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

APPELLANTS' APPENDIX
VOLUME 6

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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).

EXHIBIT B

In the Matter Of:

Farris vs Rives, M.D., et al.

MICHAEL B. HURWITZ, M.D., FACS

September 18, 2019

Job Number: 573931

6A.App.1091

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

DEPOSITION OF MICHAEL B. HURWITZ, M.D., FACS, a witness herein, noticed by Schuering Zimmerman & Doyle, LLP, taken at 510 Superior Avenue, Newport Beach, California, at 3:07 p.m. on Wednesday, September 18, 2019, before Delia M. Satterlee, CSR 9114.

Job Number 573931

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INDEX

WITNESS: MICHAEL B. HURWITZ, M.D., FACS

EXHIBITS

MICHAEL B. HURWITZ, M.D., FACS,
a witness herein, having been sworn, testifies as
follows:

-EXAMINATION-

BY MR. DOYLE:

Q. Please tell us your full name.

A. Michael Hurwitz.

Q. Business address.

A. 510 Superior Avenue, Suite 200G, Newport Beach, California 92663.

Q. Have you given a deposition before?

A. I have.

Q. About how many times?

A. Probably ten times or so. I've got a complete list there (indicating).

Q. Are you generally familiar with the process?

A. Yes, I am.

Q. Can I dispense with the various does and don'ts you've probably heard a number of times?

A. Yes, you may.

Q. The only thing I would ask is: If I should pose a question and for whatever reason my question is not clear to you, will you let me know so I can restate

or rephrase it in some way?

A. Yes, I will.

Q. Okay. We have marked some things that you brought with you today. Is this your complete file in this case?

A. Yes, it is, with the exception of depositions that I reviewed electronically.

Q. Your rebuttal report, did that list some dep- -- Well, strike that.

Can you tell me which depositions you have reviewed?

A. I'd have to look at the rebuttal report. I've reviewed all of those that are listed on the rebuttal report.

Q. The only one listed on the rebuttal -- I'm sorry. In the expert report, we have the deposition of Dr. Rives. And in the rebuttal report, you said you reviewed expert reports by Dr. Carter and Dr. Jewell, but there's no mention of depositions.

A. Okay. So I hadn't reviewed the depositions at that point. I have since reviewed depositions on -- depositions of Carter and Jewell, Erlich, Stein, Rives. I reviewed also a deposition of Rives in the Center case.

Q. Any other depositions?

A. And I briefly looked at --

I'd have to -- I -- I'd need a memory check here.

I looked at --

MR. JONES: If you like, we can verify on our end if we've sent him over anything.

THE WITNESS: I was sent depositions. There was a deposition of the husband of -- of the plaintiff, and there were some others that were included that I -- I did not review. I haven't read the depositions of the neurologists.

MR. DOYLE:

Q. Have you been provided Mrs. Farris's deposition?

A. I don't know that I've seen that one.

Q. Dr. Chaney's deposition?

A. I don't believe so. Who is Dr. Chaney?

Q. Mrs. Farris's primary care physician.

A. No, I did not read it.

Q. When you say you've not reviewed the neurologists, are you talking about the neurology experts in this case?

A. I believe so.

Q. These various depositions that you told me about, did you take any notes when you read them?

A. No.

Q. Did you mark or highlight in any form or fashion the transcripts when you read them?

A. No.

Q. What was your understanding why you were given Dr. Rives's deposition in this other case?

A. The reason was to demonstrate his interpretation of the events leading up to the discovery of the gastric perforation as a pulmonary process.

Q. Well, did you find any striking or important similarity -- similarities or dissimilarities in that Center deposition?

A. To be fair, I didn't -- I didn't -- I had already reviewed everything else, and it didn't really change my opinion.

Q. Okay. We marked as Exhibit A --

(Exhibit A identified.)

MR. DOYLE:

Q. Just tell me generally what is in Exhibit A.

A. So you asked for all of my correspondence with Mr. Hand, and so I provided that, a series of e-mails, mostly -- almost entirely around, you know, reviewing the records and getting in contact with them. So there's nothing of significance in there.

I've also provided my CV, as you requested, and a list of the cases in which I've testified as a -- as an

expert and my depositions.

And I have also provided, I believe in here somewhere -- was my bill to -- was my -- my bill for services --

Q. Okay.

A. -- as an expert witness.

Q. Tell me what Exhibit B is, which has on top a correspondence to you dated June 26, 2019.

(Exhibit B identified.)

MR. DOYLE:

Q. This was a separate mailing from Mr. Hand with the CD, the imaging, and these are the interpretations of -- these are the radiol- -- radiologist's interpretations.

Had you seen the radiology reports for this case prior to receipt of Exhibit B?

A. Whatever is included in the hospital records I had seen, so a lot of this was duplicated.

Q. And when you say "in the hospital records," you were pointing to the binder we marked as Exhibit C?

A. Correct.

Q. Okay.

(Exhibit C identified.)

MR. DOYLE:

Q. Then I'm not going to mark these, but we have a

couple of CDs. One of them says "Farris St. Rose CD." And stapled to it is -- stapled to it is a description of the contents and a couple of imaging studies.

Did you look at this CD?

A. I did not.

Q. The other CD that has a handwritten note that says "Complete records if needed," did you look at those?

A. No. I believe that's a -- that's the same thing that's in the binder that you have as evidence on a disc.

Q. Have you -- your -- Have you looked at the -- any CT images yourself?

A. I briefly looked at them. It's been some time.

Q. How long ago?

A. Whenever I received that (indicating) -- Whenever I received this (indicating). So it would have been in the end of June or beginning of July.

Q. Is there yet another CD somewhere that has the imaging studies that you reviewed?

A. There is.

Q. Do you know where that is?

A. I think it's in my office. I can get that for you.

Q. Let's do that at a break.

And then we've marked as Exhibit C a three-ring binder. Tell me generally, what is Exhibit C?

A. Exhibit C is the hospital records from St. Rose Dominican Hospital.

Q. Okay. Did you review the entirety of these records?

A. As much as I could.

Q. When you reviewed the records, did you make any handwritten or typed notes?

A. No.

Q. Did you make any marks, notes or highlighting on the records themselves as you reviewed them?

A. No.

Q. The top of Exhibit C has what looks like a three-page letter from George Hand. It doesn't have a date. But is it your understanding this is a letter from Mr. Hand those first three pages?

A. It looks like it, yeah. Yes.

Q. Did this come with the binder?

A. Yes.

Q. And you looked at this before you started going through the records? It's right on top.

MR. JONES: Objection.

THE WITNESS: I don't know in --

MR. JONES: Speculation.

THE WITNESS: -- which order I looked at it.

MR. DOYLE:

Q. Well, in all likelihood, you looked at the cover letter first before going to the records?

MR. JONES: Objection; speculation --

THE WITNESS: To be --

MR. JONES: -- asked and answered.

THE WITNESS: To be honest, I have -- I don't think I did. I think I just opened the records.

(A discussion is held off the record.)

MR. DOYLE:

Q. Why do you think you skipped the cover letter that came with it?

A. Well, first of all, I don't even remember what's in the cover letter, so I don't recall the specifics of it. It looked like a summary of -- of the case, and I just don't recall when I looked at it.

Q. Okay. At some point in time you read the letter?

A. Yes.

Q. So with the exception of the CD that's in your office that you'll get for us at a break, we have in front of us your complete file for this case?

A. Yes.

Q. Have you discussed this case with any

colleagues?

A. No.

Q. Have you done any research specifically for this case on any particular topic?

A. No.

Q. Now, the term "colotomy," what does that mean?

A. That is a hole in the colon.

Q. And that could be anywhere along the length of the colon and its different parts?

A. Yes.

Q. If you have a hole in the small bowel, what is that called?

A. An enterotomy.

Q. And if you have one in the rectum, is there a term?

A. I'll -- I'll call it a proctotomy or a rectotomy or a colotomy.

Q. When performing surgery -- abdominal surgery on a patient who has had a surgical history and the presence of adhesions, what are the common causes of a colotomy in general?

MR. JONES: Objection; overbroad, vague, compound.

THE WITNESS: Colotomies can occur during the course of dissection of adhesions.

MR. DOYLE:

Q. How does that happen?

A. Well, there's a number of ways that can happen. It can be caused by putting traction on the bowel as you're dissecting it, tearing the bowel, essentially.

It can be caused by physically cutting into the bowel with a sharp implement.

It can -- They can be -- Colotomies can be caused by a thermal injury, so using a thermal device on the bowel can lead to a colotomy.

Colotomies can also be deliberate. We make colotomies when we are creating an anastomosis. So sometimes colotomies are deliberate for that purpose.

Q. The -- You mentioned that traction on the bowel can result in a tearing of the bowel in a colotomy. How does that work? What is the mechanics of that?

A. If one is tugging on the bowel or pulling on the intestine in some manner and the intestine is tethered, you can essentially rip the intestine.

Q. And how does a thermal colotomy occur?

A. Well, a thermal source in contact with a bowel can essentially burn the bowel. And just as with a sharp instrument, one can go all the way through the bowel with a heat source, such as cautery. One can also go partially through bowel with a heat source and lead to a partial-thickness thermal injury that can develop

later into a colotomy as the tissue dies.

Q. When we use the term "colotomy," are we referring to an injury that goes all the way through the bowel?

A. I think that when one mentions a -- when one says "colotomy," one is typically referring to a full-thickness injury. If you're talking about a partial-thickness injury, you might call that a partial-thickness injury or you might call it a partial-thickness colotomy, I suppose. More commonly, if you cut the outside of the bowel but not the inner layer of the bowel, you might call that a serosal injury.

Q. So when dissecting adhesions, you can sometimes have a partial-thickness injury to the bowel; for example, just the serosa.

A. Correct.

Q. And you can also have a full-thickness injury, which is commonly called a colotomy, where the injury goes all the way through the mucosa into the lumen of the bowel?

A. Correct.

Q. And I think you mentioned these can occur inadvertently or intentionally.

A. Correct.

Q. I assume -- You're a general surgeon.
A. Yes, I am.
Q. I assume you have encountered inadvertent colotomies over the years?
A. I have.
Q. The fact that a colotomy occurs during an abdominal procedure does not necessarily mean the care was below the standard of care. Fair statement?
A. Yes.
Q. How many times have you inadvertently caused a colotomy? Best estimate.
MR. JONES: Object to form.
THE WITNESS: I -- I would be making up an answer if I tried to answer that. I -- I've been in practice or in training since 1988, so that's a long time to try and estimate the number of colotomies I've seen. Over that period of time, perhaps several dozen.
MR. DOYLE:
Q. Less than 50, then?
A. Probably.
Q. In those instances where you yourself encountered an inadvertent colotomy, were there some that you repaired?
A. Well, hopefully they were all that I repaired.
Q. Well, sometimes you may see a colotomy and make

a decision that rather than repairing --

A. Oh.

Q. -- the hole itself, that you're going to fix the problem with a resection and an anastomosis; correct?

A. I would say that the vast majority of inadvertent bowel injuries have been in small bowel rather than in large bowel. And sometimes I've repaired those with suture, closing the hole. But there have been times when I've had to resect a section of bowel -- of the small intestine.

I would say that the vast majority have been in small bowel and not in colon. True colotomies are -- are reasonably infrequent, and I can't recall having to resect bowel because I put holes in it, but I'm sure that's happened at some point in my career.

Q. So as you sit here today, your thinking is that those colotomies that you have encountered over the years, typically you have repaired them rather than doing a resection and an anastomosis. Fair statement?

A. I think that's reasonable.

Q. And in your own experience when you have repaired colotomies, do you have a preference for sutures versus staples?

A. Well, my preference would be to close with

suture. Staples can be used; but especially during an open operation when you have the facility to close with suture, I prefer that.

Q. Why do you prefer a -- Well, let's -- let's focus for a moment -- Well, strike that.

Have you repaired colotomies with sutures laparoscopically?

A. I have.

MR. JONES: Objection; foundation.

MR. DOYLE:

Q. Have you ever repaired a colotomy laparoscopically using a stapler?

A. Probably.

Q. How many times would be your best estimate? Less than five?

A. None -- I can't recall any specific cases where I've had to do that. I'm sure I've done it at some point in the past.

Q. Are you familiar with the Endo GIA stapler?

A. I am.

Q. Do you use it?

A. Yes, I do.

Q. What do you use it for?

A. I've used it to divide the bowel endoscopically.

I've used it to remove an appendix.

I've used it to – during -- I've used it during the course of sigmoid colectomies, for example.

Q. In a typical month, how often will you use an endoscopic stapler?

A. Probably four or five times.

Q. I mean, do you have any standard-of-care criticism of Dr. Rives and his decision to use a stapler to close the colotomies in this case?

A. (No response.)

Q. Or is that surgeon's choice?

A. My concern about Dr. Rives' choice of using a stapler in this case isn't specific to him just using a stapler but using a stapler across an area of colon that he has separated from mesh using a thermal instrument. And my concern is that using the thermal instrument, the LigaSure bipolar device, to separate the transverse colon from the mesh to which it was densely adherent put that section of bowel at risk of tissue necrosis. And then stapling across the bowel in order to close it, I think he created a situation where he may have been stapling thermally injured bowel. And in that case, it's difficult to get a good purchase on -- on the colon.

My criticism is more in the use of the thermal

device for the dissection than it is in using a stapler.

Q. Do you use the LigaSure?

A. I have used the LigaSure, and I've also used the Harmonic scalpel, but I don't use it in approximation with bowel.

Q. Have you stopped using one and instead started using the other?

A. No. They both have their place. Sometimes it's a function of what's available to us.

Q. Does one carry a higher risk of thermal injury than the other?

A. Well, both carry a risk of thermal injury, and the manufacturer of each will tell you that the other has a higher risk of thermal injury. But they both have the potential for lateral thermal spread, for the spread of heat beyond that which is being cauterized. So I consider them both to be potentially dangerous when the device is against the serosa of the bowel.

Q. You did a fellowship in surgical oncology?

A. So when I was at Harbor-UCLA in 19- -- between 1994 and '95, I was a -- I was kind of a hybrid between a junior faculty and a -- essentially a breast oncology fellow. So it wasn't a formal fellowship, but I was helping to run the breast clinic. I was working with a mentor who was involved in the breast clinic. And I was

also an attending at Harbor during that same period of time as a -- as a clinical instructor.

Q. Well, on your CV, you say you did a fellowship in surgical oncology.

A. Well, that was the --

Q. Got to let me finish my question, please.

On your CV, you said you did a surgical oncology fellowship at Harbor-UCLA. Was that a formal or an informal program?

A. Well, it was formal in that I did receive a certificate and so forth, so yes.

Q. And then you also have, under "Fellowship," "Advanced Minimally Invasive Surgery."

Was that a formal MIS fellowship?

A. Yes, it was.

Q. For one -- For the two years at L.A. County-USC?

A. One year, '97 to '98.

Q. Is that where you encountered Dr. Katkhouda?

A. Yes, it is.

Q. Your CV has some publications including publications where you co-authored publications with Dr. Katkhouda. My question is; any of your publications on the CV have any pertinence or relevance to the issues in our case?

A. No.
Can I go off the record for a second?
MR. JONES: No.
MR. DOYLE: No. We need to keep going. At the break.
THE WITNESS: Okay.
MR. DOYLE:
Q. When a colotomy is repaired with sutures, does the literature indicate that there's a certain failure rate?
A. There is a certain failure rate, certainly.
Q. What is that failure rate for a colotomy repair with sutures?
A. You know, I don't have the -- the current literature number off the top of my head, but I would estimate it to be probably 10 percent, something of that nature.
Q. And then how about a colotomy repair with staples? What is the -- What does the literature have for the failure rate in that instance?
A. I would imagine it to be similar.
Q. And when we say "failure rate" and reference the literature, what we're talking about is the -- the repair is done; and then subsequent to the repair, something comes undone or comes apart and there is

leakage of bowel contents?

A. Correct.

Q. In general, why do you have an approximate 10 percent failure rate for a colotomy repair whether it's with sutures or staples? What physiologically happens afterwards?

A. Well, a number of things can affect the integrity of the tissue. I mentioned thermal injury as one. Tissue ischemia because of inadequate blood supply is another. That inadequate blood supply could be due to factors intrinsic to the patient or due to the patient's underlying, you know, health. Injuries, you know, failure of the -- of the suture repair due to other host factors like the presence of infection can lead to breakdown of a staple line or a breakdown of a sutured repair. Technical failure in performance of the suture closure or staple closure can lead to breakdown of the repair, to name a few.

Q. Okay. Any other common ones that come to mind?

A. Other health problems related to the patient: patients on steroids, for example, hypotensive patients, smokers, a number of reasons that staple ends can fail, sutures can fail.

Q. If a patient is obese, does that increase the risk of a colotomy repair failure?

A. In and of itself it shouldn't if it's done correctly. If -- If a patient's significantly obese, they might have other significant health concerns that could impact the repair. If somebody has diabetes, for example, that might impact their ability to heal. If -- If they've got vascular disease they may not have adequate blood supply to the area being sewn. So -- So indirectly, I suppose.

Q. You were provided with the records of Dr. Chaney, according to your expert report, Mrs. Farris's primary care physician.

Are those in the binder?

A. I do not believe so.

Q. Let me show you my copy of your -- and you can ignore my highlighting (indicating). But does your report list Dr. Chaney's office and billing records as records provided to you?

A. It does, and I believe I read them -- I reviewed these records early on.

Q. Where -- Where are they?

A. That's a good question. I don't know offhand.

Q. Well --

A. I must have them in a file.

Q. What other records on that list are not contained in Exhibit C?

MR. JONES: Objection; foundation.
MR. DOYLE: Well, if you want, I'll have him look at Exhibit C and look for Chaney's records, but I don't think they're in there.
THE WITNESS: Anything that's on this list wouldn't be in that binder, so I must have another file that I -- I did not bring in. So I'll be sure to get that to you.
MR. DOYLE:
Q. Would that be in your office with the CD?
A. No. That would be at home.
Q. This expert report, is this something you drafted or someone drafted for you?
A. I wrote it.
Q. Okay. From beginning to end?
A. As I recall.
Q. Are you aware that Ms. Farris was diagnosed with diabetes mellitus type II prior to July of 2015?
A. May I see my report?
Q. I've marked this up (indicating). Do you not have a...
A. I don't have a copy.
Q. Well -- Okay. You say here, "Titina Farris was an obese type II diabetic female."
A. So yes, I was aware of it.
Q. Were you aware that she was generally

noncompliant with the diabetes recommendations for treatment?

A. I may have been at the time that I wrote that report. I don't recall that specifically.

Q. Were you aware the prior to July of 2015, her blood sugars often were out of control?

MR. JONES: Objection; overbroad.

THE WITNESS: Again, I -- I may have been at the time that I wrote that. I don't recall that specifically.

MR. DOYLE:

Q. I mean, if we assume those facts to be true, would that be the kind of diabetic patient that would have an impaired ability to heal?

A. Yes, for sure.

Q. And I apologize if I asked you this question already, but in terms of using a stapler to repair a colotomy, have you ever done that?

A. Yes.

Q. How many times?

A. Somewhere less than 50, but I've done it.

Q. Okay. You told me that you've encountered somewhere less than 50 colotomies over your career. So each time?

A. You know, to be fair, I can't recall, over all

these years, how many times I've encountered colotomies in my own practice. If I'm doing a case as an open procedure, I would, as I said, close that with sutures.

In terms of laparoscopic cases where I would have -- where I would use a stapler and I encountered a colotomy, I can't recall a specific instance of that. But given that I've been doing this for a very long time, in all likelihood it's happened; I just can't recall a specific instance that I can call to mind.

Q. Do you remember in Dr. Rives's report referring to the blue load for the --

A. Mm-hmm.

Q. -- stapler?

A. Yes.

Q. Can you tell me what the blue load is?

A. So there is different color-coded cartridges that are used with these mechanical stapling devices, and the -- the color designates the staple height.

So the blue load is typically used for intestine, most specifically small intestine or large intestine.

The green load is used for thicker tissue, like stomach.

And the white load typically is a vascular cartridge used for small- -- for narrower staple lines.

So we -- So when we're using these Ethicon

products, those are the three colored staplers that we typically have to choose from.

Q. Would you assume that your failure rate for a colotomy repair using sutures would mirror what's described in the literature or be more or less?

MR. JONES: Objection; foundation.

THE WITNESS: I think in my personal experience, I have had far fewer than 10 percent of my closures leak. Now, I may have been off with my 10 percent estimate because I said I didn't consult the literature. That was off the top of my head. But I think in my -- my numbers have been small. I don't recall too many leaks in my career, so I may be lucky or I may just not have had many leaks.

MR. DOYLE:

Q. Do you recall in your career repairing a colotomy with a stapler, whether it's laparoscopic or open, and it goes on to have a leak?

A. Not specifically.

Q. In a typical week, how many days are you in the OR?

A. Typically three, and then I'm also on call some weekends, so sometimes as many as five or six.

Q. And in a typical week, you'll perform how many surgical procedures?

A. Anywhere from seven to 15 procedures.
Q. And what number or percentage of those typically are open versus laparoscopic?
A. I'd say they're probably 75 percent laparoscopic.
Q. When Dr. Rives performed his surgery on July 3, 2015, did you see in his operative report a description of creating inadvertently two colotomies?
A. Yes, I did.
Q. Do you have an opinion whether there were more than two inadvertent colotomies during that procedure?
A. Well, I know that the pathology report for the specimen resected by Dr. Hamilton showed three colotomies.
Q. You also noted in Dr. Hamilton's operative report, she described only seeing one colotomy; correct?
A. That's correct.
MR. JONES: Objection; foundation.
MR. DOYLE:
Q. And you would expect, if Dr. Hamilton saw three colotomies, that she would comment on that number.
MR. JONES: Objection; argumentative, foundation.
THE WITNESS: Having been in cases like that, I know that when Dr. Hamilton was in there, her goal was to get the damaged section of intestine out. So what we

looked for in those cases is a healthy proximal end to divide and a healthy distal end to divide to get out the bad section.

The goal in that situation is to look for the good tissue on either end, to remove the im- -- impaired section and get beyond all the areas of damage, not necessarily to catalog the injuries that are within that section. So the fact that she didn't account for all of those doesn't surprise me.

She also described very inflamed tissue, so that can obscure the -- that it can obscure the -- the appearance of the perforation when looking at it grossly in that circumstance.

MR. DOYLE:

Q. Did you consider the possibility that when Dr. Hamilton was manipulating the transverse colon, that she inadvertently created one or two colotomies in the section that she knew she was going to resect?

A. Well, she described -- she described during her operation that she had an area of deserosalization of -- of the colon. So she does describe that, but she does not describe a colotomy.

I think that had Dr. Hamilton knowingly gone into the bowel full thickness, she would have described it. And I say that only based upon her dictation technique.

She seems to leave, you know, little out of the dictation even to the point that she described tearing her glove on the -- on the Securestrap tack. So I think had she knowingly put a hole in the colon, she would have described it.

Q. Similarly, if she had seen three holes, she would have described three holes, not one. Fair statement?

A. Had -- Could she -- Had she been able to see them. But again, in this circumstance, we're looking for the healthy tissue down below and the healthy tissue up above and just to get that section out before more stuff spills out of it. So I think her focus would have been on getting that proximal and distal resection.

Q. Okay. Going back to the question I asked, did you consider the possibility that Dr. Hamilton, not intentionally but inadvertently, caused two colotomies when manipulating the transverse colon and resecting it?

MR. JONES: Objection; asked and answered, argumentative.

THE WITNESS: It's possible.

MR. DOYLE:

Q. Did you consider that possibility?

A. Yes.

Q. And you acknowledge that that's a possible

explanation for what the pathologist found?

MR. JONES: Objection; asked and answered.

THE WITNESS: It's possible.

MR. DOYLE:

Q. Now, did you consider the possibility that the pathologist's manipulation of the bowel segment prior to the gross examination caused what appeared to be a second and third hole?

A. I considered that, but I don't think that's -- that's likely.

Q. Why not?

A. Well, generally speaking, pathologists, in my experience, can tell the difference between something that occurred in live tissue versus something that happened in the specimen handling. So pathologists typically inspect specimens after it's -- after they've been fixed in formalin, so they can tell the difference between something that's occurred in -- in -- in -- in the moment in realtime and something that's occurred during the processing afterward.

Furthermore, pathology is -- you know, is, by its very nature, a forensic specialty, so pathologists tend to be careful in not damaging the evidence, if you will. So I -- I think it's unlikely that the hole was caused by the pathologist.

Q. You're familiar with the term "reasonable degree of medical probability" or "certainty"?

A. Yes.

Q. What is your understanding of that term?

A. That there's a 51 percent chance that -- that something occurred in such a way.

Q. Is it your opinion to a reasonable degree of medical probability or certainty that at the end of Dr. Rives's surgery on July 3rd, there was a third colotomy not repaired?

A. I think it's to a reasonable degree of certainty that there was a third injury. But what I can't tell you is whether that was a full-thickness injury or a partial-thickness injury. In other words, was this an injury that occurred that was not apparent to him at the time by virtue of using a thermal energy device.

Q. Well, a thermal injury can cause a through-and-through perforation at the time of the application of the instrument, or it may cause a partial injury that necroses and opens later; true?

A. True.

Q. Is it your opinion that there was some thermal injury to -- Strike that.

Is it your opinion to a reasonable degree of

medical probability that there was some thermal injury to the transverse colon at the point in time when Dr. Rives completed the procedure on July 3rd?

A. I think it's possible.

Q. Okay. I'm interested in -- Can you tell me to a reasonable degree of medical probability that at the end of Dr. Rives's surgery on July 3rd, there was a thermal injury, whether it was partial thickness or full thickness?

A. I think that -- I'll put it this way: I think that the injuries that occurred to the colon did not happen in a vacuum; it did not happen by themselves. They were a consequence of the manipulation of the bowel, however that occurred.

The use of thermal injury -- The use of thermal energy to dissect bowel from mesh is contraindicated because of the potential for a thermal injury such as this. I can't say with certainty that there was a thermal injury, but clearly there were three injuries to the colon that occurred during the course of the dissection, at Dr. Rives' hand. So I think it's reasonable to suspect that -- or to believe that he caused the injury. I can't tell you with a reasonable degree of certainty that it was specifically the thermal injury that caused that third hole.

Q. And according to Dr. Rives's operative report, there were two inadvertent colotomies; correct?

A. Correct.

Q. Both in the transverse colon.

A. Correct.

Q. Both of which he repaired.

A. Correct.

Q. Can you tell me to a reasonable degree of medical probability where in the transverse colon either one of those were located?

A. I'd have to go back to his operative report to look at that.

Q. Would you have expected them to be visible to him through the laparoscope?

A. Clearly the two were -- that he saw were visible to -- to him through the laparoscope.

I think it's possible laparoscopically to overlook injuries that occur, particularly in an area that you've been dissecting off of the abdominal wall or off of mesh.

The challenge with laparoscopy -- one challenge with laparoscopy is that you're looking at something in -- in two dimensions. You don't really have the ability to feel or touch it or to handle it as you would if you were doing an open surgery. So your ability to

inspect the colon is somewhat hampered. So it is certainly possible that he could have overlooked an injury because he was laparoscopic.

Q. Are you able to tell me to a reasonable degree of medical probability that there was a third full-thickness injury -- in other words, a through-and-through colotomy -- at the end of Dr. Rives's procedure on July 3rd?

A. No.

Q. Are you able to tell me to a reasonable degree of medical probability that there was a third but partial-thickness injury at the end of his surgery on July 3rd?

A. I think it -- there was one or the other, but I can't tell you which, and I can't speculate as to whether it was 51 percent in favor of a full or a partial. But -- But the conditions were set at that operation. If it wasn't a full-thickness injury at that time that was overlooked, then it was an injury that developed subsequently --

Q. Well, if --

A. -- in an area that was injured.

Q. If it wasn't a full-thickness injury at the end of the surgery on July 3rd, when did the hole open up, to a reasonable degree of medical probability?

A. Well, sometime over the ensuing days.
Q. What range of days?
A. Well, I would say that --
(Interruption in proceedings.)
THE WITNESS: I would say that range could be anywhere as -- as early as 24 hours to as late as 72, three or four days.
MR. DOYLE:
Q. So is it your opinion to a reasonable degree of medical probability that by July 8th, there was a full-thickness injury to the transverse colon?
A. Well, I think clearly by that time there was a full-thickness injury, whether it was at one of the two staple lines or whether it was at this third injury.
Q. Well, do you have an opinion to a reasonable degree of medical probability that one or both of the staple lines failed, leading to a full-thickness opening?
A. Well, we have the pathology report that shows that there was an opening at a staple line where there was a full-thickness injury.
Q. Are you able to discern which staple line that was, based on Dr. Rives's operative report?
A. No.
Q. And is it your opinion to a reasonable degree

of medical probability that the opening at one staple line described by the pathologist was present as of July 8th?

A. I think that to a reasonable degree of medical certainty, that at some point between the 3rd and -- I would characterize it a little more narrowly -- perhaps the 6th or 7th, sometime in that time frame, there was clearly an intra-abdominal source of sepsis, so I think we have to therefore conclude that there was a perforation in the bowel, whether it was at the third site that wasn't yet discovered or at one of the two colotomy sites that were stapled.

Q. So when you had the -- this full-thickness injury or perforation of the bowel open up sometime between July 3rd and July 6th, 7th, that time range, there would then be spillage of bowel contents.

A. There would be -- There would certainly be leakage of bacteria and possibly frank spillage of content.

Q. But when you said a few moments ago that -- that clearly -- Strike that.

When you said a few moments ago that by the 6th or 7th of July there was clearly an intra-abdominal source of sepsis, what you're saying is by that point in time, there's an opening in the bowel and there is spillage of

bacteria and bowel contents; true?

A. You know, not necessarily you can have a perforation in the bowel that can -- that can allow bacteria to escape into the peritoneal cavity that can lead to intra-abdominal sepsis and not have frank spillage of fluid or colon contents into the abdominal cavity.

For example, we can -- we see patients who are septic with perforations that have temporarily sealed themselves off with something, either omentum or the abdominal wall or some adjacent structure that can create intra-abdominal sepsis.

Q. How big was this hole by the 7th?

A. Well, I wasn't there. I can't tell you the answer to that. I can tell you --

Q. What's your estimate?

A. -- in looking at the pathology report -- you know, I'd have to look at it, but how big the hole was at the time that the specimen was resected. How big the hole was on the -- on the 7th I can't tell you. It's -- It's a little bit immaterial because it doesn't take a large hole to release bacteria from within the colon to outside the colon.

Q. Are you able to give me a reasonable estimate of the range of size of this through-and-through

perforation that you believe existed as of July 6th or 7th?

A. Well, it can be anything from, you know, the range of -- of, you know, a millimeter or two to a centimeter or more. Again, it's -- it's -- it's a little irrelevant because patients can become profoundly septic with tiny holes in the colon.

Q. And can a patient become -- Well, strike that.

You said a patient could become profoundly septic even with a tiny hole. That would occur because there is spillage of bacteria; correct?

A. Correct.

Q. And in some patients, not much bacteria can cause a lot of problems where some patients that same amount of bacteria would not cause the same cascade of problems. Fair statement?

A. Yes.

Q. Given your opinion that there was a through-and-through perforation by July 7th with a range perhaps of 1 to 2 milliliters to 1 centimeter or more in size, how do you explain the results of the July 9th CT scan?

A. (No response.)

Q. And let me ask you a foundational question.

You understand that CT scan was done with triple

contrast.

A. Yes.

Q. How do you explain the CT findings given your opinion about the presence of a hole at the time of that CT scan?

A. Well -- So a CT scan is a diagnostic tool. It's just one tool that we have at our disposal. And as with any diagnostic imaging, there's the potential for false positives and false negatives.

CT scans are limited by a number of things. One is that they're subject to interpretation. They're subject to the -- to the tolerances of the imaging capability, and they miss things. And it's certainly not inconceivable that the CT scan under-called the extent of infection.

In fact, frankly, in the presence of somebody who is septic, to rely on a CT scan to determine whether one should intervene surgically is foolish, and you have to take one imaging study and -- in the context of everything else that's going on. So the fact that the CT scan didn't show clear evidence of a perforation doesn't mean that that -- that there was no perforation. It's possible that the perforation could have temporarily sealed with omentum, for example, or the bowel could have stuck to something else like the

abdominal wall. So the fact that the CT is -- is -- you know, doesn't show the problem doesn't mean there's no problem.

Q. Okay. My question is this: To a reasonable degree of medical probability, can you tell me why the July 9th CT scan did not show any extravasation of oral contrast through this hole you have described?

MR. JONES: Objection; overbroad, vague, asked and answered.

THE WITNESS: Can I answer it again?

MR. DOYLE:

Q. Doctor, you provided me a general explanation of why a CT scan wouldn't show a hole. I'm interested in why this CT scan did not show this hole.

So my question is: Can you tell me to a reasonable degree of medical probability why the CT scan on July 9th there was no extravasation of oral contrast through the hole?

MR. JONES: Same objection that I just made.

THE WITNESS: Well, it's certainly likely that the hole had been -- occurred and sealed off by omentum or something else.

MR. DOYLE:

Q. And --

A. There's something preventing that contrast in

the colon lumen from leaking out through the hole.

Q. Did you consider the possibility that there was not yet a hole?

A. Well, one can consider that possibility, but it's illogical in the presence of evidence of intra-abdominal sepsis.

Q. At the time of Dr. Rives's surgery, given the two colotomies, you would expect there to be some minute amount of bacteria escaping from the transverse colon into the peritoneum; correct?

A. Yes.

Q. And that bacteria that has escaped from the transverse colon during the procedure on July 3 can cause an intra-abdominal infection.

A. Yes.

Q. Peritonitis.

A. Yes.

Q. And...

A. So given that that injury during surgery can cause peritonitis and given that Dr. Rives knew that he had caused at least two colotomies during the course of the operation, as I said in my previous documents, it's incumbent upon him to rule that out as a source of sepsis and do something about it.

Q. The two colotomies that Dr. Rives described

seeing and repairing, do you have an opinion to a reasonable degree of medical probability how those were caused? What was the mechanism?

A. They occurred during the course of dissecting the -- the colon from the mesh.

Q. Was it a -- tugging and pulling a sharp instrument or a through-and-through thermal injury?

A. Or some bottom combination of all three perhaps.

Q. And I'm asking you to a reasonable degree of medical probability whether you have an opinion how those two colotomies occurred. And if you don't, that's fine.

A. I can't say with certainty which technique specifically led to those specific holes.

Q. The rectal contra- -- Have you ever ordered a CT scan with rectal contrast?

A. I have.

Q. And the rectal contrast typically will pass how far up?

A. It depends. There is this -- It just depends. I mean, I -- I wouldn't necessarily expect it to get all the way to the transverse colon, but it depends on how much is used and how much pressure is put upon it.

Q. And you would expect the oral contrast to make

it to and through the transverse colon; correct?
A. It should if enough time is allowed from the time it's administered to the time the imaging is taken.
Q. When you looked at the actual images for the July 9th CT scan, did you look at the transverse colon to see if there was contrast within the lumen of the bowel?
A. There was contrast, and there was contrast beyond it.
Q. So there was contrast not only in the transverse colon but also in the descending colon as well.
A. Yes.
Q. And whether that was oral contrast, rectal contrast or some combination of the two, one would not know.
A. True.
Q. But we do know there was contrast all the way across the transverse colon down the left colon and through the rectum; correct?
A. Yes.
Q. Did you consider the possibility that the pressure caused by the rectal contrast caused a staple line to open?
A. That's possible, but it doesn't explain the

sepsis that was occurring prior to the study that was done.

Q. Okay. But the sepsis that was occurring prior to the study that was done can be explained by spillage of bacteria before the colotomies were repaired; true?

A. That is true --

Q. Okay. And --

A. -- yes.

MR. JONES: Hold on. Hold on. Let him finish his answer.

MR. DOYLE: Well, I got a plane to catch, and you guys -- you -- you showed up 30 minutes late, so I'd like to just --

MR. JONES: No, no.

MR. DOYLE: -- keep moving.

MR. JONES: He gets to finish his answer.

THE WITNESS: Okay. It's -- It's -- It's true. But if you've got a patient who's got abdominal sepsis, intra-abdominal sepsis, whether it's from a perforation that's actively spewing stuff out or it's from a perforation -- or it's from the colotomy at the time of surgery, it's still intra-abdominal sepsis. And the thing that should be done by a reasonable and prudent surgeon taking care of that patient is to reoperate.

So -- So we're splitting hairs a little bit as to

whether -- as to the source of it. Whether it's actively coming out or whether it came out at the time of surgery and then stopped coming out after the colotomy was closed with staples, it still occurred. And if the patient is exhibiting signs of sepsis -- and all indications are that the patient was exhibiting signs of sepsis that was intra-abdominal, not pulmonary or anything else -- then it's incumbent upon the surgeon to go back.

The worst thing that he could do -- The worst-case scenario is he goes back and takes a look and it turns out everything's fine. He's ruled out a -- an intra-abdominal source. But he didn't do that.

So I -- I think it's, to a -- a significant extent, splitting hairs to determine exactly when the bacteria came out. The patient clearly was septic postop.

MR. DOYLE:

Q. But, Doctor, wouldn't you agree that if there's spillage of bacteria at the time of the colotomies, the colotomies are repaired, there's no more spillage of bacteria but that bacteria goes on to cause an intra-abdominal infection, that can lead to an abscess; true?

A. True.

Q. And an abscess often is treated by an

interventional radiologist with a drain rather than a general surgeon performing an open or a laparoscopic procedure; true?

A. If an abscess develops -- If -- If a -- If an abscess develops in an area that's essentially walled off, that's contained by something, by loops of intestine, for instance, or by bowel, and that -- that infection is well contained and well controlled and on CT scan you see an abscess that's discrete and that can be drained, certainly that's an indication for drainage.

In this case, that wasn't what was going on. That wasn't the case. There wasn't a drainable abscess. So one could say, "Well, there's not a drainable abscess because there's no infection," but that's not what's going on here. What's going on here is you've got a patient who's got intra-abdominal sepsis but isn't fortunate enough to have a drainable abscess. They've got peritonitis; they've got -- they've got sepsis; and it demands that the surgeon go back to surgery and wash the abdomen out.

Q. What are the peritoneal signs?

A. Well, peritoneal signs can be a rigid abdomen. They can be abdominal tenderness. They can be a distended abdomen. They can be absent bowel sounds. They can also be very difficult to determine in a

patient who is intubated and sedated and particularly a patient who had an encephalopathy who isn't really responding to normal cues. There's a lot of things that can obscure physical examination. So --

Q. I understand. I was just asking you what the signs are.

A. So I said those.

Q. Okay. Thank you.

You mentioned abdominal tenderness. But as a peritoneal sign, that's a specific type of tenderness called rebound tenderness; true?

A. True.

Q. And rebound tenderness is something different than generalized abdominal tenderness; true?

A. Well, rebound tenderness, um --

Q. Is that true or not?

MR. JONES: He can answer the question the way that he needs to answer the question.

THE WITNESS: Yes. But it's -- it's not a valuable sign in somebody who's unable to respond appropriately.

MR. DOYLE:

Q. Did I ask that question?

A. No, but I answered it.

Q. I understand. You know, I understand you want to be advocate here, but if you could just -- if you

could just answer my questions --

MR. JONES: Okay.

MR. DOYLE:

Q. -- then we can --

MR. JONES: We're not going to have any of this nonsense with you trying to instruct my witness on what he -- how he is to answer or not answer a question. So -- So he is able to answer it how he feels it is appropriate. And if your question -- the call of the question cannot be answered with a "yes" or "no," he can answer it the way he needs to.

MR. DOYLE:

Q. Can we continue?

A. Yes.

Q. All right. What role does a physician's judgment play in their treatment of a patient?

A. Well, a physician's judgment is important in treatment of a patient.

Q. Why is it important?

A. So we have to apply sound medical judgment to the decisions we make in the -- in the care of our patients. Sound medical judgment requires that you consider the pros and cons of -- of any given approach, that you consider the ramifications of -- of the actions you're taking, that you provide the patient with an

opportunity to consider those -- those risks and benefits of -- of both sides of a -- of -- of -- of an issue and come to the correct conclusion. They require that you apply the -- you know, your education and your training to help guide you in those decisions.

So part and parcel of surgical decision-making is understanding the risks and the benefits of -- of the approach that you're taking. If you are taking a conservative, nonoperative approach to a patient, for example, you have to consider what the potential deleterious effect of that nonoperative course may be and also what the deleterious effects could be of -- of surgical intervention.

And it's also incumbent upon the physician to have that discussion with the patient so they can make an informed decision. If the patient is incapacitated, then that falls to, you know, whoever has got, you know -- you know, whoever is, you know, in -- in charge of their care.

Q. So it sounds like judgment is an important component of a physician's care of a patient.

A. Yes.

Q. And one has to exercise their judgment when looking at the pros and cons of different alternative ways of approaching a patient; correct?

A. Yes.

Q. Can you and I agree that -- that in surgery, there are a number of situations where you might have two different general surgeons go about treating care -- treating a patient differently yet both be within the standard of care?

A. Yes, but I don't think this is one of those circumstances.

Q. I asked you a general question, Doctor.

Can you agree as a general matter that you can have situations where two general surgeons can be taking care of a given patient and both be within the standard of care even though they're taking of the patient differently?

A. Yes. That hypothetical exists.

Q. And that's part the art of medicine as well; correct?

A. Yes.

Q. And can a physician err in judgment?

A. Yes.

Q. Can a physician err in judgment and still be within the standard of care?

A. Yes.

Q. Can a physician err in judgment, be within the standard of care, yet unfortunately cause their patient

some injury?

A. Yes.

Q. Has that happened to you where you have looked back on your care of a patient and thought that you had erred in judgment but were within the standard of care yet unfortunately caused some injury?

A. Yes.

Q. Have you ever been a defendant in a malpractice case?

A. Yes.

Q. How many times?

A. I was -- I've been named in three cases. Two of those were -- never went anywhere. They were dismissed outright. And one went to arbitration. And in that -- And that case had very -- really no similarity to this, but -- so yes.

Q. Was there an arbitrator's award against you?

A. No. The arbitrator dismissed the case without judgment.

Q. The other side had an expert witness?

A. Yes.

Q. Who disagreed with your expert witness.

A. I -- I don't remember whether the other side had an expert witness. I -- I have to assume they did.

Q. And assuming the other side had an expert

witness, presumably that expert witness disagreed with your expert witness about whether your care was within the standard of care.

A. Yes.

Q. Yours said "Okay"; theirs said "Not okay."

A. Right.

Q. How does that happen?

A. You know, clearly -- How is it that you can get an expert to take any position?

Q. Sure.

A. Is that what you're asking --

Q. Sure.

A. -- how -- how can you get an expert to take any position?

I -- I think that you can look at things from different perspectives and through different lenses.

I happen to feel that in this case -- and -- and -- and I will say I have not done a lot of expert witness work, but I have done expert witness both on the defense side and on the plaintiff side. People have different perspectives on things. That doesn't mean both sides are right every time. And in this case, it is very clear to me that sound surgical judgment required that Dr. Rives recognize that this is an intra-abdominal source of sepsis that is not improving with antibiotic

therapy alone and that surgical intervention is required. And I, frankly, find it hard to see the perspective of the other side. So I feel that he did not exercise sound judgment in this case.

Q. Do you know Dr. Brian Jewell?

A. No, I do not.

Q. From reading the information provided to you, did it appear to you that he's a well-qualified general surgeon?

A. Yes.

Q. Do you know Dr. Bart Carter?

A. I do not.

Q. Based upon the information provided to you, would you agree that he's a well-qualified general surgeon?

A. Yes.

Q. Do you practice in a group here?

A. I do.

Q. How many general surgeons in the group?

A. 12.

Q. Are all board certified?

A. Yes.

Q. At Hoag Memorial, are there general surgeons on staff who are not board certified?

A. No.

Q. Do you know any -- Go ahead.

A. I was going to say that they're either board certified or board eligible. I believe that everybody is -- has -- everybody that's on staff has been in practice long enough to be certified.

Q. Do you know any general surgeons, perhaps socially or professionally, that are not board certified?

A. If they're not board certified, they don't talk about it. I -- I wouldn't know.

Q. You saw in this case that Dr. Rives is not board certified.

A. Yeah, I saw that.

Q. You were provided with the details of why.

A. Yes.

Q. And would you agree with me that as a general proposition, a general surgeon can still be well qualified, well trained and competent even though he or she is not board certified?

MR. JONES: Objection; overbroad, speculation.

THE WITNESS: I think that i- -- i- -- it's certainly possible that a good surgeon can be a good surgeon despite having failed board exams. I don't necessarily think that an ability to pass a board makes you a better surgeon. But -- I don't want to qualify

that. I don't -- I don't -- I -- I -- I can't point to data that would show a board-certified surgeon is better than a non-board-certified surgeon except that there's a reason that we have boards, and there's a reason that surgeons are required to pass boards in order to be board certified because -- because it's important to maintain that -- that knowledge base and to show that you've mastered the information.

MR. DOYLE:

Q. Do you have any information about how Dr. Rives has maintained his knowledge in general surgery?

A. No.

Q. Or minimally invasive surgery?

A. No.

Q. Any of the courses or lectures or -- or what he does to remain current?

A. No.

Q. Can we agree as a general matter that a general surgeon who is not board certified can practice within the standard of care?

A. Yes.

Q. That you have to look at the care, not the absence of board certification; correct?

A. Correct.

Q. Have you been practicing long enough where,

like me, you remember paper hospital charts?

A. Yes, fondly.

Q. As do I.

In the days of paper hospital charts, generally when multiple physicians would be following a patient -- for example, a patient in the ICU -- the physician would either write a note or dictate a note for that particular day's visit; correct?

A. Correct.

Q. And that note would go into the chart.

A. Yes.

Q. And if you wanted to look at a particular physician's thinking over, say, a one-week period of time, you could read their different progress notes and you could figure out the evolution of their thinking, typically.

A. Yes.

Q. Can't do that with electronic medical records, can you?

A. Well --

Q. Can you?

A. Yes, you can. I would -- I would disagree with that.

Q. All right. Well --

A. But it's challenging because you have to get

past a lot of filler. But ultimately, when reviewing charts, you go to the -- to the Assessment and Plan portion of the progress note, and -- and that's where we, you know, free text or free -- you know, free type in our -- our conclusions and what we plan to do going forward.

So I -- I would disagree with the notion that -- that you can't draw conclusions like you could from a paper chart. To the contrary, I think you can read them better. You can read -- You don't have to worry about doctors' handwriting. You just have to wade through a lot more filler that -- that doesn't contribute to the -- to the discussion.

Q. What system does Hoag use?

A. We use a system call Epic.

Q. What system does St. Rose-San Martin use?

A. I don't know.

Q. Was it your impression when you were reviewing these records that different physicians could choose different templates for creating progress notes?

A. It looked to be the case to me.

Q. And the same is true for Epic, isn't it?

A. More or less.

Q. So some physicians may choose to have certain information self-populated, and others choose not to

have that information self-populated.

A. Yes.

Q. A physician's progress note from a day earlier may or may not self-populate their next day's progress note, depending on the choices they've made.

A. Well, we certainly see an issue where sometimes physicians will cut and paste, copy forward and so forth, if that's what you're referring to.

Q. Well, yes. And did you see that in this case?

A. I can't think of a specific instance. I do recall seeing some things that look like it was the same thing going forward, not necessarily with Dr. Rives.

Q. Okay. But other physicians caring for Mrs. Farris?

A. Yes.

Q. You saw the same entry day after day even though that same entry was no longer germane.

A. I think so, yes.

Q. Okay. You mentioned something about having your billing records. Can you show me where the --

A. My billing records?

Q. Yeah. I thought you said something when we were going -- marking exhibits. You -- I thought you said your bills were here.

A. The -- I have the -- the invoice that I

submitted for the review of the case up to the point that I've submitted that bill.

Q. Can I see it?

A. It's old-fashioned handwritten.

Q. I like handwriting.

A. (Indicating.)

Q. You don't need to pull the clip off.

A. Here it is.

Q. I saw that earlier.

So this is something contained in Exhibit A, and it says at the top "Invoice Summary, Doctor"; correct?

A. Yes.

Q. And it's an invoice dated December 4, 2018?

A. Yes.

Q. Is this the first invoice that you created documenting the time you spent on this case?

A. Well, according to that, it says that's for additional time, but then I couldn't find the original invoice, which to me begs the question as to whether I ever sent one. So this is the only one I could find, so, um...

Q. Can you give me an estimate of the total amount of time that you have spent on this case as of December 4, 2018 when you prepared this invoice?

A. Well, how many hours is on there?

Q. On here is four hours.

A. So the initial -- So if that's my secondary invoice, I -- I probably submitted an invoice for about an hour to an hour and a half for my initial review of -- of the case and my discussion with Mr. Hand.

Q. Okay. And then the invoice that we have, then, for December 4, 2018, capturing your time after that, we have "Case review" and "discussion with Mr. Hand, 1.5." And then "Declaration prep November 13, 2018" we have "2.5"; correct?

A. Yes.

Q. And what is your fee, by the way, for reviewing records?

A. Well, the amount that I'm paid for reviewing records by National Medical Consultants is 375 an hour, but that's not the -- that's not the bill to the -- to the attorney.

Q. Is -- I forget. Is National Medical Consultants that company in New York that has provided the other experts in this case?

A. Yes.

Q. And how long have you been affiliated with them?

A. I think two or three years.

Q. Is that how Mr. Hand found you for this case?

A. Yes.

Q. And when the Complaint was filed, there was a different general surgeon who was his expert who prepared an affidavit, and --

A. Uh-huh.

Q. -- you were provided with that affidavit.

Do you recall it?

A. Yes.

Q. Do you know why that person is no longer involved?

MR. JONES: Objection; speculation, foundation.

MR. DOYLE:

Q. That's why I asked "do you know."

A. I do not.

Q. Have you had any conversations with that general surgeon?

A. No.

Q. Have you had any conversations with any of the attorneys about that other general surgeon?

A. No. I never asked.

Q. Okay. And then what is your fee for -- well, what do you get paid, and, if you know, what am I being charged for your deposition?

A. I -- I think you're being charged -- I'm not sure what you're being charged, to be honest with you.

I think it's a -- I think it's a thousand an hour.

Q. What are you getting?

A. Something less than that.

Q. How many cases have you received from NMC?

A. I'd have to look at the list there.

(Reviews document.)

Maybe -- Maybe 10 to 15, somewhere in that range. A lot of them don't really go anywhere or, you know, have any resolution. There are several that I've declined to participate in. So really it's just handful of cases that's listed there.

Q. Have you ever testified at a trial --

A. Yes.

Q. -- as a ex- --

Have you ever testified at trial as an expert witness?

A. Yes, I have.

Q. In what states?

A. California.

Q. How many times?

A. I testified -- I've testified at two trials and one arbitration.

Q. Plaintiff, defense, or combination?

A. Those were all defense.

Q. I'm looking at the "Record of Expert Deposition

and Trial Testimony" in Exhibit A. Is this all of your deposition and trial testimony or just back to a certain point?

A. That's back to, I believe, 2014. I may have had a couple of depositions prior to that, but I don't have any record of them, so I couldn't include them on the list.

Q. Any of these cases that are on this list in Exhibit A, do they have any issues similar to our case?

A. No.

Q. Oliver versus Blanco-Cuevas, the general surgeon in Las Vegas, do you remember what that case was about?

A. That was a patient who died of exsanguinating hemorrhage following a laparoscopic chol- -- a laparoscopic to open cholecystectomy.

Q. Have you worked with Mr. Hand on other cases?

A. There's one other case that I've worked on with him.

Q. And the new counsel, Bighorn Law --

Am I saying that right?

MR. JONES: Yeah, big.

MR. DOYLE: Yeah.

Q. These guys. Have you worked with the new associated counsel before?

A. No.

Q. The money that you earn as an expert witness, does that go to you? Does it go to some academic institution, some philanthropic organization? What happens to it?

A. It goes to me.

Q. And if you look at the percentage of time that you spend doing medical/legal work compared to your practice of medicine, what would those numbers be?

A. Maybe 5 percent of my time.

Q. Same question for earned income from medical/legal work versus other earned income.

A. 5 percent or less.

Q. And I apologize. You might have said this a moment ago. But when you went through Mrs. Farris's records from the St. Rose Hospital, you did see, in the progress notes, information that was self-populated; correct?

A. Well, certainly every progress note is loaded with labs and vitals and everything that -- all that is self-populated.

Q. But there was also information entered by physicians on prior days that was also carried forward into a subsequent day.

A. Probably. I -- I can't -- I can't think of a

specific example, but I believe there may be that.

Q. Do you recall seeing sometimes notes in just small letters and sometimes notes in all capital letters?

A. No, but I'd be happy to...

Q. Does that have any meaning to you, knowing what you know about electronic medical records, if you see someone's note that has small letters and then, at the end of the note, it's all capital letters?

A. Well, it would suggest either that it was cut and paste, you know, or copied forward or something of that nature.

Q. I want to ask you some questions about sepsis generally.

The definition of sepsis has changed and evolved over the years. Can we agree?

A. Yes.

Q. In -- Strike that.

Are you familiar with the Third International Consensus Definitions for Sepsis and Septic Shock that came out in 2016?

A. Not specifically.

Q. Are you aware of the American College of Surgeons' definitions for sepsis and septic shock?

A. I mean, I have a good understanding of what

sepsis and septic shock are. I don't know if I can, you know, quote the American College of Surgeons version, but...

Q. Would you agree with me that the defi- -- the commonly used definition of sepsis in 2015 was Systemic Inflammatory Response Syndrome plus an infection?

A. Yes. And the -- And Systemic Inflammatory Response Syndrome is -- is -- has sort of -- seems to have fallen out of favor a little bit in response to sepsis syndrome.

Q. Right. And it fell out of fa- -- started failing out of favor in 2016 when there were different consensus definitions; correct?

A. Yes.

Q. All right. But in 2015, the commonly used definition of sepsis did include Systemic Inflammatory Response Syndrome as part of the definition.

A. Oh. Okay.

Q. "Yes"?

A. I believe so.

Q. And Systemic Inflammatory Response Syndrome, short for that is SIRS, S-I-R-S?

A. Yes.

Q. So I'm just going to say SIRS.

A. Okay.

Q. Would you agree that one of the criteria for SIRS back in 2015 was a temperature greater than 38 degrees Celsius or less than 36 degrees Celsius?

MR. JONES: Objection; foundation.

THE WITNESS: I don't know the answer to that.

MR. DOYLE:

Q. Would you agree that one of the SIRS criteria in 2015 was a heart rate greater than 90?

MR. JONES: Objection; foundation.

THE WITNESS: I will take your word for that.

MR. DOYLE:

Q. Would you agree that one of the SIRS criteria in 2015 was a respiratory rate greater than 20?

MR. JONES: Objection; foundation.

THE WITNESS: I believe so.

MR. DOYLE:

Q. Would you agree that one of the SIRS criteria in 2015 was a white blood cell count greater than 12 or less than 4 or greater than 10 percent bands?

MR. JONES: Foundation.

THE WITNESS: I was not aware of that specifically.

MR. DOYLE:

Q. Were you aware that in 2015, the definition of severe sepsis was SIRS plus an infection plus organ dysfunction?

MR. JONES: Foundation.
THE WITNESS: I -- I -- I don't recall what the definition was in 2015 or 2016.
MR. DOYLE:
Q. Can we agree that amongst practicing physicians, the term "sepsis" can be bandied about sometimes loosely?
A. Yes.
MR. JONES: Objection; vague.
MR. DOYLE:
Q. Can we agree that when "SIRS" was being commonly used, that it too was bandied about sometimes loosely?
MR. JONES: Vague.
THE WITNESS: I -- I don't -- I -- I don't know that I can answer whether somebody was bandying that about loosely. I think -- I think that sepsis in 2015, as with sepsis in 2019, is apparent to clinicians taking care of patients and -- and we don't generally look up the consensus statement of our parent organization to determine whether our patients are septic.
MR. DOYLE:
Q. Well, but if you're going to be expert witness in a medical malpractice case, you want to use the terms precisely; true?

MR. JONES: Objection; vague, argumentative.

THE WITNESS: I think when you have a -- a patient who is -- who is tachycardic, has a increased respiratory rate, has a leukocytosis, respiratory failure and organ dysfunction, I think we can agree that that patient has signs of sepsis.

MR. DOYLE:

Q. And can you tell me what the current definition of "sepsis" is according to the American College of Surgeons, which you are a member of?

A. I am a member of the American College of Surgeons.

Sepsis is the -- and I can't tell you the exact verbiage of -- of the statement, but sepsis is the -- is the derangement in -- in a patient's health with derangement in metabolic processes, vital signs and other abnormalities in -- in response to a -- an infectious process that leads to a cascade of inflammatory events.

Q. Based on your review of Mrs. Farris's records and going back to 2015 when "SIRS" was still being used, did she meet the criteria for having SIRS on July 4th?

A. I'd have to look at -- go back to her -- I'd have to go back to that date to look at it.

Q. And if I asked you the same question for each

day up to the time of Dr. Hamilton's surgery, would your answer be the same?

A. Well, I -- she clearly exhibited signs of -- of -- of SIRS and sepsis. She had -- She had respiratory failure; she had tachycardic -- tachycardia; she had an increased respiratory rate. Ultimately she required intubation. She had a profound leukocytosis. She had at least low-grade fevers. All that was partially mitigated by the broad spectrum antibiotics that she was on. But I -- I think that -- that any reasonable physician would recognize that she had evidence of sepsis, whether you call it SIRS with infection or sepsis.

Q. Here's my question: Did she have SIRS as that definition was used in 2015 on July 8th?

A. I'm going to, uh...

MR. JONES: Object foundation.

THE WITNESS: I would have to look at all of her vitals and look at the definition and go line by line and tell you whether they met -- she met the SIRS criteria at that time. But she was clearly septic.

MR. DOYLE:

Q. Same question for July 9. Same answer?

A. I believe she did.

Q. Okay. If the definition of sepsis in 2015

included a patient having SIRS yet you can't tell me whether she met the criteria for SIRS on any particular day, how do you come to the conclusion that she met the definition of "sepsis" in 2015 on a particular day?

MR. JONES: Objection; compound, argumentative.

THE WITNESS: I think, first of all -- I think, first of all, it's irrelevant because you've got a patient who is clinically -- that -- who clinically has an ongoing infection, and that should be apparent to any surgeon, whether or not they're board certified.

I -- I would leave the definition and the parsing of -- of the definition to infectious disease or critical care experts, but I would say that -- that any reasonable and prudent surgeon is going to recognize that this patient has an infectious source of their acute and unrelenting illness. So I -- I don't understand the reliance upon the definition to determine that.

MR. DOYLE: Okay.

Q. But I get to be the lawyer; right?

A. Okay.

Q. Okay. Did Mrs. Farris's renal function improve between July 4 and July 15?

A. Yes.

Q. Did her left shift improve between July 4th and

July 15th?

A. There was a time when it did, yes.

Q. Did her blood pressure improve between July 4 and July 15?

A. Yes.

Q. Did her heart rate improve between those dates?

A. Yes.

Q. Did her temperature improve between those dates?

A. Before it got worse? Yes. She was -- There were times when she was not febrile.

Q. Between July 4th and July 15th, was she requiring less ventilatory support?

MR. JONES: Objection; vague, form.

THE WITNESS: I'd have to go back and look at that again. I don't know the answer to that.

MR. DOYLE:

Q. Between July 4th and July 15th, did her mental status improve?

MR. JONES: Objection; vague, form.

THE WITNESS: Her encephalopathy improved.

MR. DOYLE:

Q. That would be her mental status --

A. Yes.

Q. -- correct?

Between July 4 and July 15, the a-fib resolved; true?

MR. JONES: Objection --

THE WITNESS: Yes.

MR. DOYLE:

Q. Between --

MR. JONES: -- vague.

MR. DOYLE:

Q. -- July 4 and July 15, her blood glucoses came under control; correct?

A. Yes.

Q. Between July 4 and July 15, her abdominal pain improved?

MR. JONES: Objection; vague, speculation, form.

THE WITNESS: Yes, there were times that it did.

MR. DOYLE:

Q. Did you see that each physician who saw her each day -- or virtually each physician documented abdominal examination?

A. Yes.

Q. Did you ever see someone document any peritoneal signs?

A. Specifically using that term?

Q. Correct.

A. I don't recall.

Q. Have you ever had a patient or a patient's family become unhappy with you and your care?

A. Probably.

Q. Have you ever had a patient or a patient's family who you're taking care of the patient and the patient or the family asked for a second opinion from a different general surgeon?

A. Yes.

Q. Have you been in a situation yourself where the patient or the patient's family says, "Dr. Hurwitz, I'd rather you stop taking care of me. I want someone else to take care of me"?

A. I can't -- I can't -- I can think of one, yes.

Q. And in that situ- -- In your own experience, when a patient or the patient's family member asked you to step out of the case and let someone else take over, you did so?

A. Yes.

Q. When you -- When you were in a situation where you had a patient or a patient's family member say, "Hey, Dr. Hurwitz, I'd like to get a second set of eyes" or "get a second general surgery opinion on this case," you agreed?

A. Yes.

Q. And I assume that's happened to your partners

or colleagues here?

A. Yes.

Q. Something that happens from time to time, patients are unhappy with a particular individual?

A. Correct.

Q. The conversation that you had with counsel today, how long did you guys talk?

A. Maybe 30 minutes.

Q. Were you --

A. 20, 30 minutes.

Q. Were you provided with any records that had not already been provided to you?

A. No.

Q. Were you provided with any information orally that was information you were not already aware of?

A. No.

Q. What was the gist of the conversation today?

A. I can't tell you exactly. We just went over -- We went over the -- the case and -- and -- I can't specifically recall the exact nature of the discussion. We went over the -- my interpretation of the x-rays, for example.

Q. Did you have films up?

A. No.

Q. What did you -- Were there any x-ray -- Well,

strike that.

Did you discuss any of the plain films?

A. Yes.

Q. Which plain films did you discuss specifically?

A. The chest x-rays from the -- from the beginning of the case forward.

Q. And what was your conclusion, having looked at those -- Films or reports?

A. Reports. But I'd looked at the films previously.

Q. And what was your conclusion?

A. That there wasn't evidence to support the notion that this was sepsis secondary to an aspiration pneumonia or aspiration pneumonitis, that it wasn't a pulmonary source of -- of sepsis as the source of all this.

Q. Did you see, on July 4th, Dr. Rives's note about Ms. Farris drinking a SoBe beverage?

A. Yes.

Q. What's a SoBe beverage?

A. I think that's like an ice tea or something.

Q. She was NPO at that point in time; correct?

A. Yes.

Q. Nothing by mouth.

A. Correct.

Q. Not supposed to be drinking thin or thick fluids; correct?

A. Correct.

Q. Not supposed to be drinking a SoBe beverage; correct?

A. Correct.

Q. Because drinking such a beverage puts a patient at risk for aspiration.

MR. JONES: Objection; calls for speculation.

THE WITNESS: It does.

MR. DOYLE:

Q. And if a patient were to aspirate drinking such a beverage, that can cause an aspiration pneumonia or pneumonitis, generally speaking.

A. Particularly if that patient vomits as a consequence of drinking the beverage and -- and aspirates because of that.

Q. Have you ever heard the term "microaspirate"?

A. I suppose so.

Q. Can a patient microaspirate during intubation for general anesthesia?

A. Yes.

Q. If a patient is obese, are they at increased risk for microaspiration during intubation for general anesthesia?

A. I think if a patient is -- Particularly if a patient is morbidly obese or is being intubated having not been NPO prior to surgery for some period of time, aspiration is possible.

Q. What is your definition of "morbidly obese" in terms of a BMI?

A. 40.

Q. Do you recall what Ms. Farris's BMI was on admission?

A. I thought it was -- and correct me if I'm wrong. I thought it was around 31 maybe.

Q. When you reviewed Dr. Chaney's records, the primary care physician, I assume you noticed in Dr. Chaney's records her diagnosis of a peripheral neuropathy before July of 2015?

A. I recall that, yes.

Q. And peripheral neuropathy is a -- is a complication of diabetes.

A. Yes.

Q. And the risk of peripheral neuropathy increases if a patient is noncompliant with the treatment for diabetes.

A. That's my understanding, but I'm not a neurologist.

Q. As a general surgeon, do you have any reason to

disagree with Dr. Chaney's diagnosis of a peripheral neuropathy due to diabetes?

A. No.

Q. The ICU at Hoag, is it open or closed?

A. What do you mean?

Q. Is there a single intensivist group that has the contract or can any intensivist see a patient in the ICU at Hoag?

A. It's closed.

Q. Who has the contract?

A. There's a group of intensivists that cover the ICU.

Q. How often will you have one of your postop patients in the ICU?

A. Occasionally. You know, once or twice a month maybe.

Q. In those instances where you have a patient in Hoag's closed ICU, is the critical care medicine specialist typically the attending in the ICU?

A. In other words, do we sign out our care to that --

Q. No.

A. -- doctor? I don't know what you mean by that.

Q. Who's the captain of the ship when one of your postoperative patients requires an ICU admission?

A. Well, I'll generally -- I'll generally defer to the intensivist when it comes to ventilatory management and -- and drips and so forth.

Q. And other medical issues as well; correct?

MR. JONES: Objection; speculation, overbroad.

THE WITNESS: Typically if the -- the patient's got a surgical problem, I'll manage the surgical problem, if there's a wound issue for example. And other specialists are also involved in the care of critically ill patients, the pulmonologi- -- or not the pulmonologists necessarily but the nephrologists, cardiologists and so forth.

MR. DOYLE:

Q. You saw there was a nephrologist involved in Mrs. Farris's care?

A. Yes.

Q. Cardiologist?

A. Yes.

Q. Infectious disease specialist?

A. Yes.

Q. Critical care medicine?

A. Yes.

Q. In addition to Dr. Rives?

A. Yes.

Q. There was also a hospitalist that was seeing

her from time to time in the ICU.

A. Yes.

Q. Is it your understanding that at St. Rose back in 2015 -- and tell me if you don't know -- that the critical care medicine specialist would be the one typically writing the orders and arranging for the consults of a patient in the ICU?

A. I don't know.

Q. Here at Hoag when you have a patient of yours in the ICU and is being followed by one or more specialists in the ICU, do you communicate with those specialists?

A. Yes.

Q. Orally and by way of the hospital records?

A. By -- Orally by way of the hospital records and also by secured text and other means at our disposal.

Q. And so you're generally communicating with the specialists who are following your patients to see how your patient is doing.

A. Yes.

Q. And you always appreciate their insight and input.

A. Yes.

Q. And I assume over the years you've had a patient in the intensive care unit followed by the

critical care specialist or some other specialist, and that physician has come to you with a concern about something going on inside the abdomen.

A. I'm sure that's happened, yes.

Q. And you would, of course, appreciate their advice and input.

A. Yes.

Q. Have you had conversations with a critical care -- Well, strike that.

When you've had your postop patients in the ICU and they're being followed by one or more specialists, have you ever had discussions with those specialists about taking your patient back to surgery?

A. Yes.

Q. Bounce the idea off of them, see what they think?

A. Yes.

Q. You might be interested in what they think are the pros and cons of surgery from a medical or perhaps renal point of view?

A. Or whether the patient is stable enough for surgery, yes.

Q. I mean ultimately the decision whether a patient goes back to surgery is yours, but you certainly welcome advice and input from others.

A. That is true.

Q. Is there any particular piece of literature that you're going to be using or referring to at trial when you testify?

A. Not necessarily, no.

Q. I mean, as you sit here today, are you aware of any literature that you're going to be bringing to trial to support your opinions or refute the opinions that are different than yours?

A. No, I can't -- None that spring to mind, but I reserve the right to do so.

Q. In your opinion --

MR. JONES: Just one thing so you're aware: The same -- The same studies that Dr. Stein -- sorry -- that Dr. Stein talked about in his deposition, those were provided along with Dr. Stein's deposition, so he has those.

MR. DOYLE: Okay.

We okay to continue, or do you want to take a break? Let's take five minutes. I want to go through my notes and --

THE WITNESS: Okay.

MR. DOYLE: I mean, I'm hoping we'll finish by 6:00.

THE WITNESS: Okay.

(A recess is taken.)

MR. DOYLE: Let's go back on.

Q. Dr. Hurwitz, at the break did you get the CD you mentioned earlier that was in your office?

A. Yes, I did.

Q. And tell me what's written on it.

A. "Titina Farris, St. Rose-San Martin 2015 Admission Films."

Q. Did you review all of the images on this CD or just some?

A. Most of them. They're -- I -- I believe I reviewed all of them, yes.

Q. So it's your opinion, Doc- -- Strike that.

It's your opinion the standard of care required Dr. Rives to take Ms. Farris back to the operating room; correct?

A. Correct.

Q. At what point in time or what's the latest point in time he could do so and, in your opinion, still be within the standard of care?

A. Well, I would say that -- that beginning on the 5th when she went into -- when -- when she required intubation, from that point forward he had an obligation to take her to the operating room.

I think clearly it was evident within -- it was

evident by the -- within the next 48 to 72 hours that she was declining and showing evidence of intra-abdominal sepsis. I think it was incumbent upon him to do so. I would say even on -- up to the 9th. I think beyond that he's clearly delaying taking her back, and I think that beyond that -- that time frame, he's below the standard of care.

I think that -- that it's -- it's difficult when you look at something incrementally to say, "Okay. Well, now we've passed the point where it's standard of care." I don't know that there's a bright line. But there's clearly a time frame over the 48 to 72 hours from the time that she evidenced -- that she showed clear evidence of decline that he should have taken her back to the operating room.

Q. So -- Don't let me put words in your mouth. I know you wouldn't. I'm just trying to understand.

Are you saying that -- that say by the morning of July 9th, the standard of care mandated a return to the operating room by that point in time, and whether he took her back earlier would be a matter of debate or judgment?

MR. JONES: Objection; compound, misstates.

THE WITNESS: I think that he's -- that over that time frame, it is clearly evident that the patient is

showing clear evidence of intra-abdominal sepsis.

I think that it's reasonable to take a couple of days to see if her course improves with antibiotics. But I think it became evident, as her white blood cell count remained elevated and she showed other signs of sepsis, that she was not improving and any improvement that she was exhibiting was incremental and minimal and was not -- and was negligible in the -- in the scheme of things. And I think that by the time the patient was seen in second-opinion consultation by Dr. Ripplinger, who clearly expressed his concern, I think that it -- it was incumbent upon Dr. Rives to take her back.

Now, I would quibble a little with the morning of the 9th. Dr. Ripplinger saw her on the morning of the 9th. So had Dr. Ripplinger seen her, communicated his concerns with Dr. Rives, I -- I think at that point it was clear that the patient needed to go back. And -- And I think beyond that point, it -- he's clearly below the standard of care.

So the exact time when he crosses that line is difficult to say. But I'd say -- I would say that by the time that he's had that opportunity to have a second opinion -- and Dr. Ripplinger clearly was concerned about the status of this patient -- I think it was incumbent upon him to take her back.

I think that -- I -- I think that relying upon a CAT scan to make that determination was a mistake.

MR. DOYLE:

Q. So again, I -- just for purposes of trial, I need to understand what your opinion is going to be.

But if we assume hypothetically Dr. Rives had taken Mrs. Farris back to the operating room sometime on July 9th after Dr. Ripplinger had seen her, that would have been within the standard of care?

A. I -- I would -- I would think that that would be -- I think that would be reasonable.

Q. And within the standard of care.

A. Yes.

Q. Okay. And I assume over the years you've been involved in M&M meetings.

A. Yes.

Q. Grand rounds.

A. Yes.

Q. Peer review.

A. Yes.

Q. I assume you have participated in meetings where there have been frank discussions about a particular physician's care of a particular patient.

A. Yes.

Q. And in those frank discussions, well-qualified

and reasonable physicians might disagree about the care and the quality of care; correct?

A. Yes.

Q. And so, you know, what's important in our case is not a personal criticism or "I would have done something differently," but rather it's the standard of care. So what I'm hearing you say is -- is if Dr. Rives had performed surgery on --

(Interruption in proceedings.)

MR. DOYLE: I'll start over.

Q. If Dr. Rives had taken Mrs. Farris back to the operating room on July 9th after Dr. Ripplinger had seen her, that would have been reasonable and within the standard of care.

A. I think that -- Yes. I would --

Q. Okay.

A. I would grant you that.

Q. And taking her back on the 10th would be below standard of care.

A. Again, it's -- I would say "yes," that's true as well.

Q. Did the standard -- Okay.

A. Yes. I would agree with you on that -- in that case.

Q. So if he takes her back to surgery on the 10th,

that would be too late and below the standard of care.

A. I think it's pushing it. It's pushing it. It's -- It's pushing that standard. It -- It's -- There's not a clear line. There's not -- It's -- It's a -- It's very difficult to say, "Well, this is where the standard of care stops, and this is where below the standard of care begins." It's very clear that several days have gone by and the day -- and the -- and even -- even the 9th is pushing it; right? But I'm saying the 9th because at least then he gets a second opinion from Dr. Ripplinger.

So I would say if on the 9th he takes that advice, he discusses it with Dr. Ripplinger, he goes to surgery, I'd say it's kind of late to be doing this but at least you got the patient back to the operating room. You wait another day, you're just pushing it down the road even further. So I'll leave it at that.

Q. If Dr. Rives had taken her back to the operating room on July 9th, of course there would have been a second surgery; correct?

A. Yes.

Q. There would have been the care and medical expenses incurred with that surgery; correct?

A. Yes.

Q. And I noticed in your affidav- -- or in your

initial report, that you reviewed the hospital bills in this case; correct?

A. Yes.

Q. And you indicated they were reasonable, necessary or -- I don't remember.

A. Yeah.

Q. Okay. But taking her back on the 9th, there still would have been medical bills incurred for the surgery, the anesthesia and the hospital; correct?

A. Correct.

Q. And even taking her back to surgery on the 9th, she would have required some length of time in the hospital before she could be discharged home.

A. Yes.

Q. Can you tell me to a reasonable degree of medical probability -- Well, strike that.

If he had taken her back to surgery on the 9th, it's likely that in the postoperative period, she would have spent some time in the ICU; correct?

A. Correct.

Q. Because she was still on the ventilator.

A. Correct.

Q. Even with surgery on the 9th, they would have to keep her in the ICU, keep her on the ventilator for some period of time until they could wean her from the

ventilator; correct?

A. Correct.

Q. And treat her other medical problems that were still ongoing; correct?

A. Yes.

Q. Can you tell me to a reasonable degree of medical probability -- and if you can't, that's fine. But can you tell me to a reasonable degree of medical probability: With surgery on the 9th, at what point in time would she have been able to go home?

A. (No response.)

Q. And if it would be speculating, tell me that too.

A. It would be somewhat speculative. But give her a -- assuming she has surgery on the 9th -- on the 9th she would require a colostomy as she ended up getting several days later -- it certainly would have hastened her recovery, so perhaps she would have gone home a week later. But that is speculative.

Q. Okay. But even with surgery on the 9th, she was going to need the colostomy, and she was going to need the colostomy takedown later; correct?

A. I think she would have needed a colostomy whether she were operated on the 9th or whether she were operated on the 5th. So regardless of -- And again,

standard of care, you know, even giving him the benefit of the doubt of the 9th, even had he operated her on the -- on the 5th, she would have ended up with a colostomy. She would have had to have her infected synthetic mesh removed. So it would have been a -- a big operation. But it would have hastened her recovery, gotten her off of the ventilator sooner. She may have avoided having a tracheostomy, and she would have been out sooner.

Q. Well, typically if you have a patient on a ventilator, you don't want them on the ventilator for more than 10 or 14 days with an oral intubation; correct?

A. True.

Q. After 10 to 14 days, the risk of infection to the patient goes up enough where you need to do a tracheostomy and to have -- and breathe the patient through the trach tube.

A. In some cases unless it's evident that the patient's respiratory status is improving to the point where it appears that they'll be weaned.

Part of the reason she was in respiratory failure was because of this ongoing intra-abdominal sepsis and the compromise of her -- of her diaphragm to expand in order to ventilate adequately. And it's reasonable to

expect that her resp- -- her pulmonary status would have improved, her respiratory status would have improved with -- sooner with earlier operation. And the earlier that they had done that, the sooner she would have recovered.

Q. Can you tell me to a reasonable degree of medical probability that with surgery on July 9th, that Mrs. Farris would not have a foot drop today? Or would that be speculation on your part?

A. That's beyond the scope of my expertise.

Q. And a critical illness polyneuropathy, is that beyond your area of expertise?

A. Yes.

Q. Would it be beyond your area of -- Strike that.

Would it be beyond your area of expertise to tell me how her condition today would be different with surgery on the 9th rather than on the 17th?

A. I don't know what her condition is today, so I can't answer that.

Q. Okay. Dr. Ripplinger. Did Dr. Ripplinger recommend surgery in his note, or did he -- he mention surgery but then recommend a CT scan and perhaps surgery depending on what the CT scan showed?

A. That's correct.

Q. The latter?

A. The latter.

Q. Any criticism of that recommendation by Dr. Ripplinger?

A. Yes. I disagree with him. I --

Q. Okay.

A. I think that the patient clearly needed surgery. The patient needed surgery several days ago. I think that -- I -- I can't -- I -- I can't explain Dr. Ripplinger's opinion or his motives in couching it in those terms. I think that -- I have no issue with ordering a CT scan; but, as I said before, there is the potential for false negatives, and I certainly wouldn't base my opinion upon it. So I -- I disagree with Dr. Ripplinger. I think the patient should have gone into surgery.

Q. And when we look at Dr. Farooq, the infectious disease specialist, his or her -- I'm not sure if it's a man or a woman -- but his or her consultation on July 4th, you saw in the note the comment "This could represent fecal peritonitis"; correct?

A. Yes.

Q. And then did you see those exact same words in each subsequent note by Dr. Farooq?

A. Yes.

Q. Do you know whether that was something that was

simply carried forward, or was that an actual reflection of what she was thinking that day? He or she.

A. I don't know the answer to that.

Q. You mentioned in your report -- back to the medical bills for a moment -- "The medical expenses incurred were reasonable, necessary and customary for the treatment rendered to Titina Farris."

What research did you do, if any, to look at medical expenses in Las Vegas?

A. I did not research medical expenses in Las Vegas.

Q. Did you research medical expenses anywhere?

A. Well, I think given what I do, I have a -- a -- you know, there was nothing in those expenses that struck me as being un- -- aside from the fact that they were high, as being outrageous or outlandish or -- or in some way beyond what is expected in a hospital course of this duration.

Q. And in your own practice of medicine, how often are you called upon to review hospital bills?

A. Not often, but I know it -- I -- you know, I understand how things are billed and I, you know, have some general knowledge about that.

Q. When was the last time you reviewed an actual patient's actual hospital bill from Hoag?

A. Well, I've had patients bring me -- It's been awhile, but I've had patients bring me bills and point to things and complain about them. So I've seen what bills look like, and I know that bills are -- I know that bills, you know, are derived from a chargemaster, and that chargemaster may be wildly inflated and was ultimately negotiated to a much lower rate by the insurance company or -- or based upon the contract that the patient -- you know, the insurer has with the hospital. So, you know, I think these -- this was within what was within reason for a hospital to bill for a patient's care.

Q. But we can agree, nonetheless, that if Dr. Rives had provided appropriate care to Ms. Farris, she still would have incurred some percentage of those hospital bills.

A. Yes.

MR. JONES: I'm sorry. I'm just going to object to that last question as being vague.

MR. DOYLE:

Q. Take no offense. I ask everybody the same question: Have you ever had a problem or an issue of any sort with the California Medical Board?

A. No.

Q. Or any other board where you have had a

license?

A. No.

Q. Ever had a problem of any sort with hospital privileges anywhere?

A. No.

Q. Ever had a problem of any sort with a medical society or organization?

A. No.

Q. Have you thrown anything away?

A. What do you mean?

Q. That was provided to you, or have you tossed anything?

A. No.

Q. What was the cause of her anasarca?

A. Well, in all likely, that was a combination of factors that involved this sepsis syndrome, or SIRS as it was known back then, humoral factors that are released, on top of which patients receive a large volume of fluid intraoperatively. Patients are third-spacing fluid. They're -- as part of that fight or flight response. So there's a lot of reasons that patients can develop anasarca when critically ill.

Q. Did you discuss with any of plaintiffs' counsel what you perceive to be weaknesses in their case?

A. Not specifically weaknesses.

Q. Well, generally what are you --

A. Well --

Q. -- thinking?

A. -- I -- I think that the -- as -- as we discussed, things change incrementally over time. So it's day one, patient's exhibiting signs of sepsis. Is it okay not to go back to the operating room on day one? "Okay. Well, we'll give you day one." Day two, day three, day four, at what point are we beyond the standard of care? You can't keep your head in the sand forever.

So I think that the challenge is in determining at what point you're ignoring a problem. And I think I'm being very generous with saying July 9th, but there's clearly a progression of this patient's disease that is being ignored. So if -- I don't know if you would call it a weakness, but I think that that's a challenge.

Q. So -- I'm trying to wrap this up.

As of July 9, what was going on with her that says to you "Standard of care requires surgery"?

A. She's still septic.

Q. Okay. Just give me the laundry list.

A. She's still septic.

She still has a leukocytosis.

She's been on antibiotics for days and days.

She's still in respiratory failure.

She's not improving.

Most significantly I think is that Dr. Rives knew that he had created an injury to the bowel during the course of a laparoscopic hernia repair that would otherwise be an outpatient procedure, and now you've got a patient who's septic in the ICU.

He used a thermal source to dissect the bowel from the mesh.

Q. I'm going to get to the standard of care in a moment. I just want to get the list so we can finish up here.

A. Okay.

Q. So --

MR. JONES: Well --

MR. DOYLE:

Q. -- I'm looking --

No. Counsel --

MR. JONES: Well, he's --

MR. DOYLE: -- I just want to finish.

MR. JONES: -- he's answering the question. It's --

MR. DOYLE: I'm going to come --

MR. JONES: -- part of his answer.

MR. DOYLE: I'm going to come back to it.

MR. JONES: It's part of his answer.
MR. DOYLE: I'm promise I'm going to come back.
MR. JONES: Look, if you want to withdraw the last question, that's fine, and we can scratch it. But --
MR. DOYLE: Fine.
MR. JONES: -- otherwise you have to let him answer it.
MR. DOYLE: Fine. We'll just keep going.
Q. Go ahead, Doctor.
THE WITNESS: Can you read back to me what I said?
MR. DOYLE: Read the whole answer.
I'm just trying to finish up by 5:30 --
THE WITNESS: Okay.
MR. DOYLE: -- but we'll keep going.
Why don't you read the question too.
(The record is read by the reporter.)
THE WITNESS: So can I pick up from there?
MR. DOYLE: Sure.
THE WITNESS: So -- So he has every reason to expect that her illness, her ongoing and prolonged illness, is a result of something going on in the abdomen, and he's not doing what is necessary, which is take the patient to the operating room, period.
Q. I'm trying to get the data points --
A. I appreciate that.

Q. -- that -- that -- that -- that you believe the standard of care required him to consider and make that decision.

A. Yes.

Q. As of July 9th, you said she's still septic; correct?

A. Yes.

Q. She still has the leukocytosis, which is the increased white blood cell count; correct?

A. Yes.

Q. She's been on antibiotics for days; correct?

A. Yes.

Q. She has respiratory failure; correct?

A. Yes.

Q. He knew that he had caused two colotomies and had used thermal injury; correct?

A. Yes.

Q. And she's not improving; correct?

A. Correct.

Q. Any other data points that he should have been looking at and incorporating into his decisions?

A. She has a synthetic mesh in the abdomen that he placed in the presence of a bowel injury, knowing the significant likelihood that that synthetic mesh will get infected because it's been exposed to bowel contents

either macroscopically or microscopically. That mesh is at very high risk of -- of becoming infected.

Q. Any other data points?

A. She has intra-abdominal sepsis that's not improving with nonoperative management. It's time to go to the operating room.

Q. When you said she was not improving, was she improving in any ways?

A. She's -- She's making small incremental improvements in various limited aspects. And one can attribute that to the excellent critical care support she's getting. She's -- She's getting broad spectrum antibiotics from the infectious disease specialist. She's getting respiratory care. She's being hydrated. She's being maintained. So -- So she's see- -- she's showing little areas of -- of improvement, but it's window dressing, because ultimately those things aren't going to save her.

And anybody who's taking care of patients with intra-abdominal sepsis knows that ultimately you are going to have multisystem problems, and you're going to have organ system failure. And ultimately, if not addressed, these things will progress to death.

So -- So these areas of minor improvement that you can point to where the white blood cell count might drop

by a point or two are insignificant.

Q. And what are the other insignificant incremental improvements besides the WBC?

A. Well, you mentioned them earlier: decrease in the tachycardia or a -- a slight decrease in the fever curve. That's two examples.

Q. Okay. The term "defi-" -- I'm sorry.

The term "standard of care," what -- what -- what is that term or what is your definition?

A. The standard of care is what a reasonable and prudent physician would do under cir- -- in similar circumstances.

Q. So let me just -- I just want to get the list -- I think we've covered a lot of this in some form or fashion -- of what Dr. Rives did or didn't do that was below the standard of care, keeping in mind my earlier comments that I'm not interested in your personal criticisms or what you would have done differently, understanding that there can be various ways of going about taking care of a different patient.

But in terms of something that Dr. Rives did or didn't do that was below the standard of care, was there anything in 2014?

A. No.

Q. Was there anything that he did or didn't do in

the office on June 23, 2015 that was below the standard of care?

A. I don't believe so.

Q. On July 3, 2015, prior to the procedure, was there anything Dr. Rives did or didn't do that was below the standard of care?

A. No. I may take issue with something, but I would say that -- as you said, that there are areas to disagree that do not fall below the standard of care.

Q. Okay. So now it's surgery on July 3. I just -- If you can, just give me the list of what you believe he did or didn't do that was below the standard of care. I may or may not have any follow-up questions. Then I'm just going to march forward chronologically.

A. With regard to the surgery, I think where he fell below the standard of care was in using a thermal energy source -- in this case the LigaSure bipolar device -- to -- to dissect bowel from the underlying mesh to which it was densely adherent. And that created a -- a situation where he's -- he's -- he's -- he's -- his intraoperative technique is flawed in the use of that thermal energy.

The appropriate thing to do -- The standard of care would dictate that you do not use a thermal energy source against the bowel and that if you have any

concerns about the integrity of the bowel during the course of the operation, then the standard of care would dictate that you convert to an open operation, if necessary, to complete the procedure.

So that's it.

Q. Okay. I'm just trying to find out what he did or didn't do that was below the standard of care.

Are you telling me that his failure to convert to a laparotomy was below the standard of care?

A. I think that the -- the standard of care -- the intraoperative technique that fell below the standard of care was using the thermal energy source to dissect the bowel from the mesh.

Q. And in terms of the standard of care, is there anything else that he did or didn't do intraoperatively that was below the standard of care? Again setting aside personal criticisms or "I would have done it this way" or...

A. I understand. No. I would leave it at that.

Q. Then on July 3 after the surgery -- we'll get -- was there anything that day he did or did not do that was below the standard of care?

A. Not to my knowledge.

Q. Now, by July 4th she's in the ICU, and she's intubated, so let me just ask you -- rather than doing

day by day, let me ask you: Between July 4th and July 9th, which we've already talked about, is there anything else Dr. Rives did or didn't do that was below the standard of care in that time period other than not taking her back to the operating room?

A. I can't think of a specific -- a specific instance.

Q. And I assume...

A. Can I re- -- Can I readdress that?

I -- I would say he fell below the standard of care in failing to exercise sound medical judgment in the approach to this patient in determining whether to intervene surgically, "sound medical judgment" meaning considering fully the risks and benefits of his approach, the risk of nonoperative bene- -- management versus a risk of surgery, and the failure to consider all these -- these issues.

Q. And his failure to exercise sound medical judgment, as you have just described, was that below the standard of care?

A. Yes.

Q. And that failure to exercise sound medical judgment led to his not doing surgery by July 9.

A. Yes.

Q. And if we look at the time period then from

July 9 to July 17th when Dr. Hamilton operates, in terms of something Dr. Rives did or didn't do below the standard of care, would it be the same comments?

A. Yes.

Q. And then, of course, once Dr. Rives is off the case and Dr. Hamilton is on the case, he's no longer involved in her care; correct?

A. Correct.

Q. Then nothing he would have or could have or should have done.

A. Correct.

Q. So have you now given me each and every -- Strike that.

In these last few minutes -- and plus, of course, going through the deposition and your two reports -- have you now given me each and every standard-of-care opinion concerning Dr. Rives and his care of Ms. Farris?

A. Yes.

Q. And all the bases for those opinions?

A. I believe so.

Q. In your report you say "Failure to adequately repair iatrogenic bowel perforations during the July 3, 2015 operation." I mean, having given this case additional thought and study, would you withdraw that particular opinion?

A. Well, you over- -- he -- I think that -- that -- that clearly he failed to repair these completely; but again, I think that's a consequence of -- of his faulty intraoperative technique, and I think his o- -- intraoperative technique led to those damages. So it -- it's...

Q. Let me quote from your report. "Dr. Rives fell beneath the accepted standard of care as follows:"

Item Number 2 says "Failure to adequately repair iatrogenic bowel perforations" --

A. Mm-hmm.

Q. -- "during the July 3, 2015."

Sitting here at this moment in time, is that yet another standard-of-care opinion, or is -- or would we -- would we say at that point in time he adequately repaired the two colotomies, but your criticism is the use of the thermal device? And that was a long question, but...

A. I would say that my criticism is that he -- he used the thermal device to cause the injury.

I think that the -- at the -- as far as I can tell, at the time that he closed the injuries, he thought he had gotten a good closure. I think time showed that these -- these opened up. But I think his failure was in how he dissected the bowel, creating the injuries,

and the fact that he didn't go back to reoperate. So I would say that while his closure may have been temporarily adequate, it was these other factors that were below the standard of care.

Q. So in terms of the -- the actual technique that he used to close the two colotomies that he saw, the technique he used for both, while you might disagree, was appropriate and within the standard of care?

MR. JONES: Objection; misstates.

THE WITNESS: I think that he -- I -- I'm trying to be charitable, but I -- I think that he -- he did a lousy job. He had these injuries. He zipped across them with a stapler, and the patient ultimately be- -- became septic.

I would say that using a stapler is not below the standard of care, so I -- I'm not going to say that using a stapler on these injuries is below the standard of care. The standard of care was in not recognizing the injury when it occurred.

So I would say the -- the -- the standard-of-care breach is in using the thermal energy on the bowel, which is clearly a standard-of-care failure, and failing to recognize the perforation and the -- and the intra-abdominal sepsis timely. So those are the two standard-of-care failures.

MR. DOYLE:

Q. When you have inadvertently caused colotomies, did you do a lousy job?

A. I mean, not -- not every one of my operations has been perfect. I think that -- that there's always room for improvement. There's always a learning opportunity. So --

Q. But you characterized his creation of the two colotomies, as I understood you, as "a lousy job."

A. Well, I think --

MR. JONES: Objection; misstates.

THE WITNESS: Well, I think that his handling of the operation was poor, and I -- and -- but where I'm going to say that he fell below the standard of care is in using the thermal energy on the bowel, which is clearly a breach of the standard of care. But I will grant you that using a stapler to close a colotomy is an acceptable way to close a colotomy, so it's difficult to say that's below the standard of care.

MR. DOYLE: Okay.

Q. Then if we -- As a general matter, can there be a partial thickness thermal injury to bowel that is not visible at the time of surgery?

A. Yes.

Q. And can you have a non-visible

partial-thickness injury to bowel caused by thermal energy where then, after the surgery, there is decreased blood flow, necrosis of tissue, and then opening up of a perforation?

A. Yes.

Q. Okay. In some form or fashion today and in your two reports, have we covered all the topics and areas you understand you're going to be testifying about at the time of trial?

A. Yes.

Q. Then -- Oh. Has there been any discussion about illustrations or demonstrative exhibits for trial with counsel?

A. No.

Q. And can we agree that for some period of time after Dr. Hamilton's surgery, that Mrs. Farris remained critically ill?

A. Yes.

Q. And can we also agree that during those days after Dr. Hamilton's surgery, she too was concerned about whether there was still some intra-abdominal problem?

A. Yes.

Q. Okay. That's all I have. Thanks.

MR. JONES: I have just really a quick couple of

follow-ups.

-EXAMINATION-

BY MR. JONES:

Q. The answers that you've given, have those -- with respect to the record, have they taken for granted that Dr. Rives in his notes was candid and complete?

MR. DOYLE: Object to the question.

MR. JONES:

Q. Or did -- Or have you -- So, for example, when Dr. Rives in his record states that he saw two colotomies and that he was able to sew it all up and everything was kind of normal at that point, are you taking him at his word for that, or are you -- are you assuming he was being untruthful?

A. I'm taking him at his word.

Q. Okay. And so some of your opinions where you have not made a definitive determination as to whether or not a standard of care has been breached, that could potentially change if there was evidence that what has been represented is not exactly the truth. Is that fair?

A. Yes.

MR. DOYLE: Calls for speculation.

MR. JONES:

Q. And just as -- as -- for example, if there was fecal matter at the time of the operation that hadn't been identified that could have been identified, that would be something you'd take issue with. Would that be fair?

A. Well, he didn't -- he didn't describe any fecal matter contamination.

Q. So did you take it for granted, then, that he was indicating essentially there was none?

A. I can only -- I can only draw conclusions based upon what's entered in the -- in the operative report.

Q. Right. And so that's all I'm getting at.

If there were additional significant findings like that that were there, that wouldn't be something that you would say is okay; correct?

A. So if there were significant -- if there was evidence that something took place in the operating room that isn't in the operative report and had come to light later, then I would reserve my right to change my opinion.

Q. Fair enough.

And if there -- evidence came out, for example, that Dr. Rives didn't have necessarily a really good view or angle to be able to -- to safely staple, for example, that would be something that would cause you to

have a different opinion about the staples?

A. Well, the whole idea of stapling the bowel is to get a good purchase and to make sure you've closed it completely. Where you can err and where you can be below the standard of care is where -- if you don't get enough tissue in the -- in the staple. So if you're -- if you're just pulling up the edge of the mucosa and stapling it, you're not going to get a good closure. You have to make sure that you're getting a full-thickness closure.

I -- You know, I have no way of knowing whether he got a good closure or not other than hi- -- what -- his statement in the operative report. If it turns out that he just -- he didn't close the bowel well or didn't get good tissue apposition, then that's a -- a different issue. But I have no way of knowing. I'm not there. I'm not seeing how he's doing the staple lines.

The preferred way to do this if you've got a -- you know, an inflamed bowel that you've dissected away from – you know, a torn-up bowel that you dissected away from the abdominal wall, if you can't see it clearly, you have to open. But can I say that -- I -- I don't know that he couldn't see it clearly because he didn't say that in his operative report.

Q. Okay. And if -- if he had misdiagnosed -- For

example, if he -- if he ruled out sepsis at a time that she did have sepsis and the evidence was there indicating sepsis, would that be below the standard of care?

A. Yes.

Q. Okay. Do you recall that happening at one point in the records?

A. Well, I think clearly he's -- he's misinterpreting her intra-abdominal sepsis as arising from a respiratory source. So I would say all that is below the standard of care. I didn't separate that from – I mean, in my mind, that's the same as not going to the operating room. I mean you're -- you're not diagnosing the problem; you're not going to the operating room.

But -- But if you want to break that down into discrete elements, his failure to diagnose intra-abdominal sepsis would be part one of the failure, the breach of standard of care, and breach two would be not going to the operating room to fix it.

Q. Okay. And then -- And then just as you gave him latitude where you said he probably should have gone into operation on the 5th but you gave him up to essentially the 9th, each -- each day and each opportunity had -- he had to perform after the 9th would

have, again, been a breach at that point as well; correct?

A. Yes.

MR. JONES: That's all.

-EXAMINATION-

BY MR. DOYLE:

Q. You're not going to testify at trial that Dr. Rives is a liar?

A. No.

Q. Or that he's been untruthful?

A. No.

Q. You were provided with his deposition; correct?

A. Yes.

Q. He certainly could have been asked questions about how he used the stapler and his -- his -- his closure of those two colotomies; correct?

A. Correct.

Q. Nobody asked him those questions.

A. No.

Q. Okay. So you have no idea.

A. Correct.

Q. Pure speculation on your part as to how he closed them.

A. And that's why I --
MR. JONES: Misstates.
THE WITNESS: That's why I made the statement that I did.
MR. DOYLE: Okay. Thanks.
THE REPORTER: And, Mr. Jones, you are requesting a copy?
MR. JONES: Yes. Thank you.
(The proceedings concluded at 5:53 p.m.)
***

STATE OF CALIFORNIA) ss

I, Delia M. Satterlee, CSR 9114, do hereby declare:

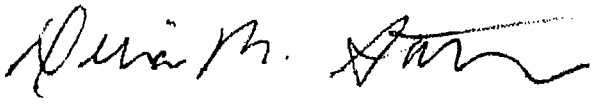
That, prior to being examined, the witness named in the foregoing deposition was by me duly sworn pursuant to Section 2093(b) and 2094 of the Code of Civil Procedure;

That said deposition was taken down by me in shorthand at the time and place therein named and thereafter reduced to text under my direction.

I further declare that I have no interest in the event of the action.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

WITNESS my hand this 1st day of October 2019.



Delia M. Satterlee, CSR 9114

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:

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MICHAEL B. HURWITZ, M.D., FACS - 09/18/2019
Index: advocate..application

MICHAEL B. HURWITZ, M.D., FACS - 09/18/2019
Index: breached..catch

MICHAEL B. HURWITZ, M.D., FACS - 09/18/2019
Index: critical..demands

MICHAEL B. HURWITZ, M.D., FACS - 09/18/2019
Index: demonstrate..discussion

E

MICHAEL B. HURWITZ, M.D., FACS - 09/18/2019
Index: happen..hypothetically

MICHAEL B. HURWITZ, M.D., FACS - 09/18/2019
Index: infection..intubated

N

MICHAEL B. HURWITZ, M.D., FACS - 09/18/2019
Index: offense..outside

MICHAEL B. HURWITZ, M.D., FACS - 09/18/2019
Index: practicing..purpose

MICHAEL B. HURWITZ, M.D., FACS - 09/18/2019

Index: Uh-huh..want

EXHIBIT C

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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#: A-16-739464-C DEPT. XXXI

BEFORE THE HONORABLE JOANNA S. KISHNER
DISTRICT COURT JUDGE
MONDAY, OCTOBER 7, 2019

RECORDER'S TRANSCRIPT OF PENDING MOTIONS

APPEARANCES:

For the Plaintiffs: KIMBALL JONES, ESQ.
JACOB G. LEAVITT, ESQ.

For the Defendants: THOMAS J. DOYLE, ESQ.
CHAD C. COUCHOT, ESQ.

RECORDED BY: SANDRA HARRELL, COURT RECORDER

Case Number: A-16-739464-C

INDEX

INDEX OF EXHIBITS

FOR THE PLAINTIFF	MARKED	RECEIVED
None		

FOR THE DEFENDANT	MARKED	RECEIVED
None		

Las Vegas, Nevada, Monday, October 7, 2019

[Case called at 8:34 a.m.]

THE COURT: Okay. Ferris v. Rives, 739464. Can I have appearance of counsel, please?

MR. JONES: Kimball Jones and Jacob Leavitt for the Plaintiffs, Your Honor.

MR. DOYLE: And Tom Doyle and Chad Couchot for the Defendants.

THE COURT: Okay. As you know, today is the day of the continuation. Got a couple of different matters on for today.

[Court and Clerk confer]

THE COURT: Okay. So today is a continuation of the Plaintiff -- it was Plaintiffs' motion for sanction under Rule 37 for Defendant's intentional concealment of Defendant Rives' history of negligence and litigation. And then -- and motion to file leave to amend complaint to add claim for punitive damages on order shortening time. Now, as you know, this was originally on hearing last week. During that hearing, the -- was a motion. There was -- the Court has signed the order shortening time.

Now, the Court did not get the appropriate courtesy copies, which was the Court's having to go through this pile again. Okay. So at the end of that hearing -- I'm restating part of this for the benefit of counsel that was not here at the last hearing. So with regards to the last hearing, the Court specifically stated and offered the opportunity only --

because although it was not in Defendant's opposition to motion for sanctions, there was no affidavit, no declaration, nothing with regards to Dr. Rives. So it gave the Court no basis as to have any understanding whatsoever about whether or not -- what his position was.

Okay. So in light of that, I obviously -- of course Supreme Court precedent, including *Young v. Ribeiro*, *Johnny Young v. Ribeiro* as well as *State Farm v. Hansen* this Court used to evaluate various factors and of course *Valley Health* as well as *v. Doe* in making certain determinations. And so in order to do, the Court offered the opportunity to do a hearing under *Johnny Ribeiro*, although as that case cites and cases subsequently have cited, the Court's not required to do so, but offered a hearing.

There was no objection. I believe Plaintiff's counsel specifically said that -- I don't want to misstate your words. It wasn't -- they seem to have concurred. They definitely did not raise an objection, but they seemed to have concurred that it would be a good idea. Defense counsel was giving the opportunity, if they chose, if that felt after consultation with their client and obviously, they know their obligations under Nevada Supreme Court precedent, including specifically *State Farm v. Hansen* and hopefully -- I'm going to have to confirm that was fully complied with. Was that fully complied with?

MR. COUCHOT: I'm sorry, Your Honor?

THE COURT: Was Nevada law, *State Farm v. Hansen* fully complied with? I'm not asking about the content of any of your conversations with regards to your client, but because of the serious

nature of this hearing, including terminating sanctions, this Court just wants to ensure -- because I see just the two of you all here, and of course it's a public courtroom. Anyone's more than welcome to be here, but I'm going to -- individual in the last row, are you counsel or are you just an observer probably from the appropriate insurance company? I'm not asking who you are. You're more than welcome to be here, whoever you are, but I'm only asking if you're here in a private capacity as counsel for Dr. Rives. Are you?

UNIDENTIFIED SPEAKER: No.

THE COURT: That's all I was asking. Okay. In light of that, then of course, the Court always asks just to confirm that applicable state law has been complied with. So I'm just asking Defense counsel. I wanted to make sure. The reason -- one of the reasons why the Court set the hearing for today is to give Defense counsel full opportunity to speak with Dr. Rives directly, coordinate among yourselves and determine whether or not A, you wanted the evidentiary hearing, B, who you wanted to call for the evidentiary hearing, including Dr. Rives.

As the Court specifically stated at the last hearing, no one was requiring Dr. Rives to testify, provide an affidavit, provide a declaration or do anything. It was completely up to you. I just needed confirmation, A, you wanted the hearing and B, if you were -- if you did want the hearing, whether Dr. Rives would or would not be testifying, we could do scheduling, because you all specifically stated you only wanted an hour.

And the Court, in light of that, as I told you I would be doing,

because there was other cases that needed time, would be scheduling something specifically based on your requirements and the Court has done so. So I have another matter starting at 10:00, because you all said you needed an hour, which got the 8:30 to 9:30. In an abundance of caution, I scheduled the next one at 10:00, knowing that probably be a few minutes of preliminary time period and scheduling another one from 1:00 to 5:00. So some of these other cases, I told you that needed this Court's time, so today was three different, special settings.

So in light of that, I wanted to give everyone enough time that they could speak with whomever they deemed that they needed to speak with to ensure that you had a full opportunity to be heard. So today is the continuation of that motion for sanctions, without going into -- it's the long version. I'm just going to call it motions for sanctions. In addition, as you all know, the Court had also set for the prior hearing date the Court's own order, because of the two separate issues.

One, both counsel, in providing documents to this Court, which on more than when occasion that were violative of multiple rules, even after the Court notifying the parties and/or their offices, as detailed in that Court's order, which you all know, because you had notice of, and it was set for last week and it was continued to today. You have the order of which I speak with regards to that. In the intervening time, unfortunately, there has been additional inappropriate, impermissible conduct by Defense counsel and continuing violations of the rules, some of which has prompted the Court to do an additional order, which was

set for today to be heard as well as even subsequent to that order -- didn't think this one was possible.

Looks like there's even more conduct, which the Court has to address as well and see -- since that most recent conduct happened on Friday, and I don't even have a judicial day, I'm not sure -- well, the Court's going to decide whether it's -- how it's going to address that most recent issue, because that ties is not only to today's first prong, the evidentiary hearing, but the Court's continued concern, despite specific citation to case law rules, rules of professional conduct, NRCPs, statutory authority, case authority, local rules, you name it.

In writing, in minute orders, in memos, there continues to be, it seems, a blatant disregard of many of the Court rules. Any being probably a little strong, since I guess some of them are followed. They actually do get filed electronically, but there has been numerous -- I would use the term numerous. I won't use the term many. I'll say numerous.

When I use Court rules, I'm not talking specific Department 31. I'm talking Supreme Court. Lot of rules of civil procedure is also created by, obvious, the Supreme Court and a whole bunch of others that I've named and subsequently put forth in writing, stated in court, including blatant statements that are not accurate in declarations. So the Court has to address those as well.

Whether we will have time for all of that today in the slotted hour, stay tuned. We don't know. If not, looks like you may be coming back on Thursday or Friday this week, after you have your calendar call,

which of course, everything is due at the calendar call, depending on what the Court's ruling is today. If not, remember, everything's still due, depending on the Court's ruling today.

Okay. When I say depending on the ruling today, meaning unless the Court's rule is that it strikes everything, then you all knew, and you all knew when this date was set, and you all knew with everything that everything is still due. So I'm sure everyone's intending to comply. Nothing was alleviated with regards to everything that's due at the calendar call tomorrow.

Is that clear to everyone?

MR. DOYLE: Yes, Your Honor.

MR. JONES: Yes, Your Honor.

THE COURT: Okay. Just making sure. So and then also, we had the order shortening time on the striking of the supplemental witnesses, which I don't know if we're going to be able to get to that today or not, but we also have that, Plaintiffs on the supplemental witnesses, the 18 recorded witnesses that was asserted.

So going to the evidentiary hearing portion, since like I said, it's -- obviously, it's counsel's obligation, not the Court's obligation, but the Court always does want to make sure that everything is complied with and that you know, we don't have people that don't have law degrees getting on the stand and some things like that about things being fully noticed.

So in that regard, since today's evidentiary hearing was solely to provide Defense to the wish -- to the extent the Defense wish to

call any witnesses, even though they have not requested such in their opposition, to the extent that they wish to call any witnesses, because of the fact there was terminating sanctions being sought and also lesser sanctions as well being sought. Give them an opportunity, if they wish to call any witnesses in response to that, that was the sole thing that this Court allowed. And I believe this Court was abundantly clear. Does anyone think that this Court said anything else, other than evidentiary hearing today, in which witnesses could be called, if Defense chose to do so?

MR. JONES: I understand it was a Barry hearing, Your Honor, where the Defense was going to have the opportunity.

THE COURT: Was that your understanding as well?

MR. COUCHOT: I understand, yes, Your Honor.

THE COURT: Okay. The Court did not -- and the reason why the Court was asking that question is because we're now going to go into what happened on Friday. Contrary to this Court's express, multiple times stated and in fact, clearly stated so much that I even said does everyone understand the process was you can choose to have the hearing or not. You can choose whether you wanted somebody to testify or not and that you then needed to provide this Court written confirmation.

The only written paper this Court was supposed to get was a written confirmation of whether A, Defense wanted the hearing to take place and B, whether or not Dr. Rives was going to testify. And the reason why the Court needed that, as the Court clearly said, is because I

needed to know if there was going to be a hearing, so that everyone could be prepared and knew if they had a need to be here at 8:30 or not and I could schedule other matters. And two, in fairness to everyone, they needed to know who the witness or witnesses would be, so that people could prepare.

Okay. This Court did not implicitly, explicitly or in any manner whatsoever tell anyone they could do supplemental briefing. And I don't think anyone's going to say that this Court said anyone could do supplemental briefing. Counsel for Plaintiff, did this Court say anyone could do supplemental briefing?

MR. JONES: No, Your Honor --

MR. LEAVITT: No, Your Honor.

MR. JONES: -- you did not.

THE COURT: Counsel for Defense, you were here. Did the Court say you could do supplemental briefing?

MR. COUCHOT: No, Your Honor.

THE COURT: So contrary to the Court's express statements, express limited to try and allow, because Defense counsel did not even put it in their opposition, to allow that one aspect, if they wished to call a witness or witnesses, whoever they wished to call for an evidentiary hearing to take place this morning and they only stated one, so that's the only reason why the Court used the singular, is that there was, instead, it appears, Friday -- and I need to get on my system.

Friday there was a pleading filed, a rogue pleading filed, a pleading in direct violation of yet another Court's specific order that

occurred, which the Court has to address first. The Court's going to address it in two manners. The Court's going to address it first, just procedurally, for today's sanction hearing. Then the Court's going to have to address it second with regards to the Court's own orders on what sanctions need -- may be imposed, up to, including terminating sanctions, up to and including all sanctions, as the Court specifically put in is order.

Fully on notice under *Valley Health Systems v. Doe* and all the RPC aspects, all the Rule 37s, the whole panoply is all included in the Court's order. That's going to be have to be taken into account, because of the pattern of conduct. This is not the first, second, third or -- if I remember, it may be, but definitely not the first or second time this has happened. So when I say this, meaning the disregard of the Court's specific directive with regards to this case by Defense counsel, who was present in court, their law firm present in court.

So from a procedural standpoint, with regards to the hearing, the Court's question is this. Was there any express agreement by Plaintiff's counsel, albeit in contravention of the Court's specific directive, to allow under EDCR 7.50, some additional briefing by Defense?

MR. JONES: Not at all, Your Honor. No, we were very upset about it.

THE COURT: Okay. Do you waive or -- do you waive or wish the Court to consider the briefing filed by Defendants?

MR. JONES: We do, Your Honor. We agree that it's --

THE COURT: Excuse -- I said --

MR. JONES: Oh.

THE COURT: -- do you waive the fact that -- do you waive, and do you wish the Court to consider their briefing?

MR. JONES: No, not at all, Your Honor.

THE COURT: I just need --

MR. JONES: We don't --

THE COURT: -- to know if you're raising an objection or not. I just need to know your position, so --

MR. JONES: Your Honor, we object to the briefing. In fact, we pro -- I produced a motion to strike, but because I couldn't get it on OST, there was --

THE COURT: What do you mean --

MR. JONES: -- no way for me to --

THE COURT: -- you couldn't get on OST?

MR. JONES: -- to produce it, since it was filed on Friday, so no, we do not think it's appropriate to be considered, Your Honor.

THE COURT: Okay. So I'm going to address that portion first. Counsel for Defense?

MR. DOYLE: Your Honor, after consultation with appellate counsel, a decision was made to file the supplemental brief to --

THE COURT: Excuse me. Appellate counsel told you to disregard as -- what appellate counsel in the State of Nevada told you to specifically disregard a Court's directive, and why is that appellate counsel not here?

MR. DOYLE: The appellate counsel did not advise us to

disregard a Court's directive.

THE COURT: Did you tell the appellate counsel that there was a specific Court directive of the only thing that could occur, because of your failure to even include on behalf of your client anything about his own position in your opposition?

MR. DOYLE: Well, I --

THE COURT: I'm not asking about the content. I'm only asking did you advise --

MR. DOYLE: No.

THE COURT: Okay. So you did not advise them that the Court gave a specific directive of the only thing that could be taken into account additionally?

MR. DOYLE: Well, that -- I guess that's an overly narrow interpretation. That was not -- I read the transcript, and it was my impression that if -- erroneously so, that I thought it would be helpful to have the supplemental opposition --

THE COURT: Counsel -- my question. I'm interrupting you. It's very narrow, because you do have limited time, and I have another case at 10:00, okay, because of the specific request of your co-counsel, how much time he needed, okay? My specific request was who's the name of the counsel that you are saying told you to file this brief? If you're saying it's not you, then I'm going to have to consider that counsel for sanctions, too. So I want to know.

MR. DOYLE: His name is Robert Eisenberg. He did not tell us to --

THE COURT: Okay. Robert Eisenberg I'm very familiar with. I would be very surprised under this scenario, that Robert Eisenberg, if fully aware of all the facts -- did you provide him a copy of the transcript?

MR. DOYLE: No.

THE COURT: Okay.

MR. DOYLE: Oh, wait. I take that back. He did have a copy of the transcript. I'm sorry. I did provide it to him.

THE COURT: Your -- so, Mr. Eisenberg needs to be here for sanctions as well, because you are saying that on his advice and counsel, you chose to disregard this Court's specific directive?

MR. DOYLE: No, I -- it's not on his advice and counsel. We were talking about the issues raised in the motion, the issues raised in our --

THE COURT: I'm not asking about the content.

MR. DOYLE: I --

THE COURT: I'm just trying to get a specific -- you understand what the Court's specific question is. This Court is asking -- okay -- Mr. Couchot was here. This Court was try -- because of the pattern of what you all have been filing, this Court set out a specific procedure, a specific procedure of do you want an evidentiary hearing. Mr. Couchot said that you, Mr. Doyle, would be handling it, not him.

To give you all benefits of the doubt, the best possible opportunity, so that everyone could speak about it and make a determination, people were not having to make a determination in court, to give you a full opportunity to speak with both your clients in a

tripartite relationship, okay? To make a full, well-reasoned determination. This Court wasn't requiring that anybody make the determination in court. The Court was offering, but then giving you time in which you could fully consult with whomever you wished to do, if you wished an evidentiary hearing.

Johnny Ribeiro says what -- *Young v. Johnny Ribeiro* says what it says in subsequent case law. The Court doesn't need to offer it. You didn't even request it. You didn't even request it during the hearing. And I say you, meaning your firm, didn't on behalf of Dr. Rives. The Court just offered it.

The Court offered it, but did not require anyone to have it. Okay. I had no objection. So full waiver issue on the Plaintiffs, so I had no issues there, so it was just an offer to Defense if they wished to have any witnesses of their choosing in the time period they chose for today's date at 8:30. Based on this statement it was going to be an hour.

So with that in mind, then the Court wanted a specific writing from Defense counsel CC'ed to all parties and to the Court by a time period that Mr. Couchot and Ms. Newberry, who are here, Ms. Clark Newberry, seemed to be in agreement with, that that was sufficient time. Nobody asked me for any more time to consult with whomever they needed to consult with, to find out A) if they wanted the hearing, and B) if Dr. Rives or anybody else was going to be testifying so it would be put in just purely for a scheduling statement. No substance.

There was no request in that letter. There was no request by motion. There is a proper procedure if somebody wishes to file a

motion, right? If you wish to file a motion, there is a procedure if you wish to file a supplemental brief in the State of Nevada and under our local rules. No such procedure was followed. There was not even an OST submitted to the Court to request a supplemental brief. There was no oral request in Court. There wasn't even an improper request in the letter for a supplemental brief. There was nothing.

Then it came on Friday, less than a judicial day before today's hearing. That is the reason why this Court has to ask under that factual scenario, since none of those rules were followed, and you said it was just filed, okay, and gave no chance whatsoever, because Mr. Couchot knew, and Ms. Aimee Clark Newberry knew, because they were here in court, that counsel for Plaintiffs even stated that they would be out of town on Friday, because they were all aware that my JA came into court.

Because inadvertently, I started to say I could do the hearing on Friday, and then my JA came into court, and I believe I made some statement like, oops, I have this tendency to try and schedule things because I'm so -- try to help the parties out and try and schedule things, when JA has to remind me that I, too, scheduled to be at that same conference for -- CLE conference, right? And that both counsel were willing not to attend that conference if the Court was specifically scheduling, because they said that they both were going to be out of town.

So counsel for Defense who were here, I'm paraphrasing, it may have been shorter than that, my JA came in, so that's why I said

Monday, so you can give more time to Defense. So we knew that Plaintiffs were out -- Plaintiffs' counsel were out of town, and the Court was out of town on Friday, and yet still filed something in Friday. I'm not saying that -- no one is sneaking in the door. Obviously, the Court had backup in the court. My team knows how much I was calling, texting, and on the phone, and everyone at the conference saw how much I was on the phone.

Anyway, so obviously, the Court was fully available and could handle anything if it came in the door, but nothing did come in the door, because the Court was more than checking on this and every one other of its cases to ensure that everyone was fully taken care of, albeit while I was out of the jurisdiction at a CLE conference with several of our justices, Court of Appeals, et cetera. So, you know, we all were fully available to take care of our work, as well as obviously get our required, continuing legal education.

So that being said, that's why the Court has to ask the question is you didn't follow any of the procedures. So if you're telling me you didn't follow any of those procedures or you didn't file an OST or request supplemental briefing in any manner whatsoever because Robert Eisenberg told you not to, then of course, in fairness, I'd give him due process and give him an opportunity to explain.

MR. DOYLE: Okay. I'm not sure what the question is, but the decision to file the supplemental brief was mine after speaking to Bob Eisenberg about various issues. He did not say we shouldn't file it, and the decision was mine.

THE COURT: Okay. And a decision not to file any request or permission to seek leave to file a supplemental brief from me, that determination, please?

MR. DOYLE: I made that determination, and I didn't feel it was necessary under the circumstances given the significant and serious nature of the sanctions being requested. The fact that it's on an order shortening time, that's not a lot of time to deal with this to try and corral all the information and figure out what happened, and to get all the, what I believe to be, the necessary information in front of the Court so that it could make an informed decision, I proceeded in that fashion.

THE COURT: But, counsel, you had a full opportunity to put all that same information in your opposition and you chose to do so; did you not?

MR. DOYLE: No. It was done on a --

THE COURT: You knew about --

MR. DOYLE: -- it was done on an order shortening time.

THE COURT: And was there any request --

MR. DOYLE: We had been --

THE COURT: -- with regards to the ordering shortening time to extend the hearing date? It was at the Court's own decision that we gave the evidentiary hearing. Anything in the opposition to request additional time, either for briefing, to continue the hearing to a different date, this Court received nothing from Defense counsel, nor the information that you sought, which has its own issues on hearsay which the Court hasn't even gotten to. But that information, you could have

easily picked up the phone, if you wanted to, and called Mr. Hand any day you chose to do so, correct?

MR. DOYLE: I did --

THE COURT: And that could've been before the opposition was filed, correct?

MR. DOYLE: I did call Mr. Hand and left him a message last week, and he did not return my call, because I wanted to discuss with him my conversation with Mr. Brenske, and Mr. Hand did not return my telephone call.

THE COURT: And you could have picked up the phone and called Mr. Brenske at any time whatsoever when they first filed their motion, right, way back? And they discussed it with you before they filed the motion. I believe it was back around September 12th or 13th, correct? Which is --

MR. DOYLE: And I did -- I did call Mr. Brenske and talked to him, and that was the basis for the statement that I put in my declaration.

THE COURT: Counsel, this Court's question is -- let's walk through dates, please. Okay. Plaintiffs' motion for sanctions was submitted to this Court on order shortening time by its date -- well, it's dated September 16th. It was submitted to the Court for signature. The Court dated it on the 18th, and it shows it was personally served on the 19th of September, okay?

Now, the Court does not have available to it when it was electronically filed to Defendants. I don't know if it was filed before it was submitted to the Court on order shortening time, but in the affidavit

on that motion, it said that it had spoken -- prior to filing OST in accordance with the EDCR, they need to reach out to opposing counsel.

The affidavit sets forth that it did reach out to opposing counsel and that they spoke with opposing counsel so that there would have been -- even if the -- if the declaration is accurate and the pleading date is accurate, at the latest, based on what is presented here, at the latest, September 16th, Defense counsel would have been aware of the allegations contained in the motion. Based on the purported rogue document filed without the Court's permission, you did not contact Mr. Brenske until on or about October 2nd.

MR. DOYLE: That is correct.

THE COURT: That means between September 16th and October 2nd, you had the full opportunity to contact Mr. Brenske, put that information in your opposition to the original motion for order shortening time or B) request of this Court or first opposing counsel, or this Court, to have continued the original motion, requested additional time to have done opposition to the original motion for order shortening time, or like I said, to have continued the hearing in the first place, or to have even addressed the fact that you were in the process of trying to reach out to Mr. Brenske or some such information somewhere in your opposition, but instead, there was nothing about that whole topic area in your opposition.

And in fact, it wasn't until the Court even set -- offered you the opportunity to even have the evidentiary hearing, it's like you didn't seem to address that issue. So that's why the Court's asking you the

question. I'm not seeing how your statement that you can disregard the rules has any basis whatsoever when you would've had, at the latest, at least from September 16th to have a full opportunity to do this way before your opposition to the original motion, or you had several remedies that you could have taken place way back in September, but you chose not to do any of those, nor was there any request made at the hearing, in the letter after the hearing, or before the supplemental brief. That's why the Court is asking you that question.

MR. DOYLE: And I wish I had a crystal ball, or I could take a time machine and put myself back a couple of weeks and do things differently, but given the exigent circumstances and the significant relief being sought by Plaintiffs, we proceeded in what I believe to be an expeditious manner, trying to gather all the information necessary. Frankly, I didn't know we could request an extension of an order shortening time. I've never seen that happen. We just -- we assumed, given that we had the impending trial date and the terminating sanctions --

THE COURT: Well, counsel, therein lies part of the challenge that this Court is going to have to address with you, right? Please read the rules. Please stop violating all the rules. Please actually read the rules when the Court sends you memos that sets it forth, right, because they're there. They're there for you to read and to comply with, and you would have found it there, if you had read them.

And as an experienced litigator, you know you can't say you didn't know it existed, so you just were going to violate them and do

what you wanted to do. Plus, as you know, you even stated in your statement that your alleged conversation, which you know the Court can't take into account substantively because it's pure hearsay, even regardless of all the procedural issues is pure hearsay. Is Mr. Brenske here in court? No. Did you subpoena him? No. Did you have a full opportunity to do so if you chose to do so? Yes. You were not limited in the number of witnesses. Any witnesses you chose to could be here at 8:30. There was no limitation. It's whoever you wanted. He's not here, the Court can't take it into account, as you know. It's hearsay.

You know it shouldn't have been in your declaration in the first place because you know it's not personal knowledge as an experienced litigator, so there would be no basis to have any exigent circumstances. There's nothing -- as you know, the Court can't, by law, take it into account, so there would be no reason to even file it in the first place. So there would be no basis to violate the rules because you know the underlying substances. You can't ask this Court to violate its oath of office by taking into account hearsay.

So at this juncture, this Court cannot take into account, procedurally or substantively, a "supplement" that was A) filed in direct -- and these are all independent bases, so it's not the totality. The totality meets it. It independently meets it. The Court specifically -- you did not request it -- offered the additional -- the hearing was supposed to be over that day, but for the fact that the Court was concerned with the lack of what was in that opposition with the extent of the nature of the sanctions against one of your clients, okay, to ensure that both of your clients'

interests were represented so that -- okay, the Court offered the evidentiary hearing. Otherwise, that hearing would have been over that day.

So what you filed on Friday is a rogue document that the Court cannot consider procedurally because A) it was filed less than a judicial day, B) filed in direct contravention of this Court's specific -- without any leave, which could have easily been sought, was not sought. There's no good cause for it not to be sought, even the very "looking at the document" so that you had the conversation on the 2nd, but you still chose to wait until a date of the 4th to even file the document, giving no time whatsoever, fully prejudice to Plaintiffs, who have specifically objected, any opportunity to respond, knowing even independently, if you forgot that they were out of town -- they did state in open court that they were out of town, but that's even a non-sequitur. Even if they were in town or out-of-town, they could've done work over the weekend, I guess. So I'm not taking into account they were out of town.

I just -- that is not a factor that the Court is legally stating, but it just presents an even different concern, but that's not something that the Court is taking into account legally, but you did know that. So procedurally, it's a per se violation of the rules in and of itself. It's even more so a violation of the rules because the Court specifically said what could be done. You had full opportunity to ask for relief while you were here in court last week, and no one did so. Not in your brief, did not ask in open court, did not ask in a follow-up letter the Court did, and did not ask in any other motion before the Court, but instead -- and then even on

the alleged conversation you did it on the 2nd, you then waited until Friday to even file it, giving no chance for Plaintiffs to have any opportunity to respond.

That all procedurally is detrimental to Plaintiffs, a violation of the rules, a violation of specific court directive procedurally, all cannot be done independently. The violation aspect is going to have to be addressed separately shortly, with regards to the substantive aspect, even if the Court somehow could overlook all of those procedural hurdles, which it cannot, but independently, I would, to give you the benefit of the doubt, the Court said is there any way, I can give you the benefit of the doubt and look at it from a substantive manner. But the Court even looking at it -- if it tried to even look at a substantive manner, the Court can't, because it's pure hearsay.

It's pure hearsay because it was based -- supposedly, based upon any purported conversation with another individual who is not present in court when you had a full opportunity today on the evidentiary hearing to have any witnesses you chose to bring. If you chose to have Mr. Brenske present here in court, you could have asked him to be here either by subpoena or by request. He is not here. It is now 9:10, and I need to get you all started with the actual other portion, so --

MR. DOYLE: And I guess the impetus for my phone call with Mr. Brenske was the fact that there was nothing, and still today, there's nothing from George Hand who was the only --

THE COURT: Counsel. Counsel. This is not a time -- the

Court's doing its ruling of why I'm not considering it, okay? So substantively, pure hearsay. Counsel who is an experienced litigator knew the procedural aspects fully available, and because -- it's more egregious in this case, because of the numerous times that this Court has, in open court, with three separate attorneys from your firm, or your associated firms, plus the memos you've gotten in writing and served onto you, plus the two orders the Court has, and in those orders where the Court has referenced all the other -- not all -- actually, let me be very clear. It wasn't all.

I only gave you EGs. I gave you examples of other occasions where you've been specifically reminded to read the rules and given specific examples of not following the rules, and the Court even -- you're pending dispositive striking for your failure to follow the rules and litigation tactics and then you do another one?

That presents a huge challenge, okay? And particularly, since this just -- this Court had just done another order where it had just outlined it. You were subject to having the Court evaluate Rules of Professional Conduct, a whole panoply to do this again. Can't do it on all of that. Substantively, it's hearsay. Pure and simple. Cannot be considered, will not be considered, should have never been filed, and the Court has to evaluate, in addition under Rule 11 if there's any good basis, in addition to all the other factors, that unfortunately -- but the Rule 11 factor is not to be taken into account for this dispositive hearing. That is for the Court's other hearing that the Court has already set up because of Defense counsel, and potentially their client's pattern of

conduct in this case.

So with that being said, the Friday document that was filed shall not be considered by this Court because it cannot be considered by this Court, either procedurally or substantively under any basis. And there was nothing even in the document that even -- in the document itself, even provided any support on how the Court could hear it. There was nothing in the pleading itself on another substantive alternative basis that even said why the Court could consider the supplement. There was nothing even procedurally that addressed the procedural nature of it being filed on Friday, or any basis for the Court to consider it.

So it can't be considered, it won't be considered. The law does not allow me to consider it, and I've gone through all the prejudicial nature. The impropriety of it being filed will be addressed in the Court's portion, which it has to do because of the conduct as stated in the two court orders.

So getting to the -- now, that takes care of that Friday pleading, so we are back to where we were, which is what the Court provided. You have the pending motion for dispositive, which was Plaintiffs' motion. Everyone had had a full opportunity to argue everything is what this Court had been told, other than -- and people who were ready for the Court to rule, and then the Court then offered the evidentiary hearing in regards to the witness testimony because the Court asked some questions of Defense counsel, simple questions like whether or not they provided things to their client, which Defense counsel couldn't answer, or stated he didn't know.

So at this juncture, to the extent that Defense wishes to call any witnesses, the Court will now provide that opportunity. Realize any witnesses you call, you have to ensure that you fully advise your client everything that you need to advise your client under Nevada law. I've already cited a couple of the cases. You know the case law. If he chooses -- if you're advising him to take the stand, even if there's no RPC issues or anything like that, no conflict issues, no -- I don't know if I said *State Farm v Hansen* issues.

So if you wish to call whatever witnesses you wish to call, Defense counsel, and remember, there's cross-examination by Plaintiffs' counsel, and the Court may have some questions if the parties don't address the issues that the Court had. And then the Court will make a ruling on Plaintiff's outstanding motion. So counsel for Defense, if there's any witnesses you'd like to call, feel free to all your first witness.

MR. DOYLE: I'd like to call Dr. Barry Rives and then when his testimony is finished, I'd like to make some closing remarks.

THE COURT: That was not part of it. It was just -- it was just to call any witnesses.

MR. DOYLE: So I'm not --

THE COURT: It was not requested by anybody last week. Your co-counsel -- neither of your co-counsel made that request. That was not the scope of this. Nobody requested that. You all requested the time period for the one hour just for the questioning, and the only person that was discussed was Dr. -- now if you brought somebody else,

of course, the Court didn't limit it to that. I said any witnesses because I wanted to get everyone a full chance for any counsel to discuss with anybody, any counsel that may not have been present in court that day. But no such request was made. There is --

[Court and Clerk confer]

THE COURT: I don't recall, I was going to go see if we have a copy. I don't recall if the letter said that request, but this Court is not aware of any said request for any closing response.

All oral argument was taken care of. It was only the witness testimony that -- that was what -- the only thing that --

MR. DOYLE: The witness testimony necessarily requires some comment by me --

THE COURT: No, it --

MR. DOYLE: -- when the witness is done testifying.

THE COURT: Well, then your --

MR. DOYLE: And --

THE COURT: -- counsel should have asked that last week. Nobody asked that -- the Court was not -- okay, at this juncture, you may call your first witness.

MR. DOYLE: All right. Dr. Rives.

THE COURT: Okay.

BARRY RIVES, DEFENDANT, SWORN

THE CLERK: Thank you, please be seated. Could you please state and spell your name for the record?

THE WITNESS: Barry James Rives, R-I-V-E-S.

THE CLERK: Thank you.

DIRECT EXAMINATION

BY MR. DOYLE:

Q Good morning, Dr. Rives.

A Good morning.

Q Over the years, have you given a number of depositions?

A Yes, I have.

Q Have you testified at trial several times?

A Yes, I have.

Q Did you take an oath each time?

A Yes, I did.

Q And do you understand you took an oath this morning?

A Yes.

Q Do you understand you took an oath before -- or at the beginning of the Farris deposition?

A Yes.

Q And your understanding of the oath that you took at the time of the Farris deposition and today means what to you?

A To tell the truth, the whole truth, and nothing but the truth. So help me God.

Q And anything else?

A That's it.

Q Do you understand -- at the time you gave the Farris deposition, did you understand the penalties that you could face, if you did not carry out that oath?

A Yes.

Q Did you understand the penalties that you faced if you lied, or were deceitful at the Farris deposition?

A Of course.

Q And what did you understand those to be?

A I could be guilty of perjury.

Q And at the Farris deposition, did you -- in response to any of the questions at the time of the deposition, did you lie?

A No.

Q Were you deceitful?

A No.

Q Did you withhold information?

A Not at all.

Q I want to ask you some questions about the discovery responses, the request to produce documents and the interrogatories. There was a set of each to you individually and then as well as to your professional corporation, Laparoscopic Surgery of Nevada. Did we send those to you on April 12, 2017?

A I believe so, yes.

Q Did we send you a copy of the request to produce documents with draft responses we had prepared?

A Yes.

Q Did we send you the two sets of interrogatories with draft responses we had prepared?

A Yes.

Q. Had you talked to anyone in my office before you received those draft responses, either Mr. Couchot, myself, or anyone else, about the interrogatories or request to produce documents?

THE COURT: The Court's going to interject here, because the Court is being clear. The Court is not asking that anyone disclose any attorney-client communications. If your client is going to waive that, I need -- then (a) this Court needs to know that; and (b), this Court needs to have a clear understanding that he has been advised clearly of what that means, the impact of it, the full extent of what he's doing, because there's a distinction between how that can be handled.

And you, as his counsel, I just want to ensure that the Court is not asking any of that. The Court just needs to know if you're trying to elicit communications between Dr. Rives and your office, that he has (a) been advised of his rights, and the attorney-client privilege, and if he's waiving it, what that impact is. The Court just wants to make sure that he has been fully advised of such.

MR. DOYLE: And my client has been fully advised, and I think the answer to the question will show that there is no attorney-client privilege to violate.

THE COURT: No worries. The Court just --

MR. DOYLE: Thank you for that.

THE COURT: -- to ensure that everyone has a full opportunity, and there's nothing done inadvertently. Thank you, so much.

MR. DOYLE: Thank you.

BY MR. DOYLE:

Q Doctor, before you received on April 12th, 2017, the request to produce documents and the special interrogatories, was there a conversation between you and someone in my office about preparing the draft responses?

A No.

Q Was it your understanding my office had prepared those draft responses with no input from you?

A Correct.

Q Is it your understanding that we prepared those draft responses based on information that we had obtained over the years representing you in other cases?

A That is correct.

Q And --

THE COURT: Counsel, I've got to -- I'm hearing your questions, but by the very nature of your questions, this Court's not getting the nexus of how you said this is not eliciting attorney-client communication. How can a person have an understanding of your office's practices without having a communication with someone from your office, and know specifically about how your office did his interrogatories --

MR. DOYLE: Okay.

THE COURT: -- without having some conversation with someone in your office? That's why this Court was -- it's not the first hearing this Court has done, that's why this Court was very specific in

trying to give that step.

MR. DOYLE: I'm going to go on. Let me -- let me --

THE COURT: That's fine, counsel.

MR. DOYLE: Okay. Thank you, Your Honor.

THE COURT: The Court's concerned about waiver issues right now. The Court's just saying that. Okay.

BY MR. DOYLE:

Q Doctor, concerning the special interrogatories that were sent to you as an individual and the draft responses that we prepared, did you review those draft responses?

A No.

Q Why not?

A I believe when I looked at the email, I opened up the first PDF, which had to do with, I believe disclosure of materials, and it looked like a bunch of legalese, and I assumed everything else was the same.

Q Did you rely on my office to -- for the information contained in the responses to those interrogatories?

A Yes.

Q Before -- after you received the draft responses to the special interrogatories directed to you, did you and I have a conversation about those draft responses back in April or May of 2017, before they went out?

A No.

Q Did you have a conversation about them with anyone else in my office?

A No.

Q The first time that you saw the responses to those interrogatories, was that recently?

A Within the last week or two, yes.

Q And did you sign and return to us a verification for the special interrogatories that were directed to you personally?

A To me personally, no.

Q Doctor, if you had reviewed the draft interrogatory answers, do you believe you would have noticed that they contained an old office address?

A Yes.

Q Do you believe you would have noticed that Center was not on the list of cases?

A Yes.

MR. JONES: Your Honor, I'm just going to object. I don't know when the last time it was that the Doctor testified and wasn't just led into a question with a yes or no.

THE COURT: I'm sorry, so what's -- I'm not hearing your --

MR. JONES: Every question -- every question has been leading, Your Honor, and I would just request that he actually elicit --

THE COURT: Okay.

MR. JONES: -- testimony from the Doctor.

THE COURT: Sustained because this is your witness.

MR. DOYLE: Okay.

BY MR. DOYLE:

Q Doctor, when you looked at the answers to interrogatories

recently, were supplemental responses prepared?

A Yes, I believe so.

Q And what was corrected based upon the information in the draft responses, that we had prepared, and you had not seen? What was changed, or amended?

A I noticed that the existing office address was incorrect. So that had to be amended. That the Center case wasn't in there, so that had to be amended. That there was a response to whether I'd been on any medical committees, regarding the hospital, that was left either blank, or that was -- didn't include my chief of surgery, and all of the other stuff that I had done for the hospitals. So I believe that had to be amended as well.

Q Okay. Now, when you sat for your deposition in Farris, what did you review to prepare for the deposition?

A My office notes and the medical notes.

Q When you prepared for the deposition in Farris, did you review any of the interrogatory responses, either by you, or by your professional corporation?

A No.

Q Did you review, to prepare for the deposition, the request to produce documents that had been prepared -- or the responses prepared on your behalf and your anticipated --

MR. JONES: Your Honor, I'm going to just object again. I would appreciate it if he'd elicit something from the Doctor, rather than telling the Doctor the answer, and asking for a yes or no.

THE COURT: Counsel, I need that in the form of a proper objection, if that's an objection.

MR. JONES: Your Honor -- leading, Your Honor.

THE COURT: Sustained.

BY MR. DOYLE:

Q Doctor, did you review any discovery responses to prepare for your deposition in Farris?

A No.

Q At the deposition, who was the attorney that was present for the Farrises?

A George Hand, I believe.

Q Did George Hand mark as an exhibit for the deposition a copy of the interrogatory responses from you --

MR. JONES: Objection, Your Honor. Leading.

THE COURT: Sustained. That's going to leading. Counsel, three sustains on the same basis. Please stop it.

BY MR. DOYLE:

Q What did Mr. Hand mark and show you at the deposition concerning interrogatory answers?

THE COURT: Counsel --

MR. JONES: Objection, Your Honor. Foundation. Leading.

THE COURT: -- that's a leading question, please. You've already been admonished. I already just advised you on the very last question, please do not do it indirectly what the Court has just admonished you not to do directly. I am sustaining the objection and

you will be -- have sanctions against you if you do it a third time. Are we clear?

MR. DOYLE: Yes.

THE COURT: Thank you.

BY MR. DOYLE:

Q What did Mr. Hand show you?

A I believe at one point during the deposition he handed me a set of the interrogatories and my CV.

Q And what did he ask you to do when he handed you those documents?

A He asked me to review my CV and see if it was up to date.

Q What did you do in response to his question?

A I think there was some dates, like in the medical -- my medical license, the expiration date wasn't updated. There were some small little factors like that, that I said needed to be updated. And then he asked me to hand it back to him.

Q What do you mean by he asked you to hand it back to him?

A He asked the CV and the interrogatories be handed back to him.

Q What did you do when he asked you that?

A I handed it to him.

Q Do you recall at the deposition whether you were asked questions about interrogatory number 3?

A Yes, I was.

Q What do you recall about interrogatory number 3? What was

that about?

A I believe that's when he went through a list of my prior cases and asked me for information regarding those cases.

Q Did you answer his questions?

A Yes.

Q Can you tell us if your answers were accurate?

A Yes, they were.

Q When Mr. Hand got to the end of asking you about cases where you had been a Defendant, did he ask you about the Center case?

A No, he --

MR. JONES: Leading, Your Honor, again.

THE COURT: Counsel that is leading 101.

MR. DOYLE: Okay.

THE COURT: Sustained.

MR. DOYLE: Did --

THE COURT: And counsel, what did I say?

MR. DOYLE: Okay.

THE COURT: Counsel?

MR. DOYLE: I understand.

THE COURT: But you're not listening.

MR. DOYLE: I --

THE COURT: You're hearing me, but --

MR. DOYLE: I thought it was not a leading question, I apologize, Your Honor. I'm not doing this intentionally. Let me try again. I'm sorry.

BY MR. DOYLE:

Q Were you asked a question about the Center case?

A Regarding the interrogatories?

Q Yes.

A No.

Q Were you asked whether there were any other cases?

A I was asked if I had been deposed as an expert witness for either a patient or for a defendant doctor.

Q And how did you respond to that question?

A I gave him two examples that I could remember at that time, where I had been deposed or went to Court as an expert witness.

Q Did the Center case come up?

A The Center case did come up, yes.

Q How did it come up?

A Right at the end of that particular question, he asked me -- he, being Mr. Hand, asked me regarding that question, were there any others that I could think of at that time. I could not recall any other time that I did an expert witness for either a patient or a defendant doctor, and Chad at that time mentioned Center's not on there. And I didn't really understand what he was referring to, because Center is a case where I was a Defendant, not an expert witness or something else to another matter. And I think from there, we then talked about the Center case.

Q Did you answer all of Mr. Hand's questions about the Center case?

A Yes.

Q Were your answers accurate?

A Yes, they were.

Q At that time, Doctor, did you have any reason to hide from Mr. Hand the Center case?

MR. JONES: Your Honor, leading, again.

THE COURT: Did you have any reason to hide the Center case?

MR. DOYLE: Did you --

THE COURT: Counsel, would you consider that a leading question?

MR. DOYLE: No, I don't, actually.

THE COURT: Doesn't it presuppose the answer to the question? Did you have any reason to hide the Center case? That is a leading question, counsel. You're an experienced litigator, you know that. That is sustained.

MR. DOYLE: Okay.

THE COURT: Please ensure that you ask open ended questions. This Court is very concerned about how you're asking these questions. They do not appear to be open ended to your client.

MR. DOYLE: Okay.

BY MR. DOYLE:

Q Doctor, at the time of the Farris deposition, what thoughts were going through your head about the Center case?

A None.

Q Why not?

A A) to me, they weren't material to the issue at hand. I was focused on my care and my medical responsibilities to Mrs. Farris in my deposition -- or my answers to questions in that regard.

Q The deposition transcript in Farris, did you -- tell us whether you received it.

A I received a letter and transcript within the last week or two, regarding that.

Q Did you receive the deposition transcript before then?

A No, I did not.

MR. DOYLE: That's all I have then. Thank you.

THE COURT: Thank you. Any questions by Plaintiff's counsel?

MR. JONES: Yes, Your Honor.

THE COURT: And since there's two of you, only one will be asking questions, correct.

MR. LEAVITT: That is correct.

MR. JONES: That is correct, Your Honor.

THE COURT: I appreciate it. Thank you.

MR. JONES: Your Honor, I have some binders here that just have some exhibits that I know I'll reference a couple of them, but I may reference several.

THE COURT: Are they exhibits that have been introduced in this case and are already on your pretrial through your joint pretrial memorandum? What I'm trying to get clear is that they were exhibits that have been produced in this case, they were at your 2.67, you know

what I mean, exchanged as proposed exhibits, et cetera. Meaning they're not new exhibits coming in for the first time today.

MR. JONES: Yes, with the exception of a couple, Your Honor. So what we have is the answer and complaint, and then we have the Answers to Interrogatories by Dr. Rives for his corporation and for himself personally. There's three sets of those each. Right? So there's six.

THE COURT: Okay. So they're --

MR. JONES: Our 2.67 --

THE COURT: So they've been E-served. Okay. So what you're talking about --

MR. JONES: They have been E-served, Your Honor.

THE COURT: -- the pleadings that have been E-served. I just want to ensure that there's no surprises that come up from either side. Right? Fairness --

MR. JONES: Correct.

THE COURT: -- to both sides forward -- forward and fair to both sides in each and every case.

MR. JONES: That -- that is correct, Your Honor. And we have disclosed the deposition that the doctor gave in the *Center* case. That is also included here.

THE COURT: That was attached to the pleadings with your Exhibit 3, I think.

MR. JONES: That is correct, Your Honor.

THE COURT: Okay. So let's see, the Court's not taking any

position. We'll see what I hear from the other side --

MR. DOYLE: Yeah.

THE COURT: -- as you go through. So the Court's not taking a position until you do what you do. I just --

MR. JONES: And --

THE COURT: With that representation --

MR. JONES: -- Your Honor, may I approach to provide --

THE COURT: Of course.

MR. JONES: -- a copy to the Court?

THE COURT: Right.

MR. JONES: And also to the --

THE COURT: Like I said, the Court's not going to take any position until I hear what you're saying and what you're asking.

MR. JONES: Yeah. Thank you, Your Honor.

[Counsel confer]

CROSS-EXAMINATION

BY MR. JONES:

Q All right. Doctor, the binder that you have in front of you, I'd just like to go through it with you relatively quickly. If you can look -- turn to Tab 1. This is the complaint of the Farrises against yourself in this case and against the Laparoscopic Surgery of Southern Nevada. Does that appear correct?

A It does.

Q Okay. Have you seen this document before?

A I believe I have, yes.

Q Okay. Let's go ahead and turn to Tab 2. This is your answer to the Plaintiff's complaint in this matter. Have you seen this document before?

A I believe so, yes.

Q All right. Turn to Tab 3, please. This is Defendant Barry Rives -- Dr. Barry Rives' response to Plaintiff Titina Farris' first set of interrogatories. And you can see up in the top right-hand corner it says, "Electronically served 4/17/2017 at 1:20 and 37 seconds, p.m."?

A Yes.

Q Okay. Have you seen this document before?

A A couple weeks ago, yes.

Q Okay. So you did not see this document prior to April 17th, 2017; is that correct?

A That is correct.

Q Okay. If you turn to Tab 4, this document was electronically served on September 13th, 2019, and it's entitled, "Defendant Dr. Barry Rives' supplemental response to Plaintiff Titina Farris' first set of request for production of documents." Have you seen this document before?

A Yes, I have.

Q Okay. And when did you first see this document?

A Just about that time.

Q About the 13th of September?

A Sometime in that frame, yeah.

Q Okay. When you say, "that frame," what are the parameters of the frame that you would provide?

A Maybe within one or two weeks of it being filed.
Q Either --
THE COURT: Counsel, can you re-ask that question? I didn't --
MR. JONES: Yes. I'm trying to establish the time frame whereby the doctor identified it.
BY MR. JONES:
Q Doctor --
THE COURT: Which tab is that? I was trying -- I --
MR. JONES: Oh. Tab 4, Your Honor.
THE COURT: One or two weeks -- can you please re-ask the question? I was trying to --
MR. JONES: Certainly.
THE COURT: -- get the date --
MR. JONES: Yes.
THE COURT: -- that you got listed. Please. Thank you.
BY MR. JONES:
Q So I asked you when it was that you first observed this document, Doctor. And -- go ahead?
A "Defendant Dr. Rives' supplemental response to Plaintiff Titina Farris' first set of requests for production of documents." The supplemental response --
Q Yes.
A -- was sometime in September.
Q Okay. Do you have any -- anymore narrower parameters

than sometime in September to identify when it was that you saw this document for the first time?

A No, I don't.

Q Okay. All right. Did you ever see either of these documents, whether it be Exhibit 3 or Exhibit 4, prior to September 2019, Doctor?

A The supplemental response and -- hold on one second -- Defendant response to first set -- no.

Q Okay.

A The first time I saw these was sometime in September of this year.

Q Okay. Thank you, Doctor.

THE COURT: So that question was Tabs 3 and 4? When you're doing it by tabs rather than titles, I'm trying to make sure I've got the correct --

MR. JONES: Thank you.

THE COURT: -- titles of what you're saying. So --

MR. JONES: I appreciate it, Doctor -- Your Honor.

THE COURT: Because the Court needs to be clear.

MR. JONES: Right.

BY MR. JONES:

Q And to be clear, Doctor, the tabs we were talking about were 3 and 4, which would have been the initial responses and the supplemental responses, correct?

A The supplemental response to request for production of documents and the response to Plaintiff's first set of interrogatories,

correct.

Q Okay. And those were the documents that one -- the first was served 4/17/2017, and the second was served 9/13/2019, correct?

A Correct.

Q Okay. And those were -- you saw those for the first time both in September of 2019. Fair?

A That is correct.

Q All right. Turn to Tab 5. So this document is titled, "Defendant Dr. Barry Rives' first supplemental response to Plaintiff Titina Farris' first set of interrogatories." And this is dated 9/25/2019, correct?

A That is correct.

Q Have you ever seen this document before?

A I have.

Q Okay. And when did you first see this document?

A Sometime in September.

Q Okay. Did you see it before, after, or concurrently with the -- the document that was served 9/13/2019, the supplemental response, versus the first supplemental response?

A I don't have an independent recollection of that.

Q You don't have an independent recollection of when you saw each?

A No. I got a number of emails in the last couple of weeks, all through September, with different interrogatories, different supplements asking me to review, and then verify, get it notarized, and resigned.

Q Okay.

A So which one came in one email versus the other, I'd have to review my emails for that.

Q Based on your recollection, did you see them all at one time or did you see them on multiple occasions?

A I saw them on multiple vacation -- multiple occasions.

Q Okay. And as we sit here today, you couldn't tell like me or the Court when it was that you saw one versus the other. Is that fair?

A Exactly, no.

Q Okay. All right. All of them in September 2019 for the first time?

A I believe September or possibly even late August, but sometime in the last four to six weeks, yes.

Q Okay. Let's go ahead and -- I want to be very brief with the next three. If you took at Tabs 6, Tabs 7, and Tabs 8, these are essentially the mirror responses or -- the responses are different, and the questions are different, but these were served at the exact same times as the aforementioned three that we went through. And these are with respect to Defendant Laparoscopic Surgery Center of Southern Nevada -- Surgery of Nevada, LLC's responses.

And so the first, which is Tab 6, was electronically served 4/17/2017, the seventh tab is your supplemental responses, and the eighth tab is the first supplemental responses. Again, these are for your corporation. Correct?

A Correct.

Q All right. Tab Number 6, have you ever seen this before?

A Yes, I have.
Q When did you see this, Doctor?
A Within the last couple weeks.
Q Okay. The same timeline as the aforementioned three that we just went through?
A Correct.
Q Okay. Number 7?
A Same timeline.
Q Okay. Number 8?
A Same timeline.
Q Okay. Now, Doctor, are you sure that you have not seen these before, any of these six that we just went through, prior to September of 2019?
A Yes.
Q Okay. Why are you so sure of that, Doctor?
A Because when I had a chance to review them, there were errors on there that I needed to have them corrected.
Q And that's true both for the ones for your corporation as well as for your Answers to Interrogatories for yourself personally?
A I'd have to go through them again to verify that.
Q Please do so.

[Witness reviews document]

THE WITNESS: Yeah, I reviewed them in September of this year, because I needed to correct the address on my corporation's responses as well.

BY MR. JONES:

Q Okay. So because of that, you can say with certainty for the Court that this is the first time you saw them, was September 2019, correct?

A Or sometime in September, yes.

Q Right. Sometime in September 2019?

A Oh, 2019. Yes.

Q Okay. And that you've never seen either one before, correct?

A That is correct.

Q All right. Doctor, who is Teresa Duke?

A Teresa Duke is head of credentialing at St. Rose -- actually St. Rose, all campuses.

MR. JONES: Your Honor, I have another exhibit that I didn't think I was going to be needing to attach. We received this from Defense counsel within the last week or so, two weeks perhaps. One through paralegals. We reached out to them for a copy of the verification in this case. I'd like to distribute verifications signed by Dr. Rives that we've received within the last week.

THE COURT: Is that the one that came in the night before the last --

MR. JONES: No, Your Honor.

THE COURT: -- hearing?

MR. JONES: This is one that -- that we happened to receive by email within the last week or so.

THE COURT: All right. But what I'm asking is, I think at the

original hearing set on order shortening time in this case on 9/26 on the 10 a.m., you all disclosed to me at the hearing on 9/26 that -- I believe you said the evening before, you received a verification. Is that the verification you're talking about that's in your hand, or is this a different verification? I'm just trying to get an understanding of --

MR. JONES: Absolutely.

THE COURT: -- what verification is this.

MR. JONES: Yes. And, Your Honor, I'll -- so after we got Defendant's opposition, we asked them if they had a verification, and their paralegal sent us this, which is a verification of Dr. Rives for his surgery center.

THE COURT: Okay. So --

MR. JONES: It appears to contradict what Dr. Rives just testified to, Your Honor.

THE COURT: Okay. Well, let's see it, and see what people's position is. So you're saying you got this from the paralegal of the Doyle firm? I'm just trying to get an understanding who you got it from, when you got, and where you got it, if you don't mind, please.

MR. JONES: Absolutely, Your Honor. When we saw Defendant's opposition, much of it said, well --

THE COURT: Okay.

MR. JONES: -- it's really not that bad because there wasn't a verification, I reached out to Mr. Hand and I said, is there a verification? And he said, oh, let me check. And his paralegal sent an email to the paralegal asking for verification from Mr. Doyle's office, and they sent

over this verification.

THE COURT: Okay.

MR. JONES: And so we received this in the last week or two, is my --

THE COURT: Okay.

MR. JONES: -- understanding, Your Honor.

THE COURT: So time frame -- just so the Court has an understanding here, just -- because you all are talking about a lot of different time frames. Defendant filed their opposition. Since I don't have the final stamped copy -- I'm looking at the date on page 22. Okay? It says September 24, 2019. Okay? So your understanding is you got this verification some point between September 24 and when the hearing took place on September 26, or you got it -- I'm just --

MR. JONES: No. That's --

THE COURT: I'm trying to chronology it.

MR. JONES: Right.

THE COURT: I'm trying to get the correct chronology here, please.

MR. JONES: My understanding is right around that time, Your Honor.

THE COURT: Okay.

MR. JONES: That's my understanding.

Now, to be clear, the -- at the hearing, I didn't mention this because it didn't seem directly on point at all, since this is only a verification of the company, not of his individual responses.

THE COURT: Okay. Okay.

BY MR. JONES:

Q Dr. Rives, what is this document that I've just handed you?

A It's a verification regarding Laparoscopic Surgery of Nevada's response to Plaintiff Titina Farris' first set of interrogatories.

Q All right. And can you read -- it says verification. And can you please read what it says below that?

A "I, the undersigned, declare I have read the foregoing document, and know the contents thereof. I am informed and believe that the matters stated therein are true. And on that ground, I allege that the matters stated therein are true. I declare under penalty of perjury that the foregoing is true and correct. Executed on the 27th of 2017 at Henderson, Nevada."

Q Is that your signature, Doctor?

A That is.

Q All right. And Teresa Duke is a notary at St. Rose?

A She's head of medical credentialing, but she's a notary, yes.

Q Okay. And she's notarized documents for you before?

A Yes, she has.

Q And you don't doubt -- you don't deny that you signed in document, that it was notarized?

A No, I don't.

Q Okay. All right. So, Doctor, what you testified to before, a moment ago, that you had never seen this document up until September of 2019, that's not true, is it?

A No. It is true.
Q So, Doctor, you had this verification notarized when?
A The 27th, 2000- -- April 27th, 2017.
Q Okay. And you did that without looking at the document that it attached to?
A The documents came as an email. The first PDF I pulled up was for something regarding discovery. I read it as a bunch of legalese. They asked me, can you approve these? So I printed out the last verification, had it signed and notarized.
Q Okay. So -- and you didn't go back to read what you were swearing under penalty of perjury was true?
A You mean the other documents?
Q Right.
A No.
Q Okay. What did you believe this related to, Doctor, at the time that you swore under penalty of perjury that the answers were true?
A To the documents prepared by my legal counsel.
Q Okay. All right. And you did so. It says, "I have read the foregoing document and know the contents thereof." That was not true when you signed this?
A No.
Q Okay. And you have no idea whether or not the information stated therein was true or not, did you, because you hadn't reviewed any of it?

A I did not review it. Having been with this counsel for many years and seeing these in the past, half the time I can't make sense of them, so I assume what their due diligence has been is true. Yes.

Q Okay. All right. But you certainly did not verify that any of the statements therein were true, correct?

A I did not review them sentence by sentence, no.

Q And your understanding when you signed this was that you were affirming that everything they had sent to you was true, correct?

MR. DOYLE: Objection. It mischaracterizes the evidence.

MR. JONES: I don't think it does at all.

THE COURT: Okay. I need an answer -- I need a further -- since this is me and an evidentiary -- I don't have a jury -- I need a further explanation. I don't want --

MR. DOYLE: This is --

THE COURT: -- it in his presence though because I do not want to -- in light of the issues that were raised with these leading questions, I need this done in a manner that explains to the Court. So we have a couple of ways of doing that.

MR. DOYLE: Can we approach?

THE COURT: But I want to ensure that you are fine with your client, because we have those mixed interests because he is a client who is also entitled to hear things.

So, counsel, what do you suggest? You're his counsel.

MR. DOYLE: I'd like to just point out what's wrong with the question. And the suggestion in the question is inaccurate about this

document.

MR. JONES: Your Honor, I'm happy to rephrase the question and see if I can accomplish what I'm attempting to accomplish --

THE COURT: Okay.

MR. JONES: -- with something that is --

THE COURT: Since it's rephrased, the Court will --

BY MR. JONES:

Q Doctor, a moment ago you testified --

THE COURT: -- not address it.

Go ahead.

MR. JONES: Oh, sorry.

BY MR. JONES:

Q Doctor, a moment ago you testified that you got all of these documents from counsel, and that you knew that they wanted a verification signed, so you printed off the very last page of all of them and signed that, correct?

A That is correct.

Q Okay. And you did that believing that this was a verification saying that everything they had sent you was true. Is that fair?

MR. DOYLE: Objection. It mischaracterizes the evidence.

THE COURT: The Court's going to overrule the objection because he said, "Is that fair."

THE WITNESS: I'm sorry. You're going to have to -- I got lost in all this, quite honestly.

MR. JONES: You bet, Doctor.

BY MR. JONES:

Q You printed off this last page, and you signed it as a verification that you were saying that everything they had sent you was true --

A Correct.

Q -- is that -- all right, Doctor. Now, I want to go through -- you've been deposed numerous times, and that dealt with previously, and you were under oath in each occasion; isn't that true?

A That is true.

Q And you've answered interrogatories in numerous cases, and you would know that you -- that those are under penalty of perjury as well, correct, when you answered those?

A My counsel has answered those interrogatories for me, yes.

Q But you knew -- but you signed verifications for those interrogatories, correct?

A I believe so, yes.

Q And the verifications to those interrogatories were sworn under penalty of perjury, were they not?

A I believe so, yes.

Q And you're the one swearing under penalty of perjury that they're true, aren't you?

A Yeah, I guess. Yeah.

Q Okay. All right. Now, Doctor, during your deposition, you stated that -- in this case, you stated that Mr. Hand provided you with some documents, including your CV and including interrogatory

responses; is that true?

A Rereading the deposition and the best of my recollection, yes.

Q Okay. When did you reread that deposition, Doctor?

A Sometime in the last week or two.

Q Okay. Any time before that since the time of your deposition?

A I do not -- I don't think I even had the deposition. No.

Q Okay. So you believe the first time you saw that deposition since the deposition was sometime last week or two?

A I believe so, yes.

Q We can agree that that deposition as taken October 24th, 2018?

A I have no reason to quibble with that.

Q Okay. Let's just flip over to Exhibit 10.

MR. JONES: Your Honor, I have a few more questions still. Is there --

THE COURT: Here's what we're going to -- how much time do you estimate that you still need?

MR. JONES: Maybe ten minutes. Something like that.

THE COURT: Okay. And how much do you need for your final rebuttal or your final -- are you going to do redirect?

MR. DOYLE: So far, no.

THE COURT: Okay.

MR. DOYLE: But I haven't heard everything.

THE COURT: Okay. Then Tena says I'm fine for the other case that's waiting, estimate we're probably more likely to start closer to 10:15 just to let you know, best estimate. Okay. So if you need to be doing something, we won't call -- you know what I mean? We won't start without you, let's put it that way. But more likely 10:15. Okay. Thank you.

Go ahead, counsel.

BY MR. JONES:

Q Now, Doctor, the -- when he handed those to you, did he give you the impression that you weren't really permitted to really look through those answers?

A Say that again?

Q Well, I'll say it the other way. Was it clear that he wanted you to review what he was handing you?

A He asked me to review the CV part, yes.

Q Okay. But he handed you both things?

A Yes.

Q Did he say, please review your CV, but don't review the interrogatories?

A He asked me only to review the CV.

Q Okay. All right. Did you, at any time, review the interrogatories at that time?

A No, I don't believe I did.

Q Did you even look at them as -- during the course of that deposition?

A I don't believe I did.

Q Okay. Do you have an actual recollection of either looking at them or not looking at them during that deposition?

A To the best of my recollection is that I did not.

Q Okay. So I just want to ask you again. Do you have an independent recollection of that? Do you actually recall answering his questions about interrogatories without them in front of you versus with them in front of you?

A In -- you mean independent of all other information like rereading the deposition?

Q I'm asking you right now, do you have a memory in your mind of the deposition that is so clear that you can tell the Court with certainty, based on your memory, whether or not you answered the questions with the deposition -- or interrogatories in front of you?

A To the best --

MR. DOYLE: Objection. Argumentative.

THE COURT: Court's going to overrule that.

THE WITNESS: Am I allowed to answer?

BY MR. JONES:

Q Yes.

A To the best of my recollection, to the best memory I have as I sit here today is that I did not have those when he asked me about them.

Q Okay. Do you have a recollection of answering those questions --

THE COURT: Bless you.

BY MR. JONES:

Q -- and that the interrogatories were not in front of you?

A Yeah, I believe I just stated that.

Q Okay. All right. Okay. If you can turn to page 10 of Exhibit 10, down at the very bottom of that page, beginning line 25, there's a question. It says,

"If I could direct you to response number 3. And the question is if you had ever been named as a defendant in any case arising from alleged malpractice or negligence? So I'm just going to go over these with you. We are on page 2."

So are you saying that as he's saying that to you that you did not have that document in front of you?

A That's correct because he asked for it back on page 10, around question -- line 1 or 2 where he says, "Can I see those interrogatories again for a second. Thank you."

Q Okay. And so you're saying that when he did that there was only one set of interrogatories, and he was just talking to you only at that time?

A Correct.

Q Okay. So when he was asking -- when he was saying if he could direct you to response number 3, he was holding the only set of interrogatories himself and not directing you to anything?

A He was holding the interrogatories and going through the list that he was reading. I was listening to him as he was reading the list of cases.

Q Okay. Doctor, have you looked at any portion of the deposition of the *Center* case within the last month?

A Yes.

Q When was that?

A Within the last two weeks maybe.

Q Was that also in relation to this hearing?

A Yes, it was.

Q Okay. In the *Center* case, do you recall being asked about prior medical malpractice cases in which you had been involved?

A I believe so, yes.

Q And you'd agree that when you were under oath in the *Center* case, you also had taken an oath to tell the truth, and as you stated, the whole truth and nothing but the truth, correct?

A That is correct.

Q And that was true for today, at the deposition in the Farris case, and the deposition in the *Center* case, correct?

A That covers all aspects of my life, yes.

Q Okay. Let's go ahead and go to Exhibit 9. And you'd agree this is a copy of your deposition in the *Center* case, correct?

A It appears to be, yes.

Q Okay. Now, in the *Center* case, you also failed to mention the Farris case when you were asked about medical malpractice cases you'd been involved in, correct?

MR. DOYLE: Objection. Mischaracterizes the evidence.

THE COURT: The Court can't make a ruling on that because

you're referencing a hundred plus page document. So the Court's going to have reserve and hear what the answer is and then rule afterwards and let you each provide what you want to provide afterwards.

Go ahead.

BY MR. JONES:

Q. Go ahead, Doctor. Answer.

A. I'm sorry; you're going to have to remind me.

Q. Yes, Doctor. You'd agree that you failed to name the Farris case when you were asked about medical malpractice cases in which you had been involved during your *Center* deposition?

A. When I reviewed my deposition I realized that I had left off both pending cases, Brown and Farris.

Q. Okay. So you failed to disclose that you had the Farris case, and you failed to disclose that you had the Brown case during your *Center* deposition?

A. No, I misunderstood the question. I thought it was related to matters that had been settled. So I talked about the four cases that had been settled. I didn't realize that included the three pending cases, which would have been *Brown, Center, and Farris* at that time.

Q. Okay. But you would agree in retrospect, having reviewed this in the last two weeks, that the question required you to be candid even about the Farris and the *Brown* case, correct?

A. In retrospect, yes.

Q. Okay. And so you're just saying at the time, you misunderstood it, correct?

A That is correct.

Q And because of that, you gave incomplete testimony, correct?

A That is correct.

Q Okay. Now, you'd agree that your attorney understood the call of the question in the Farris case to require you to mention the *Center* case when you were being deposed in the Farris case?

MR. DOYLE: Objection. Speculation.

THE WITNESS: I'd say you'd have to ask Chad.

THE COURT: Wait just a second. Hold on. Can you repeat that question? You understood --

BY MR. JONES:

Q During your deposition --

MR. JONES: I think it's a fair objection, Your Honor. I think it is speculative. I'm going to move on.

THE COURT: Okay. You're going to rephrase. Since it's been withdrawn, then the Court need not rule?

MR. JONES: Yes, I'll withdraw --

THE COURT: Okay.

MR. JONES: -- the question, Your Honor.

BY MR. JONES:

Q Now, do you recall if Mr. Brenske, after you failed to divulge the Farris case during the *Center* case, if Mr. Brenske, the attorney in the *Center* case, reminded you of the Farris case at some point?

MR. DOYLE: I'm going to object. It mischaracterizes his

testimony.

THE COURT: I'm going to overrule that objection because it's a do you recall if this happened, so it's not testimony.

THE WITNESS: You mean do you -- do I recall after having read the deposition?

BY MR. JONES:

Q I asked if you recalled.

A Well, does that include rereading my deposition? Because something jogs your memory or --

Q Answer it the way you see fit, Doctor.

A Rereading my deposition on *Center*, Mr. Brenske readdresses me towards the two pending cases. Yes.

Q Okay. So after he asked you and you hadn't mentioned those cases, he later brought those cases up to you?

A He did. Yes.

Q Okay. All right. And do you recall providing Mr. Brenske an explanation about what happened in the Farris case?

A I'd have to review that.

Q Doctor, can you give a short description about what happened in the Farris case?

A Right now?

Q Yeah.

A Oh, Ms. Farris came to me because she had a recurrent eventual hernia. I recommended surgery for that. Went through all the risks, benefits, alternatives regarding the surgery. We did a presumed to

be outpatient surgery. During that surgery, there were injuries to the transverse colon that are repaired at that time. Subsequently, she developed sepsis and had a prolonged hospital course.

Q Okay. Now, Doctor, when you were asked to provide a description from Mr. Brenske, you don't recall what it is that you stated?

A Not without reviewing the record, no.

Q All right. I'll refer you to page 18 of your deposition in this case. This is Exhibit 9, beginning at line 3, going through 12.

"Q With regard to the next case, Farris --

A Wait, I'm not there yet.

Q Oh, okay.

A Hold on.

Q My apologies, Doctor.

A Where are we at? Page 18 --

Q Page 18.

A Oh, there are four pages to a page. Okay.

Q Yes. Yeah. I apologize. That's the only version I have at this time.

A No worries.

Q Page 18, beginning at line 3. Tell me when you're ready.

A Go ahead.

"Q With regard to the next case, Farris v. Reeves, is that case still ongoing?

"A Yes.

"Q 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 in that case?"

And then your answer is there. Doctor, can you read your answer?

"A The patient had a laparoscopic hernia repair and resulted in oculocutaneous fistula postoperatively that required subsequent surgery."

Q That's not accurate, is it, Doctor?

A It -- yeah, it is.

Q That is accurate?

A Yeah.

Q When was she diagnosed with oculocutaneous fistula by you?

A It was when she had her CT scan showing the extravasation, and she had to go -- be taken back to surgery. I don't recall the exact date of that.

Q And you're saying that you diagnosed her with that condition?

A I diagnosed her with that -- I don't know --

Q With oculocutaneous fistula?

A Well, it hadn't fistulized yet, but it was a leak, so it was going to be oculocutaneous fistula, effectively, yes.

Q Did she develop oculocutaneous fistula, Doctor?

A She went to surgery.

Q She did go to surgery.

A Right.

Q Did she develop oculocutaneous fistula, Doctor?
A No.
Q She did not?
A No.
Q Okay. Now, you testified under oath here on page 18 that it resulted in oculocutaneous fistula.
A Correct.
Q Isn't that what your testimony was?
A It was.
Q Okay. And in fact, you never diagnosed her with oculocutaneous fistula, did you?
A We diagnosed her with oculo -- we diagnosed her with a perforation to the colon. That's the development of oculocutaneous fistula. Whether you want to say it's matured and she's leaking stool out of her skin or whether you want to say she has a perforation and that's going to be the subsequent outcome of it, whichever part of that time frame you want to be definitive, depends upon your definition, I guess.
Q Okay. In any event, you would agree with me that she was never diagnosed with oculocutaneous fistula; isn't that true?
A She was not diagnosed with oculocutaneous fistula.
Q And she was not diagnosed by you or by anyone else, was she?
A She didn't develop oculocutaneous fistula because she went back to surgery --
Q Okay.

A -- on that day or the day after, I should say.
Q On -- you mean like 13 days after the original surgery?
A When Dr. Hamilton [phonetic] did the surgery.
Q Okay.
A Correct.
Q Got it. Is there any reason that you didn't tell Mr. Brenske that she developed bilateral foot drop?
A No.
Q Is there any reason that you didn't tell Mr. Brenske that she became septic post-op day one?
A No.
Q Is there any reason you didn't tell Mr. Brenske that she remained septic, and you didn't recommend surgery for more than 11 days?
A No.
Q Okay. You knew that those were all issues, allegations made against you in the *Center* case, though, correct?
A Correct. He asked me to summarize, not allege what the allegations against me were.
Q Okay. And you agree that all of those are commonalities in this case, correct?
A No.
Q No?
A Not at all.
Q Those that I just mentioned are not?

A With the *Center* case?
Q That's correct, those three things.
A But Center never had foot drop.
Q Okay. Her feet were amputated instead, correct?
MR. DOYLE: Your Honor, relevance.
THE COURT: The Court's going to sustain for the purpose of today's evidentiary hearing.
MR. JONES: Okay.
THE COURT: I'll sustain his objection.
MR. JONES: All right.
BY MR. JONES:
Q Doctor, you agree that the documents that you received in April of 2017 failed to list the *Center* case, correct?
A That is correct.
Q Okay. And you agree that you signed a verification that you believed was attesting to the truthfulness of those documents, although you never reviewed them yourself?
A Basically, yes.
Q Okay. And you'd agree that during your deposition, you never provided information about the *Center* case until after your attorney stepped in and mentioned what has come into the transcript as *Center*, correct?
A Yeah. I was never asked about the *Center* case. No.
Q You ultimately were asked about the *Center* case, weren't you?

A In the part that you were talking about, no. But later, yes.
Q Okay. After your attorney mentioned the case, you were then asked about it?
A That is correct.
Q Okay. And when you were asked about the *Center* case, you didn't mention that she developed sepsis post-op day one, correct?
A I don't recall what I said. I'd have to review it on the deposition.
Q Okay. Let's go ahead to page 10.
MR. JONES: Your Honor?
THE COURT: A few more moments, Counsel.
MR. JONES: Okay.
THE COURT: You went into an area that was outside, so you --
MR. JONES: That's fair enough. I can shut it down, Your Honor, if you'd like me to.
THE COURT: We've got a moment or two, and then --
MR. JONES: Okay.
THE COURT: -- I'm going to see if counsel has an understanding of the case.
MR. JONES: I will be finished in one minute.
BY MR. JONES:
Q Page 13, Doctor, of Exhibit 10.
A Okay.
Q Are you there?

A Yes, I am.

Q Let's see. Okay. It's actually on page 14. Sorry, beginning line 3 says, "Can you tell me what that case involved?" And your answer?

A "Patient had diaphragmatic tear laparoscopically. She aspirated and became septic."

Q Okay. And while those are things that you may have argued in your trial in that case, you'd agree with me that the allegations were that she became septic post-op day one?

A That was an allegation, yes.

Q Right. And you agreed that that was the case, in fact, did you not?

A Yeah.

Q And also, that there was an 11-day period in which she remained septic without surgical --

MR. DOYLE: Objection. Relevance. Relevance.

THE COURT: I'm going to sustain it as to that's a substantive question not for purposes of today's evidentiary hearing.

MR. JONES: Thank you, Your Honor. I'll move on.

BY MR. JONES:

Q Doctor, is it your practice to swear under oath without knowing or reviewing information you're swearing to?

A No.

Q It just happened in this case?

A That is correct.

MR. JONES: That's all, Your Honor.

THE COURT: Thank you. Counsel?

MR. DOYLE: I don't have any questions.

THE COURT: Okay. The Court has a few follow-up questions. I'm going to tell you what the Court's questions are and it's really going to be up to -- if either counsel does not wish the Court to ask any of these questions, then I won't. It's really as simple as that, okay?

So I'm going to tell you what the question is. Well actually, there's a few of them, okay? First question is the Court would like to have a better clarification of how Dr. Rives knew in April 2017 to get into the email to find the verification, to sign the verification.

MR. DOYLE: No objection.

MR. JONES: No objection, Your Honor.

THE WITNESS: I was sent an email from my attorneys with --

THE COURT: And the Court's not asking about the content of any communications, but the way you described it --

THE WITNESS: Okay.

THE COURT: -- I'm trying to just get an understanding of how you knew -- you said you opened up --

THE WITNESS: An email.

THE COURT: -- an email, the last page and to find the verification on the last document, in the last page of the last document. So I'm trying to have an understanding of how you knew which document --

THE WITNESS: There's --

THE COURT: -- to know, to find a verification.

THE WITNESS: So there's a list of pdf files, and there's a truncated title to each pdf file. It doesn't give the complete title. And I believe the last one says verification, so I clicked on that one to print it out, have it signed and notarized.

THE COURT: Okay. So the Court's follow up question is was there only -- I'm trying to get an understanding of what this email looked like to the extent without in any way invading the attorney client privilege. Was there only one truncated document that said verification? That's the next question. Anyone that doesn't want the Court to ask it, then the Court won't.

MR. DOYLE: No objection.

MR. JONES: No objection, Your Honor.

THE WITNESS: There were -- if I recall correctly, six pdf files. And as I scanned through them that was the one that came out of in my mind that said verification on them.

THE COURT: So the Court doesn't feel that that answered the Court's direct question of whether or not there was only one that said verification. As there were six, was there only one that said verification is really the question the Court was asking. I was trying to get an understanding if there was one or more than one that had the word verification on it.

THE WITNESS: I can't remember, Your Honor.

THE COURT: Okay. And I'll tell you the Court's next question would be is whether or not this witness has signed other interrogatories

in the past and understands what the verification is, without in any way asking from any communications with any counsel, but understands what a verification is from the past, so he's got an understanding of how he knew to look for the verification in this case from the email. Not getting into content or any communications, of course. Just trying to get a background.

MR. DOYLE: No objection.

MR. JONES: No objection.

THE WITNESS: In the email, it asked me if I approve, to sign the verification.

THE COURT: Okay. The Court's question was a little different about whether or not there had been any prior signing of --

THE WITNESS: Oh. My apologies.

THE COURT: -- interrogatories and verifications or was this the first time. Does anyone have any objection to that question being re-asked so that it clarifies?

MR. DOYLE: No, Your Honor.

MR. JONES: No objection.

THE WITNESS: My apologies, Your Honor. I misunderstood. I'm sure that in the past, I've been asked to verify these before.

THE COURT: Okay. Okay. Those were the Court's questions. So it is 10:16. Dr. Rives came on the stand, Madam Court Reporter, what time?

COURT REPORTER: 9:16.

THE COURT: 9:16. An hour. Just what you all asked for. So,

you all being provided the exact amount of time that you specifically requested on 9/26 to having today for the totality of today's hearing, the Court finds that it has provided you. And that hour was supposed to take into account also really the Court's ruling as well, so the Court's given you a full hour to give you an opportunity. It's offered direct examination, cross-examination, offered but did not wish any response. So the witness can feel free to go off the stand.

So the Court's position at this juncture is the Court did exactly what the parties asked for, after the Court offered the evidentiary hearing. In the intervening time, the Court did go and ask -- just let my Law Clerk leave to make sure -- I wanted to make sure I reread the letter of September 30th, 2019, just to see if there was any request for any additional argument, oral argument, because the Court knows it did not receive anything subsequent to that. There's no request in this letter. It just says, you know -- it just says whether he was intending to testify at the hearing scheduled at 8:30. Correspondence via the Court and counsel, Dr. Rives will testify.

So there's no request for any additional oral argument. The Court gave you all extensive oral argument to the extent everybody wished to do as much as you wanted to. In fact, the Court even, on 9/26, gave you a partial inclination to one portion of Plaintiff's motion and that was as to the punitive damages portion, to give you some indication so that to the extent that was of assistance, so that you could fully prepare for tomorrow's calendar call, but said that the other requested sanction aspects were still on the table for today's evidentiary hearing to really

allow you to narrow where you were going for today.

So while I heard Defense counsel mention that you'd like to do some kind of summation at the end, the Court doesn't see that that was requested previously by anyone. This was set up specific when I had counsel -- Plaintiff's table on 9/26, whoever you all chose to come at the hearing date, which was supposed to be the total final only hearing date. I had two counsel on Defense. Nobody asked on 9/26. Nobody asked in any of the intervening time, either in the letter -- I even double-checked the inappropriately -- which is now stricken, by the way.

The Court specifically ordered stricken the improperly rogue documents filed on 9/30, specifically contrary for all the reasons that the Court said previously, obviously, the quote supplemental and that declaration, post -- and for supplemental, because -- for all the reasons the Court stated. It's not even there, a request for oral argument, so I double-checked that just to see by chance, even if it was. So even giving the benefit of the doubt with regards to -- the Court even -- if by implication, somebody may have intended that somewhere, the Court can't take that into consideration, because that is -- for all the reasons, it's impermissible.

The Court's not reiterating everything it said for the first time period this morning at 8:30, so that can't be considered. Those we're striking, but in any event, there was nothing on the face of that document that requested specific additional oral argument, and I've given the other side an opportunity to do so. And the Court -- you all knew I was scheduling something right after you. In fact, you all thought

I was scheduling right after I gave some time.

So here's what the Court's going to do. The Court is going to say as follows. We didn't get to the motion to strike the affirmative defenses, did not get to the other motions that were also going to be taken care of, because I wanted to ensure -- we went longer on the testimonial portion, so I wanted to ensure everyone had a full opportunity to have that taken care of.

So the Court's going to do the following. The Court's going to give you its ruling on the 10th, but here's what we're going to do. I'm going to tell you the first part of the Court's ruling, okay? Because that's going to be important for tomorrow's purposes. For tomorrow's purposes, here's what you're going to hear. The first portion of the requested ruling was for terminating sanctions, okay? For terminating sanctions. And I will give you my longer analysis on Thursday.

But the short version of its for there to be terminating sanctions, those terminating sanctions would need to be due, as you know, to the conduct of Dr. Rives, okay? Under *Young v. Ribeiro*, well, I'm just going to short-version it. All analysis setting forth, citing *Young v. Ribeiro*, I will cite all the different provisions of the other applicable case law, NRCP 37 -- 7.60, all the different basis I -- actually, your motion's really on 37, but when listening, while there is egregious conduct, the one mitigating factor for reason why this Court doesn't find solely on this motion alone -- not taking into account everything else that the Court needs to address -- for counsel's conduct, for all the other issues that the Court still needs to address.

But for Plaintiff's motion alone, the Court doesn't find that terminating sanctions under the applicable case law and the rules, would be appropriate, because Dr. Rives' conduct in and of itself would not rise to the level for terminating sanctions, based on his testimonial evidence presented today, taking into account the following. The Court -- after I get through the whole analysis, what I'll give you further on Thursday, when you're coming back is the prejudice to Plaintiff issue.

By Plaintiff's own declaration in their motion, they acknowledge that they did not look at some of this information, until, I'm going to put it, summer of this year. Whereas, this deposition, or some of this information was clear, was October 2018. So the prejudice aspect, solely for this motion only, Plaintiff's motion only, I do have to look at prejudice. Prejudice under *Johnny Ribeiro* is that some of that prejudice, this Court finds, could have been mitigated, if it had been looked at earlier.

There could have been some additional things the Court would have had the ability potentially to have done. And that -- taking that into account, which was one of the factors the Court does specifically need to take into account. I'm not in any way minimizing the egregious conduct, which will be discussed later, by both counsel and client, okay, which the Court will be evaluating and going through. But the reason why the Court doesn't find it merits at this juncture purely on Plaintiff's motion only, which is the only thing I'm addressing right now, is because by Plaintiff's own declaration, this information was available.

I'm not in any way adopting the oppositions' position that

you needed to look at Odyssey. They had an -- sorry. Yeah. They had an affirmative -- Defense had an affirmative obligation to give you the correct information. I'm in no way adopted their position. However, some of this information was available to Plaintiffs in a manner that it could have been evaluated, because there was enough in that October deposition that a reasonable inquiry could have gotten you some information and gotten some relief requested from the Court in a more timely manner that could have alleviated some of the prejudice, which is a factor this Court does have to consider under *Johnny Ribeiro*, and that's why the Court doesn't find it to be appropriate to do terminating sanctions.

All other sanctions up to that are on the table and will be further discussed on Thursday. The reason why I needed -- important to tell you the terminating was not happening is because you have your calendar call tomorrow. So I want to make it clear, I would expect to see everything tomorrow, as you have been told all along, okay? Since January, not since September, as improperly stated in people's declarations. So we will be seeing you tomorrow at your calendar call. Thank you so very much.

MR. DOYLE: Your Honor, if I may --

THE COURT: That's -- this hearing is now over. We'll be seeing you tomorrow at your calendar call. I need to get to my next case that's patiently -- you're already taking 25 of their minutes.

MR. DOYLE: A quick question. I was going to be traveling on Thursday. The Court hasn't set a time for the hearing on Thursday,

but could I do that by telephone, rather than physically being present?

THE COURT: How important you think this --

MR. DOYLE: I'll be here personal --

THE COURT: -- is for you, that's up to you.

MR. DOYLE: I'll be here personally on Thursday.

THE COURT: That's up to you.

MR. DOYLE: All right.

THE COURT: The Court's not requiring, because there's no evidentiary basis. Thursday is we're going to go over that. We're going to go over all the other sanction components against you and your firm, so it's however important you feel it is. If you want a telephonic request, you can have a telephonic.

MR. DOYLE: Okay.

THE COURT: It's up to you. The Court's not requiring people to be here in person. I was going to suggest 1:30 on Thursday the 10th. See you all. But I was going to discuss that further tomorrow? Okay. But anticipated time is going to be Thursday the 10th at 1:30. If you want to be here telephonically, telephonically is fine. Plaintiff's counsel, if one of you want to be here telephonically, once again, it's your choice.

MR. JONES: We will be here, Your Honor.

THE COURT: That's up to you.

MR. LEAVITT: We'll be present.

THE COURT: The Court's not requiring somebody to be here in present [sic]. The Court's going to go over all those issues. It's how you wish to be here.

MR. JONES: Your Honor, would you like to retain a copy of the binder that I dropped --

THE COURT: I am going to just for purposes that you -- easy way, instead of me having to click on the system, I've got mine. I'll keep it until Thursday. But I'll see you tomorrow, okay?

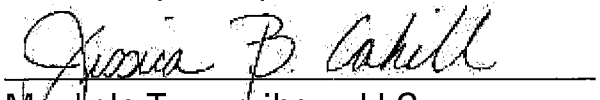
MR. JONES: Okay.

THE COURT: Thank you so much.

MR. JONES: Absolutely, Your Honor.

[Proceedings concluded at 10:26 A.M.]

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio-visual recording of the proceeding in the above entitled case to the best of my ability.



Maukele Transcribers, LLC
Jessica B. Cahill, Transcriber, CER/CET-708

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 22nd day of October , 2019, service of a true and correct copy of the foregoing:

DEFENDANTS BARRY RIVES, M.D. AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S OPPOSITION TO PLAINTIFFS' RENEWED MOTION TO STRIKE

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.

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