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 7

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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).

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

REPLY IN SUPPORT OF, AND SUPPLEMENT TO, PLAINTIFFS' RENEWED MOTION TO STRIKE DEFENDANTS' ANSWER FOR RULE 37 VIOLATIONS, INCLUDING PERJURY AND DISCOVERY VIOLATIONS ON AN ORDER SHORTENING TIME

Plaintiffs PATRICK FARRIS and TITINA FARRIS, by and through their attorneys of record, KIMBALL JONES, ESQ. and JACOB G. LEAVITT, ESQ., with the Law Offices of **BIGHORN LAW** and GEORGE F. HAND, ESQ., with the Law Offices of **HAND & SULLIVAN**, LLC, and hereby submit this Reply in Support of, and Supplement to, Plaintiffs' Renewed Motion to Strike

Case Number: A-16-739464-C

Defendants' Answer for Rule 37 Violations, Including Perjury and Discovery Violations on an Order Shortening Time ("Reply").

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

DATED this 22nd day of October, 2019.

BIGHORN LAW

By: */s/ Kimball Jones*
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DECLARATION OF KIMBALL JONES, ESQ. IN SUPPORT OF PLAINTIFF'S REPLY AND DECLARATION FOR AN ORDER SHORTENING TIME

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

1. That I am an attorney duly licensed to practice law in the State of Nevada and a partner with the Law Offices of Bighorn Law.
2. That I am personally familiar with the facts and circumstances surrounding this matter and am competent to testify hereto.
3. That after the submission of Plaintiffs' Motion, on October 21, 2019, I continued questioning Defendant Rives under oath.
4. That Defendant Rives, under questioning, revealed that he could not give a refund to Plaintiff for puncturing Plaintiff's abdomen because he received "payments from Insurance."
5. That this testimony violated the strict prohibition against testimony on insurance payments given by the Court in this matter.
6. That Plaintiffs and Defendants had stipulated to remove any reference to insurance payments from exhibits.
7. That this further violation of the Court's orders effects not only the jury's potential findings of liability, but could also prejudice the jury from giving a sufficient award for Plaintiff's damages.
8. As such, further sanctions are warranted for Defendants' continued violation of court orders and strict rules.
9. That this Declaration is made in good faith, and not for the purposes of delay.

FURTHER YOUR DECLARANT SAYETH NAUGHT.

/s/ Kimball Jones
KIMBALL JONES, ESQ.

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

This issue goes to the heart of litigation and a fair trial. The United States Supreme court states as follows:

> **The remedy for speech that is false is speech that is true. This is the ordinary course in a free society. The response to the unreasoned is the rational; to the uninformed, the enlightened; to the straightout lie, the simple truth.**
>
> *United States v. Alvarez*, 567 U.S. 709, 727, 132 S. Ct. 2537, 2550, 183 L. Ed. 2d 574 (2012) (emphasis added).

Defendants' Opposition appears to not take the issues faced by this court in the seriousness nature that it deserves. The opposition is a seven-page *ouroboros* of false statements swallowing *prior* false statements made--finally collapsing in on itself is the best way to describe the actions, trial outbursts of insurance and SoBe, continued speaking objections, making false statements of nonexistent medical by Defendants and counsel for the same.

Defendants attempt to explain away the perjury Dr. Rives engaged in by claiming that Dr. Rives' testimony was correct, and that Defense Counsel cannot recall the sidebar conversation that he engaged in on Friday October 18, 2019.

This argument is simply not credible. Defense Counsel informed Counsel and the Court in sidebar on October 18, 2019 that Dr. Rives had prepared his testimony with the assistance of Ms. Hanegan, but that it was improper to ask Dr. Rives about the subject on the basis that it would violate attorney client privilege.

Furthermore, this "explanation" requires the logical leap that Defense Counsel was so "hands-off" with his own client's testimony that he 1) paid an expert to help his client with his testimony; 2) arguably confirmed to the court that this preparation occurred, claiming it to be attorney client privilege in one breath, then saying it never happened in another is nonsensical; and 3) only later found that Rives and Hanegan could not get their schedules aligned to meet up—thus wasting thousands of

dollars of his clients' money. This explanation makes no sense whatsoever nor does it coincide with statements made by Defense Counsel. Any competent attorney, particularly one who had spent thousands of dollars on an expert with the planned purpose of "witness preparation" would ensure that this meeting transpired. See *Opposition*, at Page 3.

Yet, Defendants expect the Court to ignore the "planned purpose" of Defendants' retention of this expert; to ignore when Defense Counsel said that Defendant DID meet with Ms. Hanegan; to ignore the misinformation contained within the opposition itself; and to believe instead that Defense Counsel was "misinformed," and that Defendant was not lying. Defendants' explanation is simply not credible and is a further assault on any notion of integrity.

Similarly, Defendants' argument that Dr. Rives does not understand the meaning of "under penalty of perjury" is an **impotent argument**, unless Defense counsel is now admitting to not preparing his client and instructing him (as this Court has cautioned all parties to do) on what is not permitted in court. Dr. Rives gave testimony ten (10) days prior stating he understood that he knew that interrogatories were sworn statements. Moreover, Defendant is a constant litigant with substantial education, training and experience signing these documents with the assistance of counsel.

Defendants' argument does not excuse this 180-degree shift in testimony. It is perjury. It is obstruction and intentional. It is an utter failure to tell the truth on a level that seems pathological in nature. It appears Defendants are looking for a mistrial in an effort to mitigate their exposure to verdict and sanctions.

Defendants' then admit that they "misunderstood" this Court's Order forbidding use of Dr. Hurwitz's testimony. This argument is dismissed as untrue as well. Defendants' excuse could be believed if they ceased using the deposition testimony after Plaintiffs' initial objection and seeing, as Defendants admit, that "it became clear that the Court intended to prohibit the transcript to be used for any purpose." *Opposition*, at Page 5. **Yet, if this was the case, then Defendants would have stopped**

using the deposition testimony. As this Court witnessed with its own eyes, this is not what occurred. Defendants responded to Plaintiffs' objection and the Court's strident upholding of the objection, by continuing to use the deposition testimony.

Finally, Defendants dismiss the noted changes in Plaintiffs' renewed Motion for Sanctions by declaring that the prior sanction was adequate. Defendants have failed to note Plaintiffs' arguments that it was Defendant Rives, not just Defense Counsel, who have attempted to make end-run after end-run around the Court's rules. This final "Opposition" establishes that Defendant and Counsel are unable to truthfully engage with the Court—telling one story in the morning, and then writing another story at night. This gamesmanship cannot end in Defendants' favor. Their repeated distortions of truth, violations of Court orders, false sworn testimony, cannot continue to be chalked up to "misunderstandings"—these are deliberate actions which have hit the broadside of Plaintiffs' case. Any of these actions viewed separately would merit Rule 37 sanctions in the form of Striking Defendants' Answer. Yet, all of these offenses have been committed by the same party, in the same case. Defendants' actions have decimated Plaintiffs' ability to not only prove liability, but now to prove damages. As such, the most severe of sanctions are warranted.

This Court, though it has not tried, cannot contain Defendants and Defense counsel from making their own rules and not simply ignoring the rules, rather actively going against Court Orders. This is bellied in the fact that Defense Counsel was admonished outside the presence of the jury and warned in clear terms that he is treading on causing a mistrial. Then, the next day of trial, he has proven to not abide by the rules, nor his client who was also present at the admonishment.

II. LEGAL ARGUMENT AND ANALYSIS

A. Defendants' Prior Actions Warrant Striking of Defendants' Answer.

As noted above, Defendants' "explanations" are not believable. Defendants have failed to crystallize how Defendant Rives' perjury transpired; failed to clarify how Defendant Rives failed to

understand what perjury means when he understood its meaning ten (10) days prior; failed to obey the Court's clear order on Dr. Hurwitz; and failed to absolve themselves of the damage they had done to Plaintiffs' case.

Perjury: As noted above, Defendants' explanation is non-sensical. Defendants admit that they had a planned purpose of Defendant Rives meeting with a paid consultant, Amy Hanegan, who sat next to Defendant Rives for three (3) days of voir dire, to prepare his testimony. Despite this being the most important job Defense Counsel would have, he, allegedly, was lackadaisical about ensuring that his client met with the person he assuredly paid thousands of dollars to, to prepare his testimony. This cannot be true. What was Counsel doing in the days and weeks prior to this multi-million-dollar malpractice case if not ensuring that his client's testimony was adequate?

It is painfully obvious that this "explanation" is merely a further distortion of the truth and an attempt to cover for Defendant's perjury. What Counsel stated to the Court, both in sidebar on October 18, 2019, and again on October 21, 2019 is what actually transpired. Rives met with Hanegan, and then Rives lied about it on the stand. This perjury, as well as Defense Counsel's puzzling attempt to explain it away is grounds for Striking of Defendants' Answer on its own.

Testimony of Interrogatories: Defendants' attempt to excuse Rives' inability to understand that Interrogatories are sworn to, by explaining that Dr. Rives is not an attorney. See *Opposition*, at Page 4, lines 17-21. This "explanation" fails to explain how Dr. Rives understood the definition of the terms ten (10) days prior, but then could not remember the terms in trial. Absent a medical explanation for Rives' memory issues—which was not proffered by Defendants in opposition—the only explanation for this inexplicable *about-face* from Dr. Rives, is that he committed perjury under oath as to whether he understood that interrogatories are sworn documents. Defendants have failed to explain the converse testimonies issued by Dr. Rives, and as such, this is further evidence of perjury by the Defendant. Striking of Rives' answer is merited.

Dr. Hurwitz's Deposition Testimony: Defendants likewise fail to explain why, if they simply misunderstood this Court's Order, that they persisted in using Dr. Hurwitz's deposition testimony even after it became clear what this Court's Order actually was. Defendants' use could be attributed to a "misunderstanding" on the first question. Their persistence, and the use of line by line questioning of the deposition was a blatant, contemptuous act after being warned **twice** by the court to not use the deposition.

Sanctions due to Rives' Conduct: Defendants' final argument fails to address the fact that the prior sanction was softened by this Court due to it being viewed as punishing Defendant for Defense Counsel's mistakes. The continued violations by Defendant himself, not Counsel, demonstrate that Defendant was just as culpable, if not more so, then Counsel in violating this Court's Orders. As such, striking of Defendant's answer is a fair, proportional sanction due to the numerous, inexplicable actions committed by Defendant.

B. Defendants' Violation of the Court's Prohibition of Collateral Source Testimony Merits Further Sanctions.

As noted in Plaintiffs' Counsel's Declaration above, Defendants compounded the multitudinous discovery violations and violations of the very bedrock tenets of integrity already committed in this matter--by violating the Court's strict prohibition against referencing insurance payments in this matter. As will be more fully outlined below, 1) Defendants knew that Plaintiffs' insurance plan was an ERISA plan and subject to federal subrogation; 2) Defendants agreed to not mention Plaintiffs' insurance coverage; 3) as Plaintiffs' health insurance is an ERISA medical plan, NRS 42.021 is inapplicable, and the Court's findings in *Proctor* mandates that no testimony of collateral sources of income may be presented; 4) That this disclosure by Defendants not only violated this Court's Orders, it severely prejudices Plaintiffs' ability to receive a fair damages award.

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All prior discovery violations in this matter affected Plaintiffs' ability to prove liability. This latest violation of this Court's Orders goes directly to Plaintiffs' ability to claim damages. As such, further sanctions are required to make Plaintiffs whole. Therefore, it has become necessary that Plaintiffs request that this Court Grant Plaintiffs' request to Strike Defendants' Answer, and also to Order that all of Plaintiffs' past medical expenses are awarded—leaving the jury to determine what future damages may be awarded as well as a jury instruction that insurance coverage is not to be considered when awarding Plaintiffs' damages.

Defendants were aware of Plaintiffs' ERISA Coverage:

On July 5, 2019, Plaintiffs made their Seventh Supplement to ECC Disclosures. In this disclosure, Plaintiffs disclosed Plaintiff Titina Farris' Health and Welfare Benefit plan—Plaintiffs' health insurance plan. See *Plaintiffs' Seventh Supplement*, attached hereto as **Exhibit "1."** This disclosure notes from the outset that it is an ERISA plan:

> The Plan has been established and shall be maintained with the intention of meeting the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and any other pertinent laws and regulations. The Plan is also intended to qualify as a cafeteria plan under the provisions of section 125 of the Internal Revenue Code of 1986, as amended (the "Code") and applicable regulations issued and effective thereunder.
>
> See *Id.*, at Page PLTF 11525.

The plan contains no fewer than 12 references to "ERISA". Furthermore, to establish that there is no conceivable way that Defendants could not be aware of the fact that this was a federal plan, free from the encumbrances of NRS 42.021, the plan contains three pages dedicated solely to subrogation and recovery rights under federal law. See *Id.*, at PLTF 11552-11555. This disclosure was made **three (3) months prior to trial.** Defendants were in no wise blindsided by this revelation, as they had knowledge of it for months prior to trial.

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Defendants agreed to remove any reference to Plaintiffs' Insurance:

Furthermore, as this Court is well aware, during the October 8, 2019 calendar call, this Court asked both Plaintiffs and Defendants to adjourn to the anteroom of the Court and to remove any and all references to Plaintiffs' insurance coverage from exhibits. Defendants were well aware of this Court's prohibition against testimony on Insurance coverage. Defendants cannot argue that there was no Order from this Court on this topic, or that they "misunderstood" the thrust of this Court's Orders—clearly this Court had Ordered all evidence of collateral sources to be stricken from exhibits. As such, Defendant Rives' blatant incantation of Defendants' insurance can be viewed as nothing less than an intentional act of contempt.

ERISA Pre-empts NRS 42.021:

Defendant Rives' comments about Plaintiffs' insurance coverage has utterly prejudiced Plaintiffs' case. Defendant has argued that under NRS 42.021, they are permitted to introduce evidence of insurance benefits in a medical malpractice case. However, this argument is flawed as Federal law, specifically the Employee Retirement Income Security Act (hereinafter "ERISA") preempts Nevada statute, making NRS 42.021 unconstitutional. As noted above, it is uncontroverted that Plaintiffs' insurance benefits are covered by ERISA—as Defendants are well aware.

NRS 42.021(1) states:

> In an action for injury or death against a provider of health care based upon professional negligence, if the defendant so elects, the defendant may introduce **evidence of any amount payable as a benefit to the plaintiff as a result of the injury or death pursuant to the United States Social Security Act,** any state or federal income disability or worker's compensation act, any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership or corporation to provide, pay for or reimburse the cost of medical, hospital, dental or other health care services. If the defendant elects to introduce such evidence, the plaintiff may introduce evidence of any amount that the plaintiff has paid or contributed to secure the plaintiff's right to any insurance benefits concerning which the defendant has introduced evidence.

Strict adherence to the wording of the statute is required, as noted by the Nevada Supreme Court in *Piroozi*. The Court in *Piroozi* was tasked with, among other issues, determining whether the District Court had violated 42.021 by forbidding introduction of individual settlement amounts which a plaintiff had entered into prior to trial against a number of remaining defendants. The Court noted that the 42.021 (referenced as KODIN by the Court) only referenced settlements with organizational or corporate parties, "Although "KODIN stops 'double-dipping' by informing juries if plaintiffs are receiving money from other sources for the same injury," this provision does not appear to include individual settlement amounts; it may include organizational and corporate settlements... if the settlement was with an organization or corporation, it is possible that NRS 42.021 might dictate a different outcome." *Piroozi v. Eighth Jud. Dist. Ct.*, 131 Nev. Adv. Op. 100, 363 P.3d 1168, 1175 (2015).

As noted above, Plaintiffs' health insurance was an ERISA health plan. It is settled law in Nevada that NRS 42.021 is pre-empted by ERISA's Federal pre-emption rights. See *McCrosky v. Carson Tahoe Reg'l Med. Ctr.*, 408 P.3d 149, 155 (Nev. 2017).

The Court in *McCrosky* noted:

> Nevada has adopted a "*per se* rule barring the admission of a collateral source of payment for an injury into evidence for any purpose." *Proctor v. Castelletti*, 112 Nev. 88, 90, 911 P.2d 853, 854 (1996) ("Collateral source evidence ... greatly increases the likelihood that a jury will reduce a plaintiff's award of damages because it knows the plaintiff is already receiving compensation."). NRS 42.021(1) created an exception to that rule in the medical malpractice context, allowing defendants such as CTRMC to introduce evidence of collateral payments that the plaintiff received from third parties. The purpose of this law, according to the summary that was presented to voters in the ballot initiative that enacted it, was to prevent "double-dipping"—that is, the practice of plaintiffs receiving payments from both health care providers *and* collateral sources for the same damages. Secretary of State, Statewide Ballot Questions 16 (2004), https://www.leg.state.nv.us/Division/Research/VoteNV/BallotQuestions/2004.pdf. To protect plaintiffs from having their awards overly diminished, however, the second half of the enacted statute—NRS 42.021(2)—prohibits collateral sources from also recovering directly from plaintiffs.
>
> Federal law complicates matters. 42 U.S.C. § 2651(a) provides that when the United States is required to pay for medical treatment on behalf of an individual, and the hospital

> becomes liable in tort to that individual, "the United States shall have a right to recover ... the reasonable value of the care and treatment so furnished," and the United States' right to payment is subrogated to the individual's claim against the hospital. In short, § 2651(a) allows the United States to recover from a plaintiff who prevails in a medical malpractice suit the Medicaid payments the plaintiff received—exactly what NRS 42.021(2) prohibits. When state and federal law directly conflict, federal law governs. *See* U.S. Const. art. VI, cl. 2; *Nanopierce Techs., Inc. v. Depository Tr. & Clearing Corp.*, 123 Nev. 362, 370–71, 168 P.3d 73, 79–80 (2007). Therefore, federal law preempts NRS 42.021(2) from preventing recovery of federal collateral source payments, such as Medicaid payments.
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> *McCrosky v. Carson Tahoe Reg'l Med. Ctr.*, 133 Nev. 930, 936–37, 408 P.3d 149, 154–55 (2017).

Furthermore, pursuant to *Proctor*, collateral source evidence is per se inadmissible in Nevada. "We now adopt a *per se* rule barring the admission of a collateral source payment for an injury into evidence for any purpose." *Proctor v. Castelleti*, 112 Nev. 88, 90 n.1, 911 P.2d 853, 854 n.1 (1996). Collateral source evidence inevitably prejudices the jury because it greatly increases the likelihood that a jury will reduce a plaintiff's award of damages because it knows the plaintiff is already receiving compensation. The Nevada Supreme Court held that ***"no matter how probative the evidence of a collateral source may be, it will never overcome the substantially prejudicial danger of the evidence."*** *Id.*, at 91, 911 P.2d at 854, (Emphasis added).

Likewise, the Court held that the district court had no discretion over whether to admit collateral source evidence at trial as there were no circumstances where the probative value of collateral source evidence outweighs its prejudicial effect. *Id.* Admitting such evidence, including disability insurance payments, is reversible error because it affects the substantial rights of a plaintiff, his/her right to a fair trial, and his/her right to be fairly compensated for injuries resulting from a defendant's negligence. *Id.* In *Proctor,* the Court held that the district court erred in admitting evidence of disability insurance payments. *Id.*, at 9, 911 P.2d at 854.

Similarly, in *Bass-Davis v. Davis*, 122 Nev. 442, 134 P.3d 103 (2006), the Court reaffirmed *Proctor* and held that the district court erred in admitting evidence, in an action seeking damages for lost wages, that Bass-Davis received compensation from her employer during a leave of absence. *Id.*,

at 454, 134 P.3d at 110-11. In both cases, the Court determined that the collateral source evidence of compensation and benefits prejudiced the plaintiff's ability to receive fair compensation for injuries caused by the defendant that were inadmissible regardless of probative value. In 2012, the Nevada Supreme Court reaffirmed its "per se rule barring the admission of a collateral source of payment for an injury into evidence for any purpose." *Tri-county Equip. & Leasing, LLC v. Klinke*, 128 Nev. Adv. Rep. 33, 2012 Nev. LEXIS 72, *7 (2012), (citing *Proctor*, 112 Nev. 88, 911 P.2d 853).

Defendants may argue that NRS 42.021 carves out an exception for collateral source admission in medical malpractice cases. However, as noted above, ERISA, and all other federal law, preempts NRS 42.021. As Plaintiffs' insurance benefits are covered under ERISA, no reference may be made to them under the Court's rationale in *McCrosky*.

Finally, based upon issues of federal preemption in this area, NRS 42.021 has been found to be unconstitutional by numerous district courts in Nevada. As the Court noted, "Pursuant to the Supremacy Clause of the United States Constitution, state laws that conflict with federal law are without effect." *Altria Grp., Inc. v. Good,* 555 U.S. 70, 76, 129 S.Ct. 538, 172 L.Ed.2d 398 (2008). (Internal citations omitted). NRS 42.021 has repeatedly been found to be preempted by Federal law because sections of the statute forbid federal agencies such as Medicare and Medicaid from recovering monies paid out to plaintiffs.

Judges which have ruled that NRS 42.021 is unconstitutional and preempted by Federal law include Judge Jennifer Togliatti who excluded collateral source evidence of Medicaid payments in a medical malpractice action, holding NRS 42.021 was preempted by federal law. Case No. A513624, *Greenberg v. Steven D. Lampinen, M.D. et. al*, February 6, 2009; Judge David R. Gamble of the Ninth Judicial District Court found Medicare's federally codified rights of reimbursement and subrogation pursuant to 42 U.S.C. § 2651(a) preempted NRS 42.021 in an Order dated September 29, 2008); and Judge James C. Mahan finding NRS 42.021 was clearly preempted by federal ERISA statutes (Case

No. A557814, *Hohnhorst v. William Kyle, M.D. et. al*, April 11, 2011. Recently, by Order dated September 11, 2015, in *Tablak v.Schoenhuas*, Case No. A699483, Judge Crockett ruled NRS 42.021 was federally preempted by an ERISA plan.

As noted above, federal law reigns supreme over NRS 42.021. This was explicitly noted in a mandatory holding by the Court in *McCrosky*. Likewise, the Equal Protection Clause of the Fourteenth Amendment states, "No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." NRS 42.021, as applied in this case violates the equal protection clause. KODIN, later codified as 42.021 discriminates based upon the classification of plaintiffs in tort litigation.

The Supreme Court in *McCrosky* noted that NRS 42.021 is preempted by Federal law. As such, Defendants' invocation of insurance payments was a direct violation of this Court's prohibition against collateral source payments, and more pointedly, this Court's Order in this case, ordering that no reference to insurance be given.

Defendants' Overt Testimony Prejudiced Plaintiffs' Case:

This latest act of contempt of this Court's Rules and Orders—as well as the violation of the stipulation agreed to by the parties in their September 11, 2019 2.67 conference--is the proverbial "final straw." Defendants acts of discovery abuses—failing to comply with 16.1, committing perjury under oath in deposition, committing perjury under oath in testimony, failing to update answers, failing to comply with Rule 33, the inappropriate use of Dr. Hurwitz's deposition testimony—all of these abuses affected Plaintiffs' ability to prove liability. This final violation impacts Plaintiffs' ability to prove her damages. Defendants have systematically violated this Court's Rules in Order to attempt to make proving Plaintiffs' case impossible. At this point, after so many abuses, Plaintiffs are left to wonder if Defendants are attempting to cause a mistrial.

The jury simply cannot be expected to "forget" that Plaintiffs had insurance coverage in this matter. This knowledge, caused simply by Defendants failure to abide by this Court's Order to "remove any reference to insurance" is damning to Plaintiffs' ability to prove damages.

This violation, as was the perjury committed by Dr. Rives at trial, is a failure attributable to the Defendant, not to counsel. Dr. Rives deliberately invoked Plaintiffs' insurance coverage despite this Court's prohibition against such testimony.

The same Rule 37 authority which allows for sanctions for discovery violations or other inappropriate trial conduct allows the Court to tailor sanctions which will alleviate the now total prejudice done to Plaintiffs' case by Defendants' actions:

> Two sources of authority support the district court's judgment of sanctions. First, NRCP 37(b)(2) authorizes as discovery sanctions dismissal of a complaint, entry of default judgment, and awards of fees and costs.
> ...
> Second, courts have "inherent equitable powers to dismiss actions or enter default judgments for ... abusive litigation practices." *TeleVideo Systems, Inc. v. Heidenthal,* 826 F.2d 915, 916 (9th Cir.1987) (citations omitted). Litigants and attorneys alike should be aware that these powers may permit sanctions for discovery and other litigation abuses not specifically proscribed by statute.

Young v. Johnny Ribeiro Bldg., Inc., 106 Nev. 88, 92, 787 P.2d 777, 779 (1990)

The Supreme Court has enumerated numerous factors for the trial Court to utilize to determine an appropriate sanction based upon a party's behavior.

> Under NRCP 37(b)(2)(C), when a party fails to make a discovery disclosure pursuant to NRCP 16.1, the district court may make "[a]n order striking out pleadings or parts thereof ... or dismissing the action or proceeding or any part thereof, or rendering a judgment by default against the disobedient party."
>
> In *Young,* we articulated the abuse-of-discretion standard with regard to discovery sanctions:
>
> The factors a court may properly consider include, but are not limited to, the degree of willfulness of the offending party, the extent to which the non-offending party would be prejudiced by a lesser sanction, the severity of the sanction of dismissal relative to the severity of the discovery abuse, whether any evidence has been irreparably lost, the feasibility and fairness of alternative, less severe sanctions, such as an order deeming facts relating to improperly withheld or destroyed evidence to be admitted by the offending party, the policy favoring adjudication on the merits,

> whether sanctions unfairly operate to penalize a party for the misconduct of his or her attorney, and the need to deter both the parties and future litigants from similar abuses.
>
> *Valley Health Sys., LLC v. Estate of Doe by & through Peterson*, 134 Nev. 634, 639, 427 P.3d 1021, 1027 (2018), as corrected (Oct. 1, 2018).

Defendants' actions have prejudiced every facet of Plaintiffs' case. Plaintiffs' attempts to prove Defendants' foreknowledge of the dangers of failing to treat and diagnose sepsis were thwarted by Defendants' refusal to truthfully disclose their litigation history. Such incomplete and evasive testimony was **specifically found to merit default judgment** in *Kelly*, "affirming sanctions of striking defendant's answer and entering default judgment against defendant based on defendant's incomplete and evasive answers to interrogatories." See *Kelly Broad. Co. v. Sovereign Broad., Inc.*, 96 Nev. 188, 192, 606 P.2d 1089, 1092 (1980) as cited in *Young v. Johnny Ribeiro Bldg., Inc.*, 106 Nev. 88, 94, 787 P.2d 777, 780 (1990).

Likewise, Defendants' perjury and use of Dr. Hurwitz's testimony affected Plaintiffs' ability to establish the nature of Plaintiffs' injuries.

This final overt act of contempt, this invocation of Plaintiffs' insurance coverage incapacitates Plaintiffs' ability to have a fair, measured reaction from the jury as to Plaintiffs' damages. Now, the jury will ultimately devalue Plaintiffs' damage award by concluding that insurance covered Plaintiffs' surgeries. This violation of this Court's Orders in this matter also violate *Proctor* and this Court's Rules against collateral source testimony. As such, further sanctions, in addition to Striking of Defendants' Answer are necessary.

C. Past Medical Expenses are Properly Awarded.

As the jury now cannot look at Plaintiffs' damages without concluding that insurance covered these expenses—an award granting Plaintiffs' past medical damages is warranted. This serves as a proportional sanction to the damage done by Defendants' actions. As such, as a baseline, damages of **$1,083,679.94** are properly awarded to Plaintiffs in this matter. This baseline award must also be

accompanied by an Order from this Court instructing the jury to not consider insurance benefits when deciding Plaintiffs' future damages.

D. In the Alternative, an Admonition, and Jury Instruction are Necessarily Given.

Should this Court hesitate to Order past medical damages as a sanction, the only other "fair and feasible" sanction would be for this Court to admonish Defendant and Defense Counsel in front of the jury. To note that Defendants broke the Court's Ruling on Collateral Source testimony, and then to instruct the jury that they are not to consider insurance benefits in any wise, except to note that Defendants are covered by liability insurance in this matter.

This Court has repeatedly seen the gamesmanship at play in this case. This Court has seen how Defendants are seemingly unable to comport with this Court's Rules on decorum, honesty, and fair discovery. As such, Striking of Defendants' Answer is a fair, proportional sanction, which will serve to ensure that the damage to Plaintiffs' attempts to prove liability are not fatal. Furthermore, the sanction of awarding Plaintiffs' verified past medical damages is essential to cure the damage done to Plaintiffs' attempts to prove damages in this matter. Finally, these sanctions will ensure that this type of willful misconduct is discouraged in the future.

III. CONCLUSION

Based on the above, Plaintiffs respectfully requests that this Court GRANT Plaintiffs' Motion and Strike Defendants' Answer.

DATED this 22nd day of October, 2019.

BIGHORN LAW

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JACOB G. LEAVITT, ESQ.
Nevada Bar No. 12608
716 S. Jones Blvd.
Las Vegas, Nevada 89107
Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

Pursuant to NRCP 5, NEFCR 9 and EDCR 8.05, I hereby certify that I am an employee of **BIGHORN LAW**, and on the 22nd day of October, 2019, I served the foregoing ***REPLY IN SUPPORT OF, AND SUPPLEMENT TO, PLAINTIFFS' RENEWED MOTION TO STRIKE DEFENDANTS' ANSWER FOR RULE 37 VIOLATIONS, INCLUDING PERJURY AND DISCOVERY VIOLATIONS ON AN ORDER SHORTENING TIME*** as follows:

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

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

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

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

EXHIBIT "1"

SECD
George F. Hand, Esq.
Nevada State Bar No. 8483
ghand@handsullivan.com
Samantha A. Herebck, Esq.
Nevada State Bar No. 14542
sherbeck@handsullivan.com
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, Nevada 89129
Telephone: (702) 656-5814
Facsimile: (702) 656-9820

Attorneys for Plaintiffs
TITINA FARRIS and PATRICK FARRIS

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA LLC; DOES I-V, inclusive; and ROE CORPORATIONS I-V, inclusive, Defendants.	Case No.: A-16-739464-C Dept. No.: 31 **PLAINTIFFS' SEVENTH SUPPLEMENT TO EARLY CASE CONFERENCE DISCLOSURE OF WITNESSES AND DOCUMENTS**

Pursuant to NRCP 16.1, Plaintiffs, TITINA FARRIS and PATRICK FARRIS, by and through their attorneys of record, George F. Hand, Esq. of Hand & Sullivan, LLC, hereby submits their **Seventh Supplement** to Early Case Conference Production of Documents and List of Witnesses:

PRELIMINARY STATEMENT

Plaintiff's NRCP 16.1 Disclosures are subject to, and incorporates by reference, the following objections:

A. Plaintiff objects to each and every individual request for pretrial disclosure of witnesses and evidence by Plaintiff to the extent that it requests either documents or information about documents that are protected from discovery by the attorney-client privilege or attorney work

product immunity. Plaintiff's response to each and every individual request is limited to documents that are not subject to such privilege or immunity. However, in the event that a document subject to immunity or privilege is produced by Plaintiff, it will have been through inadvertence and shall not constitute waiver of the privilege or immunity applicable to the document produced or any other protected documents.

B. This response is limited to documents which Plaintiff knows are in its custody, possession, or control as of the date of production. Plaintiff reserves the right to produce and use responsive documents when discovered, or when their significance becomes known.

C. All evidentiary objections are reserved to time of trial, and no waiver of any objection is to be implied from any response made in the spirit of cooperation and discovery obtained herein. Nor is it Plaintiffs ' intention by these responses to make any information, otherwise objectionable at the time of trial, admissible by these responses. Any and all objections, including but not limited to, foundation and admissibility are reserved.

D. The following responses reflect the total information in possession of Plaintiffs and their attorney, employees, agents or other representatives. Obviously, not all of the facts and information contained in the responses are within the personal knowledge of Plaintiffs themselves. Accordingly, Plaintiffs have relied on the advice and assistance of their attorney in providing this list of witnesses and exhibits.

E. Each of the following responses is rendered and based upon information in the possession of the responding party at the time of the preparation of this disclosure. Discovery will continue as long as permitted by statute or stipulation of the parties, and the investigation of these responding parties' attorney and agents will continue to and throughout the trial of this action. Plaintiffs therefore, specifically reserve the right to introduce, at the time of trial, any evidence from any source which may hereinafter be discovered, and testimony from any witness whose identity may hereinafter become known.

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If any information has unintentionally been omitted from these responses, this responding party reserves the right to apply for relief so as to permit the insertion of the omitted data from these responses.

These introductory comments shall apply to each and every response given herein, and shall be incorporated by reference as though fully set forth in all of the responses appearing on the following pages.

I.

WITNESSES

1. Titina Farris, Plaintiff
c/o Hand & Sullivan, LLC
3442 N. Buffalo Drive
Las Vegas, NV 89129

Titina Farris, Plaintiff, is expected to testify regarding the facts and circumstances of the claims alleged in the Complaint and alleged damages.

2. Patrick Farris, Plaintiff
c/o Hand & Sullivan, LLC
3442 N. Buffalo Drive
Las Vegas, NV 89129

Patrick Farris, Plaintiff, is expected to testify regarding the facts and circumstances of the claims alleged in the Complaint and alleged damages.

3. Barry Rives, M.D., Defendant
c/o Schuering Zimmerman & Doyle, LLP
400 University Avenue
Sacramento, California 95825-6502

Dr. Rives is expected to testify regarding the facts and circumstances of the claims alleged in the Complaint and alleged damages.

4. Person Most Knowledgeable
Laparoscopic Surgery of Nevada
c/o Schuering Zimmerman & Doyle, LLP
400 University Avenue
Sacramento, California 95825-6502

Person Most Knowledgeable for Laparoscopic Surgery of Nevada is expected to testify regarding the facts and circumstances of the claims alleged in the Complaint and alleged damages.

5. Person Most Knowledgeable
St. Rose Dominican – San Martin Campus
8280 West Warm Springs Road
Las Vegas, Nevada 89113

Person Most Knowledgeable for St. Rose Dominican – San Martin Campus is expected to testify regarding his/her examination, treatment, diagnosis and overall health conditions of Plaintiff.

6. Bess Chang, M.D.
8530 W. Sunset Road
Las Vegas, NV 89113

Dr. Chang is expected to testify regarding his examination, treatment, diagnosis and overall health conditions of Plaintiff.

7. Elizabeth Hamilton, M.D.
10001 Eastern Avenue
Ste. #200
Henderson, NV 89052

Dr. Hamilton is expected to testify regarding her examination, treatment, diagnosis and overall health conditions of Plaintiff.

8. Naomi Chaney, M.D.
5380 South Rainbow Blvd.
Las Vegas, NV 89118

Dr. Chaney is expected to testify regarding her examination, treatment, diagnosis and overall health conditions of Plaintiff.

9. Person Most Knowledgeable
Desert Valley Therapy
6830 W. Oquendo, #101
Las Vegas, NV 89119

Person Most Knowledgeable for Desert Valley Therapy is expected to testify regarding his/her examination, treatment, diagnosis and overall health conditions of Plaintiff.

10. Person Most Knowledgeable
Steinberg Diagnostic Medical Imaging Centers
9070 W. Post Road
Las Vegas, NV 89148

Person Most Knowledgeable for Steinberg Diagnostic Medical Imaging Centers is expected to testify regarding his/her examination, treatment, diagnosis and overall health conditions of Plaintiff.

11. Lowell Pender
(Son of Titina Farris)
3620 Mountain River Street
Las Vegas, NV 89129

Lowell Pender, is expected to testify regarding the facts and circumstances of the claims alleged in the Complaint and alleged damages.

12. Addison Durham
(Brother of Titina Farris)
2740 Montessori
Las Vegas, NV 89117

Addison Durham is expected to testify regarding the facts and circumstances of the claims alleged in the Complaint and alleged damages.

13. Sky Prince
(Daughter of Titina Farris)
6450 Crystal Dew Drive
Las Vegas, NV 89118

Sky Prince is expected to testify regarding the facts and circumstances of the claims alleged in the Complaint and alleged damages.

14. Steven Y. Chinn, M.D.
6950 W. Desert Inn Rd., #110
Las Vegas, NV 89117

Dr. Chinn is expected to testify regarding his examination, treatment, diagnosis and overall health conditions of Plaintiff.

15. Person Most Knowledgeable
CareMeridian
3391 N. Buffalo Drive
Las Vegas, NV 89129

Person Most Knowledgeable for CareMeridian is expected to testify regarding his/her examination, treatment, diagnosis and overall health conditions of Plaintiff.

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16. Amy Nelson
3213 Whites Drive
Austin, TX 78735

Amy Nelson is expected to testify regarding the facts and circumstances of the claims alleged in the Complaint and alleged damages.

17. Christine Garcia
231 James Adkins Drive
Kyle, TX 78640

Christine Garcia is expected to testify regarding the facts and circumstances of the claims alleged in the Complaint and alleged damages.

18. Person Most Knowledgeable
St. Rose Dominican – Siena Campus
3001 St. Rose Parkway
Henderson, Nevada 89052

Person Most Knowledgeable for St. Rose Dominican – Siena Campus is expected to testify regarding his/her examination, treatment, diagnosis and overall health conditions of Plaintiff.

19. Michael Hurwitz, M.D.
510 Superior Avenue
Suite 200G
Newport Beach, CA 92663
(949) 791-6767

Dr. Hurwitz will testify as to his expert opinion regarding the medical treatment and care rendered to Titina Farris and causation of the injuries to Titina Farris. Dr. Hurwitz will also testify in accordance with his expert report, curriculum vitae and testimony list.

20. Justin Willer, M.D.
741 Ocean Parkway
Brooklyn, NY 11230
(718) 859-8920

Dr. Willer will testify as to his expert opinion regarding the medical treatment and care rendered to Titina Farris and causation of the injuries to Titina Farris. Dr. Willer will also testify in accordance with his expert report, curriculum vitae and testimony list.

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21. Alan J. Stein, M.D.
509 12th Street
Apt. 1D
Brooklyn NY 11215
(718) 369-4850

Dr. Stein will testify as to his expert opinion regarding the medical treatment and care rendered to Titina Farris and causation of the injuries to Titina Farris. Dr. Willer will also testify in accordance with his expert report, curriculum vitae and testimony list.

22. Dawn Cook, RN, CNLCP, LNCP-C, CLCP, LNC, CFLC
1001 E. Sunset Road, #97553
Las Vegas, NV 89193-7553
(702) 544-2159

Dawn Cook will testify as to her expert opinion regarding the Life Care Plan formulated for Titina Farris, including the necessary future medical treatment, therapies and services required for Titina Farris and the costs and expenses associated with Titina Farris's life care plan. It is expected that Dawn L. Cook will testify as to her expert opinion regarding the medical treatment and care rendered to Titina Farris and causation of her injuries; the reasonableness and necessity of the treatment and care rendered to Plaintiff Titina Farris; the costs of medical care and treatment, including the usual, customary and reasonable charges for said treatment. Dawn L. Cook will also testify in accordance with her expert report, curriculum vitae and testimony list.

23. Terence M. Clauretie, PHD
4505 S. Maryland Parkway
Las Vegas, Nevada 89154-6025
(702) 985-3223

Dr. Clauretie will testify as to his expert opinion regarding the economic losses of Titina Farris, including the present value of Titina Farris's Life Care Plan. Dr. Clauretie will also testify in accordance with his expert reports, curriculum vitae and testimony list.

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24. Alex Barchuk, M.D.
1125 Sir Francis Drake Blvd.
Kentfield, CA 94904
(415) 485-3508

Dr. Barchuk will testify as to his expert opinion regarding the medical treatment and care rendered to Titina Farris and causation of the injuries to Titina Farris as well as his examination of Titina Farris. Dr. Barchuk will also testify in accordance with his expert report, curriculum vitae and testimony list.

25. Person(s) Most Knowledgeable and/or Custodian of Records
MGM Resorts International /UMR Medical
c/o Russell Oliver & Stephens Attorneys
5178 Wheelis Drive
Memphis, TN 38117

Person(s) Most Knowledgeable and/or Custodian of Records for MGM Resorts International/UMR Medical is expected to testify as to his/her knowledge of the provisions, terms, claims and/or payments regarding the subject MGM Resorts Health and Welfare Benefit Plan in regard to Titina Farris and Patrick Farris.

II.

DOCUMENTS PRODUCED

1. CD containing the following documents:

DOCUMENT	BATES LABEL NO.
St. Rose Dominican Hospital Record	PLTF000001-PLTF008648
Dr. Rives Records	PLTF008649-PLTF008697
Dr. Chang Records	PLTF008698-PLTF008706
Dr. Hamilton Records	PLTF008707-PLTF008727
Photographs of Titina Farris	PLTF008728-PLTF008742
Desert Valley Therapy Records and Billing	PLTF008743-PLTF008823
Dr. Hamilton Records and Billing	PLTF008824-PLTF008907
St. Rose Dominican – San Martin Campus Billing Records for July, 2015 admission	PLTF008908-PLTF009101
St. Rose Dominican – Siena Campus Billing Records for July, 2016 admission	PLTF009102-PLTF009124
Dr. Chaney Medical Records	PLTF009125-PLTF0010091
Dr. Chaney Billing Records	PLTF0010092-PLTF0010121
Advanced Orthopedics & Sports Medicine Records and Billing	PLTF0010122-PLTF0010148
Diagnostic films taken at St. Rose Dominican Hospital	Not bates stamped

Video of Titina Farris taken by Lowell Pender on April 13, 2015	Not bates stamped
Videos of Titina Farris, Patrick Farris, Addison Durham, Lowell Pender and Sky Prince	Not bates stamped
Marriage Certificate	PLTF0010149
Dr. Steven Y. Chinn, M.D. Medical and Billing Records	PLTF0010150-PLTF0010174
CareMeridian Medical and Billing Records	PLTF0010175-PLTF10474
St. Rose Dominican Hospital-Siena Campus Medical Records	PLTF10475-PLTF11390
Steinberg Diagnostic Medical Imaging Medical and Billing Records	PLTF11391-PLTF11451
Notice of No Film/Images on file for St. Rose Dominican Hospital-Siena Campus	PLTF11452-PLTF11456
National Vital Statistics Reports United States Life Tables, 2015	**PLTF11457-PLTF11520**
MGM Resorts Health and Welfare Benefit Plan	**PLTF11521-PLTF11561**

Plaintiff also designates and incorporates herein all documents, witnesses, and tangible items disclosed by any other party in this action pursuant to NRCP 16.1; all documents produced by all parties in response to Requests for Production of Documents; and all exhibits to depositions taken in this action.

III.

COMPUTATION OF DAMAGES

Pursuant to NRCP 16.1 (a)(l)(C), Plaintiff provides the following computation of damages, which is not intended to be all-inclusive. Discovery is continuing and Plaintiff reserves the right to supplement any computation and damage amount.

	Provider	Charges
1	St. Rose Dominican San Martin Campus	$ 908,033.12
2	St. Rose Dominican Siena Campus	$ 104,120.04
3	Barry Rives, M.D.	$ 11,929.00
4	Bess Chang, M.D.	$ 1,018.00
5	Naomi Chaney, M.D.	$ 6,570.00
6	Elizabeth Hamilton, M.D.	$ 12,801.00
7	Desert Valley Therapy	$ 4,473.15
8	Advanced Orthopedic & Sports Medicine	$ 4,973.00
9	Southern Nevada Pain Center	$ 1,015.00
10	CareMeridian	$ 28,747.63
11	Steinberg Diagnostic Medical Imaging	$ 6,126.30

TOTAL	$ 1,089,806.24
Past Medical and Related Expenses	$ 1,089,806.24
Future Medical and Associated Expenses	
Medical Care	$ 98,503.98
Allied Health	$ 1,112,088.31
Complications	$ 31,362.20
Diagnostics	$ 23,322.20
Procedures	$ 77,975.10
Home Care	$ 1,562,263.83
Equipment	$ 114,799.71
Home Modifications	$ 81,080.00
Total:	$ 3,101,395.33
Total Special Damages	$ 4,191,201.57

Plaintiffs reserve the right to supplement this Calculation of Damages with any and all other relevant documents and records, which come into their possession during discovery. Further, Plaintiffs reserve the right to seek other damages in an amount to be proven at trial, whereby a jury will decide upon a sum of money sufficient to reasonably and fairly compensate Plaintiffs for the following items:

1. The reasonable medical expenses Plaintiff has necessarily incurred as a result of the accident/incident and the medical expenses which the Jury believes the Plaintiff is reasonably certain to incur in the future as a result of the accident/incident.

2. The physical and mental pain, suffering, anguish, and disability endured by the Plaintiff from the date of the accident/incident to the present.

3. The physical and mental pain, suffering, anguish, and disability which the Jury believes the Plaintiff is reasonably certain to experience in the future as a result of the accident/incident.

4. The loss of consortium, loss of society, affection, assistance and conjugal fellowship by Plaintiff Patrick Farris from the date of the accident/injury to present.

5. The loss of consortium, loss of society, affection, assistance and conjugal fellowship which the Jury believes Plaintiff Patrick Farris is reasonably certain to experience in the future as a result of the accident/injury.

Plaintiff reserves the right to supplement this Calculation of Damages with any and all other relevant documents and records which come into their possession during discovery.

Plaintiffs TITINA FARRIS and PATRICK FARRIS reserve the right to supplement this witness list as discovery proceeds and to call any witness identified by any party. Plaintiffs TITINA FARRIS and PATRICK FARRIS further reserve the right to supplement this witness list as discovery proceeds to call any witness identified, for purposes of impeachment/rebuttal.

Dated: July 5, 2019

HAND & SULLIVAN, LLC

By: _____

George F. Hand, Esq.
Nevada State Bar No. 8483
Samantha A. Herbeck, Esq.
Nevada State Bar No. 14542
3442 North Buffalo Drive
Las Vegas, Nevada 89129
Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I am employed in the County of Clark, State of Nevada. I am over the age of 18 and not a party to the within action. My business address is 3442 N. Buffalo Drive, Las Vegas, NV 89129.

On July 5, 2019, I served the within document(s) described as:

PLAINTIFFS' SEVENTH SUPPLEMENT TO EARLY CASE CONFERENCE DISCLOSURE OF WITNESSES AND DOCUMENTS

on the interested parties in this action as stated on the below mailing list.

☐ (BY MAIL) By placing a true copy of the foregoing document(s) in a sealed envelope addressed to Defendant's last-known address. I placed such envelope for collection and mailing following ordinary business practices. I am readily familiar with this Firm's practice for collection and processing of correspondence for mailing. Under that practice, the correspondence would be deposited with the United States Postal Service on that same day, with postage thereon fully prepaid at Las Vegas, Nevada. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit.

☒ (BY ELECTRONIC SERVICE) By e-serving through Odyssey, pursuant to Administrative Order 14-2 mandatory electronic service, a true file stamped copy of the foregoing document(s) to the last known email address listed below of each Defendant which Plaintiff knows to be a valid email address for each Defendant.

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

Anna Grigoryan
(Type or print name)

(Signature)

Farris v. Rives, et al.

Court Case No.: A-16-739464-C

SERVICE LIST

Thomas J. Doyle, Esq. Chad C. Couchot, Esq. calendar@szs.com **SCHUERING ZIMMERMAN & DOYLE, LLP** 400 University Avenue Sacramento, California 95825-6502 (916) 567-0400 (916) 568-0400 Fax *Attorneys for Defendants*	Kim Mandelbaum, Esq. filing@memlaw.net **MANDELBAUM ELLERTON & ASSOCIATES** 2012 Hamilton Lane Las Vegas, Nevada 89106 (702) 367-1234 *Attorneys for Defendants*

MGM RESORTS
HEALTH AND WELFARE BENEFIT PLAN

As Amended and Restated Effective January 1, 2012

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MGM RESORTS
HEALTH AND WELFARE BENEFIT PLAN

As Amended and Restated Effective January 1, 2012

ARTICLE I

INTRODUCTION

MGM Resorts International (the "Company") maintains the MGM Resorts Health and Welfare Benefit Plan (the "Plan") to provide certain health and welfare benefits to eligible Employees, as defined herein.

The Company now desires to amend and restate the Plan effective January 1, 2012 in order (i) to reflect the provisions of all prior amendments to the Plan, (ii) to make certain benefit design changes and clarifications, and (iii) to make certain changes as required by law and as may be recommended by counsel.

Accordingly, this document sets forth the Plan, as amended and restated effective January 1, 2012. This document, as it may be duly amended, together with any other documents incorporated herein by reference ("Incorporated Documents") as each may be amended, constitutes the Plan in its entirety.

The Plan has been established and shall be maintained with the intention of meeting the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and any other pertinent laws and regulations. The Plan is also intended to qualify as a cafeteria plan under the provisions of section 125 of the Internal Revenue Code of 1986, as amended (the "Code") and applicable regulations issued and effective thereunder.

The Company reserves the right to alter, amend, modify or terminate the Plan in whole or in part, at any time and for any reason, in a manner consistent with the provisions of Article XIX.

In the event that the provisions of a document describing or governing a Benefit conflict with the provisions of this document or any other documents governing the Benefits, the Plan Administrator shall use its discretion to interpret the terms and purpose of the Plan consistent with applicable law to resolve any conflict. However, the terms of this document shall not enlarge the rights of a Participant or his or her beneficiary to Benefits.

ARTICLE II

DEFINITIONS

Whenever used in the Plan, the following words and phrases shall have the respective meanings specified in this Article unless the context plainly requires a different meaning, or the

documents describing or governing a Benefit contain a definition applicable to that Benefit. When a defined meaning is intended, the term shall be capitalized in the Plan.

2.1 Affordable Care Act means together the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, which was signed into law on March 23, 2010; and H.R. 4872, the Health Care and Education Reconciliation Act of 2010, which was signed into law on March 30, 2010, as amended, and the applicable regulations issued and effective thereunder.

2.2 Benefit(s) means the health and welfare benefits as described herein and within each Incorporated Document.

2.3 Claims Administrator means a person or persons, or entity or entities appointed by the Company to serve as the administrator of claims under the Plan with the responsibility for review and payment of claims and recordkeeping related thereto and, to the extent directed by the Company, to exercise its discretionary authority in the review of claim payments (including eligibility for benefits claimed) and claim denials under the terms of the Plan. In the case of any Plan benefits provided under a group insurance contract, the insurance company shall be the Claims Administrator for the benefits provided under that group insurance contract unless otherwise provided in the contract. If no Claims Administrator is authorized to act under the terms of a Benefit's governing documents, the Plan Administrator shall be the Claims Administrator.

2.4 COBRA means the coverage rights which are conferred by Code section 4980B, *et seq.*, and ERISA section 601, *et seq* (as such statutes were created by the Consolidated Omnibus Budget Reconciliation Act of 1985, and amended thereafter), and the applicable regulations issued and effective thereunder.

2.5 Code means the Internal Revenue Code of 1986, as amended from time to time, and the applicable regulations issued and effective thereunder.

2.6 Company means MGM Resorts International and any successor or assign thereof which adopts the Plan by action of its Board of Directors (or that Board's designee).

2.7 Dependent means a Spouse, Domestic Partner or dependent child of an Employee who is eligible for coverage under the terms of the Benefit's Incorporated Documents.

2.8 Domestic Partner means, for purposes of the Plan, a same-sex partner as defined in the Company's affidavit, including a same-sex spouse or civil union partner as recognized by state law.

2.9 Effective Date means (except as otherwise set forth herein) January 1, 2012, the general effective date of the provisions of this amended and restated Plan.

2.10 Employee means a person who is classified by the Employer as a common law employee of the Employer. The term "Employee" does not include (i) any employee of the Employer who is a member of a collective bargaining unit and is covered under a collective

bargaining agreement unless the collective bargaining agreement provides for the employee's participation in the Plan, (ii) any contract employees, or leased employees of the Employer as defined in Code section 414(n), or (iii) any person who is not classified by the Employer as a common law employee of the Employer, notwithstanding any later reclassification by a court or any regulatory agency of the person as a common law employee of the Employer. Classification of persons as Employees shall be determined by the Employer in its discretion.

2.11 **Employer** means the Company and each subsidiary or affiliate that employs Employees and is a member of the Company's controlled group, as described in Code sections 414(b) or (c), other than MGM Grand Detroit, LLC and Mandalay Employment, LLC.

2.12 **ERISA** means the Employee Retirement Income Security Act of 1974, as amended from time to time, and the applicable regulations issued and effective thereunder.

2.13 **FMLA** means the Family and Medical Leave Act of 1993, as amended.

2.14 **Full-Time Employee** means an Employee who is designated to work full-time by the Employer.

2.15 **Health Care Components** means the Benefits that provide medical, wellness program, prescription drugs, dental, vision, employee assistance benefits and health care spending account benefits under the Plan.

2.16 **HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as codified under Code section 9801, *et seq.*, and ERISA section 701, *et seq.*

2.17 **Incorporated Document** means each written arrangement incorporated under this Plan, including each insurance policy, administrative services agreement, HMO agreement and Summary Plan Description, that constitutes part of an "employee welfare benefit plan" within the meaning of Section 3(l) of ERISA and that provides Benefits under the Plan. The insurance policy governing any insured Benefit shall constitute the official plan document for the purpose of benefit determinations and shall supersede the provisions of any Summary Plan Description with respect to such Benefit.

2.18 **Participant** means any Employee, and where applicable, eligible Dependent, who participates in the Plan in accordance with the terms of the Benefits.

2.19 **Participation Date** means, with respect to any Participant, the date on which his or her participation in the Plan commences, as provided in Article III.

2.20 **Plan** means the MGM Resorts Health and Welfare Benefit Plan, as set forth herein, and as may be amended from time to time, together with any and all appendices and supplements.

2.21 **Plan Administrator** means the Company or such other person or committee of one or more persons (which may include employees, officers or directors of the Company) as

may be designated by the Company in writing to administer the Plan as provided herein. The "Plan Administrator" shall be the "named fiduciary" of the Plan within the meaning of ERISA Section 402(a).

2.22 Plan Year means the twelve (12) month period beginning on January 1 and ending on the next following December 31.

2.23 Qualifying Life Event means any event, which qualifies as a status change or other event under Code section 125, which permits an Employee to make a pre-tax election change.

2.24 Required Contribution means the contribution, if any, required to be paid by a Participant for Benefits, as determined by the Plan Administrator.

2.25 Spouse means a person of the opposite sex who is legally married (other than by common-law) to the Participant. A Spouse does not include a former spouse following legal separation, final decree of dissolution or divorce, or a common law spouse.[1]

2.26 Summary Plan Description means the most recent version of each summary plan description for each Benefit, as amended from time to time with a summary of material modifications or a new summary plan description, each of which forms a part of the Plan, and which sets forth the terms and conditions relating to eligibility for coverage, the levels and types of Benefits, any Required Contributions and the source of benefit payments and funding, if applicable.

2.27 USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE III

ELIGIBILITY AND PARTICIPATION

3.1 Employee Eligibility.

(a) Full-Time Employees. Except as provided below, each Employee who is a Full-Time Employee is eligible to participate hereunder as of his or her Participation Date, which is the first day after the Employee completes ninety (90) calendar days of active continuous employment with the Employer as a Full-Time Employee. Each Employee who is designated by the Employer as an "on-call," "part-time," or "temporary" employee is not eligible to participate hereunder.

(b) Full-time Flex or Part-time with Benefits. Each Employee who is classified by the Employer as a "full-time flex" or "part-time with benefits" Employee shall be eligible to participate hereunder as of his or her Participation Date, which is the first day after the Employee

[1] BHFS question/comment: Please confirm that the Plan excludes separated spouses?

completes ninety (90) calendar days of active continuous employment with the Employer during which such Employee completes an average of thirty (30) hours of work for the Employer per week determined by an audit conducted every calendar quarter.

(c) Employees who Become Non-Bargaining. The Participation Date of an Employee who becomes a Full-Time Employee in a non-bargaining position after being a Full-Time Employee covered by a collective bargaining agreement that does not provide for coverage hereunder shall be the first business day of the week following the date on which the employment status change (transfer transaction) is entered in the Employer's Human Resource system, provided that the Employee has completed ninety (90) calendar days of active continuous employment with the Employer starting from his or her original date of hire.

(d) Change in Employment Status from Part-time or On-call or Temporary to Full-Time or Full-time Flex or Part-time with Benefits Status. The Participation Date of an Employee who becomes a Full-Time, "full-time flex," or "part-time with benefits" Employee after being a "part-time," "on-call," or "temporary" Employee shall be the first business day of the week following the date on which the employment status change (transfer transaction) is entered in the Employer's Human Resource system, provided that, as of such date, the Employee has completed ninety (90) calendar days of active continuous employment for the Employer during which such Employee completes an average of thirty (30) hours of work for the Employer per week determined by an audit conducted every calendar quarter.

(e) The Signature Condominiums, LLC Employees. The Participation Date of an Employee who is treated as a "new hire" by The Signature Condominiums, LLC ("Signature") on or after March 1, 2006, and who is covered under the PPO or HMO[2] [Benefits under the Plan on the day before his or her date of new hire, shall be the Employee's date of new hire by Signature. The Participation Date of an Employee who is treated as a "new hire" by Signature on or after March 1, 2006, and who is covered under a collectively bargained health plan on the day before his or her date of new hire, shall be the first day after the Employee completes ninety (90) calendar days of active continuous employment as a Full-Time Employee with Signature starting from his or her date of new hire.

(f) Circus Circus Reno Employees. The following provisions apply to Employees of Circus Circus Reno only.

(i) New Employees. To be eligible to participate in the Plan, new Employees of Circus Circus Reno must satisfy subparagraphs (A) and (B) below.

(A) Waiting Period Required. The Employee must complete ninety (90) calendar days of active continuous employment with the Employer. If the Employee meets the requirements of subparagraph (B) below, then the Employee shall be eligible to become a Participant as of his or her Participation Date, which is the first day after the Employee's completion of this waiting period.

[2] BHFS question: Should the DCHP be included here?

(B) Full-time Employment Required. The Employee must be employed by the Employer on a full-time basis, as determined by the Plan Administrator, in its sole discretion, immediately preceding the Employee's Participation Date.

(I) Initial Full-time Test. An Employee shall be deemed to be employed on a "full-time basis" if he is Actively Employed, at his customary place of employment, for an average of thirty (30) or more hours per week (or such other number of hours as may be established by the collective bargaining agreement covering his or her employment with the Employer). The computation period shall be determined by the Plan Administrator in its sole discretion, but shall be selected so as to facilitate obtaining the necessary data, making the necessary computations, and notifying Employees of their options in a timely manner.

(II) Failure of Initial Full-time Test. If an Employee does not meet the requirements of the initial full-time employment test during his applicable computation period determined pursuant to subparagraph (I), the Employee's hours worked shall be reviewed each subsequent calendar quarter and the Employee shall be deemed to be employed on a "full-time basis" if he or she is Actively Employed, at his or her customary place of employment, for an average of thirty (30) or more hours per week (or such other number of hours as may be established by the collective bargaining agreement covering his or her employment with the Employer) for the three (3) month period immediately preceding the first day of any calendar quarter thereafter.

(ii) Continuing Employees. To remain eligible to participate, an Employee must continue to be Actively Employed for an average number of hours (the "Average Hours Requirement") as specified below, so as to continue to be considered a Full-Time Employee.

(iii) Computation of Full-Time Employment.

(A) Except in the case of the Initial Full-Time Test applied to new Employees as described in subparagraph (f)(i)(B)(I), an Employee's status as a Full-Time Employee shall be measured on a calendar quarter basis as set forth in subsection (B).

(B) An Employee shall be deemed to be employed on a "full-time basis" if he or she is Actively Employed, at his or her customary place of employment, for an average of thirty (30) or more hours per week (or such other number of hours as may be established by the collective bargaining agreement covering his or her employment) for the three (3) month period immediately preceding the first day of any calendar quarter thereafter.

(iv) Loss of Coverage.

(A) So long as all requirements for coverage other than the Average Hours Requirement continue to be met, a Participant whose Active Employment throughout a calendar quarter fails to meet the Average Hours Requirement shall not lose

coverage hereunder until the end of the first calendar quarter coinciding with the date that he or she has failed to meet the Average Hours Requirement for two consecutive calendar quarters.

(B) If an Employee's Active Employment is less than necessary to meet the Average Hours Requirement for two (2) consecutive calendar quarters, then he or she shall not be eligible to participate for the following calendar quarter; provided, however, that if an Employee fails to meet the Average Hours Requirement solely as a result of a leave taken pursuant to the FMLA, or any other leave of absence approved by the Company, generally not to exceed sixty (60) days, such person shall not cease to be an eligible Employee, and upon his return from such leave, shall have his or her eligibility for coverage measured based on the calendar quarter ended immediately prior to his leave of absence.

(C) An Employee whose Plan coverage is terminated solely because of his or her failure to meet the Average Hours Requirement for two (2) consecutive calendar quarters may again become eligible to participate on the first day of the first calendar quarter following the first calendar quarter during which his or her Active Employment throughout such calendar quarter meets the Average Hours Requirement.

For purposes of this subparagraph (f), "Active Employment" or "Actively Employed" shall mean that an Employee is: (1) actively at work at the Employer's regular place of business or another location to which the Employee may be required to travel to perform the duties of his or her employment with the Employer; (2) on an approved vacation or is absent due to a hospital confinement or other health factor; (3) on an approved military leave of absence; or (4) on an approved leave of absence and receiving workers' compensation benefits.

(g) For purposes of this Section 3.1, an Employee shall also be treated as in active continuous employment with the Employer during any period of absence from work due to any health factor.

3.2 Dependent Eligibility. A Dependent shall be eligible for coverage under the terms of the Benefit's Incorporated Documents.

3.3 Qualified Medical Child Support Orders. The Plan shall honor any qualified medical child support order ("QMCSO") that provides for Plan coverage for an alternate recipient, in the manner described in Section 609 of ERISA and in accordance with the Plan's QMCSO procedures.

3.4 Participation. Each Employee and Dependent shall become a Participant on the Employee's Participation Date provided that (i) the Employee has commenced work by such date and completed the applicable waiting period, and (ii) the Employee completes the enrollment process as prescribed by the Plan Administrator, including submitting all required documentation, no later than thirty-one (31) days after such date, except as provided in Section 3.9.

3.5 Termination of Participation/Continuation During Certain Leaves of Absence. This Section shall apply only to the Health Care Components. A Participant's

coverage under other Benefits shall terminate or be continued in accordance with the terms of the applicable Benefit's Incorporated Documents.

(a) Termination of Participation/Death of Participant.

(i) A Participant's participation shall terminate as of the date the Participant ceases to be an eligible Employee (or Dependent, as applicable) hereunder, except as may be otherwise provided in Section 3.1(f) and this Section.

(ii) A Participant must provide to the Plan Administrator notice of a legal separation, divorce, or a Dependent's loss of dependent status within thirty-one (31) days after such event. If this notice is not provided within sixty (60) days after such event, COBRA coverage shall not be available to the former Spouse or Dependent whose coverage terminates as a result of such event.

(iii) If a Participant dies while actively employed by an Employer, the Participant's Dependents shall continue to be covered hereunder as provided in the applicable Incorporated Document.

(b) Continuation During Certain Leaves of Absence.

(i) Approved Personal Leave of Absence. If a Participant is on an approved personal leave of absence from the Employer, the Employer shall continue coverage hereunder for thirty (30) days provided that the Participant pays the applicable premium contribution. Coverage under the Plan shall terminate on the thirty-first (31st) day after the start of the Participant's leave of absence.

(ii) FMLA/Medical Leave. If a Participant is on FMLA or other approved medical leave from the Employer, as described in the Employer's leave policy, the Employer shall continue coverage hereunder for the Participant for a period not to exceed eighty-four (84) days in a rolling twelve-month period (or such longer period if required by law) only if the Participant pays for coverage for that period at the Plan's rates that would apply if the Participant was not on FMLA leave.

(iii) Workers' Compensation Leave. If a Participant is on a qualified Employer-approved workers' compensation leave, the Employer shall continue coverage hereunder for the Participant during that leave only if the Participant pays for coverage for that period at the Plan's rates that would apply if the Participant was not on leave.

(iv) Military Leave. Subject to all conditions set forth in the Company's military leave policy, the Employer shall continue coverage for a Participant who is an Employee and his or her enrolled Dependents at no cost to the Employee during the Employee's military leave of absence from the Employer.

(c) Continuation During Other Events. The Plan may provide continuation coverage during certain layoffs or other leaves in accordance with the Employer's personnel policies and as communicated to Participants.

3.6 Rehired/Reinstated and Transferred Employees.

(a) Rehired/Reinstated Employees. An Employee who is rehired by an Employer shall be eligible to participate in the Plan and make new benefit elections, provided such Employee satisfies the eligibility requirements of Section 3.1. Notwithstanding the foregoing, if a former Employee is rehired by an Employer during the same Plan Year and within six (6) months of the date his or her prior participation ended, his or her elections shall be reinstated. If an Employee is considered by the Employer as "reinstated" under the Employer's personnel policies, the provisions of those policies with respect to eligibility shall apply for purposes of this Plan and Benefits.

(b) Transferred Employees. A Participant who transfers from one Employer to another Employer shall retain coverage hereunder. An Employee who transfers from an affiliate or subsidiary of the Company that is not an Employer to an Employer shall be credited with past service with that prior employer for purposes of eligibility hereunder.

3.7 Enrollment.

(a) Initial Enrollment. An eligible Employee must enroll for coverage hereunder for himself or herself and any Dependents by completing the enrollment process as prescribed by Plan Administrator within thirty-one (31) days after his or her Participation Date. To complete the enrollment process, the Employee must provide to the Plan Administrator documentation of dependent status of any Dependents (such as marriage certificates or birth certificates) as prescribed by the Plan Administrator. The Participant's initial coverage period is the period beginning on his or her Participation Date and ending on December 31 of that year. An eligible Employee who fails to complete the enrollment process timely may become a Participant on a later date as provided in this Section.

(b) Annual Enrollment. The Employer shall have an annual enrollment period during which an Employee may change his or her benefit elections. Benefit elections made during this period shall generally become effective January 1st and shall remain in effect through the next December 31st. A Participant's enrollment elections shall remain in effect each subsequent Plan Year unless changed during annual enrollment or in connection with a Qualifying Life Event; provided, however, that a Participant contributing on a post-tax basis due to late enrollment, as described in Section 3.9, shall be automatically re-enrolled in the subsequent Plan Year on a pre-tax basis. Notwithstanding the foregoing, the Participant must affirmatively re-enroll each year in the Health Care Spending Account and Dependent Care Spending Account. To complete the enrollment process, the Employee must provide to the Plan Administrator documentation of dependent status of any Dependents (such as marriage certificates or birth certificates) as prescribed by the Plan Administrator.

(c) Special Enrollment. An eligible Employee may enroll himself or herself and his or her Dependent(s) in health coverage under the Plan if: (i) the Employee or Dependent was covered under a group health plan or had health insurance coverage from another source at the time coverage hereunder was made available to the individual, (ii) the Employee or Dependent certifies that other health coverage was the reason for declining coverage, (iii) the loss of such coverage was due to exhaustion of COBRA, or due to loss of eligibility for coverage or employer contributions toward coverage were terminated, and (iv) the Employee or Dependent requests enrollment no later than thirty-one (31)[3] days after the loss of such other coverage. Provided these requirements have been met, coverage hereunder shall be effective the first day following the loss of other coverage. If an Employee or Dependent loses other coverage due to his or her failure to pay Required Contributions or for "cause," as determined by the Plan Administrator, such individual shall not have any special enrollment rights hereunder.

In addition, to the extent required by HIPAA, an eligible Employee with a new Dependent as a result of marriage, birth, adoption, or placement for adoption, may be permitted to enroll himself or herself and his or her Dependents in health coverage under the Plan within sixty (60) days after the marriage, birth, adoption, or placement for adoption.

Each Employee or Dependent, who is eligible for coverage under the group health coverage under the Plan, but not enrolled, may enroll for group health coverage under the terms of the Plan if either:

(i) the Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State Children's Health Insurance Program ("CHIP") under Title XXI of the Social Security Act and (a) coverage of the Employee or Dependent under such a plan is terminated as a result of loss of eligibility for such coverage, and (b) the Employee requests coverage under the group health coverage under the Plan no later than 60 days after the date such coverage terminates; or

(ii) the Employee or Dependent becomes eligible for assistance, with respect to group health coverage under the Plan, under a Medicaid plan or State CHIP (including under any waiver or demonstration project conducted under or in relation to such a plan), and the Employee requests coverage under the group health coverage under the Plan no later than 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

3.8 Qualifying Life Event Enrollments and Required Enrollment Changes.

Except as otherwise provided in Section 3.7, in the case of a Qualifying Life Event that permits adding a Dependent to coverage under the Plan, for coverage to be effective for such Dependent, the Participant must enroll the eligible Dependent within sixty (60) days of the event. In the case a Participant changes status from Employee to Dependent or from Dependent to Employee, the person must re-enroll under the new status within thirty-one (31)[4] days of the change. Enrollment must be completed in the manner required by the Plan Administrator. If

[3] BHFS Question: Should this be 60 days also?
[4] BHFS Question: Should this be 60 days also?

enrollment is not completed by the deadlines provided herein, the enrollment shall be considered a "late enrollment," as described in Section 3.9.

Notwithstanding the foregoing, an Employee who undergoes an employment status change and therefore becomes newly eligible to participate in the Plan must complete the enrollment process as prescribed by the Plan Administrator, including submitting all required documentation, no later than sixty (60) days after the date that the Employee satisfies the eligibility requirements.

3.9 Late Enrollment.

(a) The provisions of this subsection (a) apply to Employees and Dependents other than Employees and Dependents of Employees of Circus Circus Reno. If an Employee, other than a Circus Circus Reno Employee, does not enroll within the time period provided for an initial enrollment, as a special enrollment, or during the time periods provided for Qualifying Life Event enrollments, the enrollment shall be considered a "late enrollment." If the Employee enrolls and it is a "late enrollment," coverage hereunder shall be effective as of the first day of the month after enrollment is completed, and premium payments shall be made after-tax.

(b) Employees of Circus Circus Reno must enroll within the time periods provided under the Plan, and shall not be permitted to enroll late as described in subsection (a) above. If the Employee does not timely enroll, the Employee shall not be permitted to enroll until the next open enrollment period or unless the Employee experiences a special enrollment pursuant to Section 3.7(c) or Qualifying Life Event.

ARTICLE IV

CLAIMS ADMINISTRATION AND PROCEDURE

The Plan may contract with a Claims Administrator to administer the benefits hereunder. The Participant must follow the Plan's claims procedure, as provided in the Incorporated Documents or as provided by the Plan Administrator or Claims Administrator and communicated to Participants, to be eligible for a Benefit hereunder. All claims must be submitted to the Claims Administrator for payment and must contain such information as is required by the Claims Administrator.

Appeals of adverse benefit determinations shall be processed in accordance with the claims and appeals procedures set forth in Incorporated Documents (including the Summary Plan Descriptions) of the applicable Benefits. The Plan Administrator shall have no authority with respect to any matter as to which a Claims Administrator under any Summary Plan Description is empowered to make final claim determinations. If, however, a Claims Administrator is not empowered to make final claim determinations for a Benefit, then the Plan Administrator shall be the claims administrator and shall make such determinations in accordance with the procedures set forth in the applicable Incorporated Document.

In the event that (i) the Incorporated Documents governing the Benefit do not prescribe a claims procedure for Benefits that satisfies the requirements of Section 503 of ERISA or (ii) the Plan Administrator determines that the procedures described above with respect to a particular Benefit do not apply, the claims procedures described in the final regulations issued by the U.S. Department of Labor regulations at 29 C.F.R. Section 2560.503-1 shall apply with respect to the Benefit.

With respect to the non-grandfathered Medical Benefits, the claims, appeals and external review procedures shall be administered in compliance with the Affordable Care Act.

ARTICLE V

MEDICAL BENEFITS

Medical Benefits are described in the applicable Incorporated Documents.

ARTICLE VI

WELLNESS PROGRAM BENEFITS

Wellness Program Benefits are described in the applicable Incorporated Documents

ARTICLE VII

DENTAL BENEFITS

Dental Benefits are described in the applicable Incorporated Documents.

ARTICLE VIII

VISION BENEFITS

Vision Benefits are described in the applicable Incorporated Documents.

ARTICLE IX

LIFE INSURANCE AND AD&D BENEFITS

Life Insurance and Accidental Death and Disability Benefits are described in applicable Incorporated Documents.

ARTICLE X

LONG-TERM DISABILITY BENEFITS

Long-Term Disability Benefits are described in applicable Incorporated Documents.

ARTICLE XI

SHORT-TERM DISABILITY BENEFITS

Short-Term Disability Benefits are described in the applicable Incorporated Documents.

ARTICLE XII

EMPLOYEE ASSISTANCE PROGRAM BENEFITS

Employee Assistance Program Benefits are described in the applicable Incorporated Documents.

ARTICLE XIII

SEVERANCE PAY PROGRAM BENEFITS

Severance Pay Program Benefits are described in the applicable Incorporated Documents.

ARTICLE XIV

LEGAL PLAN BENEFITS

Legal Plan Benefits are described in the applicable Incorporated Documents.

ARTICLE XV

SUPPLEMENTAL INSURANCE BENEFITS

Supplemental Insurance Benefits are described in the applicable Incorporated Documents.

ARTICLE XVI

CAFETERIA PLAN BENEFITS

This Article XVI contains the terms that are applicable only to the Health Care Spending Account ("Health Care FSA") and Dependent Care Spending Account ("Dependent Care FSA") and the premium conversion benefits under the Plan. To the extent this Plan provides permitted taxable benefits and qualified benefits under Code section 125, it is intended to qualify as a cafeteria plan under Code section 125. This document is intended to satisfy the written plan documents requirements of Proposed Treasury Regulations section 1.125-1. The cafeteria plan is for Employees only.

16.1 Definitions. Capitalized terms used in this Article XVI are defined as follows, or if not defined herein, as defined elsewhere in the Plan:

(a) **Dependent** means, (1) for purposes of the Health Care FSA, an individual (as defined in Code section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof), and any child (as defined in Code section 152(f)(1)) of the taxpayer who as of the end of the taxable year has not attained age 27; and (2) for purposes of the Dependant Care Spending Account, a qualifying individual as defined in Code section 21(b)(1).

(b) **Dependent Care Expenses** means expenses that are considered to be employment-related expenses under Code section 21(b)(2) relating to expenses for the care of a qualifying individual, as defined in Code section 21(b)(1) paid for by the Participant provided, however, that this term shall not include any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan.

(c) **Earned Income** means all income derived from wages, salaries, tips, self-employment, and other Employee compensation (such as disability or wage continuation benefits), but does not include any amounts received pursuant to any dependent care assistance program under Code section 129, any amounts received as a pension or annuity, or any amounts received pursuant to workers compensation). Earned Income is computed without considering community property laws. Earned Income of a Spouse who is a full-time student, as defined in Code section 21(e) or who is Physically or Mentally Incapable of Self-Care is deemed to be not less than $250 per month for Participants with one Dependent or $500 per month for Participants with two or more Dependents.

(d) **Physically or Mentally Incapable of Self-Care** means incapable of caring for ones hygienic or nutritional needs, or requires full time attention of another person for ones own safety or the safety of others.

(e) **Medical Care Expense** means, for purposes of the Health Care FSA, a Participant's and a Dependent's expenses incurred during the Plan Year for medical care, as defined in Code sections 213(d)(1)(A) and (B). To be a Medical Care Expense, the medical care must be essential to diagnose, cure, mitigate or prevent a disease or disorder or to affect an unsound structure or function of the mind or body. Incurred refers to the date the medical is provided – not to the date charged, billed, or paid.

(f) **Period of Coverage** means the Plan Year, with the following exceptions: (i) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, and (ii) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates.

(g) **Qualified Reservist Distribution** means a taxable distribution to a Participant of all or a portion of the balance in the Participant's Health Care FSA if:

(i) the Participant was (by reason of being a member of a reserve component (as defined in section 101 of title 37, United States Code)) ordered or called to active duty for a period of one hundred and eighty (180) days or more or for an indefinite period, and

(ii) the distribution is requested during the period beginning on the date of such order or call and ending on the last day of the Plan Year which includes the date of such order or call.

(h) **Salary Reduction** means the amount by which the Participant's compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits provided under this Plan.

16.2 Health Care Spending Account. The Health Care FSA allows Participants to receive benefits in the form of pre-tax reimbursement for Medical Care Expenses. A notational account is established on behalf of each Employee who elects the Health Care FSA to which the Participant allocates Salary Reduction contributions for the reimbursement of Medical Care Expenses. The Health Care FSA is an employee welfare benefit plan, as defined in ERISA and is intended to qualify as a health plan under Code section 105(e). This document is intended to satisfy the written plan document requirement of Treasury Regulation section 1.105-11(b)(1)(i). To the extent necessary, other provisions of the Plan are incorporated by reference herein.

(a) Eligibility. All Employees who meet the eligibility requirements of Section 3.1, with the exception of Employees of Circus Circus Reno, may enroll and make elections for Health Care FSA in accordance with the Plan's procedures.

(b) Account Minimum. The minimum annual contribution is the $120.

(c) Account Maximum. The maximum annual contribution is $2,000. If an Employee and Spouse both work for the Employer, each may contribute the maximum to separate accounts. Medical Care Expenses for each covered Dependent may be claimed once. If an Employee is hired mid-year, the account maximum shall be prorated based on the number of pay periods remaining in the Participant's Period of Coverage. If a Participant elects to participate in the Health Care FSA, he or she must determine the total amount of his or her annual contribution during the Employee's initial or annual enrollment.

(d) Uniform Coverage and Irrevocability. A Participant has immediate access to the total amount of the annual contribution on the first day that the Participant's election is effective. The entire annual election may be reimbursed for Medical Care Expenses (minus any amounts already reimbursed), regardless of the amount actually in the Participant's account at the time. An election to participate in the Health Care FSA is irrevocable for the duration of the Plan Year except as permitted in connection with a Qualifying Life Event.

(e) Tax Considerations. The amount allocated to this account may be used to reimburse Medical Care Expenses which may also qualify for a medical deduction for federal income tax purposes. A Participant who participates in this account cannot claim any Medical Care Expenses that are reimbursed through this account as a deduction on his or her federal income tax return.

(f) Health FSA Exclusions. The following items are not considered Medical Care Expenses under the Code and/or for purposes of the Health Care FSA:

(i) Drugs obtained in an illegal way.

(ii) Controlled substances if the substance violates federal law, even if prescribed by a physician.

(iii) Vitamins or dietary nutritional supplements available without prescription.

(iv) Insurance premiums of any kind including those for health maintenance organizations, life insurance, long term care, loss of earnings, accidental death or dismemberment, automobile insurance, and group medical or other health insurance.

(v) Cosmetic surgery or other similar procedures unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.

(vi) Funeral or burial expenses.

(vii) Household and domestic help (even though recommended by a qualified physician due to the Participant's or Dependent's inability to perform physical housework).

(viii) Custodial care.

(ix) Massage therapy unless prescribed by a physician to treat a specific injury or trauma.

(x) Costs for sending a child to a special school for benefits the child may receive from the course of study and disciplinary methods.

(xi) Health club dues with respect to general membership.

(xii) Weight loss drugs or programs unless for a specified disease diagnosed by a physician such as: obesity, heart disease, or diabetes.

(xiii) Social activities, such as dance lessons, even if recommended by a qualified physician for general health improvement.

(xiv) Swimming lessons, even if recommended by a physician for general health.

(xv) Maternity clothes.

(xvi) Diaper service or diapers.

(xvii) Uniforms or special clothing, such as maternity clothing.

(xviii) Transportation expenses not primarily for and essential to medical care.

(xix) Home or automobile improvements or other similar capital expenses to the extent that they appreciate value of personal assets.

(xx) Teeth bleaching.

(xxi) Exercise equipment or programs unless prescribed by a doctor to treat a specific medical condition.

(xxii) Qualified long-term care services or nursing home services.

(xxiii) Capital expenses.

(xxiv) Household improvements to treat allergies.

(xxv) DNA collection and storage.

(xxvi) House improvements (i.e., exit ramps, widening doorways).

(xxvii) Mattresses, even if to treat a medical condition.

(xxviii)Personal use items (i.e., shampoo, hand lotion).

(xxix) Special foods needed to treat a special illness or ailment, even if prescribed by a physician and do not substitute normal nutritional requirements.

(xxx) Over-the counter or nonprescription drugs or items unless specifically permitted under applicable law, regulations, or other guidance issued by the relevant government agency(ies).

(xxxi) Other items not described in Code section 213(d).

(g) Funding. The Participant must complete a Salary Reduction agreement to specify the amount of his or her Health Care FSA contributions. Thereafter, the Participant's Health Care FSA shall be credited with the portion of compensation that the Participant has elected to forgo through Salary Reduction. These portions shall be credited as of each pay period.

(h) Claims Procedures for Health Care FSAs. The following claims procedures apply to the Health Care FSA, but do not supersede the claims procedures provided elsewhere in the Plan.

(i) Time to Submit Claims. All claims for reimbursement must be submitted on or before March 31 of the year following the end of the Plan Year. Amounts for which claims were not submitted by March 31 shall be forfeited.

(ii) Procedures for Submitting Claims. A Participant may elect automatic reimbursement, meaning that medical and/or dental expenses that are not covered by the Medical or Dental Plan in which the Employee is enrolled shall be forwarded for payment under the Health Care FSA. For all other Medical Care Expenses, the Participant must submit a claim form to the Claims Administrator and provide any required proof as requested. Claims may be submitted as Medicare Care Expenses are incurred during the Plan Year. Eligible Health Care FSA expenses shall be reimbursed as long as the amount requested is at least $25 and the amount does not exceed the limit of the Participant's contributions for the year, including any prior withdrawals and any availability restrictions. The $25 minimum claim requirement shall be waived at the end of the Plan Year to assure that the Participant receives the tax benefit of all eligible expenses, up to the contribution limit for the year.

(iii) Qualified Reservist Distributions. A Participant may make a written request to the Plan Administrator or its delegate for a Qualified Reservist Distribution.

A Qualified Reservist Distribution shall not be made based on an order or call to active duty of any individual other than the Employee. After a Participant requests a Qualified Reservist Distribution and before the Plan Administrator may distribute an amount, the Plan Administrator must first receive a copy of the order or call to active duty.

The balance that can be distributed is limited to the amount of the Participant's actual payroll deductions made as of the date of the request (i.e., the amount contributed to the Health Care FSA as of that date), less any amount that has already been disbursed for valid claims received as of the date of the request.

The Plan Administrator shall pay the Qualified Reservist Distribution to the Participant within a reasonable time, but not more than sixty (60) days, after the request for the Qualified Reservist Distribution has been made.

After requesting a Qualified Reservist Distribution in a Plan Year, the Participant may not, for that Plan Year, request any more Qualified Reservist Distributions or submit any further claims for reimbursement with respect to Medical Care Expenses incurred after the date the Qualified Reservist Distribution is requested.

(i) Termination of Participation. A Participant shall cease participation in the Health Care FSA when he or she is no longer eligible to participate, when the Participant revokes his or her election to participate in the Health Care FSA, or when the Participant terminates employment or dies unless the Participant elects continuation coverage.

16.3 Dependent Care Spending Account. The Dependent Care FSA allows a Participant to receive benefits in the form of pre-tax reimbursement for Dependent Care Expenses incurred on behalf of one or more of his or her Dependents. A notational account is established on behalf of each Employee who elects the Dependent Care FSA to which the Participant allocates Salary Reduction contributions for the reimbursement of Dependent Care Expenses. The Dependent FSA is not subject to ERISA. The Dependent Care FSA is intended to qualify as a dependent care assistance provision under Code section 129. This document is

intended to satisfy the written plan document requirement of Code section 129(d)(1). To the extent necessary, other provisions of the Plan are incorporated by reference herein.

(a) Eligibility. All Employees who meet the eligibility requirements of Section 3.1, with the exception of Employees of Circus Circus Reno, may enroll and make elections for the Dependent Care FSA in accordance with the Plan's procedures.

(b) Account Minimum. The minimum annual contribution is $120.

(c) Account Maximum. The maximum annual contribution is $5,000, subject to the limitations set forth below. The Participant may not be reimbursed in excess of the contributions made at any point in time. Once Dependent Care Expenses are incurred, the Participant may file a claim and be reimbursed for up to the maximum amount of the Participant's account balance. If a Participant elects to participate in the Dependent Care FSA, he or she must determine the total amount of his or her annual contribution amount during the Employee's initial or annual enrollment.

If the Participant's Spouse has a Dependent Care Spending Account through his/her Employer, the combined contribution cannot be more than the account maximum. If the Participant and Spouse both work for the same Employer, both may contribute to the account, but may not contribute more than the account maximum.

(d) Maximum Reimbursement Available. The Participant can be reimbursed for up to the least of the following amounts: (a) the year-to-date amount that has been withheld from the Participant's compensation for the Dependent Care FSA less any prior reimbursements for Dependent Care Expenses during the Period of Coverage; (b) $5,000 (or $2,500 for a married Participant filing a separate federal income tax return); or if less (c) the Participant's Earned Income (or if less, the Participant's Spouse Earned Income, if the Participant was married at the end of his or her tax year).

Reimbursements payable under the Plan to each highly compensated employee, as defined in Code section 414(q), are limited to the extent necessary to avoid violating Code section 129(d)(8).

(e) Irrevocability Rule. An election to participate in the accounts is irrevocable for the duration of the Plan Year except as permitted in connection with a Qualifying Life Event or a change in cost or coverage as provided in Section 16.3(i). The Participant cannot reduce his or her election for Dependent Care FSA to a point where the annualized contribution is less than the amount already reimbursed. Any change in an election affecting the Dependent Care FSA pursuant to this Section shall also change the maximum reimbursement benefit for the Period of Coverage remaining in the Plan Year. The maximum reimbursement benefit following an election change is calculated as follows:

Balance (if any) remaining in the reimbursement account as of the end of the portion of the Plan Year immediately preceding the change in election.

\+ Plus total contributions the Participant is scheduled to make for the remainder of the Plan Year as affected by the election change.

Maximum reimbursement benefit for Period of Coverage remaining in the Plan Year.

(f) Dependent Care FSA Exclusions. The following items are not considered Dependent Care Expenses under the Code and/or for purposes of the Dependent Care FSA:

(i) Payments to the Participant's child who is under age 19 and who is caring for a younger child.

(ii) Tuition expenses for schooling in the first grade or higher.

(iii) Food or clothing expenses.

(iv) Overnight camp expenses.

(v) Expenses in excess of the Participant's taxable income or that of the Participant's Spouse, whichever is less.

(vi) Expenses incurred when the Participant is not working.

(vii) Expenses incurred prior to the coverage date or after the Plan Year ends.

(viii) Expenses claimed as a deduction or credit for federal or state tax purposes.

(ix) Expenses incurred if the Participant's Spouse is not engaged in gainful employment during the hours dependent care is needed, the Spouse is not a full-time student and the Spouse is not physically or mentally disabled or otherwise incapable of caring for Dependent(s).

(x) Any expenses that do not qualify under Code section 21.

(g) Funding. The Participant must complete a Salary Reduction agreement to specify the amount of his or her Dependent Care FSA contributions. Thereafter, the Participant's Dependent Care FSA shall be credited with the portion of compensation that the Participant has elected to forgo through Salary Reduction. These portions shall be credited as of each pay period.

(h) Claims Procedures for Dependent Care FSAs. The following claims procedures apply to the Dependent Care FSA.

(i) Time to Submit Claims. All claims for reimbursement must be submitted on or before March 31 of the year following the end of the Plan Year. Amounts for which claims were not submitted by March 31 shall be forfeited.

(ii) Procedures for Submitting Claims. When the Participant incurs a Dependent Care Expense, the Participant may submit a claim to the Claims Administrator on a claim form. The Participant must attach a receipt from the qualified caregiver indicating the services provided and the tax identification number or social security number of the caregiver.

(iii) Reimbursements After Termination. When a Participant terminates participation in the Dependent Care FSA, the Participant's Salary Reductions shall terminate. On and after the date the Participant terminates participation in the Plan, the Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred during the Period of Coverage prior to his or her termination and may also claim reimbursement for any Dependent Care Expenses incurred after his or her termination and through the last day of the Plan Year of the termination.

(i) Change in Coverage or Cost. A Participant may make a prospective election change with respect to the Dependent Care FSA that is on account of and corresponds with a change by the Participant in the dependant care service provider. For example:

(i) If the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and

(ii) If the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, the Participant may cancel coverage.

The "Change in Cost" provision applies to Dependent Care FSA only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code section 152.

16.4 Premium Conversion. The premium conversion feature of the Plan allows Participants to elect to pay for his or her share of the premiums for medical, vision, dental, voluntary employee life, voluntary disability and supplemental insurance coverage under the Plan, on a pre-tax salary reduction basis or elect cash, in the manner prescribed by the Plan Administrator. An election to participate in the premium conversion feature of the Plan is irrevocable for the duration of the Plan Year except as permitted in connection with a Qualifying Life Event.

ARTICLE XVII

PLAN ADMINISTRATION

17.1 Plan Administrator. It shall be the principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of Participants and by operating the Plan uniformly for similarly-situated individuals. The Company shall have the authority to remove itself as Plan Administrator and appoint a new Plan Administrator from time to time by action of the Company's Board of Directors.

17.2 Powers and Authority of Plan Administrator. The Plan Administrator shall have sole discretionary power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator's powers shall include, but shall not be limited to, the discretion to do the following, in addition to any other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;

(b) the discretionary authority and the exclusive right to interpret the Plan and other documents, to decide questions and disputes, to supply omissions, and to resolve inconsistencies and ambiguities arising under the Plan and other documents, which interpretations and decisions shall be final and binding for the purposes of the Plan and to decide any matters arising in connection with the administration and operation of the Plan;

(c) To appoint such agents, counsel, accountants, consultants and other persons (regardless of whether they also provide services to the Employer) as may be required to assist in administering the Plan;

(d) To allocate and delegate its responsibilities under the Plan and to designate other persons from time to time to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing;

(e) To request and obtain information and records from the Participant or any other party as it deems necessary and proper in its sole discretion for any purpose under the Plan, and to require that Participants provide proof of eligibility for coverage or benefits under the Plan as a condition to being eligible for coverage or benefits, with such proof including, among other things, submission to an examination by a physician of the Plan Administrator's choice, evidence of marital status, dependent status, or other status, or other documentation or evidence, as determined in its sole discretion;

(f) To develop enrollment forms and any other forms or processes necessary for Plan administration; and

(g) To make such administrative or technical amendments to the Plan as may be reasonable necessary or appropriate to carry out the intent of the Company, including such

amendments as may be required or appropriate to satisfy the requirements of the Code and ERISA and the rules and regulations from to time in effect under any such laws, or to conform the Plan with other governmental regulations or policies. [5]

The Plan Administrator has sole and complete discretionary authority in the exercise of all of its powers and duties as to invoke the arbitrary and capricious standard of review as opposed to the de novo standard. All actions and determinations of the Plan Administrator shall be final and binding.

17.3 Plan Administrator and Claims Administrator Decisions Final. Except to the extent that a Claims Administrator has discretionary authority as provided below, the Plan Administrator shall have the discretionary authority to determine eligibility for benefits, to interpret the Plan, to make factual determinations under the Plan, and to decide claims under the terms of the Plan. A Claims Administrator shall have the discretionary authority to determine eligibility for benefits, to interpret the terms of any documents describing and/or governing the Benefits for which it has claims administration responsibility and to decide claims. Subject to applicable law, any interpretation of the provisions of the Plan (including any Summary Plan Description) and any decisions on any matter within the discretion of the Plan Administrator or the Claims Administrator, as the case may be, made in good faith shall be binding on all persons. A misstatement or other mistake of fact shall be corrected when it becomes known, and the Plan Administrator shall make such adjustment on account thereof as it considers equitable and practicable. Neither the Plan Administrator nor the Claims Administrator shall be liable in any manner for any determination of fact made in good faith.

17.4 Records and Reports. Subject to the provisions of Article XVII, the Plan Administrator shall direct the Employer to maintain such records of its activities and of Participants and operations as it deems necessary and appropriate, and shall comply with all reporting requirements. Plan records pertaining to the Employer or its Employees (subject to any confidentiality protections required by law or established by the Plan Administrator's rules) shall be available for examination by the Plan Administrator at reasonable times during normal business hours. Plan records pertaining to a Participant shall be available for examination by such Participant upon written request at reasonable times during normal business hours.

The Plan Administrator and its delegates shall make such reports to the Employer as the Employer or the Plan fiduciaries shall reasonably request, and such reports to government authorities as applicable law shall require.

17.5 Reliance on Information. The Plan Administrator, and any person or entity authorized to act on its behalf, shall be entitled to rely on the accuracy and genuineness of any written materials, directions or documents furnished by or on behalf of any Employee or the Employer (unless the Plan Administrator has actual knowledge that such written item is inaccurate or is not genuine) and shall be fully protected in acting or relying in good faith thereon. The Plan Administrator shall have no obligation to take any action upon the occurrence

[5] BHFS Comment: Please confirm it is the Company's intent for the Plan Administrator to make such amendments without the Board's or its designee's involvement.

of any event unless and until it has received proper and satisfactory evidence of such occurrence. The Benefits payable under the Plan to or on behalf of a Participant are conditioned on the Participant's furnishing full, true and complete documents, data or other information reasonably related to the administration of the Plan requested by the Plan Administrator.

17.6 Indemnification of Plan Administrator. The Plan Administrator and any person or entity authorized to act on its behalf, shall be indemnified by the Employer against any and all liabilities, damages, costs and expenses (including reasonable attorney's fees) incurred by it by reason of any act or failure to act of the Plan Administrator made in good faith and consistent with the provisions of the Plan in the administration of the Plan, including costs and expenses incurred in defense or settlement of any claim relating thereto.

ARTICLE XVIII

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

18.1 Use and Disclosure of Protected Health Information (PHI). The following provisions of this Article XVIII apply only with respect to any Health Care Component of the Plan that is a "covered entity" for purposes of HIPAA. The Plan and the Company shall use and disclose PHI to the extent of and in accordance with the uses and disclosures required and permitted by 45 C.F.R. Parts 160 and 164 of HIPAA. This includes the right to use or disclose PHI for payment, treatment and health care operations. The Plan shall disclose PHI to the Company only in accordance with 45 C.F.R. Section 164.504(f) and this Article XVIII.

18.2 Definitions. Whenever used in this Article XVIII, the following terms shall have the respective meanings set forth below.

(a) "Health Care Operations" include, but are not limited to, the following activities:

(i) conducting quality assessment and improvement activities;

(ii) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(iii) rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(iv) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);

(v) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(vi) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies; and

(vii) business management and general administrative activities of the Plan, including, but not limited to:

(A) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

(B) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers provided that PHI is not disclosed to such policyholder, plan sponsor or customer;

(C) resolution of internal grievances;

(D) the sale, transfer, merger or consolidation of all or part of the Plan with another covered entity (as defined in 45 C.F.R. Section 160.103) or an entity that following such activity shall become a covered entity and due diligence related to such entity;

(E) creating de-identified health information in a limited data set, in accordance with 45 C.F.R. Section 1640.514; and

(viii) fundraising for the benefit Plan.

(b) "Individually Identifiable Health Information" means information that is a subset of health information, including demographic information collected from an individual, and: (i) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of the health care to an individual; and (iii) that identifies the individual; or (4) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(c) "Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of benefits under the Plan. These activities include, but are not limited to, the following:

(i) determination of eligibility or coverage (including coordination of benefits) and cost sharing amounts;

(ii) adjudication or subrogation of health benefit claims (including appeals and other payment disputes);

(iii) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(iv) billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess loss insurance) and related health care data processing;

(v) review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;

(vi) utilization review, including precertification and preauthorization of services, concurrent and retrospective review of services; and

(vii) disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed name and address, date of birth, social security number, payment history, account number and name and address of the provider and/or health plan).

(d) "Plan Administrative Functions" means administrative functions performed by the Company on behalf of the Plan, which are limited to those functions listed under the definition of "Payment" and "Health Care Operations." Plan Administrative Functions do not include functions performed by the Company in connection with any other benefit or benefit plan of the Company.

(e) "PHI" means Individually Identifiable Health Information that is transmitted or maintained electronically, or any other form or medium.

(f) "Privacy Official" shall mean the individual appointed by the Company pursuant to 45 C.F.R. Section 164.530(a)(1)(i) who is responsible for the development and implementation of the Company's privacy policies and procedures.

18.3 Disclosures of PHI to the Company. The Plan hereby incorporates the provisions listed in Section 18.4 below to enable it to disclose PHI to the Company and acknowledges receipt of written certification from the Company that the Plan has been so amended.

18.4 Company Compliance with Privacy Conditions. Pursuant to 45 C.F.R. Section 164.504(f)(2)(ii), the Company agrees to:

(a) not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law;

(b) ensure that any agents, including subcontractors, to whom it provides PHI received by the Plan agree to the same restrictions and conditions that apply to the Company with respect to such PHI;

(c) not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

(d) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Company unless authorized by an individual;

(e) report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which the Company becomes aware;

(f) make PHI available to an individual in accordance with the access requirements, as described in 45 C.F.R. Section 164.524;

(g) make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. Section 164.526;

(h) make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. Section 164.528;

(i) make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and

(j) if feasible, return or destroy all PHI received from the Plan that the Company still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

18.5 Company Compliance with Security Conditions. Pursuant to 45 C.F.R. Section 164.314(b)(1), the Company agrees to:

(a) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

(b) ensure that adequate separation required by 45 C.F.R. Section 164.502(f)(2)(iii) is supported by reasonable and appropriate security measures;

(c) ensure that any agent or subcontractor to whom it provides PHI agrees to implement reasonable and appropriate security measures to protect the information; and

(d) report to the Plan any security incident of which it becomes aware.

18.6 Separation Between the Plan and the Company. The Plan shall only disclose PHI to the following employees: the Privacy Official and those individuals who assist in the administration of the Plan at the Employer.

18.7 Limitations on PHI Access and Disclosure. The persons described in this Article may only have access to and use and disclose PHI for Plan Administrative Functions and as required by law. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

18.8 Noncompliance Issues. If the Company becomes aware of a violation of this Article XVIII, the Company shall inform the Privacy Official, who shall cause the violation to be investigated and shall determine in accordance with the Plan's privacy policies and procedures what sanctions, if any, shall be imposed.

ARTICLE XIX

AMENDMENT AND TERMINATION

19.1 Amendment of the Plan. The Company shall have the sole discretionary right to modify or amend the Plan in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by its Board of Directors or the Board's designee and duly executed on behalf of the Company.

19.2 Termination of the Plan. The Company shall have the sole discretionary right to terminate the Plan at any time as designated by a written instrument adopted by its Board of Directors or the Board's designee and duly executed on behalf of the Company. With respect to any portion of the Plan that has been terminated, the rights of persons covered by the Plan at that time shall be limited to benefit claims incurred as of the date of Plan termination.

ARTICLE XX

MISCELLANEOUS PROVISIONS

20.1 Limitation of Rights. The establishment, maintenance and provisions of the Plan shall not be considered or construed: (a) as giving to any Employee any right to continue in the employment of the Employer; (b) as limiting the right of the Employer to discipline or discharge any of its Employees; (c) as creating any contract of employment between the Employer and any Employee; or (d) as conferring any legal or equitable right against the Plan Administrator or the Employer. No Employee or other person shall have any guaranteed or vested right to receive Plan benefits.

20.2 Subrogation and Right to Recovery.

(a) Definitions. The following defined terms are used in this subsection:

(i) "Covered Expenses" means any expenses or charges reimbursed or benefits paid under the Plan.

(ii) "Covered Person" means anyone covered under the Plan, including minor Dependents.

(iii) "Recoveries" means all monies paid to the Covered Person—or to any agent, attorney or beneficiary of, or trustee for, such Covered Person—by way of judgment, settlement, or otherwise to compensate for all losses caused by an injury or sickness, whether or not said losses reflect Covered Expenses. "Recoveries" further includes, but is not limited to, recoveries for medical, dental or other expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever. All such payments received from any sources shall be deemed to be first for Covered Expenses regardless of whether the payments are so designated by the parties, and regardless of any limitations on the ability of the Covered Person to collect medical expenses from the Third Party. The Plan shall be reimbursed in full, regardless of whether the Covered Person has been made whole, before any amounts (including attorney fees and court costs) are deducted from such payments.

(iv) "Subrogation" means the Plan's right to pursue and lien upon the Covered Person's claims for medical, dental or other charges against the other person.

(v) "Third Party" means any third party including another person or a business entity.

(b) Intent and Purpose of the Plan. To the extent that conflicting Subrogation or Recovery provisions exist in an insurance contract which is an Incorporated Document, such provisions in the insurance contract shall govern. The intent and purpose of the Plan is to provide payment for those Covered Expenses not paid or payable by any Third Party. For example, a Covered Person may incur Covered Expenses due to an injury or sickness which may be caused by the act or omission of a Third Party or for which a Third Party may be responsible for payment. In such circumstances, any Recoveries or other payments due from or payable by Third Parties on account of Covered Expenses shall be the property of the Plan and, if paid directly to a Covered Person—or to an agent, attorney or beneficiary of, or trustee for, such Covered Person—up to the amount paid by the Plan, shall be held in trust for the benefit of the Plan. Failure to forward such sums received from Third Parties to the Plan shall constitute unjust enrichment of the Covered Person or other party converting such funds to its own benefit, shall create a constructive trust over such funds and shall subject such Covered Person or other constructive trustee, among other available remedies, to an equitable action by the Plan for disgorgement. Accepting benefits under this Plan for Covered Expenses automatically creates the trust for the benefit of the Plan and assigns to the Plan any rights the Covered Person may have to any Recoveries or related payments from any Third Party. To avoid unjust enrichment of any Third Party, the Plan shall be further entitled to pursue any claim that the Covered Person has against any Third Party, whether or not the Covered Person chooses to pursue that claim, and by accepting benefits under this Plan, the

Covered Person automatically assigns to the Plan the Covered Person's claims for Recoveries against such Third Party.

(c) Amount Subject to Plan's Rights to Payment. The Plan has equitable rights to receive amounts paid by Third Parties and to Subrogation and reimbursement. These rights provide the Plan with a 100%, first-dollar priority over any and all Recoveries and funds paid or payable by a Third Party to a Covered Person relative to an injury or sickness, including any amounts relating to any claim for non-medical or dental charges, attorney fees, or other costs and expenses. The Plan shall be reimbursed in full, regardless of whether the Covered Person has been made whole, before any amounts (including attorney fees and court costs) are deducted from such payments. The Plan's rights hereunder are limited to the extent to which the Plan has made, or shall make, payments for Covered Expenses and for its court costs and attorneys' fees if the Plan needs to file suit in order to avoid unjust enrichment of the Covered Person or any Third Party.

In the sole and absolute discretion of the Plan Administrator or its designated representative, payments under the Plan shall be reduced by any Recoveries paid or owed by a Third Party if a Covered Person resolves any claim for a Recovery prior to payment by the Plan. In the event the Plan is not reimbursed in full by the Third Party determined responsible for the Covered Expenses of the Covered Person, the Plan Administrator nonetheless may deduct any outstanding amounts from any and all future Plan benefit payments. The Covered Person shall be responsible for any and all attorneys' fees or other legal costs incurred by the Covered Person in an attempt to hold a Third Party liable for the Covered Expenses.

(d) Conditions Precedent to Coverage. In the event a Covered Person incurs Covered Expenses for which a Third Party is or may be liable, an advance of Plan benefits shall be provided contingent upon each of the following terms and conditions which are deemed agreed to by each Covered Person upon enrollment in the Plan:

(i) To the extent of Covered Expenses that are or may be incurred, the Covered Person transfers his rights to any Recoveries for which a Third Party may be liable to the Plan.

(ii) The Covered Person shall promptly notify the Plan Administrator or its designee of any legal or administrative proceeding or of any negotiations which could result in payments by any Third Party for injuries or sickness which resulted in Covered Expenses as well as any potential legal claims the Covered Person may have against any Third Party resulting from the acts which caused the Covered Expenses to be incurred.

(iii) The Covered Person shall have no legal or equitable right or title to Recoveries from Third Parties as payment for costs and expenses paid or payable by the Plan and shall hold such Recoveries, up to and including the total amount paid or payable by the Plan as Covered Expenses, in trust for the Plan. Any such funds, whether obtained by action at law, settlement or otherwise, up to the amount of Covered Expenses, are the property of the Plan and shall be remitted to the Plan at the earliest opportunity.

(iv) The Covered Person shall permit Subrogation for claims that the Covered Person may have against any Third Party and, in such event, the Covered Person shall cooperate with the Plan Administrator or its designated representative, acting in the Plan Administrator's sole and absolute discretion, to assist in the collection of such claim, whether by action at law or otherwise.

(v) When a right of Recoveries exists, the Covered Person shall execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's rights as a condition to having the Plan make payments. In addition, the Covered Person shall do nothing to prejudice the right of the Plan.

The Plan shall have no obligation whatsoever to a Covered Person if these terms and conditions are not satisfied. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any Covered Expenses incurred on account of injury or sickness caused by a Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first-dollar rights hereunder, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

(vi) Recovery from another Plan under which the Covered Person is Covered. The Plan's entitlement to funds recovered or recoverable from Third Parties also applies when a Covered Person recovers under any uninsured or underinsured motorist plan (which shall be treated as Third Party coverage when recovery or Subrogation is in order), school insurance plan, homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

(e) Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

20.3 COBRA. Notwithstanding any provision of the Plan to the contrary, the Plan shall provide Participants with all health care continuation rights to which they are entitled under COBRA and, to the extent applicable, any other similar state law.

20.4 USERRA. Notwithstanding any provision of the Plan to the contrary, the Plan shall provide Participants with coverage as required by USERRA, and the applicable regulations issued and effective thereunder.

20.5 FMLA. Notwithstanding any provision of the Plan to the contrary, the Plan shall provide Participants with coverage as required by FMLA, and the applicable regulations issued and effective thereunder.

20.6 Other Federal Laws. Notwithstanding any provision of the Plan to the contrary, the Plan shall be administered at all times in accordance with the preexisting condition limitation, creditable coverage, certificate of coverage delivery, special enrollment period, notification and other applicable requirements of HIPAA.

All elections and benefits under this Plan shall be subject to all applicable non-discrimination and other rules under the Code and other applicable law (including, effective January 1, 2010, the Genetic Information Nondiscrimination Act of 2008, and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and as applicable, the Affordable Care Act). The Plan shall be administered in compliance with such rules and the Company may take any actions it considers advisable to comply with such rules.

20.7 No Assignment. To the extent permitted by law, no Benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, assignment, pledge, attachment, garnishment, execution, levy, lien or encumbrance of any kind, and any attempt to accomplish the same shall be void. Notwithstanding the foregoing, the Plan Administrator shall have the right, in its sole discretion, to accept a valid assignment for payment of Plan benefits made by a Participant to a hospital, doctor, dentist or other medical services provider.

20.8 Severability. Any provision of the Plan shall be severable, so that if any Plan provision is held to be invalid or unenforceable such invalid or unenforceable provision shall be severed from the Plan and the Plan shall operate without regard to such severed provision. In such event, the Plan shall be construed and enforced as if such severed provision had not been included herein.

20.9 Mistake or Misstatement of Fact. Any mistake of fact or misstatement of fact shall be corrected when it becomes known and proper adjustment made by reason thereof.

20.10 Governing Law. The Plan shall be construed in accordance with the laws of the State of Nevada, to the extent not preempted by federal law.

20.11 Provisions of Plan to Control. Summary Plan Descriptions shall be furnished to eligible Employees setting forth, in summary form, the essential features of the Benefits of the Plan and to whom such Benefits are payable. The Summary Plan Description may incorporate insurance documents which fully describe the various Plan Benefits. In the event of any inconsistency between the Summary Plan Description documents and the specific provisions of this document or other Plan documents (such as amendments or insurance contracts or policies maintained in conjunction with the Plan), this document and such contracts or policies shall govern.

20.12 Titles and Captions. All titles and captions used in this Plan are used as a matter of convenience and for reference only, and in no way shall they be considered in determining the scope or intent of the Plan or in interpreting or construing any Plan provisions.

20.13 Recovery of Benefit Overpayment and Effect of False Certifications. If any Plan Benefit paid to or on behalf of a Participant should not have been paid or should have been paid in a lesser amount, and the Participant or any other appropriate party fails to repay the amount promptly, the overpayment may be recovered by the Plan Administrator from the Participant, such party, or from any monies then payable by the Plan. Any such amounts that are not repaid when due may be deducted, at the direction of the Plan Administrator, from other benefits payable under this Plan with respect to the Participant or Dependent. The Plan

Administrator also reserves the right to recover any such overpayment by appropriate legal action. The Participant shall pay all costs of the Plan, including without limitation, attorneys' fees, should the Plan pursue any means available under the law to recover any amount owed to the Plan by the Participant. If an Employee falsely certifies eligibility for Plan participation or does not inform the Plan Administrator of termination of eligibility, the Employer reserves the right to take disciplinary action, including termination of employment, and the right to seek reimbursement for benefits paid on behalf of the ineligible individual. Coverage under the Medical Benefits shall not be rescinded unless the Participant performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan. The Plan shall provide advance notice of any such rescission.

20.14 Funding. The amount and timing of any Required Contributions with respect to each Benefit shall be determined by the Employer from time to time. The Employer reserves the right to change the amount of Required Contributions at any time. Nothing herein requires any Employer to contribute with respect to any Benefit, or to maintain any fund or segregate any amount for the benefit of any Participant or beneficiary, except to the extent specifically required. Benefits under the Plan may be provided in the sole discretion of the Employer through a trust, one or more insurance contracts and/or HMO contracts, or directly from the assets of the Employer. The cost of each Benefit is paid by the Employer and/or Employees as determined by the Employer from time to time in the Employer's discretion.

20.15 Treatment of Certain Policy Payments. Where an insurance policy provides for payment of premiums directly from the Employer, unless the insurance policy states otherwise, payable dividends, retroactive rate adjustments, experience refunds or rebates are not plan assets. These dividends, retroactive rate adjustments, experience refunds or rebates are Employer property, which the Employer may retain to the extent they do not exceed the Employer's aggregate contributions to the Plan cost made from its own funds.

20.16 Benefits. Benefits shall be paid solely in the form, in the amount, and pursuant to the terms of the Plan including the Incorporated Documents.

20.17 Limitations on Liability for Benefits.

(a) Source of Benefits For Fully Insured Benefits. All Benefits that are fully insured shall be paid or provided for under the Plan solely by the insurance company or other entity contractually responsible to pay for or to provide such benefits. The Employer assumes no liability or responsibility with respect to any obligor and does not guarantee that such Benefits shall be payable or paid, or that any Benefit shall be funded. Benefits provided under a fully insured Plan shall be provided only to the extent any Benefit continues to be maintained.

(b) Benefits Limited. Nothing contained in this Plan is intended to obligate the Employer, the Plan, or the named fiduciaries to provide benefits or any other item of value other than as provided in accordance with the terms of the Benefit. Further, notwithstanding any provision in the Plan or of any documents governing the Benefits to the contrary, neither the Employer, the Plan, nor the named fiduciaries guarantee that benefits shall be provided at a level sufficient to satisfy any particular community or other standard of "medical necessity."

(c) Limitation of Rights to Benefits. No Employee, Participant, former Participant or other interested person shall acquire by reason of the Plan any right in or title to any assets, funds or property of the Plan or any Employer. No Employer, employee, officer, director, agent or member of the Employer guarantees in any manner the payment of Plan Benefits.

IN WITNESS WHEREOF, MGM Resorts International has caused this amended and restated Plan to be executed below by its duly authorized representative this _____ day of _____, 2013, to be effective as of the Effective Date set forth herein.

MGM RESORTS INTERNATIONAL

By:_____

Its:_____

ATTEST:

By:_____

Its:_____

APPENDIX A

INCORPORATED DOCUMENTS[6]

APPLICABLE DOCUMENT	APPLICABLE BENEFIT
Contract between the Company and Blue Cross Blue Shield	Medical Benefits
Summary Plan Description for the Direct Care Health Plan	Medical, Prescription Drug, Dental and Vision Benefits
Summary Plan Description for the Preferred Provider Organization	Medical, Prescription Drug, Dental and Vision Benefits
Summary Plan Description for the Health Maintenance Organization	Medical, Prescription Drug, Dental and Vision Benefits
Contract between the Company and Liberty Dental Plan of Nevada, Inc. and Evidence of Coverage	Dental Benefits
Contract between the Company and EyeMed Vision Care and Evidence of Coverage	Vision Benefits
Wellness Plan Policy Issued: May 21, 2012	Wellness Program
Contract between the Company and UMR Care Management	
Contract between the Company and ComPsych®	Employee Assistance Program
Contract between the Company and GuidanceResources	
Contract between the Company and CIGNA	
Contract between the Company and Harmony Healthcare	
Contract between the Company and Health Plan of Nevada, Inc.	
Insurance Policy issued by Sun Life Assurance Company of Canada and Certificates of Coverage for the	Life, Dependent Life, Accidental Death &

[6] CJW@BHFS comment: Please review and edit as needed.

Insurance Policy issued by Sun Life Assurance Company of Canada and Employee Group Benefits Booklets	Dismemberment, Short-Term Disability and Long-Term Disability Benefits
Insurance Policy issued by AFLAC	Supplemental Insurance Benefits

All references to the Contracts and Insurance Policies shall include all applicable amendments and riders.

This Appendix shall be subject to modification without formal amendment to the Plan.

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

ORDER ON PLAINTIFFS' MOTION TO STRIKE DEFENDANTS' FOURTH AND FIFTH SUPPLEMENTS TO NRCP 16.1 DISCLOSURES

Plaintiffs' Motions to Strike Defendants' Fourth and Fifth Supplements to NRCP 16.1 disclosures having come on for hearing before this Honorable Court on the 10th day of October, 2019, at 1:30 p.m., with KIMBALL JONES, ESQ. and JACOB G. LEAVITT, ESQ. with the Law Offices of **BIGHORN LAW**, appearing on behalf of Plaintiffs, and THOMAS J. DOYLE, ESQ., CHAD C. COUCHOT, ESQ. and AIMEE CLARK NEWBERRY, ESQ., with the Law Offices of **SCHUERING**

Case Number: A-16-739464-C

ZIMMERMAN & DOYLE, LLP, appearing on behalf of Defendants, and with the Honorable Court having reviewed the pleadings and papers on file herein and with hearing the arguments of counsel:

Discovery in this matter closed on July 24, 2019. Defendants submitted their Fourth Supplement to NRCP 16.1 Disclosure of Witnesses and Documents on September 12, 2019— fifty (50) days after the close of discovery. On September 23, 2019, Defendants submitted their Fifth Supplement to NRCP 16.1 Disclosure of Witnesses and Documents. The witnesses were known prior to the close of discovery or should have been known based on the Records, documents, and Facts of the case, JLL

As to the witnesses disclosed in Defendants' 4th and 5th Supplemental NRCP 16.1 disclosures, the Court found Defendants' late disclosure was not "harmless" and Defendants did not meet their burden of proving the disclosures was substantially justified.

The striking of these untimely disclosed supplements is supported by NRCP 37(c)(1), which states, "(1) A party that without substantial justification fails to disclose information required by Rule 16.1, 16.2, or 26(e)(1), or to amend a prior response to discovery as required by Rule 26(e)(2), is not, unless such failure is harmless, permitted to use as evidence at a trial, at a hearing, or on a motion any witness or information not so disclosed. In addition to or in lieu of this sanction, the court, on motion and after affording an opportunity to be heard, may impose other appropriate sanctions. In addition to requiring payment of reasonable expenses, including attorney's fees, caused by the failure, these sanctions may include any of the actions authorized under Rule 37(b)(2)(A), (B), and (C) and may include informing the jury of the failure to make the disclosure."

As Plaintiffs were harmed by this late disclosure of witnesses, and as Defendants were unable to justify their late submission, ~~the~~ AND NO Alternative Relief would be applicable in light of the trial date of the medical malpractice case, JLL the witnesses and documents disclosed therein (not including expert reports) are properly stricken and excluded from trial. Regarding the supplemented expert reports, the Court will not strike the reports, but the experts are not permitted to expound upon the opinions therein.

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THEREFORE, IT IS HEREBY ORDERED that Plaintiffs' Motion to Strike Defendants' Fourth and Fifth Supplements to NRCP 16.1 Disclosures is GRANTED IN PART AND DENIED IN PART.

IT IS FURTHER ORDERED that the witnesses and documents, excepting Defendants' supplemental expert reports, are hereby stricken; the witnesses may not be called and the documents may not be used at trial.

IT IS FURTHER ORDERED that Defendants' supplemental expert reports are not stricken, though the experts are not permitted to expound upon the opinions therein.

DATED this 21 day of October, 2019.

DISTRICT COURT JUDGE

Respectfully Submitted By:	Approved as to Form and Content By:
BIGHORN LAW **HAND & SULLIVAN, LLC** **KIMBALL JONES, ESQ.** **JACOB G. LEAVITT, ESQ.** 716 S. Jones Blvd. Las Vegas Nevada 89107 *&* **GEORGE F. HAND, ESQ.** 3442 N. Buffalo Drive Las Vegas, Nevada 89129 Phone: (702) 656-5814	**SCHUERING ZIMMERMAN & DOYLE, LLP** **MANDELBAUM ELLERTON & ASSOCIATES** **KIM MANDELBAUM, ESQ.** 2012 Hamilton Lane Las Vegas, Nevada 89106 *&* **THOMAS J. DOYLE, ESQ.** **CHAD C. COUCHOT, ESQ.** 400 University Avenue Sacramento, California 95825 *Attorneys for Defendants*

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

PLAINTIFFS' TRIAL BRIEF REGARDING IMPROPER ARGUMENTS, INCLUDING "MEDICAL JUDGMENT," "RISK OF PROCEDURE" AND "ASSUMPTION OF RISK"

COME NOW Plaintiffs PATRICK FARRIS and TITINA FARRIS, by and through their attorneys of record, KIMBALL JONES, ESQ. and JACOB G. LEAVITT, ESQ., with the Law Offices of **BIGHORN LAW** and GEORGE F. HAND, ESQ., with the Law Offices of **HAND & SULLIVAN**, LLC, and hereby submit this Trial Brief Regarding Improper Arguments, Including "Medical Judgment," "Risk of Procedure" and "Assumption of Risk."

Case Number: A-16-739464-C

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

DATED this 23rd day of October, 2019.

BIGHORN LAW

By: */s/ Kimball Jones*

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MEMORANDUM OF POINTS AND AUTHORITIES

I. FACTUAL HISTORY

Plaintiff Titina Farris was a patient of Defendants. Defendant RIVES, while performing surgery on Plaintiff, negligently cut her colon. Thereafter, RIVES failed to adequately repair the colon and sanitize the abdominal cavity. RIVES then failed to recommend any surgery to repair the punctured colon for eleven (11) days, during which time Plaintiff was on the verge of death due to the predictable sepsis that ensued as a result of RIVES initial negligence. As a further result of RIVES negligence, Plaintiff developed "dropped feet" and now cannot walk without assistance.

II. DEFENDANTS ARE PROPERLY PRECLUDED FROM MAKING "MEDICAL JUDGMENT" AND "RISK OF PROCEDURE" ARGUMENTS

A. "Error in Judgment" and "Medical Judgment" Arguments are Inadmissible in Nevada.

The Nevada Supreme Court has noted that so-called "Error in Judgment" arguments are inadmissible in Nevada:

> Finally, we are asked to examine two jury instructions which, when read together, constitute a variation of the "error-in-judgment" instruction. Although respondent accurately reports that not all error-in-judgment instructions are identically phrased, **we conclude that any instruction specifying nonliability for certain errors in judgment, or the applicability of "honest" or "best" judgment, may fall under the rubric of "error-in-judgment."**
> ...
> **Upon careful reflection, we agree with the growing number of courts that have rejected the error-in-judgment instruction.**

Parodi v. Washoe Med. Ctr., Inc., 111 Nev. 365, 370, 892 P.2d 588, 591 (1995).

As such, any argument from Defendants that Defendants should not be liable because they erred in judgment, "used their best judgment," or that they gave an "honest effort" to care for Plaintiff Titina Farris is not permissible. Similarly, any suggestion to the jury that the standard of care might be based on "best judgment," "surgical judgment," or that liability is not properly found for an "error in judgment," are all equally improper given the logical conclusion that such suggestions reach. These

will obviously lead a jury to believing the state of law relates to the surgeon's "best judgment" or that an "error in judgment" is a valid defense, even though these arguments are rejected in Nevada.

B. Assumption of Risk and Risk of Procedure Arguments are Likewise Impermissible.

It is improper to argue that a surgeon's actions did not fall below the standard of care on the basis that the patient "assumed the risk" or that the complication was a "known risk."

> The assumption of risk doctrine was applied incorrectly in this instance. Primary implied assumption of risk "arises when 'the plaintiff impliedly assumes those risks that are inherent in a particular activity.' " *Turner v. Mandalay Sports Entm't,* 124 Nev. 213, 220, 180 P.3d 1172, 1177 (2008) (quoting *Davenport v. Cotton Hope Plantation,* 333 S.C. 71, 508 S.E.2d 565, 570 (S.C.1998)). It has also been described as "resulting from a relationship that a plaintiff voluntarily accepts involving a lack of duty in the defendant and known risks which the plaintiff impliedly assumes." *Mizushima v. Sunset Ranch,* 103 Nev. 259, 262, 737 P.2d 1158, 1160 (1987), *overruled in part by Turner,* 124 Nev. at 221, 180 P.3d at 1177. This situation has been most recognized where the plaintiff is a spectator or a participant in sporting events. *See Turner,* 124 Nev. 213, 180 P.3d 1172 (spectator at a baseball game); *Fortier v. Los Rios Community College,* 45 Cal.App.4th 430, 52 Cal.Rptr.2d 812 (Ct.App.1996) (student injured in football class); *Swagger v. City of Crystal,* 379 N.W.2d 183 (Minn.Ct.App.1985) (spectator at a Softball game).
>
> 1 In the matter before us, primary implied assumption of risk does not apply. A physician has a duty to render reasonable care that is expressly set forth in Nevada law. *See* NRS 41A.009; *Fernandez v. Admirand,* 108 Nev. 963, 968–69, 843 P.2d 354, 358 (1992). While there are risks that arise from engaging in drug-seeking behavior, the physician-patient relationship is not one where because of inherent risks, the patient has agreed that the physician no longer owes her a duty of care. *Turner,* 124 Nev. at 220, 180 P.3d at 1177; *see Spar v. Cha,* 907 N.E.2d 974, 982 (Ind.2009) (recognizing that primary implied assumption of the risk "has little legitimate application in the medical malpractice context" because a patient is entitled to expect that medical services be rendered in accordance with the standard of care); *see also Storm v. NSL Rockland Place, LLC,* 898 A.2d 874, 884–85 (Del.Super.Ct.2005) (noting that a primary implied assumption of the risk defense generally does not apply in the healthcare context as it would require a patient to consent to allow a healthcare provider to exercise less than ordinary care in the provision of services); *Morrison v. MacNamara,* 407 A.2d 555, 568 (D.C.1979) (noting that "because of the doctor's ability to understand and interpret medical matters, the doctor generally owes a greater duty to his patient than the patient owes to himself"). It was therefore error to enter summary judgment in this matter on the basis of primary implied assumption of risk.
>
> *Marty ex rel. Marty v. Malin,* 128 Nev. 916, 381 P.3d 638 (2012).

As such, any argument that Plaintiffs assumed any risk associated with the surgical procedures or post-operative treatment in this case is improper. Moreover, it is improper for any expert or attorney to suggest the expert did not fall below the standard of care on the basis that the associated complication was a "known risk" or that the patient "assumed the risk."

Demonstrating Plaintiffs' understanding of the risks of a procedure does not constitute that they understood and consented to Defendants' malpractice. However, there is a danger that a juror could assume that this is noted by an acknowledgement by the Plaintiffs that they understood the procedure had risks or by a showing that the Plaintiff Titina Farris signed the "risks of procedure" clause.

> [We] held that where a lack of informed consent is not in issue in a medical malpractice case, evidence of information given to the patient concerning the risks of surgery is irrelevant to the sole issue in the case: Whether the physician departed from the standard of care. We observed that such evidence "could only serve to confuse the jury because the jury could conclude ... that consent to the surgery was tantamount to consent to the injury...." *Id.* at 528–29, 593 S.E.2d at 317.
>
> *Holley v. Pambianco*, 270 Va. 180, 183, 613 S.E.2d 425, 427 (2005)

In the instant matter, like in *Holley*, Plaintiff Titina Farris' consent is simply not a material issue in this case. As such, any testimony as to whether Plaintiffs "consented" to the treatment risks prejudicing the jury against Plaintiffs by arguing that Plaintiff Titina Farris consented to the negligence Dr. Rives exhibited in treating her.

III. CONCLUSION

Any statement, argument, or suggestion that "error in judgment," "medical judgment," "honest effort," shield Defendants from liability is improper in Nevada. Such arguments are improper in the

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form of an argument, a statement by an expert, or a jury instruction. Similarly, any suggestion that Defendants are not liable due to "risk of the procedure" or because "plaintiff assumed the risk" is unfounded in medical malpractice within the State of Nevada and should not be stated in argument, by any expert or as a jury instruction.

DATED this 23rd day of October, 2019.

BIGHORN LAW

By: */s/ Kimball Jones*

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CERTIFICATE OF SERVICE

Pursuant to NRCP 5, NEFCR 9 and EDCR 8.05, I hereby certify that I am an employee of **BIGHORN LAW**, and on the 23rd day of October, 2019, I served the foregoing ***PLAINTIFFS' TRIAL BRIEF REGARDING IMPROPER ARGUMENTS, INCLUDING "MEDICAL JUDGMENT," "RISK OF PROCEDURE" AND "ASSUMPTION OF RISK"*** as follows:

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

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

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/s/ Erickson Finch
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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 NO.: A-16-739464-C DEPT. NO.: XXXI

PLAINTIFFS' TRIAL BRIEF ON REBUTTAL EXPERTS MUST ONLY BE LIMITED TO REBUTTAL OPINIONS NOT INITIAL OPINIONS

Plaintiffs PATRICK FARRIS and TITINA FARRIS, by and through their attorneys of record, KIMBALL JONES, ESQ. and JACOB G. LEAVITT, ESQ., with the Law Offices of **BIGHORN LAW** and GEORGE F. HAND, ESQ., with the Law Offices of **HAND & SULLIVAN, LLC**, and hereby submit this Trial Brief on Rebuttal Experts Must Only be Limited to Rebuttal Opinions Not Initial Opinions.

Case Number: A-16-739464-C

This Trial Brief is made and based upon all of the pleadings and papers on file herein and the attached Memorandum of Points and Authorities pursuant to EDCR 2.20 and 7.27.

DATED this 24th day of October, 2019.

BIGHORN LAW

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MEMORANDUM OF POINTS AND AUTHORITIES

I. STATEMENT OF RELEVANT FACTS

Plaintiff Titina Farris was a patient of Defendant Rives. Rives, while performing surgery on Plaintiff, negligently cut her colon in at least two (2), and possibly three (3), places. Thereafter, Rives failed to adequately repair the colon and/or sanitize the abdominal cavity. With feces actively in her abdomen, Plaintiff predictably went into septic shock and was transferred to the ICU. Nevertheless, Rives still failed to recommend any surgery to repair the punctured colon for eleven (11) days, during which time Plaintiff's organs began shutting down and her extremities suffered permanent impairment. Ultimately, Plaintiff developed critical care neuropathy, destroying all nerve function in her lower legs and feet, commonly referred to as bilateral drop foot.

The issue of limiting Dr. Adornato to rebuttal opinions only was discussed at the EDCR 2.67 conference on September 11, 2019.

On December 19, 2018, Defendants disclosed eight (8) Rebuttal experts, specifically Dr. Bruce Adornato, See *Rebuttal Expert Disclosure*, attached hereto as **Exhibit "1."**

Defendants noted that Adornato, is a "rebuttal witnesses and that their reports are being produced to "rebut" a report from Plaintiffs' initial experts:

> Dr. Adornato is a neurologist. Dr. Adornato is a rebuttal witness. He will provide opinions rebutting the opinions of plaintiffs' expert, Dr. Justin Willer.

See *Id.* at Page 3:7-8. See also *Adornato Report*, attached hereto as **Exhibit "2."**

As such, these aspects of Dr. Adornato's testimony are properly limited and this Brief is provided to support Plaintiffs' objection should Defendants seek to go outside of rebuttal opinions.

II. LEGAL SUPPORT

Rebuttal evidence is "intended **solely** to contradict or rebut evidence **on the same subject matter** identified by another party." *NRCP 16.1(a)(2)(C)(ii)*. For this reason, rebuttal witnesses are disclosed after initial witness disclosures. *Id.* This later disclosure deadline does not apply to any party's witness whose purpose is to contradict a portion of another party's case in chief **that should have been expected and anticipated by the disclosing party, or to present any opinions outside of the scope of another party's disclosure.** *Id.* (emphasis added).

Duty, breach, causation and damage opinions are all initial opinions that cannot be offered by any expert not designated as an initial expert.

Nevada's Federal Courts have repeatedly made persuasive decisions on the propriety of utilizing rebuttal experts to present new theories. These courts have declared that rebuttal expert reports are not the proper venue for presenting new arguments. Instead, rebuttal expert opinions should only address new, unforeseen issues upon which the opposing party's initial experts have opined. *Nunez v. Harper*, 2014 WL 979933, *1 (D. Nev. Mar. 11, 2014) (*citing R&O Constr. Co.*, 2011 WL 2923703 at *2). "If the purpose of expert testimony is to contradict an expected and anticipated portion of the other party's case-in-chief, then the witness is not a rebuttal witness or anything analogous to

one." *Id.* Presenting a new, alternative theory of causation is not a rebuttal opinion; rather, it is an expected and anticipated portion of a party's case-in-chief. See *Amos v. Makita U.S.A., Inc.*, 2011 WL 43092, *2 (D. Nev. Jan. 6, 2011).

Finally, a party cannot abuse the rebuttal date and use it as "an extension of the deadline by which a party must deliver the lion's share of its expert information." *Amos*, 2011 WL 43092 at *2 (citing *Sierra Club, Lone Star Chapter v. Cedar Point Oil Co., Inc.*, 73 F.3d 546, 571 (5th Cir. 1996).

In *R&O Constr. Co. v. Rox Pro Int'l Group, Ltd.*, 2011 U.S. Dist. LEXIS 78032 (D. Nev. July 18, 2011) the District Court of Nevada addressed a similar situation to that in the case at bar in which an expert who was offered by the defense to address an expected and anticipated portion of the plaintiff's case in chief was improperly disclosed as a rebuttal expert.

The court explained that:

> Fed. R. Civ. P. 26(a)(2)(C)(ii) permits the admission of rebuttal expert testimony that is "intended solely to contradict or rebut evidence on the same subject matter identified" by an initial expert witness. *TC Sys. Inc. v. Town of Colonie*, NY, 213 F.Supp.2d 171, 179 (N.D.N.Y. 2002). Rebuttal expert reports "necessitate 'a showing of facts supporting the opposite conclusion' of those at which the opposing party's experts arrived in their responsive reports." *Bone Care Int'l, LLC v. Pentech Pharmaceuticals, Inc.*, 2010 U.S. Dist. LEXIS 104549, 2010 WL 389444 (N.D. Ill. Sep. 30, 2010) (quoting *ABB Air Preheater, Inc. v Regenerative Environmental Equip., Inc.*, 167 F.R.D. 668, 669 (D.N.J. 1996). Rebuttal expert reports are proper if they contradict or rebut the subject matter of the affirmative expert report. *Lindner v. Meadow Gold Dairies, Inc.*, 249 F.R.D. 625, 636 (D. Haw. 2008). They are not, however, the proper place for presenting new arguments. *1-800 Contacts, Inc. v. Lens.com, Inc.*, 755 F.Supp.2d 1151, 1167 (D. Utah 2010); see *LaFlamme v. Safeway, Inc.*, 2010 U.S. Dist. LEXIS 98815, 2010 WL 3522378 (D. Nev. Sep. 2, 2010); cf. *Marmo v. Tyson Fresh Meats*, 457 F.3d 748, 759 (8th Cir. 2006) ("The function of rebuttal testimony is to explain, repel, counteract or disprove evidence of the adverse party.") (citation omitted). "**If the purpose of expert testimony is to 'contradict an expected and anticipated portion of the other party's case-in-chief, then the witness is not a rebuttal witness or anything analogous to one**'" *Amos v. Makita U.S.A.*, 2011 WL 43092 at *2 (D. Nev. Jan. 6, 2011) (quoting *In re Apex Oil Co.*, 958 F.2d 243, 245 (8th Cir. 1992)); see also *Morgan v. Commercial Union Assur. Cos.*, 606 F.2d 554, 556 (5th Cir. 1979); *LaFlamme*, 2010 U.S. Dist. LEXIS 98815, 2010 WL 3522378 at *3. Rather, **rebuttal expert testimony "is limited to 'new unforeseen facts brought out in the other side's case.'"** *In re President's Casinos, Inc.*, 2007 Bankr. LEXIS 4804, 2007 WL 7232932 at * 2 (E.D. Mo. May 16, 2007) (quoting *Cates v. Sears, Roebuck & Co.*, 928 F.2d 679, 685 (5th Cir. 1991)). (Emphasis added).

The bright line authority in this jurisdiction is that rebuttal expert testimony "is limited to **'new unforeseen facts brought out in the other side's case.'**" In this case it is undisputed that the causation of Plaintiffs' injuries and the future care they would require were anticipated parts of their case in chief and therefore any experts designated by the Defendants regarding the Plaintiffs' loss of earnings, should have been designated by the Initial Expert Disclosure Deadline.

The court in *R&O Constr. Co. v. Rox Pro Int'l Group, Ltd.*, 2011 U.S. Dist. LEXIS 78032 (D. Nev. July 18, 2011) explained that because the "rebuttal experts" in that case were not true rebuttal experts they were improperly disclosed. The court explained:

> While both McMullin's and Hoff's reports address the same general subject matter of the case, Hoff's report does not directly address the findings, i.e. "the same subject matter," of McMullin's report. Therefore it is not a rebuttal expert report within the meaning of Rule 26(a)(2)(C)(ii). See *Vu v. McNeil-PPC, Inc.*, 2010 U.S. Dist. LEXIS 53639, 2010 WL 2179882 at *3 (C.D. Cal. May 7, 2010) (finding that such a broad meaning would all but nullify the distinction between an initial "affirmative expert" and a "rebuttal expert."); see *International Business Machines Corp. v. Fasco Indus., Inc.*, 1995 U.S. Dist. LEXIS 22533, 1995 WL 115421 (N.D. Cal. Mar.15, 1995) ("rebuttal experts cannot put forth their own theories; they must restrict their testimony to attacking the theories offered by the adversary's experts."). McMullin's report offers opinions and conclusions regarding the structural insufficiency of the design for the installation of a stone veneer on the project, the requirement that the stone veneer installation be accomplished with an anchored system and the resulting irrelevance of the bond between stone and mortar, and R&O's role in bringing potential design deficiencies to the attention of WD Partners. By comparison, Hoff's report details theories regarding the failure of the stone and mortar, and makes observations regarding the "responsibilities" of the various players — general contractor/subcontractor and architect — with regard to installation. **The report's findings do not speak to "new unforeseen facts" brought out in McMullin's report**, see *In re President's Casinos, Inc.*, 2007 Bankr. LEXIS 4804, 2007 WL 7232932 at * 2; rather, they set forth an alternate theory, viz., that the stone failure is related to installation and mortar errors. Although causation may be demonstrated in various ways, "simply because one method fails, the other does not become "rebuttal."" See *Morgan v. Commercial Union Assur. Cos.*, 606 F.2d at 555. Nor is a rebuttal expert report the proper place for presenting new arguments. *1-800 Contacts, Inc. v. Lens.com, Inc.*, 755 F.Supp.2d at 1167. (Emphasis added).
>
> Because the report is not a rebuttal report, it is untimely and must be stricken unless Real Stone can show that the untimely disclosure was substantially justified or harmless. See *Rule 37(c)(1)*. Here, Real Stone's late disclosure is not substantially justified. Notably, it had named Hoff as an expert and provided his curricula vitae within the time limit set for the disclosure of initial experts, but it did not produce a report. Despite the

> relevant inspections having been performed on February 11 and 16, 2009, prior to the filing of the lawsuit, Real Stone does not justify its failure to timely disclose the report.
>
> As to the issue of harm, the Hoff report was not disclosed until nearly nine weeks after the initial expert cutoff date of November 10, 2010. Discovery cutoff has already been extended three times in this case, and the latest cutoff date has passed. Although no trial date has yet been set, the dispositive motion deadline was April 8, 2011. Accordingly, R&O is prejudiced by the Hoff report, because the time to designate rebuttal experts has passed, as well as the discovery cutoff and dispositive motion deadlines. A scheduling order "shall not be modified except upon a showing of good cause and by leave of . . . a magistrate judge." *Fed.R.Civ.P. 16(b)*. Real Stone did not seek an extension of the deadline to disclose initial experts, nor has it shown good cause for the failure to do so. **Accordingly, Hoff's report must be stricken**. See e.g. *Yeti by Molly*, 259 F.3d at 1107. (Emphasis added).

That causation was an expected and central component to the case precludes any rebuttal witnesses from offering faux-rebuttal testimony which opines on alternative causation opinions in their rebuttal reports:

> Rebuttal experts are not allowed to put forth their own theories; instead, "**they must restrict their testimony to attacking the theories offered by the adversary's experts**."
>
> *Downs v. River City Grp., LLC*, No. 3:11-CV-00885-LRH, 2014 WL 814303, at *5 (D. Nev. Feb. 28, 2014) (Emphasis added).
>
> Even if it is not outside that scope, the subject of the causation of the fire is an expected and anticipated portion of Defendant's case-in-chief, and therefore Hyde cannot be a rebuttal expert or anything analogous to a rebuttal expert. *Apex Oil,* 985 F.2d at 245.
>
> Allowing Hyde to testify as more than a rebuttal expert would allow Makita to use the 30 day deadline for disclosure of rebuttal experts as an extension of time for disclosing the lion's share of its expert information. See *Sierra Club,* 73 F.3d at 571. Causation of the fire is the central issue of this entire litigation. Makita knew that long before the expert disclosure deadlines.
>
> *Amos v. Makita U.S.A., Inc.*, No. 2:09-CV-01304-GMN, 2011 WL 43092, at *2 (D. Nev. Jan. 6, 2011).

Dr. Adornato cannot go outside of rebuttal testimony and offer opinions as to causation of foot drop. He was never disclosed as an initial expert and thus, cannot offer this opinion.

///

///

Dr. Adnornato's rebuttal report has improper causation opinions, however, Defendants are aware of the rules on rebuttal experts and though Plaintiffs do not think Defendants will violate the rules this brief is in support of the rules and case law governing rebuttal experts.

Expert medical causation opinions are always initial.

This resolution is strengthened by the Court's finding in *R&O*—which notes that Rebuttal Testimony is exclusively limited to "unforeseen" facts:

> **[R]ebuttal expert testimony "is limited to 'new unforeseen facts brought out in the other side's case.'"** *In re President's Casinos, Inc.*, 2007 Bankr. LEXIS 4804, 2007 WL 7232932 at * 2 (E.D. Mo. May 16, 2007) (quoting *Cates v. Sears, Roebuck & Co.*, 928 F.2d 679, 685 (5th Cir. 1991)).
>
> *R&O Constr. Co. v. Rox Pro Int'l Group, Ltd.*, 2011 U.S. Dist. LEXIS 78032 (D. Nev. July 18, 2011). (Emphasis added).

The bright line authority in this jurisdiction is that rebuttal expert testimony "is limited to **'new unforeseen facts brought out in the other side's case.'**"

Adornato's report goes outside the the rules, however, it is not certain as to whether Defendants will go outside the rules governing rebuttal opinions.

Commissioner Beecroft in this jurisdiction came to the same conclusion as the Federal Courts did in *Nunez* and *Amos*—that rebuttal experts are not to be used to establish a new case-in-chief. Commissioner Beecroft gave this opinion in a decision on an automobile crash case, *Mangus v. Abram*, A-11-634090-C, (8th Judicial District Court January 7, 2013). In *Mangus,* Defendant disclosed a biomechanical accident reconstructionist as an initial expert, and plaintiff scrambled to rebut, seeking permission to examine defendant's vehicle in order to disclose a rebuttal expert. Defendant refused, arguing that plaintiff knew prior to the initial expert disclosure deadline that defendant would enlist a biomechanical expert because defendant requested permission for his expert to inspect plaintiff's vehicle. *Id.* As a result of this disclosure, plaintiff could anticipate that the biomechanical expert would be part of defendant's case in chief and should have disclosed her *own* initial biomechanical expert

instead of abusing the rebuttal process to compensate for her oversight. Commissioner Beecroft not only denied plaintiff's motion to compel inspection of defendant's vehicle, but went further, striking plaintiff's biomechanical rebuttal expert altogether on the grounds that plaintiff should have disclosed said expert as initial. *Id.*

III. CONCLUSION

Based on the above, Plaintiffs submit this Trial Brief as a support on limitation of Rebuttal Experts.

DATED this 24th day of October, 2019.

BIGHORN LAW

By: */s/ Jacob G. Leavitt*

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CERTIFICATE OF SERVICE

Pursuant to NRCP 5, NEFCR 9 and EDCR 8.05, I hereby certify that I am an employee of **BIGHORN LAW**, and on the 24th day of October, 2019, I served the foregoing ***PLAINTIFFS' TRIAL BRIEF ON REBUTTAL EXPERTS MUST ONLY BE LIMITED TO REBUTTAL OPINIONS NOT INITIAL OPINIONS*** as follows:

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

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

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/s/ Erickson Finch
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EXHIBIT "1"

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

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al., Defendants.	CASE NO. A-16-739464-C DEPT. NO. 31 **DEFENDANTS BARRY J. RIVES, M.D. AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S REBUTTAL DISCLOSURE OF EXPERT WITNESSES AND REPORTS**

Defendants BARRY J. RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC ("Defendants") hereby disclose pursuant to Nevada Rules of Civil Procedure Rule 26 and 16.1 the name of their rebuttal expert witnesses who may be called at trial.

///

///

RETAINED EXPERTS

1. Bart Carter, M.D., P.C.
2240 West 16th Street
Safford, AZ 85546

Dr. Carter is a general surgeon and will testify as to the issues relating to the standard of care, causation and damages, if any. Dr. Carter's initial report, curriculum vitae including publication history, fee schedule and testimony history were previously disclosed. His rebuttal report is attached hereto as Exhibit A.

2. Brian E. Juell, M.D.
6554 S. McCarran Blvd., Suite B
Reno, Nevada 89509

Dr. Juell is a general surgeon and will testify as to the issues relating to the standard of care, causation and damages, if any. Dr. Juell's initial report, curriculum vitae including publication history, fee schedule and testimony history were previously disclosed. His rebuttal report is attached hereto as Exhibit B.

3. Lance Stone, D.O.
484 Lake Park Avenue
Oakland, CA 94610

Dr. Stone is a physician medicine and rehabilitation specialist. Dr. Stone is a rebuttal witness. He will provide opinions rebutting the opinions of plaintiffs' experts, Dr. Alex Barchuk and Dawn Cook. His opinions are described in his attached report and the life care plan prepared by Sarah Larsen. Dr. Stone's report, curriculum vitae including publication history, and fee schedule are attached hereto as Exhibit C. Dr. Stone was asked to identify the matters he has testified in during the prior four years. Dr. Stone indicated he does not maintain a list of testimony. He recalled having given approximately five depositions during the past four years. The only matter in which he could recall the name of the case was *Baxter v. Dignity Health*.

4. Sarah Larsen, RN
Olzack Healthcare Consulting
2092 Peace Court
Atwater, CA 95301

Ms. Larsen is an life care planner. Ms. Larsen is a rebuttal witness. She will provide opinions rebutting the opinions of plaintiffs' expert, Dawn Cook. Ms. Larsen's report, curriculum vitae including publication history and list of deposition/trial testimony and fee schedule are attached hereto as Exhibit D.

5. Bruce Adornato, M.D.
177 Bovet Road, Suite 600
San Mateo, CA 94402

Dr. Adornato is a neurologist. Dr. Adornato is a rebuttal witness. He will provide opinions rebutting the opinions of plaintiffs' expert, Dr. Justin Willer. Dr. Adornato's report, Curriculum Vitae including publication history, list of deposition/trial testimony and fee schedule are attached hereto as Exhibit E.

6. Kim Erlich, M.D.
1501 Trousdale Drive, Room 0130
Burlingame, CA 94010

Dr. Erlich is an infectious disease expert. Dr. Erlich is a rebuttal witness. He will provide opinions rebutting the opinions of plaintiffs' expert, Dr. Alan Stein. Dr. Erlich's report, Curriculum Vitae including publication history, list of deposition/trial testimony, and fee schedule are attached hereto as Exhibit F.

7. Scott Kush, M.D.
101 Jefferson Drive
Menlo Park, CA 94025

Dr. Kush is a life expectancy expert. Dr. Kush is a rebuttal witness. He will provide opinions rebutting the opinions of plaintiffs' expert, Dr. Alex Barchuk, as they pertain to life expectancy. Dr. Kush's report, Curriculum Vitae including publication history, list of deposition/trial testimony and fee schedule are attached hereto as Exhibit G.

8. Erik Volk
1155 Alpine Road
Walnut Creek, CA 94596

Mr. Volk is an economist. Mr. Volk is a rebuttal witness. He will provide opinions rebutting the opinions of plaintiffs' expert, Dr. Terrence Clauritie. Mr. Volk's report,

curriculum vitae including publication history, list of deposition/trial testimony and fee schedule are attached hereto as Exhibit H.

NON-RETAINED EXPERTS

1. See NRCP 16.1 disclosures.

Defendants reserve the right to call any experts identified by any other party to this action.

The above expert witnesses may not be the only ones called by defendants to testify. Defendants reserve the right to later name other expert witnesses prior to trial. Defendants also reserve the right to call to testify at trial expert witnesses not named whose testimony is needed to aid in the trial of this action and/or to refute and rebut the contentions and testimony of plaintiff's expert witnesses.

Dated: December 19, 2018

SCHUERING ZIMMERMAN & DOYLE, LLP

By _____

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CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 19th day of December, 2018, service of a true and correct copy of the foregoing:

DEFENDANTS BARRY J. RIVES, M.D. AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S REBUTTAL DISCLOSURE OF EXPERT WITNESSES AND REPORTS

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

EXHIBIT "2"

December 18, 2018

Chad C. Couchot, esq.
Schuering, Zimmerman & Doyle, LLP
400 University Avenue
Sacramento, CA 95825

RE: FARRIS VERSUS RIVES

Dear Mr. Couchot:

Per your request, I reviewed this matter to rebut the opinions of Dr. Justin Willer and to comment on the cause of Titina Farris' injuries.

My qualifications to offer an opinion are detailed in my attached Curriculum Vitae. I am a physician licensed to practice medicine in the State of California. I earned a medical degree from UC San Diego in 1972. From 1973 to 1976 I attended residencies in internal medicine and neurology at the University of California, San Francisco Hospitals. From 1976 to 1978, I was a fellow at the National Institutes of Health in Neuromuscular Disease and served as a lieutenant commander in the United States Public Health Service. I am board certified in internal medicine, neurology, electrodiagnostic medicine and sleep medicine. I have practiced neurology for nearly 40 years and I have been on the adjunct clinical faculty at Stanford School of Medicine since 1978. I am currently an adjunct clinical professor at Stanford University School of Medicine and have active privileges as attending physician at the Palo Alto Veterans Administration Hospital.

I have extensive experience in diagnosing and treating patients with peripheral neuropathy, having completed a fellowship in peripheral nerve and muscle disease and being board certified in electrodiagnostic medicine. In addition, I have conducted independent research in the area of diabetic neuropathy and I have published several papers in that area. I was Director of the Stanford Neuromuscular Laboratory for five years and have performed and reviewed hundreds of peripheral nerve biopsies.

My publication history is included in my attached CV. My fee schedule is attached as is also a statement of my court and deposition testimony in the past 4 years.

With respect to this matter, I have reviewed extensive medical records including those of Advanced Orthopedics and Sports Medicine, Desert Valley Therapy, the medical records of Dr. Naomi Chaney, St. Rose Dominican Hospital records, and records of Dr. Beth Cheng, and the report of plaintiff's expert Dr. Justin Willer.

My review of the records has revealed the following pertinent facts: Ms. Farris has longstanding diabetes mellitus, which, according to her physician, historically been "poorly controlled" and "the patient continues to engage in dietary indiscretion".

Her history of diabetes mellitus is recorded in the 09/16/14 office note of Dr. Naomi Chaney. At the time, her symptoms included foot pain as a result of her diabetic neuropathy. In 2014, a year prior to the events in question, Ms. Farris was treated with substantial amounts of oral narcotics in the form of Norco and was also taking gabapentin for nerve pain.

In her intake questionnaire in her visits to the orthopedists, she in her own hand describes"nerve pain" ... "since 2012".

With respect to her hospitalization in 2015 and her clinical care therein, I believe that the attending physicians are correct in that she most likely did suffer what is termed critical care neuropathy, a poorly understood, but well recognized sensory and motor neuropathy which can be precipitated by prolonged critical care status and which may have been exacerbated by her underlying and longstanding diabetic peripheral neuropathy.

I find that the report of Dr. Willer, plaintiff's expert neurologist, is lacking in that he fails to acknowledge Ms. Farris's pre existent diabetic neuropathy as a significant factor in her current disability. Her preexistent history of severe diabetic neuropathy required narcotic medication, and gabapentin, a medication commonly used to treat nerve pain. Most of Dr. Chaney's office visit notes before and after August 2015 mention the diabetic neuropathy and poor control of blood sugars. In the section of Dr. Willer's report regarding reviewed materials, he acknowledges that the records of Advanced Orthopedics and Sports Medicine from 07/02/14, 11/25/14, and 05/05/15 indicate a history of "diabetic neuropathy," but he does not comment as to the severity of the problem, which required narcotic medication and consultation. In addition, he did not mention that following the events in the summer of 2015 when she underwent her hernia surgery and ICU hospitalization, she continued to engage in dietary indiscretion and continued to have neuropathic pain.

For example, the 04/26/17 office note of Dr. Naomi Chaney notes that the patient continues to have neuropathic pain. She says: "I have explained this is in part related to diabetes." She notes that the patient continued to have poorly controlled diabetes.

Based on my education, training, and experience and review of the pertinent documents, I have reached the opinion that Ms. Farris suffered from a significant painful diabetic neuropathy prior to the events of August 2015 and that this was in part due to her poorly controlled diabetes, which continues to the present time.

It is my opinion that it is more likely than not that she will continue to have painful diabetic neuropathy and that this characteristically and typically worsens with time in terms of disability due to pain, weakness, and impaired sensation, often accompanied by gait imbalance.

None of these facts are considered by Dr. Willer in his report.

Furthermore, it is my opinion that a substantial portion of her current disabilities and pain are related to her underling neuropathy in addition to her critical care neuropathy.

All the opinions offered in this report are offered to a reasonable degree of medical probability.

Bruce T. Adornato, M.D.
Adjunct Clinical Professor of Neurology
Stanford School of Medicine
Palo Alto Neurology

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

PLAINTIFFS' TRIAL BRIEF ON ADMISSIBILITY OF MALPRACTICE LAWSUITS AGAINST AN EXPERT WITNESS

Plaintiffs PATRICK FARRIS and TITINA FARRIS, by and through their attorneys of record, KIMBALL JONES, ESQ. and JACOB G. LEAVITT, ESQ., with the Law Offices of **BIGHORN LAW** and GEORGE F. HAND, ESQ., with the Law Offices of **HAND & SULLIVAN, LLC**, and hereby submit this Trial Brief on Admissibility of Malpractice Lawsuits Against an Expert Witness.

Case Number: A-16-739464-C

This Trial Brief is made and based upon all of the pleadings and papers on file herein and the attached Memorandum of Points and Authorities pursuant to EDCR 2.20 and 7.27.

DATED this 26th day of October, 2019.

BIGHORN LAW

By: */s/ Kimball Jones*

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MEMORANDUM OF POINTS AND AUTHORITIES

I. STATEMENT OF RELEVANT FACTS

Plaintiff Titina Farris was a patient of Defendant Rives. Rives, while performing surgery on Plaintiff, negligently cut her colon in three (3) places, though the third hole was likely the result of a burn that was not identified during the surgery. Thereafter, Rives failed to adequately repair the colon and/or sanitize the abdominal cavity. With feces actively in her abdomen, Plaintiff predictably went into septic shock and was transferred to the ICU. Nevertheless, Rives still failed to recommend any surgery to repair the punctured colon for twelve (12) days, during which time Plaintiff's organs began shutting down and her extremities suffered permanent impairment. Ultimately, Plaintiff developed critical care neuropathy, destroying all nerve function in her lower legs and feet, commonly referred to as bilateral drop foot.

Defendants in this matter have submitted a trial brief suggesting that an expert's medical malpractice history is an improper area of inquiry on cross examination. However, Defendants' brief fails to note any relevant law. The reason Defendants' brief cannot list any relevant law to support their position is because the case law directly contradicts the positions espoused in Defendants' brief.

In Deposition of Defense Expert Dr. Brian Juell, on June 12, 2019, Plaintiffs' Counsel inquired into whether Dr. Juell had himself ever been a defendant in a medical malpractice case:

> Q Have you ever been a defendant in a malpractice case?
> A Yes.
> Q Okay. Can you tell me about it? How many were there?
> A Jeez, I've been sued four times, I think. When I was a resident, I was involved in the care of a trauma patient that developed complication from an arterial line that ended up with limb loss. But I was a resident and, you know, that did go to trial. I wasn't in trial; but I was -- I think there was a settlement made on my behalf by the University. I wasn't party to that settlement resolution, but I was deposed. You know, there was a situation where I really was trying to do the right thing for the patient; but the attending physician ultimately made the decision to try to reverse that situation, but it was too late. **So the -- then I was sued on a case here where a patient had aspiration pneumonia following a hernia repair**, and the cause of the aspiration was due to a medication error by the nursing staff, you know, that led to obtundation and failure to, you know, protect his reflexes. I was deposed, but dropped from that lawsuit. **Then I was sued on a very**

> **complicated case where the patient also had aspiration pneumonia, but developed shock and had complications following a vascular procedure and died.** And I really didn't do anything wrong, but there was a settlement made on my behalf. I agreed to settle, and then the insurance company and arbitration led to a settlement of $150,000. That was basically risk management, you know, on behalf of the insurance company. I think, you know, they, they told me that I would probably win the case, you know, if it went to trial; but they elected not to pursue it. And then I had a case of a nerve injury that resolved, and I was dismissed with prejudice on that case by the judge. So I think those are the only four times that I've personally been sued.

See *Deposition of Dr. Juell*, attached hereto as **Exhibit "1,"** at Pages 92:19-94:15.

It is of the utmost pertinence that Defense Counsel did not choose to object to Plaintiffs' Counsel's questions on this matter. As such, as mandated by NRCP 32, Defendants waived the opportunity to object to this question and topic in trial.

Furthermore, the Court will take note that Dr. Juell was sued following abdominal surgeries where shock transpired, and Dr. Juell attributes their injuries to aspiration pneumonia. This is the same testimony which Dr. Juell is attempting to give in these proceedings. This involvement in cases similar to Plaintiffs' case, with injuries similar to Plaintiff, goes directly to credibility, reliability, and bias. Courts across the country have noted that this line of questioning is proper, and in fact, that it is reversible error to forbid cross-examination on this topic.

As such, these aspects of Dr. Juell's professional history are properly admitted, and this Brief is provided to support Plaintiffs' pursuit of this line of questioning upon an objection from Defendants.

II. LEGAL SUPPORT

A) Failure to Object to Deposition Testimony Results in Waiver of the Chance to Object at Trial.

NRCP 32(d)(3)(B) explicitly notes that a failure to object to questions during deposition results in waiver of the opportunity to object to the same question at trial:

> (B) Objection to an Error or Irregularity. An objection to an error or irregularity at an oral examination is waived if:
> (i) it relates to the manner of taking the deposition, the form of a question or answer, the oath or affirmation, a party's conduct, or other matters that might have been corrected at that time; and (ii) it is not timely made during the deposition.

B) An Expert Witness's History of Malpractice is Admissible for Credibility and Bias.

Plaintiffs made a dutiful search of Nevada authority accepting or forbidding cross-examination on prior malpractice lawsuits made against an expert witness, and it appears that Nevada is silent on the issue. Multiple courts across the Country have noted the propriety of this line of questioning:

> On the other hand, the Court will admit evidence regarding other medical malpractice lawsuits that have been brought against [the plaintiff's] experts. The Court believes that, when an individual testifies as an expert, they necessarily open themselves up to an evaluation of their credibility and experience.
>
> *Upky v. Lindsey*, No. CIV 13-0553 JB/GBW, 2015 WL 3862944, at *19 (D.N.M. June 3, 2015).

> For the same reason, the trial judge committed reversible error by refusing the cross-examination of the medical witness concerning a malpractice case which was pending against him. The Underhills had a right to cross-examine the medical expert on all matters relating to every issue. CR 43.06. Evidence to show bias of an expert witness is relevant. 39 A.L.R. 4th 742 (1985).
>
> *Underhill v. Stephenson*, 756 S.W.2d 459, 461 (Ky. 1988).

> As to the trial court's refusal to allow plaintiff to impeach defendant Wilkins' medical expert, **Dr. Parker, by cross examining him on a prior medical negligence claim brought against him, we find that the trial judge improperly denied plaintiff's request to cross examine Dr. Parker in this manner**.
>
> Defendants argue that evidence that Dr. Parker had previously been sued for medical negligence was not relevant to *638 plaintiff's negligence action against defendant Wilkins. We agree that this evidence is not relevant to the question of defendant Wilkins' negligence, but **we hold that evidence of prior medical negligence claims brought against the expert witness is admissible to show bias or interest on the part of the expert.** Cross examination is available to establish bias or interest as grounds of impeachment. 1 Brandis, N.C.Evidence § 42 (2d ed. 1982). Evidence of a witness' bias or interest is a circumstance that the jury may properly consider when determining the weight and credibility to give to a witness' testimony. 1 Brandis, N.C.Evidence § 45 (2d ed. 1982). We hold that the jury should be allowed to consider that an expert witness in a medical negligence case has previously been sued for medical negligence, for the jury could find that this would lead the expert witness to have a bias or interest. We note that if evidence to show bias is brought out on cross examination, the witness would be entitled to explain the evidence on redirect examination. *Id.* Of course, the trial judge retains the discretion to restrict and control the extent and scope of both cross examination and redirect examination. *Id.*, §§ 36 and 42.
>
> The trial judge erred in preventing cross examination of defendant Wilkins' expert witness concerning prior medical malpractice claims brought again the expert witness.

> This action prevented the jury from hearing facts from which bias or interest on the part of the expert witness could be inferred. We therefore reverse the judgment of the trial court as to defendant Wilkins and remand for a new trial.
>
> *Willoughby v. Kenneth W. Wilkins, M.D., P.A.*, 65 N.C. App. 626, 637–38, 310 S.E.2d 90, 97–98 (1983). (Emphasis Added).

Courts have been particularly inclined to admit questioning on past medical malpractice when an expert has been sued for malpractice in cases similar to the case they are testifying to:

> Plaintiffs contend that the court abused its discretion by excluding evidence of a prior law suit brought by plaintiffs' attorney, in his individual capacity, against defendant's expert medical witness. The prior suit involved the attorney's child and was settled out of court. Allegedly, it involved a brachial plexus injury occurring under circumstances similar to those alleged in the present action. The court properly excluded any reference to the involvement of plaintiffs' attorney in the prior suit. Such evidence is a clear appeal for jury sympathy likely to distract jurors from the relevant issues at trial. The court, however, also excluded all evidence of the prior suit, even without reference to plaintiffs' attorney, because the suit was settled without an admission of liability. The court permitted general questions about the expert's professional experience with similar injuries, and questions asking if the expert had ever been sued and if he resents suits against physicians.
>
> **We determine that the excluded evidence was relevant to a crucial issue, bias or interest, and if admitted, could have had a controlling influence on a material aspect of the case, i.e. whether defendant deviated from the applicable standard of care. In *Hayes v. Manchester Memorial Hosp.*, 38 Conn.App. 471, 661 A.2d 123 (1995), the court found an abuse of discretion in excluding evidence of a similar suit brought against an expert witness physician. The court reasoned that it would be against the expert's interest to testify to a deviation of care in circumstances similar to those giving rise to his own liability. As the *Hayes* court stated: "The evidence excluded goes to the principal issue to be resolved by the jury, whether the duty of the defendants to conform to the applicable standard of care was breached...."** *Id.*, 661 A.2d at 126.
>
> *Irish v. Gimbel*, 1997 ME 50, ¶¶ 24-25, 691 A.2d 664, 674. (Emphasis Added).

A party could conceivably argue that evidence of past lawsuits is impermissible character evidence and that it would prejudice a juror's opinion of the expert witness. This fact scenario was addressed by the *Hayes* Court:

> The plaintiff first argues that the trial court improperly limited the cross-examination of Goodman, the expert witness called by the defendants to testify as to the proper standard of care. The trial court refused to allow the plaintiff to cross-examine Goodman, for purposes of attacking his credibility, as to a lawsuit brought against him. That lawsuit

alleged the same or similar claims of medical negligence against Goodman as those present here. The trial court, while allowing the complaint against Goodman to be marked for identification, and recognizing that the plaintiff's claim of relevance went to both motive and bias rather than professional competence, ruled that the prejudicial effect of that evidence outweighed its probative value. The court determined that the allegations in the two lawsuits were superficially similar, but noted that sufficient opportunity existed "in the ordinary manner, of also exploring his motive as well as his bias ... in connection with his activity on behalf of defendants."

The plaintiff contends that the jury should have been informed of the similar lawsuit against Goodman because this information would have been relevant in determining Goodman's credibility, bias and motive. The lawsuit against Goodman involved the reading and ordering of X rays. That suit was pending at the time Goodman was deposed as an expert witness in this case, but it was settled prior to Goodman's giving testimony.[2] The plaintiff contends that this evidence was sufficient to demonstrate Goodman's motive to testify as he did. In order to remain consistent and not to admit that he had failed to conform to the applicable standard of care, he had to conclude that the defendant did not deviate from the standard of care in the alleged misreading of X rays and failure to order additional X rays. The plaintiff argues that it was thus in Goodman's best interest to give the opinion that he did and that it would have been contrary to his interest to testify that there had been a deviation in this case.

"Generally, evidence is admissible to prove a material fact that is relevant to the cause of action alleged by the plaintiff. *Chouinard v. Marjani,* 21 Conn.App. 572, 575, 575 A.2d 238 (1990). A trial court has broad discretion in ruling on the admissibility of evidence, and we will not disturb such a decision absent an abuse of discretion. *Id.* Nevertheless, '[t]he exercise of discretion to omit evidence in a civil case should be viewed more critically than the exercise of discretion to include evidence. It is usually possible through instructions or admonitions to the jury to cure any damage due to inclusion of evidence, whereas it is impossible to cure any damage due to the exclusion of evidence.' *Larensen v. Karp,* 1 Conn.App. 228, 237, 470 A.2d 715 (1984)...." *Martins v. Connecticut Light & Power Co.,* 35 Conn.App. 212, 217, 645 A.2d 557, cert. denied, 231 Conn. 915, 648 A.2d 154 (1994).

Cross-examination is an indispensable means of eliciting facts that may raise questions about the credibility of witnesses and, as a substantial legal right, it may not be abrogated or abridged at the discretion of the court to the prejudice of the party conducting that cross-examination. *Richmond v. Longo,* 27 Conn.App. 30, 38, 604 A.2d 374, cert. denied, **126 222 Conn. 902, 606 A.2d 1328 (1992). It is well settled that the credibility of an expert witness is a matter to be determined by the trier of fact. *In re Juvenile Appeal,* 184 Conn. 157, 170, 439 A.2d 958 (1981). Such a witness can be examined concerning the factual basis of that expert's opinion. *State v. Steiger,* 218 Conn. 349, 372, 590 A.2d 408 (1991). An important function of cross-examination is the exposure of a witness' motivation in testifying. *Greene v. McElroy,* 360 U.S. 474, 496, 79 S.Ct. 1400, 1413, 3 L.Ed.2d 1377 (1959).

The trial court found that the prejudicial impact of the proffered cross-examination evidence relating to the witness' credibility due to his motive or bias outweighed its

probative value. "In order to exclude evidence on the ground of prejudice, there must be undue prejudice great enough to threaten an injustice." *Martins v. Connecticut Light & Power Co.,* supra, 35 Conn.App. at 220, 645 A.2d 557. The burden of showing that the evidence may unduly arouse the jurors' emotions of hostility or sympathy rests with the party claiming prejudice. *Id.*

"When the evidence is relevant and the likelihood of prejudice is not great, deviation from the general rule of admissibility is not warranted and discretion has been abused if the evidence is excluded." *Id.,* at 221, 645 A.2d 557; see also *Batick v. Seymour,* 186 Conn. 632, 638, 443 A.2d 471 (1982). **We do not agree with the trial court's finding that the evidence was unduly prejudicial. Any resulting prejudice cannot be so undue and so great as to threaten an injustice. A basic and proper purpose of cross-examination of an expert is to test that expert's credibility.** *Richmond v. Longo,* supra, 27 Conn.App. at 38, 604 A.2d 374. **Motive for testifying is certainly a permissible line of questioning for that purpose. The plaintiff was deprived of the right to have the jury, as trier of fact, weigh the credibility of the expert witness by assessing his motives for testifying as he did. We conclude that the trial court abused its discretion in excluding that evidence.**

Hayes v. Manchester Mem'l Hosp., 38 Conn. App. 471, 472–75, 661 A.2d 123, 125–26 (1995). (Emphasis Added).

The jury is consigned to consider the credibility of an expert witness. An expert witness who has been sued for treatment similar to the treatment he has been retained to testify to, has an inherent bias in testifying in a way which not only exonerates the Defendants, but also exonerates himself.

Furthermore, an expert's credibility is properly explored in cross-examination. If an expert mis-diagnosed the same condition at issue before the bar, the jury should know of this fact and be able to consider whether that expert's testimony is credible and reliable.

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III. CONCLUSION

Based on the above, Plaintiffs submit this Trial Brief Supporting Admissibility of Malpractice Lawsuits Against an Expert Witness.

DATED this 26th day of October, 2019.

BIGHORN LAW

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CERTIFICATE OF SERVICE

Pursuant to NRCP 5, NEFCR 9 and EDCR 8.05, I hereby certify that I am an employee of **BIGHORN LAW**, and on the 27th day of October, 2019, I served the foregoing ***PLAINTIFFS' TRIAL BRIEF ON ADMISSIBILITY OF MALPRACTICE LAWSUITS AGAINST AN EXPERT WITNESS*** as follows:

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

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

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An employee of **BIGHORN LAW**

EXHIBIT "1"

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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 No. A-16-739464-C
Dept. 31

VIDEOTAPED DEPOSITION OF BRIAN E. JUELL, M.D.
Wednesday, June 12, 2019
8:41 a.m.
Reno, Nevada

Reported by: Terry Ellis Thompson
Nevada CCR #6
Computer-Assisted Transcription

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BILL STEPHENS, Videographer
BILL STEPHENS PRODUCTIONS, INC.

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BE IT REMEMBERED, that on Wednesday, June 12, 2019, at the hour of 8:41 a.m. of said day, at the Offices of Bonanza Reporting & Videoconference Center, 1111 Forest Street, Reno, Nevada, before me, TERRY ELLIS THOMPSON, a Certified Court Reporter, personally appeared BRIAN E. JUELL, M.D., who was by me first duly sworn, and was examined as a witness in said cause.

(Exhibit 1 through 11 were marked.)

BRIAN E. JUELL, M.D.,
having first been duly sworn, testified as follows:

THE VIDEOGRAPHER: Good morning.
We are now on the record. The time is 8:41 a.m. The the date is June 12, 2019.
This is the deposition of Brian E. Juell, M.D. The caption of the case is Titina Farris and Patrick Farris versus Barry Rives, M.D. et al., Case No. A-16-739464-C, in the District Court of Clark County, Nevada.
This deposition is being taken on behalf of the Plaintiffs.
Would all attorneys present please identify

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yourselves and state the parties you represent.
MR. HAND: For Plaintiffs, George Hand.
MR. DOYLE: Tom Doyle for Dr. Rives.
THE VIDEOGRAPHER: Thank you. We are located at Bonanza Reporting & Videoconference Center at 1111 Forest Street in Reno, Nevada.
My name is Bill Stephens, Certified Legal Videographer, representing Bill Stephens Productions, Incorporated, at 10580 North McCarran Boulevard, No. 115-319, Reno, Nevada, 89503.
I'm not related to the parties involved and have no interest in the financial outcome of this deposition.
The court reporter is Terry Thompson from Bonanza.
Terry, would you please swear in the deponent.
(The witness was sworn.)
THE VIDEOGRAPHER: Please proceed.
EXAMINATION
BY MR. HAND:
Q Good morning. Is it pronounced Juell?
A Yes.
Q Good morning, Dr. Juell. My name is George Hand. I'm one of the attorneys who represents Titina

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Farris and her husband Patrick Farris in this matter.
I'm going to ask you some questions regarding your expert opinions you've given in this case.
And before I do that, is there any reason you can't give your best testimony today?
A No.
Q If I don't make myself clear with any question, let me know and I'll rephrase it. Is that understood?
A Yes.
Q Have you testified before as an expert in any malpractice case?
A Yes.
Q Can I do away with the usual admonitions? That is, you understand you're under oath, the same way you'd be in court. Do you understand that?
A Yes.
Q Before I get into the testimony, I premarked some exhibits to save some time.
I'll just read them in: Exhibit 1 is the Deposition Notice for Dr. Juell.
Exhibit 2 is Dr. Juell's report dated November 6th, 2018.
Exhibit 3 is Dr. Juell's report dated

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December 16th, 2018.
Exhibit 4 is Dr. Juell's CV.
Exhibit 5 is the July 3rd '15 operative report by Dr. Rives.
Exhibit 6 is the operative report dated July 16th, '15, by Dr. Elizabeth Hamilton.
Exhibit 7 is the consultation by Dr. Farooq Shaikh dated July 4th, 2015.
Exhibit 8 is discharge summary dated August 15th, '15, by Dr. Mojica.
Exhibit 9 is a consultation dated July 9th by Dr. Ripplinger.
Exhibit 10 is a rebuttal report of expert Michael Hurwitz.
Exhibit 11 is a rebuttal report of expert Alan Stein.
Dr. Juell, I'm going to show you the notice of deposition.
Have you seen that before?
A Yes.
Q Have you brought those documents with you that were requested?
A No. The only document that I did bring this morning is the CD of the x-rays on the Plaintiff from St. Rose Dominican.

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I was unable to find my notes or records in printed form. I do have the records on an e-mail that was recently transmitted to me from Mr. Couchot's secretary, which I did review in preparation.
I may still have the records. I just was unable to locate them. I have been involved in looking at several cases over the last two years, some of which settled, and those records were destroyed.
So I don't know if they were inadvertently destroyed, but this is the only thing that I was able to bring this morning.
I did meet with Mr. Doyle prior to the swearing in this morning, and he did provide me with some printed copies of some of the pertinent testimony in my reports, which I do have with me this morning.
Q Do you have any billing records as to what you've charged so far --
A I don't have those.
Q -- for your time?
A I asked Mr. Doyle about it, if I had received payment.
My wife is my administrator. And I

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generally don't -- you know, she doesn't really tell me and I don't really ask about the -- I tell her how many hours I've spent and then I think she takes care of the billing; and I don't have those records.

Q Do you know how much you've charged so far for --

A I don't.

Q -- your work on the case?

A I don't.

Q All right. I'm going to ask if you locate those documents to provide them to Mr. Doyle or --

A I will do so.

Q -- or an attorney from his firm.

Do you recall what you reviewed prior to today?

A Yes. I reviewed the records, obviously, from St. Rose hospital in Las Vegas. I'll have to say they were somewhat difficult to review. But, you know, I did review those in preparation for today and also for the, my report.

I reviewed the deposition of Dr. Rives.

I reviewed the Plaintiffs' experts' reports and rebuttals to my report.

I reviewed my report.

I reviewed my rebuttal report. And I also

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just recently reviewed the x-rays. I hadn't had -- I believe I was given a copy of them, but I couldn't open them for some reason. I think there was a password on the CD; and I hadn't actually seen the x-rays until just this last week. And I did look at them again last night.

And I saw this morning a report that Mr. Doyle gave me from one of his experts in the defense of Dr. Rives from an infectious disease doctor, Dr. Ehrlich, which I had not seen up until this morning.

But I believe that's what I have reviewed.

I hadn't ever seen the Complaint that you filed, you know, in court, I suppose to, when you filed the lawsuit. But I did discuss that with Mr. Doyle this morning as to what the allegations of malpractice were against Dr. Rives.

And I just had that conversation. I still haven't seen that document, but...

Q Now, only opinion questions I may ask you about, I ask that they be to a reasonable degree of medical probability; is that understood?

A Yes.

Q If you can't say to a reasonable degree of medical probability, you just let me know.

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A I will.

Q When -- do you know the date Titina Farris was discharged from the hospital?

A No, I don't specifically recall.

Q Do you know what her discharge summary contained in terms of what her condition was upon discharge?

A I don't recall the exact -- I did review that, but I don't recall her condition.

I think she was discharged into like a skilled care or rehab. So she must have had some ongoing medical issues.

Q I've marked as Exhibit 8 the discharge summary. I will ask you to look at that.

Dr. Juell, have you seen that document before your review?

A Yes.

Q And when you were -- do you know when you were first hired to review this case?

A I don't recall.

Q Do you know how you were hired?

A I think Mr. Doyle's office contacted my office and asked if I would be willing to look at the records.

Q Have you ever done a review of any other

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cases for Mr. Doyle's office?

A I believe I have, yes.

Q Do you know how many cases you've done reviews on?

A Pardon?

Q Do you know how many cases you've done reviews on?

A For Mr. Doyle or for anybody?

Q His firm, his firm.

A I don't have an exact number. I probably have done this around 10 times, I would think.

I have testified in court as an expert on one previous case.

I have testified in court on several occasions for, as a treating physician; and I have also testified before the Board of Medical Examiners as an expert on one occasion -- though I have reviewed other cases for them -- just one time in an actual court situation.

But I don't -- I can't recall the specific number of times.

Q Have you ever testified as an expert witness in Clark County?

A No -- well, for the Medical Board, that was in Clark County.

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Q Have you ever testified in a case involving issues that are present in this case, such as sepsis, bowel perforation?
A Yes, that was the case that I testified for on the Medical Board was a bowel perforation case resulting as a complication from a laparoscopy.
Q And what was your specific role in that case?
A I was asked by the Medical Board to look at the case regarding issues of malpractice regarding the surgeon.
Q And how many times have you testified in court as an expert witness on a malpractice case?
A Just, I think on just one occasion. Otherwise, I was involved as a treating physician, but testifying in the defense.
Q The case you testified in, do you know what court it was?
A Washoe County.
Q Do you know what kind of case that was?
A It was a case regarding delayed diagnosis for breast cancer.
Q And were you an expert for the plaintiff or the defendant?
A For the defendant.

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Q Have you ever testified in a court case or reviewed a court case on behalf of a plaintiff?
A Yes. The Board of Medical Examiner case, which I referred to, that was the only time I've been involved against, you know, against the physician.
Q But in a civil action, in terms of testifying to the standard of care and those issues on behalf of a plaintiff, have you ever done that?
A No.
Q Have you ever authored any expert reports on behalf of a plaintiff in a malpractice case?
A No.
Q So in terms of how long you've been doing expert work, do you know how long you've been doing it?
A Just probably, that case with the delayed diagnosis of breast cancer was probably over twenty years ago.
Q Okay. So have you given previous depositions in medical malpractice cases?
A Yes.
Q Do you know how many depositions you've given?
A Not specifically, but I think probably six to eight times.

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Q Have those been, any of those been on behalf of a plaintiff?
A No.
Q And I think you said none of those involved perforated bowel or sepsis issues?
A No.
Q Do you recall what kind of cases those ones were?
A I think delayed diagnosis. Let's see, problems resulting from infection. I don't really specifically recall the details.
Q Looking at the discharge summary, there's a final diagnosis section on Page, I'm looking at the lower left-hand corner, it says Page 2; and this appears to be authored August 11th, '16.
A Okay, I found it, yes.
Q Looking at Diagnosis No. 1, acute respiratory failure, status post trach on T-piece tolerated well, off the vent.
Do you have an opinion as to the cause of Titina Farris's acute respiratory failure?
A Well, I think it was probably acute on chronic respiratory failure.
I believe that she had aspiration pneumonia, as well as complications from sepsis, so

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that her acute respiratory failure was probably multifactorial.
Q When you're talking about pulmonary aspiration syndrome, is that involving aspiration of foreign material into the lung?
A Yes.
Q Okay. Did any other of the treating providers diagnose pulmonary aspiration syndrome?
A Not to my knowledge.
Q Looking at final diagnosis No. 2, perforated viscus with intraabdominal sepsis still status post, exploratory laparoscopic removal of prosthetic mesh and wash out partial colectomy.
Do you have an opinion as to the cause of the perforated viscus?
A The perforated viscus was a suture line failure resulting from repair or as a consequence of repair.
Q Do you have an opinion as to whether that repair -- let me withdraw that.
Am I correct there were two documented colotomies during the July 3rd --
A That's correct.
Q -- '15 procedure of Dr. Rives?
I'm going to show you Dr. Rives' operative

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report, which I marked as Exhibit 5.
A Yes, I've seen this document before. And you're correct, I believe there were two documented colotomies.
Q Now, this laparoscopic hernia repair, is that a procedure you do?
A Yes.
Q How many of those have you done?
A I don't know, hundreds.
Q Have you ever experienced a colotomy in doing a laparoscopic hernia repair?
A Yes.
Q And have you repaired those with staplers?
A Yes.
Q And what kind of stapler did Dr. Rives use?
A He used an Endo-GIA, which I believe is an Ethicon device.
THE REPORTER: Which is -- I'm sorry.
THE WITNESS: Is made by Ethicon, at least with that name, I believe.
BY MR. HAND:
Q Is that a device that you use regularly?
A I do use that device.
Q Looking at his operative report -- and I'm looking at the lower corner, you see Page 54, going

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down, Page 55. Do you see that? It's over at the same --
A Yes, 54 and 55.
Q And it appears that in freeing the colon from the mesh there were -- I'll use Dr. Rives' words -- there was a small tear in the colon and there was a second small colotomy also noticeable, also repaired with an Endo-GIA 54 -- 45 tissue load. And he states (reading): After successive firing, the staple lines appear to be intact.
A Yes.
Q So in repairing the colotomy, what is the objective of the surgeon when doing that?
A Well, in this case it was either a partial or full thickness injury. And so the goal, obviously, is to close that completely so that there's no enteric content leak.
Q Is there a standard of care in the method of repairing a colotomy or colotomies such as the ones present in this --
A Yes.
Q Can you explain that?
A Well, I mean, as long as it achieves the outcome, it would meet the, you know, as we just stated, it would meet the standard of care.

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Q What if the --
A The method, I mean, that would be surgeon's choice, you know, based on his judgment at the time of operation.
Q What if the staple line fails?
A Well, then there would be a leak. And obviously the patient would be subjected to complications, you knows, infection.
Q Okay. If a staple line fails, is that beneath the standard of care?
A No.
Q Why not?
A Well, it's a recognized complication of that surgery.
Q Are there also colotomy repairs that do not fail?
A Of course.
Q Have you undergone or reviewed any literature as to why a colotomy repair would fail?
A Well, it's part of my specialty as a general surgeon, so, yes.
Q What are some of the reasons a colotomy would fail?
A Well, typically most colotomies fail or repairs fail because of tissue ischemia at the site

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where, you know, failure of blood supply; tension, you know, if there was tension on the repair or anastomosis, that can lead to failure.
If there was infection, you know, around the repair, that can, you know, certainly lead to local ischemia and breakdown.
But generally it's a malperfusion, you know, of the bowel wall where the repair was done that leads to failure.
But then there would be technical issues, too, I mean, if the repair wasn't adequate, that is certainly a possibility as well.
Q Okay. Is it your opinion the repair was adequate here?
A That was the opinion of Dr. Rives.
So I wasn't present at the operation.
It would be, you know, obviously the surgeon performing the procedure would have to make that determination. But I believe that he did believe that it was adequate.
Q Do you have an opinion as to why there was a failure of the staple line?
A Well, I think the patient obviously had complications early in the course of her recovery.
And, I mean, there were multiple factors

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that could lead to, you know, malperfusion of the staple line and the late leak, you know, that occurred.

I don't believe -- and I have documented that in my reports -- I don't believe that there was a technical issue with the repair initially, and that the leak was delayed.

And during that time period, 12 days or whatever that took place from the time of surgery up until the time the leak was diagnosed, the patient was in ICU, she required fluid resuscitation, edematous tissue. She probably had some malperfusion from infection and sepsis, and she had edema of the tissue. She probably had inadequate nutrition, which is typical, you know, for this phase of recovery.

And so there were multiple factors that led to, you know, the leak developing.

Q Can you rule out that this was, the colotomy -- not the colotomy -- the staple line failure was not due to inadequate technique?

A Well, I don't think there's evidence of that because there would have been manifestations, you know, from, you know, early on after the repair.

I mean, it wouldn't have been something that came up in a delayed fashion.

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Q In your opinion, when was this patient first septic?

A Well, I think she had septic syndrome within the first 24 to 36 hours after operation.

Q What are the signs of sepsis?

A Oh, typically patients have fever. They'll have elevated white count. Tachycardia is probably the primary vital sign that can develop hypotension, shock, evidence of malperfusion, lactic acidosis, and those -- probably other finding.

Q Separate from the signs, are there symptoms of sepsis?

A Yes. Most people, when you have sepsis, generally speaking, you have inadequate oxygen delivery. So patients tend to be, you know, confused or have encephalopathy.

They can sometimes, you know, the lack of oxygen delivery can make them anxious.

The, you know, tachycardia, diaphoresis, fever, and, you know, manifestations of shock should have developed.

Q There's also, going down in that final diagnosis, No. 4, colostomy.

Do you have an opinion as to why a colostomy was required here?

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A Well, I think when this patient had delayed perforation of the bowel and had established peritonitis at the time of operation; and to do a primary colonic anastomosis in that setting would be contraindicated, and fecal diversion, you know, was appropriate.

Q So if I understand, do you agree a colostomy was necessary in this case?

A Yes.

Q Then there is noted to be leukocytosis. What is that?

A Just elevated white count.

Q Do you have an opinion as to the cause of the elevated white blood count?

A I think it was due to her septic syndrome.

Q Then it's noted T2DM. What is that?

A Type 2 diabetes, mellitus, I believe.

Q No. 10, HTN. What is that?

A That refers to hypertension.

Q And then No. 11, AKI/ATN. What is that?

A That refers to acute kidney injury.

Q Do you have an opinion as to -- well, let me rephrase that.

Did you, in your review of the records, note that there was an issue with Mrs. Farris's

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kidneys?

A Yes, she had azotemia, or elevated kidney function tests; and initially oliguria, which is low urine output. And I don't believe she ever progressed to dialysis, but she did have some renal impairment.

Q In your opinion what was the cause of the issues with the kidneys?

A Well, she probably had some pre-existing propensity for kidney failure due to her diabetes, which can lead to kidney failure, and also her hypertension.

And then she obviously had surgical stress, you know, and sepsis, you know, as a complication of her initial operation.

And that would lead to the acute kidney injury.

Q Now, looking at your report, which I've marked as Exhibit 2, dated November 6th, 2018.

Do you have that report? Or I can give you this one if you --

A No, I have one right here.

MR. DOYLE: Here, why don't you look at his and I can use this one.

THE WITNESS: Okay, thank you.

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BY MR. HAND:
Q You note -- I'm looking at the first paragraph of your report. Do you see what I'm referring to?
A Yes.
Q When you were given the materials for review, what were you asked to do?
A Basically to -- the question posed was whether Dr. Rives' care of Titina Farris was outside accepted surgical standards.
Q What do you mean by accepted surgical standards?
A Well, just what the usual and customary expertise that a surgeon should, you know, provide a patient.
Q Then you state also specifically did that care constitute malpractice.
What do you mean by malpractice?
A Well, where it would be outside the accepted surgical standard.
Q And when you talk about accepted surgical standards, where are you getting your criteria or definition of accepted surgical standards?
A I guess that would be my opinion of what accepted surgical standards are.

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Q Is there any literature or medical books, treatises you reviewed prior to coming here today regarding this case?
A No.
Q Did you consult any articles, journals, treatises, in forming your opinions in this case before you did your report?
A Not specifically, no. But over the course of my practice I obviously read that literature.
Q Are there any books you read regularly, treatises?
A Yes.
Q What are those?
A Oh, I read the Journal of American College of Surgeons.
I do continuous CME with an education tool that they publish. I read the Journal of Trauma.
I read the Journal of Critical Care.
And I do, on occasion, you know, consult surgical books.
Q Do you know any of the surgical books --
A I look at U-Tube videos now, a lot of different things to continue my medical education.
Q Do you know any of the books you consult?
A No, not specifically.

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Q Are there any books you would consider like a reliable authority on the --
A Yes.
Q -- medical issues that are here in this case?
A I'm sure there are standard surgical textbooks.
Q Do you know any of them?
A Yeah. I haven't read them recently. But there is one, I think, by Schwartz -- it's a pretty common book -- and there is another major book but I don't remember the editor.
Q So going down on your report further, you talk about -- I'm looking at Paragraph 3 now -- I'm reading the sentence (reading): Mobilizing and freeing the colon from the previously placed mesh, scar tissue and hernia was complicated by an injury to the colon.
And then you state (reading): Satisfied with these repairs, he completed the hernia repair with intraperitoneal onlay prosthetic mesh implantation secured with concentric rows of fixation tacks.
So when you use these words, "satisfied with these repairs," what's your basis for saying

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that?
A Well, I think as he documented it in his operative report, that he had the colotomies, and he repaired them with the stapler, and he felt that the repairs were adequate.
Q Then you go on to state (reading): Dr. Rives weighed the risks and benefits of this procedure, taking into account knowledge of this relatively high-risk patient for complications and hernia recurrence and his perceived quality of surgical repair.
So when you state Dr. Rives weighed the risks and benefits of this procedure, what's your basis for that statement?
A Well, basically that's what all surgeons would do when they were confronted with the situation.
You know, they have to decide whether they wanted to convert to an open procedure, they have to decide whether they felt the repairs were adequate; they'd have knowledge if there was contamination, you know, to the operation.
And then you have to weigh, you know, how you're going to complete the operation based on your care of that specific patient, you know.

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And that comes down to surgical judgment.
Q How many colotomies have you repaired in the course of your career?
A Oh, I'm sure hundreds.
Q Have you ever had one fail subsequently?
A Yes.
Q How many have failed, out of the percentage of repairs you've done?
A I'm sure I've probably had that happen a dozen times, maybe even more frequently.
It's a low-level risk. I mean, it depends on your volume of surgical care.
But I would say that most colonic anastomosis, depending on the position, you know, probably have a leak rate of three to five percent. And some, probably one to two percent of those become clinically significant, where reoperation is required.
So, I mean, I think any busy surgeon in general surgery that's doing these type of surgeries is going to have this complication. It's unavoidable. It's just a statistical risk.
Q Well, in the ones that you did that failed, were you able to determine the cause of the failure?
A On occasion. There were specific problems.

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Otherwise, it's just a general risk factors, which, many of which are the patient's risk factors.
You know, patients -- there's a wide variety of patient's ability to heal. You know, some of that is, you know, based on the strength of scar tissue, genetic factors, you know, propensity to infection, which may also be genetic, your co-morbidities.
Sometimes it's been technical, you know, where there was probably tension on the anastomosis, you know. Like for low, low rectal anastomosis, you know, bringing the bowel down might have been under tensions, so there might have been technical issues in some cases.
But I've certainly had those complications.
Q Have any of your patients where a colotomy repair failed ever gone into septic shock?
A Of course, yes.
Q And you mentioned that Dr. Rives weighed the risk and benefits of this procedure.
Wasn't it an alternative to do an open procedure, a laparotomy here?
A Yes.
Q Are there any advantages to doing that as opposed to laparoscopic?

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A There might have been. And it comes down to judgment.
I think that he felt very secure with what he did; and, you know, obviously took into account, you know, the patient, the fact that she had previous failure.
I think he was very motivated to complete the operation laparoscopically.
But if you did an open procedure, I mean some, obviously you could, you know, test the anastomosis maybe more thoroughly, you know; compress it, you know; try to move fecal material through there, you know, to see if there was a leak.
But I don't believe that Dr. Rives felt that that was necessary. He felt quite confident that his repairs were adequate.
Q Then you go on to state (reading): Dr. Rives admitted Titina Farris to the hospital for postoperative care.
Why was she admitted?
A I think that she just probably had risk factors, you know, for complications. And that was the indication.
And pain control. I think she was in quite a bit of pain, you know, after the operation.

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And so those are the two major indications I think for admission.
Q And then you state Titina Farris fared poorly in the early postoperative period.
A Yes.
Q Explain what you mean by fared poorly.
A Well, her condition deteriorated. She had respiratory problems primarily. Then she developed tachycardia. She had low urine output. She required IV fluid administration, pain management; but ultimately her condition rapidly deteriorated to the point where she had to be admitted to the ICU for care.
Q In your opinion what was the cause of her faring poorly?
A Well, I think that she probably had an ileus, you know, as a result of the operation, that, you know, that required, you know, some resuscitation.
Then she developed, I believe, primarily pulmonary stress. I think that she developed aspiration pneumonia, or had aspiration, pulmonary aspiration syndrome.
And I think that's the reason that her condition deteriorated. It looked like shock, and

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obviously there was a differential diagnosis that was considered at that time in terms of the course of treatment that she received.

Q When you say shock, define that for me.

A Well, she had tachycardia. I don't believe that she had significant hypotension; but she developed lactic acidosis and had an elevated white count; and obviously respiratory failure, which ultimately she had to be intubated early on and receive mechanical ventilatory support.

So she had a shock-like syndrome.

Q Then you state she had poor respiratory parameters. What are her poor respiratory parameters?

A Well, I believe she had tachypnea, or rapid breathing. She had increasing need for oxygen level administration.

Q Do you know what the cause of the poor respiratory parameters were?

A I believe that she had aspiration.

Q What is your -- take me through the steps you used to come to that opinion that she had aspiration syndrome.

A Well, her deterioration was fairly progressive, you know, from the time that she had the

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operation.

She was fed early, you know, and -- or at least she was taking fluids in; that she had vomited.

And then she developed this tachycardia and respiratory failure.

And then her initial chest x-ray, I believe, showed pulmonary infiltrate in the right upper lobe, which is the dependent portion of the lung; and I think was consistent with aspiration.

And then she subsequently had a CT scan, which demonstrated that the area in the upper lobe and also she had lower lobe consolidation and dependent portions of her lung, which I think would be also consistent with probable aspiration syndrome.

Q Then you go on -- anything else you want to add to that?

A No.

Q Then you go on to state she required oxygen administration. Why did she require that?

A She wasn't -- I think that because of lung damage, either from atelectasis, you know, or collapse of the lung, which is typical for patients who have abdominal surgery. They don't breath very deeply, so they don't fully expand their lungs.

And then also I think specifically in her

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case that she probably had, you know, aspiration, you know, gastric content, or stomach contents into her lungs.

And that that created a problem with oxygen delivery. So she required higher levels of oxygen in order to meet her, her needs.

Q Then you say she had low urine output. Why did she have low urine output?

A I think she developed like a systemic inflammatory syndrome, and probably had fluid leakage, you know, from her capillaries; and was requiring fluid resuscitation. While they were catching up with that, she develops evidence of acute kidney injury; and, you know, her urine output was low as a consequence.

Q Then you said (reading): She required IV fluid boluses. Why was that?

A To meet those fluid needs that she was developing due to the inflammation.

Q Then you state she had a tachycardic arrhythmia. Do you have an opinion why she had that?

A Well, I think it was part of the syndrome that she had with the tachycardia.

That certainly can be a direct consequence of pulmonary aspiration. But inflammation, in

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general, that's your cardiac output increases in this situation; and that's a mechanism, you know, make your heart beat faster.

But she probably had an arrythmia because it was an abnormally elevated heart rate, which could contribute to actually poor cardiac output. 'Cause the heart doesn't have time to fill adequately, you know, between beats.

Q Was that -- was one of the causes of that sepsis?

A It can be. But she may have had some underlying, you know, undiagnosed heart problems as well.

Q In this case what was --

A So it may have a propensity, you know, to develop tachyarrhythmias.

Q In your opinion what was the most likely cause of the tachycardic arrhythmia?

A I think her respiratory failure and the low oxygen level. And then it may have just been a circus rhythm that developed, you know, a recurrent abnormal rhythm that was self propagating. And she had cardiac consultation and appropriate pharmacologic therapy, and that resolved.

Q Did she have any cardiac issues prior to

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this --
A Not that were documented, to my recollection.
Q And then she was transferred to the ICU.
Do you know who, which doctor transferred her to the ICU?
A I believe it was the hospitalist, and I don't remember the name.
Q Why did she need admission to the ICU?
A Well, she had this unstable cardiac rhythm and obviously impending respiratory failure. And so they transferred to the ICU so that they can monitor her condition and intervene when necessary.
Q And I think we talked about her cardiology consultation a second ago, and you also talked to, talked about the kidney function; correct?
A Yes.
Q Then you state she developed a high white blood count. When did she develop a high white blood count?
A I think very early.
Q Do you know -- okay, I'm sorry.
A I don't remember if the first white count was done prior to -- I think it probably was done prior to her being admitted to the ICU, but she did

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have an elevated white count.
Q What is the, in general terms, the normal white blood count for a patient with Miss Farris's presentation?
A Well, normally -- obviously when you have an operation, you know, that's a surgical stress, that, you know, in most normal patients does elicit a stress response, you know, release of stress hormones. And some of those, you know, epinephrine, norepinephrine, they do cause demargination of the white blood cells. The white blood cells kind of hang out along the lining of the blood vessels. And those hormones cause them to let loose so they can circulate.
And obviously white blood cells are important in your immune responses.
So most patients in this early postoperative period would have leukocytosis. Sometimes it's more exaggerated than others.
But it would be unusual to see a patient this early after operation have a normal white blood cell count.
Q Do you have a number for a normal white blood cell count?
A Yeah, normally it's around less than about

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10,500.
Q Do you know what her white blood count was on July 4th?
A I don't specifically recall, but I believe it was elevated.
Q Okay. Do you know what her blood count was on July 5th?
A Again, I don't specifically recall. But I, I believe that she had a persistent elevated white count through most of her early and somewhat protracted postoperative course.
Q So on July 5th, that's two days after the surgery, correct?
A Yes.
Q And I'll represent to you her white blood count on that day was 23.3.
A I, I think that's quite reasonably correct.
Q Is there any medical significance to that high white blood count?
A It's a high white blood cell count.
Q And I'll represent to you on July 4th, the white blood count was 18.9, the day before.
A Okay, fine.
Q The hemoglobin was nine. Is there any medical significance to that, on July 5th the

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hemoglobin was nine?
A Well, obviously I think it was down, you know, from where she had, you know, had been when she came in.
It is low. It reflects anemia. A normal hemoglobin is around 11 to 12 grams.
So it could have been as a result of the fluid resuscitation that she had and the inflammatory situation that she had going on metabolically that there was dilution.
And it's also conceivable that she may have had some, you know, acute blood loss as, you know, a part of the operation.
Q On July 5th I'll represent to you that her hematocrit was 27.
Is there any medical significance to that?
A Well, it's low. But actually anemia is a little bit helpful in this situation because the blood flows more smoothly, you know, through the capillaries. And so actually being a little bit anemic is actually a benefit, when you have malperfusion situation; but it's not normal. I mean, she's anemic, not so much so that she would require transfusion.
Q Now, on July 6, '15, I'll represent to you

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that the white blood count was 25.8.
Is that a high white blood count?
A Yes.
Q Do you have an opinion as to the cause of the high white blood count on July 6th, '15?
A She had persistent inflammatory syndrome.
Q In your opinion did she have any signs or symptoms of infection on July 6th, '15?
A Well, I think that that was the presumptive diagnosis, that she had infection. And they did bring in an infectious disease specialist, and she had been placed on broad spectrum antibiotics.
They didn't have positive blood cultures or urine culture.
I don't believe I ever saw them get a sputum culture, although I wouldn't be surprised if I reviewed the records that there was one at some point in time.
But that her condition, you know, was this systemic inflammatory syndrome, which infection is a possible cause of.
Q You state she developed lactic acidosis. What is that?
A Lactate is a metabolite that rises in the blood and can be measured; that's the blood test.

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And there are other causes of acidosis. Lactate is a metabolic acid that's metabolized in the liver.
So the reason that lactate rises is due to anaerobic metabolism, meaning metabolism in the cells in the absence of oxygen.
And the reason for that is due to malperfusion, you know, inadequate oxygen delivery or impaired ability to utilize oxygen, which is a consequence of metabolic derangement.
Q Let me show you what I have marked as Exhibit 7, which is an infectious disease consultation on July 4th, '15.
A Yes.
Q Have you had a chance to review that?
A I have reviewed this previously, yes.
Q If I state this correctly, this is an infections disease consultation on July 4, '15 at 1837; so that's 6:37 p.m., is that right?
A Yes.
Q And it's done by Dr. Farooq Shaikh.
A That's correct.
Q And do you know who requested this infectious disease consultation?
A It indicates that Dr. Akbar, who I believe was the hospitalist now. I told you earlier I didn't

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recall his name, but now I remember.
Q All right. I'm just going to go over this with you briefly.
A Sure.
Q It states in the first page (reading): Thank you, Dr. Akbar, for this referral for fecal peritonitis, low-grade fever and leukocytosis, persistent intraabdominal infection or sepsis.
Did I read that correctly?
A Yes, you did.
Q Do you agree with that statement?
A That that's what Dr. Akbar referred to you, for this reason? Yes.
Q Do you agree with --
A I agree that that's why he made this referral.
I think that was in the differential diagnosis at the time. I mean, obviously this is very early after the operation.
As I've stated in my report, I don't think there was necessarily evidence for that; but there was obviously, you know, some contamination that occurred at the time of operation due to the colotomies, you know, that Dr. Rives encountered.
And so I think that this was the reason

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that, you know, this is one of the basis that Dr. Akbar wanted to be covering, you know, was if this was a possibility as the underlying cause for the patient's decline, that that's why they got the infectious disease in early. Also I think the patient had acute kidney injury manifestations. So their expertise, Dr. Akbar felt would be helpful in her management; and got them involved early.
Q You just mentioned the term differential diagnosis. Could you explain --
A Well, when you encounter a patient like this with septic syndrome, that we previously discussed, I mean, obviously there has to be -- there's consideration by the, you know, intensivist, or the critical care doctor, or any doctor involved in her care, as to what the underlying cause is.
And so there are always more than one possible cause. And so that's a list of potential etiologies, then that's -- we refer to that as a differential diagnosis.
Q Is there a method wherein the -- there is a priority in the differential diagnosis depending on the severity of the condition?
A Well, obviously you want to try to determine the underlying cause as soon as possible,

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particularly if there's bacterial infection, as the underlying cause, because the sooner that you, you know, correct that and how you will correct that will have a bearing.

So, yes, there is some urgency to go through that list, which they did.

I mean, they, they considered a differential diagnosis.

I think the pulmonary embolism was a consideration.

They did a pulmonary angiogram.

They did consider the possibility of this fecal peritonitis. They did an abdominal CT Scan early in the course of the treatment. They did blood cultures to look to see if the patient had bacteremia.

They supported the patient, you know, and corrected her tachycardia and also, you know, supported her pulmonary function during that time, so a lot of things were going on.

But there was a differential diagnosis.

And Dr., I don't know if I'm saying this right, was it Shaikh? Anyway, the infectious disease specialist was brought in for that specific possibility, to make sure the antibiotics that were

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being administered were adequate; and also that in light of the patient's declining kidney function, that they were -- would not result -- the choice of antibiotics wouldn't result in additional injury to the kidneys.

Q In medicine is there a general proposition that the earlier the diagnosis the better the outcome for the patient is?

A I mean that's --

MR. DOYLE: Let me just object --

THE WITNESS: That's an opinion.

MR. DOYLE: It's vague and it's an incomplete hypothetical.

THE WITNESS: I can say that that's obviously -- you know, it seems logical, you know, that the earlier that you solve the problem, the better the patient will do. But that's not always the case, of course.

Some patients just don't take kindly to any type of injury and have a protracted course, or die.

BY MR. HAND:

Q Going to Page 32 where it states Assessment and Plan. It states (reading): 52-year-old female, status post reduction of incarcerated incisional hernia, operative nick to the colon and repair.

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Is that a -- do you agree with that statement?

A That that's what happened? Yes, this is what happened.

Q Okay.

A Then he goes on to say that she has these findings and that this could, could represent fecal peritonitis. It doesn't say it does, it just says it could. So it's part of the differential diagnosis.

Then he goes on to say what his plan is to help the patient.

Q All right. The doctor also states (reading): Now with postoperative abdominal pain. Do you agree with that statement?

A Yeah, she did have postoperative abdominal pain.

Q Distension, do you agree with that statement?

A Yes.

Q Sepsis, do you agree with that statement?

A Well, she had septic syndrome. It depends on how you want to define sepsis, but yes.

Q Leukocytosis, do you agree with that?

A Right, we previously discussed her elevated white count.

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Q Fever.

A She has low grade fever.

Q And then he states this could represent fecal peritonitis.

A Correct.

Q What is fecal peritonitis?

A Well, it's a term that he's using to -- I think he's probably -- what he's referring to there is what the bacteriology might be, you know, having feces, which is colonic contents. You know, obviously there are a lot of bacteria in the colon, and many of which are pathogenic.

And, you know, that's, by using that term, it defines what type of antibiotics that he's going to use to try to cover potential infections from those organisms.

Q Okay, fecal peritonitis in this case, if it occurred, would have been caused from the colotomies during the --

A That was my assumption.

Q Okay. And at that point where the infectious disease doctor saying it could be fecal peritonitis.

Do you have an opinion as to whether at that time, on July 4th when he made that consultation

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report, whether the patient had fecal peritonitis?
A Well, I mean obviously I wasn't part of the care at that point in time.
But it is certainly reasonable to, in terms of choice of antibiotics, to cover that potential event.
But, no, I do not believe that the patient had fecal peritonitis at that time.
Q And why is that?
A Oh, well, obviously that's the whole reason I reviewed the case, you know, from multiple documents, review of the x-rays, review of physicians' notes, you know, in terms of physical findings; my knowledge as a surgeon of how fast these things develop.
I mean, it would be unusual, even with, you know, a major per, a viscus perforation, to have this fulminant of a response this early in the course of, you know, recovery from surgery.
Takes time, you know, for that type of infection to develop.
You know, if there was a heavy amount of fecal contamination at the time of operation, I think Dr. Rives would have converted to an open procedure, obviously.

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That was one of the things that he probably had to consider. And I think he testified to that effect in his deposition that there wasn't.
I mean, I think it's too early in the course for her to develop that. And that's been, you know, the basis of my report.
Q What are the signs of fecal peritonitis?
A Well, obviously you're going to have septic syndrome, which she had. So it's in the differential diagnosis.
I mean, there would have been, I think there would have been clinical manifestations, you know. She would have had, you know, obvious peritonitis. From physical examination, there are certain signs, you know, that would lead you to make that conclusion; that she would have, you know, involuntary guarding. She would have potentially a mass because she had a big, you know, hernia sac.
She might have had changes in the skin. She might have had bacteremia, which she never had.
So, you know, I think that there would have been other evidence of that.
And then, of course, you know, she was subject to radiologic evaluation, which really didn't support that diagnosis.

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So -- and I don't believe that her doctors taking care of her actually felt that she had that. I think it was confounding to them as to what the underlying cause was.
But they were, you know, continued to have that as an operational diagnosis so that they, you know, felt their treatment was appropriate in the event that she did have that.
But I don't think Dr. Rives or any of these doctors actually felt that she had fecal peritonitis, based on, you know, the physical findings.
But she had a protracted course, and was failing to improve; and so I think that they continuously considered that as a possibility.
Q You just stated the radiological studies didn't support the diagnosis of fecal peritonitis.
What study are you referring to?
A CT Scan that she had early, I think it was on the 4th.
Q And what would be shown on that CT Scan if she had fecal peritonitis?
A Well, she would have had a lot of free air. She had some. I mean, you would expect that.
There would have been, you know, it should have been more complicated than what, you know, you

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would normally expect to see after a laparoscopic procedure, you know. There wasn't a lot of air or anything.
It wasn't done with contrast because of considerations, you know, for -- at least there wasn't any oral contrast given.
Because this patient, I think, already had respiratory problems and aspiration and had abdominal distension and plus had acute kidney injury with rising creatinine in her urine. So they wanted to limit the amount of contrast that they gave her.
But there was -- the findings I think were interpreted by the radiologist and also by myself when I looked at the x-rays, that these were expected, you know, radiologic images for a patient that had a hernia repair.
Q At some point she was put on a ventilator, is that right?
A Yes.
Q Why was that necessary?
A Just because she couldn't meet her respiratory demands.
Q And do you have an opinion --
A Oxygenation.
Q -- why she couldn't meet her demands?

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A I think she aspirated. And, you know, she had respiratory impairment which is typical for postoperative, you know -- any patient is going to have some respiratory, you know, embarrassment after an operation of this type. But it was compounded, I think, in her because of aspiration.

Q And then you note she had tachycardia.

A Yes. I think here, it says it was atrial flutter which is, you know, an abnormal rhythm, you know, of the heart, which is fast. Atrial flutter is a fast heart rate. I mean, she had cardiac arrhythmia.

MR. DOYLE: You doing okay? He's kind of fast.

THE REPORTER: Yeah, I'm fine, thank you.

(Discussion off the record.)

BY MR. HAND:

Q Now, you also state that the patient's rapid early decline was primarily respiratory with hypoxemia and increasing obtundation.

What is obtundation?

A Just cognitive impairment. Lack of responsiveness, confusion.

Q Then you state the rapid deterioration is inconsistent with intraabdominal infection as this

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would take longer to develop.

What time period, in your opinion, would intraabdominal infection manifest in this case?

A Well, it wouldn't be -- generally it could develop, start developing, you know, obviously, immediately. But in most situations it usually takes several days.

Q Do you have an opinion as to when the intraabdominal infection presented?

A I believe it was somewhere between July 9th and July 15th.

Q And what's the basis of that opinion?

A Well, obviously it has to do with the patient's clinical course, you know, up until the 9th, when they did a CT Scan. At that time they did a CT Scan with triple contrast, where they gave IV contrast, oral contrast and rectal contrast, retrograde up the colon, to determine whether there was a fecal leak at the anastomosis.

And I did review that x-ray, and I believe the contrast did reach the area where the surgery had been performed on the repairs.

And there was no leak at that time. And also the other CT manifestations actually had not progressed significantly.

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There wasn't, you know, a lot of other evidence of a leak at that time.

There was fluid in the abdomen, fluid in the hernia sac, but there wasn't a lot of free air; there wasn't a lot of inflammatory changes around where the colon had been repaired.

But then basis clinical course actually did begin to deteriorate before July 15th which she had been relatively stable up until that point. Then she showed some deterioration in terms of her exam and other parameters.

And then that led to a CT Scan being performed on the 15th, which showed a massive amount of free air. There is no doubt there was a leak at that time.

So that's when the decision was made to reoperate.

Q Did this patient ever improve from the day after the surgery, July 4th, up until the reoperation on July 16th?

A Yes, yes, her condition stabilized.

Q When did she --

A I think she began improving after the first 48 hours in ICU.

Her tachycardia resolved.

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She really didn't have a spiking fever curve.

She still had respiratory failure, but there was some -- there was some improvement, I think, in terms of her oxygenation or lactic acidosis resolved. And, you know, her urine output improved; kidney function, I think, stabilized.

So I mean, yeah, she did improve.

Q Over the course of that period, July 4th to July 16th, did her white blood count improve?

A No. I think she did have a persistent leukocytosis. It fluctuated, but never normalized.

Q And if you have a persistent high white blood count, are there criteria to assess what's causing that high white blood count?

A Well, ongoing. I mean, that's why the patient's in the ICU and has multiple consultants is there -- obviously that's a point that they're considering every single day she was in the ICU as to why she wasn't improving or why that white count wasn't improving. I mean, she was improving, but she wasn't well. I mean, she still required, you know, mechanical ventilatory support, she was still requiring sedation, she was still requiring antibiotics, I mean, based on the fact that her white

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count was elevated.
I mean, that was, I think, every physician that saw her every day was trying to figure out why the white count was still elevated. And that was why there was ongoing concerns.
Q In your opinion do you think Dr. Rives did anything wrong in the care of this patient?
A No. I mean, obviously there are different ways to do things. I mean, surgery, I mean, within acceptable standards, you know.
I think that -- I don't really think he did anything wrong. I think he did a surgery that he thought would be adequate.
He obviously did that surgery with concern for the patient's welfare; that he was attentive in the postoperative period.
You know, I think that he diligently saw the patient and re-evaluated her on a continuous basis.
And that she did ultimately suffer a surgical complication. And I think he was in a position where he could have, you know, managed that. But the family chose to change horses at that time in terms of surgical care.
So I don't think that he did anything

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wrong.
Q When you talk about surgical complication, surgical complication can be, am I correct in stating this, an iatrogenic issue?
A Yes.
Q Was that the kind of complication we had here, an iatrogenic --
A I think so. I mean, I think he did probably an adequate repair; but that, you know, that it ultimately failed, which I think any repair can fail.
Q So a complication can be negligently caused and non-negligently caused, is that a fair --
A Yes.
Q -- statement? So...
MR. DOYLE: When you get ready to shift gears, can we take a break?
MR. HAND: We can take one now.
MR. DOYLE: I need to use the men's room.
MR. HAND: We can take one now.
THE VIDEOGRAPHER: We are off the record at 9:55.
(Recess taken.)
THE VIDEOGRAPHER: We are back on the record at 10:04. Please go ahead.

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BY MR. HAND:
Q Dr. Juell, do you have an opinion as to whether any of the other physicians involved in the care of Mrs. Farris fell below the standard of care?
A No.
Q They did not?
A I don't believe so. I mean, retrospectively, maybe they could have done better, they could have done other things to take care of -- you know, do things -- I mean, in the temporal nature of their care, I think they were diligent, based on her progress and examination.
Q Now, on July 9th, was there a consultation by another surgeon?
A Yes.
Q Let me show you what's marked as Exhibit 9.
A Thank you.
Q A report of a Dr. Ripplinger?
A Correct.
Q Have you seen that report?
A Yes, I have.
Q Does he indicate there should be a fairly low bar to reoperation?
A Yes.
MR. DOYLE: I object. It mischaracterizes

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the evidence.
MR. HAND: Okay.
MR. DOYLE: In that you didn't read the whole sentence for him.
BY MR. HAND:
Q Okay. I'm going to ask you to go to Page 19 on the lower left corner.
A Okay.
Q Do you see where it says impression and plan?
A Yes.
Q And I'm going to ask if I read this correctly (reading): I would be concerned about possible colon leak or possibly early severe mesh infection. Would have low threshold for reoperation, since patient is not doing well after incarcerated incisional hernia repair. Will not actively follow.
Did I read that correctly?
A Yes.
Q In your opinion should that consultation have put Dr. Rives on a heightened awareness of a possible leak?
MR. DOYLE: I'll object, it's vague.
THE WITNESS: I'm sure Dr. Rives was considering that on a daily basis, you know. I don't

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think it would change anything for Dr. Rives.
BY MR. HAND:
Q Now, I'm going to show you Dr. Hamilton's operative report from July 16, '15.
It's Exhibit 6.
Have you seen that?
A I haven't.
Q Now, looking -- let me know when you've had a chance to look at it.
A I'm ready for a question.
Q Looking at Page, at the bottom, 43. It's the first page of the operative report.
A Yes.
Q It has preoperative diagnosis, postoperative diagnosis. And the -- they appear to be the same, preoperative and postoperative. And postoperative diagnosis: 1, perforated viscus with free intra-abdominal air.
Based on your review of the records and your expertise, do you agree with that diagnosis?
A Yes.
Q No. 2, sepsis. Do you agree with that diagnosis?
A Yes.
Q 3, respiratory failure. Do you agree with

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that diagnosis?
A Yeah.
Q Anasarca, do you agree with that diagnosis?
A Yes.
Q And fever, do you agree with that?
A She did have fever at this point.
Q All right. And then leukocytosis, do you agree with that diagnosis?
A Yes, uh-huh.
Q And 7, 8 and 9, do you agree with those diagnoses?
A Yes.
Q Going to what you did, and going to the next page, 44.
A Sure.
Q Do you see where she states findings: Cavity identified under the bulging skin on the abdominal wall with evidence of free air upon entering into the abdomen. Do you see where I just read from?
A Yes.
Q All right. And, 2, infected-appearing mesh with stool covering it and purulent feculent contamination at the level of the mesh.
Do you see that finding?

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A Yes.
Q Do you have an opinion as to the cause of that finding, No. 2, infection-appearing mesh?
A On the -- there was a hole in the colon, and that was the cause.
Q The No. 3, Doctor notes: Approximately a quarter-size or three centimeter hole in the transverse colon anteriorly associated with the staples in the colon wall.
A Yes.
Q Do you have a recollection of the size of the colotomy or colotomies that Dr. Rives repaired? If you want to look at his operative report --
A I could look at his operative report.
Q Do you have it there?
A I don't think so.
I think you showed it to me. Maybe it is here.
Yes, here it is.
I don't think he stated the size. They were small.
Q Would it be fair to say that the hole that's referred to in Dr. Hamilton's report is larger than the one he repaired?
A It, it wouldn't be surprising.

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Q Do you have an opinion as to when, if you can -- I don't know if you can or not -- this hole became three centimeters or quarter-sized in the transverse colon?
A I don't really have an opinion. I mean, there's a lot of swelling. When you have a perforation like that, the holes become bigger over time, or, you know, appear bigger.
I'm not surprised by the size, you know, considering that length of the staple line that was used to close it.
I don't think there's a bearing on the size it was initially and the size it was at the time when they found the hole.
I mean, I think it's just the result. I mean, it was along the staple line. The staple line failed.
Q Do you know how many holes Dr. Hamilton found in her reoperation or operation on July 16th?
A Maybe she said so on the operative report.
According to her findings, just one.
But then, maybe there's more detail.
Just one, I think.
Q You note also (reading): She was failing to improve clinically and her abdomen remained

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distended, in your report. Do you recall saying that?
A In Dr. Hamilton's report?
Q No, no, in your report.
A I believe she did have persistent abdominal distention. Part of that was due to the anasarca, which is like edema of the tissue.
Q Was any of that consistent with sepsis, the distended abdomen?
A No, not directly.
Q And she is not improving clinically at this point. Why is that, in your opinion?
A Well, she's -- she probably had, you know, her comorbidities. She had pneumonia, pretty well established pneumonia by this point.
So, I mean, there were a lot of reasons.
She actually -- you know, there were parameters that were improving, you know, up until just the days antecedent to the CT Scan and operation around the 15th.
You know, her blood sugar was controlled, her tachycardia was controlled, her renal function was improving. She did still have an elevated white count, but nobody was really documenting any progression of physical findings, you know, in terms

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of the abdominal situation.
But she was still on the ventilator, I mean, she was still languishing, you know.
So I think they were, you know, obviously still concerned.
Q You go on to state that Titina Farris is a patient who had significant risk for surgical intervention. You state poor healing by failing to heal her initial hernia repair.
Did you consider that the initial hernia repair was not done technically correct?
A No. I mean, obviously I have a different opinion about how hernias should be repaired, you know.
I think that, you know, I've devoted a lot of my career, particularly recently, to improving the results of, you know, ventral incisional hernia repair.
We employ a lot of different techniques, want to do that, which I think have led to improved results.
The -- I think when patients fail, the primary reason is usually the patient, you know, not so much the technique, though.
I think patients that develop hernias to

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begin with have a propensity to do so. I think there's probably underlying genetic factors.
And she had diabetes, which is a known risk factor for hernia repair failure. And also she had obesity, which is also, you know, a risk factor for repair.
She didn't smoke, which I stated was fortunate, because that's a primary risk factor for failure for hernia repair to be successful.
But she definitely had risk factors.
Q Well, the infection that Mrs. Farris was diagnosed with by Dr. Hamilton in her second surgery, did her diabetes have any relation to that infection?
A Yes, I'm sure.
Q What is that?
A Well, I mean it increased the risk of infection. You know, having an elevated blood sugar. She had, you know, blood sugars out of control, initially when she, you know, had that early, you know, metabolic and physiologic collapse. I mean, her blood sugars are running four to 500.
I mean, I had a patient yesterday in surgery that presented, preoperatively had blood sugar elevation, but canceled.
I mean, it's a known direct association

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between your blood sugar level and your percentage risk of infections.
I mean, you definitely -- there's a relationship.
Q Did her diabetes have anything to do with the staple lines giving way?
A I, I don't know that you could make a specific connection between those. I mean, there's so many factors that contributed to that, so...
Q What were the factors that contributed to the staple line giving way?
A Well, I mean, she had this septic syndrome, she had malperfusion; she had multiple manifestations and multiple organ systems. The bowel is going to be affected, I mean...
Q Now, you state on July 17th, in your report -- that may have been a mistake. I think you maybe meant July 15th -- but you say it is well-established peritonitis. The family's decision to replace him only added to the difficulty of the delayed subsequent surgery.
MR. DOYLE: Do you still have that report available?
THE WITNESS: My report?
MR. DOYLE: Yeah. Just so you can see what

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he is looking at.
MR. HAND: Here is your other report.
THE WITNESS: Yeah, thank you.
MR. DOYLE: And I'm sorry to interrupt, are we on the first report or the second report now?
We have a report November --
MR. HAND: This is on the first report, I believe.
MR. DOYLE: Okay.
THE WITNESS: I see that the date of operation is listed at 7/16, but at the top of the page on Dr. Hamilton's report indicated that the time of the operation was, or the operative report was 7/17/2015.
But I do see now that it was the 16th.
So I -- I know that they got the CT Scan on the 15th. And that demonstrated it. And I understand that they decided then they were going to go with, you know, Dr. Ripplinger's group and Dr. Hamilton to do the surgery.
I -- I have to say that I always kind of, when I read the report I was wondering why there was a delay, you know, in taking the patient to the operating room, you know, once they had that CT Scan on the 15th. And that she obviously was going to

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require reoperation.
And I -- it wasn't explained in the records, you know.
I know Dr. Ripplinger saw her on the 9th, and then Dr. Hamilton was called in to do the surgery, but he assisted.
So, I mean, he was available -- I don't know, that was always a point of question that I had in my mind when I was reviewing the record.
But if you said I stated in my report it was 17th, but it was actually the 16th, I would give you that.
BY MR. HAND:
Q Yes.
A I mean, obviously there was some shifting of the team and that took time, I mean.
You know, the family said Dr. Rives told them they need an operation right away. Then they said they wanted to change surgeons, and then that had to be organized. So obviously there was some delay, but...
Q Do you have any criticism of the family for changing --
A No, I mean, that I don't. I, you know -- it's always about the patient, you know. The family

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is going to have an opinion. And maybe they didn't have a strong feeling with Dr. Rives, you know, confidence; maybe their confidence was, you know, shaken, you know, that he had done this repair and it failed, and then she had to have another operation.
And, you know, I don't know the dynamics there, but that happens.
It's certainly, you know, I don't know that it's ever happened to me.
But I have patients come and see me, I operate on them and then I find they are operated on by different surgeons, so...
I mean, I have learned that not everybody likes you, or that they have their privilege to make a decision to go with somebody else.
I mean, it's really, I always think it's about the patient, you know. I don't know, I'm mature enough to be able to accept that, you know. Patients do what they think is best for them.
And I think the patient was stable, you know, in that period of time when they were changing surgeons. You know, I don't think there was, you know -- she was -- her condition was stable enough to allow that to take place at that time.
Q Was there any medical benefit to the

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patient from July 9th up until the second surgery on July 16th?
And my question is, were any medical benefit by Dr. Rives not reoperating during that time period?
A Between the 9th and the 15th?
Q Yes.
A I mean, I don't think she would have had a particularly different course. I mean, again, you know, the earlier you intervene the better.
You know, you change the course of things. And so would she have, you know, been able to go home by the 17th if he'd operated on the 9th?
No, this patient was sick, and she was going to take a long time to get well.
And that's what happened. So the difference of a few days there I don't think contributed to any significant degree on the patient's ultimate recovery.
Q Was, in your opinion, this outcome that the patient had a good outcome from this procedure?
A I think so. I mean, she survived. I mean, there was significant mortality risk.
And she obviously had a complicated course.
And I presume that she probably required

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reoperation at some point to reverse her colostomy. I don't know how that turned out.

Yeah, definitely, she recovered.

Q Do you know what her condition is now?

A I don't.

Q Do you have an opinion as to any point in time during this course from the surgery up until the second surgery whether this outcome would have been avoidable with another intervening surgery?

MR. DOYLE: Just objecting --

MR. HAND: I'll rephrase it --

MR. DOYLE: Looking at you, the objection is --

MR. HAND: I'll rephrase it.

MR. DOYLE: Okay.

BY MR. HAND:

Q In your opinion, would this outcome have been avoidable if an earlier surgical intervention was done?

A I'm not sure which outcome you're referring to. Her survival, or --

Q Her, let's just call it her sequelae from the, from the --

A Well, I'm not sure what those are.

Q Okay.

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A But I can say that she obviously had a, you know, she had an operation. She had a complication develop that was directly related to that operation and that was corrected.

I don't know that if she had an earlier operation she would have been able to avoid a colostomy. I think that would, probably would have been necessary because it wasn't like, you know, in the first 24 hours or something they discovered a leak, and they can go in and perhaps, you know, then there might have been an opportunity to do a direct repair.

Most surgeons I think would do a fecal diversion.

You know, she obviously had an infection and then she required, you know, additional care with, you know, further CT Scans. I believe she had percutaneous drainage procedures.

But these are, you know, expected, you know, complications after this type of, you know, this type of disaster, you know.

So I don't know that it would have been any different.

Q Is source control the most important step in the definitive management of sepsis?

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A Yes.

Q And what is the standard of care in determining, in obtaining source control?

MR. DOYLE: Object. It's an incomplete hypothetical, you know.

THE WITNESS: I don't know that there is a standard.

I think most people would, you know, obviously a delayed diagnosis can contribute to adverse outcome.

So a prompt diagnosis -- diligence, you know, which I think the physicians providing care for her were diligent, you know.

BY MR. HAND:

Q On July 4th, the day after the surgery, with a white blood count of 18.9, hemiglobin 11.1; and then going to the next day, July 5th, where the white blood count is now 23.3.

My question is, on July 5th, 2015, with the white blood count of 23.3, and having that infectious disease consultation that we discussed, what is the standard of care at that point for Dr. Rives in treating this patient?

A Well, due diligence and, you know, consider -- I mean, as a surgeon you obviously want

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to consider the fact that there may have been a surgical complication or misadventure.

So maybe -- I think he clearly did that.

Q How did he clearly do that?

A Well, just by, you know, his diligent care of the patient, you know; the appropriate consultation; CT Scan of the abdomen; you know, his physical examination of the patient, you know; his perception of her course; his consideration for potentially other causes.

You know, and he was weighing that against the risk of reoperation.

I mean, some surgeons, I suppose, would pull the trigger with a patient that deteriorated like this and just, you know, reoperate just as a diagnostic intervention, you know.

But, I mean, you have to weigh -- you have this patient. This patient obviously has problems. I mean, she's sick and you don't want to compound that with an unnecessary surgery.

So, I mean, you have to weigh that risk and benefit out. And I think that's what he did. I don't think that he was negligent.

Q Well, on July 6, '15, did the standard of care of his treatment change in any fashion, what he

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was required to do?
A No. I think he had gotten the CT Scan by that point; really didn't show evidence of the leak. Her physical examination was not adversely changing.
I mean, her metabolic situation was actually improving, you know; she had improved glucose control, decreasing lactic acidosis; her tachycardia, I think, had resolved or had been treated at that time.
It just -- the 6th was like every other day that he attended her, I'm sure, that, you know.
The fact that she was, you know, improving -- I mean, she was stabilized -- you know, the fact she was improving, I'm sure there was consideration every day as to what, you know, the situation was.
Q We're going to the 9th, after that other consult. Did the standard of care for Dr. Rives change at all after seeing the other consultation -- and at that point her white blood count's 22.9 -- did the standard of care change at all knowing what Dr. Ripplinger said.
A Anyway, when Dr. Ripplinger was brought in as a second opinion, which I think, you know, was probably prompted by the family, make sure they weren't missing anything.

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And he said get another CT Scan, which they got. And he didn't come back for follow-up, you know, review the scan or, you know, document his opinion any further.
He just said well, I would get a CT Scan, but I'd have a little threshold for reoperation.
Well, he got the CT Scan with triple contrast and it didn't show a leak. And, quite honestly, I looked at the x-rays, and I don't see a leak.
You know, I think the fluid that she did have in the hernia sac and also in the abdomen were probably communicating. I think that the repair may have failed a little bit, you know, in terms of the mesh that allowed that communication.
And in that hernia sac was very up close to the skin. You know, when he examined her, you know, I think that Dr. Ripplinger said that he could feel fluid, you know. But he didn't say it was red or indurated, you know, or thickened or inflamed or, you know.
And he was, just had, like everyone else, like I think Dr. Rives, you know, they were considering the possibility of surgical complication every day. But the CT Scan didn't show one.

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So I think Dr. Rives just, you know, weighed everything out and decided that, you know, continue the care; that she wasn't deteriorating, and, you know, just to make that decision on a day-by-day basis.
But I think when his condition, when her condition deteriorated, you know, prior to the CT Scan of the 15th, which was diagnostic of bowel perforation, I mean, her clinical condition deteriorated prompting that CT Scan.
And I think that led to the diagnosis and the subsequent operation, which was appropriate.
Q Well, so my question is, during that period, after the 9th up through the 15th, did the standard of care for Dr. Rives change in any way from before that?
A No, same standards applied.
Q Were there other criteria to consider besides CAT Scans in determining whether the patient has a bowel leak?
A Yeah. I mean, her global situation -- I think her physical examination would have demonstrated, you know, would have changed adversely, you know.
I don't have -- when I reviewed the records

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I didn't see that that was occurring, you know.
I think, you know, I mean, if there had been other interventions, it could have been done, you know.
Just my impression was that everyone involved in the care was considering that as a possibility; but there wasn't, you know, any strong evidence to do anything up until the time that her condition deteriorated and then they got the CT Scan of the 15th.
I mean, it was always in the back of their minds or in the front of their minds; and there was always a consideration. But the clinical situation really wasn't progressing to the point where there was a smoking gun for operation prior to the 15th.
Q It seems to be you're using plural in this assessment of the patient.
Who's responsible to make the decision for reoperation in this case?
A Well, ultimately the, the surgeon, you know, is the captain of the ship, I would say. And then I would consider that if I was, you know, taking care of the patient.
I mean, the other doctors can't operate. I mean, they are medical doctors.

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They don't -- operation isn't an arrow in their quiver, you know, for caring for the patient.

So the surgeon has to make that decision, you know, to reoperate, and the family has to consent.

So, but I think all of them are communicating, I presume, that's the way medicine is. You have people do, you know, providing care; and that they, you know, communicate in the record and also presumably in conversations among themselves.

And they're all advocating for what they think is necessary for the patient.

So it's, it is a plural, you know, the care team.

Q The surgeon who's making the decision here is Dr. Rives, is that right?

A Yes.

Q Did you see any note where Dr. Rives disagreed with any of the consultation notes?

A I don't recall seeing that, no.

Q Now, did you have a chance to review reports by Dr. Hurwitz and Dr. Stein in this case?

A Yes, uh-huh.

Q Dr. Hurwitz -- I didn't mark this. I can if you want or I can show it to you. I'm just going

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to read some questions from it and then ask you about it.

Dr. Juell, have you seen this report?

I think you did. You referred to it in the rebuttal report?

A Yes, I have seen this.

Q Going to the third page.

A Okay.

Q Dr. Hurwitz says (reading): Titina Farris was tachycardic with a heart rate as high as 140 beats per minute, and was noted by Dr. Rives to have a markedly elevated white blood count of 18.9, and her blood glucose level elevated to 517.

Is that a correct statement?

A I believe so, yes.

Q And then he quotes the infectious disease consultation, and we've discussed that already.

And then going down to the bottom paragraph, he states (reading): Titina Farris continued to deteriorate and developed respiratory failure requiring intubation.

Is that a correct statement?

A Yes.

Q And then CT on the second postoperative day showed fluid around the liver and in the pelvis; is

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that correct?

A That is correct.

Q Then it states (reading): Over several days her white blood count elevation worsened despite broad spectrum antibiotic therapy.

Is that a correct statement?

A Well, it did go up, yes.

Q Okay. And then he states (reading): She continued to display evidence of sepsis and remained intubated on a ventilator.

Is that a correct statement?

A I think septic syndrome -- it's a reasonable operating diagnosis, yes.

Q He further states (reading): Despite this, Dr. Rives documented on July 6th, 2015 that she was progressing as expected, and further stated that patient has improved but still have not ruled out further surgery if condition does not improve or worsens.

Is that a correct statement of Dr. Rives' progress note from July 6th?

A I think it is, correct.

Q And then he notes Dr. Ripplinger's statement --

MR. DOYLE: Which, for the record, is a

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mischaracterization of the statement.

THE WITNESS: Right.

MR. HAND: Well, I can read the whole statement if you'd like into the record. We can do that. Do you have Dr. Rippinger's -- let's clarify that.

MR. DOYLE: Here, I got it.

It's under his impression and plan. Why don't you take a moment and read the whole thing.

THE WITNESS: I've read that.

BY MR. HAND:

Q All right. I'm going to go to Page, if you look at the bottom, Page 17, in the lower corner.

A On Dr. Ripplinger's --

Q Yes.

A -- consultation?

Q Yes.

A Yes, I have it.

Q And he notes (reading): White blood cell count this morning is 22.600. Do you see where I'm at?

A Yes, laboratory data.

Q All right. So going to the bottom, the last paragraph, impression and plan, states (reading): I think there's a reason to be concerned

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for possible leak from one of the two colon repairs, or an early aggressive infection of the mesh causing some of the patient's problems.

Did I read that correctly?

A Yes, it says some of the patient's problems.

Q Then he states (reading): I would recommend a repeat CT Scan of the abdomen and pelvis done with intravenous oral and rectal contrast and to help rule out leak from the colon.

Did I read that correctly?

A Yes.

Q (Reading): I think there should be a fairly low threshold for at least a diagnostic laparoscopy.

Did I read that correct?

A Yes.

Q (Reading): Or even laparotomy if there are any significant abnormalities noted on the CT Scan, especially if there is an increase in free fluid in the abdomen, I would be concerned for possible bowel leak.

Did I read that correct?

A Yes.

Q So going back to Dr. Hurwitz's report, he

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states, going to the fifth page in his report, he states -- do you see where I'm at, Doctor, down to where he says (reading): Dissection of the transverse colon from the previously placed mesh using a thermal energy source resulted in at least two colotomies.

Do you see what I'm referring to?

A Yes.

Q Okay. He states (reading): The stapled repairs of the colotomies were inadequate and did not hold, resulting in spillage of fecal contents into the abdominal cavity.

Do you agree with that statement?

A No. I mean, they were adequate for, you know, a period of time; but ultimately they did fail.

Q Okay.

A So I don't know that the repairs were inadequate. I would disagree with that. But there's no doubt that they failed.

Q Then it states (reading): The patient was allowed to become septic and deteriorate to critical condition due to ongoing spillage of stool from the perforated colon.

Do you agree with that statement?

A No. I mean, she was -- she did have septic syndrome. But I don't think that she deteriorated to

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the point of -- I mean, she was failing to improve but she didn't deteriorate to critical condition. I mean, she could have been a lot sicker; but she was heading that direction, you know, at the point when the diagnosis was made.

But then appropriate intervention took place.

Q Then he states down in the last paragraph, he states that (reading): It was known that there were at least two holes created during the July 3rd, '15 surgery. This should have put Dr. Rives on notice of a potential problem and the source of the infectious process.

Do you agree with that statement?

A Well, of course. I mean, I'm sure Dr. Rives agreed with that, too.

Q I'm going to show you Dr. Hurwitz's rebuttal, expert report. I don't know if you've seen that yet.

A Uh-huh.

Q Okay, if you go down to the second paragraph.

A Okay.

Q States -- I'm going to read it to you -- (reading): It was incumbent upon Dr. Rives, with full

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knowledge that the colon had been perforated and repaired during surgery, to presume an intraabdominal source of the sepsis until proven otherwise.

Do you agree with that statement?

A Yes.

Q Then down at the last sentence he says, referring to Dr. Ripplinger (reading): Dr. Ripplinger's note should have heightened Dr. Rives' concern and prompted a return to the operating room.

Do you agree with that statement?

A Well, as I stated earlier, I don't think it would heighten my concern or Dr. Rives' concern, you know, if another surgeon had that opinion. It's already on the, you know, on the daily consideration, you know, the surgeon would have seeing the patient.

I mean, it's just another opinion, you know.

But, you know, he basically did what Dr. Ripplinger recommended, I mean, getting another CT Scan with triple contrast, which as I've testified today and in my records that it didn't show a leak.

I mean, that, that's the crutch of the situation. I don't think that Dr. Rives fell below the standard of care.

Q Well, going down to the second to last

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paragraph, he talks about what you stated in your report, that she was at increased risk from surgical intervention due to multiple risk factors including diabetes, obesity, previously demonstrated tendency toward poor wound healing.

A Correct.

Q Then he states (reading): These risk factors should have heightened Dr. Rives' concern about possible surgical complications when she became septic postoperatively.

Do you agree with that statement?

A Yes. I mean, and Dr. Rives had that appropriately heightened concern.

Q Then it states, referring to you, (reading): Dr. Juell also suggests that the sepsis could initially have been attributed to pneumonia. Inclusion of pneumonia in the differential diagnosis of sepsis does not absolve Dr. Rives of the responsibility to rule out an intraabdominal source.

Do you agree with that statement?

A No, it doesn't, and it didn't.

Q All right. I'm going to show you the rebuttal report of Dr. Stein. I don't know if you've seen that.

A I think I have.

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Q I marked his initial report. I'm going to go over that with you briefly.

A The one you handed me or the --

Q Go through the first one.

A Okay. I don't know that I have that one, but...

MR. DOYLE: What are you looking for?

THE WITNESS: He was going to go over the initial report of Dr. Stein.

MR. DOYLE: Do we have that?

THE WITNESS: I don't think I have that.

BY MR. HAND:

Q Why don't we just go to the rebuttal report.

A Okay, I have that.

MR. DOYLE: Yeah, I think you just marked -- 11 was Stein's rebuttal report.

MR. HAND: Why don't we look -- I didn't. I had it -- you're right.

BY MR. HAND:

Q Let's just look at the rebuttal.

A Sure.

Q Go to the second page, if you could. He talks about your opinions.

He states (reading): Respiratory insufficiency is part of the septic syndrome. Studies and the clinical course eliminated the possibility she had sepsis from pneumonia.

Is that a correct statement?

A No.

Q Then he goes on to state -- and I'm going down the paragraph -- significantly, other causes of infection/sepsis such as aspiration pneumonia, pulmonary embolism, or urinary tract infection were excluded.

Is that a correct statement?

A Well, she didn't have pulmonary embolism or urinary tract infection; but as I testified or stated that I do believe she had aspiration pneumonia, so that is not a correct statement.

Q He states (reading): If a perforation is suspected but the imaging is equivocal, abdominal exploration is needed.

Is that a correct statement?

MR. DOYLE: Object, the statement's vague.

MR. HAND: All right.

THE WITNESS: I mean, you have -- obviously that's a vague statement.

BY MR. HAND:

Q Dr. Juell, could you read your rebuttal report for me.

We've marked it as an exhibit.

A Yes, I have it.

Q Okay. You make a statement on the first page, you talk about Dr. Hurwitz does not explicitly state his experience in diagnosis of anastomotic leaks.

Can you tell me what you mean by that?

A Well, he's a surgeon, I believe. And that he doesn't really indicate what his experience is with, you know, diagnosis of anastomotic leaks or suture failures, so...

Q Do you have any issue with his qualifications as a --

A No, I don't know anything about him, to tell you the truth.

I know he's a board certified surgeon. I have respect for that.

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

A Yes.

Q Okay. Can you tell me about it? How many were there?

A Jeez, I've been sued four times, I think. When I was a resident, I was involved in

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the care of a trauma patient that developed complication from an arterial line that ended up with limb loss.

But I was a resident and, you know, that did go to trial.

I wasn't in trial; but I was -- I think there was a settlement made on my behalf by the University. I wasn't party to that settlement resolution, but I was deposed.

You know, there was a situation where I really was trying to do the right thing for the patient; but the attending physician ultimately made the decision to try to reverse that situation, but it was too late.

So the -- then I was sued on a case here where a patient had aspiration pneumonia following a hernia repair, and the cause of the aspiration was due to a medication error by the nursing staff, you know, that led to obtundation and failure to, you know, protect his reflexes.

I was deposed, but dropped from that lawsuit.

Then I was sued on a very complicated case where the patient also had aspiration pneumonia, but developed shock and had complications following a

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vascular procedure and died.

And I really didn't do anything wrong, but there was a settlement made on my behalf. I agreed to settle, and then the insurance company and arbitration led to a settlement of $150,000. That was basically risk management, you know, on behalf of the insurance company. I think, you know, they, they told me that I would probably win the case, you know, if it went to trial; but they elected not to pursue it.

And then I had a case of a nerve injury that resolved, and I was dismissed with prejudice on that case by the judge.

So I think those are the only four times that I've personally been sued.

MR. HAND: He has got to change his tape.

THE VIDEOGRAPHER: We are going off the record at 10:54. This ends Media No. 1.

(Recess taken.)

THE VIDEOGRAPHER: This is Media No. 2 in the deposition of Brian E. Juell, M.D., on June 12th, 2019.

We are back on the record at 10:56.

Please go ahead.

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BY MR. HAND:

Q Dr. Juell, have you ever been disqualified as an expert witness in a case?

A No.

Q Those cases you just talked to me about where you were involved as a litigant, were any of those dealing with bowel injury or sepsis?

A No.

Q And the opinions you've given here today, are those your complete opinions you intend to give in the case --

A Yes.

Q -- if you're called to testify? Are there any other --

MR. DOYLE: Well, of course, supplemented by what's contained in his reports, which you haven't covered yet.

THE WITNESS: Yeah.

MR. DOYLE: And then also, just in fairness to you, I don't know if you've covered everything concerning his review of the images, although he's talked about that from time to time.

BY MR. HAND:

Q All right. Well, let me ask you this way. Is there anything not contained in your reports or

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what you've testified to today that you would give opinions on?

A Yeah. I hadn't seen the x-rays until just last week.

And I think that there are some findings on that CAT Scans that do clearly show that the patient had progressive pneumonia developing.

And I would have included that in my report had I seen those. That was not part of the reports that were generated by the radiologist at the time of operation.

But I could see that in retrospect.

The other opinion I have is that I believe the fluid in the hernia sac was communicating with the area where the colon was repaired, at least early and I think subsequently. And I do think that perhaps by July 9th that that hernia repair may have failed, which would have made that fluid continuous, you know, with the process of infection.

Obviously when Dr. Hamilton operated she just, when she cut into the area, she just released air; but there was fluid and stool around the mesh.

The fluid was obviously pushed back into the abdominal cavity when the air accumulated underneath the repair, or when the bowel perforated

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the pressure of the air displaced the fluid back into the abdominal cavity.

But I think by the 9th, I couldn't really see the mesh repair and completeness. And it looks to me like there's a free flow of fluid into this hernia sac, which is very close to the surface of the skin.

So I, I'm very, would be very surprised if there was a leak at any point; that there would have been significant manifestations, you know, on the skin at that period of time when infection would have been established. And the pneumonia was progressive during that period.

So I -- my opinion was reinforced by the fact that when I reviewed those scans, that there wasn't evidence of a leak up until the time of the 5th, the CAT Scan of the 15th, and the patient showed immediate preceding deterioration.

Q All right.

A And I don't think -- I don't know, I won't saying anything. I have an opinion.

Q Did you have an opinion --

A Well, I just, you know, Dr. Hurwitz in his reports never made mention of what his impressions were of the films, you know. He obviously reviewed

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the reports, but I don't know that he actually, you know, looked at the films.

But, I mean, obviously he's testifying, you know, for the plaintiff, so...

Q What do you mean by that?

A Well, I mean, to me, if he looked at those, he might, you know, at least share my opinion about that.

Q Are the films, as you read them, any different than they were read by the radiologist --

A Yes.

Q -- at the hospital? Which films are different?

A Well, the initial angiogram really doesn't comment about the consolidation of the lung. The second CT Scan, I don't really see a reference regarding the pneumonia.

And then I think the third CT Scan, I mean, she's got complete pneumonia of the right lung almost. And I don't remember seeing that in the reports. But I haven't reviewed those reports since I looked at those films.

But that was my memory.

MR. HAND: All right. Thank you, Dr. Juell.

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I don't have anything else.

THE WITNESS: You're welcome.

MR. DOYLE: Okay.

THE VIDEOGRAPHER: We are off the record now at 11:00 o'clock.

This ends this deposition.

(The deposition was concluded at 11:00 a.m.)

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-oOo-

I, BRIAN E. JUELL, M.D., hereby declare under penalty of perjury that I have read the foregoing pages 1 through 98; that any changes made herein were made and initialed by me; that I have hereunto affixed my signature.

DATED: _____

_____

BRIAN E. JUELL, M.D.

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ERRATA SHEET/CORRECTIONS

PAGE	LINE	CORRECTION

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STATE OF NEVADA,)
) ss.
COUNTY OF WASHOE.)

I, TERRY ELLIS THOMPSON, a Certified Court Reporter in and for the County of Washoe, State of Nevada, do hereby certify;

That on the 12th day of June, 2019, at the offices of Bonanza Reporting & Videoconferencing Center, 1111 Forest Street, Reno, Nevada, I reported the videotaped deposition of BRIAN E. JUELL, M.D., who was sworn by me and deposed in the matter entitled herein; that the reading and signing of the deposition were requested by Counsel for Defendants;

That the foregoing transcript, consisting of pages 1 through 99, is a full, true and correct transcript of my stenotype notes of said deposition to the best of my knowledge, skill and ability.

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

DATED: At Reno, Nevada, this 24th day of June, 2019.

Terry Ellis Thompson, Nevada CCR #6

Electronically Filed
10/28/2019 4:00 PM
Steven D. Grierson
CLERK OF THE COURT

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

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al., Defendants.	CASE NO. A-16-739464-C DEPT. NO. 31 **DEFENDANTS BARRY RIVES, M.D.'s AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S TRIAL BRIEF ON REBUTTAL EXPERTS BEING LIMITED TO REBUTTAL OPINIONS NOT INITIAL OPINIONS**

Defendants BARRY J. RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC ("Defendants") hereby provide this Court with the following trial brief in support of their position Defendants' rebuttal expert witness Dr. Bruce Adornato can properly testify to all opinions contained in his December 18, 2018, Rebuttal Report, his September 20, 2019

Case Number: A-16-739464-C

Supplemental Report[1], his deposition, and in defense thereof. As discussed in more detail below, Dr. Adornato's opinions are proper rebuttal opinions because his opinions directly rebut and contradict the opinions of plaintiffs TITINA FARRIS and PATRICK FARRIS' ("Plaintiffs") neurology expert witness Dr. Justin Willer. Moreover, Plaintiffs failed to bring a timely motion in limine or otherwise address the issue of Dr. Adornato's testimony with this Court until approximately 2 weeks into trial. A last minute Order preventing Dr. Adornato from testifying to his proper rebuttal opinions would substantially prejudice Defendants in the presentation of their defense. Accordingly, Plaintiffs' request to limit some of Dr. Adornato's opinions should be denied.[2]

Dated: October 28, 2019

SCHUERING ZIMMERMAN & DOYLE, LLP

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[1]Plaintiffs' Trial Brief regarding Dr. Adornato's testimony does not reference Dr. Adornato's September 20, 2019, Supplemental Report, which was subject to this Court's ruling on Plaintiffs' Motion to Strike Defendants' Fourth and Fifth NRCP 16.1 Disclosures. Accordingly, Defendants' Trial Brief focuses on the propriety of Dr. Adornato's opinions contained in his December 18, 2018 Report, and not the September 20, 2019 Supplemental Report which Plaintiffs do not appear to challenge in their Trial Brief.

[2]It is unclear from Plaintiffs' Trial Brief which specific opinions contained in Dr. Adornato's December 18, 2019, Rebuttal Report Plaintiffs contend are inappropriate rebuttal opinions.

DECLARATION OF THOMAS J. DOYLE, ESQ.

I, THOMAS J. DOYLE, declare as follows:

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

2. I am making this declaration based upon my personal knowledge and if called to testify to the matters asserted herein, I could do so competently.

3. Attached hereto as Exhibit 1 is a true and correct copy of our file copy of Dr. Willer's October 22, 2018 report.

4. Attached hereto as Exhibit 2 is a true and correct copy of all non-Nevada state authority cited in Defendants' Trial Brief.

5. Attached hereto as Exhibit 3 is a true and correct copy of pertinent portions of the deposition of Dr. Willer.

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

Executed this 28th day of October, 2019, at Las Vegas, Nevada.

/s/ Thomas J. Doyle
THOMAS J. DOYLE

MEMORANDUM OF POINTS AND AUTHORITIES

I.

BACKGROUND

This medical malpractice action arises from the care and treatment Defendants provided to Ms. Farris in connection with a laparoscopic hernia repair. Plaintiffs disclosed Dr. Willer, a neurologist, as an initial expert witness. Dr. Willer's October 22, 2018 Report contained opinions regarding the cause of Ms. Farris' current disabilities.

Specifically, Dr. Willer asserted the following opinions in his October 22, 2018 Report:

> Ms. Farris has bilateral foot drop, truncal instability, steppage gait and sensory loss below both knees.
>
> To a reasonable medical certainty, her bilateral foot drop, truncal instability, steppage gait and sensory loss below both knees is related to a diffuse sensorimotor polyneuropathy which in Ms. Farris' case is due to critical illness polyneuropathy.
>
> The proximate cause of the critical illness polyneuropathy was the sepsis that resulted from the tears in her colon that developed during the course of the repair of her incarcerated hernia.
>
> As is typical for critical illness polyneuropathy it was preceded by septic encephalopathy. The difficulty weaning from the ventilator was caused by the critical illness polyneuropathy.

Exhibit 1, p. 7.

Though Dr. Willer noted Ms. Farris' history of diabetes, he failed to recognize the significant of that aspect of Ms. Farris' medical history in the formulation of his opinion her diffuse sensorimotor polyneuropathy was caused by critical illness polyneuropathy, and not associated to at least some degree with her history of diabetes. Accordingly, Defendants disclosed a neurologist, Dr. Adornato, to rebut and critique Dr. Willer's opinions.

///

///

In connection with their rebuttal disclosure of Dr. Adornato, Defendants disclosed his December 18, 2018 Rebuttal Report which specifically rebutted the opinions of Dr. Willer as follows:

> My review of the records has revealed the following pertinent facts: Ms. Farris has longstanding diabetes mellitus, which, according to her physician, historically been "poorly controlled" and "the patient continues to engage in dietary indiscretion."
>
> ...
>
> I find that the report of Dr. Willer, plaintiff's expert neurologist, is lacking in that he fails to acknowledge Ms. Farris's pre existent diabetic neuropathy as a significant factor in her current disability. Her preexistent history of severe diabetic neuropathy required narcotic medication, and gabapentin, a medication commonly used to treat nerve pain. Most of Dr. Chaney's office visit notes before and after August 2015 mention the diabetic neuropathy and poor control of blood sugars.
>
> In the section of Dr. Willer's report regarding reviewed materials, he acknowledges that the records of Advanced Orthopedics and Sports Medicine from 07/02/14, 11/25/14, and 05/05/15 indicate a history of"diabetic neuropathy," but he does not comment as to the severity of the problem, which required narcotic medication and consultation. In addition, he did not mention that following the events in the summer of 2015 when she underwent her hernia surgery and ICU hospitalization, she continued to engage in dietary indiscretion and continued to have neuropathic pain.
>
> ...
>
> It is my opinion that it is more likely than not that she will continue to have painful diabetic neuropathy and that this characteristically and typically worsens with time in terms of disability due to pain, weakness, and impaired sensation, often accompanied by gait imbalance.
>
> None of these facts arc considered by Dr. Willer in his report. Furthermore, it is my opinion that a substantial portion of her current disabilities and pain are related to her underling neuropathy in addition to her critical care neuropathy.

Exhibit 2 to Plaintiffs' Trial Brief, p. 2-3.

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Plaintiffs did not file a Motion in Limine to limit the opinions of Dr. Adornato. On October 24, 2019, approximately 2 weeks into trial, Plaintiffs filed a Trial Brief seeking a vague and non-specific limitation of certain opinions by Dr. Adornato.

II.

ARGUMENT

A. DEFENDANTS' DISCLOSURE OF DR. ADORNATO AS A REBUTTAL EXPERT WITNESS WAS TIMELY AND PROPER.

"Initial" or "case-in-chief" expert witnesses generally must be disclosed at least 90 days before the close of discovery, or at the time agreed upon by the parties and the Court. NRCP16.1(a)(2)(E)(i)(a). Rebuttal experts generally must be disclosed within 30 days after initial experts. NRCP 16.1(a)(2)(E)(i)(b).

Rebuttal testimony is testimony that contradicts or rebuts evidence on the same subject matter identified in another party's expert witness disclosure. NRCP 16.1(a)(2)(E)(i)(b). Rebuttal experts must restrict their opinions to attacking the theories offered by the adversary's experts. *R&O Constr. Co. v. Rox Pro Int'l Grp., Ltd.*, 2011 U.S. Dist. LEXIS 78032, at *8 (D. Nev. July 18, 2011)[3]. The function of rebuttal testimony is to explain, repel, counteract or disprove evidence of the adverse party and is limited to new, unforeseen facts brought out in the other side's case. *Id.* at *5. "If the purpose of expert testimony is to contradict an expected and anticipated portion of the other party's case-in-chief, then the witness is not a rebuttal witness or anything analogous to one." *Amos v. Makita U.S.A., Inc.*, 2011 U.S. Dist. LEXIS 158103, at *4 (D. Nev. Jan. 6, 2011) (citation omitted); NRCP. 16.1(a)(2)(E)(ii). The later rebuttal disclosure deadline does not apply to any party's expert witness whose purpose is to contradict a portion of another party's case in chief that should have been expected and anticipated by the disclosing party, or to present any opinions outside of the scope of another party's

[3] All non-Nevada state case law is attached hereto as Exhibit 2.

disclosure. *Amos v. Makita U.S.A., Inc.*, 2011 U.S. Dist. LEXIS 158103, at *4 (D. Nev. Jan. 6, 2011).

1. *Defendants' Designation of Dr. Adornato as a Rebuttal Expert Witness was Proper and Timely Because His Opinions Contradict and Rebut Dr. Willer's Opinions.*

Defendants' disclosure of Dr. Adornato as a rebuttal expert witness was timely and proper under NRCP 16.1(a)(2)(E)(i)(b) because his opinions directly contradict and rebut the opinions of Dr. Willer regarding the cause of Ms. Farris' current health condition. Plaintiffs' characterization of Dr. Adornato's opinions as per se initial opinions because the opinions relate to the issue of causation is inaccurate and misleading. As a preliminary matter, there is no authority cited by Plaintiffs to support the proposition that opinions related to the standard of care, causation and damages are always, per se initial opinions. Such a rule would vitiate the ability for any party in a medical malpractice action, where the issues are only the standard of care, causation and damages, to make rebuttal expert disclosure to rebut or attack the opposing party's expert's opinions.

Dr. Adornato's rebuttal opinions contradict and rebut Dr. Willer's Report. Specifically, Dr. Adornato contradicts and rebuts Dr. Willer's failure to incorporate Ms. Farris' significant history of poorly controlled diabetes into his opinions regarding the cause of her current conditions.

While Dr. Willer acknowledged Ms. Farris' history of diabetes, he opines that Ms. Farris' bilateral foot drop, truncal instability, steppage gait and sensory loss below both knees is related to a diffuse sensorimotor polyneuropathy which in Ms. Farris' case is due to critical illness polyneuropathy. Exhibit 1. Dr. Willer failed to address the significance Ms. Farris' history of diabetes in her current complaints, and Dr. Adornato merely identified Dr. Willer's flawed analysis and incomplete opinion regarding Ms. Farris' current health condition.

///

As outlined in the cited language from Dr. Willer Report and Dr. Adornato's Rebuttal Report above, Dr. Adornato's rebuttal opinions squarely rebut and contradict Dr. Willer's opinion regarding Ms. Farris' complaints of bilateral foot drop, truncal instability, steppage gait and sensory loss below both knees. Dr. Adornato was properly and timely disclosed as a rebuttal expert witness to rebut and contradict the opinions of Dr. Willer. Plaintiffs therefore are not entitled to an Order preventing Dr. Adornato from testifying at trial as to his properly disclosed rebuttal expert opinions.

2. Defendants' Designation of Dr. Adornato as a Rebuttal Expert Witness Was Proper and Timely Because Defendants Could Not Have Reasonably Anticipated Dr. Willer Would Disregard Such a Significant Aspect of Ms. Farris' Medical History.

Defendants' disclosure of Dr. Adornato as a rebuttal expert witness was timely and proper under NRCP 16.1(a)(2)(E)(ii) because Defendants did not reasonably expect Plaintiffs would disclose a neurologist who would disregard Ms. Farris' significant history of poorly controlled diabetes, reliance on pain medication and diabetic neuropathy. Ms. Farris' history of poorly controlled diabetes, reliance on pain medication and diabetic neuropathy is a significant and central facet of her health condition as outlined in the voluminous medical records produced in this case, including the medical records from Dr. Naomi Chaney. It was a surprise to Defendants, in reviewing the Report of Dr. Willer, that he completely failed to acknowledge the significance of her diabetes history and incorporate at least some aspect of her history of poorly controlled diabetes, diabetic neuropathy and complaints of pain in his opinion as to the cause of her current health complaints. Accordingly, it became necessary for Defendants to retain a neurologist to rebut and point out the flaws of Dr. Willer's opinions.

As Defendants did not reasonably anticipate Plaintiffs' expert neurologist's failure to attribute any aspect of Ms. Farris' significant history of diabetes to her current health complaints, Defendants' disclosure of a rebuttal expert neurologist to contradict and rebut

those flawed opinions was proper under NRCP 16.1(a)(2)(E)(ii). Plaintiffs therefore are not entitled to an Order preventing Dr. Adornato from testifying as to his opinions at the time of trial.

B. PLAINTIFFS' MOTION TO PROHIBIT DR. ADORNATO FROM TESTIFYING TO THE OPINIONS CONTAINED IN HIS REBUTTAL REPORT IS UNTIMELY AND PREJUDICIAL TO DEFENDANTS.

Plaintiffs have failed to timely address their concerns regarding the testimony of Dr. Adornato. Although Plaintiffs were aware of Defendants' disclosure of Dr. Adornato as a rebuttal expert witness in December 2018, Plaintiffs did not take the necessary steps to address the issue of Dr. Adornato's testimony. Plaintiffs never filed an objection to Defendants' rebuttal expert disclosure. Similarly, Plaintiffs did not file a motion in limine to address the propriety of Dr. Adornato's opinions. On October 24, 2019, on the last day of the second week of trial, Plaintiffs' filed the instant Trial Brief to limit Dr. Adornato's testimony at trial.

Allowing Plaintiffs to block Dr. Adornato's testimony, at the eleventh hour, would substantially prejudice Defendants. If Plaintiffs obtain an Order substantially limiting Dr. Adornato's testimony at trial, only days before he is expected to testify, Defendants will be left scrambling to re-calibrate their defense.

While there would be substantial prejudice to Defendants if Plaintiffs' last-minute request to limit Dr. Adornato's testimony were granted, there is no prejudice to Plaintiffs in allowing Defendants to put on Dr. Adornato as set forth in their rebuttal expert disclosures. Dr. Adornato's report was available to Dr. Willer prior to his deposition, and in fact Dr. Willer had Dr. Adornato's Rebuttal Report prior to his deposition. See, Exhibit 3, p. 12:12-13:9. As a last minute Order limiting Dr. Adornato's testimony would substantially prejudice Defendants in the presentation of their defense, Plaintiffs' request for limitations to Dr. Adornato's testimony, beyond those already ordered by this Court relative to

Plaintiffs' Motion to Strike Defendants Fourth and Fifth NRCP 16.1 Disclosures, which dealt with Dr. Adornato's Supplemental Report, should be denied.

III.

CONCLUSION

As discussed in more detail above, Dr. Adornato was timely and properly disclosed as a rebuttal expert witness because his opinions directly rebut and contradict the opinions of Dr. Willer, and Defendants did not reasonably anticipate Plaintiffs' would disclose a neurologist who would completely disregard the importance of Ms. Farris' history of poorly controlled diabetes, need for pain medication and diabetic neuropathy in his opinions. Accordingly, Plaintiffs' request to limit the testimony of Dr. Adornato in any way must be denied.

Dated: October 28, 2019

SCHUERING ZIMMERMAN & DOYLE, LLP

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

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 28th day of October, 2019, service of a true and correct copy of the foregoing:

DEFENDANTS BARRY RIVES, M.D.'s AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S TRIAL BRIEF ON REBUTTAL EXPERTS BEING LIMITED TO REBUTTAL OPINIONS NOT INITIAL OPINIONS

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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EXHIBIT 1

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Mr. George Hand Esq.
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October 22, 2018

Materials Reviewed:

1) Affidavit Vincent E. Pesiri MD

2) Dignity Health St Rose Dominican-San Martin Campus

-Discharge summary with Admission Date of 7/5/2015 and Discharge Date of 8/11/2015 indicating Ms. Farris had a perforated viscus, incarcerated incisional hernia with repair, colostomy and "Encephalopathy 2nd to sepsis and Med's (Opiates and Benzodiazepine)"

-Operative report 8/7/2014 Barry Rives MD indicating excision of abdominal wall lipoma/mass and repair of incarcerated ventral hernia with mesh.

-Operative report 7/3/2015 indicating laparoscopic reduction and repair of incarcerated incisional hernia with mesh and Colonorraphy.

-Operative report 7/16/2015 Elizabeth Hamilton MD indicating an exploratory laparotomy, removal of prosthetic mesh and washout of abdomen, partial colectomy and right ascending colon end ileostomy, extensive lysis of adhesions, retention suture, decompression of the stool from the right colon and fecal disimpaction was performed.

-Operative report 7/18/2016 indicating exploratory laparotomy, completion of right hemicolectomy with ileocolic anastomosis, addition small bowel obstruction and repair of incisional hernia.

-Surgical pathology report prosthetic abdominal mesh and transverse colon and omentum.

-Progress notes Geraldine Bent APM 8/8/2015

-Surgical progress notes 8/1,2,3,4,5,6,7,8,9,10,11/2015.

3) Report of Thomman Kuruvilla DPM from 8/31/2015 indicating that she "suffered a dropfoot and severe peripheral neuropathy without any motor function of the bilateral lower extremity.

4) Report of NCV/EMG of the lower limbs

5) Physical therapy noted from 8/10-2015

6) Progress Note of Naomi Chaney MD from 9/1/2015 indicating "She had gone in for elective surgery for hernia and had complications related to the surgery…She has known history of diabetes, neuropathy and now critical care neuropathy with foot drop.

7) Records Advanced Orthopedics and Sports Medicine from 7/2/2014, 11/25/2014 and 5/5/2015 indicating history of "diabetic neuropathy". "Regarding the bilateral feet, there is pain noted. Strength reported as normal.

8) Mammogram 6/16/2014

9) Report of MRI of the lumbosacral spine from 6/13/2014 indicating the presence of mild facet disease at L4-L5 and L5-S1.

10) Report of MRI of the lumbosacral spine from 6/22/2016 indicating normal study.

11) Reports of CT abdomen from 6/12/2015 and 3/21/2016.

12) Chest Radiograph 9/16/2015 report.

13) Report of Lower Extremity Arterial Doppler 1/11/2017

14) Report of MRI of the left foot from 1/11/2017.

15) Video clips of examination of Ms. Farris which includes the demonstration of bilateral foot drops and markedly unsteady gait.

16) Life Care Plan and examination from Alex Barchuk MD from 3/20/2018.

- "Sensation: Severely impaired below the knees bilaterally to temperature and light touch. Absent position sense in the toes and ankles bilaterally. Decreased sensation in the median nerve distribution bilateral hands."

- "3+/5 motor strength bilateral upper extremities with normal tone and isolated movement. Hip flexors 3+/5 bilaterally. Hip extensors 3+/5 bilaterally. Knee extensors 3/5/ bilaterally. Knee flexors 3/5 bilaterally. Foot dorsiflexors and plantar flexors 0/5 bilaterally.

- "Sit to stand is possible only with upper extremity support and use of a walker."

- "Steppage gait with impaired balance. Unable to tandem. Unable to ambulate on toes or heels. Severe instability without use of a walker requiring direct physical contact."

17) progress note from Dr. Elizabeth Hamilton from July 17, 2016.

18) Progress Notes Southern Nevada Pain Center from 8/23/2018, 6/27/2018, 5/30/2018, 4/30/2018 and 4/5/2018 indicating the presence of a foot drop and absent foot inversion and eversion.

19) Records from Care Meridian Buffalo with admission date of August 12, 2015 indicating the presence of a foot drop (page 194 of 300).

III. Critical Illness Polyneuropathy and Myopathy

Myopathy and Polyneuropathy accompany sepsis[1]. Bolton et. al reported 5 patients in critical care units from 1977 to 1981 who demonstrated a primary, distal, axonal degeneration of motor and sensory fibers. The condition was named critical illness polyneuropathy (CIP)[1].

Bolton et. al. found that CIP was associated with sepsis and multiple system organ failure was 70%[1]. It is often preceded by septic encephalopathy and is followed by difficulty weaning the patient from a ventilator[1].

Critical Illness Myopathy (CIM) risk factors are acute respiratory disorder including in conjunction with the use of high-dose intravenous steroids and nondepolarizing blocking agents[1,2]. Other risk factor include acidosis, liver and lung transplantation and hepatic failure[2]. Prolonged intubation is also a risk factor.

CIP and CIM presents with flaccid paralysis[1,3]. CIP also presents with hyporeflexia or areflexia, muscle atrophy and distal sensory loss[3].

Critical Illness Myopathy develops in 35% of patients with status asthmaticus[3], and may occur in the absence of sepsis[3].

CIM sometimes have a proximal predominant flaccid weakness frequently with ventilatory failure[3]. Facial weakness may occur but extraocular muscle weakness is rare. Deep tendon reflexes may be normal or reduced and sensation is normal[3].

Nerve conduction studies commonly demonstrate a reduction in the amplitude of the compound muscle action potentials (CMAP) with amplitudes usually less than 50% of the lower limit of normal[3].

In critical illness myopathy the reduction is CMAP amplitude is out of proportion to the reduction in the corresponding sensory nerve action potential (SNAP)[3]. Sensory responses are usually normal in amplitude[3].

Needle EMG examination frequently reveals fibrillation potentials diffusely and relatively early in the clinical course and motor unit potentials are short in duration and of low amplitude with polyphasia in proximal and distal muscles[3].

CIP has reductions in the amplitudes of both the CMAPs and Snaps usually without significant reduction in conduction velocity of the motor nerves[3].

Fibrillation potentials are also noted in distal and proximal muscles (noted in the diaphragm in 29% of patients) with decreased recruitment, nascent units and long duration motor unit potentials[3].

Critical illness myopathy histopathologic features include muscle fiber atrophy and lysis of the myosin heavy chains. Necrosis and regeneration ranges from none to severe[3].

Critical Illness Polyneuropathy demonstrates degeneration of motor and sensory axons, but nerve biopsies are sometimes normal. Hyperglycemia, hypoalbuminemia and nutritional factors may increase the risk of development of CIP[3].

Mortality for critical illness polyneuropathy is up to 50%3. Long term prognosis is much better for critical illness myopathy[3,4] with up to 88% of CIM patients recovering within 1 year whereas patients with combined CIM/CIP only 55% were recovered within 1 year[4].

Some studies have shown that the patients with persistent disabilities had critical illness polyneuropathy with or without critical illness myopathy and central nervous system insults[3].

IV. Specific Causation

Ms. Titina Farris underwent surgery on 8/7/2014 by Barry Rives MD with excision of abdominal wall lipoma/mass and repair of incarcerated ventral hernia with mesh.

She underwent surgery on 7/3/2015 with laparoscopic reduction and repair of incarcerated incisional hernia with mesh and Colonorraphy. During the surgery a small tear was created in the colon.

Following surgery, she had to be emergently intubated on 7/5/2015 and was septic. Difficulty weaning from the ventilator was noted and the patient subsequently underwent a tracheostomy on July 14, 2015. She was subsequently extubated on August 8, 2015.

Ms. Farris was admitted on 7/5/2015 and discharged on 8/11/2015. Ms. Farris had a perforated viscus, incarcerated incisional hernia with repair, colostomy and "Encephalopathy 2nd to sepsis and Med's (Opiates and Benzodiazepine)"

She underwent another operation on 7/16/2015 by Elizabeth Hamilton MD an exploratory laparotomy, removal of prosthetic mesh and washout of abdomen, partial colectomy and right ascending colon end ileostomy, extensive lysis of adhesions, retention suture, decompression of the stool from the right colon and fecal disimpaction was performed for a perforated viscus.

She underwent re-operation on 7/18/2016 and had an exploratory laparotomy, completion of right hemicolectomy with ileocolic anastomosis, addition small bowel obstruction and repair of incisional hernia.

Surgical pathology report from July 17, 2015 indicated specimen A consisted of prosthetic abdominal mesh and specimen be consisted of transverse colon and omentum with "3 foci of colonic ulceration with trans mural acute inflammation and perforation." Also noted was "associated acute serositis and omentum with acute inflammatory exudate and reactive changes."

"3 trans mural defects are identified along the length of the colon. The 1st defect is located roughly within the mid aspect, measures 2.0 x 1.6 cm and the borders are inked orange. This defect is located 2.9 cm from the green inked margin and 2.8 cm from the black inked margin. 2nd defect is located within a markedly thinned area of wall with an overall measurement of 3.7 x 3.5 cm." "The 3rd defect measures 1.0 x 0.4 cm."

Abdominal drains were placed by radiology on 7/30 and 7/31 to drain pus from the abdomen. She was eventually extubated and the abdominal drains were removed. Discharge summary notes "neuropathy pain in her legs" for which she was started on Lyrica.

She also experienced an "encephalopathy 2nd to sepsis and med's (opiates and benzodiazipines)" which was improving at the time of discharge.

She was then transferred to a rehabilitation facility.

At some point the patient developed weakness in particular severe distal weakness of the lower extremities. Dr. Elizabeth Hamilton noted on July 17, 2016 that she had "neuropathy in the foot reportedly due to prolonged hospitalization last year." Dr. Hamilton also noted that Ms. Farris was tearful at times and her impression included depression.

Dr. Barchuk noted that she is experiencing pain in her legs and lower back pain and severe unsteadiness necessitating a walker to ambulate with at least 2 falls in the year prior to Dr. Barchuk's examination. She needs help dressing, showering, cleaning, meal preparation and toileting.

Dr. Barchuk noted that Ms. Farris can sit for a total of 4 hours a day and stand for a total of 2 hours per day and cannot lift more than three pounds.

Dr. Barchuk also reported that she has severe sensory loss below the knees, depression and anxiety. On examination he noted decreased range of motion at the neck and lower back, severe sensory loss below the knees, steppage gait, quadriparesis and a right ankle contracture.

Dr. Barchuk also noted she cannot walk on her heels and toes. Dr. Barchuk also noted "severe instability without use of a walker, requiring direct physical contact."
In his discussion, Dr. Barchuk also indicated she had Dupuyten's contractures in both hands.

Video clips of her examination demonstrate bilateral foot drops, sensory loss below the knees and severe truncal instability.

Dr. Steven Y. Chinn (Southern Nevada Pain Center noted absent foot dorsiflexion, inversion and eversion in examinations performed in 2018,

PAST MEDICAL HISTORY:
Allergies: Aspirin.
Surgical History: C-section, reversal of colostomy 2016, as above.
Medications: Buspar, Xanax, Citalopram, Percocet, Metformin, Januvia, Lisinopril, Carvedilol, Jardiance, Duloxetine, Insulin.
Past Illnesses: Diabetes, hypertension, dyslipidemia and reflux.

Summary and Opinion:

Ms. Titina Farris underwent surgery on 8/7/2014 by Barry Rives MD and again on 7/3/2015 with laparoscopic reduction and repair of incarcerated incisional hernia with mesh, but during the surgery a tear was created in the colon.

She subsequently developed sepsis and encephalopathy and weakness of the lower limbs decreased sensation below the knee.

Ms. Farris has bilateral foot drop, truncal instability, steppage gait and sensory loss below both knees.

To a reasonable medical certainty, her bilateral foot drop, truncal instability, steppage gait and sensory loss below both knees is related to a diffuse sensorimotor polyneuropathy which in Ms. Farris' case is due to critical illness polyneuropathy.

The proximate cause of the critical illness polyneuropathy was the sepsis that resulted from the tears in her colon that developed during the course of the repair of her incarcerated hernia.

As is typical for critical illness polyneuropathy it was preceded by septic encephalopathy. The difficulty weaning from the ventilator was caused by the critical illness polyneuropathy.

To a reasonable medical certainty, Ms. Farris' clinical course is not consistent with Guillain-Barre syndrome (Acute Inflammatory Demyelinating Polyneuropathy) which usually reaches its nadir with 4 to 6 weeks and is followed by recovery.

The acute motor and sensory axonal polyneuropathy (AMSAN) variant of Guillain-Barre syndrome is likewise not consistent with her presentation and is typically preceded by an acute diarrheal illness which Ms. Farris did not have.

To a reasonable medical certainty, her clinical course is likewise not consistent with critical illness myopathy which usually shows improvement with time (up to 88% of patients recover within 1 year[4]) and is not typically associated with sensory loss.

Critical illness myopathy is also associated with use of high dose intravenous steroids and neuromuscular blocking agents which Ms. Farris did not receive.

To a reasonable medical certainty, given that it has been more than 3 years since the onset of her foot drop, sensory loss and truncal instability her deficits are permanent. Recovery can occur in critical illness polyneuropathy, but this usually occurs within the first year following the initial event and if there has been no recovery within the first-year recovery is unlikely.

As she ages her gait will deteriorate further and she will require a motorized wheelchair. She will also need transportation to and from medical appointments which will include a handicapped accessible van. A handicapped accessible van should be replaced every 7 years.

She is at increased risk of falling and permanently has a higher risk of a fractured hip requiring a surgical repair, spinal cord injury and intracranial hematoma including the risk of death.

She will require at least 8-10 hours per day of assistance with dressing, toileting, showering, meal preparation, shopping and household cleaning.

A trial of biofeedback, acupuncture and/or acupressure should be done and if she has significant pain relief should be continued on an ongoing basis.

Ms. Farris should also be referred to a neurologist for treatment of her neuropathic pain on an ongoing basis. To a reasonable medical certainty, she will require adjustment of her prophylactic medication or switching her to alternate medication.

She will require periodic courses of physical therapy to address acute exacerbations of her truncal instability as she ages.

She will require modification of her domicile to make it handicapped accessible including installing handicapped accessible doors, sinks and toilets. This may also include installation of a wheelchair ramp or a chair lift.

Given the presence of depression as noted by Dr. Hamilton, the patient will require ongoing psychologic therapy either from a psychologist or a psychiatrist. A trial of group therapy should be tried and if helpful should continue on an ongoing basis.

To a reasonable medical certainty, she is not capable of even sedentary work (capability to perform sedentary work requires a patient to lift at least 10 pounds).

I, Justin Willer MD, being a licensed physician to practice in the state of New York on penalties of perjury to hereby affirm the contents of the foregoing is true the best of my knowledge and information.

These interpretations are based upon my education and experience in medicine and the specialty of neurology, and I hold these opinions to a reasonable degree of medical certainty.

I hold the right to amend my opinions if appropriate and when additional information becomes available to me.

Sincerely yours,

Justin Aaron Willer, MD

REFERENCES:

1) Bolton, CF, Neuromuscular Manifestations of Critical Illness, Muscle & Nerve 32: 140-163, 2005.

2) Govindarajan, R, Jones, D, Galvez, N, AANEM Case Study: Critical Illness Polyneuropathy, October 2014.

3) Lacomis, D, Electrophysiology of Neuromuscular Disorders in critical illness, Muscle & Nerve 47:452-463, 2013.

4) Koch, S, et. al., Long-term recovery in critical illness myopathy is complete, contrary to polyneuropathy, Muscle & Nerve 50:431-436

EXHIBIT 2

User Name:
Date and Time: Monday, October 28, 2019 10:28:00 AM PDT
Job Number: 101309999

Document (1)

1. *R&O Constr. Co. v. Rox Pro Int'l Group, Ltd., 2011 U.S. Dist. LEXIS 104450*
   Client/Matter: 1737-10881
   Search Terms: R&O Constr. Co. v. Rox Pro Int'l Grp., Ltd.
   Search Type: Natural Language
   Narrowed by:

Content Type	Narrowed by
Cases	-None-

R&O Constr. Co. v. Rox Pro Int'l Group, Ltd.

United States District Court for the District of Nevada

September 14, 2011, Decided; September 14, 2011, Filed

2:09-cv-01749-LRH-LRL

Reporter
2011 U.S. Dist. LEXIS 104450 *; 2011 WL 4344027

R&O CONSTRUCTION COMPANY, Plaintiff, v. ROX PRO INTERNATIONAL GROUP, LTD.; et al., Defendants.

Subsequent History: Summary judgment granted by *R&O Constr. Co. v. Rox Pro Int'l Group, Ltd., 2011 U.S. Dist. LEXIS 131633 (D. Nev., Nov. 9, 2011)*

Prior History: *R&O Constr. Co. v. Rox Pro Int'l Group, Ltd., 2011 U.S. Dist. LEXIS 102398 (D. Nev., Sept. 12, 2011)*

Core Terms

Stone, declaration, court finds, harmless, implied warranty of merchantability, implied warranty of fitness, particular purpose, motion to strike, witnesses, veneer, second amended complaint, summary judgment motion, express warranty

Counsel: **[*1]** For R&O Construction Company, Plaintiff: Kent F Larsen, LEAD ATTORNEY, Smith Larsen & Wixom, Las Vegas, NV; Michael D. Stanger, Callister Nebeker & McCullough, Salt Lake City, UT.

For Real Stone Source, LLC, Defendant: Leonard T. Fink, Springel & Fink LLP, Las Vegas, NV.

For WD Partners, Inc., Defendant: Keith C Cramer, LEAD ATTORNEY, Gordon & Rees, San Diego, CA; Robert S. Larsen, LEAD ATTORNEY, Gordon & Rees LLP, Las Vegas, NV.

For Arizona Stone & Architectural Products NV, LLC, Defendant: Jason R. Wigg, LEAD ATTORNEY, Barron & Pruitt, North Las Vegas, NV; David L. Barron, Barron & Pruitt, LLP, Las Vegas, NV.

Judges: LARRY R. HICKS, UNITED STATES DISTRICT JUDGE.

Opinion by: LARRY R. HICKS

Opinion

ORDER

Before the court is plaintiff R&O Construction Company's ("R&O") motion to strike the declarations of Christopher Collins ("Collins") and Robert S. Larsen ("Larsen") submitted in support of defendant WD Partners, Inc. ("WD Partners") motion for summary judgment (Doc. #73, Exhibit 1; Exhibit 2 [1]). Doc. #83. WD Partners filed an opposition (Doc. #97) to which R&O replied (Doc. #99).

I. Facts and Background

This is a construction defect action. R&O was the general contractor for a Home **[*2]** Depot store in Las Vegas, Nevada. R&O subcontracted the construction of the required stone veneer, manufactured by defendant Rox Pro International Groups, Ltd. ("Rox Pro"), to non-party New Creation Masonry Inc. ("New Creation"). New Creation purchased the stone veneer from defendant Arizona Stone and Architectural Products NV, LLC ("Arizona Stone"). Allegedly, the stone veneer failed and R&O was forced to make substantial structural repairs to the Home Depot store.

On September 3, 2009, R&O filed its initial complaint against defendants Rox Pro; Real Stone Source, LLC ("Real Stone"), the distributor for Rox Pro; Arizona Stone; and WD Partners. Doc. #1. R&O filed a first amended complaint on February 5, 2010 (Doc. #22) and a second amended complaint on June 29, 2010 (Doc. #48). The second amended complaint alleges ten causes of action: (1) implied warranty of merchantability - Arizona Stone; (2) implied warranty of fitness for a particular purpose - Arizona Stone; (3) implied warranty of merchantability - Real Stone; (4) implied warranty of fitness for a particular purpose - Real Stone; (5) implied warranty of merchantability - Rox Pro; (6) implied warranty of fitness for a particular **[*3]** purpose - Rox Pro; (7) express warranty - Real Stone and Rox Pro; (8) express warranty - Arizona Stone, Real Stone, and Rox Pro; (9) negligent misrepresentation - WD Partners and Real Stone; and (10) breach of contract - WD Partners. Doc. #48.

On March 22, 2011, defendant WD Partners filed a motion for summary judgment. Doc. #73. In support of its motion, WD Partners attached the declarations of Christopher Collins (Doc. #73, Exhibit 1) and Robert S. Larsen (Doc. #73, Exhibit 2). Thereafter, R&O filed the present motion to strike the declarations for failure to disclose Collins and Larsen as witnesses pursuant to *Rule 37 of the Federal Rules of Civil Procedure*. Doc. #83.

II. Discussion

Federal Rule of Civil Procedure 37 states in pertinent part that "if a party fails to provide information or identify a witness as required by *Rule 26(a)* or *(e)*, the party is not allowed to use that information or witness to supply evidence on a motion . . ., unless the failure was substantially justified or is harmless." *FED. R. CIV. P. 37(c)(1)*. This sanction is "self-executing" and "automatic." *Yeti by Molly Ltd. v. Deckers Outdoor Co., 259 F.3d 1101, 1106 (9th Cir. 2001)*.

[1] Refers to the court's docket number.

Here, it is undisputed that **[*4]** Collins and Larsen were not disclosed as witnesses in this action in accordance with *Rule 26*. Therefore, the court finds that their declarations are properly excludable under *Rule 37(c)(1)*.

In opposition, WD Partners argues that the late disclosures of Collins and Larsen were harmless because Collins was indirectly identified as a witness in relation to the design contract and Larsen's declaration contains information that is cumulative of other evidence already provided to the court. *See* Doc. #97. However, the court finds that WD Partners' arguments are without merit. First, the court finds that Larsen's declaration contains additional non-cumulative statements for which there is no other identified source. Second, as to Collins, the court notes that he was never actually identified as a possible witness in this action. His name was only briefly mentioned in another witness's deposition as a person somewhat connected to the design contract. Therefore, the court finds that WD Partners has not made a sufficient showing that its failure to identify Collins and Larsen was harmless. *See Yeti by Molly Ltd., 259 F.3d at 1107* ("Implicit in *Rule 37(c)(1)* is that the burden is on the party facing **[*5]** sanctions to prove harmlessness."). Accordingly, the court shall grant R&O's motion to strike.

IT IS THEREFORE ORDERED that plaintiffs motion to strike (Doc. #83) is GRANTED. The clerk of court shall STRIKE the declaration of Christopher Collins attached as Exhibit 1 and the declaration of Robert S. Larsen attached as Exhibit 2 to defendant's motion for summary judgment (Doc. #73).

IT IS SO ORDERED.

DATED this 14th day of September, 2011.

/s/ Larry R. Hicks

LARRY R. HICKS

UNITED STATES DISTRICT JUDGE

End of Document

User Name:
Date and Time: Monday, October 28, 2019 10:29:00 AM PDT
Job Number: 101310264

Document (1)

1. *Amos v. Makita U.S.A., Inc., 2011 U.S. Dist. LEXIS 2729*
   Client/Matter: 1737-10881
   Search Terms: Amos v. Makita U.S.A., Inc.
   Search Type: Natural Language
   Narrowed by:

Content Type	Narrowed by
Cases	-None-

Amos v. Makita U.S.A., Inc.

United States District Court for the District of Nevada

January 6, 2011, Decided; January 6, 2011, Filed

2:09-cv-01304-GMN-RJJ

Reporter
2011 U.S. Dist. LEXIS 2729 *; 2011 WL 43092

MASON AMOS, Plaintiff, v. MAKITA U.S.A., INC., Defendant.

Subsequent History: Sanctions disallowed by ***Amos v. Makita U.S.A., Inc.***, *2011 U.S. Dist. LEXIS 158103 (D. Nev., Jan. 6, 2011)*

Core Terms

discovery, wire, diligence, melting, deposition, scheduling order, beading, Electronic, Microscope, Scanning, eutectic, good cause, electrical, Emergency, days

Counsel: **[*1]** For Mason Amos, State Farm Fire & Casualty Company, Plaintiffs: Christopher Eric Mumm, LEAD ATTORNEY, Phillips, Harper & Harper, LLC., Reno, NV; Gerald A Phillips, LEAD ATTORNEY, Phillips, Harper & Harper, Reno, NV; Nik Walters, LEAD ATTORNEY, Law Office of Nik V. Walters, Reno, NV.

For Makita U.S.A., Inc., Defendant: Holly S. Stoberski, LEAD ATTORNEY, Las Vegas, NV; Jeffrey A. Swedo, LEAD ATTORNEY, Gordon & Rees LLP, Irvine, CA.

Judges: ROBERT J. JOHNSTON, United States Magistrate Judge.

Opinion by: ROBERT J. JOHNSTON

Opinion

ORDER

Defendant's Emergency Motion to Extend Discovery to Allow Scanning Electronic (sic) Microscope Examination of Incident Wire (#43)

This matter comes before the Court on Defendant's Emergency Motion to Extend Discovery to Allow Scanning Electronic (sic) Microscope Examination of Incident Wire (#43). The Court also considered Plaintiff's Opposition (#45) and Defendant's Reply (#46).

BACKGROUND

This is an insurance subrogation case. In April 2008, a fire broke out at Mason Amos' home while he was at work. Amos claims the fire was ignited by a failed Makita battery and battery charger.

One of Plaintiff's experts, Eric Andersen, opines that beading on an electrical wire in a junction box in the **[*2]** kitchen was caused by eutectic melting[1] as a result of the battery-ignited fire. Defendant's expert, Jack Hyde, believes that failure of the beaded electrical wire in the junction box was the cause of the fire.

Discovery in this matter closed on June 28, 2010, after an extension was granted by the Court. Makita deposed Andersen on May 27, 2010. Makita claims that this is the first it heard of Andersen's theory involving eutectic melting to explain the beading on the electrical wire. Makita now seeks to add an expert metallurgist, Dr. Thomas Read, and also to allow the destructive testing of the beaded electrical wire with the aid of a scanning electron microscope. This test, Makita claims, will aid it in determining whether the beaded wire is made of some mixture of copper and another metal or solely of copper. Makita asserts that this will help in determining the causation of the fire. Plaintiff opposes the motion.

DISCUSSION

Defendant's **[*3]** Emergency Motion to Extend Discovery to Allow Scanning Electronic[2] (sic) Microscope Examination of Incident Wire (#43) fails to comply with Local Rules 6-1(b) and 26-4.

Local Rule 6-1 requires that: "Immediately below the title of such motion ... there shall also be included a statement indicating whether it is the first, second, third, etc., requested extension." Defendant's Motion (#43) contains no such statement and is Defendant's second request for a discovery extension. Local Rule 26-4 provides that all motions to extend discovery must be "received by the Court no later than twenty days before the discovery cut-off date or any extension thereof." LR 26-4. Defendant's motion was filed on September 23, 2010, eighty seven days after the extended discovery cut-off date of June 28, 2010. In other words, Defendant's Motion (#43) is one hundred seven days late.

Federal Rule of Civil Procedure 16(b)(4) and LR 26-4 allow the Court to modify a scheduling order only upon a showing of good cause. The good cause standard primarily considers the diligence of the party seeking the amendment. *Johnson v. Mammoth Recreations, Inc., 975 F.2d 604, 609 (9th Cir. 1992)*. **[*4]** The scheduling order can be modified if it cannot reasonably be met despite the diligence of the party seeking the extension. *Id.* Carelessness is not compatible with a finding of diligence and offers no reason for a grant of relief. *Id.* If the moving party was not diligent, the inquiry should end. *Zivkovic v. S. California Edison Co., 302 F.3d 1080, 1087 (9th Cir. 2002)*; *Johnson, 975 F.2d at 609*.

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[1] Eutectic Melting is when two metals with dissimilar melting points meet and the subsequent composition has a melting point lower than the metal with the higher melting point. Andersen Deposition at 56:24-57:7, Exhibit C, Attached to Defendant's Motion (#43).

[2] Also referred to by the parties as a Scanning Electron Microscope.

Good cause may be found if the moving party can show that it could not comply with the schedule due to matters that could not have been reasonably foreseen at the time of the issuance of the scheduling order. *Kuschner v. Nationwide Credit, Inc., 256 F.R.D. 684, 687 (E.D. Cal. 2009)*. The moving party must also have been diligent in seeking an amendment once it became apparent that it would not be able to comply with the scheduling order. *Id.*

Defendant, Makita, argues that it was unable to comply with the scheduling order because new information became known to them during the deposition of Plaintiff's expert Eric Andersen. Specifically, Makita claims that it did not know about Andersen's hypothesis that beading on a grounding wire inside an electrical junction box near the kitchen cabinet may **[*5]** have been caused by eutectic melting.

Makita argues that Plaintiff is responsible for the delay in filing this motion because Plaintiff tried to trick Makita into agreeing to mediate by falsely suggesting: "Agree to mediate, and we'll let you test the wire." Defendant's Reply (#46) at 8.

Therefore, Makita asserts that discovery should be extended in order for them to observe the wire with the assistance of a scanning electron microscope to determine the chemical composition of the wire. This test will allow Makita to determine whether the wire consists of two metals (evidence of eutectic melting) or solely of copper, thereby allegedly refuting Andersen's hypothesis.

Plaintiff argues that Makita knew, or should have known, of Andersen's theory and its need for a metallurgist long before Andersen's deposition. Plaintiff points out that Andersen's deposition was held May 27, 2010, and Makita's Motion (#43) was not filed until September 23, 2010 [120 days].

Here, Makita's reasons for filing a late motion to extend discovery is not supported by good cause. Makita has not been diligent in complying with the scheduling order, nor has it been diligent once it determined it could not comply. Causation **[*6]** of the fire is the central issue in this litigation. Makita's expert, Jack Hyde, testified that he had enough information to form his opinion that the point of origin of the fire was in the electrical junction box in the kitchen as of November 2008. Hyde Deposition, Exhibit 1 at 119:12-22, Attached as Exhibit 1 to Plaintiff's Opposition (#45). This is possibly the earliest that Makita should have known that it would need a metallurgist or other expert to determine the cause of the beading on the wire. It could have anticipated that Plaintiff's experts would form their own explanations of the beading, whether it be eutectic melting or some other theory. Makita did nothing.

The absolute latest that Makita could have known it needed an expert to analyze the wire would have been at Andersen's deposition held on May 27, 2010. Andersen Deposition at 1, Exhibit C, Attached to Plaintiff's Motion (#43). Therein, Andersen discusses eutectic melting at length. Andersen Deposition at 56:18-59:22, Exhibit C, Attached to Defendant's Motion (#43). At this time, discovery was already closed, and Makita's First Motion to Extend Discovery (#21) was still pending before the Court.[3]

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[3] Defendant's Motion **[*7]** (#21) was granted extending discovery 45 days, to June 28, 2010. Order (#39).

Though Makita talked with Plaintiff about another possible extension, and began looking for a metallurgist, it took no action with the Court. Instead, Makita waited until September 23, 2010, four months after the deposition. Such a delay is not evidence of diligence.

Makita claims that its delay was caused by Plaintiffs refusal to cooperate and because Makita relied on alleged suggestions by Plaintiff that if Makita agreed to mediate, Plaintiff would allow it to test the wire. The facts show just the opposite. Makita cannot blame Plaintiff for its own lack of diligence. While it is important and valuable for parties to work together to solve discovery disputes, a scheduling order "is not a frivolous piece of paper, idly entered, which can be cavalierly disregarded by counsel without peril." *Johnson, 975 F.2d at 610*; *quoting Gestetner Corp v. Case Equipment Co., 108 F.R.D. 138, 141 (D.C. Me. 1985)*. Makita has failed to show good cause that discovery should be extended.

Further, Makita's characterization of this motion as an "emergency" is misplaced. An emergency of Makita's own creation due to a lack of diligence **[*8]** is not a basis to reope discovery to allow the designation of an expert. The date to disclose experts passed over six months ago. *See*, Discovery Plan and Scheduling Order (#11).

ORDER

Based on the foregoing, and good cause appearing therefore,

IT IS HEREBY ORDERED that Defendant's Emergency Motion to Extend Discovery to Allow Scanning Electronic (sic) Microscope Examination of Incident Wire (#43) is **DENIED**.

DATED this 6th day of January, 2011.

/s/ Robert J. Johnston

ROBERT J. JOHNSTON

United States Magistrate Judge

End of Document

EXHIBIT 3

DISTRICT COURT

CLARK COUNTY, NEVADA

----------X

TITINA FARRIS and PATRICK FARRIS,

Plaintiffs,

-against-

Case No.:
A-16-739464-C

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

Defendants,

----------X

26 Court Street, Suite 506
Brooklyn, New York 11242

Wednesday, July 17, 2019
10:17 a.m. - 12:20 p.m.

EXAMINATION BEFORE TRIAL of The Non-Party Witness, BY: JUSTIN A. WILLER, M.D.

Pursuant to Order, before Jasmine Rodriguez, Certified Court Reporter and Notary Public of the State of New York.

A. I don't keep printed copies. They're basically on a computer. Yes, there would be a copy of invoices.

Q. I assume you can, without much effort, provide to Mr. Hand those billing-related records?

A. Yes, I should be able to.

Q. And I assume you can provide to Mr. Hand, without much effort, what is currently contained on your tablet in order to comply with the notice for your deposition?

A. Yes, I should be able to.

Q. So why don't you list for me the file names that you have on your tablet so when we receive them later, I can cross-reference them?

A. Well, basically, I have a folder for Titina Farris; we have a note marked PM&R; we have rebuttal reports from Dr. Horowitz and Dr. Stein; some notes from Advance Ortho; deposition of Dr. Rives, records from Dr. Chaney from 1/5/15 through 6/30 and a separate note from 9/1; deposition of Dr. Jewell and Dr. Carter; defendant's rebuttal of disclosure; defendant's initial expert witness disclosure; Adornato rebuttal report, A-d-o-r-n-a-t-o; EMG that was done; life care plan; Steinberg Diagnostic Economic report; Dr. Barchuk; life care plan addendum; depositions from

Ms. Farris and her husband; and deposition for Volk, V-o-l-k; two folders of notes from July 16th through July 31st, 2015; and a second folder from July 3rd through July 15, 2015; my report; the zip folders from which the previous files were unzipped; photographs and videos; life care plan; PowerPoint containing the videos; one folder marked August 1st through -- 2015 through August 11th; and Farris -- folder marked Farris rehab notes.

Q. The PowerPoint with the videos, what is the PowerPoint?

A. PowerPoint is a PowerPoint. It's a program made by Microsoft.

Q. Well, I understand that, Doctor. Is that a PowerPoint you created or someone else --

A. No. It was sent to me.

Q. Okay. You have to let me finish my question, please.

Is it a PowerPoint that you prepared, or was it sent to you?

A. It was sent to me.

Q. Do you know who prepared the PowerPoint with the videos?

A. No.

Q. Are there any records that were provided

CERTIFICATE

I, Jasmine Rodriguez, a Shorthand Reporter and Notary Public of the State of New York, do hereby certify:

That, JUSTIN A. WILLER, Non-Party Witness, whose examination is hereinbefore set forth, was duly sworn, and that such examination is a true record of the testimony given by such witness.

I further certify that I am not related to any of the parties to this action by blood or marriage; and that I am in no way interested in the outcome of this matter.

Jasmine Rodriguez

Notary Public

Electronically Filed
10/28/2019 11:55 AM
Steven D. Grierson
CLERK OF THE COURT

BRIEF

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Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC et al., Defendants.	CASE NO.: A-16-739464-C DEPT. NO.: XXXI

PLAINTIFFS' TRIAL BRIEF REGARDING DISCLOSURE REQUIREMENTS FOR NON-RETAINED EXPERTS

Plaintiffs PATRICK FARRIS and TITINA FARRIS, by and through their attorneys of record, KIMBALL JONES, ESQ. and JACOB G. LEAVITT, ESQ., with the Law Offices of **BIGHORN LAW** and GEORGE F. HAND, ESQ., with the Law Offices of **HAND & SULLIVAN, LLC**, and hereby submit this Trial Brief Regarding Disclosure Requirements for Non-Retained Experts.

///

This Trial Brief is made and based upon all of the pleadings and papers on file herein and the attached Memorandum of Points and Authorities pursuant to EDCR 2.20 and 7.27.

DATED this 28th day of October, 2019.

BIGHORN LAW

By: */s/ Jacob G. Leavitt*

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Attorneys for Plaintiffs

MEMORANDUM OF POINTS AND AUTHORITIES

I. STATEMENT OF RELEVANT FACTS

Plaintiff Titina Farris was a patient of Defendant Rives. Rives, while performing surgery on Plaintiff, negligently cut her colon in at least two (2), and possibly three (3), places. Thereafter, Rives failed to adequately repair the colon and/or sanitize the abdominal cavity. With feces actively in her abdomen, Plaintiff predictably went into septic shock and was transferred to the ICU. Nevertheless, Rives still failed to recommend any surgery to repair the punctured colon for twelve (12) days, during which time Plaintiff's organs began shutting down and her extremities suffered permanent impairment. Ultimately, Plaintiff developed critical care neuropathy, destroying all nerve function in her lower legs and feet, commonly referred to as bilateral drop foot.

A. APPLICABLE LEGAL PRINCIPLES

NRCP 16.1(a)(2)(C)-(D) states:

> (C) Witnesses Who Do Not Provide a Written Report. Unless otherwise stipulated or ordered by the court, if the witness is not required to provide a written report, this disclosure must state:
> (i) the subject matter on which the witness is expected to present evidence under NRS 50.275, 50.285, and 50.305;
> (ii) a summary of the facts and opinions to which the witness is expected to testify;
> (iii) the qualifications of that witness to present evidence under NRS 50.275, 50.285, and 50.305, which may be satisfied by the production of a resume or curriculum vitae; and
> (iv) the compensation of the witness for providing testimony at deposition and trial, which is satisfied by production of a fee schedule.
> (D) Treating Physicians.
> (i) **Status.** A treating physician who is retained or specially employed to provide expert testimony in the case, or whose duties as the party's employee regularly involve giving expert testimony on behalf of the party, must provide a written report under Rule 16.1(a)(2)(B). Otherwise, a treating physician who is properly disclosed under Rule 16.1(a)(2)(C) may be deposed or called to testify without providing a written report. A treating physician is not required to provide a written report under Rule 16.1(a)(2)(B) solely because the physician's **testimony may discuss ancillary treatment, or the diagnosis, prognosis, or causation of the patient's injuries, that is not contained within the physician's medical chart, as long as the content of such testimony is properly disclosed under Rule 16.1(a)(2)(C)(i)-(iv).**

(Emphasis added).

Generic disclosures that do not provide specific facts regarding each non-retained expert's opinion are inadequate. *Langermann v. Prop. & Cas. Ins. Co.*, 2015 U.S. Dist. LEXIS 105378 (D. Nev. Aug. 10, 2015). The Court in Langermann noted:

> For each medical provider the Plaintiff indicated a "person most knowledgeable" would testify and provided the same description of the subject matter of their anticipated testimony: "[s]aid witness will testify to his/her knowledge regarding the medical treatment provided to Marike Greyson resulting from the subject accident"...These disclosures are insufficient to comply with Plaintiff's obligations under Rule 26(a)(2)(C). The disclosure contains no information about the facts and opinions on which each provider is expected to testify as required by Rule 26(a)(2)(C)(ii). The disclosure contains only the most generic, unhelpful description of the subject matter on which each provider is expected to present evidence under Rules 702, 703, or 705 Federal Rules of Evidence as required by Rule 26(a)(2)(C)(i) of the Federal Rules of Civil Procedure.
>
> *Langermann v. Prop. & Cas. Ins. Co. of Hartford*, No. 2:14-CV-00982-RCJ, 2015 WL 4724512, at *4 (D. Nev. Aug. 10, 2015)[1]

The Supreme Court of Nevada has identified three "overarching requirements" for expert testimony and opinions to be admissible pursuant to NRS 50.275: qualification, assistance, and limited scope. *Higgs v. State,* 222 P.3d 648, 658, 126 Nev._ (2010). Relevant to the instant Motion is that the expert "must be qualified in an area of scientific, technical or other specialized knowledge, and the expert's "testimony must be limited to matters within the scope of his or her specialized knowledge." *Id.; Hallmark v. Eldridge,* 124 Nev. 492, 498 (2008) (citing to Nev. Rev. Stat. 50.275).

Nevada trial judges assume the role of a gatekeeper in assessing whether experts satisfy these requirements and have "wide discretion, within the parameters of NRS 50.275, to fulfill their gatekeeping duties." *Higgs,* 222 P.3d at 658. In performing its gatekeeping duties, "the district court *must* first determine that the witness is indeed a qualified expert." *Cramer v. Dep. of Motor Vehicles,* 240 P.3d 8, 12, 126 Nev._ (2010) (emphasis in original). In determining whether a person is properly

[1] As the Nevada Supreme Court stated in *Executive Mgmt. Ltd.*, "[f]ederal cases interpreting the Federal Rules of Civil Procedure are strong persuasive authority because the Nevada Rules of Civil Procedure are based in large part upon their federal counterparts." *Executive Mgmt. Ltd. v. Ticor Title Insur. Co.*, 118 Nev. 46, 38 P.3d 872 (2002).

qualified, a district court should consider the following factors: (1) formal schooling and academic degrees, (2) licensure, (3) employment experience, and (4) practical experience and specialized training. *Hallmark,* 124 Nev. at 499.A trial court properly strikes expert testimony if the expert testifies outside of his field of expertise. *Griffin v. Rockwell Int'l,* 96 Nev. 910, 911 (1980).

Commissioner Bulla and Commissioner Beecroft jointly analyzed the requirements for disclosures of non-treating physicians in a 2013 Bar Journal article and noted:

> FRCP 26 requires that the subject matter and a summary of the facts and opinions which the non-retained expert witness is expected to testify about be disclosed, even in the absence of a written report. The recent amendments to NRCP 16.1 (a)(2)(B), adopted as an outgrowth of ADKT 472, now mirror these federal requirements. The Nevada rule additionally requires disclosure of the non-retained expert's qualifications, and his or her fees for providing testimony at deposition and trial.
>
> While there is no specified format for the manner in which this information should be produced, from a practice standpoint, these additional requirements may be satisfied by producing the non-retained expert's curriculum vitae and fee schedule. The non-retained expert does not have to prepare the actual disclosure, nor is he or she required to produce documentation. What is critical is that the non-retained expert's opinions are fully disclosed, at the same point in time that expert disclosures are due.
>
> Failure to disclose an expert's opinion may result in its exclusion at trial. If, for example, the disclosure is that a physician will testify in accordance with his or her office chart, the chart should encompass all opinions to be given at trial. Since this is often not the case, to avoid exclusion at trial, the attorney should list as part of his or her client's disclosures any additional opinions not specifically identified in the treating physician's medical records.
>
> Although there are also no minimum requirements for what constitutes a non-retained expert's qualifications, such information as confirmation of the non-retained expert's license and date of licensure, area of practice, address, and telephone number should be included in the NRCP 16.1 (a)(2) disclosures. Other information, such as the non-retained expert's education, can be accessed on websites of professional organizations and be included in the disclosure.
>
> See Bulla, Bonnie A.; Beecroft Jr., Chris A. "*Required Expert Disclosures under Recent Amendments to NRCP 16.1(a)(2)(B) and(C),*" Clark County Bar Association, May 1, 2013.

Just because a witness may be qualified as an expert generally does not automatically qualify him to give an opinion based on facts beyond his knowledge, even though the opinion may be within

the general range of his expertise. *Choat v. McDorman,* 86 Nev. 332, 335 (1970). An expert's testimony must be limited to matters within the scope of his specialized knowledge. *Hallmark,* 124 Nev. at 498 (citing to Nev. Rev. Stat. 50.275).

Furthermore, an expert's opinion must be based upon scientific principles and testing, not based upon a patient's own self-reporting. [The Experts] were relying on a mere temporal coincidence of the pesticide application and the Hannans' alleged and self-reported illness. Such a relationship is insufficient to establish a prima facie case on the element of causation. *Hannan v. Pest Control Servs., Inc.,* 734 N.E.2d 674, 682 (Ind. Ct. App. 2000).

Finally, NRS 48.035 notes, "evidence may be excluded if its probative value is substantially outweighed by considerations of undue delay, waste of time or needless presentation of cumulative evidence." In the instant matter, already in trial, witness after witness have testified as to Plaintiff Titian Farris' medical treatment and medical records, including the records made by Dr. Chaney. As such, Dr. Chaney's testimony is unduly cumulative.

Generic disclosures that do not provide specific facts regarding medical provider's testimony are inadequate. The Court in *Langermann* noted:

> For each medical provider the Plaintiff indicated a "person most knowledgeable" would testify and provided the same description of the subject matter of their anticipated testimony: "[s]aid witness will testify to his/her knowledge regarding the medical treatment provided to Marike Greyson resulting from the subject accident"...These disclosures are insufficient to comply with Plaintiff's obligations under Rule 26(a)(2)(C). The disclosure contains no information about the facts and opinions on which each provider is expected to testify as required by Rule 26(a)(2)(C)(ii). The disclosure contains only the most generic, unhelpful description of the subject matter on which each provider is expected to present evidence under Rules 702, 703, or 705 Federal Rules of Evidence as required by Rule 26(a)(2)(C)(i) of the Federal Rules of Civil Procedure.
>
> *Langermann v. Prop. & Cas. Ins. Co. of Hartford*, No. 2:14-CV-00982-RCJ, 2015 WL 4724512, at *4 (D. Nev. Aug. 10, 2015).

Likewise, Rule 16.1 notes that a non-retained treating physician may give testimony outside of their treatment opinions on facts such as **"testimony ancillary treatment, or the diagnosis,**

prognosis, or causation of the patient's injuries, that is not contained within the physician's medical chart, as long as the content of such testimony is properly disclosed under Rule 16.1(a)(2)(C)(i)-(iv)."

The Court in *Khoury v. Seastrand,* 132 Nev. Adv. Op. 52, 377 P.3d 81, 90 (2016) examined the reporting requirements for treating physician witnesses and expert witnesses. "While a treating physician is exempt from the report requirement, this exemption **only extends to 'opinions [that] were formed during the course of treatment.'** " *Id.,* 335 P.3d at 189 (quoting *Goodman v. Staples the Office Superstore, LLC,* 644 F.3d 817, 826 (9th Cir.2011)). **Where a treating physician's testimony exceeds that scope, he or she testifies as an expert and is subject to the relevant requirements.**" *Khoury v. Seastrand*, 132 Nev. Adv. Op. 52, 377 P.3d 81, 90 (2016).

In 2011 the Nevada Supreme Court outlined the requirements of experts. *Williams v. Eight Judicial Dist. Court of State, ex rel. Cnty. of Clark*, 127 Nev. Adv. Op. 45, 262 P.3d 360, 367-68 (2011). In *Williams*, a nurse was presented as an expert as to medical causation related to the contraction of Hepatitis C during an endoscopy procedure. The Court recognized that the nurse had substantial qualifications, but found him unqualified to opine as to medical causation nonetheless because he was not experienced diagnosing medical causation:

> Nurse Hambrick has extensive experience in cleaning and disinfecting the type of equipment used during an endoscopy procedure. He is a registered nurse in Texas, has been certified in gastroenterology for ten years, and he is currently the manager of the gastroenterology lab at the Methodist Dallas Medical Center. He has also been published in a peer-reviewed journal regarding biopsy and tissue acquisition equipment, written and spoken extensively on the topic of infection control, and has trained over 75 people on proper disinfection techniques. Additionally, he served as director of the national board of directors for the Society of Gastroenterology Nurses and Associates.
>
> Despite his experience with endoscopy equipment and disinfectant techniques, Nurse Hambrick has little, if any, experience in diagnosing the cause of hepatitis C. Nurse Hambrick never indicated, and Sicor did not contend, that Nurse Hambrick ever made medical diagnoses to assess cause. In fact, Nurse Hambrick noted that in his previous nursing positions, doctors, not nurses, always determined the cause of illnesses indicated on a patient's chart. Also, by Sicor's own admission, Nurse Hambrick is only a leading expert on "endoscopic reprocessing" and "the standards governing and proper means of

> disinfecting gastrointestinal endoscopy equipment." This does not, by extension, qualify him to testify regarding medical causation. We thus conclude that, while Nurse Hambrick may be more than qualified to testify as to proper cleaning and sterilization procedures for endoscopic equipment and can testify on those subjects, **he does not possess the requisite skill, knowledge, or experience to testify as an expert witness** regarding the medical cause of hepatitis C transmission at ECSN.
>
> *Id.* (Emphasis added).

The Nevada Supreme Court has also explained the requirements for expert testimony, "If a person is qualified to testify as an expert under NRS 50.275, the district court must then determine whether his or her expected testimony will assist the trier of fact in understanding the evidence or determining a fact in issue." *Hallmark v. Eldridge*, 124 Nev. 492, 500 (2008).

The *Williams* Court clearly outlined what expertise is required for expert opinions: at the very least you must be an expert in the field you are giving testimony for. Even though the nurse in *Williams* was clearly an expert in his own right, he could not testify as to medical causation because he was not trained and did not have expert experience diagnosing.

II. CONCLUSION

Based on the above, Plaintiffs respectfully submit this Trial Brief Regarding Disclosure Requirements for Non-Retained Experts for this Court's consideration.

DATED this 28th day of October, 2019.

BIGHORN LAW

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CERTIFICATE OF SERVICE

Pursuant to NRCP 5, NEFCR 9 and EDCR 8.05, I hereby certify that I am an employee of **BIGHORN LAW**, and on the 28th day of October, 2019, I served the foregoing ***PLAINTIFFS' TRIAL BRIEF REGARDING DISCLOSURE REQUIREMENTS FOR NON-RETAINED EXPERTS*** as follows:

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

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

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

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

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al., Defendants.	CASE NO. A-16-739464-C DEPT. NO. 31 **DEFENDANTS BARRY RIVES, M.D.'s AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S TRIAL BRIEF REGARDING PROPRIETY OF DISCLOSURE OF NAOMI CHANEY, M.D. AS A NON-RETAINED EXPERT WITNESS**

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Case Number: A-16-739464-C

Defendants BARRY J. RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC ("Defendants") hereby provide this Court with the following trial brief in support of their position plaintiff TITINA FARRIS's treating physician Dr. Naomi Chaney can properly testify at trial, and in response to Ms. Farris and plaintiff PATRICK FARRIS' ("Plaintiffs") Trial Brief Regarding Non-Retained Expert Disclosure Requirements filed on October 28, 2019.

Dated: October 29, 2019

SCHUERING ZIMMERMAN & DOYLE, LLP

By */s/ Thomas J. Doyle*
THOMAS J. DOYLE
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400 University Avenue
Sacramento, CA 95825-6502
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Attorneys for Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC

DECLARATION OF THOMAS J. DOYLE, ESQ.

I, THOMAS J. DOYLE, declare as follows:

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

2. I am making this declaration based upon my personal knowledge and if called to testify to the matters asserted herein, I could do so competently.

3. Attached hereto as Exhibit 1 is a true and correct copy of pertinent portions of the deposition of Dr. Chaney.

4. Attached hereto as Exhibit 2 is a true and correct copy of my firm's file copy of Plaintiffs' Initial Disclosure of Expert Witnesses.

5. Attached hereto as Exhibit 3 is a true and correct copy of my firm's file copy of Plaintiffs' Second Supplemental Disclosure of Expert Witnesses.

6. Attached hereto as Exhibit 4 is a true and correct copy of my firm's file copy of Plaintiffs' expert neurologist Dr. Justin Willer' report.

7. Attached hereto as Exhibit 5 is a true and correct copy of all non-Nevada state authority cited in Defendants' Trial Brief.

8. Attached hereto as Exhibit 6 is a true and correct copy of Defendants' First Supplemental NRCP 16.1 Disclosure.

9. Plaintiffs did not address any concerns regarding our disclosure of Dr. Chaney with me prior to trial, including at the EDCR 2.67 conference.

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

Executed this 29th day of October, 2019, at Las Vegas, Nevada.

/s/ Thomas J. Doyle
THOMAS J. DOYLE

MEMORANDUM OF POINTS AND AUTHORITIES

I.

BACKGROUND

This medical malpractice action arises from the care and treatment Defendants provided to Ms. Farris in connection with a laparoscopic hernia repair. Dr. Chaney was Ms. Farris' primary care physician prior to and after the care at issue. Exhibit 1, p. 7:20-24, p. 8:19-21.

The parties have been well aware of the role Dr. Chaney played in Ms. Farris' health care throughout the course of this case. On October 24, 2016, Plaintiffs first disclosed Dr. Chaney as a witness in their Initial NRCP 16.1 Disclosures. Exhibit 2. On September 7, 2018, Plaintiffs disclosed Dr. Chaney's medical and billing records. Exhibit 3.

Dr. Chaney's care was reviewed by Plaintiffs expert witness Dr. Justin Willer. *See*, Exhibit 4, and then discussed in detail in Defendants' rebuttal expert witness Dr. Bruce Adornato's rebuttal report. In December 2018, Defendants disclosed Dr. Chaney pursuant to NRCP 16.1 as follows: "Dr. Chaney is expected to testify regarding her examination, treatment, diagnosis and overall health conditions of Plaintiff." Exhibit 6.

On May 19, 2019, Dr. Chaney gave a deposition. Exhibit 1. Plaintiffs' counsel attended the deposition and had the opportunity to cross-examine her. During her deposition, Dr. Chaney testified as to her care and treatment of Ms. Farris, including the issue of her history of diabetes and diabetes-related health problems at length. Exhibit 1, p. 20:23-23:1, p. 39:7-15, p. 49:11-16, p. 53:5-14.

Plaintiffs failed to address any concerns regarding Defendants' disclosure of Dr. Chaney as a treating physician and non-retained witness prior to trial, including at the EDCR 2.67 conference. Declaration of Thomas J. Doyle, ¶ 9. Plaintiffs did not file a Motion in Limine regarding Dr. Chaney's testimony at trial. On October 28, 2019, more than two

weeks into trial, Plaintiffs filed a Trial Brief to support their anticipated argument Dr. Chaney should not be allowed to testify.

II.

ARGUMENT

The disclosure of non-retained expert witnesses, such as treating physicians, are governed by less extensive disclosure requirements than those applicable to retained expert witnesses. *See*, NRCP 16.1(a)(2)(c). The purpose of disclosure requirements for non-retained expert witnesses is to increase efficiency and reduce unfair surprise. *See, Carrillo v. B & J Andrews Enters., LLC*, 2013 U.S. Dist. LEXIS 12435 (D. Nev. 2013), *citing Brown v. Providence Medical Center*, 2011 U.S. Dist. LEXIS 111098 (D. Neb. 2011.) In fact, the disclosure regarding a non-retained treating physician may include that the physician will testify in accordance with her medical chart. NRCP 16.1(a)(2)(D)(iii).[1]

While a party may fail to comply with all disclosure requirements for non-retained expert witnesses, other Courts have declined to prevent the disclosing party from calling that witness at trial where the failure to comply with all disclosure requirements for the non-retained expert witness was harmless. *See, Carrillo v. B & J Andrews Enters., LLC*, 2013 U.S. Dist. LEXIS 12435 (D. Nev. 2013.) For example, were the non-retained expert witness was listed in the parties' initial disclosures, the treatment records associated with the non-retained treating physician were not voluminous and the parties were able to conduct discovery regarding the non-retained treating physician, any perceived harm was mitigated. *Id.*

Here, the parties have been well aware of the role Dr. Chaney played in Ms. Farris' health care throughout the course of this case. On October 24, 2016, Plaintiffs first disclosed Dr. Chaney as a witness in their Initial NRCP 16.1 Disclosures. Exhibit 2. On

[1]Plaintiffs omitted sub-section (iii) in their citation to NRCP 16.1(C)-(D) in their Trial Brief.

September 7, 2018, Plaintiffs disclosed Dr. Chaney's medical and billing records. Exhibit 3. The experts reviewed Dr. Chaney's care and medical records. *See*, Exhibit 4, 5.

In December 2018, Defendants disclosed Dr. Chaney pursuant to NRCP 16.1 to "testify regarding her examination, treatment, diagnosis and overall health conditions of Plaintiff." Exhibit 6. Thereafter, Plaintiffs had the opportunity to conduct discovery regarding Dr. Chaney, including their participation at her deposition on May 19, 2019.

At the deposition of Dr. Chaney on May 19, 2019, all subject areas outlined in NRCP 16.1(a)(2)(c) were explored. Dr. Chaney testified to her qualifications as Ms. Farris' treating primary care physician, and as an internal medicine physician. See, Exhibit 1, p. 4:18-21, 7:20-24, 8:19-21. She also testified to her hourly rate of $500. Exhibit 1, p. 65:1-7. Most notably she provided lengthy testimony regarding her care and treatment of Ms. Farris, include her history of diabetes and diabetes related health issues. Exhibit 1, p. 20:23-23:1, p. 39:7-15, p. 49:11-16, p. 53:5-14.

Plaintiffs therefore have not been harmed in anyway by Defendants' disclosure of Dr. Chaney as a non-retained expert witness. Accordingly, an Order preventing Dr. Chaney from testifying would be improper.

Additionally, Plaintiffs failed to address any concerns regarding Defendants' disclosure of Dr. Chaney as a treating physician and non-retained witness prior to trial, including at the EDCR 2.67 conference. Declaration of Thomas J. Doyle, ¶ 9. Plaintiffs did not file a Motion in Limine regarding Dr. Chaney's testimony at trial. On October 28, 2019, more than two weeks into trial, Plaintiffs filed a Trial Brief to support their anticipated argument Dr. Chaney should not be allowed to testify. Allowing Plaintiffs to block Dr. Chaney's testimony, at the eleventh hour, would substantially prejudice Defendants. If Plaintiffs obtain an Order precluding Dr. Chaney's testimony at trial, only days before she is expected to testify, Defendants will be left scrambling to re-calibrate their defense.

///

While there would be substantial prejudice to Defendants if Plaintiffs' last-minute request to preclude Dr. Chaney's testimony were granted, there is no prejudice to Plaintiffs in allowing Defendants to put on Dr. Chaney. Plaintiffs were aware of Dr. Chaney's role in this case at the time of their Initial NRCP 16.1 Disclosure. Plaintiffs had access to Dr. Chaney's medical records prior to the time for their Initial Expert Witness Disclosures, and Plaintiffs' expert witness Dr. Willer, in fact reviewed Dr. Chaney's records. Finally, Plaintiffs had the opportunity, well before trial to fully understand Dr. Chaney's opinions as a treating physician and to obtain information regarding her qualifications and fee for testifying. As a last minute Order precluding Dr. Chaney's testimony would substantially prejudice Defendants in the presentation of their defense, a request by Plaintiffs to exclude or limit the testimony of Dr. Chaney should be denied.

III.

CONCLUSION

As discussed in more detail above, Plaintiffs are not harmed by Defendants' disclosure of Dr. Chaney. Accordingly, Plaintiffs' request to limit or to preclude the testimony of Dr. Chaney in any way must be denied.

Dated: October 29, 2019

SCHUERING ZIMMERMAN & DOYLE, LLP

By */s/ Thomas J. Doyle*
THOMAS J. DOYLE
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(916) 567-0400
Attorneys for Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 29th day of October, 2019, service of a true and correct copy of the foregoing:

DEFENDANTS BARRY RIVES, M.D.'S AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S TRIAL BRIEF REGARDING PROPRIETY OF DISCLOSURE OF NAOMI CHANEY, M.D. AS A NON-RETAINED EXPERT WITNESS

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

EXHIBIT 1

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS,

Plaintiffs,

vs.

Case No. A16-739464

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

Defendants.

DEPOSITION OF NAOMI L. CHANEY, M.D.

LAS VEGAS, NEVADA

THURSDAY, MAY 9, 2019

REPORTED BY: KATHERINE M. SILVA, CCR #203
JOB NO: 543933

Does that make sense?

A. Yes.

Q. Okay. So I'm going to ask you probably during the deposition to give some estimates, but I don't want you to guess at anything, okay?

A. Yes.

Q. All right. At some point you'll have an opportunity to look at the transcript of your deposition. You can make any changes to it.

However, if you made a change that actually matters to this lawsuit as opposed to a typographical one, that could be commented upon at trial. Okay?

A. Yes.

Q. Any reason why you cannot give your best testimony here today?

A. No.

Q. Okay. Are you aware of the fact that --

Or do you know Titina Farris?

A. Yes.

Q. Okay. She was your patient for a number of years, is that correct?

A. She is my patient.

Q. All right. When was the last time that

you saw Mrs. Farris, to the best of your recollection?

A. I think three weeks ago, two weeks ago.

Q. I only have records that go through March of last year.

Can you give me your best estimate of how many times Ms. Farris has been seen in your office since that time?

A. Two.

Q. Two times, okay.

So there was a recent appointment about four weeks ago?

A. Two to three weeks ago.

Q. Thank you.

Two to three weeks ago and then there was probably one other appointment in the interim between that appointment and March of 2018?

A. Yes.

Q. Okay. Are you still her primary care physician?

A. Yes.

Q. Okay. Are you aware that Mrs. Farris and her husband have filed a lawsuit against Dr. Barry Rives?

A. Yes.

Q. Oh, I'm sorry, I'm talking about as of January 2015.

Was neuropathy an active problem at that point?

A. Yes.

Q. Was she still taking pain medications?

A. Yes.

Q. And did your assessments at that point still include chronic pain?

A. Yes.

Q. Do you know the specific pain complaints that were associated with her chronic pain at that point?

A. Back pain, leg pain.

Q. Got it.

All right. I want to skip forward to February 8, 2015. If you could find that note for me, it's the next one, and actually the quality of the copy is such that I can't tell if it's February 6th or February 15th. Perhaps you can tell.

A. I can't tell.

Q. All right. My best estimate is it's February 6th so we'll go with that date.

Can you please read the history of

present illness portion of that note for me?

A. The patient is here in interval follow up. She requires refills on her pain medication. She has history of type 2 diabetes, insulin required, not well controlled.

Historically she's reluctant to see physicians and developed diabetic neuropathy as a consequence. She has a longstanding history of low back pain with a normal MRI.

She has neuropathy which has been improved with Cymbalta. She has some tachycardia today without complaining of chest pain or chest pressure.

She's been seen by a cardiologist during a hospital evaluation for chest pain. She underwent a stress test which was normal.

Q. Is it your understanding that the neuropathy that was affecting her legs was a consequence of her uncontrolled diabetes?

A. Please repeat.

Q. Was it your understanding at that point that the pain complaints that she had in her legs were a result of neuropathy due to uncontrolled diabetes?

A. Yes.

Q. Okay. Your note mentions that she was -- reluctant to see some specialists. Which specialists was she reluctant to see?

A. When I first met Titina and she complained of chest pain, I had recommended at that time that she go to the ER. She seemed fearful about going to the ER, and didn't, and then did go back there.

So I don't know what Titina is thinking, but she appeared to be fearful of going to doctors.

Q. And that was an issue that she had had since she established care with you in approximately 2014?

A. I just remember that first time when she came to the office and she complained of symptoms and then when I referred her and she didn't go, I can't tell you why she didn't go.

I can tell you that when I've talked to them about it, it's usually about financials.

Q. Okay. But at this point in time when you perceived her being fearful of being treated and you referred her to the emergency department, that was before the hospitalization at issue in this lawsuit; is that right?

A. That's correct.

Q. Okay. What was the purpose -- I'm sorry.

So going back. When you mentioned she was reluctant to see physicians, were you speaking about anything in addition to the referral to the emergency department for the complaint of chest pain or was that solely --

A. It would be the referrals. So I referred Titina in the past to cardiology. I referred her to endocrinology multiple times.

Q. Did she comply with those recommendations to go to cardiology or endocrinology?

A. No.

Q. Do you have an understanding as to why she did not follow through with those recommendations?

A. I think it was multifactorial.

Q. And what is your understanding of the various factors?

A. When I've talked to them over this particular issue, it was financial largely, transportation.

Q. Any other issues that factored into her

A. It's very vague what I wrote so I can't tell you what exactly was said. I would imagine it would be similar to what we've talked about multiple times which is that I'd like her to do and that she had barriers for financial reasons, transportation.

Q. Okay. What were your assessments at that point?

A. Chronic body pain, diabetes, neuropathy, diabetic foot ulcer, dyslipidemia, abnormal urine.

So I would not say the diabetic foot ulcer would have been the right -- if I was to be very like -- had plenty of time, I would just say ulcer.

Q. Okay. Is it fair to say that you don't have an opinion as to the etiology of that foot ulcer?

A. As I said earlier, what I remember is that she left the hospital and the rehab and when she came and presented to me, she had wounds on her feet.

Q. Okay. The last --

The most recent note that I have is the last one in that stack. If you could turn to it,

described was -- began April of 2019; is that right?

A. Yeah, it just literally a month or so ago.

Q. Okay. So at this point it's too earlier to assess her progress with that new program?

A. I don't even know if it's been implemented. We talked about it. You have to have a smart phone and a computer.

Q. Okay. The past medical history stated in the March 22nd, 2018 includes chronic diabetic ulcer -- multiple referrals.

Did she have diabetic ulcers as of that time?

A. I don't know.

Q. Do you know what the origin of that past medical history as noted in your note comes from?

A. Well, she had an ulcer. The only ulcer that I know of is after she was in the hospital and she has diabetes. So it would be more correct for me to say ulcer.

Q. Okay. And multiple referrals. What referrals is that referring to?

good reason why she's been unable to comply, is that what you are telling me?

A. Well, I have more than one non -- of patients whose sugars aren't well controlled.

Q. Sure.

A. And when I talk to them about it as I said, I don't do this just with Titina. I've done this with many of my uncontrolled insulin-using diabetics. I find that there's emotional overlays.

So one particular person when I talked to her about it, then she had shared with me that her son had died and there's a lot of other things going on.

Q. Sure.

A. So Titina and her husband are very private people. I cannot tell you why -- I don't know why. I just don't want to make any assumptions about her.

Q. Absolutely.

A. That's it.

Q. But objectively speaking, she had a history of noncompliance with treatment recommendations, fair to say?

A. Yes.

LAS VEGAS, NEVADA; THURSDAY, MAY 9, 2019

9:54 o'clock a.m.

-o0o-

(The court reporter was relieved of her duties under Rule 30(b)(4) of the Nevada Rules of Civil Procedure.)

Whereupon --

NAOMI L. CHANEY, M.D.

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

EXAMINATION

BY MR. COUCHOT:

Q. Please state your name for the record?

A. Naomi Lee Chaney.

Q. And, Dr. Chaney, you are a physician?

A. Yes.

Q. What is your specialty?

A. Internal medicine.

Q. Approximately how many depositions have you given in the past?

A. This would be my third.

Q. Okay. So since this is your third

Does that make sense?

A. Yes.

Q. Okay. So I'm going to ask you probably during the deposition to give some estimates, but I don't want you to guess at anything, okay?

A. Yes.

Q. All right. At some point you'll have an opportunity to look at the transcript of your deposition. You can make any changes to it.

However, if you made a change that actually matters to this lawsuit as opposed to a typographical one, that could be commented upon at trial. Okay?

A. Yes.

Q. Any reason why you cannot give your best testimony here today?

A. No.

Q. Okay. Are you aware of the fact that --

Or do you know Titina Farris?

A. Yes.

Q. Okay. She was your patient for a number of years; is that correct?

A. She is my patient.

Q. All right. When was the last time that

you saw Mrs. Farris, to the best of your recollection?

A. I think three weeks ago, two weeks ago.

Q. I only have records that go through March of last year.

Can you give me your best estimate of how many times Ms. Farris has been seen in your office since that time?

A. Two.

Q. Two times, okay.

So there was a recent appointment about four weeks ago?

A. Two to three weeks ago.

Q. Thank you.

Two to three weeks ago and then there was probably one other appointment in the interim between that appointment and March of 2018?

A. Yes.

Q. Okay. Are you still her primary care physician?

A. Yes.

Q. Okay. Are you aware that Mrs. Farris and her husband have filed a lawsuit against Dr. Barry Rives?

A. Yes.

MR. COUCHOT: So, Dr. Chaney, as customary for a treating physician, I will pay you for your time. I think if --

You mentioned you don't have a standard rate and I suggested $500 an hour. Is that acceptable to you?

THE WITNESS: Yes.

MR. COUCHOT: Okay. Will you send me a W-9 so that I can issue a check to you?

THE WITNESS: Yes.

MR. COUCHOT: Okay. Thank you. That's it.

THE WITNESS: Thank you.

THE COURT REPORTER: Do you want a copy?

MR. PITEGOFF: You know what, let me ask George.

Yes, he does want one.

(READ AND SIGN NOT REQUESTED)

(Thereupon the deposition was concluded at 11:07 a.m.)

* * * *

CERTIFICATE OF REPORTER

STATE OF NEVADA)
)SS
COUNTY OF CLARK)

I, Katherine M. Silva, a certified court reporter, Clark County, State of Nevada, do hereby certify: That I reported the taking of the deposition of the witness, NAOMI L. CHANEY, M.D., commencing on THURSDAY, MAY 9, 2019, at 9:54 o'clock a.m.

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

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

IN WITNESS WHEREOF, I have hereunto set my hand in my office in the County of Clark, State of Nevada, this 20th day of May, 2019.

Katherine M. Silva

Katherine M. Silva, CCR #203

EXHIBIT 2

EWDI
George F. Hand, Esq.
Nevada State Bar No. 8483
ghand@handsullivan.com
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, Nevada 89129
Telephone: (702) 656-5814
Facsimile: (702) 656-9820

Attorneys for Plaintiffs
TITINA FARRIS and PATRICK FARRIS

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA LLC; DOES I-V, inclusive; and ROE CORPORATIONS I-V, inclusive, Defendants.	Case No.: A-16-739464-C Dept. No.: 31 **PLAINTIFFS' EXPERT WITNESS DISCLOSURES**

COMES NOW Plaintiffs by and through their attorneys, Hand & Sullivan, LLC hereby disclose the following expert witness information pursuant to Nevada Rules of Civil Procedure 16.1 as follows:

1. Michael Hurwitz, M.D.
510 Superior Avenue
Suite 200G
Newport Beach, CA 92663
(949) 791-6767

It is expected that Dr. Hurwitz will testify as to his expert opinion regarding the medical treatment and care rendered to Titina Farris and causation of the injuries to Titina Farris. Dr. Hurwitz will also testify in accordance with his expert report, curriculum vitae and testimony list. Attached as Exhibit 1.

A. The written report of Dr. Hurwitz is attached hereto.

B. Dr. Hurwitz's curriculum vitae with list of publications is attached hereto.

C. Dr. Hurwitz's fee schedule is attached hereto.

D. Dr. Hurwitz's list of testimonies is attached hereto.

2. Justin Willer. M.D.
741 Ocean Parkway
Brooklyn, NY 11230
(718) 859-8920

It is expected that Dr. Willer will testify as to his expert opinion regarding the medical treatment and care rendered to Titina Farris and causation of the injuries to Titina Farris. Dr. Willer will also testify in accordance with his expert report, curriculum vitae and testimony list. Attached as Exhibit 2.

A. The written report of Dr. Willer is attached hereto.

B. Dr. Willer's curriculum vitae with list of publications is attached hereto.

C. Dr. Willer's fee schedule is attached hereto.

D. Dr. Willer's list of testimonies is attached hereto.

3. Alan J. Stein, MD
509 12th Street
Apt. 1D
Brooklyn NY 11215
(718) 369-4850

It is expected that Dr. Stein will testify as to his expert opinion regarding the medical treatment and care rendered to Titina Farris and causation of the injuries to Titina Farris. Dr. Willer will also testify in accordance with his expert report, curriculum vitae and testimony list. Attached as Exhibit 3.

A. The written report of Dr. Stein is attached hereto.

B. Dr. Stein's curriculum vitae with list of publications is attached hereto.

C. Dr. Stein's fee schedule is attached hereto.

D. Dr. Stein's list of testimonies is attached hereto.

4. Dawn Cook, RN, CNLCP, LNCP-C, CLCP, LNC, CFLC
1001 E. Sunset Road, #97553
Las Vegas, NV 89193-7553
(702) 544-2159

It is expected that Ms. Cook will testify as to her expert opinion regarding the Life Care Plan formulated for Titina Farris, including the necessary future medical treatment, therapies and services required for Titina Farris and the costs and expenses associated with Titina Farris's life care plan. It is expected that Dawn L. Cook will testify as to her expert opinion regarding the medical treatment and care rendered to Titina Farris and causation of her injuries; the reasonableness and necessity of the treatment and care rendered to Plaintiff Titina Farris; the costs of medical care and treatment, including the usual, customary and reasonable charges for said treatment.

Dawn L. Cook will also testify in accordance with her expert report, curriculum vitae and testimony list.

Attached as Exhibit 4.

A. The written Life Care Plan of Dawn Cook, RN, CNLCP, LNCP-C, CLCP, LNC, CFLC is attached hereto.

B. The Past Medical Bill Review for Titina Farris of Dawn Cook, RN, CNLCP, LNCP-C, CLCP, LNC, CFLC is attached hereto.

C. Dawn Cook, RN, CNLCP, LNCP-C, CLCP, LNC, CFLC's curriculum vitae with list of publications is attached hereto.

D. Dawn Cook, RN, CNLCP, LNCP-C, CLCP, LNC, CFLC 's fee schedule is attached hereto.

E. Dawn Cook, RN, CNLCP, LNCP-C, CLCP, LNC, CFLC's list of testimonies is attached hereto.

5. Terrence M. Clauretie, PH.D.
4505 S. Maryland Parkway
Las Vegas, Nevada 89154-6025
(702) 985-3223

It is expected that Dr. Clauretie will testify as to his expert opinion regarding the economic losses of Titina Farris, including the present value of Titina Farris's Life Care Plan. Dr. Clauretie

will also testify in accordance with his expert reports, curriculum vitae and testimony list. Attached as Exhibit 5.

A. The written report of Dr. Clauretie are attached hereto.

B. Dr. Clauretie's curriculum vitae with list of publications is attached hereto.

C. Dr. Clauretie's fee schedule is attached hereto.

D. Dr. Clauretie's list of testimonies is attached hereto.

6. Alex Barchuk, M.D.
1125 Sir Francis Drake Blvd.
Kentfield, CA 94904
(415) 485-3508

It is expected that Dr. Barchuk will testify as to his expert opinion regarding the medical treatment and care rendered to Titina Farris and causation of the injuries to Titina Farris as well as his examination of Titina Farris. Dr. Barchuk will also testify in accordance with his expert report, curriculum vitae and testimony list. Attached as Exhibit 6.

A. The written report of Dr. Barchuk is attached hereto.

B. Dr. Barchuk's curriculum vitae with list of publications is attached hereto.

C. Dr. Barchuk's fee schedule is attached hereto.

D. Dr. Barchuk's list of testimonies is attached hereto.

E. Dr. Barchuk's PowerPoint, pictures and videos from examination of Titina Farris.

Exhibits 1-6 are contained in the attached CD.

Plaintiffs, reserves the right to supplement their expert disclosures pursuant to NRCP 16.1(a)(2) and NRCP 26(e)(1). Additionally, Plaintiffs reserve the right to call as witnesses at trial any experts designated by any party to this action regardless of whether said party is still a part of the action at the trial of this matter.

Dated: November 15, 2018

HAND & SULLIVAN, LLC

By: George F. Hand

George F. Hand, Esq.
Nevada State Bar No. 8483
3442 North Buffalo Drive
Las Vegas, Nevada 89129
Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I am employed in the County of Clark, State of Nevada. I am over the age of 18 and not a party to the within action. My business address is 3442 N. Buffalo Drive, Las Vegas, NV 89129.

On November 15, 2018, I served the within document(s) described as:

PLAINTIFFS' EXPERT WITNESS DISCLOSURES

on the interested parties in this action as stated on the below mailing list.

[X] (BY MAIL) By placing a true copy of the foregoing document(s) in a sealed envelope addressed to Defendant's last-known address. I placed such envelope for collection and mailing following ordinary business practices. I am readily familiar with this Firm's practice for collection and processing of correspondence for mailing. Under that practice, the correspondence would be deposited with the United States Postal Service on that same day, with postage thereon fully prepaid at Las Vegas, Nevada. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit.

[X] (BY ELECTRONIC SERVICE) By e-serving through Odyssey, pursuant to Administrative Order 14-2 mandatory electronic service, a true file stamped copy of the foregoing document(s) to the last known email address listed below of each Defendant which Plaintiff knows to be a valid email address for each Defendant.

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

Anna Grigoryan
(Type or print name)

(Signature)

Farris v. Rives, et al.
Court Case No.: A-16-739464-C

SERVICE LIST

Thomas J. Doyle, Esq. calendar@szs.com SCHUERING ZIMMERMAN & DOYLE, LLP 400 University Avenue Sacramento, California 95825-6502 (916) 567-0400 (916) 568-0400 Fax *Attorneys for Defendants*	Kim Mandelbaum, Esq. filing@memlaw.net MANDELBAUM ELLERTON & ASSOCIATES 2012 Hamilton Lane Las Vegas, Nevada 89106 (702) 367-1234 *Attorneys for Defendants*


Verbatim
PLAINTIFF'S
INITIAL EXPERT DISCLOSURES
A-16
FAPP0001-C

EXHIBIT 3

EWDI
George F. Hand, Esq.
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Telephone: (702) 656-5814
Facsimile: (702) 656-9820

Attorneys for Plaintiffs
TITINA FARRIS and PATRICK FARRIS

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA LLC; DOES I-V, inclusive; and ROE CORPORATIONS I-V, inclusive, Defendants.	Case No.: A-16-739464-C Dept. No.: 31 **PLAINTIFFS' SECOND SUPPLEMENTAL EXPERT WITNESS DISCLOSURE**

COMES NOW Plaintiffs by and through their attorneys, Hand & Sullivan, LLC hereby disclose the following pursuant to NRCP 16.1:

Terence M. Clauretie, PH.D report of July 5, 2019.

Plaintiffs reserve the right to supplement their expert disclosures pursuant to NRCP 16.1(a)(2) and NRCP 26(e)(1). Additionally, Plaintiffs reserve the right to call as witnesses at trial any experts designated by any party to this action regardless of whether said party is still a part of the action at the trial of this matter.

Dated: July 12, 2019

HAND & SULLIVAN, LLC

By: _____
George F. Hand, Esq.
Nevada State Bar No. 8483
3442 North Buffalo Drive
Las Vegas, Nevada 89129
Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I am employed in the County of Clark, State of Nevada. I am over the age of 18 and not a party to the within action. My business address is 3442 N. Buffalo Drive, Las Vegas, NV 89129.

On July 12, 2019, I served the within document(s) described as:

PLAINTIFFS' SECOND SUPPLEMENTAL EXPERT WITNESS DISCLOSURE

on the interested parties in this action as stated on the below mailing list.

☐ (BY MAIL) By placing a true copy of the foregoing document(s) in a sealed envelope addressed to Defendant's last-known address. I placed such envelope for collection and mailing following ordinary business practices. I am readily familiar with this Firm's practice for collection and processing of correspondence for mailing. Under that practice, the correspondence would be deposited with the United States Postal Service on that same day, with postage thereon fully prepaid at Las Vegas, Nevada. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit.

☒ (BY ELECTRONIC SERVICE) By e-serving through Odyssey, pursuant to Administrative Order 14-2 mandatory electronic service, a true file stamped copy of the foregoing document(s) to the last known email address listed below of each Defendant which Plaintiff knows to be a valid email address for each Defendant.

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

Anna Grigoryan
(Type or print name)

(Signature)

Farris v. Rives, et al.
Court Case No.: A-16-739464-C

SERVICE LIST

Thomas J. Doyle, Esq. Chad C. Couchot, Esq. calendar@szs.com **SCHUERING ZIMMERMAN & DOYLE, LLP** 400 University Avenue Sacramento, California 95825-6502 (916) 567-0400 (916) 568-0400 Fax *Attorneys for Defendants*	Kim Mandelbaum, Esq. filing@memlaw.net **MANDELBAUM ELLERTON & ASSOCIATES** 2012 Hamilton Lane Las Vegas, Nevada 89106 (702) 367-1234 *Attorneys for Defendants*

REVISED REPORT ON PRESENT VALUE OF A LIFE CARE PLAN FOR

MS. TITINA FARRIS

July 5, 2019

Terrence M. Clauretie, Ph.D.

I. ASSIGNMENT

I have been asked by Mr. George Hand to revise my estimate of the present value of a life care plan for Ms. Titina Farris. The earlier report indicated a present value of $3,463,164. This revision reflects an increase in the hours for companion care and does not account for a change in the date of thi revised report or the interest rates as of July, 2019.

REVISED ESTIMATE OF PRESENT VALUE OF LIFE CARE PLAN: ***$4,663,473.***

II. MATERIALS RELIED ON

For this purpose I have relied on the following material:

1. Revised report on life care plan by Ms. Dawn Cook, RN, June 14, 2019,
2. Forecast of future growth rate in non-medical labor from the 2018 Annual Report of the Trustees of the OASDI (if applicable),
3. Consumer Price Index published by the United States Department of Commerce,
4. Life expectancy tables from the United States government,
5. Forecast of future medical costs by Trustees of the United States Hospital and Supplementary Insurance Trust Funds, 2018 (for forecast of growth of medical costs) available by clicking on the following link: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads//tr2015.pdf See Table II.C.1 pp. 10-16 (also attached to this report),
6. Interest Rates on United States Treasury Bonds (to replace future costs to present value), available by clicking on the following link: http://www.treasury.gov/resource-center/data-chart-center/Pages/index.aspx,

III. CALCULATIONS

Table one shows the client information in this case. Table two shows the future cost as outlined by Ms. Dawn Cook without a growth rate or discount rate applied. The total for each item in the plan and the total for the plan in table two are identical to the totals in the Cook report (with the exception of the revision for companion care). Table three shows the future costs applying a

3.50% annual growth rate for medical and professional costs. The growth rates in these costs come from items #2 and #5 above. The discount rate is the rate of interest on government bonds that mature in the next twenty-nine years as of October 2018. The present value of the life care plan is ***$4,663,473***.

Table One – Client Information

Client Name	Titina Farris
Gender	Female
Age	56 (eoy)
Life Expectancy	85

TABLE TWO
COSTS IN 2018 DOLLARS

							$98,504
	$17,953	**$13,465**	**$1,696**	**$33,693**	**$7,403**	**$22,598**	**$1,696**
	#1	#2	#3	#4	#5	#6	#7
AGE AT EOY	PM&R	INTERN. MED.	ORTHO	PODIATRY	PSYCHOL.	PSYCHOL.	PLASTIC SURGEON
56	$155	$116	$242	$2,035	$64	$873	$242
57	$619	$464	$0	$1,131	$255	$776	$0
58	$619	$464	$0	$1,131	$255	$776	$0
59	$619	$464	$0	$1,131	$255	$776	$0
60	$619	$464	$242	$1,131	$255	$776	$242
61	$619	$464	$0	$1,131	$255	$776	$0
62	$619	$464	$0	$1,131	$255	$776	$0
63	$619	$464	$0	$1,131	$255	$776	$0
64	$619	$464	$242	$1,131	$255	$776	$242
65	$619	$464	$0	$1,131	$255	$776	$0
66	$619	$464	$0	$1,131	$255	$776	$0
67	$619	$464	$0	$1,131	$255	$776	$0
68	$619	$464	$242	$1,131	$255	$776	$242
69	$619	$464	$0	$1,131	$255	$776	$0
70	$619	$464	$0	$1,131	$255	$776	$0
71	$619	$464	$0	$1,131	$255	$776	$0
72	$619	$464	$242	$1,131	$255	$776	$242
73	$619	$464	$0	$1,131	$255	$776	$0
74	$619	$464	$0	$1,131	$255	$776	$0
75	$619	$464	$0	$1,131	$255	$776	$0
76	$619	$464	$242	$1,131	$255	$776	$242
77	$619	$464	$0	$1,131	$255	$776	$0
78	$619	$464	$0	$1,131	$255	$776	$0
79	$619	$464	$0	$1,131	$255	$776	$0
80	$619	$464	$242	$1,131	$255	$776	$242
81	$619	$464	$0	$1,131	$255	$776	$0
82	$619	$464	$0	$1,131	$255	$776	$0
83	$619	$464	$0	$1,131	$255	$776	$0
84	$619	$464	$0	$1,131	$255	$776	$0
85	$464	$348	$0	$0	$191	$0	$0

TABLE TWO CONTINUED

$8,161	**$6,587**	**$7,598**	**$68,380**	**$7,316**	**$24,482**	**$679,171**
#8	#9	#10	#11	#12	#13	#14
DIETICIAN	PT EVAL	PT	PT	OT	OT	POOL PROG.
$281	$227	$0	$0	$252	$844	$0
$281	$227	$3,799	$0	$252	$844	$17,873
$281	$227	$3,799	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
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$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$281	$227	$0	$2,533	$252	$844	$23,831
$0	$0	$0	$0	$0	$0	$17,873

TABLE TWO CONTINUED

		$1,112,088	***$31,362***		***$23,322***	***$2,056***	***$18,003***
$46,166	**$227,341**	**$36,888**	**$31,362**	**$2,133**	**$21,190**	**$2,056**	**$15,947**
#15	#16	#17	#18	#19	#20	#21	#22
MESSAGE THERAPY	ACCUP. THERAPY	WOUMD CLINIC	ER & PHYSIC.	MRI	DIAG. OTHER	TRIGGER POINT	ARTHRO-SCOPIES
$873	$1,960	$8,973	$873	$2,133	$0	$343	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$343	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$343	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$15,947
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$343	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$343	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$1,592	$7,839	$997	$1,081	$0	$757	$0	$0
$719	$5,880	$0	$208	$0	$0	$343	$0

TABLE TWO CONTINUED

$59,972			*$2,588,325*	*$114,800*	*$81,080*	
$59,972	**$2,501,391**	**$68,664**	**$18,270**	**$114,800**	**$81,080**	**$4,127,456**
#23	#24	#25	#26	#27	#28	**$4,127,456**
CARPAL TUNNEL	COMPANION CARE	HOME MAIN.	CASE MNGMT.	DME	HOME MOD.	
$0	$9,809	$592	$630	$3,827	$81,080	$116,424
$0	$39,238	$2,368	$630	$3,827	$0	$84,850
$0	$39,238	$2,368	$630	$3,827	$0	$93,341
$0	$39,238	$2,368	$630	$3,827	$0	$89,542
$0	$39,238	$2,368	$630	$3,827	$0	$90,026
$0	$39,238	$2,368	$630	$3,827	$0	$89,542
$0	$39,238	$2,368	$630	$3,827	$0	$89,884
$0	$39,238	$2,368	$630	$3,827	$0	$89,542
$0	$51,009	$2,368	$630	$3,827	$0	$101,798
$0	$54,933	$2,368	$630	$3,827	$0	$105,237
$0	$54,933	$2,368	$630	$3,827	$0	$105,237
$0	$54,933	$2,368	$630	$3,827	$0	$105,237
$0	$54,933	$2,368	$630	$3,827	$0	$106,064
$59,972	$66,704	$2,368	$630	$3,827	$0	$192,927
$0	$78,475	$2,368	$630	$3,827	$0	$128,779
$0	$78,475	$2,368	$630	$3,827	$0	$128,779
$0	$78,475	$2,368	$630	$3,827	$0	$129,264
$0	$78,475	$2,368	$630	$3,827	$0	$128,779
$0	$78,475	$2,368	$630	$3,827	$0	$129,122
$0	$109,865	$2,368	$630	$3,827	$0	$160,169
$0	$141,255	$2,368	$630	$3,827	$0	$192,044
$0	$141,255	$2,368	$630	$3,827	$0	$191,559
$0	$141,255	$2,368	$630	$3,827	$0	$191,559
$0	$141,255	$2,368	$630	$3,827	$0	$191,559
$0	$141,255	$2,368	$630	$3,827	$0	$192,386
$0	$141,255	$2,368	$630	$3,827	$0	$191,559
$0	$141,255	$2,368	$630	$3,827	$0	$191,559
$0	$141,255	$2,368	$630	$3,827	$0	$191,559
$0	$141,255	$2,368	$630	$3,827	$0	$191,559
$0	$105,941	$1,776	$0	$3,827	$0	$137,570

TABLE THREE

GROWTH		3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%
		#1	#2	#3	#4	#5	#6	#7
AGE		PM&R	INTERN.	ORTHO	PODIATRY	PSYCHOL.	PSYCHOL.	PLASTIC
YEAR			MED.					SURGEON
2018	56	$155	$116	$242	$2,035	$64	$873	$242
2019	57	$641	$481	$0	$1,170	$264	$803	$0
2020	58	$663	$497	$0	$1,211	$273	$831	$0
2021	59	$686	$515	$0	$1,254	$283	$860	$0
2022	60	$710	$533	$278	$1,297	$293	$890	$278
2023	61	$735	$551	$0	$1,343	$303	$922	$0
2024	62	$761	$571	$0	$1,390	$314	$954	$0
2025	63	$788	$591	$0	$1,439	$325	$987	$0
2026	64	$815	$611	$319	$1,489	$336	$1,022	$319
2027	65	$844	$633	$0	$1,541	$348	$1,057	$0
2028	66	$873	$655	$0	$1,595	$360	$1,094	$0
2029	67	$904	$678	$0	$1,651	$373	$1,133	$0
2030	68	$935	$702	$366	$1,708	$386	$1,172	$366
2031	69	$968	$726	$0	$1,768	$399	$1,213	$0
2032	70	$1,002	$752	$0	$1,830	$413	$1,256	$0
2033	71	$1,037	$778	$0	$1,894	$428	$1,300	$0
2034	72	$1,073	$805	$420	$1,961	$443	$1,345	$420
2035	73	$1,111	$833	$0	$2,029	$458	$1,392	$0
2036	74	$1,150	$862	$0	$2,100	$474	$1,441	$0
2037	75	$1,190	$893	$0	$2,174	$491	$1,492	$0
2038	76	$1,232	$924	$482	$2,250	$508	$1,544	$482
2039	77	$1,275	$956	$0	$2,328	$526	$1,598	$0
2040	78	$1,320	$990	$0	$2,410	$544	$1,654	$0
2041	79	$1,366	$1,024	$0	$2,494	$563	$1,712	$0
2042	80	$1,414	$1,060	$553	$2,582	$583	$1,772	$553
2043	81	$1,463	$1,097	$0	$2,672	$603	$1,834	$0
2044	82	$1,514	$1,136	$0	$2,766	$624	$1,898	$0
2045	83	$1,567	$1,175	$0	$2,862	$646	$1,964	$0
2046	84	$1,622	$1,217	$0	$2,962	$669	$2,033	$0
2047	85	$1,259	$944	$0	$0	$519	$0	$0

TABLE THREE CONTINUED

3.50% #8 DIETICIAN	3.50% #9 PT EVAL	3.50% #10 PT	3.50% #11 PT	3.50% #12 OT	3.50% #13 OT	3.50% #14 POOL PROG.
$281	$227	$0	$0	$252	$844	$0
$291	$235	$3,932	$0	$261	$874	$18,499
$301	$243	$4,069	$2,713	$270	$904	$25,528
$312	$252	$0	$2,808	$280	$936	$26,421
$323	$261	$0	$2,906	$289	$969	$27,346
$334	$270	$0	$3,008	$300	$1,003	$28,303
$346	$279	$0	$3,113	$310	$1,038	$29,294
$358	$289	$0	$3,222	$321	$1,074	$30,319
$371	$299	$0	$3,335	$332	$1,112	$31,380
$384	$310	$0	$3,452	$344	$1,151	$32,479
$397	$320	$0	$3,572	$356	$1,191	$33,615
$411	$332	$0	$3,698	$368	$1,233	$34,792
$425	$343	$0	$3,827	$381	$1,276	$36,010
$440	$355	$0	$3,961	$395	$1,320	$37,270
$456	$368	$0	$4,100	$408	$1,367	$38,574
$471	$381	$0	$4,243	$423	$1,414	$39,925
$488	$394	$0	$4,391	$437	$1,464	$41,322
$505	$408	$0	$4,545	$453	$1,515	$42,768
$523	$422	$0	$4,704	$469	$1,568	$44,265
$541	$437	$0	$4,869	$485	$1,623	$45,814
$560	$452	$0	$5,039	$502	$1,680	$47,418
$580	$468	$0	$5,216	$520	$1,739	$49,077
$600	$484	$0	$5,398	$538	$1,799	$50,795
$621	$501	$0	$5,587	$557	$1,862	$52,573
$643	$519	$0	$5,783	$576	$1,928	$54,413
$665	$537	$0	$5,985	$596	$1,995	$56,317
$688	$556	$0	$6,195	$617	$2,065	$58,289
$712	$575	$0	$6,411	$639	$2,137	$60,329
$737	$595	$0	$6,636	$661	$2,212	$62,440
$0	$0	$0	$0	$0	$0	$48,469

TABLE THREE CONTINUED

3.50% #15 MESSAGE THERAPY	3.50% #16 ACCUP. THERAPY	3.50% #17 WOUMD CLINIC	3.50% #18 ER & PHYSIC.	3.50% #19 MRI	3.50% #20 DIAG. OTHER	3.50% #21 TRIGGER POINT	3.50% #22 ARTHRO-SCOPIES
$873	$1,960	$8,973	$873	$2,133	$0	$343	$0
$1,648	$8,114	$1,032	$1,119	$0	$783	$0	$0
$1,705	$8,398	$1,068	$1,158	$0	$811	$0	$0
$1,765	$8,692	$1,105	$1,199	$0	$839	$0	$0
$1,827	$8,996	$1,144	$1,241	$0	$868	$0	$0
$1,891	$9,311	$1,184	$1,284	$0	$899	$0	$0
$1,957	$9,637	$1,226	$1,329	$0	$930	$421	$0
$2,025	$9,974	$1,268	$1,376	$0	$963	$0	$0
$2,096	$10,323	$1,313	$1,424	$0	$997	$0	$0
$2,170	$10,684	$1,359	$1,474	$0	$1,031	$0	$0
$2,246	$11,058	$1,406	$1,526	$0	$1,068	$0	$0
$2,324	$11,445	$1,456	$1,579	$0	$1,105	$0	$0
$2,406	$11,846	$1,506	$1,634	$0	$1,144	$518	$0
$2,490	$12,260	$1,559	$1,691	$0	$1,184	$0	$24,940
$2,577	$12,690	$1,614	$1,751	$0	$1,225	$0	$0
$2,667	$13,134	$1,670	$1,812	$0	$1,268	$0	$0
$2,760	$13,593	$1,729	$1,875	$0	$1,312	$0	$0
$2,857	$14,069	$1,789	$1,941	$0	$1,358	$0	$0
$2,957	$14,562	$1,852	$2,009	$0	$1,406	$637	$0
$3,060	$15,071	$1,917	$2,079	$0	$1,455	$0	$0
$3,168	$15,599	$1,984	$2,152	$0	$1,506	$0	$0
$3,278	$16,145	$2,053	$2,227	$0	$1,559	$0	$0
$3,393	$16,710	$2,125	$2,305	$0	$1,613	$0	$0
$3,512	$17,295	$2,199	$2,386	$0	$1,670	$0	$0
$3,635	$17,900	$2,276	$2,469	$0	$1,728	$783	$0
$3,762	$18,526	$2,356	$2,556	$0	$1,788	$0	$0
$3,894	$19,175	$2,439	$2,645	$0	$1,851	$0	$0
$4,030	$19,846	$2,524	$2,738	$0	$1,916	$0	$0
$4,171	$20,540	$2,612	$2,834	$0	$1,983	$0	$0
$1,950	$15,945	$0	$564	$0	$0	$929	$0

TABLE THREE CONTINUED

3.50% #23 CARPAL TUNNEL	3.50% #24 COMPANION CARE	3.50% #25 HOME MAIN.	3.50% #26 CASE MNGMT.	2.80% #27 DME	2.80% #28 HOME MOD.	**$7,613,103** TOTAL	DISC. RATE	**$4,663,473** PRESENT VALUE
$0	$9,809	$592	$630	$3,827	$81,080	$116,424	0.00%	$116,424
$0	$40,611	$2,451	$652	$3,934	$0	$87,793	2.41%	$85,727
$0	$42,032	$2,536	$675	$4,044	$0	$99,934	2.33%	$95,434
$0	$43,503	$2,625	$698	$4,157	$0	$99,191	2.30%	$92,650
$0	$45,026	$2,717	$723	$4,274	$0	$103,190	2.31%	$94,181
$0	$46,602	$2,812	$748	$4,393	$0	$106,196	2.33%	$94,644
$0	$48,233	$2,911	$774	$4,516	$0	$110,303	2.39%	$95,729
$0	$49,921	$3,012	$802	$4,643	$0	$113,696	2.43%	$96,107
$0	$67,169	$3,118	$830	$4,773	$0	$133,782	2.47%	$110,058
$0	$74,867	$3,227	$859	$4,906	$0	$143,118	2.50%	$114,598
$0	$77,488	$3,340	$889	$5,044	$0	$148,093	2.54%	$115,239
$0	$80,200	$3,457	$920	$5,185	$0	$153,241	2.52%	$116,541
$0	$83,007	$3,578	$952	$5,330	$0	$159,818	2.54%	$118,278
$93,794	$104,322	$3,703	$985	$5,479	$0	$301,224	2.56%	$216,858
$0	$127,027	$3,833	$1,020	$5,633	$0	$207,893	2.60%	$145,136
$0	$131,473	$3,967	$1,055	$5,791	$0	$215,130	2.62%	$145,955
$0	$136,075	$4,106	$1,092	$5,953	$0	$223,459	2.64%	$147,276
$0	$140,837	$4,249	$1,131	$6,119	$0	$230,369	2.66%	$147,435
$0	$145,766	$4,398	$1,170	$6,291	$0	$239,025	2.69%	$148,230
$0	$211,216	$4,552	$1,211	$6,467	$0	$307,036	2.72%	$184,393
$0	$281,068	$4,711	$1,254	$6,648	$0	$381,160	2.75%	$221,550
$0	$290,905	$4,876	$1,297	$6,834	$0	$393,456	2.74%	$223,031
$0	$301,087	$5,047	$1,343	$7,025	$0	$407,179	2.76%	$223,695
$0	$311,625	$5,223	$1,390	$7,222	$0	$421,382	2.78%	$224,273
$0	$322,532	$5,406	$1,438	$7,424	$0	$437,968	2.80%	$225,740
$0	$333,820	$5,596	$1,489	$7,632	$0	$451,290	2.82%	$225,173
$0	$345,504	$5,791	$1,541	$7,846	$0	$467,032	2.84%	$225,493
$0	$357,597	$5,994	$1,595	$8,066	$0	$483,323	2.86%	$225,726
$0	$370,112	$6,204	$1,651	$8,291	$0	$500,183	2.88%	$225,872
$0	$287,300	$4,816	$0	$8,524	$0	$371,219	2.90%	$162,026

IV. COMPENSATION

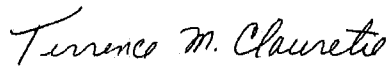
My charges are $350 per hour for non-testimony work and $450 per hour for all testimony. I have allocated one hour to this updated report.

V. ATTACHMENTS

In addition to the materials relied upon I have attached or previously provided the following:

1. Curriculum Vitae
2. Testimony history
3. Invoice

Respectfully Submitted,



Terrence M. Clauretie, PH.D.

OCTOBER 2018 INTERST RATES

Daily Treasury Yield Curve Rates

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Select type of Interest Rate Data

Daily Treasury Yield Curve Rates Go

Select Time Period

Current Month Go

Date	1 Mo	3 Mo	6 Mo	1 Yr	2 Yr	3 Yr	5 Yr	7 Yr	10 Yr	20 Yr	30 Yr
10/01/18	2.13	2.23	2.40	2.60	2.82	2.90	2.96	3.04	3.09	3.18	3.24
10/02/18	2.14	2.23	2.41	2.61	2.82	2.88	2.94	3.01	3.05	3.14	3.20
10/03/18	2.15	2.23	2.41	2.62	2.85	2.94	3.02	3.10	3.15	3.24	3.30

Wednesday Oct 3, 2018

MEDICAL AND PROFESSIONAL COSTS GROWTH RATES

Table II.C1.—Long-Range Values[a] of Key Assumptions for the 75-year Projection Period

Long-range assumptions	Intermediate	Low-cost	High-cost
Demographic:			
Total fertility rate (children per woman), for 2032 and later	2.0	2.2	1.8
Average annual percentage reduction in total age-sex-adjusted death rates from 2015 to 2090	.78	.42	1.16
Average annual net immigration (in thousands) for 2016 to 2090	1,291	1,629	961
Economic:			
Average annual percentage change in:			
Productivity (total U.S. economy), for 2026 and later	1.68	1.98	1.38
Average wage in covered employment from 2026 to 2090	3.80	5.03	2.59
Consumer Price Index (CPI-W), for 2019 and later	2.60	3.20	2.00
Average annual real-wage differential (percent) for 2026 to 2090	1.20	1.83	.59
Unemployment rate (percent, age-sex-adjusted), for 2022 and later	5.5	4.5	6.5
Annual trust fund real interest rate (percent), for 2026 and later	2.7	3.2	2.2
Programmatic:			
Disability incidence rate (per 1,000 exposed, age-sex-adjusted) in 2090	5.4	4.3	6.4
Disability recovery rate (per 1,000 beneficiaries, age-sex-adjusted) in 2090	10.4	12.6	8.3

[a] See chapter V for details, including historical and projected values.

Table IV.B1.—Components of Increases in Total Allowed Charges per Fee-for-Service Enrollee for Practitioner Services

[In percent]

Calendar year	Physician fee schedule					CPI	DME	Lab	Other
	MEI	Physician update	Modified update[1]	Residual factors	Total increase[2]				
Aged:									
2007	2.1%	0.0%	−1.4%	3.5%	2.1%	2.9%	2.9%	9.8%	4.7%
2008	1.8	0.5	−0.3	4.0	3.7	4.1	6.4	7.3	4.2
2009	1.6	1.1	1.4	1.6	3.0	−0.7	−7.4	8.4	7.9
2010	1.2	1.3[3]	2.3	1.6	3.9	2.1	1.2	1.4	3.3
2011	0.4	0.9	0.8	2.3	3.1	3.6	−3.7	−2.8	4.4
2012	0.6	0.0	−1.2	1.0	−0.3	2.1	0.7	6.4	3.2
2013	0.8	0.0	−0.1	0.2	0.1	1.4	−10.4	0.1	2.6
2014	0.8	0.5	0.5	0.6	1.2	1.5	−14.3	6.4	2.6
2015	0.8	0.2[4]	−0.5	0.7	0.2	−0.4	6.7	2.6	4.4
2016	1.1	0.8	−0.4	−0.2	−0.6	1.0	−5.8	−2.5	7.2
2017	1.2	0.5	0.1	1.5	1.6	2.2	−5.7	6.0[5]	4.1
2018	1.8	0.5	−0.5	2.0	1.6	3.0	4.9	−0.8	2.9
2019	3.0	0.5	0.9	4.0[6]	4.9	2.6	11.3	5.1	4.0
2020	2.8	0.0	0.3	3.1	3.4	2.6	5.5	5.3	4.5
2021	2.6	0.0	0.1	3.4	3.5	2.6	5.5	13.8	4.3
2022	2.6	0.0	0.1	3.5	3.7	2.6	5.3	5.2	4.5
2023	2.4	0.0	0.1	3.5	3.7	2.6	5.3	5.2	3.8
2024	2.3	0.0	0.0	3.5	3.5	2.6	5.3	13.6	5.6
2025	2.2	0.0	0.0	1.0	1.0	2.6	5.3	5.2	4.7
2026	2.2	0.6	0.1	3.6	3.8	2.6	5.2	5.2	4.7
Disabled (excluding ESRD):									
2007	2.1	0.0	−1.4	1.7	0.3	2.9	2.2	10.4	4.1
2008	1.8	0.5	−0.3	3.7	3.4	4.1	6.3	11.8	8.7
2009	1.6	1.1	1.4	4.5	5.9	−0.7	−2.4	21.0	9.7
2010	1.2	1.3[3]	2.3	2.6	4.9	2.1	1.4	−4.3	2.8
2011	0.4	0.9	0.8	1.9	2.7	3.6	−3.0	6.4	3.4
2012	0.6	0.0	−1.2	2.1	0.9	2.1	1.0	24.7	1.9
2013	0.8	0.0	−0.1	1.3	1.2	1.4	−9.5	10.6	1.2
2014	0.8	0.5	0.5	1.8	2.3	1.5	−11.2	13.4	4.1
2015	0.8	0.2[4]	−0.5	0.4	−0.2	−0.4	7.2	5.9	6.2
2016	1.1	0.8	−0.4	0.4	0.0	1.0	−4.0	−12.9	8.7
2017	1.2	0.5	0.1	1.3	1.4	2.2	−6.0	5.7[5]	4.1
2018	1.8	0.5	−0.5	1.9	1.5	3.0	4.7	−0.8	3.1
2019	3.0	0.5	0.9	4.0[6]	4.9	2.6	11.2	5.1	4.0
2020	2.8	0.0	0.3	3.1	3.4	2.6	5.5	5.3	4.7
2021	2.6	0.0	0.1	3.3	3.5	2.6	5.4	13.8	4.5
2022	2.6	0.0	0.1	3.4	3.5	2.6	5.2	5.0	4.5
2023	2.4	0.0	0.1	3.3	3.5	2.6	5.2	5.0	3.6
2024	2.3	0.0	0.0	3.4	3.4	2.6	5.1	13.4	5.7
2025	2.2	0.0	0.0	0.8	0.8	2.6	5.1	5.0	4.7
2026	2.2	0.6	0.1	3.4	3.6	2.6	5.1	5.0	4.6

[1]Reflects the physician update and all legislation affecting physician services—for example, the addition of new preventative services enacted in 1997, 2000, and 2010.

[2]Equals combined increases in the modified update and residual factors.

[3]A physician payment price change occurred on June 1, 2010.

[4]A physician payment price change occurred on July 1, 2015.

[5]Beginning in 2018, payments under the laboratory fee schedule will no longer include an adjustment for economy-wide productivity. Instead, payments will reflect a survey of private sector lab payments and will be updated every 3 years.

[6]For 2019-2024, physicians in an advanced APM will receive an incentive payment amounting to 5 percent of their Medicare payments for the year. For those same years, a total of $500 million is available for additional payment adjustment under the merit-based incentive payment system (MIPS) for certain high-performing physicians.

Table IV.B8.—Key Factors for Part D Expenditure Estimates[1]

Calendar year	National health expenditure (NHE) drug trend[2]	Part D per capita cost trend[3]	Manufacturer rebates[4]	Plan administrative expenses and profits[5]
Historical data:				
2007	4.2%	1.4%	9.6%	13.6%
2008	1.5	3.8	10.4	13.2
2009	3.8	2.9	11.1	12.7
2010	−0.7	1.3	11.3	13.6
2011	1.5	3.7	11.5	13.1
2012	−0.6	−1.8	11.7	12.1
2013	1.8	2.6	12.9	12.2
2014	11.5	10.9	14.3	11.9
2015	8.1	8.3	18.2	11.6
Intermediate estimates:				
2016	4.1	2.5	22.0	12.0
2017	4.8	3.5	23.8	10.7
2018	6.6	6.7	24.0	11.6
2019	5.4	6.1	24.1	11.3
2020	5.3	5.9	24.3	11.3
2021	5.4	5.6	24.5	11.2
2022	5.5	5.2	24.7	11.1
2023	5.4	5.2	24.9	11.1
2024	5.4	5.1	25.0	11.0
2025	5.4	4.1	25.0	11.0
2026	5.4	5.2	25.0	10.9

[1]These factors do not reflect the impact of the sequestration for 2013-2025.
[2]On February 15, 2017, the CMS Office of the Actuary published the NHE projections through calendar year 2025; for 2026, the drug trend is the same as was used in 2025.
[3]Values reflect ACA add-on and other law changes.
[4]Expressed as a percentage of total drug costs.
[5]Expressed as a percentage of total gross plan benefit payments, which include plan benefits and administrative expenses with profits.

Table II.C1.—Key Assumptions, 2041-2091

	Intermediate	Low-Cost	High-Cost
Economic:			
Annual percentage change in:			
Gross Domestic Product (GDP) per capita[1]	3.9	5.0	2.7
Average wage in covered employment	3.8	5.0	2.6
Private nonfarm business multifactor productivity[2]	1.1	—	—
Consumer Price Index (CPI)	2.6	3.2	2.0
Real-wage differential (percent)	1.2	1.8	0.6
Real interest rate (percent)	2.7	3.2	2.2
Demographic:			
Total fertility rate (children per woman)	2.00	2.20	1.80
Annual percentage reduction in total age-sex adjusted death rates	0.72	0.41	1.03
Net annual immigration	1,245,000	1,570,000	955,000
Health cost growth:			
Annual percentage change in per beneficiary Medicare expenditures (excluding demographic impacts)[1]			
HI (Part A)	3.7	[3]	[3]
SMI Part B	3.6	[3]	[3]
SMI Part D	4.5	[3]	[3]
Total Medicare	3.7	[3]	[3]

[1]The assumed ultimate increases in per capita GDP and per beneficiary Medicare expenditures can also be expressed in real terms, adjusted to remove the impact of assumed inflation. When adjusted by the chain-weighted GDP price index, assumed real per capita GDP growth under the intermediate assumptions is 1.6 percent, and real per beneficiary Medicare cost growth is 1.5 percent, 1.3 percent, and 2.3 percent for Parts A, B, and D, respectively.

[2]Private nonfarm business multifactor productivity is published by the Bureau of Labor Statistics and is used as the economy-wide private nonfarm business multifactor productivity to adjust certain provider payment updates.

[3]See section III.B3 for further explanation of the Part A alternative (low-cost and high-cost) assumptions. Long-range alternative projections are not prepared for Parts B and D.

ORIGINAL COST ESTIMATES FROM THE COOK REPORT HOME CARE

IS NOW $2,501,391

Total Lifetime Costs	
CATEGORY	**LIFETIME CHARGES**
Medical Care	$98,503.98
Allied Health	$1,112,088.31
Complications	$31,362.20
Diagnostics	$23,322.20
Procedures	$77,975.10
Home Care	$1,562,263.83
Equipment	$114,799.71
Home Modifications	$81,080.00
Total:	**$3,101,395.33**

EXHIBIT 4

JUSTIN AARON WILLER MD, FAAN
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Mr. George Hand Esq.
Hand & Sullivan LLC
3442 Buffalo Dr
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October 22, 2018

Materials Reviewed:

1) Affidavit Vincent E. Pesiri MD

2) Dignity Health St Rose Dominican-San Martin Campus

-Discharge summary with Admission Date of 7/5/2015 and Discharge Date of 8/11/2015 indicating Ms. Farris had a perforated viscus, incarcerated incisional hernia with repair, colostomy and "Encephalopathy 2nd to sepsis and Med's (Opiates and Benzodiazepine)"

-Operative report 8/7/2014 Barry Rives MD indicating excision of abdominal wall lipoma/mass and repair of incarcerated ventral hernia with mesh.

-Operative report 7/3/2015 indicating laparoscopic reduction and repair of incarcerated incisional hernia with mesh and Colonorraphy.

-Operative report 7/16/2015 Elizabeth Hamilton MD indicating an exploratory laparotomy, removal of prosthetic mesh and washout of abdomen, partial colectomy and right ascending colon end ileostomy, extensive lysis of adhesions, retention suture, decompression of the stool from the right colon and fecal disimpaction was performed.

-Operative report 7/18/2016 indicating exploratory laparotomy, completion of right hemicolectomy with ileocolic anastomosis, addition small bowel obstruction and repair of incisional hernia.

-Surgical pathology report prosthetic abdominal mesh and transverse colon and omentum.

-Progress notes Geraldine Bent APM 8/8/2015

-Surgical progress notes 8/1,2,3,4,5,6,7,8,9,10,11/2015.

3) Report of Thomman Kuruvilla DPM from 8/31/2015 indicating that she "suffered a dropfoot and severe peripheral neuropathy without any motor function of the bilateral lower extremity.

4) Report of NCV/EMG of the lower limbs

5) Physical therapy noted from 8/10-2015

6) Progress Note of Naomi Chaney MD from 9/1/2015 indicating "She had gone in for elective surgery for hernia and had complications related to the surgery...She has known history of diabetes, neuropathy and now critical care neuropathy with foot drop.

7) Records Advanced Orthopedics and Sports Medicine from 7/2/2014, 11/25/2014 and 5/5/2015 indicating history of "diabetic neuropathy". "Regarding the bilateral feet, there is pain noted. Strength reported as normal.

8) Mammogram 6/16/2014

9) Report of MRI of the lumbosacral spine from 6/13/2014 indicating the presence of mild facet disease at L4-L5 and L5-S1.

10) Report of MRI of the lumbosacral spine from 6/22/2016 indicating normal study.

11) Reports of CT abdomen from 6/12/2015 and 3/21/2016.

12) Chest Radiograph 9/16/2015 report.

13) Report of Lower Extremity Arterial Doppler 1/11/2017

14) Report of MRI of the left foot from 1/11/2017.

15) Video clips of examination of Ms. Farris which includes the demonstration of bilateral foot drops and markedly unsteady gait.

16) Life Care Plan and examination from Alex Barchuk MD from 3/20/2018.

- "Sensation: Severely impaired below the knees bilaterally to temperature and light touch. Absent position sense in the toes and ankles bilaterally. Decreased sensation in the median nerve distribution bilateral hands."

- "3+/5 motor strength bilateral upper extremities with normal tone and isolated movement. Hip flexors 3+/5 bilaterally. Hip extensors 3+/5 bilaterally. Knee extensors 3/5/ bilaterally. Knee flexors 3/5 bilaterally. Foot dorsiflexors and plantar flexors 0/5 bilaterally.

- "Sit to stand is possible only with upper extremity support and use of a walker."

- "Steppage gait with impaired balance. Unable to tandem. Unable to ambulate on toes or heels. Severe instability without use of a walker requiring direct physical contact."

17) progress note from Dr. Elizabeth Hamilton from July 17, 2016.

18) Progress Notes Southern Nevada Pain Center from 8/23/2018, 6/27/2018, 5/30/2018, 4/30/2018 and 4/5/2018 indicating the presence of a foot drop and absent foot inversion and eversion.

19) Records from Care Meridian Buffalo with admission date of August 12, 2015 indicating the presence of a foot drop (page 194 of 300).

III. Critical Illness Polyneuropathy and Myopathy

Myopathy and Polyneuropathy accompany sepsis[1]. Bolton et. al reported 5 patients in critical care units from 1977 to 1981 who demonstrated a primary, distal, axonal degeneration of motor and sensory fibers. The condition was named critical illness polyneuropathy (CIP)[1].

Bolton et. al. found that CIP was associated with sepsis and multiple system organ failure was 70%[1]. It is often preceded by septic encephalopathy and is followed by difficulty weaning the patient from a ventilator[1].

Critical Illness Myopathy (CIM) risk factors are acute respiratory disorder including in conjunction with the use of high-dose intravenous steroids and nondepolarizing blocking agents[1,2]. Other risk factor include acidosis, liver and lung transplantation and hepatic failure[2]. Prolonged intubation is also a risk factor.

CIP and CIM presents with flaccid paralysis[1,3]. CIP also presents with hyporeflexia or areflexia, muscle atrophy and distal sensory loss[3].

Critical Illness Myopathy develops in 35% of patients with status asthmaticus[3], and may occur in the absence of sepsis[3].

CIM sometimes have a proximal predominant flaccid weakness frequently with ventilatory failure[3]. Facial weakness may occur but extraocular muscle weakness is rare. Deep tendon reflexes may be normal or reduced and sensation is normal[3].

Nerve conduction studies commonly demonstrate a reduction in the amplitude of the compound muscle action potentials (CMAP) with amplitudes usually less than 50% of the lower limit of normal[3].

In critical illness myopathy the reduction is CMAP amplitude is out of proportion to the reduction in the corresponding sensory nerve action potential (SNAP)[3]. Sensory responses are usually normal in amplitude[3].

Needle EMG examination frequently reveals fibrillation potentials diffusely and relatively early in the clinical course and motor unit potentials are short in duration and of low amplitude with polyphasia in proximal and distal muscles[3].

CIP has reductions in the amplitudes of both the CMAPs and Snaps usually without significant reduction in conduction velocity of the motor nerves[3].

Fibrillation potentials are also noted in distal and proximal muscles (noted in the diaphragm in 29% of patients) with decreased recruitment, nascent units and long duration motor unit potentials[3].

Critical illness myopathy histopathologic features include muscle fiber atrophy and lysis of the myosin heavy chains. Necrosis and regeneration ranges from none to severe[3].

Critical Illness Polyneuropathy demonstrates degeneration of motor and sensory axons, but nerve biopsies are sometimes normal. Hyperglycemia, hypoalbuminemia and nutritional factors may increase the risk of development of CIP[3].

Mortality for critical illness polyneuropathy is up to 50%3. Long term prognosis is much better for critical illness myopathy[3,4] with up to 88% of CIM patients recovering within 1 year whereas patients with combined CIM/CIP only 55% were recovered within 1 year[4].

Some studies have shown that the patients with persistent disabilities had critical illness polyneuropathy with or without critical illness myopathy and central nervous system insults[3].

IV. Specific Causation

Ms. Titina Farris underwent surgery on 8/7/2014 by Barry Rives MD with excision of abdominal wall lipoma/mass and repair of incarcerated ventral hernia with mesh.

She underwent surgery on 7/3/2015 with laparoscopic reduction and repair of incarcerated incisional hernia with mesh and Colonorraphy. During the surgery a small tear was created in the colon.

Following surgery, she had to be emergently intubated on 7/5/2015 and was septic. Difficulty weaning from the ventilator was noted and the patient subsequently underwent a tracheostomy on July 14, 2015. She was subsequently extubated on August 8, 2015.

Ms. Farris was admitted on 7/5/2015 and discharged on 8/11/2015. Ms. Farris had a perforated viscus, incarcerated incisional hernia with repair, colostomy and "Encephalopathy 2nd to sepsis and Med's (Opiates and Benzodiazepine)"

She underwent another operation on 7/16/2015 by Elizabeth Hamilton MD an exploratory laparotomy, removal of prosthetic mesh and washout of abdomen, partial colectomy and right ascending colon end ileostomy, extensive lysis of adhesions, retention suture, decompression of the stool from the right colon and fecal disimpaction was performed for a perforated viscus.

She underwent re-operation on 7/18/2016 and had an exploratory laparotomy, completion of right hemicolectomy with ileocolic anastomosis, addition small bowel obstruction and repair of incisional hernia.

Surgical pathology report from July 17, 2015 indicated specimen A consisted of prosthetic abdominal mesh and specimen be consisted of transverse colon and omentum with "3 foci of colonic ulceration with trans mural acute inflammation and perforation." Also noted was "associated acute serositis and omentum with acute inflammatory exudate and reactive changes."

"3 trans mural defects are identified along the length of the colon. The 1st defect is located roughly within the mid aspect, measures 2.0 x 1.6 cm and the borders are inked orange. This defect is located 2.9 cm from the green inked margin and 2.8 cm from the black inked margin. 2nd defect is located within a markedly thinned area of wall with an overall measurement of 3.7 x 3.5 cm." "The 3rd defect measures 1.0 x 0.4 cm."

Abdominal drains were placed by radiology on 7/30 and 7/31 to drain pus from the abdomen. She was eventually extubated and the abdominal drains were removed. Discharge summary notes "neuropathy pain in her legs" for which she was started on Lyrica.

She also experienced an "encephalopathy 2nd to sepsis and med's (opiates and benzodiazipines)" which was improving at the time of discharge.

She was then transferred to a rehabilitation facility.

At some point the patient developed weakness in particular severe distal weakness of the lower extremities. Dr. Elizabeth Hamilton noted on July 17, 2016 that she had "neuropathy in the foot reportedly due to prolonged hospitalization last year." Dr. Hamilton also noted that Ms. Farris was tearful at times and her impression included depression.

Dr. Barchuk noted that she is experiencing pain in her legs and lower back pain and severe unsteadiness necessitating a walker to ambulate with at least 2 falls in the year prior to Dr. Barchuk's examination. She needs help dressing, showering, cleaning, meal preparation and toileting.

Dr. Barchuk noted that Ms. Farris can sit for a total of 4 hours a day and stand for a total of 2 hours per day and cannot lift more than three pounds.

Dr. Barchuk also reported that she has severe sensory loss below the knees, depression and anxiety. On examination he noted decreased range of motion at the neck and lower back, severe sensory loss below the knees, steppage gait, quadriparesis and a right ankle contracture.

Dr. Barchuk also noted she cannot walk on her heels and toes. Dr. Barchuk also noted "severe instability without use of a walker, requiring direct physical contact."
In his discussion, Dr. Barchuk also indicated she had Dupuyten's contractures in both hands.

Video clips of her examination demonstrate bilateral foot drops, sensory loss below the knees and severe truncal instability.

Dr. Steven Y. Chinn (Southern Nevada Pain Center noted absent foot dorsiflexion, inversion and eversion in examinations performed in 2018,

PAST MEDICAL HISTORY:
Allergies: Aspirin.
Surgical History: C-section, reversal of colostomy 2016, as above.
Medications: Buspar, Xanax, Citalopram, Percocet, Metformin, Januvia, Lisinopril, Carvedilol, Jardiance, Duloxetine, Insulin.
Past Illnesses: Diabetes, hypertension, dyslipidemia and reflux.

Summary and Opinion:

Ms. Titina Farris underwent surgery on 8/7/2014 by Barry Rives MD and again on 7/3/2015 with laparoscopic reduction and repair of incarcerated incisional hernia with mesh, but during the surgery a tear was created in the colon.

She subsequently developed sepsis and encephalopathy and weakness of the lower limbs decreased sensation below the knee.

Ms. Farris has bilateral foot drop, truncal instability, steppage gait and sensory loss below both knees.

To a reasonable medical certainty, her bilateral foot drop, truncal instability, steppage gait and sensory loss below both knees is related to a diffuse sensorimotor polyneuropathy which in Ms. Farris' case is due to critical illness polyneuropathy.

The proximate cause of the critical illness polyneuropathy was the sepsis that resulted from the tears in her colon that developed during the course of the repair of her incarcerated hernia.

As is typical for critical illness polyneuropathy it was preceded by septic encephalopathy. The difficulty weaning from the ventilator was caused by the critical illness polyneuropathy.

To a reasonable medical certainty, Ms. Farris' clinical course is not consistent with Guillain-Barre syndrome (Acute Inflammatory Demyelinating Polyneuropathy) which usually reaches its nadir with 4 to 6 weeks and is followed by recovery.

The acute motor and sensory axonal polyneuropathy (AMSAN) variant of Guillain-Barre syndrome is likewise not consistent with her presentation and is typically preceded by an acute diarrheal illness which Ms. Farris did not have.

To a reasonable medical certainty, her clinical course is likewise not consistent with critical illness myopathy which usually shows improvement with time (up to 88% of patients recover within 1 year[4]) and is not typically associated with sensory loss.

Critical illness myopathy is also associated with use of high dose intravenous steroids and neuromuscular blocking agents which Ms. Farris did not receive.

To a reasonable medical certainty, given that it has been more than 3 years since the onset of her foot drop, sensory loss and truncal instability her deficits are permanent. Recovery can occur in critical illness polyneuropathy, but this usually occurs within the first year following the initial event and if there has been no recovery within the first-year recovery is unlikely.

As she ages her gait will deteriorate further and she will require a motorized wheelchair. She will also need transportation to and from medical appointments which will include a handicapped accessible van. A handicapped accessible van should be replaced every 7 years.

She is at increased risk of falling and permanently has a higher risk of a fractured hip requiring a surgical repair, spinal cord injury and intracranial hematoma including the risk of death.

She will require at least 8-10 hours per day of assistance with dressing, toileting, showering, meal preparation, shopping and household cleaning.

A trial of biofeedback, acupuncture and/or acupressure should be done and if she has significant pain relief should be continued on an ongoing basis.

Ms. Farris should also be referred to a neurologist for treatment of her neuropathic pain on an ongoing basis. To a reasonable medical certainty, she will require adjustment of her prophylactic medication or switching her to alternate medication.

She will require periodic courses of physical therapy to address acute exacerbations of her truncal instability as she ages.

She will require modification of her domicile to make it handicapped accessible including installing handicapped accessible doors, sinks and toilets. This may also include installation of a wheelchair ramp or a chair lift.

Given the presence of depression as noted by Dr. Hamilton, the patient will require ongoing psychologic therapy either from a psychologist or a psychiatrist. A trial of group therapy should be tried and if helpful should continue on an ongoing basis.

To a reasonable medical certainty, she is not capable of even sedentary work (capability to perform sedentary work requires a patient to lift at least 10 pounds).

I, Justin Willer MD, being a licensed physician to practice in the state of New York on penalties of perjury to hereby affirm the contents of the foregoing is true the best of my knowledge and information.

These interpretations are based upon my education and experience in medicine and the specialty of neurology, and I hold these opinions to a reasonable degree of medical certainty.

I hold the right to amend my opinions if appropriate and when additional information becomes available to me.

Sincerely yours,

Justin Aaron Willer, MD

REFERENCES:

1) Bolton, CF, Neuromuscular Manifestations of Critical Illness, Muscle & Nerve 32: 140-163, 2005.

2) Govindarajan, R, Jones, D, Galvez, N, AANEM Case Study: Critical Illness Polyneuropathy, October 2014.

3) Lacomis, D, Electrophysiology of Neuromuscular Disorders in critical illness, Muscle & Nerve 47:452-463, 2013.

4) Koch, S, et. al., Long-term recovery in critical illness myopathy is complete, contrary to polyneuropathy, Muscle & Nerve 50:431-436