

IN THE SUPREME COURT OF THE STATE OF NEVADA

Ferrellgas, Inc., a foreign
corporation, **Mario Gonzalez and**
Carl Kleisner,

Petitioners,
vs.

The Eighth Judicial District Court
of the State of Nevada ex rel the
County of Clark and the
Honorable Joanna S. Kishner,

Respondents.

Joshua Green, an individual

Real Party in Interest.

Supreme Court No.: 82670

Electronically Filed
Jun 21 2021 02:06 p.m.

District Court No. 19-00038100
Elizabeth A. Brown
Clerk of Supreme Court

APPENDIX VOLUME I

Matthew G. Pfau, Esq.

Nevada Bar No. 11439

Marjorie L. Hauf, Esq.

Nevada Bar No. 8111

8950 W. Tropicana Ave., #1

Las Vegas, Nevada 89147

702 598 4529 TEL

*Attorneys for Joshua Green, Real
Party in Interest*

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EXHIBIT “1”

The Doctor–Patient Relationship

Challenges, Opportunities, and Strategies

Susan Dorr Goold, MD, MHSA, MA, Mack Lipkin, Jr., MD

The doctor–patient relationship has been and remains a keystone of care: the medium in which data are gathered, diagnoses and plans are made, compliance is accomplished, and healing, patient activation, and support are provided.¹ To managed care organizations, its importance rests also on market savvy: satisfaction with the doctor–patient relationship is a critical factor in people’s decisions to join and stay with a specific organization.^{2–5}

The rapid penetration of managed care into the health care market raises concern for many patients, practitioners, and scholars about the effects that different financial and organizational features might have on the doctor–patient relationship.^{6–10} Some such concerns represent a blatant backlash on the part of providers against the perceived or feared deleterious effects of the corporatization of health care practices. But objective and theoretical bases for genuine concern remain. This article examines the foundations and features of the doctor–patient relationship, and how it may be affected by managed care.

A SPECIAL RELATIONSHIP

The relationship between doctors and their patients has received philosophical, sociological, and literary attention since Hippocrates, and is the subject of some 8,000 articles, monographs, chapters, and books in the modern medical literature. A robust science of the doctor–patient encounter and relationship can guide decision making in health care plans. We know much about the average doctor’s skills and knowledge in this area, and how to teach doctors to relate more effectively and efficiently.^{11,12} We will first review data about the importance of the doctor–patient relationship and the medical encounter, then discuss moral features. We describe problems that exist and are said to exist, we promulgate principles for safeguarding what is good and improving that which requires remediation, and we finish with a brief discussion of practical ways that the doctor–patient relationship can be enhanced in managed care.

The medical interview is the major medium of health care. Most of the medical encounter is spent in discussion

between practitioner and patient. The interview has three functions and 14 structural elements (Table 1).¹³ The three functions are gathering information, developing and maintaining a therapeutic relationship, and communicating information.¹⁴ These three functions inextricably interact. For example, a patient who does not trust or like the practitioner will not disclose complete information efficiently. A patient who is anxious will not comprehend information clearly. The relationship therefore directly determines the quality and completeness of information elicited and understood. It is the major influence on practitioner and patient satisfaction and thereby contributes to practice maintenance and prevention of practitioner burnout and turnover, and is the major determinant of compliance.¹⁵ Increasing data suggest that patients activated in the medical encounter to ask questions and to participate in their care do better biologically, in quality of life, and have higher satisfaction.¹⁶

Effective use of the structural elements of the interview also affect the therapeutic relationship and important outcomes such as biological and psychosocial quality of life, compliance, and satisfaction. Effective use gives patients a sense that they have been heard and allowed to express their major concerns,¹⁷ as well as respect,¹⁸ caring,¹⁹ empathy, self-disclosure, positive regard, congruence, and understanding,²⁰ and allows patients to express and reflect their feelings²¹ and relate their stories in their own words.²² Interestingly, actual time spent together is

Table 1. Functions and Elements of the Medical Interview

Functions

1. Determine and monitor the nature of the problem
2. Develop, maintain, and conclude the therapeutic relationship
3. Carry out patient education and implementation of treatment plans

Structural elements

1. Prepare the environment
2. Prepare oneself
3. Observe the patient
4. Greet the patient
5. Begin the interview
6. Detect and overcome barriers to communication
7. Survey problems
8. Negotiate priorities
9. Develop a narrative thread
10. Establish the life context of the patient
11. Establish a safety net
12. Present findings and options
13. Negotiate plans
14. Close the interview

Received from the Division of General Medicine, University of Michigan Medical Center, Ann Arbor, Mich (SDG); and New York University Medical Center, New York, N.Y. (ML).

Presented in part at the SGIM Symposium on Managed Care, Washington, D.C. May 1, 1997.

Address correspondence and reprint requests to Dr. Goold: Division of General Medicine, 3116 Taubman Center, 1500 E. Medical Center Dr., Ann Arbor, MI 48109-0376.

less critical than the perception by patients that they are the focus of the time and that they are accurately heard. Other aspects important to the relationship include eliciting patients' own explanations of their illness,^{23,24} giving patients information,^{25,26} and involving patients in developing a treatment plan.²⁷ (For an overview of this area of research, see Putnam and Lipkin, 1995.²⁸)

A series of organizational or system factors also affect the doctor-patient relationship. The accessibility of personnel, both administrative and clinical, and their courtesy level, provide a sense that patients are important and respected, as do reasonable waiting times and attention to personal comfort. The availability of covering nurses and doctors contributes to a sense of security. Reminders and user-friendly educational materials create an atmosphere of caring and concern. Organizations can promote a patient-centered culture,²⁹ or one that is profit- or physician-centered, with consequences for individual doctor-patient relationships. Organizations (as well as whole health care systems) can promote continuity in clinical relationships, which in turn affects the strength of in those relationships. For instance, a market-based system with health insurance linked to employers' whims, with competitive provider networks and frequent mergers and acquisitions, thwarts long-term relationships. A health plan that includes the spectrum of outpatient and inpatient, acute and chronic services has an opportunity to promote continuity across care settings.

The competition to enroll patients is often characterized by a combination of exaggerated promises and efforts to deliver less. Patients may arrive at the doctor's office expecting all their needs to be met in the way they themselves expect and define. They discover instead that the employer's negotiator defines their needs and the managed care company has communicated them in very fine or incomprehensible print. Primary care doctors thus become the bearers of the bad news, and are seen as closing gates to the patient's wishes and needs. When this happens, an immediate and enduring barrier to a trust-based patient-doctor relationship is created.

The doctor-patient relationship is critical for vulnerable patients as they experience a heightened reliance on the physician's competence, skills, and good will. The relationship need not involve a difference in power but usually does,³⁰ especially to the degree the patient is vulnerable or the physician is autocratic. United States law considers the relationship fiduciary; i.e., physicians are expected and required to act in their patient's interests, even when those interests may conflict with their own.⁹ In addition, the doctor-patient relationship is remarkable for its centrality during life-altering and meaningful times in persons' lives, times of birth, death, severe illness, and healing. Thus, providing health care, and being a doctor, is a moral enterprise. An incompetent doctor is judged not merely to be a poor businessperson, but also morally blameworthy, as having not lived up to the expectations of patients, and having violated the trust that is an essential

and moral feature of the doctor-patient relationship.³¹ Trust is a fragile state. Deception or other, even minor, betrayals are given weight disproportional to their occurrence, probably because of the vulnerability of the trusting party (R.L. Jackson, unpublished manuscript).

EFFECTS OF MANAGED CARE

A managed care organization serves a defined population with limited resources in an integrated system of care. Thus, a single organization may both provide and pay for care. Organizations as providers have duties such as competence, skill, and fidelity to sick members. Organizations as payers have duties of stewardship and justice that can conflict with provider duties. Managed care organizations thus have conflicting roles and conflicting accountability.

An organization's accountability to its member population and to individual members has a series of inherent conflicts. Is the organization's primary accountability to its owners, to employer purchasers, to its population of members, or to individual, sick members? If these constituents somehow share the accountability, how are conflicting interests resolved or balanced? For example, the use of the primary care clinician to coordinate or restrain access to other services involves the primary care clinician in accountability for resource use as well as for care of individual patients. Although unrestricted advocacy for all patients is never really achievable, the proper balance and the principles of balancing between accountability to individual patients, a population of patients, or an organization need to be made explicit and to be negotiated in new ways.³²⁻³⁴

Does paying physicians by salary, capitation, risk withholds, or bonuses, with a variety of incentives to withhold (more or less) needed care from patients, represent a conflict of interest for physicians and violate the fiduciary nature of the relationship? All mechanisms for paying physicians, including fee-for-service reimbursement, create financial incentives to practice medicine in certain ways. We still lack a calculus to minimize or even describe in fine detail how such conflicts affect our ability to justify trusting relationships. Even-handed social attention seems appropriate to all the different mechanisms of payment. Balanced assessment of how the details of remuneration systems influence doctor's willingness to act on behalf of patients will best protect both the health of the public and the health of doctor-patient relationships. This is a priority for a new form of empirical, ethical research.

"Whose doctor is it anyway?" expresses one of the most critical problems inherent in managed care for the doctor-patient relationship. Patients correctly wonder if doctors are caring for them, the plan, or their own jobs or incomes (the latter is equally problematic in fee-for-service care). This ambiguity erodes trust, promotes adversarial relationships, and inhibits patient-centered care. The recent controversy over gag rules has only confirmed this

set of fears in the mind of the public which is now seeking regulation of the managed care industry through the political process. As illustrated in Figure 1, the interests of patients, plans, and doctors can overlap to a greater or lesser extent. Professional ethics dictate that physicians attempt, as individuals and as a profession, to ensure that their interests and those of their patients are congruent in clinical practice. Plan interests, however, can pull physicians away from this goal, as the organization's values and their implementation inevitably influence attitudes, behavior, and experiences. Alternatively, plans could promote patient-centered care by trying to maximize the extent to which patient, doctor, and plan interests overlap. For example, promoting continuity, communication, and prevention can further all three interests so long as value (and not cost alone) is seen as the plan's product. Similarly, resource stewardship can be honestly promoted as a way to ensure that quality care is available for future patients.

Another feature of managed care organizations is their emphasis, in principle, on primary care. They often rely on primary care clinicians to manage, coordinate, or restrain access to other services. Members are required to choose or are assigned a primary care physician. With the

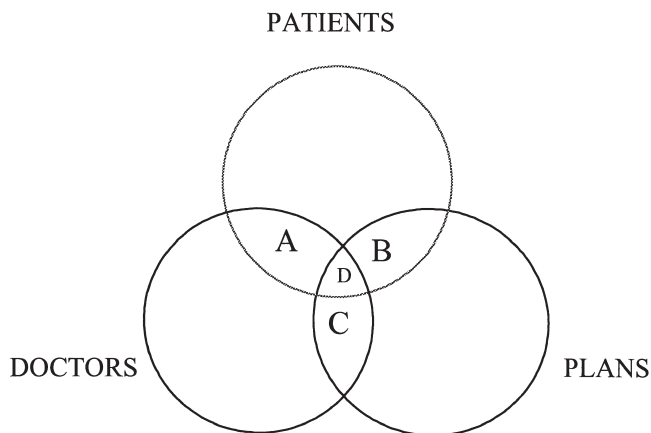


FIGURE 1. Overlapping and conflicting interests. The interests of patients (top circle), doctors (left circle), and health plans (right circle) may overlap to a greater or lesser degree, depending on the actors and the circumstances. Employers' interests are likely to be approximated by plans' interests, as plans in a competitive market respond to buyers. Physicians should be both empowered and motivated to continually increase the size of area A; the more that their interests and the interests of patients (sick and well) overlap, the greater the likelihood of decision making that maximizes patient well-being. Plans may try to increase area C, by aligning financial incentives for physicians to correspond with greater profit (or other organizational goals) in order to ensure that physicians make decisions in the plan's interest. Plans may also strive to increase area B, for instance, by cutting physician reimbursement, in order to make the plan more attractive to potential enrollees. Ideally, area D is large, representing the confluence of plan, patient, and doctor interests, and all three parties strive to continually increase it.

primary care emphasis comes an *opportunity* for the development of strong relationships between primary care doctors and their patients. In addition, new relationships with patients who in the past never sought care and seldom entered into a doctor–patient relationship may be more likely in a system that emphasizes wellness and primary care, although this may be more apparent than real. It is unclear at present how a “relationship” between a primary care physician and a member of the physician's panel, who have never met, should be characterized, or what responsibilities are associated with it. It is not yet demonstrated that an emphasis, in principle, on primary care leads to stronger relationships, and to what extent countervailing forces such as lack of continuity counter this.

Integrated systems, characteristic of most managed care plans, introduce opportunities for improvement in continuity across the spectrum of care. For example, opportunities arise for case management or for coordinating care between doctors' offices, hospitals, nursing homes, and home care so that individuals do not fall through the cracks of a fragmented system. With integration come new responsibilities for doctors and other health care practitioners for communication, teamwork, and a more longitudinal approach to patient care. This continuity may be thwarted, however, by turnover in staff or members.

Standardization of practice, sometimes relying on “evidence-based medicine,” is often used by managed care to minimize costs or maximize or ensure quality of care. Standardization is often touted as promoting fairness by treating like individuals in like manner. Both standardization and the application of evidence-based principles in choosing care standards, however, rely on value judgments about what counts as good evidence and how that evidence should be interpreted and applied. The danger to the doctor–patient relationship in these movements is that individual patients with their individual needs and preferences may be considered secondary to following practice guidelines, adherence to which may form part of an evaluation measure of physician's performance. Using practice guidelines and the “standard of care” to determine which benefits are covered, and for whom, ignores the incredible variation in patient preferences and characteristics. This approach treats the disease without reference to the illness.³⁵ Rather than treating individuals with similar illnesses in like manner, the result is that individuals who merely have the same disease are treated in like manner. Fairness is sacrificed to uniformity.³⁶ Reliance on “data” may discount the patient's own story, thus discounting specific evidence about personal aspects of disease and its meaning and value. Obviously, discounting the person depreciates the relationship.

Continuous quality improvement and total quality management are industrial strategies³⁷ lately applied in the health care arena. Although quality improvement efforts are by no means unique to managed care organizations (MCOs) in the health care industry, a few individual

MCOs and the American Association of Health Plans have been leaders in promoting quality initiatives and include them in the accreditation process. Implementing continuous quality improvement may work *for* the doctor-patient relationship by enhancing competence and the perception of competence, or it may work *against* the doctor-patient relationship if it diminishes practitioner flexibility or accountability, or if it is perceived by practitioners as a manifestation of distrust by the organization.

The effort to cut costs to increase competitiveness or profit means having doctors be more "productive" by seeing patients faster. The first thing dropped as visit length shortens is psychosocial discussion.³⁸ So far, the average length of visits in the United States does not seem to have dropped significantly, probably because of inherent inefficiencies in scheduling and doctors' abilities to finagle time to fit the needs of patients.³⁹ Yet both patients and doctors feel a heightened sense of time pressure, and patients worry about being on a conveyor belt with a production-line-oriented doctor. As companies attempt to increase providers' efficiency, these fears will be realized unless thwarted by consumers, professionals, or more visionary organizations. Less time, otherwise, will mean less relating time and damage to care: less-accurate and incomplete data; difficulty in identifying the real problems; less efficiency in test and treatment choices based on knowledge of the individual patient; less trust; less healing; more errors and more waste.³⁹ A penny of good communication time may avert a pound of unnecessary or even harmful spending used to reassure an anxious patient or substitute for a sketchy history.

We believe that in the long run the trust of the public that the physician is doing the absolute best for the patient must be maintained so that the doctor-patient relationship preserves its healing functions. At the moment, the momentum of control is such that industry and corporate leaders have the upper hand and care is or will

suffer as a result. Only if consumers and the medical profession stand together and insist on standards that protect the doctor-patient relationship will it endure the acid raining against its delicate face.

WHAT PRACTITIONERS CAN DO

Table 2 lists several principles physicians can follow to retain professional standards and nurture and sustain the public's trust in doctor-patient relationships. The first priority is to enhance knowledge, skills, and attitudes of doctors, patients, and plans in the doctor-patient relationship. Currently, neither doctors and patients, nor plans have adequate skills in the doctor-patient relationship. Most doctors currently practicing have never been critically observed interviewing a patient, breaking bad news, or denying a patient's request for an unnecessary test. Doctors need no longer suffer from a lack of this skill—it is learnable and quickly taught. Physicians should each ensure their own competence in this vital area.

Physicians should focus on continuity: in their relationships with individual patients, between their patients and other clinicians (including specialists and nurses), and with the organization as a whole. Trust is most realistic when a relationship has a history of reliability, advocacy, beneficence, and good will (R.L. Jackson, unpublished manuscript). Continuity encourages trust, provides an opportunity for patients and providers to know each other as persons and provides a foundation for making decisions with a particular individual. It allows physicians to be better advocates for their patients and allows patients some power by virtue of the personal relationship they have with this physician. Patients value continuity in and of itself, apart from its effect on health outcomes,^{40,41} although its current value seems to be about \$15 per month in added premium. Industry estimates are that an average patient will change plans and doctors if continuity

Table 2. Principles for Enhancing the Doctor-Patient Relationship in Managed Care

Physicians	Plans
Enhanced knowledge, skills, and attitudes of doctors, patients, and plans in the doctor-patient relationship	Enhance knowledge, skills, and attitudes of doctors, patients, and plans in the doctor-patient relationship Encourage attention to psychosocial aspects of care Monitor satisfaction with visit time
Foster continuity	Avoid decisions that interrupt continuity
Protect the interests and the preferences of individuals	Promote a patient-centered culture Separate administrative rule communication from patient care
Contribute to quality improvement and standardization efforts	Standardize with protection for individual needs and preferences
Practice prudence in medical spending decisions	Protect patient confidentiality
Minimize conflict of interest	Eliminate intrusive incentives in physician contracts
Review contracts for potential effects on doctor-patient relationship	Structure employer contracts to encourage accountability to members Promote candor in advertising (and elsewhere)

costs more than \$180 per year.⁴² Rapid changes between plans, mergers, acquisitions, closings, changing panels of providers within plans, and physician non-competition clauses all detract from the continuity of patient care. Physicians should advocate for continuity as an important goal for themselves in their individual practices, as members of a group practice, as a profession, and within their organizations.

Practitioners should work to protect the interests and the preferences of individuals. Utilization management, standardization, guidelines, and other cost-containment efforts are morally neutral. They may be necessary to ensure that resources needed to care for those who are not yet sick are available when the time comes. Whereas administrators and managers must responsibly steward the pooled resources of health insurance premiums, each physician in a managed care organization should primarily be an advocate for individual patients. This is not to say that physicians should ignore the cost implications of their decisions, or that they should be unconcerned with resource stewardship, merely that their primary responsibility as practitioners should be for the care of their patients.

Health care administrators, whose primary responsibility is stewardship, should not ignore the need for competence, compassion, and individualization of care. Physicians' roles as patient advocates mean they must attend to the needs of individual patients who may be exceptions to the rules or otherwise have special needs. As patient advocates, physicians must ensure that policies and procedures put in place that threaten the ability to individualize care do not go unchecked. Since this power may be beyond the capacity of individual physicians, it may require organization at the level of the whole profession.

Practitioners should contribute to quality improvement efforts. For efforts to be focused on improving the quality of care and not solely on restraining resource use, the role of physicians is indispensable. Physicians know when access is too tightly restrained and their patients' care is suffering, when restrictions on the use of particular drugs or equipment constitute unacceptable impingements on the quality of care, or in what circumstances a procedure is probably unnecessary. Physicians can, and should, serve as "quality police" by noticing, remarking, and, ideally, working for change when they see a feature that is detrimental to patient care. In addition, they should be proactive in spearheading and making clinically and humanly relevant quality improvement efforts in their organization.

Practitioners can practice prudence. Physicians should be prudent in their use of resources, and at a minimum should not waste resources by providing services of no benefit to patients. Physicians often complain that patients come in asking for x-rays, blood tests, and other services when physicians are skeptical of any benefit. Conversely, many patients have noted physician's overuse of "tests." The role of insurers in the health care system means that a service rarely has direct costs for an individual patient,

though it may be costly. Indeed, our culture seems to rely on technology to answer questions with a greater certainty than the technology can deliver. Physicians themselves have contributed to a culture of medical practice in which objective test results are given more credence and are felt to be more reliable than the subjective story of the patient or assessment of the physicians. In truth more than 80% of diagnoses are made by history alone.⁴³ Physicians need to control their own reliance on objective but noncontributing data. By fostering a system of care in which concern for cost is acceptable and unnecessary services are not provided, physicians can be perceived as being socially responsible and perhaps restore some credibility in this area to the profession.

Because it is a matter of integrity not to waste resources on tests or other services, physicians must talk to patients, find out why they are requesting certain services, and meet those needs in other ways. We must educate patients about the limited ability of medical technology and the potential for harm in any treatment. This, again, involves skills that many physicians need to learn in order to understand the patient's underlying concerns, cultural background, and life history.

Physicians need to pay close attention to financial and nonfinancial incentives that might provide a strong conflict of interest when making decisions for individual patients. Physicians must look at how they are paid, realize how it might influence the care of their patients, and take steps to ensure that such concerns do not intrude unduly into decisions at the individual patient level. Remuneration schemes must be scrutinized for this possibility by paying attention to the number of patients the scheme affects, the ability to spread risks over a large population of patients in the case of capitated payment schemes, the implicit and explicit goals of remunerative strategies (including cost containment, but also potentially quality, patient satisfaction, continuity, and other worthy goals), and the extent to which the arrangements are public or, at least, open and understandable to patients. It is important to recognize that large fee-for-service payments and salaries without productivity standards or quality standards are equally likely to influence the care of individual patients and should be scrutinized with equal seriousness. Similarly, things like the size of a physician's panel of patients, its cultural variety, or morbidity can affect relationships because of their influence on time available per patient visit.

When taking on responsibility for a panel of patients, physicians could be said to join a relationship in theory that does not yet exist in reality. Physicians, working with their plan, should spearhead efforts to reach out to such members if only to ensure they are educated about preventive medicine issues and encourage them to follow healthy lifestyles. Although patients and doctors alike will not find frequent visits necessary when someone remains healthy, still the relationship between patient and physician may become important later, should the patient

become seriously ill. Something as simple as an annual "Health Care Maintenance Reminder" postcard (with the doctor's name) may help members feel their faceless doctor is nonetheless caring for them. Developing relationships with all enrolled members is also a way for physicians and plans to become more accountable for the care of those who are not seen in clinical practice.

STRATEGIES FOR MANAGED CARE PLANS

A number of strategies that MCOs can use to strengthen doctor-patient relationships are listed in Table 2. Often, plans do not know how to detect and remediate problems in doctor-patient relationships, how to train their practitioners and their staff to relate effectively and efficiently, or how to train their enrollees to be effective in their own care. As we now know how to do all of these things, there is no longer justification for poor performance in the encounters between providers and patients. Doctors need training in dealing with difficult patients, about common aspects of life adjustment such as reaction to illness, in recognizing the underlying psychological problems that remain a leading cause of seeking medical care, in negotiating, and in handling tough situations like breaking bad news. Courses such as those of the American Academy on Physician and Patient (AAPP) can provide such skill. Patients need to be taught to organize their approach to care, to ask questions, to negotiate, and to discuss feelings. The AAPP, the Northwest Institute, the Bager Institute, and others can provide such training.

Plans can promote a culture that is patient- and member-centered. This variation on "put the customer first" acknowledges the vulnerability of patients as ill persons needing care, compassion, and special attention. It also implicitly and explicitly makes care, not profit, the center of attention for those doing the daily work of providing health care. Physicians and other clinicians are encouraged to put their patients' good first, ahead of profit (their own or the organization's), politics (e.g., reluctance to whistleblow or disclose mistakes), or personnel (e.g., the convenience of the other staff). Conserving resources for future patients or to expand services becomes an important part of serving the member population. Although creating a culture that is patient-centered is not a quick or easy task, there are resources available.⁴⁴

It is useful for plans to separate patient care from administrative rules communication. Too often, the practitioner is the person who has the difficult task of saying "no" to a patient.⁴⁵ Plans can be purposefully deceptive or vague in communicating what they will not do for a member, when they are trying to enroll new members.⁴⁶ It would ease the situation between doctor and patient if the patient clearly understood when the doctor said no that (when applicable) this is not the doctor's decision but the plan's. This approach is likely to require regulatory change.

Plans can structure contracts with employers that encourage accountability to the membership rather than

the employer. It is hard to balance the competing interests of sick and well members, those who need resources now and those who may need them later, staff and the community. Employers' standing in decisions that affect primarily their employee members adds more complexity, and is fraught with conflict. The illusion remains that employers pay for health insurance. Actually their *not* paying the premiums would increase real wages for their employees, drop the cost of living, increase profits, or increase income due to greater competitiveness. This illusion, however, affects how health insurers view their accountability. Managed care plans do what it takes to please employers, because employees are their customers. The member, sick or well, has little voice. One way to alleviate this situation is to ensure that members have a voice, either through their employer or union, or in the health plan itself, for example, through representation on guideline development initiatives or benefits committees. If policies can be said to be self-imposed by the membership, physicians making judgments about resource use are acting for their patients, current and future, and not for employers.^{47,48} Another strategy is to require management to use the same plans their employees do.

Plans must eliminate intrusive incentives in contracting with physicians. Intrusive incentives are those that combine strength (i.e., are large either in absolute or relative terms) with a tight linkage to individual patient care decisions. If a single decision about a single patient (including the decision to accept a chronically ill person into one's practice) is likely to result in a significant financial loss to the physician, then the relevant incentive is too intrusive. The intrusiveness of incentives is a product of the incentive's size (e.g., how much money is at stake) and its link to *individual* care decisions. For instance, if referring a patient to a specialist "costs" a physician a loss out of the physician's pool, it is tightly linked. If, however, a prepaid arrangement covers several thousand patients, the relative size (or impact) of the incentive is small. Incentives need not be only financial; peer pressure, leisure time, the threat of deselection, or a sense of fulfillment from work may also influence patient care decisions and thus also should be subject to scrutiny.

Plans can standardize "with heart." Moderating the variation in clinical practice has often been touted as a way to save money without compromising quality of care. Yet some variation is necessary and inevitable. An organization that does not allow clinicians to open the gate for the justifiable exception to the rule, or is overly skeptical of clinical judgment about those with rare or poorly characterized conditions, ignores to its peril the rich variety of the human condition.

The openness and honesty of a system or organization can contribute to a climate of trustworthiness. For instance, discrepancies between marketing messages ("we provide everything") and the availability of medications, equipment, or specialty care ("that's not covered in your plan") create entitlement and convert it to disenchantment,

resulting in an atmosphere of distrust that inevitably includes the doctor-patient relationship. Health care organizations may not relish the idea of promoting honest talk about limited resources and their consequences, but should at a minimum not try to raise expectations of unlimited access to unlimited services.

Plans should promote patient privacy and confidentiality. The expectation of privacy is one of the most important aspects of the doctor-patient relationship and influences the disposition to trust, but confidentiality is no longer solely in the doctor's control. Organizational personnel have access to patient information and must be required to keep it private, taught how to keep it private, and monitored to be sure they do.

Time is another prerequisite for trust. Plans should determine a reasonable minimum average time for doctor visits. They should pay attention when doctors or patients complain they do not have enough time together. Because the time of visit varies by type of visit, type of doctor, and complexity of the patient, patient complaints about visit time may be a useful patient-centered indicator of potential trouble in doctor-patient relationships.

Plans can encourage consideration of psychosocial issues in all forms of patient care. An organization can use continuing education, promotional materials, patient-directed education, and quality improvement efforts to promote this aspect of patient care. In doing so, discussions about these areas between doctors and patients will be enabled, patient satisfaction will increase, and unnecessary visits, such as to the emergency department for panic attacks, may even go down. Organizational change may be a more efficient way to promote caring than changing either medical education or the process by which medical students are selected.⁴⁹

Plans should avoid business decisions that interrupt continuity between doctors and patients. Mergers and acquisitions, adding and deleting physician groups, agreeing to short-term contracts with employers, expanding or selling out, all are decisions with profound implications for one-on-one relationships between doctors and patients. To minimize harm when these decisions are unavoidable, exceptions can be made for those with important, established relationships. The "old doctor" may accept the standard fee, or the patient may be willing to contribute to some degree. If necessary, the patient's care can be gradually (as opposed to abruptly) established with a new physician "in the plan." The latter strategy enables patients to take control over their choice of doctors and gives them time to find one acceptable to them in the network.

CONCLUSIONS

As Chairman Mao said, the first step in solving a problem is calling it by its right name.⁵⁰ Only then can it be discussed and its particular features in a given site identified. The second step is agreeing on its high priority.

The third step is obtaining appropriate consultation and choosing solutions. The solution will often be training practitioners and staff. To everyone's regret, there is no quick fix here although major improvements can be initiated in as short as a daylong course.⁵¹ Such interventions need to be part of an ongoing commitment to this area, steady work through a continuous quality improvement-type process, and regular training and renewal of skills. Groups like the AAPP can provide such long-range training efforts. Many plans already monitor practitioner skills in these areas through patient satisfaction surveys, and these may effectively identify those needing extra help. Attention to the training of patients is another critical part of creating effective partners for care. So also is employers' education as to the importance of this area, as their decisions may be critical in directing resource allocation. Finally, we believe the medical profession needs to provide data-based standards and establish principles physicians will not violate and to which plans must adhere. Otherwise, this will be done in a haphazard way by corporate interests.

We have outlined briefly the fundamentals of the doctor-patient relationship, some features of the health care system found particularly in managed care settings that affect it, and approaches for protecting and sustaining the doctor-patient relationship in these settings. These are aimed at physicians and plans, but should be of interest to policy makers, other health care administrators, and consumer groups. In change there is opportunity. Our current opportunity is to examine the doctor-patient relationship, the context in which that relationship operates, and in particular, the influence of changes in the financing and organization of health care. The doctor-patient relationship deserves our serious attention and protection during these dangerous times.

Dr. Goold's contribution to this work was supported by the Picker Commonwealth Scholars Program (National Program Office, Association of Health Services Research, 1130 Connecticut Ave., N.W., Suite 700, Washington, DC 20036) and the Department of Veterans Affairs.

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EXHIBIT "2"

DISTRICT COURT

CLARK COUNTY, NEVADA

MARCO CENTENO-ALVAREZ,)
Plaintiff,)
vs.) CASE NO. A510230
CURTIS COE and DOES I) DEPT. NO. XXIV
through X, inclusive; and)
ROE CORPORATIONS I through)
X, inclusive,)
Defendants.)
_____)

DEPOSITION OF LEWIS M. ETCOFF, Ph.D.

SATURDAY, SEPTEMBER 25, 2010

9:02 A.M.

AT 8475 S. EASTERN AVENUE, SUITE 200

LAS VEGAS, NEVADA

REPORTED BY: MICHELLE R. FERREYRA-MAREZ, CCR No. 876
LST JOB NO.: 1-127566

1 DEPOSITION OF LEWIS M. ETCOFF, Ph.D.,
2 taken at 8475 S. Eastern Avenue, Suite 200, Las Vegas,
3 Nevada, on SATURDAY, SEPTEMBER 25, 2010, at 9:02 a.m.,
4 before Michelle R. Ferreyra-Marez, Certified Court
5 Reporter, in and for the State of Nevada.

6 APPEARANCES:

7 For the Plaintiff:

8 VANNAH & VANNAH
9 BY: ROBERT D. VANNAH, ESQ.
400 South Fourth Street
Sixth Floor
10 Las Vegas, NV 89101
(702) 369-4161
11 (702) 369-0104 Fax

12 For the Defendants:

13 RANALLI & ZANIEL, LLC
14 BY: GEORGE M. RANALLI, ESQ.
ERNEST MP MORAN, ESQ.
15 3041 West Horizon Ridge Parkway
Suite 140
16 Henderson, NV 89052
(702) 477-7774
17 (702) 477-7778 Fax

I N D E X

WITNESS: LEWIS M. ETCOFF, Ph.D.

EXAMINATION

PAGE

Examination By Mr. Vannah

4

Examination By Mr. Ranalli

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Further Examination By Mr. Vannah

99

E X H I B I T S

(None marked.)

1 LAS VEGAS, NEVADA, SATURDAY, SEPTEMBER 25, 2010;

2 9:02 A.M.

3 -000-

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

10 Whereupon,
11

12 LEWIS M. ETCOFF, Ph.D.,
13 having been first duly sworn to testify to the truth,
14 the whole truth and nothing but the truth, was examined
15 and testified as follows:

16
17 EXAMINATION

18 BY MR. VANNAH:

19 Q. Could you state your full name, please?

20 A. Lewis Marvin Etcoff.

21 Q. Do you mind if I not explain the deposition
22 process to you this morning?

23 A. I'm -- I don't mind at all.

24 Q. First housekeeping question, did I understand
25 that you audiotaped this meeting?

1 A. Yes.

2 Q. What happened to the audiotape?

3 A. I have it.

4 Q. Is there a copy for me?

5 A. There is, once I dig through all of this, I
6 think we may have an extra copy.

7 Q. Okay.

8 MR. RANALLI: Bob, if I can just interject,
9 and I don't mean to interrupt, I think before I have it
10 attached to the deposition, I'm going to instruct him
11 not to give it because I think there's an issue of that
12 whether it is even disclosable because it wasn't
13 supposed to be videotaped according to Bixler. You
14 weren't privy to that, but there was an issue that
15 arose right prior to the IME, so I would like to
16 address it to Bixler before I disclose it or have it
17 produced.

18 MR. VANNAH: Well --

19 MR. RANALLI: He's not going to destroy it.
20 And then if Bixler allows it, obviously he can, but I
21 have an objection to that because it wasn't even
22 suppose to be audiotaped.

23 MR. VANNAH: Well, that's a problem. I want
24 it. I mean, whether it comes into evidence or not, I
25 won't play it or anything for whatever reason, but

1 bottom line is -- I don't want to do that, but I do
2 want a copy of it.

3 MR. RANALLI: I don't have a copy.

4 MR. VANNAH: Well, you have a copy.

5 MR. RANALLI: I'm going to instruct him not to
6 produce it at this point.

7 MR. VANNAH: I don't think you can instruct
8 him. He's an independent -- but I want it. I mean, I
9 don't want you to instruct him. He's an
10 independent -- he's not your -- you don't own him.

11 MR. RANALLI: No, I don't. But Bixler had
12 indicated, to my recollection, that it wasn't supposed
13 to be audiotaped. There was no requirement for someone
14 to be in the room or audiotaping it.

15 MR. VANNAH: I was -- I'm not saying -- I
16 don't care. The point is that it is audiotaped, and I
17 want a copy of it. I don't want to get -- I'm leaving
18 Wednesday morning, and I'm not going to be around.

19 MR. RANALLI: We can have Adam file -- you
20 know, do a motion or even a conference call with the
21 judge. I don't care.

22 THE WITNESS: Can we go off the record for a
23 second?

24 MR. VANNAH: Yes. Let's go off the record.

25 (Off the record.)

1 MR. VANNAH: Back on the record.

2 BY MR. VANNAH:

3 Q. Let me just get kind of to the heart of a
4 couple of things. You know, about 98 percent of the
5 time, I agree with what you say. I mean, I don't like
6 it, but I agree with it. This isn't one of those
7 cases, though.

8 A. Okay.

9 Q. I will tell you where I'm having trouble with
10 it, and that is your conclusion that he is a
11 malingerer. So if we go through this and I convince
12 you that that's not a reasonable diagnosis to a
13 reasonable degree of psychological certainty, would it
14 be fair enough to say, Well, okay. I change my mind?

15 A. Sure.

16 Q. Let's talk about what is the definition of the
17 word "malingering" under the DSM-IV TR.

18 A. In DSM-IV TR, there are four symptoms, if you
19 will. And in DSM-IV, it says, Malingering should be
20 strongly perspective of any combination of the
21 following as noted: One would be a medical/legal
22 context of presentation. Two --

23 Q. Well, let's stop right there. Let's take one
24 at a time. Okay? Because otherwise my mind doesn't
25 work that fast. So this is a medical/legal

1 presentation?

2 A. Yes.

3 Q. So every time you're involved in doing an
4 independent psychological exam where there's a
5 plaintiff and defendant, that's met; right?

6 A. That's met, correct.

7 Q. So that's not -- I mean, that's interesting.
8 But you are not relying very heavily on that; right?

9 A. No. I'm just --

10 Q. I just want to take each of these one at a
11 time.

12 A. Yes. Correct.

13 Q. Otherwise every single time you did an
14 independent psychological -- well, it must be
15 malingered because there's a context here of
16 medical/legal issues in a litigation setting?

17 A. Yes. In fact, it's not uncommon in this day
18 and age for psychologists to test for malingered, even
19 in one medical/legal situation such as returning war
20 veterans who are claiming PTSD or some sort of a pain
21 disorder as a result of being in the war.

22 Or adults seeking accommodations under the
23 Americans with Disabilities Act for medical school, law
24 school, graduate school. It's becoming the rule of
25 thumb or the standard of care in psychology to

1 perform -- to take a look at whether someone is
2 exaggerating, even if they're not in a medical/legal
3 context. Anytime there's a medical/legal context, you
4 consider it. It doesn't mean the person is, you just
5 have to consider it.

6 Q. Well, if I understand what you are saying,
7 taking away the fancy words, you are saying anytime
8 somebody has something to gain by acting like they are
9 hurt, you have to consider whether or not they're
10 sincere or not?

11 A. That's correct. Yes.

12 Q. Probably not the words out of the DSM-IV, but
13 probably better than what's in there?

14 A. Well, the DSM-IV has a very antiquated
15 definition of malingering, which is why I used a much
16 more sophisticated recent research based definition,
17 which I'm sure we will get into, but let's continue.

18 Q. So the first one is litigation --

19 A. Litigation.

20 Q. -- to break it down in simple terms.

21 What's the second one?

22 A. Yes. The second one says, Marked discrepancy
23 between the person's claim stressor disability and the
24 objective findings.

25 Q. Okay. Hold that thought.

1 What's the third?

2 A. The third one says, The lack of cooperation
3 during the diagnostic evaluation and in complying with
4 the prescribed treatment regimen.

5 Q. Let's see if we can knock it out. Certainly
6 number three doesn't apply to this guy; right? He has
7 been very cooperative?

8 A. He has been very cooperative during my
9 evaluation.

10 Q. Was it during your evaluation or --

11 A. And I would say that I didn't see evidence to
12 suggest that he was not compliant on his functional
13 capacity examination with Karen Crawford. He -- he may
14 have been less honest or accurate in his functional
15 capacity examination with Terrence Dineen. He
16 certainly -- well, he was noncooperative going into
17 physical therapy as prescribed by Dr. Dunn, but -- so
18 there were, I guess, findings on both sides.

19 Q. What's --

20 A. Just -- just using this script.

21 Q. Sure. What's the fourth criteria?

22 A. The presence of antisocial personality
23 disorder.

24 Q. Anti --

25 A. Social -- Antisocial personality disorder.

1 And there is no such finding anywhere of that.

2 Q. What is antisocial personality disorder?

3 A. It would be someone who is like a sociopath
4 who would have no -- who would lie, cheat, and steal
5 and have no qualms about so doing, criminal.

6 Q. Do --

7 A. They are self-centered, they don't care who
8 they hurt, they have no conscience. That's not him.

9 Q. So those are the four criteria?

10 A. Yeah.

11 Q. So the litigation, I mean, it is what it is.
12 There is litigation. So he's no different than all
13 other litigants, just as far as litigation?

14 A. Yes.

15 Q. Motivation possibilities; right?

16 A. Yes.

17 Q. So on the lack of cooperation, he was
18 certainly cooperative with you; right?

19 A. Yes.

20 Q. You don't put a lot of stress on that third
21 one; right? I kind of would like to get down to what
22 we really --

23 A. Yeah. I mean, I -- I -- I hope I made clear
24 that the definition of malingering pain disability was
25 taken from the Spine Journal article.

1 Q. You made that clear.

2 A. So -- well, yeah.

3 Q. But this is DSM-IV TR; right?

4 A. It is.

5 Q. I thought it was your Bible or something?

6 A. It's not -- it's not my Bible. It's -- we use
7 it to diagnose. In fact, in the DSM-V, as far as I
8 know, malingering isn't even going to be in as a
9 diagnosis. They are taking it out. So psychiatry
10 who -- which is the profession that writes this, is
11 just taking it out because they know that malingering
12 isn't a mental disorder. So in a couple of years, you
13 won't even be -- we won't even be referring to this
14 book for any type of exaggerating -- purposely or
15 exaggerated symptoms of any type.

16 Q. That's a good point. I mean, not necessarily
17 a disorder, but maybe a very clever person who is
18 malingering to get benefits. It may not be a disorder.
19 I mean, I see your point. It may not be a disorder.
20 It's just a purposeful effort to fool somebody?

21 A. Yes.

22 Q. Now we come down to marked discrepancy, and
23 that's where, you know, I read what you wrote, and I'm
24 going to have some severe disagreements with you. I
25 don't usually have that. Usually I recognize when you

1 say something about my clients. You know, I will say,
2 Yeah, I thought the person was pretty nutty myself.

3 But in this case, what you seem to say is the
4 marked discrepancies are -- well, let's talk about the
5 marked discrepancies. Because, I mean, you are talking
6 about this videotape. Let me just point out a humorous
7 thing first.

8 A. Okay.

9 Q. I always say, and you know, I don't know if I
10 made it up. I don't think I did, but just because you
11 are paranoid doesn't mean people aren't out to get you.
12 You probably heard that before; right?

13 A. Sure.

14 Q. In this case, it turns out people are out to
15 get him; right? I mean, people -- George Ranalli and
16 his videographer -- I don't know if you know that they
17 spent 400 hours following this guy around?

18 A. I read that yesterday in some records that I
19 just saw that there were that many hours. I'm not sure
20 if there were that many hours of videotape, but the
21 company or companies that followed him around spent 400
22 hours following him around. I don't know how many
23 hours of videotape was produced.

24 Q. So if he's got delusions of people following
25 him around, it wouldn't be too delusional if he's got

1 400 hours of people sneaking up on him, taking pictures
2 of him, doing what some people might think is nefarious
3 activity; right?

4 A. That's not delusional at all.

5 Q. So he's right about that?

6 A. Yes.

7 Q. So marked -- I've got somebody doing what they
8 call doing a rainbow kick. I'm not a soccer expert,
9 but some kind of a kick that a person can do, and
10 lifting some suitcases, which I don't know what was in
11 them or how heavy they were. Is that what we're
12 looking at? Well, things that you viewed specifically
13 that this person could do that you were concerned about
14 might be discrepancies. Is that the right word from
15 what --

16 A. Yes. That's not the major reason I made the
17 diagnosis, but that had some bearing.

18 Q. What was it about the rainbow kick that caused
19 you personally with your -- what you observed with your
20 expertise to say that's at variance with what a person
21 can do taking appropriate, heavy duty narcotics?

22 A. I think that it wasn't so much that I, as a
23 nonphysician, looked at the rainbow kick and said,
24 That's medically impossible given his condition. I
25 didn't say that. I looked at the rainbow kick, but I

1 think even more so the luggage carrying three days
2 before his lumbar surgery as behavior inconsistent with
3 a person about to have surgery, or in this case a
4 person saying to doctors that I can't bend from the
5 waist or twist at all. That was more important to me.
6 I -- I don't know medically whether his rainbow kick
7 would constitute absolute evidence that he's fine or
8 there's nothing wrong with him.

9 And I have read Dr. Dunn's and Dr. Schifini's
10 depositions, and I have read Dr. Rothman's deposition
11 and Dr. Rappaport, and they disagree about the weight
12 that one should give to the videotape.

13 I'm basically saying to you that I saw the
14 videotape. The videotape isn't crucial evidence to me,
15 but it was some evidence that given what he tells his
16 doctors, he may be more capable physically of doing
17 normal physical things than he has told his treating
18 physicians.

19 Q. And I think you got buffaloed a little bit on
20 some stuff.

21 A. Okay.

22 Q. You mention Rothman. What is your impression
23 about what Rothman is saying? Because I know Rothman.
24 I have taken his deposition 15 times, and I know what
25 he's going to say.

1 A. I don't have an independent impression.

2 Q. Well --

3 A. I don't know him. I have never met him.

4 Q. No, no, that's okay. But I read -- you
5 reference him in the report, and I think that you might
6 have misunderstood Rothman's opinion, because I know
7 what his opinion will be without even talking to him.

8 A. Okay.

9 Q. It's the same every time. Let's see where you
10 referenced him here.

11 A. He might have -- I know in 2006 he did a
12 records review.

13 Q. Right. But in your report here, you
14 actually -- let me see if I can --

15 A. Oh --

16 MR. RANALLI: What page?

17 THE WITNESS: Page 13, bottom paragraph in the
18 summary conclusion section, Dr. Rothman's medical
19 opinion was that Mr. Centeno's MRI of the cervical
20 spine did not indicate spinal trauma myomalacia.

21 BY MR. VANNAH:

22 Q. Right. Do you know what myomalacia is?

23 A. It's cord damage, a bruise on the cord.

24 Q. Right. And you know that 98 percent of the
25 cases that you are going to be involved with, that I'm

1 involved with, are not going to involve myomalacia;
2 right?

3 A. I didn't know that.

4 Q. Myomalacia is a very serious condition.

5 A. I have that.

6 Q. You have that?

7 A. I have that.

8 Q. Okay. Well, myomalacia is where you actually
9 have the damage to the cord itself.

10 A. That's what I have.

11 Q. Right. And untreated, it can end up with
12 quadriplegia, paraplegia, serious clonus problems?

13 A. Yes.

14 Q. All sorts of issues. About 98 percent of the
15 cases -- probably 99 percent of the cases you are going
16 to review in your lifetime, or have reviewed in your
17 lifetime dealing with spine injuries, are usually
18 dealing with internal disk disruption or disk
19 herniation, compression on the nerve that emanates from
20 the spinal cord as opposed to actual damage to the cord
21 itself. Do you understand that concept?

22 A. I do.

23 Q. So I'm assuming that Rothman said, I don't
24 think he has myomalacia. That doesn't rule out, of
25 course, other serious problems that require surgery,

1 agreed?

2 A. Agreed.

3 Q. What you may not have known about Dr. Rothman
4 is that he will testify under oath, he will, that the
5 fact that he doesn't see -- all he's saying is I'm a
6 radiologist. And believe me, I know this for a fact.
7 He will say, I'm a radiologist. I looked at a film,
8 and I just read the film. I don't know why they pay me
9 all this money to do that, but defense people love me,
10 because when I read the film, and I say when I read the
11 film, I don't see any anatomical abnormalities on the
12 film. And I say, I understand that. So what? And he
13 says, Well, that's true. So what? It's a good point.
14 Because that doesn't mean the guy is not injured. It
15 doesn't mean he doesn't have internal disk disruption.
16 It doesn't mean all that at all. He says, It doesn't
17 mean he doesn't need surgery. It doesn't mean it
18 didn't happen from the accident. It just means that
19 I'm reading the x-ray. I'm just reading an MRI.
20 That's all they asked me to read it, so I read it, and
21 I wrote down that I didn't see it on the MRI. I mean,
22 so I read that here. I had a bad feeling that maybe
23 you had read too much into Rothman's opinion that the
24 MRI itself doesn't -- does that make sense? Can you
25 comment on that?

1 A. I -- to the extent that I recall my thinking
2 in writing that paragraph, what I was attempting to do
3 is rather than taking sides or being an advocate or not
4 commenting on the treating doctors or giving more
5 weight to the defense retained doctors, I commented on
6 all of the doctors who had seen Mr. Alvarez and what
7 their opinions were and said that there seems to me to
8 be disagreement among them.

9 But I didn't take sides with the disagreement.
10 I just said Schifini and Dunn have interpreted the MRI
11 films as appearing to show greater spinal trauma,
12 leading to Dr. Dunn eventually performing a cervical
13 discectomy. Rothman didn't see spinal cord damage. So
14 I was just comparing them.

15 Q. Well, I'm not sure that Dunn and Schifini are
16 going to testify that they did the surgery based on an
17 MRI.

18 A. Well, I don't think they will either.

19 Q. Yeah. And I know that Rothman will not say
20 that based on this MRI, this person wasn't a surgical
21 candidate, I know he won't. And I just want to bring
22 that to your attention. I mean, when I read it, the
23 implication in your report was that Rothman's opinion
24 varied from Dunn and Schifini, and I don't necessarily
25 believe that it does. Do you see what I'm saying?

1 A. Yes. And if their opinions are the same,
2 then -- and I was incorrect in interpreting their
3 opinions differently, I would say that I was wrong.

4 Q. Well, I'm talking about Rothman. Not -- the
5 other guys are paid a lot of money. They will say
6 whatever he wants them to say. You understand
7 secondary gain in the area of expert witnesses, too;
8 right?

9 A. Sure.

10 Q. That meaning that when a person is an expert,
11 sometimes some people, because they get paid a lot of
12 money over the years and it becomes substantial,
13 recognize that if they are their opinions don't match
14 up with what their master wants it to be that over a
15 period of time that the master will find someone else
16 that's more lucrative opinions. Do you understand what
17 I'm saying? You do recognize that; right?

18 A. Yes.

19 Q. So if I understand you what you are -- I
20 assume you read -- I read Mortillaro's -- and that's
21 what I hate about Saturday depositions, because I'm up
22 till midnight reading on a Friday night all this crap,
23 which I should be doing something more fun. But did
24 you get a chance to read Mortillaro's statement where I
25 think he kindly chided you, I suppose, a little bit.

1 He felt that you had misinterpreted some things. Did
2 you get a chance to read his deposition on that?

3 A. There was the June 30th deposition and then a
4 September something deposition. I read both of them
5 within the past couple of days. Would that have been
6 the September deposition?

7 Q. I don't remember which one. The latest.

8 A. I remember some chiding, but specifically if
9 you can tell me where to turn, I can find it.

10 Q. No. I thought he -- you know, I didn't bring
11 anything, but I have it in my head. I thought he was
12 not unkind. What he was saying is that he's reviewed
13 those films.

14 A. Yes.

15 Q. I don't know if he had reviewed them, but he
16 heard about the films. But his point was this, as a
17 psychologist that neither him or you should be looking
18 at a film, or what he understood as films, and say,
19 Well, as a psychologist, I can look at a film and tell
20 you even though the person's taking strong narcotics,
21 that's inconsistent with what he should be able to do.
22 And you are not saying that; right?

23 A. I'm not saying that.

24 MR. RANALLI: I'm just going to make an
25 objection. I don't think Mortillaro said he talked

1 about the films. I just took his deposition, but --

2 MR. VANNAH: But he talked about the videos.

3 MR. RANALLI: The videos, yeah. Oh, I'm
4 sorry. I thought you were talking about the MRIs. I'm
5 sorry.

6 MR. VANNAH: No, the videos.

7 BY MR. VANNAH:

8 Q. Did you understand it to be the videos when I
9 was referring to --

10 A. Yes. Yes, the video. I know what you are
11 asking.

12 Q. I know I'm old school, but --

13 MR. RANALLI: My fault. Sorry.

14 BY MR. VANNAH:

15 Q. I don't think digital -- digitally --

16 A. I got it. Got it.

17 Q. So I just want to make sure I understand, you
18 are not stating that in your opinion, from your review
19 of the video, that in your opinion that the video is
20 inconsistent with what this person should or should not
21 have been able to do, considering what the doctors had
22 diagnosed him with; is that fair to say?

23 A. That's fair to say.

24 Q. What you are saying, if I understand it, is
25 that you are in that regard relying on this guy out of

1 Reno, Rappaport, and someone else that may have been
2 retained by the defendant that says they don't think
3 it's consistent with what the person should or
4 shouldn't have been able to do based on the diagnosis;
5 is that fair to say?

6 A. I think it's fair to say that I relied to some
7 extent upon the doctors saying -- I recognize that
8 doctors said it was -- that his behavior on the
9 videotape was not inconsistent with his medical
10 condition and that Dr. Rappaport or perhaps one
11 other -- could have been Rothman -- said that it was
12 inconsistent. I give their -- I relied to some extent
13 on the doctors, but also I included my -- my lay or
14 psychological bend that this was inconsistent with how
15 he described himself to his treating physicians.

16 The soccer kick wasn't of great importance to
17 me.

18 Q. So let me rule that out. The soccer kick that
19 you looked at there, you saw a soccer kick, whatever it
20 is, that wasn't of great significance to you,
21 personally?

22 A. What I'm trying to say, and I think what you
23 are asking me, is that I'm not making a -- I'm not a
24 physical therapist. I'm not a physician. I am not a
25 professional who can say whether a rainbow soccer kick

1 is consistent or inconsistent with a person's back
2 problems. I -- that's not my area of expertise.

3 What I was trying to say in my report is that
4 the soccer kick certainly and the carrying of the
5 baggage a few years earlier right before lumbar surgery
6 was inconsistent with the way he described his own
7 ability to doctors who were treating him. In other
8 words, he would say I can't bend, I can't twist, I can
9 only pick up five pounds and carry it or eight pounds.
10 But that didn't appear to be consistent with the
11 rainbow kick or the carrying of all the bags and
12 rolling one. That's what I was saying.

13 Q. So, you know, you understand what I'm bothered
14 by and what I'm going to tell the jury in this case is
15 that, you know, they followed this guy for 400 hours
16 and come up with two minutes' worth of video over a
17 guy's lifetime, 400 hours of trailing him, and say,
18 Hey, you should look at these two videos and just trash
19 the guy. That bothers you a little bit, too; doesn't
20 it?

21 MR. RANALLI: Object to the form. Go ahead.

22 THE WITNESS: Well, I'm not -- I don't think a
23 person should be trashed, period. And certainly I'm
24 not trashing the guy. And I understand what you are
25 saying, and I think, you know, that your point is, Gee,

1 in 400 hours of following this guy, this is all you've
2 got? I would do the same thing if I were an attorney.
3 And so with that, yeah. But that -- yeah. But that's
4 still not the reason why I have this -- these diagnoses
5 that I've made.

6 BY MR. VANNAH:

7 Q. You are not relying that heavily on the video
8 of two minutes or three minutes' worth of video on your
9 diagnosis of malingering; is that fair to say?

10 A. That's fair to say.

11 Q. All right.

12 A. There were lots of different things.

13 Q. And I want to get to those. Because I want to
14 rule that in or out, because that seems to be --

15 A. It's not a big factor.

16 Q. You are obviously not relying heavily on
17 Rothman, especially after I told you what he is going
18 to say at trial, even though I didn't bother to bring
19 him, he will say at trial -- because I have him 15
20 times and I will read it to him 15 times if I need
21 to -- that I'm not saying whether he did or didn't need
22 surgery. I'm just simply saying that the MRI didn't
23 seem to have any major anatomical abnormalities. So
24 you are not relying heavily on him if that's the case;
25 right?

1 A. I'm not going to give any medical opinion that
2 he did or didn't need surgery.

3 Q. No, no, no. I know you wouldn't do that. I
4 mean, you don't need to tell me that. I knew that.
5 But I'm trying to see what you are relying on? Because
6 you may be relying on something that turns out not to
7 be reliable.

8 A. Okay.

9 Q. Do you see what I'm saying? I mean, if you
10 were relying on -- for example, if you were relying on
11 what Dr. Rappaport said and Dr. Rappaport came to trial
12 and said, You know what? I just said that because I
13 got paid a lot of money and I need to make a yacht
14 payment and I don't need to believe it, you wouldn't
15 need to rely on him anymore; right?

16 A. Right.

17 Q. So I'm trying to decide what doctors you are
18 relying on, what medical doctors that you feel stated
19 specifically that his activity level, for lack of
20 better words, was inconsistent with what one would
21 expect if he was that badly injured. So I am trying to
22 find out which doctors you are relying on.

23 A. I guess --

24 Q. It can't be Rothman, because he didn't say
25 that.

1 A. No, no. I think you can say, and I will say
2 the jury, I'm not relying on anyone. I'm not giving
3 weight to -- I'm not giving a lot of weight to
4 anybody's opinions, physicians' opinions. I'm looking
5 at this in a little different way, I think.

6 Q. All right. So I don't waste a lot of time on
7 the video, you are saying that the video was not a very
8 significant part of your opinion as to malingering; is
9 that fair to say?

10 A. Yes.

11 Q. Obviously the Rothman statement that the MRI
12 didn't show myomalacia, for example, or significant
13 abnormalities, you are not relying very heavily on
14 that?

15 A. Correct.

16 Q. Because Rothman will say that it doesn't
17 really mean anything as far as whether or not the
18 person was a surgical candidate.

19 A. Okay.

20 Q. If he does that, you wouldn't rely on an
21 opinion like that; right? I mean, his opinion is what
22 I will tell you it's going to be, and is that the MRI
23 doesn't show significant abnormalities, but that
24 doesn't rule out major injury as a result of the
25 accident. There's not much that you can get from that;

1 right?

2 A. Right.

3 Q. So that really brings us -- what doctor have
4 you relied on that made a statement and what is that
5 statement that you are relying on? And if it's none of
6 those, what -- in other words, there's a doctor that
7 said that I believe that his behavior on the videos is
8 inconsistent, is there someone in particular that you
9 are relying on that made that statement?

10 A. I relied on Rappaport and -- and -- who's the
11 other guy?

12 MR. VANNAH: Who is it?

13 MR. RANALLI: Helm.

14 THE WITNESS: Helm who said that. I saw two
15 doctors who said that's inconsistent. I, whether right
16 or wrong, as a psychologist, looked at the bag carrying
17 and the soccer kick and thought it could be, but I am
18 not a medical doctor. It looked inconsistent with what
19 he told -- what he told his doctors he is capable of.
20 So his behavior in those instances, those two instances
21 seemed inconsistent with what he was telling Mr. Dineen
22 in 2006 or his doctors. That's what I will say.

23 BY MR. VANNAH:

24 Q. How heavy were those suitcases?

25 A. I would say they -- I can't tell you the

1 weight, but they didn't look light --

2 Q. Well --

3 A. -- I don't know the weight.

4 Q. I -- airlines now weigh suitcases.

5 A. Okay.

6 Q. And when I go to the airport, I pick up a
7 suitcase -- well, before I pick them up, I look at the
8 suitcase my wife packs, and I -- and truly when I look
9 at it and it's closed, I have a hard time guessing how
10 much it weighs. I mean, I know it's going to weigh at
11 least ten pounds because the suitcase weighs ten
12 pounds, but I don't know what she's got in there. But
13 the point is when I go and put it on the scale --

14 A. Yeah.

15 Q. -- I'm always -- it varies anywhere from 25 to
16 45 to 50 pounds.

17 A. Fine. Yeah.

18 Q. Is that fair to say?

19 A. I would say, yeah.

20 Q. So was this a big suitcase?

21 A. I guess to make -- let me try to say this as
22 best a way as I can. For someone who was walking with
23 a cane and had terrible radiculopathy and had had
24 cervical surgery and myomalacia, I wouldn't have
25 dreamed of picking up bags for -- and rotator cuff

1 surgery -- and picking up two bags, putting them on my
2 shoulders, wheeling one, and carrying four at a time.
3 That is clearly inconsistent with being in significant
4 pain. If we assume that the bags weigh 25 to 45 pounds
5 each or some of them or a couple, that behavior, show
6 that to the jury and see what they see.

7 Q. Well, that's not fair to ask a jury to make
8 medical decisions.

9 A. That's just common sense. It's not even a
10 medical decision.

11 Q. Well --

12 A. I -- I have been there. Make it -- that's the
13 proper place for that evidence. I can't tell you what
14 the bags weighed. All I can tell you is I've had
15 similar and worse physical symptoms, and what he did
16 there was absolutely inconceivable to me that he would
17 have chosen to do all of those bags at the same time
18 and walk with no apparent pain, that was a -- that was
19 a piece of evidence that suggested that he may not be
20 in as much as pain or as much disability is what I am
21 getting to as what he has claimed to.

22 And my whole diagnosis of pain related
23 disability is not against him as a person. All I'm
24 saying is his malingering is I can't do anything. I
25 can't do any job. He never tried to get a job. And my

1 point is I don't see evidence that he ever -- that he
2 couldn't do something. I don't mean go back to hard
3 labor. I wouldn't expect him to do that. But I think
4 he's feigning a complete incapacity to work in
5 any -- in any type of job. That's my -- that's the
6 whole diagnosis.

7 Q. You're a bright guy, you live in Las Vegas,
8 and you have seen the economy we're in right now?

9 A. Yes.

10 Q. People that are very -- at this point in time,
11 people that are very -- at this point in time, people
12 who are very educated people are having trouble finding
13 jobs. You will recognize that?

14 A. Yes.

15 Q. Does he read English?

16 A. I have read records that his reading of
17 English is of elementary school level. I didn't have
18 the opportunity to actually test his reading ability,
19 so I have read that it's maybe high elementary level.

20 Q. And I understand that, but I understand his
21 English skills and speaking aren't too bad?

22 A. No. They're excellent.

23 Q. But education wise, he didn't even finish the
24 7th grade in Spanish; right?

25 A. I believe you are right.

1 Q. And I remember 7th grade. I had a client once
2 that dropped out in 6th grade, and she said she didn't
3 see anything in the future would be of any great value
4 to her because she just wanted to be a housewife and
5 raise children. She thought that she got all she
6 needed in the 6th grade. She really meant that. Met
7 those kind of people?

8 A. On occasion.

9 Q. I know you're not a vocational
10 rehabilitationist, okay? I recognize that. But being
11 a person with a Ph.D. and a person I consider very
12 bright, you do recognize that a person that doesn't
13 read Spanish, doesn't write Spanish -- I'm sorry,
14 doesn't read English, doesn't write English, has a 7th
15 grade educational background, and has worked all his
16 life in heavy labor, it might be kind of hard to find a
17 job for that kind of person; right?

18 A. Agreed.

19 Q. His wife is studying to be a psychiatrist, so
20 that's impressive. Maybe she can get a job and she
21 could work with you some day; right?

22 A. Let's see the degree -- let's see the degree
23 first.

24 Q. You did read that; right?

25 A. I did. I did.

1 Q. People have big hopes and dreams. Like I
2 remember a girl in her first year of college, I said
3 what are studying? I'm studying to be a judge. Right
4 now she is taking rudimentary algebra. My guess is
5 that she didn't become a judge, so people have
6 aspirations. But you recognize -- and I think it comes
7 to psychologically -- do you recognize that lack of
8 education, that lack of total immersion in English when
9 you are in a foreign country has got to be frustrating
10 in finding a job when you just did heavy labor?

11 A. I agree.

12 Q. Well, I mean, when you make the statement that
13 you think there's a job, what kind of job do you think
14 he can do with his educational background?

15 A. I'm not a vocational expert. I imagine --

16 Q. I know, but you brought that up.

17 A. -- that he -- no. I imagine there are jobs
18 for someone who is fluent in English and very fluent in
19 Spanish, who is in a trade either at the company that
20 he didn't really return to, which is hard to
21 understand, or other -- or that there may be jobs that
22 do not involve heavy labor that would take advantage of
23 his bilinguality where he would -- as he said to me, he
24 wanted to -- he saw himself as a foreman. He wanted to
25 work for the City doing nonlabor kinds of jobs in the

1 trades. There's a good chance that he could -- you
2 know, there's a possibility that he could go for his
3 dream.

4 Q. What dream? I mean, becoming a big
5 contractor?

6 A. An inspector or I -- just about, you know,
7 there are so many lines of work.

8 Q. Well, let's just take inspector. How many
9 inspectors do you think work for the City of Las Vegas
10 that don't read and write English? I hope none.
11 Seriously.

12 A. I don't know. I would imagine --

13 Q. Well, think about that.

14 A. I would imagine they need English. And I'm
15 not certain that he is so below par English that he
16 couldn't learn enough English to get a job.

17 My point, Bob, is that he never tried. I
18 understand he's at a disadvantage. I agree he's at a
19 disadvantage. But he never made any attempt to -- to
20 get any type of job after this. He didn't even tell
21 his own employer that he wasn't coming back, which is
22 really unusual for someone who supposedly had a good
23 position in a company for nine years or so. He just
24 doesn't come back except for a half day here or
25 something and doesn't even say I resign or couldn't

1 work or try to get a desk job, get accommodations under
2 the Americans with Disabilities Act. He never tried.
3 That's the -- that's the crux of my opinion.

4 Q. Well, now let's -- I don't want to be hearing
5 this Disability Act at trial. You are not an expert in
6 that area; right? Or are you?

7 A. At what?

8 Q. The American with Disabilities Act.

9 A. I -- I know -- I'm not a lawyer, but I know
10 disabilities.

11 Q. Well, no. They don't have to -- you
12 understand if he's a heavy laborer and he's unable to
13 do that anymore, they don't have to accommodate him and
14 say, Here. You can work at a desk, right? You know
15 that is not the law?

16 MR. RANALLI: Object as to form.

17 THE WITNESS: I don't know that, but I will
18 take your word for it.

19 BY MR. VANNAH:

20 Q. Well, no. They don't have to do that.

21 A. Okay.

22 Q. If you were a dealer, maybe, and you were
23 dealing cards and you needed to have something behind
24 you, you can still do the same job. They might have to
25 accommodate that, but you understand if a person is

1 seriously injured and he was a heavy laborer, he can't
2 go back and say, You have to accommodate me, make me a
3 heavy laborer, although I can't do the job anymore?

4 A. That makes sense.

5 Q. You are not relying obviously on the fact that
6 he could have gone back and been a heavy laborer --

7 A. No, no. I -- I --

8 Q. Let me finish -- and get some accommodations
9 under the federal act because that doesn't allow that?

10 A. No. No. I didn't -- I didn't believe that
11 given his two back surgeries -- or neck and back
12 surgeries that going back to a heavy laborer job would
13 likely be appropriate. Although, again, that's a
14 medical decision, but it didn't seem right to me. I
15 thought that the evaluations that he had -- well,
16 Dr. Dunn released him to light duty. Dr. Schifini
17 released him. The -- Karen Crawford released him.

18 Q. To light duty, though?

19 A. Light duty. So if there's some sort of a
20 light-duty position that a guy like this could get, he
21 should be trying -- he should have rehabilitation
22 provided.

23 Q. I agree. And what has the defendant provided?
24 What has the defendant who fell asleep and ran into
25 this guy, what have they offered him in the way, Hey,

1 we want to help you get rehabilitated? Anything?

2 A. Well, I guess not or you wouldn't ask me that
3 question. I don't see -- I don't see any records that
4 an offer to have rehabilitation has been made or taken
5 up.

6 Q. Yeah. I always get a kick when they always
7 complain about, Well, why did you do this on a lien?
8 You could have got it cheaper on cash. The question
9 is: How come you didn't offer him some cash and say,
10 Hey, we would like to pay for your medical bills. You
11 didn't see that either; right?

12 MR. RANALLI: Object as to form.

13 BY MR. VANNAH:

14 Q. No, no. My question is: Did you see where
15 the defendants offered to pay his medical bills?

16 A. No.

17 Q. Or ever offer to give him any kind of
18 rehabilitation or assist him?

19 A. I didn't see that.

20 Q. I didn't either.

21 So I'm trying to come down here to this
22 diagnosis. So what are the other -- to kind of rule
23 out my opinion of -- rule out the videotape, because as
24 you say, that's not a significant thing. And now we're
25 down to his effort to get a job, which you do recognize

1 would be difficult in this economy in any event;
2 agreed? Think about that. And people can't get jobs
3 right now with law degrees, according to what I see on
4 TV.

5 A. I understand but people try to get jobs. He
6 has made no -- and correct me if I'm wrong -- since the
7 day of this accident, he has made no attempts to go
8 back to work, to go on an interview, to try to get
9 different education or training. He has made no
10 attempts to get any type of work.

11 Q. Well, let me ask you this: Did you ask him
12 that question?

13 A. Yes.

14 Q. Did you say: What efforts have you made to go
15 back to work?

16 A. I think we talked about it.

17 Q. What did he say?

18 A. I think -- the most he said is in North
19 Carolina, he was set up for a job interview and nothing
20 happened. But you have to say that the preponderance
21 of the evidence is that he's never made a serious or
22 even not so big attempt to return to work after this
23 accident.

24 Q. Why don't we explore that. Any thoughts that
25 you have about work?

1 A. No.

2 Q. What are the other discrepancies you are
3 talking about?

4 A. Well, if we go by -- we've got external -- in
5 other words, there is -- not that he -- there is an
6 external incentive to not go back to work because he
7 could win a lot of money in a personal injury lawsuit.

8 Q. Now, see, I think that's wrong, by the way.

9 A. Okay.

10 Q. I tell every one of my clients if you can go
11 back to work, you should go back to work because juries
12 will be more likely to award you money if they see you
13 are trying.

14 A. Okay.

15 Q. Wouldn't you agree that actually is true?

16 A. If I was juror, I would certainly agree with
17 that.

18 Q. So how is that an incentive to not go back to
19 work if, in fact, the juries are actually bothered by
20 that and tend to be less?

21 MR. RANALLI: I'm going to object to the form.

22 BY MR. VANNAH:

23 Q. See, you brought that up. I actually disagree
24 with you. I don't agree at all that a person -- well,
25 unless a person is like blind and her legs are cut off

1 and have lost one arm and they can't hear, I think that
2 would be hard to find a job. Maybe it would be easier
3 to find a job. People feel more sympathy. I don't
4 know. But, I mean, my point is that --

5 A. It can go either way. I would say that some
6 juries -- it just depends upon the jury you would get
7 and the type of human beings. Some people if you
8 present this person as so disabled or so much in pain
9 that he can't do anything, then the jury could award
10 him a lot more than if he attempted -- in other words,
11 if you could present your client as, Well, he would
12 have tried to get work, but he was in such pain that he
13 couldn't even make -- make it to an interview or even
14 think about getting a job and the jury believes from
15 the presentation of evidence that that's true, then
16 you'll -- you'll get a lot more money than you would, I
17 think --

18 Q. But when you made that statement, I just
19 wanted to disabuse you of that --

20 A. Okay.

21 Q. -- which I find that juries tend to be more
22 sympathetic for someone who tries to go back to work
23 and gets a job at a lower rate and makes an effort.
24 You wouldn't disagree that, in general, psychologically
25 people would be more kind to somebody who is out there

1 doing their best?

2 A. I would think that people would want people to
3 make an attempt --

4 Q. Okay.

5 A. -- to go back to work.

6 Q. Okay.

7 A. There was evidence from the physical
8 examinations from the time of this accident on that the
9 amount of pain that he said he was in may have been
10 exaggerated, given the objective medical findings from
11 his first visit to the doctor saying you can return to
12 work in five days, to his eight sessions with Dr. Katz
13 who said you can return to work without as much
14 lifting, to Dr. Schifini who -- or Dr. Dunn who
15 released him back to work, even after the
16 surgical -- after the surgeries. All of that evidence
17 to Ms. Crawford, there was so many different
18 professionals who had worked with him, even his
19 surgeons who said you can work, not at heavy labor, but
20 you can work, and that he didn't work is suggestive of
21 him attempting not to go back to some work.

22 Q. Let me talk to you about that a little bit.
23 You would agree with me from a psychological standpoint
24 that a person who is in substantial pain, that may
25 affect your ability to work?

1 A. Yes.

2 Q. And especially if the kind of work they're
3 going to be doing is in a job where they -- where the
4 person doesn't read English, doesn't write English, and
5 has a 7th grade education in a Spanish speaking third
6 world country; right?

7 A. I don't see how that goes together.

8 Q. Okay.

9 A. I can see if a person is in a lot of pain, you
10 don't want him to lift bricks.

11 Q. I'm having a hard time understanding who is
12 going to hire this guy from my experience. I can't
13 even imagine -- there just aren't jobs out there right
14 now that I can even think of what he could do. Well,
15 why -- I can't come to any conclusion why an employer
16 would want to hire this guy. What is it that he's got
17 that an employer would want?

18 A. He's got a nice personality. He's
19 intelligent. He has interpersonal skills. He's
20 bilingual. He could do sales. He could use his
21 bilingual -- I -- he is not such an unemployable person
22 on the face of my spending time with him.

23 Q. Those are such nice things. So these are nice
24 things that you can see about him?

25 A. Yeah.

1 Q. Okay. That's good stuff.

2 A. Just because he can't read English very well
3 doesn't mean he couldn't be successful with a nonlabor
4 like job.

5 Q. When I was in high school, they used to tell
6 me that you want to read English well and write it, you
7 can't have a job that doesn't require you to go out and
8 do back breaking work. I learned that much. Didn't
9 they tell you that in guidance counselors?

10 MR. RANALLI: I'm going to object to form.

11 THE WITNESS: I don't remember.

12 BY MR. VANNAH:

13 Q. No, seriously -- well, when you went to high
14 school, I remember the big deal was to make sure you
15 graduate from high school. That was a big deal. They
16 would always say if you can't read and write English
17 well -- my English teachers used to tell me that -- you
18 are going to have a hard time getting a job other than
19 back breaking type of work. Don't you remember that,
20 too? I know we went to different high schools, but --

21 A. I think my father told me to stay -- go to
22 college so I wouldn't end up being a salesman like him.
23 So that's what I -- I understood what you are saying.

24 Q. So let's get beyond the working thing and go
25 to what are the other discrepancies that you see. We

1 talked about the videotape. He's not, in your opinion,
2 making enough effort to get a job, even in a limited
3 capacity?

4 A. Okay. Let's go through my report, and
5 starting at page 15 --

6 Q. Let me go there. Hang on a second. I'm
7 there.

8 A. We have been through paragraph four,
9 that -- we have gone through the inconsistencies of him
10 telling people -- or we have been through the
11 videotapes.

12 Q. Okay. Beat that to death.

13 A. The next paragraph, and one of the criteria in
14 the Spine Journal article is that a person's
15 self-reported history is a discrepancy with documented
16 history. And --

17 Q. And, you know, I think that's crap, but go
18 ahead.

19 A. Okay.

20 Q. Well, I don't know who this idiot is that
21 writes this stuff.

22 A. He's a -- he's a really smart person. I know
23 that.

24 Q. Oh, he's a smart person? All right.

25 A. He's too smart. And the third one probably is

1 too. I just don't know him. But anyway, this
2 is -- this article is a seminar article.

3 Q. I know. But I hear people all the time that
4 talk about -- people tend to brag about what they have
5 done in their life a little bit.

6 A. Sure.

7 Q. And they exaggerate a little bit.

8 A. I --

9 Q. And I have seen people do that all the time.

10 MR. RANALLI: Mr. Vannah never does that about
11 his trial results.

12 THE WITNESS: No, no.

13 MR. VANNAH: Well, no, there are cases.

14 THE WITNESS: I --

15 BY MR. VANNAH:

16 Q. But the point is that I do see people that
17 tend to exaggerate their life accomplishments.

18 A. You are right.

19 Q. And I don't see people. I think most people
20 do that.

21 A. I will grant that most people do that. But
22 one of the things that you look at is that -- there's
23 not -- one of the reasons I'm looking is to see what is
24 he exaggerating. So he's saying to -- to his rehab
25 specialist, I have been a foreman for ten years, which

1 we know isn't true.

2 Q. How do we know that's -- I mean, what is a
3 foreman?

4 A. His position is -- could he have
5 misinterpreted?

6 Q. Well, I mean, if he thinks he's in charge?

7 A. I understand.

8 Q. In other words, if the boss says to him,
9 Hey -- what's his first name?

10 A. Bob, I understand what you are getting at.

11 Q. You know, I used to work in a little bit of
12 construction and they would say, Hey, you are in charge
13 of these idiots, and I was one of the idiots. But I
14 might have thought, Hey, today I'm the foreman.

15 A. I agree. It could be that he just may have
16 blown himself up to be bigger than he is. That's very
17 possible. The other side of this is that in cases such
18 as this, you put a point down for people who -- by
19 blowing himself up to the foreman position, he's
20 influencing a potential expert to raise the level of
21 his award.

22 Q. Oh, okay.

23 A. Do you see that?

24 Q. I see that.

25 A. That's it.

1 Q. Now I get your point. Because he said he
2 wasn't formally a foreman, I don't even know what that
3 means. I've got -- let me just give you an example. I
4 have girls in my office come to me and say, I'm tired
5 of being a legal secretary. I want to be a paralegal.
6 I go, Poof. You are a paralegal. Are you happy now?
7 Now I want more money. Well, no. You are not getting
8 more money, but you are a paralegal. By the way, if
9 you want to be a legal assistant, I can do that too for
10 you. The point is --

11 A. The point is you are cheap.

12 Q. Yeah. The point is that I can pay people what
13 I want. I can call them a foreman. The point is that
14 if you are put in charge of a group of people --

15 A. I'm getting in touch with your staff as soon
16 as we are out of here. They are all going to have new
17 business cards.

18 Q. I don't want them to read this. They can all
19 be paralegals. That's easy to do.

20 A. Okay.

21 Q. Buy them business cards and they can be a
22 paralegal --

23 A. There you go.

24 Q. -- and they don't need the raise now because
25 they have got prestige.

1 A. I'll tell that to your staff.

2 MR. RANALLI: Do you hear that, Ern. That's
3 what we say when we get hit up.

4 BY MR. VANNAH:

5 Q. That's those hierarchy of things.

6 A. That's it.

7 Q. So the point is, you know, if the boss tells
8 him every day, Hey, you know, what's his first name?

9 A. Tony, he goes by.

10 Q. Oh, Tony. You know today, Tony, I'm putting
11 you in charge. Yeah, you do a good job out there.
12 Make sure everyone does a good job digging those holes.
13 He goes home and tells his wife, You know, I was
14 foreman today. I was in charge.

15 A. I'm in charge.

16 Q. So when you say formally the foreman, I mean,
17 that's like formally paralegal. I mean, I don't know
18 that --

19 A. I'm not saying that your theory isn't right,
20 your hypothesis isn't right. I can see that people do
21 that. I agree. That's very possible. I also see the
22 opposite of what I say is also very positive.

23 Q. Well, if he said he was the owner of the
24 company and he was like the chief financial officer in
25 that -- now I have friends who have lived a Walter --

1 A. Uh-huh.

2 Q. -- they actually have said things that
3 actually were just so far out there later I have read
4 about them in the press, like wow. But saying that you
5 have been a foreman when you are put in charge, but you
6 don't have the -- well, you know what I am saying?

7 A. (Witness nods.)

8 Q. So beyond that, what's this other stuff,
9 though?

10 A. Well --

11 Q. For example, here's one you write.

12 A. Okay.

13 Q. Dr. Dunn told him that he would be in danger
14 of paralysis below the waist if he did not choose to
15 undergo lumbar surgery. Now, did somebody diagnose him
16 with myomalacia?

17 A. No. He said --

18 Q. That's why I'm asking you.

19 A. No. That's why I put that there. He said
20 that the reason he was in such pain or that he needed
21 lumbar surgery was because Dr. Dunn reportedly told him
22 he would be in danger of paralysis below the waist if
23 he didn't get it. So I said, Well, okay. Did Dr. Dunn
24 really say that? And Dr. Dunn didn't say that.

25 Q. Well, let me just tell you, this is my field

1 of expertise, so maybe I should write these articles
2 for you guys.

3 A. Okay.

4 Q. When I have clients come see me, I mean -- and
5 I say, What did the doctor say? I'm telling you, it
6 is -- the guy's -- their explanation of what's going to
7 happen to them is so far removed from reality
8 that -- and I don't think they're lying. I mean --

9 A. Okay.

10 Q. -- I think they hear what they hear.

11 A. Which -- which is part of his pain disorder.
12 He may catastrophize, which is why he has a pain
13 disorder diagnosis.

14 Q. Well, sometimes doctors who are talking to the
15 people, they use the word "paralysis," especially when
16 they're talking about the surgery, because that's one
17 of the risks. And so what will happen is the person
18 sits there and listens, and the doctor will say, Well,
19 I recommend the surgery to you. Let me tell you what
20 the risks are. You could be dead when this is over.
21 You could be paralyzed. You could become a
22 quadriplegic. They actually explain --

23 A. Oh, I know.

24 Q. -- these risks.

25 A. I know.

1 Q. So, I mean, here's this guy with a 7th grade
2 education from a third world country who doesn't read
3 and write English listening to this conversation, and
4 he comes back with the thought of, Wow, I could be
5 paralyzed.

6 A. I respectfully disagree with your hypothesis
7 about this. I think he's bright enough to know that
8 Dr. Dunn didn't tell him that if you didn't have the
9 surgery, you would be in danger of paralysis. In fact,
10 Dr. Dunn basically said he could go out -- I have told
11 people they could go out and run a marathon. He
12 wasn't -- this wasn't a neurological condition. It was
13 an orthopedic condition, and there was nothing wrong
14 with him carrying what he wanted to carry if he could
15 withstand the pain. I don't believe that he
16 misunderstood that.

17 Q. Well, let me ask you this then: Who was it
18 that he misrepresented about the paralysis? Is that
19 you? Is it you that he said -- or who did he make this
20 misrepresentation to?

21 A. Oh, I would have to look it up. There has
22 been so many records. I could find it for you if we
23 took a break, but it was -- and if you guys know off
24 the top of your head -- I mean, I can turn to it. It
25 was in the records.

1 Q. So it's not to you that he made that
2 representation?

3 A. No. It would have been in --

4 Q. I wasn't sure.

5 A. -- yeah. So that was something.

6 Q. So that brings me to dumb-dumb doctors, too.
7 You know, I just did a case the other day where I'm the
8 arbitrator, the judge basically, and Dr. Kabins, who I
9 think is a very bright guy, had the guy getting run
10 over while he was riding on a bicycle when, in fact, he
11 was in a car and got hit by a truck. I mean, you do
12 recognize that when you go through boxes and boxes of
13 medical records, if you don't find a discrepancy, you
14 should be worried? Because if there's no discrepancy
15 there, that is telling me something that why aren't
16 there discrepancies; right? There's always
17 discrepancies in medical records.

18 A. Sure. Yeah.

19 Q. I mean, the one I was talking about yesterday,
20 the guy was on a bicycle when, in fact, he was in a
21 car. I don't think I have ever looked at records in a
22 box and there weren't discrepancies. Wouldn't you
23 agree with that?

24 A. Yes.

25 Q. So if we are now talking about that you don't

1 even know who he said this to, maybe the person that is
2 hearing it is hearing something that doesn't make
3 sense. But is that it on this?

4 A. No. There's more.

5 Q. No. I mean, is that it on this paralysis
6 thing?

7 A. I guess.

8 Q. If there's more -- okay.

9 A. Another thing was that he misrepresented to me
10 and to others his history of alcohol abuse.

11 Q. Now that's an interesting question. You know,
12 I'm not so certain -- what makes you so certain that he
13 had alcohol abuse? I know you have got that one record
14 where his wife went in and said, Hey, yeah -- I mean,
15 what wife doesn't think her husband drinks too much? I
16 mean, every wife thinks that.

17 A. I think I have a record in 2001, Dr. Abar or
18 something, that he was not only given a diagnosis of
19 Alcohol Abuse but put on Antabuse to stop him from
20 drinking. He admitted to me in my interview, without
21 knowing that what he was saying was significant to me,
22 that on Friday nights he and the boys typically for
23 years would go out and have 10 or 12 beers. Now, 10 or
24 12 beers is a lot of beers.

25 And this guy's got GERD and gastritis. In

1 2006, he was hospitalized at North Vista Hospital after
2 having his functional capacity exam and Ms. Crawford
3 say to him -- or come up with the conclusion that he
4 can go back to work in medium level, the next day he
5 gets drunk and was hospitalized. He's got an alcohol
6 abuse problem. I think his wife -- he told me his wife
7 has been upset with his drinking. He's had Antabuse.
8 They diagnosed him with Alcohol Abuse. Dr. Gamada when
9 doing his evaluation said that he over drinks. I mean,
10 it's everywhere. He tried to kill himself drinking too
11 much and taking pills. When he's in stressful
12 situations where his whole family -- he has alcoholism
13 throughout his family. He has alcohol abuse, and he
14 doesn't want to represent it. He doesn't -- he
15 downplays or doesn't tell people. He omits that
16 history.

17 Q. Now, we have got the misunderstanding of what
18 Dr. Dunn said, that he drinks. He's a Mexican heavy
19 laborer on a Friday night that drinks heavy on a Friday
20 night. And I'm not being -- I'm not saying
21 anything -- I'm just saying that that's probably not an
22 unusual situation for heavy laborers, period.

23 A. It may not be. Maybe heavy laborers become
24 alcoholics because that's what they do.

25 Q. Well, not all heavy laborers after work on a

1 Friday night -- they go out and they get with the guys
2 and their wives get mad at them because they don't get
3 home till 1:00 o'clock in the morning.

4 A. You know, that doesn't mean anything. The
5 fact that he's drinking 10 to 12 beers -- I like to
6 drink a couple of beers after my -- when I was younger
7 and played softball with the guys, but I drank two.
8 And maybe I was a teetotaler, but 10 to 12? And he's
9 got gastritis and GERD and liver enzyme problems, and
10 he's hospitalized after he drinks.

11 Q. All right.

12 A. He's got an alcohol problem --

13 Q. All right.

14 A. -- and he's hiding it from someone.

15 Q. Okay.

16 A. And that's another thing. He also didn't tell
17 me the truth that he had been arrested before until I
18 asked it a second time in a certain way. So he's not
19 as -- I know his daughter and his wife depicted him in
20 their depositions as being an honest guy, and I know
21 honest people sometimes lie. He -- in these
22 situations, he isn't -- he is covering up and omitting
23 things about him that would not benefit his case. And
24 that --

25 Q. Oh, well, first of all, it wouldn't make any

1 difference in this case. It has no difference in this
2 case.

3 A. What's that?

4 Q. Because it doesn't come into evidence.

5 A. Well, that's a point that the judge has to
6 decide.

7 MR. RANALLI: I'm going to object to that.
8 That will be decided at a hearing, but the doctor has
9 to have some type of evidence.

10 MR. VANNAH: Well, no. You got -- the bottom
11 line is he doesn't just get to get up in front of a
12 jury and say, Have you ever been arrested before?

13 MR. RANALLI: No. The arrest I agree, but the
14 alcohol is --

15 MR. VANNAH: I'm talking about the arrest.

16 MR. RANALLI: Oh, I'm sorry.

17 BY MR. VANNAH:

18 Q. I'm not talking about the alcohol. The
19 alcohol is another story. But the arrest, you know,
20 you don't get to have the lawyers say, Weren't you
21 arrested for shoplifting --

22 A. Okay.

23 Q. -- twelve years ago?

24 A. Okay.

25 Q. Now if he was convicted of something --

1 A. Yes.

2 Q. -- that comes in. But I mean, the point is:
3 Did you ever see the arrest records?

4 A. No.

5 Q. What was he arrested for exactly?

6 A. He said something about an altercation with
7 his wife in the mid '90s. And there was something in
8 his mental health records that he had been arrested on
9 another occasion. I mean, I don't remember offhand,
10 but it was a --

11 MR. RANALLI: It involved DUI.

12 THE WITNESS: DUI.

13 BY MR. VANNAH:

14 Q. You know, I have never had a DUI. But if I
15 had a DUI, especially being arrested, I might not
16 remember that as being an arrest, you know.
17 Maybe that's -- to me, an arrest -- I suppose I have
18 been arrested for speeding, but they didn't put me in
19 handcuffs and take me away. But --

20 A. Yeah, but -- I don't know.

21 Q. But when you questioned him further, he
22 brought up the other incidences?

23 A. So my question?

24 Q. So when you asked him more about it, he
25 probably remembered it; right?

1 A. Yes.

2 Q. When you prompted him, was he candid about it?

3 A. Yes.

4 Q. Anything else?

5 A. Yes. The other part of this definition is, Do
6 you have psychological evidence of symptom
7 magnification, which I didn't have the opportunity to
8 do any of the psychological tests. Dr. Mortillaro did,
9 but I reviewed all of those test results, and there
10 was -- the records were replete with very significant
11 consistent overlapping descriptions of him as having a
12 good possible somatization disorder, mental problems,
13 all sorts of things, alcohol or drug problems.
14 Dr. Mortillaro -- or Gamada actually wrote the report
15 and left all of that out, which you undoubtedly read in
16 my report or my records review when I went over that.

17 But if we take a look at all of the
18 psychological -- if we're in trial and you put up on
19 the board what Dr. Mortillaro ended up saying and what
20 the test results actually said, it's clear to anybody
21 that they left out anything that could be damaging to
22 this guy's case, putting in only -- and purposely did
23 that -- but if you look at the whole test results, it
24 was clear that this guy is a magnifier of symptoms. So
25 that was another piece of it. I mean, putting all this

1 together, he could have gone back to work in something.
2 That's -- that's the basis of this diagnosis. Putting
3 all these different things back together, he made no
4 attempt to do anything.

5 I'm not saying he is a bad guy. I'm not
6 saying he is a sociopath. I'm saying there's lots of
7 evidence that he didn't even try to mitigate his
8 damages in terms of trying to go back to work.

9 Q. So in malingering, what you are really saying
10 about malingering, as I understand it, and maybe
11 even Dr. Mortillaro see this -- is that you feel when
12 you talk about him being a malingerer, what you feel or
13 what you are saying is that he could have gone back to
14 work and do some kind of work?

15 A. In fact, that's what I wanted to -- I think I
16 said it.

17 Q. Okay.

18 A. First -- I didn't say he was a bad guy. What
19 did I say? Let me just exactly -- I said -- page 15
20 bottom paragraph, In summary, in my professional
21 opinion based on a reasonable degree of psychological
22 certainty, Mr. Centeno-Alvarez has feigned being unable
23 to work in any capacity for purposes of secondary gain.

24 Q. All right. Now look --

25 A. That's -- that's it. That's my opinion.

1 In -- in its nutshell.

2 Q. Okay. All right. So you are not saying
3 obviously that he lied to doctors to get treatment or
4 anything?

5 A. No.

6 Q. You are just saying that -- okay. I'm with
7 you.

8 A. It's --

9 Q. So what you are saying is that you believe
10 that he -- well, I will just read it to you: You
11 believe that he has intentionally feigned inability to
12 work in any capacity in order to convince a jury that
13 he should get more money for his loss of income over
14 his lifetime than he should?

15 A. Or to for -- yeah, to get money.

16 Q. Right.

17 A. That he didn't want to go back to work, he
18 wanted money, that's it.

19 Q. All right.

20 A. So that's -- that's -- that's the meaning of
21 that diagnosis.

22 Q. Okay. You are not --

23 A. We haven't talked about any other diagnoses,
24 but that's the meaning of that diagnosis.

25 Q. That diagnosis you are suggesting that the

1 malingerer is his inability to go back to work?

2 A. Correct.

3 Q. Okay. All right.

4 A. And on that note, can I take a bathroom break?

5 MR. VANNAH: Yes. Of course, you can.

6 (Off the record.)

7 MR. VANNAH: Back on the record.

8 BY MR. VANNAH:

9 Q. Let's talk about something more interesting.

10 I want to ask you about -- did Mortillaro do the

11 MMPI-2?

12 A. No.

13 Q. Did you review any -- well, he did a PAI. And

14 refresh me, that's the something --

15 A. Personality Assessment Inventory.

16 Q. Apparently there was -- and a P3, what's a P3?

17 A. Pain profile -- pain something profile.

18 It's --

19 Q. And a BBHI-2?

20 A. And that would be the Brief Behavioral Health

21 Inventory-2.

22 Q. On all three of those, did it come back that
23 there was a suggestion of symptom magnification in all
24 three?

25 A. I believe so. Let me -- let me answer by

1 looking at the actual results. The BBHI-2, that
2 certainly came out with test results that suggested
3 possible symptom exaggeration if -- and with a proviso
4 always if the medical results, the objective medical
5 test results, didn't explain the level of disability.

6 So there's always -- if the general medical
7 condition doesn't explain the level of the person's
8 disability and these scales are high, then there is a
9 possible diagnosis of a somatoform disorder, which was
10 there an the BBHI-2.

11 Q. And -- okay.

12 A. Do you want me to do the others?

13 Q. Yes. Let's do those one at a time. Then I'm
14 going to follow up with you on that?

15 A. Well, interestingly, I just want to point out,
16 he took the pain profile in English and was able to
17 read the items appropriately, which he did with all of
18 them, so he's got some English abilities.

19 He had more depression than the average pain
20 patient, a lot more somatic distress than the average
21 pain patient, and somewhat more anxiety than the
22 average pain patient.

23 Q. Okay.

24 A. And then the last one was the PAI.

25 Q. Right.

1 A. This was the test -- it's the strongest of the
2 tests. It has validity scales that show that he was
3 possibly denying problems with drinking or drug use,
4 was not acknowledging unpleasant or negative aspects of
5 himself, and wasn't necessarily -- and was giving
6 a -- portraying himself as being sort of free of common
7 shortcomings that most people would admit.
8 Diagnostically, without going through this whole
9 thing --

10 Q. So he was trying to portray himself in a
11 better light?

12 A. Psychologically, yes.

13 Q. If I understand, for example, the question on
14 the MMPI-2 is always -- I would always find this
15 interesting -- it says, I never gossip?

16 A. I never gossip.

17 Q. And so if you endorse that as true, that's one
18 of the questions that tend to show that you kind of
19 portray yourself in a false light; right?

20 A. Correct.

21 Q. I know the MMPI is similar, but is that the
22 same thought process?

23 A. Similar thought process. And the PAI
24 indicated some possible drug problems.

25 Q. Well, he has --

1 A. Somatic over -- let's see. A degree of
2 somatic concern unusual even in clinical samples.
3 These somatic complaints are likely to be chronic and
4 accompanied by fatigue and weaknesses and renders the
5 respondent incapable of performing in a minimal role
6 with expectations. Diagnostically, he has a lower
7 level of treatment motivation than most individuals in
8 treatment settings.

9 Q. What does that mean, treatment motivation?

10 A. Probably psychological, not medical treatment.
11 It's more psychological.

12 Q. Okay.

13 A. So putting it all together, diagnostic
14 considerations included a major depressive disorder, a
15 somatization disorder, PTSD or schizophrenia,
16 personality disorder with mixed personality disorder.
17 These are all the things that were consistent with the
18 personality test results.

19 Q. The schizophrenia and paranoid -- well,
20 paranoid, we talked about that a little earlier. One
21 of the questions that we talked about, if you think
22 people are following you, and it turns out George was
23 following him; right?

24 A. Right. I mean, I agree. Not George himself
25 but --

1 Q. His people?

2 A. -- a company. And I didn't conclude he was
3 paranoid, but his treating docs in North Carolina have
4 given him a diagnosis recently or in the past couple of
5 years of schizoaffective disorder, which is a serious
6 mental illness involving both mood disorder and unusual
7 psychotic thinking.

8 MR. VANNAH: Off the record.

9 (Off the record.)

10 MR. VANNAH: Back on the record.

11 BY MR. VANNAH:

12 Q. The PAI came out with a rule out diagnosis;
13 right?

14 A. Several. Several.

15 Q. If I understand that correctly, what it means
16 is, Hey, these are suggestive of a possibility of these
17 various things?

18 A. Yes.

19 Q. And you need to rule them out. I presume the
20 way one rules them out is to do a clinical interview
21 and go over some of these things?

22 A. And/or records review, yes.

23 Q. So I read that Dr. Mortillaro said that he
24 actually -- either he or his assistant there or
25 somebody -- had a conversation to rule these things

1 out. You saw that in his deposition; right?

2 A. Yes.

3 Q. Do you think he is lying about that, that he
4 ruled these things out?

5 A. I would be surprised if either of them did
6 anything of the sort, knowing how they function.

7 Q. You need to elaborate on that?

8 A. I would be surprised if Dr. Mortillaro spent
9 more than a few minutes just saying hello to this guy
10 and ruled anything out. I would be surprised --
11 Dr. Gamada is not even a psychologist, and he did the
12 whole evaluation. So it would be more interesting to
13 have him on the stand and see what he has to say. I
14 don't think that if Dr. Mortillaro says we ruled all of
15 his stuff out that that is true.

16 Q. Okay.

17 A. From having known him for years and knowing
18 how he does his work.

19 Q. Now did you rule in or rule out somatoform
20 disorder during your interview?

21 A. Yeah. He has a pain disorder, which is one
22 type of somatoform disorder, which everybody agrees
23 Dr. Mortillaro or I -- or whoever -- not
24 Dr. Mortillaro, but Dr. Filaso (phonetic). I don't
25 know.

1 Q. And what pain disorder? Is that just what
2 it's called, a pain disorder?

3 A. Pain disorder, which means that he had -- I
4 said quite frankly and forthrightly in my evaluation
5 that this accident caused him a general medical
6 condition or conditions, in that the pain
7 resulting -- that he has pain and actually his doctors
8 will say he needed back surgeries from the incident.
9 And the pain disorder is partly a result of this
10 accident and is related to this accident and also means
11 that he tends to experience more pain subjectively
12 than -- not necessarily due to medical problems, but
13 the way he is psychologically than -- he experiences
14 more pain than he may not -- than most people,
15 reasonable people, would experience.

16 Q. Let me talk to you about that a little bit.
17 Because I remember acutely one time as being struck by
18 a deposition down in LA with a really good
19 psychologist, someone of your level, and what he was
20 pointing out is that the person that was involved in
21 the accident was like a spring-loaded box, meaning
22 that --

23 A. (Witness nods.)

24 Q. -- this person was doing very well. It was a
25 woman, actually. Her name was Proctor -- Proctor

1 versus Cansaleti (phonetic) -- saying that Ms. Proctor
2 was doing very well and functioning very well with her
3 personality, although she was spring-loaded and that
4 the accident caused her to unfortunately develop a
5 serious somatoform disorder and specifically the same
6 category of pain disorder, wherein she experienced
7 these things much worse than an ordinary person would.
8 Is that sort of thinking what you are talking about
9 here? The way I am putting it is in much more of an
10 analogy for you today.

11 A. I -- I can't say that he is akin to a
12 spring-loaded object. I would just say that --

13 Q. I like my little analysis.

14 A. And some people are more spring-loaded. I
15 don't know if I would say he was a really tightly wound
16 guy, but he had this accident, he had two surgeries
17 after the accident that don't appear -- that he would
18 have had he not had this accident. Whether the
19 surgeries are necessary or premature, that's not for me
20 to say.

21 He was out of work. He was having pain. I
22 think that people who have alcohol problems, there's a
23 lot of research showing that they are very prone.
24 There's a huge correlation between alcohol abuse and
25 developing a pain disorder. There's a correlation

1 between having depression and developing a pain
2 disorder. There's also the opposite. There's the
3 possibility that pain results in depression and overuse
4 of alcohol and anxiety and anger.

5 So I am not saying -- I'm saying that the pain
6 disorder that he's having is associated with this
7 accident, but it is also worsened by his alcohol abuse,
8 probably worsened by the amount of narcotics and other
9 drugs that these guys are -- that these doctors are
10 prescribing him, which is amazing.

11 Q. We need to talk about that a little bit.
12 Because you are not going to come to trial and say the
13 doctors are prescribing too much narcotics; right?

14 A. No, no, no. I'm just saying that as a
15 psychologist, you know -- I may not testify to this,
16 but if you are on a lot of psychotropic medications,
17 you can -- those in and of themselves can interact in a
18 way to cause problems.

19 Q. Let me see if I can break this down because
20 I'm like a rat. I need a little bit of cheese at a
21 time to understand it and digest it.

22 A. Okay.

23 Q. So let's talk about that. The alcohol abuse
24 problem that he had you believe pre-existed this
25 accident; right?

1 A. Yes.

2 Q. Is that a psychological disorder that's
3 recognized under the DSM-IV?

4 A. Alcohol abuse, yes.

5 Q. I was going to ask you, then, so what -- and I
6 always get confused on the axis, but what would be the
7 psychological diagnosis, if any, that you reached for
8 this individual that he had prior to the accident other
9 than -- I assume that alcohol abuse would be one?

10 A. Other than that, I didn't have any
11 pre-existing psychological diagnoses.

12 Q. So then I just want to get that straight. So
13 pre-existing psychological diagnoses would include
14 alcohol abuse, which is a recognized DSM-IV TR
15 diagnosis; right?

16 A. Yes.

17 Q. And that's all?

18 A. Yes.

19 Q. Subsequent to the accident, he's developed a
20 pain disorder?

21 A. Yes.

22 Q. It's your opinion that the fact that he had a
23 pre-existing psychological disorder, that being alcohol
24 abuse, made him more susceptible to developing the pain
25 disorder as a result of this accident and the sequella

1 of treatment that he received; right?

2 A. Possibly, yeah.

3 Q. Well, is that to a reasonable degree of
4 medical probability that he was susceptible, more
5 susceptible than the ordinary person?

6 A. Yes.

7 Q. Now the pain disorder that we're referring to
8 is limiting it to that pain disorder, that's not --
9 that's something that's not conscious; right? That's
10 just something that he experiences?

11 A. Yes.

12 Q. And that's a result of his particular
13 psychological makeup that makes him develop that;
14 right?

15 A. Yes.

16 Q. And that you believe to a reasonable degree of
17 psychological certainty is a result of the accident
18 superimposed by his pre-existing problem?

19 A. Yes.

20 Q. Does that pain disorder affect his ability to
21 be employed, by the way, in some respect? I mean, I
22 know it's not the whole thing --

23 A. Yes.

24 Q. -- but would that be something that would
25 affect --

1 A. Yes.

2 Q. Do you agree with that?

3 A. Uh-huh.

4 Q. That's a yes?

5 A. Yes.

6 Q. All right. Now, the major depressive
7 disorder, he has that; right?

8 A. Yes.

9 Q. And I sure can't disagree with you.

10 A. Well, he's --

11 Q. I mean, pretty much any psychologist would
12 have to agree that he has a major depressive disorder;
13 right?

14 A. Yes.

15 Q. To the point that a couple of times he has
16 attempted suicide?

17 A. At least once.

18 Q. I got the feeling that that was a serious
19 attempt, too. Did you get that feeling or did you
20 think it was one of those things -- and I don't
21 understand that stuff very much, but I hear people
22 saying, Well, the guy is just crying out help, but some
23 people actually do it?

24 A. You know, I don't know about that. I have
25 read it in different ways. I'm not sure -- I guess

1 there could have been a more serious attempt because he
2 owns weapons, and he could have just shot himself.

3 Q. Right.

4 A. I think he was very distraught with the
5 outcome of the trial. He was very upset with himself,
6 probably, for turning down the million dollar offer and
7 getting practically nothing. He was probably upset
8 that the jury didn't claim -- didn't give him more than
9 \$36,000. He decided, you know, I don't even want to
10 wake up. Now whether he was -- it was a suicide
11 attempt. He took a lot of alcohol, but he does that a
12 lot, so I don't know -- but it looked like a suicide
13 attempt. And then --

14 Q. The hospitalized one?

15 A. The one -- yeah. A couple of weeks later, he
16 did that. It looked like that -- losing the trial was
17 clearly the single important stressor that set him off
18 into a major depressive disorder.

19 Q. So what we wouldn't be allowed to talk about
20 is prior proceedings. I think that's the way it's put.

21 A. Prior proceedings?

22 MR. RANALLI: Correct.

23 BY MR. VANNAH:

24 Q. So is it your opinion to a reasonable degree
25 of psychological certainty that part of his major

1 depressive disorder is based upon the prior proceedings
2 that pre-existed, the trial that we're going to?

3 A. Yes.

4 Q. What percentage of his major depressive
5 disorder would you give to the prior proceedings as
6 opposed to the action and the treatment that he has
7 received?

8 A. 90 percent, 80 percent. A vast majority of
9 it. It's hard to put a number on it, but --

10 Q. Okay.

11 A. -- it's the single -- it's it.

12 Q. You write down major depressive disorder,
13 single episode. That's the attempt to kill himself?
14 That's that narrow period of time?

15 A. He's remained obviously -- he remained
16 depressed badly for a period of time afterwards
17 according to his wife, according to his daughter,
18 according to him, but I think once he got into
19 counseling, he has been much better and he's coming out
20 of it.

21 Q. It looked that way. I was reading your
22 report, and it looked like when you talked to him that
23 he was saying -- do you believe that counseling was
24 helpful for him?

25 A. Yes.

1 Q. Would you agree that that was well advised
2 that he had that counseling?

3 A. Yes.

4 Q. Now the schizophrenia, you come up with the
5 diagnosis -- are you coming up with the diagnosis of
6 schizophrenia?

7 A. No.

8 Q. Schizophrenia, tell me what that is again, in
9 layman terms?

10 A. It's a thought disorder where you may be
11 hallucinating or delusional, having any irrational
12 thoughts that you believe are rational. He's been
13 diagnosed recently in North Carolina with a
14 schizoaffective disorder, which is an offshoot -- it's
15 a combination of -- if you are schizophrenia, abnormal
16 thinking psychosis, and here's a major depressive
17 disorder with some serious mood disorder, they
18 together -- if you have both a mood disorder and crazy
19 thinking, you can have a schizoaffective disorder,
20 meaning that you have the crazy thinking and the
21 depression, the serious depression. And that's his
22 diagnosis. Working diagnosis lately or in the past
23 year or so, I'm not -- I don't think that's -- I
24 don't -- I don't see it as being accurate.

25 Q. Okay.

1 A. He doesn't strike me as a crazy person, to use
2 layman's words. I think that when he talks about being
3 followed -- I think that when he talks about his
4 paranoia or perhaps mental health experts are assuming
5 that he's really paranoid.

6 Q. For example, that's a good point. For
7 example, when he says people are following me around --

8 A. They may think that he is crazy.

9 Q. If I told you that, that I think people are
10 following me every day and following me around --

11 A. I would believe you.

12 Q. Well, you might. But you might think, Well,
13 maybe Vannah's become a little paranoid.

14 A. If you meant it --

15 Q. But if you found out that the FBI was
16 following me around --

17 A. Then you are right.

18 Q. -- then I wouldn't be paranoid. I would be
19 accurate?

20 A. Yes.

21 Q. So there's a fine line there?

22 A. Yeah. Now it doesn't mean that you can't be
23 followed around and paranoid. That happens
24 occasionally. But, you know, he may have a
25 schizoaffective disorder, but I would be surprised if

1 he doesn't really have the thought disorder.

2 Q. Maybe the professionals there don't recognize
3 that there's some truth to what he is saying and
4 they're just making an assumption, yeah, right,
5 whatever?

6 A. Possible. That's -- that's -- that's a
7 hypothesis.

8 Q. So let's talk about your diagnosis. You don't
9 diagnosis him with any sort of schizophrenia or that
10 subcategory that you mentioned?

11 A. Correct.

12 Q. Do you diagnose him with a -- well, let me ask
13 you this: You wrote this, and I want to make sure I
14 understand it. The PAI suggested a pre-existing
15 personality disorder with borderline paranoid and
16 avoidant features. By pre-existing, what did you mean
17 by -- did you mean pre-existing the accident?

18 A. Probably for years and years.

19 Q. Did you believe that after you had your
20 meeting with him and reviewed the data, do you believe
21 that, in fact, he had a pre-existing personality
22 disorder with borderline paranoid and avoidant
23 features, meaning pre-existing the accident?

24 A. Well, I think in reading Dr. Mortillaro's
25 critique of me, I wanted to set the record straight.

1 If you look at what I did, and I actually remember my
2 thinking, I never diagnosed him with a personality
3 disorder. I saw that the PAI said Rule out a
4 Personality Disorder, NOS.

5 Q. What's NOS?

6 A. Not otherwise specified, which they also said
7 was a mixed personality disorder. You've got features
8 of a couple different personality disorders. What I
9 said to myself, because I remember this, is that I
10 don't know enough about his past. There is not enough
11 collateral evidence that he had a personality disorder,
12 which is sort of the same way that -- the same thing
13 that the PAI is saying, Rule Out a Personality
14 Disorder. I brought it down a notch. I -- I lessened
15 it and said Borderline Paranoid and Avoidant
16 Personality Features. That's not a diagnosis. It's
17 just as noted on the PAI, that the PAI is showing
18 borderline, paranoid, and avoidant features, but that
19 he doesn't -- I never said that he had a personality
20 disorder.

21 Q. Okay.

22 A. So I'm not -- I'm not diagnosing him with a
23 personality disorder. I could have said Rule Out
24 Borderline, Paranoid, and Avoidant Personality Features
25 as noted by the PAI. That might have been better for

1 more exact, but it means the same thing.

2 Q. Did you rule that out --

3 A. I --

4 Q. -- or did you not rule that out?

5 A. I don't know whether -- and I don't think it's
6 particularly -- no one is going to know this. I don't
7 think it's particularly case relevant.

8 Q. Fair enough.

9 A. I'm not going to use it in my opinion. I just
10 said that this was on the PAI and --

11 Q. So when we come right down to it --

12 A. Yes.

13 Q. -- I want to make sure that I got it all. So
14 what I am getting is you believe that he has a -- and I
15 don't know if he still has it -- you believe he has
16 alcohol abuse?

17 A. Yes. By history. It may be over because he
18 said he hasn't used it since 2008 or something like
19 that.

20 MR. RANALLI: '08.

21 THE WITNESS: So if that's true -- now he has
22 also said in the past he wasn't using but was.

23 BY MR. VANNAH:

24 Q. Well, just because -- yes.

25 A. If we assume it's true, then he had alcohol

1 abuse up until 2008 to some point.

2 Q. All right.

3 A. That is with the -- by history.

4 Q. And do you have -- I mean, you know, sometimes
5 people, regardless if they're not being candid about
6 that, there's ways to find out. For example, if
7 they're in a hospital and they do a blood alcohol on
8 them or they get a DUI or there's lots of ways you can
9 find out, Well, that person obviously is wrong about
10 not having a problem because they're not drinking. But
11 have you seen any evidence to indicate to you in any
12 way, shape, or form that he isn't being true when he
13 said he hasn't drank since he stopped in 2008?

14 A. There is no way of finding out if that is
15 incorrect.

16 Q. So let me ask you this: As a psychologist, if
17 he has ceased drinking for over two years, does that
18 mean he no longer has a legitimate diagnosis of alcohol
19 abuse?

20 A. Yes.

21 Q. So right now you don't have an opinion to a
22 reasonable degree of psychological certainty that he
23 has an alcohol abuse diagnosis at this time; right?

24 A. Correct.

25 Q. So I'm looking at this time. So if I

1 understand your diagnosis, it would be the Pain
2 Disorder, which falls within the Somatoform Disorder;
3 right? That would be one?

4 A. Yes.

5 Q. And then he had the Major Depressive Disorder,
6 Single Episode. That would be number two, second
7 diagnosis?

8 A. And that followed the trial, and that's in
9 full remission. So if we're using those criteria, he
10 doesn't have that now any longer.

11 Q. So right now, all he would have is the
12 Somatoform Disorder with the subcategory of Pain
13 Disorder?

14 A. And that pain-related disability of
15 malingering, meaning that --

16 Q. Oh, yeah.

17 A. -- he's -- he could be -- he's feigning or
18 that he isn't capable of doing any type of work when he
19 is capable probably -- I believe he's capable. And I
20 think his doctors who have treated him have -- have
21 told him that he is capable of going back to some sort
22 of employment.

23 Q. And so do I, by the way?

24 A. Oh.

25 Q. But it doesn't mean that there are any jobs

1 for him because of his lack of education. I actually
2 believe that. I'm more cynical about people hiring
3 people who can't do the work.

4 A. Okay.

5 Q. It's a buyers' market out there right now. I
6 mean, they're getting incredibly talented people very
7 cheaply. You would be amazed what I can get for \$8.50
8 an hour with a college education. I will have to hire
9 George.

10 A. No. I am working -- I am working as an
11 attorney for three different law firms. They hired me
12 at \$10.50 an hour.

13 Q. Well, I was going to offer you a job today.

14 A. I am trying to work my way up to a decent
15 hourly wage.

16 Q. I am going to hire you as a paralegal.
17 Everyone has that ability.

18 A. These aren't coming to trial, right?

19 Q. No, of course not.

20 I think I'm with you. So what we have now is
21 the diagnosis now would be the Somatoform Disorder,
22 which specifically is the pain disorder we have talked
23 about?

24 A. Yes.

25 Q. And malingering as it relates specifically to

1 his ability to work?

2 A. Yes.

3 Q. Right?

4 A. With a past history of alcohol abuse, a past
5 history right after the accident of an adjustment
6 disorder with depressed mood, meaning after the
7 accident as a result of the accident he had pain and
8 this hurt and that hurt. And he had surgery, so he
9 became depressed, and we know that. So that is
10 there --

11 Q. And let me just interrupt you. And that you
12 believe was caused by the accident --

13 A. Yes.

14 Q. -- to a reasonable degree of probability?

15 A. Yes.

16 Q. Okay. Go ahead.

17 A. And then the major depressive disorder was not
18 caused by the accident. It was caused by losing
19 the -- what do we call it now?

20 Q. By the earlier proceedings?

21 A. By the earlier proceedings. And that's pretty
22 much a lot better. And I think there's probably more
23 going on in his marriage than either of them may be
24 willing to admit on -- in terms of pre-existing
25 problems in the marriage. And I think those stressors

1 in the marriage, his wife had her own back surgery.

2 His wife had --

3 Q. All of which -- all of which we can't bring in
4 either.

5 MR. RANALLI: Well, that -- if Dr. Etcoff
6 testified to that to a reasonable degree of
7 probability, that's according to Bixler.

8 MR. VANNAH: Well, actually you don't have a
9 reasonable degree of probability that anything in the
10 marriage is caused -- in other words, we know that
11 early in the marriage they had a disagreement. I don't
12 know -- are they still married?

13 MR. RANALLI: They got a divorce and then got
14 remarried.

15 MR. VANNAH: Which is strange, but whatever.

16 BY MR. VANNAH:

17 Q. Not that people get a divorce and get
18 remarried. It's just the way it happened. You know,
19 they signed the papers before they got fully married,
20 whatever that means. I don't know. I don't do
21 divorces.

22 A. I don't know.

23 Q. But certainly, I have heard you use the
24 word -- and I know you are very straight with me -- you
25 have used the words that you have had some suspicions

1 there's more going on in the marriage than meets the
2 eye; right? Actually, every marriage -- I look at
3 marriages all the time and say, Oh, this is the
4 greatest couple I've ever met. And, I mean, a month
5 later, they are divorced and the woman tells me, He was
6 the biggest pig I've ever met. I've hated him for the
7 last ten years. And I was like, Wow. At dinner you
8 seemed so friendly and lovey-dovey. So as you sit here
9 today, I know you've got thoughts of maybe there was
10 something in his marriage, but you certainly are not
11 going to state to a reasonable degree of psychological
12 certainty or probability that there's some sort
13 of -- that the marriage itself is causing psychological
14 issues; fair to say?

15 A. I think it would be fair to say that there had
16 to be some psychological issues with this guy within
17 his marriage previously because of the fact that his
18 wife was mentally ill, if the records about her are
19 true, that she cuts herself, that she has been a
20 bipolar disorder and disassociated disorder, he
21 couldn't have possibly been married to a mentally -- a
22 seriously mentally ill person and not have stress. So
23 I can reasonably say that there was stress in their
24 relationship as a result of her mental illness. To
25 what extent? I don't know. But was -- was there

1 stress that would have made the marriage harder?

2 Absolutely.

3 Q. No, no. I mean, there's stress in any
4 marriage. But if you have a wife and she's mentally
5 ill --

6 A. Mentally ill, yeah.

7 Q. -- it would make it worse.

8 A. If she has been that -- if she has been so bad
9 that she can't work, that she has psychotropic drugs,
10 that she has dissociative disorder, had some terrible
11 trauma in her past, this has to have affected the
12 relationship.

13 Q. Right. But you are not saying to a reasonable
14 degree of psychological certainty that that's caused
15 any major portion of this pain disorder, for example,
16 that he has?

17 A. I think the psychological portion of the pain,
18 I think that it has some -- something to do with the
19 pain disorder. In other words, his -- the stress in
20 his life is causing him to believe that he's in more
21 pain than he necessarily needs to be in. The stress in
22 his marriage, the stress in his life as a whole has
23 something to do with that.

24 I mean, even the literature shows that if you
25 want -- people who are chronically in pain, if you -- I

1 know Dr. Dunn said, Well, let's do another level -- he
2 will probably need another level of cervical surgery
3 and lumbar surgery because, you know, there's
4 breakdown. The research shows that it's hardly ever
5 that a bigger part of someone's pain is emotional and
6 psychological, even greater than anything absolutely
7 wrong with their spine. I mean -- I'm talking back
8 problems. So I think that this guy psychologically for
9 reasons with his marriage, maybe reasons within his
10 past, or all sorts of things made his pain greater than
11 it needed to be.

12 Q. In any event, it all pre-existed this
13 accident?

14 A. It pre-existed this accident.

15 Q. All right. So everybody has stress in their
16 marriage; right? You agree with that?

17 A. Yes.

18 Q. I just don't think I can think of any marriage
19 that isn't a life stressor.

20 A. Everybody's marriage has stress.

21 Q. Not because of anything that I do. But my
22 wife and kids cause me stress. Believe me, if they
23 weren't around all the time -- my wife has been gone
24 for a week, and my stress level has gone down, other
25 than eating -- or foraging for food.

1 A. That's bad.

2 Q. So what you are saying is that he had some
3 stress in his marriage?

4 A. Yes.

5 Q. And that's --

6 A. Beyond ordinary marital stress because of his
7 wife's mental illness. That adds to stress.

8 Q. Right. Well, we will see what the judge
9 says --

10 A. Okay.

11 Q. -- but I don't think the judge is going to let
12 all that crap in, but, you know, I don't know.

13 A. I don't know.

14 Q. But I don't think he should. And, you know,
15 we already had a retrial once, and I don't want to do
16 this again.

17 So the bottom line is that it's your opinion
18 that because of certainly problems that Ms. Alvarez had
19 in the past that this marriage was maybe even more
20 stressful than the ordinary marriage would be --

21 A. And may still --

22 Q. -- or any ordinary marriage is?

23 A. -- have in the present. She may still have in
24 the present if she is mentally ill and all of those
25 treatments -- if these are still in existence.

1 Q. Let me ask you a question: You don't know one
2 way or another what she is going through right now;
3 right?

4 A. Other than I saw her in the videotape, and she
5 is certainly sad -- I mean, she is a very attractive,
6 well spoken, intelligent, but she looked depressed and
7 angry, intense, and anxious. She didn't look happy.

8 Q. You could see that in the videotape?

9 A. Yes.

10 Q. She just looked like an unhappy person?

11 A. She looked like an unhappy person.

12 Q. And maybe she is.

13 A. Maybe it was just that day.

14 Q. How many times did you see her? Just that one
15 time?

16 A. Yes.

17 Q. Well, I look happy today. But, you know, if
18 you saw me a couple of nights ago when I was --

19 A. It may have just been a bad day for her.

20 Q. Fair to say -- let me just put it this way:
21 You can't look at the videotape and say to the jury, I
22 saw a videotape of her where she looked unhappy.

23 A. (Witness nods.)

24 Q. Therefore, in my opinion, she has got a
25 personality disorder; right? You are not going to say

1 that?

2 A. No, I'm not.

3 Q. I know you are not.

4 Would it be fair to say that you are not in a
5 position at this point in time to make any diagnoses of
6 her as having any kind of personality disorders at all?

7 A. Of course not.

8 Q. And you have never looked at any testing done
9 on her; right?

10 A. Correct.

11 Q. And you have never interviewed her to try to
12 make that determination; fair?

13 A. Yes.

14 Q. Did she come with her husband when you
15 interviewed him?

16 A. No.

17 Q. So you have never met her, actually?

18 A. No.

19 Q. Okay. I didn't know that.

20 Okay. Well, that's really -- well, I always
21 ask you this question: Is there anything that I
22 haven't covered today that you think, Hey, I expected
23 you to talk about --

24 A. No.

25 MR. VANNAH: That's fair. I don't have any

1 further questions.

2
3 EXAMINATION

4 BY MR. RANALLI:

5 Q. I just have a few follow-ups. I want to make
6 sure all your opinions are out there so there's no
7 issues. First I want to follow up with Bob's question
8 regarding Ms. Centeno's prior condition. You reviewed
9 the last several depositions that I sent to you of the
10 daughters as well?

11 A. Yes.

12 Q. I believe either the daughters or the mom
13 indicated that she still has her psycho -- I think she
14 still self-mutilates is what one of the witnesses just
15 recently testified to?

16 A. Yes.

17 Q. What effect, if any, does that have to a
18 reasonable degree of psychological probability based on
19 your expertise the fact that she doesn't work
20 since -- I believe she had her incident back in '96.
21 She had a lumbar fusion as well. The psycho -- how do
22 you pronounce that, the type of drugs that she's on?

23 A. Psychotropic.

24 Q. Psychotropic drugs.

25 MR. VANNAH: Tropic.

1 MR. RANALLI: Tropic, sorry.

2 BY MR. RANALLI:

3 Q. According to her testimony, I believe the
4 husband told the children that she's depressed, her
5 back hurts, she's restricted, the fact that she
6 self-mutilates, she has posttraumatic, I believe,
7 stress disorder as well. How does it, if at all,
8 affect him in terms of his mood, depression, things
9 like that to a reasonable degree of your professional
10 opinion?

11 A. It has to make him less happy and more anxious
12 and sometimes more irritable and angry. It would be a
13 negative -- together or even separately, there's a lot
14 of stress in his life.

15 Q. Does that also bleed into common sense? For
16 example, if I live with a partner and they're cutting
17 themselves, they're self-mutilating, they're constantly
18 depressed, they don't work, they can't do the functions
19 around the house, does that affect the partner, the
20 nonaffected partner that doesn't have those symptoms?

21 A. Of course.

22 Q. So everything wouldn't be blamed on this
23 accident?

24 MR. VANNAH: Well, wait a minute. That's so
25 broad. What do you mean by everything when you are

1 saying that?

2 MR. RANALLI: Understood. That's fair.

3 BY MR. RANALLI:

4 Q. So in terms of this chronic depression,
5 obviously there was a big part given the prior
6 proceeding. But the chronic depressive state, the
7 other moods that he has would not all be the same --

8 MR. VANNAH: Let me -- let me -- because I'm
9 going to try to help here because I understand what you
10 are saying with this. I don't think he said there's
11 chronic depression, actually. I don't think there's
12 such a diagnosis of chronic depression right now. I
13 think there was major depressive disorder.

14 BY MR. RANALLI:

15 Q. I may have mispronounced it, but the
16 depressive disorder is what I'm speaking about.

17 A. The major depressive -- and the question again
18 is?

19 Q. I know you attributed 80 to 90 percent as a
20 result of a prior proceeding. What part does the
21 wife's medical condition play into that disorder as
22 well?

23 MR. VANNAH: And let me help you. I'm not
24 going to argue that there was major depressive disorder
25 that he went through is related at all to this

1 accident. I'm not making that claim.

2 MR. RANALLI: Okay.

3 BY MR. RANALLI:

4 Q. No. But since the time of the accident -- I
5 mean, did you believe when you were discussing with
6 Mr. Vannah that prior to the accident that he would
7 have had these type of stressors in his life already --

8 A. Yes.

9 Q. -- which would have continued throughout after
10 the accident? Is that what you are saying as well?

11 A. Yes.

12 Q. And that's to a reasonable degree of
13 psychological probability?

14 A. Yes.

15 And if he's still depressed some and it's no
16 longer a major depressive disorder, he -- some of his
17 depression may likely -- more likely than not be
18 related to his wife's mental illness, some would be his
19 physical condition, some would be his being in
20 litigation, some would be things I don't even know
21 about.

22 Q. I understand. Pain is subjective from a
23 psychological standpoint as well?

24 MR. VANNAH: Pain is subjective from any
25 standpoint.

1 THE WITNESS: Yes.

2 BY MR. RANALLI:

3 Q. Just making sure. Okay.

4 I want to explore a little more regarding
5 Karen Crawford, the functional capacity we located in
6 someone else's medical records and the difference
7 between the outcome of the FCE with Karen Crawford
8 versus the outcome with Terrence Dineen and the alcohol
9 abuse and between that time.

10 A. You know, that's -- there's so many records.
11 One of the things I -- I saw was in -- and I have a
12 little outline of what went -- you know, what came
13 first and just sort of a chronology. And it was, I
14 think, November 15, 2006, Karen Crawford did a
15 functional capacity evaluation or examination and
16 determined that Mr. Alvarez couldn't do heavy labor any
17 longer but could do a medium physical demand, whatever
18 that is. I don't know what that is. Four days later,
19 he was hospitalized at North Vista Hospital having
20 admittedly consumed a dozen beers the night before at a
21 boxing match and having severe GI distress for which he
22 needed to be hospitalized.

23 I thought that was an interesting coincidence
24 that he passed an examination suggesting -- indicating
25 that he could go back to work, and four days later, he

1 got so drunk that he needed to be hospitalized. And
2 that got my antenna up. I wondered if he got drunk --
3 I said to myself, I wonder if he got drunk because he
4 did well on that examination and knew that they're
5 going to say he has to go back to work. Then I didn't
6 come to any conclusion, but then a day later after he
7 left the hospital, he saw another expert, Terrence
8 Dineen, for examination and told Mr. Dineen, after five
9 days ago being cleared, that he can't bend from the
10 waist or carry more than eight pounds for short
11 distances.

12 Q. Did it just contradict what he did five days
13 ago?

14 A. I guess it did. So that was really -- that --
15 that sort of still --

16 Q. What's your opinion to a reasonable degree of
17 psychological probability regarding this finding?

18 MR. VANNAH: Which finding?

19 BY MR. RANALLI:

20 Q. The --

21 MR. VANNAH: The speculation that he went out
22 and got drunk because he didn't like the FCE?

23 THE WITNESS: I can't prove that, but I think
24 that it is --

25 MR. VANNAH: So you don't have an opinion to a

1 reasonable psychological degree that he went out and
2 got drunk because he didn't like the FCE?

3 THE WITNESS: I can't prove that.

4 MR. VANNAH: Because he drank anyway like
5 that?

6 THE WITNESS: Could be. Could be.

7 MR. VANNAH: He drank when he saw the soccer
8 game and his team lost?

9 BY MR. RANALLI:

10 Q. What you do have is you have two competing FCE
11 exams?

12 A. I have two competing, only five days apart
13 with completely different findings.

14 Q. This happened obviously after the incident of
15 why we're here today?

16 A. Yes.

17 Q. And then he was able to manage his way to a
18 boxing match as well; right?

19 A. Yes.

20 Q. He wasn't working at all?

21 MR. VANNAH: He wasn't boxing.

22 MR. RANALLI: I got you.

23 BY MR. RANALLI:

24 Q. But, yeah. He can't work, but he managed to
25 get himself to watch boxing; right?

1 MR. VANNAH: Yeah. He was able to sit down
2 and watch a boxing match.

3 MR. RANALLI: All right. That sounds good.
4 BY MR. RANALLI:

5 Q. In terms of your opinion to a reasonable
6 degree of psychological probability regarding alcohol
7 use after the accident, what's your opinion regarding
8 that alcohol abuse?

9 A. He used alcohol before the accident
10 excessively, he used it after the accident excessively.

11 Q. How does that affect his pain behaviors,
12 assuming his pain behaviors are true?

13 A. Well, it's not good for his pain behaviors.
14 It's exacerbating. If he's using alcohol and using
15 these pain medications together, I think it's dangerous
16 and it's against doctors orders, and it makes him more
17 impaired than he needs to be. It's hurting yourself
18 when you drink that much and you're taking
19 psychotropics, narcotics, and diuretics,
20 antidepressants, muscle relaxants. It's not good for
21 you. So he's harming himself by doing that.

22 Q. Did you read Dr. Dunn's testimony regarding
23 his opinions to a probability regarding alcohol,
24 consuming alcohol while taking narcotic medications?

25 A. I did.

1 Q. Would you agree with those --

2 A. Yes.

3 Q. -- from your psychological standpoint?

4 A. Yes.

5 Q. Work is therapeutic from a psychological
6 standpoint?

7 A. Yes.

8 MR. VANNAH: I disagree.

9 MR. RANALLI: I don't have anything else.

10 Well, let me just -- wait a second. I'm done.

11

12 FURTHER EXAMINATION

13 BY MR. VANNAH:

14 Q. How much have you charged for all this stuff?

15 A. I don't have my -- this week? I mean --

16 Q. Just give me --

17 A. -- the bills?

18 Q. Well, I mean, that's a lot of crap to read.

19 And you are here -- you met with George this morning?

20 A. Yes. For 20 minutes.

21 Q. What time did you guys get together?

22 A. Around 8:30.

23 Q. Did you talk to him about this little sheet
24 you had? Because he was really --

25 A. Oh, yeah.

1 Q. Did you tell him these are things that I can
2 bring up?

3 A. I had mentioned when I was doing my timeline
4 that I had seen this --

5 Q. But I noticed he didn't really get into that.
6 He just happened to ask you about the question you had
7 all written down, so I assume that you --

8 A. Well, it's just the timeline.

9 Q. You brought that to his attention and said I
10 thought this might be helpful?

11 A. Well, I just said this is something that I
12 noticed in all of this.

13 Q. But did you say to him, This might be helpful.
14 You might want to bring this out? It might be helpful
15 to your case. Truthfully.

16 A. I may have. I don't know if I said it. He
17 may have said it.

18 MR. RANALLI: Well, I'm going to use it in
19 trial. I will tell you right now.

20 THE WITNESS: I believe I may have recognized
21 it, but he --

22 MR. RANALLI: You mean comparing the FCEs?

23 THE WITNESS: Yeah.

24 MR. VANNAH: I don't doubt you are going to do
25 a lot of stuff in trial.

1 BY MR. VANNAH:

2 Q. My point was if you said, Hey, I have got some
3 stuff here that might be helpful to you?

4 A. No. I don't talk that way. I mentioned that
5 by the way -- and he didn't think he would remember
6 this part, so I mentioned that he thought it was pretty
7 positive, and he didn't say, you know, talk about it.
8 He just was here and -- and I could tell he liked it.

9 MR. RANALLI: I forgot about the boxing match
10 for the first trial, but I am going to bring the gloves
11 this time.

12 THE WITNESS: Yeah. This is like a boxing
13 match.

14 BY MR. VANNAH:

15 Q. We are back to money. I mean, so what have
16 you billed?

17 A. What have I billed?

18 Q. Yes. What have you -- yeah. I just want --

19 A. The whole thing?

20 Q. Yeah. The whole thing?

21 A. We have billed out, and not counting
22 preparation for things I have no clue --

23 Q. Right.

24 A. We billed out November 12, 2008 was
25 \$13,000 -- no. It was \$13,742.55.

1 Q. That was what year?

2 A. That was 2008. That was the records review.
3 I spent 17.25 hours and Dr. Belmont, my associate in
4 organizing and going through and reviewing the records
5 and dictating that review, 28 hours. Then in --
6 May 27, 2010, the work for the actual IPE or
7 independent psychological evaluation was \$7,037.50, of
8 which I spent 13.5 hours and Dr. Belmont 8.25 hours.
9 And a month later, more records came. June 25, 2010,
10 there was a bill for \$2,832.75, of which I spent 5.5
11 hours and Dr. Belmont 3.25 hours. And that's it.

12 Q. And --

13 A. No other bills have been made.

14 Q. Obviously, I have paid you today two hours for
15 how much?

16 A. For you?

17 Q. Yeah, for me.

18 A. Tell the --

19 Q. Yeah. For me it was double, but --

20 A. I think it's like \$500.00 per hour. It's like
21 \$1,000.

22 Q. That's --

23 A. That's my understanding. I think that's it.

24 Q. And I think --

25 A. You may have paid that already.

1 Q. No, I'm sure I did. Well, honestly, I know we
2 did.

3 A. I know. You are --

4 Q. For trial, what do you charge?

5 A. I think for half day \$1,750 and for full day
6 twice that.

7 Q. You are probably going to spend some time
8 getting ready. You have got to go through this to get
9 ready. What do you think that's going to cost, just a
10 rough estimate? Because you want to be prepared and
11 thorough, because you know I'm going to be asking you
12 questions.

13 A. I have no clue. I guess five to ten hours in
14 preparation. That's a guess.

15 Q. What do you charge per hour when you are doing
16 that kind of work?

17 A. Free.

18 Q. What do you charge per hour?

19 A. Free.

20 Q. Three?

21 A. No, free.

22 Q. Seriously?

23 A. No. I charge \$350.00.

24 Q. So it looks like, I mean, a reasonable
25 estimate you would have charged 13 plus 7 -- 14 plus 7,

1 21 plus 3, 24, 25 -- 26, 27, 28, 29 -- about \$30,000?

2 A. Makes sense.

3 Q. Have you worked with George before or is this
4 your first time?

5 A. No. I think we have done a couple of cases
6 before. Not a zillion. I -- I don't -- he would know
7 better than I do. I don't even try to remember.

8 Q. Thirty bazillion?

9 A. I don't know. A couple. I know it's not that
10 much.

11 Q. What percentage of your time in the last few
12 years have you been doing defense medical/legal -- I
13 call it medical/legal, but psychological/legal versus
14 plaintiff?

15 A. It's all 80/20, defense versus plaintiff, in
16 that area.

17 MR. VANNAH: Okay. That's all the questions I
18 have.

19 MR. RANALLI: That's all I have.

20 MR. VANNAH: Thanks.

21 THE WITNESS: Thank you.

22 (Thereupon, the deposition concluded at
23 11:18 a.m.)

24

25

1 CERTIFICATE OF DEPONENT

2	PAGE	LINE	CHANGE	REASON
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10 * * * * *

11
12 I, LEWIS M. ETCOFF, Ph.D., deponent herein, do hereby
13 certify and declare under the penalty of perjury the
14 within and foregoing transcription to be my deposition
15 in said action; that I have read, corrected and do
16 hereby affix my signature to said deposition.

17
18 _____
19 LEWIS M. ETCOFF, Ph.D., Deponent
20
21
22
23
24
25

1 CERTIFICATE OF REPORTER

2 STATE OF NEVADA)
COUNTY OF CLARK)

3 I, Michelle R. Ferreyra-Marez, a Certified Court
4 Reporter licensed by the State of Nevada, do hereby
5 certify: That I reported the deposition of LEWIS M.
6 ETCOFF, Ph.D., commencing on Saturday, September 25,
7 2010, at 9:02 a.m.

8 That prior to being deposed, the witness was
9 duly sworn by me to testify to the truth. That I
10 thereafter transcribed my said stenographic notes into
11 written form, and that the typewritten transcript is a
12 complete, true and accurate transcription of my said
13 stenographic notes, and that a request has been made to
14 review the transcript.

15 I further certify that I am not a relative,
16 employee or independent contractor of counsel or of any
17 of the parties involved in the proceeding, nor a person
18 financially interested in the proceeding, nor do I have
19 any other relationship that may reasonably cause my
20 impartiality to be questioned.

21 IN WITNESS WHEREOF, I have set my hand in my
22 office in the County of Clark, State of Nevada, this
23 27th day of September, 2010.

24
25 MICHELLE R. FERREYRA-MAREZ, CCR No. 876

EXHIBIT “3”

TRANSCRIPT OF MEDICAL EXAMINATION

Transcribed from
DVD provided by
Richard Johnson, Esq.

Transcribed by: Jennifer A. Clark, RDR, CCR #422

Page 2

1 DR. DUKE: What -- what kind of -- how
 2 did you get run in -- or what was the mechanism of
 3 the action of the accident?
 4 MR. RIBERA: As -- as far
 5 as (unintelligible) --
 6 DR. DUKE: What -- what actually
 7 happened during the car wreck?
 8 MR. RIBERA: The -- the vehicle got hit
 9 from the side by -- from a vehicle that was coming
 10 down going eastbound on Charleston right where the
 11 Home Depot there is on Hualapai and Charleston. The
 12 inlet that --
 13 DR. DUKE: Uh-huh.
 14 MR. RIBERA: Right where you come out of
 15 the parking lot.
 16 DR. DUKE: So the other vehicle got hit,
 17 pushed into you --
 18 MR. RIBERA: No. He hit us. We were --
 19 he was blindsided from a vehicle that was turning
 20 into the Home Depot parking lot. That's why he was
 21 never seen. He was behind him, so he wasn't seen
 22 until he was coming out further. And he came and
 23 hit the -- hit the -- hit the whole quarter panel
 24 side and then spun the whole truck around. And then
 25 they deemed it -- they totaled it, I guess.

Page 3

1 DR. DUKE: Did you get knocked out?
 2 MR. RIBERA: Did I get knocked out?
 3 DR. DUKE: Yeah.
 4 MR. RIBERA: No, no.
 5 DR. DUKE: Okay. Did you have a seat
 6 belt on?
 7 MR. RIBERA: Did I what?
 8 DR. DUKE: Have a seat belt on?
 9 MR. RIBERA: Yes.
 10 DR. DUKE: Okay. These are just
 11 standard questions.
 12 MR. RIBERA: No problem.
 13 DR. DUKE: And did you get taken to the
 14 hospital or anything like that?
 15 MR. RIBERA: No.
 16 DR. DUKE: When did you first seek
 17 medical attention?
 18 MR. RIBERA: It was a few weeks
 19 afterwards is when I first sought medical attention.
 20 I thought the pain was just going to go away, and it
 21 never did, so that's when I decided to go in when
 22 I -- when I couldn't take it no longer.
 23 DR. DUKE: Okay. And now let's -- let's
 24 go over -- you -- you had -- you went down to
 25 Scottsdale --

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1 MR. RIBERA: Yes.
 2 DR. DUKE: -- to get some laser spine
 3 surgery?
 4 MR. RIBERA: Correct.
 5 DR. DUKE: Which -- which never works.
 6 MR. RIBERA: I had Dr. Flangas say the
 7 same thing.
 8 DR. DUKE: We thought about -- we were
 9 renaming our office. We were going to rename it to
 10 the Laser Spine Institution Correction --
 11 MR. RIBERA: Correction facility.
 12 DR. DUKE: Correction Facility, yeah.
 13 MR. RIBERA: So are you getting a lot of
 14 patients back from that?
 15 DR. DUKE: Oh, yeah. Tons.
 16 MR. RIBERA: Do you really? You know,
 17 it's funny, 'cause the pain was different when I
 18 first went in there. It was -- it was more of a --
 19 it was sharper before the surgery. Like, I mean,
 20 I -- well, now I can tolerate sitting down. Before
 21 the surgery, I couldn't. I mean, I couldn't sit
 22 down more than 15, 20 minutes, and I had to get up.
 23 I had to be walking around, and that took the pain
 24 away.
 25 DR. DUKE: So what -- what pain were you

Page 5

1 looking to get rid of with laser spine surgery?
 2 MR. RIBERA: Kind of what I'm feeling
 3 right now. I thought it was going to be gone
 4 completely. I mean, that was (unintelligible) --
 5 DR. DUKE: What exactly are you feeling?
 6 I don't know that.
 7 MR. RIBERA: It's kind of a numbness and
 8 a burning down right at the tailbone, right -- right
 9 at the base, like --
 10 DR. DUKE: In the middle?
 11 MR. RIBERA: Right in that area right in
 12 there.
 13 DR. DUKE: Okay. So right in the
 14 middle.
 15 MR. RIBERA: Like right down below
 16 the -- like, almost like the bottom of the -- the
 17 bone. You know, 'cause I guess that's the bottom of
 18 your spine right down there.
 19 DR. DUKE: Did you have any leg pain
 20 before the laser spine surgery?
 21 MR. RIBERA: No.
 22 DR. DUKE: Did you have any after?
 23 MR. RIBERA: It -- the pain came and
 24 went. It -- the left -- the pain in my left leg
 25 comes and goes. It doesn't -- it's not there every

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1 day.
 2 DR. DUKE: When did it start?
 3 MR. RIBERA: It's kind of there every
 4 day.
 5 Huh?
 6 DR. DUKE: When did it start?
 7 MR. RIBERA: It started sometime after
 8 that, you know. I didn't -- I didn't notice it
 9 until I just felt a frequent pain. It was not
 10 frequent but just pain that was coming in my left
 11 leg, and it would be kind of numbing. And it would
 12 last for a week -- it would last anywhere from three
 13 or four days to a couple of weeks, and then it would
 14 go away.
 15 DR. DUKE: Uh-huh.
 16 MR. RIBERA: And then a month later, it
 17 would be back. And to -- you know, you couldn't do
 18 this, you couldn't do that and get comfortable.
 19 You -- you sit on the couch, elevate it, and just
 20 whatever you did --
 21 DR. DUKE: Uh-huh.
 22 MR. RIBERA: -- it wouldn't get --
 23 wouldn't be comfortable. And that's --
 24 DR. DUKE: So the -- the -- the symptoms
 25 that you had surgery for at the Laser Spine

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1 Institute was pain and burning at the base of your
 2 spine.
 3 MR. RIBERA: Yes. I didn't notice this
 4 until after, and if it was there before, I --
 5 DR. DUKE: How long after?
 6 MR. RIBERA: I can't recall. I -- I
 7 really don't -- I really don't know, to be honest
 8 with you. You know, like I said, it could have been
 9 there before it, and it's still there now and I just
 10 never noticed it.
 11 You know, I do have very -- I have -- I
 12 have a high tolerance for pain, so when I have pain
 13 in my body, I'm usually -- it's at the extreme
 14 before I go in.
 15 DR. DUKE: What kind of work do you do?
 16 MR. RIBERA: I'm a serviceman for
 17 elevators.
 18 DR. DUKE: Okay. Now, in your --
 19 your -- no neck symptoms, no arm symptoms that
 20 you're -- that you're treating for right now;
 21 correct?
 22 MR. RIBERA: No arms, but I -- I had a
 23 bunch of pain in the back of the neck leading up --
 24 DR. DUKE: Are you relating it to the
 25 accident or not? Do you think --

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1 MR. RIBERA: I think it's attributed to
 2 but --
 3 DR. DUKE: Did you make a claim for it,
 4 though? Have you sued them for neck symptoms?
 5 MR. RIBERA: Oh, well, just the whole
 6 back. I mean, that's part of the back, isn't it?
 7 DR. DUKE: Well, usually people, they
 8 sue for their lumbar spine or their cervical spine.
 9 MR. RIBERA: Oh, I mean, I didn't
 10 realize -- I mean, I -- I get treatments for that.
 11 I get massages for that and stuff like that from --
 12 I've had people come to the house and the entire --
 13 you know, other massage therapists.
 14 DR. DUKE: Let's -- let's go over
 15 your --
 16 MR. RIBERA: But -- but not necessarily
 17 saying, you know, this is, you know --
 18 DR. DUKE: Okay. Let's go over your
 19 current symptoms starting with the most severe.
 20 Number one, what's the most severe
 21 symptom you have?
 22 MR. RIBERA: It's -- it's the L4-L5-S1
 23 pain.
 24 DR. DUKE: Let me just -- just tell me
 25 what the symptoms are. If you use L4-5, that's a

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1 diagnosis.
 2 MR. RIBERA: Okay. Well, I just thought
 3 from what the doctors say, it's just -- the pain
 4 level. Lower back? Is that fair enough?
 5 DR. DUKE: So low back pain.
 6 MR. RIBERA: Yes. That's the more
 7 severe.
 8 DR. DUKE: So low back pain is number
 9 one. It's kind of like right at the belt line; is
 10 that right?
 11 MR. RIBERA: Belt line? No, I think
 12 it's below the belt line.
 13 DR. DUKE: Below the belt line.
 14 MR. RIBERA: Yeah.
 15 DR. DUKE: Does it go into the buttocks
 16 at all?
 17 MR. RIBERA: Vaguely. I mean, even
 18 if -- if it does too much, I really don't notice it
 19 'cause of the -- the spot right at the -- at the
 20 base of -- that's where the main burden of the pain
 21 is at.
 22 DR. DUKE: So really no buttock pain.
 23 MR. RIBERA: Not really, no.
 24 DR. DUKE: And often do you get the leg
 25 pain?

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1 MR. RIBERA: I would say -- I would say
 2 I probably get it once every six weeks to two
 3 months, and it lasts for a week or two.
 4 DR. DUKE: What part of the leg does it
 5 involve?
 6 MR. RIBERA: What -- only this left leg.
 7 DR. DUKE: (Unintelligible.)
 8 MR. RIBERA: Never the right leg.
 9 DR. DUKE: Pardon me?
 10 MR. RIBERA: It's like right in the --
 11 is this the quad?
 12 DR. DUKE: The top of the thigh?
 13 MR. RIBERA: Yeah, quad area and kind of
 14 goes through down here. And then with that at
 15 times, I'll get this tingling in my -- I know you
 16 guys described as something like needles.
 17 DR. DUKE: Uh-huh.
 18 MR. RIBERA: Pins and needles, that's
 19 when I get on -- on -- on the left -- on the left
 20 foot area. And then but -- but that that doesn't
 21 always come with this. Sometimes this pain is here
 22 without that pain. As a matter of fact, when I was
 23 out in your lobby waiting, I had the left -- I had
 24 the tingling in the left foot.
 25 DR. DUKE: Okay.

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1 MR. RIBERA: Almost like a numbness,
 2 like it's -- almost like it's fallen asleep, but I
 3 know -- and I thought that -- there's -- there's no
 4 pressure on it. It shouldn't be falling asleep.
 5 There's nothing --
 6 DR. DUKE: Okay. Number 2?
 7 MR. RIBERA: That kind of feeling.
 8 DR. DUKE: What's the second most
 9 problematic thing? We can -- we can call that 2.
 10 What would be number 3?
 11 MR. RIBERA: Okay. The mid back.
 12 DR. DUKE: (Unintelligible.)
 13 MR. RIBERA: And -- and like I said,
 14 that's being overshadowed by -- by everything that's
 15 happened with the lower back.
 16 DR. DUKE: Okay.
 17 MR. RIBERA: And the neck. I would say
 18 that those two things --
 19 DR. DUKE: Okay.
 20 MR. RIBERA: I mean, anytime I move my
 21 neck, there's -- I mean, there's -- there's -- it
 22 just -- it feels like all the muscles are tight in
 23 the neck.
 24 DR. DUKE: What are the --
 25 MR. RIBERA: That's kind of what it

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1 feels like.
 2 DR. DUKE: What are your -- your current
 3 medications include morphine?
 4 MR. RIBERA: Yes.
 5 DR. DUKE: Do you take that every three
 6 hours?
 7 MR. RIBERA: Every four to six hours.
 8 DR. DUKE: I mean, that's an outrageous
 9 amount. Wow. So --
 10 MR. RIBERA: I probably take about a
 11 four a day. So I take one -- and I'm just taking
 12 the same thing on Percocet.
 13 DR. DUKE: Who's got you on the drugs?
 14 MR. RIBERA: Dr. Erkulwater.
 15 DR. DUKE: Okay. Wow.
 16 MR. RIBERA: Southern Nevada Pain
 17 Center.
 18 DR. DUKE: Do you -- do you know that
 19 these are highly, highly addictive?
 20 MR. RIBERA: Uh-huh.
 21 DR. DUKE: How long total have you been
 22 on the narcotics?
 23 MR. RIBERA: I switched to the morphine
 24 on --
 25 DR. DUKE: Just narcotics in general.

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1 MR. RIBERA: Oh, shit. From the -- I --
 2 I am going to say since May -- I'm going to say
 3 about mid May 2007.
 4 DR. DUKE: Had you ever been on
 5 narcotics before?
 6 MR. RIBERA: No, never, never.
 7 DR. DUKE: Never (unintelligible) --
 8 MR. RIBERA: Not that I could remember.
 9 I mean, I --
 10 DR. DUKE: (Unintelligible) Long-term
 11 use.
 12 MR. RIBERA: Yes, yeah. You know, I'm
 13 not a -- I might have gone in for something in the
 14 past and I had something that I didn't realize
 15 was --
 16 DR. DUKE: Any kind of drug use?
 17 MR. RIBERA: No.
 18 DR. DUKE: Have you ever been through
 19 any addictions?
 20 MR. RIBERA: No.
 21 DR. DUKE: Programs?
 22 MR. RIBERA: No (unintelligible).
 23 DR. DUKE: Alcoholism? No alcohol
 24 addiction?
 25 MR. RIBERA: No.

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1 DR. DUKE: And then what about have you
 2 ever had a -- you know, a worker's comp claim
 3 before?
 4 MR. RIBERA: Worker's comp claim? I
 5 don't think so, no.
 6 DR. DUKE: Okay. Yeah, this is just
 7 standard stuff.
 8 MR. RIBERA: Yeah, no problem.
 9 DR. DUKE: Just standard stuff.
 10 Any other car wrecks?
 11 MR. RIBERA: I did get in a little
 12 fender-bender that I ran -- I ran into a guy ahead
 13 of me at a stop light that I -- this is after the
 14 accident. It's probably about nine months ago, but
 15 it was nothing. It was no --
 16 DR. DUKE: There was (unintelligible) --
 17 MR. RIBERA: -- claim, yeah.
 18 DR. DUKE: Did he claim an injury?
 19 MR. RIBERA: No, no. It was just, like,
 20 he didn't even -- you know, it was nothing really --
 21 you know, being honest, you know, to tell you about
 22 that, it was just something that I just bumped into
 23 the guy on. So yeah, no -- no -- no report was
 24 done. He didn't ask for any insurance thing to fix
 25 his car or whatever so --

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1 DR. DUKE: Sure, sure.
 2 MR. RIBERA: You know (unintelligible),
 3 you look at the (unintelligible), you see the
 4 light's green so you start coasting. Oh, shoot.
 5 DR. DUKE: Right, right.
 6 MR. RIBERA: One of those.
 7 DR. DUKE: Now -- okay. How did you get
 8 down to the Laser Spine Institute?
 9 MR. RIBERA: How did I get down?
 10 DR. DUKE: Yeah. I mean, did -- was
 11 it -- how were you referred down there?
 12 MR. RIBERA: Oh, oh, oh, oh. Well, a
 13 lady at -- a friend of ours, my wife and I, at
 14 Choice Center of Las Vegas said that she had surgery
 15 from Dr. Perry in Scots -- in Tampa, Florida, and
 16 she recommended me just to go take a look at it.
 17 So we did. We did some research online,
 18 and I called them up, and they sent me some stuff
 19 (unintelligible).
 20 I listened to some of the -- you know,
 21 the -- the golfers that are on there. They got the
 22 one professional golfer saying, yeah, you know, all
 23 his pain went away and all that so -- you know, when
 24 you're -- when you're in pain, you're -- you're
 25 (unintelligible) to anything at that point to get --

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1 alleviate the pain and -- and --
 2 DR. DUKE: What -- what percentage of
 3 your pain went away with surgery?
 4 MR. RIBERA: It changed. It didn't --
 5 it didn't -- I wouldn't say it went away. It just
 6 changed to kind of a --
 7 DR. DUKE: So overall --
 8 MR. RIBERA: Yeah, I would say -- I
 9 would say -- well, enough that I can sit down in a
 10 chair now and take it for at least an hour before
 11 I'm -- I'm -- it's driving me nuts.
 12 DR. DUKE: So would you have done it
 13 again? Would you do it again?
 14 MR. RIBERA: Would I do it again? Good
 15 question. Knowing what I know right now with the --
 16 with the pain still there, I would say -- I would
 17 say no.
 18 I had to pay a lot of money out of my
 19 pocket too. That was the screwy thing, 'cause
 20 they -- you know, you have to get, you know, med --
 21 what do you call it? Med -- Med Choice. Is that
 22 what it's called? Yeah.
 23 DR. DUKE: Yeah. And so --
 24 MR. RIBERA: And a lot of people
 25 referred you too, and I just took -- I took another

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1 route because I didn't hear about you until
 2 afterwards (unintelligible). That's how that goes.
 3 DR. DUKE: Let me -- let me check your
 4 strength now.
 5 Dr. Flangas is excellent.
 6 MR. RIBERA: Is he?
 7 DR. DUKE: Oh, yeah.
 8 MR. RIBERA: Okay.
 9 DR. DUKE: Let's check your strength out
 10 here.
 11 MR. RIBERA: All right.
 12 DR. DUKE: Hold your arms like this real
 13 stiff, yeah. Hold it there. Now like this and pull
 14 and pull. And push towards me, push, and push.
 15 Fingers apart, real far apart, real far apart.
 16 Good. Fingers up and pull. And pull.
 17 Then raise up your knees straight up.
 18 To the side. Leg straight out like this. Pull your
 19 toes back. This side straight out. Pull your toes
 20 back. Excellent.
 21 So the strength test is good.
 22 So just any other -- the low back pain,
 23 that's really the main thing.
 24 MR. RIBERA: Oh, I'd give anything for
 25 it.

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1 DR. DUKE: Yeah. Do you know that --
2 how hard it is for your body to get rid of back pain
3 when you're on opiates? Did anybody talk to you
4 about that?

5 MR. RIBERA: No.

6 DR. DUKE: It's super hard. And -- and
7 there's a lot of studies that show that being on
8 opiates chronically impairs your body's ability to
9 get rid of aches and pains, low back pain. And
10 there's some studies that suggest that it won't --
11 that it won't go away once it gets started and you
12 start the opiates.

13 MR. RIBERA: Why would they --

14 DR. DUKE: 'Cause it down regulates your
15 opiate receptors. It shuts down your endorphin
16 system.

17 MR. RIBERA: To heal?

18 DR. DUKE: Correct.

19 And it hypersensitizes your body to
20 pain. It also blunts and masks some of the
21 protective things that should be done to help it go
22 away, but since you're on the morphine, those get
23 blocked so you do things you shouldn't do, and then
24 you end up just redamaging it. So it's like
25 shooting up your knee with lidocaine in a -- in a

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1 football player and having him go out and play
2 anyway, and they end up just wrecking their knee.

3 MR. RIBERA: Because they don't --
4 because -- right.

5 DR. DUKE: They don't feel it.

6 MR. RIBERA: Because they're not
7 (unintelligible) --

8 DR. DUKE: Yes.

9 MR. RIBERA: -- major injury because
10 they don't feel it.

11 DR. DUKE: Correct.

12 MR. RIBERA: Right.

13 DR. DUKE: And so you're doing things
14 you probably shouldn't be doing, movements that are
15 exacerbating the pain, hypersensitization to pain.
16 It -- it is a disaster.

17 MR. RIBERA: Okay.

18 DR. DUKE: And -- and pretty much use of
19 long-term, high-dose, you know, morphine, it's
20 just been completely abandoned. And it's shocking
21 that -- that you're being managed that way because I
22 can -- I would bet any amount of money that no
23 matter what is done, you will not get better as long
24 as you have the drugs onboard.

25 MR. RIBERA: So what's the plan of

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1 attack? I mean, what would you do with me?

2 DR. DUKE: You get rid of the drugs
3 first, and then you get through that. And you know,
4 on opiates for four years, that's a major problem,
5 'cause your body gets used to it. You get addicted
6 to it so sometimes you have to see an addiction
7 medicine specialist.

8 MR. RIBERA: Really? I bet you I could
9 quit tomorrow.

10 DR. DUKE: Boy, I tell you, that would
11 be the best thing you ever did.

12 MR. RIBERA: I -- I would just be in
13 pain, and that would be the part that sucks.

14 DR. DUKE: Yeah. But -- and the pain
15 would be worse than while you were on it too
16 because, you know, you're hypersensitized to pain,
17 so the pain level goes up. It actually takes, like,
18 three months for it to come down again, and pain
19 levels drop. It takes a while and -- it takes about
20 three months for people to say I'm not in any more
21 pain than whenever I was taking the drugs. By month
22 four, about a hundred percent of people are better
23 than they were taking the drugs.

24 MR. RIBERA: Really?

25 DR. DUKE: Yeah.

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1 MR. RIBERA: So now they're just dealing
2 with that -- that little bit of pain without the
3 drugs.

4 DR. DUKE: Correct. But it's better.

5 It's better. And I've had innumerable patients, I
6 mean, more than I can count that thought they needed
7 surgery, but we got them off the drugs, and in four
8 months, I don't need surgery, you know. They said
9 I -- my pain is so much better. I thought I needed
10 surgery, but I don't.

11 MR. RIBERA: Huh.

12 DR. DUKE: So I would -- before I
13 committed myself to having my back sliced open
14 again, that's -- that's the route I would go.

15 MR. RIBERA: Okay.

16 DR. DUKE: You know, it's my advice.

17 The -- you know, the -- I think part of
18 your -- the issue too with your case that's
19 difficult is that -- and I think what's raised red
20 flags is that I -- you know, you were seen for this
21 lifting injury at (unintelligible) -- at home, you
22 know, right after the car wreck. And then you had
23 several notes that said onset of pain, two weeks
24 ago, like, in -- in mid May, you know, a month after
25 the accident.

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1 You wrote a letter to Blue Cross/Blue
2 Shield saying that I'm not being treated for a car
3 wreck. I had a lifting injury at home. I was
4 lifting cabinetry. And then it was only later that
5 it switched. You know, the history changed, and I
6 think that's what's got a red flag raised on your
7 case. And so -- and then to -- you know, it makes
8 it very difficult, you know, those -- those kind of
9 things, because it's hard to go back and undo and
10 erase the -- the medical record, which says what it
11 says, you know.

12 Hopefully you have medical insurance and
13 can cover future treatment as you need it.

14 MR. RIBERA: Uh-huh.

15 DR. DUKE: Litigating it is going to be
16 very, very difficult. Just -- just --

17 MR. RIBERA: How else -- won't the
18 attorneys -- won't the attorneys hash that out
19 because that's what they're there for?

20 DR. DUKE: Absolutely.

21 MR. RIBERA: I mean, building cabinets,
22 what -- what -- that's what I was doing at the
23 time -- at the time. Then when they asked me,
24 what -- what were you doing at the time of the
25 injury? I was doing cabinets in the garage when my

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1 they had -- they brought me in and out of the
2 anesthesia. They talked to me. I -- I remember
3 that. And they would say do you feel anything now
4 and -- and -- and I remember swearing and using foul
5 language like a mad man. And then they would -- I
6 was out, and then they kept doing that back and
7 forth. And I could hear the pinging sound, almost
8 like an MRI kind of a sound. And I don't know if
9 that was just the dissect -- discotomy thing that
10 they were doing, cleaning the disc up around the --
11 around the thing or what but --

12 DR. DUKE: They did a plasma disc
13 decompression. Did they tell you that's an
14 experimental procedure, nonstandard?

15 MR. RIBERA: I know we talked. I know
16 we sat and we talked, and we have a counsel thing.
17 You know, you're up there for five days. You
18 went -- you went there and -- and they sent me up
19 for -- for some x-rays up there because mine weren't
20 correct when they shot. The MRIs were good that I
21 sent up. They could use those.

22 And then the next day was a consultation
23 with the doctor. I think the third day was the
24 surgery. That was on a Friday.

25 DR. DUKE: Uh-huh.

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1 son picked me up so -- and then, you know, we'll let
2 them hash that out.

3 DR. DUKE: Yeah, absolutely.

4 MR. RIBERA: Yeah, so --

5 DR. DUKE: So yeah. It is what it is.

6 MR. RIBERA: Yeah.

7 DR. DUKE: So anyway, any -- any
8 other -- you mentioned your current symptoms. You
9 mentioned your -- your current medications, your
10 current, you know, exam.

11 Oh, can I see the incision they did for
12 that surgery that they did at Laser Spine.

13 MR. RIBERA: I'm going to assume it's
14 back here somewhere.

15 DR. DUKE: Okay. So you don't really
16 see anything?

17 MR. RIBERA: (Unintelligible) It's right
18 in, let's say, where I had that patch at. Maybe
19 right in here?

20 DR. DUKE: Okay. So it's --

21 MR. RIBERA: It's small. It was only --
22 I mean, it's --

23 DR. DUKE: A little dot.

24 MR. RIBERA: Yeah, yeah.

25 All I can remember is I remember they --

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1 MR. RIBERA: I had to stay over the
2 weekend and come back on the Monday and then be
3 seen -- be seen before I got sent home.

4 DR. DUKE: Okay.

5 MR. RIBERA: But I don't know. I mean,
6 it's weird, 'cause all the people that -- it's funny
7 'cause the people that were all coming out of the
8 surgery, all -- all of them felt better when they
9 came out. I mean, you heard all the stories from
10 all the people that were -- you know, people that
11 were there, like, on their fourth day and they said,
12 oh, I feel great right now and all this horse -- you
13 know. Who knows? I mean --

14 DR. DUKE: So the -- let me see here.

15 MR. RIBERA: So you would never go that
16 route; right?

17 DR. DUKE: No.

18 Now, you'd had some back pain in your
19 life prior; correct.

20 MR. RIBERA: Yeah, I've had the basic
21 back stuff where, you know, I've gone to the
22 chiropractors before and then done, you know,
23 maintenance adjustments, you know. I was -- I was
24 currently seeing a chiropractor that I went into,
25 like, four times a year every -- you know, every

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1 three, four -- three, four months, I'd go get an
 2 adjustment just to -- just kind of a maintenance
 3 thing, you know.
 4 DR. DUKE: Yeah.
 5 MR. RIBERA: It wasn't like I was going
 6 to see him every week because I was -- I was -- you
 7 know, 'cause I was injured or whatever. Nothing
 8 like that. It was just more -- more maintenance
 9 more than anything.
 10 DR. DUKE: Has any --
 11 MR. RIBERA: Kind of like changing the
 12 oil.
 13 DR. DUKE: Has -- has anybody told you
 14 that any of the imaging studies shows evidence of
 15 injury to -- from the car wreck -- car wreck?
 16 MR. RIBERA: Well, Flangas -- Flangas
 17 had mentioned to me that he thinks I need surgery.
 18 DR. DUKE: But I mean has anybody said
 19 this MRI shows damage from your car wreck?
 20 MR. RIBERA: You know, I don't know if
 21 I'm allowed to talk about any of that.
 22 DR. DUKE: Oh, yes, you are. I mean,
 23 I -- you know, basically --
 24 MR. RIBERA: This is medical. That is
 25 an exam that you're giving on me. I mean --

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1 DR. DUKE: Right, right, right, right.
 2 But what I need to know is what your understanding
 3 is of what the films showed to you, you know,
 4 what -- how it's been represented to you, you know.
 5 I mean, that -- I just thought -- has it been
 6 represented to you that -- that the films showed
 7 damage from the wreck?
 8 MR. RIBERA: No, it -- again, I don't
 9 know, you know. I'm going to, you know, leave that
 10 one alone.
 11 DR. DUKE: Is it --
 12 MR. RIBERA: Definitely -- definitely it
 13 wasn't done building cabinets in my garage that I've
 14 been doing for 25 years, building these kind of
 15 cheapo lightweight cabinets. I'll tell you that
 16 right now. That's just my opinion. You've been a
 17 doctor for how many years? I mean, I've been
 18 building cabinets since 1979, you know. I'm not no
 19 weekend lawyer guy that doesn't know what he's doing
 20 in the garage.
 21 DR. DUKE: Yeah.
 22 MR. RIBERA: You know, it's unfortunate
 23 the way I wrote up -- I wrote up the thing, you
 24 know, but it is what it is on that -- on that
 25 record, you know.

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1 DR. DUKE: And -- and you know there --
 2 there was multiple other records that -- where you
 3 were seen after that where you said that the pain
 4 had started, you know, almost exactly to the same
 5 date that you had the incident in your house, you
 6 know; that basically you'd -- you'd seen several
 7 physicians, and to none of them did you relate it to
 8 the car wreck at all. Why -- why is that?
 9 MR. RIBERA: I don't know, 'cause the
 10 car wreck was pretty brutal.
 11 DR. DUKE: Uh-huh.
 12 MR. RIBERA: I don't know. But building
 13 cabinets (unintelligible) -- that's what I was doing
 14 for, like, a whole month, you know. But you know,
 15 it's like that's my -- you know, I had a, you know,
 16 cabinet business in the past. I know what I'm
 17 doing. And it's like -- you know, and I know that
 18 was -- I know I was doing that at the time of the
 19 accident. Yes, that's what I was doing was building
 20 cabinets. I also was going to work every day and,
 21 you know, mowing my lawn every -- once a week and
 22 those standard things in life, you know, doing --
 23 doing the honey-dos around the house.
 24 DR. DUKE: Sure.
 25 MR. RIBERA: You know.

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1 DR. DUKE: And you realize that
 2 99 percent of people that need back surgery aren't
 3 in car wrecks. They -- they're doing the normal
 4 things. They're -- they're mowing the grass.
 5 They're coughing, sneezing, sitting down. The types
 6 of things that people have surgery for are not car
 7 wrecks.
 8 MR. RIBERA: Not even getting hit at
 9 60 miles an hour?
 10 DR. DUKE: No. That happens -- whenever
 11 people need surgery for that, it's usually instantly
 12 that they need it, like within ten minutes. They go
 13 to the hospital. They have a broken back. They
 14 have a surgery. Almost never does it end up
 15 resulting in delaying surgery years down the road.
 16 Almost never, because the -- it's either going to
 17 damage it, or it's not going to damage it.
 18 And what you have -- what you have MRI
 19 findings of is degenerative disc disease, which is
 20 from age, genetics, building cabinets, walking,
 21 blah, blah, blah. You know, it's not due to acute
 22 trauma so --
 23 MR. RIBERA: When it happened, it could
 24 have been the straw that broke the camel's back,
 25 though.

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1 DR. DUKE: Yeah. Again, if it -- it
2 breaks it instantly, though, you know, if it -- if
3 it does.
4 MR. RIBERA: Okay.
5 DR. DUKE: I will -- I will -- and
6 you're -- let's see. I don't think there's anything
7 else. You've had -- you've had only two to three
8 pain injections?
9 MR. RIBERA: I think I've had more than
10 that. I think I had two or three just from Dr. Lee.
11 He left the -- he left the practice years ago.
12 DR. DUKE: Well, have any of them helped
13 you?
14 MR. RIBERA: They seem like they have.
15 They kind of -- they kind of -- they seem like
16 they -- they -- they lessen it some. Like, I
17 probably need to go back and do it again.
18 DR. DUKE: Briefly, they help?
19 MR. RIBERA: Yeah, they seem like
20 they're good for, like, three to six months.
21 What's your opinion on them?
22 DR. DUKE: It depends on why you're
23 getting them, you know. That's what really makes
24 the difference there.
25 MR. RIBERA: What's the purpose of them

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1 that it's supposed to do?
2 DR. DUKE: Well, in people that have
3 nerve compression and neuropathic pain, like
4 radiating leg pain, that's what it's for. It never
5 works for back pain.
6 MR. RIBERA: So it -- it would help
7 this?
8 DR. DUKE: Well, if -- if you had it
9 more frequently, I would say possibly. But you --
10 you know, you don't have it that often.
11 MR. RIBERA: 'Cause my understanding
12 with what Dr. Weiss -- Weiss did, whatever his name
13 is, in LSI in Scottsdale, that the nerve was
14 touching, like, the disc and -- and he would clean
15 up around the disc so the nerve -- or use some sort
16 of a laser to keep the nerve from touching the disc
17 so that that would keep the pain from -- I mean,
18 that was my kind of understanding of it. I don't
19 know.
20 DR. DUKE: All right. Well, very good.
21 MR. RIBERA: All right, sir.
22 DR. DUKE: Yeah, I wish you the very
23 best of luck.
24 MR. RIBERA: All right.
25 DR. DUKE: Dr. Flangas is an excellent

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1 doctor.
2 MR. RIBERA: Oh, okay.
3 DR. DUKE: I'd let him operate on me any
4 day.
5 MR. RIBERA: Would you really?
6 DR. DUKE: Oh, absolutely.
7 MR. RIBERA: Good.
8 DR. DUKE: Yeah, he's got great hands.
9 He's got great hands. He really -- he's one of the
10 best in town for sure.
11 MR. RIBERA: Oh, good, yeah.
12 DR. DUKE: Okay.
13 MR. RIBERA: Yeah.
14 DR. DUKE: So anyway --
15 MR. RIBERA: Yeah, he mentioned that
16 30 -- he said something about if I had surgery that,
17 you know, there would be, like, a 30 percent chance
18 of getting better and a 70 percent chance of staying
19 the same or being worse.
20 DR. DUKE: Yeah.
21 MR. RIBERA: I mean, those aren't odds I
22 like to hear.
23 DR. DUKE: No, no.
24 MR. RIBERA: You know.
25 DR. DUKE: But he's being truthful.

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1 MR. RIBERA: Yeah. That's -- that's why
2 I went to him, 'cause I heard he's a straight-up
3 guy.
4 DR. DUKE: He's straight -- straight-up,
5 honest guy, yeah.
6 MR. RIBERA: Yeah.
7 DR. DUKE: Absolutely he is. Well, I'll
8 take care --
9 MR. RIBERA: Okay, sir. Thank you for
10 your time.
11 DR. DUKE: You're very welcome and --
12 MR. RIBERA: Okay. All right.
13 DR. DUKE: Just go out to the right.
14 They'll take care of all the paperwork for you.
15 MR. RIBERA: Okay.
16 DR. DUKE: Appreciate it. Bye-bye.
17 Take care.
18 (Unintelligible) Down the hall and then
19 take a left.
20 MR. RIBERA: All the way down?
21 DR. DUKE: Yeah.
22 MR. RIBERA: Okay. See you later.
23 (End of recording.)
24
25

1 CERTIFICATE OF REPORTER

2 STATE OF NEVADA)

3 SS:

4 COUNTY OF CLARK)

5 I, Jennifer A. Clark, certified court
6 reporter, do hereby certify that the foregoing
7 transcript constitutes a full, true, and accurate
8 record of the disc provided to me by Richard
9 Johnson.

10 IN WITNESS WHEREOF, I have hereunto
11 affixed my hand this ____ day of _____,
12 2011.

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14
15 _____
16 Jennifer A. Clark, RDR, CRR, CCR 422
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13:12 14:6,8				
14:17,23 15:10				
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1979 27:18				
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20 4:22				
2007 13:3				
2011 34:12				
25 27:14				
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3 11:10				
30 32:16,17				
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422 34:15				

EXHIBIT “4”

1.71 UNSAFE CONDITION NOTICE (RED TAG)

Description

The Unsafe Condition Notice is used as a Customer warning whenever an unsafe condition or any condition that prevents a system, part of a system, or appliance from being placed in operation.

Policy

An Unsafe Condition Notice must be properly completed and attached to all gas systems, portions of gas systems, incomplete gas systems, or appliances that are unsafe or are not placed in operation by Ferrellgas personnel.

- Red tag and disable any incomplete, dangerous or defective systems or dangerous or defective gas burning equipment in accordance with Chapter 7.44 of the Ferrell Way, Incomplete and Disconnected Systems.

Disabling Red Tagged Equipment

Shut off and disable any company-owned equipment when red tagging.

Disable Customer owned appliances and equipment only with Customer's permission.

Shut off and disable company owned tanks in cases where the Customer is not available or refuses permission to disable unsafe appliances or equipment.

- Disabling is not required for equipment that is safe.
- Contact a Supervisor or the Ferrellgas Emergency Assistance Hotline at 1-800-205-5127 in cases where shutting off the entire system would cause additional unsafe conditions, i.e., freezing or interruption of industrial processes.

Continued on next page

Disabling Systems

To disable a system, actions beyond simply turning a valve to the “off” position and red tagging must be taken to prevent the use of the system. Such actions include, but are not limited to:

- Removing a valve handle, such as the service valve handle
- Removing a regulator
- Using a clamshell, lock, wire, cable tie, plastic or lead seal, or similar device to prevent a valve from being operated without physically removing the securing device
- Disconnecting and plugging or capping a line, such as a pigtail or hogtail
- Removing a pump or motor or vaporizer (plug or cap supply line if pump or vaporizer is removed)

Disabling Appliances

To disable a dangerous or defective appliance, actions beyond simply turning a valve to the “off” position and red tagging must be taken to prevent the use of the appliance. Such actions include, but are not limited to:

- Removing the handle of the manual shutoff valve
- Disconnecting and capping or plugging the gas line
- Disconnecting the electrical energy to the appliance or equipment

Unsafe Company Owned Tanks and Cylinders

Do not use an unsafe condition notice for defective company owned tanks or cylinders.

- Take action appropriate to the defect, i.e., evacuate or replace the container, or allow Customer to use the propane in the container.
- Attach a Ferrellgas Danger Tag (OPR-1174) to the filler valve to prevent filling until repairs have been made.
- Follow company procedures for notifying Field Management to prevent deliveries to the container.

Use and Distribution

A ample supply of these tags must be maintained at every Ferrellgas Retail location and in every Ferrellgas vehicle.

An Unsafe Condition Notice must be prepared and attached to each appliance or piece of gas-burning equipment or the shutoff valve of the container as necessary.

Continued on next page

1.71 UNSAFE CONDITION NOTICE (RED TAG)



Note: The list of unsafe conditions below is not all-inclusive. Ferrellgas policy requires all unsafe conditions or suspected unsafe equipment conditions to be red tagged.

Condition	Attach Unsafe Condition Notice and . . .	Check These Boxes
Out-of-gas/interruption of service situation - Leak test results unacceptable (No amount of product or pressure in container)	Leave container unfilled and close the shutoff valve.	Box 3: The gas supply has been turned off to the entire gas system.
Out-of-gas/interruption of service situation - Leak test results unacceptable (Any amount of product or pressure in container)	Close the shutoff valve and disable the container. <ul style="list-style-type: none"> Do not disable Customer owned containers without the permission of the Customer. 	Box 3: The gas supply has been turned off to the entire gas system.
Defective gas system	Close the shutoff valve and disable the container. <ul style="list-style-type: none"> Do not disable Customer owned containers without the permission of the Customer. 	Box 3: The gas supply has been turned off to the entire gas system.
Unsafe appliance or gas-burning equipment	Shut off the gas supply at the closest manual shutoff valve. <ul style="list-style-type: none"> Follow procedure for disabling equipment. 	<ul style="list-style-type: none"> Box 1: This gas-burning equipment must be placed in operation by a qualified technician. Box 2: The gas supply has been turned off to this equipment.

Continued on next page

Condition	Attach Unsafe Condition Notice and . . .	Check These Boxes
Leak or unsafe condition in gas piping	Isolate and disable affected portion by shutting off the gas supply at the closest manual shutoff valve or disconnect the piping and plug open lines. <ul style="list-style-type: none"> • Follow procedure for disabling equipment. 	Box 2: The gas supply has been turned off to this equipment.
Incomplete system or portion of system	Shut off and disable the container or turn off the gas to the affected portion of the system at the closest manual shutoff valve or disconnect and plug open lines. <ul style="list-style-type: none"> • Follow procedure for disabling equipment. 	<ul style="list-style-type: none"> • Box 1: This gas-burning equipment must be placed in operation by a qualified technician. • Box 2: The gas supply has been turned off to this equipment.
Questionable system or piece of gas-burning equipment	Attach red tag to manual shutoff valve and leave equipment shut off.	<ul style="list-style-type: none"> • Box 1: This gas-burning equipment must be placed in operation by a qualified technician. • Box 2: The gas supply has been turned off to this equipment.
Ferrellgas Employee unfamiliar with operation of specific equipment	Attach red tag to manual shutoff valve and leave equipment shut off.	<ul style="list-style-type: none"> • Box 1: This gas-burning equipment must be placed in operation by a qualified technician. • Box 2: The gas supply has been turned off to this equipment.

Continued on next page

Completion

The Unsafe Condition Notice must always be correctly completed and distributed to the Customer and filed in the Service Center Red Tag file.

Use this table to properly complete the Unsafe Condition Notice (Red Tag).

Documentation Area	Action To Be Taken
Customer name and address	Print information legibly
Unsafe condition	Legibly print unsafe condition
Action boxes	Check appropriate box(es)
Customer signs on the signature line	<p>If the Customer is home: Have customer sign</p> <p>If the Customer is home but refuses to sign: Print "customer refuses to sign"</p> <p>If the Customer is not home: Print "customer not home"</p>
Signed by boxes	Check the box for the appropriate part signing tag
Time and date	Legibly print the actual time and date of delivery
Employee signature space	Sign the form. Do not use initials, first names or nicknames. Please use full names.
Propane supplier and location	Print the name of the supplier and the Retail office location, i.e. Ferrellgas, Anywhere, MO 12345.
Telephone number	Print the Retail office location's area code and phone number

Continued on next page


1.71 UNSAFE CONDITION NOTICE (RED TAG)

Customer name		Date
Address		
City	State	ZIP
The following UNSAFE CONDITION has been observed:		
<hr/>		
<hr/>		
<input type="checkbox"/> 1. This gas-burning equipment must be placed in operation by a qualified technician.		
<input type="checkbox"/> 2. The gas supply has been turned off to this equipment.		
<input type="checkbox"/> 3. The gas supply has been turned off to the entire gas system.		
I acknowledge receipt of this notice and understand that I cannot operate this gas system or equipment until repairs have been made or the unsafe condition(s) corrected.		
Customer signature		
<input type="checkbox"/> Tenant <input type="checkbox"/> Owner <input type="checkbox"/> Representative <input type="checkbox"/> Customer not available		
_____:____ (a.m./ p.m.) ____/____/____		
Employee Signature		
Propane supplier and location		
_____ Telephone number Container valve or applicable equipment		

Continued on next page

Distribution of Copies

Use this table to properly distribute copies of the Unsafe Condition Notice.

Part	Distribution
Completion instructions and carbons	Discarded properly.
White paper (original) copy	<p>Send to the Service Center to be placed in the Red Tag file.</p>  <p>Note: If associated with a Ferrellgas System Check (FSC), ensure a photo copy of the red tag is attached to the FSC and placed in the Service Center FSC file.</p>
Long portion of the tag	<p>Detach and attach it to the container service valve or handle of meter shutoff valve if entire system is shut off.</p> <p>or</p> <p>Detach and attach it to the gas control of a specific appliance taken out of service.</p>
Short portion of the tag	Attach to the main entrance of home or building if the entire system is shut off.

Retention and Filing of Copies

Permanently file the white paper copy (original) in the Service Center Red Tag file.

Mobile Device Entry

Each time an Unsafe Condition Notice is filled out it must be documented in the Mobile Device using the RED_TAG_ADD work activity.

Note: Locations not utilizing the Mobile Device will use the Unsafe Condition Notice (Red Tag) only.

Ordering

Order this tag from our current forms provider using item # OPR-1046.

1.71

1.71 UNSAFE CONDITION NOTICE (RED TAG)

EXHIBIT “5”

Miller v. Sisolak

Deposition of:
Lewis M. Etkoff, Ph.D., A.B.N.

August 25, 2014



500 South Rancho Drive, Suite 8A
Las Vegas, Nevada 89106
Telephone **702.474.6255**
Facsimile 702.474.6257

www.westernreportingservices.com

1	1	3
2	DISTRICT COURT	
3	CLARK COUNTY, NEVADA	
4	ALEXANDER MILLER and STELLA)	
5	MILLER,)	
6	Plaintiff,)	
7	vs)Case No. A-12-665098-C	
8	ASHLEY SISOLAK; DOES I through)	
9	X, inclusive and ROE BUSINESS)	
10	ENTITIES I through X,)	
11	inclusive,)	
12	Defendants.)	
13	MITSUI SUMITOMO INSURANCE USA)	
14	INC.,)	
15	Plaintiff,)	
16	vs)	
17	ASHLEY LAUREN SISOLAK; STEPHEN)	
18	SISOLAK; and DOES I through X,)	
19	inclusive,)	
20	Defendants.)	
21	DEPOSITION OF LEWIS M. ETCOFF, PH.D., A.B.N.	
22	Taken on Monday, August 25, 2014	
23	At 1:58 p.m.	
24	At 8475 South Eastern Avenue, Suite 205	
25	Las Vegas, Nevada	
	Reported by: Marnita J. Goddard, RPR, CCR No. 344	

1	2	4
2	A P P E A R A N C E S	
3	FOR THE PLAINTIFFS:	
4	JOSEPH L. BENSON, II, ESQ.	
5	BENSON & BINGHAM	
6	11441 Allerton Park Drive	
7	Suite 100	
8	Las Vegas, Nevada 89135	
9	FOR PLAINTIFF MITSUI SUMITOMO INSURANCE USA INC.:	
10	LISA A. TAYLOR, ESQ.	
11	ATTORNEY AT LAW	
12	5664 North Rainbow Boulevard	
13	Las Vegas, Nevada 89130	
14	FOR THE DEFENDANTS:	
15	ANDREW J. VAN NESS, ESQ.	
16	ROGERS, MASTRANGELO, CARVALHO & MITCHELL	
17	300 South Fourth Street	
18	Suite 710	
19	Las Vegas, Nevada 89101	
20		
21		
22		
23		
24		
25		

1 I N D E X
2 WITNESS EXAMINATION
3 LEWIS M. ETCOFF, PH.D., A.B.N.:
4 (BY MR. BENSON) 4

9 E X H I B I T S
10 Number Description Page
11 Ex. 1 Internet Article 80
12 Ex. 2 Report 80
13 Ex. 3 (Retained by Dr. Etcoff)
14 (To be marked when received)

1 (Upon inquiry by the reporter prior to the
2 commencement of the proceedings, Counsel present
3 agreed to waive the reporter requirements as set
4 forth in NRCP 30(b)(4) or FRCP (b)(5), as
5 applicable.)
6 LEWIS M. ETCOFF, PH.D., A.B.N.,
7 having been first duly sworn, was
8 examined and testified as follows:
9 EXAMINATION
10 BY MR. BENSON:
11 Q. It's Dr. Lewis Etcoff; correct?
12 A. It is.
13 Q. Fantastic. You have a Ph.D. in what, sir?
14 A. Clinical psychology.
15 Q. And what does the A.B.N. stand for?
16 A. That I am a diplomat or board certified, in
17 other words, by the American Board of Professional
18 Neuropsychology, and we use those initials, A.B.N.
19 Q. How long have you been practicing?
20 A. Since 1984.
21 Q. Has that been mostly in Nevada?
22 A. Completely in Nevada.
23 Q. And you've been licensed continuously since
24 1984?
25 A. Yes.

<p style="text-align: right;">5</p> <p>1 Q. And what kind of practice do you primarily 2 run? I know you've been hired as an expert in this 3 case, but what do you primarily do? 4 A. I do two different types of practices: a 5 clinical practice and a forensic practice. The 6 clinical practice typically involves evaluating 7 children, doing assessments or testing, but no therapy 8 or any kind of counseling. Most of the cases are 9 regarding whether -- if they're having trouble at 10 school or is that because they have learning 11 disabilities or attentional problems or psychiatric 12 difficulties causing that. So that's probably -- 13 until recently, it was probably two-thirds of my 14 practice. And now I've sort of really cut back on the 15 clinical and see fewer clinical cases. 16 The other part of my practice is doing these 17 types of evaluations for either plaintiff or defense 18 attorneys, essentially just in the area of personal 19 injury, to see whether someone has emotional or 20 cognitive changes as a result of an accident or an 21 incident. 22 Q. So currently you say that's about 25 percent 23 now versus the 75 percent clinical? 24 A. It's switched around. It's probably -- I 25 probably spend more time now on the forensic than on</p>	<p style="text-align: right;">7</p> <p>1 A. Yes, there is. I think taking a lien 2 essentially puts a physician or a psychologist or any 3 expert in a conflicted position. Because if you 4 accept a lien, you know that the only chance of you 5 getting paid for the work you do is if the plaintiff 6 wins the case. And, as a result, unconsciously, if 7 not consciously, as a human being you will probably 8 tend to side a little more with the plaintiff because 9 you know that you're not going to get paid unless that 10 person wins the case. Even if they do win the case, 11 from my experience over 30 years, you are lucky if you 12 get paid 10 to 50 cents on the dollar. Because that 13 happens commonly. So I just decided a long time ago 14 not to bother putting myself in a compromised ethical 15 position. This way if I take a case, it doesn't 16 really matter what my opinion is because I'm doing 17 what I'm doing and getting paid for my time. 18 Q. Right. When's the last time you did lien 19 work? 20 A. Probably the early '90s. 21 Q. So you have been a lien provider, though? 22 A. Two or three times. 23 Q. In 2014 how many times has the Rogers 24 Mastrangelo law firm hired you? 25 A. I don't know.</p>
<p style="text-align: right;">6</p> <p>1 the clinical as I age and kind of try to do less work. 2 Q. Fair enough. Just for the record, forensic, 3 in your view, means what? 4 A. Working as a consultant or an expert for an 5 insurance company or an attorney who retains me to 6 take a look at a case they have. 7 Q. Currently, can you give me an estimate as to 8 maybe how much plaintiffs' work you've done versus 9 defendants'? 10 A. Typically, I don't take liens and haven't 11 for 20, 25 years. So it's heavily retained by 12 defense. About 90 percent defense, 10 percent 13 plaintiff. 14 Q. The insinuation by that answer is that you 15 do plaintiffs' work, but you do it on lien work? 16 A. No lien. If the plaintiffs retain me, 17 they'll actually pay me for doing my evaluation. 18 Q. I understand. As a plaintiff, a plaintiffs' 19 firm, they would just pay you just like they would pay 20 any other expert; right? 21 A. Correct. 22 Q. The distinguishment between lien and expert 23 payment really has no reason -- there's not a reason 24 for that, is there, in terms of why you maybe do more 25 defense?</p>	<p style="text-align: right;">8</p> <p>1 Q. Is it more than ten? 2 A. I really doubt it. 3 Q. Can you give me your best estimate? 4 A. It would be a guess. I could find out 5 specifically. 6 Q. I'll take a guess right now. 7 A. Probably less than five. 8 Q. That's just in 2014; correct? 9 A. It's a guess. Yeah. I mean, I could find 10 out the exact answer for you by just asking my office 11 manager. 12 Q. Is there a particular firm in town that you 13 work with more than others? 14 A. Not to my knowledge. 15 Q. Who is the last plaintiffs' firm that hired 16 you? 17 A. The one that comes to mind is Kravitz, 18 Schnitzer, Johnson. 19 Q. You believe that's a plaintiffs' firm? 20 A. Yes. They do business litigation too. That 21 was a plaintiff's case. I got a couple of plaintiff 22 cases from that firm. 23 Q. When were you hired on that case? 24 A. How long ago? 25 Q. Yes.</p>

<p style="text-align: right;">9</p> <p>1 A. Gosh. On the case I'm thinking about, two</p> <p>2 years ago. But it's been an ongoing case. So I've</p> <p>3 been doing work throughout the two years.</p> <p>4 Q. Can we agree that most of your work is done</p> <p>5 for the defense?</p> <p>6 A. Yes, we can.</p> <p>7 Q. There's not really a reason why it's</p> <p>8 defense, in your view, because you get expert fees;</p> <p>9 correct?</p> <p>10 A. My view is that most personal injury</p> <p>11 attorneys don't want to put out the money to hire</p> <p>12 experts unless they know they have a slam dunk case.</p> <p>13 When there is a slam dunk case, they'll pay me. But</p> <p>14 if it's a case that isn't such a hot case for them or</p> <p>15 they can't see that it's going to be a big case,</p> <p>16 they'll get someone who will accept a lien.</p> <p>17 Q. I see. How much do you charge?</p> <p>18 A. I think I charge like \$360 an hour for my</p> <p>19 work. I have associates who I charge \$265 an hour who</p> <p>20 do some of what you see in front of you, organize and</p> <p>21 review records.</p> <p>22 Q. Understood. In this case, you were asked to</p> <p>23 review and do an IME for Alexander Miller; is that</p> <p>24 correct?</p> <p>25 A. Yes.</p>	<p style="text-align: right;">11</p> <p>1 neuropsychological evaluation. That was 11 hours</p> <p>2 and -- 11 and a half hours. That was billed in</p> <p>3 November of 2013.</p> <p>4 Q. So have you stated all of your hours on this</p> <p>5 case so far?</p> <p>6 A. Except for studying for today, yes.</p> <p>7 Q. How many hours did you study for today?</p> <p>8 A. Four.</p> <p>9 Q. As part of your preparation today, what did</p> <p>10 you do?</p> <p>11 A. I read my report. I looked through all of</p> <p>12 my data, the psychological tests I administered. I</p> <p>13 read through all of the newest records that I got just</p> <p>14 recently from Dr. Fazzini. I read through</p> <p>15 Dr. Fazzini's records. I looked through my billing</p> <p>16 and I looked at the photographs from the accident and</p> <p>17 a couple of Dr. Hibbard's reports.</p> <p>18 Q. I think that was referenced somewhere when</p> <p>19 you sent a letter to their office that you had</p> <p>20 reviewed the Plaintiff's Third Supplement List of</p> <p>21 Witnesses and Documents; is that correct?</p> <p>22 A. There's not much to review.</p> <p>23 Q. What was in that third supplement?</p> <p>24 A. That's probably in here. Besides that stuff</p> <p>25 where you say who is going to be testifying, which I</p>
<p style="text-align: right;">10</p> <p>1 Q. I believe his wife as well, or no?</p> <p>2 A. No.</p> <p>3 Q. Just Alex. Okay.</p> <p>4 Approximately how many hours did you bill on</p> <p>5 that case so far?</p> <p>6 A. I'd have to look it up. Let's see. In the</p> <p>7 early part of 2014, I billed for my time 28.25 hours</p> <p>8 and my staff 32.25 hours in sorting, organizing,</p> <p>9 reviewing records, and some of my staff members helped</p> <p>10 me test Mr. Miller.</p> <p>11 Q. Okay.</p> <p>12 A. I have more.</p> <p>13 Q. Go ahead.</p> <p>14 A. In May I had a telephone consultation with</p> <p>15 Mr. Ira Spector, who is a rehab counselor. I spent</p> <p>16 half an hour talking to him. Then in June of this</p> <p>17 year, I received new records regarding the case,</p> <p>18 vocational report, medical reports, a new report from</p> <p>19 Dr. Hibbard. And I spent a total of five hours. That</p> <p>20 was a bill of \$2,042.75.</p> <p>21 Q. We can all do the math, I guess. But that's</p> <p>22 pretty much the hours that you have in this?</p> <p>23 A. And previous to doing the evaluation, I also</p> <p>24 was asked to look at Dr. Hibbard's first evaluation of</p> <p>25 Mr. Miller as a consultant before I did a forensic</p>	<p style="text-align: right;">12</p> <p>1 don't really spend much time looking at, there was</p> <p>2 some evaluation from Dr. Hibbard, Dr. Fazzini reports,</p> <p>3 I think an MRI report. There was -- oh, gosh,</p> <p>4 Terrence Dineen's report. I read that today.</p> <p>5 Q. So that kind of includes what you reviewed,</p> <p>6 then, as far as the third supplement; correct?</p> <p>7 A. Yes.</p> <p>8 Q. The admonitions we normally give, are you</p> <p>9 comfortable with waiving those? I kind of jumped into</p> <p>10 things.</p> <p>11 A. Waive.</p> <p>12 Q. How many times have you had your deposition</p> <p>13 taken?</p> <p>14 A. Couple hundred.</p> <p>15 Q. That's fair, then. We'll skip those.</p> <p>16 A. Unless something has changed.</p> <p>17 Q. I think we're fine there.</p> <p>18 So you were asked in this case to, I guess,</p> <p>19 do a records review and also do a clinical evaluation</p> <p>20 with Mr. Miller; correct?</p> <p>21 A. Forensic evaluation. Different than a</p> <p>22 clinical evaluation.</p> <p>23 Q. So one was in person and one was more of a</p> <p>24 records review; right?</p> <p>25 A. Yes.</p>

<p style="text-align: right;">13</p> <p>1 Q. When you were asked to do the records review</p> <p>2 side of it, was there anything in your review that</p> <p>3 struck you that Mr. Miller was a malingerer?</p> <p>4 A. No.</p> <p>5 Q. So it wasn't until you actually did testing</p> <p>6 that you came up with that conclusion?</p> <p>7 A. Yes.</p> <p>8 Q. Aside from being a malingerer, you also kind</p> <p>9 of stated that he feigned some of the results; is that</p> <p>10 correct?</p> <p>11 A. The malingering is the cognitive part, that</p> <p>12 he was making memory -- he was trying to perform worse</p> <p>13 on memory tests than he should have been performing.</p> <p>14 So on tests that are specifically designed to catch</p> <p>15 and differentiate between people who are giving</p> <p>16 solidly optimal effort and those who are not giving --</p> <p>17 well, they are giving good effort, but they're giving</p> <p>18 good effort to make themselves appear as if they have</p> <p>19 problems. Consistently he made an impression on those</p> <p>20 tests where his test results indicated that he was</p> <p>21 trying to do worse to show me that he had memory</p> <p>22 problems.</p> <p>23 Q. So anything other than -- I guess except for</p> <p>24 the testing that you did, per se, was there anything</p> <p>25 in the records that you read through that indicated</p>	<p style="text-align: right;">15</p> <p>1 Q. Here's the thing. You're testifying that</p> <p>2 that was a significant finding for you; correct?</p> <p>3 A. It was. But not as significant as the</p> <p>4 testing. But it was consistent with his exaggerated</p> <p>5 memory disturbances.</p> <p>6 Q. Do you believe that plaintiffs actually know</p> <p>7 how fast other cars are moving?</p> <p>8 A. No. But you can usually -- I assume that</p> <p>9 they know if they've been hit at 40 miles an hour</p> <p>10 versus 10 or 5 or 60 miles an hour. I think any human</p> <p>11 being with a modicum of intelligence could guess</p> <p>12 within range like that.</p> <p>13 Q. Was it the difference in range or was it the</p> <p>14 fact that he told two different stories that was</p> <p>15 significant to you?</p> <p>16 A. I think it was the difference between the</p> <p>17 actual hit of the car into his versus what he told</p> <p>18 people who he had seen as physicians or providers,</p> <p>19 that it was so much greater.</p> <p>20 Q. Is it your understanding that he saw the</p> <p>21 impact?</p> <p>22 A. No. He was in the car. He felt the impact.</p> <p>23 Q. When you did your evaluation with the</p> <p>24 records, did you end up doing any conclusions or</p> <p>25 letters to defense counsel about your review of that?</p>
<p style="text-align: right;">14</p> <p>1 that there was inconsistencies in him being a</p> <p>2 historian or anything that he told to his medical</p> <p>3 providers?</p> <p>4 A. I think when I was reviewing some of it</p> <p>5 today, it occurred to me that he exaggerated the two</p> <p>6 providers who he saw for treatment the speed at which</p> <p>7 the vehicle he was a passenger in was struck. I think</p> <p>8 twice he said the vehicle was struck at 45 miles an</p> <p>9 hour, and to another doctor he said the vehicle was</p> <p>10 struck at 60 miles an hour. Clearly, he knew that</p> <p>11 wasn't the case.</p> <p>12 Q. Do you remember where in the records that</p> <p>13 you're referring to that?</p> <p>14 A. I could find it.</p> <p>15 Q. Sure.</p> <p>16 A. I think. Or could I?</p> <p>17 Q. Are you referencing your report?</p> <p>18 A. It will take me five or ten minutes to find</p> <p>19 it. If you want me to do it at a break or something</p> <p>20 like that, I could. It was probably in the records I</p> <p>21 reviewed and who he spoke to. It would probably be</p> <p>22 easier to get on the computer -- not that I could do</p> <p>23 this -- and look for, like, 45 miles an hour. It</p> <p>24 would come up in the report. But we can do that if</p> <p>25 you'd like.</p>	<p style="text-align: right;">16</p> <p>1 A. My records review was more so looking over</p> <p>2 Dr. Hibbard's work. And, yes, I did -- I was asked to</p> <p>3 prepare potential deposition questions for Dr. Hibbard</p> <p>4 based upon the enormous number of mistakes she made in</p> <p>5 administering and scoring and interpreting the tests</p> <p>6 she gave to your client.</p> <p>7 Q. Got it. Speaking of scoring, do you score</p> <p>8 your own stuff?</p> <p>9 A. I do.</p> <p>10 Q. You have a staff, though; correct?</p> <p>11 A. I do.</p> <p>12 Q. Do they also score stuff for you?</p> <p>13 A. They do. Sometimes computers score.</p> <p>14 Depends upon the test.</p> <p>15 Q. In this case I think that your report was</p> <p>16 signed by yourself as well as another person?</p> <p>17 A. Dr. Gunther, I'm guessing.</p> <p>18 Q. How many people work for you?</p> <p>19 A. Currently I have three associates, part</p> <p>20 time. I have Dr. Karen Kampfer, who works as a school</p> <p>21 psychologist. She works for me 20 hours a week. She</p> <p>22 was one of the first people I had ever employed back</p> <p>23 in the 1990s to do this. So she's got years and years</p> <p>24 of experience. I have a predoctoral intern, Bethany</p> <p>25 Ghali, G-H-A-L-I, who is a licensed clinical social</p>

<p style="text-align: right;">17</p> <p>1 worker and just completed her dissertation for her 2 doctorate in psychology at Capella University. She 3 works full time, and I supervise her. I just took on 4 a very part-time person, a retired school psychologist 5 who is working nine hours a week and who will be doing 6 forensic records reviews. Her name is Melinda Hauret, 7 H-A-U-R-E-T. She was one of the supervisors of school 8 psychologists in the Clark County School District. 9 And I have an office manager. 10 Q. Fantastic. Looking at this report that you 11 did, it's roughly 60 pages or so -- the actual report 12 I think is more in the -- 27 pages, but the full thing 13 I think was many pages. 14 A. Yes, it was. 15 Q. I see Karen Kampfer's name is signed on 16 this. What did she do as part of the preparation of 17 your report? 18 A. Karen Kampfer -- I can't tell you exactly 19 what she did on this. She did some of the testing. 20 She probably -- I can find out. She may have sat in 21 on my interviews. I think I had like 32 pages -- 22 yeah, she was in on the interview. I always have two 23 people in the interview with me, me and someone else. 24 The reason I do that is because I fully realize I am 25 not perfect. When I'm asking questions and taking</p>	<p style="text-align: right;">19</p> <p>1 did. 2 A. She administered the California Verbal 3 Learning Test. The personality tests are taken by the 4 person themselves. Whoever gives it to them just gives 5 them the directions. The Stroop, S-T-R-O-O-P, Color 6 and Word Test was administered by her. The Test of 7 Memory Malinger was administered by her. The 8 WAIS-IV, Wechsler Adult Intelligence Scale, Fourth 9 Edition, was administered by Ms. Ghali. My doctoral 10 intern administered the Woodcock-Johnson-III Tests of 11 Achievement. And the other tests I administered. 12 Q. How long did your IME last with Mr. Miller? 13 A. It was over two days. So give or take six 14 hours a day. Probably around 12 hours. 15 Q. Is that typically how you administer tests 16 in your clinical practice? 17 A. Clinical practice, typically I get 18 everything done in one day, especially if they're 19 kids. They've lived fewer years and there's less to 20 talk about. Even the teenagers I can usually start at 21 about 8:45 and be done at around 3:30. 22 Q. So I'm clear, the testing itself, though, 23 how long does the testing itself take out of the 24 12 hours that you saw Mr. Miller? 25 A. I would say -- let me see what the billing</p>
<p style="text-align: right;">18</p> <p>1 notes, I'm not going to be perfect. I may not exactly 2 understand how people answer me or be able to keep up 3 with it, so I have a second person taking notes 4 sometimes or just listening. Usually taking notes. 5 And when I then dictate the part of my evaluation that 6 is the interview of the person I've seen, the person 7 who was in the room reads what I said and compares my 8 recollection or the words I thought I heard to what he 9 or she heard, and then we talk about whether I heard 10 it correctly or not. So it allows for greater 11 validity and accuracy. 12 Q. Do you know whether Karen Kampfer is 13 expected to testify in this case? 14 A. No. I am the expert. 15 Q. So that we're clear, what did you do 16 specifically and what did she do on this case? She 17 sat in on the interview. 18 A. Yes. So I interviewed pretty much all of 19 the questions. She may have asked a question or two. 20 But typically she doesn't. It looks at least three 21 hours of interviews. I interviewed his wife. Then 22 there were a lot of tests that we gave. So I will go 23 through the tests and tell you who did what, if that's 24 what you're interested in. 25 Q. Actually, if you could just tell me what she</p>	<p style="text-align: right;">20</p> <p>1 says. I'm going to guess it's six, seven hours. 2 Let's see. I would say the testing was about six, six 3 and a half hours. On top of that you have to score 4 the tests and interpret them. But the actual 5 administration, six to seven hours. 6 Q. And it's fair to say that the tests that 7 Karen did -- one, two, three, four, five, six -- 8 roughly six of those tests -- how many total tests 9 were given? 10 A. Thirteen. 11 Q. So we can reasonably assume the 13 tests 12 were done in that six and a half hours, roughly? 13 A. Some of it, like the two intelligence tests, 14 take about two and a half hours. But they're not 15 hours that we do anything. The person is sitting in a 16 room filling in the tests. 17 Q. In terms of the malingering tests, are there 18 any tests that you performed to do that or was that 19 all done by Karen? 20 A. I did the -- trying to think. There were 21 malingering indicators on the personality tests, the 22 MMPI-2-RF and the MMPI-2. I did a lot of the motor 23 tests, but there were no malingering tests within 24 there. She did the Test of Memory Malinger, the 25 CVLT, and the -- one of the subtests from the CVLT and</p>

<p style="text-align: right;">21</p> <p>1 the Reliable Digital Span that comes off of the IQ</p> <p>2 test. She administered those.</p> <p>3 Q. So she did the majority of the malingering</p> <p>4 tests; correct?</p> <p>5 A. Yes.</p> <p>6 Q. You relied on her data; correct?</p> <p>7 A. Yes, I did.</p> <p>8 Q. Are these objective or subjective tests?</p> <p>9 A. Objective.</p> <p>10 Q. Completely?</p> <p>11 A. As complete as they can be. I mean, there's</p> <p>12 literature on them and norms. Yeah, they're</p> <p>13 objective.</p> <p>14 Q. And you are aware that Dr. Hibbard did the</p> <p>15 same tests; is that correct?</p> <p>16 A. I wouldn't say she did the same tests. But</p> <p>17 we did a lot that overlapped. No two</p> <p>18 neuropsychologists, if you look at their test</p> <p>19 batteries, does the exact same battery of tests. But</p> <p>20 she and I did many of the same tests.</p> <p>21 Q. If they are so objective, why redo them?</p> <p>22 A. Well, if I don't do them, I would not be</p> <p>23 following the standards and practices of forensic</p> <p>24 neuropsychology.</p> <p>25 Q. Which says?</p>	<p style="text-align: right;">23</p> <p>1 articulate and expressive. So if one really has brain</p> <p>2 damage, one's speech doesn't change subject to</p> <p>3 subject. So he wanted to talk about stuff that he</p> <p>4 wanted to tell me about. About his career, he sounded</p> <p>5 like a disc jockey with that mellifluous voice. He</p> <p>6 had no word finding problems. He was just normal as</p> <p>7 can be. But when he was talking about how the</p> <p>8 accident bothered him, he would be slower. That's a</p> <p>9 common sign of someone trying to look impaired.</p> <p>10 Q. Aren't there different types of brain</p> <p>11 damage?</p> <p>12 A. Yep.</p> <p>13 Q. And they have different types of symptoms;</p> <p>14 correct?</p> <p>15 A. Yes.</p> <p>16 Q. What is your understanding, if any, of what</p> <p>17 his diagnosis is in terms of the medical side of his</p> <p>18 brain damage?</p> <p>19 A. Well, until recently, when there were</p> <p>20 medical records showing that he has some MRI problems</p> <p>21 that were recent, I saw nothing in his medical records</p> <p>22 suggesting that there was anything wrong with his</p> <p>23 brain. At worst someone said, oh, maybe he had a</p> <p>24 postconcussion syndrome. And there is enormous</p> <p>25 research on postconcussion syndrome that shows that</p>
<p style="text-align: right;">22</p> <p>1 A. That you have to try to see whether someone</p> <p>2 is malingering in a case that is a legal case.</p> <p>3 Q. But doesn't that require some subjective</p> <p>4 part -- on your part?</p> <p>5 A. I've been doing this for a long time. I can</p> <p>6 watch a person and tell on a subjective level, not on</p> <p>7 a test level, whether they are giving their best</p> <p>8 effort or whether they're attempting to look like</p> <p>9 they're in more pain than they are really in. Having</p> <p>10 any number of symptoms that they want me to believe</p> <p>11 they're having. So there is a subjective component.</p> <p>12 In terms of the tests themselves, those are objective</p> <p>13 signs of effort to look as if one has problems that</p> <p>14 one doesn't.</p> <p>15 Q. Did you remember when you were -- but you</p> <p>16 didn't sit through the malingering side. So as far as</p> <p>17 you are concerned, what tests required your subjective</p> <p>18 impressions?</p> <p>19 A. Even in my interview I could talk to him and</p> <p>20 see from being a clinical psychologist when he spoke</p> <p>21 about his -- the problems he has from the accident,</p> <p>22 his voice -- he would stutter. He would speak more</p> <p>23 slowly. He put on a way of speech that was completely</p> <p>24 different than when I asked him about his job as a</p> <p>25 bigshot in the music industry when he was voluble and</p>	<p style="text-align: right;">24</p> <p>1 there should be no neuropsychological abnormalities</p> <p>2 after a year. Well, a year, after several weeks they</p> <p>3 go away. So if you retest or test someone a year out,</p> <p>4 they will be normal on all the neuropsychological</p> <p>5 tests. If they are not, it's not because their brain</p> <p>6 isn't working well. It's because there's some other</p> <p>7 motivation or stresses in their lives, such anxiety,</p> <p>8 depression, drugs they're being given that cause them</p> <p>9 to perform poorly.</p> <p>10 Q. Did you review some records at some point</p> <p>11 that have changed your mind or enlightened you to his</p> <p>12 traumatic brain injury diagnosis?</p> <p>13 A. No.</p> <p>14 MR. VAN NESS: Object as to form.</p> <p>15 THE WITNESS: He doesn't have a brain injury</p> <p>16 from this accident. What really is the cause of his</p> <p>17 problems is that he got fired from a very prestigious</p> <p>18 identity -- prestigious high-paying position in the</p> <p>19 music industry that his identity was very closely tied</p> <p>20 with. That has caused him definite psychiatric and</p> <p>21 psychological problems. This car accident didn't</p> <p>22 really do anything to him.</p> <p>23 Q. (BY MR. BENSON) Why was he fired?</p> <p>24 A. I don't know. You'd have to talk to his</p> <p>25 boss.</p>

<p style="text-align: right;">25</p> <p>1 Q. You've just given testimony here as to your 2 opinion, that he didn't have brain damage, it was 3 because of him being fired, but you don't know the 4 reason for him being fired? 5 A. Right. But I know he doesn't have brain 6 damage from this accident. So it couldn't be that. 7 That's my opinion. 8 Q. Did you do most of the interview? 9 A. All of it. 10 Q. How do you document your conversations with 11 a potential -- I guess not really a client but a 12 potential patient or, in this case, an adverse 13 witness? 14 A. Not an adverse witness. Just a person I'm 15 evaluating. 16 Q. Well, okay. We can agree to disagree on 17 that. 18 A. I'm right. More than anyone I've ever met, 19 having reviewed so many other people's, I take 20 voluminous notes that you can read, I hope, and it 21 sort of tells you exactly what I asked and what they 22 said. Then you can compare what I asked and said to 23 what's in the report and figure out whether -- 24 Q. Got it. So you have approximately, I don't 25 know, half a ream of notes there. Is that a fair</p>	<p style="text-align: right;">27</p> <p>1 Q. So you've given a list here that is fairly 2 exhaustive of the records that you reviewed and the 3 depositions you reviewed; correct? 4 A. Yes. 5 Q. Then on page 2 of your report you indicate 6 that you are going to remain objective and neutral 7 during this evaluation; correct? 8 A. Yes. 9 Q. You mention in this educational history on 10 page 3 that he recalled taking his PSATs but not his 11 SATs. Then you put a note in here. This is likely an 12 inaccurate recollection on his part. 13 A. What was unlikely was that they weren't 14 offered. 15 Q. I see. Okay. 16 A. I think the SATs -- if he took his PSATs, 17 I've never heard of SATs not being offered. And I 18 said that's probably unlikely to be correct. 19 Q. When do the PSATs start? 20 A. I don't know. 21 Q. Do you know when the SATs started? 22 A. No. 23 Q. How do you know it's likely inaccurate, 24 then? 25 A. Because I took the PSATs and SATs and I'm</p>
<p style="text-align: right;">26</p> <p>1 statement? 2 A. 32 handwritten pages. 3 Q. I don't think we've got a copy of your file. 4 I don't know if we've requested it or not. Is that 5 something we can get? 6 A. Yes. I'll have my office manager give you 7 the notes. You probably don't want all of the records 8 you already have. 9 Q. Just your notes would be great. I know, 10 looking through your report, there are a ton of 11 quotations. That was my next question. Do you 12 record -- 13 A. Yes. 14 Q. You do. And where would those tapes be? 15 A. Oh, no, I record little quote marks. No, I 16 don't ever record. Unless someone is recording me, I 17 don't record. It would be enormously time consuming 18 to reconstruct everything. That's why I have a second 19 person in the room. 20 Q. So we've got to rely on your notes, then, as 21 opposed to actual audio recordings? 22 A. Correct. 23 Q. So going to your report, if we can, you just 24 did one report for Alexander Miller; is that correct? 25 A. Yes.</p>	<p style="text-align: right;">28</p> <p>1 older than him. 2 Q. Where did you go to school? 3 A. Randolph High School in Randolph, 4 Massachusetts. 5 Q. So you took a history; correct? 6 A. Yes. 7 Q. During that history -- I mean, you've got a 8 lot of pages here of history. You go into his 9 occupational history. You cover primarily mostly his 10 employment. 11 A. We talked a lot about his employment 12 history. 13 Q. Marital history. 14 A. Marital history. It's the same type of 15 interview I do with everybody. 16 Q. What's your goal when you are taking a 17 history like this? 18 A. Getting to know someone, trying to figure 19 out what they're like, personality characteristics, 20 seeing how accurate they are, comparing what they tell 21 me to the collateral records that substantiate or 22 don't substantiate what they tell me. Just basically 23 getting to know them. 24 Q. Behaviorally you looked at Mr. Miller and 25 was there anything behaviorally that he showed signs</p>

<p style="text-align: right;">29</p> <p>1 of that you found uncharacteristic?</p> <p>2 A. Besides the difference in how he spoke about</p> <p>3 his perceived subject accident-related symptoms and</p> <p>4 how he spoke when he was talking about things he loved</p> <p>5 to talk about to tell you about his job, his</p> <p>6 occupation, his profession, no, nothing else. He was</p> <p>7 a very nice man. A gentleman. Respectful.</p> <p>8 Cooperative. Easy to talk to. As was his wife.</p> <p>9 Q. Did you find him intelligent?</p> <p>10 A. Yes.</p> <p>11 Q. You said here his eye contact was</p> <p>12 appropriate. Seated posture was relaxed. No visible</p> <p>13 manifestation of pain.</p> <p>14 A. Correct.</p> <p>15 Q. Apparently you go by facial grimacing to</p> <p>16 notice that?</p> <p>17 A. Facial grimacing, a lot of fidgetiness,</p> <p>18 restlessness, getting up, how he sits and gets up out</p> <p>19 of a chair, how he walks, whether he says, "I'm in a</p> <p>20 lot of pain" or "Ah." Verbal or nonverbal signs of</p> <p>21 pain that everybody who is human would manifest if</p> <p>22 they were in pain.</p> <p>23 Q. And he was respectful to you?</p> <p>24 A. Yes.</p> <p>25 Q. You mention on page 13 here -- says,</p>	<p style="text-align: right;">31</p> <p>1 Q. Let's kind of go through a few of these</p> <p>2 tests that you did. The TOMM test --</p> <p>3 A. Uh-huh.</p> <p>4 Q. -- is that something that you administered?</p> <p>5 A. That was administered by Dr. Kampfer.</p> <p>6 Q. In that test, basically we got some results</p> <p>7 from three trials; is that right?</p> <p>8 A. Yes.</p> <p>9 Q. Can you explain to us basically what a trial</p> <p>10 means?</p> <p>11 A. The person would be shown pictures of common</p> <p>12 objects, one after another, every three seconds. And</p> <p>13 following 50 such pictures, the person would be shown</p> <p>14 two pictures, 50 different pages containing two</p> <p>15 pictures on the page. One would be what they already</p> <p>16 saw. One would be something that they never saw. We</p> <p>17 would ask them to point to or tell us which picture</p> <p>18 they saw. You do that first, when they're first</p> <p>19 learning it, and then you do it right -- you give the</p> <p>20 test a second time. You ask them a second time to do</p> <p>21 it again. And then 20 minutes later you don't give it</p> <p>22 to them again but you ask them to try to remember</p> <p>23 which of the two pictures we're showing you you saw</p> <p>24 previously, previously twice.</p> <p>25 Q. That's something that whoever is giving the</p>
<p style="text-align: right;">30</p> <p>1 "Mr. Miller was personable and rapport was easily</p> <p>2 established. His attitude towards my staff was</p> <p>3 respectful. He appeared comfortable working with me</p> <p>4 and my staff, although his emotional expression struck</p> <p>5 me as shallow." What do you mean by that?</p> <p>6 A. Well, if you're sad, you can really be sad,</p> <p>7 or if you're happy, you can really be happy and look</p> <p>8 it. He didn't have that kind of affect of typically</p> <p>9 where he really looked whatever he was saying he was</p> <p>10 feeling, except once when he cried when he was talking</p> <p>11 about getting fired. That was the most poignant part</p> <p>12 of the interview, talking about getting fired and how</p> <p>13 terrible that was for him. In that he was not</p> <p>14 emotionally shallow. It was as if he was experiencing</p> <p>15 it again.</p> <p>16 Q. A big part of your work is pediatrics, or</p> <p>17 used to be?</p> <p>18 A. Still. Not as much. Yes, it has been.</p> <p>19 Q. Is it fair to say that your range goes from</p> <p>20 pediatric to adults?</p> <p>21 A. Yes. That's fair.</p> <p>22 Q. You kind of go through some of the</p> <p>23 neuropsychological test results. They start on</p> <p>24 page 13.</p> <p>25 A. Yes.</p>	<p style="text-align: right;">32</p> <p>1 test, they're the ones who control the speed; correct?</p> <p>2 A. Yes.</p> <p>3 Q. You are stating that the policy should be</p> <p>4 every three seconds that they show that; right?</p> <p>5 A. Yes.</p> <p>6 Q. So when she's doing this test, is she</p> <p>7 manually scoring this, then?</p> <p>8 A. Yes.</p> <p>9 Q. And those results would be where?</p> <p>10 A. Right here in the book.</p> <p>11 Q. Is that part of your written notes or is</p> <p>12 that some other section?</p> <p>13 A. That's part of the raw test data. If you</p> <p>14 want that, if you have an expert -- like if</p> <p>15 Dr. Hibbard is going to be your expert, I would be</p> <p>16 more than happy to send all of the psychological test</p> <p>17 data to her as she sent to me.</p> <p>18 Q. Fair enough. We'll probably want to get</p> <p>19 that from you.</p> <p>20 So that I'm clear here, the test results</p> <p>21 that you have put in your report here were less than</p> <p>22 39 on Trial 1, less than 49, and then less than 49 on</p> <p>23 Trial 3; is that correct?</p> <p>24 A. Yes. I could give you the exact scores on</p> <p>25 each trial, which I probably put in there.</p>

<p style="text-align: right;">33</p> <p>1 Q. I'm sorry. I think that's the standard that 2 I just read to you. 3 A. Yes. 4 Q. The actual scores, according to page 13, 5 were 33, 44, and 46. 6 A. Yes. 7 Q. I think on the third one, that fell into the 8 normal range? 9 A. It did. 10 Q. Can you give me the ranges, where they cut 11 off, so we can evaluate what -- 12 A. Forty-five for Trials 2 and 3. There's been 13 more recent research, which I noted -- the author is 14 Stenclik, et al., 2013 developed norms also for the 15 TOMM, Trial 1. 16 Q. How off do you have to be before it's 17 significant to you? 18 A. You have to be under 45 on Trials 2 and 3. 19 On Trial 1, less than 39. 20 Q. Then that's when it starts making -- it's 21 clear to you that -- 22 A. Yes. The lower it is the more they're 23 obviously not trying to -- they're telling you things 24 they know to be false. This was just within the range 25 of being significant. Not way into the range.</p>	<p style="text-align: right;">35</p> <p>1 Q. Did Dr. Hibbard administer the same tests? 2 A. I believe she did. 3 Q. How did you guys get such different results? 4 A. He tried harder for her. That's the only 5 explanation. 6 Q. Do you know what the ranges were that -- of 7 the testing that she did? 8 A. I'd have to look it up. I don't know it 9 offhand. 10 Q. Is there any -- to do all these tests within 11 a six-hour period, I mean, from an outsider, seems 12 brutal. Is there any scientific background that would 13 show that maybe you won't get the best results by 14 cramming it all in one session? 15 A. Some people do it in one session. I don't. 16 Because -- especially when people are coming out of 17 town. It is hard. It's hard for us. I'm tired after 18 doing a full day. So I try to break it out over two 19 sessions so that it isn't as anxiety producing or as 20 difficult for people. Some people do it all in one 21 day. Some people do it over three days. It just 22 depends upon their philosophy or where they work and 23 how many hours they can allocate to any one person. 24 Q. You mention here in your conclusions -- it 25 says, "His test result is clearly indicative of</p>
<p style="text-align: right;">34</p> <p>1 Q. Some people that you've tested have scored 2 as low as what? 3 A. I've had people score as low as 20 out of 50 4 correct. It's rare, but it happens. 5 Q. And that's just a straight loser right 6 there? You know right away they're lying? 7 A. Straight loser. 8 Q. So there is a range, though, that -- is 9 there a margin of error in here? 10 A. I can't -- you know what? I don't know if 11 there's a specific margin of error. We use cut 12 scores. There are times when a score of 43 or 44, 13 although it suggests the person is malingering, I'll 14 look at the rest of the data and say you know what? 15 I'm not going to call that person a malingerer based 16 upon one cut score that was off. So I won't do that. 17 The only time I'll call someone malingering is when 18 they have several -- three, four, five -- test results 19 that are in that range. I don't rely on just one 20 test. 21 Q. Did you feel like you needed to retest this 22 part or these three parts or you felt like these were 23 good scores? 24 A. Yes. I mean, I didn't retest anything. I 25 mean, they were all good scores.</p>	<p style="text-align: right;">36</p> <p>1 feigned auditory-verbal memory dysfunction." 2 Is that the right adjective? It's clearly 3 indicative? 4 A. Well, on the CVLT, yes. 5 Q. I'm sorry. I switched gears here. We're 6 now on the CVLT? 7 A. We're on the other test, yes. 8 Q. Let's go back up. Mr. Miller's test 9 results -- going back to the TOMM. "Mr. Miller's test 10 results on the TOMM indicate that he was purposely 11 performing worse than he could have in order to 12 impress his examiners that he has memory disturbance." 13 So you made that conclusion just based on 14 these numbers; is that correct? 15 A. I made that conclusion based on everything 16 together. 17 Q. But he was normal in his third trial; 18 correct? 19 A. Yes. 20 Q. Yet you still feel like he was trying to 21 impress you? 22 A. That statement is based upon not only his 23 TOMM results but all of the other test results in this 24 section of the report. Had he just taken the TOMM and 25 had I not administered any of the other tests in this</p>

<p style="text-align: right;">37</p> <p>1 section, I wouldn't have said that. I would have said 2 that it appears he may not have given his best effort. 3 Q. The California Verbal Learning Test is 4 another test, CVLT. Can we call it that? 5 A. Yes, CVLT. 6 Q. He scored a 14 out of 16? 7 A. No, that's the cut score for whether someone 8 is feigning memory disturbance or not. Anything under 9 14 is indicative of feigned memory disturbance. His 10 score was well below that. 11 Q. What was his score? 12 A. I've got to look it up. I'm -- I think it 13 was 10 out of 16. But I want to really be accurate, 14 which means I have to find it. Not that. Not that. 15 Here it is. It's 10 out of 16. 16 Q. Can you just explain to me like you did with 17 the other tests how this one is performed? 18 A. Well, a person is given a set of 16 words 19 five times in a row and then asked after each -- it's 20 a memory test battery. It's really not a test 21 specifically designed for malingering. It's just that 22 the research has shown that the part of this test 23 that's sensitive to malingering is the part he failed. 24 So I'll give you 16 words. After each 25 trial, you tell me as many of them as you can recall.</p>	<p style="text-align: right;">39</p> <p>1 Thousands of people have been taking this 2 test and they find that people who can't -- who tell 3 you fewer than 14 of the 16 words are not -- are 4 purposely not telling you all that they know. So when 5 you get down to ten, that's a very rare event. After 6 you've heard something five times and you've practiced 7 it, it's hard to not have remembered the word "cat," 8 for example. 9 Q. Are they basic words like "cat"? 10 A. Uh-huh. 11 Q. Do you know the words that you used with 12 him? 13 A. Uh-huh. 14 Q. What were they? 15 MR. VAN NESS: Are you trying to get his raw 16 data? 17 Q. (BY MR. BENSON) I'm just curious. 18 A. I'm going to give you a couple of the words. 19 I don't want to tell you the whole list because this 20 is sort of copyrighted material. And if you guys go 21 out and tell your clients, hey, when you get this 22 test, here's some of the words on it, it screws up 23 psychology in a big way. 24 So there are clothing and fruit and tools. 25 Q. Talking about like hammer?</p>
<p style="text-align: right;">38</p> <p>1 And we just keep going over it. I do it a second 2 time, you do it a second time. Third time, third 3 time. Fourth time, fourth time. Fifth time, fifth 4 time. Add up all the words and I get a scaled score, 5 a score that compares you to your age and education 6 matched peer group. Then there is a short delay. 7 Then there is a second list of words called List B, 8 which is all new lit words. Then I ask you after I 9 tell you List B, what do you remember of List B? So 10 that sort of gets you off track a little. Then I say, 11 hey, let's go back to List A that we did five times. 12 Tell me all of the words that you remember without 13 cues from me. And that person just says I remember 14 da, da, da, da, da, da, this many words. And then 15 20 minutes later I ask them for -- right afterwards I 16 will actually say, I'm going to give you a hint. I'm 17 going to tell you to tell me all the words that were 18 animals -- I'm making that up -- and you would just 19 say, oh, animals, and that's a cue. And you would try 20 to remember all the animals to see whether when you 21 are cued your performance improves. We do the same 22 thing 20 minutes later. At the very end of the test, 23 I read a list of something like 50, 60 words off, and 24 I ask you, if the word was on the list, say yes. If 25 it's a word that wasn't on the list, say no.</p>	<p style="text-align: right;">40</p> <p>1 A. Yeah. 2 Q. Or are they more complicated than that? 3 A. No. No. 4 Q. I can imagine if you gave a hard word, 5 right, that would be harder to remember? 6 A. They're common words that people with no 7 education should be able to remember. 8 Q. So he got 10 out of 16 on that? 9 A. On that last long delay cued recall 10 component. 11 Q. What about the research that females do 12 better on that test? 13 A. I'm not familiar with that. On which test? 14 Q. On the CVLT. 15 A. The CVLT 1 or 2? I am unfamiliar with the 16 research. Though I could read an article, if you have 17 one in mind, and give you my opinion. 18 Q. I just printed something off the internet. 19 Obviously it's not super science. 20 Memorylossonline.com. It's done by Catherine Myers, 21 which is also copyrighted by her book "Memory Loss and 22 the Brain." 23 We'll attach this as Exhibit 1. 24 Says here that overall women tend to perform 25 better than men on the CVLT, especially in their</p>

<p style="text-align: right;">41</p> <p>1 ability to make use of category information. 2 I found that actually on other Web sites 3 too. Your testimony is that you don't see a 4 distinguishing fact between male and female? 5 A. Well, there are norms for males and females. 6 In other words, if a woman takes this test, I go to 7 the female norms and see whether her scores are 8 indicative of normal performance for females in a 9 certain age group or not. So, no, I don't know the 10 research on each of the different indices on this 11 test. But that doesn't surprise me. Women do better 12 than men at a lot of stuff. 13 Q. So on this test, you're basically really 14 testing his memory? Is that all you are testing? 15 A. Yes. 16 Q. What medications was he on when you took 17 this test? 18 A. I don't remember him being on much of 19 anything. He was on Adderall, is all I think he told 20 me he was taking. 21 Q. What is Adderall? 22 A. It's a psychostimulant used to treat ADHD. 23 Q. How does that affect someone who is 24 taking -- 25 A. It would improve his memory.</p>	<p style="text-align: right;">43</p> <p>1 testing? 2 A. I don't believe so. He was sort of reticent 3 to take these medicines as he said to me and hadn't 4 been taking them as prescribed for a while and then 5 decided to. I can't remember. I can try to look it 6 up. 7 Q. Is there any research for someone who might 8 be taking medication how that affects the test scores? 9 A. He was on a very low dosage of Aricept, 10 5 milligrams. He can't tell if it's helping. I'd 11 have to read it more carefully. I don't know if he 12 took the Aricept that day. 13 Q. Wouldn't you want to get a baseline, I mean, 14 with someone like this, to really truly test them? 15 Like no medication and then test them? 16 A. If the world worked that way, sure. 17 Sometimes I do that with ADHD kids. I'll have them 18 not -- I'll have them come in, mom and dad bring the 19 pill, I test them in the morning without the medicine 20 and see how inattentive or impulsive they are. Then I 21 have them take the medication over lunch and then do 22 similar tests, measuring similar skills in the 23 afternoon to measure whether the pill has improved 24 their motor speed or memory functioning or attention 25 and concentration. Handwriting. It does a lot of</p>
<p style="text-align: right;">42</p> <p>1 Q. It should improve it? 2 A. Oh, yeah. 3 Q. But you don't know whether or not he took 4 it? Wouldn't it be important to know that prior to 5 doing your testing? 6 A. I believe I asked him, and he told me he 7 took it. 8 Q. How much was he taking? 9 A. I think he takes 10 milligrams. It would be 10 in my report. That was my recollection. That's a 11 normal dosage. 12 Q. Is that all he was taking? 13 A. I believe so. 14 Q. What's Aricept? 15 A. Aricept is a medicine that's used with 16 Alzheimer's patients to sort of improve memory to the 17 extent that it works. It's sort of -- I don't see too 18 many -- I don't see too many people with Alzheimer's 19 disease. I've read about Aricept. It works a little 20 bit maybe. But neurologists are fond of prescribing 21 it to people with Alzheimer's disease in the hope, 22 since it is FDA approved, that it could slow down the 23 loss in memory functioning. So I think his 24 neurologist gave him Aricept. 25 Q. Was he taking Aricept when you did his</p>	<p style="text-align: right;">44</p> <p>1 different things. 2 Q. In this case, you could have done that too; 3 correct? 4 A. I suppose I could have told him -- well, I 5 could have suggested don't take any medication until I 6 see you and then if you want your medication later, go 7 ahead. But in forensic cases, I usually don't tell 8 people not to take their medications. 9 Q. Are you allowed to tell people not to take 10 their medications? 11 A. I don't think so. 12 Q. Can you prescribe medication? 13 A. No. 14 Q. So moving on, then, you did the Reliable 15 Digit Span Test, the RDS? 16 A. Yeah. Reliable Digit Span is just a way to 17 manipulate the data from the Digit Span Test from the 18 IQ test battery. It's the number of digits that a 19 person twice in a row correctly recalls. And his 20 Reliable Digit score, which is a very big indicator of 21 effort, was well into the he's not trying so hard 22 range and he's not doing what he could do. 23 Q. So what was his score? 24 A. He had like a scaled score of like -- I can 25 tell you exactly. He had forward digits, just four.</p>

<p style="text-align: right;">45</p> <p>1 Backward digits, two, which is --</p> <p>2 Q. What does that mean?</p> <p>3 A. Miserable. I mean, you could be -- you</p> <p>4 could take an eight-year-old who could do better than</p> <p>5 that.</p> <p>6 Q. Just tell me, what type of a test? How does</p> <p>7 it go?</p> <p>8 A. I would say numbers to you, like 3, 4, 2, 1.</p> <p>9 And you would say 3, 4, 2, 1. Starts off at two or</p> <p>10 three or four in a row, five in a row, six in a row,</p> <p>11 to see how many numbers you can keep in working memory</p> <p>12 and recall.</p> <p>13 Q. How do we know what questions were asked of</p> <p>14 him?</p> <p>15 A. It's in the test.</p> <p>16 Q. It's in the test?</p> <p>17 A. Oh, yeah.</p> <p>18 Q. And we have copies of all that?</p> <p>19 A. Have everything.</p> <p>20 Q. Did you administer the RDS test?</p> <p>21 A. Dr. Kampfer. The Digit Span Subtest. The</p> <p>22 RDS is just a way of looking at the data.</p> <p>23 Q. Is that an age corrected score on his? Do</p> <p>24 you know?</p> <p>25 A. Yes.</p>	<p style="text-align: right;">47</p> <p>1 ready for dinner, went to a show. There's nothing</p> <p>2 wrong with him. That's not a brain injury.</p> <p>3 Q. What makes you think that you have to hit</p> <p>4 your head to have a brain injury?</p> <p>5 A. You can have a -- you don't have to hit your</p> <p>6 head to have a brain injury. You can have an injury,</p> <p>7 like blast injury, like in war, or a terrible whiplash</p> <p>8 injury where you're having diffuse axonal problems.</p> <p>9 But there is no evidence that any of that happened</p> <p>10 here.</p> <p>11 Q. You are basing that on what exactly?</p> <p>12 A. All of the records I reviewed and everything</p> <p>13 that he took, the behavior, his behavior. There's</p> <p>14 just nothing there.</p> <p>15 Q. What about the recent MRIs that Fazzini</p> <p>16 ordered?</p> <p>17 A. I have no clue. I have no opinion about</p> <p>18 those since I'm not a physician. Why didn't -- I</p> <p>19 was -- we were talking about this beforehand. I said,</p> <p>20 you know what? If he -- if those are really there, if</p> <p>21 that's truly well read, then he's developed something</p> <p>22 in his brain three years after this accident. Had it</p> <p>23 been there before, it would have shown on the other</p> <p>24 tests.</p> <p>25 Q. Do you know what kind of MRIs were taken</p>
<p style="text-align: right;">46</p> <p>1 Q. Why is that important?</p> <p>2 A. Well, people -- the older you get, the less</p> <p>3 well you do on things is the general rule. So while</p> <p>4 vocabulary pretty much stays fine and unaltered until</p> <p>5 70ish or thereabouts, things like digit span or</p> <p>6 psychomotor speed where you're measuring speed of</p> <p>7 processing or fluid intelligence where you have new</p> <p>8 data that you've never seen before and you have to</p> <p>9 manipulate it gets worse as you get older.</p> <p>10 Q. How is it malingering versus someone who</p> <p>11 might just have a true brain damage?</p> <p>12 A. Well, if you fail a lot of the malingering</p> <p>13 indicators, it looks like malingering. His</p> <p>14 intelligence is intact. He did well on a lot of the</p> <p>15 tests, which is common in people who are malingering.</p> <p>16 They pick and choose what they want to do poorly upon.</p> <p>17 But I think the burden of proof is on you to show me</p> <p>18 he hit his head. He was knocked unconscious for a bit</p> <p>19 of time. We've got abnormalities on the CAT scan.</p> <p>20 Abnormalities on an MRI. Abnormalities on an EEG.</p> <p>21 Posttraumatic amnesia. He wasn't lucid at the scene.</p> <p>22 None of that exists. There is absolutely no evidence</p> <p>23 that this guy hit his head, was knocked unconscious,</p> <p>24 had posttraumatic amnesia. He had a normal CT.</p> <p>25 Couple of normal MRIs. He went back to the hotel, got</p>	<p style="text-align: right;">48</p> <p>1 before and after? Excuse me, not before and after.</p> <p>2 You are saying that the MRIs were the same?</p> <p>3 A. Every machine is different. But I'm saying</p> <p>4 the likelihood of him having suddenly -- if there's</p> <p>5 something wrong with his brain now, as his wife said,</p> <p>6 maybe he has Alzheimer's disease. Maybe he is</p> <p>7 dementing. But he showed none of the signs of brain</p> <p>8 injury.</p> <p>9 Q. Did he show Alzheimer's in your testing?</p> <p>10 A. Nope. Because in Alzheimer's you will see</p> <p>11 word finding problems, dysnomia. His word finding was</p> <p>12 excellent. Not only did he ace the word finding test</p> <p>13 that he did also for Dr. Hibbard but he also -- he's</p> <p>14 very articulate.</p> <p>15 Q. And he has got no college degree; correct?</p> <p>16 A. Correct.</p> <p>17 Q. Did you do an IQ test?</p> <p>18 A. It was done. Dr. Kampfer administered the</p> <p>19 IQ test.</p> <p>20 Q. Which test is that exactly?</p> <p>21 A. The Wechsler Adult Intelligence Scale IV.</p> <p>22 Q. What did he score on that?</p> <p>23 A. There's a bunch of different scores. Are</p> <p>24 you interested in all of them, the full scale IQ?</p> <p>25 There is a bunch of scores.</p>

49	51
<p>1 Q. Why don't you tell me what a normal IQ is</p> <p>2 and then we'll establish that.</p> <p>3 A. A normal IQ would be 90 to 110. That would</p> <p>4 be two-thirds -- or make that -- hold it. Let me see.</p> <p>5 From 85 to 115 would encompass 67 percent of the human</p> <p>6 race. Ninety to 110 is considered average. 110</p> <p>7 starts the high average. 120 starts the superior</p> <p>8 range. 89 and below to 80 is considered below</p> <p>9 average, or low average. And then below 80 is</p> <p>10 borderline until you reach below 70, which is then</p> <p>11 significantly impaired.</p> <p>12 Q. How did Alex score on your exam?</p> <p>13 A. The IQ test is divided into subtests or</p> <p>14 index scores. There's a verbal comprehension index</p> <p>15 score which measures his verbal facility. He earned a</p> <p>16 score of 114, which means that he did better than</p> <p>17 82 out of a hundred people his age, or in his age</p> <p>18 group.</p> <p>19 There's also tests that are called</p> <p>20 perceptual reasoning, which are visual reasoning</p> <p>21 tests. He earned an index score of 111, meaning that</p> <p>22 he did better than 77 out of a hundred people his age</p> <p>23 in visual reasoning. We measured his working memory,</p> <p>24 which is attention and concentration for numbers and</p> <p>25 arithmetic problems. He scored in the low average</p>	<p>1 couple of numbers and a bunch of words and manipulate</p> <p>2 the numbers without the use of paper tends to be a</p> <p>3 harder thing to do well upon than digit span which</p> <p>4 makes digit span much easier to perform. Because all</p> <p>5 you have to do is remember the numbers 1, 3, 6, 2, 4,</p> <p>6 5 and repeat 1, 3, 6, 2, 4, 5. A lot easier than</p> <p>7 doing a math problem in your head. He did much</p> <p>8 better, significantly better, in mental arithmetic,</p> <p>9 50th percentile, than he did on digital span,</p> <p>10 9th percentile.</p> <p>11 Q. On page 16 there's a distinction here</p> <p>12 between his reading and his math. You clearly</p> <p>13 indicate that his math was lower.</p> <p>14 A. You are looking at achievement test, not the</p> <p>15 intelligence test. That's a whole other battery of</p> <p>16 tests we did.</p> <p>17 Q. Gotcha. So he had a different score, then,</p> <p>18 between your IQ and then that other test; correct?</p> <p>19 A. Let's take a look. On the</p> <p>20 Woodcock-Johnson-III test of achievement, we</p> <p>21 administered three different math tests. One's called</p> <p>22 math fluency. Math fluency is do you know seven plus</p> <p>23 one equals eight, ten minus two equals eight. It's a</p> <p>24 three-minute test that you give kids or adults and</p> <p>25 just go at it and do these one digit</p>
50	52
<p>1 range at the 23rd percentile with a working memory</p> <p>2 index score of 89. We measured his simple processing</p> <p>3 or information processing speed using a pencil. He</p> <p>4 scored in the average range at the 30th percentile</p> <p>5 with a processing speed index score of 92. Taking all</p> <p>6 of that together, his full scale IQ, what we call the</p> <p>7 IQ, was average, 104. 61st percentile, average range.</p> <p>8 We also have one other score which is called</p> <p>9 the General Ability Index, which is an interesting</p> <p>10 one. A good one. It takes out the working memory and</p> <p>11 processing speed parts of the test because information</p> <p>12 processing speed and working memory are not higher</p> <p>13 level thinking skills. So the General Ability Index</p> <p>14 includes only the verbal comprehension and perceptual</p> <p>15 reasoning subtests and measure higher level reasoning</p> <p>16 skill. He did better than 82 out of a hundred people</p> <p>17 his age, earning a General Ability Index score of 114.</p> <p>18 Q. How long does it take to perform the</p> <p>19 IQ test, though?</p> <p>20 A. Hour and a half, give or take.</p> <p>21 Q. He scored lowest on his math?</p> <p>22 A. No. His math was actually better than his</p> <p>23 digit span, which makes no sense because -- he's doing</p> <p>24 mental -- he's doing word problems in his mind. A</p> <p>25 word problem in your mind where you have to remember a</p>	<p>1 addition/subtraction/multiplication problems as fast</p> <p>2 as you can.</p> <p>3 In math fluency, he scored in the limited to</p> <p>4 average range at a 7th grade equivalent,</p> <p>5 7.1 grade equivalent. So slower than expected.</p> <p>6 Especially in comparison when he did higher level math</p> <p>7 on calculations, fractions, division, several digit</p> <p>8 multiplication, things like that, he scored at a first</p> <p>9 year college level in the average to advanced range.</p> <p>10 Then when we gave him higher level word problems on</p> <p>11 the Applied Problems Subtest, he scored at 12.5 grade</p> <p>12 equivalent, in the average range, exactly where his</p> <p>13 peer group -- people who have that type of education</p> <p>14 should fall typically.</p> <p>15 So his weakest was in math fluency. And</p> <p>16 math fluency is much easier than all of the rest of</p> <p>17 the math tests.</p> <p>18 Q. I guess I'm curious on this. If you have a</p> <p>19 left brain/right brain person, you've always heard</p> <p>20 someone who might be right brained is more into math</p> <p>21 and engineering and someone left brained might be into</p> <p>22 arts and music and that kind of thing. Is there any</p> <p>23 truth to that?</p> <p>24 A. Popular gobbledegook.</p> <p>25 Q. So someone might be very good at math and</p>

<p style="text-align: right;">53</p> <p>1 still be in the arts?</p> <p>2 A. Yes. And doing cubism or something.</p> <p>3 Q. Anything significant in, like, his motor</p> <p>4 skills?</p> <p>5 A. I did his motor skills stuff, his tests.</p> <p>6 I'll look it up. Motor skills. I did all of that</p> <p>7 battery. The actual -- I want to go to my report</p> <p>8 where I actually made sense of the motor skills.</p> <p>9 Sorry. His right-handed motor test results were much</p> <p>10 superior to his left-handed motor test results.</p> <p>11 We measured strength of grip using a hand</p> <p>12 dynamometer, finger-tapping speed using a little</p> <p>13 finger-tapping machine, and dexterity, or hand/eye</p> <p>14 dexterity, putting pegs into a pegboard as fast as you</p> <p>15 can.</p> <p>16 I asked him, do you notice differences in</p> <p>17 the way you perform left hand to right hand? He</p> <p>18 answered my left hand and arm is not as strong and</p> <p>19 dexterous as my right. He said that he doesn't have</p> <p>20 the same level of sensation in his left upper</p> <p>21 extremity as I did prior to the auto accident. He</p> <p>22 describes sensations of numbing and tingling in his</p> <p>23 left hand at the base of his thumb and said that one</p> <p>24 of his physicians explained, quote, this is related to</p> <p>25 damaged discs in my neck, vertebrae, misalignment, and</p>	<p style="text-align: right;">55</p> <p>1 had a shoulder, rotator cuff, a number of --</p> <p>2 Q. (BY MR. BENSON) You lift weights, right.</p> <p>3 A. Any of that.</p> <p>4 Q. Information processing speed. This is part</p> <p>5 of the IQ test?</p> <p>6 A. Part of it is, yes. Part of it is extra</p> <p>7 tests that aren't part of the IQ test. Different</p> <p>8 tests that measure different types of information</p> <p>9 processing.</p> <p>10 Q. Briefly, can you tell me how he scored on</p> <p>11 the processing speed?</p> <p>12 A. On the intelligence test processing speed,</p> <p>13 he was in the average range. On a test called the</p> <p>14 Stroop Word Subtest, which you give the person to read</p> <p>15 words, three words, red, green, and blue, that are in</p> <p>16 no particular order. You read them as fast as you</p> <p>17 can. You stop them after a certain number of seconds.</p> <p>18 He was average. He read that in average fashion.</p> <p>19 Then you have them read colors -- red, green, and</p> <p>20 blue. So not the word, but the color red is there,</p> <p>21 the color green is there, and you read the colors as</p> <p>22 fast as you can. His reading speed was quicker than</p> <p>23 his color reading speed. His color reading speed was</p> <p>24 mildly impaired. T-score of 35. Not that anyone</p> <p>25 knows what that is. That was off.</p>
<p style="text-align: right;">54</p> <p>1 pressure. He's had trigger-point injections by</p> <p>2 Dr. Kulick for this. The last a few months before.</p> <p>3 Basically that all of these problems were a result of</p> <p>4 the subject accident and didn't preexist the subject</p> <p>5 accident.</p> <p>6 Q. So right-hand strength is usually shown when</p> <p>7 you are right-handed; is that correct?</p> <p>8 A. Yes.</p> <p>9 Q. So he's fairly normal on that point?</p> <p>10 A. Below average but unimpaired. Still within</p> <p>11 normal range.</p> <p>12 Q. Someone who has traumatic brain injury or</p> <p>13 mild traumatic brain injury or the type of brain</p> <p>14 injury that he may have or may not have, would they</p> <p>15 necessarily have a motor skill problem?</p> <p>16 MR. VAN NESS: Object as to form of the</p> <p>17 question.</p> <p>18 THE WITNESS: Depends upon where the brain</p> <p>19 was hurt. If it was in the motor strip or the</p> <p>20 prefrontal area or deep into the cerebellum possibly,</p> <p>21 he could have some motor coordination problems. It</p> <p>22 isn't so unusual to have lousy scores on these tests,</p> <p>23 because you have other nonbrain-related problems and</p> <p>24 your -- like I have arthritis. So if I were asked to</p> <p>25 do these tests, I would mess them up. You can have</p>	<p style="text-align: right;">56</p> <p>1 Then we gave him the reading fluency test</p> <p>2 from the Woodcock battery, and he was average at</p> <p>3 reading sentences at a normal rate. He was slow at</p> <p>4 the math fluency, which I already discussed. And his</p> <p>5 speech was either halting or very fast. It just sort</p> <p>6 of changed.</p> <p>7 Q. Language skills, he did real well?</p> <p>8 A. Good language skills.</p> <p>9 Q. Is that something you can fake if you wanted</p> <p>10 to?</p> <p>11 A. Oh, yeah. You can try to. I'm pretty good</p> <p>12 at catching fakers at that. But you can try.</p> <p>13 Q. And you noticed he didn't fake that;</p> <p>14 correct?</p> <p>15 A. Nope. Nope.</p> <p>16 Visual organization skills, good.</p> <p>17 Attention, working memory skills, we've done some of</p> <p>18 that already. The best -- there's so many different</p> <p>19 of these tests. Page 17 at the end, I said, taken</p> <p>20 together, Mr. Miller's attentional abilities and</p> <p>21 working memory ranged from below average,</p> <p>22 9th percentile, on the WAIS-IV Digit Span to average</p> <p>23 on WAIS-IV arithmetic. That was 50th percentile.</p> <p>24 With most of the tests falling between the 16th and</p> <p>25 27th percentiles.</p>

<p style="text-align: right;">57</p> <p>1 Q. That's good or bad?</p> <p>2 A. It's okay. Not great. Worse than his</p> <p>3 visual thinking skills, worse than his verbal thinking</p> <p>4 skills, but not terrible.</p> <p>5 Q. How can you tell if someone has brain</p> <p>6 damage, from your point of view, when you take all</p> <p>7 these tests and look at them?</p> <p>8 A. That's the art of putting all of these</p> <p>9 things together and looking at all the tests, looking</p> <p>10 at the data. Is there medical evidence of brain</p> <p>11 damage? Is there not medical evidence of brain</p> <p>12 damage? Talking to the person. Do they look and</p> <p>13 sound and talk like a brain-damaged person or they</p> <p>14 don't. What are the test results? Are they</p> <p>15 consistent and say one thing or are they inconsistent</p> <p>16 and all over the place?</p> <p>17 Q. What about the symptoms he was having right</p> <p>18 after the accident?</p> <p>19 A. He said he was having headaches and he</p> <p>20 really had to be in a dark room for a while and he</p> <p>21 couldn't go back to work and then was going back part</p> <p>22 time. Could be, if that was a brain damage. That</p> <p>23 would be consistent with brain damage. It could be</p> <p>24 that. Could have had headache problems for whatever</p> <p>25 reason.</p>	<p style="text-align: right;">59</p> <p>1 are under enough stress, you'll have headaches,</p> <p>2 stomachaches, diarrhea, low back pain. All sorts of</p> <p>3 things. Because you're in stress. You lost your job,</p> <p>4 in his case. You know, all of that. These were some</p> <p>5 of the things that the MMPI-2-RF mentioned. Looks</p> <p>6 like he has some marital problems. We talked about</p> <p>7 this. I actually went through the results with him</p> <p>8 and asked him, do these results make sense or not make</p> <p>9 sense? Because I want to see if he's -- these tests</p> <p>10 bring out group norms. So just because it says</p> <p>11 something about you doesn't mean that sentence or that</p> <p>12 attribute that you seem to be high on is true. So I</p> <p>13 ask. Well, it says here that you may be having</p> <p>14 marital problems. And I listen. Well, you know, I do</p> <p>15 have marital problems and here's why or my libido is</p> <p>16 low. So I'll ask the people and say, here's what the</p> <p>17 tests say about you, given what you told the test,</p> <p>18 does this make sense to you?</p> <p>19 Q. He's been married for a long time; right?</p> <p>20 A. Yes.</p> <p>21 Q. Is it -- are you diagnosing him with marital</p> <p>22 problems?</p> <p>23 A. No. I don't know him well enough. I mean,</p> <p>24 he told me he has marital problems. I'm not --</p> <p>25 Q. Did you get at a cause of why he has marital</p>
<p style="text-align: right;">58</p> <p>1 Q. Do you know if he had a history of</p> <p>2 headaches?</p> <p>3 A. I don't think he told me he did or it would</p> <p>4 have been in my report.</p> <p>5 Q. Anything else? I know there's a lot of</p> <p>6 stuff to cover in your report. But is there anything</p> <p>7 that is super important that you think that I would</p> <p>8 like to know about? I know that's kind of a crazy</p> <p>9 question. Is there anything that you would testify to</p> <p>10 that you think is important in the next five, six</p> <p>11 pages there?</p> <p>12 A. I mean, I could go through his personality</p> <p>13 test results if you want.</p> <p>14 Q. What's important about that?</p> <p>15 A. The MMPI-2 indicated that he may be</p> <p>16 malingering cognitive symptoms. That's a very</p> <p>17 well-respected, excellent personality test that says</p> <p>18 this guy is presenting memory complaints that make no</p> <p>19 sense. So he may be malingering cognitive symptoms.</p> <p>20 Which is what I said he was doing, given all of the</p> <p>21 other test results I've been talking about.</p> <p>22 It also suggests that a somatoform disorder,</p> <p>23 which means that if you can't substantiate his</p> <p>24 physical complaints via objective medical evidence,</p> <p>25 then they may be of psychological origin, which if you</p>	<p style="text-align: right;">60</p> <p>1 problems?</p> <p>2 A. I don't have any real -- I don't know enough</p> <p>3 about them to say that he has marital problems for any</p> <p>4 particular reason.</p> <p>5 Q. And you are not blaming the fact that he got</p> <p>6 terminated from work or that he's not working based on</p> <p>7 his marital problems?</p> <p>8 A. No opinion.</p> <p>9 Q. The MMPI, can that be affected by his use of</p> <p>10 Adderall?</p> <p>11 A. No. At most he would do it better. He</p> <p>12 would make careless errors, but otherwise, no. And to</p> <p>13 make this go quicker, in the summary section, I</p> <p>14 basically list out as logically as I can why I have</p> <p>15 the opinions I have. You probably want to ask me</p> <p>16 about that.</p> <p>17 Q. So you looked at the property damage. You</p> <p>18 thought that was significant; right?</p> <p>19 A. I thought the person who knocked into him</p> <p>20 had significant property damage.</p> <p>21 Q. Did you look at those photos?</p> <p>22 A. Yes.</p> <p>23 Q. Was that part of your report? I didn't</p> <p>24 see --</p> <p>25 A. I don't know if I -- I mentioned that I saw</p>

<p style="text-align: right;">61</p> <p>1 the photos. I don't know if I had any particular --</p> <p>2 since you would tell me, hey, you're not an accident</p> <p>3 reconstructionist. So you can't rely on it. I saw</p> <p>4 the photos.</p> <p>5 Q. I think we can all use common sense at some</p> <p>6 degree. But you did look at both sets of photos?</p> <p>7 A. I did.</p> <p>8 Q. Your summary said you only looked at</p> <p>9 Mr. Marino's vehicle, which would have been the</p> <p>10 suburban?</p> <p>11 A. Then I'm wrong. I looked at both.</p> <p>12 Q. All the photographs are in your file?</p> <p>13 A. In there.</p> <p>14 Q. Can you show me them?</p> <p>15 A. Sure. See if they're here. Yep. They're</p> <p>16 black and white. I don't know if they were black and</p> <p>17 white originally. Just whatever. There's a lot of</p> <p>18 them.</p> <p>19 Q. Do you normally get the photographs?</p> <p>20 A. Oh, yeah. Police reports, ambulance</p> <p>21 reports, photographs, depositions.</p> <p>22 Q. Do you rely on police reports?</p> <p>23 A. Oh, yeah. I think those are important.</p> <p>24 Because they are objective. And the person was there</p> <p>25 and they saw something. Just like -- looks like about</p>	<p style="text-align: right;">63</p> <p>1 A. Looks pretty damaged.</p> <p>2 Q. Is that significant?</p> <p>3 A. Significant damage.</p> <p>4 Q. Is there anywhere in your report where you</p> <p>5 reference that?</p> <p>6 A. I don't believe so. She wasn't the one</p> <p>7 suing for medical problems.</p> <p>8 Q. That's your rationale?</p> <p>9 A. I mean, maybe I just didn't think of it. I</p> <p>10 am very willing to say that her car was very damaged</p> <p>11 and his car was hardly damaged at all.</p> <p>12 Q. Based on that, you came up that -- your</p> <p>13 diagnostic impression is V65.2, malingering, of</p> <p>14 cognitive disorder?</p> <p>15 A. Yes.</p> <p>16 Q. You go on to say -- here's a paragraph.</p> <p>17 I'll just kind of go through it. Maybe it's</p> <p>18 important. Evidence of -- this is on page 25, second</p> <p>19 paragraph, "Evidence of malingering during this</p> <p>20 evaluation included Mr. Miller's variable style of</p> <p>21 speaking where, as reported previously in this report,</p> <p>22 he spoke in a more halting manner, taking longer than</p> <p>23 normal to express himself, especially in the front</p> <p>24 office and waiting room situations."</p> <p>25 In the waiting room, how do you know how</p>
<p style="text-align: right;">62</p> <p>1 40 pages or so of photographs.</p> <p>2 Q. Keep it right there. I just want to flip</p> <p>3 through what you've got. I'm just looking at what</p> <p>4 you've already got numbered as B001. There's 10. Go</p> <p>5 on to 11. Here's 12, 13, 14, 15, 16, 17, 18, 19, 20,</p> <p>6 21.</p> <p>7 A. Then the other car.</p> <p>8 Q. I just wanted to keep going here. Looks</p> <p>9 like you've got C and then they start at D. What kind</p> <p>10 of car was she driving?</p> <p>11 A. Was it a Honda? I don't remember.</p> <p>12 Q. But her air bags went off; right?</p> <p>13 A. It looks it, yes.</p> <p>14 Q. Is that significant to you?</p> <p>15 A. Yeah.</p> <p>16 Q. Why is that significant?</p> <p>17 A. She hit him -- the front of her car hit him</p> <p>18 at a decent enough speed that whatever that speed</p> <p>19 happens to be that makes an air bag go off.</p> <p>20 Q. In your report you don't mention that that's</p> <p>21 being significant, do you?</p> <p>22 A. I'm not an accident reconstructionist.</p> <p>23 Q. But you mention that the vehicle that my</p> <p>24 client was in was minor, but you failed to mention --</p> <p>25 how do you rate that damage to the Nissan?</p>	<p style="text-align: right;">64</p> <p>1 he's talking?</p> <p>2 A. I imagine my office manager or anyone who is</p> <p>3 in my office who spoke to him mentioned that.</p> <p>4 Q. Is that documented somewhere?</p> <p>5 A. Don't know. Should be. But I don't know.</p> <p>6 Q. It's in your report; right?</p> <p>7 A. Yes.</p> <p>8 Q. So you are relying on this?</p> <p>9 A. Yes.</p> <p>10 Q. Then you say when he's with you, he speaks</p> <p>11 in an articulate, intelligent, and eloquent manner.</p> <p>12 A. When he's talking about the stuff he's proud</p> <p>13 about himself. The way he presented himself changed.</p> <p>14 If you have brain damage, you don't speak perfectly</p> <p>15 when you speak about something you like about yourself</p> <p>16 and then start stuttering and going slowly when you</p> <p>17 are speaking about your injuries.</p> <p>18 Q. Did he ever speak slowly and in a halting</p> <p>19 manner when he was in front of you?</p> <p>20 A. Oh, yeah.</p> <p>21 Q. When?</p> <p>22 A. During interview.</p> <p>23 Q. But you said that he did quite well when he</p> <p>24 was doing that, articulate, intelligent, and eloquent.</p> <p>25 A. When he was speaking about his career. When</p>

<p style="text-align: right;">65</p> <p>1 he was speaking about his accident, things like that, 2 he tended to be much slower and less exact. I think I 3 said -- I'm pretty sure I said that. 4 Q. You are saying this variability in his 5 presentation suggests that he was consciously 6 attempting to manipulate the impressions of the 7 examiners. You are telling me your front desk clerk 8 is the one that you are comparing this to? 9 A. No. I also saw this. 10 Q. Who is the front desk clerk? 11 A. That would have been Donna Calendar. 12 Q. Does she take her own notes? 13 A. No, she doesn't. 14 Q. Does she have any credentials? 15 A. Nope. 16 Q. Do you claim to know what someone is 17 thinking? 18 A. I don't. 19 Q. Out of all the tests that you gave in terms 20 of malingering, what do you rely on the most? 21 A. None. I rely on -- what makes the diagnosis 22 stick is when you have two, three, four, five 23 different test results. The greater number the test 24 results that the literature indicates is consistent 25 with a malingering diagnosis the more -- that is when</p>	<p style="text-align: right;">67</p> <p>1 was clearly competent. 2 Q. What happened, do you think? 3 A. I have no clue. She would know. But I 4 don't know. 5 Q. The testing -- do you have her report in 6 your file? 7 A. Somewhere. Which one? 8 Q. The neurological reevaluation. 9 A. Possibly. 10 Q. Looks like it's 24 pages. The date was 11 March 14, 2014. 12 A. Probably in this section. 13 Q. Probably in that last -- 14 MR. VAN NESS: Third supplement. 15 Q. (BY MR. BENSON) Third supplement. 16 A. I have it, I think. Yes. 17 Q. You reviewed that? 18 A. I did. 19 Q. Looks like you've got some highlights on 20 that? 21 A. Yes. 22 Q. What did you highlight about that? 23 A. I just use highlighters. If something looks 24 like it might be interesting, I highlight it. I 25 highlight magazines and newspapers too.</p>
<p style="text-align: right;">66</p> <p>1 I will give the diagnosis. If it was just the TOMM or 2 just the MMPI-2 or just the CVLT, I would never say 3 malingering. Never. 4 Q. How do you contrast that with someone else 5 who, like Dr. Hibbard, who is not -- not really a 6 plaintiff's expert when she did the testing? 7 A. Contrast meaning what? 8 Q. How do you contrast, like, her results? You 9 take a variety of results when you do this; right? 10 A. Yes. 11 Q. You are only relying on what you did or your 12 staff did or your front desk clerk did? 13 A. Well, I tried to rely on what she did, but 14 she made so many errors, it was hardly believable how 15 many errors she made. So -- 16 Q. Did you find out that those errors were 17 insignificant? Because she did a rebuttal report. 18 A. They were significant. I mean, I wouldn't 19 trust anything she does. I mean, seriously. If a 20 doctoral student who I was training made that many 21 errors, I would send that person back to their school 22 and say don't return. That's how bad it was. It was 23 so beneath standards. I couldn't believe it, for 24 someone who has got a diplomate. So I place no 25 credibility on her work. Though once upon a time she</p>	<p style="text-align: right;">68</p> <p>1 Q. When you reviewed her supplement or 2 reevaluation versus her other report, was there 3 anything that you found significant in the 4 reevaluation? 5 A. More errors. 6 Q. That she did more errors the second time? 7 A. Just fraught with errors. 8 Q. Let's go through them, please. 9 A. I'm not sure I can pick them all out at this 10 point. I didn't bother writing a -- I wasn't asked to 11 write up all the different errors. 12 Q. Generally looking at it, you apparently have 13 come up with the conclusion that there are errors; 14 correct? 15 A. Well, I looked at it back then and I picked 16 out things that were errors, but I didn't really place 17 any emphasis on the report as a result of her lack of 18 competence in administering, scoring, and interpreting 19 tests. 20 Q. You're looking at page 21. What on there is 21 so glaring to you? 22 A. Right offhand, I can't tell you. Hold it. 23 Hold it. Hold it. Maybe I can tell you. No, I don't 24 think I did -- I didn't do anything. So, no, right at 25 this point, I was just trying to figure out -- I can't</p>

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<p>1 tell you. I am not ready at this point to tell you 2 all the errors she made. I just found things. It 3 would take me a good hour, hour and a half to go back 4 and try to reconstruct the errors here. I just gave 5 up. Since I wasn't going to give it any credence, I 6 just said, okay, this is ridiculous. Maybe she did a 7 better job the second time. 8 Q. She gives the comparisons what the testing 9 was on October 3rd, 2011, and then she gives the 10 scores of the retesting of March; correct? 11 A. But you can't rely that any of the things in 12 here are accurate. Some are; some aren't. 13 Q. Right. And we are just going by what you're 14 saying; right? 15 A. I mean, I can prove it, if it comes down to 16 going on the stand. If that comes down to it, I'll be 17 able to say this is exactly what she did and show you 18 why it wasn't right. 19 Q. Everything you guys did was perfect; right? 20 A. Well, give my stuff to her. Have her pick 21 out as many mistakes as you can. Good luck to you. 22 There will be fewer. Perfect? Never. 23 I mean, I'm just looking. Here's a mistake. 24 I mean, they're everywhere. A scaled score of 16, a 25 graduate student knows it means 98th percentile. She</p>	<p>1 2011. Don't know why she did that. She also omitted 2 the D-KEFS 20 questions abstract and total scores from 3 2011 in comparing them. I don't know why she did 4 that. She was, I guess -- she learned that she should 5 have given a good personality test. She did that at 6 least. 7 Q. What were her -- were those consistent with 8 what you found? 9 A. Let me take a look. I'd have to look it up 10 and compare all the different subtests. 11 Q. I know it's laborious. This is my one shot, 12 man. 13 A. That's different. That's not bad. 14 MR. BENSON: Off the record for a second. 15 (Discussion off the record) 16 THE WITNESS: This is why I didn't spend as 17 much time. She didn't even include the most important 18 scales. 19 Q. (BY MR. BENSON) What was that? 20 A. Those are the higher order and reconstructed 21 clinical scales. Those are the meat of the test. She 22 left those out. It's just not worth the time. 23 Q. What do you mean she left that out? 24 A. It's not in here. She put in some of the 25 validity scales. Then she went to the --</p>
70	72
<p>1 has 84th percentile. Then she says very superior. 2 Very superior is the 98th percentile, not the 84th 3 percentile. This is like first year of graduate 4 school. 5 Here's another one. Scaled score 19, 6 50th percentile. 50th percentile is average. 7 99th percentile is very superior. The scaled score of 8 19 is the highest score you can get. There is nothing 9 higher. If you get a scaled score of 19, you are 10 unbelievable. 11 Q. Are you going by the old or are you going by 12 the new? 13 A. What is it? 14 Q. What page are you referencing? 15 A. Page 10 of the new. 16 Q. You are referencing the old one. Those are 17 the ones where she made the corrections. 18 A. Where did she make the corrections? 19 Q. They're in the new report on the last two 20 pages. 21 A. Okay. I see. The last two pages. Let me 22 see. It looks like she omitted some of the scores on 23 the D-KEFS test that she had placed in the other test 24 result. I don't know why she did that. She omitted 25 two tests, the D-KEFS fill dots and empty dots from</p>	<p>1 Q. Are you saying it's not part of her report 2 or that she left it out? 3 A. She left it out of the entire chart. There 4 are a bunch of things that she didn't put in here. 5 God knows why. I don't know why. 6 Q. Do you know that for sure? 7 A. Swear on a stack of Bibles. 8 Q. That the analysis -- 9 A. There's scales missing. I can show you the 10 scales that are missing. It might have been just 11 another careless error. 12 Q. That's primarily on the mood and 13 personality; correct? 14 A. Yes. That's what I just saw on that test, 15 the test scores. But in terms of the -- I can't give 16 you -- besides the few things I wrote down here that 17 were mistakes, I would have to take an hour and go 18 through here. She made so many mistakes. I would 19 literally have to go through every single thing that 20 she wrote and compare it to the raw data. Now, I 21 didn't get the raw data from this testing. There was 22 no sense in trying to figure it out. Because without 23 the raw data, I can't figure out whether she scored 24 the retesting correctly or incorrectly. I mean, on 25 the first testing, she changed things -- she changed</p>

<p style="text-align: right;">73</p> <p>1 things that they told her were wrong. 2 Q. Same goes for her too. She would need your 3 raw data to actually evaluate what you did? 4 A. I would give it to her in a heartbeat. 5 Q. Just looking, then, at pages 21, 22, 23, and 6 24 of the retesting that was done on March 14th, 7 2014 -- 8 A. 21, 22, 23. Yep. 9 Q. So looking at those, it's kind of a summary, 10 would you agree, of the neurological tests that 11 she did? 12 A. Yes. 13 Q. Out of that summary, are there particular 14 tests in there that are the malingering at least tests 15 or the feigning tests that you would highlight? 16 A. There is Reliable Digit Span, Rey 15. 17 Q. This is on page 21? 18 A. That's on page 21. 19 Q. I'm going to star that one. 20 A. Dot Counting, Rey 15, Reliable Digit, and 21 she used the CVLT recognition as I did. There he did 22 perfectly. He gives better effort for her. This 23 MVLVT -- those are the ones I think that are 24 specifically for malingering. 25 Q. So he did a 16 out of 16 both times, right,</p>	<p style="text-align: right;">75</p> <p>1 raw data to see the real scores versus what she put in 2 there. 3 Q. I have a few things to go over here. 4 Did your testing reveal that he was 5 depressed? 6 A. Yes. Some. 7 Q. Is there a way of scaling that? 8 A. Get to that answer. I was going to say 9 dysthymic disorder. So probably mild to moderate 10 depression. Not severe major depressive disorder. 11 Q. What is PTSD? 12 A. Posttraumatic stress disorder. 13 Q. Does he have that? 14 A. No. 15 Q. Can you tell me more about what PTSD is? 16 A. PTSD, if you have a life-threatening 17 event -- you're in a terrible car wreck, you're a 18 prisoner of war, someone holds you up by gun, rape, 19 seeing someone else die or almost die. Terrible -- 20 you know, soldier stuff. Concentration camp. But 21 terrible auto accidents. You can see something that's 22 beyond the range of human experience that is life 23 threatening and you have nightmares and you get very 24 frightened. You have a nervous system reaction that 25 makes you very anxious.</p>
<p style="text-align: right;">74</p> <p>1 with her? 2 A. Yes. 3 Q. Then with you he did a 10 out of 16? Oddly. 4 A. Oddly, but yes. 5 Q. Then the dot counting test, E-score equals 6 13. 7 A. I never use dot counting; so I can't make 8 sense of it. 9 Q. Anything else that you noticed on the first 10 page here that it goes towards the malingering or the 11 feigning of symptoms? 12 A. Those -- the rest are not malingering tests. 13 Q. On the next page, are there any that are 14 malingering tests? 15 A. Digit Span can be, but he was okay on that. 16 Q. In fact, that's the one where he got a nine 17 and he got an eight there? 18 A. Yes. 19 Q. That's within the range; right? 20 A. That's normal. 21 Those -- I think the malingering tests were 22 on the first page of that. 23 Q. So no other tests, then, really go to the 24 malingering except for that first page? 25 A. Offhand. But I would have to look at her</p>	<p style="text-align: right;">76</p> <p>1 Q. On page 21 of your report, you indicate that 2 he has got anxiety-related disorders, including PTSD. 3 A. Those are the rule-outs from the MMPI-2. 4 Those are things it could be, but you look at it and 5 see whether -- those are differential possibilities. 6 So I diagnosed him with an adjustment 7 disorder with mixed anxiety and depressed mood, 8 meaning that he's somewhat anxious and somewhat 9 depressed. He's lost his job. He's not the 10 breadwinner. He's trying to find himself. That all 11 makes for an unhappy guy. 12 Q. You do a fair amount of personal injury; 13 correct? 14 A. Yes. 15 Q. Do you do workers' compensation? 16 A. Hardly ever. 17 Q. Do you have any general opinions of workers' 18 compensation doctors? 19 A. No. 20 Q. You read all the records, including 21 Dr. Chacko in this one? 22 A. Yes. 23 Q. What kind of doctor is Dr. Chacko? 24 A. Was he a neurologist? Off the top of my 25 head.</p>

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<p>1 Q. I don't believe so, but --</p> <p>2 A. I got to look it up. I read it over again</p> <p>3 today. Look for Chacko. If you could find when he</p> <p>4 saw him, I will find out.</p> <p>5 Q. March 2012.</p> <p>6 A. March 2012? Neurological. I was right.</p> <p>7 Neurological exam.</p> <p>8 Q. You were right. You are relying on</p> <p>9 Dr. Chacko as part of your assessment?</p> <p>10 A. All of the doctors. I read all of them. I</p> <p>11 mean, in forensic cases, you get doctors saying one</p> <p>12 thing and then doctors saying the opposite. Whatever</p> <p>13 you -- there's something for you or -- you are going</p> <p>14 to get a lot of different opinions.</p> <p>15 Q. Have you spoken to the expert neurologist</p> <p>16 hired by the Sisolaks?</p> <p>17 A. Nobody. I have spoken to no one.</p> <p>18 Q. Did you rely on their reports at all, the</p> <p>19 neurology reports?</p> <p>20 A. As much as I relied on all of the reports.</p> <p>21 I mean, I read them. They go into the equation of</p> <p>22 helping me form my opinions. I don't give greater</p> <p>23 credence necessarily to Dr. Chacko versus someone</p> <p>24 else.</p> <p>25 Q. Have you read Dr. Chacko's deposition?</p>	<p>1 I do need to know what you relied on. So go ahead and</p> <p>2 attach that.</p> <p>3 THE WITNESS: You want all the medical</p> <p>4 records?</p> <p>5 MR. BENSON: Whatever you relied on.</p> <p>6 THE WITNESS: Oh, my God. I'm not going to</p> <p>7 be able to go through there and tell you that. That's</p> <p>8 crazy.</p> <p>9 MR. BENSON: Is this your file here?</p> <p>10 THE WITNESS: Yes. Two files.</p> <p>11 MR. BENSON: It's got about four reams?</p> <p>12 THE WITNESS: Yeah. I read everything. How</p> <p>13 much of it was --</p> <p>14 MR. BENSON: I don't know what you relied</p> <p>15 on. If they only gave you half the medical records,</p> <p>16 and you're giving me opinions --</p> <p>17 THE WITNESS: That should be in my report.</p> <p>18 In my report, it will say here's the records I</p> <p>19 reviewed.</p> <p>20 MR. BENSON: I'll be fair with you. I'll</p> <p>21 skip the medical records for now. We want to make</p> <p>22 sure we have all the notes, all the testing data, the</p> <p>23 photographs that you relied on, the estimates that you</p> <p>24 relied on --</p> <p>25 THE WITNESS: You want photos?</p>
78	80
<p>1 A. Yes.</p> <p>2 Q. After that deposition, you still have the</p> <p>3 same opinion?</p> <p>4 A. I don't remember his deposition. I didn't</p> <p>5 read it today.</p> <p>6 MR. BENSON: All right. I'll pass the</p> <p>7 witness.</p> <p>8 MS. TAYLOR: I don't have any questions at</p> <p>9 this time.</p> <p>10 MR. BENSON: Before we end the deposition,</p> <p>11 I'd like to attach as Plaintiffs' Exhibit 2, the</p> <p>12 report, and then 3 would actually be his entire file.</p> <p>13 MR. VAN NESS: With the exception of what he</p> <p>14 can't produce to you, which he will produce to your</p> <p>15 expert.</p> <p>16 THE WITNESS: Let me make it easy. Entire</p> <p>17 file, billing records, interview records. I'll send</p> <p>18 the test results to Dr. Hibbard if you give me her</p> <p>19 address. So the psych data goes to Hibbard. The</p> <p>20 interview goes to you. The correspondence with</p> <p>21 attorney goes to you. The billing goes to you. In</p> <p>22 terms of the medical records, you want us to make</p> <p>23 copies of this? It will cost you an arm and a leg. I</p> <p>24 don't care. 60 cents a page.</p> <p>25 MR. BENSON: It's not that I want that. But</p>	<p>1 MR. BENSON: Yeah. That are part of your</p> <p>2 report today that's going to go directly to her.</p> <p>3 THE WITNESS: Okay. You got it.</p> <p>4 MR. BENSON: That will be 3.</p> <p>5 THE WITNESS: If you give me Dr. Hibbard's</p> <p>6 address, or give it to Donna. Call from your office.</p> <p>7 We will send all of that stuff to her too.</p> <p>8 MR. BENSON: It's on her report. Right at</p> <p>9 the bottom. You have a copy of her report; right?</p> <p>10 THE WITNESS: Yes. That is the right</p> <p>11 address.</p> <p>12 MR. BENSON: That's it.</p> <p>13 (Exhibits 1 and 2 were marked)</p> <p>14 (The deposition was concluded</p> <p>15 at 3:42 p.m.)</p> <p>16 * * * * *</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>

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1 CERTIFICATE OF DEPONENT

2 I, LEWIS M. ETCOFF, PH.D., A.B.N., deponent
 3 herein, do hereby certify and declare the within and
 4 foregoing transcription to be my deposition in said
 5 action, subject to any corrections I have heretofore
 6 submitted; and that I have read, corrected, and do
 7 hereby affix my signature to said deposition.

8
 9
 10
 11 _____
 12 LEWIS M. ETCOFF, PH.D., A.B.N., Deponent

13 Subscribed and sworn to before me this
 14 ____ day of _____, ____.

15
 16
 17
 18 STATE OF NEVADA)

ss:

19 COUNTY OF CLARK)

20

21

 Notary Public

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1 CERTIFICATE OF REPORTER

2 I, Marnita J. Goddard, CCR No. 344, a
 3 Certified Court Reporter licensed by the State of
 4 Nevada, do hereby certify:

5 That I reported the deposition of the
 6 witness, LEWIS M. ETCOFF, PH.D., A.B.N., commencing on
 7 Monday, August 25, 2014, at the hour of 1:58 p.m.;

8 That prior to being examined, the witness was
 9 by me first duly sworn to testify to the truth, the
 10 whole truth, and nothing but the truth; that I
 11 thereafter transcribed my related shorthand notes into
 12 typewriting and that the typewritten transcript of
 13 said deposition is a complete, true, and accurate
 14 record of testimony provided by the witness at said
 15 time.

16 I further certify (1) that I am not a
 17 relative or employee of an attorney or counsel of any
 18 of the parties, nor a relative or employee of any
 19 attorney or counsel involved in said action, nor a
 20 person financially interested in the action, and (2)
 21 that pursuant to NRCP 30(e), transcript review by the
 22 witness was not requested.

23 IN WITNESS WHEREOF, I have hereunto set my
 24 hand in my office in the County of Clark, State of
 25 Nevada, this ____ day of _____, 2014.

 Marnita J. Goddard, RPR, CCR No. 344

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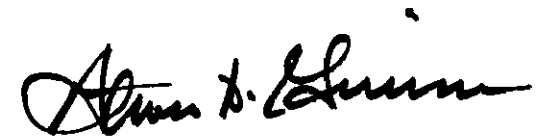
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EXHIBIT “6”



CLERK OF THE COURT

RTRAN

DISTRICT COURT
CLARK COUNTY, NEVADA

MITCH WILSON,

Plaintiff,

vs.

SCOTT YANCEY, ET AL.,

Defendants.

CASE NO. A680635

DEPT. 16

BEFORE THE HONORABLE BONNIE A. BULLA, DISCOVERY COMMISSIONER
FRIDAY, APRIL 3, 2015

RECORDER'S TRANSCRIPT OF PROCEEDINGS
YANCEY DEFENDANTS AND GOLIATH PROPERTIES LLC'S MOTION TO
COMPEL INDEPENDENT MEDICAL EXAMINATION

APPEARANCES:

For the Plaintiff:

ADAM GANZ, ESQ.,
JASON LATHER, ESQ.

For the Defendants:

WILLIAM MAUPIN, ESQ.

For Amy Yoncey/Scott Yancey/Goliath:

STACEY A. UPSON, ESQ.

RECORDED BY: FRANCESCA HAAK, COURT RECORDER

1 Las Vegas, Nevada - Friday, April 3, 2015, 10:30 a.m.

2 * * * * *

3 DISCOVERY COMMISSIONER: Wilson.

4 MR. GANZ: Good morning, Your Honor. Adam Ganz, on behalf of the Plaintiff,
5 Mitch Wilson.

6 DISCOVERY COMMISSIONER: Good morning.

7 MR. GANZ: And my associate, Jason Lather.

8 DISCOVERY COMMISSIONER: Good morning.

9 MR. LATHER: Good morning. Do you need Bar numbers, or do you --

10 THE CLERK: You're in the computer.

11 DISCOVERY COMMISSIONER: You're in the computer, so you're fine.

12 MS. UPSON: Good morning. Stacey Upson, on behalf of the Yanceys and the
13 Goliath enterprise.

14 DISCOVERY COMMISSIONER: Good morning.

15 MR. MAUPIN: Bill Maupin, Bar number 1315.

16 DISCOVERY COMMISSIONER: And you are here for?

17 MR. MAUPIN: For the Defendants.

18 DISCOVERY COMMISSIONER: Thank you. All right. Everyone may have a seat.
19 I'm going to give both sides time to argue, but I felt that it was just important for me to make
20 a couple of preliminary observations and hopefully try to reinforce what I think my role is as
21 Discovery Commissioner.

22 First of all, I do not have the authority nor will I prevent Dr. Duke from
23 performing Rule 35 exams in the Eighth Judicial District Court; that is not within my
24 purview. I can't make that type of a decision. I have to look at each case individually, and
25 there have been cases where I have disqualified him from performing the Rule 35 exams for

1 very specific reasons, and there was a case recently I believe either Wednesday or last
2 week -- it all sometimes runs together -- where I allowed him to perform that Rule 35 exam.
3 So I am looking at these issues on a case-by-case basis, and if there are rumors or -- out in
4 the community that I've disqualified this gentleman, that is just not correct. So make sure
5 that you properly indicate what I have done.

6 Number two, a Rule 35 exam is not a matter of right, nor are Defendants
7 automatically entitled to one. It is within the Court's discretion, and there are some very
8 persuasive language in a case called Storlie, S-T-O-R-L-I-E, versus State Farm, it's 2010
9 Westlaw 549.0777. It is not reported in F2d, but of course we can cite to those decisions as
10 persuasive authority even though they're not reported, but I can't cite to unreported Supreme
11 Court decisions and neither can you all. So that's just a little bit of a tip for you, and I would
12 highly recommend you read that case.

13 Number three, a Rule 35 examiner must be free from bias, and this is from the
14 American Medical Association which was actually cited in one of the other cases called
15 Hudson, and the case number for that, if you choose to look it up, is A676211. But what the
16 American Medical Association says is the examiner is independent and must arrive at his or
17 her diagnoses and opinions independently of the referring source, remuneration, others'
18 opinions, or personal bias. The examiner is a medical professional who is not involved in the
19 patient's care, and by not being involved in the patient's care, that means not advocating one
20 way or the other.

21 Number four, the Court does have the authority to exclude evidence. Now, I
22 can just make a recommendation. The District Court Judge has to turn it into an order by
23 signing the Report and Recommendation. But that includes preventing a Rule 35 examiner
24 from conducting a Rule 35 exam based on bias. And Magistrate Judge Foley persuasively
25 explained in the Pham versus Walmart Stores case, 2012 Westlaw 195.7987; this too is not

1 reported; and Pham, by the way, is P-H-A-M versus Walmart Stores. And he says in that
2 opinion: A physician who engages in a pattern or practice of providing improper,
3 inflammatory opinions may justify an order barring him from performing a medical exam
4 pursuant -- or medical examination pursuant to Rule 35. The Court, however, will not
5 disqualify -- in this case it was Dr. Cash -- based on a single report in an unrelated case.

6 So if I was just looking at one other report by Dr. Duke in an unrelated case,
7 that is not sufficient under at least Judge Foley's analysis, and I'm not sure just one report is
8 the standard anyway, but you have to take a look at what is being said and analyze it as it's
9 intended. So clearly one report is not sufficient.

10 Before proceeding any further, I do want to make sure that I am correct on a
11 couple of facts. Number one, Dr. Duke did not perform a records review on Mr. Wilson in
12 this case, is that correct?

13 MS. UPSON: Correct.

14 DISCOVERY COMMISSIONER: Okay. Number two, defense counsel, you have
15 worked with Dr. Duke and he has performed Rule 35 exams for your firm on multiple
16 occasions.

17 MS. UPSON: Correct.

18 DISCOVERY COMMISSIONER: Mr. Ganz, your firm has deposed Dr. Duke on
19 multiple occasions involving Plaintiffs where he has performed a Rule 35 exam on your
20 clients.

21 MR. GANZ: Correct, Your Honor.

22 DISCOVERY COMMISSIONER: And I don't want to put words in anyone's mouth,
23 but having reviewed some of those transcripts, is it fair to say that there are some -- a little
24 bit of animosity between the Plaintiff's firm and Dr. Duke?

25 MR. GANZ: It hasn't been brought out in court documents, Your Honor, but I can

1 tell you that Dr. Duke, and me, and the firms that I've been involved in, have at least a ten-
2 to fifteen-year history of some problems that occurred between former partners of his,
3 between former partners of mine, between issues that were going on with Federal
4 investigations. There's a whole lot of stuff that was going on back in the day, and I think
5 some of that has spilled over into this stuff. I didn't bring any of that stuff out only because I
6 was dealing with specifically the cases that I had presented to you last time were all, if I'm
7 not mistaken, all my cases that I had taken his deposition on.

8 DISCOVERY COMMISSIONER: But Dr. Duke knows who you are.

9 MR. GANZ: Oh, I presume so. Yeah, I've -- oh, yeah, absolutely, he knows who I
10 am, I mean, and --

11 DISCOVERY COMMISSIONER: And he knows you can depose him and take a
12 deposition, at least in one exchange I saw. And I don't think -- and let me just state this. It's
13 very difficult when you're reading a document to know what dynamics are going on. I
14 didn't see -- I mean, Dr. Duke didn't say anything improper. I don't think Plaintiff's counsel
15 said anything improper. But it was definitely a cross-examination.

16 MS. UPSON: And I would just put for the Court's record in relation to that is when
17 we had the conference call a couple weeks ago on this issue, and you said you thought there
18 were issues with counsel, and I said I wasn't aware, and you said I should talk to Dr. Duke, I
19 did, and Dr. Duke said he has had depositions with him. There's nothing personal in his
20 mind regarding the depositions. He knows Plaintiffs' counsel go after him. It's no different
21 than them or any of the others, and he has no personal animosity one way or the other to any
22 of the Plaintiffs' attorneys in town.

23 DISCOVERY COMMISSIONER: Thank you. All right. So I need to know what the
24 current condition is of the Plaintiff now --

25 MR. GANZ: Sure.

1 DISCOVERY COMMISSIONER: -- 'cause we've spent a couple of months --

2 MR. GANZ: And I think that's a absolutely great point to start at, Your Honor.

3 First of all, I need to apologize because I've heard that you've had other
4 hearings, some references, that somehow that I proliferated this particular prior ruling in
5 another one of my cases, and I wanted you to understand that I had nothing to do with it.

6 My original intent was for my cases and my clients, and that's why I provided
7 information from my cases to you in order to make those decisions. I didn't go out and get
8 hundreds of reports and try to say that he's a bad guy in the community. I try to really focus
9 it on my clients and my cases, so I really want you to understand that that is --

10 DISCOVERY COMMISSIONER: For the record, the Court's not saying he's a bad
11 guy either. That's not the issue, just as it's not personal animosity from Dr. Duke to the
12 Plaintiffs. It's not personal animosity by the Court to Dr. Duke. The issue is whether or not
13 he should be performing the Rule 35 exam in this case.

14 MR. GANZ: And --

15 DISCOVERY COMMISSIONER: Just so we're clear.

16 MR. GANZ: And here's the --

17 DISCOVERY COMMISSIONER: Go ahead.

18 MR. GANZ: -- the facts on that, Judge. They asked to use Dr. Duke. We said no.
19 They filed a motion. We did an opposition. We outlined the stuff, and then we get this reply
20 brief that wasn't heard before the last hearing. And in the reply brief it talks about, well, the
21 client, Mr. Wilson, has not been truthful with this person, has not been truthful with this
22 person, and it's not uncommon that people, you know, doctors can come to those
23 conclusions based upon inconsistent testimony, and so on and so forth. And in her brief she
24 actually said that the causation is ultimately gonna be the issue in this case as it is in many
25 cases with IME doctors, and so on and so forth. What that doesn't do, Your Honor, is it

1 doesn't put my client's physical condition in controversy, and that's what the point of the
2 Rule 35 exam should be.

3 Just saying causation doesn't necessarily -- my client's had two major
4 surgeries, neck and low back, already, already had the surgeries, so --

5 DISCOVERY COMMISSIONER: How is your client doing today?

6 MR. GANZ: He's doing relatively well, but I do believe, in all candor to the Court,
7 that future damages will be at issue and in controversy. I'm not trying to say that I don't
8 believe that will be. So a limited examination with regard to that by somebody who's
9 unbiased I would have absolutely no qualms with, and that's what I've tried to convey to Ms.
10 Upson on a couple different occasions.

11 The problem is, Your Honor, is I don't believe that his condition with regards
12 to all the stuff that she wanted to talk about in that reply brief, causation, and whether or not
13 he told this doctor this, and whether or not he told that doctor that, that stuff's not his
14 physical condition at issue and should not be the subject of a Rule 35 examination.

15 DISCOVERY COMMISSIONER: I agree with you.

16 MR. GANZ: They could do a records review on that. She's already pretty much
17 written it for him in this -- I don't mean it that way.

18 DISCOVERY COMMISSIONER: Oh, he writes quite well by himself.

19 MR. GANZ: My point is the issues have already been well outlined. Those issues are
20 already decided. There's no reason why he needs to put my client in a room by himself and
21 go through a physical examination on those issues and redepose him himself and come up
22 with his own bases for saying that he's inconsistent and add additional evidence to what
23 she's already got for no reason when his physical condition is not at issue. That's the first
24 issue.

25 The second part of that is exactly what you talked about in the Pham case. It

1 must be somebody who is unbiased. He's already, in my opinion, biased towards my
2 Plaintiffs in my cases. It's pretty obvious. I haven't had a single issue, and I've showed you
3 just on five, and I didn't go back more than even three or four years. I could show you that
4 his opinions are if they file a lawsuit they have secondary gain issues. Well, how do you
5 explain the pain that they had on that particular day? Well, they have a lawsuit and,
6 therefore, I believe they're just exaggerating those complaints over that period of time.

7 There is nothing specific about any of my people other than the fact that they
8 filed a lawsuit, and that's what I tried to bring out to Your Honor, and I don't believe that's
9 the appropriate person to put hands on my client.

10 DISCOVERY COMMISSIONER: Thank you. All right. Do -- would you prefer to
11 hear what I found in my limited review, or would you prefer, Ms. Upson, Mr. Maupin, to
12 make some statements for the record? I'm happy to do it either way.

13 MR. GANZ: Are they both going to be able to argue, Your Honor? They represent
14 one individual here.

15 DISCOVERY COMMISSIONER: Well, do you want your associate to argue too?
16 I'll listen to what he has to say as well. I mean, listen, here --

17 MR. GANZ: I understand.

18 DISCOVERY COMMISSIONER: Here's --

19 MR. GANZ: It's a big issue and I understand.

20 DISCOVERY COMMISSIONER: This is a huge issue, and we've got -- and as I
21 understand it, Mr. Maupin is actually here for Dr. Duke on some level, but he has associated
22 in with the Defendants.

23 MR. MAUPIN: I am -- just to clarify that, I am here to represent the Defendants in
24 this case.

25 DISCOVERY COMMISSIONER: Okay.

1 MR. MAUPIN: I also separately represent Dr. Duke, and I was retained by him to
2 deal with the, primarily, the improper and egregious use of your order in the Thorne case for
3 impeachment in front of a District Court Judge who he persuaded to allow that impeachment
4 with no briefing.

5 DISCOVERY COMMISSIONER: Well, I really don't know what to say to that other
6 than I think my orders have been very clear that they've been case specific. That's all I can
7 say.

8 MR. MAUPIN: And I agree with that.

9 DISCOVERY COMMISSIONER: And that's what is important, and I just said I
10 allowed Dr. Duke to perform a Rule 35 exam within the last week, and I wouldn't strike him.
11 So the issue is this case. That's what it is. And, you know, because of that I was almost
12 hesitant to review -- I have three boxes of these materials, and they weren't provided to me
13 in any meaningful way. The reports weren't stapled together. They weren't divided by year.
14 They didn't point out the reports that found injury and those that didn't. They were just
15 thrown in the boxes. And so I picked one box to review and did not review -- and I declined
16 to review anymore.

17 MS. UPSON: Can I just make one brief comment?

18 DISCOVERY COMMISSIONER: Yes.

19 MS. UPSON: He put those in boxes. They were separated by no injury, soft tissue
20 injury, and more significant injury and our cover letter when they came over -- obviously, I
21 didn't have the box to open them -- but the cover letter said which box was which.

22 DISCOVERY COMMISSIONER: No, it didn't, and maybe -- I don't know.

23 MS. UPSON: We had a cover letter that came with this because he told --

24 DISCOVERY COMMISSIONER: All right. Well, then that is -- then I will take
25 responsibility for that, but I just got the three boxes in my office, that's what I got, with your

1 cover letter saying these are the three boxes.

2 And, you know, I find that interesting because I went through what I would
3 call box one and I found no injury and injuries in box one. So I'm not sure how they were
4 divided. I found all different years, Ms. Upson. I found 2011, 2012, 2014, all just put
5 together.

6 I am going to decline to go through the other boxes. I am telling you though
7 that in box one that I reviewed, I did, in fact, find ten cases where he recommended some
8 form of surgery, and then in the -- there were a certain number of cases where he did not.
9 But you know what? The injury-noninjury really isn't the dispositive issue here, so I'm glad
10 you told me that. I will certainly go back and look at your cover letter. But that's really not
11 the issue here.

12 The issue is whether or not there's bias or prejudice, and these are -- and I will
13 tell you this is what I looked at. I looked at whether or not in that report, somewhere in that
14 report, there was an indication of secondary gain. That's one thing I looked for. And then
15 the next thing I looked for is whether or not there was some suggestion that the Plaintiff had
16 some psychological issue or psychiatric underlay that is an explanation for the injuries, and
17 the reason I looked at those two things in particular and, again, is because that's what I
18 would consider to be inflammatory under the Federal Court case, and this is why --
19 because what -- and to Dr. Duke's credit, many times, not every time, but many times he
20 says it could be conscious or subconscious, but that's not really -- it's not about the person
21 being examined. It's about his point of view. It's what he's looking for because we're
22 trying to figure out what his objectivity is.

23 Now, and also in fairness to Dr. Duke -- and I gave this lecture the other day
24 when I had to clarify my Report and Recommendation in the other case again, although it's
25 clearly in my recommendation what I said -- I see the same Plaintiffs' doctors over and over

1 and over again. So it is no wonder that on the Rule 35 exams you see the same defense
2 examiners over and over and over again. You know, when I get a time, maybe I'll rewrite
3 Rule 35. I think it is being used as a litigation tool and it is not being used for the purpose it
4 is supposed to be, which is really trying to figure out if something's wrong with the Plaintiff
5 and what's related and what is unrelated, and right now it's just -- it's a tool. It's no more
6 than a -- it's litigation bullying is what it is, with all due respect to my defense friends out
7 there. That's what it is. It's using a rule to bully in litigation and, frankly, I don't think Dr.
8 Duke deserves to be used that way or any other physician, and I think it's the Bar's
9 responsibility to get hold of this Rule and figure out how it should be used because, frankly,
10 it's very distressing to me.

11 So I reviewed box one, and I'm not sure, Ms. Upson, whether -- I can tell you I
12 did find ten cases that had injury, multiple cases had no causation, some cases had minimal
13 injury, so I'm not sure they were actually divided that way. I'm not disputing what you said.
14 I'm just saying in this box one I found a little bit of both.

15 So all I'm really concerned about today are the two issues I talked about,
16 whether or not there was secondary gain and whether or not there was some psychological
17 underlay that caused the problem because to me those are the two inflammatory issues.
18 People can have psychiatric or psychological problems ten years ago, but that shouldn't
19 preclude them from recovering ten years later in an auto accident if they're genuinely hurt.
20 But if that's the, you know, if that's the underlying analysis, then that could be a problem. If
21 in cases it's always secondary gain, or that's the reason for the causation, that could be a
22 problem because when juries hear that objectively, oh, they just want money, okay, that's
23 inflammatory, or they're just nuts, or they're acting strange so they can't, you know, really be
24 having all these injuries. That's also inflammatory.

25 I reviewed 87 -- or, I'm sorry, I apologize. I reviewed 86 cases in box one.

1 There were more in there, but many of them were duplicative. They had the -- I think I had
2 three reports from the same patient that were exactly alike, and there were a couple reports I
3 wasn't sure were complete, so I didn't want to take a look at those. So the number that I
4 reviewed in this box was 86.

5 Then what I did was I came up with four categories -- secondary gain; second,
6 minimal treatment; third, no causation; and four, psychological underlay or psychiatric
7 underlay or -- and I also included drug abuse in there because that seemed to go hand-in-
8 hand with the psychological problems, and it may well, in fact, be part of the same problem.

9 MR. GANZ: What was category number three, Your Honor? I missed it.

10 DISCOVERY COMMISSIONER: Causation.

11 MR. GANZ: Causation. Thank you.

12 DISCOVERY COMMISSIONER: Lack of causation.

13 The way these reports are written, they're all the same format, which actually
14 was very helpful to me because then I could just go to the discussion section, and I would
15 expect him to follow the same format. That's reasonable, and it makes it easier to follow
16 what he's doing, so I just went to the discussion section.

17 Of the 86 cases I reviewed, 52 of them had either comments on secondary gain,
18 psychological problem with the Plaintiff or both. I was wondering if over the years it
19 changed, so I looked at these per year, you know, as the more he did, the more he developed
20 this belief that there was secondary gain or psychological overlay, but that's not what I
21 found.

22 In 2011, for the cases, I reviewed 22 cases total in 2011, and of that 8 cases had
23 some secondary gain, and 9 cases had some underlying psychiatric issue.

24 And then in 2012 there was only one case that had the secondary gain, and then
25 there were a few cases that had the underlying issue.

1 In 2013 there were 26 cases, 14 cases had either secondary gain or psychiatric
2 issues mentioned.

3 And, finally, in 2014, there were 23 cases, 12 of which had secondary gain or
4 psychiatric issues mentioned as the reason why the Plaintiff was not healing or had the
5 problems the Plaintiff had.

6 Well, that's more than one case, and the substantial majority of the cases that I
7 reviewed mentioned that, and the issue really becomes is that, in and of itself, inflammatory
8 to disqualify Dr. Duke. Even if I say no, in and of itself, it isn't, I still have to go back to this
9 case and look at the context, and this is my concern, and actually, believe it or not, my
10 concern is for the defense -- I know you find that shocking, but it's true, and for Dr. Duke --
11 because here's what I don't want to have happen after all these discussions we've had, after
12 all the cross-examination that the Plaintiff has done, after Dr. Duke, preparing all these
13 materials and feeling probably not really happy about it, and the discussions that have been
14 ongoing, and the one case that got taken out of context and used in another case, and I --
15 what I don't want to have happen is I don't want him to be skittish -- I don't like that word. I
16 just can't think of a better word at the moment -- for doing the Rule 35 exam. He needs to be
17 able to do the Rule 35 exam how he sees fit, and he's not going to be able to do it here
18 because he knows what he's up against. And then we devalued his role as the Rule 35
19 examiner, and in this case, and specifically with this firm and this lawyer they've been going
20 at it with Dr. Duke.

21 So how is that fair to the Defendant, who you represent, Ms. Upson, or to the
22 Plaintiff, who has to be examined? In this case, I don't think it's fair. I have no problem
23 giving you your Rule 35 exam, but it's not going to be with Dr. Duke in this case for those
24 reasons. And you are welcome to object to my Report and Recommendation, absolutely
25 welcome to.

1 And I want to make it clear that that does not mean I am striking Dr. Duke in
2 every case. Another case that I allowed him to go forward in, neither the Plaintiffs or the
3 Defendants really had any exposure to him, and everybody was fine with it. We put some
4 parameters in place. Fine. And understand that in terms of the impeachment of all the
5 evidence that's out there, you know, he's a retained expert technically, so he'll have to deal
6 with that on his own, and I'm sure he will. I've heard he's very persuasive in trial, and he
7 obviously has worked very hard over the years in doing these examinations.

8 So I looked at the totality of the circumstances -- love that phrase -- and I
9 looked at it from what I found in the box of materials, and I, you know, I just took one box at
10 random, and I looked at the briefing again. I looked at the cross-examination in the
11 depositions. I looked at this firm and the fact that this firm has a longstanding history, and I
12 looked at your firm, Ms. Upson. You used him quite a bit.

13 So I think on balance in this case only I'm going to disqualify him, not -- let's
14 say not disqualify. I'm going to require you to use someone else, not Dr. Duke. But you can
15 have your Rule 35 exam, and you have plenty of time because your initial disclosure is not
16 'til September, so go find a practitioner if you want your Rule 35 exam.

17 Now, let me make this clear because you're going to need to add this,
18 Plaintiff's counsel, to the Report and Recommendation. Dr. Duke can testify as an expert in
19 this case.

20 MR. GANZ: We understand.

21 DISCOVERY COMMISSIONER: He can testify as a retained expert. I'm not -- that
22 is not within my purview to strike him, and I'm not going to. He is certainly capable of
23 doing that, and, you know what, sadly, he may or may not be right on his, you know, review
24 of the records. I don't know. Seems like you're very confident in your Plaintiff's injuries,
25 and he certainly was injured.

1 So having said all that, he can testify. He just cannot perform the Rule 35
2 exam. And the last time I checked, experts can look at materials that are even hearsay, so he
3 could certainly look at the Rule 35 report and make comment on it, and whether or not that
4 that's cumulative evidence is for the Judge to decide, not for me.

5 Anything further?

6 MS. UPSON: I have a few comments, but you can go first.

7 MR. MAUPIN: I am here strictly to address a finding that was made in the Thorne
8 case that got --

9 DISCOVERY COMMISSIONER: Yeah. I don't think I can do that unless I have
10 counsel present --

11 MR. MAUPIN: Oh, I'm not asking --

12 DISCOVERY COMMISSIONER: -- in all that case.

13 MR. MAUPIN: I'm not representing anybody in the firm. I'm talking about how it
14 got used in another case, and --

15 DISCOVERY COMMISSIONER: Okay.

16 MR. MAUPIN: -- I'm not asking you to rule in the other case.

17 MR. GANZ: You're asking -- she's -- counsel for that case is not here. I don't think
18 he is, number one. Number two, he doesn't have any standing in the Thorne case.

19 DISCOVERY COMMISSIONER: Yeah.

20 MR. MAUPIN: I'm not arguing the Thorne case. I'm arguing the effect of this
21 because the Court, this Court, this morning brought up the problem of using this, these -- a
22 bias finding. You didn't make that finding this morning, and, as I understand it -- and I'd
23 like to, in some clarification, might ease all of the controversy over this. As I understand it,
24 the order today is that the motion to have Dr. Duke perform the independent medical
25 examination is denied. We believe that that is the appropriate method by which you should

1 deal with a motion like this, on a case-by-case basis.

2 The problem is -- and I understand that you have made no findings of bias
3 because that would end up in a -- if he was actually used as a witness in a case, that would be
4 a subject of cross-examination at the trial as I understand the explanation of the ruling this
5 morning. So the problem has been that this -- the ruling in this other case that he's biased
6 against all Plaintiffs I think has been undermined by the examination this morning, and the
7 transcript of the hearing indicates, of the hearing in front of Judge Bare, over the probative
8 value of the finding in the Thorne case of bias, is pretty egregious.

9 DISCOVERY COMMISSIONER: Well, again --

10 MR. MAUPIN: And --

11 DISCOVERY COMMISSIONER: -- Mr. Maupin, it's not that I -- I don't mean to cut
12 you off, but I just don't feel comfortable talking about that case because I don't have the
13 attorneys here that are present. And I understand the concern about the ruling as it relates to
14 this case, and, again, I looked at the totality of the circumstances here. But I am going to --
15 you know, a part of what I did look at was the two inflammatory statements, and, you know,
16 and those two I talked about, and they came out in a majority of the one box that I reviewed,
17 and that gave me cause for concern, and it is a bias issue, and I'm not specifically finding in
18 this case that he is bias, but I looked at that, and those are, in my humble opinion in
19 reviewing the case law and looking at his documents, I think that is clearly a problem. I
20 think it is bias and inflammatory.

21 But I don't want to go there anymore because I am concerned about this Report
22 and Recommendations being misused, and I don't want it misused. It's for this case, and I'm
23 looking at the totality of the circumstances, but I don't want anyone to think that somehow I
24 don't think he's -- I think everything he's doing is okay. I don't think that. I am very
25 concerned that in 50 -- the majority, the substantial majority of the reports, I have these, what

1 I consider to be, inflammatory. And we don't have to explore it further because it is not
2 alone -- you know, by itself it's not the basis for my ruling, and I don't know how much
3 more clear to say that.

4 I don't want to be taken -- I can't -- I'm not in a position to understand or
5 defend what happened before that District Court Judge, and I'm not going to do that today
6 because that would be improper. But I understand the concern, so I'm trying to make it
7 really clear, and I do expect to see in the Report and Recommendation section that this ruling
8 is only for this case.

9 MR. GANZ: But it will include the terms bias, and it will include these issues on
10 those specific cases that you found that raised concern.

11 DISCOVERY COMMISSIONER: Because that's what I looked at.

12 MR. GANZ: Exactly.

13 DISCOVERY COMMISSIONER: That's what I looked at, and I think there is a
14 problem here.

15 MR. MAUPIN: Well --

16 DISCOVERY COMMISSIONER: But I don't have to reach the ultimate conclusion
17 today.

18 MR. MAUPIN: Well, I'm not here to -- my role here is not to litigate the merits of
19 the disqualification in this case. The -- what I am requesting is a statement from the Court
20 that the review of these records is not to be understood that Dr. Duke has a bias or prejudice
21 involving all personal injury Plaintiffs.

22 DISCOVERY COMMISSIONER: I appreciate what you're saying, but I'm not going
23 to do it, and the reason I'm not going to do it is because it's not -- was not specifically what I
24 addressed today, and I just don't think it's proper. If somebody -- but, you know, part of the
25 problem in that other case, Mr. Maupin, is no one objected to the Report and

1 Recommendations.

2 MR. MAUPIN: That is -- then that's a very good point. The reason that there was no
3 objection was that the -- after the ruling, your ruling in the discovery dispute, the lawyers and
4 the principal, as they call themselves -- I think it's the insurer -- decided simply not to use
5 Dr. Duke, hire someone else, and then not challenge the report. No one told -- no one told
6 Dr. Duke anything about this, that his bias was being litigated, until --

7 DISCOVERY COMMISSIONER: I'm sorry I opened --

8 MR. MAUPIN: -- after the order --

9 DISCOVERY COMMISSIONER: -- the door.

10 MR. MAUPIN: -- was -- no, no -- until after the order approving the DCRR was
11 entered. He has never been asked to contribute to any of this business, and this -- and in that
12 case this has -- this is neither the Court nor Your Honor was given the opportunity to even
13 hear from him, not because of this lawyer here, but because the lawyer that hired him.

14 DISCOVERY COMMISSIONER: Well, here's my belief. If that's going to be
15 litigated in a evidentiary hearing type format, a District Court Judge has to do that. I'm
16 not -- it's not me. All I'm looking at -- and, again, obviously I am saying he can testify as
17 the retained expert, so I'm not making a ruling on his ability to do that. I'm just looking at,
18 in this case, whether or not he's the proper person, the proper doctor, independent of his
19 qualifications -- we're not talking about that -- independent of his qualifications to perform
20 the Rule 35 exam, and the test is his independence and his bias, and I am concerned that in
21 the majority of the reports I looked at that there were secondary gain issues, psychological
22 underlay that explained all the patient's complaints, and it just was more than one report.
23 And if you have that perception going in because you've prepared so many of the Rule 35
24 exams and so often you find that, then, yes, I think that rises to the level of potential. I'll say
25 that -- potential bias. But I don't even have to go there completely.

1 You know, this is not the basis for my decision completely. I'm looking at the
2 totality of the circumstances. But I don't want anyone to walk away thinking I don't think
3 there's a problem here because there is. There is a problem, and it falls into the category of
4 inflammatory statements which the rules say goes to bias. So the bias word is appropriate,
5 but the issue isn't whether he's bias. It just relates to this case. So I guess from that
6 perspective don't put in that he's biased against all personal injury Plaintiffs because I'm not
7 finding that today.

8 MR. GANZ: Okay.

9 DISCOVERY COMMISSIONER: Okay. Yes, ma'am.

10 MS. UPSON: Thank you. I understand the Court's ruling, and I just want to make a
11 couple of comments on the record, obviously, because the Report and Recommendation's
12 coming out. First I want to address the comment about litigation bullying and the defense
13 bar, and is that what is occurring, and is there --

14 DISCOVERY COMMISSIONER: Well, let me say this clearly. It's on both sides,
15 because I see the same treating doctors on both sides, but we're using the Rule 35 exam I
16 think improperly.

17 MS. UPSON: But in relation to that, when you look at who's involved in litigation in
18 the community, you do see the same Plaintiff treaters over, and over, and over, and over. In
19 those cases there's not always objective medical evidence regarding an injury, and if there's
20 not objective medical evidence regarding an injury, there has to be some type of cause or
21 analysis of why they may be continuing to complain of subjective complaints.

22 So the fact that Dr. Duke has put in reports notations regarding secondary gain
23 and psychological issues, that, in and of itself -- and we respectfully disagree with the
24 Court's comment -- doesn't create an inflammatory basis or a bias, and I just want to put on
25 the record why. In every single case that we deal with involving Plaintiffs with the same

1 doctors you see over and over -- you could say Dr. Cass, Grover, all of those guys -- they, in
2 every single case, address secondary gain issues through their treatment. They do that in the
3 form of Waddell findings. They don't really use the term Waddell findings anymore. They
4 say secondary gain. They look for things that are inconsistent within the records.

5 DISCOVERY COMMISSIONER: Well, then when I see them before me, I'll take
6 that into account.

7 MS. UPSON: But that's what has to be looked at here, is if there's a bias or
8 inflammatory statements made by Dr. Duke.

9 DISCOVERY COMMISSIONER: And I believe that there is, so let me make that
10 very clear, you know, and I don't want to -- I appreciate everybody's position here. But
11 based on what I reviewed -- and that includes the cases that the Plaintiff's counsel submitted
12 to me that they've been involved in --there are two inflammatory and I'm going to say
13 potentially biased problems, and that is the secondary gain issue and the psychological
14 underlay or psychiatric underlay that the patient presents with. And, yes, I do believe those
15 are inflammatory, and I think I found that today.

16 MS. UPSON: But for the record, in relation to what's inflammatory, what he's doing
17 is a forensic review and he's giving forensic opinions based upon his review. His review and
18 analysis of those particular issues are no different than the analysis of any other doctor in this
19 community. So to say he is somehow bias because it's in some of the reports, if he held a
20 true bias, you would see it in every single report; it's not there, so that --

21 DISCOVERY COMMISSIONER: Well, because it's not always appropriate. He has
22 found cases where there's been injury, but he has, in a substantial majority of the cases,
23 referred to secondary gain and psychiatric issues in a substantial majority. We're not talking
24 about one or two cases. We're talking in one box, 57. That is substantial, and part of it is
25 because he's done so many of these exams, which brings me back to my concern in this case.

1 I don't think it's fair for -- to ask him to be the Rule 35 examiner in this case
2 because if it's true, that the Plaintiff is malingering or whatever your defense is on this
3 case -- I don't know what your causation defense is or if he has other issues -- Dr. Duke, to
4 put him in a position of having to decide that with the background would not be fair to him.
5 Do you understand what I'm saying? Because then he would -- would he go, oh, I can't say
6 that. I've got to step back. Just kind of like I feel right now talking about a ruling in another
7 case. Do I need to back down from what I'm doing today because somebody is upset that it
8 was taken out of context? Is he going to have to back down from performing a proper Rule
9 35 exam because, oh, my gosh, maybe I'll be challenged on my objectivity even though I
10 really believe this person is completely making all this stuff up? That's the problem. And
11 the reason it's a problem in this case is that there's history between your firms and Dr. Duke,
12 and I just think at the end of the day it's not fair to ask the Plaintiff, who chose his lawyer,
13 and was unaware probably of all these other Rule 35 exams, was unaware of them, to ask
14 him to submit now to a Rule 35 exam by an examiner who there is clearly history with this
15 Plaintiffs' firm. That's what concerns me.

16 MS. UPSON: But then what's gonna happen every single time there's a case with
17 Mr. Ganz, he's gonna use that and say, no, Dr. Duke can't be used. It should be Dr. Duke
18 doing a forensic review, giving forensic opinions. If he then makes an opinion that's
19 completely contrary to what he's done before and he doesn't think that it's there, that's an
20 issue for cross-examination.

21 DISCOVERY COMMISSIONER: Ms. Upson, I don't know why you're fighting so
22 hard on this, and I appreciate your loyalty to Dr. Duke. But this is a situation that could hurt
23 the Defendant. I would find another Rule 35 examiner without the same concerns. It doesn't
24 mean that you can't use Dr. Duke as your retained expert. But I think the examination needs
25 to be done by somebody else. And, unfortunately, when you are this active in the litigation

1 community and perform I think -- the last, one of the last motions I had, someone said 375,
2 and I might be off a little bit, but Rule 35 exams, that's a lot. And that's not the test, but
3 when you see the repetitive statements, it's a problem, and I don't want to restate my ruling,
4 so.

5 MS. UPSON: And I accept. I'll just put two more comments on, and then we'll stop,
6 and we'll just reserve it. My loyalty isn't to Dr. Duke. It's to the process. And what we
7 have in this --

8 DISCOVERY COMMISSIONER: Mine is too.

9 MS. UPSON: -- to this community is only so many doctors that do this type of work.
10 You have -- and just by way of example, in the last trial I just had with Dr. Lemper, over the
11 last five years he indicated he's had several thousand patients from Glen Lerner's office,
12 several thousand. We only have a few doctors in this community that do IMEs in relation to
13 the neck and spine, less than five, so they're --

14 DISCOVERY COMMISSIONER: Well, maybe I'll just start denying all IMEs.
15 Maybe we just won't do any more. You know, with all due respect, I care about the process
16 too, and that's why I'm taking the time with this, because I know how important it is. So
17 please don't think I don't care about the process.

18 MS. UPSON: I wasn't even implying that. I was just saying I didn't want the Court
19 or the record to reflect that my loyalty was to Dr. Duke. It was to the process of the defense
20 as a whole, and I was not implying that the Court is, in any way, not taking the process just
21 as seriously.

22 DISCOVERY COMMISSIONER: Okay.

23 MR. MAUPIN: May I just? This is gonna sound strange coming from one of the
24 parties, but the personal injury litigation system, and not only that, the commercial tort
25 litigation system has -- is obviously a forensic exercise. When a treating physician, however

1 that physician comes to be retained, is performing clinical functions, but when you take that
2 doctor and put him on the stand, or have him write a report, and then he's -- he or she is
3 asked the question did what you saw in the clinical environment, does it relate to some event
4 that has legal significance, and if you think so, you must so state, to a reasonable degree of
5 medical probability; that is where the clinician switches from the clinician into a forensic
6 witness because that's a forensic exercise. The term reasonable degree of medical
7 probability has absolutely zero meaning in the clinical environment. No doctor ever thinks
8 about that.

9 Rule 35 is simply a process or defines a process that addresses the fact, that
10 shift from the clinical side to the forensic side, and the idea is to level the playing field.
11 Now, I must say on -- you know, in fairness to Dr. Duke, he's just a -- he's a doctor. He gets
12 called for these exams. The legal significance of the number of exams he's done, I think
13 he's now aware of it because he knows full well he can be cross-examined about all that.

14 But make no mistake about it. The process that you're engaged in right now
15 about how to use Rule 35, what's the scope of discovery, what's the fairness with regard to
16 how personal injury litigants, both Plaintiffs and Defendants, should be treated is part of a
17 commitment that the Discovery Commissioners have made to this process since the
18 Discovery Commissioner system was invented back in the 1980s. And so there's no
19 question about that the process of developing that balancing test is a difficult one.

20 And I have to simply state that there is -- one of the considerations in the order
21 today has to do with the fact that the animosity or dynamic between this lawyer and Dr.
22 Duke. It has been said that he has said that Dr. Duke hates all personal injury clients. I want
23 to make sure that, from my interaction with him, Dr. Duke doesn't hate anybody.

24 DISCOVERY COMMISSIONER: Thank you, Mr. Maupin. Anything further?

25 MR. GANZ: Very quickly, Your Honor. Procedurally, because there may potentially

1 be a objection --

2 DISCOVERY COMMISSIONER: Objection, right.

3 MR. GANZ: -- to this, can we ask you to preserve what you have been provided until
4 that ruling is done or --

5 DISCOVERY COMMISSIONER: I was absolutely going to say that.

6 MR. GANZ: Okay.

7 DISCOVERY COMMISSIONER: I'm hanging on to everything so that I've marked
8 my box one so it's box one, and candidly, you know, I apologize that I missed I guess the
9 breakdown here, but --

10 MS. UPSON: If I could interrupt briefly. I got the E-mail from Cathy on the letter.
11 She didn't put it in the letter, so I take back what I said before.

12 DISCOVERY COMMISSIONER: Okay.

13 MS. UPSON: But she was supposed to have put in the letter what each box was. We
14 will do a new letter saying what each box was.

15 DISCOVERY COMMISSIONER: Okay. That's fine. You can. Just send a copy to
16 the Plaintiff so it's not ex parte.

17 [Counsel conferring off the record - not transcribed]

18 DISCOVERY COMMISSIONER: And I'll put it with the box, but I -- again, just to
19 give some comfort here to the defense, that really wasn't, you know, my concern because in
20 this box I'm not sure how the breakdown really worked 'cause I found both. I did find there
21 he recommended surgery in several of the cases I looked at, so, you know, I'm not sure how
22 the breakdown worked with this particular box. That's all that I'm saying.

23 MR. GANZ: Your Honor, the last thing I'd like, if I could, just say is I recognize this
24 put a great strain on you, and I do appreciate you taking the time. I know Ms. Upson does as
25 well, Mr. Maupin as well.

1 DISCOVERY COMMISSIONER: I know you both do. I understand.

2 MR. GANZ: This is not easy, and you're being thrown right into the fire; that is hard
3 to make decisions either way. So I appreciate you taking the time, and certainly we will
4 work with them getting an order that all can be content with and make sure we talk about
5 potential bias and also talk about with this specific case, and make sure that that is strictly
6 adhered to.

7 DISCOVERY COMMISSIONER: And I will be very careful when I review the
8 report. I do want to say this. I think it's all of our responsibility, the bench, the Bar,
9 everybody's responsibility to figure this out because it is very distressing to see the same
10 treating doctors on one side to, as you said, there's a limited pool I guess of Rule 35
11 examiners. I think I can count, when I was in private practice, I think I can count on one
12 hand the time I did Rule 35 exams. Now, I did a different practice area. I didn't do the
13 automobile. But I have a very wise teacher who really, you know, we used them when we
14 had to, not as a matter of course, and that's where I think we need to change our focus.

15 But, Plaintiff's counsel, you all have responsibility too. So everybody has
16 responsibility. So on that happy note, have a wonderful weekend. Thank you. Plaintiff's
17 counsel, you prepare my Report and Recommendation.

18 MR. GANZ: Ten days, is that what you need?

19 DISCOVERY COMMISSIONER: Ten days. Run it by both Mr. Maupin and Ms.
20 Upson, please, and to approve as to form and content. And the status check for that will be?

21 THE CLERK: May 8th at 11.

22 DISCOVERY COMMISSIONER: But don't be here for that, Plaintiff's counsel.

23 MR. GANZ: We'll get it done.

24 DISCOVERY COMMISSIONER: Get the homework done. Okay. Great. Thank
25 you very much. Have a nice weekend.

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MR. MAUPIN: You have a nice weekend yourself.

[Proceeding concluded at 11:21 a.m.]

* * *

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio-video recording of this proceeding in the above-entitled case.



FRANCESCA HAAK
Court Recorder/Transcriber

EXHIBIT “7”

In The Matter Of:
Maria Fernandez vs.
Mitiku Tamiru Weldegiorgis, et al.

Lewis M. Etcoff, Ph.D., A.B.N.
June 23, 2015



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1	APPEARANCES:	1	LAS VEGAS, NEVADA; TUESDAY, JUNE 23, 2015
2	For the Plaintiff:	2	2:09 P.M.
3	PICKARD PARRY PFAU	3	-oOo-
4	BY: ZACHARIAH B. PARRY, ESQ.	4	Whereupon --
5	10120 South Eastern Avenue, Suite 140	5	(In an off-the-record discussion held prior to
6	Henderson, Nevada 89052	6	the commencement of the proceedings, counsel agreed to
7	(702) 910-4300	7	waive the court reporter's requirements under
8	(702) 910-4303 (Facsimile)	8	Rule 30(b)(4) of the Nevada Rules of Civil Procedure.)
9	zach@pickardparry.com	9	
10		10	LEWIS M. ETCOFF, Ph.D., A.B.N.,
11		11	having been first duly sworn to testify to the truth,
12		12	the whole truth, and nothing but the truth, was examined
13		13	and testified as follows:
14		14	EXAMINATION
15		15	BY MR. PARRY:
16		16	Q. Good afternoon, Dr. Etcoff. It's 2:09 p.m. My
17		17	name is Zack Parry. I represent the plaintiff in this
18		18	case, Maria Fernandez in this case.
19		19	A. Hi. It's nice to meet you.
20		20	Q. You too.
21		21	I understand you've given many depositions over
22		22	the course of your career?
23		23	A. Yeah.
24		24	Q. Are you comfortable dispensing with the
25		25	admonitions?

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1 A. I am.
2 Q. Very good. You have in front of you what I
3 presume is Maria Fernandez's case file?
4 A. Correct.
5 Q. Is that the entire file?
6 A. Yes.
7 Q. Is that something we can make a copy of to
8 attach as an exhibit for the court reporter?
9 A. Yes.
10 Q. Okay. We can do that at the end, if that would
11 be better for you.
12 What is your understanding of what happened in
13 this case with the mechanism of the accident that is the
14 subject of this case?
15 A. I believe that Ms. Fernandez was in her business
16 when a car crashed through the front of her store nearly
17 hitting her and going well into the store, causing some
18 destruction.
19 Q. Is that an understanding you got from your
20 interview with Ms. Fernandez?
21 A. Yes, and from other records in the case that I
22 reviewed.
23 Q. And you've been identified by the defendants as
24 an expert in this case?
25 A. I believe so.

Page 6

1 Q. Can you tell me how you were initially contacted
2 and who contacted you?
3 A. Yes. I believe that Mr. Goates contacted me
4 and -- on or around January 7th, 2015, as you'll see in
5 the section of my notebook, Attorney Work Product.
6 Q. So was your first contact via correspondence?
7 A. It was probably on the phone. I didn't speak
8 with him. It was probably my office manager, since I
9 tend not to speak to attorneys when they first call,
10 unless they absolutely insist.
11 Q. Sure.
12 A. And then after my office manager I believe
13 explained what the contract is and such, we sent a copy
14 of the contract to Mr. Goates, who wrote that -- you
15 know, signed the contract and gave us records to review.
16 Q. Sure. And what's the name of your office
17 manager?
18 A. Donna Callender.
19 Q. I met Donna.
20 What is your understanding of what you were
21 asked to do?
22 A. As in -- well, in this case I was asked to do
23 what you guys call an IME, an Independent Medical
24 Examination. But since I'm not a physician, I call it a
25 Forensic Psychological Examination. And that's

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1 essentially what I was asked to do.
2 Q. Perform a psychological evaluation of
3 Ms. Fernandez and then render your opinions with regard
4 to what?
5 A. With regard to how the subject accident affected
6 her psychologically, and that would be it.
7 Q. Okay.
8 A. Of the problems she has today, to what extent
9 are those problems directly caused by the subject
10 accident.
11 Q. And as a result of this psychological
12 evaluation, you prepared a report; correct?
13 A. Correct.
14 Q. And that report is dated February 27th, 2015?
15 A. It is.
16 Q. Have you ever worked with Mr. Goates before?
17 A. I -- we met for about 15 minutes before this,
18 and I don't remember ever meeting him in person. And we
19 both have vague recollections that years ago I may have
20 or did work on a case with him, though neither of us
21 could recall that case.
22 Q. Do you remember ever talking to me?
23 A. No. But did I?
24 Q. Yeah, we have.
25 A. So that's what my memory's like.

Page 8

1 Q. Okay, sure. That's fine.
2 Have you prepared any supplemental reports or
3 addendums to the report that aren't included in that
4 February 27th, 2015 report?
5 A. I haven't.
6 Q. Do you have any plan on supplementing that
7 report?
8 A. I may as of today. Because when we met, I asked
9 Mr. Goates if there were other case materials that I
10 haven't yet received, and he said yes. And I said, Well
11 if you want me to take a look at the other case
12 materials, if that's of importance to the case, send
13 them. And he suggested he would, and then I would be
14 able to write a supplement to the report.
15 Q. Were you able to identify any of those documents
16 that he says he has that you don't yet have?
17 A. To the extent I remember, it would be
18 depositions of Ms. Fernandez, Dr. Pineiro, and
19 Dr. Mortillaro, an economist's report, and possibly some
20 medical records from either Dr. Pineiro or a
21 chiropractor that she had seen or told me she had seen
22 for white a while.
23 Q. Of these items that you've identified that you
24 have not been provided, or that you were not provided
25 prior to preparing your report -- and as I understand,

<p style="text-align: right;">Page 9</p> <p>1 have yet not been provided -- are there any of those 2 that you think may be necessary towards forming your 3 opinion, or the review of those may change the opinions 4 that you've come up with? 5 A. I would say the review of those could very well 6 change my opinion. It just depends on what's in those 7 records. And from having read my report, I have some 8 unanswered questions -- 9 Q. Sure. 10 A. -- about the case. So, yes, my opinions could 11 change, depending upon what's in the records. And more 12 likely than not, especially her evaluation -- her 13 deposition would be important for me to either bolster 14 my opinion or change my opinion. 15 Q. Did you ask for any of those materials 16 previously? 17 A. I personally didn't. I may have assumed that if 18 they existed they would be forwarded to me. 19 Q. In reviewing your report, you make reference to 20 the certain tests and test results, et cetera. As part 21 of your file are the raw -- is the raw data from those 22 tests in your file? 23 A. Yes. 24 Q. Other than the documents that you may not have 25 received, what else was discussed with Mr. Goates prior</p>	<p style="text-align: right;">Page 11</p> <p>1 Q. Sure. "Dr. Etcoff is expected to testify 2 concerning his review of plaintiff's medical records and 3 his opinion with respect to the nature and extent of the 4 injury, if any, plaintiff sustained in the subject 5 incident, including his opinions with respect to the 6 reasonableness of plaintiff's treatment and prognosis." 7 A. That may not have been said correctly by 8 Mr. Goates, in the sense I am not a physician and I'm 9 not going to have opinions on her medical condition. I 10 reviewed medical records to help me understand what she 11 was experiencing, but I don't opine on medical 12 conditions unless it's within my area of 13 neuropsychological expertise and we know that a 14 physician has -- a person has a brain injury. Then I 15 feel comfortable saying they have a brain injury. 16 Q. The distinction between medical injury and 17 psychological injury, is that an easy one to make? 18 A. It can be. 19 Q. So in some circumstances, it's very clear this 20 is medical and this is psychological? 21 A. Yes. 22 Q. In other circumstances, perhaps the line is 23 blurred? 24 A. It's like a Venn diagram. 25 Q. Okay. So I'm going to ask you during the course</p>
<p style="text-align: right;">Page 10</p> <p>1 to us commencing the deposition? 2 A. We talked about a psychologist with whom he is 3 on the other side of the case, Mr. Goates has, and he 4 asked me familiarity with that psychologist. 5 Q. Any other discussions that related to the case 6 other than what you've already discussed? 7 A. No. 8 Q. Have you seen the expert designation that 9 Mr. Goates prepared to describe and summarize the nature 10 of your testimony? 11 A. No. 12 Q. Okay. I'm going to read to you what it says, 13 and I'm going to ask you if you agree with the 14 characterization. 15 It says, quote, "Dr. Etcoff is expected to 16 testify concerning his review of plaintiff's medical 17 records and his opinion with respect to the nature and 18 extent of the injury, if any, plaintiff sustained in the 19 subject incident, including his opinions with respect to 20 the reasonableness of plaintiff's treatment and 21 prognosis," end quote. 22 Is that a fair representation of your expertise 23 in this case? 24 A. Could you state it again? Because I don't want 25 to make a mistake.</p>	<p style="text-align: right;">Page 12</p> <p>1 of this deposition, if there is an area of questioning 2 that I ask you about that falls outside the scope of 3 your expertise, will you let me know? Or if it's in 4 this gray area, if you wouldn't mind identifying that 5 for me? 6 A. Okay. 7 Q. Along that line, if there are medical doctors in 8 this case who render medical opinions, would it be fair 9 to say you would defer to them as far as it relates to 10 their medical opinions? 11 A. Yes. 12 Q. Can we stipulate that you'll only be providing 13 opinions regarding psychology and neuropsychology in 14 this case? 15 A. Well, neuropsychology is irrelevant in this 16 case, since she didn't have a brain injury. So clinical 17 psychology, yes. 18 Q. Okay, very good. And Maria is not your patient? 19 A. Correct. 20 Q. You didn't provide any treatment to her? 21 A. Correct. 22 Q. You didn't prescribe her any medications? 23 A. Couldn't if I wanted to. I'm not licensed. I'm 24 not a physician. 25 Q. You never consulted with any of her doctors?</p>

Page 13

1 **A. Did not.**
2 Q. And you were never involved in her treatment in
3 any capacity?
4 **A. You're right.**
5 Q. You are a professional expert witness; correct?
6 **A. Am I a professional expert witness? What does**
7 **that term mean?**
8 Q. Sure. You are an expert witness?
9 **A. Yes. In this case and in others, correct.**
10 Q. Can you estimate how many cases you've been an
11 expert witness in?
12 **A. Hundreds.**
13 Q. And you've been paid for your testimony and your
14 opinions?
15 **A. Yes.**
16 Q. And so my understanding of the word
17 "professional," is someone who engages in a certain
18 activity for money. Is that a fair understanding?
19 **A. Yes.**
20 Q. If I ask if you're a professional expert
21 witness, does that make more sense now?
22 **A. It just has a derogatory sound to it. I do**
23 **clinical work, I do forensic work and, as a part of my**
24 **forensic work, at times I have to be an expert witness,**
25 **and I am.**

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1 Q. Sure. So, in fact, I want to clarify the
2 difference between clinical and forensic because I may
3 not have the same understanding you do. The way I
4 understand it, clinical work is where you actually are
5 providing treatment to patients; is that right?
6 **A. Or evaluations for patients. Where there is a**
7 **doctor-patient relationship, confidentiality, the**
8 **privilege is theirs, yes.**
9 Q. And the forensic work would be more like in this
10 case where you're hired not by the patient, but you
11 still do an evaluation but there's not this
12 doctor-patient relationship?
13 **A. Yes.**
14 Q. Okay. When did you start providing expert
15 testimony?
16 **A. How long ago?**
17 Q. Yes.
18 **A. I would be -- I would have to guess. But it was**
19 **around the time of the Pep-Con blast.**
20 Q. Sure.
21 **A. '88, '89.**
22 Q. That's an interesting pairing.
23 **A. Isn't it?**
24 Q. Yeah, how we remember things. You know better
25 than I do how that works.

Page 15

1 **A. Well, I was talking about it this weekend with**
2 **my cycling group -- for some reason, someone brought up**
3 **something -- oh, they asked where that plant went or**
4 **something --**
5 Q. Sure.
6 **A. -- so we all talked about it. But that was my**
7 **first, I think, case when I was brought up as a**
8 **neuropsychological expert, because one of the people who**
9 **had been injured had been driving, and a blast knocked**
10 **him from his driver's seat into the passenger's seat, at**
11 **which time a rock flew through the window and fractured**
12 **his skull and he was in terrible shape.**
13 Q. Wow.
14 **A. So that was my introduction to forensic**
15 **psychology.**
16 Q. Sure.
17 **A. Since then, I used to do and stopped doing**
18 **family custody evaluations, and I did 100, 150 of those**
19 **for years for family court; and I also did criminal**
20 **competency, especially in trial, mostly death penalty**
21 **litigation, for Mike Pescetta and Phil Kohn, a special**
22 **end of the public, Mike Cherry.**
23 Q. Sure.
24 **A. And I did that for seven, eight, nine years, and**
25 **then I decided not to do that anymore. And this is**

Page 16

1 **what's left, personal-injury work.**
2 Q. How much of your time would you say is dedicated
3 to forensic as opposed to clinical work?
4 **A. It's literally about 50/50.**
5 Q. How much of the money would you -- would you
6 proportion the money the same way, you make as much in
7 forensic or more?
8 **A. No. I think the money is significantly greater**
9 **from the forensic, because each forensic case takes a**
10 **lot longer than each clinical case. So the forensic**
11 **income is a lot greater.**
12 Q. So how would you apportion that?
13 **A. It's probably, like, 80 percent from forensic**
14 **and 20 percent from clinical.**
15 Q. Is it fair to say that more often than not you
16 testify for defendants as opposed to plaintiffs?
17 **A. Yes, it's fair to say.**
18 Q. How would you apportion that?
19 **A. I've been asked that many times. It's about**
20 **90 percent for defense, 10 percent for plaintiffs.**
21 Q. And as part of your expert report, you provided
22 a curriculum vitae; correct?
23 **A. I did.**
24 Q. So that would have been February. Has that
25 changed, or is there an updated version of your C.V.

Page 17

1 since February?

2 **A. I -- there may be an article that I was a**

3 **co-author on that was added, but I can give you the most**

4 **recent one and you can -- it's not -- the changes are**

5 **maybe another article.**

6 Q. Whatever happened in the last six months?

7 **A. Exactly. Nothing --**

8 Q. Yeah, if you wouldn't mind providing that to me

9 as well.

10 **A. Okay.**

11 Q. From looking at your C.V. -- and you have

12 provided a list of testimony going back to, I believe

13 2011 -- it looked like there were -- of the testimony,

14 there were two cases where you testified for plaintiffs

15 and all the rest were defendants; does that sound about

16 right?

17 **A. Yes.**

18 Q. And how much do you earn in a year for your work

19 in the forensic field?

20 **A. I'm -- I would guess around \$400,000.**

21 Q. Other than the 15 minutes you've spent with

22 Mr. Goates prior to the deposition, have you spent any

23 time talking to his office personally?

24 **A. No.**

25 Q. How about any of your staff?

Page 18

1 **A. No.**

2 Q. Does your staff bill separately than you do for

3 the work performed on the present case?

4 **A. Yes. I bill the staff -- my staff -- not Donna,**

5 **the office manager -- but I have two post-docs who work**

6 **with me, one of whom works predominantly or, at this**

7 **point, only on legal work, Dr. Karen Kampfer. And the**

8 **other, Dr. Bethany Schlinger, works with me on clinical**

9 **cases.**

10 Q. So has -- sorry, Dr. Karen --

11 **A. Kampfer.**

12 Q. -- Kampfer?

13 **A. K-a-m-p-f-e-r.**

14 Q. Has Dr. Kampfer participated or assisted in any

15 way in this case?

16 **A. Yes. In all my cases, I have a copilot, a**

17 **second person, my associate, sitting here during the**

18 **interview because I am not perfect. And when I'm trying**

19 **to take notes and listen and then dictate what I thought**

20 **someone said, I want someone there who can read what I**

21 **thought I heard and correct if I didn't hear it**

22 **correctly, delete, add, edit. So Dr. Kampfer gives me**

23 **that second, kind of a reliability measure --**

24 Q. Quality control?

25 **A. Quality control. That's the way to put it.**

Page 19

1 **And then does -- well, in this case, there was**

2 **not much -- the testing was just explaining the**

3 **directions to Ms. Fernandez. But in other -- when**

4 **you're doing an IQ test or this and that -- she may do**

5 **some of that and I'll do some other tests.**

6 Q. Sure. You listed a number of publications that

7 you have authored in your C.V. Other than what you

8 might have authored since the C.V. was provided to us,

9 have all your publications been included in there?

10 **A. Well, as I said before, there may be one more**

11 **publications that was just accepted in a peer-review**

12 **journal, but I'm not sure since I don't pay a lot of**

13 **attention to that, like what had happened or when it's**

14 **coming out. I would have to check.**

15 Q. Okay. And regarding questions of timing, that's

16 fine. But are there -- are there any articles that you

17 have written that you've deliberately chosen not to

18 include in your list of articles?

19 **A. No.**

20 Q. Okay. Do you use the same version of your C.V.

21 in every case that you're hired for in a forensic

22 setting?

23 **A. Of course.**

24 Q. Do you remember a 13-hour continuing education

25 seminar on November 20, 2004, put on by the National

Page 20

1 Academy of Neuropsychology, where one of the topics

2 discussed was Assessment of Response Bias: Beyond

3 Malingering Tests, put on by Dr. Scott Millis? Do you

4 remember that?

5 **A. I don't, but I could have gone to it.**

6 Q. Okay.

7 **A. It wouldn't have been 13 hours by one person.**

8 Q. No. It was a 13-hour seminary, and he was among

9 one of the presenters.

10 **A. Did I go to it? If it's something on my C.V. --**

11 Q. Well, it's on your C.V.

12 **A. Did I go to it?**

13 Q. No. My question isn't if you went to it. I

14 presume you did because it's on your C.V. The question

15 is if you remember it?

16 **A. I don't.**

17 Q. Okay. Are there certain continuing education

18 requirements that go along with your licensure?

19 **A. Yes. Do you want to know them?**

20 Q. No, I don't. I can look that up if I want.

21 Okay. Have you testified since December 2014?

22 **A. I testified yesterday.**

23 Q. In what case was that?

24 **A. That's how bad my memory is.**

25 Q. Sure.

Page 21

1 A. I'm sorry. If I can close a file, that's the
2 end of it.
3 It was -- the plaintiff's name was
4 Reinmann and --
5 Q. Can you spell that for the court reporter?
6 A. R-e-i-n-m-a-n-n, a woman -- I forget her first
7 name. And who it's against, I can't even tell you at
8 this point. It was not particularly relevant in my
9 opinion.
10 Q. Sure. Is that one that you -- was that a
11 deposition testimony or trial testimony?
12 A. Trial.
13 Q. Was that one that you had previously provided
14 deposition testimony for?
15 A. No.
16 Q. I'm going to assume -- you can correct me if I'm
17 wrong, though -- that the updated version of your C.V.
18 will not have that on there?
19 A. You are right.
20 Q. Other than that case, will any case in which
21 you've testified since September 2014 be on the C.V. you
22 provided me?
23 A. Yes.
24 Q. And were you representing the plaintiff or the
25 defendant on that case, the Reinmann case?

Page 22

1 A. I was retained by the defense.
2 Q. Yeah, I don't know if "represented" is the right
3 word, so --
4 A. That's why I corrected you.
5 Q. Sure. All right. I'd like to direct your
6 attention to your report.
7 Who prepares -- who types out this report?
8 A. My transcriptionist.
9 Q. Is that someone on staff, or an independent
10 third party you hire?
11 A. Independent third party.
12 Q. So you send them a video -- or an audio tape?
13 A. An actual cassette tape.
14 Q. Okay. It's a digital?
15 A. Really, I'm behind. This is the best I can do.
16 Q. Sure. All right.
17 A. I do this, I plug it in, it e-mails to her, and
18 she hears and types it up and gets it back to me the
19 next day.
20 Q. Is that the entire report is dictated, or just
21 the Findings section?
22 A. I mean, it depends upon what I dictated. I
23 might have just dictated -- whatever I dictate that day
24 is done the next day -- because she's unbelievable --
25 and then so this may go through -- I may not -- I

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1 rarely, if ever, whether it's clinical or forensic,
2 dictate everything in one day. So I'll do parts and
3 then edit, send the editing back, then do the test
4 results or the diagnostic impressions, the summary. It
5 can be done in several days, over several stages.
6 Q. So you send an audio file with this
7 transcription and she -- is it a she?
8 A. She.
9 Q. -- she sends back some sort of Word document
10 that has the words; it's transcribed?
11 A. Yes.
12 Q. And what do you do with that document? Do you
13 hand it here to someone here on staff and they insert it
14 into the report based on the formatting you use?
15 A. No, that is the report. I mean, what you see is
16 what she did.
17 Q. Okay.
18 A. This is me talking to her. And then editing, I
19 or Karen, Dr. Kampfer, would look through before giving
20 it to Mr. Goates, try to catch every typo or incomplete
21 sentence or wording, and this is exactly what the
22 transcriptionist last typed.
23 Q. So who formats it, the bold-set and underlines
24 and puts spacing between?
25 A. Well, I tell her the sections, and she puts the

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1 bolding in and --
2 Q. So that's part of what's dictated?
3 A. Yes. I'll say "Referral Information," and then
4 I'll say blah, blah, blah, "Records Review."
5 Q. Are you the one who dictates the entire thing,
6 or does Dr. Kampfer dictate some of it?
7 A. Dr. Kampfer dictates the addendum, which is the
8 Review of Records, and that's typical. In my cases,
9 since I have several cases typically going on at the
10 same time, her job is to get all of the case materials,
11 arrange them chronologically, and dictate a Records
12 Review.
13 Then I read, edit if it's too long or has too
14 much in there that I don't care about, and then that
15 becomes the addendum of the records that were reviewed.
16 That's from Page 14 on this report.
17 Q. Sure. And so --
18 A. And I dictate. The rest of it's me.
19 Q. So for the first 13 pages in this case, you
20 dictated, and from 14 on, she did?
21 A. Yes.
22 Q. So on Page 14, there's a summary of a police
23 report. That would have been Dr. Kampfer?
24 A. Yes.
25 Q. Okay. And you review the work she dictated

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1 before it goes out as well, or do you just review your
2 section?
3 **A. No, I review everything.**
4 Q. Do you review the original underlying records,
5 or do you just trust her summary of them?
6 **A. I usually trust her summary. Sometimes I**
7 **want -- I will always review the psychology records;**
8 **sometimes I'll review the medical records just so I get**
9 **a better flavor. Sometimes I'll look at the**
10 **interrogatories or the depositions, so it really depends**
11 **upon how much time do I have, how many records there**
12 **are. But in terms of accuracy, she's almost as**
13 **obsessive-compulsive as I am.**
14 Q. Sure. In this case, did you review the actual
15 medical records?
16 **A. I've read everything.**
17 Q. Okay. So this is not one of those cases where
18 you just trusted her for the summary? You've actually
19 looked at the medical records in this case?
20 **A. Since -- no. I read some of the medical records**
21 **before she dictated the summary. But in preparation for**
22 **today, I read everything.**
23 Q. Okay.
24 **A. Just to be clear.**
25 Q. Thank you. Were you aware there was a video of

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1 the subject accident?
2 **A. I saw it.**
3 Q. You have reviewed the video?
4 **A. I watched the video, yes.**
5 Q. On your Records Review, I don't see the video
6 listed there. Is that something that you reviewed
7 before you prepared your opinion or since?
8 **A. Before.**
9 Q. Okay. So is that just an oversight that it's
10 not included on there?
11 **A. I guess it was an oversight. I mean, I wasn't**
12 **hiding that I saw the video. It wasn't -- I should have**
13 **put it in. But I didn't -- it didn't bear on the**
14 **opinions I made.**
15 Q. Okay, all right. Is there anything else you
16 reviewed prior to preparing the records that isn't
17 included on the list of your Records Review?
18 **A. No.**
19 Q. Are all of your opinions that you formed from
20 reviewing the records and examining Ms. Fernandez and
21 reviewing her test results, are all those contained in
22 Pages 1 through 13 of your report?
23 **A. Yes.**
24 Q. Are there any additional opinions you have that
25 are not in this report?

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1 **A. No.**
2 Q. Are there any additional opinions you anticipate
3 forming in testifying to a trial that have not been
4 included in this report?
5 **A. Nothing right now.**
6 Q. Depending on what you see in the other
7 information?
8 **A. Right, exactly.**
9 Q. You agree that Ms. Fernandez suffered from
10 travel anxiety resulting from this subject accident?
11 **A. Yes.**
12 Q. You agree that she suffered from post-traumatic
13 stress disorder as a result from the subject accident?
14 **A. Yes.**
15 Q. You agree that Maria suffered from unspecified
16 depressive disorder as a result of this subject
17 accident?
18 **A. Yes. And for --**
19 Q. With a qualification?
20 **A. With a qualification, there's more going on that**
21 **meets the eye, but I just don't know what that other**
22 **stuff is because I don't have enough records. I**
23 **think -- well, it depends upon the theory of your case.**
24 Q. The theory of my case?
25 **A. Or it depends upon -- well, let me try to put it**

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1 **into words.**
2 **She is depressed, I think, and angry -- those**
3 **are the two big emotions that she showed me --**
4 **because -- and she said it so much in words -- that she**
5 **thought she was pretty much set for life with her doing**
6 **well at her wireless store or stores.**
7 **And then things happened. She had a partner who**
8 **was dishonest, and she found about it and she said she**
9 **lost a lot of money and she had taken money out of her**
10 **IRA. So there were financial difficulties in doing this**
11 **business independent from the accident that caused some**
12 **depression --**
13 Q. Uh-huh.
14 **A. -- and stress. Then the accident itself**
15 **happened and closed the business for a period of time**
16 **until it was -- the insurance company, I guess, made it**
17 **whole.**
18 **But she didn't go back to work. Whether she**
19 **didn't go back to work because she had PTSD and couldn't**
20 **go there, that's possible; or whether there were other**
21 **reasons, I'm not sure. But certainly after this**
22 **accident, that was the last day she had her store open.**
23 **So her depression is related to this accident to**
24 **the extent that had the accident not happened, she would**
25 **still be having this store and not having to go back to**

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1 work doing something that she thought she didn't have to
2 do for the rest of her life.
3 Q. Dealing?
4 A. Dealing cards.
5 Q. Where did you get the information that the
6 insurance company had fixed everything and it was her
7 choice not to go back to the store?
8 A. I think she told me that the insurance company
9 made -- she even said she had the damage fixed, and I
10 assumed it was the insurance company that paid for it.
11 And I know she didn't go back to work there because she
12 didn't go back to work there. It never -- I don't know
13 why she didn't sell it or why -- I don't know happened.
14 I want to see her deposition to see if those questions
15 were asked.
16 Q. Sure. Did you mention anything in your report
17 about the store being repaired and her not going back?
18 A. I don't recall. I can -- I may have or may not
19 have.
20 Q. Is that fact significant to any of your
21 opinions?
22 A. Ummm --
23 Q. Let me put it a different way.
24 A. Yes.
25 Q. Is the truth or falsity of that fact significant

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1 in any way in forming your opinions?
2 A. It doesn't affect my diagnoses. It could affect
3 whether -- if she claims that but for this accident she
4 would still be working at the store and doing well, I'm
5 not sure that's exactly true --
6 Q. Uh-huh.
7 A. -- because I want more information and she
8 exaggerates a lot. But it could be relevant to that
9 type of an opinion, but I don't have that opinion. So I
10 didn't make that opinion, and I don't have enough
11 information on which to make an opinion like that.
12 Q. Okay. You indicated in your report -- this is
13 on Page 9, if you wanted to look at it --
14 A. Uh-huh.
15 Q. -- that Ms. Fernandez broke into tears
16 periodically during the evaluation.
17 A. Yes.
18 Q. Does that have any significance for you, or your
19 opinions for that matter, at all?
20 A. I think it helped substantiate that she was
21 depressed and that she was emotionally labile.
22 Q. What does "labile" mean?
23 A. It means her emotions changed a lot within a set
24 period of time. She could be neutral, happy, crying and
25 sad, angry; and those emotions came and went depending

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1 upon what we talked about.
2 Q. Is that consistent with depression?
3 A. Yes. The crying, yes.
4 Q. What about the -- is it lability? The
5 lability (sic) --
6 A. Sure.
7 Q. -- of her emotions?
8 A. I mean, it's not a -- you're not going to find
9 it in the DSM-5, but the DSM-5 is not perfect. But
10 people who are depressed in an agitated depression can
11 be labile. And again, just depending upon what you're
12 talking about. If you bring up subjects that remind a
13 person of something that it makes them angry, they
14 become angry, some people.
15 So it was -- her lability was not unusual. It
16 was not a psychiatric or psychological abnormality. It
17 was her emoting about whatever we were talking about,
18 and that's how she felt about that subject.
19 Q. Okay. I'm on Page 9 still of your report. The
20 paragraph beginning on November 13th, 2014, do you see
21 that one? 11/13/14?
22 A. Uh-huh.
23 Q. The last sentence there reads, "Also, the fact
24 that she was dealing cards at that time and continues
25 dealing cards today (even seven nights in a row) is

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1 evidence that the pain complaints she made to Dr. Gamazo
2 in November 2014 were exaggerated and not representative
3 of reality."
4 Can you explain what you meant by that?
5 A. What I tried to say -- and as I was reading it
6 over today, I thought, Oh, boy, they're going to ask me
7 about this sentence -- what I was trying to --
8 Q. So you're saying I'm predictable?
9 A. You're predictable. I'm predictable. I should
10 have known.
11 Given the fact that there is overwhelming
12 evidence that she inadvertently, or sometimes
13 inadvertently exaggerates just how terrible her life is,
14 and that she went back to work -- not just working 20,
15 30, 40 hours. She's working seven nights a week -- it
16 suggests to me that the pain that she complains about to
17 Dr. Gamazo is inconsistent with the number of hours she
18 works, and inconsistent with her complaints to
19 Dr. Pineiro.
20 Q. Uh-huh.
21 A. So that's what I was trying to say. Meaning,
22 not represented reality. In reality, she's standing on
23 her feet for hours, seven nights a week, which anybody
24 our age -- my age, her age -- I'm a little older than
25 her -- would find difficult and you'd have an aching

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1 back after work, but she's doing it.
2 If she were in 10/10 level pain that she
3 described to Dr. Mortillaro, she wouldn't be holding a
4 job, she wouldn't be at work.
5 Q. Is that one of those medical opinions, or is
6 that one of those areas where you have expertise?
7 A. That's one of those in the middle of the Venn
8 diagram opinions.
9 Q. All right. Would her experiencing great levels
10 of pain and working seven night in a row, could that
11 just be evidence that she's a tough lady?
12 A. Yep.
13 Q. And I notice that you used the word "suggest,"
14 when you said that, and I think that more or less that's
15 going to be a running theme here; right? Because
16 psychology -- these psychological batteries of tests,
17 they don't ever do more than suggest a conclusion; is
18 that right?
19 A. They give you -- yeah, you infer from test
20 batteries what a person is like, given the studies that
21 have been done using that test battery. So it's not two
22 plus two equals four. You get inferences, or you make
23 inferences based upon the test results.
24 Q. Sure. On the paragraph above that, you note
25 that Dr. Mortillaro concludes that, quote, "her travel

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1 anxiety and PTSD had been greatly reduced,' and as a
2 result, he deemed her ready for discharge from
3 psychotherapeutic treatment."
4 Now, the fact that here PTSD had been greatly
5 reduced -- and I don't know if I'm parsing words here or
6 not -- but that means that there still were PTSD
7 symptoms; right? It hadn't completely resolved; it had
8 been greatly reduced?
9 A. That's what it sounds like to me.
10 Q. Okay. Let's talk about this evaluation that she
11 had done at your office. This was a two-day affair;
12 right? She came in two consecutive days?
13 A. No.
14 Q. It was just one day?
15 A. Correct, one day.
16 Q. Do you remember the date? Do you have that in
17 front of you?
18 A. 2/19/15.
19 Q. So February 19th, 2015, she came in. Do you
20 remember how long she was here?
21 A. I can't tell you exactly, but it probably
22 started at 9:00 in the morning and ended somewhere
23 between 3:00, 3:30, and 4:00, 4:40.
24 Q. So it was pretty much all day?
25 A. Pretty much all day.

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1 Q. Is that typically how these psychological
2 evaluations are done?
3 A. A one-day evaluation, such as when you don't
4 have to do a lot of cognitive testing, one day you can
5 usually get it done. That's oftentimes will -- yes.
6 Q. Okay. Now, I'm pretty sure she came back the
7 next day. Are you recalling that she didn't, or are
8 you -- let's just before we go down too far, let me make
9 sure you're sure.
10 A. I can tell you by looking in my calendar.
11 February 19th.
12 I know what you're talking about. I'm going to
13 guess what you're talking about. One day with her on
14 the 19th, a Thursday, I'm betting that she came in on
15 another day to fill out the MMPI-2. And I can tell you
16 that in a second.
17 Yes. Two days previous to that in order to save
18 time for the interview, she had come to the office for
19 about an hour and a half to complete one of the
20 personality tests, the MMPI-2.
21 Q. All right. So she came in on the 17th for an
22 hour and a half or two hours, or however long it took to
23 complete the Minnesota Multiphase Personality Inventory?
24 A. Yes.
25 Q. And that was the second one. Two?

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1 A. Yes.
2 Q. And then she came back a couple days later. And
3 I'm presuming, by then not only did you have the test
4 results, but then you performed your personal evaluation
5 and an interview and all that other stuff?
6 A. Correct. And another personality test.
7 Q. So on the 17th when she came in, who would she
8 have met with? First off, would it have been here in
9 your office?
10 A. Yes.
11 Q. And would she have met with you at all that day?
12 A. I don't know if I said hello to her. I would
13 imagine Dr. Kampfer administered -- explained the test
14 to her.
15 Q. So if you had any interaction with her at all,
16 whether it was --
17 A. It was, Hi, Dr. Etcoff. See you in a couple of
18 days.
19 Q. Okay. How is that test administered? Is it
20 proctored, or is she given instructions and left alone,
21 or how does that work?
22 A. It's not like someone's standing in her room.
23 She has her own office. She's given instruction. We
24 figure out if she understands how to do it, because it's
25 not that difficult to do --

<p style="text-align: right;">Page 37</p> <p>1 Q. Sure.</p> <p>2 A. -- and she sits at a desk. The door is</p> <p>3 partially open, and my office manager is there in case</p> <p>4 she hears her on the phone or calling people. And so</p> <p>5 it's proctored.</p> <p>6 Q. Sure. Is she instructed not to get on her phone</p> <p>7 and not to look at Facebook or whatever?</p> <p>8 A. I don't know if Dr. Kampfer actually said that</p> <p>9 to her.</p> <p>10 Q. But that's something you watch for?</p> <p>11 A. Yes. Because there's research that attorneys</p> <p>12 commonly tell their clients that there are these</p> <p>13 validity scales and what they measure and what to do and</p> <p>14 what to not do. Now, the literature also says it</p> <p>15 doesn't help -- which is wonderful for me -- but</p> <p>16 oftentimes people are already set up to know what's on</p> <p>17 the test or to --</p> <p>18 Q. Trying to game it?</p> <p>19 A. Yes.</p> <p>20 Q. Trying to come across in a way --</p> <p>21 A. Fail the test.</p> <p>22 Q. -- that it looks like they passed it? Is</p> <p>23 that --</p> <p>24 A. Yeah. Try to put their best foot forward for</p> <p>25 their case.</p>	<p style="text-align: right;">Page 39</p> <p>1 Q. If not in validity, how else might that</p> <p>2 manifest, this coaching?</p> <p>3 A. It could be if an attorney says, Whenever you</p> <p>4 see a question about physical pain, answer yes.</p> <p>5 Whenever you see a question about depression, answer</p> <p>6 yes. It could be anything like that.</p> <p>7 Q. Well, how would that show on the test results,</p> <p>8 though?</p> <p>9 A. What would happen is that she -- she would --</p> <p>10 oh, no. The attorney would say something like, When you</p> <p>11 see questions on depression, don't answer all of them as</p> <p>12 yes, but answer half, three-quarters of them as yes.</p> <p>13 Don't tell your peers.</p> <p>14 Q. No.</p> <p>15 A. And then I don't know of anyone -- I can't say a</p> <p>16 single person I've ever evaluated has -- I had thought</p> <p>17 they'd been coached.</p> <p>18 Q. Sure.</p> <p>19 A. I've never caught anyone being coached, and I</p> <p>20 never even -- I just rely on the test results.</p> <p>21 Q. Okay. What is the MMPI designed to measure?</p> <p>22 A. It's designed to measure personality --</p> <p>23 Q. Sorry, just for clar- -- sorry, I don't mean to</p> <p>24 interrupt. But just for clarification, when I say</p> <p>25 "MMPI," I'm specifically referring to the MMPI-2.</p>
<p style="text-align: right;">Page 38</p> <p>1 Q. Get a valid, fake, bad result?</p> <p>2 A. Yes.</p> <p>3 Q. Okay. That blows my mind, but --</p> <p>4 A. And I'm not. It's true. But I'm not saying she</p> <p>5 did that. I have no evidence. I'm not saying that that</p> <p>6 was her.</p> <p>7 Q. So based on your understanding, if she were to</p> <p>8 receive sort of coaching or outside help, that wouldn't</p> <p>9 change the test results? It wouldn't help?</p> <p>10 A. It wouldn't help.</p> <p>11 Q. Or you'd get caught? It would show?</p> <p>12 A. It would show or -- it would show on the zillion</p> <p>13 validity scales that are there. But it doesn't seem to</p> <p>14 work.</p> <p>15 Q. Sure. So let's say she were to have done --</p> <p>16 hypothetically, obviously -- let's say she were to have</p> <p>17 engaged in some sort of coaching or gets some sort of</p> <p>18 outside involvement, would that show up as an invalid</p> <p>19 test result?</p> <p>20 A. It could if --</p> <p>21 Q. Go ahead.</p> <p>22 A. I mean, it shouldn't if she was well-coached.</p> <p>23 Q. Uh-huh, sure.</p> <p>24 A. But if she's not so well-coached, it very well</p> <p>25 could.</p>	<p style="text-align: right;">Page 40</p> <p>1 A. Same thing as the MMPI, but just more modern.</p> <p>2 Making sure -- this is where it measures</p> <p>3 personality characteristics, what might be called Axis I</p> <p>4 or acute psychiatric symptoms. The extent to which a</p> <p>5 person like this might have associated problems, whether</p> <p>6 they might use alcohol, whether they might be hostile</p> <p>7 and aggressive, whether they might be suicidal. It</p> <p>8 measures a lot of different -- a lot of different</p> <p>9 things. Anxiety, depression, somatic complaints,</p> <p>10 anti-authority attitudes, problems with your family,</p> <p>11 social introversion, social extroversion, paranoia,</p> <p>12 thought disorder, mania, ego strength. I can give --</p> <p>13 it's like 50 scales.</p> <p>14 Q. Is it fair to call it a diagnostic tool?</p> <p>15 A. Yes.</p> <p>16 Q. Is it -- and it works in conjunction with the</p> <p>17 DSM-5; correct?</p> <p>18 A. No.</p> <p>19 Q. So it doesn't identify certain diagnoses that</p> <p>20 are defined in the DSM-5?</p> <p>21 A. Well, I mean, if there's a depression -- if it</p> <p>22 says a person's depressed, it doesn't have anything to</p> <p>23 do with DSM-5 diagnostic criteria, I would then have to</p> <p>24 figure out if there's a lot of depression on the scale</p> <p>25 and then the person looks depressed and the history</p>

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1 shows she depressed, then I would have to say to myself,
2 Well, what type of depression is it? Is a major
3 depressive disorder with or without psychotic features?
4 Is it a -- what used to be called a dysthymic
5 disorder, or the kind of characterological low-grade
6 depression? Is it an adjustment disorder with depressed
7 mood, which means that it will go away once the stressor
8 resolves? Is it depressive personality characteristics
9 in an acute major depressiveness? All of those things I
10 have to do.
11 Q. So if I were to dumb this down, is it fair to
12 say that the MMPI is a starting tool that gives you kind
13 of a ballpark, and then you can work from there and go
14 into the specific diagnostic criteria to narrow it down
15 and actually confirm the diagnosis; is that correct?
16 A. Yes. It gives you inferences based upon the
17 normative samples. So that when someone has a clear
18 MMPI-2 result, you can infer certain things about them
19 and then check to make sure that it seems to make sense.
20 Q. Do you always administer the MMPI in your
21 forensic cases?
22 A. Either the MMPI-2 or the newer MMPI-2-RF, which
23 is a bit shorter and a little different.
24 Q. How do you decide which one you're going to use?
25 A. I can't really tell you that. It depends

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1 upon -- it depends upon the person, how much
2 perseverance I perceive them to have. If they are very
3 upset about having to sit and take a long test, I'll go
4 to the shorter one that is just -- it's good.
5 Or there may be things on the MMPI-2-RF that
6 aren't on the MMPI-2 that I'm looking for. And
7 sometimes what you can really -- you can do the MMPI-2
8 if they will sit through it and, from it, you can derive
9 an MMPI-2-RF, because the same MM- -- the MMPI-2-RF
10 questions are a part of the greater MMPI-2, so that I
11 will sometimes run both just to see if there's
12 consistency or inconsistency. One picks up one thing
13 that the other test didn't pick up, as an inference that
14 I can follow up on.
15 Q. So how is the MMPI -- or what kind of test is
16 it? Is it a multiple-choice test?
17 A. No. It's a statement, and you answer
18 true/false; mostly true, mostly false, of how you're
19 feeling recently.
20 Q. So what is it? Is it like you circle T or you
21 circle F?
22 A. You fill in T or F with a pencil, you circle.
23 Q. So is this a Scantron test?
24 A. It isn't a Scantron test, though it can be.
25 There are different -- you can do it off a computer --

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1 we don't do that -- you can probably do a Scantron and
2 send it to a publishing company. We actually enter the
3 data. Donna would go to the software and enter all of
4 the data, and then click on the type of report that I'm
5 looking for, and it would spit out all of the different
6 scales and all of the different elevations.
7 And you can get a test report that has an
8 interpretive report, which I always seem to get. So you
9 can get a score test report -- just the scores, no
10 interpretation -- you do your own. Or you can get an
11 interpretive report, and that goes to the attorneys and
12 then they see that.
13 So there are different iterations of the
14 reports.
15 Q. But the process in your office, anyway, is she
16 fills out -- she fills in the bubble with a pencil,
17 hands it to Donna. Donna --
18 A. Or hands it to us -- me, Dr. Kampfer. We make
19 sure had that she's filled it out and that she hasn't
20 left too many blank or double that said true and false.
21 We look for errors. And then if there were errors,
22 we'll ask her to go back and make a choice, true or
23 false or leave it blank; it's up to you.
24 And then when that's done, if even necessary,
25 then we give it to Donna and she enters all of the

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1 responses in the computer.
2 Q. Did you have to tell Maria in this case to go
3 back and change her answers or fill more in or anything
4 like that?
5 A. I don't remember.
6 Q. Do you know if it was you or Dr. Kampfer who
7 actually looked at the score sheet before giving it to
8 Donna?
9 A. It probably would have been -- I don't remember.
10 I'm -- I don't know. It was probably Dr. Kampfer, but I
11 don't know. I can't tell you, really.
12 Q. And would it be in the records if she had been
13 asked to go back and fill it in again or complete the
14 test?
15 A. It might not or it might, depending upon if I
16 remembered to put it in the report. Because it's so
17 common that people leave blank too many, and we say, Can
18 you go back and try to fill out and leave no more than
19 ten blanks. Or they'll double -- they'll do true and
20 false because they'll forget the directions. So that's
21 so common that I might not even mention it.
22 Q. Is this a timed test?
23 A. No.
24 Q. She has as much time as she wanted to take it?
25 A. Yes. But it should take about an hour and a

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1 half for the MMPI-2, maybe about 50 minutes or so for
2 the MMPI-2-RF.
3 Q. I think you mentioned earlier that Maria was
4 here on the 17th between an hour and a half to two
5 hours?
6 A. That's an guesstimate. If that's all she did,
7 and that's all she did on that date, that's what it
8 should have been.
9 Q. Okay. So your estimate is based on what it
10 should have taken, not at all based on what it actually
11 took?
12 A. Correct. I don't know how long she was here. I
13 would have been told when someone's here for hours and
14 hours and hours and hours. I'm usually told, This
15 person is taking way too long. Something's going on.
16 And then I intervene, and so I don't -- I don't recall
17 that happening.
18 Q. Okay. In this case, was it Donna who took the
19 score sheet and entered it into the software?
20 A. Yes.
21 Q. Do you still have the actual score sheet?
22 A. Yes.
23 Q. And that's part of that file?
24 A. (Witness shakes head.)
25 Q. And then in the printout that is generated from

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1 the input, does that also have the answers that were
2 marked?
3 A. No. It --
4 Q. Go ahead.
5 A. It doesn't. Because her MMPI-2 was invalid, it
6 just says this report is invalid, and it doesn't give
7 you -- and it usually will state, which I put in my
8 report, as to the six or seven reasons it can be
9 invalid. And then I try to deduce why this was invalid.
10 Q. Is there any way to go back and check if the
11 answers that Maria gave were the same as the ones that
12 were input by Donna?
13 A. Sure.
14 Q. How would we do that?
15 A. Just have them -- we'll have Donna or anybody --
16 your own expert can run the whole thing all over again.
17 Q. We'd have to input them again to see if we get
18 the same thing?
19 A. Sure.
20 Q. So when -- so the interpretation of the test
21 scores is done electronically?
22 A. It goes to the publishing company that has all
23 of the research and provides a empirically-based
24 research-based interpretation from which I look at it
25 and try to see -- and I'll even go over with someone the

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1 MM- -- I'll say, The MMPI-2 suggests that you are A, B,
2 C. Does that make sense to you?
3 And then I try to figure out -- sometimes they
4 agree that's me, sometimes they disagree, sometimes I
5 agree with disagreement, sometimes I don't agree with
6 their disagreement -- but I try to make sense of the
7 MMPI-2 by going over some of the test results.
8 In this case, I literally -- and I was telling
9 one of the things I did say to Mr. Goates before, which
10 I didn't previously mention, which is unlike what a
11 hired expert would tend to do when he's hired by one
12 side or another -- I -- she failed -- she produced an
13 invalid MMPI-2. Were I somewhat -- how do I put it? --
14 one-sided, I could have left it at that and just
15 basically said she produced an invalid MMPI-2, which
16 means that she's probably indiscriminately describing
17 and exaggerating all sorts of symptoms that human beings
18 couldn't possibly all have. And that would have
19 benefitted his case.
20 But being me, an honest person, I said to
21 myself -- I told her, I said, "Ms. Fernandez, I know you
22 spent a lot of time doing this. You -- it didn't come
23 out valid. I think you complained of so many different
24 things that it was -- the test was invalid. I can't
25 have you take this test over, but let me give you

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1 another personality test, if you'll do it, and try to be
2 as honest as you can and, you know, not blow everything
3 up into" -- I didn't put it to her that way -- "but try
4 to take this one," hoping that now we would get
5 something that was relevant and would give us some
6 answers.
7 But she produced that, and the personality
8 assessment inventory was also invalid. So now I have
9 two invalid test results, but I did the right thing
10 ethically. There aren't many people who do that, but I
11 did it because I thought that was the right thing to do.
12 Q. You mentioned that sort of the typical expert or
13 the expert that is one-sided?
14 A. Yes.
15 Q. Do you remember saying something about that?
16 A. Yes.
17 Q. What did you mean by that?
18 A. Well, I think there is -- I've got a large
19 library of forensic books -- forensic neuropsychology,
20 forensic clinical psychology. I've been to hundreds of
21 hours of training. It's pretty widely known by lawyers
22 and by psychologists that the independent medical
23 examination or the independent psychological examination
24 may not be independent if the person doing the
25 evaluation wants to please the referral source and will

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<p>1 say just about anything to slant the case to please the 2 person. 3 So there are many such experts out there. And 4 some lawyers may think I'm one of them, but I certainly 5 don't see myself that way -- 6 Q. Sure. 7 A. -- even though I get most of my cases from 8 defense firms. 9 Q. What does "validity" in a test score mean? 10 A. That it measures what it says it's measuring. 11 Q. And that's -- that and reliability are two 12 things you're going to look for in a test result; right? 13 A. Yes. 14 Q. And reliability has to do with repeating the 15 test -- 16 A. Yes. 17 Q. -- and getting the same scores -- 18 A. Yes. 19 Q. -- within the same range, so to speak? 20 A. Yes. 21 Q. Are you able to make an assessment as to the 22 reliability of test results if the test is only taken 23 once? 24 A. Yes. 25 Q. How is that?</p>	<p>1 She did the same exaggerated presentation on the 2 Beck Anxiety Inventory, the Beck Depression Inventory 2, 3 the P3, and my two objective tests, which are even 4 better than the ones that he used -- symptom checklists 5 and questionnaires which you can fake very easily. 6 These actually are very difficult to fake. 7 So there's reliability over time, one-time 8 test-retest reliability. Not the same test, but she 9 presented similarly both times. 10 Q. And because of her results on the MMPI, you had 11 her take the PAI? 12 A. I had her take the PAI in the hope that she 13 would kind of do it better and do it more validly so 14 that we can discuss, Here's how these test results 15 depict you. This is what you said about yourself, 16 here's what it says about you. Does this make sense or 17 not? 18 Q. So what's the PAI? 19 A. It's another objective, a more recently 20 developed objective personality test, the Personality 21 Assessment Inventory. 22 Q. Does it measure similar things that the MMPI is 23 designed to measure? 24 A. Yes. These overlap. 25 Q. Is it similar in that she filled it out, it's</p>
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<p>1 A. Well, you're not doing a test-retest 2 reliability; you're doing how -- you're using the 3 validity scales to assess whether -- what is the 4 possibility that any human being in this large number of 5 people who have taken this test could possibly have this 6 many symptoms of all of these different types versus 7 this many symptoms here but few over here. 8 So the validity scales mostly, but in 9 conjunction with other scales, can tell you that the 10 test is -- the person's -- how the person behaved in 11 taking the test, or why the test was valid or invalid. 12 Q. So did the spit-out or the test results, the 13 interpretive report, if you will, give an indication 14 whether her test results were also reliable or 15 unreliable? 16 A. I don't know if it said that. I mean, I can say 17 they're reliable against Dr. Mortillaro's test results 18 in 2012, I think, or '13 or whatever it was. 19 Q. And that was also the MMPI? 20 A. No. But the way she took these tests with 21 complaining of everything under the sun happening at the 22 highest possible level -- sort of like I'm in 10 out of 23 10 pain from head to toe -- which is sort of what she 24 said to Dr. Mortillaro -- it's not humanly possible, but 25 that's how she presented herself.</p>	<p>1 inputted into the computer, it spits out a report? 2 A. Yes. She has four choices to -- it's not just 3 true/false, but false, somewhat true, usually true, 4 always true or very true. 5 Q. Sure. 6 A. So it's a little different and it's shorter. 7 Q. Does that also come with a built-in interpretive 8 section? 9 A. Yes. 10 Q. Is that something you got on hers? 11 A. You'll read it. 12 Q. Okay. You mentioned earlier -- and this is the 13 report -- that there are a number of reasons that a test 14 could be invalid? 15 A. Yes. 16 Q. In fact, I think there were seven that you 17 listed -- well, there were seven and then five. There 18 were two different sections. Do you know what I'm 19 talking about? 20 A. Yes. This is right from the MMPI-2 in the 21 Profile Validity section. It says, "She responded to 22 the MMPI-2 items in an exaggerated manner, endorsing a 23 wide variety of symptoms and attitudes. These results 24 may stem from a number of factors, including 25 indiscriminately claiming extreme psychological</p>

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<p>1 problems" -- which is what I think she did -- "a low 2 reading level, a 'plea for help,' or severe 3 psychological deterioration or psychosis. Her responses 4 were probably not random because she was consistent in 5 her item responses. The resulting MMPI-2 profile is not 6 likely to be a valid indication of her personality and 7 symptoms. The interpreter is cautioned against making 8 clinical or administrative decisions on the basis of 9 this MMPI-2 protocol without determining the reasons for 10 the extreme responding," closed quote. 11 Q. Can you turn to Page 8 of your report, if you 12 don't mind? 13 This has to do with probably the parallel 14 explanation for the interpretation of invalid results of 15 the PAI? 16 A. Yes. 17 Q. It says -- there's a quote -- do you see where 18 it says Page 6 in parentheses, the fifth line down -- or 19 the big, long paragraph, fifth line down, Page 6? 20 A. Yep. Yep. 21 Q. Later in that same line it says, "The PAI" -- 22 quote, "The PAI provides a number of validity indices 23 that are designed to provide an assessment of factors 24 that could distort the results of testing. Such factors 25 could include failure to complete test items properly,</p>	<p>1 A. You're right. That's why I couldn't rule it 2 out. 3 Q. Okay. 4 A. That means I haven't made that decision, but 5 it's possible. 6 Q. Malingering would necessarily mean being 7 untruthful or lying; right? 8 A. Yes. 9 Q. Would -- can someone subconsciously lie, or 10 would that mean they would have to make a conscious, 11 knowing mistruth? 12 A. Great question. Yes, you can subconsciously 13 lie; but it's not a lie, so that wouldn't be 14 malingering. 15 Q. Okay. 16 A. And there's lots of people like that. That's a 17 very interesting part of psychology. 18 Q. Okay. And presumably, if you were going to 19 reach the conclusion that she is malingering after 20 reviewing subsequent reports, that would be -- or 21 subsequent information, that would be included in the 22 subsequent report? 23 A. It would. And the evidence on which I based it. 24 Q. Did you get a sense as to whether Ms. Fernandez 25 trusted you?</p>
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<p>1 carelessness, reading difficulties, confusion, 2 exaggeration, malingering, or defensiveness." Okay? 3 A. Yes. 4 Q. Were those factors -- did you consider those 5 factors -- I mean, you included them in your report, so 6 I'm presuming, but correct me if I'm wrong -- that these 7 were factors you considered before reaching a 8 conclusion? 9 A. Yes. 10 Q. And the conclusion that you reached was that you 11 could rule out all but malingering; is that right? 12 A. I'm saying there's a possibility that she's 13 malingering in the sense -- I should define 14 "malingering" -- that she is consciously and purposely 15 exaggerating the extent of her disability for secondary 16 gain. I can't say that in court because I don't know; I 17 don't have all the information. But I could give you -- 18 and I did -- put all of the different reasons or 19 evidence that could lead to that diagnosis. But I 20 didn't have enough for me. 21 Q. So is it my understanding, then, that the 22 opinion -- at least what I inferred was your opinion 23 from the report that Ms. Fernandez is in fact 24 malingering -- is not something that you'll be 25 testifying to in court?</p>	<p>1 A. You know, it's not uncommon. I've done so many 2 of these for -- depending upon the person, the attorney, 3 the attorney's belief about what I'm going to do. There 4 are some people who come in here and they're so nice. 5 I'm so happy that they were so nice. We talk about it 6 afterwards, Oh, that was so nice. They were cordial and 7 courteous. 8 And some people come in here and they would just 9 as soon hit me across the head with a baseball bat 10 before they even met me. And that happens too. 11 She was emotional, but I think we had rapport. 12 I was nice to her. She was -- I don't remember her 13 being, you know, critical of me or saying nasty things 14 or calling her attorney complaining, or whatever. 15 Q. Sure. Now, I'm not -- I don't know hardly 16 anything about the MMPI, so I'm going to ask questions 17 out of ignorance, and I probably know about as much as a 18 juror might, so -- 19 There are a number of -- I'm going to use the 20 wrong terminology here -- but from my research, it looks 21 like there's different types of -- let me get the right 22 word here -- validity measures, CNS, LF, F minus K, 23 F-Back. Do you know what I'm talking about? 24 A. Yes. 25 Q. Is a "validity measure," is that a good</p>

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1 description of those?
2 **A. Yes.**
3 Q. Okay. Do you have her F score?
4 **A. I do.**
5 Q. And what was her F score?
6 **A. The raw F score was 23; the T score, which is**
7 **the score we use to say how many standard deviations**
8 **above or below of mean that score represents was 116;**
9 **and --**
10 Q. Does that mean 16 percent above the mean?
11 **A. 116 T score.**
12 Q. Standard deviations above the mean?
13 **A. Well, 50 is your mean, and every 10 points is a**
14 **standard deviation. So 60, 70, 80, 90, 100, 110 -- so**
15 **almost seven standard deviations above the mean. And**
16 **knowing statistics, as I do --**
17 Q. It's a tiny percentage?
18 **A. Uh-huh, one in 100,000.**
19 Q. That was her T score for the test results?
20 **A. Yes, on the F scale.**
21 Q. Okay, all right. What about the F-Back scale?
22 **A. She had 18 raw score; T score of 112 --**
23 Q. Okay.
24 **A. -- which is that rare also.**
25 Q. And you're getting this information from the

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1 same page?
2 **A. Yes.**
3 Q. Is there a page number on there --
4 **A. 2.**
5 Q. -- to help me identify it later?
6 **A. This is Page 2 of the Interpretative Report?**
7 Q. Yes.
8 **A. Yes.**
9 Q. And the F minus K, where does she fall there?
10 **A. It doesn't -- we don't use the F minus K.**
11 **That's an old thing that's sort of been supplanted by --**
12 **yes, so go ahead. We don't use that anymore.**
13 Q. Okay, all right. What about the FS? Is that
14 something you guys use?
15 **A. The superlative? Or what's the FS?**
16 Q. From what -- the description here I have,
17 infrequent somatic response.
18 **A. Ahhh, that isn't -- that isn't --**
19 Q. It might have been something only on the R, the
20 MMPI -- the other one you talked about.
21 **A. The 2-R.**
22 Q. The 2-R?
23 **A. That might be where that is. It's not on this**
24 **one. But we have lots of scale measures of that, other**
25 **than on the validity scales.**

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1 Q. Okay.
2 **A. So, yes, we can give you that information, but**
3 **it's not --**
4 **MR. GOATES:** It's 3:15. How long do you
5 anticipate going further?
6 **MR. PARRY:** I think I paid for two hours.
7 **THE WITNESS:** -- usually, what happens.
8 **MR. GOATES:** Okay.
9 **THE WITNESS:** Oh, may I say something?
10 **BY MR. PARRY:**
11 Q. Uh-huh.
12 **A. So I want you to look at this.**
13 Q. Sure.
14 **A. On the MMPI-2 when it spits out her report, it**
15 **doesn't have any of these red lines. I wrote a note so**
16 **that any psychologist reviewing this, I put these red**
17 **lines in so that I could get a visual idea of how high**
18 **or low each of these scales were. So I said, "Note for**
19 **Psychologist who may review this MMPI-2." I added the**
20 **red lines to the Pages 2, 4, and 5, for purposes of**
21 **visual illustration, i.e., so I could see the relevant**
22 **scale elevations, Lewis Etcoff, Ph.D., blah, blah, blah.**
23 **So this, if you just have your psychologist**
24 **reproduce by entering this into the computer, they will**
25 **get hopefully the same scores. There may be a -- you**

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1 know, the person who puts it in may do it wrong once or
2 twice. Donna may have made a mistake or two; I hope
3 not. But the red stuff I drew in so I can look at it,
4 because that's how I was trained to look.
5 Q. To originalize it. What about these blue dots?
6 Is that --
7 **A. Oh, that's my pen. Just kind of -- the blue dot**
8 **is a way of lining up there's the F scale, there's the**
9 **FB scale. So when it says 116, I would take a ruler,**
10 **and here's my ruler (indicating), and I would put 116.**
11 **There's 100, 110, 120. That's about 116.**
12 Q. So you didn't just draw those red lines; you
13 actually plotted the graph yourself too; right?
14 **A. Right. Yes. That's what that is.**
15 Q. All right. I appreciate the clarification.
16 Other than the -- well, all right. We've talked
17 about the MMPI and its results. I want to spend some
18 time talking about what happened on the 19th when
19 Ms. Fernandez came in.
20 **A. Yes.**
21 Q. So she came into your office on the 19th, we're
22 assuming around 9:00 because that's when you typically
23 do it --
24 **A. We start at 9:00, yeah.**
25 Q. So do you remember if Maria --

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1 A. May I get some water?
2 Q. Yeah. If you wouldn't mind referring to your
3 notes --
4 (Discussion held off the record.)
5 **BY MR. PARRY:**
6 Q. Do you know if Maria showed up on time?
7 A. I don't know for a fact, but I believe she did,
8 or I would have -- I know when someone's late.
9 Q. Sure. Is it something where -- well, so, walk
10 me through it. She shows up at 9:00. Does someone give
11 her some stuff to fill out at first, or she walks
12 back --
13 A. So Donna will say, "Ms. Fernandez is in the
14 waiting room." I'll say, "Great." I'll grab a coffee,
15 grab my water, put my stuff on the desk. I'll say,
16 "Dr. Kampfer," if she shows, "Let's go introduce
17 ourselves," blah, blah, blah. We introduce ourselves
18 and have her come back here, give her some water, some
19 coffee, whatever she wants.
20 When we sit down, the first thing I do is an
21 informed-consent spiel so that she knows who retained
22 me -- and I can give you the spiel, if you want. You
23 don't want it.
24 Q. This is in your office, isn't it?
25 A. It's right here.

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1 Q. Okay.
2 A. So before I actually interview her, I say, "I'm
3 retained by Mr. Goates, who's representing the defense.
4 I'm a psychologist licensed in the state of Nevada.
5 This isn't confidential. I am going to ask you
6 questions about your life before this thing and after
7 this thing, and I want you to tell me as best you can
8 what your symptoms and problems are that you believe are
9 related to this accident. There's no confidentiality as
10 opposed to when you see a psychologist regularly,
11 because this is in court. So what you tell me -- and
12 I'm writing it down. It can be in my report.
13 And then it goes into the public domain. If I
14 ask you a question that you don't want to answer it, you
15 don't have to. Maintain your rights. Just tell me, "Go
16 on to the next question," and I'll do that.
17 At the end of this I write a report.
18 Dr. Kampfer and I edit it, make sure it's accurate. We
19 send it to Mr. Goates. Mr. Goates sends it to your
20 attorney. Months later, more often than not, your
21 attorney will come in and depose me to see why I have
22 the opinions I have."
23 Q. There I am being predictable again.
24 A. Everybody -- well, not everybody.
25 And then 95 -- 98 of 100 times your case will

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1 settle, and then in the other 2 to 5 percent you'll go
2 to court and I could be called as an expert witness by
3 either side, depending on what my opinions are, and
4 cross-examined by the other side.
5 Do you feel you can -- are we okay? Can you --
6 how do you feel today? Can you go through with this?
7 Yes. Okay, here we go.
8 And then we start out with, Let's do simple
9 stuff, like where do you live? Who do you live with?
10 How old are you? What's your address? I just kind of
11 let them warm up because they're sometimes a little
12 freaked out about the whole thing.
13 Q. This is all oral?
14 A. Yeah.
15 Q. And you're taking notes?
16 A. Oh, yeah.
17 Q. And this is you, not Dr. Kampfer?
18 A. She's silent.
19 Q. But she's in the room?
20 A. She's just sitting and watching and listening.
21 Q. Okay. So you get through the warmup, you get
22 some information about her background, and then what?
23 Do you get into some of the more --
24 A. And you'll see from my notes. I literally -- my
25 ethical obligation is to be as transparent as I possibly

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1 can be. So you will literally -- if you -- I have bad
2 handwriting. You can ask me, if you want.
3 I mean, I'll literally -- the order of what I
4 asked and how she answered is pretty obvious. And then
5 you'll compare my notes to what's in the report, and it
6 will be pretty darn the same thing. I may have changed
7 a word. I mean, I don't take -- I'm not tape-recording
8 it and putting in quotes perfectly. But when I put in a
9 quote, it's absolutely a quote, a short one, or pretty
10 close to it.
11 So it's just literally page after page of what I
12 asked. I usually put parentheses around my question,
13 and then what she said. And there's -- here's subject
14 accident injuries. How you doing emotionally? What
15 treatments have you had? You worked at the Palms, you
16 said. Tell me about that. How is your financial
17 situation? What were you like before the subject
18 accident? All of these things are all in here, so you
19 can just read everything I did and know exactly where
20 everything came from, because that's what I'm supposed
21 to do.
22 Q. And how long does that interview typically last?
23 A. Two to three and a half hours.
24 Q. And after that, what's the next step? So we're
25 at, like, lunchtime now normally; right?

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1 A. Yes. And what we might do is I might interview
2 for an hour or 50 minutes, and then I typically will
3 take a bathroom break, or they'll need a bathroom break,
4 and then come back and do another bunch of interviewing.
5 And then I'll give them a break.
6 And in this case, I probably gave her the
7 Personality Assessment Inventory after explaining that
8 the other one didn't come out. Can you try this one?
9 Sometimes I'll let her, the person -- that might take
10 her to lunch, but she's not completely through, so then
11 she'll go to lunch and come back and finish it, and
12 we'll talk some more after I have those results and go
13 over that.
14 And then sometime in midafternoon I run out of
15 things to ask about. I'll review her records, because
16 oftentimes medical records are inaccurate, or you want
17 to see how they respond to what was in their medical
18 records and compare consistency with what they told you
19 versus what the records say. So all of that is involved
20 in the interview.
21 Q. It sounds like fun, actually. So --
22 A. Sometimes.
23 Q. -- then the inter- -- you said sometime in the
24 afternoon you run out of questions. Then is it over,
25 you're done, she goes home?

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1 A. It's over.
2 Q. So the whole thing -- the whole day is pretty
3 much one long interview, and maybe they took a test
4 there?
5 A. Yes.
6 Q. Okay.
7 A. I've just got to give you an idea.
8 Q. Sure.
9 A. So I had 15 pages of handwritten notes. I've
10 had 25 pages or 30 pages. So 15 pages, the tests, and
11 that's that.
12 Q. And you indicated you have not read
13 Dr. Pineiro's deposition transcript?
14 A. Not yet.
15 Q. Is that something that you plan on doing or at
16 least under the discretion of Mr. Goates, you will if
17 he'll send it to you?
18 A. Correct.
19 Q. And that's something that you would like to
20 read?
21 A. Yes.
22 Q. Will be you offering opinions in this case
23 related to the genuineness or extent of Maria's back
24 pain?
25 A. Nope.

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1 Q. Beyond the scope of your expertise?
2 A. Yes. Well, now, I should say I could be
3 asked -- I could be asked: Of all of her complaints,
4 does she tend to exaggerate her pain? I would have to
5 say yes. And there's enormous evidence of that.
6 But am I going to say she's exaggerating her
7 back pain? I can't say that she's exaggerating her back
8 pain, period. I can just say she is prone to
9 exaggerating pain, exaggerating depression, exaggerating
10 even symptoms that are psychotic she was endorsing.
11 Q. Someone who exaggerates their symptoms, what
12 potential psychological explanations could there be for
13 that?
14 A. They could have histrionic personality
15 characteristics where they're just emotion-driven and
16 they make mountains out of molehills.
17 Q. It doesn't seem like a PC term, histrionic.
18 A. It is actually. No, it is.
19 Q. Like the wandering uterus?
20 A. That's good. You've been doing your homework.
21 That's very good. It used to be called hysterical, so
22 that wasn't PC, so they changed it to histrionic.
23 Q. Histrionic is okay.
24 A. Men can be histrionic.
25 Q. Sure.

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1 A. It can be -- now I forgot the question. What
2 was the question?
3 Q. What possible psychological explanations could
4 there be for someone who exaggerates their symptomology?
5 A. It can be many things. It could be a cry for
6 help. I want you to know how much I'm hurting,
7 therefore unconsciously I'm going to just -- if there's
8 a choice or I'm on the borderline, I'm going to say yes
9 to I've got this, I've got that, I've got this, I've got
10 that. It could be completely outside of awareness
11 when -- it could be a cry for help. But in this case,
12 she didn't want help and she had help, so I ruled that
13 out.
14 Q. What do you mean she didn't want help?
15 A. In other words, psychological help. She wasn't,
16 like, I'm going to complain to this extent in the hope
17 that you tell me to go back to psychotherapy. Or I want
18 you to -- I want you to, in your report -- this could be
19 conscious or unconscious -- I want you to see how bad
20 off I am so that I hope you say, Boy this person needs
21 anti-depressants, or see a psychiatrist, or more
22 biofeedback, or go back to Dr. Mortillaro, which I said,
23 Go back to Dr. Mortillaro. You're feeling depressed."
24 Q. So you ruled out the plea for help as a --
25 A. I don't think that was her motivation. I'm

1 inferring that's not her motivation. She didn't have a
2 reading problem. I saw all of the stuff she had filled
3 out for Dr. Mortillaro for us, and she couldn't have had
4 a reading problem and done what she did legitimately or
5 validly.

6 She wasn't psychotic. I don't think -- I'm not
7 convinced that she was malingering; though if I felt
8 like making that case, you'd have a hard time with me in
9 court telling me I'm wrong, because I could wrap it up
10 in 11 different packages in a pretty kind of way. But I
11 won't do that until I really think she is. But there's
12 stuff there for that. She's exaggerating.

13 Q. What about the defensiveness?

14 A. Oh, no, not defensive. My God. She had the
15 exact opposite of defensiveness. Defensiveness is when
16 you and your wife are divorcing and you have children
17 and you're such jerks that you have to come to a
18 psychologist to see -- you know, you're just so
19 impossible. Like, if you're a jerk -- that's not PC.

20 Q. Uh-huh.

21 A. And then when you're at the psychologist's
22 office and when we give you an MMPI-2, you deny any
23 problems. Or a policeman, same thing. Airline pilot,
24 like the guy who ran the plane into the mountain.

25 Q. Just the opposite?

1 A. Exactly. You're defensive when there's
2 something at risk: Your children, your job. But in
3 this case, most plaintiffs, if anything, are the
4 opposite, though, sometimes I see ones who are --
5 they're wonderful. They actually don't complain as much
6 as they should be complaining. And I'll put that;
7 they're worse than they're telling me they are, and so
8 they're really credible.

9 Q. One of -- you mentioned a dozen different little
10 things you can package this up with if you decided to go
11 in that direction. And based on your report, I think I
12 know what some of those are, if not all of them.

13 A. Yes.

14 Q. I think you mentioned the fact that she had
15 self-diagnosed two broken toes. Do I remember that?

16 A. Yes.

17 Q. And it -- you seem to think -- and I don't want
18 to put words in your mouth, but I'm going to, so fix
19 them if I'm doing it wrong -- but you seem to think that
20 the fact that she never sought any diagnosis or
21 treatment for the broken toes belied the claim or
22 contradict -- or at least caused a question as to
23 whether the self-diagnosis was accurate?

24 A. Exactly. Show me broken toes in the medical
25 records. I understand what she said. You know, you

1 can't really fix broken toes anyway, so why go to the
2 doctor? I -- a normal human being would probably want
3 to know if they're broken, especially if they have
4 insurance that covers it. But, you know, it was just
5 unusual.

6 Q. Did you get the sense that she's the type of
7 person who is reluctant to go to a doctor?

8 A. I don't know if she's reluctant. I couldn't say
9 that. She's been to doctors. She's had surgeries, so
10 she's certainly not -- she goes. She'd been to
11 Dr. Pineiro a lot; she went to her chiropractor. I just
12 don't have the records. She's had surgeries. So I
13 believe she's reluctant to go to a doctor.

14 Q. She told you that she had seen Dr. Littlefield
15 for chiropractic care?

16 A. Yes.

17 Q. And that was one thing -- what's your opinion
18 on -- or how does her reporting of the treatment from
19 Dr. Littlefield, how does that affect your opinion as to
20 the exaggeration of her symptoms, if at all?

21 A. Not at all.

22 Q. Okay. There was a part in your report where you
23 mentioned that she wasn't sure if she had gotten
24 X rays --

25 A. Yes.

1 Q. -- or radiological studies --

2 A. Yes.

3 Q. -- through her treatment with Dr. Littlefield?

4 A. Yes.

5 Q. Can you explain to me what the significance of
6 that might be?

7 A. As someone who's had many radiological -- if
8 you've ever had a CT scan, you don't forget. If you've
9 ever had an MRI, you'd damn well never forget it.
10 X rays, you know, you've had X rays. It's hard to
11 believe that she would forget, having diagnostic tests
12 that are just -- X rays, everybody has X rays. I
13 would -- it's weird to forget that you've had an X ray
14 or a CT scan or an MRI scan of your back, or whatever is
15 bothering you. It's unusual to forget.

16 Q. That's if you had it, and then you don't
17 remember if you had it?

18 A. Yes.

19 Q. Would it be less unusual if she hadn't had it
20 and wasn't sure if she had?

21 A. That would be less unusual. I'm thinking that
22 she didn't have it. Because if she did have them, it's
23 obvious. You know you had it.

24 Q. In fact, you'll see this in Dr. Littlefield's
25 medical records and his deposition, he did not order

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1 X rays because he determined that the cause was muscular
2 and had nothing to do with it.
3 **A. That answers my question.**
4 Q. So does that change your opinion at all with
5 respect to her not being able to recall if she had any
6 diagnostic --
7 **A. Wipe that one off my report.**
8 Q. Okay. What did Ms. Fernandez tell you about
9 the -- well, before I ask that, can you explain the
10 difference between a suicide attempt and suicidal
11 ideations?
12 **A. A suicidal ideation is you think of killing**
13 **yourself, or tried the thought on and maybe think about**
14 **how you would do it if you were going to do it. You**
15 **assume, then, that you're pretty sad and foregone and**
16 **hopeless. Suicide attempt is when you open that bottle**
17 **of pills and swallow as many as you can, or drink,**
18 **drink, drink, drink, drink, drink, and then open the**
19 **bottle of pills and swallow them. Or run your car into**
20 **a wall or off the cliff. It's a behavior. The suicidal**
21 **attempt is a behavior; the suicidal ideation is**
22 **thoughts.**
23 Q. What about opening -- drinking, opening pills
24 but then not actually taking the pills. Where would
25 that fall in the spectrum? I mean, I don't --

Page 74

1 **A. In between.**
2 Q. So it wouldn't be an attempt, but it could be
3 something more than ideation?
4 **A. Yes.**
5 Q. Is that something that's common -- is that a
6 difference that most people would understand, where the
7 line is?
8 **A. I don't know. I could explain it easily. I**
9 **think you understood it.**
10 Q. Well, you can explain it as a doctor, and I can
11 understand it.
12 **A. Yes.**
13 Q. But you treat all sorts of -- not just treat,
14 but you examine all sorts of different people from
15 different socioeconomic, different education levels. Is
16 that -- would a normal person understand the difference
17 between how much behavior had to be undertaken before it
18 actually qualified as a suicide attempt?
19 **A. I don't think so, because I'm not sure it would**
20 **be agreed upon by mental health professionals. Though,**
21 **I would be of the mind to say if she opened the bottle**
22 **and didn't take the pills, that she was close to taking**
23 **the pills and that would be nearly a suicide attempt.**
24 Q. Did she discuss with you the details of what she
25 described as a suicide attempt?

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1 **A. I don't believe so.**
2 Q. Did you discuss the suicide attempt with her?
3 **A. I -- you know, I thought I went over this today.**
4 **Do you know if it's in my report?**
5 Q. I know the suicide is in your report.
6 **A. I don't know if actually --**
7 Q. I can help you find it real quick.
8 **A. Yeah. It may have been nothing more than a**
9 **brief discussion.**
10 Q. It's at the bottom of Page 3.
11 **A. Thank you. Oh. So she was very -- she was**
12 **tearful. And so I said, Do you feel depressed, and she**
13 **said she did and she told me she had suicidal thoughts**
14 **but she wouldn't take her life because she's a**
15 **Christian.**
16 So I asked her, Have you ever attempted to take
17 a life, and she said, "Yes, I have." I asked when.
18 "Right after this happening," meaning the subject
19 accident, she answered. However, she didn't actually
20 attempt to take her life; rather, she had thoughts to
21 take her life while sitting in her car, which she
22 considered driving to her death. That was what she told
23 me.
24 Q. So you'll see this in her deposition, but I'm
25 going to make some representations to you to fill in

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1 some of these facts and get your opinion on it.
2 What she said here is accurate, but it's not --
3 or least what you report as her having said -- is
4 accurate but not complete. My understanding of what
5 happened is she actually got in her car; she drove down
6 to Hoover Dam. Her plan was to take her life at
7 Hoover Dam. She actually got to Hoover Dam and she was
8 sitting in her car, contemplating her life, and
9 ultimately decided not to. Got courage, chickened out,
10 however you want to say it, but decided not to take her
11 life.
12 So if the facts as I relayed them are what
13 happened, would you find fault with her for saying that
14 she had attempted to take her life?
15 **A. Not at all.**
16 Q. Okay. I want to ask you too about -- it's the
17 same paragraph, the second section where it says --
18 Actually, let me follow through. So that would
19 be more akin to opening the bottle and being about to
20 swallow the pills; right?
21 **A. Yes. Driving to Hoover Dam is even worse.**
22 Q. She actually took steps?
23 **A. Yes. That was --**
24 Q. Okay. Ms. Fernandez also reported, quote, "I
25 don't like -- I don't feel like having sex. My marriage

Page 77

1 is down the drain," closed quotes. Do you remember
2 having this discussion with her?
3 **A. Yes.**
4 Q. And my interpretation of your reaction to that
5 is based on -- well, your reaction or your opinion is
6 your marriage can't be down the drain. Your husband was
7 so kind to you in the waiting room, and he kissed you
8 and told he loved you when he dropped you off. Is that
9 ringing a bell?
10 **A. Yes. Yes.**
11 Q. It's the same paragraph here.
12 **A. Yes. Which was poignant because I see**
13 **plaintiffs and their spouses who they're sitting on**
14 **opposite sides of the waiting room. They can't stand**
15 **each other. You can tell they have a bad marriage.**
16 **This guy was -- it's like I remember him. He was just**
17 **so genuinely nice to her and loving. So that took me**
18 **aback.**
19 Now, I might be wrong. I might -- you can say,
20 I'll represent to you that they're divorcing, and then
21 I'll say, Okay. What it looked like was not what I
22 thought it what was, what reality is.
23 Q. Well, I'm going to be unpredictable here. As
24 far as I know, he is a kind, nice gentleman.
25 But I do have a few questions about that.

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1 Because if a -- would you agree that sexual intimacy is
2 an important part of a marriage?
3 **A. Yes.**
4 Q. And then if a wife is unable to engage in a
5 sexual relationship, she might feel like she's failing
6 as a wife?
7 **A. Correct.**
8 Q. And these thoughts of -- or these feelings that
9 she's failing as a wife might lead to her belief that
10 her marriage is not going well because she's not
11 contributing like the way she feels she should, even if
12 the husband is okay and patient and loving?
13 **A. Makes sense.**
14 Q. If you can turn to Page 10. I don't know what
15 page you're on now, but Page 10, the last paragraph on
16 Page 10.
17 Referring to the reports to Dr. Pineiro. I'll
18 just read that, so we know where we're at. It's the
19 line -- it's a little over halfway through the last
20 paragraph where it says "Yet."
21 **A. Yes, "Yet."**
22 Q. "Yet, she made no complaints of travel anxiety
23 to Dr. Pineiro and appeared to only hint at having a
24 traumatic event occur recently in her life, though
25 Dr. Pineiro never again mentioned any posttraumatic

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1 symptoms in her medical records."
2 You have Dr. Pineiro's medical records; right?
3 **A. Yes.**
4 Q. Do you have them there with you?
5 **A. I do.**
6 Q. Would you mind turning to those real quick?
7 **A. Yes. And that's incorrect. Because I looked at**
8 **them today, and he still had the diagnosis of rule out**
9 **PTSD on several records. What I think I was trying to**
10 **say but did so inelegantly, is neither in Dr. -- there**
11 **was never any meat on the bone.**
12 In other words, Dr. Pineiro didn't comment she's
13 been complaining of nightmares and reliving the event,
14 or that this car went through her store. There was
15 nothing mentioned, except -- and that's how I -- that's
16 why I wrote it the way I did. But I know that he had
17 written in his notes that rule-out state in his records.
18 Q. Well, let's look at them real quick. I do
19 appreciate that clarification. If you could -- I don't
20 know that yours have Bates labels. I don't think so.
21 **A. I do.**
22 Q. So if you could go to the May 21st, 2012 report.
23 **A. May 21st?**
24 Q. Yes.
25 **A. April 17th, 2012. Okay, sorry.**

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1 Q. That's all right.
2 **A. Oh, no. I don't have that.**
3 Q. You don't have the May 21st, 2012 records?
4 **A. No. Right, that's why I was searching. My**
5 **first record -- and I asked her about this, I think --**
6 **of her visit with Dr. Pineiro was 12/12/12, December 12,**
7 **2012.**
8 Q. Okay. Well, I'll represent to you that there
9 was a record May 21st, 2012, which was three days after
10 the accident. There's one June 8th, 2012; there was one
11 August 6th, 2012 -- and I'll just read you real quick
12 some of the things that she said to Dr. Pineiro, and it
13 sounds like it might change your opinion.
14 Quote, "The patient is in the clinic very
15 anxious, stating that while she was in her office, a car
16 drove right inside the office causing severe damage to
17 her property. She did not have any direct trauma, but
18 the patient had to move quickly out of the way not to be
19 injured, and since then she has been having
20 chest-wall-type of musculoskeletal pain."
21 And under the Impression, he said "anxiety,
22 increased social stressors and possible PTSD. We
23 discussed the use of some other anti-depression
24 medication, but the patient states that she'll see a
25 psychiatrist. She's very upset and stressed about the

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1 event that took place, where she stated that she was
2 almost killed."

3 So that was May 21st, 2012, three days after the
4 accident.

5 **A. Okay.**

6 Q. And then on June 8th, quote, "The patient is in
7 the clinic, still very distraught. Stated she cannot
8 sleep and that she has dreams about the car going into
9 her office and she almost getting killed. Extensive
10 discussion with the patient about her symptoms, which
11 are consistent with PTSD. I do agree with a psychiatry
12 evaluation, as well as a psychotherapy evaluation."

13 Then on August 6th, 2012, quote, "The patient is
14 in the clinic stating she is doing better as far as her
15 depression, but still having significant anxiety from
16 the accident that she had. And apparently she also lost
17 her business secondary to this accident. The patient is
18 to follow up with psychology and psychiatry as
19 previously instructed."

20 So with that added context, does that change
21 your opinion insofar as it relates to that paragraph we
22 just read?

23 **A. Absolutely.**

24 Q. And how does that change it?

25 **A. She -- the records I don't have, but requested**

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1 **to have, given the fact that she had told me that she**
2 **had seen Dr. Pineiro before -- well, before -- it's like**
3 **2010, if I recall correctly --**

4 Q. Uh-huh.

5 **A. -- those records clearly show that she sought**
6 **treatment from him, explained the accident, had PTSD**
7 **symptoms and depression, and wasn't going back to work.**
8 **So, yes, that's now consistent with what she saw -- she**
9 **had told Dr. Mortillaro.**

10 Q. Okay. Did you get a copy of the EMT report? It
11 would have been dated May 18th, 2012. The report was
12 actually created by the fire department.

13 **A. Let's see. Yeah.**

14 Q. You do have it?

15 **A. I've got the Las Vegas Metropolitan Department**
16 **Traffic Accident Report. I don't have -- that's not**
17 **what you're talking about?**

18 Q. No. I'm talking about fire department, the
19 paramedic report.

20 **A. No, I don't have that.**

21 Q. Is that something that would interest you?

22 **A. Absolutely.**

23 Q. Okay. I see Mr. Goates writing that down. I
24 assume you'll be seeing that.

25 So you don't know of any treatment she might

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1 have received at the scene?

2 **A. Correct.**

3 Q. In your report, you were critical of the fact
4 that she did not go to the hospital on the day of the
5 accident.

6 **A. Yeah. I'm wondering why -- with all of these**
7 **problems she was having -- she was scared, her heart was**
8 **palpitating, she said her blood pressure rose, her toes**
9 **were broken -- she had insurance, go to somebody.**

10 Q. So when you made that opinion, you were unaware
11 that there were paramedics on the scene and that she
12 did --

13 **A. Oh, no. I knew -- she told me, I think, that**
14 **she was seen by the fire department, if I recall, but**
15 **I'll check my report. But I obviously didn't put two**
16 **and two together until now that there was a paramedic's**
17 **report that I didn't receive.**

18 So she got help at the scene and then didn't
19 follow up later on; but, for whatever reason, I think
20 she just, with her toes, felt, Well, they're broken. I
21 don't know if they're broken, but they're broken. I'm
22 just saying I don't know. And she -- I don't know why
23 she didn't go to an emergency room. It could have
24 been -- I can read the answer, I guess, in the EMT
25 report.

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1 Q. But now you know she did go see her family
2 doctor within three days?

3 **A. Yes.**

4 Q. And that changes things?

5 **A. Yes.**

6 Q. You indicated too -- and I think if you looked
7 at Dr. Pineiro's report, that the rule-out PTSD line is
8 not only in the December 2012 report, but in every
9 subsequent report.

10 **A. It carried through.**

11 Q. All right. What does "rule out" --

12 **A. Why does it say that?**

13 Q. Yeah. What does it mean when a doctor put in --
14 and you've used the same thing. What does it mean "rule
15 out" certain, you know, whatever it is?

16 **A. Well, it's similar to diagnostic impressions.**
17 **When you see diagnostic impressions from a physician,**
18 **they're saying, At this time, given what I know, here's**
19 **my differential diagnoses. I'm not -- you know, they**
20 **way they write it, people think, Oh, it is a myocardial**
21 **infarction. Well, it may not turn out to be that, but**
22 **they're thinking it could be this, it could be that, it**
23 **could be that.**

24 Rule out, I'm imagining -- and you may have
25 asked him in his deposition -- he says, I'm not a

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1 psychiatrist. He probably says to himself, I don't know
2 PTSD as well as a psychiatrist or psychologist, but it
3 looks like it to me, but I'm not trained like that, so
4 I'm going to put "rule out." So conservative.
5 Q. So is "rule out" just like an asterisk on a --
6 it's like a -- this isn't my diagnosis, but --
7 A. Yeah, but it looks like --
8 Q. -- it looks like it.
9 A. That's what I do. It looks like. I'm not sure
10 about it.
11 Q. Is malingering a diagnosis? Would you call it a
12 diagnosis?
13 A. I mean, it's in the DSM-5 and 4. I mean, it's
14 not a psychiatric diagnosis. It is more of an
15 intention. It's not a -- it's not -- it's something
16 that you can do, but it's not a psychiatric problem.
17 Q. So it is in the DSM-5?
18 A. I believe it's barely mentioned.
19 Q. Would you mind pulling it out? I am interested
20 in seeing what it says.
21 A. Okay.
22 Q. DSM-5 is fairly new, isn't it?
23 A. Yes.
24 Q. DSM-4 has been around for a long time?
25 A. Yes. But this thing is getting some pretty bad

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1 press.
2 Q. Is it really?
3 A. They have something like -- they've made so many
4 mistakes. And the numbers of what these disorders are,
5 I learned there must be six or seven pages of errors.
6 Q. Really? They need to put out an edition.
7 A. They're going to do a 5.1, 5.1. It's not
8 perfect.
9 Here it is. Here is the malingering section at
10 the bottom to here. And it's not a really -- it's a
11 crappy section. It's not -- it's just not psychiatry's
12 area of expertise. Psychologists do a much better job
13 with this, but this is what the DSM-5 is.
14 Q. Sure. And this is under the subheading
15 "Nonadherence to Medical Treatment." It's on Page 726,
16 and the code is, is V65.2 (Z76.5). I'm just going to
17 read this.
18 A. Sure.
19 Q. "The essential feature of malingering is the
20 intentional production of false or gross exaggerated
21 physical or psychological symptoms motivated by external
22 incentives such as avoiding military duty, avoiding
23 work, obtaining financial compensation, evading criminal
24 prosecution, or obtaining drugs. Under some
25 circumstances, malingering may represent adaptive

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1 behavior; for example, feigning an illness while captive
2 of an enemy at wartime. Malingering should be strongly
3 suspected if any combination of the following is noted:
4 "1) Medicolegal context of presentation -- for
5 example, the individual is referred by an attorney to
6 the clinician for examination, or the individual
7 self-refers while litigation of criminal charges are
8 pending.
9 "2) Marked discrepancy between the individual's
10 claimed stress or disability and the objective findings
11 and observations.
12 "3) Lack of cooperation during the diagnostic
13 evaluation and in complying with the prescribed
14 treatment regimen.
15 "4) The presence of anti-social personality
16 disorder. Malingering differs from factitious disorder
17 in that the motivation for symptom production and
18 malingering is an external incentive, whereas in
19 factitious disorder external disorders are absent.
20 Malingering is differentiated from conversion disorder
21 and" somatic --
22 A. Symptoms disorders.
23 Q. -- "symptom-related mental disorders by the
24 intentional production of symptoms and by the obvious
25 external incentives associated with it. Definite

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1 evidence of feigning (such as clear evidence that loss
2 of function is present during the examination but not at
3 home) would suggest a diagnosis of factitious disorder
4 if the individual's apparent aim is to assume the sick
5 role, or malingering if it is to obtain an incentive
6 such as money."
7 And I read that because I don't have a copy, but
8 I'll have to get one. But now I have what I need.
9 A. Okay.
10 Q. So to me, this looks like kind of a definition
11 and not really a -- it doesn't provide guidance as to
12 factors that you would look at to diagnose someone; is
13 that fair?
14 A. Yes. It's bare bones. It's accurate, but it's
15 bare bones.
16 Q. Okay. There's not a test that you can
17 administer that would -- that has the aim of detecting
18 malingering, or is there?
19 A. Oh, gosh, there are lots now. I can't -- there
20 isn't a journal article in neuropsychology that comes
21 out that doesn't. I joke every time I open up one of my
22 peer-review journals. I ask myself, How many
23 malingering test articles are there going to be there?
24 Ten years ago, you barely saw anything. Then,
25 it just started. It just has a life of its own, like

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1 autism. You know, autism was rare, and now one out of
2 58 people. Malingering articles, thousands; tests,
3 lots. There are -- it's -- I could go on. Yes, there's
4 many. I can test for malingering of all sorts of
5 things.
6 Q. And these tests that you mention, are there any
7 that are done for their express purpose to test for
8 malingering?
9 A. Many.
10 Q. Okay. What are some of the more well-recognized
11 or more reputable tests?
12 A. Okay, let's see. We've got Green, Dr. Green's
13 Word Memory Test; the Test of Memory Malingering; The
14 Carb, C-a-r-b; the Portland Digit Recognition Test; Rey
15 15-Item Test. Oh, God. The Medical Symptom Validity
16 Test; that's another Dr. Green one. I'm -- that's
17 plenty that I can roll off the top of my head.
18 Q. Sure. Did you ever --
19 A. And the MMPI-2 has distinct malingering scales.
20 Q. And that was going to be one of my next
21 questions. The test that you mention, is that -- is the
22 express purpose to test for malingering, or is that one
23 of the conclusions that can be drawn from certain test
24 results?
25 A. Never should you draw a conclusion that someone

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1 is malingering from just one test or just two tests,
2 although there are actual formulas where if a person
3 does poorly on these two tests that the actual
4 statistical probability of them feigning something or
5 exaggerating or malingering purposely is X percent.
6 But typically, we're all told to -- and we all
7 do -- we never make that diagnosis unless there's -- you
8 know, you've seen the records, collateral records;
9 you've hopefully seen the person or someone in your
10 field has recently seen the person and did a very
11 competent job that you can refer to.
12 The tests, symptom validity tests as they're
13 known, have been accomplished, that they've failed those
14 tests; that there are all these symptom validity
15 indicators within regular tests that you can use to see
16 whether they're feigning all sorts of things that they
17 never, not in a million years, knew that they were
18 feigning.
19 So there's -- so we never just make a diagnosis
20 of malingering based upon one symptom validity test. We
21 always look at consistency between the test results and
22 other test results; consistency between the test results
23 and their presentation; consistency between the test
24 results and how they live their life; consistency
25 between the test results and the medical records. All

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1 of that.
2 Q. Okay. To be clear, although you believe, it's
3 your opinion, that Maria Fernandez exaggerated her
4 symptoms, you have not seen enough evidence or heard
5 enough from her or gotten enough to be able to reach the
6 opinion that she is malingering in this case?
7 A. Absolutely right.
8 Q. However, you reserve the right to reach that
9 conclusion based upon further information that may be
10 provided to you?
11 A. Yes.
12 Q. And based on the discussions that you and I have
13 had, a number of these factors that you have considered
14 might point towards or suggest malingering are no longer
15 factors; is that right?
16 A. Correct.
17 MR. PARRY: That's all the questions I have. If
18 we could just get a copy of that for the court reporter,
19 then that would be --
20 THE WITNESS: A copy of my -- yeah, the medical
21 records. Donna -- we never let them out of the office.
22 Donna will do all that and get it to you. Just give
23 your card to her, and she'll have this in a day or two
24 to you.
25 MR. PARRY: Yeah, and I was going to suggest --

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1 MR. GOATES: I just have one question, Doctor.
2 EXAMINATION
3 BY MR. GOATES:
4 Q. With regards to your opinions, you're being paid
5 for your time, not your opinions; correct?
6 A. Absolutely.
7 MR. GOATES: Thank you.
8 (Exhibits 1 and 2 were marked for
9 identification.)
10 (The deposition concluded at 3:56 p.m.)
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1 CERTIFICATE OF DEPONENT
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19 * * * * *
20 I, LEWIS M. ETCOFF, Ph.D., A.B.N., deponent herein,
21 do hereby certify and declare that the within and
22 foregoing transcription to be my deposition in said
23 action; that I have read, corrected and do hereby affix
my signature to said deposition, under penalty of
perjury.

24 _____
25 LEWIS M. ETCOFF, Ph.D., A.B.N., Deponent Date

1 CERTIFICATE OF REPORTER
2 STATE OF NEVADA)
3 COUNTY OF CLARK) SS:

4 I, Jean M. Dahlberg, a duly commissioned and licensed
5 Court Reporter, Clark County, State of Nevada, do hereby
6 certify: That I reported the taking of the deposition
7 of the deponent, Lewis M. Etcoff, Ph.D., A.B.N.,
8 commencing on Tuesday, June 23, 2015, at 2:09 p.m.

9 That prior to being examined, the deponent was, by
10 me, duly sworn to testify to the truth. That I
11 thereafter transcribed my said shorthand notes into
12 typewriting and that the typewritten transcript of said
13 deposition is a complete, true and accurate
14 transcription of said shorthand notes.

15 I further certify that I am not a relative or
16 employee of an attorney or counsel of any of the
17 parties, nor a relative or employee of an attorney or
18 counsel involved in said action, nor a person
19 financially interested in the action.

20 IN WITNESS WHEREOF, I have hereunto set my hand in my
21 office in the County of Clark, State of Nevada, this
22 29th day of June, 2015.

23
24 _____
25 JEAN M. DAHLBERG, RPR, CCR NO. 759, CSR 11715

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