prepared a Life Care Plan Report in connection with the above entitled matter based on my review of the expert reports, depositions and medical records provided, and upon the recommendations of Lance Stone, M.D. The life Care Plan Report has been prepared in accordance with Federal Rules of Civil Procedure- Rule 26 and is attached." See *Larsen Report*, attached hereto as **Exhibit "2."**

Kush's report notes, "My analyses and opinion of Ms. Titina Farris' life expectancy is based on (I) a review of the materials provided including her medical records, a report, depositions, and other documents, (2) a review of a relevant body of medical and scientific literature, (3) the standard scientific methods for calculating life expectancy, (4) my education, training, experience and expertise." See *Kush Report*, attached hereto as **Exhibit "3."**

These reports, as will be more fully outlined below, not only fail to address Plaintiffs' experts' reports, but they are entirely created to combat long-known aspects of Plaintiffs' case in chief. These are initial expert reports, disclosed after the deadline and after Plaintiffs' chance to rebut these claims had passed.

This same issue is inherent in Dr. Bruce Adornato's report. Adornato at least as the decency to name-drop Dr. Willer—who he is supposedly rebutting—yet, Adornato's report is nothing but initial expert opinions, which are addressing the long-known aspects of Plaintiffs' case-in-chief. See *Adornato Report*, attached hereto as **Exhibit "4."** As such, Defendants' "Rebuttal" experts, Adornato, Larsen, and Kush are properly Stricken from Trial.

Other named witnesses: Carter, Juell, Stone and Erlich, all delve into standard of care opinions or causation opinions. Neither is appropriate from a "Rebuttal" witness. As such, these aspects of their testimony are properly limited.

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II. LEGAL ARGUMENT AND ANALYSIS

Rebuttal evidence is "intended **solely** to contradict or rebut evidence **on the same subject matter** identified by another party." *NRCP 16.1(a)(2)(C)(ii)*. For this reason, rebuttal witnesses are disclosed after initial witness disclosures. *Id.* This later disclosure deadline does not apply to any party's witness whose purpose is to contradict a portion of another party's case in chief **that should have been expected and anticipated by the disclosing party, or to present any opinions outside of the scope of another party's disclosure.** *Id.* (emphasis added).

Nevada's Federal Courts have repeatedly made persuasive decisions on the propriety of utilizing rebuttal experts to present new theories. These courts have declared that rebuttal expert reports are not the proper venue for presenting new arguments. Instead, rebuttal expert opinions should only address new, unforeseen issues upon which the opposing party's initial experts have opined. *Nunez v. Harper*, 2014 WL 979933, *1 (D. Nev. Mar. 11, 2014) (*citing R&O Constr. Co.*, 2011 WL 2923703 at *2). "If the purpose of expert testimony is to contradict an expected and anticipated portion of the other party's case-in-chief, then the witness is not a rebuttal witness or anything analogous to one." *Id.* Presenting a new, alternative theory of causation is not a rebuttal opinion; rather, it is an expected and anticipated portion of a party's case-in-chief. See *Amos v. Makita U.S.A., Inc.*, 2011 WL 43092, *2 (D. Nev. Jan. 6, 2011).

Finally, a party cannot abuse the rebuttal date and use it as "an extension of the deadline by which a party must deliver the lion's share of its expert information." *Amos*, 2011 WL 43092 at *2 (citing *Sierra Club, Lone Star Chapter v. Cedar Point Oil Co., Inc.*, 73 F.3d 546, 571 (5th Cir. 1996).

In *R&O Constr. Co. v. Rox Pro Int'l Group, Ltd.*, 2011 U.S. Dist. LEXIS 78032 (D. Nev. July 18, 2011) the District Court of Nevada addressed a similar situation to that in the case at bar in which an expert who was offered by the defense to address an expected and anticipated portion of the plaintiff's case in chief was improperly disclosed as a rebuttal expert.

The court explained that:

> Fed. R. Civ. P. 26(a)(2)(C)(ii) permits the admission of rebuttal expert testimony that is "intended solely to contradict or rebut evidence on the same subject matter identified" by an initial expert witness. *TC Sys. Inc. v. Town of Colonie*, NY, 213 F.Supp.2d 171, 179 (N.D.N.Y. 2002). Rebuttal expert reports "necessitate 'a showing of facts supporting the opposite conclusion' of those at which the opposing party's experts arrived in their responsive reports." *Bone Care Int'l, LLC v. Pentech Pharmaceuticals, Inc.*, 2010 U.S. 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. 1996). Rebuttal expert reports are proper if they contradict or rebut the subject matter of the affirmative expert report. *Lindner v. Meadow Gold Dairies, Inc.*, 249 F.R.D. 625, 636 (D. Haw. 2008). They are not, however, the proper place for presenting new arguments. *1-800 Contacts, Inc. v. Lens.com, Inc.*, 755 F.Supp.2d 1151, 1167 (D. Utah 2010); see *LaFlamme v. Safeway, Inc.*, 2010 U.S. Dist. LEXIS 98815, 2010 WL 3522378 (D. Nev. Sep. 2, 2010); cf. *Marmo v. Tyson Fresh Meats*, 457 F.3d 748, 759 (8th Cir. 2006) ("The function of rebuttal testimony is to explain, repel, counteract or disprove evidence of the adverse party.") (citation omitted). "**If the purpose of expert testimony is to 'contradict an expected and anticipated portion of the other party's case-in-chief, then the witness is not a rebuttal witness or anything analogous to 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).

The bright line authority in this jurisdiction is that rebuttal expert testimony "is limited to **'new unforeseen facts brought out in the other side's case.'**" In this case it is undisputed that the causation of Plaintiffs' injuries and the future care they would require were anticipated parts of their case in chief and therefore any experts designated by the Defendants regarding the Plaintiffs' loss of earnings, should have been designated by the Initial Expert Disclosure Deadline.

The court in *R&O Constr. Co. v. Rox Pro Int'l Group, Ltd.*, 2011 U.S. Dist. LEXIS 78032 (D. Nev. July 18, 2011) explained that because the "rebuttal experts" in that case were not true rebuttal experts they were improperly disclosed. The court explained:

> While both McMullin's and Hoff's reports address the same general subject matter of 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

meaning of Rule 26(a)(2)(C)(ii). See *Vu v. McNeil-PPC, Inc.*, 2010 U.S. Dist. LEXIS 53639, 2010 WL 2179882 at *3 (C.D. Cal. May 7, 2010) (finding that such a broad meaning would all but nullify the distinction between an initial "affirmative expert" and a "rebuttal expert."); see *International Business Machines Corp. v. Fasco Indus., Inc.*, 1995 U.S. Dist. LEXIS 22533, 1995 WL 115421 (N.D. Cal. Mar.15, 1995) ("rebuttal experts cannot put forth their own theories; they must restrict their testimony to attacking the theories offered by the adversary's experts."). McMullin's report offers opinions and conclusions regarding the structural insufficiency of the design for the installation of a stone veneer on the project, the requirement that the stone veneer installation be accomplished with an anchored system and the resulting irrelevance of the bond between stone and mortar, and R&O's role in bringing potential design deficiencies to the attention of WD Partners. By comparison, Hoff's report details theories regarding the failure of the stone and mortar, and makes observations regarding 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).

Because the report is not a rebuttal report, it is untimely and must be stricken unless Real Stone can show that the untimely disclosure was substantially justified or harmless. See *Rule 37(c)(1)*. Here, Real Stone's late disclosure is not substantially justified. Notably, it had named Hoff as an expert and provided his curricula vitae within the time 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.

As to the issue of harm, the Hoff report was not disclosed until nearly nine weeks after the initial expert cutoff date of November 10, 2010. Discovery cutoff has already been extended three times in this case, and the latest cutoff date has passed. Although no trial date has yet been set, the dispositive motion deadline was April 8, 2011. Accordingly, R&O is prejudiced by the Hoff report, because the time to designate rebuttal experts has passed, as well as the discovery cutoff and dispositive motion deadlines. A scheduling 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).

The facts in the *R&O Construction* case are very similar to the facts in the subject case. Larsen, Adornato, and Kush were not disclosed as initial experts and their reports were not made to the

Plaintiffs until a month after the initial expert disclosure deadline. This designation was improper and untimely and this Court should follow the reasoning of the *R&O Construction* case and Strike the untimely and improper expert designation of these three "rebuttal" experts.

In the instant case, Defendants negligently failed to care for Plaintiff Titina before and after she developed sepsis. The effect this damage had on her health and her future are catastrophic. This—liability and damages, including future damages—was the entire sum and substance of Plaintiffs' initial complaint and Defendants' subsequent answer. Plaintiffs' initial Complaint spelled out with laser precision that they believed that Defendants were liable for Plaintiffs' injuries and for the damage caused by Defendants' negligence. That causation was an expected and central component to the case precludes any rebuttal witnesses from offering faux-rebuttal testimony which opines on alternative causation opinions in their rebuttal reports:

> Rebuttal experts are not allowed to put forth their own theories; instead, "**they must restrict their testimony to attacking the theories offered by the adversary's experts.**"
>
> *Downs v. River City Grp., LLC*, No. 3:11-CV-00885-LRH, 2014 WL 814303, at *5 (D. Nev. Feb. 28, 2014) (Emphasis added).
>
> Even if it is not outside that scope, the subject of the causation of the fire is an expected and anticipated portion of Defendant's case-in-chief, and therefore Hyde cannot be a rebuttal expert or anything analogous to a rebuttal expert. *Apex Oil,* 985 F.2d at 245.
>
> Allowing Hyde to testify as more than a rebuttal expert would allow Makita to use the 30 day deadline for disclosure of rebuttal experts as an extension of time for disclosing the lion's share of its expert information. See *Sierra Club,* 73 F.3d at 571. Causation of the fire is the central issue of this entire litigation. Makita knew that long before the expert disclosure deadlines.
>
> *Amos v. Makita U.S.A., Inc.*, No. 2:09-CV-01304-GMN, 2011 WL 43092, at *2 (D. Nev. 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

their side of the adversarial process. Defendants' preparation for their case in chief did just that—as they timely disclosed their own initial Medical Providers.

Despite clearly understanding that reasonableness of medical care, causation, and damages, including future life care, was part of the Plaintiffs' case-in-chief, Defendants are now abusing the disclosure process by attempting to ambush Plaintiffs by sneaking in *additional* medical experts and life care experts to give entirely new alternate theories of causation for Plaintiffs' injuries when it is no longer possible for Plaintiffs to hire experts to rebut these new opinions. Defendants added these new voices a month after the deadline for initial experts had passed.

Furthermore, these "Rebuttal" expert reports provided do not appropriately address or rebut Plaintiffs' initial expert opinions, but instead seek to introduce new opinions—including reports which fail to even reference Plaintiffs' initial expert reports, which they are supposedly rebutting.

This masquerade will confuse the jury and significantly prejudice the Plaintiffs, who have appropriately followed Nevada Rules of Civil Procedure and the Court's process for disclosures, in a timely and respectful manner. Therefore, this Court should Strike Defendants' rebuttal experts' testimony, and allow Defendants to make their arguments through their initial experts.

A. <u>The Opinions of Larsen, Adornato, and Kush Address Issues That Were Long-Anticipated Portions of Plaintiffs' Case in Chief; As Such, They Are Properly Stricken.</u>

Nevada Rules of Civil Procedure state in plain language what qualifies as rebuttal testimony, stating definitively that rebuttal deadlines are not created to give counsel a second chance to argue what "should have been expected and anticipated by the disclosing party." *NRCP 16.1(a)(2)(C)(ii)*. Furthermore, Nevada Courts, as addressed above, have declared the impropriety of subverting process by utilizing rebuttal experts to present a new case-in-chief or to present new theories after the period for disclosing initial expert witnesses has passed.

Defendants should easily have expected and anticipated that Plaintiffs would make one of their core causes of action against Defendants for their negligence in causing Plaintiff Titina to undergo

substantial medical treatment and damages, that the treatment provided after the subject incident was reasonable, and that Plaintiff Titina would require care in the future. Defendants had every reason to expect, anticipate and prepare for that debate in their disclosure of initial experts.

Plaintiffs were again circumspect about this goal to prove that Defendants' behavior led to the medical care sought by Plaintiffs, and that such subsequent care was reasonable in light of Plaintiff Titina's injuries. Plaintiffs disclosed their initial experts and noted that they would be testifying as to the reasonableness of Plaintiff Titina's medical care. In their reports, Plaintiffs' initial experts testified to the nature of Plaintiffs' injuries, how they were caused by Defendants' negligence and how the subsequent care, and cost thereof, was reasonable.

Nevertheless, more than a month after the deadline to disclose initial expert witnesses, Defendants disclosed eight (8) experts as "rebuttal experts," including Jensen, Kush, and Adornato. While Plaintiffs take issue with each of these witnesses, Adornato most blatently fails to conform to those restrictions required for rebuttal disclosure.

Adornato Report Deficiencies:

Dr. Adornato's report mentions Dr. Willer's initial report. However, each and every one of his opinions critiques a long-known portion of Plaintiffs' case-in-chief, and could only be properly disclosed through an initial expert disclosure, if at all. See *Exhibit 4*.

Adornato attacks Plaintiffs' long-known causation opinions, which were outlined in Plaintiffs' Complaint from the beginning of the case. Moreover, these opinions were found within the medical records Plaintiffs disclosed early on. Adornato takes issue with elements of Plaintiff Titina's medical records, which were available to Defendants – for years. Adornato does not comment on anything new or novel; he simply fills the role of an additional initial expert, though he is disclosed as "rebuttal" only.

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In addition, Adornato gives a new, novel theory that was never addressed by Dr. Willer—and one that is a direct causation opinion, which is inappropriate in a rebuttal report:

> Based on my education, training, and experience and review of the pertinent documents, I have reached the opinion that Ms. Farris suffered from a significant painful diabetic neuropathy prior to the events of August 2015 and that this was in part due to her poorly controlled diabetes, which continues to the present time.
>
> See *Exhibit 4*, at Page 2.

This causation opinion is couched as one Dr. Willer failed to consider—yet, if this was Defendants' belief as to the causation of Plaintiff Titina's injuries, it may only enter from an initial expert. This is true for numerous reasons. First, expert medical causation opinions are always initial. Second, Dr. Willer's opinion that Adornato departs from was not new, but was rather a well-known opinion in Plaintiffs' case-in-chief from the commencement of the case, requiring Defendants to contradict it, if at all, in their initial expert disclosure. Third, Adornato's opinion is entirely formed from medical records in Defendants' possession – for years.

As this is the sum of Adornato's testimony, it is properly Stricken. As Adornato does not have a single appropriate rebuttal opinion in this matter, but has instead offered initial opinion only, he must be Stricken in this matter to avoid further prejudice to Plaintiffs and abuse by Defendants.

This resolution is strengthened by the Court's finding in *R&O*—which notes that Rebuttal Testimony is exclusively limited to "unforeseen" facts:

> **[R]ebuttal 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)).
>
> *R&O Constr. Co. v. Rox Pro Int'l Group, Ltd.*, 2011 U.S. Dist. LEXIS 78032 (D. Nev. July 18, 2011). (Emphasis added).

The bright line authority in this jurisdiction is that rebuttal expert testimony "is limited to **'new unforeseen facts brought out in the other side's case.'**" In this case it is undisputed that the causation of Plaintiffs' injuries and the future care they would require were anticipated parts of their case in

chief and therefore any experts designated by the Defendants regarding the Plaintiffs' loss of earnings, should have been designated by the initial expert disclosure deadline. Everyone was aware of Plaintiff Titina's diabetes even prior to her surgery, and certainly long before the lawsuit was filed. Moreover, the fact that Defendants' initial experts both note the role of diabetes in their analysis makes it clear that Defendants were aware of the matter long before rebuttal disclosures.

Adornato's report is inappropriate because he is not addressing "new" "unforeseen" facts elicited by Dr. Willer—he is simply creating new, novel theories based on the medical records that Willer (and all of Defendants' initial experts) already relied upon. These facts have been known by Defendants – for years, prior to Dr. Willer's reports.

Larsen Report Deficiencies:

Nurse Larsen's report consists of twenty-two (22) pages of new, novel theories for Plaintiff Titina's life care plan—testimony which should have been part of Defendants' case in chief. Larsen notes that she based her report on Defendants' own "rebuttal" expert of Dr. Stone, and not as any rebuttal to Plaintiffs' initial expert reports:

> My opinions, which are set forth in the Life Care Plan Report for Ms. Farris, are based upon the review of expert reports, my 19 years of experience in nursing, academia and life care planning, and the current costs associated from the Las Vegas and Henderson, Nevada areas for the outlined recommendations for medical care, treatment and supplies. I have consulted with Dr. Stone regarding his opinions of future care needs for Ms. Farris. I have outlined the recommendations of Dr. Stone in the Life Care Plan Report. I reserve the right to modify my report in the event additional information is provided.

See *Exhibit 2*, at Page 2.

This opinion is inappropriate from a "rebuttal" witness. Plaintiffs' future medical needs are an anticipated part of their case in chief, particularly in a case where it is well known by all parties that Plaintiff Titina lost her ability to walk independently as a result of the subject incident. Defendants 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'

experts—she is merely delving into new opinions which are inappropriate coming from a rebuttal expert. It is crystal clear that this is a causation opinion which is being shoe-horned into a rebuttal report.

Further, it is telling that, in a report where Larsen is supposed to be rebutting Cook, she is instead quoting from Defendants' "rebuttal" expert, Dr. Stone, to prove her initial opinions. Larsen does not even discuss or note the opinions of Plaintiffs' experts in her report, neither does she incorporate or consider their opinions. Rather, Larsen simply creates a new set of novel opinions about Plaintiff Titina's future care needs based on nothing more than the information that was readily available from the commencement of the case, combined with the other opinions offered by Defendants' "rebuttal" expert Dr. Stone. There was nothing new in Plaintiffs' initial expert disclosure that surprised Defendants, or that Larsen needed for the opinions formed here. Defendants' attempt to circumvent the discovery deadlines in this matter disqualifies them from presenting this opinion. Therefore, Larsen should be Stricken as a witness in this matter.

Kush Report Deficiencies:

Likewise, Dr. Kush's report is wholly an initial expert report. As noted above, Dr. Kush fails to address Plaintiffs' experts' reports in any regard, never once referring to them in his reports—aside from a one-line claim, that he reviewed them. Its contents, however, are never addressed.

Kush, after noting Plaintiff Titina had diabetes then concludes:

> **To a reasonable degree of scientific certainty, I have calculated Ms. Titina Farris' life expectancy, as of the date of this report, to be 21.5 additional years.**

See *Exhibit 3* (Emphasis in original).

Dr. Kush's report is another initial report. Kush provides opinions about Plaintiff Titina's physical condition both before and after the subject incident. Kush provides opinions about how long Plaintiff Titina will live. These opinions should have come from an initial expert—one that Plaintiffs could have rebutted. Instead, Defendants have snuck this initial opinion in from their rebuttal

witness—making a rebuttal impossible in this matter. Defendants had the opportunity to calculate Plaintiff Titina's lifespan in the initial stages of litigation in this matter—yet they chose not to do so. Instead they are violating this Court's scheduling order by presenting initial opinions in the guise of rebuttal opinions. As such, Dr. Kush's initial testimony, couched as rebuttal, must be Stricken.

i. Additional Support in Striking these "Rebuttal" Reports.

Both Kush and Larsen's report exemplify the type of inappropriate "rebuttal" report noted by the Federal District Court:

> "Courts have repeatedly held that an expert is improperly designated as a rebuttal expert when he has failed to review the initial expert report, or otherwise failed to indicate that he was aware of the opinions offered by the initial expert." *See, e.g., Clear-View Techs., Inc. v. Rasnick*, 2015 WL 3509384, at *4 (N.D. Cal. June 3, 2015) (internal quotations and alterations omitted) (citing *Houle v. Jubilee Fisheries, Inc.*, 2006 WL 27204, at *3 & n.4 (W.D. Wash. Jan. 5, 2006) and *Amos*, 2011 WL 43092, at *1). Quite simply, "an expert cannot be said to 'rebut' testimony he or she has never seen or reviewed." *Clear-View Technologies*, 2015 WL 3509384, at *4.
>
> *Felix v. CSAA Gen. Ins. Co.*, No. 215CV02498APGNJK, 2017 WL 1159724, at *3 (D. Nev. Mar. 28, 2017).

These three (3) experts, Adornato, Larsen and Kush, were improperly utilized and violate the Nevada Rules of Civil Procedure, because any issues that Defendants thought would pertain to causation of damages and reasonableness of care must have been included in their initial expert disclosure. This is obvious since damages, reasonable care and causation are essential to Plaintiffs' case in chief and were a well-known portion of Plaintiffs' case from the commencement of this litigation. Defendants chose to ignore the proper role and scope of rebuttal experts in order to stack the deck against Plaintiffs and compensate for the oversights of their initial experts' reports. This prejudices the entire testimonial process and leaves Plaintiffs without recourse to the luxuries of time and lavish testimony that Defendants enjoy as a result of their strategy.

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.

Commissioner Beecroft in this jurisdiction came to the same conclusion as the Federal Courts did in *Nunez* and *Amos*—that rebuttal experts are not to be used to establish a new case-in-chief. Commissioner Beecroft gave this opinion in a decision on an automobile crash case, *Mangus v. Abram*, A-11-634090-C, (8th Judicial District Court January 7, 2013). In *Mangus,* Defendant disclosed a biomechanical accident reconstructionist as an initial expert, and plaintiff scrambled to rebut, seeking permission to examine defendant's vehicle in order to disclose a rebuttal expert. Defendant refused, arguing that plaintiff knew prior to the initial expert disclosure deadline that defendant would enlist a biomechanical expert because defendant requested permission for his expert to inspect plaintiff's vehicle. *Id.* As a result of this disclosure, plaintiff could anticipate that the biomechanical expert would be part of defendant's case in chief and should have disclosed her *own* initial biomechanical expert instead of abusing the rebuttal process to compensate for her oversight. Commissioner Beecroft not only denied plaintiff's motion to compel inspection of defendant's vehicle, but went further, striking plaintiff's biomechanical rebuttal expert altogether on the grounds that plaintiff should have disclosed said expert as initial. *Id.*

In the instant case, Defendants have had ample reason to acknowledge and anticipate Plaintiffs' damages, including reasonableness of care, future life care and medical causation, all central to Plaintiffs' case. Importantly, Defendants did attack these positions through the use of their initial experts – proving Defendants' knew of these elements in Plaintiffs' claimed damages. Therefore, Defendants should not be allowed to abuse rebuttal disclosures, which by their very nature are limited in scope, to further bolster initial expert opinions. Like Plaintiffs, Defendants should have prepared their best case in line with the law, and debated damages, causation, and reasonableness on an even playing field, disclosing all initial expert opinions on the deadline to do so, as Ordered by this Court. To do otherwise prejudices the judicial process and rewards the Defendants' circumvention of this Court's Rules and Processes. Therefore, this Court must Strike Defendants' rebuttal experts, Adornato,

Larsen, and Kush, and focus on the debate between the properly retained initial and rebuttal expert witnesses.

B. The Opinions of Stone and Erlich must be Limited to Preclude Testimony on Standard of Care and Causation.

As noted above, the bright line authority in this jurisdiction is that rebuttal expert testimony "is limited to **'new unforeseen facts brought out in the other side's case.'"** As the standard of care (including breaches of the same) and medical causation are always part of Plaintiffs' case-in-chief, these are areas that can only be addressed by initial experts, rather than by rebuttal experts. Yet, Defendants' Rebuttal experts delve into declaring that Rives' actions were within the standard of care, and gave opinions on causation.

Dr. Stone opines on Causation:

> Based upon my independent review of Ms. Farris medical records I agree in general with Dr. Barchuck's diagnosis. However, the medical records I reviewed support my conclusions that several medical problems were preexisting or unrelated to surgery.

See *Stone Report*, attached hereto as **Exhibit "5."**

Whether Plaintiffs' injuries were actually preexisting is a new and novel theory, and one which is not based on new evidence. Stone admits that his opinion is coming from a record review, not from Barchuck's report. This opinion may properly be made by an initial expert, but cannot be made by Dr. Stone, who is exclusively a rebuttal expert. As such, Plaintiffs request that Dr. Stone's testimony be limited to pure rebuttal opinions and that he be precluded from offering any opinions regarding the standard of care of medical causation of injury, which issues are exclusively initial in nature.

Similarly, Dr. Erlich presents improper standard of care opinions:

> It is my opinion that, from an Infectious Diseases standpoint, Dr. Rives met the standard of care in his evaluation and management of Ms. Farris.

See *Erlich Report*, attached hereto as **Exhibit "6."**

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All of the information regarding infectious disease was known by Defendants – for years. The primary source of infectious disease analysis comes from Plaintiff Titina's treatment from July 3 – 15, **2015**. To permit Dr. Erlich to provide opinions regarding the standard of care, as a purely "rebuttal" expert, would prejudice Plaintiffs and reward Defendants for violating Nevada rule.

Dr. Erlich also states:

> The abnormalities seen on July 15, 2015 had not been present on the CT scan which was performed on July 9, 2015, and therefore the patient did not have a bowel perforation at 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.

Id.

From the commencement of the case, the issue of how/when Plaintiff Titina developed a bowel leak, was questioned. This was such a central issue of the case, from the beginning, that Defendants produced two (2) initial experts in this case to comment on it. Both provided the same opinion outlined here by Dr. Elrich. Clearly, this was not a new issue and is not the province of rebuttal experts. As such, Dr. Elrich must be precluded from offering opinions about when Plaintiff Titina developed an active and ongoing bowel leak, as this has been a central point of the case from the beginning, has already been addressed by Defendants' initial experts, is now an improper "rebuttal" opinion and is clearly Defendants attempt to gang up against Plaintiffs through expert numerosity.

Therefore, the Opinions of Stone and Erlich must be Limited to Preclude Testimony on Standard of Care and Causation.

III.

CONCLUSION

Clearly, all of the information opined about by these "rebuttal" experts was well known by all parties – long before the initial expert disclosure deadline. As such, any expert opinions about this information were required to be produced, if at all, no later than the initial expert disclosure deadline.

Giving Defendants carte blanche to untimely interject new theories and arguments is severely prejudicial to Plaintiffs and will confuse the basic issues of the case. It also allows a dangerous precedent of abusing rebuttal disclosures to gain unfair adversarial advantage. Therefore, this Court should Strike Defendants' rebuttal experts Adornato, Larsen, and Kush, while precluding Defendants' other rebuttal experts from offering any opinions as to standard of care or medical causation, as such topics are well known portions of Plaintiffs' case-in-chief and are reserved for initial experts.

Again, Defendants' Rebuttal Experts Larsen, Adornato, and Kush have given exclusively inappropriate testimony that should have been (and certainly was) anticipated as part of Plaintiffs' case in chief. Therefore, based on the foregoing law, facts, and analysis, Plaintiffs respectfully requests their Motion to Strike Defendants' Rebuttal Experts be Granted.

DATED this 16th day of September, 2019.

BIGHORN LAW

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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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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 J. RIVES, M.D. AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S REBUTTAL DISCLOSURE OF EXPERT WITNESSES AND REPORTS**

Defendants BARRY J. RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC ("Defendants") hereby disclose pursuant to Nevada Rules of Civil Procedure Rule 26 and 16.1 the name of their rebuttal expert witnesses who may be called at trial.

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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

Ms. Larsen is an life care planner. Ms. Larsen is a rebuttal witness. She will provide opinions rebutting the opinions of plaintiffs' expert, Dawn Cook. Ms. Larsen's report, curriculum vitae including publication history and list of deposition/trial testimony and fee schedule are attached hereto as Exhibit D.

5. Bruce Adornato, M.D.
177 Bovet Road, Suite 600
San Mateo, CA 94402

Dr. Adornato is a neurologist. Dr. Adornato is a rebuttal witness. He will provide opinions rebutting the opinions of plaintiffs' expert, Dr. Justin Willer. Dr. Adornato's report, Curriculum Vitae including publication history, list of deposition/trial testimony and fee schedule are attached hereto as Exhibit E.

6. Kim Erlich, M.D.
1501 Trousdale Drive, Room 0130
Burlingame, CA 94010

Dr. Erlich is an infectious disease expert. Dr. Erlich is a rebuttal witness. He will provide opinions rebutting the opinions of plaintiffs' expert, Dr. Alan Stein. Dr. Erlich's report, Curriculum Vitae including publication history, list of deposition/trial testimony, and fee schedule are attached hereto as Exhibit F.

7. Scott Kush, M.D.
101 Jefferson Drive
Menlo Park, CA 94025

Dr. Kush is a life expectancy expert. Dr. Kush is a rebuttal witness. He will provide opinions rebutting the opinions of plaintiffs' expert, Dr. Alex Barchuk, as they pertain to life expectancy. Dr. Kush's report, Curriculum Vitae including publication history, list of deposition/trial testimony and fee schedule are attached hereto as Exhibit G.

8. Erik Volk
1155 Alpine Road
Walnut Creek, CA 94596

Mr. Volk is an economist. Mr. Volk is a rebuttal witness. He will provide opinions rebutting the opinions of plaintiffs' expert, Dr. Terrence Clauritie. Mr. Volk's report,

curriculum vitae including publication history, list of deposition/trial testimony and fee schedule are attached hereto as Exhibit H.

NON-RETAINED EXPERTS

1. See NRCP 16.1 disclosures.

Defendants reserve the right to call any experts identified by any other party to this action.

The above expert witnesses may not be the only ones called by defendants to testify. Defendants reserve the right to later name other expert witnesses prior to trial. Defendants also reserve the right to call to testify at trial expert witnesses not named whose testimony is needed to aid in the trial of this action and/or to refute and rebut the contentions and testimony of plaintiff's expert witnesses.

Dated: December 19, 2018

SCHUERING ZIMMERMAN & DOYLE, LLP

By _____

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