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 8

ROBERT L. EISENBERG (SBN 950)
LEMONS, GRUNDY & EISENBERG
6005 Plumas Street, Third Floor
Reno, NV 89519
775-786-6868
775-786-9716 fax
rle@lge.net

ATTORNEYS FOR APPELLANTS

CHRONOLOGICAL INDEX TO APPELLANTS' APPENDIX

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

EXHIBIT 5

LexisNexis

User Name:
Date and Time: Tuesday, October 29, 2019 9:44:00 AM PDT
Job Number: 101422698

Document (1)

1. *Brown v. Providence Med. Ctr., 2011 U.S. Dist. LEXIS 111098*
Client/Matter: 1737-10881
Search Terms: Brown v. Providence Medical Center
Search Type: Natural Language
Narrowed by:

Content Type	Narrowed by
Cases	-None-

Brown v. Providence Med. Ctr.

United States District Court for the District of Nebraska

September 27, 2011, Decided; September 27, 2011, Filed

8:10CV230

Reporter
2011 U.S. Dist. LEXIS 111098 *; 2011 WL 4498824

JEFF BROWN, Individually and as Co-Special Adminstrators of the Estate of KB, Deceased, and SHERRI GOTHIER, Individually and as Co-Special Administrators of the Estate of KB, Deceased, Plaintiffs, v. PROVIDENCE MEDICAL CENTER, Wayne, Nebraska, BENJAMIN J. MARTIN, M.D., and MERCY MEDICAL SERVICES, Inc., Sioux City, Iowa, Defendants.

Subsequent History: Motion denied by *Brown v. Providence Med. Ctr., 2011 U.S. Dist. LEXIS 131320 (D. Neb., Nov. 14, 2011)*

Prior History: *Brown v. Providence Med. Ctr., 2011 U.S. Dist. LEXIS 60186 (D. Neb., June 6, 2011)*

Core Terms

Disclosure, depositions, boys, motion for a protective order, healthcare provider, discovery response, Supplemental, deposing

Counsel: **[*1]** For Jeff Brown, Individually and as Co-Special Adminstrators of the Estate of KB, Deceased, estate of KB, Sherri Gothier, Individually and as Co-Special Administrators of the Estate of KB, Deceased, estate of KB, Plaintiffs: Joseph B. Muller, Ronald J. Palagi, LEAD ATTORNEYS, PALAGI LAW OFFICE, Omaha, NE.

For Providence Medical Center, Wayne, Nebraska, Defendant: John M. Walker, William R. Settles, LEAD ATTORNEYS, LAMSON, DUGAN LAW FIRM, Omaha, NE.

For Benjamin J. Martin, M.D., Mercy Medical Services, Inc., Sioux City, Iowa, Defendants: Heather H. Anschutz, Robert M. Slovek, LEAD ATTORNEYS, KUTAK, ROCK LAW FIRM - OMAHA, Omaha, NE.

Judges: F.A. Gossett, United States Magistrate Judge.

Opinion by: F.A. Gossett

Opinion

ORDER

Defendants filed a Motion to Compel (filing 139) requesting that the court order Plaintiffs to (1) supplement their discovery responses in accordance with *Fed. R. Civ. P. 26(e)*; (2) amend their Disclosure of Healthcare Providers to comply with the requirements of *Fed. R. Civ. P. 26(a)(2)(C)*; and (3) produce Plaintiff Sherri Gothier's four minor sons for deposition. In response, Plaintiffs filed a Motion for Protective Order (filing 147) requesting that the court prevent Defendants from deposing Ms. **[*2]** Gothier's sons or, alternatively, specify the terms to govern the depositions.

For the reasons set forth below, the court concludes that Defendants' Motion to Compel should be granted and that Plaintiffs' Motion for Protective Order should be granted, in part.

1. Defendants' Motion to Compel

A. Supplementation of Discovery

Since the filing of Defendants' Motion to Compel, Plaintiffs have supplemented their discovery responses. Nevertheless, Defendants continue to maintain that Plaintiffs' discovery responses are deficient. *Fed. R. Civ. P. 26(e)* obligates Plaintiffs to supplement discovery responses that are incomplete or incorrect. To the extent that Plaintiffs have not fully supplemented their discovery responses in accordance with *Fed. R. Civ. P. 26(e)*, they shall do so. Any necessary supplementation shall occur by or before October 4, 2011.

B. Compliance with Rule 26(a)(2)(C)

Defendants contend that Plaintiffs have failed to comply with *Fed. R. Civ. P. 26(a)(2)(C)*, which establishes the disclosure requirements for expert witnesses who are not required to provide a written report. The Rule provides that such expert disclosures must state:

> (i) the subject matter on which the witness is expected **[*3]** to present evidence under *Federal Rule of Evidence 702*, *703* or *705*; and
> (ii) a summary of the facts and opinions to which the witness is expected to testify.

Fed. R. Civ. P. 26(a)(2)(C)(i)-(ii).

Plaintiffs filed a Disclosure of Healthcare Providers (filing 101) ("Disclosure") by the expert witness disclosure deadline. Although the Disclosure identifies thirteen healthcare providers, neither it, nor Plaintiffs' later-filed Amended Disclosure of Healthcare Providers (filing 124), provides a summary of the facts and opinions to which each listed provider is expected to testify as required by *Fed. R. Civ. P. 26(a)(2)(C)*. Plaintiffs contend that the medical records, as well as the information regarding these thirteen individuals contained in Plaintiffs' Amended Supplemental Disclosure of Non-Expert Witnesses (filing 126), is sufficient to provide Defendants with notice regarding the subject matter, facts and opinions of these experts. The court disagrees.

Although the information required under Fed. R. Civ. P. 26(a)(2)(C) "is less extensive than an expert report under 26(a)(2)(B), . . . the two forms of disclosure share the goal of increasing efficiency and reducing unfair surprise." Skyeward Bound Ranch v. City of San Antonio, No. SA-10-CV-0316 XR, 2011 U.S. Dist. LEXIS 59304, 2011 WL 2162719, at *2 (W.D. Tex. June 1, 2011.) **[*4]** The court will not place the burden on Defendants to sift through medical records in an attempt to figure out what each expert may testify to. Moreover, the limited information contained in Plaintiffs' Amended Supplemental Disclosure of Non-Expert Witness, a document which Plaintiffs concede is not a model of clarity, is insufficient under Rule 26(a)(2)(C). Plaintiffs have an obligation to provide information regarding the expected testimony of their expert witnesses in a coherent manner. Plaintiffs shall amend their expert disclosures of healthcare providers so as to comply with Fed. R. Civ. P. 26(a)(2)(C) by or before October 4, 2011.

C. Depositions of Sherri Gothier's Minor Sons

Defendants desire to depose Plaintiff Sherri Gothier's four minor sons - ages 18, 17, 15 and 13. Plaintiffs object to the requested depositions, and have filed a motion for a protective order seeking to bar the same. Plaintiffs argue that the boys' testimony is irrelevant and unnecessary because Plaintiffs will not call the boys to testify at trial and, additionally, because the boys had limited interaction **[*5]** with KB in the days before her death. Plaintiffs further contend that deposing the boys would cause them undue emotional trauma.

"Parties may obtain discovery regarding any nonprivileged matter that is relevant to any party's claim or defense." E-P Intern. Distribution, Inc. v. A & A Drug Co., No. 8:07CV186, 2009 U.S. Dist. LEXIS 70862, 2009 WL 2486390, at *3 (D. Neb. Aug. 12, 2009). In this suit, Plaintiffs contend that their daughter KB's death was caused by Defendants' medical negligence. KB underwent a tonsillectomy at Providence Medical Center ("PMC") on January 18, 2010, and died just over a week later. Plaintiffs' complaint contains statements concerning KB's condition following her surgery through her transfer from PMC on January 24, 2010, and alleges that Defendants failed to properly assess KB's condition on January 24, 2010. Defendants deny that they failed to properly assess KB's condition and affirmatively allege that any damages were caused by the intervening actions or omissions of other individuals.

Ms. Gothier's sons, who lived in the same household as KB, were home a portion of the time between KB's surgery and her transfer to PMC on January 24, 2010. The boys' observations and interactions with **[*6]** KB in the week after KB's surgery is relevant to the issues in this suit. Therefore, Plaintiffs will be ordered to produce the boys for deposition.

2. Plaintiffs' Motion for Protective Order

Plaintiffs' Motion for Protective Order requests that the court prevent Defendants from deposing Ms. Gothier's sons and asks that the court (1) prescribe a discovery method other than depositions; (2) specify the terms of discovery and/or (3) forbid inquiry into certain matters in order to minimize the emotional strain on the children. As explained above, Defendants are entitled to depose Ms. Gothier's sons. However, due to the sensitivity of the issues involved, as well as the boys' purported limited interaction with KB in the days before her death, the

depositions will each be limited to one hour. The court believes that defense counsel can secure the desired information within this amount of time. The court trusts that defense counsel will conduct the depositions is such a way as to not cause the boys undue emotional trauma.

IT IS ORDERED:

1. Defendants' Motion to Compel (filing 139) is granted.

2. To the extent necessary, Plaintiffs shall supplement their discovery responses in accordance with their **[*7]** obligations under *Fed. R. Civ. P. 26(e)* by or before October 4, 2011.

3. Plaintiffs shall amend their expert disclosures of healthcare providers so as to comply with the requirements of *Fed. R. Civ. P. 26(a)(2)(C)* by or before October 4, 2011.

4. Plaintiffs' Motion for Protective Order (filing 147) is granted, in part. The depositions of Plaintiff Sherri Gothier's minor sons shall each be limited to one hour in duration. In all other respects, Plaintiffs' Motion is denied.

DATED September 27, 2011.

BY THE COURT:

/s/ F.A. Gossett

United States Magistrate Judge

End of Document

LexisNexis

User Name:
Date and Time: Tuesday, October 29, 2019 9:43:00 AM PDT
Job Number: 101422544

Document (1)

1. *Carrillo v. B&J Andrews Enters., LLC, 2013 U.S. Dist. LEXIS 10210*
Client/Matter: 1737-10881
Search Terms: Carrillo v. B & J Andrews Enters., LLC
Search Type: Natural Language
Narrowed by:

Content Type	Narrowed by
Cases	-None-

Carrillo v. B&J Andrews Enters., LLC

United States District Court for the District of Nevada

January 24, 2013, Decided; January 24, 2013, Filed

Case No. 2:11-cv-01450-MMD-CWH

Reporter
2013 U.S. Dist. LEXIS 10210 *; 2013 WL 310365

PEGGY CARRILLO, Plaintiff, vs. B&J ANDREWS ENTERPRISES, LLC, et al., Defendants.

Subsequent History: Motion granted by, in part, Motion denied by, in part *Carrillo v. B&J Andrews Enters., LLC*, 2013 U.S. Dist. LEXIS 12435 (D. Nev., Jan. 29, 2013)

Prior History: *Carrillo v. B&J Andrews Enters., LLC*, 2012 U.S. Dist. LEXIS 147870 (D. Nev., Oct. 15, 2012)

Core Terms

subpoena, notice, commanding, inspection, entities, parties, production of documents

Counsel: **[*1]** For Peggy Carrillo, Plaintiff: Leslie M Stovall, LEAD ATTORNEY, Jared B Anderson, Leslie Mark Stovall, Las Vegas, NV.

For First Columbia Community Management, Inc., Boulder Oaks Community Association, Defendants: Jane Eberhardy, The Marks Law Group, Las Vegas, NV.

For JJS Development, LLC, doing business as Jan Pro Cleaning Systems of Las Vegas, Defendant: David M. Brown, Moran Law Firm, LLC, Las Vegas, Ne; Justin Smerber, Moran Law Firm, LLC, Las Vegas, NV; Lewis W. Brandon , Jr., Moran & Associates, Las Vegas, NV.

For Jan-Pro Franchising International, Inc., Defendant: Lewis W. Brandon , Jr., LEAD ATTORNEY, Moran & Associates, Las Vegas, NV; David M. Brown, Moran Law Firm, LLC, Las Vegas, Ne; Justin Smerber, Moran Law Firm, LLC, Las Vegas, NV.

For Social Security Administration, Defendant: Carlos A Gonzalez, LEAD ATTORNEY, U.S. Attorney's Office, Las Vegas, NV.

For JJS Development, LLC, doing business as Jan Pro Cleaning Systems of Las Vegas, Jan-Pro Franchising International, Inc., Cross Claimants: Lewis W. Brandon , Jr., LEAD ATTORNEY, Moran & Associates, Las Vegas, NV; David M. Brown, Moran Law Firm, LLC, Las Vegas, Ne; Justin Smerber, Moran Law Firm, LLC, Las Vegas, NV.

For First Columbia **[*2]** Community Management, Inc., Boulder Oaks Community Association, Jan-Pro Franchising International, Inc., Boulder Oaks Community Association, Cross Defendants: Jane Eberhardy, The Marks Law Group, Las Vegas, NV.

Judges: C.W. Hoffman, Jr., United States Magistrate Judge.

Opinion by: C.W. Hoffman, Jr.

Opinion

ORDER

This matter is before the Court on Defendants' Motion to Compel Compliance with *Rule 45* Subpoenas (#69), filed April 18, 2012; and Plaintiff's Response (#81) and Countermotion to Quash (#82), filed May 8, 2012.

BACKGROUND

This case was originally filed in Clark County District Court on May 27, 2011. It was removed on September 8, 2011. It is a premises liability case arising out of a slip and fall allegedly caused by Defendants' negligence. The event giving rise to Plaintiff's claims occurred on May 13, 2010, when Plaintiff allegedly tripped over the upturned corner of a rubber mat located in a communal bathroom at the Boulder Oaks RV Resort. Plaintiff is seeking damages on claims of negligence and gross negligence.

By way of this motion, Defendants seek an order compelling production of documents from several different entities and individuals pursuant to *Fed. R. Civ. P. 45*. The *Rule 45* subpoenas were served **[*3]** in early March 2012. Defendants assert that the following entities did not respond or file timely objections: Kaiser Permanente; Kaiser Foundation Health Plan, Inc.; Sears Roebuck & Company; Metropolitan Life Insurance Company; Michael Edward Roy, P.A.; and the United States Treasury. Consequently, Defendants request that the Court compel compliance and hold each in contempt pursuant to *Rule 45(e)*. Defendants acknowledge that Plaintiff's retained medical experts, Dr. Douglas Seip and Dr. Chad Hanson, produced documents in response to the *Rule 45* subpoenas, but seek an order compelling further disclosure of their "expert files."

Defendants also seek an order compelling the Social Security Administration and the Center for Medicare and Medicaid Services to comply with *Rule 45* subpoenas. Both entities objected to the subpoenas on the ground that the subpoena is not an order of the court. Defendants assert that the agencies are authorized to release the requested records pursuant to a court order and, therefore, request an order compelling compliance. The Social Security Administration requests that the subpoena directed toward it be quashed because it cannot disclose records pertaining **[*4]** to an individual without that individual's consent. Medicare and Medicaid Services objected on similar grounds.

DISCUSSION

Federal Rule of Civil Procedure 45 provides that a subpoena commanding production of documents may either be issued separately or in conjunction with a subpoena to attend a deposition. *Fed. R. Civ. P. 45(a)(1)(C)*. If a *Rule 45* subpoena for production or inspection is

issued separately from a subpoena commanding a person's attendance, it must be issued "from the court for the district where production or inspection is to be made." Fed. R. Civ. P. 45(a)(2)(C). A Rule 45 subpoena must be served on the person or entity to whom it is issued. Fed. R. Civ. P. 45(b)(1). "If the subpoena commands the production of documents, electronically stored information, or tangible things the inspection of premises before trial, then before it is served, a notice must be served on each party." The unexcused failure to obey a Rule 45 subpoena may result in a finding of contempt. Fed. R. Civ. P. 45(e).

Defendants' motion (#69) suffers from several critical defects. First, Rule 45(b)(1) requires that "[i]f the subpoena commands the production of documents, electronically stored information, **[*5]** or tangible things, or inspection of premises before trial, then before it is served, a notice must be served on each party." *See* Fed. R. Civ. P. 45(b)(1); *see also* Adv. Committee Notes to 2007 Amendment ("Courts . . . have tended to converge on an interpretation that requires notice to the parties before the subpoena is served on the person commanded to produce or permit inspection. That interpretation is adopted in amended Rule 45(b)(1) to give clear notice of the general present practice."); Adv. Committee Noted to 1991 Amendments ("The purpose of such notice is to afford other parties an opportunity to object to the production or inspection, or to serve a demand for additional documents or things . . . . [O]ther parties may need notice in order to monitor the discovery and in order to pursue access to any information that may or should be produced."); Biocore Medical Technologies, Inc. v. Khosrowshahi, 181 F.R.D. 660, 667 (D. Kan. 1998) (interpreting Rule 45(b)(1) to require notice prior to service of a subpoena duces tecum); Murphy v. Bd. of Educ. of the Rochester City Sch. Dist., 196 F.R.D. 220, 225 (W.D.N.Y. 2000) (all subpoenas at issue sought documents only, and the court **[*6]** found that the commanding party's issuance of subpoenas without notice to opposing counsel violated Rule 45(b)(1) notice requirement); *Schweizer v. Mulvehill, 93 F. Supp.2d 376, 411 (S.D.N.Y. 2000)* (same).

Here, the subpoenas seeks production of documents independent of a deposition and, therefore, each is subject to Rule 45(b)(1)'s notice requirement. Unfortunately, there is nothing in the record to support the conclusion that Plaintiff was given the required notice prior to service of the subject subpoenas. The Court rejects any argument that would equate the previously approved stipulated protective order (#37) with notice under Rule 45(b)(1). The protective order addresses the broad parameters of information that might be sought through the use of Rule 45 subpoenas. It does not address the specifics of each individual subpoena. The plain language of the rule requires that notice of the subpoena commanding production be given prior to service, not simply general notice that a party may utilize Rule 45 to obtain information. The purpose of this rule is highlighted in this matter as several of the issued subpoenas appear to seek production of records well beyond the scope of the parties' **[*7]** protective order. [1] Due to the failure to provide adequate notice before service of the subpoenas, the Court must strike the subpoenas. *See* McCurdy v. Wedgewood Capital Management Co., Inc., 1998 U.S. Dist. LEXIS 18875, 1998 WL 964185 (E.D. Pa.) (noting that the remedy for failure to provide adequate notice is generally the striking of the issued subpoenas, but leaving open the possibility of more severe sanctions on a party that abuses or misuses the subpoena power).

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[1] For example, the Rule 45 subpoena issued to the Social Security Administration requests the "[c]omplete file of [Plaintiff] Peggy Carrillo." It does not contain any of the limitations as to time or scope set forth in the protective order.

A separate ground for denial of Defendants' motion (#69) is Local Rule 26-7(b), which states: "Discovery motions will not be considered unless a statement of the movant is attached thereto certifying that, after personal consultation and sincere effort to do so, the parties have been unable to resolve the matter without Court action." A motion to enforce a *Rule 45* subpoena is a discovery motion. As such, prior to consideration, the Court must be satisfied that the moving party made a sincere effort at personal consultation **[*8]** prior to bringing the motion. Defendants' counsel did not provide a statement certifying that he made a sincere effort at personal consultation prior to filing this motion. This failure is particularly troublesome to the Court as at least three (3) of the subpoenaed entities provided written objections to the subpoenas and two (2) of the subpoenaed individuals actually produced responsive materials. There is nothing in the record indicating that even after receiving written objections or allegedly deficient production Defendants' counsel made sincere efforts at personal consultation. The rules require more. [2]

CONCLUSION

Defendants' motion **[*9]** (#69) fails for the procedural infirmities noted herein. Other than striking the improper *Rule 45* subpoenas, the Court declines to consider any of the additional potential sanctions identified in *McCurdy v. Wedgewood Capital Management Co., Inc., 1998 U.S. Dist. LEXIS 18875, 1998 WL 964185 (E.D. Pa.)*.

Based on the foregoing and good cause appearing therefore,

IT IS HEREBY ORDERED that Defendants' Motion to Compel Compliance with *Rule 45* Subpoenas (#69) is **denied**.

IT IS FURTHER ORDERED that the Social Security Administration's Countermotion to Quash (#82) is **denied as moot**.

IT IS FURTHER ORDERED that the *Rule 45* subpoenas attached to Defendants' motion (#69) are **stricken**.

DATED this 24th day of January, 2013.

/s/ C.W. Hoffman, Jr.

C.W. Hoffman, Jr.

United States Magistrate Judge

End of Document

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[2] The Court also notes that even after receiving written objections and allegedly deficient responses, there is nothing indicating that Defendants gave "notice" to the responding entities of their intent to file a motion to compel. *See Fed. R. Civ. P. 45(c)(2)(B)(i)* ("If an objection is made, the following rules apply: (i) At any time, on notice to the commanded person, the serving party may move the issuing court for an order compelling production or inspection."). This is an additional ground upon which denial of Defendants' motion (#69) is appropriate.

EXHIBIT 6

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

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

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

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al., Defendants.	CASE NO. A-16-739464-C DEPT. NO. 31 **DEFENDANTS BARRY RIVES, M.D.'S AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S FIRST SUPPLEMENT TO NRCP 16.1 DISCLOSURE OF WITNESSES AND DOCUMENTS**

Under the authority of Rule 16.1(a)(1) of the Nevada Rules of Civil Procedure, Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC hereby submits this first supplemental list of witnesses and documents as follows (the new information is in bold):

///

A. LIST OF WITNESSES

1. Titina Farris
c/o George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129

Ms. Farris is expected to testify regarding the facts and circumstances giving rise to this action.

2. Patrick Farris
c/o George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129

Mr. Farris is expected to testify regarding the facts and circumstances giving rise to this action.

3. Barry Rives, M.D.
c/o Thomas J. Doyle
Schuering Zimmerman & Doyle, LLP
400 University Avenue
Sacramento, CA 95825

Dr. Rives is expected to testify regarding the facts and circumstances surrounding this matter, including his care and treatment of Plaintiff Titina Farris.

4. Person Most Knowledgeable
Laparoscopic Surgery of Nevada
c/o Schuermg 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
40 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

Addison Durham 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
Care Meridian
3391 N. Buffalo Drive
Las Vegas, NV 89129

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

B. DOCUMENTS

1. Medical and billing records from Laparoscopic Surgery of Nevada

(BR000001-BR000049). (CD will be mailed.)

2. Medical records from St. Rose Dominican Hospital (previously produced by plaintiffs.)

3. Medical records from Dr. Barry Rives (previously produced by plaintiffs.)

4. Medical records from Dr. Noami Change (previously produced by plaintiffs.)

5. Medical records from Dr. Elizabeth Hamilton (previously produced by plaintiffs.)

6. Photographs of plaintiff Titina Farris (previously produced by plaintiffs.)

7. Medical and billing records from Desert Valley Therapy (previously produced by plaintiffs.)

8. Medical and billing records from Dr. Hamilton (previously produced by plaintiffs.)

9. Medical and billing records from St. Rose Dominican Hospital - San Martin Campus for July 2015 admission (previously produced by plaintiffs.)

10. Medical and billing records from St. Rose Dominican Hospital - San Martin Campus for July 2016 admission (previously produced by plaintiffs.)

11. Medical records from Dr. Chaney (previously produced by plaintiffs.)

12. Billing records from Dr. Chaney (previously produced by plaintiffs.)

13. Medical and billing records from Advanced Orthopedics & Sports Medicine (previously produced by plaintiffs.)

14. Diagnostic films taken at St. Rose Dominican Hospital (previously produced by plaintiffs.)

15. Video of Titina Farris taken by Lowell Pender on April 15, 2015 (previously produced by plaintiffs.)

16. Videos of Titina Farris, Patrick Farris, Addision Durham, Lowell Pender and Sky Prince (previously produced by plaintiffs.)

17. Marriage certificate (previously produced by plaintiffs.)

18. Medical and billing records from Dr. Steven Y. Chinn (previously produced by plaintiffs.)

19. Medical and billing records from Care Meridian (previously produced by plaintiffs.)

Defendants reserve the right to supplement this list of documents as discovery continues and to submit any exhibit of any other party. Said Defendants further reserve the right to amend this list of witnesses, documents and tangible items should, during the course of the discovery of this matter, additional witnesses and documentation become known to defendants or defendants' counsel. Defendants hereby incorporate all documents produced by the parties in their Early Case Conference Disclosures and supplements by reference.

Dated: December 4, 2018

SCHUERING ZIMMERMAN & DOYLE, LLP

By _____

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

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 4th day of December, 2018, service of a true and correct copy of the foregoing:

DEFENDANTS BARRY RIVES, M.D.'S AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S FIRST SUPPLEMENT TO NRCP 16.1 DISCLOSURE OF WITNESSES AND DOCUMENTS

was served as indicated below:

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

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

☐ by depositing in the United States Mail, first-class postage prepaid, enclosed ;

☐ by facsimile transmission; or

☐ by personal service as indicated.

Attorney	Representing	Phone/Fax/E-Mail
George F. Hand, Esq. HAND & SULLIVAN, LLC 3442 North Buffalo Drive Las Vegas, NV 89129	Plaintiff	702/656-5814 Fax: 702/656-9820 hsadmin@handsullivan.com

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

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Steven D. Grierson
CLERK OF THE COURT

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

GEORGE F. HAND, ESQ.
Nevada Bar No.: 8483
HAND & SULLIVAN, LLC
3442 N. Buffalo Drive
Las Vegas, Nevada 89129
Phone: (702) 656-5814
Email: GHand@HandSullivan.com

Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC et al., Defendants.	CASE NO.: A-16-739464-C DEPT. NO.: XXXI ***HEARING DATE REQUESTED***

PLAINTIFFS' MOTION TO QUASH TRIAL SUBPOENA OF DR. NAOMI CHANEY ON ORDER SHORTENING TIME

COMES NOW Plaintiffs PATRICK FARRIS and TITINA FARRIS, by and through their attorneys of record, KIMBALL JONES, ESQ., and JACOB G. LEAVITT, ESQ., with the Law Offices of **BIGHORN LAW** and GEORGE F. HAND, ESQ., with the Law Offices of **HAND & SULLIVAN, LLC**, and hereby submit this Motion to Quash the Trial Subpoena of Dr. Naomi Chaney on Order Shortening Time ("Motion").

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

DATED this 29th day of October, 2019.

BIGHORN LAW

By: */s/ Kimball Jones*
KIMBALL JONES, ESQ.
Nevada Bar.: 12982
JACOB G. LEAVITT, ESQ.
Nevada Bar No.: 12608
716 S. Jones Blvd.
Las Vegas, Nevada 89107

GEORGE F. HAND, ESQ.
Nevada Bar No.: 8483
HAND & SULLIVAN, LLC
3442 N. Buffalo Drive
Las Vegas, Nevada 89129

Attorneys for Plaintiffs

NOTICE OF MOTION ON ORDER SHORTENING TIME

TO: All INTERESTED PARTIES, AND THEIR ATTORNEYS OF RECORD

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

DATED this _____ day of October, 2019.

_____
DISTRICT COURT JUDGE

Respectfully submitted by:

BIGHORN LAW

By: */s/ Kimball Jones*
KIMBALL JONES, ESQ.
Nevada Bar.: 12982
JACOB G. LEAVITT, ESQ.
Nevada Bar No.: 12608
716 S. Jones Blvd.
Las Vegas, Nevada 89107

GEORGE F. HAND, ESQ.
Nevada Bar No.: 8483
HAND & SULLIVAN, LLC
3442 N. Buffalo Drive
Las Vegas, Nevada 89129

Attorneys for Plaintiffs

DECLARATION OF KIMBALL JONES, ESQ. IN SUPPORT OF PLAINTIFF'S MOTION ON ORDER SHORTENING TIME

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

1. I am an attorney duly licensed to practice law in the State of Nevada and an attorney with the Law Offices of BIGHORN LAW.
2. I am personally familiar with the facts and circumstances surrounding this matter and am competent to testify hereto.
3. That the reason this Motion must be heard on an Order Shortening Time is because trial is ongoing in this matter and Defendants noticed a subpoena commanding Dr. Chaney to testify in this matter tomorrow, on October 30, 2019.
4. On October 28, 2019 Dr. Chaney's counsel, Todd Weiss, Esq., stated in open court the belief that subpoenas for his client to testify in this trial had expired. Mr. Weiss then requested that Dr. Chaney not be subpoenaed again as it had already caused hardship for Dr. Chaney.
5. On October 29, 2019 Defense Counsel, Thomas Doyle, Esq., represented to the Court and to counsel that Dr. Chaney was agreeable to testify in the afternoon of October 30, 2019.
6. After leaving the courthouse on October 29, 2019, at around 4:48 p.m., I called Mr. Weiss, and asked him if it was true that Dr. Chaney had agreed to testify on October 30, 2019. Mr. Weiss informed me that Dr. Chaney had so agreed, but only after a promise from Mr. Doyle to pay her an expert fee for each of the days previously summoned as well as for her testimony on October 30, 2019; meaning that Dr. Chaney only agreed to testify after being promised payment by Defendants of three (3) times her normal expert fee for trial testimony.
7. I believe Defendants' subpoena is untimely. I also believe Defendants' actions in acquiring Dr. Chaney's agreement to testify are improper.

8. Trial is ongoing in this matter. As such, Order Shortening Time is warranted.

9. 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. STATEMENT OF RELEVANT FACTS

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 twelve (12) 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.

Defendants have subpoenaed Dr. Naomi Chaney to compel her to testify previously in this matter—without verifying there was even time for Dr. Chaney to testify. This undoubtedly caused Dr. Chaney to rearrange her affairs and her practice schedule to attend. Defendants have just issued a third subpoena to Dr. Chaney compelling her attendance at trial. See *Subpoena*, attached hereto as **Exhibit "1."**

However, there now appears to be a quid pro quo exchange of Defense Counsel of paying Dr. Chaney an amount undisclosed at this time, based upon information and belief, three (3) times the rate of her trial testimony. Her rate of trial testimony is unknown, as it was never disclosed since Dr. Chaney was NEVER disclosed as an expert witness, rebuttal witness or testifying treating physician pursuant the NRCP 16.1(a)(2)(D)(i) or (ii).

NRCP 45 notes that a Subpoena is mandatorily quashed when it, "fails to allow reasonable time for compliance." Defendants' subpoena fails to give Dr. Chaney reasonable time to attend trial, and it is properly quashed. The fact that Dr. Chaney offered to make herself available on condition of being paid an unreasonable and improper sum for testifying, does not change this reality.

Defendants' disclosure fails to comply with NRCP 16.1(a)(2)(c), and as such, she is properly excluded as a witness in this matter.

Defendants' Failed to Properly Disclose Dr. Chaney Under NRCP 16.1(a)(2)(C)

Defendants' disclosure of Dr. Chaney does not list out, as required by NRCP 16.1(a)(2)(C) requires the following:

> (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**.

(Emphasis added).

Defendants had a duty, just as in every other expert disclosure to disclose, a summary of the FACTS which Dr. Chaney would be testifying to; her CV; compensation by way of a fee schedule; and a list of prior testimony.

NONE of the requirements were adhered to as to this witness.

Plaintiffs are prejudiced in that (1) there is no summary of facts Defendants intend to illicit; (2) there is no CV to justify or qualify Dr. Chaney (nor has one ever been supplied); and (3), there is no fee schedule.

It is common practice to disclose treating physicians, however, the law MUST be complied with.

Furthermore, Dr. Chaney's testimony is necessarily limited in this matter to such a degree, that any testimony she gives will be cumulative.

Additionally, Dr. Chaney was not ever properly named as a non-retained treating expert in this matter. Defendants have listed Dr. Naomi Chaney as a witness in their 16.1 ECC disclosures. See *Fifth Supplement to Defendants' ECC Disclosure*, attached hereto as **Exhibit "2."** Dr. Chaney is not noted

as being an expert witness and was not noted as such in Defendants' Expert Witness disclosures. See *Defendants' Expert Witness Disclosures*, attached hereto as **Exhibit "3."** Under Defendants "Non-Retained Experts" heading in their expert disclosures, there is a note in Defendants' Expert Disclosures stating "See NRCP 16.1 disclosures."

In Defendants' description of Dr. Chaney's testimony in their ECC disclosure, there is no mention of expert testimony. Instead, the note states, "Dr. Chaney is expected to testify regarding her examination, treatment, diagnosis and overall health conditions of Plaintiff," which is identical language used for more than a dozen other witnesses. See *Exhibit "2,"* at Page 3, lines 13-14.

Furthermore, Dr. Chaney's testimony in this matter is cumulative, as witness after witness in these proceedings have already testified as to Plaintiff Titina Farris' medical records and treatment.

Moreover, Dr. Chaney is unqualified to give any expert testimony in this matter. Dr. Chaney is not a neurologist, nor an endocrinologist. Yet, in deposition, Defendants repeatedly asked Dr. Chaney for her opinions on these topics and she readily gave them. As she is unqualified to testify on these matters, and failed to perform even rudimentary testing that a neurologist or an endocrinologist would perform, her testimony will not assist the finder of fact in this matter.

Can Defendants Back Pay a Witness in Exchange for Testimony?

Finally, and most egregiously, Defendants are now improperly **paying** Dr. Chaney to appear in this matter and deliver testimony. It goes without saying that a "non-retained" expert cannot be "retained" to give testimony. Furthermore, the Rule 45 sample subpoena notes that a witness may only be paid $25.00 per day, plus mileage.

Yet, (based upon information and belief) after Defendants were unable to secure the testimony of Dr. Chaney causing them to agree to pay their "unpaid" "non-retained" treating physician an expert fee to secure her testimony.

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When was Defense Counsel going to tell this Court he paid for her testimony? Or Plaintiffs?

Defendants' actions appear to be a violation of the Nevada Rules of Procedure, NRS 50.225, and the Rules of Professional Conduct RPC 3.4. This is bellied in the fact that Plaintiffs would not have known about this quid pro quo unless a call was made to Dr. Chaney's counsel.

This payment should have been at a MINIMUM disclosed to Plaintiffs' counsel by Defense Counsel at the time of disclosure. This Court should have heard this first from Defense Counsel, but instead, as has been the pattern and practice, it had to be brought to light by Plaintiffs.

Defense Counsel failed to put this payment in the subpoena and in its Trial Brief electronically served October 29, 2019 – after Defense served the subpoena and surely after Defense had a quid pro quo arraignment for trial testimony outside the knowledge of Plaintiffs or this Court.

It is notable that Defendants conduct of paying a non-retained witness for testimony is the same conduct that has resulted in at least one other attorney being suspended from the practice of law.

In *Matter of Discipline of Callister*, a disciplinary proceeding grows out of a letter and follow-up email that Callister sent D.E., who witnessed a will Callister's client disputed. In them, Callister offers D.E. $7,000 "[i]n exchange for your honest testimony ... that you never witnessed the Decedent signing a will."

Matter of Discipline of Callister, 401 P.3d 211 (Nev. 2017).

The Court continued:

> It is black-letter law that, "[a] lawyer may not offer or pay to a witness any consideration ... contingent on the content of the witness's testimony," Restatement (Third) of the Law Governing Lawyers § 117(2) (Am. Law Inst. 2000), whether the bargained-for testimony is "truthful or not." *HomeDirect, Inc. v. H.E.P. Direct, Inc.*, No. 10 C 812, 2013 WL 1815979, at *4 (N.D. Ill. Apr. 29, 2013). Such payments, or offers of payment, even if they do "not constitute outright bribery ... violate the spirit of the law and cast into doubt the integrity of the proceedings." *OptimisCorp v. Waite,* C.A. No. 8773-VCP, 2015 WL 5147038, at *15 (Del. Ch. August 26, 2015) (quotation omitted).

Matter of Discipline of Callister, 401 P.3d 211 (Nev. 2017).

The attorney in *Callister* was suspended from the practice of law for 35 days. *Id.*

Defendants Failed to Properly Change Status of Dr. Chaney

Should this Court not consider that a similar violation has occurred, at a minimum, Dr. Chaney has been "converted" from being a non-retained expert, to a retained expert and there is a rule for that, NRCP 16.1(a)(2)(D)(iii) ad (iv) which states as follows;

> (ii) **Change in Status.** A treating physician will be deemed a retained expert witness subject to the written report requirement of Rule 16.1(a)(2)(B) if the party is asking the treating physician to provide opinions outside the course and scope of the treatment provided to the patient.
>
> (iii) **Disclosure.** The disclosure regarding a non-retained treating physician must include the information identified in Rule 16.1(a)(2)(C), to the extent practicable. In that regard, appropriate disclosure may include that the physician will testify in accordance with his or her medical chart, even if some records contained therein were prepared by another healthcare provider.

(Her testimony, therefore, may not be presented as she has failed to produce a written report.)

See NRCP 16.1(a).

Finally, the limits of payment are noted in NRS 50.225:

> For attending the courts of this State in any criminal case, or civil suit or proceeding before a court of record, master, commissioner, justice of the peace, or before the grand jury, in obedience to a subpoena, each witness is entitled:
> (a) To be paid a fee of $25 for each day's attendance, including Sundays and holidays.
> (b) Except as otherwise provided in this paragraph, to be paid for attending a court of the county in which the witness resides at the standard mileage reimbursement rate for which a deduction is allowed for the purposes of federal income tax for each mile necessarily and actually traveled from and returning to the place of residence by the shortest and most practical route. A board of county commissioners may provide that, for each mile so traveled to attend a court of the county in which the witness resides, each witness is entitled to be paid an amount equal to the allowance for travel by private conveyance established by the State Board of Examiners for state officers and employees generally. If the board of county commissioners so provides, each witness at any other hearing or proceeding held in that county who is entitled to receive the payment for mileage specified in this paragraph must be paid mileage in an amount equal to the allowance for travel by private conveyance established by the State Board of Examiners for state officers and employees generally.
> 2. In addition to the fee and payment for mileage specified in subsection 1, a board of county commissioners may provide that, for each day of attendance in a court of the

> county in which the witness resides, each witness is entitled to be paid the per diem allowance provided for state officers and employees generally. If the board of county commissioners so provides, each witness at any other hearing or proceeding held in that county who is a resident of that county and who is entitled to receive the fee specified in paragraph (a) of subsection 1 must be paid, in addition to that fee, the per diem allowance provided for state officers and employees generally.

Therefore, as Dr. Chaney was improperly disclosed under Rule 16.1; as her testimony is cumulative; and as she is unqualified as an "expert" in this matter, her testimony is properly excluded in this case. Furthermore, the unethical payment to Dr. Chaney violates the Rules of Professional Conduct, and disqualifies Dr. Chaney from testifying as her testimony is now secured by payment, and as a retained expert she has failed to produce an expert report in violation of Rule 16.1.

II. LEGAL ARGUMENT AND ANALYSIS

A. Legal Authority.

NRCP 45(c)(3)(A) notes:

When Required. On timely motion, the court that issued a subpoena shall quash or modify the subpoena if it: (i) fails to allow reasonable time for compliance.

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.
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> *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).

[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).

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 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.
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> 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 Titina Farris' medical treatment and medical records, including the records made by Dr. Chaney. As such, any testimony from Dr. Chaney is unduly cumulative and is properly excluded.

B. The Subpoena Commanding Dr. Chaney's Attendance is Properly Quashed Under Rule 45.

As the Court is aware, Dr. Chaney's attendance has twice been mandated by subpoena. This certainly required that Dr. Chaney go to great lengths to rearrange her medical practice to attend trial on those days. Now, Defendants have again subpoenaed Dr. Chaney's attendance to trial to occur on October 30, 2019.

Rule 45 mandates that the Court quash any subpoena which "fails to allow reasonable time for compliance." Dr. Chaney cannot be sent for and dismissed *ad infinitum* by Defendants, particularly with insufficient time to attend trial. As such, the subpoena in this matter is properly quashed by the Court.

C. Dr. Chaney's Testimony was Not Properly Disclosed Under NRCP 16.1 and is Properly Excluded; Therefore there is No Prejudice to Defendants' Case in this Matter.

As noted above, Defendants failed to note that Dr. Chaney was a non-retained expert in this matter. Dr. Chaney is only listed as a "witness" in Defendants' NRCP 16.1 ECC disclosures. See *Exhibit "1."* Dr. Chaney is not mentioned in Defendants' Expert witness disclosures. There is merely a note directing readers to refer to Defendants' 16.1 disclosures. This description is insufficient to satisfy the requirements of 16.1.

Furthermore, the generic description merely states, "Dr. Chaney is expected to testify regarding her examination, treatment, diagnosis, and overall health conditions of Plaintiff." This same description, with only slight variables for the identity of the witness, is used to describe the testimony expected from twenty-four (24) of the thirty-three (33) witnesses identified in Defendants' ECC disclosures.

These generic disclosures that do not provide specific facts regarding Dr. Chaney's actual testimony. 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).

Defendants' failure to properly disclose this testimony properly results in Dr. Chaney's testimony being excluded.

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)."**

There is no such description in Defendants' disclosure, and as such, at a minimum, Dr. Chaney's testimony cannot veer outside of the strict limits of her treatment.

The Court in *Khoury* 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).

As Defendants have failed to comply with Rule 16.1, Dr. Chaney cannot testify in this matter. Her testimony was not adequately described, and thus it Must be Stricken.

Of course, this analysis would be appropriate for a "non-retained" treating physician—which Dr. Chaney no longer is. As she accepted three (3) days' payment to testify in this matter, she is a retained expert in Defendants' employ, and as will be noted below, she is doubly-forbidden from testifying in this matter under Rule 16.1, as she failed to produce a retained expert's report.

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D. Dr. Chaney is Not an Expert in Endocrinology or Neurology and Thus Her Testimony Will Not Assist the Finders of Fact.

Should the Court allow Dr. Chaney to testify, she must not be allowed to testify as an "expert." Dr. Chaney is a general practitioner. She has no education or training in endocrinology or neurology. Dr. Chaney's own testimony states that fact:

> ·Well, what is the purpose of the referral to the endocrinologist, from your perspective?
> A.· ·Well, if I can't achieve the appropriate goals, then I need another layer of assistance for the patient.

See Deposition of Dr. Chaney, attached hereto as **Exhibit "4,"** at Page 24:7-12.

Dr. Chaney is unqualified to act as an endocrinologist or a neurologist and was required to refer her to experts in those fields for assistance. Yet, Dr. Chaney repeatedly gave testimony in her deposition which would require expertise in endocrinology or neurology. Dr. Chaney lacks the skill, expertise, training or education necessary to testify on these matters.

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.(emphasis added)

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.

Dr. Chaney has no expertise in matters of endocrinology or neurology. She is unqualified to testify as to causation of Plaintiff Titina Farris' injuries.

Furthermore, Dr. Chaney has not testified that she tested Plaintiff Titina Farris or examined her in a way in which a neurologist or endocrinologist would have tested or examined her. Dr. Chaney relied solely upon self-reports from Plaintiff Titina Farris and gave unqualified opinions which were outside the scope of her expertise in deposition.

If Dr. Chaney is allowed to give speculative testimony outside the scope of her general expertise, the jury will give her undue weight due to her status as a physician. As such, Dr. Chaney is properly excluded from testifying in any regard in this matter.

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As Dr. Chaney's testimony is properly excluded, Defendants will experience no prejudice as a result of quashing the testimony seeking her testimony.

E. Dr. Chaney's Treatment Testimony is Necessarily Excluded as it is Cumulative.

NRS 48.035 excludes testimony and evidence which is cumulative. Dr. Chaney's testimony, as noted above, is properly excluded. As Dr. Chaney is not an expert, at most, she must be required to limit her testimony solely to her treatment of Plaintiff Titina Farris. This Court and the Jury have heard testimony time and time again as to Plaintiff Titina Farris' treatment by Dr. Chaney. As such, Dr. Chaney has nothing new to add to the testimony and evidence already given in this matter related to Plaintiff Titina Farris' treatment. It is therefore cumulative and properly excluded.

The Cumulative nature of any testimony which Dr. Chaney could demonstrates that there is simply no prejudice to Defendants' case by quashing the insufficient testimony compelling Dr. Chaney's attendance in this matter.

F. The Payment to Dr. Chaney to Secure Her Testimony.

NRPC 3.4(b) provides that an attorney shall not "Falsify evidence, counsel or assist a witness to testify falsely, or offer an inducement to a witness that is prohibited by law." As this Court is well aware, on October 28, 2019 Dr. Chaney's counsel, Todd Weiss, Esq., stated in open court the belief that subpoenas for his client to testify in this trial had expired. Mr. Weiss then requested that Dr. Chaney not be subpoenaed again as it had already caused hardship for Dr. Chaney. Yet, on October 29, 2019 Defense Counsel, Thomas Doyle, Esq., represented to this Court and to Counsel that Dr. Chaney was agreeable to testify in the afternoon of October 30, 2019.

After leaving the courthouse on October 29, 2019, at around 4:48 p.m., Plaintiffs' Counsel called Mr. Weiss, and asked him if it was true that Dr. Chaney had agreed to testify on October 30, 2019. Mr. Weiss informed Plaintiffs' Counsel that Dr. Chaney had so agreed, **but only after a promise from Mr. Doyle to pay her an expert fee for each of the days she was previously summoned as**

well as for her testimony on October 30, 2019; meaning that Dr. Chaney only agreed to testify after being promised payment by Defendants of three (3) times her normal expert fee for trial testimony.

This inducement to pay a witness for testimony is tampering. There is no statutory right to payment for an unpaid witness to attend trial, aside from $25.00 and mileage. See NRS 50.225. Defendants are seeking to tamper with Dr. Chaney's testimony by paying her three (3) times her "expert" witness fee to guarantee that she testifies in court. This is akin to the matter of *Callister*, where the Court declared:

> It is black-letter law that, "[a] lawyer may not offer or pay to a witness any consideration ... contingent on the content of the witness's testimony," Restatement (Third) of the Law Governing Lawyers § 117(2) (Am. Law Inst. 2000), whether the bargained-for testimony is "truthful or not." *HomeDirect, Inc. v. H.E.P. Direct, Inc.*, No. 10 C 812, 2013 WL 1815979, at *4 (N.D. Ill. Apr. 29, 2013). Such payments, or offers of payment, even if they do "not constitute outright bribery ... violate the spirit of the law and cast into doubt the integrity of the proceedings." *OptimisCorp v. Waite,* C.A. No. 8773-VCP, 2015 WL 5147038, at *15 (Del. Ch. August 26, 2015) (quotation omitted).
>
> *Matter of Discipline of Callister*, 401 P.3d 211 (Nev. 2017).

Even if this Court should determine that the content of the testimony was not bargained for, there is certainly the expectation, due to the bargaining for three (3) times her daily "expert" rate, that beneficial testimony will be given.

Furthermore, in retaining Dr. Chaney's services, she is now a retained expert, and as such, Rule 16.1 requires that she produce an expert report.

> Unless otherwise stipulated or ordered by the court, this disclosure must be accompanied by a written report — prepared and signed by the witness — if the witness is one retained or specially employed to provide expert testimony in the case or one whose duties as the party's employee regularly involve giving expert testimony. The report must contain:
> (i) a complete statement of all opinions the witness will express, and the basis and reasons for them;
> (ii) the facts or data considered by the witness in forming them;
> (iii) any exhibits that will be used to summarize or support them;
> (iv) the witness's qualifications, including a list of all publications authored in the previous ten years;

(v) a list of all other cases in which, during the previous four years, the witness testified as an expert at trial or by deposition; and
(vi) a statement of the compensation to be paid for the study and testimony in the case.

As Dr. Chaney is now a retained expert, she is properly stricken in this matter as she has failed to produce a timely report of her testimony, her compensation, her qualifications, and ever opinion she will offer.

In no wise can Dr. Chaney be allowed to testify in this matter. Defendants have completely sullied any "impartial" testimony that she could give as a treating physician by paying her what can be assumed to be thousands of dollars to secure her testimony in this matter. Any discipline this Court should see fit to impose upon Defense Counsel for this violation would be appropriate—including referral to the State Bar. Furthermore, as a retained expert that has not produced a report in violation of Rule 16.1, her testimony is properly excluded.

III. CONCLUSION

Dr. Chaney was not properly Disclosed in this matter. There is no proper description as to the nature of her testimony even before she was a "non-retained" expert. Furthermore, she was not disclosed as an expert, whether retained or non-retained, in this matter. Finally, the Subpoena compelling her attendance fails to give her sufficient time to attend trial.

Dr. Chaney is unqualified to give any expert testimony or to opine as to causation. There is no indication that Dr. Chaney has consulted medical records or any expert reports or journals in her care for Plaintiff Titina Farris. Furthermore, Dr. Chaney's testimony, which must be limited to the scope of her treatment based on this lack of expertise, will be cumulative, merely going over the same well-worn ground which numerous witnesses have already testified on. Rule 45 mandates that this Court quash any subpoena which gives insufficient time to respond.

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///

Finally, Defendants have corrupted Dr. Chaney's testimony by paying her to secure her testimony. Furthermore, as a retained expert, Dr. Chaney was required to timely produce a Rule 16.1 report—something Defendants failed to produce.

Based on the foregoing law, facts, and analysis, Plaintiffs respectfully requests that their Motion to Quash Defendants' Subpoena of Dr. Chaney be GRANTED.

DATED this 29th day of October, 2019.

BIGHORN LAW

By: */s/ Jacob G. Leavitt*
KIMBALL JONES, ESQ.
Nevada Bar.: 12982
JACOB G. LEAVITT, ESQ.
Nevada Bar No.: 12608
716 S. Jones Blvd.
Las Vegas, Nevada 89107

GEORGE F. HAND, ESQ.
Nevada Bar No.: 8483
HAND & SULLIVAN, LLC
3442 N. Buffalo Drive
Las Vegas, Nevada 89129

Attorneys for Plaintiffs

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 29th day of October, 2019, I served the foregoing ***PLAINTIFF'S MOTION TO QUASH TRIAL SUBPOENA OF DR. NAOMI CHANEY ON ORDER SHORTENING TIME*** as follows:

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

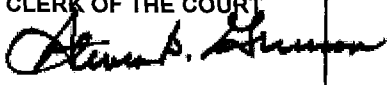
☐ U.S. Mail—By depositing a true copy thereof in the U.S. mail, first class postage prepaid and addressed as listed below:

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

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

EXHIBIT "1"

Electronically Filed
10/29/2019 7:29 AM
Steven D. Grierson
CLERK OF THE COURT



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

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

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

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al., Defendants.	CASE NO. A-16-739464-C DEPT. NO. 31 **TRIAL SUBPOENA - CIVIL REGULAR**

THE STATE OF NEVADA SENDS GREETINGS TO:

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

YOU ARE HEREBY COMMANDED, that all and singular, business and excuses set aside, you appear and attend on Wednesday, October 30, 2019, at the hour of 1:30 p.m.,

Case Number: A-16-739464-C

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

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

ITEMS TO BE PRODUCED:

Your entire medical chart of TITINA FARRIS.

Dated: October 29, 2019

SCHUERING ZIMMERMAN & DOYLE, LLP

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

EXHIBIT "A"

NEVADA RULES OF CIVIL PROCEDURE

RULE 45

(c) Protection of Persons Subject to Subpoena.

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

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

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

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

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

(B) If a subpoena

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

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

(d) Duties in Responding to Subpoena.

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

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

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 24th day of October, 2019, service of a true and correct copy of the foregoing:

TRIAL SUBPOENA - CIVIL REGULAR
was served as indicated below:

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

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

☐ by depositing in the United States Mail, first-class postage prepaid, enclosed ;

☐ by facsimile transmission; or

☐ by personal service as indicated.

Attorney	Representing	Phone/Fax/E-Mail
George F. Hand, Esq. HAND & SULLIVAN, LLC 3442 North Buffalo Drive Las Vegas, NV 89129	Plaintiffs	702/656-5814 Fax: 702/656-9820 hsadmin@handsullivan.com
Kimball Jones, Esq. Jacob G. Leavitt, Esq. BIGHORN LAW 716 S. Jones Boulevard Las Vegas, NV 89107	Plaintiffs	702/333-1111 Kimball@BighornLaw.com Jacob@BighornLaw.com

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

EXHIBIT "2"

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

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

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

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al., Defendants.	CASE NO. A-16-739464-C DEPT. NO. 31 **DEFENDANTS BARRY RIVES, M.D.'S AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S FIFTH SUPPLEMENT TO NRCP 16.1 DISCLOSURE OF WITNESSES AND DOCUMENTS**

Under the authority of Rule 16.1(a)(1) of the Nevada Rules of Civil Procedure, Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC hereby submits this fifth supplemental list of witnesses and documents as follows (the new information is in bold):

///

A. LIST OF WITNESSES

1. Titina Farris
c/o George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129

Ms. Farris is expected to testify regarding the facts and circumstances giving rise to this action.

2. Patrick Farris
c/o George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129

Mr. Farris is expected to testify regarding the facts and circumstances giving rise to this action.

3. Barry Rives, M.D.
c/o Thomas J. Doyle
Schuering Zimmerman & Doyle, LLP
400 University Avenue
Sacramento, CA 95825

Dr. Rives is expected to testify regarding the facts and circumstances surrounding this matter, including his care and treatment of Plaintiff Titina Farris.

4. Person Most Knowledgeable
Laparoscopic Surgery of Nevada
c/o Schuermg 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
40 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

Addison Durham 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
Care Meridian
3391 N. Buffalo Drive
Las Vegas, NV 89129

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

16. Gregg Ripplinger M.D.
10001 S Eastern Ave #201
Henderson, NV 89052
(702) 914-2420

Dr. Ripplinger is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

17. Thomas Gebhard, M.D.
2400 S Cimarron Rd Ste 100
Las Vegas, NV 89117
(702) 477-0772

Dr. Gebhard is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

18. Matthew Treinen D.O.
5495 S Rainbow Blvd Ste 203
Las Vegas , NV 89118
(702) 477-0772

Dr. Treinen is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

19. Ravishankar Konchada M.D.
5495 S Rainbow Blvd, Suite 101
Las Vegas, NV, 89118
(702) 477-0772

Dr. Konchada is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

20. Tanveer Akbar M.D.
520 Fremont Street
Las Vegas, NV 89101
(702) 382-5200

Dr. Akbar is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

21. Kenneth Mooney M.D.
10001 S Eastern Avenue, Suite 203
Henderson, NV 89052
(702) 616-5915

Dr. Mooney is expected to testify about the care, and treatment, and diagnosis of

Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

22. Alka Rebentish M.D.
6088 S Durango Drive 100
Las Vegas, NV 89113
(702) 380-4242

Dr. Rebentish is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

23. Arvin Gupta M.D.
6970 W Patrick Lane, Suite 140
Las Vegas, NV 89113
(702) 588-7077

Dr. Gupta is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

24. Ali Nauroz M.D.
657 N Town Center Drive
Las Vegas, NV 89144
(702) 233-7000

Dr. Nauroz is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

25. Syed Zaidi M.D.
9280 W Sunset Road, Suite 320
Las Vegas, NV 89148
(702) 534-5464

Dr. Zaidi is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

26. Ashraf Osman M.D.
5380 S Rainbow Blvd, Suite 110
Las Vegas, NV 89118
(725) 333-8465

Dr. Osman is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

27. Charles McPherson M.D.
3121 Maryland Pkwy #502
Las Vegas, NV 89109
(208) 415-5795

Dr. McPherson is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

28. Teena Tandon M.D.
6970 W Patrick Lane, Suite 140
Las Vegas, NV 89113
(702) 588-7077

Dr. Tandon is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

29. Farooq Shaikh M.D.
3880 S Jones Blvd
Las Vegas, NV 89103
(702) 636-6390

Dr. Shaikh is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

30. Howard Broder M.D.
2865 Siena Heights Drive, Suite 331
Henderson, NV 89052
(702) 407-0110

Dr. Broder is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

31. Doreen Kibby PAC
2865 Siena Heights Drive, Suite 331
Henderson, NV 89052
(702) 407-0110

Dr. Kibby is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

32. Herbert Cordero-Yordan M.D.
2300 Corporate Circle, # 100
Henderson, NV 89074
(702) 731-8224

Dr. Cordero-Yordan is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

33. Darren Wheeler, M.D.
4230 Burnham Avenue
Las Vegas, NV 89119
(702) 733-7866

Dr. Wheeler is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

B. DOCUMENTS

1. Medical and billing records from Laparoscopic Surgery of Nevada (BR000001-BR000049).

2. Medical records from St. Rose Dominican Hospital (previously produced by plaintiffs.)

3. Medical records from Dr. Barry Rives (previously produced by plaintiffs.)

4. Medical records from Dr. Noami Change (previously produced by plaintiffs.)

5. Medical records from Dr. Elizabeth Hamilton (previously produced by plaintiffs.)

6. Photographs of plaintiff Titina Farris (previously produced by plaintiffs.)

7. Medical and billing records from Desert Valley Therapy (previously produced by plaintiffs.)

8. Medical and billing records from Dr. Hamilton (previously produced by plaintiffs.)

9. Medical and billing records from St. Rose Dominican Hospital - San Martin Campus for July 2015 admission (previously produced by plaintiffs.)

10. Medical and billing records from St. Rose Dominican Hospital - San Martin Campus for July 2016 admission (previously produced by plaintiffs.)

11. Medical records from Dr. Chaney (previously produced by plaintiffs.)

12. Billing records from Dr. Chaney (previously produced by plaintiffs.)

13. Medical and billing records from Advanced Orthopedics & Sports Medicine (previously produced by plaintiffs.)

14. Diagnostic films taken at St. Rose Dominican Hospital (previously produced by plaintiffs.)

15. Video of Titina Farris taken by Lowell Pender on April 15, 2015 (previously produced by plaintiffs.)

16. Videos of Titina Farris, Patrick Farris, Addision Durham, Lowell Pender and Sky Prince (previously produced by plaintiffs.)

17. Marriage certificate (previously produced by plaintiffs.)

18. Medical and billing records from Dr. Steven Y. Chinn (previously produced by plaintiffs.)

19. Medical and billing records from Care Meridian (previously produced by plaintiffs.)

20. Billing records from St. Rose Dominican Hospital - Siena Campus (BR-SRDSB000001-BR-SRDSB000015);

21. Medical and billing records from Dr. Elizabeth Hamilton (BR-HAMILTON000001-BR-HAMILTON000073);

22. Records of Bess Chang, M.D. (CHANG000001-CHANG000008) (CD will be mailed);

23. Advanced Orthopedics & Sports Medicine (AOSM000001-AOSM000029) (CD will be mailed);

24. Certificate of no imaging from Dr. Chang (CHANG-CNR-IMAGING000001-

CHANG-CNR-IMAGING000002);

25. Medical records from Southern Nevada Pain Center (SNPC000001-SNPC000051) (CD will be mailed);

26. Medical records from Internal Medicine of Spring Valley (IMSV000001-IMSV000888) (CD will be mailed);

27. Medical records from Care Meridian (CM000001-CM000299) (CD will be mailed);

28. Certificate of no imaging from Dr. Hamilton (HAMILTON-CNR-IMAGING000001-HAMILTON-CNR-IMAGING000002) (CD will be mailed);

29. Medical records from ATI Physical Therapy (ATI000001-ATI000081) (CD will be mailed);

30. Medical records from St. Rose Dominican Hospital - Siena Campus (BR-SRDSM000001-BR-SRDSM000927) (CD will be mailed);

31. Certificate of no imaging from St. Rose Dominican Hospital - Siena Campus (BR-SRDM-CNR-IMAGING000001-BR-SRDM-CNR-IMAGING000002) (CD will be mailed);

32. Dr. Bart Carter's expert report (previously produced);

33. Dr. Brian Juell's expert report (previously produced);

34. Dr. Carter's rebuttal expert report (previously produced);

35. Dr. Juell's rebuttal expert report (previously produced);

36. Dr. Lance Stone's rebuttal expert report (previously produced);

37. Sarah Larsen's rebuttal expert report (previously produced);

38. Dr. Bruce Adornato's rebuttal expert report (previously produced);

39. Dr. Kim Erlich's rebuttal expert report (previously produced);

40. Dr. Scott Kush's rebuttal expert report (previously produced);

41. Erik Volk's rebuttal expert report (previously produced);

42. Dr. Erlich's supplemental expert report;

43. Dr. Juell's supplemental expert report;

44. Dr. Adornato's supplemental expert report;

45. Dr. Adornato's Stanford Profile;

46. Article: The Natural History of Chronic Painful Peripheral Neuropathy in a Community Diabetes Population;

47. Article: The Natural History of Painful Diabetic Neuropathy - a 4-year Study.

Defendants reserve the right to supplement this list of documents as discovery continues and to submit any exhibit of any other party. Said Defendants further reserve the right to amend this list of witnesses, documents and tangible items should, during the course of the discovery of this matter, additional witnesses and documentation become known to defendants or defendants' counsel. Defendants hereby incorporate all documents produced by the parties in their Early Case Conference Disclosures and supplements by reference.

Dated: September 23, 2019

SCHUERING ZIMMERMAN & DOYLE, LLP

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

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 23rd day of September, 2019, service of a true and correct copy of the foregoing:

DEFENDANTS BARRY RIVES, M.D.'S AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S FIFTH SUPPLEMENT TO NRCP 16.1 DISCLOSURE OF WITNESSES AND DOCUMENTS

was served as indicated below:

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

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

☐ by depositing in the United States Mail, first-class postage prepaid, enclosed ;

☐ by facsimile transmission; or

☐ by personal service as indicated.

Attorney	Representing	Phone/Fax/E-Mail
George F. Hand, Esq. HAND & SULLIVAN, LLC 3442 North Buffalo Drive Las Vegas, NV 89129	Plaintiff	702/656-5814 Fax: 702/656-9820 hsadmin@handsullivan.com
Kimball Jones, Esq. Jacob G. Leavitt, Esq. BIGHORN LAW 716 S. Jones Boulevard Las Vegas, NV 89107	Plaintiffs	702/333-1111 Kimball@BighornLaw.com Jacob@BighornLaw.com

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

EXHIBIT "3"

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

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

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

DISTRICT COURT

CLARK COUNTY, NEVADA

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

Pursuant to NRCP 16.1 (a)(2) and (3), Defendants hereby disclose the names of all expert witnesses and information as follows:

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 report, Curriculum Vitae including publication history, fee schedule and list of deposition/trial testimony are attached hereto as Exhibit A.

Dr. Carter charges $2,000 for deposition testimony.

Dr. Carter charges $3,500 a day of trial testimony.

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 report including fee schedule and list of deposition/trial testimony and Curriculum Vitae including publication history are attached hereto as Exhibit B.

Dr. Juell charges $1,000 an hour for deposition testimony (with a one hour minimum).

Dr. Juell charges $1,500 an hour for trial testimony (with an eight hour minimum).

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.

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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: November 15, 2018

SCHUERING ZIMMERMAN & DOYLE, LLP

By _____

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

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 15th day of November, 2018, service of a true and correct copy of the foregoing:

DEFENDANTS BARRY J. RIVES, M.D. AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S INITIAL 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.

Attorney	Representing	Phone/Fax/E-Mail
George F. Hand, Esq. HAND & SULLIVAN, LLC 3442 North Buffalo Drive Las Vegas, NV 89129	Plaintiff	702/656-5814 Fax: 702/656-9820 hsadmin@handsullivan.com

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

EXHIBIT "4"

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

DEPOSITION OF NAOMI L. CHANEY, M.D., taken at 3770 Howard Hughes Parkway, Suite 300, Las Vegas, Nevada on THURSDAY, MAY 9, 2019 at 9:54 o'clock a.m., before Katherine M. Silva, Certified Reporter, in and for the State of Nevada.

APPEARANCES:
For the plaintiff:
PITEGOFF LAW OFFICE
BY: JEFF PITEGOFF, ESQ.
330 East Charleston Boulevard
Suite 100
Las Vegas, Nevada 89104
For the defendants:
SCHUERING ZIMMERMAN & DOYLE, LLP
BY: CHAD C. COUCHOT, ESQ.
400 University Avenue
Sacramento, California 95825

I N D E X

Witness: NAOMI L. CHANEY, M.D.

E X H I B I T S

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

deposition, I'm going to run through the ground rules that you've probably heard before just to make sure we are both on the same page.

The most important thing to keep in mind during the deposition is that Kathy, our court reporter, has the difficult task of writing down every single word that we say.

So if we were to speak over each other, as we do in normal conversation, it makes her job difficult or impossible to do.

So we have to make a conscious effort, even though it's an unnatural way of speaking, to allow the person to finish their sentence before we start talking.

Does that make sense?
A. Yes.
Q. You took an oath, it's the same oath that you would take to tell the truth in front of a judge or jury.

Does that make sense?
A. Yes.
Q. We can't just – we can't speak at the same time. We also can't communicate in gestures or uh-huh or unt-uh because while it makes perfect sense in person, it does not make much

sense when we are reading the record, okay?
A. Yes.
Q. We can take a break at any point. I'm going to try my very best to not take very long, but this is not an endurance test by any means. So let me know if you want to take a break at any point, okay?
A. Okay.
Q. It's my obligation to ask you clear questions. I'm not a physician. I will probably ask questions that do not make sense at some point.
Please ask me for clarification. If you do not ask me for clarification, I'm going to assume my question made sense. Is that fair?
A. Yes.
Q. Okay. Do you understand the difference between a guess and an estimate?
Let me give you a little example. A guess is something that's complete speculation and an estimate is something based in fact.
So, for example, if we said how long is this table, you could give me an estimate, but if I said how long is the table in my office, that would be a complete guess.

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. Okay. Have you ever discussed the lawsuit with Mrs. Farris or her husband?
A. Discussed?
Q. I can be a little bit more specific.
Have you ever had any conversations with them where they asked you your opinion about the merits of their lawsuit or anything to that affect?
A. We have not had discussions about the merit of the lawsuit.
Q. Okay. And what was the context of the discussions that you did have with her about the lawsuit?
A. That she was having a lawsuit.
Q. Did she ever ask you any of your opinions related to the lawsuit in any way?
A. No.
Q. Okay. Have you ever spoken to Mrs. Farris's counsel, her and her husband's counsel, I should say?
A. I don't think I have. So let me clarify on that.
Q. Sure.
A. I think he came to my office to pick up the records.

Q. Got it.
Did you ever have a conversation with –
And are you speaking about George Hand, do you know?
A. I don't know.
Q. Okay.
A. But there was no conversations.
Q. Very good.
A. It was like handing things over.
Q. Okay. Very good.
When approximately did Mrs. Farris establish care with you?
A. 2014 I believe.
Q. Okay. Now, if you wouldn't mind looking –
Actually let's mark these as exhibits.
(Exhibits 1 & 2 marked)
Q. (BY MR. COUCHOT) Okay. So the first note that I found in the records that I subpoenaed from your office was from June 19, 2014. That's the note on top of Exhibit 2, but the chief complaint is refill. So to me that suggests that she had – that was not the established care visit.

Is that a fair assumption?
A. That would be correct.
Q. Okay. Do you have an estimate of how long Mrs. Farris had been a patient of yours as of June 19, 2014?
Does that make sense?
A. No. You are asking me when did she establish and how long has she been seen prior to this date?
Q. Yes. And if it is 2014, I don't need anything more specific.
A. No, I don't think it was 2014. Whatever, the note should be there.
Q. This is the earliest note I have in the chart, and it's not a big issue to me whether – when the first presentation was, but I'm just wondering if you happen to know.
So the first one I was able to find was June of 2014.
A. Okay.
Q. So do you have any independent –
A. I would say 2013. I mean I did not review the charts before I came.
Q. Okay. Very good.
But your best estimate is she had been a patient since approximately 2013?

A. I would say 2013.
Q. Okay. Very good.
A. So I started with this particular insurance product in, I believe, 2012. So they became patients under this insurance product. So it would be 2012 and forward, but I'm not sure if it was 2012.
Q. And the insurance product is the MGM?
A. Direct Care.
Q. Got it.
Okay. So it had to be after 2012 or 2012 or later, but you believe it was probably 2013?
A. Yes.
Q. Okay. Very good.
So since this is the first note that we have, why don't we focus on this point in time and kind of move forward from there.
Can you tell me what Mrs. Farris's active medical problems were at the point of this note on June 19th, 2014?
A. She has diabetes, she has chronic pain, she has neuropathy, she has high cholesterol and blood pressure.

Q. What were her current medications at that point?
A. What is written down is the Cymbalta, Gabapentin, Dilantin, Lisinopril, Metformin, the narcotic Onglyza, Pravastatin and she wouldn't have been on both the Lisinopril and the Valsartan, so she would be on one or the other.
Q. Okay. You described them as narcotics. There's two entries for Norcos.
Are those medications that would be in the alternative, or is she on two different dosages?
A. No, she would be on one or the other.
Q. Okay. And what was the purpose of the pain – the narcotic pain medications at that point?
A. She complained of back pain.
Q. Okay. What was your understanding of the cause of the chronic pain problem that you described as a current medical problem?
A. She came to my practice on this medication.
Q. Okay. And was that back pain or was –
A. Back pain.
Q. Okay. Got it.

And did you mention she had a diagnosis of neuropathy at that point?
A. The Gabapentin and the Cymbalta are typically used for neuropathy as well.
Q. And what were the symptoms that she had that led to that diagnosis of neuropathy?
A. When people complain of pain or burning in their feet.
Q. So what I'm getting at is do we know specifically if it was in the feet or in the arms or both or are you able to tell me?
A. It was – she didn't complain of things in her arms.
Q. Okay. So she had a diagnosis of neuropathy at that point based on complaints of pain in the feet?
A. Uh-huh.
Q. Is that a yes?
A. Yes.
Q. Thank you.
Okay. I want to skip to the next presentation which is – actually it's two presentations forward in this note, it's August 20, 2014. If you could find that note for me.
A. Yes.

Q. Okay. Can you read for me the history of present illness portion of your note?
A. Patient is here in interval follow up. She has type –
Q. Let me pause you for one second. She's writing down every single word and we tend to read fast so if you can slow down just a little bit. Sorry.
A. Patient is here in interval follow up. She has known type two diabetes, insulin requiring, with a long-standing history of noncompliance.
She has peripheral neuropathy with a history of back pain. MRI of the lumbar spine was unrevealing for any pathology. She's tried to treat her pain symptoms with Ibuprofen without improvement. The patient also requires Norco.
Q. Is that an accurate reflection of her medical condition as reported to you at the time?
A. Could you please restate the question?
Q. Sure.
Is that an accurate statement of her history of present illness as you understood it at the time?
A. The patient has type 2 diabetes,

insulin requiring. She has complaints of peripheral neuropathy, and complaints of back pain.
Q. Okay. What did you mean by longstanding history of noncompliance?
A. As a physician, when we are treating patients and we make recommendations and things aren't followed – which is very common with many patients for various reasons. So making that statement in that note like that would not I think fairly represent a patient.
I think it sounds harsh as if they are intending not to comply –
Q. Sure.
A. – with the recommendations.
Q. And I don't think anyone would infer that she was intending herself harm.
A. Right.
Q. But is that a statement indicating that you were giving her treatment recommendations and she was not following them?
A. It would be a statement that I made recommendations and it appeared that she did not follow them.
Q. Okay. And that had been the case for

some time as evidenced by the fact that you chose to describe it as a longstanding history; correct?
A. Correct.
Q. Okay. What type of health problems can result from uncontrolled diabetes?
A. There are so many.
Q. Eye problems?
A. Yes.
Q. Kidney problems?
A. Yes.
Q. Could it lead to endstage renal disease?
A. Yes.
Q. Is the fact that Mrs. Farris had hypertension significant when considering the problems associated with uncontrolled diabetes?
A. Could you repeat that?
Q. Is the fact that Mrs. Farris had hypertension significant in considering the fact that she had uncontrolled diabetes?
A. The question I think you are asking is is it problematic that she has high blood pressure and diabetes that's not uncontrolled –
Q. Yes.

A. – is that a problem?
Q. Yes.
A. Yes.
Q. And why is that?
A. It puts her at additional risk factors for other problems like heart disease.
Q. Okay. I want to fast forward to January 5th of 2015. I believe that's the next note in the chart. If you could find that for me.
Can you please read the history of present illness in this portion of the note?
A. The patient is here in interval follow up. She requires refills on her medication. The patient is not monitoring her blood glucose on a regular basis. I've asked the patient to please document her blood glucose and she can text me her numbers. She reports full compliance with all medications.
Q. All right. How was her diabetes being managed at that point; is she controlled, well controlled, not controlled?
A. I would have to look at the associated labs, but I think it would be fair to say during the time that she has been my patient she has not

been controlled.
Q. Okay.
A. Did I answer that?
Q. Yes, that's sufficient, thanks.
A. Okay.
Q. And the note mentions that you asked her to send you her glucose levels. What is the purpose of that?
A. I do this commonly with my patients who aren't controlled. So Titina is not unusual in that I offer additional access to me.
My goal is that we rapidly get them controlled, and so I'd like them to give me their glucose numbers before breakfast and before dinner and then we can ramp up insulin and see if we can titrate her so she's controlled.
Q. And did she comply with that recommendation?
A. She did.
Q. And at this point in time, is Mrs. Farris continuing to complain of pain?
A. Yes.
Q. And is neuropathy an active problem?
A. She's managed currently by a pain management specialist.

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

decision not to follow through, as far as you know?

A. Those are the answers that they gave me.

Q. Got it.

And what is the purpose of being –

Well, what is the purpose of the referral to the endocrinologist, from your perspective?

A. Well, if I can't achieve the appropriate goals, then I need another layer of assistance for the patient.

Q. And so endocrinology would be basically a higher level of care for diabetes management, is that fair to say?

A. Yes.

Q. And what about the cardiology referral, what is the purpose of that?

A. She has lots of risk factors.

Q. And that recommendation –

Those recommendations to endocrinology and cardiology, those preceded July of 2015, fair to say?

A. July of 2015 is important because –

Q. That's when the hospitalization at

issue was.

A. Okay.

Q. Okay.

A. So July is when the incident occurred?

Q. Yes.

A. Okay. And you are asking me what question again?

Q. If those referrals to endocrinology and cardiology began before July of 2015; is that correct?

A. That's what it states. The referrals would be in there.

Q. Okay. Very good.

If we could move forward to the next note in the chart, it's March 5, 2015. Can you read the history of present illness portion of that note for me?

A. The patient was asked to come in today for further evaluation, secondary to her blood work. The blood work demonstrates abnormal control of her blood glucose. Her cholesterol is elevated as well as her triglycerides.

Prolonged discussion with the patient of a hemoglobin A1c of 12.3. Discussion about referral to endocrinologist. Patient agrees to

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redouble her efforts.
I've explained to the patient I cannot emphasize enough the need for improved control. I've asked the patient to please send me her readings. She agrees.
She requires refills on medication. We discussed Crestor, mandatory that we improve her cholesterol profile.
Q. When you say that you cannot emphasize enough the need for improved control, what are you telling Mrs. Farris to make that point?
A. That.
Q. You are telling her --
A. I cannot emphasize enough. Like I'm very straightforward.
Q. And are you articulating that there are certain adverse consequences that are likely to follow if she does not improve her uncontrolled diabetes?
A. I can't tell you what I said on that day.
Q. Can you tell me what you would typically tell a patient in this situation based on the – your interpretation of the remarks in your note?

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A. I would comment about the diseases that you outlined earlier.
Q. All right. Was there a control about her cholesterol at that point?
A. Was her cholesterol controlled?
Q. No. I'm sorry.
Was there a concern about her cholesterol at that point?
A. Yes.
Q. Okay. How does that factor into your concerns about her diabetic management, if at all?
A. Well, it increases her risk for heart disease.
Q. The A1c level of 12.3, is that an abnormal value?
A. Yes.
Q. What significance does an A1c of 12.3 have to you as a internal medicine physician?
A. That she's not controlled and she's at risk for other problems.
Q. If we can move on to the next note, April 3rd, 2015. Can you please read the?
A. Patient is here on interval follow up. She requires refills on her medication. Patient

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states that her blood glucose has improved and is not regularly sending me her numbers.
I explained to the patient that I'm more than willing to participate in improving her diabetes. She complains of shoulder pain. She requires refills.
Q. Okay. Is that common about not regularly sending me her numbers meaning that she's not sending you her glucose levels as you had directed her to do?
A. That's not uncommon for patients to fall off.
Q. I understand.
A. Okay.
Q. But that's what that means; is that correct?
A. Yes.
Q. Okay. And at that point you remained control – excuse me, you remained concerned about her -- the control or lack of control of her diabetes. Is that fair to say?
A. Yes.
Q. What were your assessments at that point?
A. Type two diabetes not controlled,

Page 29

polyneuropathy and diabetes, chronic pain syndrome, hypertension.
Q. All right. We can move onto the next note, May 5, 2015.
A. Okay.
Q. Can you please read the history of present illness portion of the note?
A. Yes. Patient is here in interval follow up. She requires refills and would like to have relief from the pain in her shoulder.
I explained to the patient that her diabetes has not been well controlled and she does require improved diabetic control and clearance from cardiology. She's reluctant. She reports that she is fully compliant with all medications.
Q. So at that point her – it's fair to say her diabetes was poorly controlled?
A. Yes.
Q. It sounds like you like dogs because there's a very specific description of the types of dogs she has.
A. Yes, I like dogs a lot, and I think they are a good support for the patient.
Q. All right. What is your –

What was your thought process at the time about the cause of her shoulder pain?
A. I can't comment on what I thought then.
Q. Okay. Did you at some point refer her to an orthopedic surgeon for complaints of the shoulder pain?
A. By the next note, it appears I did.
Q. Okay. And it's my understanding that she was referred to Dr. Yee; is that right?
A. Well, the fact that she saw him and that was in my note, which is interesting because I don't typically refer to Dr. Yee.
Q. But it appears that she was seen by an orthopedic surgeon with regard to the complaints of her -- of her pain in her shoulder; is that right?
A. Yes.
Q. Okay. And did you come to an understanding of what was the cause of the pain in the shoulder based on the assessments of the orthopedic surgeon who evaluated her?
A. She states left shoulder impingement syndrome.
Q. And do you have an opinion as to the etiology of the shoulder impingement syndrome;

was it traumatic, was it caused by a chronic illness or anything like that?
MR. PITEGOFF: Objection, speculation, foundation. Calls for an expert opinion.
Q. (BY MR. COUCHOT) Yes.
So you can go ahead and answer if you have an answer, but if you would have to speculate, just let me know.
A. Could you ask the question again?
Q. Sure.
Did you come to any understanding about the etiology of the left shoulder impingement syndrome?
MR. PITEGOFF: Same objections.
THE WITNESS: I definitely would not associate it with her diabetes.
Q. (BY MR. COUCHOT) Okay. Did you have any understanding of the cause of it whatsoever?
A. Unt-uh.
Q. That's a no?
A. No.
Q. Okay. If we could move on to the note, the June 4, 2015, and let me know when you have that note.
A. I have it.

Q. All right. Could you please read the history of present illness portion of that note?
A. Patient is here in interval follow up for labs performed in preparation for surgery. I've explained to the patient that although her A1c is improved, she continues to demonstrate poor control. I have advised the patient that she must see an endocrinologist. She states that she's in agreement.
She also has had an elevated white count, and reports that she has a cough that is nonproductive. She also received a steroid injection which may cause elevation of white count.
Q. At that point her diabetes is still poorly controlled?
A. That's what I wrote.
Q. And that's your belief?
A. Yes.
Q. And did she end up seeing an endocrinologist as she agreed to do at that point?
A. No.
Q. Do you have an understanding as to why she did not see an endocrinologist?

A. The reasons as I previously outlined.
Q. All right. If we could move on to the next note, June 30, 2015.
My belief, based on review of your records, is that this was the last time that you saw her prior to the surgery at issue in this lawsuit.
Do you have any reason to believe otherwise?
A. No.
Q. Okay. Can you read the history of present illness portion of that note for me please?
A. Patient is here in interval follow up. As we are moving into the holidays, she's here early, requires refills on her pain medication. She has not contacted me with respect to her numbers, but agrees that she will try again. She has been referred to the endocrinologist. She reports that she's been fully compliant with all her medications.
Q. What were her current medical problems at that point in time?
A. It would be the same.
Q. Diabetes, hypertension, neuropathy,

chronic pain?
A. Yes.
Q. Okay. And would those also be your assessments at that point, those same, type 2 diabetes, uncontrolled chronic pain syndrome, hypertension?
A. Yes.
Q. All right. At that point was she continuing to regularly take narcotic pain medication for foot pain?
A. Yes, and back pain.
Q. And back pain, okay.
There are some records in your chart from Spring Valley Hospital Medical Center that have to do with the treatment of an ulcer on the foot in February of 2017.
Do you remember Mrs. Farris having that issue?
A. I remember she had an ulcer in her foot after she had been discharged from the rehab after she had the surgery and was injured during that surgery.
Q. Okay. And do you have an understanding of whether that foot ulcer was due to – was that a diabetic foot ulcer or something else or do you

know?
A. My impression then – I'm going to read this.
Q. Okay. This is actually the Spring Valley Hospital note. I did not –
We could look for your note if you think it would be helpful to find your note in that time period.
A. Titina went that day – she came earlier that day to my office with a fullness here that seemed to suddenly come on.
Q. One second. You are pointing to –
A. A mass on her left anterior chest, as I recall, and she was very distraught, and we weren't sure what the etiology was, and she was sent over to the hospital.
In terms of their documentation of her left heel, I would not say it was a diabetic foot ulcer. What I believe –
What I remember was that after she came out of the hospital, she had wounds in her feet that were slow to heel and she had been referred out for wound care and she was seeing podiatry and it was slow to heal and it was – it was a burden for her to go –

I mean I don't know why, but they learned to manage her feet over time themselves. So I don't know if that is a reflection of that continued injury.
Q. Okay. And the reason why I ask, if we can flip forward to the next note that I have in these records is from August 2nd, 2017 and your assessments on the second page of the note include diabetic foot ulcer and I'm wondering if we are speaking about the same condition that Mrs. Farris was treated for at Spring Valley Hospital Medical Center in February of 2017 or if that is something else?
A. What I remember is that Titina had an injury to her foot from the time that she came out of the surgery and it slowly healed. She did not have a new diabetic foot ulcer, as far as I'm aware, and I would ask her often to look at her feet.
Q. Okay. Can you please read slowly the history of present illness portion of your August 2nd, 2017 note?
A. Patient is here on interval follow up to discuss the results of the labs and pap smear. The results were very concerning and this was

conveyed to the patient. She has diabetes that is not controlled. She has lipid levels that place her at risk for spontaneous pancreatitis. We discussed this at length. She's under the care of the wound care specialist and understands that the wound care is compromised with elevated glucose. We talked about all these items at length.
So that would support what I was saying earlier.
Q. Okay.
A. The patient defers going to the endocrinologist/cardiologist at this time. She will redouble her efforts in terms of managing her blood glucose. She has my number and she is to text me her numbers daily. She agrees with the plan.
She is also seeing the wellness coach. Her urine is abnormal, but she has no symptoms. We will repeat urine in light of her history of C diff.
Q. Thank you.
And when you say the results were very concerning, what results were you referring to?
A. Based on this, I would think it would

be her triglycerides.
Q. And what is significant about her triglycerides?
A. You can have spontaneous pancreatitis with triglycerides greater than 800.
Q. And was the poor control of her diabetes affecting her ability to heal at that point, for her foot wound to heal?
A. I don't know why her foot wound didn't heal well. Elevated glucose would make it harder to heal.
Q. Okay. And it was your concern that the wound care –
When you say that the wound care was compromised with elevated glucose levels, is it fair to say that you were concerned that her ability to heal was compromised by the fact that her diabetes was poorly controlled?
A. I would be concerned about any wounds in any person if their sugar levels were elevated.
Q. Okay. And what does it mean when she says that – when you say that Mrs. Farris has deferred going to a cardiologist or endocrinologist?

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,

it's March 22nd, 2018.
Can you please slowly read the history of present illness portion of that note?
A. The patient was asked to come in with her husband for frank discussion regarding noncompliance with recommendations. I've explained again my concern as we received notification from the endocrinologist's office regarding two schedules and one no show.
As a consequence, they will not reschedule the patient again. I did discuss with the patient if their inability to go to other physicians include barrier, financial barriers, that then we will attempt to manage the diabetes together by having daily interaction on glucose readings and titrate up with short acting.
Additionally, the patient will need to be on cholesterol-lowering medications as I explained that she's at high risk of pancreatitis and quite frankly death.
We will need to move the patient forward to cardiology, but in the meantime her goals are to lower the glucose readings. Weekly medications would be helpful, but place the patient risk for pancreatitis and, therefore, we

must get the glucose down with insulin and other agents before we can switch her. They state that they will try.
Additionally, I explained to the patient the practice will no longer write for chronic pain medication. She will have to establish a pain management specialist.
Q. Okay. And so is it fair to say you offered her additional ways for you to help closely manage her diabetes in light of the fact that she had not seen an endocrinologist? Is that a fair reading of this note?
A. Uh-huh.
Q. Yes?
A. Yes.
Q. Okay. And did she take advantage of those opportunities that you presented –
A. Yes.
Q. – to her?
And please explain what exactly she did?
A. So during that time, because of the ongoing issues, and my discussions with Patrick and Titina, I stopped and paused down and just tried to imagine what they were going through

with her not being able to walk, the things that were occurring at her home, and what I did is I combed through my medication closet and I looked for a copay cards that would give them a zero dollar copay and I offered them samples of any insulin because I believed them when they told me that they couldn't go for financial reasons.

So my hope at that time was if I could offset the money that they would have to spend with the medications, then they could then start going to the specialists.

Q. And did they?

A. Well, during that time the numbers that she texted me were improving, that's my recollection, and her daughter at that time had moved in and she's a vegan and she was helping her make meals which helped Patrick a lot.

Q. So –

A. So there appeared to be a strong plan in place where they were being offloaded with the help of her daughter, her adult daughter, that had moved in with preparing meals.

So Patrick wasn't responsible then for making the meals and then the numbers that she was reporting to me were quite good.

Q. And so was it your assessment at that point that she no longer needed to be seen by an endocrinologist or cardiologist?

A. Never.

Q. I'm sorry, that was --

A. I would always want her to see the subspecialist and I was attempting to get the numbers controlled.

When I would talk to Titina and Patrick about this, what struck me about them is I call them glass half full people. So they look at a situation and they always feel that they can make it better.

So even this last appointment that I had with her and her hemoglobin A1c was better, worse than this one, but better than previous, she still feels that she can get control of it.

And so I'd say: Titina, we've tried it this way for a long time now, we have to move it in a different direction so she agreed.

Q. And it sounds like she was historically in agreement with your treatment recommendations but that didn't necessarily reflect that she would actually follow those recommendations. Is that fair to say?

A. Historically that would appear to be the case, but every time we talked, it did seem like she was going to try or – I don't believe that anybody doesn't want to get better.

So she would send me her numbers, we would talk about what she ate.

Q. Sure, I understand that.

But in your experience as a physician, is a patient's past behavior an indication of generally speaking about how they will behalf in the future?

A. People do surprise me at times and that's what we go for as physicians that they are going to try and do things better. So I have patients all the time that do things better.

Q. Okay. And is it fair to say that normally when a patient's behavior changes significantly it's due to some type of significant health problems such as the hospitalization that Mrs. Farris went – underwent in July of 2015?

MR. PITEGOFF: Objection, form, speculation, foundation. You can answer.

Q. (BY MR. COUCHOT) Does that question make sense?

A. No.

Q. Okay. So –

MR. PITEGOFF: Unintelligible, add that one.

THE WITNESS: Your question I feel you are asking is do I see people typically change after a major event. The answer is sometimes yes and sometimes no.

What I definitely remember after the surgery – after the incident when she came to my office with dropped foot, after she learned how to walk again, is that they were very motivated and her main motivation at that time was to have the takedown of the stoma. So what I remember is Patrick and her were very motivated.

Q. (BY MR. COUCHOT) And did her diabetes management improve at that point during the time when Mrs. Farris was very motivated?

A. It seemed to, yes. So what I remember was – and I don't have the information right in front of me. They were very motivated so they could have the surgery for the stoma – for it to be taken down.

Q. Okay. And after the colostomy was taken down, did she continue in your – from your

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perspective to be motivated in changing her control of her medical conditions?
A. She appeared to be motivated and, you know, so during this time situations would occur like she passed a fecal mass from her rectal stump that was very traumatizing, she ended up having C diff with multiple visits, multiple other doctors.
So it wasn't like she was seeing me and that was it, it was lots of things involved.
Q. Sure.
But as of March 22nd, 2018, you thought that her management of her chronic illnesses posed her at a high risk of pancreatitis and death, fair to say?
A. Yes.
Q. Okay. So your note mentions that you offered to have daily interaction with her with regard to her diabetes management.
Did she subsequently have daily interaction with you?
A. Yes.
Q. And does that continue to this day?
A. No.
Q. How long was she having daily

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interaction with you?
A. I would say maybe a month.
Q. Okay. What, if anything, has changed with Mrs. Farris's medical condition since this day of March 22nd, 2018?
A. Well, her triglycerides are better.
Q. Do you remember the last value -- the last A1c value?
A. 500, which is bad, but it's lower than 800.
Q. How was she doing otherwise?
How, if at all, had she changed from the way she presented to you in March of 2018?
A. Her diabetes is not controlled, but it is improved. She was hopeful that the dietary changes that she had implemented with her daughter and the fact that she's lost weight would show a much better picture.
She was very optimistic that the numbers would be good this last time and then when we talked about it, they were better, but they are still not at goal. So she wanted to try to again and I asked her let's just please move this forward and she agreed.
Q. And what does that mean?

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A. That she'll see – what I explained to her is her insurance has put out a really neat product, it's called Onduo where they will – they will –
MR. PITEGOFF: Can you spell that?
THE WITNESS: Yes. O-n-d-u-o.
So it's a product that has been put out by MGM where patients who have diabetes that isn't controlled have access to a team of support which would be people that would talk to them: Hi, we noticed your sugar isn't going well, what are you eating? What is going on?
And then if it's not controlled, they'll ramp it up up to an endocrinologist and they will give her a continuous glucose monitor system.
So this clearly shows sometimes there's a team approach that has to happen, a layered approach, to get a diabetic controlled.
So we sent her for that and that just literally came out in April and I told her about that and then we are going to try to get her into another endocrinologist and we told her we would make the appointments for her.
Q. Okay. So that product that you

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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?

A. All of the referrals that you would see in the things that I sent.
Q. Do you have any recollection of any specific referrals with regard to the ulcer aside from the wound care treatment?
A. No, there would be no other. I would probably -- what I've talked to her also in the past and we actually did an arterial ultrasound. I wanted to make sure she didn't have compromised blood flow in her lower extremities and that was partly why I wanted her to see a cardiologist.
Q. Okay. Did she take advantage of those copay cards that you gave her?
A. Uh-huh.
Q. Is that a yes?
A. Yes.
Q. And the samples of insulin, did she utilize those, do you know?
A. Yes.
Q. Okay. There is a past medical history reported of Dupuytren's--
A. Contracture.
Q. Which is a difficult word for me. It's D-u-p-u-y-t-r-e-n-s.
Can you tell me your understanding of

her history with regard to that diagnosis?
A. What I remember is that she came to the office and she had been assessed by outside physicians for this case and talked to them about the Dupuytren's contracture and she went like this. So I wasn't aware of it until just recently.
Q. Okay. So do you have any opinion as to the etiology of that condition?
A. No.
Q. Okay. Is it fair to describe Mrs. Farris as a consistently noncompliant patient throughout the years that you treated her?
A. I don't want to use the word noncompliant, but she did not comply with recommendations.
Q. Okay. Was critical care neuropathy, as documented in some of your notes including the March 22nd, 2018 note, is that a diagnosis that you ever made?
A. I think I did make that and it was her presentation after she came out of the skilled nursing facility and it wasn't done objectively, it was subjectively, but her presentation was

grossly different after she came out of the hospital.
Q. Okay. And do you have an opinion as to the etiology of the foot drop?
A. Well, she did not have foot drop before.
Q. I understand that, but do you have an opinion as to the specific etiology of the foot drop?
A. No, sir.
Q. Okay. Now, you had mentioned that you don't want to describe Mrs. Farris as a noncompliant patient.
Is it fair to say you would prefer not to describe any patient in those terms?
A. I think the word noncompliant in this particular case would -- has a negative connotation. I feel it's important that people understand that when people don't comply there's lots of reasons why and I try to figure out why so we can overcome them.
Q. I understand that.
But is your hesitance to describe Mrs. Farris as a noncompliant patient due to the fact that you believed that there may be a very

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.

Q. Okay. Is she still using a walker at this point?
A. I would say most of the time I always see her with a walker, yes. She still has drop foot.
Q. In one foot; correct?
A. One foot.
Q. Do you know her weight at this point?
A. Off the top of my head, no. Let me see what she is here.
Q. That's okay. It was 162 –
A. I would say 140.
Q. Okay. So she's lost a little bit of weight?
A. Yes.
Q. Okay. What is the current state of her anxiety problem, do you know?
Does she still have an anxiety problem?
A. Is she anxious at times? We don't talk about the anxiety much now. We haven't discussed that.
Q. So it's not a complaint that she's raised to you lately?
A. Well, no, she didn't say I'm anxious. I think they have a lot of things going on.

Q. Sure.
Is she being – is she receiving any medications for anxiety?
A. It says alprazolam, but I don't think I've written that for a while.
Q. Okay. So as far as you are aware, anxiety is not an ongoing medical problem for Ms. Farris?
A. I would say it's not a major issue for her.
Q. All right. What about depression?
What is the state of her depression at this point, as far as you know?
A. Titina and her husband are very private people so if I were to ask them directly: Are you depressed or are you anxious – I mean I had kind of characterized before she's like a glass half full. They always try to make things better, you know.
Q. Sure.
A. So I would say that when they describe situations to me, I get a sense that there's a lot of anxiety-provoking situations, but she doesn't come in and say she's anxious, she's hopeful.

Q. Do you treat her for depression?
A. She's on Cymbalta.
Q. And that's a prescription that you write?
A. Right, but it's also used for neuropathy.
Q. And, sure, that's part of the reason I'm asking.
A. Got it. I would say that it's not something we really go into.
Q. So it's not a complaint that she regularly raises with you?
A. Right. I think my focus is always – like if I have a whole set of problems I have to deal with, it's the diabetes and the cholesterol that I'm really focusing on.
Q. Okay. So diabetes and cholesterol would be the focus of your concerns that you address with Mrs. Farris in your appointments with her, is that fair to say?
A. Uh-huh.
Q. Yes?
A. Yes.
Q. Okay. At the last time you saw her, I want to ask you if you feel she needs certain

things, okay?
Do you believe that she needs bilateral custom foot orthoses?
A. Yes.
Q. A manual wheelchair?
A. I would think she would need it at times, yes.
Q. Power wheelchair?
A. We don't talk often about her activities of daily living, what she does in the house, a lot. So I would have to question her on that.
When I watch her walk and how she has to step up her leg because of the dropped foot, I would imagine it would tire her out. She has thin legs. So her walking appears to take effort.
So I would imagine during the course of the day a person would like to sit and if she needs a power wheelchair, it would – she would have to go through questions, specifically about that, but I could see that.
Q. So are you saying, yes, you do believe that –
A. Yes.

Q. – or you don't know?
Okay. Does she need a wheelchair assessable van with portable ramps, in your opinion?
A. I don't have an opinion.
Q. All right. How about a Hoyer lift, is that something she needs, in your opinion?
A. What is a Hoyer lift?
Q. It's one of those lifts –
A. Like someone is paralyzed and they lift them out and put them in a pool?
Q. It's the bedside lift where you go from a sitting position and the Hoyer lift lifts the person and puts them in the bed?
A. Well, she walks. I don't know.
Q. Would that be a no?
A. I would say I have no opinion.
Q. If she asked you to order a Hoyer lift, would you do that?
A. No.
Q. Okay. Because you don't think it's indicated?
A. Well, she would have to tell me why. Like she might tell me a story that she needs it.
Q. No, I understand that.

A. But barring a conversation of how hard it is for her to get in her bed at the end of the day, those are the discussions we've never had.
Q. Okay. But what I'm asking is based on your understanding, as you sit here today of her medical condition, the complaints that she needs – that she's made to you, do you – would you say that she needs these without having to further discuss the issue with her?
A. No.
Q. All right.
A. I do not think so.
Q. And what about the power wheelchair? Do you believe – you said yes earlier, but now –
A. Yes.
Q. Okay. All right. What about a personal care attendant? Do you believe she needs that?
A. What does a personal care attendant do?
Q. Well, how about a daily attendant to visualize the heels and assess for pressure ulcers and impaired tissue integrity? Do you think she needs that?
A. That is someone outside of her looking

at her feet?
Q. Yes.
MR. PITEGOFF: I'll object to speculation and foundation and calls for expert opinion.
Q. (BY MR. COUCHOT) You can still answer.
Do you believe, as her treating physician, that she needs a daily attendant to visualize her heels to assess for pressure ulcers and impaired tissue integrity?
A. I think that Titina and her husband are capable of assessing her feet. I am not clear what personal attendants do and she may need a personal attendant. She never comes to the office alone.
Q. Okay. So fair to say that you do not believe she needs a daily attendant, a person for daily attendant care, to visualize her heels to assess for pressure ulcers and impaired tissue integrity?
MR. PITEGOFF: Objection to form.
THE WITNESS: Specifically?
Q. (BY MR. COUCHOT) Yes, specifically that.
Fair to say you do not believe she

needs that?
A. I think Titina and her husband are capable of looking at her feet.
Q. Okay. What about pressure relief ankle foot orthoses for nighttime use, do you believe –
A. Yes.
Q. Okay. What about pain management, ongoing pain management treatment by a pain management specialists, do you believe she needs that?
A. Absolutely.
Q. What about a plastic surgery consultation? Do you believe she needs that?
A. Yes.
Q. What for?
A. Well, she had a hernia on her abdomen and then she had the revision, and she has this large weakness in her abdominal wall.
Q. What about an orthopedic consultation, do you believe she needs that?
MR. PITEGOFF: Can I just have a standing objection to the foundation, form, calls for an expert opinion?
MR. COUCHOT: Sure.

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MR. PITEGOFF: Go ahead and answer. That way I don't have to interrupt each time.
THE WITNESS: I think she would benefit from seeing an orthopedist.
Q. (BY MR. COUCHOT) To address which specific issue?
A. I'm not an orthopedist. Seeing a physiatrist perhaps about her mobility, how she can walk, exercising.
Q. Okay. So you think PM and R would be a more appropriate recommendation than an orthopedic surgeon –
A. Yes.
Q. – from the perspective of an internal medicine physician?
A. Yes.
Q. Okay. What –
A. I think she would benefit from that.
Q. What about psychology or psychiatry consultations, do you think those are required for Ms. Farris?
A. Yes.
Q. What about podiatry?
A. Yes.
Q. A dietitian consultation?

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A. Yes.
Q. Physical therapy?
A. Yes.
Q. Occupational therapy?
A. We haven't talked a lot about her hands so I don't have a comment on that. It doesn't –
Q. Don't know, is that a fair answer?
A. Don't know.
Q. All right. Massage therapy?
A. Yes.
Q. Acupuncture?
A. Yes.
Q. Continued wound care?
A. Last time I looked at her foot it was okay.
Q. So not at this point?
A. Not at this point.
Q. Trigger point injections?
A. Yes.
Q. Is there any reason why there weren't recommendations for trigger point injections in the past considering that she's had an ongoing issue with back pain for – since at least 2014?
A. Well, I think my focus mainly was the diabetes. So if I were to bring in that as well,

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and I didn't get her to the endocrinologist, it wouldn't – I wouldn't focus on that.
Q. Got it. Bigger priorities?
A. Yes.
Q. Okay. Carpal tunnel release, do you think that's a procedure that's indicated for her at this point?
A. I don't know.
MR. COUCHOT: Okay. I don't have any other questions for you.
Thank you very much.
THE WITNESS: You are welcome.
MR. COUCHOT: So I'm going to pay you for an hour and a half of your time, is that okay?
THE WITNESS: Yes.
MR. PITEGOFF: Well, I have one question. I think you actually earlier mentioned it. I just wanted to make sure.
In your records you didn't note that there was any foot drop prior to the surgery in July of 2015?
THE WITNESS: She had no foot drop.
MR. PITEGOFF: Then I've got nothing more. Thanks.

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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.)
* * * *

NAOMI L. CHANEY, M.D. - 05/09/2019

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, CCR #203

ERRATA SHEET

I declare under penalty of perjury that I have read the foregoing ____ pages of my testimony, taken on _____ (date) at _____ (city), _____ (state), and that the same is a true record of the testimony given by me at the time and place herein above set forth, with the following exceptions:

Page	Line	Should read:	Reason for change:
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Signature of Witness

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Name Typed or Printed

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CLERK OF THE COURT

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

GEORGE F. HAND, ESQ.
Nevada Bar No.: 8483
HAND & SULLIVAN, LLC
3442 N. Buffalo Drive
Las Vegas, Nevada 89129
Phone: (702) 656-5814
Email: GHand@HandSullivan.com

Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC et al., Defendants.	CASE NO.: A-16-739464-C DEPT. NO.: XXXI

PLAINTIFFS' TRIAL BRIEF REGARDING THE TESTIMONY OF DR. BARRY RIVES

COMES NOW Plaintiffs PATRICK FARRIS and TITINA FARRIS, by and through their attorney of record, KIMBALL JONES, ESQ. and JACOB G. LEAVITT, ESQ., with the Law Offices of **BIGHORN LAW** and GEORGE F. HAND, ESQ., with the Law Offices of **HAND & SULLIVAN, LLC**, and hereby submit this Trial Brief Regarding the Testimony of Dr. Barry Rives.

///

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.

DATED this 29th day of October, 2019.

BIGHORN LAW

By: */s/ Kimball Jones*
KIMBALL JONES, ESQ.
Nevada Bar.: 12982
JACOB G. LEAVITT, ESQ.
Nevada Bar No.: 12608
716 S. Jones Blvd.
Las Vegas, Nevada 89107

GEORGE F. HAND, ESQ.
Nevada Bar No.: 8483
HAND & SULLIVAN, LLC
3442 N. Buffalo Drive
Las Vegas, Nevada 89129

Attorneys for Plaintiffs

MEMORANDUM OF POINTS AND AUTHORITIES

I. STATEMENT OF RELEVANT FACTS

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 twelve (12) 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 "bilateral foot drop" and now cannot walk without assistance.

Defendants intend to call Defendant Dr. Barry Rives to testify a second time in this matter—despite Dr. Rives already providing over six (6) hours of trial testimony in this matter. In order to ensure that Dr. Rives does not exceed the scope of his testimony, or violate the agreement which was already reached between the parties and this Court in this matter (*noting that Dr. Rives will not opine on topics already addressed in his previous trial testimony*), Plaintiffs' bring this Trial Brief to Limit Dr. Rives' Testimony.

II. LEGAL ARGUMENT AND ANALYSIS

A. Dr. Rives Cannot Testify as an "Expert" in this Matter.

Defendant Rives has not been named as a testifying expert in this matter. See *Defendant's 16.1 Disclosure*, attached hereto as **Exhibit "1."**

At Dr. Rives' deposition, Defense Counsel repeatedly objected and/or would not allow Dr. Rives to answer questions deemed as "expert" opinion. The following are several such examples:

> Q And she goes on to state, "The mesh was 8 not well incorporated. I could see the purple plastic tackers." Do you have an opinion as to why, assuming this is correct, the mesh was not well incorporated when she operated on the 16th?
> MR. COUCHOT: Objection. Calls for speculation. Lacks foundation. Calls for an expert opinion.
> ...
> Q Further down, it says, "Underlying this 25 was what appeared to be the transverse colon with about a quarter size or about a 2.5 to 3 cm hole with semi chronic

appearing edges. Around it, there was active leak of green feculent material and free air". Do you have an opinion as to when that hole appeared that I'm referring to, 2.5 to 3 centimeter hole?
MR. COUCHOT: Objection. Calls for speculation. Seeks expert opinion. I'm not going to let him give a retrospect of the analysis. If he had thoughts about what he was doing at the time, I mean, I think you're entitled to that.
...
Q Do you have an opinion as to timeframe where the reoperation would have avoided a colostomy to the patient?
MR. COUCHOT: Objection. Lacks foundation. Calls for an expert opinion.
...
Q Dr. Rives, what is your understanding of the standard of care applicable to the treatment of this patient.
MR. COUCHOT: Well, I am going to object. It calls for an expert opinion –
MR. HAND: Well let me define it.
BY MR. HAND: Q Would it be a reasonable physician under the circumstances? Does that sound –
A It sounds vaguely like that. There are some parts regarding the community, herein, et cetera, et cetera. Vague.
Q So do you feel or have the opinion that you met the standard of care in your treatment of Mrs. Farris?
EURBGS: **I'm going to object. Again, we're not going to disclose him as an expert opinion**. I will let you answer that narrow question, though, as to whether you believe you reached the standard of care -- or whether you were within the standard of care.
...
Q Do you have any opinion as to the cause of these holes in the bowel?
MR. COUCHOT: Objection. Calls for an expert opinion. I'm not going to let you answer if -- but do you have an opinion?
THE WITNESS: It's hard to say without speculation. He mentions ulceration. And his differential includes ischemia, rare diverticulitis and/or prior procedures of surgery. Other than that, I can't comment.

See *Deposition of Defendant Rives*, attached hereto as **Exhibit "2,"** at Pages 74:7-15, 74:24-75:13, 78:7-11, 96:13-97:8, 99:2-11. (Emphasis added).

Given Defendants' position at deposition, it is clear they have waived any right to have Dr. Rives testify as an expert in this matter.

Moreover, the Court has noted that opinions on Standard of Care **must** come from medical experts, "We conclude that medical expert testimony regarding standard of care and causation must be stated to a reasonable degree of medical probability." *Morsicato v. Sav-On Drug Stores, Inc.*, 121 Nev. 153, 158, 111 P.3d 1112, 1116 (2005).

///

As Defendants have refused to name Defendant Rives as a medical expert in this matter and refused/objected to questions believed to be "expert" in nature, it would be improper for Dr. Rives to now render expert testimony at Trial.

An expert witness' qualifications and expertise, as well as the content of the expert's opinions, are analyzed under the criteria set out in NRS 50.275, which includes three foundational tests that every expert must pass in Nevada in order to testify in this state.

N.R.S. 50.275 states:

> If ***scientific, technical or other specialized knowledge*** ***will assist the trier of fact*** to understand the evidence or to determine a fact in issue, a witness qualified as an expert by special knowledge, skill, experience, training or education ***may testify to matters within the scope of such knowledge.***
>
> (Emphasis added).

In order to testify as an expert witness, the witness must satisfy the following three requirements: (1) he or she must be qualified in an area of scientific, technical or other specialized knowledge; **(2) his or her specialized knowledge must assist the trier of fact to understand the evidence or to determine a fact in issue; and (3) his or her testimony must be limited to matters within the scope of his or her specialized knowledge.** N.R.S. 50.275, *Hallmark v. Eldridge*, 124 Nev. 492, 189 P.3d 646 (2008). If an expert fails to satisfy any one of the three prongs listed above, the expert will fail to satisfy the foundational requirements for testimony and his or her opinions will not be permitted at trial.

In determining whether an expert's opinion is based upon **reliable methodology**, a district court should consider whether the opinion is **(1) within a recognized field of expertise; (2) testable and has been tested; (3) published and subjected to peer review; (4) generally accepted in the scientific community; and (5) based more on particularized facts rather than assumption, conjecture, or generalization**. *Id.* (Emphasis added).

///

Dr. Rives has not offered an expert report in this matter. Furthermore, Dr. Rives has not demonstrated that he is qualified as an expert to opine. Plaintiffs were unable to depose Dr. Rives on any "expert opinions," as he claimed to not have any. As such, precluding Dr. Rives' testimony as to the standard of care is the only appropriate way to prevent testimony by ambush by Dr. Rives.

Defendants may attempt to argue that as a treating physician, he is allowed to present expert opinions. The Supreme Court of Nevada exempts treating physicians from written expert reports pursuant to NRCP 26—but only for opinions formed during the course of treatment:

> While a treating physician is exempt from the report requirement, this exemption only extends to "**opinions [that] were formed during the course of treatment.**" *Goodman v. Staples the Office Superstore, L.L.C.*, 644 F.3d 817, 826 (9th Cir.2011); see *Rock Bay, L.L.C. v. Eighth Judicial Dist. Court*, 129 Nev. ——, —— n. 3, 298 P.3d 441, 445 n. 3 (2013) (noting that when an NRCP is modeled after its federal counterpart, "cases interpreting the federal rule are strongly persuasive"). Where a treating physician's testimony exceeds that scope, he or she testifies as an expert and is subject to the relevant requirements. *Goodman*, 644 F.3d at 826.
>
> *Id.* at P.3d 445. (Emphasis added).

Here, Dr. Rives did not disclose a report with conclusions based on a reasonable degree of medical probability, nor did Dr. Rives disclose a report setting forth what opinions he formed during his treatment of Plaintiff Titina Farris. In fact, Dr. Rives did not disclose an expert report at all. Certainly, expert matters as to standard of care and the like, **would not** have been "formed during the course of treatment" in this matter and could only be formed by an expert after such treatment had been rendered – hence defining "expert opinions." Therefore, as Dr. Rives did not prepare an expert report in this matter and as he refused to divulge such expert opinions at deposition, Dr. Rives is properly precluded from offering any expert opinions, such as standard of care, at trial.

B. Dr. Rives Must be Limited from Addressing Topics and Testimony Already Given in this Matter.

As the Court is well aware, Dr. Rives and Plaintiffs agreed that Dr. Rives may testify, but he is not permitted to re-visit topics already discussed during his earlier testimony. Plaintiffs believe that

In *Hallmark*, the Supreme Court found that the district court had abused its discretion when it allowed expert witness Dr. Bowles to testify because his testimony and report did not meet the qualifications of the "reliable methodology" test. *Hallmark* at 502.

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).

Defendants have already noted that Defendant Rives will not be testifying as an expert in this matter. However, this Court is warranted in precluding Dr. Rives from offering expert testimony, including testimony that Dr. Rives acted within the standard of care.

Defendants may attempt to "clean up" Dr. Rives' past testimony. Such an action would violate the agreement with this Court and Plaintiffs. Furthermore, allowing Defendant Rives to testify on matters already testified to will only lengthen these proceedings and tax this Court's schedule and resources. Therefore, Defendant Rives Must be Strictly Limited from giving testimony on subjects he has already testified to in this matter.

III. CONCLUSION

The above facts and law are offered to assist this Court with decisions that may arise during the direct examination and cross examination of Defendant Dr. Rives in this matter.

DATED this 29th day of October, 2019.

BIGHORN LAW

By: */s/ Kimball Jones*
KIMBALL JONES, ESQ.
Nevada Bar.: 12982
JACOB G. LEAVITT, ESQ.
Nevada Bar No.: 12608
716 S. Jones Blvd.
Las Vegas, Nevada 89107

GEORGE F. HAND, ESQ.
Nevada Bar No.: 8483
HAND & SULLIVAN, LLC
3442 N. Buffalo Drive
Las Vegas, Nevada 89129

Attorneys for Plaintiffs

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 29th day of October, 2019, I served the foregoing ***PLAINTIFFS' TRIAL BRIEF REGARDING THE TESTIMONY OF DR. BARRY RIVES*** 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"

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

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

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

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al., Defendants.	CASE NO. A-16-739464-C DEPT. NO. 31 **DEFENDANTS BARRY RIVES, M.D.'S AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S FIFTH SUPPLEMENT TO NRCP 16.1 DISCLOSURE OF WITNESSES AND DOCUMENTS**

Under the authority of Rule 16.1(a)(1) of the Nevada Rules of Civil Procedure, Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC hereby submits this fifth supplemental list of witnesses and documents as follows (the new information is in bold):

///

A. LIST OF WITNESSES

1. Titina Farris
c/o George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129

Ms. Farris is expected to testify regarding the facts and circumstances giving rise to this action.

2. Patrick Farris
c/o George F. Hand, Esq.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129

Mr. Farris is expected to testify regarding the facts and circumstances giving rise to this action.

3. Barry Rives, M.D.
c/o Thomas J. Doyle
Schuering Zimmerman & Doyle, LLP
400 University Avenue
Sacramento, CA 95825

Dr. Rives is expected to testify regarding the facts and circumstances surrounding this matter, including his care and treatment of Plaintiff Titina Farris.

4. Person Most Knowledgeable
Laparoscopic Surgery of Nevada
c/o Schuermg Zimmerman & Doyle, LLP
400 University Avenue
Sacramento, Califomia 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
40 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

Addison Durham 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
Care Meridian
3391 N. Buffalo Drive
Las Vegas, NV 89129

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

16. Gregg Ripplinger M.D.
10001 S Eastern Ave #201
Henderson, NV 89052
(702) 914-2420

Dr. Ripplinger is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

17. Thomas Gebhard, M.D.
2400 S Cimarron Rd Ste 100
Las Vegas, NV 89117
(702) 477-0772

Dr. Gebhard is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

18. Matthew Treinen D.O.
5495 S Rainbow Blvd Ste 203
Las Vegas , NV 89118
(702) 477-0772

Dr. Treinen is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

19. Ravishankar Konchada M.D.
5495 S Rainbow Blvd, Suite 101
Las Vegas, NV, 89118
(702) 477-0772

Dr. Konchada is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

20. Tanveer Akbar M.D.
520 Fremont Street
Las Vegas, NV 89101
(702) 382-5200

Dr. Akbar is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

21. Kenneth Mooney M.D.
10001 S Eastern Avenue, Suite 203
Henderson, NV 89052
(702) 616-5915

Dr. Mooney is expected to testify about the care, and treatment, and diagnosis of

Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

22. Alka Rebentish M.D.
6088 S Durango Drive 100
Las Vegas, NV 89113
(702) 380-4242

Dr. Rebentish is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

23. Arvin Gupta M.D.
6970 W Patrick Lane, Suite 140
Las Vegas, NV 89113
(702) 588-7077

Dr. Gupta is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

24. Ali Nauroz M.D.
657 N Town Center Drive
Las Vegas, NV 89144
(702) 233-7000

Dr. Nauroz is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

25. Syed Zaidi M.D.
9280 W Sunset Road, Suite 320
Las Vegas, NV 89148
(702) 534-5464

Dr. Zaidi is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

26. Ashraf Osman M.D.
5380 S Rainbow Blvd, Suite 110
Las Vegas, NV 89118
(725) 333-8465

Dr. Osman is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

27. Charles McPherson M.D.
3121 Maryland Pkwy #502
Las Vegas, NV 89109
(208) 415-5795

Dr. McPherson is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

28. Teena Tandon M.D.
6970 W Patrick Lane, Suite 140
Las Vegas, NV 89113
(702) 588-7077

Dr. Tandon is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

29. Farooq Shaikh M.D.
3880 S Jones Blvd
Las Vegas, NV 89103
(702) 636-6390

Dr. Shaikh is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

30. Howard Broder M.D.
2865 Siena Heights Drive, Suite 331
Henderson, NV 89052
(702) 407-0110

Dr. Broder is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

31. Doreen Kibby PAC
2865 Siena Heights Drive, Suite 331
Henderson, NV 89052
(702) 407-0110

Dr. Kibby is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

32. Herbert Cordero-Yordan M.D.
2300 Corporate Circle, # 100
Henderson, NV 89074
(702) 731-8224

Dr. Cordero-Yordan is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

33. Darren Wheeler, M.D.
4230 Burnham Avenue
Las Vegas, NV 89119
(702) 733-7866

Dr. Wheeler is expected to testify about the care, and treatment, and diagnosis of Mrs. Farris at St. Rose Dominican Hospital - San Martin Campus.

B. DOCUMENTS

1. Medical and billing records from Laparoscopic Surgery of Nevada (BR000001-BR000049).

2. Medical records from St. Rose Dominican Hospital (previously produced by plaintiffs.)

3. Medical records from Dr. Barry Rives (previously produced by plaintiffs.)

4. Medical records from Dr. Noami Change (previously produced by plaintiffs.)

5. Medical records from Dr. Elizabeth Hamilton (previously produced by plaintiffs.)

6. Photographs of plaintiff Titina Farris (previously produced by plaintiffs.)

7. Medical and billing records from Desert Valley Therapy (previously produced by plaintiffs.)

8. Medical and billing records from Dr. Hamilton (previously produced by plaintiffs.)

9. Medical and billing records from St. Rose Dominican Hospital - San Martin Campus for July 2015 admission (previously produced by plaintiffs.)

10. Medical and billing records from St. Rose Dominican Hospital - San Martin Campus for July 2016 admission (previously produced by plaintiffs.)

11. Medical records from Dr. Chaney (previously produced by plaintiffs.)

12. Billing records from Dr. Chaney (previously produced by plaintiffs.)

13. Medical and billing records from Advanced Orthopedics & Sports Medicine (previously produced by plaintiffs.)

14. Diagnostic films taken at St. Rose Dominican Hospital (previously produced by plaintiffs.)

15. Video of Titina Farris taken by Lowell Pender on April 15, 2015 (previously produced by plaintiffs.)

16. Videos of Titina Farris, Patrick Farris, Addision Durham, Lowell Pender and Sky Prince (previously produced by plaintiffs.)

17. Marriage certificate (previously produced by plaintiffs.)

18. Medical and billing records from Dr. Steven Y. Chinn (previously produced by plaintiffs.)

19. Medical and billing records from Care Meridian (previously produced by plaintiffs.)

20. Billing records from St. Rose Dominican Hospital - Siena Campus (BR-SRDSB000001-BR-SRDSB000015);

21. Medical and billing records from Dr. Elizabeth Hamilton (BR-HAMILTON000001-BR-HAMILTON000073);

22. Records of Bess Chang, M.D. (CHANG000001-CHANG000008) (CD will be mailed);

23. Advanced Orthopedics & Sports Medicine (AOSM000001-AOSM000029) (CD will be mailed);

24. Certificate of no imaging from Dr. Chang (CHANG-CNR-IMAGING000001-

CHANG-CNR-IMAGING000002);

25. Medical records from Southern Nevada Pain Center (SNPC000001-SNPC000051) (CD will be mailed);

26. Medical records from Internal Medicine of Spring Valley (IMSV000001-IMSV000888) (CD will be mailed);

27. Medical records from Care Meridian (CM000001-CM000299) (CD will be mailed);

28. Certificate of no imaging from Dr. Hamilton (HAMILTON-CNR-IMAGING000001-HAMILTON-CNR-IMAGING000002) (CD will be mailed);

29. Medical records from ATI Physical Therapy (ATI000001-ATI000081) (CD will be mailed);

30. Medical records from St. Rose Dominican Hospital - Siena Campus (BR-SRDSM000001-BR-SRDSM000927) (CD will be mailed);

31. Certificate of no imaging from St. Rose Dominican Hospital - Siena Campus (BR-SRDM-CNR-IMAGING000001-BR-SRDM-CNR-IMAGING000002) (CD will be mailed);

32. Dr. Bart Carter's expert report (previously produced);

33. Dr. Brian Juell's expert report (previously produced);

34. Dr. Carter's rebuttal expert report (previously produced);

35. Dr. Juell's rebuttal expert report (previously produced);

36. Dr. Lance Stone's rebuttal expert report (previously produced);

37. Sarah Larsen's rebuttal expert report (previously produced);

38. Dr. Bruce Adornato's rebuttal expert report (previously produced);

39. Dr. Kim Erlich's rebuttal expert report (previously produced);

40. Dr. Scott Kush's rebuttal expert report (previously produced);

41. Erik Volk's rebuttal expert report (previously produced);

42. Dr. Erlich's supplemental expert report;

43. Dr. Juell's supplemental expert report;

44. Dr. Adornato's supplemental expert report;

45. Dr. Adornato's Stanford Profile;

46. Article: The Natural History of Chronic Painful Peripheral Neuropathy in a Community Diabetes Population;

47. Article: The Natural History of Painful Diabetic Neuropathy - a 4-year Study.

Defendants reserve the right to supplement this list of documents as discovery continues and to submit any exhibit of any other party. Said Defendants further reserve the right to amend this list of witnesses, documents and tangible items should, during the course of the discovery of this matter, additional witnesses and documentation become known to defendants or defendants' counsel. Defendants hereby incorporate all documents produced by the parties in their Early Case Conference Disclosures and supplements by reference.

Dated: September 23, 2019

SCHUERING ZIMMERMAN & DOYLE, LLP

By _____

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

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 23rd day of September, 2019, service of a true and correct copy of the foregoing:

DEFENDANTS BARRY RIVES, M.D.'S AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S FIFTH SUPPLEMENT TO NRCP 16.1 DISCLOSURE OF WITNESSES AND DOCUMENTS

was served as indicated below:

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

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

☐ by depositing in the United States Mail, first-class postage prepaid, enclosed ;

☐ by facsimile transmission; or

☐ by personal service as indicated.

Attorney	Representing	Phone/Fax/E-Mail
George F. Hand, Esq. HAND & SULLIVAN, LLC 3442 North Buffalo Drive Las Vegas, NV 89129	Plaintiff	702/656-5814 Fax: 702/656-9820 hsadmin@handsullivan.com
Kimball Jones, Esq. Jacob G. Leavitt, Esq. BIGHORN LAW 716 S. Jones Boulevard Las Vegas, NV 89107	Plaintiffs	702/333-1111 Kimball@BighornLaw.com Jacob@BighornLaw.com

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

EXHIBIT "2"

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS,

Plaintiffs,

vs.

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

Defendants.

CASE NO A-16-739464-C
DEPT NO 22

DEPOSITION OF BARRY RIVES, M.D.

Taken on October 24, 2018

At 10:07 a.m.

At Veritex Las Vegas

2250 South Rancho Drive, Suite 195

Las Vegas, Nevada 89102

Reported by: Yvette Rodriguez, CCR NO. 860

APPEARANCES:

For the Plaintiffs:

BY: GEORGE F. HAND, ESQ.
HAND & SULLIVAN, LLC
3442 North Buffalo Drive
Las Vegas, NV 89129
702-656-5814
ghand@handsullivan.com

For the Defendants:

BY: CHAD C. COUCHOT, ESQ.
SCHUERING ZIMMERMAN & DOYLE, LLP
400 University Avenue
Sacramento, California 95825-6502
(916) 567-0400
ccc@szs.com

Also Present:

Leslie Smith, JD, MPH,
Senior Claims Specialist
PRO ASSURANCE
3800 Howard Hughes Parkway
Suite 550
Las Vegas, Nevada 89169
lesmithproassurance.com

LAS VEGAS REPORTING
scheduling@lvreporting.com
702.803.9363

I N D E X

WITNESS: BARRY RIVES, M.D.

-oOo-

EXHIBITS

LAS VEGAS REPORTING
scheduling@lvreporting.com
702.803.9363

LAS VEGAS, NEVADA, OCTOBER 24, 2018

10:07 a.m.

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

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Whereupon,

BARRY RIVES, M.D.,

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

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MR. HAND: We're premarking certain records as exhibits in this deposition. I will just read what we have premarked: Exhibit 1, Dr. Rives' office records. Exhibit 2, Dr. Rives' progress notes. Exhibit 3, operative report of July 3, 2015. Exhibit 4, operative report of August 7, 2014. Exhibit 5,

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702.803.9363

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

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

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EXAMINATION

-oOo-

BY MR. HAND:

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

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

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

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

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

A Yes.

Q About how many times?

A Five or seven.

Q In what — under what circumstances were those taken?

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

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

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

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

A Yes.

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

A Yes, I am.

Q And when were you licensed?

A I got my license in 2003.

Q Do you have any specialty?

A General surgery.

Q Where do you currently have hospital privileges?

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

Q What medical school did you attend?

A Hahnemann University in Philadelphia, PA.

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

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

Q What years did you do the residency?

A 1998 to 2003.

Q When did you come to Nevada?

A 2003.

Q Did you ever practice medicine in any other state?

A No, I have not.

Q Do you have any fellowships in any field?

A No, I do not.

Q Or are you board certified in any field?

A No, I do no.

Q Have you taken any board certification exams?

A Yes, I have.

Q What have you taken?

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

Q When did you take that?

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

Q Did you pass those tests?

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

Q Are you planning on applying again for that certification?

A I actually have considered that, yes.

Q So you took it one time and then --

A Yes.

Q Do you have any special training in laparoscopic procedures?

A I did during my fourth and fifth year of

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

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

A All laparoscopic hernias?

Q Yes. Prior to July '15?

A Well over five hundred.

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

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

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

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

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

Q Yes, for now.

A Okay.

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

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

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

[illegible] were you part of a practice?

A My solo practice, yes.

Q Is that Laparoscopic Surgery of Nevada,

A That is correct.

Q How long has that been in existence?

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

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

A No.

Q Are there any other employees of [illegible]

A No.

Q [illegible]

A [illegible] Nevada 89113.

Q If I could direct you to Response No.

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

A It is still pending.

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

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

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

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

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

A Again, defense verdict. It was a patient with a peritoneal colon due to metastatic lymphoma,

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

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

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

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

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

Q Is that case resolved or ongoing?

A It was dismissed.

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

A I've testified as a participant in care.

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

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

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

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

had no known drug allergies.

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

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

Q What is a lipoma?

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

Q Where was it located?

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

Q At some point did you schedule a surgery?

A Yes, I did.

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

A I have it.

Q [illegible]

A [illegible]

Q [illegible]

A [illegible]

Q [illegible] procedure

by the open method?

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

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

A Yes.

Q See where I'm referring to?

"Note that there was an incarcerated ventral hernia"?

A Correct.

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

A I have some independent recollection, yes.

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

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

Q [illegible]

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

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

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

Which sac are you referring to, the hernia sac?

A Correct.

Q [illegible]

A [illegible]

Q [illegible] preperitoneal space?

A [illegible]

Q [illegible]

A [illegible]

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

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

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

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

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

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

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

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

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

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

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

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

A It looks like it was April 30, 2015.

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

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

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

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

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

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

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

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

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

obstructed.

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

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

Q Did you discuss the options with her?

A Yes.

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

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

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

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

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

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

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

A Yes.

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

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

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

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

Q -- in reviewing the records?
A I don't recall.
Q So what I'm asking you: There is no specific notes that you removed any mesh that was placed in the August '14 surgery?
A No.
Q Going to your report, under technique, where you state, "We began by reducing the hernia, taking down the omentum. The transverse colon is severely stuck and adhered to the prior mesh repair", do you recall how much of the bowel was stuck to the -- or the transverse colon stuck to the prior mesh repair?
A I know it was stuck in at least two places.
Q And you state, "Taking this down, we had used the LigaSure device to extract it from the mesh as the mesh would not come free from the skin".
What is the LigaSure device?
A The LigaSure is a ceiling and cutting device. So it will function by, first, sealing the tissue for coagulation purposes. And then it has an associated bladed for cutting.
Q Does it have thermal energy attached to it?

A It has some thermal energy, yes.
Q Did you consider using scissors or a nonthermal device to free the bowl or the colon from the mesh?
A When I assessed what instruments to use, it all depends on what the tissue looks like and what the mesh looks like. In some cases if the adhesions are a little less dense and that I can get away from using scissors, I'll do that. But if the tissue is fairly ingrained, I want to make sure that the tissues coagulate so you don't end up with a lot of bleeding. You just cut native tissue.
I hadn't used the harmonic scalpel in at least five or seven years because of the heat distribution from that particular instrument.
Q Thin you state, "The mesh would not come free from the skin". Can you tell me what you meant by that? What skin were you referring to --
A Well, it is actually referring to the mesh.
Q And you state, "In doing so, this created a small tear in the colon using Endo-GIA blue load".
What is a Endo-GIA blue load?
A An Endo-GIA is a laparoscopic stapling device. Again, it staples in two lines and then it

has a blade that divides. So that it will remove the tissue from the staple line.
Q Clarify this note. Did the small tear in the colon come from trying to get the mesh out of the -- I mean, getting the colon out of the mesh or was it created with the stapler? I don't understand.
A No. The colotomy was made by getting the colon off of the mesh. Once you have a hole in the colon, there is various ways to repair it. One of the ways is you use a stapling device to close the defect.
A Did Mrs. Farris have bowel prep prior to this procedure?
A No, she did not.
Q Did you recommend that?
A No.
Q Why not?
A I don't do val preps for any of my colon or bowel surgeries. It causes an inflammatory cascade. Nowadays, with enhance recovery after surgery, bowel preps are probably about -- most people don't do them 70 percent of the time. Some people are still doing them 30 percent of the time.
Q So do you recall the size of the tear in

the colon?
A I believe it was about 1 cm, to the best of my recollection.
Q Just to clarify this. You say you placed a 7x0 Venture light. Would that go -- the 7x9 is -- what measurement are you using for that?
A 7x9 inches.
Q So you then state that there was a second small colotomy. What is a colotomy?
A Hole in the colon.
Q Was this through the complete wall of the colon, these holes?
A Full thickness, yeah.
Q Both were full thickness?
A Yes.
Q So the second one, do you know the size of that one?
A It was also around 1 cm.
Q And how did you see these holes?
A Through the laparoscope, yes.
Q How far apart were those holes?
A It's kind of hard to say from an independent recollection. I -- I -- when you have -- it's not like you have the colon straightened out and you can make an exact

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

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

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

A Transverse colon.

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

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

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

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

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

A No.

Q [illegible]

A [illegible]

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

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

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

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

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

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

A Yes. Irrigate drain.

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

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

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

A Yes.

Q [illegible]

A [illegible]

Q [illegible]

A [illegible] It looked quite healthy.

Q The second colotomy, did it have any ragged edges?

A [illegible]

Q [illegible]

the second colotomy?

A I do not.

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

A Sure.

Q [illegible]

Q [illegible]

Q [illegible]

correct?

A Correct.

Q And why was that?

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

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

everything looked healthy, create an anastomosis.

Q So one of the reasons to go open is if there is issues with the integrity of the bowel; is that a fair statement?

A Yes.

Q So you didn't feel it was necessary?

A Correct.

Q How did you determine if the staple or the staple repair is satisfactory?

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

Q Is there an alternative way to repair a colotomy in the colon other than using a stapler?

A There is many ways.

Q Sutures can be used?

A Sutures can be used, yes.

Q Assuming a patient is converted to a laparotomy, can you still use staplers if you choose or would you use sutures or some other method?

A You could -- depending on what the bowel

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

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

A No, not really.

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

A Mrs. Farris?

Q Yes.

A Yes, you could.

Q You can suture?

A Yes.

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

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

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

constriction by closing it, then I would use sutures or, if necessary, a laparotomy and resect the bowel.

Q So you didn't notice any thermal injury to the colon or bowel during this procedure?

A No.

Q Can you see such a thermal injury, normally?

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

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

Explain to me how that works.

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

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

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

A I do not.

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

A I do not.

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

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

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

A Into the abdominal cavity.

Q Do you recall specifically where it was placed in abdominal cavity?

A You mean, how did I introduce it?

Q No. No. Where was it within the cavity.

A When you first place it in the intra abdominal cavity, you pull it up against the abdominal wall, and then you do an approximation and pack it into place.

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

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

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

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

A Yes.

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

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

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

A Yes, we met in the preoperative holding area.

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

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

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

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

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

A I do not recall.

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

A Yes, I do.

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

What is F/C?

A Fever and chills.

Q "Patient feels short of breath."

A Correct.

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

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

A I believe it was some time in the morning.

Q And reading your note from the first -- I

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

A 23 or 22?

Q If you look at the bottom --

MR. COUCHOT: Yeah, he misspoke --

BY MR. HAND:

Q Yeah, 2231.

A Okay.

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

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

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

A No.

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

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

What did you mean by worsening?

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

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

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

Q Do you know how much the abdomen was distended?

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

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

Q How did you characterize this distention?

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

Q Tympanitic, what does that mean?

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

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

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

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

A Yes, I do.

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

A Correct.

Q Okay. What is a normal white blood count?

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

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

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

Q Can you explain that to me.

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

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

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

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

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

Her saturations appear normal at that time.

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

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

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

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

A Supraventricular tachycardia.

Q So she had a rapid heart rate?

A Correct.

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

A No, I did not.

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

So you were considering laparotomy on July 5th?

A As one my possibilities of going forward, yes.

Q Why were you considering that?

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

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

A Correct.

Q What would the signs be of a leak?

A On a CT scan?

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

A Clinically, signs of a leak are very vague

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

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

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

A Yes.

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

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

Q All right. White blood count, 22.9, is

that elevated?

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

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

Q So at this point, did she have --

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

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

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

Q What is on the prior CT scan?**

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

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

Q Was Mrs. Ferris conscious or conscious, do

you have any recollection.

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

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

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

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

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

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

A I was also concerned about leakage from the bowel.

Q We go to the note.

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

(Off the record.)

BY MR. HAND:

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

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

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

A She had various degrees of distention the entire time.

Q Then you state -- well, the distention,

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

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

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

So do you remember speaking to the husband that day?

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

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

A It does not appear so.

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

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

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

A Again, in and of itself, no.

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

A Correct.

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

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

A That she's clinically getting worse.

Q Based on what factors?

A New running fevers, increased white cell

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

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

A Possibly.

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

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

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

So at this point, what is your

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

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

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

A In the continuum of her clinical evaluation, no.

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

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

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

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

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

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

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

A Correct.

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

A That I can remember, yes.

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

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

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

Who is Dr. Mono?

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

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

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

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

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

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

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

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

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

A In regards to?

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

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

take over as surgical consultant going forward.

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

A I don't recall.

Q Do you recall the substance of the conversation?

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

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

A I don't recall.

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

A Yes.

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

A The night prior.

Q The night of the 15th?

A Correct.

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

(Off the record.)

BY MR. HAND:

Q We are going to Exhibit 6. It is a

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

A Okay.

Q Have you seen this note prior to today?

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

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

A Yes.

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

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

Q So Dr. McPherson, do you know him?

A Dr. McPherson is an ICU doctor.

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

A Where does it say that?

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

A Yes.

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

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

Do you agree with that note?

A For what you read, yes.

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

Do you agree with that note?

A I have no reason to argue with it.

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

Do you agree with that statement?

A To the best of my recollection, yes.

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

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

A Normal.

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

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

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

A Normal.

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

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

Do you agree with that note?

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

Q Assuming that the CT showed air fluid

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

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

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

Do you agree with that note?

A Yes.

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

Do you agree with that assesment that

he states?

A Basically, yes.

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

A I don't think we did.

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

A Yes, I did.

Q Is she a general surgeon?

A Yes, she is.

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

A I don't believe I have.

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

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

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

anasarca, fever, leukocytosis, recent incisional hernia repair with prosthetic mesh, previous incisiona hernia repair, and then overweight.

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

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

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

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

means by not improving.

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

Anything you disagree with that note that I just read?

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

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

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

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

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

BY MR. HAND:

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

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

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

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

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

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

A Yes.

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

Do you have any indication how long that feculent would be sitting on the mesh prior to her operating on the 16th?

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

If you know it, you can answer.

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

BY MR. HAND:

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

Do you have an opinion as to why, assuming this is correct, the mesh was not well incorporated when she operated on the 16th?

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

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

BY MR. HAND:

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

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

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

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

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

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

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

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

MR. HAND: He's not going to be -- but the thing is under, you know, 41A, he is an expert. He's operating on people. And I think I'm entitled to expert opinions, whether you disclose him as such or not because, you know, he is, by all indications, he is an expert. He is a surgeon. He does the surgery. And I

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

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

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

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

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

What are you talk about?
[illegible]: Can you repeat the question and then we will see if he has an opinion and then we well --
(Record read.)
THE WITNESS: I don't think I can make an opinion about that without severe speculation.
BY MR. HAND:
Q Okay. Do you see later then, "she had a colostomy?
A [illegible]
Q [illegible]
A [illegible] at? "He felt that a colostomy"?
Q Yes.
A Okay. I'm there.
Q All right. It says -- I'm at the last page which is 48. "We brought out an ascending colon colostomy, which this morning is pink and viable and actually is already functioning". You see where I'm referring to?
A [illegible] in the Summarry paragraph?
Q Right.
A Correct.
Q So --

A Wait. Well, that's confusing because she writes, "Which this morning is pink and viable and actually is already functioning."
Q I think she said after the colostomy.
A It sounds like she's incorporating her postoperative note with her operative note.
Q Do you have an opinion as to timeframe where the reoperation would have avoided a colostomy [illegible] the patient?
MR. COUCHOT: Objection. Lacks foundation. Calls for an expert opinion.
THE WITNESS: [illegible]
BY MR. HAND:
Q [illegible]
A [illegible] would have been likely to have an ostotomy.
Q Why is that?
A Because if you try to repair a piece of bowelel initially and it fails, it usually fails for various reasons. If you try to just simply repair that, you're risking another leak and a whole other problem. So the more direct and safest route is to resect that and bring out an ostotomy.
Q Now, have you seen any records [illegible] -- [illegible]

Did you read the whole -- or review the whole chart from her admission record from the surgery from July 15 onward?
A Her entire medical record?
Q [illegible]
A No, I did not.
Q Are you aware of what her condition was when she was discharged?
A No, I do not.
Q I want go through this. I'm just going -- this has been marked as Exhibit 14. It is basically the consultation progress notes from July 4th up [illegible]
A [illegible]
Q [illegible] do you [illegible]
A He's a hospitalist.
Q Do you know him?
A Yes.
Q And do you see [illegible] 2239.
A Okay.

Q Do you see where he makes a note, white blood count -- well, on 2237, he says, "white blood count, 21.7. And then on 2239, he makes a note, "probable sepsis".
Did you ever discuss this patient with Dr. Akbar?
A I did, but I don't have any recollection.
Q If you did discuss it, would that be something in your tradition -- you know, normally it [illegible]
A [illegible] that day.
Q Are you able to review that note in your -- when you go see the patient?
A Yes.
Q Did you attach any medical significance to his [illegible] of probable sepsis?
A [illegible]
Q Did it give any heightened sense of awareness as to the possible sepsis?
A I don't know if I was aware that [illegible] mentioned sepsis or not. I don't have a recollection of it.
Q [illegible] is a

note by Dr. Mooney on Page 40.
A Which page?
Q If you look at Page 40. It's down at the bottom there.
A 2240?
Q No. No. 40.
A Just 40? They're not in order. That's okay. I got it. Electronically signed by Mooney, Kenneth.
Q Yeah. Do you ever recall discussing this patient with Dr. Mooney?
A I probably did, but I don't have an independent recollection.
Q He states at that point, "Patient aware of on guarded prognosis". Do you see that note on Page 40?
A Oh, on top. "Patient aware of guarded prognosis".
Q And if we go to Page 31 -- it's somewhere in there, but Dr. Shaikh. Is Dr. Shaikh an infectionous disease physician?
A There is a couple Dr. Shaikhs.
Q Farooq Shaikh?
A I would have to see the note. I went all the way to 34.

Q Page 31.
A Yeah, I don't -- let's see. Here it is. Infectious disease consultation?
Q Right.
And do you know know Dr. Farooq Shaikh?
A Yes.
Q Do you recall discussing this patient with Dr. Shaikh on July 4th?
A I don't have an independent recollection of that.
Q And Dr. Shaikh states -- if you go to Page 32, assessment and plan. "Status post reduction of incarcerated incisional hernia, operative nick to the colon and repair. Now with postoperative abdominal pain, distention, sepsis, leukocytosis, and fever. This can represent fecal peritonitis".
Did you review that note during that timeframe?
A I don't recall.
Q Would that cause you any concern if an infectionous disease doctor is making a note that it could be fecal peritonitis?
A No, because I was considering the same thing already.

Q What is fecal peritonitis?
A Basically, it's saying a leak in the colon.
Q So from July 4th up until July 15th, when you were not treating the patient anymore during that time period, how did you rule out fecal peritonitis?
A It's not that it was ever ruled out. It was always a consideration. It was a matter of the patient's clinical course, what her abdominal exam looks like, what her lab results were like, what her blood pressure, heart rate, ventilatory status, what the CT Scan showed, what the radiology of the report showed. It's a combination of all those factors. Nothing is ever ruled out completely until the patient is out of the hospital, eating, and eliminating.
Q Then if we go to -- there is a note from Dr. Shaikh on -- let me go back for a second. Also, on the 4th, there is a note from a Dr. Syed Zaidi. Do you know Dr. Zaidi?
Q He is a cardiologist, it looks like.
A There has to be an easier way for me to find these out. These are not in any record whatsoever. I mean, you have them labeled such,

but.
MR. COUCHOT: I found that particular one.
THE WITNESS: Is is that okay?
MR. HAND: Sure. Whatever is easier.
THE WITNESS: Yeah.
BY MR. HAND:
Q He makes a note of acidosis. What is acidosis?
Q Acidosis is a general term meaning that the -- from a cardiac standpoint, a renal standpoint, the patient's situation is more acidotic than it is Akoline and not back to hemostasis. Acidosis can be caused by -- there is a long list of diagnoses.
Q Yeah. If weg go to the note of Dr. Shaikh, the infectious disease doctor on the 5th. Are you able to pull it out there?
MR. COUCHOT: What is the Bates stamp?
MR. HAND: The Bates stamp on that is 2194.
THE WITNESS: I've got that.
BY MR. HAND:
Q Page 2195, he states, "Course worsening". And again says, "This can represent fecal peritenonitis". This is on the 5th that we're

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

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

A He is a hospitalist.

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

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

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

A Yes.

Q Why is that?

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

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

A I don't recognize the name.

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

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

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

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

A I have no independent recollection of reviewing this note.

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

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

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

A The day after surgery?

Q Yeah?

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

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

A No.

Q How come you didn't determine the source?

A Because there are consideration for the source.

Q Such as?

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

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

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

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

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

A Yes, it can.

Q Can you explain how that can happen.

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

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

Q And if we go to the same day, Page 2149. Dr. McPhearson's notes. It's July 6th. And Page 2149, does he state -- make a note also of sepsis?

A He makes a diagnosis of sepsis, yes.

Q And do you agree with that diagnosis?

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

Q In terms of sepsis?

A In regards to any of the diagnoses.

Q Is there a reason why or is that standard?

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

They don't change a lot of these in

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

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

A Repeat that page number for me, please.

Q 2033.

A Dr. Shaikh, 7/7/2015?

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

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

A No.

Q Why is that?

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

that point.

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

A Yes.

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

A No.

Q And why is that?

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

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

A In and of itself, none.

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

A From a non-surgeon, none.

Q Why is that?

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

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

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

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

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

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

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

A On the 10th?

Q Yes.

A I don't recall.

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

A No.

Q You're on Page 1867?

A Yes.

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

A Yes.

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

A I did not speak to Dr. Shaikh about theese assesments, as far as I can recollect.

Q On July 10th, was her course worsening?

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

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

A It doesn't sound familiar at all.

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

A I do.

Q Do you agree with that note of the

diagnosis of sepsis on that date --

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

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

Do you see that?

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

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

Do you see what I'm referring to?

A Yes.

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

A In her abdomen? On his exam?

Q Yes.

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

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

micor pending from yesterday".

Do you agree with that note?

A Well, let me withdraw that.

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

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

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

A 15, what?

Q Page 1590, Dr. Mooney.

A Okay.

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

A -- on Page 51

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

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

A What date?

Q On the 14th of July.

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

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

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

A I cannot find that one.

Q Okay.

A 1573?

Q Yes.

A Yeah.

Q Let me go to Page 1581 then.

A Alka Rebentish.

Q Is she an infectionous disease doctor?

A Yes.

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

A Yes.

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

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

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

A Correct.

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

A Yes.

Q Do you agree with that assessment on that date?

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

(Off the record.)

BY MR. HAND:

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

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

MR. HAND: Well let me deine it.

BY MR. HAND:

Q Would it be a reasonable phyoision under the oircustances? Does that sound --

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

Q So do you feel or have the opinion that

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

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

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

BY MR. HAND:

Q And why was that the basis for that statement?

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

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

A Surgical pathology report?

Q Yes. Have you seen that prior to today?

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

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

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

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

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

A Wait. You're on the next page?

Q Yeah. Page 8503.

A And approximately where on the page?

Q In the middle.

A Colon, serosa -- which?

Q Yes. Where it starts serosa.

A Serosa, okay.

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

A Correct.

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

A That's what the pathologist found,

apparently.

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

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

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

BY MR. HAND:

Q Where is that Hamilton report?

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

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

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

BY MR. HAND:

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

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

Q What is the basis for that?

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

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

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

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

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

MR. COUCHOT: Thank you.

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

-oOo-

(Whereupon, the deposition concluded at 2:11 p.m.)

CERTIFICATE OF DEPONENT

PAGE	LINE	CHANGE	REASON

* * * * *

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

BARRY RIVES, M.D., Deponent Date

CERTIFICATE OF REPORTER

STATE OF NEVADA)
) ss:
COUNTY OF CLARK)

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

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

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

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

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

YVETTE RODRIGUEZ, CCR NO. 860

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Steven D. Grierson
CLERK OF THE COURT

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

GEORGE F. HAND, ESQ.
Nevada Bar No.: 8483
HAND & SULLIVAN, LLC
3442 N. Buffalo Drive
Las Vegas, Nevada 89129
Phone: (702) 656-5814
Email: GHand@HandSullivan.com

Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC et al., Defendants.	CASE NO.: A-16-739464-C DEPT. NO.: XXXI

PLAINTIFFS' OBJECTION TO DEFENDANTS' MISLEADING DEMONSTRATIVES (11-17)

COMES NOW Plaintiffs PATRICK FARRIS and TITINA FARRIS, by and through their attorneys of record, KIMBALL JONES, ESQ., and JACOB G. LEAVITT, ESQ., with the Law Offices of **BIGHORN LAW** and GEORGE F. HAND, ESQ., with the Law Offices of **HAND & SULLIVAN**, LLC, and hereby submit this Objection to Defendants' Misleading Demonstratives (11-17).

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

DATED this 29th day of October, 2019.

BIGHORN LAW

By: */s/Jacob G. Leavitt*
KIMBALL JONES, ESQ.
Nevada Bar.: 12982
JACOB G. LEAVITT, ESQ.
Nevada Bar No.: 12608
716 S. Jones Blvd.
Las Vegas, Nevada 89107

GEORGE F. HAND, ESQ.
Nevada Bar No.: 8483
HAND & SULLIVAN, LLC
3442 N. Buffalo Drive
Las Vegas, Nevada 89129

Attorneys for Plaintiffs

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 twelve (12) 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' MISLEADING DEMONSTRATIVES (11-37)

a. The Demonstrative Slides to be Given During Opening Argument are Misleading and Prejudicial.

Defendants are attempting to utilize a demonstrative which has the tendency to mislead the jurors impaneled in this matter. The demonstratives in question are slides depicting various medical conditions. However, the slides do not show Plaintiff Titina Farris' body—they are slides which have not been approved or drawn by a retained expert in this matter—and they depict a simplified artist's rendering of the body. See *Slides*, attached hereto as **Exhibit "1."**

Demonstrative exhibits are permitted when used to supplement a witness' testimony of an event, to clarify a material issue, and when said exhibits are more probative than prejudicial. *Workman v. McIntyre Construction Co.,* 617 P.2d 1281, 1291, 37 St.Rep. 1637, 1650 (Mont.1980), *citing 29* Am.Jur.2d., Evidence § 785. Since the purpose of a demonstrative exhibit is to supplement a witness' interpretation of events, these exhibits are typically introduced contemporaneous to the presentation of the witness' testimony.

These slides, which demonstrate a surgical technique using ligasure, implies that the technique chosen by Defendants was a safe one. The simplified drawing was not illustrated or approved by an expert on either side, and as such, it has little, if any, relevance to the facts of the case at bar. These

slides, which depict bodies and surgical techniques which are unrelated to the case at bar are more prejudicial than probative, as they will mislead the jury as to the nature of Plaintiff Titina Farris' medical condition, her resulting injuries, and the techniques available to Defendants to treat Plaintiff. As such, they are properly excluded from trial.

For every depiction of ligasure surgical techniques, Defendants must be required to note that it is not an accurate depiction of ligasure, and not an indication of its safety.

III. CONCLUSION

Based on the foregoing, Plaintiffs respectfully requests that this Court Preclude Defendants' Misleading Demonstratives (11-17) in this matter.

DATED this 29th day of October, 2019.

BIGHORN LAW

By: */s/ Jacob G. Leavitt*
KIMBALL JONES, ESQ.
Nevada Bar No.: 12982
JACOB G. LEAVITT, ESQ.
Nevada Bar No. 12608
716 S. Jones Blvd.
Las Vegas, Nevada 89107

GEORGE F. HAND, ESQ.
Nevada Bar No.: 8483
HAND & SULLIVAN, LLC
3442 N. Buffalo Drive
Las Vegas, Nevada 89129

Attorneys for Plaintiffs

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 29th day of October, 2019, I served the foregoing ***PLAINTIFFS' OBJECTION TO DEFENDANTS' MISLEADING DEMONSTRATIVES (11-17)*** as follows:

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

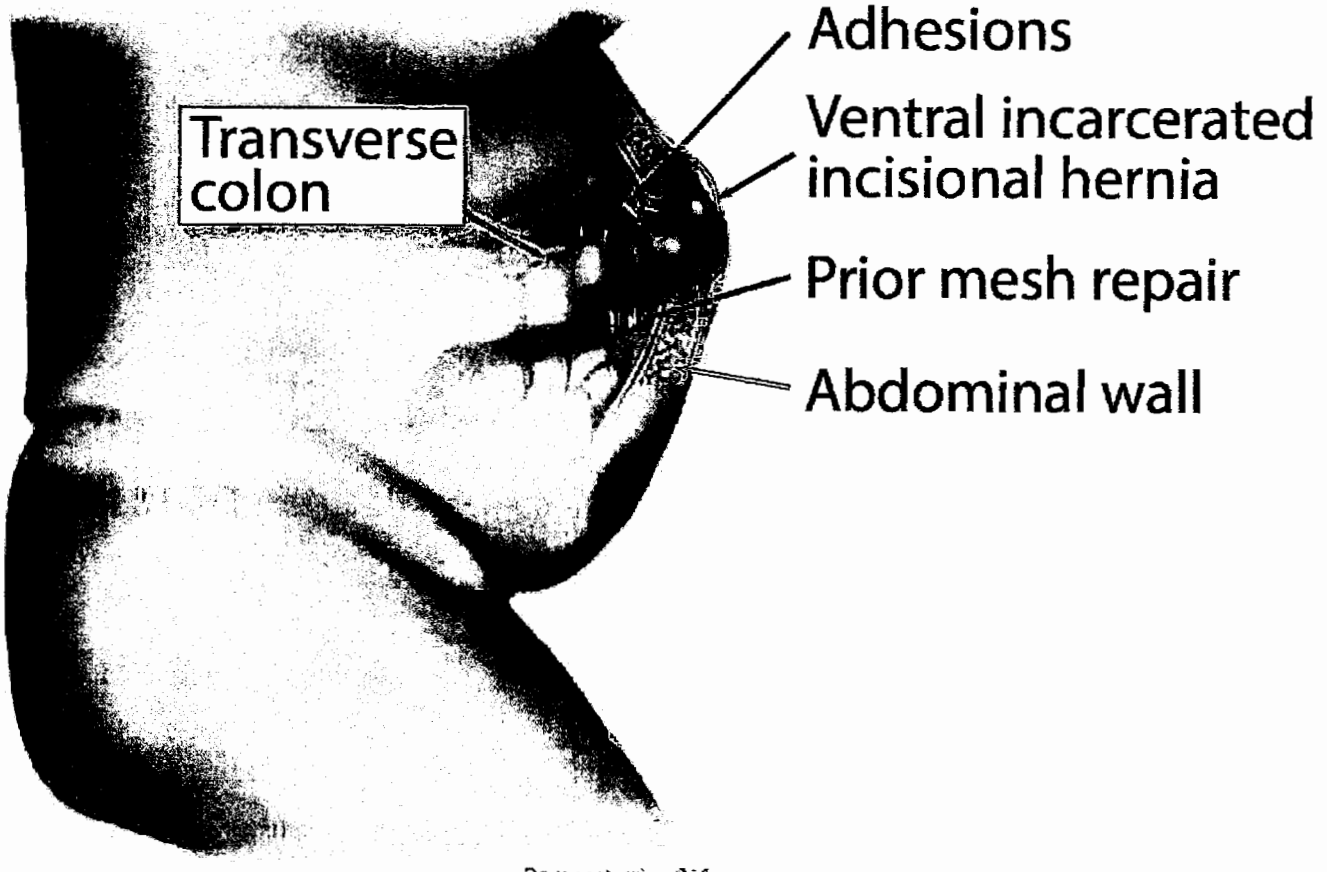
☐ U.S. Mail—By depositing a true copy thereof in the U.S. mail, first class postage prepaid and addressed as listed below:

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"

Mrs. Farris' pre-operative condition

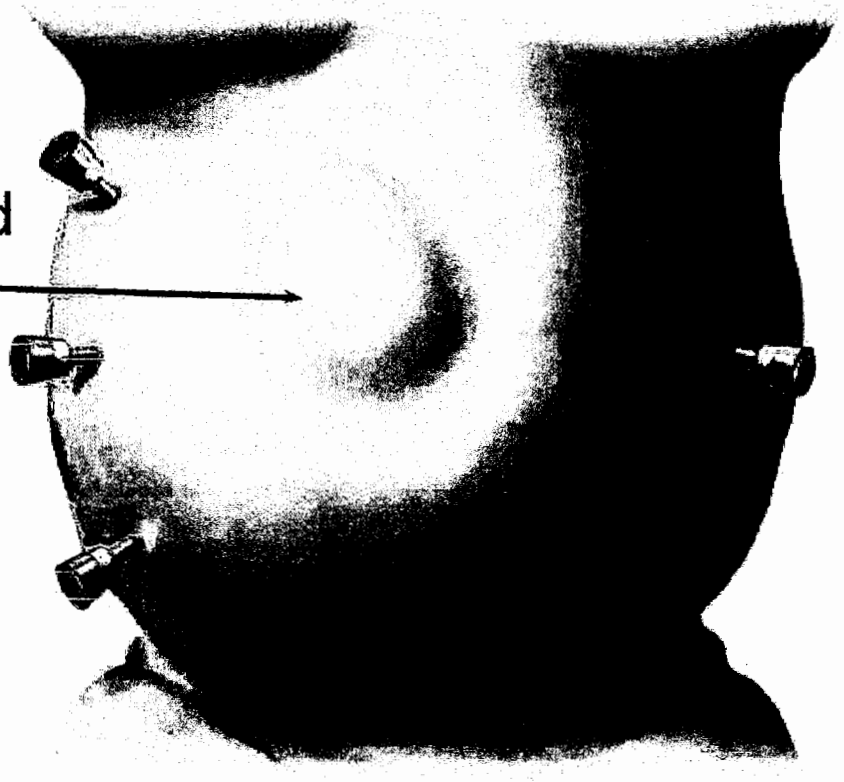


Demonstrative 011

8A.App.1725

Laparoscopic instruments are placed into the abdomen

Ventral incarcerated incisional hernia

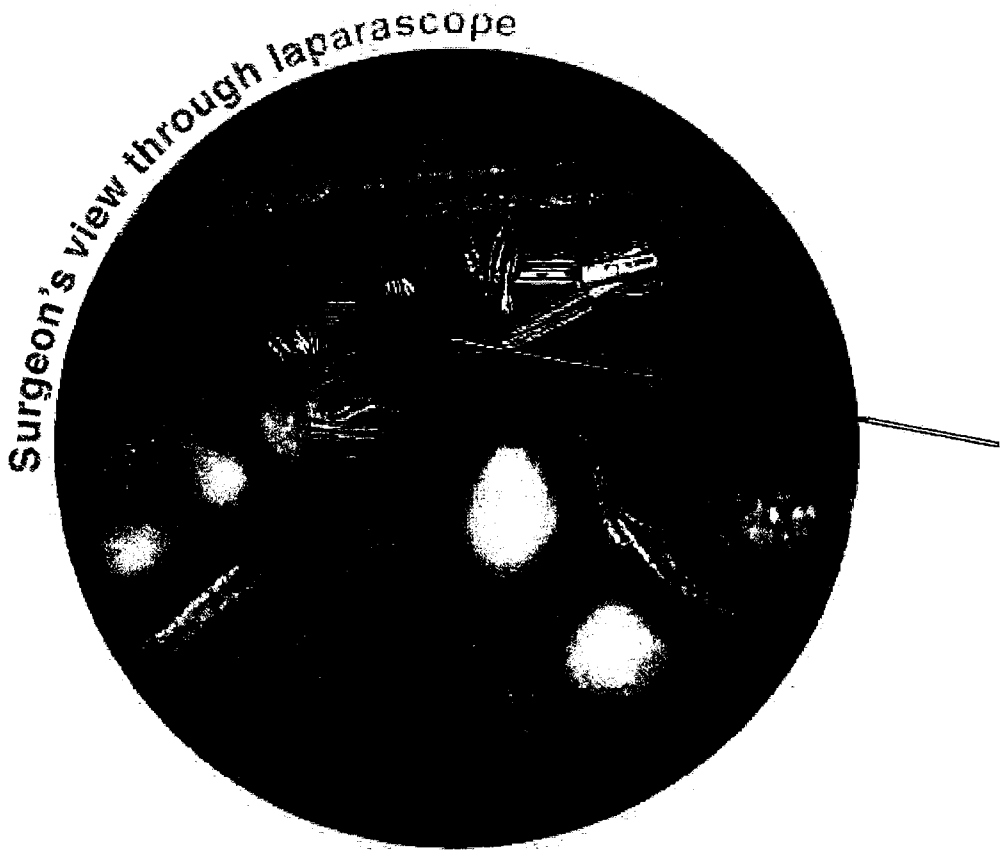


Ports placed in right upper, middle, lower, and left middle quadrants

Demonstrative 012

8A.App.1726

Transverse colon severely stuck and adhered to prior mesh repair

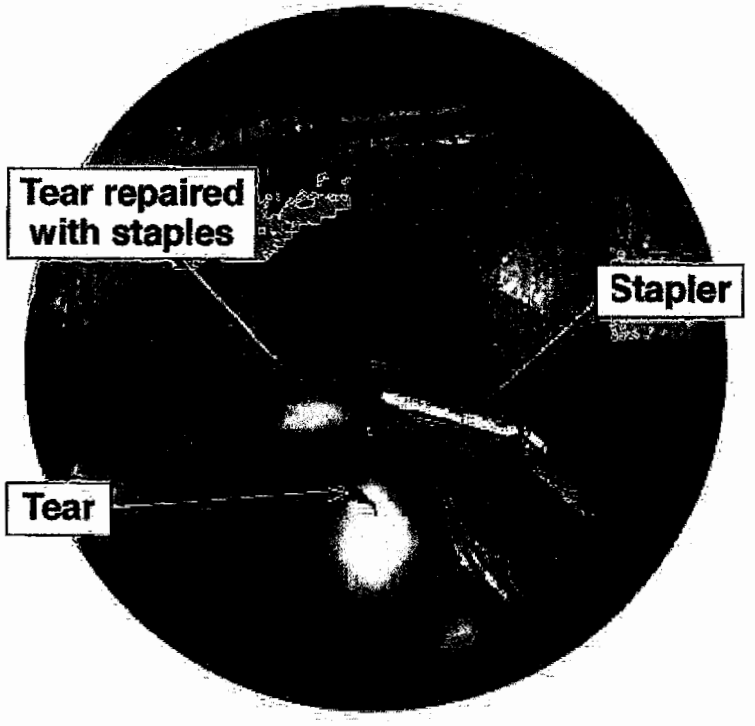


Hernia is reduced

Demonstrative 013

8A.App.1727

Colon freed from adhesions and returned to abdominal cavity



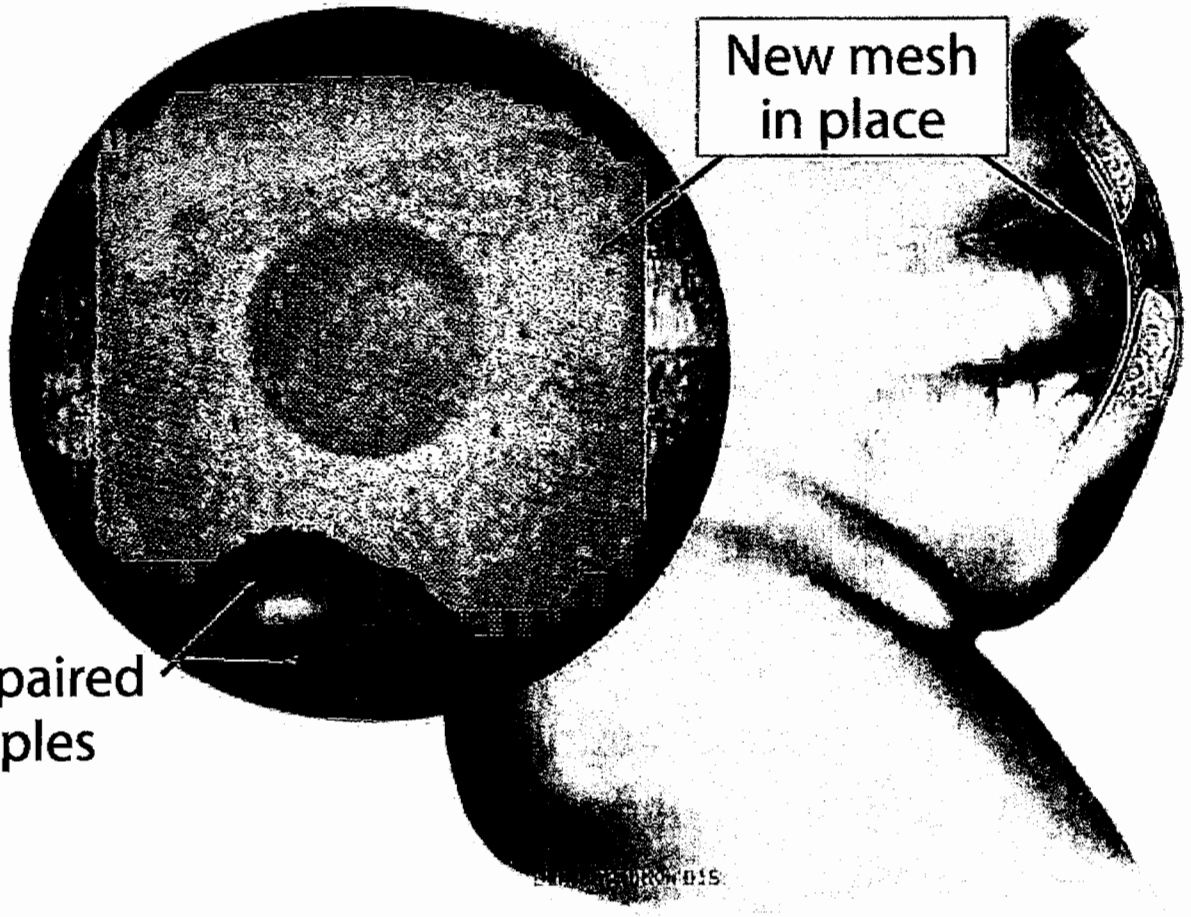
Two small tears in the colon wall are repaired using an Endo-GIA stapler

A new piece of mesh is approximated to the abdominal wall

Demonstrative 014

8A.App.1728

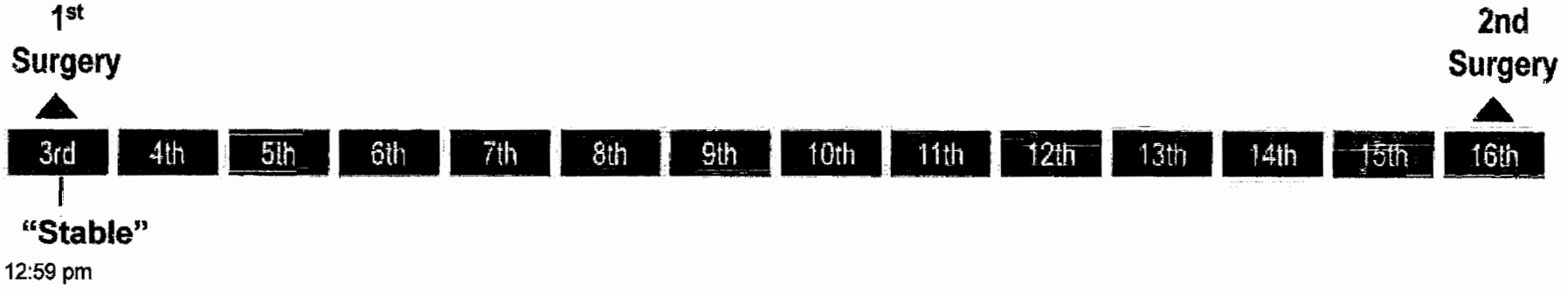
Mrs. Farris' post-operative condition



8A.App.1729

Mrs. Farris' Post-Operative Condition

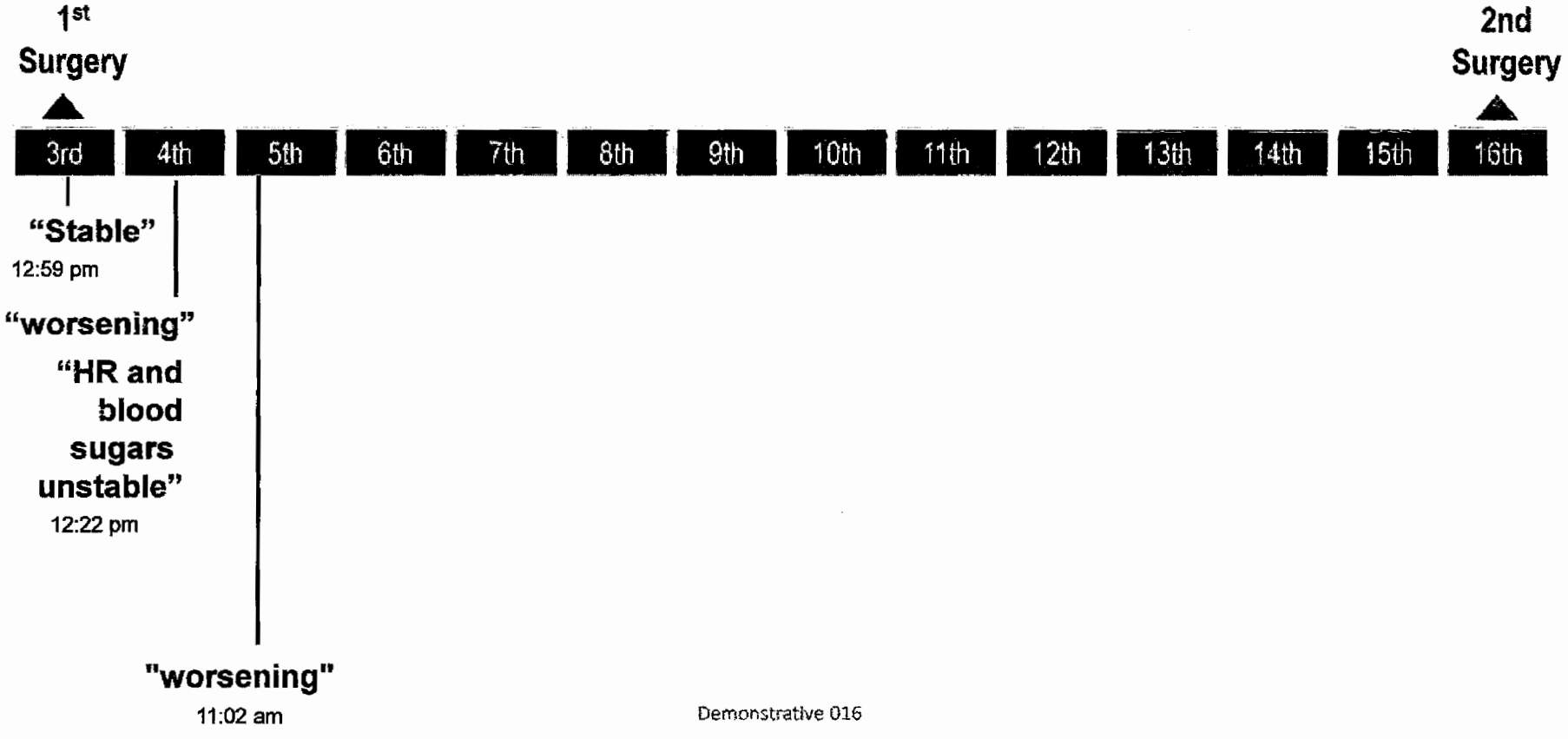
Source: Dr. Rives Notes



8A.App.1730

Mrs. Farris' Post-Operative Condition

Source: Dr. Rives Notes

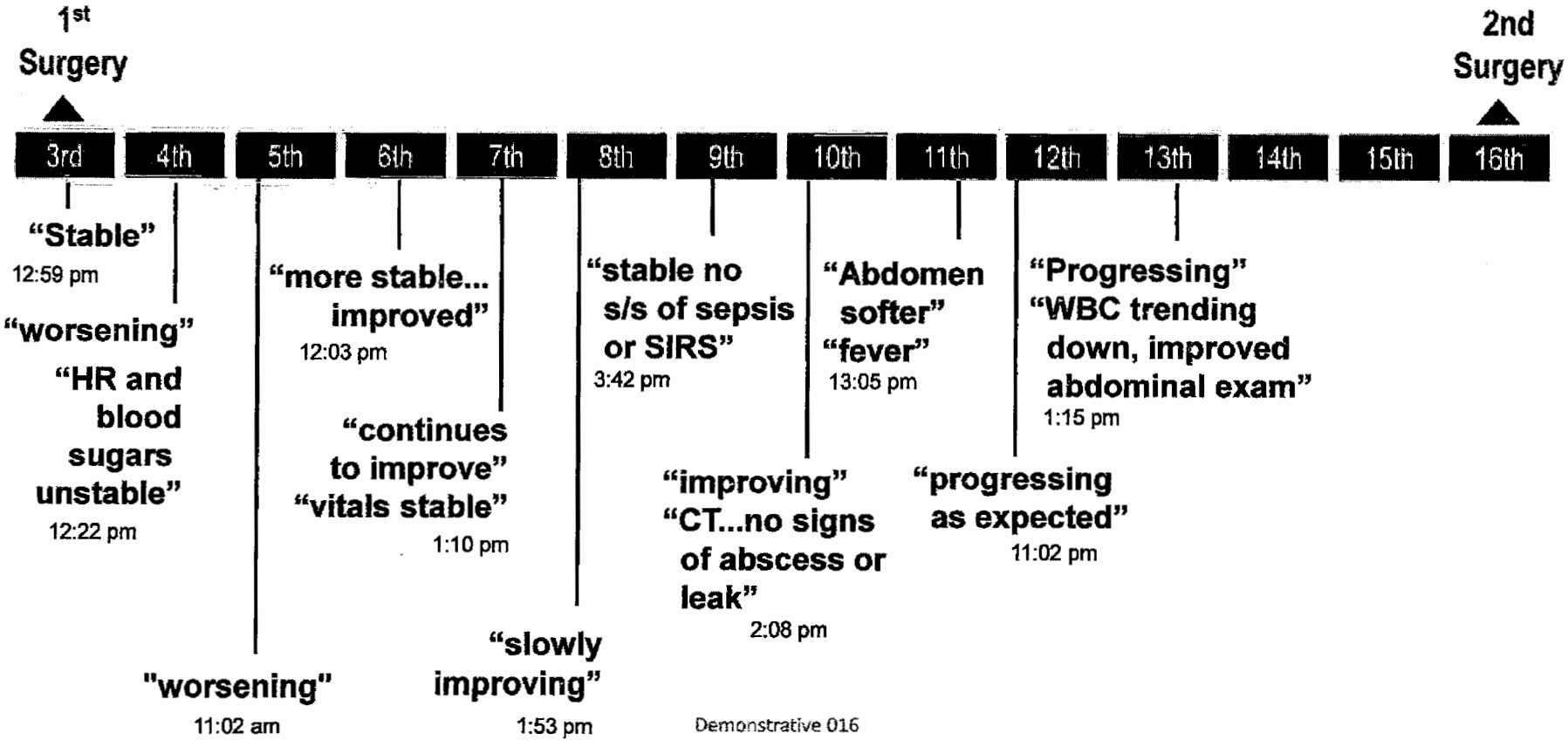


Demonstrative 016

8A.App.1731

Mrs. Farris' Post-Operative Condition

Source: Dr. Rives Notes

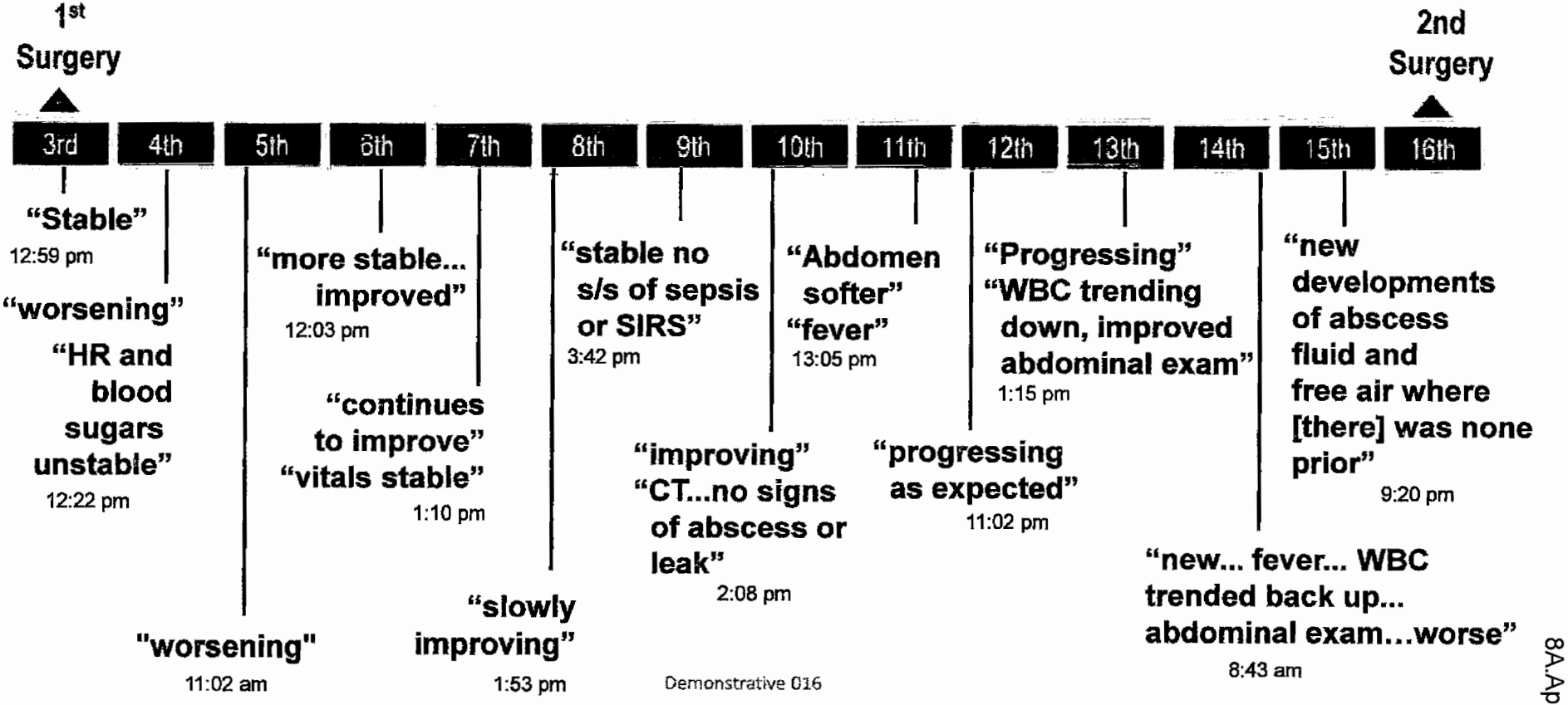


Demonstrative 016

8A.App.1732

Mrs. Farris' Post-Operative Condition

Source: Dr. Rives Notes

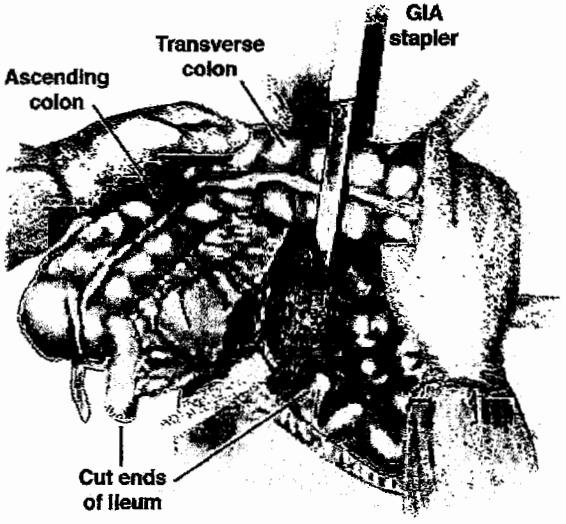


Demonstrative 016

8A.App.1733

Dr. Rives Chose Not to Rush to Surgery

Laparotomy



Resection

Colostomy

Demonstrative 017

8A.App.1734

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

GEORGE F. HAND, ESQ.
Nevada Bar No.: 8483
HAND & SULLIVAN, LLC
3442 N. Buffalo Drive
Las Vegas, Nevada 89129
Phone: (702) 656-5814
Email: GHand@HandSullivan.com

Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC et al., Defendants.	CASE NO.: A-16-739464-C DEPT. NO.: XXXI

PLAINTIFFS' TRIAL BRIEF ON DEFENDANTS' RETAINED REBUTTAL EXPERTS' TESTIMONY

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 Defendants' Rebuttal Experts' Testimony.

///

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*

KIMBALL JONES, ESQ.
Nevada Bar.: 12982
JACOB G. LEAVITT, ESQ.
Nevada Bar No.: 12608
716 S. Jones Blvd.
Las Vegas, Nevada 89107

GEORGE F. HAND, ESQ.
Nevada Bar No.: 8483
HAND & SULLIVAN, LLC
3442 N. Buffalo Drive
Las Vegas, Nevada 89129

Attorneys for Plaintiffs

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. 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.

This Brief is submitted to outline the law that is the basis of Plaintiffs' Objections to the testimony of Dr. Lance Stone, Sarah Larsen, and Eric Volk, which Plaintiffs previously objected to. See *Plaintiffs' Objection to Defendants' Pre-Trial Disclosures*, attached hereto as **Exhibit "1."**

II. LEGAL ARGUMENT

A. Dr. Stone's Disclosure Fails to Comply with Rule 16.1(a)(2)(B)(v)—a mandatory pre-requisite to testify in Nevada—and Defendants, Even the Day Before Stone's Proposed Testimony, Have Failed to Cure This Fatal Defect.

Dr. Stone's testimony list was NOT included in Defendants' Rebuttal Expert Disclosure. See *Defendants' Rebuttal Expert Disclosure*, attached hereto as **Exhibit "2."** Moreover, Dr. Stone's testimony list has never been supplemented to a subsequent disclosure, despite the known requirements under Rules 16.1(a)(2)(B)(v), 26(e)(1) and 26(e)(2).

Defendants' conduct violates Rule 16.1(a)(2)(B) which, speaking of expert reports, states in pertinent part:

> **The report must contain**:
> (i) a complete statement of all opinions the witness will express, and the basis and reasons for them;
> (ii) the facts or data considered by the witness in forming them;

(iii) any exhibits that will be used to summarize or support them;
(iv) the witness's qualifications, including a list of all publications authored in the previous ten years;
(v) a list of all other cases in which, during the previous four years, the witness testified as an expert at trial or by deposition; and
(vi) a statement of the compensation to be paid for the study and testimony in the case.

(Emphasis Added).

Despite the clarity of the rule, Defendants' failed to provide the mandatory list of prior Dr. Stone's prior testimony. As an apparent excuse, Defendants' Rebuttal Disclosure states in pertinent part:

> 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.**
>
> See *Exhibit "2."*

Believing it must have been an oversight, Plaintiffs' Counsel inquired into the missing list at Dr. Stone's deposition. Dr. Stone admitted that he had failed to present his list of cases he had appeared as a witness for and his attorney, Mr. Chad Couchot, offered a similar excuse to that offered in Defendants' Rebuttal Expert Disclosure:

> Q. How many times have you testified as an expert in a deposition?
> A. Approximately 30.
> MR. HAND: **Chad, does he have a list of those depositions? I didn't see it.**
> **MR. COUCHOT: Included in the report, there's some language about the ones that he can recall doing. He doesn't maintain a list, but I asked him to recall what -- what depositions he had given and trial, and so there's a little bit of language reflecting that, but I think it only describes one prior action that I had with him.**
> MR. HAND: Where is that in the report? I'm looking for that.
> MR. COUCHOT: Oh, actually, you know what, George? It's probably listed in our disclosure itself.
> MR. HAND: Okay.
> Q. **The case you testified that you recall, was that a trial or deposition?**
> A. **The -- it was a trial.**

Q. **What kind of case was that?**
A. **That was recently a case of an individual who had bilateral lower extremity amputation.**
Q. **And who's the law firm that retained you in that case?**
A. **The same law firm today Sherman.**
MR. COUCHOT: Schuering.

See *Deposition of Lance Stone*, attached hereto as **Exhibit "3,"** at Pages 10:8-11:8.

Clearly, the rules on this issue are not discretionary, nor do they cater to proposed experts that simply choose not to "maintain a list of testimony." Dr. Stone is an experienced expert and Defense Counsel are experienced attorneys that know the rules. As such, Dr. Stone is precluded from offering any opinions in this case on this mandatory basis alone.

B. Defendants' Failure to Disclose Dr. Stone's Role in *Center v. Rives*, if True, is Conduct that Should be Sanctioned Beyond the Striking Dr. Stone as an Expert.

From Dr. Stone's deposition testimony, it appears that Defendants' choice to not disclose the prior testimony list of Dr. Stone's may have had more to do with Dr. Stone's apparent recent testimony in *Center v. Rives*, and less to do with the claimed excuse that Dr. Stone does not maintain a testimony list at all. Unless Defense Counsel recently had Dr. Stone testify for them in a totally separate trial in yet another case of "bilateral lower extremity amputation," it appears Defendants once again intentionally concealed the *Center* case from Plaintiffs through the failure to disclose Dr. Stone's prior testimony history.

Defendants' Rebuttal Expert Disclosure stonewalls Plaintiffs by stating that **"Dr. Stone indicated he does not maintain a list of testimony**." This contemptuous response is completely unresponsive, and a direct violation of Rule 16.1. Had Dr. Stone disclosed that he previously was an expert in a case involving the same Defendant as the case at bar, with similar injuries and with similar treatment by the Defendant, the tenor and questioning in deposition would have been remarkably different.

///

The intentionality of such concealment cannot be in doubt given Defendants' statement that Dr. Stone could only recall "...the name of ... *Baxter v. Dignity Health.*" Certainly, Defense Counsel, who defended Dr. Stone's deposition and was clearly familiar with the insufficiency of Dr. Stone's disclosure based on the reviewable testimony, would have been well aware that Dr. Stone recently testified in the *Center* matter. Yet, Defense Counsel failed to make the appropriate disclosure as required. As such, failing to make that disclosure is yet one more egregious example of improper concealment of evidence meriting substantial sanctions.

C. Dr. Stone's Report is Flawed and Fails to Meet the Standards of NRS 50.275; Opinions of Nurse Larsen and Mr. Volk are Inadmissible as they are Entirely Dependent on Dr. Stone's Inadmissible Opinions.

1. Rebuttal Experts Cannot Offer New or Novel Opinions Regarding Known Elements of Plaintiffs' Case-in-Chief.

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).

From the commencement of this case Defendants were aware that Plaintiffs were claiming Dr. Rives breached the standard of care, causing substantial damages. These specific damages were known to include a prior colostomy and bilateral foot drop, a permanent condition that would impact Plaintiffs for the rest of their lives. Plaintiffs' damages in this case were not hidden, but were a well-known

element of Plaintiffs' case-in-chief, years before initial expert disclosures. On December 29, 2016 Plaintiffs answered Defendants' Interrogatories, which dealt with this issue. Plaintiff Titina Farris answered as follows:

> Interrogatory No. 13:
> Describe the past, current or future physical, mental or emotional injuries you are claiming in the lawsuit.
>
> Answer to Interrogatory No. 13:
>
> I am in chronic pain and mental upset. I cannot take care of myself, my husband, my daughter or my home. I was confined to a wheelchair for approximately one year after the surgery by Dr. Rives in July 2015. I had to wear a colostomy bag for several months. I am unable to walk or stand on my own. I also have constant pain in my feet and calves.
>
> See *Plaintiffs' Answers to Defendants' First Set of Interrogatories*, attached as **Exhibit "4."**

When initial experts were disclosed in this matter, none disputed Plaintiff Titina Farris' claim that her permanent impairment and bilateral foot drop resulted from complications of Dr. Rives' care. However, at the rebuttal expert deadline, Defendants disclosed two (2) "rebuttal" experts, Dr. Adornato and Dr. Stone, who offered new initial medical causation opinions, placing at least part of the causation of Plaintiff Titina Farris' permanent impairment and foot drop on pre-existing conditions such as diabetes and obesity. See *Exhibit "2."* See also *Rebuttal Report of Lance Stone*, attached hereto as **Exhibit "5."**

The source of this flaw is identifiable in Dr. Stone's original retention. Dr. Stone was purportedly retained to simply rebut Plaintiffs' expert, Alex Barchuck, M.D., but Dr. Stone goes beyond the scope of that assignment, stating he was hired to also "**attest to any separate and divergent opinions I may hold**." See *Exhibit "5,"* at Page 1. On its face, Dr. Stone's scope goes beyond that of a rebuttal expert under Nevada Law. Then, after reviewing Dr. Barchuck's conclusions, Dr. Stone states, "Based upon my independent review of Ms. Farris medical records I agree in general

with Dr. Barchuck's diagnosis. However, the medical records I reviewed support my conclusions that several medical problems were pre-existing or unrelated to surgery." *Id.* at Page 3.

Unsurprisingly, given his improper understanding of his role as a rebuttal expert, Dr. Stone goes on to list out twenty-one (21) new and novel opinions that he uses to form the basis of his life care plan, none of which were not considered in Dr. Barchuck's report. Thereafter, Dr. Stone fails to outline a life care plan of his own, but suggests his life care projections are outlined in the report of Nurse Sarah Larsen, which he says he endorses, though it is somewhat unclear if he reviewed it. *Id.*

Regardless, because each of these twenty-one (21) new opinions relate to a well-known portions of Plaintiffs' case-in-chief, they cannot be offered by a rebuttal expert. As such, Dr. Stone's new medical causation opinions Must be Stricken.

2. Dr. Stone's Opinions are Unscientific and Speculative.

The Court in *Hallmark* noted, an expert's testimony will assist the trier of fact only when it is relevant and the product of reliable methodology. *Hallmark v. Eldridge*, 124 Nev. 492, 189 P.3d 646 (2008). The Court then noted that in determining whether an expert's opinion is based upon reliable methodology, a district court should consider whether the opinion is **(1) within a recognized field of expertise; (2) testable and has been tested; (3) published and subjected to peer review; (4) generally accepted in the scientific community;** and **(5) based more on particularized facts rather than assumption, conjecture, or generalization**. *Id.*

Dr. Stone's opinions prove to be both speculative and changeable. One such example is that Dr. Stone claims Plaintiff Titina Farris would become "wheelchair bound" at some point in her life. Yet, in deposition, he abandons those positions:

> Q. Do you have an opinion as to the cause of the severe sensory loss and motor weakness below the knees bilaterally involving the tibial and peroneal nerves?
> A. Yes.
> Q. What is that?
> A. Critical illness polyneuropathy.

Q. Dr. Stone, do you have any information or opinion on her -- I'm talking about Titina Farris's -- mobility status before her admission to the hospital on July -- for the July 3rd, '15 surgery?
A. I believe she was ambulatory. Q. Do you know if there was any restrictions on her ambulatory status?
A. I don't believe so.
Q. Looking at number 15, it states, "Right ankle contracture with bilateral foot drop." Do you agree with that assessment?
A. Yes.
Q. And the bilateral foot drop, do you have an opinion as to the cause of -- or causes of the bilateral foot drop?
A. Yes.
Q. What is that?
A. Critical illness polyneuropathy, and poor positioning of her foot would probably be the most likely cause. So weakness in association with immobilization and lying in bed with the foot in a plantar-flex position.

See *Exhibit "3,"* at Pages 21:2-22:3.

Dr. Stone's report contains a finding which presumably struck significant damages from the resulting life care plan of Sarah Larsen, because Dr. Stone refused to connect causation to Defendants' negligence. This opinion was abandoned by Dr. Stone—but Sarah Larsen's opinion report, which purportedly relies entirely on Dr. Stone's medical opinions, remains unchanged.

Furthermore, Dr. Stone noted that his opinion that Plaintiff Titina Farris would have become dependent on a wheelchair, even without Defendants' negligence, has no scientific support:

Q. Okay. Then at the end you state, "...she would have become wheelchair dependent regardless of her surgical complications." What's the basis of that statement?
A. Well, just looking over her past history and noncompliance and risk factors, you know, for future stroke, for future MI, heart attack, for diabetic polyneuropathy involving the upper extremities, for diabetic arthropathy. So I think -- in my experience, individuals like this who develop and have these severe medical complications at a relatively young age and that are progressive, you know, usually end up becoming very disabled over time with a shortened life expectancy.
Q. Well, to a reasonable degree of medical probability -- well, excluding the foot drop she has, when would she have been wheelchair-dependent in your opinion?
A. Okay. So I'm basing this -- you know, there's -- I don't think there's any study we can find on this. I'm basing this upon 30 years of experience and, you know, a current active hospital-based practice. I would say that probably in her early to mid-'60s.
Q. Do you have any data on the percentage of -- I'll start broadly, the percentage of type two diabetics that become wheelchair-bound?
A. I don't.

Q. Do you have any data on the percentage of diabetics with diabetic neuropathy that become wheelchair-bound?
A. I do not.

Id. at 43:3-44:7.

Dr. Stone's opinions are pure conjecture. He could not identify any study which supported his speculative position. Moreover, what matters legally is what did happen—not what was likely to happen in some alternate future where Dr. Rives' negligence had not impacted Plaintiffs' life. As such, it is irrelevant if Plaintiff Titina Farris was likely to become wheelchair bound in some possible future that did not happen. What matters is what condition she was in before the negligence, the condition she arrived at due to the negligence, and her likely condition in the future as a result of the negligence.

3. Nurse Larsen and Mr. Volk Rely on Dr. Stone's Flawed Opinions.

Sarah Larsen and Eric Volk both based their reports on Dr. Stone's speculative opinions, but fail to update their life care plan even when Dr. Stone changes his opinions.

Q. Do you have an opinion as to the cause of the severe sensory loss and motor weakness below the knees bilaterally involving the tibial and peroneal nerves?
A. Yes.
Q. What is that?
A. Critical illness polyneuropathy.
Q. Dr. Stone, do you have any information or opinion on her -- I'm talking about Titina Farris's -- mobility status before her admission to the hospital on July -- for the July 3rd, '15 surgery?
A. I believe she was ambulatory. Q. Do you know if there was any restrictions on her ambulatory status?
A. I don't believe so.
Q. Looking at number 15, it states, "Right ankle contracture with bilateral foot drop." Do you agree with that assessment?
A. Yes.
Q. And the bilateral foot drop, do you have an opinion as to the cause of -- or causes of the bilateral foot drop?
A. Yes.
Q. What is that?
A. Critical illness polyneuropathy, and poor positioning of her foot would probably be the most likely cause. So weakness in association with immobilization and lying in bed with the foot in a plantar-flex position.

See Exhibit "3," at Pages 21:2-22:3.

> Q. Okay. Then at the end you state, "...she would have become wheelchair dependent regardless of her surgical complications." What's the basis of that statement?
> A. Well, just looking over her past history and noncompliance and risk factors, you know, for future stroke, for future MI, heart attack, for diabetic polyneuropathy involving the upper extremities, for diabetic arthropathy. So I think -- in my experience, individuals like this who develop and have these severe medical complications at a relatively young age and that are progressive, you know, usually end up becoming very disabled over time with a shortened life expectancy.
> Q. Well, to a reasonable degree of medical probability -- well, excluding the foot drop she has, when would she have been wheelchair-dependent in your opinion?
> A. Okay. So I'm basing this -- you know, there's -- I don't think there's any study we can find on this. I'm basing this upon 30 years of experience and, you know, a current active hospital-based practice. I would say that probably in her early to mid-'60s.
> Q. Do you have any data on the percentage of -- I'll start broadly, the percentage of type two diabetics that become wheelchair-bound?
> A. I don't.
> Q. Do you have any data on the percentage of diabetics with diabetic neuropathy that become wheelchair-bound?
> A. I do not.

Id. at 43:3-44:7.

Dr. Stone's report is flawed on its own as 1) he abandons his opinions on causation; and 2) is basing his opinion on Plaintiff Titina Farris becoming "wheelchair bound," even absent surgery on pure conjecture and speculation. However, this report is even more dangerous and prejudicial to Plaintiffs' case as Sarah Larsen based her report on Dr. Stone's flawed recommendations.

Yet, Ms. Larsen's report also fails to adhere to Dr. Stone's actual recommendations in the report. Dr. Stone notes that Plaintiff Titina Farris will need a "fully wheelchair accessible home":

> Q. All right. Looking at number 19, you state, "Fully wheelchair accessible home in five to ten years." Do you -- I want to understand what you're saying here. Do you think she would need that or doesn't need that? I'm not sure –
> A. I think she will need that because I think in, you know, five to ten years, more likely along -- ten years, she more than likely would probably be wheelchair-dependent.

Id. at 42:19-43:2.

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Despite making this recommendation, Ms. Larsen fails to include in her life-care plan this data in her list of expenses. See *Nurse Larsen's Rebuttal Report*, attached hereto as **Exhibit "6."** As Stone's report is flawed, and as Larsen fails to incorporate expenses into her report, her report is doubly flawed.

Eric Volk also bases his Economist Rebuttal on Dr. Stone's flawed report. See *Eric Volk's Rebuttal Report*, attached hereto as **Exhibit "7."** Volk's report does contain some direct rebuttal to the methodology of the report of Plaintiffs' economist, Dr. Terrence Clauretie. As such, Mr. Volk's report and testimony, as based upon Dr. Stone's flawed report, cannot give a valid alternative theory for Plaintiffs' economic needs—although it may arguably be used for the rebuttal language attacking Dr. Clauretie's methodology.

III. CONCLUSION

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

DATED this 28th day of October, 2019.

BIGHORN LAW

By: */s/ Jacob G. Leavitt*
KIMBALL JONES, ESQ.
Nevada Bar.: 12982
JACOB G. LEAVITT, ESQ.
Nevada Bar No.: 12608
716 S. Jones Blvd.
Las Vegas, Nevada 89107

GEORGE F. HAND, ESQ.
Nevada Bar No.: 8483
HAND & SULLIVAN, LLC
3442 N. Buffalo Drive
Las Vegas, Nevada 89129

Attorneys for Plaintiffs

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 29th day of October, 2019, I served the foregoing ***PLAINTIFFS' TRIAL BRIEF ON DEFENDANTS' RETAINED EXPERTS' TESTIMONY*** 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"

Electronically Filed
9/20/2019 10:21 AM
Steven D. Grierson
CLERK OF THE COURT

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

GEORGE F. HAND, ESQ.
Nevada Bar No.: 8483
HAND & SULLIVAN, LLC
3442 N. Buffalo Drive
Las Vegas, Nevada 89129
Phone: (702) 656-5814
Email: GHand@HandSullivan.com
Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC et al., Defendants.	CASE NO.: A-16-739464-C DEPT. NO.: XXXI

PLAINTIFFS' OBJECTIONS TO DEFENDANTS' PRE-TRIAL DISCLOSURE STATEMENT PURSUANT TO NRCP 16.1(a)(3)(C)

COMES NOW Plaintiffs PATRICK FARRIS and TITINA FARRIS, by and through their attorneys of record, KIMBALL JONES, ESQ. and JACOB G. LEAVITT, ESQ., with the Law Offices of **BIGHORN LAW** and GEORGE F. HAND, ESQ., with the Law Offices of **HAND & SULLIVAN**, LLC, and hereby objects to Defendants' Pre-Trial Disclosure Statement Pursuant to NRCP 16.1(a)(3)(C) as follows:

///

Case Number: A-16-739464-C

I. WITNESSES/PARTIES DEFENDANT EXPECTS TO PRESENT AT TRIAL

Plaintiffs objects to Defendants' listed witness number 12, Gary Ripplinger, M.D., as Defendant was aware of this witness from the beginning of the case, but failed to disclose this witness prior to the close of discovery in this matter. As such, Plaintiffs did not have reasonable opportunity to investigate this witness.

Further, Plaintiffs object to any testimony by Defendants' "Rebuttal" Experts Lance Stone, D.O., Sarah Laren, RN, Bruce Adornator, M.D., Kim Erlich, M.D., and Scott Kush, M.D.[1]

Finally, Plaintiffs object to the Reports of Defendants' Initial Experts, Bart Carter, M.D., Brian E. Juell, M.D., as they are cumulative given that both experts have virtually identical qualifications and opinions in the present case.

II. WITNESSES/PARTIES DEFENDANT MAY PRESENT AT TRIAL

Plaintiffs objects to Defendants' listed witnesses numbers 3 through 19, as Defendants failed to disclosure this witnesses prior to the close of discovery in this matter and as such provided Plaintiffs no opportunity to depose this witnesses.

V. DOCUMENTS DEFENDANT MAY USE AT TRIAL

Plaintiffs object to the use of any depositions of non-party witnesses for any other purpose other than impeachment or refreshing recollection, minus a proper showing of unavailability of the witness. Plaintiffs object to all exhibits attached to the deposition transcript based on relevance, hearsay, and foundation.

Plaintiffs object to the Reports of Defendants' "Rebuttal" Experts Lance Stone, D.O., Sarah Laren, RN, Bruce Adornator, M.D., Kim Erlich, M.D., and Scott Kush, M.D.

///

[1] Plaintiffs' arguments for excluding Defendants' Rebuttal Witnesses have been previously briefed in Plaintiffs' Motion to Strike Defendants' Rebuttal Witnesses.

Plaintiffs objects to the Reports of Defendants' Initial Experts, Bart Carter, M.D., Brian E. Juell, M.D., as they are cumulative given that both experts have virtually identical qualifications and opinions in the present case.

Plaintiffs reserve the right to make additional arguments and/or further objections at trial.

DATED this 20th day of September, 2019.

BIGHORN LAW

By: */s/ Kimball Jones*

KIMBALL JONES, ESQ.
Nevada Bar.: 12982
JACOB G. LEAVITT, ESQ.
Nevada Bar No.: 12608
716 S. Jones Blvd.
Las Vegas, Nevada 89107

GEORGE F. HAND, ESQ.
Nevada Bar No.: 8483
HAND & SULLIVAN, LLC
3442 N. Buffalo Drive
Las Vegas, Nevada 89129

Attorneys for Plaintiffs

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 20th day of September, 2019, I served the foregoing ***PLAINTIFFS' OBJECTIONS TO DEFENDANTS' PRE-TRIAL DISCLOSURE STATEMENT PURSUANT TO NRCP 16.1(a)(3)(C)*** 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 "2"

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

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

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

DISTRICT COURT

CLARK COUNTY, NEVADA

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

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

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Case Number: A-16-739464-C

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 _____

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

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.

Attorney	Representing	Phone/Fax/E-Mail
George F. Hand, Esq. HAND & SULLIVAN, LLC 3442 North Buffalo Drive Las Vegas, NV 89129	Plaintiff	702/656-5814 Fax: 702/656-9820 hsadmin@handsullivan.com

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

EXHIBIT "3"

Transcript of Lance Stone, D.O.
Conducted on July 29, 2019

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DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS,
Plaintiffs,
vs.
BARRY RIVES, MD; LAPAROSCOPIC SURGERY CENTER OF NEVADA LLC; DOES 1-V, inclusive; and ROE CORPORATIONS I-V, inclusive,
Defendants.

Case No. A-16-739464-C
Volume I
Pages 1 thru 50

DEPOSITION OF
LANCE STONE, DO
July 29, 2019

Reported By:
CYNTHIA J. POLISERI CSR # 11448

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INDEX OF
EXHIBITS

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BE IT REMEMBERED that, pursuant to Notice of Taking Deposition, and on Monday, July 29, 2019, commencing at the hour of 10:02 a.m., in the Offices of Regus, 3558 Round Barn Boulevard, Suite 200, Santa Rosa, California 95403, before me, Cynthia Poliseri, a Certified Shorthand Reporter in the State of California, there personally appeared

LANCE STONE, DO,

called as a witness by the Plaintiffs, who being by me first duly sworn, was thereupon examined and interrogated as is hereinafter set forth.

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GEORGE F. HAND, Attorney at Law, of the Law Offices of Hand & Sullivan, LLC, 3442 North Buffalo Drive, Las Vegas, Nevada 89129, appeared via videoconference as counsel on behalf of the Plaintiffs.
Tel: 702.656.5814 GHand@HandSullivan.com

CHAD C. COUCHOT, Attorney at Law, of the Law Offices of Schuering Zimmerman & Doyle LLP, 400 University Avenue, Sacramento, California 95825, appeared as counsel on behalf of the Defendants. Tel: 916.567.0400 ccc.szs.com

ALSO PRESENT: JAMES TERRELL, Videographer

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JULY 29, 2019 - TUESDAY 10:02 A.M.
VOLUME I
PROCEEDINGS
--oOo--
THE VIDEOGRAPHER: This begins video number one in the video deposition of Lance Stone, DO, in the matter of Titina Farris and Patrick Farris versus Barry Rives, MD, et al., as filed in the District Court of Clark County, Nevada, Case Number A-16-739464-C.
Today's date is July 29, 2019. Time on the video monitor is 10:03. The video operator James Terrell. Our court reporter is Cynthia Poliseri. Both are appearing for Planet Depos.
This video deposition is taking place at 3558 Round Barn Boulevard, Santa Rosa, California. And if counsel will now identify yourselves and state whom you represent.
MR. HAND: George Hand for the plaintiffs, Titina Farris and Patrick Farris.
MR. COUCHOT: Chad Couchot for Dr. Rives and his corporation.
THE VIDEOGRAPHER: And that's all the counsel that's on the phone or --
MR. COUCHOT: That's everybody.
MR. HAND: Correct.

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THE VIDEOGRAPHER: All right. Our reporter may swear the witness and you may proceed.
LANCE STONE, DO,
having first been called as a witness,
was duly sworn and testified as follows:
EXAMINATION BY MR. HAND:
Q. Please state your name for the record.
A. Lance R. Stone.
Q. And do you have a specific medical practice that you're engaged in?
A. Yes.
Q. What is that?
A. I'm the medical director of the acute rehabilitation unit at Santa Rosa Memorial Hospital in Santa Rosa.
Q. And what were you asked to do in this case?
A. I was asked to review a life care plan that was prepared by Dawn Cook. I was also asked to review a document prepared by Dr. Alex Barchuck, and I was also asked to collaborate with Sarah Larsen, who is a life care planner. And I was also asked to identify any agreements or discrepancies I may have with Dr. Alex Barchuck's report.
Q. Did you have any discrepancies with Dr. Barchuck's report?

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A. Yes.
Q. What were those?
A. I'm reading my report. I identified that Ms. Farris had a preexisting condition of a ventral hernia but identified that her – one moment, please. Hold on.
MR. COUCHOT: Do you want to use my copy?
THE WITNESS: Hmm?
MR. COUCHOT: Do you want to use my copy?
THE WITNESS: No, I'm just trying to read through here to -- let just read this to you.
Identify that she had several major preexisting medical co-morbidities and the medical necessity and frequency was due to preexisting condition unchanged following surgery.
I identified that she had a diabetic polyneuropathy and she should have been seeing a podiatrist -- this was preexisting, and should have been seeing a podiatrist prior to her surgery; that her Dupuytren contractures, which Dr. Barchuk identified, were unrelated to her surgery and any postsurgical complications; that she also had a mood disorder that was preexisting; that she was obese prior to her surgery and she should have been seeing and under the care of a dietician for nutritional care and counseling.
She had a preexisting chronic pain disorder, both

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related to her polyneuropathy and to chronic shoulder disorder; this was preexisting. I also felt that complementary therapy, such as massage and acupuncture therapy, offered no additional benefit over standard physical therapy and pharmacological therapy.
There was, in my opinion, no established documentation that she had a carpal tunnel syndrome, that she did have a diabetic polyneuropathy, but she had no diagnostic testing that would confirm that she had carpal tunnel syndrome. That she most likely -- again, the MRI scan that he was recommending for her shoulder was most likely unnecessary, and her shoulder problems were all preexisting. Those are some of the disagreements that I had with Dr. Barchuk's report.
MR. HAND:
Q. On what basis pathologically are you concluding that she had diabetic neuropathy prior to July 3rd of 2015?
A. It's based upon the office notes and other reports, primarily the office notes of her internal medicine physician and the progress notes that established that she had symptoms that are quite consistent with diabetic polyneuropathy.
She was an uncontrolled diabetic. She was obese, and she had very classic symptoms manifesting as pain and bilateral lower extremities burning in nature, and she was

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receiving medications that were specifically indicated for the treatment of neuropathy or neuropathic pain.

Q. Was there any EMG or nerve conduction studies done prior to July '15 --

A. No.

Q. -- that you're -- would that be important to have in terms of diagnosing --

A. No.

Q. -- diabetic polyneuropathy?

A. Not in this setting.

Q. Why not?

A. A majority of basically patients that I treat and the majority of patients that are referred to me by neurologists, neurosurgeons, internal medicine physicians, when patients have a classic clinical presentation of burning pain in lower extremities or hands associated with uncontrolled diabetes, it's usually unnecessary. And in my experience, most of the time an EMG is not offered to establish the diagnosis.

Q. Do you have any evidence that there was any nerve compromise to her feet prior to July 3rd of 2015?

A. Nerve compromise?

Q. Yeah.

A. Pain.

Q. Do you have any evidence that there was any muscle

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compromise to her feet or lower extremities prior to July 3rd, 2015?

A. No.

Q. Now -- in a deposition, as an expert?

MR. COUCHOT: You broke up there, George. Could you repeat?

MR. HAND: Yeah.

Q. How many times have you testified as an expert in a deposition?

A. Approximately 30.

MR. HAND: Chad, does he have a list of those depositions? I didn't see it.

MR. COUCHOT: Included in the report, there's some language about the ones that he can recall doing. He doesn't maintain a list, but I asked him to recall what -- what depositions he had given and trial, and so there's a little bit of language reflecting that, but I think it only describes one prior action that I had with him.

MR. HAND: Where is that in the report? I'm looking for that.

MR. COUCHOT: Oh, actually, you know what, George? It's probably listed in our disclosure itself.

MR. HAND: Okay.

Q. The case you testified that you recall, was that a trial or deposition?

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A. The -- it was a trial.

Q. What kind of case was that?

A. That was recently a case of an individual who had bilateral lower extremity amputation.

Q. And who's the law firm that retained you in that case?

A. The same law firm today Sherman.

MR. COUCHOT: Schuering.

THE WITNESS: Schuering.

MR. HAND:

Q. And those 30 times that you recall testifying, have you ever -- any of those cases or matters have anything to do with critical illness polyneuropathy?

A. I can't recall. I've been practicing for over 30 years and been acting as an expert during those 30 years, and I estimate -- probably 30 is a lower number, but I've probably performed about three depositions a year, so I can't recall 30 years ago.

But I worked in a major medical center, nationally recognized rehab center, and I've treated patients with multiple problems, including brain injury, spinal cord injury, amputation. So most likely I have had patients that I've deposed that have had critical illness neuropathy as part of their differential diagnosis or medical problem list. I just can't recall recently.

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Q. Have you ever testified in a deposition or trial on behalf of a plaintiff?

A. Yes.

Q. Okay. How many times have you testified for a plaintiff?

A. I can't recall, but I would say over the past ten years, I primarily just do defendant work. So the work I was doing for plaintiffs was probably greater than ten years ago, and I can't recall.

Q. Okay. So in the last ten years, your testimony as an expert has been for defendants?

A. Primarily, yes.

Q. Have you ever done a life care plan for -- provided information for a life care plan on behalf of a plaintiff?

A. I can't speak with certainty. I'd say the probability is yes, but I can't identify a certain case, but yes. Probably yes.

Q. Now, looking at your report, I see you have a number of publications that you mention. Do any of them bear on any of the issues in this case?

A. Can you be more specific?

Q. Well, if you look at page -- well, you have a page in your CV where you have published articles, and I'm looking at them.

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Do you have that in front of you?
A. No.
Q. Do you have your report with you?
A. Yes.
Q. Okay. Could you take your report out.
A. I have my report up.
Q. Do you have that in front of you?
A. Yes.
MR. HAND: By the way, could we have that marked as Plaintiff's Exhibit 1 at the appropriate time.
(Exhibit 1 was marked for identification.)
MR. HAND:
Q. Looking at the page where it talks about published articles, do you see where I'm referring to?
A. Give me a page number.
Q. It's not -- there's no numbers on the page.
A. Oh, okay.
Q. But page -- about five.
A. Oh, I see.
Q. Five or six. Do you see where I'm referring to?
A. I don't see it.
Q. Do you have it?
A. I have it.
Q. Okay. Where it says "Published Articles." Looking at those articles, do any of those articles bear

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upon any of the issues in this case?
MR. COUCHOT: I'm sorry, George. We're not -- we're not with you on the same page. You're talking about his report dated December 19, 2018?
MR. HAND: Well, it's the CV.
MR. COUCHOT: Oh, sorry. He doesn't have his --
THE WITNESS: Oh, I don't have my CV. You asked me about -- you asked me, do I have my report in front of me, yes. Do I have my CV in front of me, no.
MR. HAND:
Q. All right. I'll just go through these with you briefly.
A. Please.
Q. Well, let me ask you, have you -- the easier way: Have you written any articles or papers or anything that bear on the issues in this case that you can recall?
A. Can you be more specific? What issue are you talking about specifically?
Q. About foot drop. Have you written any articles, abstracts, or publications regarding foot drop?
A. Foot drop specifically, yes.
Q. Okay. Do you recall what those articles were?
A. Generally, yes. They had to do with patients with spastic foot drop, patients with spasticity, patients with reflex sympathetic dystrophy that may have had nerve pain

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or foot drop, patients with brain injury that have had foot drop.
I think there's a few on that CV; I don't have it in front of me.
Q. Have you written any articles on critical -- that dealt with the issue of critical illness polyneuropathy?
A. No.
Q. Have you written any articles, abstracts, or publications dealing with diabetic neuropathy?
A. No.
Q. In this case, how much have you billed so far for your work in the case to date?
A. I don't have that in front of me. I think I can get that figure from Mr. Couchot's office, and I'll provide that to the court reporter.
MR. COUCHOT: George, we talked about this before the depo. He doesn't retain his invoices, but I do, so I'll send them to you.
MR. HAND: That's fine.
Q. Are there any things -- you reviewed that Dawn Cook life care plan?
A. Yes.
Q. Are there any specific items you disagree with in the Dawn Cook life care plan?
A. I don't have it in front of me. I think most of

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what I've disagreed with is in my report. I can certainly -- we can certainly get the report out and go line by line. Or if you want, what might make it easier would be is if you would just ask me, or we'll get the report out and we'll go line by line.
Q. Well --
A. But most of what I've disagreed with is in my report.
Q. All right. Let's look at your report.
A. Okay.
Q. All right. Dr. Barchuk talks about depression, anxiety, and sleep disturbance in his evaluation.
Do you recall that?
A. I do recall that.
Q. Do you disagree with that assessment by Dr. Barchuk in any way?
A. I agree that -- that both the depression, anxiety, and sleep were preexisting issues and are currently -- and are currently existing issues for Ms. Farris.
Q. In your opinion, did those issues get worse after her surgery at issue in this case?
A. It's hard for me to -- to assess that because I don't really have a -- if I recall, there was not a mental health assessment done, to the best of my recollection. So I don't feel that I can comment in terms of the degree of

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if they were exacerbated based upon her surgical complications.

Q. And then chronic left heel stage decubitus. Do you have an opinion as to whether that is related to her complications from the July '15 surgery?

A. I agree that she has a wound on her heel. I disagree, though, that it is a decubitus. That's a term we no longer use. And I also disagree with the staging. But I do concur that that is new and that she does have a non-healing or poorly-healing wound of her left heel.

Q. And the probable left rotator cuff tendonitis, do you agree with that assessment or disagree with that assessment as being related to the July 2015 surgery?

A. I believe it's a preexisting condition.

Q. Going to -- in your report, looking at the second page, number 7. "Viscus perforation with intra-abdominal sepsis status post exploratory laparotomy and removal of prosthetic mesh."

Are you -- my question relates to that. Are you giving any opinions on the standard of care regarding the surgery of July 3rd, 2015?

A. No.

Q. Have you prepared life care plans on your own without the assistance of an RN?

A. No.

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Q. Are you familiar with the pricing for the different care modalities in the typical life care plan?

A. No.

Q. You rely on an RN for those numbers?

A. With the exception of I may be asked what the cost would be for a physical medicine rehabilitation physician consultation or outpatient visit, but for the remainder of the costs, such as durable medical equipment and surgeries and ER visits, I rely upon the life care planning expert.

Q. So you're not a certified life care planner.

Is that a fair statement?

A. Yes, that's correct.

Q. And then we go down to number 8, "Acute respiratory failure status post tracheostomy placement."

Do you agree with that assessment?

A. Yes.

Q. And then number 9, "History of incarcerated incisional hernia...laparoscopic repair with mesh."

Do you agree with that?

A. Yes.

Q. 10. "Encephalopathy secondary to sepsis and medications."

Do you agree with that assessment?

A. Yes.

Q. "Acute blood loss anemia."

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Do you agree with that assessment?

A. Yes.

Q. Acute -- number 12. "Acute kidney injury."

Do you agree with that assessment?

A. Yes.

Q. Number 13. "Neuropathy from prolonged immobilization."

Do you agree with that assessment?

A. I believe she has a neuropathy. I don't believe that it was due to prolonged immobilization, however.

Q. Have you seen various experts in this case diagnose Ms. Farris with critical illness polyneuropathy?

Have you seen that?

A. I believe I have.

Q. Do you agree with that diagnosis?

A. Yes, I do.

Q. So when I asked you about 13, "Neuropathy from prolonged immobilization," tell me how you disagree with that, if at all.

A. Well, the neuropathy is twofold. One, preexisting, and it's not due to the immobilization; it's -- critical illness polyneuropathy is not due to just somebody lying in bed; it's due to -- well, it's a poorly understood condition, but it's thought to occur due to multiple factors when somebody has an acute illness.

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It can be related to antibiotics. It can be related to autoimmune problems that can develop after an acute illness. And it can also develop or worsen when somebody is acutely ill and their blood sugars are poorly-controlled in a postoperative state.

So just lying in bed doesn't cause the neuropathy. These other factors contribute to a -- so she -- I do believe she has -- did develop a critical illness polyneuropathy superimposed upon a preexisting diabetic polyneuropathy, so that would be how I would characterize her neurological problem.

Q. And did you see she was assessed with sepsis during her hospitalization in July 2015?

A. I believe so.

Q. Do you believe her septic condition had anything to do causally with her critical illness polyneuropathy?

A. Well, I'm not going to hold myself out to be an expert with critical illness polyneuropathy, although I take care of a lot of patients with it. But my understanding is that sepsis can be a contributing factor to critical illness polyneuropathy.

Q. And then number 14. "Severe sensory loss and motor weakness below the knees bilaterally involving the tibial and peroneal nerves."

Do you agree with that assessment?

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A. Yes.
Q. Do you have an opinion as to the cause of the severe sensory loss and motor weakness below the knees bilaterally involving the tibial and peroneal nerves?
A. Yes.
Q. What is that?
A. Critical illness polyneuropathy.
Q. Dr. Stone, do you have any information or opinion on her -- I'm talking about Titina Farris's -- mobility status before her admission to the hospital on July -- for the July 3rd, '15 surgery?
A. I believe she was ambulatory.
Q. Do you know if there was any restrictions on her ambulatory status?
A. I don't believe so.
Q. Looking at number 15, it states, "Right ankle contracture with bilateral foot drop."
Do you agree with that assessment?
A. Yes.
Q. And the bilateral foot drop, do you have an opinion as to the cause of -- or causes of the bilateral foot drop?
A. Yes.
Q. What is that?
A. Critical illness polyneuropathy, and poor

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positioning of her foot would probably be the most likely cause. So weakness in association with immobilization and lying in bed with the foot in a plantar-flex position.
Q. And number 16. We've talked about weight gain already, I think.
A. No, we haven't.
Q. Okay. So do you agree she had weight gain after her discharge from the hospital?
A. I would say that she actually has -- what her current weight is and what her weight had been prior to surgery, she weighs less today or more recently than she did before surgery.
Q. Is the weight gain or lack of weight significant in any of your opinions in this case?
A. Yes.
Q. Okay. Can you explain that?
A. I think the weight loss after surgery will most likely contribute towards better control of her diabetes. And also, I think a lower weight is probably more helpful in terms of her transfers and ambulation and avoidance of future arthritic problems with her feet, ankles, knees, and hips.
Q. You mentioned in your report, number 18, "Chronic neuropathic musculoskeletal myofascial pain."
Do you agree with that assessment?

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A. Yes.
Q. And 19. She's noted, I believe by Dr. Barchuk, to be a high fall risk. Do you agree with that assessment?
A. I don't really have enough information to make an assessment. There wasn't a standard fall risk assessment performed by anybody that I could identify, so I don't have any way to identify her fall risk, high fall risk.
Q. Currently -- have you reviewed any EMG and nerve conduction studies in your review of this case?
A. I believe I have, although I don't have an independent recollection of the report, but I do have a fairly good recollection of the neurologist expert for the defendant who commented upon the EMG that was done after her surgery, confirming that she had an axonal and a demyelinating neuropathic process in her lower extremities.
To the best of my recollection, I don't believe that report included her upper extremities; I believe it was limited to her lower extremities, and I believe the conclusion was demyelinating and axonal neuropathy of the lower extremities.
Q. Would you expect someone with that condition bilaterally, such as Ms. Farris, to be a high fall risk?
A. Not necessarily.
Q. Why not?
A. Because there's multiple factors that go into

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identifying somebody as a high fall risk.
Q. -- those?
A. Can you repeat the question?
Q. What are those factors that go into assessing someone as a high fall risk?
A. That can be poor vision. It can be impaired executive functioning, so if somebody is impulsive. It can be poor balance. So these are typically assessments that are done by a physical therapist. They're standardized. There's multiple fall risk assessment protocols.
So those are a couple of the components that are in a fall risk assessment to determine whether somebody is at a low risk, medium, or at a high fall risk.
Q. And number 20 states, "Impaired mobility and ADL status." Do you agree with that assessment?
A. Yes.
Q. And 21, "Impaired avocational status."
Do you agree with that?
A. Yes.
Q. So the condition she has now, is it fair to state it's bilateral foot drop, in a general term?
A. Yes, I think that's the layperson's vernacular. Yes.
Q. Is that -- in your opinion, is that condition permanent?

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A. Are you speaking specifically about Ms. Farris?
Q. Farris.
A. I believe -- I believe it is most likely permanent, although there may be some opportunity for some reinnervation and improvement in her strength, but I believe, given the severity of the EMG findings, that most likely it is permanent.
Q. So talking about her ADL status, do you have an opinion as to currently, or when -- as of the date of your report, her ADL status is in terms of her activities of daily living, what she can do on her own currently.
Do you have an opinion as to that?
A. Yes.
Q. Can you explain to me what you, if anything, believe she is not capable of doing? And I can be specific, but if you have anything, you can tell me what you think she can't do on her own.
A. To the best of my recollection, I believe she can do the majority of her ADLs. She has to do them in a modified manner, so many of the activities need to be performed sitting. But to the best of my recollection, I believe she can do all of her ADLs, her basic ADLs: Dressing, toileting, grooming, and bathing.
Q. Do you think she can do housework on her own, such as mopping a floor?

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A. No.
Q. How about bathing herself? Do you believe she can get into a shower or tub on her own to bathe herself?
A. With modifications, yes.
Q. What modifications?
A. Perhaps, if she was in the shower, a shower chair. If she was performing this in a bath, it would be a bath bench. So I think with some durable medical equipment, I believe she could bathe herself or shower herself, if that's how her house is set up.
Q. Do you believe she can walk on her own unassisted for any distance currently or as of date of your report?
A. Unassisted without any device?
Q. Right.
A. No, I believe she would need a device, assistive device.
Q. Such as?
A. Front-wheeled walker and bilateral ankle/foot orthotic devices.
Q. Do you have an opinion as to how much assistance she needs from someone, currently in terms of an aide or nurse or something else.
A. I don't believe there's any clinical indication for a nurse.
Q. What about an aide?

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A. I believe she would benefit from an aide.
Q. How many hours a day would she need currently?
A. This is -- this would be primarily for light housekeeping, shopping. I would concur with the recommendation in Sarah Larsen's report.
Q. Do you have her report in front of you?
A. I don't.
MR. COUCHOT: Yeah, you do now.
THE WITNESS: I do.
MR. HAND: If we can mark that as Exhibit 2.
(Exhibit 2 was marked for identification.)
MR. HAND:
Q. Do you have that in front of you?
A. Yes.
Q. So she delineates between a direct hire and an agency hire, correct?
A. Yes, she does.
Q. So between the direct hire and the agency hire, is there any difference in the level of care or assistance that's required in each of those?
A. No.
Q. It's more a cost component by hiring an agency. You're paying overhead for their administrative costs, et cetera?
A. Yes.

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Q. So do you have Dawn Cook's report with you?
MR. COUCHOT: Is it on your disc drive?
THE WITNESS: Yes.
MR. COUCHOT: So he's got a jump drive. I can put it in my computer right now, if you want him to look at it.
MR. HAND: Yeah, if he could.
MR. COUCHOT: Sure.
MR. HAND: I'd appreciate it.
MR. COUCHOT: Sure, sure. No problem.
THE WITNESS: I have the report in front of me.
MR. HAND:
Q. All right. Let me just get to the --
Can we just take a quick two-minute break, Chad? I just got an email from your office I think I have to deal with. Can we take just a minute?
MR. COUCHOT: Yeah, sure. No problem.
MR. HAND: We'll go off.
THE VIDEOGRAPHER: All right. Off record at 10:43.
(Off the record at 10:43 a.m. and back on the record at 10:45 a.m.)
THE VIDEOGRAPHER: On record at 10:45.
MR. HAND:
Q. All right. Dr. Stone, if you go to page 16 of the report of Dawn Cook.

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A. Okay, I'm on page 16.
Q. All right. It states one -- where Ms. Cook talks about services recommended in the life care plan, it states, "Due to bilateral foot drop, Ms. Farris has difficulty ambulating without the use of assistive devices and supervision."
Do you agree with that statement?
A. I agree with that statement.
Q. "Recommendations include: Bilateral custom-fit ankle foot orthosis -- orthosis, four-wheeled walker with seat, manual wheelchair and power wheelchair."
I'm just reading this paragraph.
"Accessible van, with portable ramps will be needed for transportation. As she ages, additional recommendations include Hoyer lift and slings and home modifications to accommodate the wheelchair."
Are any of those recommendations that you disagree with?
A. The only one I would disagree with it would be the Hoyer lift and slings.
Q. Why is that?
A. We don't – we don't usually, in rehab, use a Hoyer lift for patients unless the caregiver cannot lift the patient without – or transfer the patient safely, or if the patient has upper extremity function. So, you know,

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the patient can participate in their transfer.
So Hoyer lifts are not ideal for transferring people, but I don't think in Ms. Farris's situation, even as she ages, a Hoyer lift is going to be necessary. But everything else, I would agree with.
Q. Number 2. It states, "Ms. Farris is unable to clean or maintain her home due to her limitations of mobility as a result of bilateral -- of the bilateral foot drop. Recommendation home maintenance services."
Do you agree or disagree or something else regarding that recommendation?
A. I would agree.
Q. Then number 3 talks about Mr. Farris, Patrick Farris has difficulty maintaining his role. And it states that recommendations for personal care attendant/chore assistance to allow Mr. Farris to return to the role of husband, rather than caregiver.
Do you agree, disagree, or something else regarding that recommendation?
A. Well, I don't know what to say – you know, I don't really have a comment on the first sentence, and I don't – you know, don't really know what that means. But I would agree with the recommendation for a personal care attendant to help with chore assistance.
It's rather broad in terms of what Ms. Cook is

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talking about. But in general, I would agree with the second sentence. I'm not sure what to make of the rest. But, yes, I think she needs assistance with chores.
Q. All right. Number 4, "Decreased diversional activity. Ms. Farris is unable to roam freely into the yard and engage with her pets due to the absence of wheelchair ramps. Recommendation is for ramps to be installed in the home."
Do you agree, disagree, or something else with that recommendation?
A. I would agree.
Q. 5. "Risk for Falls, Risk for Injury."
It states that she -- Ms. Farris has difficulty ambulating yet a desire to do so. The bilateral foot drop increases the risk for falls or injury. In addition to the mobility aids previously mentioned, recommendations are made for grab bar placement near the toilet and in the shower, elevated toilet seat, shower hose and shower bench.
Do you agree, disagree, or something else regarding that recommendation?
A. Agree.
Q. And number 6 refers -- discusses pressure ulcer -- pressure ulcer, repair tissue, integrity. It states, "Ms. Farris has decreased sensation in her feet due to neuropathy and history of a wound to her heel.

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Recommendations to prevent further wound development as well as assist the healing process: Daily attendant care to visualize the heels, pressure relief ankle foot orthosis for nighttime use."
Do you agree, disagree, or something else?
A. Something else.
Q. Can you explain that?
A. I would agree with the pressure relief ankle/foot orthosis, also known as a PRAFO, for nighttime use, but I don't think there's any indication that an attendant is necessary to visualize her heels. Most of the time in the majority of patients, even patients -- spinal cord injury patients, they can visualize using a mirror, if they can't directly see their affected parts, so I don't think – I don't think a daily attendant is necessary for that activity.
Q. Did she -- referring to Ms. Farris -- have any history of heal or ulcer wounds to her feet prior to this hospitalization in July of '15?
A. Not that I'm aware of.
Q. And going to number 7, "Chronic pain. Ms. Farris has developed chronic neuropathic musculoskeletal myofascial pain following her surgery in July '13. Recommendations include ongoing surveillance by her medical team."

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Do you agree, disagree, or something else regarding that recommendation?

A. I agree with the last sentence that she requires ongoing surveillance, but I don't believe that her pain developed after her surgery in 2013.

Q. Dr. Barchuk recommended, I believe, aquatic physical therapy.

Do you disagree with that recommendation?

A. I think it could be helpful once her wound has healed. I don't think it needs to be physical therapy, but I think aquatic therapy could be beneficial for her.

Q. Does Ms. Farris need physical therapy currently, or when you wrote your report?

A. I don't believe she does. I think she has an established home exercise program. And I believe in Ms. Larsen's report that I contribute to, we recommended that she sees a physical therapist annually for an update of her home exercise program.

Q. Is there anything in terms of physical therapy or treatment that can be administered to her to try to increase ambulatory function?

A. I think the administration of a home exercise program and her carrying out that program on her own and going to a gym and performing some of these activities both at home and in a gym setting would improve her

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strengthening in other muscles that are not affected. That would be helpful, but I don't think that any strengthening could most likely be applied to the muscles that are not functioning at all.

So I think the physical therapist would primarily be beneficial for updating a home exercise program for her and also contributing towards any new equipment that she may need or new orthosis that she may need to have fabricated.

Q. Do you have an opinion as to the cause of her carpal tunnel, her upper extremities?

A. Well, I'm not quite sure she has carpal tunnel. I see that as basically something that is in some of the reports, but I don't see an EMG. And I think an EMG, most of the time, at least in my practice, and most of the physicians that I work with, require an EMG to establish a diagnosis of carpal tunnel syndrome.

So I don't know that she has carpal tunnel. Her – if she does have symptoms in her hands, these may also be consistent with her diabetic neuropathy. So I think an EMG nerve conduction study to define her upper extremities would be helpful.

Q. Does she need, in the future, EMGs on a periodic basis to monitor the lower extremities?

A. No.

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Q. Why not?

A. Because it – the diagnosis has already been established, and it wouldn't – you know, it wouldn't change any of the treatment for her. At this point, the EMG might just tell you whether she is getting some reinnervation, but there would really be no benefit in terms of knowing that. So I can't envision any scenario where repeating or EMG in her lower extremities would change the outcome or change the treatment plan.

Q. How about Doppler testing to the lower extremities? Is that something that would be indicated for Ms. Farris in the future?

A. No.

Q. Why is that?

A. Well, she – I mean, as surveillance, no. If she were to develop signs or symptoms of a blood clot, yes. But in terms of just performing them as a surveillance procedure, no.

Q. All right. Looking at your report, going to page -- I believe it's page 4 where you talk about Dr. Barchuk's future care recommendations.

A. Yes.

Q. And number 1, "Physical medicine and rehab specialist."

Do you agree that she would need that type of

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specialist in the future?

A. Yes.

Q. "Primary care physician." Does she need that kind of specialist or treatment in the future?

A. Yes.

Q. "Podiatrist." Does she need the care of a podiatrist in the future?

A. Yes.

Q. "Orthopedic, hand surgery." Does she need that kind of treatment in the future?

A. There's a prob- – I think a probability, yes. Can I just make one comment?

Q. Sure.

A. I just want to be sure we're talking about that I'm saying she's going to need this, I'm not implying through my testimony that – I believe some of these things she would have needed anyway. For example, you know, podiatry and primary care.

So I just want to be clear that I'm not testifying that this is because of – all of these are because of her surgery, her post-surgical complications.

Q. So why don't we just segregate those out so the -- how did these -- Dr. Barchuk's future care recommendations, 1 through 23, are any of these -- take your time looking at them. Which of these, if any, do you opine she would have

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needed anyway?
A. Number 2, "Primary Care Physician," she would have required. Number 3, "Podiatry," she would have required. Number 4, "Orthopedic Surgery, Hand Surgery," she would have required. Number 5, "Psychology and/or Psychiatry," she would have required. Or Number 6, "Dietician," she would have required. Number 7, "Physical or Occupational Therapy," she would have required.
Massage therapy and acupuncture therapy, I think she may have – may well have benefited from that before or after. I just can't opine whether that is something that this complementary therapy is – you know, has been proven to help people, but I think that would have existed before as well.
Wound care clinic. I – that is secondary to her post-surgical complications. The adaptive – I'm sorry. I'm not answering your question correctly.
Carpal tunnel surgery. If it was present – I don't believe it was present, and I don't – and I'm not confident it's present now, so I don't really know what to say about number 11.
Joint and trigger point injections she would have needed beforehand.
MRI of her left shoulder. She was having shoulder problems prior, and I would have – she would have required

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that as well.
EMG studies of the upper lower extremities. I believe that was – those were done before anyways.
Electric wheelchair would be – would not have been required before.
The AFOs would not have been required before.
The heel protector boots, not required before.
Single-point cane, not required before.
Four-wheeled walker, not required before.
Reacher, not required before.
Binder, not required before.
Four to six hours of attendant care, not required before. And a fully wheelchair-accessible home, not required before.
Q. All right. Going to the next page, number 1, you state, "I support future PMR subspecialty care."
Can you explain that assessment to me.
A. Yes, my specialty of physical medicine and rehabilitation would be beneficial to her both for pain management and also prescribing any physical modalities, helping with her equipment needs, and I would recommend that she see a physical medicine or rehabilitation specialist to help with her disability and to help with pain management.
Q. All right. I think we've discussed some of these

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already. Going to number 5, the psychology, psychiatry. You state her mood disorder has been impacted by her acquired disability and functional impairment. You would support episodic behavioral health services.
A. Yes.
Q. Are you aware of anything in her records or medical history that made her not functional due to any kind of psychological/psychiatric disorder prior to July of '15?
A. No.
Q. So then number 7, you talk about physical and occupational therapy. Specifically, what is your recommendation, if any, as to what she would need currently as to the episodic therapeutic services?
A. Well, primarily what I had already testified to in your earlier question, that I think she should be seeing a physical or occupational therapist annually to update her equipment needs and to reassess her strength sensation, and then provide her with an updated home exercise program.
Q. Do you have an opinion as to how many hours a day she would need assistance with her ADLs, if any?
A. I think I would rely upon Sarah Larsen's report. I think Sarah's got sort of two to four hours a day.
Q. Number 12. Adaptive aquatic swim therapy program. You state you don't support that recommendation.

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Could you explain that?
A. Well, I don't – in my experience, it's not always available for individuals. I – in my experience, I don't necessarily see that it has any distinct advantages. I mean, some people like being in the water. Maybe sometimes for patients who really have spinal cord injury and are unable to move at all, it can be helpful. But I don't – I don't – I think that the same can be accomplished in a gym with a motivated patient and with equipment. So, you know, it doesn't necessarily offer any distinct advantages over a land-based program.
Q. I see.
A. And she has a wound as well, so I think that would be a contraindication.
Q. Assuming the wound healed, would that be a suitable therapy, if the wound healed?
A. I mean, I wouldn't oppose it. I don't – again, I don't think it offers any great advantages. And again, it's not always available. But I wouldn't – yeah, it – it's – the same can be accomplished in a gym.
Q. All right. Number 15, support the need for future powered mobility device.
Do you have a time frame as to when you would support that, or is it current, or something else?
A. I think she might benefit from some type of power

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device currently to allow her to get out into the community and go a longer distance. So I think that might be something, if she was interested, could help her right now.

Q. All right. 16. Bilateral custom AFO. By "AFO," what do you mean by that?

A. Those are ankle/foot orthotic devices. Those are the custom-made -- custom-fabricated polypropylene orthotics that are used to help position her foot and ankle and elevate her foot, both feet when she is walking to allow her to clear her feet.

Q. All right. And then 17. Single-point cane, reacher, abdominal binder, heal protector boots.

You support those, correct?

A. Yes.

Q. And number 18. You state -- I guess you recommend four to six hours of daily attendant services.

Is that a correct reading?

A. Yes, I think I was combining the ADLs along with the chores and things like that, shopping. So I was collectively adding those things together.

Q. Under your -- in your opinion, would the hours needed for a daily attendant increase over time or remain the same or something else?

A. I think there's a likelihood that they may increase over time.

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Q. Why is that?

A. Well, I don't think -- I don't think it would be directly related to her foot drop; I think it would more likely be related to that she has several co-morbidities. She's a diabetic. She's had these chronic shoulder problems. So she's at a higher risk for neuropathy in her upper extremities. She's at higher risk for arthritic problems, spine problems. So I think that she may become more disabled over time and may require a little bit of extra assistance. She's also at high risk for cardiac problems.

So I think a lot of her underlying medical problems are what would more likely lead to her needing additional caregiving help rather than the bilateral foot drop, which, in my opinion, is not a progressive disorder, so we wouldn't expect that to change over time. If anything, it may get a little better, but it certainly is not progressive, shouldn't get worse.

Q. All right. Looking at number 19, you state, "Fully wheelchair accessible home in five to ten years."

Do you -- I want to understand what you're saying here. Do you think she would need that or doesn't need that? I'm not sure --

A. I think she will need that because I think in, you know, five to ten years, more likely along -- ten years,

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she more than likely would probably be wheelchair-dependent.

Q. Okay. Then at the end you state, "...she would have become wheelchair dependent regardless of her surgical complications."

What's the basis of that statement?

A. Well, just looking over her past history and noncompliance and risk factors, you know, for future stroke, for future MI, heart attack, for diabetic polyneuropathy involving the upper extremities, for diabetic arthropathy.

So I think -- in my experience, individuals like this who develop and have these severe medical complications at a relatively young age and that are progressive, you know, usually end up becoming very disabled over time with a shortened life expectancy.

Q. Well, to a reasonable degree of medical probability -- well, excluding the foot drop she has, when would she have been wheelchair-dependent in your opinion?

A. Okay. So I'm basing this -- you know, there's -- I don't think there's any study we can find on this. I'm basing this upon 30 years of experience and, you know, a current active hospital-based practice. I would say that probably in her early to mid-'60s.

Q. Do you have any data on the percentage of -- I'll

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start broadly, the percentage of type two diabetics that become wheelchair-bound?

A. I don't.

Q. Do you have any data on the percentage of diabetics with diabetic neuropathy that become wheelchair-bound?

A. I do not.

Q. So if I look at the last paragraph of your report, you do not endorse Dr. Barchuk's life expectancy projection for medical research and life expectancy expert Scott Kush.

Why don't you endorse -- well, what was Dr. Barchuk's life expectancy projection?

A. I don't remember the exact number, but I believe he shared that it would be a normal life expectancy.

Q. Are you familiar with the government life expectancy tables?

A. Vaguely, yes.

Q. Do those tables include the average person, the healthy person, the unhealthy person in those tables?

A. I don't recall.

Q. Have you ever given opinions in court as to life expectancy projections?

A. No; I defer to a life expectancy expert.

Q. So in any of the life care plans you've done, you've never done a life expectancy projection?

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A. My recommendation is a life expectancy expert.
Q. So if I had to boil this down to where you disagree with Dr. Barchuk, in summary that would be what, if you could tell me?
A. I don't want to corner myself in, you know, because I don't – if you could ask me more specifically, but I don't want to, you know, make a guess. Or we can spend, you know, the next hour of me going through this, but I think I've done it already. But if you want to ask me specifically, I will, but I don't want to, you know, off the top of my head come up with some thoughts that may not be what I have already documented and reviewed.
Q. Fair enough. Do you know who assists Ms. Farris with her activities of daily living currently?
A. I don't know, specifically.
Q. Did you have -- or do you have any opinion as to the range of mobility, if any, unassisted for Ms. Farris at the time you did your report, based on the records you've seen?
A. Wait. Can you restate the question again?
Q. Do you have any opinion as to range of walking she would have unassisted, based on the records you've reviewed --
A. To the best –
Q. -- at the time?

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A. To the best of my recollection, if I'm answering your question correctly, that I have currently, without going back and reviewing the records, is that she would be basically classified as an independent household ambulator with an assistive device. I can't recall what her community mobility is as I sit here right now.
Q. So in terms of any criticism you have of the Dawn Cook life care plan, would it be fair to state you would rely on what Sarah Larsen said with regard to that plan, or do you have independent opinions on that?
A. I would support Sarah Larsen. I contributed to that plan, and I would endorse Sarah Larsen's interpretation.
Q. Have you ever worked with Sarah Larsen prior to this case?
A. I believe I have once.
Q. Are you -- do you know Dr. Barchuk?
A. I don't know him personally.
Q. So have I covered all of your opinions in this case, or are there things that you intend to testify that I haven't brought up with you?
A. At this point, no, unless I were to receive additional medical documents. But based upon what I have available to me today, those are the only opinions that I have.

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MR. HAND: All right. I don't think I have any other questions. Thank you, Dr. Stone.
THE WITNESS: Thank you.
MR. COUCHOT: Stay on the record for a second. Hey, George, should he send you an invoice? Is that what you want to do?
MR. HAND: Send to it me. Somebody emailed it from your office already. I haven't looked at it. That's the email I got.
MR. COUCHOT: No, no, that was his billing records.
MR. HAND: Oh, okay. Let me look at that.
MR. COUCHOT: Do you want to look at that before we go off -- we go off?
MR. HAND: Yeah, let me do that. I thought that was an invoice.
MR. COUCHOT: No.
MR. HAND: Okay. So for an hour and 15 minutes or what?
THE WITNESS: Well, I -- you know, I blocked off -- you know, since I had asked your -- your office was asked how long this would be. I was told an hour. So I don't -- I don't bill quarter hours, so I have to take the time off.
MR. HAND: We'll work it out, whatever it is.

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THE WITNESS: Okay.
MR. HAND: Let me just look at this email before we stop.
--oOo--
FURTHER EXAMINATION BY MR. HAND:
Q. I just have a few more questions. It won't take long --
A. Yes.
Q. -- and we'll be finished.
Dr. Stone, did you look at any of the videos of Titina Farris taken by Dr. Barchuk?
A. I don't believe I have.
Q. Did you look at any other videos of Titina Farris?
A. The only thing I independently recollect are photos. I don't recollect actually seeing a video, but photos, I recollect.
MR. HAND: All right. Thank you.
Chad, I need to speak to you about some other things once we wrap this thing up.
MR. COUCHOT: Sure, no problem. Okay, are we done?
MR. HAND: We're done. Thanks.
THE VIDEOGRAPHER: All right. Mr. Hand, this is the video operator. Do you have a video copy order?
MR. HAND: I assume we do, yeah.

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THE VIDEOGRAPHER: All right. And do you have a transcript order? Do you want to order one?
MR. HAND: I'd like the ascii and, you know, PDF with the exhibits in PDF, whatever we get.
THE VIDEOGRAPHER: And Mr. Chad, do you have video or transcript orders?
MR. COUCHOT: Yeah. I'll order a copy of the video as well, and then I'll order a full, condensed, and electronic. No double-sided, please.
THE VIDEOGRAPHER: All right. Thank you. This marks the end of the deposition of Lance Stone, DO.
We're going off the record at 11:20.
(Record closed at 11:20 a.m.)

_____
Lance Stone, DO

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STATE OF CALIFORNIA
I, CYNTHIA J. POLISERI, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth, and nothing but the truth in the within-entitled cause; that said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein stated, and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;
I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the event of this cause, and that I am not related to any of the parties thereto.

DATED: August 12, 2019

_____
Cynthia J. Poliseri, CSR No. 11448

EXHIBIT "4"

ELECTRONICALLY SERVED
12/29/2016 09:22:14 PM

ANS
George F. Hand, Esq.
Nevada State Bar No. 8483
ghand@handsullivan.com
Nelson L. Cohen, Esq.
Nevada State Bar No. 7657
ncohen@handsullivan.com
HAND & SULLIVAN, LLC
hsadmin@handsullivan.com
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.: XXII **PLAINTIFF TITINA FARRIS's ANSWERS TO DEFENDANT'S FIRST SET OF INTERROGATORIES**

COMES NOW, Plaintiff Titina Farris, by and through his attorneys of record George F. Hand, Esq. and Nelson L. Cohen, Esq. of Hand & Sullivan, LLC, and hereby responds to Defendant's First Set of Interrogatories as follows:

PRELIMINARY STATEMENT & GENERAL OBJECTIONS

These objections are applicable to each and every interrogatory, except where otherwise stated. Further, these objections are incorporated into each response as though fully set forth therein. Each response is given subject to appropriate objections (including, but not limited to, objections concerning competency, relevancy, materiality, propriety, and admissibility) which would require the exclusion of any statement contained herein if the interrogatories were asked of,

or any statement contained herein were made by, a witness present and testifying in a court. All such objections and grounds therefore are reserved and may be interposed at the time of trial. These responses are made solely for the purpose of, and in relation to, this action. This Responding Party has not completed its investigation of the facts relating to this action, has not yet completed preparation for trial. The following answers are, therefore, given without prejudice to this party's rights to allege and/or produce additional evidence of subsequently discovered or revealed facts and circumstances.

Except for facts explicitly admitted herein, no admission is to be implied or inferred. The fact that an interrogatory herein has been answered should not be taken as an admission, stipulation, or confession of the existence of any facts set forth within, implied by, or assumed under such interrogatory. Nor does such response constitute evidence of any fact thus set forth, implied, or assumed. All responses shall be construed as having been given on the basis of this Responding Party's best recollection.

Plaintiff objects to the entirety of the interrogatories, and to each and every interrogatory to which it hereunder responds, on grounds of undue burden, oppression, argumentative, needless expense, and calculation to harass, in violation of NRCP 26(g).

Plaintiff further objects to each interrogatory to the extent it requires Plaintiff to summarize, digest, characterize, and identify documents and other evidence in the possession of Plaintiff or his/her legal counsel.

Plaintiff objects to each interrogatory to the extent it seeks information protected under privilege, work product, immunity, or otherwise. Plaintiff's undersigning attorneys join in this objection to the extent such privileges are held by them.

Plaintiff objects to these interrogatories as unduly burdensome and oppressive in that they are duplicative, cumulative, and overlapping, overbroad, and are not reasonably calculated to lead to the discovery of admissible evidence, and/or fail to identify the information sought with reasonable or adequate particularity.

Plaintiff objects to each interrogatory under NRCP 33(c) to the extent such interrogatory or request requires Plaintiff to compile, extract, abstract, audit, and/or summarize, where such

compilations, extracts, abstracts, audits, and/or summaries did not exist independent from such interrogatory.

Without waiver of the foregoing, and further reserving the right to object on any ground whatsoever to the admission into evidence or other use of the following responses at trial or in any other proceeding, under reservation of its right to object on any ground at any time to a demand for further responses to the interrogatories or other discovery procedures involving or relating to the subject matter of the interrogatories; and further reserving the right to revise, amend, extend, clarify, and/or correct any of the answers set forth below, Plaintiff answers as follows:

Interrogatory No. 1:

If you contend Defendant BARRY RIVES, M.D.'s care was below the standard of care, what did he do or fail to do that was below the standard of care?

Answer to Interrogatory No. 1:

This Interrogatory is objected to on the grounds that it calls for an expert opinion and Plaintiff is not an expert. This Interrogatory is further objected to on the ground that it requires a legal/medical determination by this Plaintiff. Notwithstanding said objection and without waiving the same, Plaintiff responds as follows: See the expert reports provided with the Complaint. Discovery is continuing and this Interrogatory will be supplemented as additional information becomes available.

Interrogatory No. 2:

If you contend Defendant BARRY RIVES, M.D. or LAPAROSCOPIC SURGERY OF NEVADA, LLC's records are false, forged, altered or modified, describe why.

Answer to Interrogatory No. 2:

At the present time, I have no knowledge as to this subject. Discovery is continuing and this Interrogatory will be supplemented as additional information becomes available.

Interrogatory No. 3:

State your name and every name you have used in the past.

Answer to Interrogatory No. 3:

Titina Durham; Titina Farris.

Interrogatory No. 4:

State the date and place of your birth.

Answer to Interrogatory No. 4:

October 24, 1962, Harrisburg, PA.

Interrogatory No. 5:

State your Social Security number.

Answer to Interrogatory No. 5:

562-33-XXXX

Interrogatory No. 6:

Are you, or have you ever been a Medicare beneficiary?

Answer to Interrogatory No. 6:

No.

Interrogatory No. 7:

If you are, or have ever been a Medicare beneficiary, state: the dates you have been eligible for Medicare Benefits; all names under which you obtained Medicare benefits; and your Medicare Health Insurance Claim Number (HICN).

Answer to Interrogatory No. 7:

N/A.

Interrogatory No. 8:

State in reverse chronological order your residence addresses for the past ten (10) years.

Answer to Interrogatory No. 8:

6450 Crystal Dew Drive, Las Vegas, Nevada 89118

Interrogatory No. 9:

State in reverse chronological order the names and addresses of your employers or places of self-employment for the past ten (10) years.

Answer to Interrogatory No. 9:

Self-employed. 6450 Crystal Dew Drive, Las Vegas, Nevada 89118.

//

Interrogatory No. 10:

State the names and addresses of the schools or other academic or vocational institutions you have attended beginning with high school and the degrees you received.

Answer to Interrogatory No. 10:

High School graduate. Yucaipa High School, Yucaipa, CA. 1981.

Interrogatory No. 11:

If you have been convicted of a felony, state for each conviction, the offense, the city and state where you were convicted, the date of the conviction and the case number.

Answer to Interrogatory No. 11:

N/A.

Interrogatory No. 12:

If as a result of the injuries or damages you describe in this lawsuit, you have received or are receiving any benefits from the U.S. Government (for example, the Social Security Administration, the Veterans Administration or Medicare), the State of Nevada (for example, disability benefits or Medicaid), another state, s school district, a private health or disability insurer, a worker's compensation insurer or a private or quasi-private organization (for example, the Shriners or the Elks), state the names and addresses of the sources of the benefits, the types of benefits and the amounts of the benefits.

Answer to Interrogatory No. 12:

N/A.

Interrogatory No. 13:

Describe the past, current or future physical, mental or emotional injuries you are claiming in this lawsuit.

Answer to Interrogatory No. 13:

I am in chronic pain and mental upset. I cannot take care of myself, my husband, my daughter or my home. I was confined to a wheelchair for approximately one year after the surgery by Dr. Rives in July 2015. I had to wear a colostomy bag for several months. I am unable to walk or stand on my own. I also have constant pain in my feet and calves.

Interrogatory No. 14:

If you have received or are receiving care or services for any of the physical, mental or emotional injuries you are claiming in this lawsuit, state the names, addresses and telephone numbers of the individuals and facilities that provided the care or services.

Answer to Interrogatory No. 14:

Naomi Chaney, M.D.

Interrogatory No. 15:

If you took or are taking any medications, prescribed or not, for the physical, mental or emotional injuries you are claiming in this lawsuit, identify the medications by name and the persons who prescribed or furnished them.

Answer to Interrogatory No. 15:

I was prescribed Percocet by Dr. Chaney. I was also prescribed anxiety medication.

Interrogatory No. 16:

If health care providers told you that you may require future or additional care or services for the physical, mental or emotional injuries you are claiming in this lawsuit, state the names and addresses of the health care providers and what they said.

Answer to Interrogatory No. 16:

I am currently unable to walk, stand or perform many tasks of daily living. I will need continued therapies and medical treatment.

Interrogatory No. 17:

State the names, addresses and telephone numbers of the health care providers you have seen in the past ten (10) years for any reason.

Answer to Interrogatory No. 17:

See Plaintiffs' Early Case Conference Production of Documents and List of Witnesses. Discovery is continuing and this Request will be supplemented should additional documents become available.

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Interrogatory No. 18:

State the names, addresses and telephone numbers of the health care institutions you have visited in the past ten (10) years for any reason.

Answer to Interrogatory No. 18:

See Plaintiffs' Early Case Conference Production of Documents and List of Witnesses. Discovery is continuing and this Request will be supplemented should additional documents become available.

Interrogatory No. 19:

Do you claim a loss of income or a diminished earning capacity?

Answer to Interrogatory No. 19:

Not applicable.

Interrogatory No. 20:

State your gross monthly income at the time of the incident described in the complaint.

Answer to Interrogatory No. 20:

I am not claiming lost income.

Interrogatory No. 21:

State the dates you did not work following the incident described in the complaint and the total income you have lost to date.

Answer to Interrogatory No. 21:

Not applicable.

Interrogatory No. 22:

If you believe you will lose income in the future because of the incident described in the complaint, state an estimate of the amount of income you will lose.

Answer to Interrogatory No. 22:

Not applicable.

Interrogatory No. 23:

If there are any other damages you attribute to the incident described in the complaint, describe those damages.

Answer to Interrogatory No. 23:

See Answer to Interrogatory No. 13.

Interrogatory No. 24:

State all the physical, mental or emotional disabilities you had immediately before the incident described in the complaint.

Answer to Interrogatory No. 24:

I had no significant issues other than the reoccurrence of a hernia which led to the surgery by Dr. Rives on July 3, 2015.

Interrogatory No. 25:

If since the incident described in the complaint you sustained any new or different injuries, list the injuries.

Answer to Interrogatory No. 25:

Not applicable.

Interrogatory No. 26:

If in the past ten (10) years you filed actions or made claims or demands for compensation for any injuries, state the dates, times and places of the incidents giving rise to the actions, claims or demands and whether the actions, claims or demands have been resolved or are pending.

Answer to Interrogatory No. 26:

Not applicable.

Interrogatory No. 27:

If in the past ten (10) years you made claims or demands for worker's compensation benefits, state the dates, times, and places of the incidents giving rise to the claims or demands and the names and addresses of the worker's compensation insurers and the claim numbers for the claims or demands.

Answer to Interrogatory No. 27:

N/A.

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Interrogatory No. 28:

If you or anyone acting on your behalf interviewed percipient witnesses concerning the incident described in the complaint, state the names, addresses and telephone numbers of the persons interviewed and the dates of the interviews.

Answer to Interrogatory No. 28:

I am not aware of interviews of percipient witnesses.

Interrogatory No. 29:

If you or anyone acting on your behalf obtained written or recorded statements from percipient witnesses, state the names, addresses and telephone numbers of the persons from whom the statements were obtained, the names, addresses and telephone numbers of the persons who obtained the statements and the dates the statements were obtained.

Answer to Interrogatory No. 29:

I am not aware of interviews of written or recorded statements from percipient witnesses.

Interrogatory No. 30:

If health care providers said something to you about Defendant BARRY RIVES, M.D.'s care that you understood to be a criticism of the care, state the names, addresses and telephone numbers of the health care providers and what they said.

Answer to Interrogatory No. 30:

No.

Interrogatory No. 31:

If you filed for bankruptcy in the last three (3) years, list the court where the bankruptcy was filed and the case number.

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Answer to Interrogatory No. 31:

N/A.

Dated: December 29, 2016

HAND & SULLIVAN, LLC

By: _____

George F. Hand, Esq.
Nevada State Bar No. 8483
Nelson L. Cohen, Esq.
Nevada State Bar No. 7657
3442 North Buffalo Drive
Las Vegas, Nevada 89129
Attorneys for Plaintiffs
TITINA FARRIS and PATRICK FARRIS

VERIFICATION

STATE OF NEVADA)
) ss.
COUNTY OF CLARK)

TITINA FARRIS being duly sworn, states that she has read the foregoing **ANSWERS TO DEFENDANT'S FIRST SET OF INTERROGATORIES TO PLAINTIFF** and that the same are true to the best of her knowledge and belief.

DATED this 29th day of December, 2016

Titina Farris
TITINA FARRIS

SUBSCRIBED AND SWORN to before me
this 29th day of December, 2016

NOTARY PUBLIC in and for said
County and State

ANNA GRIGORYAN
NOTARY PUBLIC
STATE OF NEVADA
Appt. No. 16-4342-1
My Appt. Expires Dec. 5, 2020

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 December 29, 2016, I served the within document(s) described as:

PLAINTIFF TITINA FARRIS's ANSWERS TO DEFENDANT'S FIRST SET OF INTERROGATORIES

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 Wiznet, 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.

Amber S. Brown
Amber S. Brown

(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 *Attorneys for Defendants*	Kim Mandelbaum, Esq. filing@memlaw.net Mandelbaum Ellerton & Associates 2012 Hamilton Lane Las Vegas, Nevada 98106 (702) 367-1234 *Attorneys for Defendants*

EXHIBIT "5"

Chad C. Couchot, Esq.
12/19/18
SCHUERING ZIMMERMAN & DOYLE, LLP
400 University Avenue
Sacramento, CA 95825-6502

Dear Mr. Couchot

RE: Titina Marie Farris

I was retained by your office as a Board Certified Physical Medicine and Rehabilitation (PMR) physician expert. You requested I review the Life Care Plan (LCP) authored by Dr. Alex Barchuck and attest to any separate and divergent opinions I may hold. In preparation I reviewed the LCP document and also Titina Marie Farris medical records provided by your office.

I maintain a current full time clinical and prior academic medicine practice within the specialty of Physical Medicine and Rehabilitation as a healthcare provider for disabled individuals including but not limited to those with critical illness polyneuropathy. I am a qualified rehabilitation medical expert due to my professional training and clinical experience. I have not examined Ms. Farris notwithstanding I reserve the possibility my opinions may evolve if the opportunity to examine her availed itself. Based upon the documents I reviewed listed below I am confident in submitting an opinion of her future medical and rehabilitation care. My opinions are expressed below and within a separate LCP document jointly prepared with Sarah Larson, RN.

ADVANCED ORTHOPEDICS SPORTS MEDICINE
ALEX BARCHUCK, M.D.'S LCP evaluation
BARRY RIVES, M.D.
BESS CHANG, M.D.
CARE MERIDIAN (MEDICAL BILLING
CTE STONE RE RECORDS FOR REVIEW
DAWN COOK'S LIFE CARE PLAN
DESERT VALLEY THERAPY
DR. CHANEY
DR. HAMILTON
DR. STEVEN Y. CHINN MEDICAL BILLING
ELIZABETH HAMILTON, M.D.
JUSTIN WILLER, M.D.'S REPORT
LAPAROSCOPIC SURGERY OF NEVADA
PATRICK FARRIS
PHOTOGRAPHS OF PLAINTIFF
ST. ROSE DOMINICAN - SIENA CAMPUS
ST. ROSE DOMINICAN HOSPITAL

The following are the list of diagnosis Dr. Barchuck documented following his clinical examination of plaintiff:

"Ms. Titina Marie Farris is a 55-year-old married female with history of a perforated viscus with intra-abdominal sepsis with numerous sequelae who was seen at Kentfield Rehabilitation & Specialty Hospital on 3/20/2018 at which time a history was obtained and a physical examination was performed".

1. Reducible ventral hernia

2. Bilateral hand Dupuytren's Contracture

3. Probable bilateral Carpal Tunnel Syndrome

4. Probable left rotator cuff tendonitis

5. Chronic left heel stage 3 decubitus

6. Situational depression, anxiety and sleep disturbance

7. Viscus perforation with intra-abdominal sepsis status post exploratory laparotomy and removal of prosthetic mesh □

8. Acute respiratory failure status post tracheostomy placement □

9. History of incarcerated incisional hernia status post laparoscopic repair with mesh

10. Encephalopathy secondary to sepsis and medications □

11. Acute blood loss anemia □

12. Acute kidney injury □

13. Neuropathy from prolonged immobilization □

14. Severe sensory loss and motor weakness below the knees bilaterally involving the Tibial and Peroneal nerves □

15. Right ankle contracture with bilateral foot drop □

16. Weight gain □

18. Chronic neuropathic musculoskeletal myo-fascial pain □

19. High fall risk □

20. Impaired mobility and ADL status □

21. Impaired avocational status □

Based upon my independent review of Ms. Farris medical records I agree in general with Dr. Barchuck's diagnosis. However, the medical records I reviewed support my conclusions that several medical problems were pre-existing or unrelated to surgery

1. **Ventral hernia- Pre-existing condition**
2. **Bilateral Dupuytren contracture- May be inherited and develops more commonly within diabetic patient population. Dupuytren is unrelated to her procedure and surgical complications**
3. **Probable Carpal Tunnel Syndrome- Unconfirmed. Pre- existing related to diabetic polyneuropathy**
4. **Probable left rotator cuff tendonitis- Records reflect this was a pre-existing condition**
5. **Chronic left heel Stage 3 Decubitus- Inaccurate diagnosis. Wounds are no longer diagnosed or staged as "Decubitus". Ms. Farris most likely has a calcaneal pressure wound that requires accurate staging by a certified wound care specialist**
6. **Situational depression, anxiety and sleep disturbance- Pre-existing condition with exacerbation following surgery**
7. **Viscus perforation with intra-abdominal sepsis status post exploratory laparotomy and removal of prosthetic mesh- Related to surgery □**
8. **Acute respiratory failure status post tracheostomy placement- Complication of the surgery. Decannulated□**
9. **History of incarcerated incisional hernia status post laparoscopic repair with mesh**
10. **Encephalopathy secondary to sepsis and medications- Resolved complication no longer requiring care**
11. **Acute blood loss anemia- Resolved complication no longer requiring care**
12. **Acute kidney injury- Resolved complication no longer requiring care**
13. **Neuropathy from prolonged immobilization- Pre-existing diabetic polyneuropathy exacerbated by surgical complication**
14. **Severe sensory loss and motor weakness below the knees bilaterally involving the Tibia and Peroneal nerves- Pre-existing diabetic polyneuropathy exacerbated by surgical complication**
15. **Right ankle contracture with bilateral foot drop- Surgical complication related to**

prolonged bed rest and polyneuropathy
16. Weight gain- BMI is unchanged from pre hospital weight. Obesity was present prior to surgery
17. Chronic neuropathic musculoskeletal myofascial pain- Pre-existing. Exacerbated following surgery
18. Neuropathy from prolonged immobilization- Polyneuropathy was pre-existing condition secondary to diabetes
19. High fall risk- No supporting standard fall risk assessment, for example, Morse Fall Risk Scale to support conclusion
20. Impaired mobility and ADL status- Surgical complication
21. Impaired avocational status- Pre-existing exacerbated by surgical complication

Dr. Barchuck future care recommendations:

1. Physical Medicine &Rehabilitation specialist
2. Primary care physician
3. Podiatrist
4. Orthopedic, Hand Surgery
5. Psychology/Psychiatry
6. Dietician
7. Physical and Occupational Therapy
8. Massage therapy and acupuncture therapy
9. Wound clinic
10. Adaptive aquatic swim therapy program
11. Carpal Tunnel surgery
12. Joint and trigger point injections
13. MRI left shoulder
14. Electrodiagnostic studies of upper and lower extremities
15. Electric wheelchair
16. Bilateral custom AFO's
17. Heel protector boots
18. Single point cane
19. Four-wheeled seated walker
20. Reacher
21. Abdominal binder
22. Four to six hours of daily attendant/chore care services
23. Fully wheelchair accessible home in 5-10 years.

Based upon my independent review of Ms. Farris medical records, images and video I have formed conclusions that both share and differ from Dr. Barchuck's future recommendations:

1. Physical Medicine and Rehabilitation specialist- Ms. Farris has an acquired disability as a result of her post surgical complications. I support future PMR sub specialty care
2. Primary Care physician- Ms. Farris has several major pre existing medical co-morbidities and was receiving primary physician care that should continue. The medical necessity and frequency was due to pre-existing condition unchanged following surgery
3. Podiatrist- Ms. Farris has pre existing diabetic polyneuropathy. Consequently, the standard of care is Podiatric treatment. The medical necessity was pre- existing
4. Orthopaedic/Hand Surgery- Ms. Farris has polyneuropathy and perhaps Carpal Tunnel Syndrome which is speculative. The Dupuytren contractures are unrelated to her surgery and post surgical complications. Hand Surgery Orthopaedic care is therefore unrelated to her surgery and post surgical complications
5. Psychology/ Psychiatry- Ms. Farris mood disorder has been impacted by her acquired disability and functional impairment. I would support episodic behavioral health services
6. Dietician- Ms. Farris was and currently a non-compliant obese diabetic and the need for nutritional care and counseling was pre-existing
7. Physical and Occupational Therapy- Ms. Farris has an acquired disability as a consequence of her surgery and I would support episodic therapy services
8. Massage and acupuncture therapy- Ms. Farris had pre-existing chronic pain disorder related to her shoulder and polyneuropathy. Chronic pain was pre-existing. Furthermore, there is no proven advantage of complementary therapy over standard physical therapy, exercise and pharmologic care. For these reasons I do not support massage and acupuncture
9. Wound clinic- Ms. Farris likely developed a calcaneal pressure wound due to pre-existing polyneuropathy, skin care non compliance. The exacerbation of her neuropathy, improper fitted bracing and improper limb positioning likely contributed to her acquired wound. I support a comprehensive wound care center or home health nurse
10. Carpal Tunnel surgery- I am unable to identify confirmation of Carpal Tunnel Syndrome and if present is likely due to pre-existing diabetic polyneuropathy. At this time, I cannot support surgery without a confirmed diagnosis based upon EMG/NCV studies
11. Joint and trigger point injections- Ms. Farris was receiving care for pre-existing shoulder pain with injection therapy. Pre-existing condition
12. Adaptive aquatic swim therapy program- Ms. Farris has an open wound and is not medically appropriate for aquatic therapy. Furthermore, there is no proven advantage of aquatics for her condition. I do not support this recommendation
13. MRI Left shoulder- The shoulder injury and related disability are pre-existing
14. Electrodiagnostic studies of upper and lower extremities- EMG studies have been performed of the LE. The polyneuropathy was pre-existing
15. Electric wheelchair- I support the need for a future powered mobility device
16. Bilateral custom AFO- Bilateral foot drop is a new acquired disability and I support the need for bilateral custom AFO
17. Single point cane, reacher, abdominal binder heel protector boots (PRAFO), 4 WW-

I support providing these assistive devices which are standard care for the disability

18. Four to six hours of daily attendant/chore care services- Ms. Farris had pre-existing medical co-morbidities, non compliance with medical care and in all probability would have needed future attendant care. The onset of the need for a caregiver and number of hours has changed as a result of her disability
19. Fully wheelchair accessible home in 5-10 years- Ms. Farris had pre-existing medical co-morbidities, chronic pain and non compliance with her medical care. In all probability she would have become wheelchair dependent regardless of her surgical complications

In addition to this supplemental report I shared specific medical, rehabilitation and equipment recommendations in a separate detailed life care plan prepared jointly with Sarah Larsen, RN. I do not endorse Dr. Barchuck's life expectancy projection and defer to medical researcher and life expectancy expert Scott J. Kush, MD who has provided a separate analysis

Lance R. Stone, DO

Lance R. Stone, DO

EXHIBIT "6"

Olzack Healthcare Consulting
2092 Peace Court, Atwater, CA 95301
Phone: 209-358-8104 Fax: 209-358-8115
olzackhealthcare@gmail.com

December 19, 2018

Chad Couchot, Esq.
Schuering, Zimmerman & Doyle
400 University Avenue
Sacramento, CA 95825

Re: Titina Farris v. Barry Rives, M.D.; Laparoscopic Surgery of Nevada, LLC, et al.

Mr. Couchot:

Pursuant to your request, I have prepared a Life Care Plan Report in connection with the above entitled matter based on my review of the expert reports, depositions and medical records provided, and upon the recommendations of Lance Stone, M.D. The Life Care Plan Report has been prepared in accordance with Federal Rules of Civil Procedure - Rule 26 and is attached.

Opinions and Life Care Plan:

My opinions, which are set forth in the Life Care Plan Report for Ms. Farris, are based upon the review of expert reports, my 19 years of experience in nursing, academia and life care planning, and the current costs associated from the Las Vegas and Henderson, Nevada areas for the outlined recommendations for medical care, treatment and supplies. I have consulted with Dr. Stone regarding his opinions of future care needs for Ms. Farris. I have outlined the recommendations of Dr. Stone in the Life Care Plan Report. I reserve the right to modify my report in the event additional information is provided.

Records Reviewed:

A list of the expert reports, depositions and medical records reviewed is attached.

Qualifications:

I have been working in the nursing field since 1999. As a Master's prepared Registered Nurse and Family Nurse Practitioner my experience includes, but is not limited to, the following: (1) Medical – Surgical Nursing for Adult and Pediatric patients in the acute care setting; (2) Skilled Nursing care for critically ill patients in the Pediatric Intensive Care Unit of the hospital, including trauma patients and patients with

cardiac, neurological, surgical, hematological and respiratory problems; (3) Supervision and instruction of student nurses in classroom, hospital and home care settings in all areas of patient care; (4) Supervision and training of Registered Nurses, Licensed Vocational Nurses, and Nursing Assistants in Adult Acute and Long Term care, and Neonatal and Pediatric Acute and Long Term care; (5) Medical assessment, management, and education of adult and pediatric patients in the specialty ambulatory care / primary care settings with acute and chronic comorbidities; (6) Continuing Education units for individual licensure and certification; (7) Life Care Planning and Legal Nurse Consulting. My current Curriculum Vitae is attached.

Compensation:

My fee for Trial or Deposition Testimony is $400.00 an hour. My fee for preparation of the Life Care Plan Report, record review and all other services is $275.00 an hour. A copy of my fee scheduled is attached.

List of Previous Cases:

A list of cases in which I have testified in depositions, arbitrations and trials is attached.

Resources for Life Care Plan:

A list of resources used for the costs in the Life Care Plans is attached.

After your review of this report, please do not hesitate to contact me if you have any questions or comments.

Sincerely,

Sarah Larsen

Sarah Larsen, R.N., MSN, FNP, C.L.C.P.
Olzack Healthcare Consulting, Inc.

SL:bc
Enclosures

LIFE CARE PLAN

FOR

TITINA FARRIS

* * *

Dated: December 19, 2018

Prepared by:
OLZACK HEALTHCARE CONSULTING, INC.
Sarah Larsen, R.N., M.S.N., F.N.P., L.N.C., C.L.C.P.
2092 Peace Court, Atwater, CA 95301
Phone: 209-358-8104 / Fax: 209-358-8115

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Name: Titina Farris
Date of Birth: 10-24-1962
Date Prepared: 12-19-2018

LIFE CARE PLAN

Olzack Healthcare Consulting, Inc.
Sarah Larsen, RN, BSN, FNPc, CLCP
2092 Peace Ct, Atwater, CA 95301

OPTION I - HOME CARE (DIRECT HIRE)

Recommendations:	Age When Initiated / Suspended:	Frequency:	Purpose:	Cost:	Annual Cost
Option I **Home Care** Trained Attendant Direct Hire - 90% and Agency Hire - 10% (Hourly)	Age 56 to Life	2-4 hours / day	To assist Ms. Farris with activities of daily living and day to day chore work	Trained Attendant Direct Hire - 90% $13.00 to $15.00 per hour and 18% Employer Taxes and Agency Hire - 10% $21.50 / hour	**Option I** Annually $13,806.45 $2,485.16 $2,355.86
Option I Payroll Service	1 x Only 1 x / 2 weeks	1 x Only 1 x / 2 weeks	To manage payroll services for the trained attendant	Initial Fee $200.00 Bi-Weekly $44.00 to $68.00	**Option I** One Time Only $200.00 Annually $1,456.00
Option I Advertising, Agency Referral Fee Allowance	1 x / year	1 x / year	To cover costs for advertising/referral service for trained attendant	$1,000.00 / year	**Option I** Annually $1,000.00

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OPTION I - HOME CARE (DIRECT HIRE) - Continued

Recommendations:	Age When Initiated / Suspended:	Frequency:	Purpose:	Cost:	Annual Cost
Option I Housekeeping	Age 56 to Life	2-4 hours / month	For heavy housekeeping including scrubbing, vacuuming, mopping, etc.	$65.77 / hour	**Option I** Annually $2,367.72
Option I Case Management	Age 56 to Life	4-8 hours / year	Coordinates care and communicates with Ms. Farris and her health care providers as necessary	$105.00 / hour	**Option I** Annually $630.00
TOTALS:					**Option I** One Time Only $200.00 Annually $24,101.19

Resources:
Paychex, Inc.
United States Department of Labor - Occupational Wage and Salary Data

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OPTION II - HOME CARE (AGENCY HIRE)

Recommendations:	Age When Initiated / Suspended:	Frequency:	Purpose:	Cost:	Annual Cost
Option II **Home Care** Trained Attendant Agency Hire 100%	Age 56 to Life	2-4 hours / day	To assist Ms. Farris with activities of daily living and day to day chore work	Trained Attendant Agency Hire - 100% $21.50 / hour	**Option II** Annually $23,558.63
Option II Housekeeping	Age 56 to Life	2-4 hours / month	For heavy housekeeping including scrubbing, vacuuming, mopping, etc.	$65.77 / hour	**Option II** Annually $2,367.72
Option II Case Management	Age 56 to Life	4-8 hours / year	Coordinates care and communicates with Ms. Farris and her health care providers as necessary	$105.00 / hour	**Option II** Annually $630.00
TOTALS:					**Option II** Annually $26,556.35

LIFE CARE PLAN

Olzack Healthcare Consulting, Inc.
Sarah Larsen, RN, BSN, FNPc, CLCP
2092 Peace Ct, Atwater, CA 95301

FUTURE MEDICAL CARE

Recommendations:	Age When Initiated / Suspended:	Frequency:	Purpose:	Cost:	Annual Cost
Physical Medicine and Rehabilitation Specialist	Age 56 Age 56 to Life	1 Evaluation 4 x / year	To evaluate and manage issues related to mobility, pain and orthotics	Evaluation $254.00 to $500.00 Follow Up Visit $100.00 to $154.00	One Time Only $377.00 Annually $508.00
Podiatrist	Age 56 Age 56 to 57 Age 57 to Life	1 Evaluation 6-12 x / year x 1 year 4-6 x / year	To evaluate and manage wound care/foot care for Ms. Farris	Evaluation $75.00 to $175.00 Follow Up Visit $45.00 to $50.00	One Time Only $125.00 Annually To Age 57 $427.50 Age 57 to Life $237.50

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FUTURE MEDICAL CARE - Continued

Recommendations:	Age When Initiated / Suspended:	Frequency:	Purpose:	Cost:	Annual Cost
Psychologist	Age 56 to Life	10-20 x / Life	For individual and family therapy related to adjusting to health care needs	Session $100.00 to $225.00	One Time Only $2,437.50
Dietician	Age 56 Age 56 to Life	1 Evaluation 1 x / year	For dietary counseling related to weight, blood pressure and diabetes management	Evaluation $75.00 to $130.00 Follow Up Visit $45.00 to $90.00	One Time Only $102.50 Annually $67.50
Wound Clinic	Age 56	2 x / week x 3-6 months	For the evaluation and treatment of wound to left heel	Visit $249.24	One Time Only $9,720.36

FUTURE MEDICAL CARE - Continued

	Annual Cost
TOTALS:	One Time Only $12,762.36 Annually To Age 57 $1,003.00 Age 57 to Life $813.00

Resources:

Desert Orthopedic Center
Advance Orthopedics and Sports Medicine
Dynamic Pain Rehabilitation
McKenna, Ruggeroli & Helmi
Eric Brimhall, M.D.- Physiatrist
Eastern Podiatry
Jerry T Henry, DPM
Foot Care Clinic
Apache Foot and Ankle Specialist
Foot and Ankle Specialist of Nevada
Swenson Foot and Ankle
Danielson Therapy

Bree Mullin, Psy.D. – Psychologist
Life Quest Behavioral Health Quest
Anders and Dunaway Nutrition Consultants, Inc.
Your Dietician for Diabetes and Weight Control
Nutrition Moves
Nutrition by Joey
The Food Connection

WHEELCHAIR NEEDS

Recommendations:	Age When Initiated / Suspended:	Frequency:	Purpose:	Cost:	Annual Cost
Power Scooter or Power Wheelchair	Age 56 to Life	1 x / 7 years	For distance and community mobility	$1,678.17	Annually $239.74
Manual Wheelchair	Age 56 to Life	1 x / 7 years	For community mobility	$179.75	Annually $25.68
Wheelchair Cushion	Age 56 to Life	1 x / 2 years	For increased safety when using scooter or wheelchair	$31.29	Annually $15.65
Portable Ramps	Age 56 to Life	1 x / 7 years	For increased safety and mobility	$100.85	Annually $14.41
TOTALS:					Annually $295.47

DURABLE MEDICAL EQUIPMENT AND SUPPLIES

Recommendations:	Age When Initiated / Suspended:	Frequency:	Purpose:	Cost:	Annual Cost
4-Wheeled Walker	Age 56 to Life	1 x / 5 years	For increased safety and independence with ambulation	$65.83	Annually $13.17
Reacher	Age 56 to Life	1 x / 5 years	For increased safety and independence in the home and community	$11.56	Annually $2.31
Handheld Shower Head	Age 56 to Life	1 x / 5 years	For increased safety and independence with hygiene	$25.19	Annually $5.04
Shower Bench	Age 56 to Life	1 x / 5 years	For increased safety and independence with hygiene	$56.08	Annually $11.22
Grab Bars	Age 56 to Life	1 x / 5 years	For increased safety and independence with hygiene	$14.66	Annually $2.93
Single Point Cane	Age 56 to Life	1 x / 5 years	For increased safety and independence with ambulation	$14.81	Annually $2.96

DURABLE MEDICAL EQUIPMENT AND SUPPLIES - Continued	
	Annual Cost
TOTALS:	Annually $37.63

8A.App.1806

PROJECTED THERAPEUTIC MODALITIES

Recommendations:	Age When Initiated / Suspended:	Frequency:	Purpose:	Cost:	Annual Cost
Physical Therapy Evaluation	Age 56 to Life	1 x / year	To evaluate and assist in formulating a home exercise program	Evaluation $85.00 to $120.00	Annually $102.50
Occupational Therapy Evaluation	Age 56 to Life	1 x / year	To evaluate for any needs related to activities of daily living and assistive devices	Evaluation $85.00 to $120.00	Annually $102.50
Gym Membership with Pool	Age 56 to Life	Enrollment Fee 1 x Only Annual Fee 1 x / year Monthly Membership Fee 1 x / month	For physical activity to improve overall health and cardiovascular status, assist with weight management	Enrollment Fee $40.00 to $99.00 Annual Fee $0.00 to $45.00 Monthly Membership Fee $23.00 to $45.00	One Time Only $69.50 Annually $22.50 Annually $408.00

PROJECTED THERAPEUTIC MODALITIES - Continued

	Annual Cost
TOTALS:	One Time Only $69.50 Annually $635.50

Resources:
Select Physical Therapy
ATI Physical Therapy
Matt Smith Physical Therapy
Tim Soder Physical Therapy
Tru Physical Therapy
Leavitt Physical Therapy
Affiliated Therapy
Skyview YMCA
Las Vegas Athletic Clubs
Anytime Fitness Desert Inn

ORTHOTICS

Recommendations:	Age When Initiated / Suspended:	Frequency:	Purpose:	Cost:	Annual Cost
Bilateral Custom Fit AFO	Age 56 to Life	1 pair / 3-4 years	To maintain anatomical and functional positioning of ankles and feet	$66.30 / each	Annually $37.89
PRAFO	Age 56 to Life	1 x / 3-4 years	For nighttime use to help prevent pressure sores on feet	$236.30	Annually $67.51
TOTALS:					Annually $105.40

TRANSPORTATION

Recommendations:	Age When Initiated / Suspended:	Frequency:	Purpose:	Cost:	Annual Cost
Wheelchair Accessible Van (Conversion Package)	Age 56 to Life	1 x / 7 years	To transport wheelchair or power scooter for community mobility	$22,240.00	Annually $3,177.14
TOTALS:					Annually $3,177.14

8A.App.1810

RESOURCES

Olzack Healthcare Consulting, Inc.
Sarah Larsen, RN, BSN, FNPc, CLCP
2092 Peace Ct, Atwater, CA 95301

Payroll Service / Bookkeeping

Paychex, Inc.
(855) 973-2408 / National Sales Line
Set-Up Fee: $200.00 *one-time fee
Bi-Weekly: $44.00 - $68.00 / pay period
*payroll fees for 1-5 employee; prices range based on complexity of payroll (for example if wages need to be garnished)

Physical Medicine and Rehabilitation

Desert Orthopedic Center
Andrew Kim D.O. – Physiatrist
2800 East Desert Inn Road, Suite 100
Las Vegas, NV 89121
(702) 731-4088 / Caren
Evaluation: $300.00 - $500.00
Follow Up Visit: $ 100.00

Advance Orthopedics and Sports Medicine
Matthew HC Otten M.D. – Physiatrist
8420 West Warm Springs Road, Suite 100
Las Vegas, NV 89113
(702) 740-5327 / Anette
Evaluation: $254.00
Follow Up visit: $154.00

Dynamic Pain Rehabilitation
Alexander Imas, M.D. – Physiatrist
1358 Paseo Verde Parkway, Suite 100
Henderson, NV 89012
(702)982-7100 / Stephanie
Evaluation: $ 275.00
Follow Up visit: $ 100.00

McKenna, Ruggeroli & Helmi
6070 South Fort Apache Road 100
Las Vegas, NV 89148
702) 307-7700 / Daisy
Evaluation: $400.00
Follow Up Visit: $100.00

Physical Medicine and Rehabilitation - Cont.

Innovative Pain Center
Eric Brimhall, M.D.- Physiatrist
503 South Rancho Drive, Suite G44
Las Vegas, CA 89106
(702) 684-7246 / Jesiree
Evaluation: $455.00
Follow Up Visit: $100.00

RESOURCES

Podiatry

Eastern Podiatry
3777 Pecos-McLeod, Suite 103
Las Vegas. NV 89121
(702) 434-2023 / Perala
Evaluation: $120.00
Follow Up Visit: $45.00

Jerry T Henry, DPM
341 North Buffalo Drive, Suite A
Las Vegas NV 89145
(702) 242-3870 / Heather
Evaluation: $75.00
Follow Up Visit: $45.00

Foot Care Clinic
3650 South Eastern Avenue, Suite 200
Las Vegas, NV 89169
(702) 420-7970 / Cindy
Evaluation: $97.00
Follow Up Visit: $50.00

Apache Foot and Ankle Specialist
Lee Wittenberg, DPM
4840 South Fort Apache Road, Suite 101
Las Vegas, NV 89147
(702) 362-6634 / Jasmine
Evaluation: $110.00
Follow Up Visit: $45.00

Podiatry - Cont.

Foot and Ankle Specialist of Nevada
7135 West Sahara Avenue, Suite 201
Las Vegas, NV 89117
(702) 878-2455 / Yolanda
Evaluation: $175.00
Follow Up Visit: $50.00

Swenson Foot and Ankle
5380 Rainbow Boulevard, Suite 318
Las Vegas, NV 89118
(702) 873-3556 / Yarcely
Evaluation: $120.00-$140.00
Follow Up Visit: $45.00

Psychology

Danielson Therapy
Melissa Danielson, Ph.D. – Psychologist
9480 South Eastern Avenue, Suite 258
Las Vegas, NV 89123
(702) 339-5663 / Melissa Danielson
Session: $125.00 - $150.00

Bree Mullin, Psy.D. – Psychologist □
1820 East Warm Springs Road, Suite 115
Las Vegas, NV 89119
(702) 270-4357 / Cassidy
Session: $225.00

Life Quest Behavioral Health Quest
4780 Arville Street
Las Vegas, NV 89103
(720) 830-9740 / Carla
Sessions: $100.00

RESOURCES

Olzack Healthcare Consulting, Inc.
Sarah Larsen, RN, BSN, FNPc, CLCP
2092 Peace Ct, Atwater, CA 95301

Dietician

Anders and Dunaway Nutrition Consultants, Inc.
2121 East Flamingo Road, Suite 110
Las Vegas, NV 89119
(702) 382-8841 / Brenda
Evaluation: $75.00
Follow Up Visit: $45.00

Your Dietician for Diabetes and Weight Control
7655 West Sahara Avenue, Suite 110
Las Vegas, NV 89117
(702) 525-1105 / Lydia
Evaluation: $85.00
Follow Up Visit: $45.00

Nutrition Moves
Geri Lynn Grossan, Med, RDN, CDE, HTCP
7721 Leavorite Drive
Las Vegas, NV 89128
(702) 242-5730
Evaluation: $130.00
Follow Up Visit: $90.00

Nutrition by Joey
8275 South Eastern Avenue #118
Las Vegas, NV 89123
(702) 878-5639 / Cecelia
Evaluation: $95.00
Follow Up Visit: $55.00

Dietician - Cont.

The Food Connection
4215 South Grand Canyon
Las Vegas, NV 90147
(702) 664-1204 / Stephanie
Evaluation: $95.00
Follow Up Visit: $45.00 - $90.00

Physical Therapy

Select Physical Therapy
821 North Nellis Boulevard, Suite 130
Las Vegas, NV 89110
(702) 452-4563 / Liz
Evaluation: $120.00

ATI Physical Therapy
7301 Peak Drive, Suite101
Las Vegas, NV 89128
(702) 940-3000 / Kandra / Sherry
Evaluation: $85.00

Matt Smith Physical Therapy
1505 Wigwam Parkway, Suite 240
Henderson, NV 89074
(702) 568-0195 / Brent, Donna
Evaluation: $85.00

Tim Soder Physical Therapy
2779 West Horizon Ridge Parkway, Suite 100
Henderson, NV 89052
(702) 897-1222 / Chelsea
Evaluation: $95.00

Tru Physical Therapy
70 East Horizon Ridge Parkway Suite 180
Henderson, NV 89002
(702) 856-0422 / Kylie / Tayslie
Evaluation: $120.00

RESOURCES

Olzack Healthcare Consulting, Inc.
Sarah Larsen, RN, BSN, FNPc, CLCP
2092 Peace Ct, Atwater, CA 95301

Physical Therapy - Cont.

Leavitt Physical Therapy
3037 West Horizon Ridge Parkway, Suite 120
Henderson, NV 89052
(702) 263-4993 / Jeff
Evaluation: $120.00

Affiliated Therapy
9050 West Cheyenne Avenue, Suite 210
Las Vegas, NV 89129
(702) 209-0069 / Carol
Evaluation: $100.00

Occupational Therapy

Affiliated Therapy
9050 West Cheyenne Avenue, Suite 210
Las Vegas, NV 89129
(702) 209-0069 / Carol
Evaluation: $100.00

Select Physical Therapy
821 North Nellis Boulevard, Suite 130
Las Vegas, NV 89110
(702) 452-4563 / Liz
Evaluation: $120.00

Matt Smith Physical Therapy
1505 Wigwam Parkway, Suite 240
Henderson, NV 89074
(702) 568-0195 / Brent, Donna
Evaluation: $85.00

ATI Physical Therapy
7301 Peak Drive, Suite101
Las Vegas, NV 89128
(702) 940-3000 / Kandra / Sherry
Evaluation: $85.00

Gym Membership with Pool

Skyview YMCA
3050 East Centennial Parkway
North Las Vegas, NV 89081
(702) 522-7500 / Crystal
Monthly Membership: $39.00

Las Vegas Athletic Clubs
2655 South Maryland Parkway
Las Vegas, NV 89109
(702) 734-5822 / Tony
Enrollment Fee: $49.00 - $99.00
Monthly Fee: $23.00 - $31.00
Annual Fee: $0.00

Anytime Fitness Desert Inn
8490 West Desert Inn Road
Las Vegas, NV 89117
(702) 820-0660 / Steve
Enrollment Fee: $40.00 - $50.00
Monthly Fee: $35.99 - $44.99
Annual Fee: $45.00

Occupational Employment Statistics Query System

Occupational Employment Statistics

Multiple occupations for one geographical area

Area: Las Vegas-Henderson-Paradise, NV
Period: May 2017

Occupation (SOC code)	Hourly mean wage
Home Health Aides(311011)	13.83
Personal Care Aides(399021)	11.57

Footnotes:

SOC code: Standard Occupational Classification code – see http://www.bls.gov/soc/home.htm

Data extracted on December 17, 2018

LIST OF RECORDS REVIEWED FOR TITINA FARRIS

Depositions:

- Deposition of Patrick Farris taken 10-11-18
- Deposition of Titina Farris taken 10-11-18

Medical Reports:

- PM&R Life Care Planning Evaluation Report by Alex Barchuk, M.D. dated 3-20-18
- Life Care Plan Report by Dawn Cook, R.N. dated 6-6-18; Includes:
  - Past Medical Bill Review by Dawn Cook, R.N. dated 11-15-18
- Expert Report by Justin Aaron Willer, M.D. dated 10-22-18

Medical / Billing Records:

- Medical and Billing Records from Advanced Orthopedics Sports Medicine
- Medical and Billing Records from Barry Rives, M.D.
- Medical and Billing Records from Bess Chang, M.D.
- Medical and Billing Records from Care Meridian
- Medical and Billing Records from Desert Valley Therapy
- Medical and Billing Records from Naomi Chaney, M.D.
- Medical and Billing Records from Elizabeth Hamilton, M.D. (x2)
- Medical and Billing records from Steven Y. Chinn, M.D.
- Medical and Billing Records from Laparoscopic Surgery of Nevada
- Medical and Billing Records from St. Rose Dominican - Siena Campus
- Medical Records from St. Rose Dominican Hospital

Miscellaneous Records and Reports:

- 15 Wound Photos
- Video "M2U00211" (00:48 seconds)
- Video "M2U00212" (01:03 minutes)
- Video "M2U00213" (01:07 minutes)
- Video "M2U00214" (01:17 minutes)

- Video "M2U00215" (00:42 seconds)
- Video "M2U00216" (00:27 seconds)
- Video "M2U00217" (00:44 seconds)
- Video "M2U00218" (00:10 seconds)
- Video "M2U00219" (00:59 seconds)
- Video "M2U00220" (00:37 seconds)
- Video "M2U00221" (00:18 seconds)
- Video "M2U00222" (00:11 seconds)
- Video "M2U00223" (00:10 seconds)
- Video "M2U00224" (00:33 seconds)
- 2 Photos - In LCP File

EXHIBIT "7"

COHEN | VOLK
ECONOMIC CONSULTING GROUP

1155 ALPINE ROAD
WALNUT CREEK, CA 94596
T 925.299.1200
F 925.482.0824
WWW.COHENVOLK.COM

December 19, 2018

Mr. Chad C. Couchot
Schuering Zimmerman & Doyle, LLP
400 University Avenue
Sacramento, CA 95825-6502

Re: *Farris v. Rives*

Dear Mr. Couchot:

As Senior Managing Economist with Cohen | Volk Economic Consulting Group, I have been retained to value economic losses in the above captioned case. I have been asked to evaluate the future cost of care for Ms. Farris based on the opinions of Dr. Stone, Dr. Kush, and Sarah Larsen. I have also been asked to respond to economic loss analysis and/or testimony by damages experts for the plaintiff.

I have been provided with the following documents:

1. Plaintiff Patrick Farris Response to Defendant's First Demand for Production and Inspection of Documents;
2. Plaintiff Patrick Farris's Answers to Defendant's First Set of Interrogatories;
3. Plaintiff Titina Farris' Response to Defendants' First Set of Request for Production of Documents;
4. Plaintiff Titina Farris's Answers to Defendant's First Set of Interrogatories;
5. Deposition transcript of Patrick Farris taken on October 11, 2018;
6. Deposition transcript of Titina Farris taken on October 11, 2018;
7. "REPORT ON PRESENT VALUE OF A LIFE CARE PLAN FOR MS. TITINA FARRIS," dated October 9, 2018, Terrence Clauretie, Ph.D.;
8. "Life Expectancy Report Ms. Titina Farris," dated December 19, 2018, Scott Kush, M.D.;
9. "Life Care Plan for Titina Farris," dated December 19, 2018, Sarah Larsen, R.N.

My calculation report is enclosed with this letter, as are my CV, list of testimonies, and the company rate schedule. In order to complete my assignment, I have also considered information from the following sources:

United States Bureau of Labor Statistics, United States Federal Reserve, the Social Security Administration, and the Centers for Medicare & Medicaid Services.

Response to Report of Terrence Clauretie, Ph.D.:

Dr. Clauretie's methodology for computing present value relies upon applying growth rates to the Dawn Cook life care plan, with two different growth rate categories: For home modifications, Dr. Clauretie assumes a future growth rate of 2.8%; for "medical and professional costs," Dr. Clauretie assumes a future growth rate of 3.5% per year. The "medical and professional costs" growth rate of 3.5% is applied to all of the items in the Cook life care plan, with the exception of home modifications.

Dr. Clauretie's report indicates two sources for the "medical and professional costs" growth rate. One source is the "Forecast of future growth rate in non-medical labor from the 2018 Annual Report of the Trustees of the OASDI (if applicable)." No specific citation is provided for the page or table number where the underlying data is contained within the Trustees of the OASDI report.

The other source is "Forecast of future medical costs by Trustees of the United States Hospital and Supplementary Insurance Funds, 2018," for which Dr. Clauretie provides a link to a 2015 report titled "2015 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS." It is not clear why Dr. Clauretie would describe 2018 forecast data as being available in a 2015 publication. Furthermore, it is not clear exactly how the sources listed were used to arrive at the 3.5% growth rate assumption. Therefore, I cannot provide meaningful commentary at this time in response to Dr. Clauretie's methodology for concluding that costs for items placed in the "medical and professional costs" category will grow by 3.5% each and every year until 2047. If and when additional information is provided for this topic, I may augment or modify my comments as is appropriate.

Dr. Clauretie's report does not explain why he would place life care plan items such as a pool program, companion care, home maintenance and durable medical equipment into the "medical and professional costs" category. The Centers for Medicare and Medicaid Services publish price level projections for the years 2018-2026. For the category of Physician and Clinical Services, the Centers for Medicare and Medicaid Services estimates prices to increase an average of 2.2% per year through 2026. The average projected price level increases for 2018-2026 for other

categories are as follows: Durable Medical Equipment: 0.9%; Home Health Care: 1.6%. If Dr. Clauretie's analysis of future care costs were to rely upon growth rates ranging from 0.9% per year to 2.2% per year instead of 3.5%, his present value calculations would be reduced accordingly.

Dr. Clauretie discounts future care costs based on recent yields for U.S. government bonds that mature each year until 2047. One of the problems inherent in using current rates is that they most likely will be different at the date of trial, at the date a potential award is paid, and at the time the recipient may choose to invest that award. While it is certainly the case that one can lock in today's near historically low rates, it is unreasonable to suggest that one cannot earn rates in excess of recent rates over the next 25-30 years. U.S. financial markets are still impacted by what Janet Yellen, former Chairman of the Federal Reserve, called the worst financial crisis since the Great Depression. Policies and financial conditions led to historically low interest rates starting around 2008, but interest rates have recently begun to climb. Furthermore, interest rate increases are widely forecast to continue. In my opinion, using recent low interest rates as the only basis for projecting future interest returns for the 25-30 years is not reasonable.

Furthermore, as noted above, the Trustees of the OASDI – a source utilized and cited in Dr. Clauretie's report, projects an average real interest rate of 2.7 percent, implying nominal returns of 5.3%. If Dr. Clauetie were to utilize a 5.3% interest assumption for the future care cost analysis, the present cash values would be reduced significantly.

A method commonly used in the field of forensic economics for analyzing the present value of future cost of care involves examining long-run historical relationships for real interest returns (interest compared to general price inflation) and for real care cost growth rates (nominal growth compared to general price inflation). Such data is available from the Bureau of Labor Statistics and the Federal Reserve. My conclusions as to future cost of care are based on this type of analysis, and are contained in my calculation report, which is attached. My analysis results in higher net discount rates for future care than those implied by Dr. Clauretie's analysis.

Closing:

In conclusion, please note that all work is based on information provided to date. As additional information is provided to me, I may augment or change my opinions. If you have any questions, please do not hesitate to contact me.

Sincerely,

Erik Volk, M.A.

Attachments

COHEN | VOLK
ECONOMIC CONSULTING GROUP

1155 ALPINE ROAD
WALNUT CREEK, CA 94596
T 925.299.1200
F 925.482.0824
WWW.COHENVOLK.COM

FUTURE CARE COST REPORT
Valuation of Life Care Plan Prepared by Sarah Larsen

Farris v. Rives

Major Assumptions:

Private Pay
Based on 21.5 Additional Years at Age 56.2, Per Dr. Kush

December 19, 2018

Table 1A

Summary of Future Cost to Care for Titina Farris
Private Pay
Option I: Direct Hire (90%)

		Present Value
Table 3A:	Home Care	$ 409,338
Table 4:	Future Medical Care	$ 27,453
Table 5:	Wheelchair Needs	$ 4,790
Table 6:	Durable Medical Equipment and Supplies	$ 599
Table 7:	Projected Therapeutic Modalities	$ 10,789
Table 8:	Orthotics	$ 1,715
Table 9:	Transportation	$ 52,626
Total Future Care Costs:		**$ 507,310**

Table 1B

Summary of Future Cost to Care for Titina Farris
Private Pay
Option II: Agency Hire

		Present Value
Table 3B:	Home Care	$ 450,787
Table 4:	Future Medical Care	$ 27,453
Table 5:	Wheelchair Needs	$ 4,790
Table 6:	Durable Medical Equipment and Supplies	$ 599
Table 7:	Projected Therapeutic Modalities	$ 10,789
Table 8:	Orthotics	$ 1,715
Table 9:	Transportation	$ 52,626
Total Future Care Costs:		**$ 548,759**

Table 2

Actuarial Data

Date of Birth:	10/24/1962	
Date of Valuation:	3/18/2019	
Age at Date of Valuation:	56.40	years
Life Expectancy at Date of Valuation (1):	21.30	years

1 - Based on 21.5 additional years at age 56.2, per Dr. Kush's Life Expectancy Report for Titina Farris, dated December 19, 2018.

Table 3A

Future Care Costs
Home Care
Option I: Direct Hire (90%)

Description (1):	Age	Dates	Period	Frequency	Unit Cost	Annual Cost	NDR	Present Cash Value
Direct Hire Attendant (90%)	56.40	3/18/2019 - 7/4/2040	21.30	2-4hr / day	$ 16.52	$ 16,292	2.25%	$ 276,385
Agency Hire Attendant (10%)	56.40	3/18/2019 - 7/4/2040	21.30	2-4hr / day	$ 21.50	$ 2,356	2.25%	$ 39,968
Payroll Service	56.40	3/18/2019 - N/A	N/A	1x	$ 200.00	N/A	N/A	$ 200
Payroll Service	56.40	3/18/2019 - 7/4/2040	21.30	1x / 2wk	$ 56.00	$ 1,456	2.25%	$ 24,700
Advertising, etc.	56.40	3/18/2019 - 7/4/2040	21.30	1x / yr	$ 1,000	$ 1,000	2.25%	$ 16,964
Housekeeping	56.40	3/18/2019 - 7/4/2040	21.30	2-4hr / mo	$ 65.77	$ 2,368	2.25%	$ 40,172
Case Management	56.40	3/18/2019 - 7/4/2040	21.30	4-8hr / yr	$ 105.00	$ 630	2.00%	$ 10,949
Total Care Costs:								**$ 409,338**

1 - Future care costs per "Life Care Plan for Titina Farris," prepared by Olzack Healthcare Consulting, Inc., dated December 19, 2018.

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Table 3B

Future Care Costs
Home Care
Option II: Agency Hire

Description (1):	Age	Dates	Period	Frequency	Unit Cost	Annual Cost	NDR	Present Cash Value
Agency Hire Attendant	56.40	3/18/2019 - 7/4/2040	21.30	2-4hr / day	$ 21.50	$ 23,559	2.25%	$ 399,666
Housekeeping	56.40	3/18/2019 - 7/4/2040	21.30	2-4hr / mo	$ 65.77	$ 2,368	2.25%	$ 40,172
Case Management	56.40	3/18/2019 - 7/4/2040	21.30	4-8hr / yr	$ 105.00	$ 630	2.00%	$ 10,949
Total Care Costs:								**$ 450,787**

1 - Future care costs per "Life Care Plan for Titina Farris," prepared by Olzack Healthcare Consulting, Inc., dated December 19, 2018.

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Table 4

Future Care Costs
Future Medical Care

Description (1):	Age	Dates			Period	Frequency	Unit Cost	Annual Cost	NDR	Present Cash Value
PM&R - Evaluation	56.40	3/18/2019	-	N/A	N/A	1x	$ 377.00	N/A	N/A	$ 377
PM&R - Follow-Up	56.40	3/18/2019	-	7/4/2040	21.30	4x / yr	$ 127.00	$ 508	1.50%	$ 9,273
Podiatrist - Evaluation	56.40	3/18/2019	-	N/A	N/A	1x	$ 125.00	N/A	N/A	$ 125
Podiatrist - Initial Yr	56.40	3/18/2019	-	3/17/2020	1.00	6-12x / yr	$ 47.50	$ 428	1.50%	$ 425
Podiatrist - Thereafter	57.40	3/18/2020	-	7/4/2040	20.30	4-6x / yr	$ 47.50	$ 238	1.50%	$ 4,108
Psychologist	56.40	3/18/2019	-	7/4/2040	21.30	10-20x / life	$ 162.50	$ 114	1.50%	$ 2,081
Dietician - Evaluation	56.40	3/18/2019	-	N/A	N/A	1x	$ 102.50	N/A	N/A	$ 103
Dietician - Follow-Up	56.40	3/18/2019	-	7/4/2040	21.30	1x / yr	$ 67.50	$ 68	1.50%	$ 1,241
Wound Clinic	56.40	3/18/2019	-	N/A	N/A	39x	$ 249.24	N/A	N/A	$ 9,720
Total Care Costs:										**$ 27,453**

1 - Future care costs per "Life Care Plan for Titina Farris," prepared by Olzack Healthcare Consulting, Inc., dated December 19, 2018.

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Table 5

Future Care Costs
Wheelchair Needs

Description (1):	Age	Dates	Period	Frequency	Unit Cost	Annual Cost	NDR	Present Cash Value
Power Scooter/Wheelchair	56.40	3/18/2019 - 7/4/2040	21.30	1x / 7yr	$ 1,678	$ 240	2.75%	$ 3,883
Manual Wheelchair	56.40	3/18/2019 - 7/4/2040	21.30	1x / 7yr	$ 179.75	$ 26	2.75%	$ 421
Wheelchair Cushion	56.40	3/18/2019 - 7/4/2040	21.30	1x / 2yr	$ 31.29	$ 16	2.75%	$ 259
Portable Ramps	56.40	3/18/2019 - 7/4/2040	21.30	1x / 7yr	$ 100.85	$ 14	2.75%	$ 227
Total Care Costs:								**$ 4,790**

1 - Future care costs per "Life Care Plan for Titina Farris," prepared by Olzack Healthcare Consulting, Inc., dated December 19, 2018.

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Table 6

Future Care Costs
Durable Medical Equipment and Supplies

Description (1):	Age	Dates	Period	Frequency	Unit Cost	Annual Cost	NDR	Present Cash Value
4-Wheeled Walker	56.40	3/18/2019 - 7/4/2040	21.30	1x / 5yr	$ 65.83	$ 13	2.75%	$ 210
Reacher	56.40	3/18/2019 - 7/4/2040	21.30	1x / 5yr	$ 11.56	$ 2	2.75%	$ 32
Handheld Shower Head	56.40	3/18/2019 - 7/4/2040	21.30	1x / 5yr	$ 25.19	$ 5	2.75%	$ 81
Shower Bench	56.40	3/18/2019 - 7/4/2040	21.30	1x / 5yr	$ 56.08	$ 11	2.75%	$ 178
Grab Bars	56.40	3/18/2019 - 7/4/2040	21.30	1x / 5yr	$ 14.66	$ 3	2.75%	$ 49
Single Point Cane	56.40	3/18/2019 - 7/4/2040	21.30	1x / 5yr	$ 14.81	$ 3	2.75%	$ 49
Total Care Costs:								**$ 599**

1 - Future care costs per "Life Care Plan for Titina Farris," prepared by Olzack Healthcare Consulting, Inc., dated December 19, 2018.

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Table 7

Future Care Costs
Projected Therapeutic Modalities

Description (1):	Age	Dates	Period	Frequency	Unit Cost	Annual Cost	NDR	Present Cash Value
Physical Therapy Eval.	56.40	3/18/2019 - 7/4/2040	21.30	1x / yr	$ 102.50	$ 103	2.00%	$ 1,790
Occupational Therapy Eval.	56.40	3/18/2019 - 7/4/2040	21.30	1x / yr	$ 102.50	$ 103	2.00%	$ 1,790
Gym - Enrollment Fee	56.40	3/18/2019 - N/A	N/A	1x	$ 69.50	N/A	N/A	$ 70
Gym - Annual Fee	56.40	3/18/2019 - 7/4/2040	21.30	1x / yr	$ 22.50	$ 23	2.50%	$ 381
Gym - Monthly Fee	56.40	3/18/2019 - 7/4/2040	21.30	1x / mo	$ 34.00	$ 408	2.50%	$ 6,758
Total Care Costs:								**$ 10,789**

1 - Future care costs per "Life Care Plan for Titina Farris," prepared by Olzack Healthcare Consulting, Inc., dated December 19, 2018.

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Table 8

Future Care Costs
Orthotics

Description (1):	Age	Dates	Period	Frequency	Unit Cost	Annual Cost	NDR	Present Cash Value
Bilateral Custom Fit AFO	56.40	3/18/2019 - 7/4/2040	21.30	2x / 3-4yr	$ 66.30	$ 38	2.75%	$ 615
PRAFO	56.40	3/18/2019 - 7/4/2040	21.30	1x / 3-4yr	$ 236.30	$ 68	2.75%	$ 1,100
Total Care Costs:								**$ 1,715**

1 - Future care costs per "Life Care Plan for Titina Farris," prepared by Olzack Healthcare Consulting, Inc., dated December 19, 2018.

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Table 9

Future Care Costs
Transportation

Description (1):	Age	Dates	Period	Frequency	Unit Cost	Annual Cost	NDR	Present Cash Value
Conversion Package	56.40	3/18/2019 - 7/4/2040	21.30	1x / 7yr	$ 22,240	$ 3,177	2.50%	$ 52,626
Total Care Costs:								**$ 52,626**

1 - Future care costs per "Life Care Plan for Titina Farris," prepared by Olzack Healthcare Consulting, Inc., dated December 19, 2018.

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