

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.

BARRY JAMES RIVES, M.D.; and
LAPAROSCOPIC SURGERY OF NEVADA,
LLC,

Appellants,

vs.

TITINA FARRIS and PATRICK FARRIS,

Respondents.

Case No. 80271
Electronically Filed
Oct 13 2020 11:28 a.m.
Elizabeth A. Brown
Clerk of Supreme Court

Case No. 81052

APPELLANTS' APPENDIX
VOLUME 9

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51.	Offer of Proof re Defendants’ Exhibit C	11/1/19	9	1974-1976
	<u>Exhibit C</u> : Medical Records (Dr. Chaney) re Titina Farris		10	1977-2088
52.	Offer of Proof re Michael Hurwitz, M.D.	11/1/19	10	2089-2091
	<u>Exhibit A</u> : Partial Transcript of Video Deposition of Michael Hurwitz, M.D.	10/18/19	10	2092-2097
	<u>Exhibit B</u> : Transcript of Video Deposition of Michael B. Hurwitz, M.D., FACS	9/18/19	10 11	2098-2221 2222-2261

<u>NO.</u>	<u>DOCUMENT</u>	<u>DATE</u>	<u>VOL.</u>	<u>PAGE NO.</u>
53.	Offer of Proof re Brian Juell, M.D.	11/1/19	11	2262-2264
	<u>Exhibit A</u> : Expert Report of Brian E. Juell, MD FACS	12/16/18	11	2265-2268
	<u>Exhibit B</u> : Expert Report of Brian E. Juell, MD FACS	9/9/19	11	2269-2271
	<u>Exhibit C</u> : Transcript of Video Transcript of Brian E. Juell, M.D.	6/12/19	11	2272-2314
54.	Offer of Proof re Sarah Larsen	11/1/19	11	2315-2317
	<u>Exhibit A</u> : CV of Sarah Larsen, RN, MSN, FNP, LNC, CLCP		11	2318-2322
	<u>Exhibit B</u> : Expert Report of Sarah Larsen, R.N.. MSN, FNP, LNC, C.L.C.P.	12/19/18	11	2323-2325
	<u>Exhibit C</u> : Life Care Plan for Titina Farris by Sarah Larsen, R.N., M.S.N., F.N.P., L.N.C., C.L.C.P	12/19/18	11	2326-2346
55.	Offer of Proof re Erik Volk	11/1/19	11	2347-2349
	<u>Exhibit A</u> : Expert Report of Erik Volk	12/19/18	11	2350-2375
	<u>Exhibit B</u> : Transcript of Video Deposition of Erik Volk	6/20/19	11	2376-2436
56.	Offer of Proof re Lance Stone, D.O.	11/1/19	11	2437-2439
	<u>Exhibit A</u> : CV of Lance R. Stone, DO		11	2440-2446
	<u>Exhibit B</u> : Expert Report of Lance R. Stone, DO	12/19/18	11	2447-2453
	<u>Exhibit C</u> : Life Care Plan for Titina Farris by Sarah Larsen, R.N., M.S.N., F.N.P., L.N.C., C.L.C.P	12/19/18	12	2454-2474
57.	Special Verdict Form	11/1/19	12	2475-2476

<u>NO.</u>	<u>DOCUMENT</u>	<u>DATE</u>	<u>VOL.</u>	<u>PAGE NO.</u>
58.	Order to Show Cause {To Thomas J. Doyle, Esq.}	11/5/19	12	2477-2478
59.	Judgment on Verdict	11/14/19	12	2479-2482
60.	Notice of Entry of Judgment	11/19/19	12	2483-2488
61.	Plaintiffs' Motion for Fees and Costs	11/22/19	12	2489-2490
	Declaration of Kimball Jones, Esq. in Support of Motion for Attorneys' Fees and Costs	11/22/19	12	2491-2493
	Declaration of Jacob G. Leavitt Esq. in Support of Motion for Attorneys' Fees and Costs	11/22/19	12	2494-2495
	Declaration of George F. Hand in Support of Motion for Attorneys' Fees and Costs	11/22/19	12	2496-2497
	Memorandum of Points and Authorities	11/22/19	12	2498-2511
	<u>Exhibit "1"</u> : Plaintiffs' Joint Unapportioned Offer of Judgment to Defendant Barry Rives, M.D. and Laparoscopic Surgery of Nevada, LLC	6/5/19	12	2512-2516
	<u>Exhibit "2"</u> : Judgment on Verdict	11/14/19	12	2517-2521
	<u>Exhibit "3"</u> : Notice of Entry of Order	4/3/19	12	2522-2536
	<u>Exhibit "4"</u> : Declarations of Patrick Farris and Titina Farris		12	2537-2541
	<u>Exhibit "5"</u> : Plaintiffs' Verified Memorandum of Costs and Disbursements	11/19/19	12	2542-2550
62.	Defendants Barry J. Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Opposition to Plaintiffs' Motion for Fees and Costs	12/2/19	12	2551-2552

<u>NO.</u>	<u>DOCUMENT</u>	<u>DATE</u>	<u>VOL.</u>	<u>PAGE NO.</u>
(Cont. 62)	Declaration of Thomas J. Doyle, Esq.		12	2553-2557
	Declaration of Robert L. Eisenberg, Esq.		12	2558-2561
	Memorandum of Points and Authorities	12/2/19	12	2562-2577
	<u>Exhibit 1</u> : Defendants Barry J. Rives, M.D. and Laparoscopic Surgery of Nevada, LLC's Initial Disclosure of Expert Witnesses and Reports	11/15/18	12	2578-2611
	<u>Exhibit 2</u> : Defendants Barry J. Rives, M.D. and Laparoscopic Surgery of Nevada, LLC's Rebuttal Disclosure of Expert Witnesses and Reports	12/19/18	12 13	2612-2688 2689-2767
	<u>Exhibit 3</u> : Recorder's Transcript Transcript of Pending Motions (Heard 10/10/19)	10/14/19	13	2768-2776
	<u>Exhibit 4</u> : 2004 Statewide Ballot Questions		13	2777-2801
	<u>Exhibit 5</u> : Emails between Carri Perrault and Dr. Chaney re trial dates availability with Trial Subpoena and Plaintiffs' Objection to Defendants' Trial Subpoena on Naomi Chaney, M.D.	9/13/19 - 9/16/19	13	2802-2813
	<u>Exhibit 6</u> : Emails between Riesa Rice and Dr. Chaney re trial dates availability with Trial Subpoena	10/11/19 - 10/15/19	13	2814-2828
	<u>Exhibit 7</u> : Plaintiff Titina Farris's Answers to Defendant's First Set of Interrogatories	12/29/16	13	2829-2841
	<u>Exhibit 8</u> : Plaintiff's Medical Records		13	2842-2877

<u>NO.</u>	<u>DOCUMENT</u>	<u>DATE</u>	<u>VOL.</u>	<u>PAGE NO.</u>
63.	Reply in Support of Plaintiffs' Motion for Fees and Costs	12/31/19	13	2878-2879
	Memorandum of Points and Authorities	12/31/19	13	2880-2893
	<u>Exhibit "1"</u> : Plaintiffs' Joint Unapportioned Offer of Judgment to Defendant Barry Rives, M.D. and Defendant Laparoscopic Surgery of Nevada LLC	6/5/19	13	2894-2898
	<u>Exhibit "2"</u> : Judgment on Verdict	11/14/19	13	2899-2903
	<u>Exhibit "3"</u> : Defendants' Offer Pursuant to NRCP 68	9/20/19	13	2904-2907
64.	Supplemental and/or Amended Notice of Appeal	4/13/20	13	2908-2909
	<u>Exhibit 1</u> : Judgment on Verdict	11/14/19	13	2910-2914
	<u>Exhibit 2</u> : Order on Plaintiffs' Motion for Fees and Costs and Defendants' Motion to Re-Tax and Settle Plaintiffs' Costs	3/30/20	13	2915-2930
<u>TRANSCRIPTS</u>				
65.	<i>Transcript of Proceedings Re: Status Check</i>	7/16/19	14	2931-2938
66.	<i>Transcript of Proceedings Re: Mandatory In-Person Status Check per Court's Memo Dated August 30, 2019</i>	9/5/19	14	2939-2959
67.	<i>Transcript of Proceedings Re: Pretrial Conference</i>	9/12/19	14	2960-2970
68.	<i>Transcript of Proceedings Re: All Pending Motions</i>	9/26/19	14	2971-3042
69.	<i>Transcript of Proceedings Re: Pending Motions</i>	10/7/19	14	3043-3124

<u>NO.</u>	<u>DOCUMENT</u>	<u>DATE</u>	<u>VOL.</u>	<u>PAGE NO.</u>
70.	<i>Transcript of Proceedings Re:</i> Calendar Call	10/8/19	14	3125-3162
71.	<i>Transcript of Proceedings Re:</i> Pending Motions	10/10/19	15	3163-3301
72.	<i>Transcript of Proceedings Re:</i> Status Check: Judgment — Show Cause Hearing	11/7/19	15	3302-3363
73.	<i>Transcript of Proceedings Re:</i> Pending Motions	11/13/19	16	3364-3432
74.	<i>Transcript of Proceedings Re:</i> Pending Motions	11/14/19	16	3433-3569
75.	<i>Transcript of Proceedings Re:</i> Pending Motions	11/20/19	17	3570-3660

TRIAL TRANSCRIPTS

76.	<i>Jury Trial Transcript — Day 1</i> (Monday)	10/14/19	17 18	3661-3819 3820-3909
77.	<i>Jury Trial Transcript — Day 2</i> (Tuesday)	10/15/19	18	3910-4068
78.	<i>Jury Trial Transcript — Day 3</i> (Wednesday)	10/16/19	19	4069-4284
79.	<i>Jury Trial Transcript — Day 4</i> (Thursday)	10/17/19	20	4285-4331
93.	<i>Partial Transcript re:</i> Trial by Jury – Day 4 Testimony of Justin Willer, M.D. [Included in “Additional Documents” at the end of this Index]	10/17/19	30	6514-6618
80.	<i>Jury Trial Transcript — Day 5</i> (Friday)	10/18/19	20	4332-4533
81.	<i>Jury Trial Transcript — Day 6</i> (Monday)	10/21/19	21	4534-4769
82.	<i>Jury Trial Transcript — Day 7</i> (Tuesday)	10/22/19	22	4770-4938

<u>NO.</u>	<u>DOCUMENT</u>	<u>DATE</u>	<u>VOL.</u>	<u>PAGE NO.</u>
83.	<i>Jury Trial Transcript</i> — Day 8 (Wednesday)	10/23/19	23	4939-5121
84.	<i>Jury Trial Transcript</i> — Day 9 (Thursday)	10/24/19	24	5122-5293
85.	<i>Jury Trial Transcript</i> — Day 10 (Monday)	10/28/19	25 26	5294-5543 5544-5574
86.	<i>Jury Trial Transcript</i> — Day 11 (Tuesday)	10/29/19	26	5575-5794
87.	<i>Jury Trial Transcript</i> — Day 12 (Wednesday)	10/30/19	27 28	5795-6044 6045-6067
88.	<i>Jury Trial Transcript</i> — Day 13 (Thursday)	10/31/19	28 29	6068-6293 6294-6336
89.	<i>Jury Trial Transcript</i> — Day 14 (Friday)	11/1/19	29	6337-6493

ADDITIONAL DOCUMENTS¹

91.	Defendants Barry Rives, M.D. and Laparoscopic Surgery of, LLC's Supplemental Opposition to Plaintiffs' Motion for Sanctions Under Rule 37 for Defendants' Intentional Concealment of Defendant Rives' History of Negligence and Litigation And Motion for Leave to Amend Complaint to Add Claim for Punitive Damages on Order Shortening Time	10/4/19	30	6494-6503
92.	Declaration of Thomas J. Doyle in Support of Supplemental Opposition to Plaintiffs' Motion for Sanctions Under Rule 37 for Defendants' Intentional Concealment of Defendant Rives' History of Negligence and litigation and Motion for Leave to Amend Complaint to Add Claim for Punitive Damages on Order Shortening Time	10/4/19	30	6504-6505

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

<u>NO.</u>	<u>DOCUMENT</u>	<u>DATE</u>	<u>VOL.</u>	<u>PAGE NO.</u>
(Cont. 92)	<u>Exhibit A</u> : Partial Deposition Transcript of Barry Rives, M.D.	10/24/18	30	6506-6513
93.	<i>Partial Transcript re: Trial by Jury – Day 4 Testimony of Justin Willer, M.D. (Filed 11/20/19)</i>	10/17/19	30	6514-6618
94.	Jury Instructions	11/1/19	30	6619-6664
95.	Notice of Appeal	12/18/19	30	6665-6666
	<u>Exhibit 1</u> : Judgment on Verdict	11/14/19	30	6667-6672
96.	Notice of Cross-Appeal	12/30/19	30	6673-6675
	<u>Exhibit “1”</u> : Notice of Entry Judgment	11/19/19	30	6676-6682
97.	<i>Transcript of Proceedings Re: Pending Motions</i>	1/7/20	31	6683-6786
98.	<i>Transcript of Hearing Re: Defendants Barry J. Rives, M.D.’s and Laparoscopic Surgery of Nevada, LLC’s Motion to Re-Tax and Settle Plaintiffs’ Costs</i>	2/11/20	31	6787-6801
99.	Order on Plaintiffs’ Motion for Fees and Costs and Defendants’ Motion to Re-Tax and Settle Plaintiffs’ Costs	3/30/20	31	6802-6815
100.	Notice of Entry Order on Plaintiffs’ Motion for Fees and Costs and Defendants’ Motion to Re-Tax and Settle Plaintiffs’ Costs	3/31/20	31	6816-6819
	<u>Exhibit “A”</u> : Order on Plaintiffs’ Motion for Fees and Costs and Defendants’ Motion to Re-Tax and Settle Plaintiffs’ Costs	3/30/20	31	6820-6834
101.	Supplemental and/or Amended Notice of Appeal	4/13/20	31	6835-6836
	<u>Exhibit 1</u> : Judgment on Verdict	11/14/19	31	6837-6841

<u>NO.</u>	<u>DOCUMENT</u>	<u>DATE</u>	<u>VOL.</u>	<u>PAGE NO.</u>
(Cont. 101)	<u>Exhibit 2</u> : Order on Plaintiffs' Motion for Fees and Costs and Defendants' Motion to Re-Tax and Settle Plaintiffs' Costs	3/30/20	31	6842-6857

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

DISTRICT COURT
CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS,
Plaintiffs,

vs.

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

Defendants.

) CASE NO. A-16-739464-C
) DEPT. NO. 31

TRIAL SUBPOENA - CIVIL REGULAR

THE STATE OF NEVADA SENDS GREETINGS TO:

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

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

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

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

11 **ITEMS TO BE PRODUCED:**

12 Your entire medical chart of TITINA FARRIS.

13 Dated: October 29, 2019

14 **SCHUERING ZIMMERMAN & DOYLE, LLP**

15
16 By /s/ Thomas J. Doyle
17 THOMAS J. DOYLE
18 Nevada Bar No. 1120
19 400 University Avenue
20 Sacramento, CA 95825-6502
21 (916) 567-0400
22 Attorneys for Defendants BARRY RIVES,
23 M.D. and LAPAROSCOPIC SURGERY OF
24 NEVADA, LLC
25
26

EXHIBIT "A"

NEVADA RULES OF CIVIL PROCEDURE

RULE 45

(c) Protection of Persons Subject to Subpoena.

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

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

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

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

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

(B) If a subpoena

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

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

7 (d) **Duties in Responding to Subpoena.**

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

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

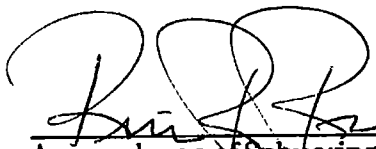
CERTIFICATE OF SERVICE

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

TRIAL SUBPOENA - CIVIL REGULAR
was served as indicated below:

- ☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);
- ☐ served on all parties electronically pursuant to mandatory NEFCR 4(b), exhibits to follow by U.S. Mail;
- ☐ by depositing in the United States Mail, first-class postage prepaid, enclosed ;
- ☐ by facsimile transmission; or
- ☐ by personal service as indicated.

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


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



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

13
14 DISTRICT COURT

15 CLARK COUNTY, NEVADA

16 TITINA FARRIS and PATRICK FARRIS,)	CASE NO. A-16-739464-C
)	DEPT. NO. 31
17 Plaintiffs,)	
)	
18 vs.)	OFFER OF PROOF RE BRUCE
)	ADORNATO, M.D.'S TESTIMONY
19 BARRY RIVES, M.D.; LAPAROSCOPIC)	
20 SURGERY OF NEVADA, LLC, et al.,)	
)	
21 Defendants.)	

22 Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC
23 hereby submit the following offer of proof:

24 If Defendants' expert witness Dr. Bruce Adornato's testimony had not been limited,
25 he would have testified in keeping with his two reports and deposition. The reports and
26 depositions are attached as exhibits A, B and C, respectively. Dr. Adornato would have

1 testified about: diabetes; how diabetes causes a diabetic peripheral neuropathy; the
2 natural history and progression of a diabetic peripheral neuropathy when diabetes is
3 uncontrolled; and the signs and symptoms of a diabetic peripheral neuropathy. He would
4 have also testified about: Titina Farris and her long-standing diabetes prior to and after
5 July of 2015; her diabetic peripheral neuropathy prior to and after July of 2015; the cause
6 of her diabetic peripheral neuropathy prior to and after July of 2015; her signs and
7 symptoms of the diabetic peripheral neuropathy prior to and after July of 2015; the
8 treatment of her diabetic peripheral neuropathy prior to and after July of 2015; and the
9 worsening, and cause of the worsening of her diabetic peripheral neuropathy after July
10 of 2015. Attached are his two reports and deposition. Exhibits A, B, and C, respectively.

11 Dated: November 1, 2019

12 **SCHUERING ZIMMERMAN & DOYLE, LLP**

13
14 By /s/ Thomas J. Doyle
15 THOMAS J. DOYLE
16 Nevada Bar No. 1120
17 400 University Avenue
18 Sacramento, CA 95825-6502
19 (916) 567-0400
20 Attorneys for Defendants BARRY RIVES,
21 M.D. and LAPAROSCOPIC SURGERY OF
22 NEVADA, LLC
23
24
25
26

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 1st day of November , 2019, service of a true and correct copy of the foregoing:

OFFER OF PROOF RE BRUCE ADORNATO, M.D.'S TESTIMONY

was served as indicated below:

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

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

Is/ Riesa R. Rice
an employee of Schuering Zimmerman &
Doyle, LLP
1737-10881

EXHIBIT A

December 18, 2018

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

RE: FARRIS VERSUS RIVES

Dear Mr. Couchot:

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

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

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

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

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

RE: FARRIS, Titina
December 18, 2018
Page 2

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

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

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

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

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

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

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

RE: FARRIS, Titina
December 18, 2018
Page 3

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

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

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

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

A handwritten signature in black ink, appearing to read "Bruce T. Adornato", written over a horizontal line.

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

EXHIBIT B

BRUCE T. ADORNATO, M.D.
Neurology

177 Bover Road
Suite 600
San Mateo, California 94402
(650) 638.2308

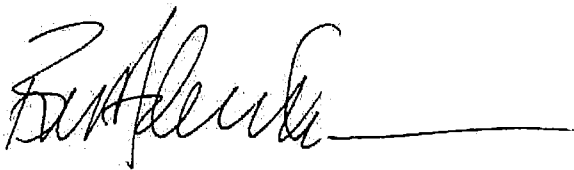
Chad C. Couchot
Schuering, Zimmerman & Doyle, LLP
400 University Avenue
Sacramento, CA 95825
September 20, 2019

RE: FARRIS VERSUS RIVES

Dear Mr. Couchot:

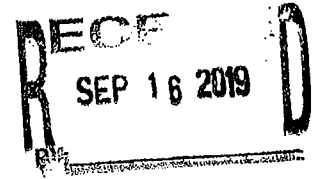
Per your request, I have reviewed the four articles provided by plaintiff's counsel regarding critical illness myopathy and critical illness polyneuropathy. These papers in general support my opinion that a major portion of Ms. Farris's current painful neuropathy is due to her pre existent painful diabetic neuropathy. Three of the four papers do not discuss pain as an issue in critical illness neuropathy and one mentions and demonstrates that a minority have neuropathic pain as a component of their disability. This paper primarily authored by Koch, specifically excludes patients with preexisting neuropathy such as is the case with Ms. Farris, and therefore is not really addressing the issue that Ms. Farris has a pre existent painful narcotics and gabapentin treated neuropathy due to her diabetes mellitus for years prior to her surgery with Dr. Rives which would be expected to worsen with time. Updated records including referral to the Southern Nevada Pain Center as of June 2019 indicate increased pain in hands and legs, more consistent with underlying and ongoing diabetic neuropathy rather than a monophasic critical illness neuropathy.

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

A handwritten signature in black ink, appearing to read "Bruce T. Adornato", followed by a horizontal line.

Bruce T. Adornato MD
Adjunct Clinical Professor of Neurology
Stanford School of Medicine
Palo Alto Neurology
San Mateo, California

EXHIBIT C



Planet Depos®
We Make It Happen™

Transcript of Bruce Adornato, M.D

Date: July 23, 2019

Case: Farris, et al. -v- Rives, M.D., et al.

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www.planetdepos.com

WORLDWIDE COURT REPORTING & LITIGATION TECHNOLOGY

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DISTRICT COURT
CLARK COUNTY, NEVADA
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TITINA FARRIS and PATRICK : Case No.
FARRIS, : A-16-739464-C
Plaintiffs, :
v. :
BARRY RIVES, M.D., LAPAROSCOPIC :
SURGERY OF NEVADA LLC; DOES :
I-V, inclusive; and ROE :
CORPORATIONS I-V, inclusive, :
Defendants. :

-----x

VIDEOTAPED DEPOSITION OF BRUCE ADORNATO, M.D.

San Mateo, California

Tuesday, July 23, 2019

10:10 a.m.

CERTIFIED COPY

Job No.: 247243

Pages: 1 - 93

Reported By: Charlotte Lacey, RPR, CSR No. 14224

Transcript of Bruce Adornato, M.D
Conducted on July 23, 2019

2

1 VIDEOTAPED DEPOSITION OF BRUCE ADORNATO, M.D., held
2 at 951 Mariners Island Boulevard, Suite 300, San Mateo,
3 California

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7 Pursuant to notice, before Charlotte Lacey,
8 Certified Shorthand Reporter, in and for the State of
9 California.

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Transcript of Bruce Adornato, M.D
Conducted on July 23, 2019

3

A P P E A R A N C E S

ON BEHALF OF PLAINTIFFS TITINA FARRIS and PATRICK
FARRIS:

KIMBALL JONES, ESQUIRE

(Via videoconference)

BIGHORN LAW

716 South Jones Boulevard

Las Vegas, Nevada 89107

(702) 333-1111

-and-

GEORGE F. HAND, ESQUIRE

(Via videoconference)

HAND & SULLIVAN, LLC

3442 North Buffalo Drive

Las Vegas, Nevada 89129

(702) 656-5814

ON BEHALF OF DEFENDANTS BARRY RIVES, M.D., and
LAPAROSCOPIC SURGERY OF NEVADA LLC:

CHAD C. COUCHOT, ESQUIRE

SCHUERING ZIMMERMAN & DOYLE LLP

400 University Avenue

Sacramento, California 95825

(916) 567-0400

ALSO PRESENT:

Lucien Newell, Videographer

Transcript of Bruce Adornato, M.D
Conducted on July 23, 2019

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I N D E X

WITNESS	PAGE
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BRUCE ADORNATO, M.D.	
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Examination by	Mr. Jones	5
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I N D E X O F E X H I B I T S

EXHIBITS	DESCRIPTION	PAGE
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Exhibit 1	Letters from Schuering Zimmerman &	11
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	Doyle, LLP	
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Exhibit 2	Handwritten notes	12
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Exhibit 3	Bruce T. Adornato, M.D., curriculum	12
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	vitae	
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Exhibit 4	Medical records	12
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Exhibit 5	Handwritten billing notes	25
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Exhibit 6	E-mail correspondence with Schuering	92
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	Zimmerman & Doyle, LLP	
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Transcript of Bruce Adornato, M.D
Conducted on July 23, 2019

5

1	P R O C E E D I N G S	09:59:36
2	THE VIDEOGRAPHER: Here begins disc number 1	10:09:31
3	in the videotaped deposition of Bruce Adornato, M.D., in	10:09:37
4	the matter of Titina Farris, et al., versus	10:09:42
5	Barry Rives, M.D., et al., in the District Court, Clark	10:09:48
6	County, Nevada, Case Number A-16-739464-C.	10:09:54
7	Today's date is July 23rd, 2019. The time on	10:10:00
8	the video monitor is 10:10. The videographer today is	10:10:05
9	Lucien Newell representing Planet Depos. This video	10:10:12
10	deposition is taking place at 951 Mariners Island	10:10:15
11	Boulevard, Suite 300, San Mateo, California.	10:10:20
12	Would court -- would counsel please voice	10:10:25
13	identify themselves and state whom they represent.	10:10:28
14	MR. JONES: Kimball Jones for the plaintiff.	10:10:34
15	MR. HAND: George Hand for the plaintiff.	10:10:37
16	MR. COUCHOT: Chad Couchot for defendants.	10:10:38
17	THE VIDEOGRAPHER: The court reporter today is	10:10:41
18	Charlotte Lacey representing Planet Depos.	10:10:43
19	Would be reporter please swear in the witness.	10:10:57
20	BRUCE ADORNATO, M.D.,	10:10:57
21	the witness herein, having been first duly sworn, was	10:10:57
22	examined and testified as follows:	10:10:57
23	EXAMINATION	10:11:06
24	BY MR. JONES:	10:11:10
25	Q All right. Can you state your name for the	10:11:10

Transcript of Bruce Adornato, M.D
Conducted on July 23, 2019

6

1	record.	10:11:11
2	A Bruce Adornato, M.D.	10:11:11
3	Q All right. Dr. Adornato, what is your	10:11:12
4	profession or occupation?	10:11:13
5	A Neurologist.	10:11:14
6	Q Have you had your deposition taken before,	10:11:15
7	sir?	10:11:18
8	A I have.	10:11:18
9	Q How many times approximately?	10:11:18
10	A More than a hundred.	10:11:22
11	Q Okay.	10:11:23
12	A Excuse me.	10:11:23
13	Q And --	10:11:23
14	A We're going to -- may I just turn up your	10:11:24
15	volume here? We're having a little trouble hearing you.	10:11:27
16	THE WITNESS: Is this the button?	
17	MR. JONES: Yes, absolutely. Please do. And	
18	I'll try to talk a little bit louder.	
19	THE WITNESS: That's -- that's better. That's	
20	a little bit better.	
21	MR. COUCHOT: Thank you.	
22	A Okay. Fine.	10:11:31
23	Q Yes. So you said that you've been deposed	10:11:31
24	over a hundred times, correct?	10:11:41
25	A Correct.	10:11:43

Transcript of Bruce Adornato, M.D
Conducted on July 23, 2019

7

1	Q	Do you have an estimate above a hundred that	10:11:43
2		you've been deposed in terms of a thousand or -- or 500	10:11:48
3		or anything like that?	10:11:51
4	A	No.	10:11:52
5	Q	Okay. Have you ever testified in trial?	10:11:52
6	A	I have.	10:11:54
7	Q	Okay. How many times?	10:11:55
8	A	I would estimate that I testified in trial	10:11:57
9		probably 40 or 50 times in the last 20 years.	10:12:03
10	Q	Okay. And in what states have you testified?	10:12:08
11	A	California. I think in the last 20 years,	10:12:13
12		that's -- that's the only time -- the only place.	10:12:20
13	Q	Okay. The -- you understand that you're under	10:12:25
14		oath today, correct?	10:12:34
15	A	Correct.	10:12:35
16	Q	All right. And do you mind if, given your	10:12:36
17		background -- do you mind if I skip the admonitions,	10:12:40
18		given the amount of times you've gone through this?	10:12:44
19	A	I don't mind.	10:12:46
20	Q	Okay. Thank you.	10:12:49
21		Did you have a chance to talk about the	10:12:51
22		deposition today with counsel prior to the deposition?	10:12:53
23	A	Briefly, yes.	10:12:57
24	Q	Tell me about that, please.	10:13:00
25	A	Just reviewed the records that I reviewed, and	10:13:03

Transcript of Bruce Adornato, M.D
Conducted on July 23, 2019

8

1	I went over my opinions in this case.	10:13:07
2	Q Okay. So you re-reviewed the same records	10:13:12
3	that you had already reviewed in the past?	10:13:16
4	A I reviewed the records that I had obtained to	10:13:18
5	see if there were any other records that were important,	10:13:21
6	and there were not.	10:13:24
7	Q Got it. So -- sorry. I -- this may be like	10:13:27
8	splitting hairs. I just don't quite understand.	10:13:32
9	So --	10:13:34
10	A Excuse me --	10:13:34
11	Q -- the records that you had --	10:13:34
12	A Could -- could you speak --	10:13:35
13	Q -- previously received --	10:13:35
14	A -- a little louder. We're at our maximum	10:13:36
15	volume here now, and we're having -- the court reporter	10:13:37
16	is grimacing, and -- and I'm -- there you go. That's	10:13:40
17	better.	10:13:46
18	Q Okay. So I'm going to -- I'm going to try and	10:13:46
19	see if I can change my positioning here a little bit.	10:13:48
20	The records that you reviewed previously that	10:13:51
21	you had received from defense counsel about this case,	10:13:54
22	those were the same records that you reviewed today in	10:13:58
23	preparation for your deposition?	10:14:01
24	A I just reviewed the list of what the records	10:14:03
25	were. We didn't actually review the records themselves.	10:14:05

Transcript of Bruce Adornato, M.D
Conducted on July 23, 2019

9

1	Q	Got it.	10:14:10
2		Now, the list that you -- that you mentioned	10:14:12
3		that you reviewed, is that -- where would you find that	10:14:14
4		list?	10:14:17
5	A	That list would be in a letter from the law	10:14:20
6		firm to me.	10:14:28
7	Q	Doctor, can you -- can you show me everything	10:14:30
8		that you have there with you that's in front of you in	10:14:34
9		terms of documents. I don't know --	10:14:36
10	A	Yes.	10:14:39
11	Q	-- if we can get the video to kind of show	10:14:39
12		that or if you can lift it up off the table so that I	10:14:43
13		can see it.	10:14:47
14	A	Okay. So I have my opinion report, which I	10:14:48
15		think you have.	10:14:51
16	Q	Correct.	10:14:57
17	A	I have a -- a couple of letters from the	10:14:57
18		Schuering law firm.	10:15:01
19	Q	Okay.	10:15:02
20	A	I have a couple of pages of notes, which are	10:15:02
21		basically a timeline in this case. I have a copy of my	10:15:08
22		CV. And then I have some selected records that I	10:15:14
23		printed from the electronic records that I have, which	10:15:21
24		include Dr. Willer's report, some data from Desert	10:15:26
25		Valley Physical Therapy, the EMG from Dr. Cheng, some	10:15:34

Transcript of Bruce Adornato, M.D
Conducted on July 23, 2019

10

1	records selected from the podiatrist at Advanced	10:15:42
2	Orthopedic & Sports Medicine, and some selected records	10:15:49
3	from Dr. Chaney.	10:15:53
4	Q Got it.	10:15:58
5	Did you print those off yourself, Doctor?	10:16:00
6	A I did.	10:16:02
7	Q Okay. Were you provided the entire record, or	10:16:03
8	were you provided those portions of the record only?	10:16:08
9	A I was provide -- I believe I was provided the	10:16:12
10	entire records.	10:16:14
11	Q There's some degree of doubt there.	10:16:17
12	Do you have a -- how -- how were -- how were	10:16:20
13	the records provided to you?	10:16:24
14	A As I recall, I think it was a link to Citrix.	10:16:27
15	Q Okay. And that was -- that was sent to you by	10:16:33
16	e-mail?	10:16:35
17	A Correct.	10:16:37
18	Q And that was sent to your e-mail account?	10:16:38
19	A That's correct.	10:16:42
20	Q The print-offs that you have there, did you go	10:16:43
21	into the records, cut and paste out the portions that	10:16:47
22	you thought were relevant, or were they already	10:16:51
23	segmented off for you?	10:16:56
24	A Well, you can print -- if you download a	10:16:59
25	record, you can print selected pages out of it. You	10:17:01

Transcript of Bruce Adornato, M.D
Conducted on July 23, 2019

11

1	don't have to cut and paste it.	10:17:06
2	Q Right. And that's -- that's what I'm asking	10:17:06
3	you. Did you go through the record and do that and	10:17:07
4	segment out and print off only certain pages, or were	10:17:09
5	they already segmented out for you?	10:17:11
6	A I went through all the -- every page of the	10:17:13
7	records and -- and chose those records as	10:17:15
8	representative.	10:17:21
9	Q Okay. And -- and you -- so did you personally	10:17:24
10	print them off? You went through and selected print off	10:17:29
11	page 3 through 5 or something like that?	10:17:32
12	A Yes.	10:17:34
13	Q Okay. When did that happen?	10:17:35
14	A Oh, gosh, I -- I can't tell you. You know,	10:17:38
15	intermittently over the last few months.	10:17:44
16	MR. JONES: Okay. All right. So let's go	10:17:52
17	ahead and let's attach these as exhibits in this case,	10:17:54
18	please, Court Reporter.	10:17:54
19	The two letters from counsel, let's attach	10:17:59
20	those as -- as Exhibit 1.	10:18:02
21	(Deposition Exhibit 1 was marked for	10:18:02
22	identification.)	10:18:02
23	MR. JONES: The good doctor's notes, let's	10:18:04
24	attach those as Exhibit 2.	10:18:07
25	(Deposition Exhibit 2 was marked for	10:18:07

Transcript of Bruce Adornato, M.D
Conducted on July 23, 2019

12

1	identification.)	10:18:07
2	MR. HAND: The CV that he has, let's attach	10:18:08
3	that as Exhibit 3.	10:18:11
4	(Deposition Exhibit 3 was marked for	10:18:11
5	identification.)	10:18:11
6	MR. JONES: And the printed off records that	10:18:11
7	he has with him, let's attach that as Exhibit 4 combined	10:18:13
8	as a grouping.	10:18:18
9	(Deposition Exhibit 4 was marked for	10:18:18
10	identification.)	10:18:18
11	Q The -- the e-mail, again, that was sent to	10:18:27
12	your e-mail box, Doctor; is that correct?	10:18:30
13	A Yes.	10:18:32
14	Q Okay. And -- and what you have there with you	10:18:32
15	printed today isn't -- isn't the entire file. That	10:18:46
16	would be just the -- the portion of the file you chose	10:18:48
17	to print, correct?	10:18:51
18	A That's right.	10:18:53
19	Q Okay. And so have you ever printed off the	10:18:53
20	entirety of the file?	10:18:57
21	A No.	10:18:58
22	Q Okay. So you went through and you reviewed it	10:19:00
23	when it was -- when it was in a PDF format or whatever	10:19:05
24	format it was in, and then afterwards you printed off	10:19:10
25	select pages.	10:19:13

Transcript of Bruce Adornato, M.D
Conducted on July 23, 2019

13

1	A	Correct.	10:19:14
2	Q	Okay. Did -- you said that you briefly had a	10:19:14
3		chance to talk with counsel today. How long did you	10:19:23
4		guys talk?	10:19:26
5	A	About ten minutes.	10:19:26
6	Q	Okay. And -- and you said that -- that the	10:19:29
7		conversation that you had covered some of the records	10:19:31
8		that you had previously reviewed, correct?	10:19:35
9	A	Correct.	10:19:38
10	Q	What -- what records specifically did you	10:19:38
11		discuss today?	10:19:41
12	A	Well, I didn't discuss the records. What I	10:19:43
13		was trying to convey was that I spoke with him, and I	10:19:46
14		said, "These are the records that I had available to me.	10:19:51
15		Are there any other significant records that I should be	10:19:54
16		seeing?"	10:19:57
17		And the answer was no.	10:19:58
18	Q	Got it. Got it.	10:19:59
19		So you just -- you just confirmed the records	10:20:03
20		that you had already reviewed were the only ones that	10:20:05
21		the attorney thought were important for you to review;	10:20:09
22		is that fair?	10:20:11
23	A	Correct.	10:20:12
24	Q	Okay. In terms of your opinions, did you	10:20:13
25		discuss any opinions that you have in this case with the	10:20:18

Transcript of Bruce Adornato, M.D
Conducted on July 23, 2019

14

1	attorney prior to the deposition?	10:20:20
2	A I told him my opinions.	10:20:22
3	Q Okay. Are those the same opinions that you	10:20:25
4	have outlined in your report?	10:20:28
5	A Gosh, I haven't looked at the report since I	10:20:31
6	wrote it. I would say basically there may be some	10:20:35
7	elaboration.	10:20:55
8	Q So you didn't read your report in preparation	10:20:55
9	for your deposition today?	10:20:58
10	A I haven't had time to look at it since --	10:20:59
11	since I wrote it. That's correct.	10:21:01
12	Q Okay. Have you had a time to look at records	10:21:03
13	since you wrote the report?	10:21:07
14	A Yes. I looked at the -- the printed records	10:21:10
15	that I have to refresh my recollection about this case.	10:21:13
16	Q Got it.	10:21:18
17	And -- and can you give me an approximate	10:21:23
18	timeline of when you printed which records?	10:21:29
19	A I -- I can't really. It was --	10:21:31
20	Q Do your very best.	10:21:35
21	A You know, I received these records in, I	10:21:39
22	guess, November. I wrote this report in December. I	10:21:49
23	would have reviewed the records and printed them out	10:21:52
24	between the time I got the records and I wrote the	10:21:56
25	report.	10:21:59

Transcript of Bruce Adornato, M.D
Conducted on July 23, 2019

15

1	Q	Okay. So -- so you would have printed all of	10:22:01
2		these records out at some point between the date you	10:22:06
3		received them in November and the time that you wrote	10:22:09
4		your report in December; is that fair?	10:22:11
5	A	Mostly. I think the only exception to that	10:22:13
6		was that I subsequently received the EMG report of	10:22:17
7		Dr. Cheng. So I actually printed that out today.	10:22:25
8	Q	When did you receive that, Doctor?	10:22:30
9	A	The Cheng report?	10:22:32
10	Q	Yes.	10:22:34
11	A	I would say a couple of months ago.	10:22:36
12	Q	Do you have a way of verifying that right now?	10:22:42
13	A	No, I don't.	10:22:45
14	Q	All right. That was, again, sent to your	10:22:49
15		e-mail address?	10:22:51
16	A	You know, let me take that back. Let me take	10:22:52
17		that back. I -- 'cause I did see the Cheng records	10:23:00
18		before I wrote the report, and I just -- I just don't	10:23:04
19		remember exactly whether I had that EMG or not. It's	10:23:08
20		not really that important.	10:23:13
21	Q	Okay. So I just -- I just want to be clear	10:23:14
22		with my questions. So you received the Cheng records	10:23:17
23		back at the time you wrote your -- your report, but you	10:23:20
24		have no recollection of the EMG record; is that fair?	10:23:22
25		From that time.	10:23:27

Transcript of Bruce Adornato, M.D
Conducted on July 23, 2019

16

1	A	Well, I don't have an independent recollection	10:23:28
2		of the EMG, but I must have seen it, because that's	10:23:32
3		essentially all there is in the Cheng records.	10:23:37
4	Q	Okay. So -- so I -- I just want to be clear.	10:23:40
5		You believe you must have seen it, but you don't have,	10:23:40
6		like you said, an independent recollection of seeing it,	10:23:44
7		correct?	10:23:46
8	A	No. I mean, this will become more -- when we	10:23:47
9		finally get into my opinions at some time, this will	10:23:48
10		become clearer to you why I wanted to look at the Cheng	10:23:54
11		records again.	10:24:00
12	Q	Absolutely. And -- and we'll get there in	10:24:02
13		just a minute, Doctor. So that's why I'm asking you	10:24:04
14		these questions, 'cause I -- I need to make sure that I	10:24:04
15		understand a -- a little bit of this.	10:24:04
16		So the -- the -- again, you don't have an	10:24:06
17		independent record of reviewing the Cheng report prior	10:24:08
18		to writing your report; is that fair?	10:24:11
19	A	Well, I did mention that in my report. So I	10:24:14
20		did review it. It -- 'cause it says, in the last	10:24:18
21		paragraph of the first page of my report "Read -- read	10:24:21
22		extensive records, which included the records of	10:24:24
23		Dr. Cheng."	10:24:28
24	Q	Okay. And -- and you are correct, Doctor.	10:24:31
25		And I -- I apologize. I -- that was not a very	10:24:34

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17

1	eloquently phrased question.	10:24:37
2	What I meant to -- to say is that you -- at	10:24:39
3	the time that you wrote your report, you don't have an	10:24:41
4	independent recollection of having reviewed the EMG	10:24:44
5	itself; is that fair?	10:24:47
6	A Well, I didn't have a recollection as of this	10:24:48
7	morning of when I reviewed it.	10:24:51
8	Q Correct.	10:24:54
9	And -- and you'd agree with me that your	10:24:55
10	report doesn't mention it, correct?	10:24:59
11	A Well, my report does mention the records of	10:25:00
12	Dr. Cheng, which are the EMG.	10:25:03
13	Q Oh, okay.	10:25:06
14	A Dr. --	10:25:07
15	Q So your report mentions records of Dr. Cheng,	10:25:08
16	but it doesn't specifically identify an EMG, correct?	10:25:14
17	A Dr. Cheng's record consists almost solely of	10:25:17
18	the EMG.	10:25:25
19	Q Okay. All right. So -- but to be clear,	10:25:26
20	Doctor, you don't have an independent recollection of	10:25:29
21	reviewing that at least prior to reviewing it this	10:25:31
22	morning; is that fair?	10:25:34
23	A I don't have an independent recollection of a	10:25:34
24	lot of things, which would include looking at the EMG	10:25:37
25	specifically.	10:25:41

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18

1	Q	Okay. Doctor, so -- so the EMG was sent to	10:25:48
2		you a second time by counsel; is that correct?	10:25:52
3	A	Yes, 'cause I requested it.	10:25:55
4	Q	Okay. And -- and when did you request it?	10:25:58
5	A	Oh, I think it was a couple months ago.	10:26:02
6	Q	And -- and again, that EMG, after you	10:26:05
7		requested it, was sent to your e-mail; is that correct?	10:26:09
8	A	Correct. Or it was --	10:26:12
9	Q	Okay.	10:26:14
10	A	You know, I don't really -- I don't recall	10:26:14
11		whether it was sent by e-mail, or it might have been a	10:26:17
12		Dropbox or Citrix or some kind of share file.	10:26:21
13	Q	Fair enough.	10:26:27
14		Is -- is there a reason why you didn't just go	10:26:27
15		back into the prior e-mail, Dropbox, or link and -- and	10:26:30
16		access it there?	10:26:33
17	A	I don't remember. It may have been difficult	10:26:37
18		to get back into it. I -- I don't know. A lot of these	10:26:41
19		require passwords, et cetera.	10:26:45
20	Q	Okay. How is it that you became aware that	10:26:48
21		there was an EMG that you wanted to review about two	10:26:52
22		months ago?	10:26:55
23	A	Well, the easy answer is I don't remember.	10:26:59
24	Q	Do you -- do you have no further answer? It	10:27:27
25		was just an epiphany --	10:27:30

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19

1	A	Oh. I -- I'm --	10:27:30
2	Q	-- that you had two months ago --	10:27:32
3	A	I'm --	10:27:32
4	Q	-- that you wanted to see an EMG?	10:27:34
5	A	-- sorry. I -- I don't really remember the	10:27:34
6		thinking that -- there are some allusions to the EMG. I	10:27:37
7		was thinking about critical care, neuropathy versus	10:27:41
8		diabetic neuropathy, and there are some differences	10:27:45
9		which can appear in the EMG. And we'll -- we can	10:27:49
10		discuss that now or later if you want.	10:27:51
11	Q	Well, we can discuss it later.	10:27:53
12		The -- and -- and so did -- did that occur to	10:27:56
13		you following a conversation with counsel or anything	10:28:02
14		like that, or this is just you, in your clinical	10:28:05
15		practice, you thought, "Hey, you know that Farris case	10:28:07
16		that I did a report for seven months ago? I -- I'd like	10:28:10
17		to see that EMG again, but I don't remember"?	10:28:15
18		I mean, how is it that -- I mean, you didn't	10:28:21
19		remember having -- that there even was an EMG, and then	10:28:22
20		all of a sudden you requested one out of the blue two	10:28:27
21		months ago. That seems like a strange happening. And	10:28:30
22		so I'm just seeking clarification on that.	10:28:33
23	A	Well, I think some of your characterization of	10:28:36
24		what occurred is not accurate. So let me try to piece	10:28:38
25		this together for you. So I -- I reviewed all these	10:28:46

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20

1	records. I came to an opinion that I expressed in the	10:28:50
2	December 18th report.	10:28:55
3	Somewhere along there, I was thinking about	10:28:56
4	this case and diabetic neuropathy, which he has, and	10:28:58
5	critical care neuropathy, and I wanted to go back and	10:29:03
6	recheck the data that was in her EMG. And the easiest	10:29:09
7	thing was to have the assistant to Mr. Couchot --	10:29:14
8	Couchot -- Couchot send it to me, which he did.	10:29:23
9	And in re-reviewing her EMG, it affirms the	10:29:28
10	thinking I had about her diabetic neuropathy versus her	10:29:36
11	critical care neuropathy. End of sentence.	10:29:41
12	Q Okay. And -- and, Doctor, again, I mean,	10:29:47
13	you -- you do understand that you are under oath today,	10:29:50
14	correct?	10:29:54
15	A Of course. Of course.	10:29:54
16	Q And so I just -- I just want to make sure	10:29:57
17	that -- that there's a couple of things that are clear.	10:30:01
18	You testified earlier that you had no	10:30:04
19	recollection of having previously reviewed an EMG,	10:30:07
20	correct?	10:30:11
21	A Well, I -- I don't think that's exactly what I	10:30:11
22	said, but whatever. You know, I -- I clearly saw the	10:30:14
23	EMG before. I, whatever, forgot about the details about	10:30:23
24	it, and I wanted to recheck that. That's probably the	10:30:26
25	simplest version and the most accurate version of what	10:30:30

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21

1	actually happened.	10:30:34
2	Q Are -- are you sure it wasn't because counsel	10:30:35
3	reached out to you and -- and asked you to do that --	10:30:40
4	A Absolutely --	10:30:43
5	Q -- at some point along the way?	10:30:43
6	A Absolutely not.	10:30:46
7	Q Okay. Have you had any other communications	10:30:50
8	with counsel in this case between today and when you	10:30:52
9	produced your report in December?	10:30:57
10	A I don't think there was a -- we had a phone	10:31:02
11	call a couple of days ago just confirming that we were	10:31:05
12	having the deposition and where it would be and	10:31:11
13	affirming that was going to happen, but nothing	10:31:14
14	substantive.	10:31:17
15	Q Okay. And how long was that phone call	10:31:18
16	approximately?	10:31:20
17	A Oh, less than five minutes.	10:31:22
18	Q Okay. And -- and so was that the only	10:31:25
19	communication, that -- that five-minute phone call and	10:31:31
20	the ten-minute conversation you had this morning, that	10:31:34
21	you have had with any counsel on this case since the	10:31:37
22	time of you issuing your report and the present day?	10:31:39
23	A As far as I recall.	10:31:44
24	Q Okay. Did you have any communications with	10:31:46
25	counsel's office? paralegals? assistants? anybody else?	10:31:47

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22

1	receptionists?	10:31:53
2	A I don't believe so.	10:31:54
3	Q Okay. And when you -- so going back to when	10:31:56
4	you produced your report, how were you contacted in this	10:32:01
5	case?	10:32:07
6	A I don't recall, but it was probably a phone	10:32:07
7	call.	10:32:10
8	Q You don't have any recollection at all of how	10:32:15
9	you were retained in this matter?	10:32:18
10	A I have a letter. I believe it was date -- the	10:32:24
11	letter that we're producing is dated November 28th,	10:32:31
12	which starts out "Thank you for agreeing to review this	10:32:33
13	matter." So there was probably a phone call, but I	10:32:34
14	don't recall the details. I don't recall anything about	10:32:41
15	that phone call last --	10:32:43
16	Q Okay.	10:32:46
17	A -- October or November.	10:32:46
18	Q There was apparently a prior phone call, but	10:32:50
19	you have no recollection of -- of what it entailed; is	10:32:53
20	that correct?	10:32:58
21	A That's correct.	10:32:58
22	Q Okay. Do you market your services as an	10:32:59
23	expert in any way?	10:33:02
24	A No.	10:33:03
25	Q Do you -- so I -- I tried to do a -- a little	10:33:10

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23

1	bit of research on you, Doctor, and I -- I was able to	10:33:14
2	find that there -- there seemed to be some -- some	10:33:18
3	places that -- that seem to be marketing you as an	10:33:20
4	expert and that you're available to -- to take on cases	10:33:24
5	and to give opinions in -- in cases.	10:33:28
6	Are you -- are you unfamiliar with your --	10:33:30
7	your connection to -- to those websites?	10:33:33
8	A Never heard of that before. I'd like -- I'd	10:33:35
9	like to see that so I could have them withdraw my name.	10:33:38
10	Q Okay. What about your LinkedIn profile? Is	10:33:43
11	that -- is that ran by you, or is that ran by someone	10:33:53
12	else?	10:33:57
13	A You know, the only reason I'm in LinkedIn, so	10:33:57
14	I can follow some other people. But I don't really use	10:33:57
15	that as a mark -- that's not a marketing tool.	10:34:06
16	Q Okay. Okay. You control, though, your own	10:34:09
17	LinkedIn; is that fair?	10:34:12
18	A "Control" would be a very loose word. I don't	10:34:12
19	think I've looked at a LinkedIn in the last year.	10:34:15
20	Q I -- I can understand your -- your phrasing	10:34:21
21	there. I -- I feel the same way.	10:34:21
22	But in any case --	10:34:21
23	A I think it has a picture --	10:34:21
24	Q -- there's still some --	10:34:21
25	A I think it has a fishing picture --	10:34:21

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24

1	Q	Go ahead.	10:34:21
2	A	-- of me up there, but that's about it, as	10:34:24
3	I	-- as I recall.	10:34:28
4	Q	So there's -- but there's no other third party	10:34:29
5	or anything that's -- that's putting information on your		10:34:32
6	LinkedIn page as far as you know; is that fair?		10:34:36
7	A	Not that I'm aware of, no.	10:34:38
8	Q	What is your billing in this case so far,	10:34:40
9	Doctor?		10:34:43
10	A	My billing is about -- about \$4,000.	10:34:43
11	Q	Do you have that billing with you today,	10:34:52
12	Doctor?		10:34:55
13	A	Yes.	10:34:55
14	Q	Okay. Could you -- can you produce that and	10:34:55
15	go through it and -- and tell us what the billing is		10:34:59
16	exactly.		10:35:03
17	A	All right. I can.	10:35:04
18		So I have an initial record review, which was	10:35:05
19	2 hours and 25 minutes, and then that was in late		10:35:13
20	November. And then there's a 15-minute or less phone		10:35:20
21	call December 14th and a record review for an hour on		10:35:25
22	the 17th and then generating a -- writing my report on		10:35:36
23	the 18th, which was three hours, and then a final		10:35:45
24	report, editing and preparation, of another half an		10:35:50
25	hour. And that's -- that's the extent of my billing.		10:35:54

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25

1	Q	Okay. Did -- did you, at any time, provide a	10:36:00
2		draft of your report to defense counsel prior to your	10:36:04
3		initial report being submitted?	10:36:07
4	A	I don't believe so. That's not my usual	10:36:12
5		practice.	10:36:15
6	Q	Okay. Is -- there's a way that you could	10:36:16
7		verify that by checking your e-mail, correct?	10:36:18
8	A	I don't know. I tend -- I tend to delete	10:36:28
9		things. I would say that I have no recollection of	10:36:32
10		providing any draft, and it's not my practice to provide	10:36:38
11		a draft to anyone.	10:36:42
12	Q	Okay. So so far we have four exhibits	10:36:52
13		attached. I'd like to attach your billing as	10:36:57
14		Exhibit 5 --	10:37:00
15	A	All right.	10:37:00
16	Q	-- to the deposition.	10:37:00
17		(Deposition Exhibit 5 was marked for	10:37:00
18		identification.)	10:37:00
19	Q	I would like to have Exhibit 6 be all	10:37:02
20		communications that you have had with defense counsel, a	10:37:08
21		print-off of -- of each and every e-mail that -- that	10:37:14
22		has -- has gone between you throughout the course of	10:37:19
23		this case.	10:37:23
24		How soon do you think you could print those	10:37:25
25		off and provide those to the court reporter, Doctor?	10:37:28

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1	A	I'll check. What's today? Later this week I	10:37:32
2		could do that.	10:37:37
3	Q	Perfect. And -- and to be clear, when I say	10:37:38
4		"defense counsel," I don't mean only the attorney. I	10:37:42
5		mean anyone from his office.	10:37:50
6	A	All right.	10:37:50
7	Q	So anyone from the defense law firm or any	10:37:50
8		other person connected to this case that provided you	10:37:50
9		information. Okay?	10:37:53
10	A	All right.	10:37:54
11	Q	Is that fair?	10:37:55
12	A	That's fine.	10:37:56
13	Q	Okay. And so that will be provided. That	10:37:57
14		will be Exhibit 6.	10:38:01
15		Okay. So again, the -- the items that you've	10:38:07
16		reviewed in this case are those that are listed in the	10:38:08
17		last paragraph of the first page of your December 18th	10:38:11
18		report; is that correct?	10:38:16
19	A	Yes.	10:38:20
20	Q	Okay. The -- I understand one of those	10:38:20
21		documents you -- you say basically references that you	10:38:25
22		would have seen the EMG study.	10:38:28
23		There -- did you -- did you review any other	10:38:30
24		diagnostic tests, studies, films, or anything like that	10:38:35
25		that you're aware of?	10:38:38

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27

1	A	No.	10:38:39
2	Q	Okay. Did -- did you review anything else,	10:38:40
3		besides what you have listed there, at any time prior to	10:38:45
4		your deposition?	10:38:49
5	A	No.	10:38:49
6	Q	Okay. Have you relied on any specific	10:38:51
7		scientific or medical studies or anything like that for	10:38:57
8		your specific opinions that you have in this case?	10:39:02
9	A	No.	10:39:04
10	Q	Doctor, where do you maintain your office?	10:39:04
11	A	My office is in San Mateo.	10:39:08
12	Q	Okay. And you -- you practice in the	10:39:12
13		specialty of neurology; is that correct?	10:39:17
14	A	I practiced neurology for 40 years, yes.	10:39:20
15	Q	Okay. And you're board certified?	10:39:27
16	A	That's correct.	10:39:29
17	Q	Okay. How long have you been board certified?	10:39:30
18	A	Since 1978.	10:39:32
19	Q	Okay. And do you have to periodically re-up	10:39:35
20		your certification, retest for that?	10:39:38
21	A	No, I don't.	10:39:41
22	Q	Okay. So you tested once in 1978, and you	10:39:42
23		haven't had to retest since that time?	10:39:45
24	A	That's correct.	10:39:48
25	Q	Okay. Are you licensed to practice medicine	10:39:48

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28

1	in any state?	10:39:53
2	A Yes.	10:39:54
3	Q What states are you licensed to practice	10:39:55
4	medicine in?	10:39:58
5	A California.	10:39:59
6	Q Okay. You're not -- you're not trained as a	10:40:01
7	biomechanical engineer, correct?	10:40:04
8	A That's correct.	10:40:07
9	Q Okay. And -- and you're not trained as an	10:40:08
10	economist; is that fair?	10:40:11
11	A Yes.	10:40:13
12	Q Okay. Doctor, how many times have you worked	10:40:14
13	for this particular defense law firm?	10:40:20
14	A Oh, probably a dozen times.	10:40:24
15	Q Okay. Over -- over what timeline	10:40:28
16	approximately?	10:40:31
17	A Over the last ten years.	10:40:32
18	Q Okay. How many times have you taken a case	10:40:36
19	with this particular attorney?	10:40:39
20	A I think this is the first time.	10:40:43
21	Q Okay. Now, you mentioned that you have --	10:40:45
22	have provided depositions over a hundred times.	10:40:56
23	How many times have you been retained as an	10:40:59
24	expert by any attorney?	10:41:02
25	A I don't know the answer to that.	10:41:05

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29

1 Q Okay. Do you -- do you have an estimate at 10:41:12
2 all? 10:41:15

3 A Well, I say -- I would say I get asked to look 10:41:19
4 at a case probably once every two weeks, and that's been 10:41:29
5 like that for the last five years. 10:41:33

6 Q And -- and you're -- of course, you're paid to 10:41:37
7 look at those cases? 10:41:41

8 A I'm what? 10:41:43

9 Q You're paid to review those cases? 10:41:43

10 A I'm -- yes, I'm hired as a medical legal 10:41:46
11 consultant and expert. 10:41:53

12 Q Got it. 10:41:54

13 And -- and what's your retainer for -- for a 10:41:54
14 basic review? 10:41:56

15 A Well, I don't -- I don't usually -- sometimes 10:41:57
16 I do if I don't know someone. But I don't, as a rule, 10:42:00
17 ask for a retainer. 10:42:06

18 Q Okay. Do you -- do you have any amount that 10:42:08
19 you typically charge for initial -- an initial review? 10:42:11

20 A It depends on the -- I charge for the review 10:42:15
21 of record time. So I charge \$575 an hour to review 10:42:19
22 records and consult. 10:42:24

23 Q Okay. And -- and so that happens about every 10:42:29
24 two weeks. 10:42:32

25 And then obviously a much smaller percentage 10:42:33

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1	of those would go as far as -- as having a deposition;	10:42:37
2	is that correct?	10:42:40
3	A Yes.	10:42:41
4	Q Okay. And in this case, the \$4,000 that --	10:42:41
5	that you charged up until this time, that doesn't	10:42:45
6	include the deposition today; is that fair?	10:42:47
7	A That's correct.	10:42:50
8	Q And it doesn't include the phone call or -- or	10:42:50
9	any prep, should you choose to charge for those, that	10:42:52
10	deal with this deposition; is that fair?	10:42:57
11	A Correct.	10:42:59
12	Q Okay. What is the split of your med legal	10:43:00
13	practice between plaintiff and defense?	10:43:06
14	A It's about two-thirds of the time I'm asked by	10:43:10
15	a defense attorney and about one-third by a plaintiff	10:43:16
16	attorney.	10:43:21
17	Q And -- and among the cases that you have --	10:43:24
18	well, let me -- let me take a step back.	10:43:28
19	In -- in the last year, how would you compare	10:43:32
20	that split? The same, or has it tended to vary one way	10:43:35
21	or the other?	10:43:42
22	A In the last year, it's actually been more	10:43:42
23	plaintiff cases. It's been more 50/50 as a --	10:43:45
24	Q Got it.	10:43:51
25	So the last year has been -- been closer to	10:43:52

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31

1	50/50, but over the course of your career, it's been	10:43:56
2	two-thirds defense, one-third plaintiff.	10:44:01
3	A Correct.	10:44:05
4	Q Is that your testimony?	10:44:05
5	A Yes.	10:44:05
6	Q Okay. And in terms of cases where you have	10:44:05
7	actually testified where you've provided deposition	10:44:08
8	testimony, what has been the -- the split?	10:44:10
9	A Testified in court?	10:44:12
10	Q No. No. Just in deposition.	10:44:15
11	A Oh, I don't know. It's probably -- it's	10:44:23
12	probably 80 percent defense, 20 percent plaintiff.	10:44:25
13	Q Okay. And what about testifying in court in	10:44:29
14	trial?	10:44:32
15	A It would probably be 90 percent defense,	10:44:33
16	10 percent plaintiff, although the last -- the last two	10:44:39
17	times I've been in court have both been plaintiff cases.	10:44:44
18	Q Got it.	10:44:53
19	How much of your practice is devoted to	10:44:53
20	work -- working as an expert versus working as a -- as a	10:44:57
21	practitioner?	10:50:21
22	A Well, about a year and a half ago, I stopped	10:45:04
23	seeing patients in my office. So my clinical care now,	10:45:08
24	seeing patients, treating patients now is restricted to	10:45:11
25	patients I see at Stanford as an adjunct clinical	10:45:16

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1	professor of neurology. I see patients only with --	10:45:24
2	with residents and not in a private practice anymore.	10:45:29
3	So that's a big change for the past 39 years when I had	10:45:33
4	a full-time neurology practice.	10:45:43
5	Q Got it.	10:45:45
6	You mentioned -- you mentioned that you also	10:45:46
7	worked at the VA. Do you still work there?	10:45:49
8	A I volunteer at the VA.	10:45:52
9	Q Okay. How often do you do that?	10:45:57
10	A Four weeks a year. I've been doing that since	10:45:59
11	about 1986.	10:46:02
12	Q And -- and at Stanford, how often do you work	10:46:05
13	at Stanford?	10:46:09
14	A Well, I go to Stanford weekly to conferences.	10:46:10
15	But the Palo Alto VA is a Stanford facility, and the	10:46:14
16	re -- the residents and the medical students that I work	10:46:21
17	with at the VA are all -- all Stanford trainees.	10:46:24
18	Q Got it.	10:46:31
19	And so -- so you go to Stanford for	10:46:38
20	conferences. Are you -- are you paid for -- for	10:46:40
21	those -- for going to these conferences?	10:46:41
22	A No, I'm not.	10:46:42
23	Q Oh, okay. So you're just an -- an attending	10:46:43
24	person at these conferences at Stanford?	10:46:46
25	A That's correct.	10:46:51

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1	Q	Okay. So when you talk about going to the	10:46:51
2		Stanford Hospital -- or let's see. What -- what do you	10:46:53
3		have here?	10:46:57
4		Adjunct clinical professor at Stanford	10:46:58
5		University School of Medicine, do you actually teach any	10:47:04
6		courses there?	10:47:06
7	A	Well, I don't teach any courses. We teach by	10:47:07
8		being the attending physician, in which all the -- all	10:47:10
9		the issues, all the examination, all of the interaction	10:47:16
10		with the patient is in conjunction with the medical	10:47:21
11		students and the residents. So that is the -- the	10:47:25
12		apprenticeship that they're going through. I'm -- I'm	10:47:29
13		teaching in that apprenticeship.	10:47:33
14	Q	Understood.	10:47:35
15		So you don't actually teach any courses at --	10:47:36
16		at Stanford, correct?	10:47:39
17	A	Correct.	10:47:40
18	Q	Okay. Do you actually -- are you actually	10:47:40
19		paid to work within the -- any -- any Stanford hospital?	10:47:43
20	A	No, I'm not.	10:47:47
21	Q	Okay. So the only -- the only time that	10:47:49
22		you're training residents is the volunteer time at the	10:47:54
23		VA; is that correct?	10:47:57
24	A	That's right.	10:47:59
25	Q	Okay. All right. So -- so when you say "I am	10:47:59

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1	currently an adjunct clinical professor at Stanford	10:48:05
2	University School of Medicine," what you mean by that is	10:48:09
3	that you do volunteer work at the VA, and Stanford	10:48:14
4	medical students who are residents are also there and	10:48:20
5	you give them training during that time?	10:48:24
6	A That's correct.	10:48:26
7	Q Okay. It -- it doesn't surprise you, then,	10:48:27
8	if -- if I were to tell you that I -- I looked you up at	10:48:33
9	Stanford, and I couldn't find any evidence of you being	10:48:36
10	faculty at Stanford at any time?	10:48:40
11	A Does it surprise me?	10:48:45
12	Q Correct. That wouldn't surprise you then,	10:48:47
13	correct?	10:48:50
14	A It wouldn't surprise me, although I am listed.	10:48:50
15	There is -- in the department of neurology, at least the	10:48:56
16	last time I checked, which was more than a year ago, I	10:48:59
17	am listed as an adjunct clinical faculty.	10:49:04
18	Q Okay. All right. I -- I tried to look you up	10:49:07
19	more recently than -- than a year ago, and I was unable	10:49:11
20	to find your -- your name or -- or any indication that	10:49:14
21	you had been on -- on their list of adjunct clinical	10:49:17
22	professors.	10:49:20
23	A Well, if you call Frank Longo, who's a	10:49:21
24	department chairman, or Tom Rando, who's at -- the	10:49:27
25	department chairman at the VA, I'll give you his e-mail	10:49:30

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1 address, I'm sure they'll confirm my credentials. 10:49:31

2 Q Okay. All right. Thank you. 10:49:35

3 Okay. Let's see. Doctor, what -- what were 10:49:56

4 you specifically retained to do in this matter? 10:49:58

5 A I was asked to look -- as I recall, I was 10:50:02

6 asked to look at this case from the perspective of the 10:50:07

7 causation of her neurologic situation. 10:50:11

8 Q Got it. 10:50:29

9 So let's -- let's talk a little bit about the 10:50:29

10 opinions that you formed. I'd like -- let's -- let's 10:50:32

11 start off -- if you wouldn't mind, let's -- let's start 10:50:35

12 going through just kind of a listing of opinions that 10:50:38

13 you -- that you formed in this case. 10:50:41

14 The -- well, let me -- I guess -- I guess let 10:50:44

15 me ask you one question about opinions. 10:50:47

16 Within your report, you provided all of the 10:50:49

17 opinions that you had about that -- this case at that 10:50:52

18 time; is that fair? 10:50:56

19 A Say that again. I'm sorry. Could you repeat 10:50:58

20 that, please. 10:51:00

21 Q Absolutely. Absolutely. When you composed 10:51:02

22 your report, you included all of the opinions you had 10:51:05

23 regarding this case at that time; is that fair? 10:51:09

24 A Yes. 10:51:13

25 Q Okay. And you understand that in Nevada, it 10:51:15

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1	is required that you provide all of your opinions within	10:51:18
2	a written report, correct?	10:51:21
3	A I'm not sure I knew that, but sounds good to	10:51:28
4	me.	10:51:31
5	Q Okay. You feel you complied with that anyway;	10:51:31
6	is that fair?	10:51:36
7	A Yes.	10:51:36
8	Q Okay. The -- there are no opinions, within	10:51:36
9	your report, that I could identify anyway, that deal	10:51:40
10	with the standard of care itself.	10:51:44
11	Is that -- is that your understanding of your	10:51:46
12	report as well, Doctor?	10:51:49
13	A Yes.	10:51:50
14	Q Okay. So you're not planning to offer any	10:51:51
15	opinions with respect to the standard of care; is that	10:51:54
16	fair?	10:51:57
17	A That's correct.	10:51:57
18	Q Okay. So your opinions really are limited to	10:51:58
19	causation opinions; is that fair?	10:52:04
20	A Yes.	10:52:06
21	Q Okay. Let's talk about the causation opinions	10:52:07
22	that -- that you have. And the first -- without going	10:52:10
23	to your report, which we'll go to in just a minute, do	10:52:17
24	you have any new opinions, since the time that you	10:52:21
25	prepared your report, that you believe are significant?	10:52:23

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1	A	No.	10:52:26
2	Q	Okay. So all of the -- the opinions that you	10:52:27
3		now have are found within your report; is that fair?	10:52:29
4	A	Yes.	10:52:32
5	Q	Okay. I'd like to go through these opinions	10:52:33
6		in -- in -- maybe not -- I don't know -- in -- in the	10:52:36
7		order that -- that makes sense to me, and -- and we'll	10:52:42
8		go through each and every one.	10:52:45
9		And if you feel like we haven't addressed any	10:52:46
10		of your opinions, would you be fur -- sure to make --	10:52:49
11		to -- to point that out to me so that we can go through	10:52:52
12		it before the deposition ends, Doctor?	10:52:54
13	A	Yes.	10:52:56
14	Q	Okay. You have an opinion that the patient in	10:52:57
15		this case, that the plaintiff suffered critical care	10:53:00
16		neuropathy; is that correct?	10:53:04
17	A	Yes.	10:53:06
18	Q	And what -- what are the resulting symptoms	10:53:07
19		that she experienced as a result of the critical care	10:53:12
20		neuropathy?	10:53:17
21	A	Weakness of the muscles of her distal legs.	10:53:19
22	Q	Got it.	10:53:32
23		And when you say "distal legs," what do you	10:53:35
24		mean?	10:53:38
25	A	Below the knee.	10:53:38

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1	Q	Okay.	10:53:40
2	A	Well -- well, let's say above -- above and	10:53:41
3		below the knee, but predominantly below the knee.	10:53:45
4	Q	Right. Right.	10:53:50
5		So kind of in the knee area and below but	10:53:51
6		prominently below?	10:53:56
7	A	Predominantly, from reviewing all the records,	10:53:57
8		most of her weakness was in her ankle flexion and	10:53:59
9		dorsiflexion. Ankle -- ankle motion.	10:54:05
10	Q	Got it. Got it.	10:54:09
11		Any -- any other symptoms, besides muscle	10:54:10
12		weakness of the distal legs, as a result of the critical	10:54:14
13		care neuropathy?	10:54:18
14	A	No. That -- that is the primary problem.	10:54:20
15	Q	Okay. Did she -- did she suffer any pain as a	10:54:26
16		result of the critical care neuropathy?	10:54:31
17	A	I believe that the vast majority of her pain	10:54:33
18		is related to her preexistent diabetic neuropathy.	10:54:38
19	Q	Numbness, do you believe that she suffered any	10:54:47
20		numbness as a result of the critical care neuropathy?	10:54:54
21	A	Yes.	10:54:57
22	Q	What numbness do you attribute to the critical	10:54:58
23		care neuropathy?	10:55:02
24	A	I would attribute a portion of the numbness	10:55:03
25		that she has in her feet, but the majority of it	10:55:06

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1	appeared to be present long before her hospitalization	10:55:16
2	in 2015.	10:55:23
3	Q Okay. Do you -- do you apportion any -- any	10:55:29
4	amount of pain to the critical care neuropathy?	10:55:32
5	A I would attribute the -- less than 10 percent	10:55:36
6	of her pain to her critical care neuropathy.	10:55:40
7	Q Okay. And the numbness, would you also	10:55:45
8	attribute less than 10 percent or more than 10 percent?	10:55:48
9	A I would attribute a third of her numbness to	10:55:50
10	her critical care neuropathy.	10:55:58
11	Q Did -- any -- any symptoms involving mobility	10:56:03
12	related to the critical care neuropathy?	10:56:09
13	A Yes.	10:56:11
14	Q What are those symptoms?	10:56:13
15	A Well, the -- her mobility problems, I would	10:56:16
16	attribute half of her mobility problems to the critical	10:56:20
17	care neuropathy and half to her preexistent	10:56:26
18	neuropathy -- diabetic neuropathy.	10:56:29
19	Q Okay. Doctor, do you have an opinion as -- as	10:56:33
20	to whether or not the plaintiff suffered foot drop as a	10:56:40
21	result of this?	10:56:46
22	A Yes.	10:56:47
23	Q As a result of critical care neuropathy?	10:56:47
24	A I didn't hear the last word you said.	10:56:50
25	Q Sorry. Do you have an opinion as to whether	10:56:53

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1	or not the plaintiff suffers from foot drop as a result	10:56:56
2	of the critical care neuropathy?	10:56:59
3	A I believe that she does have foot dorsiflexor	10:57:01
4	weakness as a result of her critical care neuropathy, at	10:57:07
5	least the majority of her foot dorsiflexor weakness I	10:57:15
6	would attribute to her critical care neuropathy.	10:57:22
7	Q Got it.	10:57:25
8	And -- and when you say -- what's the	10:57:26
9	difference between the dorsiflexor weakness that you're	10:57:27
10	talking about and what is commonly referred to as foot	10:57:32
11	drop?	10:57:34
12	A Foot drop -- these are kind of terms of art.	10:57:35
13	People -- if you have foot dorsiflexor weakness, there	10:57:40
14	are gradations of that. If it is complete, I would call	10:57:50
15	that a foot drop.	10:57:53
16	In other words, when you -- if you pick up	10:57:54
17	your -- if you're sitting in a chair and you lift your	10:57:56
18	knee up, then your -- the top of your foot would fall	10:58:00
19	down. It would drop down. So there was complete	10:58:06
20	weakness. There was no strength in the dorsiflexor. I	10:58:11
21	would call that a foot drop.	10:58:14
22	Q Got it.	10:58:16
23	A But there are -- there are grades of that, and	10:58:18
24	I -- I don't know where she is at this point. If she	10:58:20
25	had zero strength, which she did when she saw the	10:58:24

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1 podiatrist in 2015, I would call a foot drop if it were 10:58:29
2 a hundred percent. 10:58:29
3 But I think it's sometimes more accurate to -- 10:58:34
4 to refer to it as dorsiflexor weakness, which 10:58:38
5 encompasses all grades of weakness. 10:58:42
6 Q Now, in this case, you mentioned the 10:58:45
7 podiatrist. Is -- is there anything in the medical 10:58:49
8 record that indicates that she maintained some degree of 10:58:54
9 strength? 10:58:58
10 A I have not seen a -- I don't know the answer 10:59:04
11 to that, whether there's something more recent that I 10:59:07
12 haven't seen. I did not see anything that would 10:59:10
13 indicate greater than one out of five strength of foot 10:59:13
14 dorsiflexion. 10:59:19
15 Q Okay. So as far as you know, she does have 10:59:19
16 complete foot drop, is that fair, based on the records 10:59:24
17 you've reviewed? 10:59:28
18 A Based on the records that I've reviewed, yes. 10:59:29
19 Q Okay. And you attribute that foot drop 10:59:32
20 entirely to the critical care neuropathy; is that 10:59:37
21 correct? 10:59:44
22 A That's where it gets a little complicated. I 10:59:44
23 would -- I would attribute the majority of it -- there 10:59:49
24 may be -- there could well be some element due to her 10:59:52
25 diabetic neuropathy, because diabetic neuropathy is 10:59:59

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1	generally progressive with time and usually, in cases	11:00:02
2	such as this, proceeds to do -- to encompass and include	11:00:06
3	foot dorsiflexor weakness. But given the timing that --	11:00:12
4	that occurred, I would attribute the vast majority of	11:00:16
5	her foot dorsiflexor weakness to the critical care	11:00:20
6	neuropathy.	11:00:23
7	Q What percentage would you -- would you say is	11:00:25
8	attributable to the critical care neuropathy?	11:00:27
9	A I would say 90 percent.	11:00:30
10	Q Is there anything that you can relate to the	11:00:43
11	critical care neuropathy and to nothing else in terms of	11:00:45
12	symptoms?	11:00:51
13	A No.	11:00:52
14	Q And -- and as far as you're aware, Ms. Farris	11:01:02
15	lost all muscle and nerve function in both feet,	11:01:05
16	correct, following the -- the -- well, postop, I guess?	11:01:09
17	A Well, that's a little severe to say "all	11:01:14
18	muscle and nerve function." I can't say that. But she	11:01:17
19	certainly -- she had drop foot, and she continued to	11:01:20
20	have sensory loss in her lower extremities.	11:01:25
21	Q Is it fair to say that there was no records	11:01:28
22	you re -- you reviewed that demonstrate that she	11:01:32
23	retained any muscle or nerve function in either foot	11:01:37
24	following the -- the surgery and -- and her release from	11:01:41
25	the hospital?	11:01:44

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1	A	Well, she had a complete foot drop, according	11:01:51
2		to the podiatrist records as of 2015, after the	11:01:55
3		hospitalization.	11:02:05
4	Q	So you'd agree that at least with -- within	11:02:13
5		the records that you've been able to review, they	11:02:15
6		indicate that Ms. Farris lost all muscle and nerve	11:02:17
7		function in both feet following the postop, correct,	11:02:23
8		following the hospitalization?	11:02:25
9	A	Well, that's not what I -- what I would say.	11:02:26
10		Because when I reviewed the records from the podiatrist	11:02:28
11		in 2014, she had -- he noted that she had absent	11:02:31
12		sensation in her feet and absent position sense as of	11:02:39
13		July 2014.	11:02:45
14	Q	No, I -- I don't -- yeah, I don't want to talk	11:02:50
15		around each other. I -- I -- that's -- that's not quite	11:02:53
16		the question I'm asking.	11:02:55
17		I'm -- I'm asking -- I'm just confirming that	11:02:57
18		once she was released from the hospital in 2015, that	11:03:01
19		from that point forward, there's no evidence that she	11:03:05
20		had any muscle or nerve function in either foot,	11:03:08
21		correct?	11:03:16
22	A	Well, she had -- I'm not familiar with the	11:03:19
23		term, you know, "absent nerve function." That's not a	11:03:23
24		term that I'm familiar with. I -- what I would say is	11:03:27
25		that she continued to have a severe sensory neuropathy,	11:03:35

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1	and she had a foot drop in the records that I was --	11:03:37
2	that I've reviewed.	11:03:41
3	Q And the foot drop, you would relate that being	11:03:43
4	to -- to weakness. So in terms of muscle, you'd agree	11:03:45
5	with that, but you have -- you have some reservations	11:03:50
6	with -- with -- in terms of, I guess, nerve function.	11:03:53
7	Do I understand you correctly, Doctor?	11:04:00
8	A Well, "nerve function" is your term.	11:04:03
9	That's -- so, you know, we divide nerve function into	11:04:06
10	sensory and motor, and then there are some other areas.	11:04:09
11	So we can be more specific in her case because we know	11:04:13
12	that prior to the event in question, she had absent	11:04:17
13	sensation in her feet and absent --	11:04:20
14	Q Doctor, I want to talk about that.	11:04:23
15	A Let me --	11:04:25
16	Q Really -- I really do.	11:04:25
17	A I'd like to --	11:04:26
18	Q We will get into that in just a minute.	11:04:26
19	I just want to make sure that I'm clear on	11:04:30
20	these questions that I'm asking, but I promise we will	11:04:33
21	go through her -- her other conditions that you have	11:04:34
22	identified.	11:04:37
23	MR. COUCHOT: Well, Counsel, let him finish	11:04:37
24	his -- his answer. You can ask follow-up questions, but	11:04:39
25	he's entitled to finish his answer if he thinks he's	11:04:42

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1	being responsive to your question.	11:04:49
2	MR. JONES: Fair enough. Fair enough.	11:04:50
3	Q Go ahead, Doctor.	11:04:50
4	A I -- I just object. I -- I don't know what	11:04:53
5	you mean when you say "nerve function, absent nerve	11:04:54
6	function." That is not a term -- a medical term. It's	11:04:55
7	not a neurological term. And I'm saying -- so that's my	11:04:58
8	misunderstanding of your -- of your question.	11:05:04
9	Q Yeah. So -- so, I mean, obviously I -- I'm	11:05:07
10	not a neurologist, and -- and I do not know the lingo	11:05:11
11	the way that you do. But I -- I'm trying to -- to say	11:05:22
12	it in a way that -- that, I guess, makes sense to -- to	11:05:23
13	me and to someone without your degree of training.	11:05:27
14	Would you agree that when she was released	11:05:29
15	from hospitalization, that Ms. Farris had lost all	11:05:32
16	muscle function in both feet?	11:05:36
17	A Yes.	11:05:38
18	Q Okay. And in terms of nerve function, what	11:05:38
19	I -- what I'm trying to get at, Doctor, is that -- is	11:05:44
20	that the nerves were no longer firing, that they -- that	11:05:47
21	she didn't have the ability or -- or the nerves to -- to	11:05:50
22	operate in any way within her feet.	11:05:55
23	Is that just a bad way of looking at it, or is	11:05:57
24	that -- is that something that -- that we can frame in	11:06:00
25	some way?	11:06:07

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1	A	Well, I can certainly frame it in a way that	11:06:07
2		the jury can understand in using commonly understood	11:06:10
3		terminology. I -- you know, I've been talking to people	11:06:17
4		for 40 years about neurology.	11:06:19
5	Q	Awesome.	11:06:21
6		So can you -- can you tell me then -- you	11:06:21
7		know, I think you understand what I'm trying to get at	11:06:25
8		with my question when I say "nerve function" or "the	11:06:30
9		functionality of the nerves."	11:06:33
10		Were the nerves still working in her feet	11:06:34
11		after her hospitalization?	11:06:37
12	A	What I would say is the term "working" is --	11:06:40
13		is vague. They may have been working very hard, but	11:06:46
14		they were not functionally normal. So she had -- she	11:06:49
15		developed a foot drop due to her critical care	11:06:52
16		neuropathy so that her muscles were not normally	11:06:55
17		activated when she tried to walk when she left the	11:07:01
18		hospital.	11:07:04
19	Q	Got it.	11:07:04
20		All right. And, again, that was caused, in	11:07:12
21		your opinion, by critical care neuropathy -- or	11:07:15
22		90 percent of that was caused by critical care	11:07:20
23		neuropathy?	11:07:23
24	A	Yes.	11:07:23
25	Q	Okay. Let's see. Now, you have a -- a	11:07:23

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1	statement. You say, "May have been exacerbated by her	11:07:30
2	underlying and long-standing diabetic peripheral	11:07:34
3	neuropathy."	11:07:40
4	A Correct.	11:07:41
5	Q And can you -- I just want to -- I guess -- I	11:07:41
6	guess the first question I have is: The 10 percent of	11:07:42
7	her foot drop that you attribute to the -- what you call	11:07:45
8	the long-standing diabetic peripheral neuropathy, do	11:07:50
9	you -- is that a -- is that an opinion that you have to	11:07:56
10	a reasonable degree of medical probability, or do you	11:07:59
11	think it's -- it's just a possibility?	11:08:02
12	A It's a probability. It's a -- it's a medical	11:08:04
13	probability.	11:08:07
14	Q Okay. And so when you say "may have	11:08:08
15	exacerbated by her underlying and long-standing diabetic	11:08:14
16	peripheral neuropathy," is that -- is that -- are you	11:08:18
17	saying that is a possibility, or are you saying that is	11:08:19
18	a probability? Because "may," to me, tends to -- tends	11:08:23
19	to not necessarily reach that -- that level.	11:08:27
20	A Right. I would say that it is a probability	11:08:31
21	that someone who had her degree of sensory abnormalities	11:08:34
22	and diabetic neuropathy symptoms would likely have some	11:08:40
23	motor involvement as well, although a minor component of	11:08:49
24	her disability that she left the hospital with.	11:08:56
25	Q Okay. Now, you'd agree with me that there --	11:09:00

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1	there wasn't any evidence of any motor involvement prior	11:09:03
2	to her leaving the hospital, correct, in any of the	11:09:07
3	records you reviewed?	11:09:11
4	A I would say that there was -- there was an	11:09:13
5	absence of fine motor examination in the record, and so	11:09:16
6	the absence of a record doesn't mean it wasn't there. I	11:09:24
7	couldn't find any neurologist who examined her prior to	11:09:27
8	August -- or July 2015.	11:09:33
9	Q Right.	11:09:38
10	Now, someone -- someone who has complete foot	11:09:38
11	drop, as she does in this case -- right? -- you'd agree	11:09:43
12	that she most likely is going to be getting around by	11:09:48
13	way of wheelchair or walker and typically with	11:09:53
14	assistance; is that fair?	11:09:56
15	A Yes.	11:09:57
16	Q Okay. Do you have an opinion as to what her	11:09:57
17	motor function level was prior to -- to this?	11:10:01
18	A I think that her ability to ambulate was	11:10:07
19	relatively normal prior to this.	11:10:13
20	Q Okay. What about -- what about jogging or	11:10:17
21	running or anything like that?	11:10:26
22	A I didn't see any record of her jogging or	11:10:30
23	running prior to. But I wouldn't -- my expectation is	11:10:34
24	given the level of symptoms that she had with regard to	11:10:38
25	painful neuropathy, on narcotics and gabapentin, my	11:10:44

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1 experience is that people don't run or jog because those 11:10:50
2 activities exacerbate the pain, and also they have 11:10:54
3 diminished functionality, re -- diminished motor reserve 11:11:00
4 for -- for activities like that, which are much more 11:11:13
5 difficult than -- than walking. 11:11:15

6 Q Okay. So that -- that's not something that 11:11:18
7 you would expect from somebody who had long-standing 11:11:21
8 diabetic peripheral neuro -- neuropathy, correct? 11:11:27
9 Anything besides normal ambulation? 11:11:28

10 A I would not expect anything but her ability 11:11:32
11 to -- to just walk around on even ground. I -- I expect 11:11:36
12 that she would have had difficulty walking in the dark 11:11:40
13 or un -- uneven surfaces or ascending or descending 11:11:43
14 stairs given the level of sensory loss that she had 11:11:49
15 prior to July of 2015. 11:11:53

16 Q Okay. Doctor, was there -- was there anything 11:11:55
17 that you wanted to review that you weren't able to 11:12:12
18 review? 11:12:14

19 A No. 11:12:14

20 Q Okay. Let's see. All right. I want to go 11:12:17
21 through -- so your -- your opinion is that she had 11:12:40
22 long-standing diabetes, and -- and you state that it was 11:12:42
23 poorly controlled. 11:12:49

24 Can you -- can you tell me about that -- that 11:12:51
25 opinion? Why do you believe it was poorly controlled? 11:12:52

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1	A	So based upon the records of Dr. Chaney, for	11:12:55
2		the most part.	11:13:02
3	Q	And -- and what do those records say to tell	11:13:06
4		you that it was poorly controlled?	11:13:09
5	A	Well, there are multiple notations on her part	11:13:11
6		of asking the patient, trying to control her diabetes.	11:13:14
7	Q	Okay. Anything else?	11:13:26
8	A	Well, just the reports. Here a September 16,	11:13:30
9		2014, note. "Historically she's been considered a	11:13:36
10		poorly controlled diabetic and continues to engage in	11:13:38
11		dietary indiscretion."	11:13:42
12		I think there are multiple notes to that	11:13:45
13		effect. Here's --	11:13:47
14	Q	All right.	11:13:47
15	A	-- an April 26, 2017, Dr. Chaney, "She	11:13:50
16		continues to have neuropathic pain. I've explained this	11:13:54
17		is in part related to her diabetes. Patient	11:13:59
18		understand -- reports understanding and the need to	11:14:02
19		control her numbers."	11:14:05
20		There are multiple illusions to that in the	11:14:12
21		record.	11:14:16
22	Q	Absolutely. Anything else, outside of	11:14:16
23		Dr. Chaney's records, that are a -- that are a basis for	11:14:19
24		that opinion?	11:14:23
25	A	Nothing comes to mind.	11:14:25

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1	Q	Okay. Long-standing diabetes mellitus or	11:14:31
2		mellitus -- mellitus, right?	11:14:37
3	A	Most people say mellitus.	11:14:38
4	Q	Mellitus. Thank you, Doctor.	11:14:42
5		Long-standing diabetes mellitus, what are the	11:14:45
6		symptoms, Doctor, that she -- that she was experiencing	11:14:48
7		prior to the surgery in this case?	11:14:51
8	A	Well, long-standing diabetic neuropathy	11:14:52
9		produces --	11:15:00
10	Q	Let's -- sorry. If you don't mind, that -- I	11:15:01
11		am going to ask about that next. I just -- and perhaps	11:15:03
12		that's -- don't mean to interrupt you. I just -- I --	11:15:06
13		outside of neuropathy, I wanted to know what -- what	11:15:10
14		symptoms we're looking at.	11:15:13
15	A	Well, people generally may have fatigue. They	11:15:19
16		have polyuria if their -- if their glucose isn't	11:15:30
17		uncontrolled. They have -- they may have visual	11:15:34
18		blurring. They may have swings in their blood sugar	11:15:37
19		with treatment. So they feel tired. Those are the	11:15:42
20		main -- main symptoms.	11:15:49
21		Dia -- diabetes, if your blood sugar's	11:15:51
22		elevated, you may not -- may not have many symptoms at	11:15:54
23		all acutely. But I'm a neurologist. So I -- I	11:15:59
24		specialize in diabetic neuropathy.	11:16:03
25	Q	Understood. Understood.	11:16:08

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1	All right. So let's go ahead and let's --	11:16:13
2	let's talk about diabetic neuropathy.	11:16:14
3	When was -- when was she diagnosed with	11:16:19
4	diabetic neuropathy?	11:16:25
5	A I don't know when she was formally diagnosed.	11:16:26
6	I -- I think the record would indicate that she was	11:16:33
7	having neuropathic symptoms as far as back as 2012.	11:16:37
8	Q Okay. So -- so there's no place where she was	11:16:48
9	formally diagnosed; is that fair?	11:16:58
10	A I don't know if that's fair or not. I'm --	11:16:59
11	I'm not sure -- I'm not quite sure what "formally	11:17:01
12	diagnosed" entails, but I -- I think if I went back and	11:17:03
13	looked at Dr. Chaney's records, it's probably some point	11:17:07
14	in time.	11:17:10
15	The patient herself must have been diagnosed	11:17:10
16	before that because in a -- in a note -- in her intake	11:17:13
17	note in 2014, she writes, in her own handwriting, that	11:17:17
18	she's having nerve pain in her feet which began in 2012.	11:17:23
19	Q Got it.	11:17:33
20	Okay. So you're -- you're not certain of a	11:17:36
21	time of -- of any time of diagnosis; is that fair?	11:17:38
22	A I'm not certain about it. It was -- it was	11:17:43
23	obviously before 2014.	11:17:50
24	Q Okay. But you do recall seeing in the records	11:17:50
25	that she was diagnosed with diabetic neuropathy?	11:17:50

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1	A	Yes.	11:17:55
2	Q	Okay. She -- now let's -- let's talk about	11:17:55
3		the symptoms of diabetic neuropathy.	11:17:59
4		What are those symptoms?	11:18:02
5	A	So the -- the symptoms of diabetic neuropathy	11:18:05
6		are pain, sensory loss, and weakness.	11:18:07
7	Q	And sensory loss and -- and weakness, how do	11:18:21
8		those manifest themselves? How do people typically	11:18:26
9		describe those?	11:18:30
10	A	The sensory loss is often -- sensory loss or	11:18:30
11		sensory alteration, it's often diagnosed as numbness or	11:18:36
12		tingling or a feeling that there's something crawling on	11:18:40
13		your legs or the feeling of your feet are wrapped in	11:18:45
14		cotton. Sometimes people describe it feels like their	11:18:53
15		sock is creased in their shoe. When they look at it,	11:19:00
16		there's nothing there, or they feel like they're walking	11:19:06
17		on gravel. People can describe burning pain;	11:19:07
18		lancinating, sharp, stabbing pains. Pes -- sometimes	11:19:08
19		people say their feet's on fire.	11:19:12
20		There's -- oftentimes manifest by a loss of	11:19:19
21		position sense so you don't know where your feet are in	11:19:24
22		space. So that they'll report if they are taking a	11:19:28
23		shower and close their eyes, they'll fall over or they	11:19:32
24		have trouble walking in poor light or at -- when their	11:19:37
25		vision -- vision is obscured because they don't know	11:19:44

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1	where their feet are.	11:19:49
2	There's -- people often have a sense of	11:19:50
3	fatigability in their legs or weakness going up stairs.	11:20:00
4	There's a -- a full range of symptoms.	11:20:03
5	Q Got it.	11:20:06
6	And -- and do you -- do you ever classify the	11:20:07
7	symptoms that a -- that a patient has in -- in terms of	11:20:14
8	mild, moderate, major, or anything like that?	11:20:17
9	A Well, I think we all -- we all use those --	11:20:25
10	those terms -- mild, moderate, and severe -- just as	11:20:27
11	a -- a way of communicating with someone else.	11:20:30
12	Q So what -- what classifies as mild versus	11:20:34
13	moderate versus severe, Doctor?	11:20:40
14	A Well, there -- there are a lot of different	11:20:42
15	ways to look at that. I'll give you two ways.	11:20:44
16	One way I would classify a condition as mild,	11:20:47
17	if you experience the condition but it did not interfere	11:20:53
18	with your normal activities, whether they be activities	11:20:59
19	of daily living or work activities or recreational	11:21:03
20	activities.	11:21:09
21	Moderate, I would say that if the condition	11:21:11
22	causes you to modify how you do the activity or limit	11:21:13
23	the activity but doesn't prevent you from doing it, that	11:21:19
24	would be a moderate condition.	11:21:22
25	And severe would obviously be that it would	11:21:24

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1	prevent something. It would prevent walking, prevent	11:21:29
2	you from playing baseball, or prevent you from going to	11:21:32
3	work.	11:21:36
4	So that would be a simply mild moderate	11:21:36
5	severe.	11:21:41
6	The other -- the other way of looking at it	11:21:41
7	would be what type of therapy was required. If someone	11:21:44
8	had a diabetic neuropathy that required no therapy, that	11:21:48
9	would be mild.	11:21:55
10	If it was -- if you had better glucose	11:21:56
11	control, that might be a moderate therapy.	11:22:02
12	If you were on narcotic medications and	11:22:05
13	pain-modifying drugs, I would say those symptoms would	11:22:09
14	probably be severe.	11:22:13
15	Q All right. Now -- now, Doctor, in this case,	11:22:18
16	what symptoms was the plaintiff suffering from prior to	11:22:23
17	her hospitalization in 2015?	11:22:31
18	A She was suffering from pain in her feet, and	11:22:34
19	she had absent position sense, daily foot pain. Said --	11:22:45
20	so it says, "Daily -- foot pain daily and sometimes	11:22:57
21	numbness and sharp pain."	11:23:01
22	And a physical examination in 2014 said that	11:23:08
23	she had proprioceptive sensation absent, epicritic	11:23:14
24	sensation absent via Semmes Weinstein, which is a -- a	11:23:23
25	monofilament used to assess sensation.	11:23:29

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1	Q	So what does that -- what does that mean,	11:23:35
2		Doctor, for a -- for -- for a nonphysician?	11:23:37
3	A	That would mean that she had severe sensory	11:23:39
4		loss in her feet as of 2014, which would probably impair	11:23:42
5		her ability to -- to walk. It can affect her balance	11:23:52
6		and walking and would also put her at risk for damaging	11:23:59
7		the skin in her feet if she had absent sensation.	11:24:07
8		It would also portend that if this -- usually	11:24:20
9		diabetic neuropathy gets worse with time. And it would	11:24:28
10		also indicate that if her neuropathy was not arrested,	11:24:33
11		she would eventually have motor involvement, that the	11:24:38
12		motor nerves would be affected as well as the sensory	11:24:42
13		nerves.	11:24:48
14	Q	Doctor, do you have any literature or studies	11:24:49
15		that lay out that it gets worse with time or at what	11:24:53
16		rate it tends to get worse with time?	11:24:57
17	A	I have my training, education, and experience.	11:25:00
18		There are probably thousands of papers about diabetic	11:25:03
19		neuropathy.	11:25:06
20	Q	Well, Doctor, are you familiar with -- with	11:25:10
21		any studies that -- that lay out the probability of --	11:25:13
22		of someone developing diabetic neuropathy? A diabetic	11:25:17
23		obviously. Among diabetics --	11:25:23
24	A	Yes.	11:25:25
25	Q	-- the likelihood of developing diabetic	11:25:25

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1	neuropathy?	11:25:30
2	A Yes.	11:25:31
3	Q And what is that?	11:25:31
4	A Well, it depends on how you define it. If	11:25:32
5	you -- it depends on how you define "neuropathy." If	11:25:35
6	you have, you know, electrophysiologically or	11:25:39
7	symptomatically, it depends on the population of people.	11:25:46
8	There are estimates anywhere from 10 percent to -- to	11:25:48
9	50 percent.	11:25:52
10	Q In terms of those that develop diabetic	11:25:55
11	neuropathy?	11:25:59
12	A Right.	11:25:59
13	Q And that's -- that's among diabetics, correct?	11:26:00
14	That's the population group we're talking about?	11:26:05
15	A Well, the only people who get diabetic	11:26:07
16	neuropathy are diabetics.	11:26:10
17	Q Fair enough.	11:26:11
18	And, Doctor, that -- you'd agree that that	11:26:13
19	population group includes both poorly controlled and	11:26:14
20	well-controlled diabetics, correct?	11:26:17
21	A Yes.	11:26:21
22	Q You'd agree that no neurologist saw the	11:26:26
23	patient prior to -- to her going in for the procedure on	11:26:29
24	the 3rd of -- of July in 2015, correct?	11:26:34
25	A Correct.	11:26:37

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1	Q	There was no EMG taken prior to July 3rd,	11:26:37
2		2015, correct?	11:26:42
3	A	That's right.	11:26:43
4	Q	There are no notes suggesting foot drop	11:26:44
5		anywhere prior to July 3rd, 2015, correct?	11:26:48
6	A	That's correct.	11:26:52
7	Q	There's no evidence that she had loss of nerve	11:26:52
8		function in the lower extremities prior to July 3rd,	11:26:56
9		2015, correct?	11:27:00
10	A	That's incorrect.	11:27:01
11	Q	Okay. Go ahead. Correct me.	11:27:04
12	A	Well, that's where I ob -- objected to you	11:27:08
13		making up that term "nerve function," whether you're	11:27:10
14		talking about foot drop or sensory 'cause nerve function	11:27:18
15		encompasses sensation as well as motor function. And	11:27:23
16		there's abundant evidence that she had loss of sensation	11:27:28
17		prior to July 2015.	11:27:36
18	Q	Now, Doctor, I can tell you right now, as	11:27:39
19		we're sitting here, I'm sitting in a chair. And while	11:27:41
20		the loss of sensation in my feet is very light, I have	11:27:43
21		some small loss of sensation in my feet right now, as	11:27:48
22		I'm sitting here, and that's because of the position	11:27:53
23		that I'm sitting in, not because I'm a diabetic or	11:27:54
24		any -- or -- or have diabetic neuropathy.	11:27:58
25		You'd agree that a degree of loss of sensation	11:28:01

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1 is common and can be caused by many things besides 11:28:05
2 diabetic neuropathy, correct? 11:28:11
3 A Well, if you're talking about sitting in a 11:28:12
4 funny position with a transient numbness, that's 11:28:16
5 completely different from diabetic neuropathy. 11:28:20
6 Q But it manifests in the same symptoms, does it 11:28:24
7 not? 11:28:29
8 A It's -- it's totally different. ' First of all, 11:28:31
9 she had a bilateral symmetric, both extremities, painful 11:28:37
10 neuropathy with diminished reflexes -- I -- we didn't 11:28:45
11 mention that -- as well as sensory loss in both feet, 11:28:51
12 which is a completely different animal than having 11:28:58
13 temporary numbness in one foot because you crossed your 11:29:03
14 legs, which is going to get better as soon as you stand 11:29:35
15 up. 11:29:11
16 Q Certainly. 11:29:11
17 And -- and I guess my question is, though: 11:29:13
18 For that moment, we're talking about a -- a similar, if 11:29:14
19 indiscernibly similar, difference, correct, in terms of 11:29:19
20 the symptom itself? 11:29:25
21 A Perhaps in your mind. In my mind, they're not 11:29:27
22 similar. 11:29:30
23 Q Okay. In any case, you agree that there's no 11:29:36
24 evidence that she had lost any muscle function in the 11:29:39
25 lower extremities prior to July 3rd, 2015, correct? 11:29:42

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1	A	Correct.	11:29:46
2	Q	Okay. Can numbness be nonpathologic, Doctor?	11:29:47
3	A	Yes.	11:29:54
4	Q	Can numbness also be pathologic?	11:29:56
5	A	Yes.	11:29:59
6	Q	How can you tell the difference between	11:30:00
7		pathologic and nonpathologic numbness?	11:30:04
8	A	The ma -- the major difference would be	11:30:13
9		nonpathologic numbness would be short lived and	11:30:16
10		reversible within minutes.	11:30:24
11	Q	Is there any -- any other difference -- any	11:30:40
12		other criteria that we should use to determine whether	11:30:44
13		numbness is pathologic versus nonpathologic?	11:30:48
14	A	Well, I think that would be -- I think that	11:30:51
15		would be the easiest and probably the most discerning	11:30:54
16		unless you thought there was someplace in your body that	11:30:58
17		you would like to be numb and not consider it	11:31:01
18		pathologic.	11:31:05
19	Q	So whether it's transient or not?	11:31:06
20	A	Yeah. I can't think -- I -- to me, the term	11:31:10
21		"pathologic" means that there's a disease process, and I	11:31:13
22		don't know of any part of my body that would be -- go	11:31:17
23		numb on a permanent basis that you would not attribute	11:31:21
24		to a disease.	11:31:26
25	Q	Right. So the question is whether it's	11:31:29

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1	permanent or -- or transient then. If it's transient,	11:31:32
2	then that would not be pathologic? If it's permanent,	11:31:35
3	it would be pathologic.	11:31:40
4	Is that --	11:31:41
5	A Yes.	11:31:42
6	Q -- what you're saying?	11:31:43
7	A Yes.	11:31:44
8	Q Okay. And what in the previous medical	11:31:44
9	records support that it was a pathologic numbness as	11:31:47
10	opposed to a transient numbness?	11:31:54
11	A Well, there are multiple references to it	11:31:56
12	being permanent. She wasn't having temporary numbness.	11:32:00
13	She wasn't -- and then -- you know, the major -- the	11:32:05
14	major distinction would be timing, but there would be	11:32:06
15	other accompanying components that were present in her	11:32:08
16	case such as pain. Painful neuropathy would never be	11:32:18
17	benign.	11:32:26
18	Q Numbness can have a painful effect, can't it,	11:32:32
19	even if it's transient?	11:32:36
20	A It can have an uncomfortable -- yeah,	11:32:38
21	uncomfortable phase. We've all had -- you know, crossed	11:32:42
22	our legs or our arm falling asleep on your arm, and	11:32:47
23	there's a -- maybe a minute -- a minute or two. The	11:32:53
24	time component is, I think, very important. As you're	11:32:57
25	passing through pins and needles, it could be an	11:33:02

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1	uncomfortable phase before it recovers.	11:33:06
2	But I -- I can't see any -- anything in this	11:33:10
3	record that made me think that she had some kind of	11:33:17
4	temporary numbness in her feet, not diabetic neuropathy,	11:33:20
5	in 2012, 2013, 2014, 2015.	11:33:26
6	Q And, Doctor, how does a physician diagnose	11:33:33
7	large fiber neuropathy?	11:33:36
8	A Well, large fiber neuropathy is -- usually	11:33:39
9	produces a reduction in vibratory sense and absent deep	11:33:48
10	tendon reflexes and a reduction in nerve conduction	11:33:56
11	velocities.	11:34:06
12	Q So how does -- how does a physician go about	11:34:07
13	diagnosing that? What do they have to do to know?	11:34:13
14	A Well, they take a -- they take a history.	11:34:17
15	Most diabetic neuropathies are a combination of small	11:34:18
16	fiber and large fiber. So if someone had a -- a	11:34:22
17	nonpainful, absent of deep tendon reflexes, diminished	11:34:27
18	vibratory sense, and markedly reduced nerve conduction	11:34:35
19	velocities, you would say that was predominantly a large	11:34:44
20	fiber neuropathy.	11:34:48
21	Q And you'd need all that information to	11:34:49
22	definitively diagnose a large fiber neuropathy, wouldn't	11:34:53
23	you, Doctor?	11:34:57
24	A Well, in reality, most of the neuropathies we	11:34:58
25	see are mixed. But, yeah, if you felt it was important	11:35:06

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1 to -- to distinguish between a -- an axonal small fiber 11:35:10
2 or a mixed neuropathy, then you would like to have the 11:35:14
3 nerve conduction studies. 11:35:17

4 Q And that's -- and that's not what I -- I'm 11:35:20
5 just saying that if you actually were to diagnose a 11:35:22
6 large fiber neuropathy, you would need to have that to 11:35:24
7 really know, wouldn't you? 11:35:28

8 A I'm not sure what "really knows" entail -- 11:35:33
9 where we're going with this. I think in clinical 11:35:37
10 practice, most neurologists feel comfortable making a 11:35:40
11 diagnosis of a neuropathy, which would point more to a 11:35:45
12 large fiber component than a small fiber component based 11:35:49
13 on the clinical history and the diagnosis, you know, 11:35:53
14 the -- the cause. 11:35:57

15 Q So -- so you think that most neurologists 11:36:01
16 would feel comfortable making that diagnosis, although 11:36:04
17 they didn't have the data that you just mentioned that 11:36:08
18 was important to make that diagnosis? 11:36:11

19 A Well, the data that I mentioned, I -- the only 11:36:13
20 data I talked about was a -- nerve conduction studies. 11:36:16

21 Q I -- I thought you mentioned that you would 11:36:20
22 take a history, physical exam findings with particular 11:36:22
23 interest in the reflexes or diminished reflexes, and an 11:36:28
24 EMG. 11:36:33

25 Isn't that what you mentioned? 11:36:33

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1	A	Well, I'm not sure what -- what scenario	11:36:35
2		you're talking about. Are we talking about this case?	11:36:37
3		Are we talking about in office practice?	11:36:41
4	Q	I'm talking about in a generalized situation,	11:36:43
5		what is required to know whether or not someone has	11:36:48
6		large fiber neuropathy?	11:36:52
7	A	Well, I gave you -- those are the data points.	11:36:56
8		The history, the physical, and the setting and nerve	11:37:00
9		conduction studies. Those are the things that are	11:37:08
10		usually employed to make the diagnosis.	11:37:12
11	Q	Okay. Now, even though you don't have all of	11:37:15
12		those things in this case, you're comfortable making the	11:37:21
13		diagnosis that she has a degree of -- a degree of large	11:37:24
14		fiber neuropathy here?	11:37:31
15	A	Well, we do have all these things in this	11:37:32
16		case.	11:37:35
17	Q	Prior to the hospital date.	11:37:36
18	A	Correct.	11:37:40
19	Q	You have findings of diminished reflexes and	11:37:43
20		an EMG showing that she had large fiber neuropathy prior	11:37:50
21		to the hospital -- hospitalization of July 3rd?	11:37:53
22	A	Well, we had -- she had diminished reflexes.	11:37:56
23		That's present in doctor -- podiatrist record. She had	11:38:00
24		long-standing, out of -- out of control diabetes, a	11:38:08
25		classic pain -- painful diabetic symptoms in her distal	11:38:18

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1	extremities, which would make me comfortable in making a	11:38:25
2	diagnosis of diabetic neuropathy.	11:38:31
3	Q Doctor, you would agree with me many diabetics	11:38:34
4	have pain, and the -- likely somewhere in the ballpark	11:38:39
5	of 80 percent of them don't have diabetic neuropathy?	11:38:42
6	A And what kind of pain are you talking about?	11:38:46
7	Q Any type of pain associated with diabetes,	11:38:54
8	Doctor --	11:38:54
9	A Well --	11:38:54
10	Q -- oftentimes in the hands and the feet in the	11:38:59
11	extremities, and yet they don't have diabetic	11:39:02
12	neuropathy.	11:39:05
13	A I would disagree with that.	11:39:06
14	Q Okay. So -- so your view of it is anyone who	11:39:08
15	has any pain in the feet or the hands has diabetic	11:39:10
16	neuropathy if they're a diabetic?	11:39:16
17	A It -- it depends on the type of pain. If	11:39:18
18	you -- first of all, yeah, if you -- if you told me that	11:39:19
19	you had symmetric pain in your feet with a severe	11:39:21
20	diabetic nerve -- diabetes and your doctor -- Dr. Chaney	11:39:31
21	characterizes this as neuropathic pain, I would conclude	11:39:39
22	that that is most likely a diabetic neuropathy.	11:39:49
23	Q Can you know with certainty that it's	11:39:52
24	neuropathic pain absent a nerve conduction study?	11:39:57
25	A Yes. I think that's defined on critical	11:40:01

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1	grounds -- on clinical grounds.	11:40:05
2	Q Okay. All right. So what is the function of	11:40:08
3	large nerve fibers, Doctor?	11:40:14
4	A Well, large nerve fibers conduct electricity	11:40:18
5	to both sensory and motor -- to motor to muscle cells as	11:40:28
6	well as to -- from sensory receptors back to the spinal	11:40:33
7	cord.	11:40:38
8	Q And -- and what's the function of small nerve	11:40:43
9	fibers?	11:40:48
10	A And small nerve fibers are -- many of them	11:40:49
11	are -- conduct pain and some autonomic functions.	11:40:54
12	Q Did Dr. Chaney ever say where the numbness was	11:41:01
13	in her records?	11:41:09
14	A I don't -- I didn't examine it to that point.	11:41:11
15	I know that Dr. Kuruvilla, the podiatrist, certainly	11:41:17
16	did.	11:41:23
17	Q Okay. So you don't -- you don't -- you didn't	11:41:27
18	check to see where the pain might have been coming from	11:41:32
19	from Dr. Chaney's records?	11:41:34
20	A I did, yeah.	11:41:36
21	Q You did check in Dr. Chaney's records.	11:41:38
22	Did it identify the pain was coming from any	11:41:41
23	particular spot such as the feet?	11:41:43
24	A Well, my -- my sense is that she had	11:41:46
25	neuropathy in her -- in her feet because that is the	11:41:53

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1	typical location of diabetic neuropathy, and Dr. Chaney	11:41:57
2	refers to her neuropathy.	11:42:02
3	Q Okay. So although it doesn't say a body area,	11:42:11
4	you have assumed that it is the -- that it is her feet.	11:42:16
5	That's what Dr. Chaney is -- is speaking of,	11:42:19
6	correct?	11:42:23
7	A That's right. Because there's also the	11:42:23
8	records of -- of physical therapy which put her nerve	11:42:28
9	pain in her feet, 2014.	11:42:36
10	Q Got it.	11:42:49
11	Doctor, do you have any other opinions that	11:42:49
12	you have not offered today?	11:42:51
13	A The -- the only other opinion that we didn't	11:42:58
14	discuss is that critical care neuropathy usually does	11:43:05
15	not affect the electrical sensory action potentials, but	11:43:16
16	diabetic neuropathy does. And the EMG done by Dr. Cheng	11:43:25
17	shows that virtually all the sensory action potentials	11:43:31
18	are absent now, which would be more in accordance with	11:43:36
19	the diabetic neuropathy than a critical care neuropathy	11:43:41
20	with respect to the sensory symptoms.	11:43:45
21	Q Okay. And the sensory symptoms, when you say	11:43:49
22	"sensory symptoms," you're talking about the numbness	11:43:53
23	and the tingling and the pain on the surface, correct?	11:43:56
24	A And the inability to know where your feet are,	11:44:00
25	which would impair your walking abilities and your	11:44:04

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1	balance.	11:44:10
2	Q Doctor, you'd agree that -- that those	11:44:10
3	symptoms -- sensory symptoms can also be caused by	11:44:13
4	radiculopathy, correct? You can have pain and numbness	11:44:18
5	in your feet from radiculopathy, correct?	11:44:21
6	A Yes, but the symptoms are very different.	11:44:28
7	Q But how are they different between symptoms	11:44:35
8	potentially of radiculopathy versus the neuropathy that	11:44:38
9	you're talking about?	11:44:43
10	A Well, diabetic neuropathy is usually -- is --	11:44:44
11	is always -- almost always symmetric -- symmetric	11:44:49
12	bilateral, both feet, affects the toes first and ascends	11:44:54
13	up the leg in a symmetrical fashion and is ever present	11:45:01
14	and not positional.	11:45:10
15	Lumbar radiculopathy is one sided; unilateral;	11:45:12
16	usually affected by position -- sitting too long,	11:45:16
17	bending over, et cetera -- usually radiates down the	11:45:21
18	back of the leg from the buttocks down to the ankle or	11:45:26
19	the foot, often on the side of the foot in a specific	11:45:31
20	derivation on one side.	11:45:37
21	So there isn't much difficulty in	11:45:39
22	distinguishing a diabetic neuropathy from a lumbar	11:45:43
23	radiculopathy.	11:45:47
24	Q All right. Now, other than the items that	11:45:57
25	we've talked about today already, you do not attribute	11:45:59

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1	any of the plaintiff's -- Ms. Farris's medical	11:46:02
2	conditions to the diabetic neuropathy, correct, or to --	11:46:07
3	to her diabetes, correct?	11:46:12
4	A Your voice is kind of trailing off. Could	11:46:15
5	you -- could you say that again, please.	11:46:18
6	Q Yes. Other than those -- than those things	11:46:20
7	that you've already discussed, those are the things that	11:46:23
8	you -- you've taken issues with, those are all of the	11:46:26
9	opinions you have in this case; is that correct?	11:46:31
10	A Yes.	11:46:33
11	Q Okay. You would agree that being diabetic	11:46:33
12	makes a person predisposed, in an eggshell-type way, to	11:46:44
13	nerve damage?	11:46:52
14	A Yes.	11:46:53
15	Q And you agree that a doctor should always take	11:46:59
16	that into consideration when providing care, correct?	11:47:04
17	A Well, I think it's good to -- to know what	11:47:09
18	people's preexisting conditions are. Oftentimes there's	11:47:12
19	not much we can do about it.	11:47:17
20	Q Certainly. But a -- but a doctor should	11:47:19
21	always have that in their mind and take care	11:47:21
22	particularly given the sensitivities they'd be aware of;	11:47:24
23	is that fair?	11:47:29
24	MR. COUCHOT: I'm just going to object.	11:47:29
25	That's outside the scope of the -- his causation being	11:47:31

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1	as he's not commenting on the standard of care.	11:47:34
2	But with that in mind, if you have an answer,	11:47:37
3	Doctor, by all means.	11:47:41
4	A I think as a neurologist, I'm very aware and	11:47:42
5	think doctors should be very -- a neurologist should be	11:47:45
6	very aware of people who are diabetic. If that answers	11:47:48
7	your question.	11:47:53
8	Q Certainly.	11:47:55
9	And they -- and they should -- specifically a	11:47:56
10	physician should be aware of their predisposition to the	11:47:59
11	types of harms that they're more likely to suffer from,	11:48:03
12	correct?	11:48:09
13	A Well, I can only testify as to what other	11:48:09
14	neurologists would do.	11:48:12
15	Q Are you also a medical doctor?	11:48:14
16	A I am.	11:48:15
17	Q You can also testify to what other medical	11:48:16
18	doctors should do, can you not?	11:48:18
19	A Well, I'm not going to -- I'm not going to	11:48:22
20	testify as to what is in a surgeon's mind.	11:48:23
21	Q I didn't ask you about a surgeon. I asked you	11:48:25
22	about a physician.	11:48:28
23	MR. COUCHOT: Well they're the same thing,	11:48:29
24	Counsel.	11:48:32
25	But go ahead.	11:48:32

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1 A So I'm -- I can only envision, you know, 11:48:34
2 practicing as a neurologist. Can't help you with that. 11:48:37
3 Q All right. You were trained to perform 11:48:42
4 differential diagnoses in medical school, right, Doctor? 11:48:47
5 A Yes. 11:48:50
6 Q And when did they train you in medical school 11:48:50
7 on the differential diagnosis? At what point in the -- 11:48:55
8 in the four-year program? 11:48:58
9 A You know, it's been so long I don't think I 11:49:00
10 can remember. Probably in the first year or two. 11:49:03
11 Q Pretty early, right? 11:49:05
12 A Pretty early. 11:49:07
13 Q And do you agree that when a doctor performs a 11:49:09
14 differential diagnosis, they must do so with care and 11:49:13
15 skill? 11:49:19
16 A Yes, I'd agree with that. 11:49:19
17 Q Okay. And can you walk me through just the 11:49:22
18 very basic differential diagnosis. What does it mean 11:49:25
19 when I say that word or that phrase? 11:49:30
20 A A differential diagnosis means the -- the 11:49:32
21 conditions which you believe best explain the symptoms 11:49:41
22 or signs that a patient presents with. 11:49:49
23 Q Very good. 11:49:59
24 And so what you do is you identify -- whether 11:50:00
25 you write them down on paper or whether you keep them in 11:50:02

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1	mind, you identify the conditions that could explain the	11:50:06
2	symptomatology that you're dealing with; is that fair?	11:50:09
3	A That's right.	11:50:13
4	Q All right. And then you proceed to go through	11:50:14
5	those and -- and eliminate conditions until you arrive	11:50:16
6	at what you believe is the diagnosis or you shorten your	11:50:20
7	list at least in terms of the potential diagnoses; is	11:50:26
8	that fair?	11:50:31
9	A Well, yeah, you're dissecting a process that	11:50:31
10	may just occur automatically.	11:50:36
11	Q Yeah, go ahead and explain that. Sorry. I	11:50:38
12	didn't --	11:50:40
13	A Well, it's a very -- it's a very interesting	11:50:40
14	thing because he'll say -- if you see a medical student	11:50:42
15	and someone comes in with a leg -- with a limp, and the	11:50:44
16	medical student differential diagnosis may, you know,	11:50:53
17	include everything from rabies to -- to a broken leg or	11:50:58
18	a bad hip. And the more -- and the experienced	11:51:08
19	orthopedic surgeon may say, "Well, it's either a -- a	11:51:12
20	bursitis or a hip dysplasia." And so the differential	11:51:15
21	diagnosis gets more sophisticating and smaller the more	11:51:22
22	skilled or experienced the examiner.	11:51:28
23	Do you see what I mean?	11:51:30
24	Q Absolutely.	11:51:31
25	A I mean --	

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1 Q It's probably --

2 A -- as an example --

3 Q -- not the --

4 A -- if I said --

5 THE REPORTER: One at a time.

6 Q -- examiner is taking a narrow view, but it's 11:51:35

7 because they're able to quickly dissect the process, 11:51:38

8 right? You do it more and more, and you quickly 11:51:42

9 eliminate the things that shouldn't be there, right? 11:51:45

10 A And they don't -- yeah. And -- 'cause we've 11:51:47

11 had conferences about this process, which is very 11:51:50

12 interesting, in trying to computerize it. And many 11:51:54

13 times an experienced doctor can't -- there is no 11:52:00

14 differential diagnosis. You know, he knows exactly what 11:52:03

15 it is. He said, "Well, yeah, it could be" -- you know, 11:52:05

16 it's kind of like the example if you walked in a room 11:52:07

17 and you saw your grandmother, and you say, "What's the 11:52:10

18 differential diagnosis?" 11:52:12

19 Say, "Well, it's a woman as opposed to a man. 11:52:12

20 So it could have been a grandmother." 11:52:15

21 And then she's only five-foot-four. She's not 11:52:17

22 six -- and you go through this process, but when you 11:52:21

23 walked in the room, you knew immediately that was your 11:52:24

24 grandmother without going -- 11:52:27

25 Q Right. 11:52:29

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1	A	-- without going through all the steps.	11:52:29
2	Q	Understood.	11:52:32
3		In some cases -- in some cases, based on your	11:52:33
4		experience, you may pick up signs and symptoms perhaps	11:52:36
5		that really lock into a very specific differential	11:52:41
6		diagnosis without having to -- to run through a very	11:52:45
7		long or drawn out process.	11:52:47
8		Is that what you're saying?	11:52:49
9	A	That's usually the case.	11:52:51
10		MR. JONES: Okay. Let's go on a very quick	11:52:56
11		break. I think I'm about done. Let's go on a very	11:52:58
12		quick break. We'll come back in just a minute.	11:53:01
13		Okay?	11:53:02
14		THE WITNESS: All right.	11:53:02
15		THE VIDEOGRAPHER: Going off the record. The	11:53:03
16		time is 11:53.	11:53:05
17		(A recess ensued from 11:53 a.m. to	11:53:08
18		11:59 a.m.)	11:59:41
19		THE VIDEOGRAPHER: We are back on the record.	11:59:45
20		The time is 11:59.	11:59:47
21		BY MR. JONES:	11:59:50
22	Q	All right. Doctor, I'm going to ask you just	11:59:51
23		a couple of questions related to the EMG and NV -- NCV	11:59:53
24		findings that you reviewed today.	11:59:57
25		You have those with you there?	12:00:01

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1	A	I do.	12:00:02
2	Q	Okay. You'd agree that the -- that it says	12:00:03
3		there that the left lateral plantar sensory nerves	12:00:06
4		showed no response --	12:00:13
5	A	Yes.	12:00:15
6	Q	-- correct?	12:00:15
7		There's no evidence, prior to July 3rd, 2015,	12:00:15
8		that the left lateral plantar sensory nerves showed no	12:00:18
9		response, true?	12:00:25
10	A	There's no previous EMG.	12:00:26
11	Q	Right.	12:00:28
12		Doctor, you'd agree that there's no evidence,	12:00:29
13		prior to July 3rd, 2015, that the left lateral plantar	12:00:31
14		sensory nerve showed no response, true?	12:00:36
15	A	True. There is no prior EMG.	12:00:44
16	Q	Got it.	12:00:46
17		But that is a true statement, correct?	12:00:47
18	A	Yes, that's a true statement.	12:00:51
19	Q	Okay. You'd agree that the right lateral	12:00:53
20		plantar sensory nerve, in the EMG shown there, showed no	12:00:57
21		response, true?	12:01:01
22	A	That's correct.	12:01:03
23	Q	And, also, you'd agree there's no evidence,	12:01:04
24		prior to June [sic] 3rd, 2015, that the right lateral	12:01:06
25		plantar sensory nerves showed no response; is that true?	12:01:11

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1	A	Yes, because there was no prior EMG.	12:01:14
2	Q	Fair enough.	12:01:17
3		Now, Doctor, what I'm talking about is the	12:01:20
4		actual evidence that we have. And so we -- we don't	12:01:22
5		have that prior EMG.	12:01:25
6		But you don't have any other evidence, prior	12:01:26
7		to July 3rd, 2015, that the right lateral plantar	12:01:28
8		sensory nerves showed no response; is that fair?	12:01:34
9	A	Well, the evidence would be based upon her	12:01:37
10		history and examination, particularly the examination	12:01:39
11		with the podiatrist. It's likely that she did not have	12:01:42
12		a sensory action potential prior to 2015 based on the	12:01:45
13		claim --	12:01:53
14	Q	So you're -- you're saying it's likely that	12:01:53
15		she had no sensory nerve response prior to 2015?	12:01:55
16	A	Yes.	12:01:59
17	Q	Okay. And -- and that's based on -- on the	12:02:03
18		clinical, correct? That's -- that's based on your	12:02:09
19		review of the records?	12:02:11
20	A	It's based on my clinical training and	12:02:12
21		experience in treating hundreds, if not a thousand,	12:02:16
22		diabetic patients and doing nerve conduction studies	12:02:21
23		and -- and knowing the natural history of the disease,	12:02:25
24		that this --	12:02:30
25	Q	Okay.	12:02:30

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1	A	-- this sensory electrical response would most	12:02:30
2		likely have been absent at a time that she had no	12:02:35
3		sensation to a monofilament in an absent position sense.	12:02:40
4		That would be highly likely that she would have an --	12:02:44
5		absent sensory responses in her lower extremities.	12:02:49
6	Q	So let's go back to the MRI. You'd agree that	12:02:54
7		the MRI says, "Left medial plantar sensory nerves showed	12:02:58
8		no response," correct?	12:03:02
9	A	It's an EMG, not an MRI. But yeah.	12:03:03
10	Q	Excuse me. Thank you, Doctor.	12:03:06
11		So going back to the EMG, you'd agree that it	12:03:08
12		states, "The left medial plantar sensory nerves showed	12:03:11
13		no response," correct?	12:03:16
14	A	Yes.	12:03:17
15	Q	And you'd agree that there's no evidence,	12:03:17
16		prior to July 3rd, 2015, that the left medial plantar	12:03:19
17		sensory nerves showed no response, true?	12:03:22
18	A	Yes, because there was no prior EMG.	12:03:25
19	Q	Okay. And, again, the right medial plantar	12:03:27
20		sensory nerves showed no response, correct?	12:03:31
21	A	Same an -- same answer.	12:03:33
22	Q	Fine.	12:03:36
23		And you'd agree there's no evidence, prior to	12:03:36
24		July 3rd, 2015, that the right plan -- medial plantar	12:03:40
25		sensory nerves showed no response; is that fair?	12:03:43

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1	A	Same answer.	12:03:46
2	Q	All right. The -- again, the left and right	12:03:48
3		superficial peroneal sensory nerves showed no response,	12:03:53
4		correct?	12:04:00
5	A	Correct.	12:04:00
6	Q	And, again, there's no evidence, prior to	12:04:00
7		July 3rd, 2015, that the left or right superficial	12:04:07
8		peroneal sensory nerves showed no response, correct?	12:04:11
9	A	Yes, because there was no prior EMG.	12:04:15
10	Q	And then the left sural sensory and right	12:04:17
11		sural sensory nerves showed no response, correct?	12:04:27
12	A	That would be the same answers.	12:04:31
13	Q	Okay. And you'd agree that there's no	12:04:32
14		evidence, prior to July 3rd, 2015, that the left or	12:04:34
15		right sensory nerves showed no response, correct?	12:04:38
16	A	Same answers.	12:04:42
17	Q	What is the same answer? Is that a correct?	12:04:44
18	A	Same answer we've been talking about for the	12:04:46
19		last ten minutes, that there's --	12:04:49
20	Q	Go ahead and give it.	12:04:50
21	A	There's no prior EMG, although we know that	12:04:51
22		critical care neuropathy typically does not affect the	12:04:54
23		sensory action potentials and diabetic neuropathy does	12:04:59
24		makes it most likely that these were absent prior to the	12:05:04
25		performance in 2015.	12:05:09

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1	Q	Okay. And so -- so if they were absent prior	12:05:12
2		to the performance of 2015, the expectation would be	12:05:16
3		that she would have been in a similar situation in terms	12:05:19
4		of her mobility prior to July 3rd, 2015, as she was	12:05:22
5		after, correct?	12:05:27
6	A	Well, the correlation between sensory action	12:05:29
7		potentials and mobility would be very poor.	12:05:32
8	Q	Oh, okay. So you're not saying that then?	12:05:37
9	A	You said that. I -- I don't know what you're	12:05:40
10		talking about.	12:05:43
11	Q	Yeah.	12:05:46
12		With -- with the findings of this EMG, did she	12:05:49
13		walk unassisted, Doctor?	12:05:52
14	A	There's very poor correlation between nerve	12:05:54
15		conduction studies and mobility. So I -- I don't think	12:05:58
16		anyone could tell whether or not you could walk based on	12:06:03
17		the EMG or this nerve conduction study.	12:06:09
18	Q	According to the records, could she walk	12:06:19
19		unassisted at the time that this was taken, Doctor?	12:06:21
20	A	This was -- let's see. This was done in	12:06:26
21		December. Remind me. Let's see.	12:06:34
22	Q	September.	12:06:35
23	A	September 2015. My understanding is that she	12:06:36
24		needed assistance to walk at that time.	12:06:41
25	Q	Doctor, earlier when I was asking you about	12:06:47

Transcript of Bruce Adornato, M.D
Conducted on July 23, 2019

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1	the EMG and we were talking about the items needed to --	12:06:51
2	to test for -- test for -- what were we talking about?	12:06:56
3	We were talking about large fiber neuropathy, and then	12:07:07
4	we talked about the EMG. You -- you suggested that that	12:07:10
5	wasn't important.	12:07:14
6	Can you explain to me why?	12:07:15
7	A Well, I'm not sure that I suggested that it	12:07:18
8	wasn't important to you or not. That's whatever your	12:07:20
9	take was, and I don't -- what -- what would you like to	12:07:22
10	know?	12:07:25
11	Q You -- I think you said that the -- that the	12:07:26
12	EMG wasn't important to diagnose someone with large	12:07:29
13	fiber neuropathy, or did I misunderstand you?	12:07:34
14	A I don't remember if I used the term	12:07:38
15	"important" or not. I -- maybe I did. Maybe I didn't.	12:07:41
16	I'm saying that making a diagnosis of a -- a large fiber	12:07:45
17	versus small fiber neuropathy is usually based primarily	12:07:51
18	on the clinical findings and the setting in which it	12:07:56
19	occurs and it's corroborated by the EMG. I think that's	12:08:02
20	probably the most succinct way to say it.	12:08:07
21	Q Doctor, can you give an opinion, to a	12:09:17
22	reasonable degree of medical probability, as to when	12:09:24
23	these nerves became absent or be -- or -- or, I guess,	12:09:25
24	atrophied to the point of no response?	12:09:37
25	A Okay. The question is -- let me -- let me	12:09:44

Transcript of Bruce Adornato, M.D
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1	rephrase it and see if you like this.	12:09:46
2	What you're want -- what you're asking me is	12:09:49
3	when did she lose her nerve -- electrical nerve	12:09:50
4	potentials?	12:09:56
5	Q Yes. So as the EMG shows, right, that	12:09:57
6	there -- that there was a loss of nerve responses,	12:10:00
7	right, when did that happen?	12:10:07
8	A Well, let me just go back a little bit.	12:10:10
9	That -- that these nerve responses are not an all or	12:10:14
10	nothing thing. What -- what happens is when you're	12:10:19
11	doing the nerve conduction study, you're stimulating the	12:10:21
12	nerve with electric shock on the skin, and you're seeing	12:10:25
13	if there is a time -- a coordinated discharge downstream	12:10:32
14	in the -- in the nerve fiber.	12:10:42
15	If those conductions are coming at different	12:10:44
16	speeds, they may still be conducting but conducting at	12:10:47
17	slower and -- and different speeds. You won't see a	12:10:52
18	coordinated nerve potential. So someone can still have	12:10:57
19	electrical activity, but you're not recording a sensory	12:11:00
20	action potential. And that usually -- what happens is	12:11:05
21	over months and years, the electrical potential in the	12:11:08
22	sensory gets smaller and smaller and more disbursed over	12:11:14
23	time until you eventually can't record it.	12:11:18
24	So given her history, that she's got nerve	12:11:21
25	pain and neuropathy symptoms dating back to at least	12:11:24

Transcript of Bruce Adornato, M.D
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1	2012, I would say probably sometime in the last year,	12:11:29
2	she would have had progressively worsening electrical	12:11:37
3	parameters.	12:11:47
4	So it's likely that when she was examined a	12:11:48
5	year earlier by the podiatrist and had those severe	12:11:51
6	clinical findings, that she would have had no elicitable	12:11:55
7	electrical sensory action potentials.	12:12:07
8	Q Okay. And, Doctor, that's to a reasonable	12:12:09
9	degree of medical probability, that opinion?	12:12:11
10	A Yes.	12:12:13
11	Q Doctor, when you have -- when you have no	12:12:48
12	nerve response in the ankle, the lateral foot, or the	12:12:52
13	medial foot, can you move your foot?	12:12:57
14	A If you have -- are you talking about the	12:13:00
15	sensory or the motor?	12:13:03
16	Q Both.	12:13:06
17	A Well, the sensory would have no	12:13:12
18	relationship -- no relationship to it. The motor, you	12:13:16
19	would typically have very severe weakness if you had no	12:13:21
20	electrical response. You would have a minimal response	12:13:25
21	or paralysis if you had no electrical response to the	12:13:30
22	motor stimulation.	12:13:36
23	Q And then you'd agree there's no motor	12:13:40
24	response, according to the EMG, correct?	12:13:44
25	A Yes.	12:13:46

Transcript of Bruce Adornato, M.D
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1	Q	All right. And you -- and your opinion is	12:13:47
2		that that would have been the same about a year before,	12:13:49
3		correct?	12:13:53
4	A	Well, the -- this was -- this was in the	12:13:53
5		electrical nerve conduction study she had no response.	12:14:00
6		She did -- she did have electrical responses on the EMG	12:14:04
7		portion. This is all very technical.	12:14:12
8	Q	Okay. So she had no motor response, correct?	12:14:20
9	A	To the nerve conduction study, there were no	12:14:24
10		elicitable compound muscle action potentials, but that	12:14:30
11		does not necessarily mean that she was completely	12:14:35
12		paralyzed. She could still have some motor control of	12:14:37
13		the muscles, but I would expect the muscles would be	12:14:40
14		very weak, as they were clinically.	12:14:43
15	Q	Okay. And you believe that it essentially	12:14:46
16		would have -- would have had the same finding on an EMG	12:14:50
17		study a year before, correct?	12:14:53
18	A	No. I -- I said we were talking earlier about	12:14:55
19		the sensory potentials. I think that her motor	12:14:58
20		potentials were most likely -- you didn't ask me this	12:15:05
21		before, but that her -- her motor symptoms obviously	12:15:11
22		became worse due her -- due to her clinical -- critical	12:15:16
23		care neuropathy.	12:15:19
24	Q	Okay. Okay. And is that -- is that what	12:15:21
25		you're saying is the 90 percent -- 90 percent versus	12:15:25

Transcript of Bruce Adornato, M.D
Conducted on July 23, 2019

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1	10 percent that we talked about earlier, or is it	12:15:30
2	something else?	12:15:36
3	A Well, so -- well, the 90 percent, we were	12:15:36
4	talking about the majority of her weak -- 90 percent of	12:15:39
5	her weakness I would attribute to her critical care	12:15:44
6	neuropathy.	12:15:49
7	Q What percentage of her lost mobility would you	12:15:50
8	attribute to critical care neuropathy?	12:15:58
9	A Well, the weakness would be the same thing,	12:16:02
10	that her -- her ability to use her -- to move her feet	12:16:05
11	to her mobility of her feet, 90 percent of that. But	12:16:12
12	when we talk about her walking, some component of that	12:16:16
13	is due to her balance and sensory difficulties. I think	12:16:21
14	I said that a -- two-thirds of her sensory disabilities	12:16:27
15	are related to her underlying diabetic neuropathy. So	12:16:38
16	some part of her balance problem is due to the diabetic	12:16:44
17	neuropathy, but most of it is due to the weakness from	12:16:50
18	the critical care neuropathy.	12:16:55
19	Q Right. Right.	12:16:58
20	And you mentioned that in terms of mobility,	12:16:59
21	that she likely could have perhaps ambulated before but	12:17:02
22	would have difficulty with uneven surfaces or -- or the	12:17:07
23	dark rooms, things like that, and would have --	12:17:11
24	A You know, I can't hear you.	12:17:12
25	Q Oh, I'm -- I'm sorry. Let me -- let me say it	12:17:14

Transcript of Bruce Adornato, M.D
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1	better.	12:17:16
2	So -- and that's -- that's where you were	12:17:17
3	talking about how before this, she -- she possibly could	12:17:18
4	have ambulated, but she would have been -- had some	12:17:25
5	difficulty over uneven surfaces or in the dark.	12:17:29
6	Is that -- that's what you were talking about	12:17:32
7	that relates to this?	12:17:34
8	A Yes.	12:17:35
9	Q And, Doctor, would she have been in the same	12:17:47
10	state on September 14th, 2015, without critical care	12:17:52
11	neuropathy?	12:17:57
12	A What's -- I'm not sure what "state" you're	12:18:01
13	referring to.	12:18:03
14	Q Her medical state. The -- the medical state	12:18:04
15	the lack of -- of nerve responses that she had on the	12:18:08
16	EMG.	12:18:15
17	A Well, I think we've answered this already, but	12:18:19
18	her sensory electrical findings would be preexistent	12:18:27
19	from the year before. The motor findings would be worse	12:18:34
20	after the critical care neuropathy.	12:18:38
21	Q And -- and, Doctor, again, this is based --	12:18:47
22	to -- to some degree, this is based on -- on speculation	12:18:54
23	because a test was never done, correct?	12:18:57
24	A I -- I would not use the term "speculation."	12:19:00
25	I would say based on the probability of correlating --	12:19:03

Transcript of Bruce Adornato, M.D
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1	of lots of data about diabetic neuropathy, correlating	12:19:09
2	very good data about what the clinical -- what she	12:19:12
3	looked like clinically, and what you could predict the	12:19:15
4	nerve conduction studies would look like.	12:19:18
5	Q How quickly does a person typically degenerate	12:19:22
6	with a -- diabetic neuropathy from the very early stages	12:19:27
7	to -- to arriving at absolutely no nerve response?	12:19:29
8	A Well, there's some variation. But when --	12:19:37
9	when someone -- I would say the -- to -- to no	12:19:43
10	electrical sensory response a matter of a few years.	12:19:49
11	Q When you say "a few years," how many years are	12:19:53
12	we talking about approximately?	12:19:56
13	A More than one and less than five.	12:19:59
14	Q And that's -- that's the typical amount that	12:20:06
15	you'd expect to find in the literature?	12:20:11
16	A Well, you -- you -- I'm talking about this	12:20:13
17	case mostly. When you have somebody who has no	12:20:15
18	sensation and no position sense a year earlier, the odds	12:20:25
19	are very high that they're going to have absent sensory	12:20:28
20	action potentials in their feet.	12:20:34
21	Q I -- I was talking about a more generalized	12:20:38
22	question. How -- how quickly do the nerves tend to go?	12:20:43
23	A Well, I think there's a lot -- I think there's	12:20:46
24	a lot more variability from person to person. But it	12:20:48
25	does correlate well with what their examination shows.	12:20:51

Transcript of Bruce Adornato, M.D
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1 Q Okay. So what would be the range from early 12:20:57
2 stages until a complete loss -- 12:21:01
3 A Well, I'm not sure what you mean by "early 12:21:03
4 stages." You know, we're talking about -- I don't know. 12:21:05
5 Are you talking about somebody's blood sugar is 120? 12:21:09
6 I -- you know, I -- I can't -- you really have to -- 12:21:14
7 Q I'm talking about somebody who -- 12:21:14
8 A -- you have to define it much -- 12:21:14
9 THE REPORTER: One at a time. 12:21:14
10 Q -- has -- who has neuropathy -- who has 12:21:14
11 diabetic neuropathy. 12:21:21
12 A Well, it has to do with the age of the 12:21:23
13 patient, how long they've had diabetes, how severe is 12:21:26
14 their glucose abnormality. There -- there's general 12:21:31
15 correlation, but it's not perfect by any means. 12:21:37
16 Q Okay. And do you have time frames for -- for 12:21:40
17 those things, let's say, for people who are 12:21:44
18 well-maintained diabetics versus not unwell -- you know, 12:21:47
19 diabetics who do not maintain their -- their status very 12:21:53
20 well versus ages? I mean, do you -- do you have this 12:21:56
21 information? 12:21:59
22 A Well, the information exists, but it -- it 12:21:59
23 depends very much on how you define these things. 12:22:01
24 They're -- this is a very well researched area. But 12:22:05
25 they -- there's a lot of variation, depending on how the 12:22:08

Transcript of Bruce Adornato, M.D
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1	study was done and what the definitions were.	12:22:11
2	You know, if you take everybody who's two-hour	12:22:14
3	postprandial glucose is 120 or greater, that's a very	12:22:17
4	minor abnormality, and the incidence of diabetic	12:22:22
5	neuropathy is going to be very low.	12:22:27
6	If you take someone who's hemoglobin 1Ac is	12:22:30
7	10, like this woman's, the incidence of diabetic	12:22:38
8	neuropathy is going to be much higher. But even in that	12:22:42
9	group, there's going to be a lot of variability between	12:22:45
10	how quickly the neuropathy progresses.	12:22:49
11	But if you -- if you narrow it down by	12:22:52
12	somebody whose hemoglobin 1Ac is 10 and they tell you	12:22:54
13	that they -- they've had nerve pain since 2012 and they	12:22:59
14	get examined in 2014 and they have absent sensation in	12:23:04
15	their feet, then you predict that they're going to have	12:23:09
16	electrophysiologic abnormalities on sensory and motor	12:23:18
17	testing both.	12:23:20
18	Q Right.	12:23:21
19	So the basis for saying that she would --	12:23:21
20	would have a higher rate, what -- what is the rate of	12:23:25
21	someone developing -- of -- of a patient who has --	12:23:28
22	what -- what is it? 10 1 -- 10 1Ac hemoglobin?	12:23:30
23	A Yeah, hemoglobin --	12:23:37
24	Q Might develop a diabetic neuropathy. What is	12:23:38
25	the rate --	12:23:38

Transcript of Bruce Adornato, M.D
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1	A	Well, I'm going to -- all I can tell you	12:23:39
2		is I -- I gave you the scenario in this case, which is	12:23:42
3		the best you can do, 'cause you have a lot more	12:23:46
4		information. I can't -- I don't know what the incidence	12:23:49
5		is, probably quite variable, somebody who had	12:23:56
6		hemoglobin. You're talking about is it sustained	12:24:01
7		elevation, month to month? How old are they? Do they	12:24:02
8		have other symptoms of diabetic neuropathy?	12:24:07
9	Q	Okay. And -- and, again, Doctor, your	12:24:09
10		opinions today are based on your -- your clinical	12:24:10
11		experience.	12:24:13
12		You don't have any -- any specific research	12:24:13
13		that -- that you've identified, correct, to support any	12:24:16
14		of your opinions?	12:24:21
15	A	Well, I didn't -- no one asked me to produce	12:24:22
16		information. I -- certainly, it exists. I've done	12:24:25
17		research on diabetic neuropathy. I've done research in	12:24:28
18		diagnosing and treating diabetic neuropathy, which is in	12:24:34
19		my CV. And when I'm talking -- what I'm telling --	12:24:38
20	Q	And, Doctor --	12:24:45
21	A	-- is -- go ahead. Go ahead.	12:24:47
22	Q	Sorry. Were you still going?	12:24:47
23	A	I'm stopping.	12:24:49
24	Q	Oh, okay.	12:24:50
25		I asked you at the beginning of the deposition	12:24:52

Transcript of Bruce Adornato, M.D
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1	if you were relying on any literature or any medical	12:24:55
2	or -- medical studies, and -- and you said you were not.	12:24:58
3	And so I just wanted to -- to clarify that.	12:24:59
4	Do you have any medical studies that you have	12:25:03
5	relied on for your opinions in this case that I should	12:25:06
6	go and look at specifically?	12:25:10
7	A I don't have any specific literature that I	12:25:11
8	can give you, but it certainly exists. If you want to	12:25:16
9	go study this, go read UpToDate on -- the UpToDate	12:25:21
10	series on diabetic neuropathy. That will probably be	12:25:26
11	very helpful.	12:25:31
12	Q Okay. Doctor, what caused the critical care	12:25:32
13	neuropathy in this case?	12:25:36
14	A Well, the simple answer is that -- that no one	12:25:41
15	knows the exact pathogenesis of critical care	12:25:45
16	neuropathy. The -- we know it is associated with	12:25:51
17	sepsis, associated with diabetes, associated with poor	12:25:58
18	nutrition. And one of the theories is that there is	12:26:06
19	some damage to these microvasculature of peripheral	12:26:13
20	nerves due to the sepsis, but there's a lot of	12:26:20
21	variability from person to person.	12:26:24
22	There are -- you know, there's a lot of	12:26:26
23	information. Like, people who have asthma without	12:26:28
24	infection have a very high incidence of getting critical	12:26:32
25	care neuropathy if they've been intubated and been to	12:26:39

Transcript of Bruce Adornato, M.D
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1	the hospital. So there's a lot of puzzles.	12:26:43
2	There may be a lot -- there may be many	12:26:45
3	different versions of critical care neuropathy and	12:26:46
4	critical care myopathy that's multifactorial.	12:26:49
5	Did I answer your question?	12:26:58
6	Q You did. You did, Doctor.	12:26:59
7	And -- and so I guess -- I guess your opinion	12:27:02
8	on it is -- is that we don't really know, but that you	12:27:06
9	believe sepsis caused it or -- I don't know. Maybe -- I	12:27:14
10	guess your opinion is that you just aren't sure, that	12:27:16
11	it's a multifactorial thing, that the medical community	12:27:20
12	is uncertain about is your opinion?	12:27:23
13	A The medical community knows all the	12:27:25
14	associations. When it occurs, we see it. It's not --	12:27:28
15	it's not a rare diagnosis. But the exact mechanism is	12:27:30
16	not known.	12:27:34
17	Q Got it.	12:27:35
18	Is it always associated with sepsis, Doctor?	12:27:36
19	A No.	12:27:38
20	MR. JONES: Doctor, I think we're good.	12:27:48
21	Appreciate your time.	12:27:50
22	MR. COUCHOT: Can we go off the record.	12:27:52
23	THE WITNESS: My pleasure.	12:27:54
24	THE VIDEOGRAPHER: Go off the record?	12:27:56
25	MR. COUCHOT: Yeah.	12:27:57

Transcript of Bruce Adornato, M.D
Conducted on July 23, 2019

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1	THE VIDEOGRAPHER: Mr. Hand, do you want to	12:28:02
2	end the -- we're ending the deposition right now?	12:28:02
3	MR. COUCHOT: Yeah.	12:28:02
4	THE VIDEOGRAPHER: Okay. Okay. Yeah.	12:28:05
5	This marks the end of the deposition of Bruce	12:28:05
6	Adornato, M.D. We're going off the record at 12:28.	12:28:08
7	(Deposition Exhibit 6 was marked for	12:28:08
8	identification.)	12:28:13
9	(The deposition concluded at 12:28 p.m.)	12:28:13
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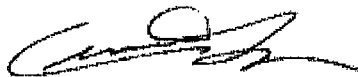
Transcript of Bruce Adornato, M.D
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CERTIFICATE OF SHORTHAND REPORTER

I, Charlotte Lacey, the officer before whom the foregoing deposition was taken, do hereby certify that the foregoing transcript is a true and correct record of the testimony given; that said testimony was taken by me stenographically and thereafter reduced to typewriting under my direction; that reading and signing was requested; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto subscribed my hand this 6th of August, 2019.



Charlotte Lacey, RPR, CSR #14224

Transcript of Bruce Adornato, M.D.
Conducted on July 23, 2019

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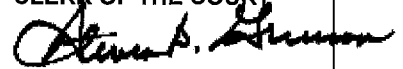
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DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS,)	CASE NO. A-16-739464-C
)	DEPT. NO. 31
Plaintiffs,)	
)	
vs.)	OFFER OF PROOF RE DEFENDANTS'
)	EXHIBIT C
BARRY RIVES, M.D.; LAPAROSCOPIC)	
SURGERY OF NEVADA, LLC, et al.,)	
)	
Defendants.)	

Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC
hereby submit the following offer of proof:

If the court had allowed the admission of Exhibit C for identification, or in the
alternative Exhibit C for identification pages 1-2,7-8,14-29,37-42,50-59,66-73,81-82,90-
93,101-104 and 106-108, Defendants would have asked Dr. Naomi Chaney to look at the

1 notes and use them to describe her examinations, treatment, diagnoses and overall
2 health conditions for her various visits with Titina Farris. Exhibit C for identification is
3 attached.

4 Dated: November 1, 2019

5 **SCHUERING ZIMMERMAN & DOYLE, LLP**

6
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CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 1st day of November , 2019, service of a true and correct copy of the foregoing:

OFFER OF PROOF RE DEFENDANTS' EXHIBIT C

was served as indicated below:

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

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