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 23

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CHRONOLOGICAL INDEX TO APPELLANTS' APPENDIX

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

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DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS, ET AL., Plaintiffs, vs. BARRY RIVES, M.D., Defendant.	CASE#: A-16-739464-C DEPT. XXXI

BEFORE THE HONORABLE JOANNA S. KISHNER
DISTRICT COURT JUDGE
WEDNESDAY, OCTOBER 23, 2019

RECORDER'S TRANSCRIPT OF JURY TRIAL - DAY 8

APPEARANCES:

For the Plaintiff: KIMBALL JONES, ESQ.
JACOB G. LEAVITT, ESQ.
GEORGE F. HAND, ESQ.

For the Defendant: THOMAS J. DOYLE, ESQ.

RECORDED BY: SANDRA HARRELL, COURT RECORDER

Case Number: A-16-739464-C

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Las Vegas, Nevada, Wednesday, October 23, 2019

[Case called at 10:00 a.m.]

THE COURT: Okay. We're on the record outside the presence of the jury. I appreciate it.

So counsel, are we -- I think you stated that you're going to have -- wait, you said Dr. Clauretie? I thought there was going to be a Dr. Juell? Is that a change? I'm sorry. Or --

MR. LEAVITT: Yes, Your Honor. Dr. Clauretie is going to testify. He's an economist. I'm sure --

THE COURT: I know.

MR. LEAVITT: -- this Court is very familiar with Dr. Clauretie. Both parties agreed last night we don't anticipate him taking much time, and then Mr. Doyle is going to bring in -- and we're not objecting because --

THE COURT: Dr. Juell?

MR. LEAVITT: -- he's an expert; yeah.

THE COURT: Okay, thanks. And what I understand, it's still 2 p.m. is the anticipated time for Dr. Hurwitz? Is that correct? Because that's one that we just are still --

MR. LEAVITT: The --

THE COURT: -- got coordinated with the appointed timely orders to get you your audio/video transmission.

MR. LEAVITT: That is correct. He received the -- I did confirm yesterday when I was outside --

THE COURT: Sure.

MR. LEAVITT: -- the courtroom trying to make sure everything --

THE COURT: No worries.

MR. LEAVITT: -- goes well. He confirmed that he received the email to log in from --

THE COURT: Okay.

MR. LEAVITT: -- IT downstairs.

THE COURT: And he's got -- and he'll be in a stationary location?

MR. LEAVITT: Yes, Your Honor. He'll be at the hospital --

THE COURT: Okay.

MR. LEAVITT: -- itself, but he has a --

THE COURT: But it's a --

MR. LEAVITT: -- laptop and he's there.

THE COURT: He's got an appropriate -- okay, that's all IT stuff. That's not something that's in my pay grade, so as long as that's all taken care of, then everyone can do what they need to do. Okay, perfect. Then would you like Dr. Clauretie to be on the stand at the time?

MR. DOYLE: Yes.

MR. LEAVITT: Why don't we do that, Your Honor?

THE COURT: Okay.

MR. LEAVITT: You want --

THE COURT: And who's taking Dr. Clauretie? Which attorney? Okay. No worries. And just remember, *Mulder v. State* so I

please don't have to -- right? Remember? He can offer his opinions, not qualify as an expert. Do appreciate it. Thanks so much.

MR. DOYLE: And Dr. Rives is on his way. He don't have to wait.

THE COURT: I was about to ask that question before we got a jury in, which is why I was pausing for one second on that one. Thank you so very much for that heads up.

[Pause]

THE COURT: We're going to wait one second. We'll get the jury in, in just a moment.

Marshal, can you get our jury in? We are ready to go. Thank you so very much.

And your other -- Mr. Jones we're not waiting for; is that correct?

MR. LEAVITT: We are not waiting --

THE COURT: And we're not waiting for Dr. Rives?

MR. LEAVITT: -- for Mr. Jones.

THE COURT: Is that correct? Correct?

MR. DOYLE: Correct.

THE COURT: Correct. Correct?

MR. LEAVITT: Correct.

THE COURT: And you've got your -- okay, we're good to go.

[Pause]

THE COURT: Is everybody ready for the jury to be brought in? Yes?

Is everyone ready for the jury to be brought in?

MR. DOYLE: Yes, Your Honor.

THE COURT: Okay. Yes, please. Thank you so much.

THE MARSHAL: All rise for the jury.

[Jury in at 10:05 a.m.]

[Within the presence of the jury]

THE MARSHAL: All jurors are accounted for. Please be seated.

THE COURT: Appreciate it.

Welcome back, ladies and gentlemen. I hope everyone had a nice and relaxing evening last night. As you can tell, similar to what we've done in the past, they have the witness already on the stand for you. So I'm going to ask counsel for Plaintiff, would you like to call your next witness?

MR. HAND: Yes, Your Honor. Plaintiff calls Dr. Clauretie.

THE COURT: Okay, thank you so very much.

Madam Clerk, would you please swear in the next witness?

THE CLERK: Yes, Your Honor.

TERRENCE CLAURETIE, PLAINTIFFS' WITNESS, SWORN

THE CLERK: Thank you. Please be seated. And could you please state and spell your name for the record?

THE WITNESS: It's Terrence Clauretie, T-E-R-R-E-N-C-E, C-L-A-U-R-E-T-I-E.

THE CLERK: Thank you.

THE COURT: Counsel, you can commence with your

questioning at your leisure.

MR. HAND: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. HAND:

Q What is your profession?

A I'm an economist.

Q Can you tell us and the jury about your educational background?

A I got my BA in economics, Stonehill College, small college outside of Boston, and I got a master's degree in economics, and then a PhD in economics. Both of those were from Washington State University. And for a while, several years ago, I was a certified public accountant, but I'm not an accountant and I don't practice anymore, and I taught at colleges and universities for about 40 years. Ended up at UNLV, ended my career there, beginning in 1988. I'm a professor of emeritus now at UNLV. I have my share of publications and textbooks and --

Q What --

A -- that's a quick summary.

Q What kind of professor were you at UNLV?

A I ended up teaching corporate finance and real estate finance. Finance is a subset of economics. Throughout my career, I taught economics, principles of economics, monetary theory and policy, futures and options, statistics. Ended up teaching mainly finance.

Q And what is economics?

A Economics in general -- it's such a wide area -- it's a study of how society produces goods and services from its resources and decides how to distribute them to the members of society, but economics is such a wide field. It could be applied to a lot of smaller categories. There are actually associations of real estate economists, forestry economists, agriculture economists. Virtually, transportation economists. Virtually any field you can think of, economists will apply economic theory and principles to those sub-fields.

Q And have you testified in court before?

A I have.

Q How many times have you testified, grossly?

A In court? A couple hundred.

Q And have you done economic calculations in various kinds of cases?

A All the time; yes, sir.

Q And have you done economic analysis of life care plans prior to today?

A I haven't taught it, but I mean, I've done life care plans -- economic analysis of life care plans probably three to four dozen times.

Q So these publications you were referring to, can you just give us a brief overview of what they are?

A Well, a lot of them are in my sub-field of economics, called real estate economics. So a lot of them are in real estate finance. My textbook is in real estate finance, but I also have some publications that relate to forensic economics, forensic meaning, economics applied to

legal situations, so I have maybe a half a dozen of those. But they're mainly research and real estate economics. Did a lot of research on the housing market in Las Vegas that was published in several journals.

Q Do you have experience in researching growth rates and interest rates and those kinds of things?

A Yes.

Q Can you explain what your experience is in that?

A Well, virtually every civil case where compensation is requested by a plaintiff versus a defendant, the losses extend into the future. So that's a little bit more difficult to estimate than say, losses that are in the past. In the past, they are kind of what they are, but when you look into the future, you've got to do a couple of things. If the loss is earning capacity, if the loss is elements of a life care plan such as this, those losses have to be estimated into the future. And pretty much they require estimating an inflation rate int hose items, and so that's one of the things that economists will do.

The other central thing that economists will do in areas like this is to try to estimate what amount of compensation today would be required to meet those future expenses or those future losses or those future costs, given the opportunity and the recognition that the person receiving the compensation has the opportunity to invest their money.

So if a loss in the future is -- let's say the loss is $1,000 two years from now, well, given the opportunity to invest money, the present value or the amount of compensation required today might only be like $950 because they could invest that money and reach that goal of having

$1,000 two years from now. So that's a really simple example, but the present value is always less than what the future losses are because of the opportunity to invest money.

So basically, what an economist does in a life care plan is to take numbers from a life care planner, grow those numbers into the future, and a reasonable rate of growth, which would -- there's sources on that, and then to calculate a present value by looking at the interest rate on the investment rate, and generally, in cases such as this, the standard is to use interest or the interest on bonds or other sources that present the less risk possible for the person that has to replace the losses. If you can imagine that you're retiring and you need a certain amount of money for your retirement, you're probably not going to put those in very risky investments, because if they're risky, you could lose money and then you don't have money for retirement.

As you get towards retirement, people say to their financial planner, I want to get out of stocks maybe and go into safe bonds and things like that, so that's the idea about the safety to put the person in investments which represent the least amount of risks possible so that they can be guaranteed to have the funds needed in the future that are estimated, whether that be retirement, whether it be life care plan, whether it be future medical cause, but whatever it is, they want to be assured that they have that money available to them.

Q Thank you.

MR. HAND: Your Honor, at this time, I request that Dr. Clauretie be allowed to offer opinions as an economist.

THE COURT: Okay. Hearing no objection, yes, you may. Please continue.

BY MR. HAND:

Q So Dr. Clauretie, let's go to this particular case. What were you asked to do in this case?

A Well, I was asked to look at a report -- actually, there were a couple of reports -- over the course of the assignment, reports by Ms. Dawn Cook in terms of her life care planning expertise and what would be needed for the Plaintiff in this particular case. To take those values and do two things to them, which I've already eluded to. One would be what's a reasonable growth rate in those items, okay?

And I can talk about those sources, where I get those sources from the growth rate, and then using United States government bonds, which are probably the most riskless bonds that one can invest in, to calculate the amount of compensation needed today -- we call that present value -- to meet those future needs given the opportunity to invest in those government bonds.

Q So how did you arrive at your estimate of financial -- of the value of the life care program? Tell us how you did that.

A Well, the first step is to look at the various items in the life care plan. Now, some of those items are going to be medical costs. Some of them items are going to be non-medical labor, such as maybe physical therapy, home care, things like that. And then in this case, a small item called durable medical equipment. Now, they're going to have different growth rates associated with them.

Let's talk about the medical costs first. The government, every year, publishes an estimate of what they think the inflation in medical costs is going to be over the short-term and the long-term. They do this because they have to know, for example, how much expenditures they're going to be making in terms of Medicare and Medicaid, for example. So once they have the demographics, the number of people that are going to come onto Medicare, the number of people that are going to die and go off of Medicare, once they have those demographic numbers, then they go, we need to know what the inflation rate is, so they have health economists that estimate what those inflation rates are.

So I just go to that document every year. They put it out in about May and I have the estimated growth rates, and right now, their forecast, short-term and long-term, for medical costs, overall, is approximately three and a half percent. A little bit higher for prescription medicines, but it's about three and a half percent.

Now, for non-medical labor, there's another report that's put out by the trustees of the OASDI. That's Social Security. They want to know how much money is going to be spent from the fund, how much money is going to come in. Money coming in, in Social Security, is from peoples' deductions, FICA. If you've got a paycheck that says FICA on it, that's going to the government, so they're going to know how much money is coming in. Well, what they want to know, what's the inflation rate and wages, because they're going to estimate this over a long time. And that particular document indicates that they believe, over the long run, about 3.8 percent would be the inflation rate. That's a forecast. I

knock that down a little to about 3.5 when I do my estimations. The final category is durable medical equipment. There are no forecasts for that, that I could find, so there are inflation rates in the past for commodities, and that's been a little bit lower than wages and medical costs, and my estimate, I believe, was about 2.8 percent, or about 2.2 maybe in my final revision.

So I'd have to look that up, but it was small. That's a very small component of the overall plan. So now, once I have all the numbers, that is the total numbers over the years that this person is going to need, these expenses, and now I have to figure out what amount of money today would be needed if they invested in government bonds. And the way that works is -- I want to make sure they're as riskless as possible. So with government bonds, there's no default risks. We don't consider the government going to default on their bonds. They can raise taxes; they can print up money if they had to. They're not going to default on the government bonds.

So unlike a corporate bond, where a corporation could go bankrupt, the government is not going to face them. There's something called interest rate risks. If you invest all your money in a 30-year bond, you might get the highest rate possible, but the problem, if market rates of interest go up, the value of those bonds go down. So you've got some risk there. So what I do is I estimate for each year in the plan, one year out, two years out, three years out, what the annual rate of interest a person could get if they invest in a one-year bond, a two-year bond, a three-year bond.

So if, for example, I know that five years out, there's a certain amount of money to be needed. I find out what the rate of interest they can make on a five-year bond, only for that amount, and I calculate the amount they'll need in five years with the amount of money needed today given the annual interest on a five-year bond, for the five-year bond. Do that for 10 years out, 15 years out, however far out the life care plan goes. It's called a lateral approach, but it guarantees that when that person needs the money for the life care plan, the bonds will mature and guarantee that amount of value. They don't have to worry about the value bonds shifting because of changes in interest rates.

Q Is that a laddered approach? Something that's --

A It's a laddered approach.

Q Yeah.

A The other thing that's very important is, that one uses when they do the report, they use the rate of interest on -- usually on that day or within a couple of weeks of that day, the rate of interest that exists at that time. Some economists will argue that, well maybe you should use what the long-term rate of interest used to be or what it may be in the future, but --

MR. DOYLE: Objection, Your Honor. Narrative.

THE COURT: The Court's going to sustain. Narrative.

THE WITNESS: Okay.

BY MR. HAND:

Q Dr. Clauretie, the laddered approach you referred to, is --

A I use the laddered approach --

Q -- that something --

A -- and I use the interest rates on the date that I do my report.

Q All right. Is that something that's a generally accepted theory or school of thought in economics to do it that way?

A Yes.

Q So the laddered approach, you did that in this case?

A Yes.

Q All right. Can you explain, mechanically, how you do this, in terms of use a spreadsheet or a program? How do you do your calculations on this?

A Sure. The first thing I do is I take all of the items in the life care plan, I put them in an Excel spreadsheet. So I have the life care planner's estimate. If it's $1,000 a year for 20 years, I put them in $1,000 every year for 20 years, and at the top, I'll total it up and it'll take $20,000. And I'll go to life care plan, and the life care plan will say the total is going to be $20,000, so I know I've got the same numbers. I do that for each item, and I do it for the total. I Make sure I've got the same total as they do, so I'm not missing anything, I'm not adding in anything. I've got the same total. That's the easy part.

What I do is I now have those numbers in the Excel spreadsheet. I import those to another spreadsheet where I grow them for growth rates and inflation, total those up, and then discount all those numbers back to present value using interest rates on government bonds that mature each year.

So my process is to take the life care plans and run this. I do two

things. Grow for inflation, reduce the amount for the ability to invest in government bonds. That's it.

Q So you did a calculation of the present value of the costs for the life care plan?

A I did a report on July the 5th, 2019 based on the numbers in the life care for Ms. Dawn Cook that was provided to me that she did on June the 14th of 2019.

Q And what is the number you have for the present value on --

A The present value is $4,666,473. Again, $4,663,473.

Q And in layman's terms, is that the amount of money needed to fund that in the future? Is that the way to explain it?

A Yes. If you consider taking that amount of money and putting it into a bucket, every year, you would take out -- and it earns interest. Every year, you would take out an amount to purchase or to obtain the items in the life care plan. You take that out. The remainder would continue to earn interest, and at the end of the life span or at the end of the time period needed, there would be nothing left in the bucket. That's kind of the concept.

Q And that's the analysis you did in this case?

A That is the analysis that I did; yes, sir.

MR. HAND: I have nothing else. Thank you. I'll pass the witness, Judge.

THE COURT: Cross-examination, counsel?

MR. DOYLE: Yes, thank you.

CROSS-EXAMINATION

BY MR. DOYLE:

Q Good morning.

A Good morning.

Q So I wanted to go back and ask you some general questions about the calculation of present value. So what you indicated is you first have to, for different items, determine a growth rate, also called an inflation rate?

A Yes, sir.

Q Then in order to calculate the present value, you also have to then determine an interest rate or an investment rate, correct?

A Yes. Actually, an investment rate for each year in the future. They're different. So a five-year bond might give you two percent, and a 10-year bond might give you two and a half percent, for example.

Q Right.

A Correct.

Q But if we were to look at a particular year, we would have a particular growth rate, and we would have a particular interest rate, correct, for a given year?

A You would.

Q all right. And so to determine the present value, you need to have the growth rate, the investment rate, and then comparing those numbers, there can be a difference between those numbers, correct?

A Oh, absolutely. The difference between the growth rate and the discount rate?

Q Yeah.

A Oh, for sure.

Q Sure.

A I mean --

Q So --

A -- not all the time, but yes.

Q All right. So if, for example, you had a growth -- and I'm just speaking hypothetically now -- if you had a growth rate of three percent and you had an interest rate of three percent, the present value number would be the same as the gross number, so to speak?

A Spot on.

Q If you have an investment rate that is greater than the growth rate, then the present value number would be less than the gross number, correct?

A Yes.

Q If, however, you have an interest rate that is less than the growth rate, then you would have a present value that turns out to be larger than the gross number, correct?

A Correct, again.

Q And in those last two scenarios I gave you, some would say the last scenario would create a negative net discount rate, correct? Where the interest rate is -- let me start --

A Yeah.

Q If you have a scenario where the interest rate is less than the growth rate, you end up with what is referred to as a negative net discount rate, correct?

A Correct.

Q In the scenario where you have the interest rate greater than the growth rate, you end up with what's called a positive net discount rate, correct?

A Correct.

Q And so if you have the positive net discount rate, then the calculation turns out to be the present value will be less than the gross number, correct?

A Correct.

Q If, however, you have or choose to use a negative net discount rate, then the present value will turn out to be larger than the gross number, correct?

A Correct.

Q And I think you stated this, but the idea behind a present cash value or present value of calculation is to determine a sum of money today that is necessary to cover future costs. The idea being that throughout that future period of time, you're spending the principal and the interest, so when you get to the end point, you have nothing left?

A Correct.

Q And just hypothetically, if, in a given year, you have something leftover, you can take that and invest that money, as well, correct? If you wanted to.

A Well, if that turned out to be the case, but you don't know if that's going to be the case because what we do is we're having a forecast.

Q Well --

A And the forecast will have some error in it, too. So there might be some years where there might be a slight shortage, and some years, there might be a slight surplus. So that if the -- if the average forecast turns out to be correct, then they would cancel each other out at the end of the time period and there still would be nothing left.

Q Okay, but I'm just speaking about a particular year using your laddered approach.

A Yes, sir.

Q Let's say -- and I'm just speaking hypothetically and I'm speaking generally, but using your laddered approach, let's say in year six, your laddered approach produces $100,000, and the person chooses, for whatever reason, to spend only $50,000 of that dollars. They would have $50,000 leftover that they could then rollover into another investment, and start accumulating interest, again. In that scenario.

A Assuming that they would have a choice to do that; correct.

Q Well, based upon your understanding of personal injury cases, I mean, the -- if there's an award to a Plaintiff based upon a future life care plan, there's no requirement or law that says they have to spend the money as detailed --

MR. HAND: Objection.

MR. DOYLE: -- in the life care plan, is there?

MR. HAND: Objection. Assuming facts not in evidence, speculation.

THE COURT: Sustained on both grounds based on what this

witness is designated for, for this case.

BY MR. DOYLE:

Q Mr. Clauretie --

THE COURT: Doctor.

MR. DOYLE: I'm sorry.

BY MR. DOYLE:

Q Dr. Clauretie, is there -- all right. So, but again, let me just -- hypothetically speaking, in your five, the income generated is $100,000, and the person only spends 50. Let's just take that as a hypothetical scenario. They could then take that $50,000 and re-invest it, correct?

A If --

Q In that scenario.

A If they opted -- I guess, if they opted not to use the items in the life care plan. For example, if some of the items in the life care plan were -- let's say they were injections for pain and they decided, well I'll just live with the pain and not spend it, I guess they could do that. I mean, there's not -- nobody is going to stand there year after year and say, well, you know, you've got to take these injections or something like that. I mean, these are all hypotheticals, but sure, a person could say, I'm not going to use these for compensation for which I'm due.

Q Okay.

A I can give you simple examples. I've got --

Q That's okay.

A Okay.

Q So you're familiar, I assume, with the rule of 72's?

A The rule of 72 is a very, very, very --
Q I'm just asking, are you familiar with it?
A I'm familiar with it; yes.
Q All right. And what the rule of 72's is a sum of money will double at a rate of the interest rate -- or 72 divided by the interest rate, correct?
A I was just going to tell you that.
Q But that --
A That's what the rule is, but it's --
Q Okay.
A It's not an accurate rule.
Q Well, let's say hypothetically, you invest -- and I'm just speaking hypothetically now. If you invest $100 at 10 percent, 10 percent in the 72 gives us 7.2, and that $100 would double and become $200 in 7.2 years, correct? That's how the rule can be applied.
A It's a rule of thumb. I mean, it wouldn't be exact and --
Q But it's close?
A Excuse me. Well, okay, but let me explain. The --
Q I'm just asking.
A Well, I'd have to actually go and calculate that for you, but I'm going to tell you that that precision gets worse as the interest rates get higher or lower. So for middle ground interest rates, it's a good approximation, but for other interest rates, it doesn't work at all. I want to tell you that.
Q All right. Using your laddered approach, can you tell me

what the range is for the interest rates that you use to determine the values for your laddered approach? What's the high and what's the low?

A I will do that for you, sir. When I did the report back in July, the lowest interest rate was about 2.30. That was like on a three-year bond, a four-year bond. They go up, and then the highest rate of interest, it was 2.9 percent, and that would've been for like a 30-year bond or something like that. Let me just check, sir. I want to check on that. It was about 28, 29 years, I think, we're going into the future. So the highest rate would be 2.9 percent when I -- in July of this year.

Q All right. So but looking at the growth rates that you used for this case and the interest rates that you have used for this case, basically, you were using a negative net discount rate, correct?

A Overall.

Q Correct?

A That's correct.

Q All right.

A The medical costs will grow faster than say two percent. That's correct.

Q So in fact, based upon your calculations using a negative net discount rate, the present value is, in fact, more than the gross value of this particular life care plan, correct?

A It is.

Q Okay. Now, you have been professor emeritus since when?

A 2011 or '12.

Q And since 2011/2012, has your occupation been pretty much

forensic economist?

A Yes. Small amount of earnings from revising my textbooks, but earned income; yes.

Q Okay. So -- and I think you told us you take on 10 to 15 new cases a month?

A That's just an approximation; yeah.

Q But a reasonable one?

A Yeah.

Q Okay.

A Yes.

Q All right.

A Well, I --

Q You said that at a deposition. That's a reasonable approximation?

A Yes, yes. I --

Q Okay.

A I think we're talking about cases or reports, but let's say 10 cases a month and reports, more than that, because sometimes, I have two or three reports on a case.

Q All right. Well, do you recall telling me at your deposition on May 22, 2019 that you take about 10 to 15 new cases per month?

A Okay.

Q Sound reasonable?

A Yes.

Q Okay. And approximately 75 percent of those cases are

personal injury cases, correct?

A I would estimate that, yes.

Q And then of those 75 percent, 90 to 95 percent of those cases are on behalf of a Plaintiff, correct?

A That would be a good estimate, yes.

Q All right. Now, you recall, as part of the discovery in this case, providing us with a case list?

A I did.

Q And it was, I think, about 30 pages long; does that sound right?

A Yes.

Q And if one adds it up, and perhaps you have done this before, someone has asked you if you've done this before in terms of depositions and trials you've done over the years, it's approaching or perhaps past 700?

A It could be more than that because that list only goes back about 15 years, and I started as an economist in court cases in 1983, and that's a long time ago. I'm getting old, so it could be -- it would be more than that. It would be maybe closer to 900, 1,000. I don't -- I don't know.

Q All right.

A But it's --

Q So --

A Yeah.

Q -- the report that you prepared for this case, did you do that on a flat rate or was that done hourly?

A Hourly.

Q And what do you charge per hour to create a report like the one you did in this case?

A Okay, let me just check that because it's in my report and I want to make sure I have the right number. $350 per hour.

Q And then for giving a deposition, your rate is what?

A $450.

Q And for coming here today?

A $450 an hour.

Q And how much time would you estimate you have spent on this case to date?

A Oh. Oh. Ten hours, maybe.

Q Okay.

A I mean, that's -- because I did like -- I did an initial report, then there was an updated report I had to do when Ms. Cook updated her report, and --

Q But about ten --

A -- maybe reading some of the documents in the case and things like that. That would be a good approximation.

Q Now, this Excel spreadsheet that you have, is that something you created as a proprietary to you?

A No, Microsoft created Excel.

Q I'm sorry, but the software that analyzes the Excel spreadsheet, you said it converts it to a different spreadsheet in order to create the different calculations. Did I hear or mishear you correctly?

A You heard me correct.

Q All right.

A But it's not software that does it.

Q Is it something that you do manually with a calculator?

A No. The second spreadsheet simply says, go to the first spreadsheet int his cell and increase it by three percent a year.

Q Okay.

A That's basically what it does.

Q So you're using an Excel spreadsheet. Are you using another program in addition to that to create your final numbers?

A No.

Q So what you're doing is you plug in the growth rate or -- or I'm sorry, you plug in the growth rate, you plug in the appropriate interest rates, and then the program does the calculations for you?

A Well, I've programmed it to do that, correct.

Q Okay. All right. Thank you.

THE COURT: Redirect, counsel?

MR. HAND: Yes, just briefly.

REDIRECT EXAMINATION

BY MR. HAND:

Q Dr. Clauretie, you were asked about the dates you used for your interest rate calculations.

A Yes.

Q Okay. What dates did you use?

A Well, the last report I did was in July.

Q Okay.
A So I used the interest rates. Either the first part of July or the last part --
Q All right.
A -- of September.
Q So --
A Let me check on that. But it was within a couple of weeks of when I did it.
Q All right.
A Excuse me. June. Either the last week in June or the first week in July.
Q And do interest rates fluctuate from time to time?
A From day to day, they don't fluctuate much, but over months, they could go up a lot or down. Well, they could go up marginally or down marginally over a period of months.
Q So since you've done your report, we're living with the interest rates at the time you did your report, correct?
A Yes. Back --
Q Okay.
A -- in late June or early --
Q Okay.
A -- July.
Q So hypothetically, if you applied the October interest rates, would that have changed your plan number?
MR. DOYLE: Objection. New opinion.

MR. HAND: I'll withdraw the question.

THE COURT: Withdrawn. The Court may not rule.

MR. HAND: Okay.

BY MR. HAND:

Q So when you're doing that laddered approach you explained to us, is there a particular reason you do that other than what we've said? Can you explain that?

A The laddered approach eliminates any interest rate risks. Interest rate risks occurs when the value of a bond goes down because the market rate of interest go up, and if you do the laddered approach, you don't have to worry about -- if you only invested in short-term bonds, you'd have to worry about reinvesting those. If you only invested in long-term bonds, you'd have to worry that interest rates might go up and make those bonds values go down. So the laddered approach gets rid of the interest rate risk, as well as the default risk.

MR. HAND: Thank you. I have no further questions.

THE COURT: Recross?

MR. DOYLE: No, Your Honor. Thank you.

THE COURT: Okay. Is this witness excused for all purposes or subject to recall?

MR. HAND: I excuse my client for all purposes.

MR. DOYLE: Excused for all purposes.

THE COURT: Okay. Witness is excused for all purposes. Thank you so very much.

THE WITNESS: Thank you.

THE COURT: Feel free to watch your step on the way out.

Okay. Then at this juncture, counsel, is Plaintiff calling its next witness or is the next witness going to be the witness by agreement of the parties to be called out of order?

MR. DOYLE: The latter.

THE COURT: Okay. So ladies and gentlemen of the jury, what we're doing to do is if you recall maybe at the beginning of the case, the Court said that sometimes by agreement of the parties, there may be a witness called out of order. So at this juncture what we're going to do is by agreement of the parties, Defense is going to call a witness.

So even though we're still in Plaintiffs' case and chief, there's going to be a witness the Defense is going to call due to scheduling, okay? So now you're going to hear the Court say, in just a second, to Defense counsel, by agreement of the parties, Defense, would you like to call a witness. So this is going to be from Defense's case-in-chief. That's the reason why you're going to see Defense counsel question the witness first, okay? So, thank you.

Then at this juncture, by agreement of the parties, counsel --

MR. LEAVITT: Yes, Your Honor, but I do think there's something we need to discuss with the Court.

THE COURT: Well then would you -- stay tuned. Counsel, would you like to approach? And sorry, can you get Dr. Clauretie back, please, Marshal?

THE MARSHAL: Okay.

THE COURT: I realize we had a juror question. My apologies going back and forth. We need to get Dr. Clauretie back. Thank you so much. Before we go to that, I realize we have a juror question. My apologies.

So counsel, I need you both to approach anyway while my Marshal is getting him. So let's get this taken care of.

[Sidebar at 10:45 a.m., ending at 10:50 a.m., not transcribed]

THE COURT: Ladies and gentlemen, while we're waiting for the rest of the juror members we're going to wait for the rest of the juror members, okay.

Counsel, we may have our juror members back. Okay.

Thank you so much. We do, so let's -- counsel, since the jury's back, let me address this issue. Thank you so very much. Okay. While the Court's not on -- ladies and gentlemen of the jury, if you recall what the Court had stated is that with regards to certain juror questions, juror questions can't -- certain ones can't be asked and don't take offense, but they can't be asked for a variety of different reasons. After consultation with counsel confirmed that these were the type of juror questions that cannot be asked, either of these.

So I'm going to say thank you again to this witness and say that you're excused. I just needed to confirm that fact, so while we're calling you back I just wanted to confirm that one fact, so thank you very much.

And, counsel, is it true and accurate that this witness is excused for all purposes; is that correct?

MR. HAND: Yes, Your Honor.

MR. DOYLE: Yes.

THE COURT: Thank you, sir, very much and thank you again. I appreciate it.

Okay. So then at this juncture, counsel do you need a moment or are we calling the next witness back -- call the next witness and just not take a break? Does that make sense?

MR. DOYLE: Yes, if we can do that.

THE COURT: Okay. So then at this juncture what we stated by agreement of the parties that there was going to be a witness in Defense case in chief that was going to be called, even though -- and then we're going to circle -- and then it's going to go back to Plaintiffs' case in chief.

So I'm going to ask Defense counsel, by agreement of the parties, would you like to call the witness that's going to be called out of order?

MR. DOYLE: Yes, please.

THE COURT: And name, please, you'd like to call who?

MR. DOYLE: Doctor Brian Juell.

THE COURT: Okay, thank you.

Marshal, can you get the next witness and then come to the stand and be sworn in. Thank you so very much.

BRIAN JUELL, DEFENDANT'S WITNESS, SWORN

THE CLERK: Thank you. Please be seated. Could you please state and spell your name for the record?

THE WITNESS: My name is Brian Juell, J-U-E-L-L.

THE CLERK: Thank you.

THE COURT: Counsel, feel free to commence with your questions at your leisure.

MR. DOYLE: Thank you.

DIRECT EXAMINATION

BY MR. DOYLE:

Q Doctor, we'll go back a bit in time. Where did you go to college?

A I went to college at the University of Utah in Salt Lake.

Q What year did you obtain your college degree?

A In 1975.

Q What did you do next by way of education?

A I went to medical school at the University of Utah, also, in Salt Lake City.

Q And how long is medical school?

A It was four years 19 -- I graduated in 1979.

Q When you were in medical school were you a member of a particular honor society?

A Yes. I was elected to alpha mega alpha, which is a medical honor society. Probably the top two or three percent of my class was elected to that society.

Q Now, after you finished medical school, what did you do first by way of training?

A I went to the University of Michigan in Ann Harbor, Michigan,

where I did general surgery residency.

Q Did you complete the residency at University of Michigan or elsewhere?

A No. I ended up completing my general surgery residency back in Salt Lake at the University of Utah.

Q Would you please explain to the ladies and gentlemen of the jury what is general surgery as a specialty?

A Well, it actually is a specialty. General is just kind of a term because of its broad scope of surgical practice. It's basically internal and external surgery. I operate -- do endocrine surgery, you can do vascular surgery, you can do non-cardiac thoracic surgery, like lung surgery, internal abdominal surgery. In my practice I do a lot of breast cancer surgery, cancers of the skin. So it's a very broad specialty.

Q Are you board certified in general surgery?

A I am.

Q What else are you board certified in?

A I'm board certified in critical care. It's a separate board certification. I have to sit for examination. It's basically a surgical critical care. And that is a big component of my practice.

Q Could you explain what that means, surgical critical care?

A I take care of patients that have been injured as a course of trauma or have complications from surgical disease in an ICU setting where I manage their care, where I can -- I manage mechanical ventilators, we orchestrate dialysis, we do nutritional support, cardiovascular support, when patients are critically ill.

Q How long have you or how long, rather, has your practice included surgical critical care?

A Well, it's been part of general surgery. You know, we take care of trauma patients. And since I started my private practice in 1984 I've been doing critical care.

Q And what percentage of your practice would you say is devoted to general surgery versus surgical critical care?

A Well, actually about 80% of my practice is general surgery and then the other 20% has to do with the management of trauma patients and critical care.

Q Tell us where you have licenses to practice medicine.

A Currently I have licenses here in the State of Nevada and also in the State of California.

Q Are you in private practice?

A I am in private practice.

Q Where?

A In Reno, Nevada.

Q How long have you been in private practice in Reno?

A Since 1984.

Q Could you give us a thumbnail sketch of your private practice since then?

A Yes. When I first -- I didn't really know much about Reno when I moved there from Salt Lake, but I joined a group. I was in that group for a little less than five years. And I had a period of time when I was in solo practice. And currently I'm in an independent private

practice which has grown since 1999 from two surgeons to now most recently we have nine surgeons in that group, four of whom do trauma and critical care surgery.

Q In addition to your private practice do you have any academic appointments?

A Yes. I'm an assistant clinical professor at the University of Nevada and that involves pretty much education of medical students.

Q How long have you been a clinical assistant professor?

A I think I received my appointment shortly after coming to Reno in 1984.

Q And in the last several years what has that entailed on your part?

A Well, like I said, we take third year medical students. They pretty much shadow us. They assist to some degree in the operating room. And then we provide them lectures and do assessments of their knowledge.

Q Do you have privileges to practice in any hospitals?

A Yes. I practice -- I have hospital privileges basically at the four hospitals in Reno, Nevada; Saint Mary's Regional Medical Center, Renown, and its sister hospital, which is called South Meadows, and then at Northern Nevada Medical Center.

Q Would you explain to the ladies and gentlemen of the jury what it means to have privileges at a hospital?

A Well, you're granted privileges as a -- you're credentialed and then you're granted privileges by the board of the hospital. They're the

ones that allow you to have privileges. And your privileges, basically, are based on your training. So in order to have privileges, for example, I have general surgery privileges, plus we have separate privileges for thoracic, trauma surgery, and then also vascular surgery. So I'm fortunate enough that my practice was -- or that my education was very broad, and I could, you know, present evidence at the time of my application that I was qualified to provide those specific surgical services.

Q Now, you said -- you used the term thoracic surgery. What does that mean, thoracic?

A Well, it's basically an operation on the chest and you can -- and the organs that are contained in there, the lungs, the swallowing tube, the esophagus. Conditions that have to do with the covering of the heart and perhaps fluid around the heart. And then there are some endocrine organs that can be in the chest; basically, tumors that can arise inside the thoracic cavity.

Q And you also used the term vascular surgery; what is that?

A That has to do with operation on the blood vessels in the body, principally the arteries and the veins. Then that extends from the heart where the blood is pumped into those vessels so that the main arteries that come off of the heart I have privileges to operate on those.

Q Now, within the broad area of general surgery, do you have a particular focus or area of interest?

A Well, it's changed, you know, over the years. Referral patterns have changed, subspecialists have come in. It's been kind of a

trend in general surgery that people go after they finish their general surgery training and they get subspecialty training in certain disciplines and then now they have come to our community.

And so things have changed in terms of the volume of surgery that I do in certain areas. But I would say in recent years abdominal wall reconstruction and hernia surgeries now have become a big part of our practice. And we do a lot of robotic surgery with the Da Vinci robot platform, which is kind of a mechanical interface that has added a lot of precision to that work and opportunity. And then I also have still a pretty good sized referral base for management of breast diseases in women and men.

MR. DOYLE: Your Honor, may this witness offer his opinions as a physician?

THE COURT: Hearing no objections, the witness may offer his opinions. Counsel, you may proceed.

BY MR. DOYLE:

Q Doctor, would you explain to the ladies and gentlemen of the jury the term hernia generally?

A Well, hernia generally is a defect in the encasing structure of the body. They can occur spontaneously or as a result of life stressors. It's common to get hernias in the groin, sometimes at the navel or the umbilicus or the bellybutton. You can have a hernia that there's a potential for it to exist there where there isn't really a strong covering of muscle or tissue. And then over the course of time and with certain stressors those can get big. And when they do get bigger, they can

contain -- internal contents from the abdominal cavity can then leave the confines of the abdomen. They're still covered by skin, but they can go out through these defects.

They can also occur as a result of trauma. They can occur as a result of previous surgery where the wounds, you know, fail to heal, incisional hernias, and they can occur in the diaphragm, you know which is the muscle between the chest cavity and the abdomen.

Q We'll come back to the details of the anatomy inside the abdomen, but for now what is it that keeps everything contained inside the abdomen?

A Well, there are layers of muscle and skin or tenderness type materials that the muscles attach to. And they form a covering of the viscera inside the intestines and the organs inside the abdomen. And then, of course, there's some bony structures, too, the pelvis, the spine, the ribs. You know, also the muscles attached to those structures.

Q Then if we're dealing with a hernia in the abdominal wall, is that also called a ventral hernia?

A If it's on the anterior aspect of the -- you know, of the abdomen, yes, it's called a ventral hernia. There are several types of ventral hernias, incisional hernias, which I mentioned, umbilical hernias or, you know, bellybutton hernias. And then hernias along the midline can occur. And there's some hernias that are unusual called Spigelian hernias that can occur kind of at the junctions of muscle, you know, layers where they attach to each other. So those are all forms of ventral hernias.

Q And just focusing on ventral or abdominal wall hernias, you mentioned that they can occur spontaneously. How does that happen as a general matter?

A Well, there are certain weaknesses in the ventral coverings of the abdomen. And as a consequence of development, you know how the embryo develops. For example, in the embryo the intestines develop in the yolk sac of the egg and that they develop outside of the confines of the abdomen in the course of their development. They're then internalized, and the coverings grow over them as the embryo elongates and matures.

And so when that process happens, sometimes that closure's not complete. And if you think about your belly button, for example, that's where the blood vessels from the placenta exchange blood with the fetus while it's developing and bring nutrition and oxygen into the fetus. And there's a connection there that doesn't -- you know, when you're born you cut the umbilical cord, but those blood vessels persist. And so where there is blood vessels, there are no -- there's no muscle. And so that's an inherent weakness, if you will.

And in the groin there are blood vessels and nerves that have to go down to your legs, to the muscles and bones and stuff in your leg. And those have to exit from the pelvis. And where they exit there's no muscle cutting them off, so there's an inherent weakness there, if you will.

And so gravity over time and aging weakens our tissues and it allows for these hernias then to develop and become necessary to be

treated.

Q Okay. How is it you became interested in abdominal wall hernias and repairs of those hernias?

A Well, I mean it's always been a part of general surgery practice. I mean we make incisions; patients then return, and they have defects. And I think that it just -- it was an area where technology was evolving and there were opportunities to improve what we were able to achieve previously. And so the science of it, there really wasn't a lot of research going into hernias until maybe the last 15 years. The American Hernia Society, which I'm a member of, is still kind of in its infancy. And there's just been some opportunities that came around for it and better understanding so that we could get better results than what we had previously been able to achieve.

Q What's your best estimate of the number of abdominal wall hernias you have encountered and repaired over the years?

A You know, I really haven't added them up, but it's a very common operation. I always say hernias are probably in the top three or four operations that we do every year. We do a lot of gallbladder surgery, we do breast surgeries, and hernias are very common. So I would estimate that I've done several thousand hernia repairs over the last 40 years.

MR. DOYLE: Your Honor, I don't remember if the Court wanted to take a morning break. Now would be just as good or I can --

THE COURT: Sure. It's a great time for everyone can stretch their legs. So, ladies and gentlemen, we're going to do -- it's 11:07, so

say 11:25. So, ladies and gentlemen, we'll take a morning recess.

During this morning recess you are admonished not to talk or converse among yourselves or with anyone else on any subject connected with this trial. You may not read, watch, or listen to any report or commentary of the trial or any person connected with the trial by any medium of information, including, without limitation, social media, texts, tweets, newspapers, television, internet, radio. Anything I'm not stating specifically is, of course, also included.

Do not visit the scene or any of the events mentioned during the trial, do not undertake any research, experimentation, or investigation or do anything else. Do not do any posting or communications on any social networking sites or any other type. Do not do any independent research, including, but not limited to, internet searches. Do not form or express any opinion on any subject matter until the case is fully and finally submitted to you at the time of jury deliberations.

With that, we wish you a very nice relaxing break. We'll see you back. Thank you so much.

THE MARSHAL: All rise for the jury.

[Jury out at 11:09 a.m.]

[Outside the presence of the jury]

THE COURT: Okay. One moment, please. Okay. We're going to stay on the record for a brief few moments. We're going to ask for the expert to go into the anteroom; is that correct?

MR. DOYLE: That's fine or he can go in the hallway.

THE COURT: Do you want him here or do you want him out?

MR. JONES: Well, definitely I'd like him out, but it may be good for Mr. Doyle and I to speak for like three minutes.

THE COURT: Okay. So here's what we'll do. We're going to go off the record. We're going to see you back at 11:20, okay. Thank you very much.

[Recess taken from 10:50 a.m. to 11:27 a.m.]

[Outside the presence of the jury]

THE COURT: Okay. On the record outside the presence of the jury. So did counsel have an opportunity to speak and do you have an agreement or is there an issue that you need addressed?

MR. JONES: Yes, we have something to address, Your Honor.

MR. DOYLE: I thought we did, but I guess we don't, so.

THE COURT: Okay. You thought we did. Okay.

MR. JONES: We do not have an agreement, Your Honor, and so we do need to address the issue.

THE COURT: So I need to have some scope or something because, counsel, you all knew if there was anything that anybody wanted addressed with regards to any witnesses, I do know I have been saying this daily, do not bring up new things while a witness on the day of a witness, right, because the Court needs to have time to prepare, to have an understanding what the issue is.

Now, fully realizing that at trial certain things come up unexpected, but obviously documents don't come up unexpected, right,

that are pictures that people want to use for purposes of their own expert witnesses because you all would know what your own expert witnesses and/or clients would already know what you want to be asking them questions on because you would have prepped them prior to their testimony, you would have already done depos, you would have already done expert reports.

So I will hear this, but I am hearing this with the reminder that this Court is doing this as completely contrary to what this Court has directed. I don't know which party yet. I'm going to hear it all first, but let's find out why nobody wants to provide things to the Court in a timely accurate manner to allow this Court to be prepared because -- so what is the issue and is anyone going to provide me a copy of anything so I can rule on something or are you just going to ask me to do it out of thin air?

So, counsel for Defense, if you're asking to provide something to a witness, I'm sure you brought extra copies for the Court. Did you bring extra copies for the Court?

MR. DOYLE: I do not have extra copies. I have my copy that I've --

THE COURT: Then how would the Court have anything that if you're asking to present something to a witness, so the first question is, was what you're asking to present to the witness, was it previously provided during discovery?

MR. DOYLE: At the calendar call, yes.

THE COURT: No. Discovery is the first question.

MR. DOYLE: No. These are all demonstrative. Well yes, the

x-ray images that are incorporated into a number of these were produced by Plaintiff during discovery.

THE COURT: Counsel, I can't play the slicing and dicing. It's a very simple question. In the form that you are asking to provide it to the witness and what is in your hand, was that presented, those documents and those forms, presented during discovery?

MR. DOYLE: No, because they include texts.

THE COURT: Okay. That was a simple question the Court was asking, okay? It's really a simple question. Okay. So it was not during discovery. Okay. So was it -- was it attached to any expert reports or anything like that? Not in discovery, not during any deposition. The only deposition taken out of discovery this Court was aware of is Doctor Hurwitz's, correct?

MR. DOYLE: That is correct.

MR. JONES: Yes.

THE COURT: September 18, okay. So that's that.

So then the next is 2.67. At the 2.67 conference was which is being asked with regard to Doctor Juell, provided the 2.67 conference in the form in whole or in part, the 2.67 conference?

MR. DOYLE: No, because as I understood it, we needed to provide demonstrative exhibits at the calendar call.

THE COURT: Counsel, I'm really going for yes, no's. I'm just -- I'm trying to get dates.

MR. DOYLE: Okay. Got it.

THE COURT: I'm just trying to get dates of when it was first

provided, right?

MR. DOYLE: Yeah.

THE COURT: Remember, you all have the chronology in your minds. I don't have the information, I'm not a fly on the wall. So I just -- I need to get information. Okay. So that's 2.67. Okay.

Then the next date this Court would -- at any time before the calendar call, were these documents provided to opposing counsel before the calendar call?

MR. DOYLE: That day, yes, before the calendar call.

THE COURT: Okay. So on October 8th before the calendar call these documents were provided?

MR. DOYLE: Yes.

THE COURT: Okay. So the Court received --

MR. DOYLE: And the Court has a set of them.

THE COURT: Counsel, counsel.

MR. DOYLE: I'm sorry, sorry, sorry.

THE COURT: The Court received documents called Defense Visuals, which I called when you were all at the bench, I called the thick set, okay? Then the Court was told at the calendar call that the parties had met and conferred and that these Defendant's visuals, this Court was told, I thought, that these were going to be the opening statement slides, and I'd have to double check, but that's what I thought, so I'd have to double check.

But then I have the transcript right here, if I can reference it. So does it mirror -- and since these aren't numbered, does it mirror this

whole packet of documents that says Farris v. Rives, M.D., Defense Visuals?

MR. DOYLE: No. It's a subset that I was going to use specifically with Doctor Juell.

THE COURT: Okay. Was it ever presented to Plaintiffs' counsel prior to today that you were going to use any subset with regards to Doctor Juell or did it come up the first time today?

MR. DOYLE: I had indicated that I would be, but I provided the actual images to them today as to which ones were which.

MR. JONES: Your Honor --

THE COURT: It would be -- I just need a point of clarification. Did you -- when you say -- what's the "it would be", because at the calendar call the packet called Defense Visuals, I was told that that no longer applied because Defense counsel had chosen to use a lot smaller set of documents for your opening statements. And the opening statement slides you used were the opening statement slides you used, which definitely were not this entire thick packet. I think everyone would agree with that; is that correct?

MR. DOYLE: Correct.

THE COURT: Okay. So the Court, because I keep everything, kept the visuals, but the Court no longer had to deal with the Defense visuals because I was told that no longer applied for opening statements because you all had reached an agreement of what was going to be used in opening statement and Defense counsel has lesser slides and there was no longer an objection. So that's what the Court knew

So from Plaintiffs' viewpoint, were you aware of what Defendant was going to use or not?

MR. JONES: Not at all, Your Honor.

THE COURT: Okay. He says he told you, so what's your viewpoint?

MR. JONES: He didn't. That didn't happen. We never had a conversation where I was told these would be used with Doctor Juell.

THE COURT: Okay, "these".

MR. JONES: Or --

THE COURT: Can we at least identify how many pages we're talking about and what the "these" are, since, no one's --

MR. DOYLE: I can identify them from the master set. There's little page numbers in the lower left -- I'm sorry, lower right.

THE COURT: What do you mean by a master set? I have --

MR. DOYLE: Defense visuals, do they have page numbers?

THE COURT: These do have page numbers. Okay. What was originally going to be -- well, some do, some don't. What was originally going to be the opening statement slides, but were the withdrawn ones; is that what we're talking about? This says Defense Visuals; it that right?

MR. DOYLE: Right. There wasn't time to -- I mean there wasn't time.

THE COURT: All I know is you told me that you were withdrawing the -- you all reached an agreement, and you did different slides for opening, correct?

MR. DOYLE: I used slides from the master package.

THE COURT: My question really was different. My question was, isn't it accurate that you told the Court that instead of using the packet that had been provided to the Court as Defense Visuals, that there was an agreement among the parties and that you withdrew many of them and instead you were using a different grouping of opening statement slides, correct?

MR. DOYLE: That was just for the opening statement, yes.

THE COURT: Did you ever tell the Court that for any reason I should even keep this packet called Defense Visuals? I don't recall you ever telling the Court that.

MR. DOYLE: No.

THE COURT: This was only the opening statements. This was only presented to the Court as to what you all said were going to be your opening statement slides. That's the only way the Court got that from this Court's understanding. Is anyone saying that you told me something different?

MR. DOYLE: As I recall, I did not limit this package to just what would be used in opening statement, but that was a long time ago. I mean these are simple illustrations and demonstrative exhibits being used to illustrate the witness' testimony.

THE COURT: But you understand part of why I need to ask these questions is because you understand there's been several instances where you've made misstatements of what this Court has said, okay? And so this Court is also in part -- we have the pending sanctions

issues, right, from the Court. So the Court also -- you have a duty of candor to the Court, right, our PC 3.3, right?

MR. DOYLE: Yes.

THE COURT: So the Court has to take all those into account. So I have to ask some of these questions because this Court wants to make sure I'm giving everyone the full benefit of the doubt, but also everyone has those additional obligations, and we have those pending issues that the Court has to evaluate.

So a distinction between what the slides may or may not be versus whether or not there was a specific request that these be held onto for any reason or these Defense visuals would be used for any other purpose for other than just for opening statement is something this Court wanted to have that information available because that would make a difference in the Court's analysis, right?

The same way as I asked you with regards to like parallel it to the Hurwitz deposition. When you stated that you had made that specific request at the calendar call to introduce the Hurwitz deposition late, I gave you the full benefit and opportunity to provide the transcript that you did. You never provided the transcript and then you realized you hadn't and then so that is the same thing here. If you did, I want to know if you did. If you didn't, I want to know if you didn't because the Court needs to know.

If you say that you specifically reserved these out for some other purpose, then the Court has to take that into consideration. If you didn't reserve it for any other purpose, although serendipitously because

this Court happens to be very detail oriented, and I try and keep everything, and so serendipitously I happen to have the packet kept for opening statements, then I need to know if that's the realm in which I'm working in.

I'm just really trying to get an understanding of what people are asserting. So that's really a simple question I'm trying to get an answer to because the slides may be what the slides are, but that's different than the question the Court was asking. Are you asserting that you stated to the Court that these visuals were going to be used for any other purpose other than opening statements, that's an affirmative yes or no. Did you state that to the Court?

MR. DOYLE: I have no recollection one way or the other, so I cannot say yes or no without going back and listening, perhaps.

THE COURT: That's fine.

MR. DOYLE: But there is one image that was used in opening statement that is --

THE COURT: Which number is that, sir?

MR. DOYLE: It unfortunately does not have a number, but it's this one and I --

THE COURT: This one, describe it.

MR. DOYLE: May I?

THE COURT: Just describe what it is.

MR. DOYLE: It says Mrs. Farris' surgical site of repair, source imaging, which is Exhibit 8 and it has the four images that say no leak, no leak, no leak, and leak. This was used in opening statement.

THE COURT: Okay.

Counsel for Plaintiff, do you have any objection to that page?

MR. JONES: To that page? I mean it's -- I do with this witness because I -- there was no reason for me to suspect or to know that this witness would be expounding on anything in particular here when it comes to imaging or these demonstratives.

THE COURT: Okay. So let's -- it looks like there's two issues that you're asking the Court to address.

I've asked Defense counsel some questions, so I need to ask Plaintiffs' counsel some questions. I need to know, do you disagree with these in totality the demonstratives, only certain ones, and what is your basis of your disagreement or your objection to them so that I have an understanding.

Once again, first I had to get the chronological, now I need to have the basis of your objections and your support for your objections.

MR. JONES: Absolutely.

THE COURT: And I need to turn to Plaintiffs' counsel to ask you those questions, please.

MR. JONES: Yes, Your Honor. So the objection is that they were not properly disclosed.

THE COURT: Okay. Was there an agreement between the parties that demonstratives to be utilized for any witnesses be disclosed, any particular time before being utilized with witnesses?

MR. JONES: No, there was not a specific agreement.

THE COURT: Okay. Go ahead.

MR. JONES: So in terms of -- so this witness, Your Honor, he offered two reports.

THE COURT: Okay. Okay.

MR. JONES: Those were in November, December of 2018. In neither report did he review any films or anything along those lines.

THE COURT: So if you were to show me the reports, your statement is in neither of those reports under documents reviewed, will they show films?

MR. JONES: That is correct, Your Honor.

THE COURT: So I appreciate people use the films differently, so do you mean x-ray, CT scans, MRI's, what do you mean by films, please?

MR. JONES: Of all types, Your Honor.

THE COURT: Okay. So not --

MR. JONES: He reviewed no films at all --

THE COURT: So --

MR. JONES: -- prior to authoring his two reports.

THE COURT: Okay.

MR. JONES: At his deposition, one month prior to the close of discovery, he said that the day before his deposition he had reviewed some films and they confirmed his opinions. Did not specify which films, did not go -- he did say x-rays and CT's in a general sense, but he did not say which ones showed what or anything along those lines, nor did he show those to counsel at the time and he just said they --

THE COURT: Is there follow-up questions and he didn't

provide the information or is there no follow-up questions?

MR. JONES: In terms of --

THE COURT: Or some third option? I'm just trying to get an understanding if it's, he brought all his work papers with him, and no one chose to look at them, or he didn't have it with him.

MR. JONES: No, he didn't have --

THE COURT: I'm trying to get an understanding of -- I wasn't there, so I have to understand.

MR. JONES: In fact, this doctor destroyed his whole file inadvertently and didn't bring it, despite the fact that it was noticed on his deposition papers.

THE COURT: Including the films that he had seen the week before?

MR. JONES: Well, he saw the films the day before.

THE COURT: Did he bring those to the deposition?

MR. JONES: I believe not, Your Honor. Now, if Mr. Hand was at the deposition, and it doesn't say it in the transcript if he brought them, but he does say that he essentially believes that he had destroyed his entire file by accident, and he did not bring that to the deposition.

THE COURT: Okay. So, sorry, but I'm going to have to ask Mr. Hand, if you don't mind. Either you ask Mr. Hand and you can ask the question. I just need to know whether these films were made available at the deposition for --

MR. HAND: There was nothing. He didn't bring anything with him to the deposition.

THE COURT: And the deposition did request --

MR. HAND: Yes.

THE COURT: Okay. Okay. Once again, facts I need to have an understanding, so.

MR. JONES: And I do have a copy of the deposition notes, Your Honor, if you'd like to see it.

THE COURT: Well, I'll ask is it disputed that the deposition notes required him to bring his file with him, Defense counsel, do I need to see the depo notice? Is there a dispute there?

MR. DOYLE: I'm looking at it.

THE COURT: Okay. So counsel for the Plaintiff, please continue and we'll find out if there's a dispute there. Go ahead.

MR. JONES: Right. And so going into it, you know, when you're talking about going to trial, there's a big difference between someone saying hey, look, I looked at some films, and they confirm my opinions versus saying hey, I'm going to have these demonstratives with boxes on very specific films that I'm going to hand you the morning of the testimony of my expert and have us ready to deal with whatever films he happens to have chosen and the demonstrative that he wants to use. And we didn't know they were intending to use them with this expert at all.

THE COURT: Okay. So I'm going to need to see this pack of what we're talking about. I mean are these straight film pictures or are these etchings and drawings that illustrate films or is it a combination of both?

MR. DOYLE: They're actual images contained in Exhibit 8.

THE COURT: Exhibit 8.

MR. DOYLE: Plaintiffs' Exhibit 8, the disk.

THE COURT: Do we have anything to show that Doctor Juell saw Exhibit 8 and timely disclosed that and made that available to Plaintiffs at his deposition?

MR. DOYLE: Yes, Your Honor. I'm reading from the deposition.

THE COURT: Okay.

MR. DOYLE: Page 7, line 21. Have you brought those -- well, let me back up. Beginning at line 17: Doctor Juell, I'm going to show you the notice of deposition. Have you seen this before? Answer: Yes. Question: Have you brought those documents with you that were requested? Answer: No. The only document that I did bring this morning is the CD of the x-rays on the Plaintiff from Saint Rose Dominican. I was unable to find my notes or records in printed form. I do have the records on an email that was recently transmitted to me from Mr. Couchot's secretary, which I did review in preparation. And then I may still have the records. I was just unable to locate them.

THE COURT: So CD, the x-ray of Plaintiff from Saint Rose --

MR. DOYLE: Dominican.

THE COURT: -- Dominican. So only x-rays and only Saint Rose Dominican; is that correct?

MR. DOYLE: Right. Exhibit 8 is the CD that he had with him that day.

MR. JONES: We don't have confirmation of that. We have confirmation of what it says here.

THE COURT: Was that attached to his deposition in any manner as an exhibit?

MR. DOYLE: No. No, it was not marked and attached.

THE COURT: Defense counsel it wasn't or Plaintiffs' counsel, neither?

MR. DOYLE: Correct. And correct. It's not --

THE COURT: It is not in his report in any manner any review?

MR. DOYLE: It's in his report dated September 9, 2019, a supplemental report at --

THE COURT: September 2019. Okay.

MR. DOYLE: After his deposition he prepared a supplemental report just out of an abundance of caution to ensure that it was in a report.

THE COURT: September 9, 2019 report. Nobody mentioned that one, so wait a second. There's a September 9, 2019 report, counsel?

MR. JONES: I don't have it in front of me.

THE COURT: Okay. Just counsel you mentioned two. And so now I'm hearing about a third. So --

MR. JONES: I recalled, Your Honor -- I mean yes, there was a September -- it was a matter of a motion to strike, but it was not stricken, so that is true, there is a September 9th report, Your Honor, and I had forgotten.

THE COURT: Does it show the CD as referred to?

MR. JONES: I don't know. I do not remember what it states.

THE COURT: So either I need Plaintiff to see it so he can either agree or I need to see it so I can read it. I just need to know if you're in agreement or if there's an issue for the Court to decide, please.

[Pause]

MR. JONES: Your Honor, in this report he does say that he reviewed the chest x-rays and the CT's.

THE COURT: Okay. And Exhibit 8, is Exhibit 8 the stipulated admitted Exhibit 8 that was both on the jump drive in Plaintiffs' version and in Defense's version was a variety of exhibits in the letter formats, including J through Z?

MR. JONES: I believe that's right, Your Honor.

THE COURT: So have it confirmed to the Court which way are you having it and remember that. I keep reminding you. When I say you all, that's to both of you.

MR. JONES: Right.

THE COURT: Remember your exhibits were supposed to be done and ready October 8th. The fact that I'm still having to tell you on October 23rd is not correct.

MR. DOYLE: We --

THE COURT: I don't want to hear it.

MR. DOYLE: Okay.

THE COURT: You know it's not correct. You were supposed to have it done by the end of that day which way it was supposed to be.

Simple. But it's a stipulated Exhibit 8; is that correct? Nobody disagrees it was a stipulated Exhibit 8, so it's both in the supplemental report that was not stricken and it's images that are on a stipulated exhibit; is that correct or not?

MR. JONES: So, Your Honor, we have not been able to verify that. We do not know if these are --

THE COURT: Oh, so you don't know that the pictures are on Exhibit 8; is that your issue?

MR. JONES: That's correct, Your Honor.

THE COURT: Well, then, the witness can't do it until you all can verify that. If you just presented these today, then how is that possible to present it without even verifying it? That's the fair thing to do, folks.

MR. JONES: And, Your Honor, I don't --

THE COURT: So I'm sending you all out to lunch and you can verify it and you're going to have to deal with it. And I'm not -- and your witness gets on at 2:00 and you're just going to have to deal with Doctor Juell because you brought up the issue today. Your witness goes on at 2:00. You have a chance to verify it because Defense counsel only gave to Plaintiffs' counsel, what you're telling me, that you were going to bring these up for Doctor Juell today; is that a correct statement?

MR. DOYLE: Those specific ones, yes.

THE COURT: Okay. So then Plaintiffs' counsel would have no ability to verify it because you were here in court in trial and wouldn't have the ability to verify that these are Exhibit 8, correct?

MR. JONES: That's correct. That is correct, Your Honor.

MR. DOYLE: That is true, but I -- there's no other possible source at hand.

THE COURT: Counsel, counsel, the appropriate thing to do is to either disclose it to them in time so that they could verify it if you wish to use it or they have an opportunity to verify it, that they are consistent with the exhibits. It would be the same thing for either side.

This is why you all are -- if you choose not to listen to the Court's directive and disobey yet another Court order that all these things must be done in advance if you want to utilize anything so that the Court can address these, not when a witness is on the stand and not when we're having a jury ready and waiting, then the impact is your client, unfortunately, is going to still be sitting here, right, and unfortunately your witness is not going to be able to have these addressed because you chose not to give them to Plaintiffs' counsel.

You had them available before today. It wasn't like you just got them this morning, right? You chose not to give them to Plaintiffs' counsel until today. That was your choice. So Plaintiffs' counsel has an opportunity to evaluate them, to see if they're consistent with the stipulated exhibit, before making a decision about whether or not he's got an objection. That's the fair thing because you could have given to him days in advance and you chose not to.

MR. DOYLE: And I gave him printed copies of each of these images with all the data, so you can easily compare it.

THE COURT: When, today?

MR. JONES: Where? Where's that?

MR. DOYLE: I gave you this.

MR. JONES: I don't have -- today?

MR. DOYLE: I gave you this.

[Counsel confer]

THE COURT: You gave them in the midst of trial; is that correct?

MR. JONES: When did you give us these?

MR. DOYLE: Today.

MR. JONES: Because all I saw were these.

MR. DOYLE: Well, I didn't know there was an issue until we were on our break. I was not aware that there was an issue until about 30 minutes ago that there's some authenticity argument that these in fact are not images from Exhibit 8.

THE COURT: Counsel, don't you think they'd have a chance to actually look at them to see? As an experienced litigator, you would want to take a look at them to see; if somebody hands you something right as a witness is on the stand or the day the witness is on the stand, you're in the midst of trial to look to see what they are?

MR. DOYLE: I guess they could take my word for it, but I know they won't, but --

THE COURT: Counsel, how many specific times have you heard the Court say if anybody wants anything, don't do it on the day the witness is on the stand, don't do it while the witness is on the stand, it has to be brought up beforehand and enough time for the Court to -- and

bring copies for the Court, which you chose not to do, as well.

If you want it heard, you've got to give enough time so it can be heard. You can't just assume that you can just do what you want and that is going to be fine.

Counsel for Plaintiff gets an opportunity to look at them. Counsel for the Plaintiff gets an opportunity to evaluate them. And if counsel for Plaintiff wants that opportunity, they get that opportunity. If they had provided it to you, you'd have the same opportunity. This is not a surprise. The Court has been telling you this, plus it's common sense, plus it's in the rules, plus it's required by the Rules of Professional Conduct, plus it's everywhere, so.

MR. DOYLE: But, Your Honor --

THE COURT: At this juncture, counsel --

MR. DOYLE: -- at our meeting we had an agreement to half of these. And then when I said I had certain ones that I wanted to evaluate and have the Court consider, if the Court would consider that, then all of a sudden none of them were admissible.

THE COURT: What meeting?

MR. DOYLE: The meeting that we had at the break where we went out to review these as to which ones were okay and not okay. Plaintiff indicated to me which ones were okay and not okay and I agreed to pull a number of them.

THE COURT: Counsel --

MR. DOYLE: And so -- and then as we're walking into court I'm told well, now, there's no agreement at all.

THE COURT: Counsel, you can appreciate the Court wasn't out there. What this Court has is you agree, both parties agree, that the documents were provided today, the day of Doctor Juell's. You already knew that there was an agreement between the parties that Doctor Juell was going to testify today. So you knew you were going to have by agreement, in fact you knew this a couple days before because you said your witness was supposed to be Wednesday. So you knew Doctor Juell was going to be today, then you knew you needed to provide anything that you wanted for Doctor Juell in enough time for Plaintiffs' counsel to review it. If you chose not to do so, then Plaintiffs' counsel gets an opportunity to do so.

It's now five minutes to noon. We now, because of you again bringing something, you've now made it so that I have to bring the jury back. Two choices, counsel. I can tell the jury they can go to lunch or I can bring them back out and give them yet another admonishing. They're on an admonishing right now. Would you like the Marshal to let them go to lunch or would you like them to come back in and be told they need to go to lunch. Which would you like?

MR. JONES: Your Honor, I think the Marshal should let them go to lunch.

MR. DOYLE: Yes, that's fine.

THE COURT: Okay. See you back at 1:15. Thank you so very much. Okay. So based on the agreement of the parties, Marshal, you can just let the jury to come back at 1:15. Does that meet both counsel's needs?

MR. JONES: Yes, Your Honor.

MR. DOYLE: I thought we were scheduled at 1:00 for the sanction's motion. Is that going to take place at a different time?

THE COURT: Well, you can appreciate that --

MR. DOYLE: No, I just --

THE COURT: Okay. Remember, even on the OST, and you can read what I handwrote after speaking with both of you, right, it says 1:00, which may be moved as a convenience of witnesses, right?

MR. JONES: Right.

THE COURT: You can see my handwriting where I put that in there. So we can't do it now at 1:00 because we now are not going to have sufficient time because by the time you all leave the courtroom, my team won't have their hour lunch. So we can't do it at 1:00.

MR. DOYLE: That's fine. That's why I'm asking so I know what to look at at lunch time.

THE COURT: Sure. Can you tell me, would you rather do the sanction's motion, or do you want Doctor Juell at 1:15?

MR. DOYLE: Doctor Juell.

THE COURT: Okay. That's -- I will do the sanction's motion when you come back for lunch if you want to.

MR. DOYLE: No, no.

THE COURT: The Court's fine, you can do either what you want. Which one do you all want, Doctor Juell --

MR. DOYLE: Doctor Juell.

THE COURT: -- or the sanction's motion? The Court will

accommodate you.

MR. JONES: We're fine with the sanction's motion, Your Honor, but we're at the convenience of the Court, Your Honor.

THE COURT: Okay. Short answer. 1:00, it has to be 1:15 because of the time you've taken now for this argument based on the fact that Defense has brought these documents presented, so in order to give Plaintiffs' counsel the time to look at things and give it a lunch hour, that has to happen. So it has to be 1:15. Whether the Court addresses your sanction motion at 1:15 or the jury gets a long good lunch is going to be fine from the Court's standpoint.

I can do your sanctions motion at 1:15 or because you have an expert that presumably you paid money to and you'd prefer to get some of that testimony taken care of, we can have the expert. But remember the Court can't allow any of these documents until either you all resolve the issue on your own or you have the Court resolve it. So regardless, it sounds like the jury might be staying out a little bit longer.

And at 2:00 Doctor Hurwitz needs to do, because that is an appointed audio/visual transmission that involves our IT Department. So the Court's fine either which way you want to do it. If you both agree you want sanction's motion, I'll do sanction's motion. If you both agree that you want Doctor Juell, I'll do Doctor Juell. The Court will be glad to do either, folks.

MR. DOYLE: Doctor Juell I think is the better way to go.

THE COURT: Counsel for Plaintiff, is that amenable to you?

MR. JONES: Your Honor, so obviously we would rather have

a sanction's motion, Your Honor, no question, but we are okay doing Doctor Juell if that's the convenience of the Court, that's fine. We'll do that.

THE COURT: They have a paid expert. Doesn't it make more sense -- you would want it if it was your paid expert, right, to give as much testimony?

MR. JONES: Yes, Your Honor, that's exactly it. That makes sense, your Honor.

THE COURT: Right. So isn't it more appropriate to have the expert and put off the motion?

MR. JONES: Yes, Your Honor.

THE COURT: Okay. So that's what we're going to do. But so then I'm going to tell you all 1:15. Marshal, you're going to tell the jury 1:30.

THE MARSHAL: 1:30?

THE COURT: So that will give you enough time to review it and then decide on any of those potential documents for Doctor Juell, is that correct? I have you back at 1:15, if we tell the jury they can come back at 1:30, yes, would that work?

MR. JONES: Yes, Your Honor.

THE COURT: Would that work for you, Defense counsel, as well?

MR. DOYLE: That works fine, Your Honor, thank you.

THE COURT: Okay. So that means you'll have I guess a half hour with Doctor Juell.

Okay, can we tell the jury1:30 so they're not -- thank you so much. So at the request of counsel the Marshal will tell the jury 1:30. They've already had their admonition. Thank you so much. At this juncture I wish you all a very nice and relaxing lunch. We'll see counsel back at 1:15 and it's up to you what you want with your client, that's completely up to you, counsel, and your respective clients, okay?

MR. JONES: Thank you

THE COURT: Just so I can address your argument issue. Thank you so much. We can go off the record.

[Recess at 11:58 a.m., recommencing at 1:18 p.m.]

THE CLERK: On the record.

THE COURT: Okay. On the record outside the presence of the jury.

Okay, counsel, I hope during your nice and relaxing lunch you were able to come to a nice agreement among yourselves.

MR. DOYLE: We did.

MR. JONES: We did, Your Honor, we did.

THE COURT: Wonderful. See how nice that works? Okay.

MR. DOYLE: What I'm going to use with Doctor Juell, rather than the illustrations or demonstratives that we prepared, we'll use the actual images from Exhibit 8. And we've agreed -- I have a set for the Court. It's 8-1 through 8-10.

THE COURT: Okay. And since you're referring to 8-1 through 8-10, can we clarify now to confirm are those --

Madam Clerk, can we double check to show to see if that's

what the Court Clerk currently has to make sure that that is the stipulated one and that everyone's on the proverbial same page on that?

MR. DOYLE: She currently has a CD, which --

THE COURT: Well, that's what the concern is. That's why you're here saying 8-1 through 8-10. That was my subtle way of saying we don't have any hard copies. So I know when you were here during the calendar call -- is that maybe in Defense exhibits before your colleague leaves? Was it maybe the Defense exhibits, that the 8 was really in the Defense exhibits at the time of the calendar call, the JZ, which was referenced a couple of different --

MR. DOYLE: Yes. And, actually, I can --

THE COURT: Maybe it should be utilized from those and is that maybe the stipulated ones? I'm just -- for you all's convenience, I am -- you know what I mean?

MR. DOYLE: Right.

THE COURT: I'm not trying to put anyone on the spot. There was the D's, the Defense, at the calendar call, the Plaintiffs' jump drive, parallel to Defense exhibits. There was a couple of different letters mentioned, including ending with J through Z. I only know that because the Court made a comment, oh J-Z, you know. That's why the Court happens to remember those. Well, I remember a lot of different things, but that's how I happen to remember those exactly.

So are those lettered ones from Defense that you'd rather use? I don't -- whichever way you're going to phrase it is fine, it's just we need it in our exhibit binder and I just didn't know who overall had

control of that. And so if anyone needed to ensure the ones on the same page, feel free, whoever needs to be here, that's great and whoever doesn't, that's perfectly fine. The Court has no viewpoint whatsoever, just --

MR. DOYLE: So we can mark, and we can take -- we can mark 8 -- we can mark what is currently labeled 8-1 through 10. We can mark those as --

THE COURT: Let's make sure they're consistent with what's currently in a D binder, then, right? Let's not create a different issue.

So, Madam Clerk, look in the D binder, are they consistent with D exhibits? Are those pictures consistent with something -- the short answer is, are those pictures consistent with anything that the Court currently has? We hope the answer is yes.

MR. DOYLE: Well, if it's consistent with the tabs in the Defense binder for E, F, V, G, H --

THE COURT: Okay. E, F, what?

MR. DOYLE: I'm sorry. It's in --

THE COURT: Defense binder.

MR. DOYLE: -- E.

THE COURT: E, as in elephant? Is there anything under those tabs? No, those tabs are blank. That's why the Court's -- pardon? Is there any pictures under Defense E, as in elephant?

THE CLERK: No, Your Honor.

THE COURT: Okay. That's what I thought. How about F, as in Frank?

THE CLERK: No.

THE COURT: Okay.

MR. DOYLE: Right, but we can pull them from 8 and I can separately mark them.

THE COURT: I think you're missing what the Court's asking the question. Right now there is no pieces of paper in either Plaintiffs' proposed exhibits or Defense proposed exhibits that match what is currently in your hand, Defense counsel; would that be correct?

MR. DOYLE: Correct.

THE COURT: Okay. That per se is a huge problem because you were supposed to fix that on October 8th. On October 8th you all had 8 and then you had various letters from D from Defense side.

MR. DOYLE: Right.

THE COURT: That was supposed to be fixed on October 8th by end of day; otherwise, it was supposed to be precluded from anyone using it.

MR. JONES: Correct.

THE COURT: Remember that?

MR. DOYLE: So even though we --

THE COURT: Feel free to look. That was the agreement of all counsel; if you didn't have it in by end of day, no one was getting to use it. That was you all specific agreement.

However, the Court has to have an understanding here. Are you then -- afterwards, however that got utilized as part of Defense opening statements without objection by Plaintiff, so it looks like it's

another court violation, rather than something that either Plaintiff or Defendant can raise an issue on prejudice because the Plaintiff gave the jump drive and was supposed to give us hard copies. Defendant was supposed to put them in in pictures. Or you all were going to ensure that you had it in the appropriate medium so that the jury can have it.

So if you're going to provide a DVD player for the jury or what, because if you provide -- did they provide a disk?

THE CLERK: Yes.

THE COURT: Okay. So we've got a disk, right?

THE CLERK: Yes.

THE COURT: Does that disk have those pictures on it?

MR. DOYLE: Yes.

THE COURT: Okay.

MR. DOYLE: Plus many, many more.

THE COURT: I sure hope it doesn't have many, many more, but okay, that's a different issue.

So the disk -- so at this juncture is the Court ever going to get an exhibit binder to go back to the jury that somehow is consistent with what you all are utilizing in court?

MR. DOYLE: We can put that together, yes.

THE COURT: Today.

MR. DOYLE: Okay.

THE COURT: Today, today, today. Okay? It was due on the 8th. There is no reason why you didn't get it to the Court on the 8th, the 9th, the 10th. I don't need to keep doing the math. So today. You're

talking ten pictures or whatever number of pictures you are. Poor Madam Clerk cannot keep on going on guessing on what it is. She has her responsibilities. She has a responsibility to get these exhibits done in a particular manner.

So whether you're calling this letters or you're calling this numbers, whatever these ten pages are, I'm glad you all came to an agreement, but we need to have them in the official court exhibits so that they are secured so that the jury can get them. Are these ten exhibits stipulated in or is some greater number stipulated in and only some of them are being used for demonstrative purposes with Doctor Juell? Which is it on that?

MR. JONES: Your Honor, as far as I'm concerned, all that we've done is we've agreed to let the Defense use these ten and then obviously we'd be able to cross with these ten as we would want for the purposes of Doctor Juell.

THE COURT: So are you still then open to using the proposed of what was Exhibit 8, that whole panoply of extra exhibits or not?

MR. JONES: Your Honor, we knew that by us not putting them in there, that they were gone, right. That was our understanding. We failed to print them off and we decided you know what, we're good, we're live without them. So that was our understanding and we just haven't brought the issue back up because as far as we were concerned, they were done.

MR. LEAVITT: We don't have them. We never got them.

MR. JONES: Right. And -- yeah, we never received the others printed off.

THE COURT: Okay.

MR. DOYLE: We go to -- just so the Court's clear, that exhibit binder we have goes to D. And then it jumps to double A. That was the point this morning, was we pointed out --

MR. LEAVITT: We haven't seen these.

MR. JONES: We're seeing these now for the first time.

THE COURT: These being these ten pictures?

MR. LEAVITT: These ten pictures.

THE COURT: Okay.

MR. DOYLE: We had an agreement in the hallway that I could use these with Doctor Juell. We just have to figure out how to mark them, I guess.

THE COURT: Well --

UNIDENTIFIED SPEAKER: As a demonstrative.

MR. DOYLE: I'd use them as demonstrative at this point.

THE COURT: Then you just -- the challenge is, counsel, I'm hearing what you're saying, but if you use them as demonstrative, right, and you call them Demonstrative 1 through 10 or whatever you call them, right?

MR. DOYLE: Yes.

THE COURT: And then later in a different witness somebody wants -- I don't know, is anyone planning on using these pictures on any other witness in this case? Let's jump to the question.

MR. DOYLE: I do not, no.

THE COURT: Plaintiffs' counsel, are you planning on using any of those pictures for any other witness in the case? I should say any other witness or closing argument, right, because if you're only using as demonstrative, they don't come in as closing argument, right? So are any of these pictures to be utilized for any other witness or in closing? It's a simple yes or no. I'm not ruling on anything, I'm just asking people's intention.

MR. DOYLE: No.

THE COURT: So no from Defense.

MR. JONES: We may use them for Doctor Hurwitz in our rebuttal case.

THE COURT: Okay. So you can understand why the Court is asking this question.

MR. DOYLE: Right.

THE COURT: You can understand why this Court goes through such great efforts not only to print out the EDCR 2.67, 2.69, but making it a very user friendly, have you all do this stuff in advance so you're not in the situation we've been every day of this trial or almost every day of this trial, because the issue becomes, if Defense counsel identifies a certain picture as demonstrative whatever today, and then it gets otherwise identified something different with any other witness or in closing, right, then that presents a challenge, particularly if down the road anyone is saying that these pictures are to be -- going to be requested to be admitted in any manner, because then you would have

two different ways that things will be phrased.

The per se you can't do, even without a Court ever saying it.

UNIDENTIFIED SPEAKER: Correct.

THE COURT: And I know darned well that this Court said this on the 8th because I gave this specific example of 8 versus the Defense ones and said --

UNIDENTIFIED SPEAKER: Correct.

THE COURT: -- you had to get that reconciled, but it doesn't even matter if I said it, you had to have done it beforehand.

UNIDENTIFIED SPEAKER: Right.

THE COURT: So long story short, are you going to try and introduce them potentially as exhibits? It doesn't matter what your answer is, I'm just trying to see if there is an issue that has to be taken care of or not.

MR. JONES: No.

THE COURT: Okay. So you can call them same, demonstratives --

MR. JONES: Correct.

THE COURT: -- as what Defense is calling them?

MR. JONES: Correct.

THE COURT: Okay. So if that's -- so demonstrative 1 through 10, is that what you're calling for?

MR. DOYLE: Yes.

THE COURT: Does that work for you, Plaintiffs' counsel? Is that a yes or a no or have I asked one question too many?

MR. JONES: The answer is definitely yes, but there's one -- the only thing I would say, Your Honor, because this is literally the first time we've seen these, we would like to reserve the right only in rebuttal of Doctor Hurwitz in his rebuttal case, in the event that we think some of the others that are of the same, that we'd be able to just add those to the back of the list, potentially.

THE COURT: Okay.

MR. JONES: Just probably --

THE COURT: That's a fair --

MR. JONES: -- the answer is we won't, but I just want to look at them to make sure.

THE COURT: Well, Defense, do you have any objection to that?

MR. DOYLE: No, we don't.

THE COURT: Okay. There being no objection -- has that -- because my wonderful Clerk, because since we are mentioning DVD's and thumb drives, did try and open up both of those and so she just wrote me a nice little post-it giving me a head's up that the DVD -- I'm reading it straight from her. The DVD and thumb drive do not have any images that can be open on a computer.

MR. JONES: Images or videos?

THE COURT: Both.

MR. DOYLE: Exhibit A you have to first click on the read, the reading program, and then once you click on the reading program, then it gives -- then it calls up all the images.

THE COURT: Well, you can appreciate for ease of a jury -- it doesn't matter for right now's purposes you'd like to take the witness in, you've agreed that demonstrative 1 through 10, they've been numbered in the little lower right-hand corner or something so everyone knows what we're talking about.

MR. DOYLE: Right now they --

MR. JONES: Yes, they have, Your Honor.

THE COURT: Defense and Plaintiff have it the same way so that you're both talking about the same pictures?

MR. JONES: Yes, Your Honor. Yep, they are.

THE COURT: Beautiful. It sounds to me like you'd like to bring the witness in and maybe the jury?

MR. DOYLE: Yes.

MR. JONES: Yes, Your Honor.

THE COURT: The jury's supposed to be 1:30. Marshal, can you check to see if we have our jury and we'll bring the witness in for right now. Okay.

THE MARSHAL: Bring the witness in?

THE COURT: Yes. Now, remember you're going to stop a minute or two before the 2:00 so that you can go to Doctor Hurwitz. Is that the intention of the parties or is there some different agreement of the parties?

MR. JONES: No, that's fine. That's the intent, Your Honor.

MR. DOYLE: What time -- what time would you -- I mean I'll keep an eye on the clock. What time would you like me to stop?

THE COURT: Whatever you all agreed to. Five to 2?

MR. JONES: He's ready at 2, yeah.

MR. DOYLE: Well, I assume it takes a few minutes to get set up.

THE COURT: It's really as simple as screens and clicking a button, so yes, there is a minute or two, yes. So he needs to be clicked in, ready to go, right?

MR. JONES: He's been alerted, Your Honor.

THE COURT: Yes.

MR. JONES: Yes, he's aware.

THE COURT: And I will tell you generally it would be the Court's practice, consistent with what has happened with Doctor Rives, since it's been a few days, would be to re-swear him in, particularly since --

MR. JONES: That's fine.

THE COURT: Now, he actually -- I may take back what I just said. I have to ask you how you want --

You can go to the stand, that's perfectly fine . Multi-task here.

Do you have all jurors?

THE MARSHAL: We do, Judge.

THE COURT: You can start bringing the jurors in. Thank you so much.

Is with the audio/visual transmission request, since the witness, Doctor Hurwitz, did already sign the affidavit that he be sworn in in this jurisdiction, it's going to be up to you all whether you wish him to

-- so that it looks consistent with what was done with Doctor Rives to re-swear him in?

MR. JONES: Sure.

THE COURT: That's going to be fine for the Court if that's what you all want so it looks consistent, but you have the unique aspect because it was an audio/visual transmission request, he had to sign that authorization anyway, already saying that it could be done.

So do you want him for consistency just re-sworn in again, so I say the same thing we do with the prior witness or do you want something different because it's an audio/visual and he's already signed it that you don't want the Court to do that. What would you all like?

MR. JONES: That's perfect, Your Honor.

MR. DOYLE: Re-swear.

MR. JONES: Re-swear is fine.

THE COURT: Okay. That's fine, the Court will do that.

The jury will be here in a second. Are you all anticipating that you're going to want to do your two experts for the rest of the day because of economics involved or are you going to want to switch to do your sanction hearing later in the day?

MR. DOYLE: How about later in the day so we can try and finish both.

MR. JONES: Later in the day.

MR. DOYLE: Well, Doctor Juell's available to come back tomorrow, if necessary.

THE COURT: Are you going to take Doctor Hurwitz to the

end of the day? The Court's going to need some time to prep.

MR. JONES: It's cross, Your Honor. It's on cross, Your Honor, so we're finished with our direct.

THE COURT: And redirect?

MR. JONES: We may have a redirect, but not an extensive one.

THE COURT: The Court needs a little head's up. There's like binders sitting in my office, there's some prep and things, so I kind of can't just do snap all of a sudden, let's jump to a motion. So I'd like a little head's up, please. Would you like the motion heard today or are you planning on finishing, doing witnesses today to get through some witnesses?

MR. DOYLE: Let's get through the witnesses today.

THE COURT: Does that work for you?

MR. JONES: Yeah, get through the witnesses, Your Honor, and if there is additional time after Doctor Hurwitz, perhaps or --

THE COURT: You're saying the very thing that I'm saying can't happen.

MR. JONES: Oh, I see.

THE COURT: You can't just say Judge, all of a sudden now we have 15 minutes, let's do the motion. You can appreciate the Court needs a little bit of time to bring in the material, et cetera, so I either need to know you're going to spend the rest of the day on witnesses or you'd like a particular time that you want the motion heard so we can have everything ready and prepared for it. Best tomorrow, is that more

what you're saying?

MR. JONES: Tomorrow's fine, Your Honor.

THE COURT: So we'll revisit it.

Okay, Marshal, let's bring in the jury. Thank you.

THE MARSHAL: All rise for the jury.

[Jury in at 1:34 p.m.]

[Within the presence of the jury]

THE MARSHAL: All jurors are accounted for. Please be seated.

THE COURT: I appreciate it. Welcome back, ladies and gentlemen, I hope everyone had a very nice lunch.

As you recall before we had the lunch break, the same witness is on the stand. The witness understands you're still under oath, correct?

THE WITNESS: Yes.

THE COURT: I do appreciate it. Feel free to continue with the examination, then. Thank you so much.

MR. DOYLE: Thank you.

DIRECT EXAMINATION CONTINUED

BY MR. DOYLE:

Q Doctor Juell, about when were you first retained by my office to look at this case?

A I think it was in May 2017.

Q Were you provided with Doctor Rives' office records?

A Yes.

Q Did you review those?
A Yes, I did.
Q Were you provided with the 8,000 plus pages of the Saint Rose Dominican Hospital, San Martin records?
A Yes, I was.
Q Did you review those?
A I did.
Q Were you provided with the imaging studies, the CT scans, chest x-rays, abdominal x-rays, from Saint Rose Dominican Hospital?
A Yes, I was provided those, and I have reviewed those.
Q Were you also provided with and did you review Doctor Rives' deposition?
A Yes, I have.
Q Could you give us an estimate of the amount of time you have spent reviewing all the materials and preparing for today?
A Probably about 25 hours.
Q Now, based on your background, training, and experience, were you able to form an opinion to a reasonable degree of medical probability whether Doctor Rives' care in 2015 complied with the standard of care?
A I do believe that his care did comply with the standard of care.
Q And his care in 2014, did that comply with the standard of care, as well?
A Yes.

Q When you reviewed the materials provided to you, did you find anything that Doctor Rives did or didn't do that was below the standard of care?

A No. I thought he was very attentive.

Q Were you able to form -- again, based on your background, training, and experience and the materials that we provided to you, were you able to form an opinion to a reasonable degree of medical probability whether there was a hole in the colon leaking bowel contents prior to July of 2000 -- I'm sorry, July 12?

A Yes. It's my opinion that there was no hole in the colon where it had been repaired up until several days before she underwent re-operation, as Ms. Farris.

Q Explain that answer, please.

A I believe the patient had several series of imaging studies. She had a hernia repair that was done laparoscopically on July 3rd. She had an initial CT scan on the 5th and then a subsequent CT scan was done on the 9th. And through that period of time, both from a clinical standpoint based on the record review of examining physicians, the patient's clinical course, and the imaging films, I saw no evidence that there was a leak from the colon or an establishing infection up until the 12th.

The reason that I use the 12th as an example is that during the second CAT scan was done on her on July 9th, contrast was given. And there is an x-ray in the record from July 12th which shows the colon to be opacified with the contrast, so that the contrast outlines the anatomy

of that hollow intestinal structure and there's no contrast outside of the anatomic confines of the bowel.

So on the CAT scan of the 15th there's clear evidence that the colon has ruptured and there is a hole, but between the 12th and the 15th that must have occurred.

Q Okay.

A And that also corresponds to when the patient had a second wave of significant clinical deterioration. So that is my opinion.

Q Okay. Based on your background, training, and experience and the materials provided to you, were you able to form an opinion to a reasonable degree of medical probability why this hole occurred or opened up sometime between July 12 and July 15?

A I don't know for sure why the hole occurred, but the reason that anastomosis or repairs on hollow viscera do fail, generally speaking, in this particular case I would say was due to a compromise in the blood supply of that organ while it was trying to heal following an initial repair because of other pre-existing physiologic challenge that the patient was experiencing due to infection, but was from another cause.

Q Would you explain that, please?

A Well, it was my opinion when I looked at the case in total that the patient had an initial episode of sepsis or, if you will, what we call systemic inflammatory response syndrome, which is a term we use. Sepsis sort of has to do with if you have your response to infection in terms of inflammation.

When I speak about sepsis, we're talking about when there is an

identifiable bacterial infection or the products of infection lead to this dysfunctional inflammatory response. But there are other conditions that look exactly the same, which are not caused by bacterial infection.

And I think in the case of Ms. Farris that she had a respiratory compromise that was initially mechanical, but subsequently became infectious. It was still being properly treated, but the operating diagnosis was different. You know, fecal peritonitis had occurred in the patient. But there really wasn't any direct evidence of that. It was just a good operating diagnosis, and the patient, in fact, responded to the clinical treatment that was aimed at that.

But I believe that the inflammatory response that she had was initially dysregulated and that that led to problems in the very microscopic circulation that weakened the repair that Doctor Rives had performed on the colon and then there may have been some mechanical movement of stool or something through that that through where it was weakened that allowed it to then rupture and infection to begin in the abdomen.

Q Now, were you able to form an opinion to a reasonable degree of medical probability why Mrs. Farris developed sepsis on July 4th?

A I believe she had initial compromise in terms of her respiratory function and that she also may have had some temporary paralysis of her intestines so she -- I think she had early feeding. There was some concern that she was getting very distended, potentially from swallowing air or fluids that weren't passing through her system at that

point in time, which is a common consequence of having abdominal surgery. And that they did try to put down a nasogastric tube to decompress her several times. And that I believe that her respiratory condition was complicated by pulmonary aspiration, where she either vomited, either/or had, you know, mouth contents go into her lungs, that then precipitated the inflammatory response that she had.

Q Based upon your review of the records, were you able to form an opinion to a reasonable degree of medical probability whether Mrs. Farris' overall condition improved between July 4th and say July 12th?

A Yes. It was my opinion that the patient initially had this very prompt deterioration from the 3rd when she had surgery to whereas in the morning of July 5th she, at 6:00 in the morning, she required intubation and be placed on a breathing machine for support of her lung function. And then obviously a lot of medical critical care intervention came to play, and her condition actually improved.

She showed some compromise at that time of her kidney function. She did have an accelerated heart rhythm, she had some instability of her blood pressure, she had low urine output, and she did have a build-up of acid in her system from not having adequate amount of fluids, you know, for profusion.

But once she did receive fluids, she got started on antibiotics, she had, you know, the support of her breathing with the ventilator and had medicines given to correct her heart rhythm disturbance, she did in fact improve and then plateau.

She remained ill in the ICU. She showed some transient improvement with her lung function where they were able to make some efforts to liberate her from the mechanical ventilator, but they hadn't been able to accomplish that in total. But her condition actually stabilized, even though she remained critically ill through that period.

Q Okay. Doctor, I want to ask you some general questions about the abdomen. Could you explain to the ladies and gentlemen of the jury first of all how the abdominal cavity is divided into different compartments?

A Yes. Well, you know, there are organs inside the abdomen, the intestines. There's the stomach where the food is initially, you know, deposited and acid comes in and muscular activity breaks the food down. And then it goes into the small intestine, which is primarily where you have molecular forms of food, and there's actions taken to allow that food to be absorbed into the bloodstream for nutrition and supplementation of processing.

And then the food passes through into the large intestine or the colon, which basically functions to regulate the final water content of the stool and prepare, you know, the stool for excretion. That's its primary function.

So those organs are all suspended by blood vessels that come off of the back of the abdominal cavity. And where those blood vessels pass, and there is also other organs, the pancreas and the kidneys, the adrenal glands, and lymphatic structures. And those are covered by a covering. And so we call those retroperitoneal.

Then the spaces between the bowel and the intestines over the liver and the spleen, we call that the peritoneal cavity because there actually is a potential free space. I mean inside of me right now I have lunch in my intestines, but there's no real space between the intestines, but I mean there's potential space. If we were to introduce fluid in there, it could be outlined because these structures have to move, they have to contract. You don't have to do peristalsis.

So there's the peritoneal cavity, which is a potential space, and it's lined by a very thin layer of cellular material that allows that to have some motion in that space. And then there's the retroperitoneal structures, which are relatively fixed in the back of the abdomen.

Q Now, in a typical adult how long is the large bowel or the colon?

A It's usually around six to seven feet long. And it's basically suspended by ligaments all the way around the outside of your abdomen from the -- on the sides. And then there's a connecting portion that transverse colon that goes across underneath your ribs. So that's why it can be so long is it's not perfectly straight, and then it's also, you know, around the perimeter.

Q Is the large bowel or colon divided into different parts?

A Yes. We call different areas --

Q Doctor, let me ask you, would you like to draw for the jury what the different parts of the colon are?

A I can if you'd like, sure.

Q And I've got red, blue, and black.

THE COURT: Can we use the hand-held microphone? Madam Court Recorder has it for you. You can hand it to -- the Marshal can hand it to the witness. If you're going to speak, we need to get you a pocket mic.

MR. DOYLE: I'm going to go back.

THE COURT: Okay. Thank you so much.

THE WITNESS: Thank you.

BY MR. DOYLE:

Q So, doctor, you need to make sure you keep the --

A Would you like me to draw on this?

Q Please. But you've got to make sure you keep the microphone up close to your mouth.

A Okay. All right. So we're going to put these lines up. This is just where the ribs are in the upper part of the abdomen. And then you would have your breast plate in here. So the colon is attached, as I said, to the sides of the abdomen. And the first portion on the right side, this would be the groin, is a fairly large receptacle. The small bowel comes down into it. And then there's a large portion of the bowel here.

The appendix comes off of this. The appendix is part of the colon. Its function is debatable some people think. It is a hollow tube that bacteria normally found in the colon can hide out in here during periods of infection of the colon to repopulate the colon with good bacteria when you've recovered from the infection. So there may actually be a reason for having an appendix. It's like the appendix of a book, though. I mean if you throw the appendix out of the book, it still reads pretty well. But it

can be subject to infection because it is a narrow tube.

And this portion of the colon is called the cecum. And then there's a portion that comes up here underneath the liver and it's rising because this is the direction of transit of the materials through the colon. This is called the ascending colon.

Underneath here, the liver is normally underneath the ribs up here. So this little corner is called the hepatic flexure because that's -- when we talk about the liver, we talk about the, you know, being hepatic structures. So that's called the hepatic flexure.

This portion then going across the abdomen lies transversely, you know, horizontally, so that's its name, transverse colon. Then there's another flexure over here, there's an organ up here that acts like a purifier to the blood. It's called the spleen. And it's kind of like an oil filter. It kind of cleans out dead red blood cells and things from your circulation. And it has some immune function. And this flexure here is called the splenic flexure. And there are actual ligaments that connect these two organs together in the retroperitoneum.

And then there's this portion of the colon here that comes down. It's called the descending colon because it's coming down, like descending in the elevator. Then there's a loop down here of extra colon, kind of comes up. It's variable in size depending on the patient. But there's like this S curve down there and I wasn't the designer, but that's the way it's shaped. And that's called from Greek, sigmoid. So a lot of times when you have diverticular disease, you hear people have diverticulitis, they can end up with infections of little pockets that can

come off of the colon. This area is quite wide in the cecum. The transverse colon is fairly wide, but as the colon narrows down here and gets -- the luminal size gets narrower.

Q And then what comes after the sigmoid colon?

A The last part is the final storage portion before you eliminate, and that's called the rectum. And the reason that there are these divisions is that all of these sections get blood supply and they have separate blood supplies coming off of the main branch here. And this comes off the aorta, which is the main artery in the abdomen. But they all have separate contributing arteries. So there's actually not only names, but it's actually the way the blood supply flows to the colon that leads to the divisions.

Q Now, have a seat again.

THE COURT: Turn that off so it doesn't cross interfere, that would be great. Thank you.

BY MR. DOYLE:

Q So in a typical adult, how long is the small bowel?

A Well, it's variable, but it can be up to 25 feet long. But it's very tightly coiled, you know. And, again, it's central. It's inside of that -- the defined borders of the colon. The small intestine runs down through the very middle of the abdomen.

Q Okay. Now, the wall of the colon, how many layers are there?

A Well, there's several layers, but typically when we talk about these hollow viscera we talk about three layers.

Q Okay. Can I interrupt you for a second?

A Yes.

Q You've used the term hollow viscera a couple of times. What does that mean?

A Well, inside, obviously inside of the intestines there's a hole where the food moves through. So that when we say viscera, we're talking about an organ, but there are solid viscera in the abdomen, too. The pancreas gland is solid, the liver is solid, the spleen is solid, the kidneys are solid, for the most part. I mean they actually have -- and most people are familiar with what organ meat looks like. You know, if you buy liver in the store, it's kind of a solid, there's no hole in it. I mean there are channels that run through it. But in the intestines there's a big hole. And that's lined by a lining that's constantly shed, if you will, and there are much of different kinds of cells in there and different functions in that lining, but we call that the mucosa.

And then there are supporting structures where the blood vessels come in and whatnot. And that's called the submucosa because it's underneath the mucosa. And then there's kind of a strong lining that holds it all together and it's called the adventitia, you know, and that's the outside of the bowel.

Q We've heard the term serosa. What is that in relation to the bowel?

A The serosa is the same as the mucosa, if you will. That's just another term for the lining of the bowel.

Q And then in terms of a typical adult at the transverse colon,

how thick is the wall?

A It's certainly less than a centimeter. It's probably about an eighth of an inch thick. It's pretty thin.

Q All right. I want to switch gears and come back to abdominal wall hernias. If someone has an abdominal wall hernia or a ventral hernia, what does it look like to someone on the outside looking into the belly of the person?

A Well, you can actually see them. A lot of patients present to me because when they wear a t-shirt or something they have, you know, a lump and/or a bulge, you know, that shows underneath their clothing. And it depends on the location where that bulge might be located, which type of hernia.

Q And depending on the circumstances, can a person who has an abdominal wall hernia go without surgery?

A Yes. Watchful waiting is an alternative to repair for some hernias. I mean there's some risks that the intestines could get stuck in there, which if they do, that's called incarceration where the intestines go through the hole and they can't get back into the belly. Sometimes that can lead to a twist that can cause strangulation, which is a twist in the blood supply. So that the intestine doesn't have any blood supply, and it dies.

So those are two major complications. Incarceration is very painful when the intestine gets stuck because gas can build up in there, and the patient has a lot of pain. And then the strangulation obviously becomes a medical emergency. But some hernias are pretty big, and

they can -- or very small. And so they have the potential for the bowel to get in there, but it's not in there all the time. And so patients can live with that. But they may be intermittingly symptomatic, so it kind of comes down to well, what risk do you want to take, and how much pain do you want to have. And patients will ultimately, you know, will tip in one direction or another, depending on, you know, how much it bothers them.

There was a study done for inguinal hernias that looked at watchful waiting versus an operation in the VA. And so they had a captive audience, so they --

MR. JONES: Your Honor, object. Narrative.

THE COURT: Sustained.

BY MR. DOYLE:

Q Doctor --

A Pardon?

MR. DOYLE: Do you want to break now?

THE WITNESS: Can I finish that one analogy?

THE COURT: The Court sustained the objection.

THE WITNESS: Pardon me?

THE COURT: The Court sustained the objection.

THE WITNESS: Okay.

THE COURT: That's a narrative, so no, you may not.

MR. DOYLE: It overruled you to continue this.

THE WITNESS: I see that. Thank you.

MR. DOYLE: All right.

BY MR. DOYLE:

Q Do some patients who have an abdominal wall hernia that is repaired go on to have a recurrence of that abdominal wall hernia?

A Yes.

Q Why does that happen?

A Well, obviously that's a challenge and why I expressed earlier that I had an interest in hernia repairs because the failure rate is higher than it should be. I mean patients don't want to go under operation one time, let alone two. And so we try to continuously improve, you know, the techniques for closing.

So the reason that hernias fail, though, a lot of times it's because if you have a hernia defect and you just sew it back together, there's a lot of tension, you know, on the repair; when you put stitches in and pull them together tight there's tension. And so that tension wants to pull the hernia back open and that does happen. The sutures might fail over time or they might pull through the tissue, you know, because of tension.

And then there are probably genetic reasons, that some patients have a weaker structural protein. It's called collagen in your body. It's the building protein, if you will. And we know there's two different kinds of it, collagen one and collagen two. The collagen two is weaker in some patients because we're not different -- I'm sorry, we are different. There's a lot of variation in the species.

And so some people have more collagen than others. And so they may be predisposed to having the hernias. They just don't heal as well. And that's illustrated very commonly in my practice because I've

operated on some patients with cancer and they might require two or three operations and they never form a hernia. And then you'll operate on somebody just one time for an emergency --

MR. JONES: Objection, Your Honor, a narrative.

THE COURT: Sustained.

THE WITNESS: -- and they form a hernia every time.

MR. DOYLE: All right. We can stop now because of our plan.

THE COURT: Sure.

So, ladies and gentlemen of the jury, by agreement of the parties, what we're going to do is we're going to stop with this witness at this juncture. And then, counsel, you're going to recall --

MR. JONES: Doctor Hurwitz, Your Honor.

THE COURT: Okay. And I'm going to mention that again in just a moment because he's going to be appearing via audio/visual conference, so he will show up on the screens. And so it'll take a moment or two for him to show up on the screens.

In light of that, this witness is going to be excused temporarily and be recalled; is that correct, counsel?

MR. DOYLE: Yes, but I --

THE COURT: So why don't you both approach.

Madam Court Recorder, why don't you turn on the white noise for a quick -- actually, you're going to get the video conference taken care of and --

[Judge and Clerk confer]

THE COURT: What I'm going to ask counsel to do for a brief

moment, I'm going to ask you if you don't mind stepping around here so I can just real quickly just ask you something briefly, all right, because the noise can't be on.

And so, ladies and gentlemen, just pause one second.

THE COURT: Ladies and gentlemen of the jury, you can't hear us, correct?

GROUP RESONSE: Uh-huh.

THE COURT: Okay. If you can at any point, raise your hand and someone --

[Pause]

THE COURT: Are the TV's both on, Marshal?

THE MARSHAL: Yes.

THE COURT: Are you getting those? Okay, thank you, sir. Just let us know when that's hooked up.

[Pause]

THE COURT: Okay, thanks so much. Since the next witness is going to be on the screens in just a second, this witness is more than welcome, you're excused, to go to either the anteroom or the hallway, whatever's comfortable for you, okay?

Just one second before the witness, before the new witness states anything, we need to have -- this witness is more than welcome to -- he's walking out and so let's give him one second. Okay.

So, ladies and gentlemen of the jury, can you see there's the two screens, you all can see? Okay. So we're just going to -- so counsel, for Plaintiff, I'm just going to -- as I stated, even though we're on the

cross-examination, just so we have clarity, this is now going back to Plaintiffs' case in chief and we are going to be --

Plaintiffs' counsel, I just wanted to confirm, you had passed the witness and it was Defense cross-examination; is that correct?

MR. JONES: That is correct, Your Honor.

THE COURT: Okay. And this is Doctor Hurwitz, correct?

MR. JONES: That is correct, Your Honor.

THE COURT: Okay. And this is Doctor Hurwitz, correct?

MR. JONES: That is correct, Your Honor.

(2:04:03 p.m.)

THE COURT: Okay. Dr. Hurwitz, just consistent with what we've done with other witnesses when it's been a few days between their testimony, realizing that you're in the midst of your testimony, Madam Clerk is just going to re-swear you in, okay? Just -- we've done that consistent with the other witnesses.

MR. HURWITZ: So -- Madam Clerk, if you don't mind. Please. Thank you so much.

THE CLERK: Yes, Your Honor. Please raise your right hand, sir.

MICHAEL HURWITZ, PLAINTIFFS' WITNESS, PREVIOUSLY SWORN

[APPEARING VIA VIDEOCONFERENCE]

THE CLERK: Thank you. Could you please state and spell your name for the record?

THE WITNESS: Michael Bruce Hurwitz, H-U-R-W-I-T-Z.

THE COURT: Okay.

THE CLERK: Thank you.

THE COURT: So for just purposes of everyone -- is the volume at an acceptable level or does it need -- everyone can hear okay and it's not too loud. Okay. So then at this juncture, counsel, you can -- it's your cross-examination. And it's up to you where you want to be and if you need a pocket microphone, we're glad to give you a pocket microphone, okay?

MR. DOYLE: I'm happy to stay right here, if that works for the video.

THE COURT: That's perfectly fine, because you've also got them on your screen in front of you, if you have your screen turned on.

MR. DOYLE: Yes.

THE COURT: Okay. So you have them on all the screens as well as the two big screens. Okay. Go ahead.

CROSS-EXAMINATION CONTINUED

BY MR. DOYLE:

Q Good afternoon, Doctor.

A Good afternoon.

Q Do you recall that when we were together on September 18, 2019, I asked you if you had ever participated in meetings, such as peer review meetings or M & M meetings, where there were frank discussions about a particular physician's care of a patient? Do you recall?

A Yes, I do.

Q And you attend --

A Yes.

Q -- you've attended such meetings, correct?

A I have.

Q And in those meetings, there have been frank discussions by well-qualified and reasonable physicians, who sometimes disagree about the care provided to a particular patient and the quality of that care. Fair statement?

A Yes.

Q In other words, it's quite common in medicine in general and general surgery, in particular, that one physician might be critical of how another physician went about taking care of a patient, but that other physician still can be within the standard of care. Fair statement?

A Yes.

Q And do you recall telling me on September 18, 2019 that I may take issue with something, but I would say that, as you said, that there are areas to disagree that do not fall below the standard of care. Do you recall that statement by you?

A I believe so, yes.

Q Now, when you testified last week, Friday under oath, you said several times that you had concerns about Dr. Rives' care. Fair statement?

A Yes.

Q And when you said that you had concerns about Dr. Rives' care, what you were indicating were there were certain aspects of his care that you disagreed with, correct?

A Yes.

Q And when you were raising these concerns about Dr. Rives' care, not only were these areas where you disagreed with him, but they were also areas, nonetheless, where his care was within the standard of care?

A Yes. I would say that's fair.

Q Now, can you -- well, would you agree that Dr. Rives' care of Mrs. Farris in 2014 was appropriate and within the standard of care?

A I mean, we could differ on the -- his operative findings or the technique that he used to fix the hernia the first time around, but I would say that it was within the standard of care, yes.

Q Okay. And can we also agree that Dr. Rives' care of Mrs. Farris in the office in 2015 prior to July was within the standard of care?

A Yes.

Q Can we also agree that Dr. Rives' care on July 3, 2015 in the hospital before surgery, that care was within the standard of care. True?

A True. Again, I -- there are areas that I might disagree with his approach, but I would say that the care is within the standard of care.

Q All right. And I appreciate that. Thank you. Now, do you recall telling me on September 18, 2019, "I think that the standard of care -- the interoperative technique," --

MR. LEAVITT: Your Honor, I object based on last Friday's objection. If you want me to get into it, I will.

THE COURT: Counsel, I need you to approach, but I'm going to have an issue on how we can do this with audiovisual to address. So let me tell you what's going to have to happen. We're going to need to

turn you off for a second. The witness is going to need to be turned off, so the screen's going to go blank for a second. That should not disconnect the connection, okay? It should just go blank. And then we'll reconnect you after the Court has finished with the bench conference. If for any reason, it disconnects, which it should not -- it has not in the past when we've done this -- then we'll reconnect. But it'll be -- you'll be on blank for a little bit and you should not be able to hear or see us, okay? And so --

THE WITNESS: Yes, ma'am.

THE COURT: -- so just a moment. So at this juncture, I'm going to have to let Madam Recorder take a second to put the witness on blank. There you go.

[Sidebar at 2:10 p.m., ending at 2:14 p.m., not transcribed]

THE COURT: Okay. What we're go to do is -- this is going to take a -- sorry. Are we back on the record?

COURT RECORDER: Should we --

THE COURT: Not yet. I'm going to explain something first, but then I will.

COURT RECORDER: Okay.

THE COURT: Thank you so very much, Madam Court Recorder. Ladies and gentlemen of the jury, just to kind of give you a heads up of what we're going to do. This is going to take a few more moments, so what we're going to do is we're going to put the witness just back up briefly, okay? Because then the Court is going to tell him that we're going to take him off again. I'm going to put you out for a

break, rather than having you sit here where you've both got white noise and black screens. And then we're going to resolve it.

We'll have you come back in, then we'll put the witness back up on the screens, okay? But we have to put him back on to tell him, so he just doesn't think that he's been disconnected, okay? So just give us one minute. So, Madam Court Recorder, if you'll put the witness back up just on the screen, so we can let him know.

Dr. Hurwitz, just to give you a heads up, we're going to have to take -- we're going to be excusing the jury for a few moments. We're going to be needing to take a break, so we're going to put you back on a black screen. It's probably going to take about ten minutes, okay?

THE WITNESS: Okay.

THE COURT: And so the disconnection should not be lost during that timeframe, because the way that this is set up is that the connection should stay on all the way until 5:00 p.m.-ish, okay?

THE WITNESS: Uh-huh.

THE COURT: But if for any reason it does, we will connect back. But -- so just so you know, it'll probably be about ten minutes-ish, okay?

THE WITNESS: Sure.

THE COURT: Ish being conceptual time frame, okay? So your screen is going to go black. I'm going to give the jury their admonishment and we're going to send them out for a break. Do appreciate it. Thank you so much, okay?

So Madam Court Recorder, if you could make the screens

black. Thank you so very much. Ladies and gentlemen of the jury, what we're going to do is -- I'm going to say ten minutes and the Marshall will let you know if it needs to be a little bit longer. It shouldn't. Hope it will be. So 2:15 to 2:25.

Ladies and gentlemen of the jury, you are admonished not to talk or converse among yourselves with anyone else on any subject connected with this trial. You may not read, watch or listen to any report or commentary of the trial, any person connected with the trial by any medium of information, including without limitation social media, texts, tweets, newspapers, television, internet or radio. Anything I've not stated specifically is of course also included. Do not visit the scene of any of the events mentioned during the trial or undertake any research, experimentation or investigation.

Do not do any posting or communications on any social networking sites or anywhere else. Do not do any independent research, including but not limited to internet searches. Do not form or express any opinion on any subject connected with the case until this case is fully and finally submitted to you at the time of jury deliberations. With that, we'll see you back shortly. Thank you so very much.

THE MARSHAL: All rise for the jury.

[Jury out at 2:16 p.m.]

[Outside the presence of the jury]

THE COURT: Okay. So we now have the jury out and the witness is off the screen. This is our understanding. Is that correct, Madam Court Recorder?

COURT RECORDER: Yeah.

THE COURT: Okay. So now I just have counsel present and your witness is going outside, but he understands the jury is just about to walk out that door, right? He understands the jury is --

MR. DOYLE: Yes, he --

THE COURT: -- about to walk out the door, what he's a few feet away from, right?

MR. DOYLE: Yes. He knows his obligations.

THE COURT: Okay. So feel free to sit down, stand or whatever is comfortable for you. You all asked to go to bench, so I'm going to let counsel for Plaintiff articulate what your objection was and then I'll let Defense counsel respond. Go ahead.

MR. LEAVITT: Sure. Yes, Your Honor. We're getting into hearsay again. There is no deposition. He asked about his deposition when we were together back on -- in September. Again --

THE COURT: Instead of using pronouns, can we make sure who the he is --

MR. LEAVITT: Oh.

THE COURT: -- because I'm dealing with two different he's. Thank you so very much.

MR. LEAVITT: There are a number in here. Sorry. Mr. Doyle indicated he was getting into the deposition here. At least that's the way I took it when he -- when Mr. Doyle said to Dr. Hurwitz, remember when we were together. Dr. Hurwitz said yes. Last week this came up before. I stood up. We objected. There is no deposition, sealed transcript or

other for reasons that we discussed last week that I do not want to get into. This Court made a ruling last Friday and order on that. It was violated last Friday and then it gets violated again today.

THE COURT: Now, let's --

MR. LEAVITT: That's --

THE COURT: The Court does need one point of clarification.

MR. LEAVITT: Sure.

THE COURT: There's a distinction between there being no deposition --

MR. LEAVITT: Right.

THE COURT: -- and there being no deposition properly lodged for an --

MR. LEAVITT: Very --

THE COURT: -- expert witness and so therefore, by not having that deposition properly lodged, that deposition transcript cannot be utilized as if it were properly lodged. That was the Court's ruling. It wasn't that the deposition --

MR. LEAVITT: Very --

THE COURT: -- itself did not exist. It's just when there's a per se violation under the rules and it's a multiple violation and there was a clear deadline and parties chose to violate EDCR 2.69, which is, in addition, reiterated in the Court's rules, the Court made that ruling, gave a full opportunity for anyone to provide it, if they thought they had asked for an exception. Nobody asked for an exception. No one provide any additional requests, and so in light of the objection raised by Plaintiff's

counsel and because it was then for the time brought to the Court's attention again by blurting out to the jury. So there are specific facts here that had the Court's ruling.

MR. LEAVITT: Right.

THE COURT: It was -- it would not be appropriate in those circumstances, as articulated and explained further by the Court last week for Defense counsel to be able to use said deposition as if he had timely lodged it with the Court --

MR. LEAVITT: Correct.

THE COURT: -- because he had not and instead had -- everything that happened and then blurted it out in front of the jury, specifically contrary to the Court's directive with a lot of the other explanations that the Court had given. That was the Court's ruling. It wasn't that the deposition did not exist. Just for a point of clarification. Feel free to continue, counsel.

MR. LEAVITT: No, I appreciate the point of clarification. I was just trying to be quick.

THE COURT: Right.

MR. LEAVITT: My apologies.

THE COURT: But that distinction does make a difference. Go ahead, counsel.

MR. LEAVITT: It does. It's very on point. Yet today, his line of questioning comes down to are you -- he's -- I don't know his thoughts. I'm not going to anticipate, but the line of questioning that I hear, that I personally would go down when I'm doing a cross-

examination is impeachment. How do you impeach and then go back after you blurted out we took the deposition last week that is not properly lodged? Mr. Doyle blurted that out to the jury. There is no way in this [indiscernible] without a properly lodged deposition to impeach an expert witness.

That's why they are sealed, and they come in and there's the opening. The Clerk opens them in front of the jury. They can see. It's for sanitation purposes of the testimony and of a deposition. Here we have -- again, I don't want to get into how he needs to do it. That is -- sorry -- how Mr. Doyle needs to do it. That is up to him. He states that we had an agreement outside. Mr. Jones was next to me the entire time. We went through the other issue that we had with him and he asked -- the exhibits.

THE COURT: Who's the he?

MR. LEAVITT: I'm sorry, Mr. Doyle. We went through those. How he plans to get into Dr. Hurwitz' deposition or try and impeach him is not my concern. My concern is this line of questioning, he can't impeach him with an improperly lodged or unlodged, lack thereof lodged deposition. So this line of questioning that he's going down and then referring to the jury after saying, hey, look, I took your deposition. Do you recall being there? And now he's referring back to the date.

And this Court afterwards -- I won't rehearse Friday. Why would I go back on what was stated Friday? That's not my challenge to know how to cross-examine a witness without a deposition. I -- there is no agreement to go outside of Friday's ruling. If there was, I wouldn't

have stood up and objected, if there was some miscommunication that Mr. Doyle understood that I didn't. There is no stipulation. As this Court addressed, when there is a stipulation, bring it in. For example, when a case settles.

Even though it settles, for example, outside, I typically come in, put it on the record. That way there's clarity. That did not happen here. Again, this line of questioning -- if you're trying to impeach somebody, the question becomes for Mr. Doyle, how do you do so without a properly lodged deposition? That is not my challenge. That is his, but to keep inferring to the jury, referring back to this time, there's a question. And at this point, we're borderline RPC 3.3(a)(1). You're representing facts that aren't there. They cannot be proven.

THE COURT: Okay. So what remedy, if any, are you requesting or where are we? I'm hearing you say that there was not an agreement, which is a question I asked you both at bench --

MR. LEAVITT: Correct.

THE COURT: -- because you had -- you and Defense counsel, who I'm going to have speak in just a second, had different views. So are you requesting any remedy or just what? I just need to know what the Court is being asked to do, if anything.

MR. LEAVITT: Sure. Sustain the objection. Let the jury know they're -- and have a -- counsel cannot -- Mr. Doyle cannot keep referring back to this deposition time that there is no lodged deposition for. That's what's going on. Continuing to do this is going to confuse the jury. Well, how come -- you know, he said deposition. Now the

Court's saying not. I don't think we need anything curative at this point, other than to say the objection's sustained and move on from that line of questioning. Trying to impeach him on a document that is not properly lodged.

THE COURT: Okay. Counsel for Defense, your position, please.

MR. DOYLE: Yes. I understood the Court's ruling consistent with what you said a few moments ago that I can't use the transcript. I can't refer to the transcript. I can't indicate that there was a transcript. If he were -- I can't use it to refresh his recollection. I can't use it to impeach him. I did not understand the Court's ruling to say I couldn't refer to the fact that there was a deposition or refer to a particular date. But be that --

THE COURT: Counsel --

MR. DOYLE: -- as it may, I'm not ref -- I have not used the word deposition yet. I was being, I thought, cautious, by saying words like when we were together on. Was it your opinion on September 18, 2019. And I'll just state it for the record. I -- you know, out of an abundance of caution, indicated to Plaintiff's counsel in the hallway what my plan was and how I plan to frame these questions. And I was given the okay. So I intend to ask questions like when we were together on September 18, 2019, was it your opinion on September 18, 2019.

I believe it's appropriate and necessary to frame the questions that way, because importantly, if the witness gives testimony today that is materially different than the testimony that he gave at his

deposition, then I would ask -- I would renew my request to lodge the deposition to demonstrate to the jury that the witness is -- has changed his testimony, has perhaps committed perjury or whatnot. I don't think that's going to happen. I hope it doesn't happen. But that would be my intent.

So again, when we --

THE COURT: Okay. Yours is too narrow --

MR. DOYLE: -- when were together, what --

THE COURT: Yours is too narrow. Okay. Just like counsel for Plaintiff's was too broad, yours is too narrow, because if you recall, what I did at the end of the day Friday, when you then had the deposition in hand and wasn't using the word deposition and then you continued with that path, I then brought you both to bench and I told you I was going to admonish you outside the presence of the jury, because you could not do indirectly what you could not do directly.

So the Court didn't say specifically how you phrased it, because that's why it was important I had to call you to the bench, because I had made it clear that you -- you can't, just because say well, I lodged the deposition and then do the very things, hold the document in your hand and then read from it or read -- paraphrase from it and just not say the word deposition and do the same thing as if you had properly lodged a deposition.

The Court was very clear that you couldn't do that, told you in advance you couldn't do that, then you did it, which is why the Court had to call you to bench and then say that I was going to admonish you

outside the presence of the jury, which is what I did at the end of the day outside the presence of the jury, admonished that inappropriate behavior, as you'd already cautioned about not doing and you did it anyway. So your interpretation of what I said, you know is too narrow, because I cautioned you about it at bench and then admonished you on Friday, so both sides -- okay -- the Court said what it said on Friday.

MR. LEAVITT: Yes.

THE COURT: One side's ordered a disc and knows fully what's said. The other side, I don't know if you did or did not order a disc, but I know at least one side did. So that being said, as far as -- I -- as far as a prong about what someone may or may not say and the request that may or may not come before the Court, the Court will address requests, any requests regarding a deposition. And let me be abundantly clear in all caps, will not be said in front of the jury.

MR. DOYLE: Of course not.

THE COURT: Okay. Just want to make sure, so everyone's hearing me okay on that, right?

MR. DOYLE: Yes.

MR. LEAVITT: Yes, Your Honor.

THE COURT: Okay.

MR. DOYLE: But the record, I'd like to --

THE COURT: I --

MR. DOYLE: -- reflect. I don't even -- I don't have the transcript in front of me. I don't have the transcript on the table. I'm not holding it. I'm simply asking questions based on handwritten notes.

THE COURT: The was specifically -- that's why the Court kept on saying Friday. The Court's not saying today. If it was today, I'd be saying today Friday, but what I'm saying is if you have a request about potentially you think that there is an inconsistency or something, the Court's not at that second step, but that will not be done in front of the jury. That will be a request to either come to bench, and then you can ask if you want it at counsel table for -- there's a full discussion, et cetera, but it will not be done in front of the jury.

MR. DOYLE: Of course.

THE COURT: That's what I'm making abundantly clear. Thank you. Okay. Now, the first prong. If there are proper questions that get asked about testimony, that's fine, but you can't do improper impeachment or proper use of a, quote, deposition that you did not properly lodge. Where that area lies between in the absence of an agreement between the other side, you have to evaluate and ensure that you do it correctly and as an experienced litigator, you need to make sure you do it correctly.

This Court can't tell you how to ask your questions. I don't know what your questions are going to be. You're the litigator. You're the attorneys on both sides. You all need to decide how to ask your questions, but you know the parameters. You both stated that -- one says there was an agreement. One says there wasn't. This is not the first, second or third time that you all on different viewpoints, on different sides have said there is or is not. So the Court was not present. That's why I have told you all over and over that if you have something

and you want to say it, feel free to say it in court.

Say it on the record. Then it's clear to every and everyone's on the same page. In the absence of that, the Court wasn't out in the hallway with you. Obviously I wasn't. You all know that. I didn't hear anything -- I can't, when I have two different viewpoints, take you both as officers of the Court and I just will view it as a misunderstanding between the two.

And so at this juncture, I do not see that there is an objection that I can sustain, because there isn't -- the last question asked when counsel for Plaintiff stood up and objected A, was -- I appreciate in this case, it was contrary to a prior Court's ruling and you phrased it in a nice, very neutral way that was not negative in front of the jury.

So the Court's not saying you had to give an evidentiary basis, because I think the way he did it was actually very -- in a very appropriate manner, because it didn't in any way imply that you were doing -- that Defense counsel was doing something inappropriately, so it's not that, but the very last question, the way it was phrased, I can't see how that one specifically would have violated with the Court said on Friday. But I think it's very clear to you both the parameters of just because there's not a physical deposition, doesn't mean that you can treat it as if there is a physical deposition sitting in front of you or not. You can ask the appropriate areas of inquiry, but you can't do things indirectly as if you had timely and properly lodged a deposition at this juncture.

I'm not at a situation right now where I have to deal with the

issue of impeachment, because so far all the issues and answers and questions have been consistent. It's answered pretty much yes to everything. Wouldn't you agree, Defense counsel? He's agreed with everything that you've said.

MR. DOYLE: So far. I was just raising --

THE COURT: Right.

MR. DOYLE: -- the possibility of something different.

THE COURT: The Court can't address something that is a contingent possibility. It has to be raised at the time it actually occurs and the Court would be glad to address it at that time, but in this case, outside the presence of the jury at bench.

MR. DOYLE: Of course. I understand. I was just giving you --

THE COURT: Okay.

MR. DOYLE: -- a heads up.

THE COURT: Right. No. I appreciate it, but since there's been some confusion in the past, the Court is being abundantly clear, so that there's no third, fourth or fifth inadvertent statements in front of the jury. Okay. Does that address each party, so we can go back to having people here or does that not? Is there any questions, clarification, anything the Court needs to do for either party?

MR. LEAVITT: No. Not on behalf of Plaintiff, Your Honor. Thank you.

THE COURT: On behalf of Defense counsel?

MR. DOYLE: I'm good. Thank you.

THE COURT: Okay. So, Marshal, let's get the jury back in. Now would you like the witness back on the screen first? Is there anything that either party thinks that the witness needs for a point of clarification before the jury comes in or are you comfortable that the witness can just be on the screen and the jury can come back in?

MR. LEAVITT: I'm comfortable with him being on the screen, Your Honor. Thank you.

MR. DOYLE: That's fine.

THE COURT: Okay. So no one thinks the witness needs anything. Okay. Then in that regard, I will make sure -- we'll get the jury and we'll give Madam Court Recorder a moment to get the witness back on. And just remember, as a friendly reminder, when you are done with all the questions with Dr. Hurwitz, we do have some questions, some juror questions, remember?

MR. LEAVITT: Oh, that's right.

MR. DOYLE: Right.

MR. LEAVITT: That's right.

THE COURT: I told you on Friday that we would have it at the end, so just remember that, because even though he's on video, we are going to have those at the end. So there's your friendly reminder in that regard. Thank you so much.

So Dr. Hurwitz, it's going to be a moment. The jury's going to be coming back in in just a moment and even though you're on video, it still would be a courtesy when they come in to stand, okay? Appreciate it. Thank you so very much. They'll be in in just a second.

You'll hear the Marshal say it in just a moment.

[Pause]

THE MARSHAL: All rise for the jury.

[Jury in at 2:34 p.m.]

[Inside the presence of the jury]

THE MARSHAL: All jurors are accounted for. Please be seated.

THE COURT: Appreciate it. Thank you so very much. Okay. Okay, so right before the break, there was an objection pending. Based on discussion, the objection/clarification, the Court clarified, so in light of the Court's clarification, the objection would be overruled. Thank you so very much. Counsel, feel free to proceed with your next question.

MR. DOYLE: Thank you.

CROSS-EXAMINATION CONTINUED

BY MR. DOYLE:

Q Dr. Hurwitz, what I want to ask and explore are your standard of care criticisms of Dr. Rives, not your personal criticisms of him, okay?

A Yes.

Q So --

THE COURT: Wait. I think our volume -- just a second. I think we lost part of our volume. Can you speak again, sir?

THE WITNESS: Hi. Can you hear me?

THE COURT: Can the jury hear okay? Can we get it a little louder, please, Madam Court Recorder. We're having some difficulty hearing.

THE WITNESS: Testing, testing.

THE COURT: Can you hear okay now? Okay. Let's try --

MR. DOYLE: I'll re-ask it when we get it.

THE COURT: Let's turn the volumes up on the TVs. Give us one second. Let's see if that helps it out. Okay. Let's re-ask the question and see if we're good to go.

MR. DOYLE: Okay.

BY MR. DOYLE:

Q Dr. Hurwitz, I want to ask you a couple of questions about your standard of care opinions or criticisms of Dr. Rives, not your personal concerns or how you might have done something differently. Do you understand that?

A Yes, I do.

Q And you understand the distinction, based upon what you and I went over probably about 10 or 15 minutes ago. You understand the distinction?

A Yes, I do.

Q All right. So in chronological order, on July 3rd, 2015, the first thing that Dr. Rives did or didn't do that was below the standard of care was his use of the ligature during surgery, correct?

A Yes.

Q Okay. And then in terms of chronological order and just the standard of care and your standard of care criticisms, the next standard of care criticism of Dr. Rives is his failure, in your opinion, to return Mrs. Farris to the operating room on July 9th, 2015. True?

A Yes. And as I said before that, while it didn't rise to the level of standard of care issue, there were, you know, ample opportunities to return her. But where I felt that he finally dropped below the standard of care was on the 9th.

Q All right. And then in terms of Dr. Rives and what he did that was or was not below the standard of care, again moving forward in a chronological order after July 9th, same comment, that he did not take her back to surgery on July 10th, correct?

A Correct.

Q Or the 11th, correct?

A Correct.

Q The 15th -- I'm sorry. The -- I forgot where I was. The 11th, 12th, 13th, 14th. On those days, same standard of care criticism of Dr. Rives as you had of him on July 9th that he did not take Mrs. Farris back to an operating room. Fair statement?

A Yes.

Q Okay. Now, I guess the corollary is if Dr. Rives had taken Mrs. Farris back to the operating room on July 9th, in your opinion, that would be appropriate and within the standard of care, correct?

A I believe that's what I said in my deposition.

Q Okay. Now, if Dr. Rives had performed surgery on July 9th, 2015, can you and I agree that it probably would have been necessary to remove a segment of Mrs. Farris' transverse colon at that point in time?

A Yes.

Q And if Dr. Rives had gone back to surgery with Mrs. Farris on

July 9th, 2015, in all probability, having removed a segment of her transverse colon, she was going to need the colostomy, correct?

A Yes, I think that's fair.

Q And she still would have been on a ventilator and in the intensive care unit in the hospital for some period of time after surgery on July 9th. Fair statement?

A Yes.

Q All right. She -- if Dr. Rives had performed surgery on July 9, 2015, she probably would have been in the hospital for another two or three weeks to recover before she could go home. Fair statement?

A I would say that's somewhat speculative. I don't know the answer to that.

Q Well, would you give me one --

A Perhaps.

Q -- would you give me one week?

A Yes.

Q Two weeks?

A Possibly. It depends on how she recovered. I can't answer that with certainty, but one week or more.

Q Now, you were asked some questions last Friday about the comment at the end of Dr. Rives' report, operative report on July 3rd that Mrs. Farris tolerated the procedure well without complications. Do you recall that comment in his operative report?

A Yes, I do.

Q When you prepare your operative reports, do you dictate?

Type them? How do you go about doing that?

A I dictate them, or we have a template that we use.

Q And if you're using a template, what that means is certainly language is already existing in the operative note and you just have to put in certain blanks, correct?

A Well, in our case, we click on whether there were or were not complications, so you have to choose one from the menu.

Q All right. But if you have to dictate the report, can you and I agree that if you're dictating an operative report, it's common to see at the end of every operative report she tolerated the procedure well without complications or words to that effect?

A That's a common phrase, yes.

Q All right. And you and I could also agree that up above that comment in the operative report itself, Dr. Rives talked about and documented the two holes he created, correct?

A Correct.

Q He documented in his operative note his repair of those holes, correct?

A Yes.

Q All right. So if someone later read the operative report for some reason, even though the saw the phrase at the end she tolerated the procedure well without complications, having read the report, they would have seen that there were two colotomies that he repaired?

A Yes, that's true.

Q When you dictate an operative report for a procedure that

you've performed hundreds and hundreds of times, can we agree that you develop a certain habit or pattern in how you dictate that operative report?

A Yes.

Q And if you're dictating an operative report for a procedure or surgery that you've performed hundreds and hundreds of times, can we agree that you're not going to include in the operative report absolutely each and every step taken along the way, correct?

A That's correct, yes.

Q And can you and I agree that when dictating an operative report for a surgery that you have performed hundreds and hundreds of times that there are certain routine steps that you take in that surgery that often do not end up in the operative report, because they're routine and happen with every operation. Would you agree with me on that?

A Yes, I would.

Q Now, colotomies can occur during dissection of adhesions, correct?

A Yes.

Q And do you recall talking about dissecting adhesions and using the words tugging or pulling on the bowel?

A Yes.

Q All right. So if you're talking to a patient or a patient's family after a surgery where you have inadvertently created one or two or more colotomies, in lay language, you would explain to the patient or the family that they occurred because of tugging or pulling, correct?

A If that's --

Q You would --

A -- how I felt that it happened, yes.

Q Okay. So not unusual to use the words tugging and pulling when describing how a colotomy occurs. Fair statement?

A If you're describe it in lay terms to someone, that is -- those are terms that you would use.

Q And you have inadvertently caused colotomies over the years yourself. True?

A Probably. Yes. I can't think of a specific instance, but there have been times I'm sure that I have.

Q Right. And when -- on those times where you're sure you've created a colotomy, you've repaired it before you close, correct?

A Correct.

Q And you've used a stapler to close colotomies in the past, correct?

A We talked about this in the deposition. I probably more frequently have sewn them closed, but I think it's acceptable to use a stapler. I don't recall whether I have specifically done that.

Q Okay. And it's your impression from reading Dr. Rives' operative note that he thought he got a good closure of those two colostomies. True?

A True.

Q And in fact, you would agree with me that those two closures held for some period of time. True?

A I assume so. I don't know how long they held for.

Q Okay. But can you and I agree that when you repair a colotomy using a stapler and you do everything right, that there is still a certain failure rate of those repairs?

A Yes, that's correct.

Q That failure rate could be as much as 10 percent, true?

A I think that's probably reasonable.

Q And so having repaired a colotomy using a stapling device, up to 10 percent of the time, you can have a failure of that repair and even though the care was appropriate and within the standard of care, you would agree?

A I think that's reasonable. That's a rough estimate. That may be -- it may be a little high or a little low, but I think that's a reasonable statement.

Q Okay. And if you have an appropriate closure of a colotomy using a stapling device and it later fails, often the reason it fails is because of reasons intrinsic and extrinsic to the patient. Fair statement?

A Yes.

Q It can fail, due to tissue ischemia, correct?

A Correct.

Q It can fail because of the presence of an infection, correct?

A Correct.

Q You and I would agree, I think, that if you have a hole in the transverse colon during a surgery like the one performed by Dr. Rives, that before it is repaired, some bacteria can escape into the abdominal

cavity, true?

A True.

Q And you also spoke about bacterial translocation last Friday. Do you recall that?

A Yes, I do.

Q And bacterial translocation, that's a microscopic process not visible to the naked eye. True?

A Yes.

Q And if during a surgery, there's an inadvertent colotomy before the hole is repaired, there is some bacteria that is able to escape into the abdomen, that's something that's microscopic. You can't see those bacteria. True?

A If it's something that you -- it can be macroscopic. It's something you can see, if there's gross spillage, but there are times when bacteria can get out through tissue that's lost its impermeability and --

Q Okay.

A -- that you would not see. That is correct.

Q Okay. So you and I would agree that during a surgery, if there's an inadvertent colotomy, bacteria can escape from inside the colon into the abdomen before the colotomy is closed and that bacteria is going to be microscopic, correct?

A Yes.

Q You and I can agree that in some patients, not much bacteria can cause a lot of problems. True?

A True.
Q And you and I can agree that in other patients, that same amount of bacteria might not cause any problems at all. True?
A True.
Q You would agree with me that between July 4 and July 15, Mrs. Farris' renal function improved. True?
A It did, yes.
Q You and I could agree that between July 4 and July 15, the left shift or bandemia, that also improved, correct?
A Yes, it did.
Q You and I can agree that between July 4 and July 15, there were times when she was afebrile. True?
A True.
Q Afebrile means no temperature, no fever, correct?
A Correct.
Q Can you and I agree that between July 4 and July 15, that Mrs. Farris' encephalopathy improved?
A That was my impression in reviewing the chart, yes.
Q And encephalopathy, that's the medical word for mental status, correct?
A Correct.
Q Between July 4 and July 15, her heart problems, in particular the AFib or a-flutter, that resolved and went away. True?
A I don't recall that specifically.
Q Between July 4 and July fi --

A I'll take your word for it.
Q I'm sorry. I didn't mean to interrupt you.
A Oh. I'm sorry. I'll take your word for that. I don't recall that specific --
Q Well, you and I can agree that between July 4 and July 15, her blood glucose came under control, true?
A Yes, it did.
Q And her abdominal pain improved at times, correct?
A I think that fluctuated, as I recall.
Q Okay. Now, how did Plaintiff's counsel find you in this case?
A So, I was retained through a company called, I believe, National Medical Consultants. There was a -- there's a gentleman that runs a service, a doctor that runs a service that finds experts for attorneys.
Q And I don't remember frankly, but were you asked about your fees last week?
A I think you asked how much I was being paid for my trial testimony.
Q Okay. And for reviewing records, what is your charge? If you now.
A So, I'm paid by this company $375 an hour to review records.
Q Now, you have had patients of your own, where the patient or the patient's family has requested a second opinion from another general surgeon. True?
A True.

Q And --
A Yes.
Q -- in those instances, you have said that's fine. I mean you don't quarrel or quibble with a patient or family request along those lines, do you?
A No, I do not.
Q And in fact, you've had at least one instance where the family asked you to step aside and be replaced by another general surgeon. True?
A Yes.
Q And you didn't quibble or argue in that situation, did you?
A No.
Q I mean, the idea --
A I didn't --
Q -- is if the patient or the patient's family wants a second opinion, you're going to say yes, because that's in the patient's best interests, correct?
A Correct.
Q And if a patient or a patient family has lost confidence in you and wants a different general surgeon, you of course are going to step aside, because that's in the patient's best interests. True?
A Yes, that's true.
Q Now, I assume you're familiar with anasarca, correct?
A Yes, I am.
Q And anasarca is an explanation for Mrs. Farris abdomen and

why it became distended. True?

A Well, it may have been. Anasarca describes the soft tissue edema that one gets when critically ill. Distention can also -- can be caused by other things as well, but anasarca would be one explanation.

Q But you saw in the medical records, you reviewed notes by multiple physicians that documented that she had this anasarca?

A Yes.

Q Thank you for your time, Dr. Hurwitz. I don't have any more questions.

THE COURT: Redirect, counsel?

MR. LEAVITT: Yes, Your Honor. Thank you.

REDIRECT EXAMINATION

BY MR. LEAVITT:

Q Doctor, can you see me if I stand up here?

A I see you.

Q Can you see me?

A I saw you a moment ago. Now I do, yes.

Q So how about I stand back here. Can you see?

A Yeah, either is fine.

Q Right there is good? All right.

MR. DOYLE: I'm sorry. I'm not going to be able to see the screen.

THE COURT: Well, you can see -- you have a screen right in front of you.

MR. DOYLE: Oh. Sorry, Your Honor.

MR. LEAVITT: It's the big one right there.

MR. DOYLE: I apologize.

THE COURT: All right.

BY MR. LEAVITT:

Q All right. I gotta get my microphone on here, Doctor. Bear with me.

MR. LEAVITT: Court's indulgence.

THE COURT: You don't need to, if you're at the podium, counsel.

MR. LEAVITT: Oh, yeah, you're right.

THE COURT: You only need it, if you're walking around.

MR. LEAVITT: If I stand there, I do not. Thank you, Your Honor.

THE COURT: No worries.

MR. LEAVITT: That works so cool. All right. Very good.

BY MR. LEAVITT:

Q Doctor, so you were just asked a lot of questions about some of the good things that were happening to her. Did Titina's white blood cell count go down from 17,000?

A No, it did not.

Q Wow. When did Titina's distension -- the distention word -- swollen, when did that go down? Was it --

A I don't believe that it --

Q Go ahead. Sorry.

A I'm sorry. I don't believe that it did.

Q Oh, all right. Okay. So let me ask you this. You were asked about this bacteria that you can't see. If you know bacteria is in there, shouldn't that be one of the first places you look where you cut, when there's an -- when somebody has a white blood cell count and they're septic?

A Well, as I think I said before, you know, if somebody is persistently showing evidence of sepsis in the presence of a hole in the colon, you know, whether it's microscopic or something larger, I mean, I think you have to first and foremost worry that there is ongoing contamination from the colon.

Q Okay. And that would be a good place to look, wouldn't it, after somebody's septic, after you cut two holes in it?

A Yes. I think it's up to -- it would be up to the surgeon to rule out the hole in the colon as the source of the sepsis.

Q Doctor, do you recall when the lung were ruled out in this case?

A Yes, I do.

Q How quickly was that?

A Well, I think it was pretty quickly apparent that there was no pneumonia as a source of the ongoing sepsis. The chest x-ray did not show evidence of pneumonia.

Q Okay. Now, if Dr. Rives, on his operative report -- and well, back up. Would you agree with me there was a complication, at least two complications in this surgery of Titina's Farris --

A Yes, I do.

Q So would it be untruthful to say that there was no complications in Titina's Farris' surgery on July 3rd, 2015.

MR. DOYLE: Objection. Character evidence.

THE COURT: Just sorry. Did not hear the objection. You said char --

MR. DOYLE: Inappropriate character evidence.

THE COURT: Overruled.

BY MR. LEAVITT:

Q Go ahead, Doctor.

A Well, it would certainly be a misstatement.

Q Okay. Misstatement. Let me ask you this. If Dr. Rives testified, even in retrospect, that he would do everything in this case the same, would that be reckless?

MR. DOYLE: Objection, Your Honor. Relevance --

THE COURT: Overruled.

MR. DOYLE: -- and scope.

THE COURT: Overruled in light of the -- overruled on both counts.

THE WITNESS: Well, I think having -- if you're talking about in retrospect and having the knowledge that in fact, it was the injury to the colon that was causing the sepsis and then yes, and then you would do the same thing over again, then yes, that would be reckless.

BY MR. LEAVITT:

Q Okay. Okay. Now, you were asked about if you've ever used a stapler to close a colotomy. In this case, a ligature was used. Correct,

doctor?

A That's correct.

Q Okay. And should you staple tissue that has been potentially compromised or burned?

A Well, I think that if you're going to staple tissue, as I believe I said last week, then you have to be sure that the tissue that you're stapling together is healthy. And if you know that a thermal energy source has been used on the bowel at that point, then you're potentially involving tissue in the stapler that is not healthy. And so you're potential -- you're creating a potential for that staple line to later become disrupted.

Q So that would increase the risk of stapling dead -- excuse me. Let me rephrase that question. Stapling tissue that's been burned, would that increase the risk of reopening?

A Yes, it would, because the staples would not have good tissue to hold onto.

Q Okay. Now, one last question, Doctor. Again, how big was the hole ultimately that was found in the tissue after it was taken and looked at by the pathologist?

A Well, as I recall, that was about 2 and a half to 3 centimeters --

Q Okay.

A -- as I recall the testimony.

Q Okay. And you recall seeing the keyring that I gave you?

A Yes.

Q It was about that size?
A About a little more than an inch.
Q Very good. Thank you, Doctor. I appreciate it.
THE COURT: Recross, counsel?
MR. DOYLE: No questions. Thank you.
THE COURT: Okay. We have some juror questions, so counsel, would you mind approaching? Thank you so very much.
[Sidebar at 3:01 p.m., ending at 3:12 p.m., not transcribed]
THE COURT: Okay. So the witness -- just so that you understand, we have some jury questions. And what I do is I read the questions as is, okay? And I'm just going to read through them ,the various questions and at the completion of the questions, since you're Plaintiffs' witness, Plaintiff then would have an opportunity to ask follow-up questions to these witness questions and then Defense would have an opportunity, okay? Do you understand?
THE WITNESS: Yes.
THE COURT: Okay. So -- okay. In your expert opinion, was the third hole overlooked or could it have opened up after the surgery?/time?
THE WITNESS: I think it -- this is going to be challenging, because there's an echo. I think it -- it's hard for me to say that with certainty. I have to think that since Dr. Rives didn't describe seeing any fecal contamination, he most likely would have seen a hole, a third hole, if he had created one and he would have addressed it, as he did the other two. So I have to think, therefore, that it may have opened up

afterward.

THE COURT: Okay. And then the second part -- slash/question/time.

THE WITNESS: I -- it would be purely speculation on my part to determine at what time it opened up --

THE COURT: Okay. Second que --

THE WITNESS: -- within the first --

THE COURT: Sorry.

THE WITNESS: -- 48 hours perhaps, 72 hours. I can't say that with certainty.

THE COURT: Was the third hole near the initial two holes?

THE WITNESS: It was in the same section of intestine that was removed. I don't have the pathology report in front of me. I think the report can probably answer that question.

THE COURT: Okay. Next. After the holes were created and identified, did Dr. Rives take the appropriate action to repair them?

THE WITNESS: Yes, I think that he made an effort to close the holes with the stapler. I think it's incumbent upon the surgeon at that time to assess whether he's getting good tissue to close the holes. So I think using the stapler is an appropriate method, if you know that you've got healthy tissue that you're closing, as I said before.

THE COURT: Okay. Would you say that Dr. Rives' postop actions were against the standard of care?

THE WITNESS: So I think that the concern that I have is that when a surgeon is faced with evidence of sepsis, somebody who's sick

and isn't recovering, after an operation in which they know that there were two holes that were placed in the colon, then I think every effort must be made by that surgeon to determine whether the source of the sepsis is coming from the colon. And so I think that failing to address that in a timely fashion is below the standard of care.

Now, I've already said that -- and it's been brought up that you know, this can be viewed differently. Ideally, one might be taking the patient back to surgery by the second postoperative day, but you know, I appreciate that there is some concern, but certainly by the 9th of July, it's evident and by the time he's been seen by a -- in second opinion by another surgeon, I think it's pretty clear -- she's been seen, I should say. I think it's pretty clear that he's falling below the standard of care by not taking the patient back to surgery.

THE COURT: Okay. Next question. What is the temperature of the ligature?

THE WITNESS: Well, I don't know that offhand. I'd be guessing. It's very hot. It's hot enough within the portion of the device that clamps on the tissue to seal tissue together. So it's very hot within the clamps and then within about a millimeter or so away from the clamp, it's still very hot. So if the device is clamped on these adhesions and is resting against the bowel as it was in this case, it's in direct contact with the intestine, so it's causing a thermal injury.

THE COURT: Okay. How thick is the colon lining? Inches/centimeters.

THE WITNESS: It's more in millimeters. The colon is a thin-

walled, tubular organ that -- it's a matter of you know, a few millimeters in thickness.

THE COURT: Okay.

THE WITNESS: So millimeters. There's two and a -- there's -- you know, there's 10 millimeters in a centimeters and 2 and a half centimeters in an inch, so that's a very -- it's thin.

THE COURT: Okay. Next. In your medical opinion, how many days after surgery could Dr. Rives have waited to operate and most likely avoided her ongoing complications or damage? And there's an e.g.

THE WITNESS: So --

THE COURT: I'm going to give you an e.g. I'm going to -- it's got an e.g. portion. E.G. If he had operated on the 5th, would she likely have had a fully recovery as anticipated? And then there's a third part, so give me a sec for the third part, okay? Third part.

THE WITNESS: Yes.

THE COURT: Without the advantage of hindsight, what date would you have likely operated, based the --

MR. DOYLE: Your Honor --

THE COURT: Counsel, sorry. Can you please both approach?

[Sidebar at 3:19 p.m., ending at 3:20 p.m., not transcribed]

THE COURT: Just one second, sir.

Okay. So I'm going to finish that last one, okay? Without the advantage of hindsight, what date would you have likely operated based

on the sepsis and increased white blood cell count?

THE WITNESS: Well, I think --

THE COURT: So, did you understand there was --

THE WITNESS: -- that --

THE COURT: -- there was three, there was three parts to that? You --

THE WITNESS: But I've forgotten the first two questions.

THE COURT: Okay. So -- so let me -- because we took a break, because of the bench conference, let me go back to it. So I'll just pause on three.

In your medical opinion, how many days after surgery could Dr. Rives have waited to operate, and mostly avoided her ongoing complications or damage, question mark. And then there's the, e.g., portion. E.G., if he had operated on the 5th, would she likely have had a full recovery as anticipated?

Break that down first, and then I'll do the last one.

THE WITNESS: Okay. So given what transpired and what -- what was in real time, I would think that on the 4th it would be too soon to have expected him to operate. It's the first postoperative day. The white blood cell count with elevate in response to stress, stress of surgery, and so forth. And you wouldn't necessarily expect -- you would -- you might expect it to be a pulmonary source, as Dr. Rives suggested.

So I would grant you that it wouldn't be on the -- on the 4th. And on the 5th, you know, she clearly is declining and requires

intubation and transfer to the unit and has to be stabilized.

So I would say that by the 6th, if she's still show signs of sepsis, if I were -- if I didn't feel there was enough evidence to get me back to the operating room on the 5th or she was in the middle of being resuscitated and worked up, then I would say no later than the 6th would have been my personal preference.

So, you know, I think that he could have waited until the 6th. But, again, as I said before, it -- by the 9th clearly, with several days of seeing that she'd been decline or not improving, one shouldn't wait any longer than that.

THE COURT: Okay.

THE WITNESS: Had he operated on the 5th, I don't know that the operation -- it would depend upon what he found intraoperatively. You know, you can't say because we don't know what it looked like in there on the 5th.

You know, there's different approaches to perforations on the colon. There are sometimes -- sometimes, for example, where you can remove more of the colon all the way down to the ileum, and occasionally get away with an anastomosis, a connection between the ileum, last part of the small intestine and the transverse colon, downstream of the perforation. It depends on where in the colon the perforation was, specifically, and how much contamination there is.

I think, chances are, had he operated on the 5th, he may have done the same operation that Dr. Hamilton did. It just depends upon what you find at the time of surgery. So it's really -- it would be

speculation. He would have done, you know, perhaps the same operation that ultimately was done.

Whether -- you know, as far as the neuropathy that developed, the -- the foot drop and so forth, I can't answer that. I'm not a neurologist, and I -- that would be beyond my scope to say -- to, you know, comment.

THE COURT: Counsel, were you saying something? Sorry.

MR. DOYLE: No.

THE COURT: Okay. Sorry.

Okay. Did you need the Court to read the third part or --

THE WITNESS: Well, the question was when would I have operated?

THE COURT: Without the advantage of hindsight, what date would you have likely operated based on the sepsis and increased white blood cell count?

THE WITNESS: I think I would have operated on the 5th, but I -- it would depend upon on how stable the patient -- how stable I felt the patient was at that time. I might conceivably have pushed it to the 6th.

THE COURT: Okay. Next question. Where would a ligature be appropriate to be used on the body? In other words, what kind of tissue would a surgeon use a ligature on?

THE WITNESS: So the ligature device is -- it's a very useful device in the right place because it clamps on blood vessels and seals them. So it's a great time saver and it's useful for surgeons. I would use

it on areas where the device is not in contact with the intestine specifically or anything else that it could damage. It can be used, for example, to free the gallbladder from the liver in some cases, or to divide small blood vessels in intestinal -- in the mesentery, the tissue that carries the blood supply to the intestine, if you're trying to deliberately seal those vessels. And you can use it a adhesions if those adhesions are -- are loose enough that -- that you can clamp the device on them without being in contact with intestine.

THE COURT: Okay. Next question. If Dr. Rives had operated on 7/9, would that have reduced the level of injury to Ms. Farris question mark? Would she likely still have foot drop?

THE WITNESS: You know, again, I'm not a neurologist, and, you know, that would be -- I -- that would be speculation on my part. I don't know the answer.

THE COURT: Okay. Are those questions to the satisfaction of the jurors that asked them? Okay.

Whoever's -- okay. Just one pause, because we hear a phone vibrating that is subtlety being turned off. Give us one second.

So consistent with the procedure, since it's Plaintiff's witness, the Plaintiff would be asked first in Plaintiff has any follow-up questions to those juror questions.

Plaintiff's counsel, do you know follow-up questions to any of those questions?

MR. LEAVITT: I do not, Your Honor.

THE COURT: Okay. Defense counsel --

MR. DOYLE: Yes, we --

THE COURT: -- do you have follow-up questions to those specific questions -- those questions of jurors.

RECROSS-EXAMINATION

BY MR. DOYLE:

Q Doctor, while you personally would have operated on the 5th or perhaps 6th of July, in terms of standard of care and what the standards of care required of Dr. Rives, the standard of care first required him to take her back to an operating room on July 9th, given all the information and without the benefit of hindsight, true?

A I think that's what I stated before, and I would standby that.

Q Okay. Great. Thank you.

THE COURT: Okay. There being -- so counsel had an opportunity to ask questions. I'm not seeing any further juror questions -- just one second -- at this juncture. Is this witness excused for all purposes subject to recall at some other point in the trial or what?

Counsel for Plaintiff first, and then I'll ask counsel for Defense.

MR. LEAVITT: Yes, Your Honor. He's subject to recall for rebuttal.

THE COURT: Okay. So counsel for Defense, do you have a position on this?

MR. DOYLE: I mean, I'm fine if he's excused, but I have no position on --

THE COURT: Okay. You have no position.

So you can appreciate your excused subject to re-call for rebuttal.

So at this juncture, Madam Court Recorder is going to disconnect you and wish you a nice rest of the day. Okay?

THE WITNESS: Thank you, Your Honor. You, too.

THE COURT: Thank you so much.

Okay. So at this juncture in just a moment, just going to do a little changing up, the witness has been disconnected. And so I understand by agreement of the parties the witness that was on prior, Dr. Juell, is going to be recalled by agreement of the parties. And so we'd be going back to Defense case in chief for the witness who is out of order. Is that correct, counsel for both parties?

MR. JONES: Yes, Your Honor.

MR. DOYLE: Yes.

THE COURT: Perfect. Okay. So Marshal, if you wouldn't mind, we can go get Dr. Juell who will return to the stand. And since he was already on the stand today, he does not get resworn in or anything, just gets a friendly reminder just like everybody else. And he'll be back in in just a moment, and we'll get that taken care of.

[Pause]

MR. DOYLE: Okay.

THE COURT: Counsel -- oh, you're going to stay there? Okay.

MR. DOYLE: Yes.

THE COURT: Then you don't need a pocket mic. Counsel,

feel free to continue with your direct examination at your leisure. Thank you so much.

MR. DOYLE: Thank you.

BRIAN JUELL, DEFENDANT'S WITNESS, PREVIOUSLY SWORN

DIRECT EXAMINATION

BY MR. DOYLE:

Q Dr. Juell, can an abdominal wall hernia be repaired by way of an open procedure, a laparoscopic procedure or a robotic procedure?

A Yes.

Q And what's the difference generally between open and laparoscopic then?

A Well, the length of the incision. Laparoscopic is minimally invasive so we operate through little tubes we call trocars. They're little valve tubes. So the incision in the abdominal wall is quite small. So consequently, it's less likely to form a hernia later say, you know, cause hernias by putting those supports in. And also it usually has a quicker recovery for the patient, less scar, less pain, a little faster recovery.

Q And then what's the difference between a laparoscopic and a robotic hernia repair?

A The robotic, the Da Vinci robotic platform, is -- it's not really a robot. It doesn't do anything on its own. It's a mechanical interface that has two pretty big advantages I think particularly in hernia repair and other operating in confined locations. One is that once you set retraction, you know, you set the robot and the operating field, it stays still. It's not dependent upon human -- people paying attention, you

know, in operating the instruments.

Two, you get a lot clearer pictures. It's like looking at a, you know, a 1080 big screen TV. It's even better than that. It's kind of like virtual reality when you're looking into the console.

Three, it has a binocular lens so it's like having two eyes where you actually can see depth because when you look at a screen, it's only two dimensional. So you get that kind of depth of feel that you don't get with a conventional laparoscopy.

And then finally, the instruments are extremely precise in terms of the manipulation of the instruments. So it allows for very precise suturing and manipulation of the tissues. It's very, very light. So you have less tissue damage, less inflammation and better precision. So we're using it a lot for hernia repairs.

Q And then what's the role of the surgeon's choice concerning the method open, laparoscopic or robotic based on his or her training and experience?

A Yeah, I think, obviously, you'd need a little bit more advanced training to do laparoscopy and robotic surgery requires special credentials and experience. I mean there's certainly laparoscopic surgeons out there that can do what I do with the robot. They have, you know, just that much more skill level and experience. But there are certain situations where open repair, very complicated and recurrent hernias where you can separate the components, the various layers in the abdominal wall that have a better outcome if you do it open rather than laparoscopic. So it just kind of depends on the particular instance.

Q Is mesh commonly used when repairing an abdominal wall hernia?

A Yes.

Q Why -- well, first of all, what is the nature of the mesh that is used for that surgery?

A The mesh is -- refers to a either manufactured or processed material that is a skeleton basically for ingrowth of scar tissue. But it can be permanent or temporary. And we use it as a structural element in hernia repairs. I would say over the last 20 years, it's really become quite standard to use that skeleton as a component of the repair because it allows and permits a higher success rate in terms of repairs. So that by adding that structure in there, it promotes a scar that tends to be more durable, so you have less recurrent hernias.

Q Okay. I want to ask you about adhesions. What are adhesions?

A Adhesions are scar bands that can form after surgery inside the abdomen. And they can form between the wall of the abdomen, the inside of the muscle layer. It can form between the outside portions of the adhesions. It can form around structures. It can form to the liver, the diaphragm, any structure where scar bands, you know, they can form. Most people think that they are caused by the drying effect of open surgery when the abdomen is open. Normally it's a moist environment and it desiccates, and the scars tend to be promoted on the dry surfaces. So when we do laparoscopic surgery, we certainly see less adhesion formation because the atmosphere remains moist. You know, it's

not -- the air is not being exchanged over the winding of these organs.

Q Do different people form adhesions differently or how does --

A Yes.

Q -- that work?

A Again, there's a lot of variation in the species, you know. We're not -- we're all human beings. We all have the same organs inside. But how we respond to injury varies quite a bit. And some people just form an exuberant amount of adhesions while other people don't tend to have that kind of inflammatory scar formation.

Q Are adhesions inside the abdomen akin to a keloid scar?

A Somewhat. They're very -- they're similar. Over scarring.

MR. JONES: Objection, Your Honor. Leading.

THE COURT: Sustained.

BY MR. DOYLE:

Q What's a keloid?

THE COURT: Jurors, disregard the beginning of that answer. Counsel, feel free to go to the next question. Thank you.

BY MR. DOYLE:

Q What's a keloid scar?

A A keloid is a description of like a very hypertrophic or thick scar on the outside, you know, as a complication of a wound-healing incision.

Q Please explain any similarities between keloid scars and adhesions.

A Well, sometimes adhesions are over exuberant as well. You

know, they can be very thin, wispy. Other times they're really very tight, thick bands.

Q When one is performing a laparoscopic abdominal wall hernia repair and encounters adhesions, what generally is necessary?

A Well, in order to repair the hernia, you have to have a, you know, good visualization of the entire hole. And so if there are scar bands to the hole, which frequently there are because the bowel gets pushed out through them, then you have to release those adhesions as a component of the operation to visualize the defect in order to affect repair.

Q What do adhesions inside the abdomen do to the structures and organs in there?

A They can be quite distorting, you know, pull them out of normal position --

Q But why --

A -- make them sticky to one another where normally they don't -- they wouldn't be intimately associated with one another. You know, there would be a movable layer in between.

Q What does the term dissection mean when talking about adhesions?

A It just -- the term dissection means to make a plane or to separate.

Q What is blunt dissection?

A Sometimes you can actually physically pull things apart, you know, the adhesions are very thin. Or in a dissecting plane, you kind of

instead of cutting it, you, you know, you put pressure on it to separate it.

Q You said dissecting plane. What does that mean?

A Oh, it's -- you -- perhaps you're trying to expose something so it may be covered by a normal structure so you'd have to cut through it or cut around it and there may be an abnormal plane from adhesions and it's -- you need to separate the structures in order to operate on them.

Q What is sharp dissection?

A Generally, that's done with a knife blade or a pair of scissors, you know, a cutting instrument.

Q The term cold scissors has been used. Are you familiar with that term?

A I'm sure it refers to just, you know, stainless steel, you know, non-energized scissors. You know, they do make a pair -- make scissors that can cut and cauterize at the same time.

Q And cauterize means what?

A And those are hot scissors.

Q Sorry. What does cauterize mean?

A Cauterize means to -- it's actually a form of desiccation where you deliver energy, electrical energy, to the tissues and you induce heat. And that causes charring which, you know, is a time practice surgical art of sealing blood -- bleeding.

Q What is a harmonic scalpel?

A Harmonic scalpel is a device that instead of using electricity, it does in a way use electricity, but in order to generate the heat at the

cutting tip of the instrument, it uses high frequency sound waves. What's called radio frequency. So it's a little bit different type of energy. It's like very tiny wavelength but high frequency sound waves, if you will. And that induces in the materials that the instrument is made of heat which again is -- can be used depending on the energy level and how frequently it's being pulsed, and this occurs, you know, millions of times a second, it can cut or cauterize.

Q And then what is a LigaSure?

A A LigaSure is a device that is used primarily for sealing tissues together. And it works by electricity. It has kind of a hot iron plate inside a shielded configuration. It looks like a pair of scissors. But when it's closed, it -- heat generates on a metal plate inside that kind of melts the tissues together. And then once they're melted together, you could pull a trigger and a knife blade separates them. So it seals tissues together and then it cuts them.

Q Is there some sort of a guard or barrier --

A There is. There's like a porcelain --

Q Doctor, hold on.

A -- insulation.

Q Hold on.

A I'm sorry.

Q Is there some sort of a guard or a barrier around the tip?

A Yes, there is. And that's what I --

Q What -- could you explain that?

A I'm sorry.

Q That's all right.

A It is -- I think it's like a porcelain tip. And so that prohibits or keeps you from grabbing too much tissue, okay, because it's kind of rounded so tissue tends to slip out. And also it doesn't heat up. It doesn't transmit the heat. So it's just the tissue that you're pushing between the jaws that is affected by the energy.

Q What does the term relative contraindication mean?

A Well, contraindication is usually, you know, something you shouldn't do in surgery. It's contraindicated. And then there are situations where you can do it if it's your only option. So that's a relative contraindication. But there is some risk associated with that maneuver.

Q Are there any contraindications or relative contraindications for LigaSure being used near bowel?

A Well, anytime you use an energized instrument there's, you know, you can injure tissue that you do not wish to injure. So an unintentional injury of those structures could occur which could lead to complications later in --

Q Can a LigaSure be used in proximity to bowel -- to dissect adhesions?

A Yes. I mean as long as you have, you know, very precise visualization of the instrument where it's being used. You can use it in tight spaces where there is a potential to injure, you know, adjacent tissues. But again, that just comes down to exposure.

Q What do you mean by exposure?

A Well, when you're operating, you want to be able to have

a -- your operative field you want to have it exposed sufficiently so that you can identify critical anatomy. So we always say exposure is the key to surgery. You know, sometimes your assistant is more important than the person actually doing the operating because they're being able to expose what the surgeon needs to see to be safe.

Q Can you explain to the ladies and gentlemen on the jury how a colotomy or hole in the colon can occur when one is using blunt dissection to deal with adhesions?

A So you have adhesions tethering the bowel and if you push on it bluntly, it could tear. It's thin, the wall, like we were describing earlier. It can be very thin. And then, obviously, the quality of the tissue depends on the patient's age, you know, underlying, you know, medical conditions. You know, different factors can make tissue weaker than it should be.

Q The possibility of inadvertently causing a colotomy when doing an abdominal wall hernia repair does that increase if there are adhesions present versus no adhesions present?

A Yes. Because --

Q Why --

A -- adhesions cause distortion and then, you know, scar tissue adherent to the outside of a colon so it makes it less maneuverable.

Q And have you inadvertently caused colotomies?

A Oh, yes.

Q Now, does the repair of a colotomy depend on the size of the hole?

A Yes and how many holes you have. You know, if you're going to affect a repair, you don't -- you want to be sure that you don't, you know, in the course of repairing it, narrow it unduly, you know, or create a partial obstruction or, you know, other considerations in terms of the outcome.

Q Now, the terms feces and stool, different or the same?

A No, they're the same.

Q If you have a hole say in the transverse colon and there is feces or stool that is spilling into the abdomen during say a laparoscopic surgery, is that something subtle or obvious?

A No, I mean it's usually fairly well apparent. It's a different color, you know, a different consistency. I mean we all know what that looks like, so I mean you don't have to be a surgeon to be able to discriminate that.

Q Can you explain to the ladies and gentlemen of the jury why if you have a hole in the transverse colon during a laparoscopic procedure you can have no spillage of stool or feces but still have bacteria escape?

A Yeah, once you expose that lining, the bacteria normally present within the abdomen there will be some even microscopic spillage. I mean you don't have to have a macroscopic spillage. It's just you have created an operation that is we call clean because, you know, you're not cutting through mucocele surface or, you know, exposing the lining of the abdomen, the peritoneum, to bacteria which are never present there normally, to clean contaminated to maybe depending if

you have a gross contamination, you know, a lot of stool spillage.

You know, then that changes the risks of subsequent infection complicating the procedure, the degree of contamination. But even just opening up the mucocele surface takes a complication rate up about 10 percent -- I'm sorry, tenfold. So maybe a clean operation should have an infection rate of 1 percent. A clean contaminated now 10 percent risk of having wound infections or intra-abdominal infection result.

Q And those numbers would they apply to a situation where you do not have actual spillage of stool or feces?

A Yeah, just going across a mucocele surface. If you have had a major spill, then the infection rate is going to be even higher, up to 20 percent. If there's established infection, then the rate is 40 percent. You know, like you have draining an abscess or something, you know, a ruptured appendix or something, the risk of wound infection now could be as high as 40 percent. But hernia repairs are generally elective clean operations, you know, low risk of infection.

Q And is that risk, though, different if it is not an initial procedure but rather a repair of a recurrence?

A Well, I guess the risk of having a bowel injury or something is increased, you know, in the face of scar tissue. But the infection risk for repair of a primary hernia or a recurring hernia is the same as long as it, you know, a clean procedure.

Q Okay. Now, what did Dr. Rives use to repair the two holes in the transverse colon that he encountered?

A So he used an instrument, a mechanical instrument, called

the endoscopic GIA stapler.

Q Would you explain to the ladies and gentlemen on the jury how this stapler works? I assume it's not like something someone would find on a desk.

A Right. When you think about how a stapler that you do find on the desk, it has a place that delivers the metal and that metal comes out and hits an anvil, you know, like a blacksmith would use, that's shaped that would make the staple then bend in a certain way. So this stapler is very finely engineered with rows of staples. There are six different rows of staples that have I don't even know how many staples in a row, perhaps 30 lined up one after another. And then there are --

Q Doctor, could I interrupt you? Maybe you could draw for us what it looks like. And you'll need the microphone. And perhaps flip the paper to a new page.

A All right. The stapler itself --

MR. DOYLE: Is the microphone working?

THE WITNESS: You think it is working or --

THE MONITOR: Hold the button until it turns green.

THE WITNESS: Green. Is it green?

MR. DOYLE: Hold on.

[Pause]

THE WITNESS: Well, the instrument is designed to go through one of those laparoscopic trocars which is a tube. So it does have like a pistol grip on it that when you grip it, it mechanically pushes the staples --

THE COURT: Excuse me.

THE WITNESS: -- through --

THE COURT: You need it closer to your mouth --

THE WITNESS: -- the --

THE COURT: -- so we can hear you. Thank you so much.

THE WITNESS: -- the staple.

THE COURT: I appreciate it.

THE MONITOR: Okay.

THE WITNESS: -- the staple anvil, okay. So it looks kind of like a long gun, if you will, but the end of it opens up and so you put the tissue in it and then close this. And if you look at the say the anvil, it's like a spatula that has these rows of staples. And there are actually six different rows, three on each side. So this is the anvil. When the staples go down, they form like a structure that looks like a B. And if you think of all these Bs lined up here so when you close the instrument and you pull the grip; it pushes mechanically through here and forms the staples. And then at the very last stage, a knife blade goes through the middle and cuts them apart. So it's a mechanism of splicing something. You put it down. You fire it. It separates it and it has three rows of staples on each side.

BY MR. DOYLE:

Q And so how does that work then to close a hole?

A I presume that he had a hole and he picked it up with an instrument, so he tented it up and then put the stapler across the two sides that were tented up to staple it off like a triangle.

Q We talked earlier about -- it actually may have been -- well, let me rephrase the question. Can a staple line fail?

A Yes.

Q What are some of the common reasons why a staple line appropriately placed can fail?

A Well, you can see that that's a fairly complicated mechanism, okay. So all things that are manufactured there's quality control issues sometimes. So we have had instruments that come out in batches that sometimes are subject to recall. There was one recently. But you can't see exactly how the staples form. So there's a technical potential failure rate that's quite low. Most of the time the reasons that things fail is because the blood supply of the two tissues being melted together is not sufficient to allow for quality healing because you have to bring in components of healing through the blood stream.

Sometimes when we have a staple line that's holding bowel together, there's too much tension on it, so that tension problem of wanting to pull it apart plus that tension restricts the blood supply into the area. And then I suppose there can be technical error, unappreciated technical error.

Q Now, what would cause decreased blood supply to the tissue leading to a failure of the staple line?

A Well, it could depend on how much bowel -- if you're talking about bowel, for example, when you splice it together, you have to separate the mesentery so sometimes if that microcirculation out to the end where you're sewing it together, you know, has to travel a distance

through the wall of the bowel. So that could be a limitation. And then the delivery of the blood, you know, by the heart, by the circulation through the body can be compromised by heart problems, you know, not -- you don't have an effective pump to push the blood out there, lung problems that don't properly oxygenate the blood or in the case of sepsis, you can have disorders and microcirculation where there's not good oxygen delivery because intracellular, inside the cell, your cell mechanism is poisoned. Even though there's lots of oxygen around, you -- the cells can't utilize it. And so that can compromise the healing of it.

Q What's a lipoma?

A A lipoma is a fatty tumor. They're common in all animals and humans. There's probably some genetic predisposition there as well. But they're usually very finely encapsulated fatty tumors that are a little bit firmer and different from your normal fat in your system.

Q Did Mrs. Farris have a lipoma in 2014?

A Yes.

Q Did Dr. Rives perform surgery to remove it?

A Yes.

Q Before he performed that surgery, was he aware that there was an abdominal wall hernia underneath?

MR. JONES: Objection, Your Honor. Speculation.

THE COURT: Sustained.

MR. DOYLE: No, she says sustained.

THE COURT: That means you can't answer.

THE WITNESS: I'm not going to.

THE COURT: Thank you.

THE WITNESS: I want to.

BY MR. DOYLE:

Q All right. Have you reviewed Dr. Rives' operative report for the surgery in 2014?

A Yes.

Q What -- going in, what was the operation going to be?

A He was going to remove a lipoma from the abdominal wall.

Q And what did he find, if anything, in addition to the lipoma?

A He found a hernia underlying the lipoma.

Q What did he do with that hernia?

A He repaired it.

Q Now, you've mentioned sepsis a couple of times, and I want to think back to 2015, that timeframe. What was sepsis or how was it defined?

A Well, people would talk about sepsis it's basically a syndrome. So there are a lot of clinical manifestations, you know, in terms of signs and symptoms the patient would exhibit and also certain metabolic or physiologic abnormalities that could be manifested in abnormal lab tests. But generally speaking, when I talk about sepsis, it has to do with specific insol [phonetic] which is a bacterial infection which may result in bacteria actually present in the blood stream. We call that bacteremia. Or it could be that bacterial infection elaborates toxins that could be in the blood stream that could then cause the

initiation of an inflammatory cascade activate the body's defense mechanisms.

Q And what do you mean by an inflammatory cascade?

A It -- the body protects itself through complicated systems that are amplified during inflammation or infection. And so it brings to bear certain infection-fighting apparatus, if you will, to try to, you know, rid the body of infection.

Q And then what is systemic inflammatory response syndrome which I'm going to call SIRS, what is that?

A Well, SIRS and sepsis look the same. But the underlying cause is different.

Q How are the underlying causes different?

A Instead of a bacterial infection, it can be something else that causes SIRS. And it's again this amplification of the body's normal defense mechanism. But it can actually become disordered. It can become out of control. So instead of infection, you know, you could have pancreatitis, you know, which is inflammation of the pancreas, is a known cause of SIRS. Sometimes pulmonary aspiration, if you aspirate acid into your lungs, the lungs are very vascular, and it can set off this inflammatory cascade. Patients that have multiple trauma, patients who have had hemorrhagic shock from bleeding, you know, like from GI bleeding or something, they can go into a shock state that looks identical to sepsis.

Q Did Mrs. Farris in July of 2015 in that time period say from July 4th to July 15th, did she have both sepsis and SIRS?

A I think she had SIRS, myself. It may have progressed into pneumonia. You know, pneumonia can be quite fulminant. But I think she had more of an inflammatory reaction rather than an infection reaction.

Q So --

A Leading to her initial post-operative collapse.

Q And what role does the white -- well, actually, let me ask you this question first. In terms of a white blood cell count or a WBC, what is the name of the laboratory study that measures the white blood cell count?

A Typically, we order a test called the CBC which is a complete blood count. So the white blood cells are part of the blood. So when we get a complete blood count, we get the red blood cells, the white blood cells and then an element in the blood that's kind of a partial cellular element called platelet count. And the platelets are like the stop leak in the blood system. If you get a cut, the platelets come in like in a radiator and plug the hole that they set off the inflammatory response.

Q Now, if you order a CBC or a complete blood count, can that come with or without a differential?

A Yes. A differential refers to the microscopic separation of the type of white blood cells. There's more than one type of white blood cell. There are polymorphonuclear type white blood cells which are chiefly involved with the defense against infection. There are lymphocytes which have multiple roles but can create antibodies. And then there are --

MR. JONES: Objection, Your Honor. Going outside of report or testimony.

THE COURT: The Court is going to sustain for right now. Jurors, disregard -- would you like to approach?

And Madam Court Reporter, we'd like to have some lovely white noise.

[Sidebar at 4:03 p.m., ending at 4:07 p.m., not transcribed]

THE COURT: So, Counsel, is the Court going to defer ruling or are you go to a different area and come back?

MR. DOYLE: Yeah.

MR. JONES: Yes, Your Honor.

THE COURT: Okay. No worries.

MR. DOYLE: We'll go to something else and come back.

THE COURT: So the jury will disregard that last answer that was started and then counsel's going to note that and go back. Thank you so much.

BY MR. DOYLE:

Q Doctor, what is tachycardia?

A Just means an elevated heartrate.

Q What is tachypnea?

A Means an elevated respiratory rate or increased respiratory effort.

Q What is anasarca?

A Anasarca is a condition where tissues get excess amount of fluid and salt, so to speak; they're usually associated so that the turgor or

rigidity of the tissues normally might be quite soft; with anasarca there's a lot of extra fluid on board so it becomes very firm and bloated in appearance.

Q And can anasarca occur anywhere in the body or body part, if you will?

A Yeah, generally speaking, anasarca makes a reference to the whole body being fluid overloaded whereas you can just have dependent edema in your legs or something, but anasarca when people use that term it's talked about whole body water is excessive.

Q Now Mrs. Farris was diagnosed with anasarca between July 4 and July 15?

A Yes, she was unstable and required a vigorous amount of fluid administration to support her blood pressure and she had a very high heart rate.

Q And how did the anasarca in her abdominal area manifest itself?

A With the thickening of the tissues and more firming up of the -- of the tissue.

Q Is there a difference between anasarca and distention when one is speaking about the abdomen?

A Yes, distention would just be, like, a lot of gas or, you know, internal contents of the intestines causing pressure, you know, where you get bloated after a Thanksgiving dinner. You know, whereas, you know, anasarca is actually thickening of the wall structures of -- of all the viscera and skin.

Q What's lactic acidosis?

A Lactic acidosis is a systemic acid that is generated during times where there is ineffective delivery or utilization of oxygens in the cell. That our cells, generally speaking, oxygen dependent for function, but under stress we can function without oxygen for short periods of time through a process called anaerobic metabolism; with oxygen it's called aerobic so we get an aerobic exercise, but if we're operating without being able to utilize oxygen there's a cost for that and there's a buildup of lactic acid which favors us early on, but if you get too much acid the body's physiology is very tightly regulated, you know, within acid based tolerance. There's just very little room for, you know, imbalance there because the enzymes that run our system have to -- can only operate within certain confines in terms of temperature, also in terms of the acid base. So when we talk about lactic acidosis it's a measurement of the excess acid in the system due to anerobic metabolism.

Q Did Mrs. Farris develop lactic acidosis on July 4th?

A Yes.

Q What was the cause of her lactic acidosis?

A She had the syndrome of tachycardia, tachypnea, requiring oxygen. She couldn't -- you know, oxygenate without supplemental oxygen and then ultimately support and so she, I believe, had hypovolemia meaning that she didn't have enough circulating fluid and so that caused her to have low blood pressure and a high rate because the heart was trying to compensate by there isn't the volume to circulate

with every pump so you increase the rate, you know, to be able to meet the same demands. And so as a consequence of that she was not delivering oxygen to her cells efficiently and that led to the development of lactic acidosis.

Q Did her lactic acidosis improve and resolve over the next several days?

A It did.

Q What was the significance of that to you?

A That the patient's condition was reversed by the therapeutic interventions that she was given.

Q And what do you mean that it was reversed?

A Well that her instability, the lactic acid, also say were able to improve the oxygen delivery by stabilizing, you know, her organ function primarily through the administration of fluids, but also they gave her medicine to slow her heart rate down so there would be bigger units per each pump of the heart so to speak.

Q Now how was the lactic acid measured or determined?

A It's a laboratory test on serum.

Q Doctor, have you had post-operative patients develop a problem and end up in the ICU?

A Of course.

Q Are you familiar with the terms open or closed ICU?

A Yes.

Q What's -- first of all what's an open ICU?

A An open ICU any doctor that has privileges, you know,

critical care privileges or ventilator privileges can admit patients there and care for them.

Q And what's a closed ICU?

A Closed ICU there's a specific team of critical care specialists that take care of the patients and, for example, in our trauma ICU in Reno, it's a closed -- closed ICU and that only the critical care trauma specialist can write orders. The other doctors that consult can talk to them and we can agree what orders should be administered to the patient, but only certain doctors can actually if -- write the order. That way there's no confusion about somebody coming and writing an order changing something and the doctor primarily responsible for the patient not knowing about the change in therapy.

Q Now when you reviewed the records Mrs. Farris ended up in the ICU?

A That's correct.

Q Was she on a ventilator?

A Yes.

Q Was she followed each day by critical care specialists?

A Yes.

Q And is pulmonology or the lungs part of the critical care specialty?

A It was in this case at St. Rose.

Q And the critical care specialists that were seeing Mrs. Farris each day between July 4th and, say, July 16th what was their role as you understood it?

A They were primarily orchestrating her care in terms of coordinating, you know, the different specialists that were consulting and they were running the ventilator and they were talking to all the different consultants to come up with a concise care -- care plan.

Q Was there a hospitalist involved in seeing Mrs. Farris when she was in the --

A Yes, there --

Q -- intensive care unit as well?

A Yes, there was.

Q What's a hospitalist?

A Generally internal medicine doctors that, kind of, watch over, you know, the patient's other medical problems and then they -- they're involved in the care to help any -- smooth any transition, you know, out of the ICU when they go out of the ICU then if they provide some continuity of care.

Q Was Mrs. Farris, between July 4th and July 16th, followed by a nephrologist?

A Yes.

Q What is a nephrologist?

A They're a specialist that looks at function of the kidney.

Q And did Mrs. Farris's kidney function improve over that period of time?

A Yes.

Q And how does one tell when a patient's kidney function is getting better?

A Well, initially, she had very low urine output; her urine output improved, you know, with administration of fluids and other therapies and then there are laboratory parameters in the blood that relate to kidney function and those also showed progressive improvement.

Q Was Mrs. Farris, from July 4th to July 16th, also followed by a cardiologist?

A Yes.

Q Did her cardiac issues resolve?

A Yes.

Q Before July 16th?

A Yes.

Q Now was Mrs. Farris, during this same period of time while she's in the intensive care unit, was she also followed by an infectious disease specialist?

A Yes.

Q What is an infectious disease specialist in terms of where they fit in?

A They're generally doctors that have a degree in internal medicine and then taken a fellowship in the treatment of infection so they have special credentials and they are consulted to optimize the recipe of antibiotics being administered to the patient or antifungal drugs or antiviral drugs, but they're basically there to, kind of, watch the cultures; watch the patient; and tailor the antibiotics because some antibiotics have toxicities in certain situations and, you know, you need to monitor their use or, you know, choose other antibiotics if, you know,

in the specific patient's, you know, situation to try to avoid adding to complications.

Q When you have a post-operative patient who has developed a problems and is in the intensive care unit being followed by multiple physicians with multiple specialties how, typically, does communication occur?

A Well, generally speaking, the critical care doctors are usually present, you know, in the ICU. You know, it's not just one patient there; they vary in size and so during the course of the day they're generally present plus it is a critical environment, you know, you don't want to be too far because patients can become, you know, unstable in a hurry. So there's usually someone there that -- the -- the critical care doctor and then the other doctors come and go. They, you know, they're caring for other patients and they come and they either directly communicate with the critical care specialist they find, you know, them and talk to them or they, you know, can write notes in the chart or they can call or we have encrypted text systems that we can use for text messaging, you know, that can -- it's compliant with privacy restrictions.

Q And then in a post-operative patient who has developed problems and is in the intensive care unit followed by all these different specialties what's the role of the general surgeon then?

A Well, obviously, the general surgeon wants to make sure that the patient's recovery from operation is as uncomplicated as possible and then it's his obligation to diagnosis complications as early as possible, you know, as they can adversely affect patient outcome. So

they're generally there; they do -- usually do, in this case, abdominal examination; they look at the wounds, but they look at everything else too because, like I said, general surgeons are trained in critical care. So, you know, if they have suggestions about how the ventilator should be managed or, you know, maybe they don't like a particular antibiotic they might talk to, you know, one or more specialists and coordinate that so.

Q The different specialists that saw Mrs. Farris each day when she was in the intensive care unit between the 4th and the 16th did they each write or create a progress note each day?

A Yes.

Q And what's a progress note?

A Well it's just a note by that specialist that's put in the medical record. It's basically there to communicate with other physicians, but you know, obviously, it can become important in other circumstances, you know, in terms of what happened, you know, and documents what happens to the patient.

Q When you were looking at the records in this case, the progress notes for the time period I've been speaking about and when you reviewed Dr. Rives' deposition can you tell us whether he was communicating with the other specialists following Mrs. Farris?

A Yes.

MR. JONES: Objection. Speculation, Your Honor, foundation.

THE COURT: Sustained based on the way the question's phrased.

MR. JONES: Okay.

BY MR. DOYLE:

Q Based upon your review of everyone's progress notes for the time period July 4th to the 16th and reviewing Dr. Rives' deposition were you able to form an opinion whether he was communicating with the different specialists each day?

A As reflected in the other specialists' notes they were noting that -- what Dr. Rives was recommending in terms of further surgical intervention on a daily basis.

Q As a general matter what is the purpose of an operative report, a report for a surgery?

A Well, generally speaking, it's a description of how the operation was performed and any events that occurred during operation that serves as a record for future reference, you know, perhaps in patients that need reoperation, you know, what was done the first time can be helpful to know before you try to, you know, go in a second time so to speak. So that's the reason that an operative report is written.

Q Does the standard of care require putting in an operative report such as the one that Dr. Rives prepared on July 3rd absolutely each and every step of the surgery?

A I mean, they have different styles in terms of detail, but it is required as a bylaw of the hospital for the surgeon to file an operative report.

Q But in terms of the actual contents of the report is there a variability based on your experience?

A Yes, they vary. Some are very highly detailed, and others are more general.

Q Does the standard of care require one particular format with one -- only one level of detail?

A No, I think there's allowed a little variability. You don't want to omit anything that, you know, say for example, there was a problem during surgery you'd better document --

MR. JONES: Your Honor, I want to object; outside the scope of any report or testimony.

THE COURT: Court's going to sustain it based on what the Court saw at the bench last time. The jury will disregard that last answer.

BY MR. DOYLE:

Q Okay. Doctor, does the standard of care, when preparing an operative report, require the inclusion of routine steps?

A Yes.

MR. JONES: Your Honor, same objection.

THE COURT: Can you all both approach, please? And please feel free to bring some things with you. Thank you.

[Sidebar at 4:24 p.m., ending at 4:38 p.m., not transcribed]

THE COURT: Okay. Court sustains the objection to that last question. I'm doing it question by question; only one question only. So the Court's ruling, obviously, only goes to that very last question. Court sustains the objection to that last question. Go ahead.

BY MR. JONES:

Q So, Dr. Juell, in your report of November 6, 2018 you indicated that by post-op day to Mrs. Farris's condition was beginning to improve; do you recall that?

A Yes.

Q Was her condition improving in various ways?

A Yes.

Q Was -- if you look at all of the data that comes with a CBC including the white blood cell count was her white blood cell count improving between July 4th and July 16th when you look at all of the data?

A In terms of the type of white blood cells there was an improvement; the total white blood cell count remained elevated.

Q Explain that, please?

A Which could be due to multiple reasons.

Q Okay. In your opinion what were the reasons for the increased white blood cell count as it remained?

A Well the patient still was intubated; she was being sedated; there was still quite a bit of systemic stress. She did have a resting elevation of her heart rate so she was hypermetabolic; some of the medicines that she was given potentially could have a side effect of raising the white blood cell count, but that was -- that was a concern on a daily basis by all doctors that were caring for her; why the white blood cell count remaining elevated?

But if you looked at the type of white blood cells there were -- immature forms were disappearing from circulation, you know, where

you could -- they could be measured which is, you know, a positive finding.

Q What are immature forms of white blood cells?

A Well the white blood cells develop in the bone marrow and, normally, you don't see immature forms in the circulation, but under stress it's like the body squeezes the bone marrow to push more white blood cells into circulation under -- you know, circumstances of inflammation or infection.

Q And so --

A So you see an immature form of a white blood cell which is called a band.

Q -- and what was the significance to you, when looking at the increased white blood cell count throughout this period of time, of the resolving or disappearing immature white blood cells?

A Well it's a positive trend, you know, developing in a patient which -- I mean, every day you try to measure progress, you know, is a patient getting worse or patient getting better? You know, it's a clinical practice of medicine. You know, you want to be -- what you're doing for the patient should be helping them and so you want to see the patient improving and, you know, she wasn't improving as fast as everybody wanted. So there was a lot of wringing of hands, you know, going on, but you know, they -- they were taking the information available and the examination available each day and, you know, trying to make good decisions for her.

Q And in the context of an increased white blood cell count

what is bandemia mean?

A It means a lot of immature forms and that's a significant stress. When the bone marrow releases those forms that aren't fully mature into the circulation it's indicative of the stress.

Q And if you're concerned about the possibility of an infection and -- and you want to look at lab data to evaluate that concern would you look at just the absolute number for the white blood cell count whether it'd be 21.2 or 24.6 or some other number?

A Well the number and also the number -- the type of white blood cells in circulation.

Q So it's not enough just to have the number you have the have the other data?

A Well the other is helpful.

Q And -- if you look at Mrs. Farris's white blood cell count and all of the types of cells within that white blood cell count was that improving between July 4th and July 16th?

A Yes, well, she clearly deteriorated on the, you know, from the 15th. I mean she had a sudden clinical deterioration, you know, that led to the final CT being obtained and, obviously, her numbers turned bad.

Q So between July 4th and, let's say, July14th --

A Yes.

Q -- when you have the improvement in the white blood cell count when you looked at all of the components of the white blood cell count what does that tell you about her sepsis or SIRS?

A That it was stabilized or improving.

MR. JONES: Objection, Your Honor, outside the scope of any prior testimony or any report.

THE COURT: Court's going to sustain the objection to that question; those were previously provided to the Court. Thank you.

BY MR. DOYLE:

Q Doctor, when you said in your initial report that Mrs. Farris's condition was beginning to improve after the second post-operative day did you include in that comment her white blood cell count when you looked at all the components?

A Yes.

Q And if you look at all the components of her white blood cell count, not just the absolute number, was it on a positive or negative trend?

A Improving, positive.

Q And so what does that tell you about whether infection or SIRS is getting better, worse, or staying the same?

MR. JONES: Objection. Again, Your Honor, outside the scope of any prior testimony or report.

THE COURT: Court's going to sustain the objection.

BY MR. DOYLE:

Q Doctor, between July 4th and July 14th was Mrs. Farris's sepsis or SIRS improving?

A Yes.

Q And when you commented in your report that her condition was beginning to improve by the second post-operative day does that

statement include improvement of her sepsis and SIRS?

A Yes.

Q When you made the statement that her condition was beginning to improve by the second post-operative day which by the -- the second post-operative day would be July 6? I'm sorry, July 5th?

A Yes.

Q When you made the statement that her condition was beginning to improve by July 5th did you include, in that statement, the issue of lactic acidosis and her lactic acid?

A Yes.

Q Doctor, what's the difference between -- and let's say you're looking at the abdomen -- what's the difference between an X-ray of the abdomen and a CT scan of the abdomen?

A Well just a plain X-ray is if you take, you know, a X-ray generating machine and you pass a, you know, a current of X-rays which are electrons, high energy electrons, through the abdomen and then have an exposure plate underneath the patient. So you just get a single shot.

Computerized tomography is a series of X-rays taken so that you actually get a cumulative more three-dimensional image of the internal structures due to the way the computer handles the images. So you're taking, you know, a thousand X-rays and then the computer generates an image which is a summary of the individual X-rays.

Q Did you review the X-rays that were performed of Mrs. Farris's chest between July 4th and the 16th?

A Yes.
Q Did you review the CT scans of her chest between those dates?
A Yes.
Q Did you review the X-rays of her abdomen between those dates
A Yes.
Q Did you review the CT scans of her abdomen between those dates?
A Yes.
Q When a physician or when a general surgeon is acting within the standard of care would the general surgeon simply rely on a single CT scan as a single data point to make decisions about patient care?
A No.
Q Why not?
A Well I have to put all the -- all the information together in order to make a good clinical decision.
Q Why is it --
A What you see; what you feel; what you hear; the laboratory data; the trends in terms of vital signs and then you have to use the images that you obtain in context with what's going on clinically.
Q Are there different types of contrasts that can be used when a CT scan is performed?
A Yes.
Q What is IV contrast; could you explain that?

A It's an -- a type of iodinated material that's injected into the veins and circulates through the patient and enhances iodine reflects of the electrons, so it tends to brighten the tissues that the iodine circulates through so that it improves the image contrast between tissues that are not well vascularized. There's different ways to use IV contrast; it can be given in certain phases where certain aspects of disease can be better visualized, but it's a contrast that's given in the vein.

Q And if you're looking at a CT scan and you're seeing IV contrasts how does that look compared to surrounding structures; brighter, darker?

A It looks brighter and it's a reflection of the degree of blood supply.

Q Now will IV contrasts get into any of the organs or structures inside the abdomen?

A Yes.

Q But which ones?

A Well all of them; they all get blood supply, but some get more than others, you know, for example, kidneys get 20 percent of, you know, the circulation every minute. Okay? Because that's how they work is to get, you know, to excrete so they get very bright when you give IV contrast. Whereas other structures are not quite as bright, but it does enhance, and infection inflammation is -- gets a lot of blood supply around infection. So sometimes you get enhancement of a rim of an abscess forming or an area where there is infection or inflammation.

Q You've used the term abscess a couple of times; could you

tell us what that is?

A An abscess is like a collection of puss, you know, or white blood cells and sometimes necrotic material, dead tissues, that can form and be walled off, you know, so it's contained and so that's what an abscess is.

Q The CT scan that was done on July 9th did it include IV contrast?

A Yes, it did.

Q Did it also include oral contrast?

A Yes.

Q What is the role of oral contrast for a CT scan like the one done for Mrs. Farris on July 9th?

A A oral contrast is to visualize -- to fill the hollow nature of those hollow viscera organs because it'll provide you a lot more information and definition to give the oral contrast.

Q The CT scan that was done on July 9th did it also include rectal contrast?

A Yes.

Q And what's the purpose of using rectal contrast when you have oral contrast as well?

A Well I think -- well, obviously, on that CT scan the idea was to completely opacify the bowel for two reasons. One is for anatomic definition, but also to see if there is a leak, you know, of the contrast b because if there's a hole it's not going to stay in the bowel and you're going to be able to see it leak out. So in this case they gave rectal

contrast so that if it -- time -- sufficient time hadn't allowed for the oral contrast to completely go all the way through, you know, the intestines that they could get the rectal contrast retrograde up the colon, you know, under column of pressure like you would for an enema, but with the contrast so that it -- the contrast would be sure to get to where the repair was on the colon.

Q Okay.

THE COURT: Counsel, this be a good time for evening break because it's two minutes before the 5:00 hour.

MR. DOYLE: Yes.

THE COURT: Eight minutes to. So, ladies and gentlemen, we're going to wish you a very nice and relaxing evening; we'll see you tomorrow. Now, remember, Friday is a state holiday so, unfortunately, don't get to see you to Friday, but we do get to see you tomorrow. We show we are starting tomorrow at -- one second, please -- I think we had told you I guess I -- did I say 10:15?

THE CLERK: Yes.

THE COURT: 10:15 is what I show I said. So 10:15 --

(Court and clerk confer)

THE COURT: Then 10:15 we will see you -- should be fine. I was able to move most of my things, so we'll get a few things in the morning. So, ladies and gentlemen, during this overnight recess you are, of course, admonished not to talk or converse among yourselves or with anyone else on any subject connected with this trial. You may not read, watch, or listen to any report or commentary of the trial; any

person connected with the trial by any medium of information including, without limitation, social media, texts, Tweets, newspapers, television, internet, radio, anything the Court's not said specifically is, of course, also included.

Do not visit the scene or the events mentioned during the trial. Do not undertake any research, experimentation or investigation. Do not do any posting or communications on any social networking sites or anywhere else. Do not do any independent research including, but not limited to internet searches. Do not form or express any opinion on any subjects connected to this case in any manner whatsoever until the case is fully and finally submitted at the time of jury deliberations. With that, we wish you a very nice, relaxing evening. Thank you so very much.

THE MARSHAL: All rise for the jury.

[Jury out at 4:53 p.m.]

[Outside the presence of the jury]

THE COURT: Okay. The jury's out. Now I remind you we said that if you wanted to do this we had to stop by 4:30. We reminded you over and over. My team has stayed late twice; they can't stay again tonight. So --

MR. DOYLE: Okay.

THE COURT: -- I'm sure you all can appreciate that that --

MR. DOYLE: Tomorrow is fine; at the Court's convenience.

THE COURT: No worries. It's just, you know, ask them to stay two nights overtime. There's been a lot of overtime on this, but got

to have -- tonight's not a good one, so.

MR. JONES: Thank you, Your Honor.

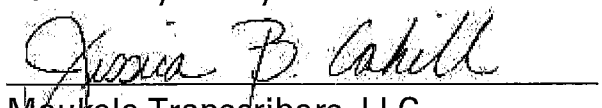
MR. DOYLE: Thank you.

THE COURT: We do appreciate it. Thank you so very much; wish you all a very nice and relaxing evening.

Madame Court Reporter, feel free to go off the record.

[Proceedings adjourned at 4:54 p.m.]

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio-visual recording of the proceeding in the above entitled case to the best of my ability.



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Jessica B. Cahill, Transcriber, CER/CET-708