IN THE SUPREME COURT OF THE STATE OF NEVADA

FERRELLGAS, INC. a foreign corporation, Petitioner, v. EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA IN AND FOR THE COUNTY OF CLARK; THE HONORABLE JOANNA S. KISHNER, DISTRICT JUDGE, and JOSHUA GREEN, an individual, Respondents.	CASE NO. 82670 DISTRICT COURT CASE NO. A-19-795381-C

PETITIONERS' REPLY APPENDIX
(VOLUME 7)

FELICIA GALATI, ESQ.
Nevada Bar No. 007341
OLSON CANNON GORMLEY
& STOBERSKI
9950 West Cheyenne Avenue
Las Vegas, NV 89129
and
MICHAEL C. MCMULLEN, ESQ.
Missouri Bar No. 33211
GREGORIO V. SILVA, ESQ.
Nevada No. 13583
BAKER, STERCHI, COWDEN
& RICE, LLC
2400 Pershing Road, Suite 500
Kansas City, MO 64108
Attorneys for Petitioner FERRELLGAS, INC.

GINA GILBERT WINSPEAR, ESQ.
Nevada Bar No. 005552
DENNETT WINSPEAR, LLP
3301 N. Buffalo Drive, Suite 195
Las Vegas, Nevada 89129
Attorneys for CARL J. KLEISNER

JAMES P.C. SILVESTRI, ESQ.
Nevada Bar No. 3603
STEVEN M. GOLDSTEIN, ESQ.
Nevada Bar No. 6318
701 Bridger Avenue, Suite 600
Las Vegas, Nevada 89101
Attorneys for MARIO GONZALEZ

APPENDIX TO PETITION FOR WRIT OF MANDAMUS

VOLUME 1

NUMBER	DOCUMENT	BATES NUMBER
1	First Amended Complaint and Jury Demand	APP- 1-8
2	Defendants' Motion to Compel NRCP 35 Examination	APP-9-68
3	Joshua Green's Opposition to Defendants' Motion to Compel Rule 35 Examination	APP-69-204

VOLUME 2

NUMBER	DOCUMENT	BATES NUMBER
4	Defendants' Reply in Support of Motion to Compel Rule 35 Exam	APP- 205 -258
5	Recorder's Transcript of Hearing Re: Defendant's Motion to Compel NRCP 35 Examination – 11/19/20	APP- 259 - 280
6	Supplemental Briefing on Defendants' Motion to Compel Neuropsychological Rule 35 Examination	APP – 281- 407

VOLUME 3

NUMBER	DOCUMENT	BATES NUMBER
7	Defendants' Reply in Support of Motion to Compel Rule 35 Exam	APP- 408 - 477
8	Transcript of Proceedings Re: Further Proceedings: Scope of Examination/Whether A Neuropsychological Evaluation is Appropriate in this Case – 12/10/20	APP- 478 - 493
9	Discovery Commissioner's Report and Recommendations	APP- 494 – 500

VOLUME 4

NUMBER	DOCUMENT	BATES NUMBER
10	Defendants' Objection to Discovery Commissioner's Report and Recommendation E-Filed on 12/22/20	APP- 501 - 750

VOLUME 5

NUMBER	DOCUMENT	BATES NUMBER
10	Defendants' Objection to Discovery Commissioner's Report and Recommendation E-Filed on 12/22/20	APP- 751 - 1000

VOLUME 6

NUMBER	DOCUMENT	BATES NUMBER
10	Defendants' Objection to Discovery Commissioner's Report and Recommendation E-Filed on 12/22/20	1001-1016
11	Joshua Green's Reply to Defendant's Objection to Discovery Commissioner's Report and Recommendations	APP- 1017 – 1107
12	Second Amended Complaint	APP – 1108 – 1119
13	Discovery Commissioner's Report and Recommendations	APP – 1120 – 1125
14	Defendants' Supplement to Objection to Discovery Commissioner's Report and Recommendation E-Filed on 12/22/20	APP – 1126 – 1137
15	Transcript of the Proceedings – Defendants Ferrellgas' Motion for Leave to Amend Pleadings to Assert Crossclaims Against Defendant Carl J. Kleisner and Motion to File Third-Party Complaint Against Defendant Kleisner Employer – 1/28/21	APP – 1138 – 1176
16	Order Denying Defendants' Objections to Discovery Commissioner's Reports and Recommendations Dated December 22, 2020, and January 12, 2012; and Affirming as Modified the Discovery Commissioner's Reports and Recommendations Granting in Part and Denying in Part Defendants' Motion to Compel an NRCP 35 Exam	APP – 1177 - 1185

PETITIONERS' REPLY APPENDIX

VOLUME 7

NUMBER	DOCUMENT	BATES NUMBER
17	Plaintiff Joshua Green's Opposition to Defendants' Motion for Reconsideration	APP- 1186 – 1362

VOLUME 8

NUMBER	DOCUMENT	BATES NUMBER
17	Plaintiff Joshua Green's Opposition to Defendants' Motion for Reconsideration	APP- 1363 – 1539

DATED this 20th day of July, 2021

/s/ *Felicia Galati, Esq.*

_____

FELICIA GALATI, ESQ.
Nevada Bar No. 007341
OLSON CANNON GORMLEY & STOBERSKI
9950 West Cheyenne Avenue
Las Vegas, NV 89129
fgalati@ocgas.com
and
MICHAEL C. MCMULLEN, ESQ.
Missouri Bar No. 33211
GREGORIO V. SILVA, ESQ.
Nevada Bar No. 13583
BAKER, STERCHI, COWDEN & RICE, LLC
2400 Pershing Road, Sutie 500
Kansas City, MO 64108
mmcmullen@bscr-law.com
Attorneys for Petitioner
FERRELLGAS, INC.

DATED this 20th day of July, 2021.

/s/ *Gina Gilbert Winspear, Esq.*

_____

GINA GILBERT WINSPEAR, ESQ.
Nevada Bar No.: 005552
DENNETT WINSPEAR, LLP
3301 N. Buffalo Drive, Suite 195
Las Vegas, Nevada 89129
gwinspear@dennettwinspear.com
Attorneys for Defendant
CARL J. KLEISNER

DATED this 20th day of July, 2021.

/s/ *Steven M. Goldstein, Esq.*

_____

James P.C. Silvestri, Esq.
Nevada Bar No. 3603
Steven M. Goldstein, Esq.
Nevada Bar No. 6318
PYATT SILVESTRI
701 Bridger Avenue, Suite 600
Las Vegas, Nevada 89101
jsilvestri@pyattsilvestri.com
sgoldstein@pyattsilvestri.com
Attorneys for Defendant
MARIO S. GONZALEZ

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 20th day of July, 2021, I sent via e-mail a true and correct copy of the above and foregoing **PETITIONERS' REPLY APPENDIX (VOLUME 7)** by electronic service through the Nevada Supreme Court's website, (or, if necessary, by U.S. Mail, first class, postage pre-paid), upon the following:

Matthew G. Pfau, Esq.
Marjorie L. Hauf, Esq.
H&P LAW
8950 W. Tropicana Avd., #1
Las Vegas, NV 89147
mpfau@courtroomproven.com
mhauf@courtroomproven.com
Attorneys for Plaintiff

Gina Gilbert Winspear Esq.
DENNETT WINSPEAR, LLP
3301 N. Buffalo Drive, Suite 195
Las Vegas, Nevada 89129
gwinspear@dennettwinspear.com
Attorneys for Defendant,
CARL J. KLEISNER

James P.C. Silvestri, Esq.
Steven M. Goldstein, Esq.
PYATT SILVESTRI
701 Bridger Avenue, Suite 600
Las Vegas, Nevada 89101
jsilvestri@pyattsilvestri.com
sgoldstein@pyattsilvestri.com
Attorneys for Defendant,
MARIO S. GONZALEZ

Honorable Judge Joanna Kishner
Eighth Judicial District Court
Department 31
200 Lewis Avenue
Las Vegas, NV 89155

.

/s/ Karla Livingston

An Employee of OLSON CANNON GORMLEY & STOBERSKI

OPPS
Marjorie L. Hauf, Esq.
Nevada Bar No.: 8111
Matthew G. Pfau, Esq.
Nevada Bar No.: 11439
H&P LAW
8950 W Tropicana Ave., #1
Las Vegas, NV 89147
702 598 4529 TEL
702 598 3626 FAX
mhauf@courtroomproven.com
mpfau@courtroomproven.com

Attorneys for Plaintiff,
Joshua Green

DISTRICT COURT

CLARK COUNTY, NEVADA

* * *

Joshua Green, an individual, Plaintiff, vs. **Ferrellgas, Inc.,** a foreign corporation; **Mario S. Gonzales,** an individual; **Carl J. Kleisner,** an individual; Does I through XXX, inclusive and Roes Business Entities I through XXX, inclusive Defendants.	Case No.: A-19-795381-C Dept. No.: XXXI **Plaintiff, Joshua Green's Opposition to Defendants' Motion for Reconsideration of 3/2/2021 Order** Hearing date: April 27, 2021 Hearing time: 9:00 a.m.
Mario S. Gonzalez, an individual; Cross–Claimant, vs. **Ferrellgas, Inc.**, a foreign corporation; **Carl J, Kleisner,** an individual; DOES 1 through 100 inclusive; and ROE Corporations 101 through 200;	

Cross–Defendants.

Mario S. Gonzalez, an individual;

Third–Party Plaintiff,

vs.

BBQ Guys Manufacturing, LLC dba Blaze Outdoor Products., a foreign corporation; **Home Depot USA, Inc.,** a foreign corporation; **KSUN Manufacturing,** a foreign corporation; Does 200 through 300 inclusive; and ROE Corporation 301 through 400;

Third–Party Defendants.

Ferrellgas, Inc., a foreign corporation;

Counter–Claimant,

vs.

Mario S. Gonzalez, an individual; DOES 1 through 100 inclusive; and ROE Corporations 101 through 200;

Counter–Defendants

Carl J. Kleisner, an individual;

Counter–Claimant,

vs.

H&P LAW

Mario S. Gonzalez, an individual; DOES 1 through 100 inclusive; and ROE Corporations 101 through 200;

Counter–Defendants.

Plaintiff, Joshua Green, through his attorneys of record, Marjorie L. Hauf, Esq. and Matthew G. Pfau, Esq. of H & P LAW, hereby files this Opposition to Defendants' Motion for Reconsideration of 3/2/2021 Order.

This Opposition is made and based upon the pleadings and papers on file herein, the following Memorandum of Points and Authorities, and upon all oral argument which may be entertained at the time of the hearing of this matter.

MEMORANDUM OF POINTS AND AUTHORITIES

I.

Introduction

This issue is not ripe for reconsideration. NRS 52.380 and NRCP 35 can be read in harmony. Further, "good cause" inherently exists in an adversarial proceeding such as a Defense Medical Examination. This Court correctly applied *both* NRS 52.380 and NRCP 35 in its March 2nd order. Defendants have not met their burden in establishing the order was erroneous per law.

II.

Law and Argument

A. Defendants have not met their burden in establishing grounds exist for reconsideration.

The Nevada Rules of Civil Procedure provide the standard for granting relief

from an order of the Court. Rule 60(b) states:

> (b) Grounds for Relief From a Final Judgment, Order, or Proceeding. On motion and just terms, the court may relieve a party or its legal representative from a final judgment, order, or proceeding for the following reasons:
>
> (1) mistake, inadvertence, surprise, or excusable neglect;
>
> (2) newly discovered evidence that, with reasonable diligence, could not have been discovered in time to move for a new trial under Rule 59(b);
>
> (3) fraud (whether previously called intrinsic or extrinsic), misrepresentation, or misconduct by an opposing party;
>
> (4) the judgment is void;
>
> (5) the judgment has been satisfied, released, or discharged; it is based on an earlier judgment that has been reversed or vacated; or applying it prospectively is no longer equitable; or
>
> (6) any other reason that justifies relief.[1]

This standard requires **substantially** different evidence to be introduced or the judge's previous decision to be viewed as clearly erroneous.[2] And, this Court readily acknowledges that "only in very rare instances in which *new issues of fact or law* are raised supporting a ruling contrary to the ruling should a motion for a rehearing be granted."[3]

1. Because no doctor-patient relationship exists, good cause is inherent in Rule 35 Examinations.

Defendants assert they have met this burden because "no evidence" exists to support a finding for good cause for Plaintiff, Joshua Green, to have an observer present at and have an audio recording of his psychological examination.[4] They have clearly missed the point. There is no doctor-patient relationship between Josh and Dr. Etcoff. In fact, Dr. Etcoff routinely concedes

[1] Nev. Rules of Civil Procedure, Rule 60(b).
[2] *Masonry & Tile Contractors v. Jolley, Urga & Wirth Ass'n*, 113 Nev. 737, 941 P.2d 486 (1997).
[3] *Moore v. Las Vegas*, 92 Nev. 402, 551 P.2d 244 (1976).
[4] *See* Defs. Mot. for Reconsideration at 6:20–24.

this deficiency in his "clinical" versus "forensic" or med-legal practice:

> MR. PARRY: Sure. So, in fact, I want to clarify the difference between clinical and forensic because I may not have the same understanding you do. The way I understand it, clinical work is where you are actually providing treatment to patients, is that right?
>
> DR. ECTOFF: Or evaluations for patients. Where there is a doctor-patient relationship, confidentiality, the privilege is theirs, yes.
>
> MR. PARRY: And the forensic work would be more like in this case *where you're hired not by the patient*, but you still do an evaluation but there's **not this doctor-patient relationship?**
>
> DR. ECTOFF: Yes.[5]
>
> MR. BENSON: And what kind of practice do you primarily run? I know you've been hired as an expert in this case, but what do you primarily do?
>
> DR. ECTOFF: I do two different types of practices: a clinical practice and forensic practice...And now I've sort of really cut back on the clinical and see fewer clinical cases. The other part of my practice is doing these types of evaluations for plaintiff or defense attorneys, essentially just in the area of personal injury, to see whether someone has emotional or cognitive changes as a result of an accident or incident.
>
> MR. BENSON: Fair enough. Just for the record, forensic in your view means what?
>
> DR. ECTOFF: Working as a consultant or an expert for an insurance company or **an attorney who retains me to take a look at a case they have**.[6]

A doctor-patient relationship is a special relationship, characterized with "trust, knowledge, regard and loyalty."[7] The doctor-patient "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."[8] The absence of a doctor-patient relationship or a

---

[5] *See* Deposition transcript of Lewis M. Etcoff, Ph.D, ABN dated June 23, 2015 in the matter of *Fernandez v. Mitiku Tamiru Weldegiorgis, et al* at 14:1–12, as Exhibit 1.

[6] *See* Deposition transcript of Lewis M. Etcoff, Ph.D, ABN dated August 25, 2014 in the matter of *Miller v. Sisolak, et al* at 5:4–6:6, as Exhibit 2.

[7] Chipidz, Fallon E., Rachel S. Wallwork, and Theodore A. Stern. "Impact of the Doctor-Patient Relationship." Prim Care Companion CNS Disord 15, no. 5 (October 22, 2015), as Exhibit 3.

[8] Gold, Susan Dorr. "The Doctor–Patient Relationship Challenges, Opportunities, and Strategies." J. Gen Intern Med. 14, no. 1 (January 1999): 26–33, as Exhibit 4.

flawed one can alter patient health outcomes.[9]

Dr. Ectoff is *hired* by the Defense to undermine diagnoses—to the point he confesses there is no doctor-patient relationship in his "forensic" or med-legal practices. Dr. Etcoff admits he *always* assumes plaintiffs are malingering or exaggerating their injuries.[10] That is not often physician-based thinking; however, it is defense-attorney philosophy. If Dr. Etcoff and Josh do not have a doctor-patient relationship, Dr. Etcoff will evaluate Josh presuming he is a malingerer, and the Defense is *literally paying* Dr. Etcoff to support their case—the Rule 35 examination is **adversarial**. Good cause exists to protect Josh from this adversarial process, with an audio recording and observer present.

B. Defendants' *Flack v. Nutribullet* arguments are irrelevant since Josh is not disputing good cause exists for a Rule 35 Examination. But, if they intended to analyze "good cause" for an observer and audio recording, Josh meets the requirements set forth therein.

A California District Court case, *Flack v. Nurtibullet, LLC*, offers factors for determining if good cause exists for a Rule 35 Examination: "for example a plaintiff who 'asserts mental or physical injury…places that mental or physical injury clearly in controversy and provides the defendants with **good cause for an examination** to determine the *existence* of such asserted injury." Note, Josh is *not* disputing good cause exists for a psychological Rule 35 Examination. He has already agreed to such on multiple occasions, and Defendants even acknowledge as much: "the parties agree an NRCP 35 psychological

[9] Exhibit 3.

[10] *See* Deposition transcript of Lewis M. Etcoff, Ph.D, ABN dated September 25, 2010 in the matter of *Centeno-Alvarez v. Coe, et al* at 9:9–12:21, as Exhibit 5.

examination is in order based on Plaintiff's alleged damages."[11]

It is perplexing why Defendants would even include the *Flack* factors, unless they are establishing these factors as parameters for establishing good cause for an audio recording and observer for Josh's psychological Rule 35 exam. Because this seems to be the only logical explanation for mentioning *Flack* (and because their motion follows the *Flack* argument by mentioning *Freteluco*[12]), Plaintiff maintains he can meet the good cause standards set forth in *Flack*: (1) the possibility of obtaining desired information by other means (2) whether plaintiff plans to prove [their] claim through testimony of expert witnesses (3) whether the desired materials are relevant and (4) whether plaintiff claims ongoing emotional distress.[13]

1. An audio recording and observer are the only means to obtain actual data for Josh's Defense Medical Examination.

While Defendants may argue Josh will obtain information regarding Dr. Etcoff's examination in his expert report, the absence of doctor-patient relationship and Dr. Ectoff's defense-driven tactics raise serious concern regarding the objectivity of his findings.

This concept was explored with Dr. Etcoff's colleague, Derek Duke, MD. In 2015, a defense counsel hired Dr. Duke for a Defense Medical Examination of a plaintiff. When plaintiff's counsel opposed the request, this Court ultimately got involved and determined Dr. Duke was *not* objective, as most of his reports concluded similar theories about plaintiffs malingering[14] More importantly to this case, then-commissioner Bonnie Bulla expressed her deep concerns

[11] *See* Defs. Mot. for Reconsideration at 8:20–21.

[12] *Id.* at 8:22–28: "In Freteluco, Plaintiff failed to meet her burden. 336 F.R.D. at 203. The Court determined there was nothing extraordinary or out of the ordinary that suggested a third-party observer was appropriate…"

[13] *Flack v. Nutribullet, L.L.C.*, 333 F.R.D. 508 (C.D. Cal. 2019).

[14] *See* Recorder's transcript of proceedings dated April 3, 2015 at 12:17–16:16, as Exhibit 6.

regarding the defense using Rule 35 examinations as litigation bullying:[15]

> COMMISSIONER BULLA: The issue is whether or not there's bias or prejudice, and these are -- and I will tell you this is what I looked at. I looked at whether or not in that report, somewhere in that report, there was an indication of secondary gain. That's one thing I looked for. And then the next thing I looked for is whether or not there was some suggestion that the Plaintiff had some psychological issue or psychiatric explanation for the injures, and the reason I looked at those things in particular, and, again, is because that's what I would consider to be inflammatory under the Federal Court case, and this is why -- because what -- and to Dr. Duke's credit, many times, not every time, but many times he says it could conscious or subconscious, but that's not really -- it's not about the person being examined. It's about his point of view. It's what he's looking for because we're trying to figure out what his objectivity is.
>
> So it is no wonder that on Rule 35 exams you see the same defense examiners over and over and over again. You know, when I get the time, maybe I'll rewrite Rule 35. I think it is being used as a litigation tool and it's not being used for the purpose it is supposed to be, which is really trying to figure out if something's wrong with the Plaintiff and what's related and what is unrelated, and right now, it's just -- it's a tool. It's no more than litigation bullying is what it is, with all due respect to my defense friends out there. That's what it is. **It's using a rule to bully in litigation** and, frankly, I don't think Dr. Duke deserves to used that way or any other physicians, and I think it's the Bar's responsibility to get hold of the Rule and figure out how it should be used because, frankly, it's very distressing to me.

This Discovery Commissioner's hearing eventually led to a hearing before the Honorable Judge Timothy Williams. There, this Court revealed Dr. Duke "disagrees with the treating doctor approximately 95% of the time," "finds symptom magnification to be a factor in approximately 108 cases or 29% of the time," "finds pending litigation to be a factor in approximately 178 cases or 48% of the time," and "suggests the patient is not being truthful or giving inconsistent information in 149 cases or 40% of the time."[16] Judge Williams ultimately found Dr. Duke has "a history of personal bias as to some treating physicians and extreme bias resulting in prejudice against personal injury plaintiffs."[17]

---

[15] *Id.* at 10:12–11:10.

[16] *See* Amended Findings of Fact and Conclusions of Law in Support of Order Precluding Derek Duke, MD from Conducting a Rule 35 Examination at 7:18–8:12, as Exhibit 7.

[17] *Id.* at 34:27–28:1.

Additionally, Dr. Duke was recorded giving questionable (at best) medical advice to a plaintiff during a Rule 35 Examination. The plaintiff, Mr. Ribera, recorded Dr. Duke without his knowledge. Again, this is a plaintiff—so **no doctor-patient relationship exists** between Dr. Duke and Mr. Ribera; Dr. Duke unequivocally should *not* be giving medical advice at all during Rule 35 Examinations, but what he is recorded saying is *disturbing*. Dr. Duke is heard essentially telling Mr. Ribera that is uncommon for car crash victims to require back surgery—even if they got hit at 60 mph.[18] Dr. Duke asked Mr. Ribera improper liability questions, including "has anyone told you that any of the imaging studies shows evidence of injury to -- from the car wreck?"[19] Dr. Duke also criticizes Mr. Ribera's treating physician, Dr. Erkulwater, and advises Mr. Ribera stop taking his pain medication cold turkey:[20]

> DR. DUKE: And -- and pretty much use of long-term, high-dose, you know, morphine, it's just been completely abandoned. And it's shocking that -- that you're being managed that way because I can -- I would bet any amount of money that no matter what is done, you will not get better as long as you have the drugs onboard.
>
> MR. RIBERA: So what's the plan of attack? I mean what would you do with me?
>
> DR. DUKE: You get rid of the drugs first, and then, you get through that. And you know, on opiates for four years, that's a major problem, 'cause your body gets used to it. You get addicted to it so sometimes you have to see an addiction specialist.
>
> MR. RIBERA: Really? I bet I could quit tomorrow.
>
> DR. DUKE: Boy, I tell you, that would be the best thing you ever did.
>
> MR. RIBERA: I -- I would just be in pain, that would be the part that sucks.
>
> DR. DUKE: So I would -- before I committed myself to having my back sliced open again, that's -- that's the route I would go.
>
> MR. RIBERA: Okay.

---

[18] *See* Transcript of Mr. Ribera's Rule 35 Examination with Derek Duke, MD at 29:1–30:3, as Exhibit 8.

[19] *Id.* at 27:1–7.

[20] *Id.* at 19:18–21:15.

DR. DUKE: You know, **that's my advice.**

Finally, Dr. Duke—who is not a lawyer—tells Mr. Ribera his case has "many red flags" and that "litigating is going to be very, very difficult."[21] He then snidely remarks he hopes Mr. Ribera has medical insurance to cover future treatment, presumably because Dr. Duke believes Mr. Ribera will lose his lawsuit.[22] This disconcerting transcript shed light on the specific need for Nevada plaintiffs to record their Rule 35 Examinations.

Josh recognizes Dr. Duke is not Etcoff, but the parallels between them are apparent. Dr. Etcoff, like Dr. Duke, is a popular Defense Rule 35 examiner. Dr. Etcoff estimates his forensic practice is "90 percent for defense, 10 percent for plaintiffs."[23] This estimate is a *bit* off. A review of Dr. Ectoff's testimony history provided by Ferrellgas in their initial expert disclosures shows Dr. Ectoff has been retained by defense firms 32 out of 33 cases in which he testified over the last 5 years—equating to 97% of the time. Plaintiff's counsel is also aware of several instances of Dr. Etcoff citing secondary gain, untruthfulness, or malingering in his reports:

Regarding her behavior during this evaluation, unlike adults malingering a Pain Disorder, [redacted] did not behave as if she was experiencing significant physical discomfort. Rather, she appeared comfortable; but, when questioned directly about how much pain she was experiencing, she answered that she was in moderate to severe pain in several sites. Her depiction of being in much more pain than she appeared is consistent with behavior typical of adults who have a Pain Disorder Associated with Both Psychological Factors and a General Medical Condition. Also consistent were her brittle and labile emotions, moodiness and irritability. The only topics of conversation that caused [redacted] to appear depressed were her son's heroin addiction, her marital relationship, and the affair that her husband and sister had. Otherwise, even when she spoke about the subject accident and her subsequent medical treatments, she seemed euthymic in mood.

There were numerous instances that, in my professional opinion, [redacted] purposely did not tell me the truth by omitting pertinent case-related information, e.g., claiming not to remember medical tests and doctors' visits that were pain-symptom driven prior to the subject accident in 2003-2005. She twice misinformed me that prior to the subject accident she had never had a chronic pain condition, musculoskeletal or otherwise. She denied having had previous medical treatment for chronic neck, upper back, lower back, and right shoulder pain complaints. She misinformed me that she couldn't remember getting shoulder x-rays and MRIs of the cervical and lumbar spine for significant pre-subject accident pain complaints. She told me that she didn't recall the EMG/NCVs provided by John Schaeffer, M.D., the neurologist she claimed she couldn't recall ever seeing. All of these answers were, in my professional opinion, disingenuous and typical of the answers that people who are malingering tend to give to examining doctors.

[21] *Id.* at 21:17–22:18.
[22] *Id.* at 22:12–13.
[23] Exhibit 1 at 5:15–20.

> **POST SUBJECT ACCIDENT CONDITIONS:** Regarding her subject accident physical injury claims, two things impress me as a psychologist. First, with the passing of time and despite excellent medical treatment, she has developed ever-worsening and serious physical disabilities to the point of being almost an invalid. Equally impressive is how she appears emotionally well adjusted, interpersonally outgoing, and euthymic in mood. It is not normal for a person who appears nearly blind and has lost use of her right upper extremity to be vivacious, upbeat, and ebullient.
>
> rape. [redacted]'s denial of any pre-subject accident depressive incidents suggests that she is either consciously or unconsciously embellishing the psychological injuries she claims are subject accident related.

It is highly unlikely *every* plaintiff Dr. Etcoff examines is exaggerating their condition. Because of the implicated bias, an audio recording and observer are the only objective means of obtaining data from Josh's Defense Medical Examination.

This factor weighs in favor of good cause.

2. Josh intends to support his case with expert witness testimony.

Josh identified Michael Elliott, Ph.D of as his treating physician.[24] Dr. Elliott is expected to testify regarding his opinions on Josh's treatment, the authenticity of his records, the necessity of the treatment and the causation of necessary treatment.[25] Dr. Elliott will further testify about the cost of Josh's psychological treatment, the cost of any future treatment recommended, and if this treatment is standard and customary within the psychological field.[26]

Because Josh intends to introduce this testimony at trial, this factor weighs in favor of good cause.

3. Whether the desired materials are relevant.

Josh intends to introduce this evidence for impeachment materials, if necessary. Per NRS 48.015, relevant evidence is "evidence having *any* tendency to make the existence of any fact that is of consequence to the determination

[24] *See* Plaintiff, Joshua Green's Initial Expert Disclosures (attachments omitted to reduce length of pleading) at 34:16–19, as Exhibit 9.
[25] *Id.* at 33:18–22.
[26] *Id.* at 33:22–26.

of the action more or less probable than it would be without the evidence."[27] Impeachment evidence is permitted to question the credibility of a witness, specifically related to "truthfulness or untruthfulness."[28]

An audio recording and observer of Josh's Defense Medical are entirely relevant to this matter. The audio recording and observer's notes will be compared to Dr. Etcoff's report to determine if he is accurately recording his findings. While Plaintiff's counsel does not intend to take the position that Dr. Etcoff is deceitful, the bias discussed at length above establishes concern for the objectivity of his reports.

Specifically, if Dr. Etcoff reports Josh is exaggerating his psychological symptoms, has significant pre-existing psychological or mental ailments (despite no evidence to support this contention), or has secondary gain, Plaintiff's counsel will cross reference these opinions with the audio recording.

4. Whether plaintiff claims ongoing emotional distress.

Because of the explosion, Josh has become "fearful of using propane."[29] He experiences flashbacks to the event[30] and has become socially withdrawn.[31] While therapy has helped a bit, Josh still suffers from anxiety.[32] He intends to claim ongoing emotional distress.

This factor weighs in favor of good cause.

[27] NRS § 48.015.
[28] NRS § 50.085(a).
[29] *See* Deposition transcript of Plaintiff, Joshua Green Vol II at 298:13–20, as Exhibit 10.
[30] *Id.*
[31] *Id.* at 299:16–24.
[32] *See* Medical records from Michael Elliott, Ph.D at GREEN 1552, as Exhibit 11.

C. Defendants propose good cause for an audio recording and observer cannot exist during a psychological Rule 35 Examination because such is intrusive, and that argument fails.

Defendants rely on *Schlagenhauf*,[33] *Flack,*[34] *Gavin*,[35] and *Franco*[36] to suggest an audio recording and observer violate the "good cause requirement."[37] Again, these cases primarily explore the good cause requirement to conduct a Rule 35 Examination—not necessarily the good cause for an audio recording and observer. Yet, *Schlagenhauf* does offer a few relevant definitions of "good cause," including "sufficiently established," "what may be good cause for one type of examination may not be so for another," "showing may be made by affidavits or other usual methods," and may be established on "the pleadings alone."[38] Essentially, *Schlagenhauf*, says courts recognize good cause when they see or hear it. Despite Defendants' contention Josh failed to file relevant evidence to constitute good cause,[39] this Court did just as *Schlagenhauf* suggests—it recognized good cause for an audio recording and observer.

What is incoherent, however, is Defendants' following argument that an audio recording and observer nullify the truth:[40]

> The Rules of Civil Procedure are designed to be tools to elicit the truth. To routinely require the presence of an observer and an audio recording during an adverse psychological/neuropsychological examination would thrust the adversary process itself into the psychologist's examining room, which would only institutionalize discovery abuse, covert adverse medical examiners into advocates, and shift the forum of controversy from the courtroom to the physician's examination room.

Rule 35 Examination's are inherently adversarial. They permit a **defense-**

---

[33] *Schlagenhauf v. Holder*, 379 U.S. 104, 85 S. Ct. 234 (1964).
[34] *Flack v. Nutribullet, L.L.C.*, 333 F.R.D. 508 (C.D. Cal. 2019).
[35] *Gavin v. Hilton Worldwide Inc.*, 291 F.R.D. 161 (N.D. Cal. 2013).
[36] *Franco v. Bos. Sci. Corp.*, No. 05-cv-1774 RS, 2006 U.S. Dist. LEXIS 81425 (N.D. Cal. Oct. 27, 2006).
[37] *See* Defs. Mot. for Reconsideration at 11:3–46.
[38] *Schlagenhauf v. Holder*, 379 U.S. 104, 85 S. Ct. 234 (1964).
[39] *See* Defs. Mot. for Reconsideration at 11:12–13.
[40] *Id.* at 11:19–24.

paid doctor to rebuke a plaintiff's symptomology and in Dr. Etcoff's own words "to take a look at whether someone is exaggerating."[41] Courts recognize this *very* real problem. A Florida court ruled Rule 35 exams are less like a "medical patient seeing [their] doctor" and "more akin to a litigant attending a deposition."[42] Former Discovery Commissioner Bulla stated Rule 35 is "not being used for the purpose it is supposed to be, which is really trying to figure out if something's wrong with the Plaintiff and what's related and what's not."[43] She further opined, "it's a tool. It's not more than a -- it's litigation bulling is what it is."[44]

This is precisely why Defendants' argument that an audio recording and an observer "thrust[s] the adversary process itself into the psychologist's examining room" fails. A Rule 35 Examination already is an adversary process, and *everyone* involved with Rule 35 is aware of this. Defense attorneys know they get their pick of an examiner; Doctors examining plaintiffs know the defense is writing their check; Plaintiffs being examined know they are being forced to see a doctor the adverse party hired, etc. Defendants have not established any further proof how an audio recording and observer make this process "more adversarial." In fact, an audio recording and observer are the only objective evidence that may even exist regarding Rule 35 Examinations. They provide a completely unbiased representation of what occurred during the examination.

D. Josh did not waive his good cause argument.

Josh acknowledges his original argument before Commissioner Truman

[41] Exhibit 5 at 8:22–9:2.
[42] *Davanzo v. Carnival Cruise Lines*, 2014 U.S. Dist. LEXIS 49061, 2014 AMC 1361, 2014 WL 1385729.
[43] Exhibit 6 at 11:1–10.
[44] *Id.*

focused on his statutory right to audio record and have an observer present during the Defense Medical Examination. Josh maintains he does have the **substantive** right to do so per NRS 52.380.

But Defendants are misplaced with their reliance on *Achrem*[45] to claim Josh could not make a good cause argument before this Court during January 26th's hearing on Defendants' Objection to Discovery Commissioner's Report and Recommendations. *Achrem* establishes "points or contentions not raised in the original hearing cannot be maintained or considered on rehearing." This refers to a "motion for reconsideration."[46] Specifically, judges should not consider evidence that is not properly submitted **before the district court** reaches a decision."[47]

As Defendants are likely aware, Commissioner Truman is *not* a District Court judge. Her recommendations are not orders; her decisions are not final until they are affirmed and adopted by the district court. Josh was well within his purview to make good cause arguments before Judge Kishner on January 26th.

E. Audio recording and an observer are used in psychotherapy sessions provided the examinee consents; so, Dr. Etcoff's refusal to audio record and allow an observer should have no bearing on Josh's statutory right to do so.

Defendants' claim requiring an audio recording and observer during Josh's psychological Rule 35 Examination violates the rules and ethics of Dr. Etcoff's profession. [48] Defendants further contend psychologists are barred from allowing third party observers to observe, take notes, or audiotape

[45] *Edward J. Achrem, Chtd. v. Expressway Plaza Ltd. Pshp.*, 112 Nev. 737, 917 P.2d 447 (1996).
[46] *Id.*
[47] *Id.*
[48] *See* Defs. Mot. for Reconsideration at 14:14–17.

copyrighted psychological and neuropsychological tests.[49] Finally, Defendants argue neither Dr. Etcoff nor any other licensed psychologist will allow "third party observers or audiotaping."[50] If Dr. Etcoff wants to make the conscious decision to restrict audio recording and observers at his own practice, that is his prerogative. The contention it is unethical or prohibited, is simply not true.

Audio recorders are widely used in psychology and psychiatry. The **American Psychological Association** published a study in 2016 regarding patient-comfort and outcomes in audio and videorecorded psychological examinations.[51] The APA study utilized 390 patients with varying diagnoses including mood disorder, anxiety disorder, [52] and substance-related disorder. [53] After a brief symptom inventory, the patients were asked to consent to audio and video recording of psychotherapy sessions. The APA determined 71% of patients were willing to consider audio or video recording after a discussion with their clinician.[54] Further, the APA established "most patients report feeling relatively comfortable with audio or video recording…in the context of appropriate safeguards for confidentiality" and patients that refused recording "were not significantly more likely to refuse treatment."[55]

The results of this APA study are promising; but what is relevant to the instant matter—and personal injury litigants as a whole—is the APA's assertion of the following:[56]

More recently, audio or video recordings have been used. Audio and video

---

[49] *Id.* at 14:19–24.
[50] *Id.* at 14:25-26.
[51] Brigge, Alexis M., Mark J. Hilsenroth, Francine Conway, Christopher Muran, and Jonathan M. Jackson. "Patient Comfort With Audio or Video Recording of Their Psychotherapy Sessions: Relation to Symptomatology, Treatment Refusal, Duration, and Outcome." Professional Psychology: Research and Practice 47, no. 1 (2016): 66–76, as Exhibit 12.
[52] Joshua Green's primary diagnosis is anxiety disorder. *See* Exhibit 11.
[53] Exhibit 12.
[54] Exhibit 12.
[55] *Id.*
[56] *Id.*

> recording have provided a partial solution for the desire for an **objective record** of the psychotherapy process in that they provide permanent, *undistorted*, **unbiased** accounts of therapy sessions. Recording allows therapists to focus entirely on the patient and remain fully present in the room without waving to worry about taking notes or memorizing the interaction. It also eliminates concerns about the unreliability of memory, perception, and thought, that are inevitable when obtaining data from human memory.

Because there is *plenty* evidence to support audio recording psychotherapy sessions, it is peculiar Dr. Etcoff would take such a hard and fast position on refusing audio recording and an observer present. The law in Nevada is clear: recording of in-person oral communication is allowed with the consent of at least one party.[57] Especially because the individual possessing the privilege of confidentiality, Josh, has waived such.

F. Audio recording and observer during the Rule 35 do not create an unfair advantage to Defendants—it provides a safeguard to Josh.

Defendants' final argument claims they are irreparably and unfairly prejudiced if this Court orders an audio recording and observer present during Josh's Rule 35 Examination. To suggest such completely disregards the prejudice Josh faces in being forced into a Defense Medical Examination in the first place. A doctor—that is literally paid by the individuals Josh is suing—will examine him under the pretense he is not injured. That doctor will then prepare a report, which will likely state Josh is a malingerer, has pre-existing symptoms, has secondary gain, etc. That is the very definition of prejudicial evidence.

If Dr. Etcoff's examination is "on the up and up," there should be nothing to hide nor *any* prejudice to Defendants; allowing an audio recording and observer protects injury victims in all civil cases where a medical examination

[57] NRS 200.620; NRS 200.650; Lane v. Allstate Ins. Co. 114 Nev. 1175 (1998).

is ordered,[58] including cases of battery, negligence, sexual violence, and among other traumas. These victims experience physical and psychological trauma from their experiences and risk revictimization during an exam performed by the hired agent of the victimizer. Regardless of the specific intent of the examiner, the risk of revictimization is a genuine risk to the injured person. The substantive protections under the statute protect the injured victim and apply to all mental and physical examinations ordered by a court during civil litigation.[59] The audio recording and observer will simply act as a safeguard to ensure Josh is treated fairly during the Rule 35 process.

G. Rule 35 and NRS 52.380 can be read harmoniously creating the ability for this Court to interpret NRS 52.380 so that it does not violate the separation of powers doctrine.

NRS 52.380 and NRCP 35 can be read harmoniously as they serve entirely different functions.[60] Rule 35 is a procedurally focused on the process of collecting evidence through medical examinations and the preservation of that evidence through recordings and observers when deemed appropriate by the district court.[61] NRS 52.380 is focused on the substantive protections of the interests of injured victims by use of an advocate that is not and cannot be appointed under Rule 35.

Although both the Rule and the Statue use the term "observer," a plain text reading shows that the Rule's "observer" and the Statute's "observer" do not have the same defined roles. And each role as defined by the Rule and the

---

[58] See NRS 52.380(7), (applying to all civil cases in which a physical or mental examination is ordered by the court).

[59] NRS 52.380(7).

[60] *Goldberg v. Eighth Judicial Dist. Court In & For Clark Cty.*, 93 Nev. 614, 617, 572 P.2d 521, 523 (1977) (the judiciary and the legislature can have overlapping functions, provided that each branch can trace it actions to a basic source of power.)

[61] NRCP 35.

Statute cannot be occupied by the same person at the same time. Each "observer" role can exist independently of the other. The Rule does not prohibit the existence of the statutory observer/advocate. The Statute does not prohibit the existence of the rule-based observer/witness.

1. "Observers" under Rule 35 act procedurally; focused on the collection and preservation of evidence process.

In 2019, Rule 35 was amended to include Subsections (a)(3) and (a)(4), dealing with court-ordered recordings and court-appointed observers.[62] By their text, Rule 35(a)(3) and (4) refer to "conditions" set by the court, and thus are reflective of the "conditions" requirement in Rule 35(a)(2).[63] Subsections (a)(3) and (a)(4) set the boundaries and limitations of a court's "conditions" under Rule 35(a)(2)(B).[64]

Under Rule 35(a)(3), the district court may order a recording as a condition of the exam.[65] If the district court orders a recording as a Rule 35(a)(2)(B) condition, the requesting party "must arrange and pay for the recording[,]"[66] The recording has obvious evidentiary value if a dispute arises as to what occurred during the exam.

2. NRS 52.380 is a statute that focuses on the substantive protection of the rights of injury victims and not the procedural collection of evidence.

The law in Nevada is clear: recording of in-person oral communication is allowed with the consent of at least one party.[67] NRS 52.380 protects this

[62] *Compare* NRCP 35 (2019) to any prior version.
[63] *See* NRCP 35(a)(3), NRCP 35(a)(4).
[64] *See* NRCP 35(a).
[65] *See* NRCP 35(a)(3).
[66] *See* id.
[67] NRS 200.620; NRS 200.650; *Lane v. Allstate Ins. Co*. 114 Nev. 1175 (1998).

substantive right in the context of civil litigation.

NRS 52.380 has a wholly different purpose than NRCP 35 and, as such, provides different substantive protections than the evidentiary protections in NRCP 35. NRS 52.380 is drafted and designed to provide protections to injury victims who are ordered to be examined by the representative of the injuring party.[68] The statute protects injury victims in all civil cases where a medical examination is ordered,[69] including cases of battery, negligence, sexual violence, cyber bullying, and mental and physical abuse, among other trauma. These victims experience physical and psychological trauma from their experiences and risk revictimization during an exam performed by the hired agent of the victimizer. Regardless of the specific intent of the examiner, the risk of revictimization is a genuine risk to the injured person. The substantive protections under the statute protect the injured victim and apply to all mental and physical examinations ordered by a court during the course of civil litigation.[70]

The statutory observer has three characteristics or powers that are unique to the statute. First, the statutory observer may be the attorney or a representative of the attorney.[71] Second, the statutory observer acts as the victim's advocate. The statutory observer may not participate or interfere with the exam generally, but has the express authority to suspend the exam to obtain a protective order if the examiner becomes abusive or exceeds the

---

[68] See e.g. *Zabkowicz v. West Bend Co*., 585 F. Supp. 635, 636 (E.D. Wis. 1984) ("[T]he defendants' expert is being engaged to advance the interests of the defendants; clearly, the doctor cannot be considered a neutral in the case."); see also (3 Def. App. 928-929). (The president of the Association of Defense Counsel of Nevada during the March 27, 2019 Assembly Judiciary Committee Meeting confirming Assemblyman Edwards' question that the Rule 35 examining "doctor is actually serving as a representative of the defendant").

[69] *See* NRS 52.380(7), (applying to all civil cases in which a physical or mental examination is ordered by the court).

[70] NRS 52.380(7).

[71] NRS 52.380(2).

scope of the examination.[72] Third, the statutory observer may make an audio or stenographic recording of the examination, thus providing the examinee the right to record what happens to his or her own person.[73] The powers and characteristics of the statutory observer are focused, not on the collection and preservation of evidence, but on the protection of the examinee.

3. NRS 52.380 and Rule 35 can be read in harmony in favor of the constitutionality of NRS 52.380.

The Nevada Supreme Court has repeatedly held that it will take every presumption in favor of the constitutionality of a statute and make every attempt to interpret a statute so that it does not conflict with the constitution.[74] Moreover, as the Nevada Supreme Court stated in 1991, "this court should avoid construing one of its rules of procedure and a statute in a manner which creates a conflict or inconsistency between them."[75]

The Nevada Supreme Court can harmonize the "good cause" requirement of NRCP 35 with permissions established in NRS 52.380 since the "good cause" requirement only applies where the recording will be used as evidentiary support for a claim or defense. If no "good cause" is found by the Court, the NRS 52.380 recording would then be used for cross examination and impeachment material in deposition or at trial.[76]

NRS 52.380 and Rule 35 can further be harmonized since, the Rule 35 witness is appointed by the court as an NRCP 35(a)(2) condition, and the NRS

---

[72] NRS 52.380(4).

[73] NRS 52.380(3).

[74] E.g. *List*, 99 Nev. at 138; *Mangarella v. State*, 117 Nev. 130, 135, 17 P.3d 989, 992 (2001) ([w]henever possible, we must interpret statutes to avoid conflicts with the federal or state constitution").

[75] *Bowyer v. Taack*, 817 P.2d 1176 (1991).

[76] NRS 50.085(3) permitting impeachment of a witness on cross-examination with questions about specific acts as long as the impeachment pertains to truthfulness or untruthfulness.

52.380 advocate appointed by the examinee or her attorney are two wholly separate people with two different roles. A plain reading of the text of Rule 35 and NRS 52.380 demonstrate that the Rule 35 witness and the statutory advocate cannot be the same person at the same time.[77]

The Rule 35 witness must be appointed by the court[78] where the statutory advocate is appointed be the examinee or her attorney.[79] The Rule 35 witness cannot be the attorney or the attorney's agent[80] where the statutory advocate expressly can be the attorney or the attorney's appointee.[81] The Rule 35 witness expressly cannot interfere with, participate in or interrupt the exam in any way.[82] The Rule 35 witness is merely an observing witness and cannot be anything more.[83]

The NRS 52.380 advocate is expressly endowed with authority to suspend the exam if the examiner is abusive or exceeds the scope of the examination.[84] The NRS 52.380 advocate is expressly empowered to represent and protect the interests of the injury victim.[85] The NRS 52.380 advocate is empowered to make an audio or stenographic recording of the exam where it is not clear that Rule 35 intends the Rule 35(a)(4) witness to make any recording.[86]

Nothing in Rule 35 prohibits an NRS 52.380 victim's advocate. Nothing in NRS 52.380 prohibits the Court from appointing a Rule 35(a)(4) witness or ordering a Rule 35(a)(3) recording. The Rule and the Statute can operate harmoniously without conflict. As such, the separation of powers doctrine is

---

[77] *In re 12067 Oakland Hills, Las Vegas, Nevada 89141*, 134 Nev. 799, 801, 435 P.3d 672, 675 (Nev. App. 2018) ("As always, the proper place to begin is with the plain text of the relevant statute.").
[78] *See* NRCP 35(a)(4).
[79] *See* NRS 52.380(1) and (2).
[80] *See* NRCP 35(a)(4)
[81] *See* NRS 52.380(2).
[82] *See* NRCP 35(a)(4)(C).
[83] *See* NRCP 35(a)(4).
[84] NRS 52.380(4).
[85] *See* NRS 52.380.
[86] *Compare* NRS 52.380(3) to NRCP 35(a).

not implicated.

III.

Conclusion

Based on the foregoing, Plaintiff respectfully requests this Court deny Defendants' Motion for Reconsideration of 3/2/2021 Order.

DATED this 9th day of April 2021.

H & P LAW

Marjorie Hauf, Esq.
Nevada Bar No.: 8111
Matthew G. Pfau, Esq.
Nevada Bar No.: 11439

Attorneys for Plaintiff,
Joshua Green

H&P LAW

Certificate of Service

I hereby certify that on the 9th day of April 2021, service of the foregoing **Plaintiff, Joshua Green's Opposition to Defendants' Motion for Reconsideration of 3/2/2021 Order** was made by required electronic service to the following individuals:

Felicia Galati, Esq.
Nevada Bar No.: 007341
OLSON, CANNON, GORMLEY, ANGULO & STROBERSKI
9950 West Cheyenne Avenue
Las Vegas, Nevada 89129
T: 702-384-4012; and
Michael McMullen, Esq.
BAKER STERCHI COWDEN & RICE
2400 Pershing Road, Suite 500
Kansas City, Missouri 64108
T: 816-474-2121

Attorneys for Defendant,
Ferrellgas, Inc.

Gina Gilbert Winspear, Esq.
Nevada Bar No.: 005552
DENNETT WINSPEAR, LLP
3301 North Buffalo Drive, Suite 195
Las Vegas, Nevada 89129
T: 702-839-1100

Attorney for Defendant,
Carl J. Kleisner

James P.C. Silvestri, Esq.
Nevada Bar No.: 3603
Steven M. Goldstein, Esq.
Nevada Bar No.: 006318
PYATT SILVERSTRI
700 Bridger Avenue, Suite 600
Las Vegas, Nevada 89101
Tel: 702-477-0088

Attorneys for Defendant,
Mario S. Gonzalez

An Employee of H & P LAW

EXHIBIT “1”

In The Matter Of:

Maria Fernandez vs.

Mitiku Tamiru Weldegiorgis, et al.

Lewis M. Etcoff, Ph.D., A.B.N.

June 23, 2015

Min-U-Script® with Word Index

DISTRICT COURT

CLARK COUNTY, NEVADA

MARIA FERNANDEZ,

Plaintiff,

vs.

MITIKU TAMIRU WELDEGIORGIS, and individual; GATSKI COMMERCIAL REAL ESTATE SERVICES, a Nevada Corporation; 4001 SOUTH DECATUR BOULEVARD HOLDINGS, LLC, a Maryland Company; KIMCO REALTY CORPORATION, a Maryland Corporation; DOES I-X, inclusive, and ROES I-X, inclusive,

Defendants.

) CASE NO.: A-14-700106-C
) DEPT NO.: VIII

DEPOSITION OF LEWIS M. ETCOFF, Ph.D., A.B.N.
DEFENDANTS' EXPERT PSYCHOLOGIST

Taken on Tuesday, June 23, 2015
At 2:09 p.m.

At 8475 South Eastern Avenue, Suite 205
Las Vegas, Nevada

REPORTED BY: JEAN DAHLBERG, RPR, CCR NO. 759, CSR 11715

APPEARANCES:

For the Plaintiff:

PICKARD PARRY PFAU
BY: ZACHARIAH B. PARRY, ESQ.
10120 South Eastern Avenue, Suite 140
Henderson, Nevada 89052
(702) 910-4300
(702) 910-4303 (Facsimile)
zach@pickardparry.com

For the Defendants:

LAW OFFICES OF KENNETH E. GOATES
BY: KENNETH E. GOATES, ESQ.
3993 Howard Hughes Parkway, Suite 270
Las Vegas, Nevada 89169
(702) 669-5200
(702) 669-5218 (Facsimile)
goatesk@nationwide.com

I N D E X

E X H I B I T S

LAS VEGAS, NEVADA; TUESDAY, JUNE 23, 2015
2:09 P.M.
-oOo-

Whereupon --

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

LEWIS M. ETCOFF, Ph.D., A.B.N.,
having been first duly sworn to testify to the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION

BY MR. PARRY:

Q. Good afternoon, Dr. Etcoff. It's 2:09 p.m. My name is Zack Parry. I represent the plaintiff in this case, Maria Fernandez in this case.

A. Hi. It's nice to meet you.

Q. You too.

I understand you've given many depositions over the course of your career?

A. Yeah.

Q. Are you comfortable dispensing with the admonitions?

Page 5

A. I am.
Q. Very good. You have in front of you what I presume is Maria Fernandez's case file?
A. Correct.
Q. Is that the entire file?
A. Yes.
Q. Is that something we can make a copy of to attach as an exhibit for the court reporter?
A. Yes.
Q. Okay. We can do that at the end, if that would be better for you.
What is your understanding of what happened in this case with the mechanism of the accident that is the subject of this case?
A. I believe that Ms. Fernandez was in her business when a car crashed through the front of her store nearly hitting her and going well into the store, causing some destruction.
Q. Is that an understanding you got from your interview with Ms. Fernandez?
A. Yes, and from other records in the case that I reviewed.
Q. And you've been identified by the defendants as an expert in this case?
A. I believe so.

Page 6

Q. Can you tell me how you were initially contacted and who contacted you?
A. Yes. I believe that Mr. Goates contacted me and -- on or around January 7th, 2015, as you'll see in the section of my notebook, Attorney Work Product.
Q. So was your first contact via correspondence?
A. It was probably on the phone. I didn't speak with him. It was probably my office manager, since I tend not to speak to attorneys when they first call, unless they absolutely insist.
Q. Sure.
A. And then after my office manager I believe explained what the contract is and such, we sent a copy of the contract to Mr. Goates, who wrote that -- you know, signed the contract and gave us records to review.
Q. Sure. And what's the name of your office manager?
A. Donna Callender.
Q. I met Donna.
What is your understanding of what you were asked to do?
A. As in -- well, in this case I was asked to do what you guys call an IME, an Independent Medical Examination. But since I'm not a physician, I call it a Forensic Psychological Examination. And that's essentially what I was asked to do.

Page 7

Q. Perform a psychological evaluation of Ms. Fernandez and then render your opinions with regard to what?
A. With regard to how the subject accident affected her psychologically, and that would be it.
Q. Okay.
A. Of the problems she has today, to what extent are those problems directly caused by the subject accident.
Q. And as a result of this psychological evaluation, you prepared a report; correct?
A. Correct.
Q. And that report is dated February 27th, 2015?
A. It is.
Q. Have you ever worked with Mr. Goates before?
A. I -- we met for about 15 minutes before this, and I don't remember ever meeting him in person. And we both have vague recollections that years ago I may have or did work on a case with him, though neither of us could recall that case.
Q. Do you remember ever talking to me?
A. No. But did I?
Q. Yeah, we have.
A. So that's what my memory's like.

Page 8

Q. Okay, sure. That's fine.
Have you prepared any supplemental reports or addendums to the report that aren't included in that February 27th, 2015 report?
A. I haven't.
Q. Do you have any plan on supplementing that report?
A. I may as of today. Because when we met, I asked Mr. Goates if there were other case materials that I haven't yet received, and he said yes. And I said, Well if you want me to take a look at the other case materials, if that's of importance to the case, send them. And he suggested he would, and then I would be able to write a supplement to the report.
Q. Were you able to identify any of those documents that he says he has that you don't yet have?
A. To the extent I remember, it would be depositions of Ms. Fernandez, Dr. Pineiro, and Dr. Mortillaro, an economist's report, and possibly some medical records from either Dr. Pineiro or a chiropractor that she had seen or told me she had seen for white a while.
Q. Of these items that you've identified that you have not been provided, or that you were not provided prior to preparing your report -- and as I understand,

have yet not been provided -- are there any of those that you think may be necessary towards forming your opinion, or the review of those may change the opinions that you've come up with?

A. I would say the review of those could very well change my opinion. It just depends on what's in those records. And from having read my report, I have some unanswered questions --

Q. Sure.

A. -- about the case. So, yes, my opinions could change, depending upon what's in the records. And more likely than not, especially her evaluation -- her deposition would be important for me to either bolster my opinion or change my opinion.

Q. Did you ask for any of those materials previously?

A. I personally didn't. I may have assumed that if they existed they would be forwarded to me.

Q. In reviewing your report, you make reference to the certain tests and test results, et cetera. As part of your file are the raw -- is the raw data from those tests in your file?

A. Yes.

Q. Other than the documents that you may not have received, what else was discussed with Mr. Goates prior

to us commencing the deposition?

A. We talked about a psychologist with whom he is on the other side of the case, Mr. Goates has, and he asked me familiarity with that psychologist.

Q. Any other discussions that related to the case other than what you've already discussed?

A. No.

Q. Have you seen the expert designation that Mr. Goates prepared to describe and summarize the nature of your testimony?

A. No.

Q. Okay. I'm going to read to you what it says, and I'm going to ask you if you agree with the characterization.

It says, quote, "Dr. Etcoff is expected to testify concerning his review of plaintiff's medical records and his opinion with respect to the nature and extent of the injury, if any, plaintiff sustained in the subject incident, including his opinions with respect to the reasonableness of plaintiff's treatment and prognosis," end quote.

Is that a fair representation of your expertise in this case?

A. Could you state it again? Because I don't want to make a mistake.

Q. Sure. "Dr. Etcoff is expected to testify concerning his review of plaintiff's medical records and his opinion with respect to the nature and extent of the injury, if any, plaintiff sustained in the subject incident, including his opinions with respect to the reasonableness of plaintiff's treatment and prognosis."

A. That may not have been said correctly by Mr. Goates, in the sense I am not a physician and I'm not going to have opinions on her medical condition. I reviewed medical records to help me understand what she was experiencing, but I don't opine on medical conditions unless it's within my area of neuropsychological expertise and we know that a physician has -- a person has a brain injury. Then I feel comfortable saying they have a brain injury.

Q. The distinction between medical injury and psychological injury, is that an easy one to make?

A. It can be.

Q. So in some circumstances, it's very clear this is medical and this is psychological?

A. Yes.

Q. In other circumstances, perhaps the line is blurred?

A. It's like a Venn diagram.

Q. Okay. So I'm going to ask you during the course

of this deposition, if there is an area of questioning that I ask you about that falls outside the scope of your expertise, will you let me know? Or if it's in this gray area, if you wouldn't mind identifying that for me?

A. Okay.

Q. Along that line, if there are medical doctors in this case who render medical opinions, would it be fair to say you would defer to them as far as it relates to their medical opinions?

A. Yes.

Q. Can we stipulate that you'll only be providing opinions regarding psychology and neuropsychology in this case?

A. Well, neuropsychology is irrelevant in this case, since she didn't have a brain injury. So clinical psychology, yes.

Q. Okay, very good. And Maria is not your patient?

A. Correct.

Q. You didn't provide any treatment to her?

A. Correct.

Q. You didn't prescribe her any medications?

A. Couldn't if I wanted to. I'm not licensed. I'm not a physician.

Q. You never consulted with any of her doctors?

Page 13

A. Did not.
Q. And you were never involved in her treatment in any capacity?
A. You're right.
Q. You are a professional expert witness; correct?
A. Am I a professional expert witness? What does that term mean?
Q. Sure. You are an expert witness?
A. Yes. In this case and in others, correct.
Q. Can you estimate how many cases you've been an expert witness in?
A. Hundreds.
Q. And you've been paid for your testimony and your opinions?
A. Yes.
Q. And so my understanding of the word "professional," is someone who engages in a certain activity for money. Is that a fair understanding?
A. Yes.
Q. If I ask if you're a professional expert witness, does that make more sense now?
A. It just has a derogatory sound to it. I do clinical work, I do forensic work and, as a part of my forensic work, at times I have to be an expert witness, and I am.

Page 14

Q. Sure. So, in fact, I want to clarify the difference between clinical and forensic because I may not have the same understanding you do. The way I understand it, clinical work is where you actually are providing treatment to patients; is that right?
A. Or evaluations for patients. Where there is a doctor-patient relationship, confidentiality, the privilege is theirs, yes.
Q. And the forensic work would be more like in this case where you're hired not by the patient, but you still do an evaluation but there's not this doctor-patient relationship?
A. Yes.
Q. Okay. When did you start providing expert testimony?
A. How long ago?
Q. Yes.
A. I would be -- I would have to guess. But it was around the time of the Pep-Con blast.
Q. Sure.
A. '88, '89.
Q. That's an interesting pairing.
A. Isn't it?
Q. Yeah, how we remember things. You know better than I do how that works.

Page 15

A. Well, I was talking about it this weekend with my cycling group -- for some reason, someone brought up something -- oh, they asked where that plant went or something --
Q. Sure.
A. -- so we all talked about it. But that was my first, I think, case when I was brought up as a neuropsychological expert, because one of the people who had been injured had been driving, and a blast knocked him from his driver's seat into the passenger's seat, at which time a rock flew through the window and fractured his skull and he was in terrible shape.
Q. Wow.
A. So that was my introduction to forensic psychology.
Q. Sure.
A. Since then, I used to do and stopped doing family custody evaluations, and I did 100, 150 of those for years for family court; and I also did criminal competency, especially in trial, mostly death penalty litigation, for Mike Pescetta and Phil Kohn, a special end of the public, Mike Cherry.
Q. Sure.
A. And I did that for seven, eight, nine years, and then I decided not to do that anymore. And this is

Page 16

what's left, personal-injury work.
Q. How much of your time would you say is dedicated to forensic as opposed to clinical work?
A. It's literally about 50/50.
Q. How much of the money would you -- would you proportion the money the same way, you make as much in forensic or more?
A. No. I think the money is significantly greater from the forensic, because each forensic case takes a lot longer than each clinical case. So the forensic income is a lot greater.
Q. So how would you apportion that?
A. It's probably, like, 80 percent from forensic and 20 percent from clinical.
Q. Is it fair to say that more often than not you testify for defendants as opposed to plaintiffs?
A. Yes, it's fair to say.
Q. How would you apportion that?
A. I've been asked that many times. It's about 90 percent for defense, 10 percent for plaintiffs.
Q. And as part of your expert report, you provided a curriculum vitae; correct?
A. I did.
Q. So that would have been February. Has that changed, or is there an updated version of your C.V.

Page 17

since February?
A. I -- there may be an article that I was a co-author on that was added, but I can give you the most recent one and you can -- it's not -- the changes are maybe another article.
Q. Whatever happened in the last six months?
A. Exactly. Nothing --
Q. Yeah, if you wouldn't mind providing that to me as well.
A. Okay.
Q. From looking at your C.V. -- and you have provided a list of testimony going back to, I believe 2011 -- it looked like there were -- of the testimony, there were two cases where you testified for plaintiffs and all the rest were defendants; does that sound about right?
A. Yes.
Q. And how much do you earn in a year for your work in the forensic field?
A. I'm -- I would guess around $400,000.
Q. Other than the 15 minutes you've spent with Mr. Goates prior to the deposition, have you spent any time talking to his office personally?
A. No.
Q. How about any of your staff?

Page 18

A. No.
Q. Does your staff bill separately than you do for the work performed on the present case?
A. Yes. I bill the staff -- my staff -- not Donna, the office manager -- but I have two post-docs who work with me, one of whom works predominantly or, at this point, only on legal work, Dr. Karen Kampfer. And the other, Dr. Bethany Schlinger, works with me on clinical cases.
Q. So has -- sorry, Dr. Karen --
A. Kampfer.
Q. -- Kampfer?
A. K-a-m-p-f-e-r.
Q. Has Dr. Kampfer participated or assisted in any way in this case?
A. Yes. In all my cases, I have a copilot, a second person, my associate, sitting here during the interview because I am not perfect. And when I'm trying to take notes and listen and then dictate what I thought someone said, I want someone there who can read what I thought I heard and correct if I didn't hear it correctly, delete, add, edit. So Dr. Kampfer gives me that second, kind of a reliability measure --
Q. Quality control?
A. Quality control. That's the way to put it.

Page 19

And then does -- well, in this case, there was not much -- the testing was just explaining the directions to Ms. Fernandez. But in other -- when you're doing an IQ test or this and that -- she may do some of that and I'll do some other tests.
Q. Sure. You listed a number of publications that you have authored in your C.V. Other than what you might have authored since the C.V. was provided to us, have all your publications been included in there?
A. Well, as I said before, there may be one more publications that was just accepted in a peer-review journal, but I'm not sure since I don't pay a lot of attention to that, like what had happened or when it's coming out. I would have to check.
Q. Okay. And regarding questions of timing, that's fine. But are there -- are there any articles that you have written that you've deliberately chosen not to include in your list of articles?
A. No.
Q. Okay. Do you use the same version of your C.V. in every case that you're hired for in a forensic setting?
A. Of course.
Q. Do you remember a 13-hour continuing education seminar on November 20, 2004, put on by the National

Page 20

Academy of Neuropsychology, where one of the topics discussed was Assessment of Response Bias: Beyond Malingering Tests, put on by Dr. Scott Millis? Do you remember that?
A. I don't, but I could have gone to it.
Q. Okay.
A. It wouldn't have been 13 hours by one person.
Q. No. It was a 13-hour seminary, and he was among one of the presenters.
A. Did I go to it? If it's something on my C.V. --
Q. Well, it's on your C.V.
A. Did I go to it?
Q. No. My question isn't if you went to it. I presume you did because it's on your C.V. The question is if you remember it?
A. I don't.
Q. Okay. Are there certain continuing education requirements that go along with your licensure?
A. Yes. Do you want to know them?
Q. No, I don't. I can look that up if I want. Okay. Have you testified since December 2014?
A. I testified yesterday.
Q. In what case was that?
A. That's how bad my memory is.
Q. Sure.

Page 21

A. I'm sorry. If I can close a file, that's the end of it.

It was -- the plaintiff's name was Reinmann and --

Q. Can you spell that for the court reporter?

A. R-e-i-n-m-a-n-n, a woman -- I forget her first name. And who it's against, I can't even tell you at this point. It was not particularly relevant in my opinion.

Q. Sure. Is that one that you -- was that a deposition testimony or trial testimony?

A. Trial.

Q. Was that one that you had previously provided deposition testimony for?

A. No.

Q. I'm going to assume -- you can correct me if I'm wrong, though -- that the updated version of your C.V. will not have that on there?

A. You are right.

Q. Other than that case, will any case in which you've testified since September 2014 be on the C.V. you provided me?

A. Yes.

Q. And were you representing the plaintiff or the defendant on that case, the Reinmann case?

Page 22

A. I was retained by the defense.

Q. Yeah, I don't know if "represented" is the right word, so --

A. That's why I corrected you.

Q. Sure. All right. I'd like to direct your attention to your report.

Who prepares -- who types out this report?

A. My transcriptionist.

Q. Is that someone on staff, or an independent third party you hire?

A. Independent third party.

Q. So you send them a video -- or an audio tape?

A. An actual cassette tape.

Q. Okay. It's a digital?

A. Really, I'm behind. This is the best I can do.

Q. Sure. All right.

A. I do this, I plug it in, it e-mails to her, and she hears and types it up and gets it back to me the next day.

Q. Is that the entire report is dictated, or just the Findings section?

A. I mean, it depends upon what I dictated. I might have just dictated -- whatever I dictate that day is done the next day -- because she's unbelievable -- and then so this may go through -- I may not -- I

Page 23

rarely, if ever, whether it's clinical or forensic, dictate everything in one day. So I'll do parts and then edit, send the editing back, then do the test results or the diagnostic impressions, the summary. It can be done in several days, over several stages.

Q. So you send an audio file with this transcription and she -- is it a she?

A. She.

Q. -- she sends back some sort of Word document that has the words; it's transcribed?

A. Yes.

Q. And what do you do with that document? Do you hand it here to someone here on staff and they insert it into the report based on the formatting you use?

A. No, that is the report. I mean, what you see is what she did.

Q. Okay.

A. This is me talking to her. And then editing, I or Karen, Dr. Kampfer, would look through before giving it to Mr. Goates, try to catch every typo or incomplete sentence or wording, and this is exactly what the transcriptionist last typed.

Q. So who formats it, the bold-set and underlines and puts spacing between?

A. Well, I tell her the sections, and she puts the

Page 24

bolding in and --

Q. So that's part of what's dictated?

A. Yes. I'll say "Referral Information," and then I'll say blah, blah, blah, "Records Review."

Q. Are you the one who dictates the entire thing, or does Dr. Kampfer dictate some of it?

A. Dr. Kampfer dictates the addendum, which is the Review of Records, and that's typical. In my cases, since I have several cases typically going on at the same time, her job is to get all of the case materials, arrange them chronologically, and dictate a Records Review.

Then I read, edit if it's too long or has too much in there that I don't care about, and then that becomes the addendum of the records that were reviewed. That's from Page 14 on this report.

Q. Sure. And so --

A. And I dictate. The rest of it's me.

Q. So for the first 13 pages in this case, you dictated, and from 14 on, she did?

A. Yes.

Q. So on Page 14, there's a summary of a police report. That would have been Dr. Kampfer?

A. Yes.

Q. Okay. And you review the work she dictated

Page 25

before it goes out as well, or do you just review your section?
A. No, I review everything.
Q. Do you review the original underlying records, or do you just trust her summary of them?
A. I usually trust her summary. Sometimes I want -- I will always review the psychology records; sometimes I'll review the medical records just so I get a better flavor. Sometimes I'll look at the interrogatories or the depositions, so it really depends upon how much time do I have, how many records there are. But in terms of accuracy, she's almost as obsessive-compulsive as I am.
Q. Sure. In this case, did you review the actual medical records?
A. I've read everything.
Q. Okay. So this is not one of those cases where you just trusted her for the summary? You've actually looked at the medical records in this case?
A. Since -- no. I read some of the medical records before she dictated the summary. But in preparation for today, I read everything.
Q. Okay.
A. Just to be clear.
Q. Thank you. Were you aware there was a video of

Page 26

the subject accident?
A. I saw it.
Q. You have reviewed the video?
A. I watched the video, yes.
Q. On your Records Review, I don't see the video listed there. Is that something that you reviewed before you prepared your opinion or since?
A. Before.
Q. Okay. So is that just an oversight that it's not included on there?
A. I guess it was an oversight. I mean, I wasn't hiding that I saw the video. It wasn't -- I should have put it in. But I didn't -- it didn't bear on the opinions I made.
Q. Okay, all right. Is there anything else you reviewed prior to preparing the records that isn't included on the list of your Records Review?
A. No.
Q. Are all of your opinions that you formed from reviewing the records and examining Ms. Fernandez and reviewing her test results, are all those contained in Pages 1 through 13 of your report?
A. Yes.
Q. Are there any additional opinions you have that are not in this report?

Page 27

A. No.
Q. Are there any additional opinions you anticipate forming in testifying to a trial that have not been included in this report?
A. Nothing right now.
Q. Depending on what you see in the other information?
A. Right, exactly.
Q. You agree that Ms. Fernandez suffered from travel anxiety resulting from this subject accident?
A. Yes.
Q. You agree that she suffered from post-traumatic stress disorder as a result from the subject accident?
A. Yes.
Q. You agree that Maria suffered from unspecified depressive disorder as a result of this subject accident?
A. Yes. And for --
Q. With a qualification?
A. With a qualification, there's more going on that meets the eye, but I just don't know what that other stuff is because I don't have enough records. I think -- well, it depends upon the theory of your case.
Q. The theory of my case?
A. Or it depends upon -- well, let me try to put it

Page 28

into words.
She is depressed, I think, and angry -- those are the two big emotions that she showed me -- because -- and she said it so much in words -- that she thought she was pretty much set for life with her doing well at her wireless store or stores.
And then things happened. She had a partner who was dishonest, and she found about it and she said she lost a lot of money and she had taken money out of her IRA. So there were financial difficulties in doing this business independent from the accident that caused some depression --
Q. Uh-huh.
A. -- and stress. Then the accident itself happened and closed the business for a period of time until it was -- the insurance company, I guess, made it whole.
But she didn't go back to work. Whether she didn't go back to work because she had PTSD and couldn't go there, that's possible; or whether there were other reasons, I'm not sure. But certainly after this accident, that was the last day she had her store open.
So her depression is related to this accident to the extent that had the accident not happened, she would still be having this store and not having to go back to

Page 29

work doing something that she thought she didn't have to do for the rest of her life.
Q. Dealing?
A. Dealing cards.
Q. Where did you get the information that the insurance company had fixed everything and it was her choice not to go back to the store?
A. I think she told me that the insurance company made -- she even said she had the damage fixed, and I assumed it was the insurance company that paid for it. And I know she didn't go back to work there because she didn't go back to work there. It never -- I don't know why she didn't sell it or why -- I don't know happened. I want to see her deposition to see if those questions were asked.
Q. Sure. Did you mention anything in your report about the store being repaired and her not going back?
A. I don't recall. I can -- I may have or may not have.
Q. Is that fact significant to any of your opinions?
A. Ummm --
Q. Let me put it a different way.
A. Yes.
Q. Is the truth or falsity of that fact significant

Page 30

in any way in forming your opinions?
A. It doesn't affect my diagnoses. It could affect whether -- if she claims that but for this accident she would still be working at the store and doing well, I'm not sure that's exactly true --
Q. Uh-huh.
A. -- because I want more information and she exaggerates a lot. But it could be relevant to that type of an opinion, but I don't have that opinion. So I didn't make that opinion, and I don't have enough information on which to make an opinion like that.
Q. Okay. You indicated in your report -- this is on Page 9, if you wanted to look at it --
A. Uh-huh.
Q. -- that Ms. Fernandez broke into tears periodically during the evaluation.
A. Yes.
Q. Does that have any significance for you, or your opinions for that matter, at all?
A. I think it helped substantiate that she was depressed and that she was emotionally labile.
Q. What does "labile" mean?
A. It means her emotions changed a lot within a set period of time. She could be neutral, happy, crying and sad, angry; and those emotions came and went depending

Page 31

upon what we talked about.
Q. Is that consistent with depression?
A. Yes. The crying, yes.
Q. What about the -- is it lability? The labileness (sic) --
A. Sure.
Q. -- of her emotions?
A. I mean, it's not a -- you're not going to find it in the DSM-5, but the DSM-5 is not perfect. But people who are depressed in an agitated depression can be labile. And again, just depending upon what you're talking about. If you bring up subjects that remind a person of something that it makes them angry, they become angry, some people.
So it was -- her lability was not unusual. It was not a psychiatric or psychological abnormality. It was her emoting about whatever we were talking about, and that's how she felt about that subject.
Q. Okay. I'm on Page 9 still of your report. The paragraph beginning on November 13th, 2014, do you see that one? 11/13/14?
A. Uh-huh.
Q. The last sentence there reads, "Also, the fact that she was dealing cards at that time and continues dealing cards today (even seven nights in a row) is

Page 32

evidence that the pain complaints she made to Dr. Gamazo in November 2014 were exaggerated and not representative of reality."
Can you explain what you meant by that?
A. What I tried to say -- and as I was reading it over today, I thought, Oh, boy, they're going to ask me about this sentence -- what I was trying to --
Q. So you're saying I'm predictable?
A. You're predictable. I'm predictable. I should have known.
Given the fact that there is overwhelming evidence that she inadvertently, or sometimes inadvertently exaggerates just how terrible her life is, and that she went back to work -- not just working 20, 30, 40 hours. She's working seven nights a week -- it suggests to me that the pain that she complains about to Dr. Gamazo is inconsistent with the number of hours she works, and inconsistent with her complaints to Dr. Pineiro.
Q. Uh-huh.
A. So that's what I was trying to say. Meaning, not represented reality. In reality, she's standing on her feet for hours, seven nights a week, which anybody our age -- my age, her age -- I'm a little older than her -- would find difficult and you'd have an aching

Page 33

back after work, but she's doing it.

If she were in 10/10 level pain that she described to Dr. Mortillaro, she wouldn't be holding a job, she wouldn't be at work.

Q. Is that one of those medical opinions, or is that one of those areas where you have expertise?

A. That's one of those in the middle of the Venn diagram opinions.

Q. All right. Would her experiencing great levels of pain and working seven night in a row, could that just be evidence that she's a tough lady?

A. Yep.

Q. And I notice that you used the word "suggest," when you said that, and I think that more or less that's going to be a running theme here; right? Because psychology -- these psychological batteries of tests, they don't ever do more than suggest a conclusion; is that right?

A. They give you -- yeah, you infer from test batteries what a person is like, given the studies that have been done using that test battery. So it's not two plus two equals four. You get inferences, or you make inferences based upon the test results.

Q. Sure. On the paragraph above that, you note that Dr. Mortillaro concludes that, quote, "'her travel

Page 34

anxiety and PTSD had been greatly reduced,' and as a result, he deemed her ready for discharge from psychotherapeutic treatment."

Now, the fact that here PTSD had been greatly reduced -- and I don't know if I'm parsing words here or not -- but that means that there still were PTSD symptoms; right? It hadn't completely resolved; it had been greatly reduced?

A. That's what it sounds like to me.

Q. Okay. Let's talk about this evaluation that she had done at your office. This was a two-day affair; right? She came in two consecutive days?

A. No.

Q. It was just one day?

A. Correct, one day.

Q. Do you remember the date? Do you have that in front of you?

A. 2/19/15.

Q. So February 19th, 2015, she came in. Do you remember how long she was here?

A. I can't tell you exactly, but it probably started at 9:00 in the morning and ended somewhere between 3:00, 3:30, and 4:00, 4:40.

Q. So it was pretty much all day?

A. Pretty much all day.

Page 35

Q. Is that typically how these psychological evaluations are done?

A. A one-day evaluation, such as when you don't have to do a lot of cognitive testing, one day you can usually get it done. That's oftentimes will -- yes.

Q. Okay. Now, I'm pretty sure she came back the next day. Are you recalling that she didn't, or are you -- let's just before we go down too far, let me make sure you're sure.

A. I can tell you by looking in my calendar. February 19th.

I know what you're talking about. I'm going to guess what you're talking about. One day with her on the 19th, a Thursday, I'm betting that she came in on another day to fill out the MMPI-2. And I can tell you that in a second.

Yes. Two days previous to that in order to save time for the interview, she had come to the office for about an hour and a half to complete one of the personality tests, the MMPI-2.

Q. All right. So she came in on the 17th for an hour and a half or two hours, or however long it took to complete the Minnesota Multiphase Personality Inventory?

A. Yes.

Q. And that was the second one. Two?

Page 36

A. Yes.

Q. And then she came back a couple days later. And I'm presuming, by then not only did you have the test results, but then you performed your personal evaluation and an interview and all that other stuff?

A. Correct. And another personality test.

Q. So on the 17th when she came in, who would she have met with? First off, would it have been here in your office?

A. Yes.

Q. And would she have met with you at all that day?

A. I don't know if I said hello to her. I would Imagine Dr. Kampfer administered -- explained the test to her.

Q. So if you had any interaction with her at all, whether it was --

A. It was, Hi, Dr. Etcoff. See you in a couple of days.

Q. Okay. How is that test administered? Is it proctored, or is she given instructions and left alone, or how does that work?

A. It's not like someone's standing in her room. She has her own office. She's given instruction. We figure out if she understands how to do it, because it's not that difficult to do --

Page 37

Q. Sure.
A. -- and she sits at a desk. The door is partially open, and my office manager is there in case she hears her on the phone or calling people. And so it's proctored.
Q. Sure. Is she instructed not to get on her phone and not to look at Facebook or whatever?
A. I don't know if Dr. Kampfer actually said that to her.
Q. But that's something you watch for?
A. Yes. Because there's research that attorneys commonly tell their clients that there are these validity scales and what they measure and what to do and what to not do. Now, the literature also says it doesn't help -- which is wonderful for me -- but oftentimes people are already set up to know what's on the test or to --
Q. Trying to game it?
A. Yes.
Q. Trying to come across in a way --
A. Fail the test.
Q. -- that it looks like they passed it? Is that --
A. Yeah. Try to put their best foot forward for their case.

Page 38

Q. Get a valid, fake, bad result?
A. Yes.
Q. Okay. That blows my mind, but --
A. And I'm not. It's true. But I'm not saying she did that. I have no evidence. I'm not saying that that was her.
Q. So based on your understanding, if she were to receive sort of coaching or outside help, that wouldn't change the test results? It wouldn't help?
A. It wouldn't help.
Q. Or you'd get caught? It would show?
A. It would show or -- it would show on the zillion validity scales that are there. But it doesn't seem to work.
Q. Sure. So let's say she were to have done -- hypothetically, obviously -- let's say she were to have engaged in some sort of coaching or gets some sort of outside involvement, would that show up as an invalid test result?
A. It could if --
Q. Go ahead.
A. I mean, it shouldn't if she was well-coached.
Q. Uh-huh, sure.
A. But if she's not so well-coached, it very well could.

Page 39

Q. If not in validity, how else might that manifest, this coaching?
A. It could be if an attorney says, Whenever you see a question about physical pain, answer yes. Whenever you see a question about depression, answer yes. It could be anything like that.
Q. Well, how would that show on the test results, though?
A. What would happen is that she -- she would -- oh, no. The attorney would say something like, When you see questions on depression, don't answer all of them as yes, but answer half, three-quarters of them as yes. Don't tell your peers.
Q. No.
A. And then I don't know of anyone -- I can't say a single person I've ever evaluated has -- I had thought they'd been coached.
Q. Sure.
A. I've never caught anyone being coached, and I never even -- I just rely on the test results.
Q. Okay. What is the MMPI designed to measure?
A. It's designed to measure personality --
Q. Sorry, just for clar- -- sorry, I don't mean to interrupt. But just for clarification, when I say "MMPI," I'm specifically referring to the MMPI-2.

Page 40

A. Same thing as the MMPI, but just more modern. Making sure -- this is where it measures personality characteristics, what might be called Axis I or acute psychiatric symptoms. The extent to which a person like this might have associated problems, whether they might use alcohol, whether they might be hostile and aggressive, whether they might be suicidal. It measures a lot of different -- a lot of different things. Anxiety, depression, somatic complaints, anti-authority attitudes, problems with your family, social introversion, social extroversion, paranoia, thought disorder, mania, ego strength. I can give -- it's like 50 scales.
Q. Is it fair to call it a diagnostic tool?
A. Yes.
Q. Is it -- and it works in conjunction with the DSM-5; correct?
A. No.
Q. So it doesn't identify certain diagnoses that are defined in the DSM-5?
A. Well, I mean, if there's a depression -- if it says a person's depressed, it doesn't have anything to do with DSM-5 diagnostic criteria, I would then have to figure out if there's a lot of depression on the scale and then the person looks depressed and the history

Page 41

shows she depressed, then I would have to say to myself, Well, what type of depression is it? Is a major depressive disorder with or without psychotic features? Is it a -- what used to be called a dysthymic disorder, or the kind of characterological low-grade depression? Is it an adjustment disorder with depressed mood, which means that it will go away once the stressor resolves? Is it depressive personality characteristics in an acute major depressiveness? All of those things I have to do.

Q. So if I were to dumb this down, is it fair to say that the MMPI is a starting tool that gives you kind of a ballpark, and then you can work from there and go into the specific diagnostic criteria to narrow it down and actually confirm the diagnosis; is that correct?

A. Yes. It gives you inferences based upon the normative samples. So that when someone has a clear MMPI-2 result, you can infer certain things about them and then check to make sure that it seems to make sense.

Q. Do you always administer the MMPI in your forensic cases?

A. Either the MMPI-2 or the newer MMPI-2-RF, which is a bit shorter and a little different.

Q. How do you decide which one you're going to use?

A. I can't really tell you that. It depends

Page 42

upon -- it depends upon the person, how much perseverance I perceive them to have. If they are very upset about having to sit and take a long test, I'll go to the shorter one that is just -- it's good.

Or there may be things on the MMPI-2-RF that aren't on the MMPI-2 that I'm looking for. And sometimes what you can really -- you can do the MMPI-2 if they will sit through it and, from it, you can derive an MMPI-2-RF, because the same MM- -- the MMPI-2-RF questions are a part of the greater MMPI-2, so that I will sometimes run both just to see if there's consistency or inconsistency. One picks up one thing that the other test didn't pick up, as an inference that I can follow up on.

Q. So how is the MMPI -- or what kind of test is it? Is it a multiple-choice test?

A. No. It's a statement, and you answer true/false; mostly true, mostly false, of how you're feeling recently.

Q. So what is it? Is it like you circle T or you circle F?

A. You fill in T or F with a pencil, you circle.

Q. So is this a Scantron test?

A. It isn't a Scantron test, though it can be. There are different -- you can do it off a computer --

Page 43

we don't do that -- you can probably do a Scantron and send it to a publishing company. We actually enter the data. Donna would go to the software and enter all of the data, and then click on the type of report that I'm looking for, and it would spit out all of the different scales and all of the different elevations.

And you can get a test report that has an interpretive report, which I always seem to get. So you can get a score test report -- just the scores, no interpretation -- you do your own. Or you can get an interpretive report, and that goes to the attorneys and then they see that.

So there are different iterations of the reports.

Q. But the process in your office, anyway, is she fills out -- she fills in the bubble with a pencil, hands it to Donna. Donna --

A. Or hands it to us -- me, Dr. Kampfer. We make sure had that she's filled it out and that she hasn't left too many blank or double that said true and false. We look for errors. And then if there were errors, we'll ask her to go back and make a choice, true or false or leave it blank; it's up to you.

And then when that's done, if even necessary, then we give it to Donna and she enters all of the

Page 44

responses in the computer.

Q. Did you have to tell Maria in this case to go back and change her answers or fill more in or anything like that?

A. I don't remember.

Q. Do you know if it was you or Dr. Kampfer who actually looked at the score sheet before giving it to Donna?

A. It probably would have been -- I don't remember. I'm -- I don't know. It was probably Dr. Kampfer, but I don't know. I can't tell you, really.

Q. And would it be in the records if she had been asked to go back and fill it in again or complete the test?

A. It might not or it might, depending upon if I remembered to put it in the report. Because it's so common that people leave blank too many, and we say, Can you go back and try to fill out and leave no more than ten blanks. Or they'll double -- they'll do true and false because they'll forget the directions. So that's so common that I might not even mention it.

Q. Is this a timed test?

A. No.

Q. She has as much time as she wanted to take it?

A. Yes. But it should take about an hour and a

Page 45

half for the MMPI-2, maybe about 50 minutes or so for the MMPI-2-RF.
Q. I think you mentioned earlier that Maria was here on the 17th between an hour and a half to two hours?
A. That's an guesstimate. If that's all she did, and that's all she did on that date, that's what it should have been.
Q. Okay. So your estimate is based on what it should have taken, not at all based on what it actually took?
A. Correct. I don't know how long she was here. I would have been told when someone's here for hours and hours and hours and hours. I'm usually told, This person is taking way too long. Something's going on. And then I intervene, and so I don't -- I don't recall that happening.
Q. Okay. In this case, was it Donna who took the score sheet and entered it into the software?
A. Yes.
Q. Do you still have the actual score sheet?
A. Yes.
Q. And that's part of that file?
A. (Witness shakes head.)
Q. And then in the printout that is generated from

Page 46

the input, does that also have the answers that were marked?
A. No. It --
Q. Go ahead.
A. It doesn't. Because her MMPI-2 was invalid, it just says this report is invalid, and it doesn't give you -- and it usually will state, which I put in my report, as to the six or seven reasons it can be invalid. And then I try to deduce why this was invalid.
Q. Is there any way to go back and check if the answers that Maria gave were the same as the ones that were input by Donna?
A. Sure.
Q. How would we do that?
A. Just have them -- we'll have Donna or anybody -- your own expert can run the whole thing all over again.
Q. We'd have to input them again to see if we get the same thing?
A. Sure.
Q. So when -- so the interpretation of the test scores is done electronically?
A. It goes to the publishing company that has all of the research and provides a empirically-based research-based interpretation from which I look at it and try to see -- and I'll even go over with someone the

Page 47

MM- -- I'll say, The MMPI-2 suggests that you are A, B, C. Does that make sense to you?
And then I try to figure out -- sometimes they agree that's me, sometimes they disagree, sometimes I agree with disagreement, sometimes I don't agree with their disagreement -- but I try to make sense of the MMPI-2 by going over some of the test results.
In this case, I literally -- and I was telling one of the things I did say to Mr. Goates before, which I didn't previously mention, which is unlike what a hired expert would tend to do when he's hired by one side or another -- I -- she failed -- she produced an invalid MMPI-2. Were I somewhat -- how do I put it? -- one-sided, I could have left it at that and just basically said she produced an invalid MMPI-2, which means that she's probably indiscriminately describing and exaggerating all sorts of symptoms that human beings couldn't possibly all have. And that would have benefitted his case.
But being me, an honest person, I said to myself -- I told her, I said, "Ms. Fernandez, I know you spent a lot of time doing this. You -- it didn't come out valid. I think you complained of so many different things that it was -- the test was invalid. I can't have you take this test over, but let me give you

Page 48

another personality test, if you'll do it, and try to be as honest as you can and, you know, not blow everything up into" -- I didn't put it to her that way -- "but try to take this one," hoping that now we would get something that was relevant and would give us some answers.
But she produced that, and the personality assessment inventory was also invalid. So now I have two invalid test results, but I did the right thing ethically. There aren't many people who do that, but I did it because I thought that was the right thing to do.
Q. You mentioned that sort of the typical expert or the expert that is one-sided?
A. Yes.
Q. Do you remember saying something about that?
A. Yes.
Q. What did you mean by that?
A. Well, I think there is -- I've got a large library of forensic books -- forensic neuropsychology, forensic clinical psychology. I've been to hundreds of hours of training. It's pretty widely known by lawyers and by psychologists that the independent medical examination or the independent psychological examination may not be independent if the person doing the evaluation wants to please the referral source and will

Page 49

say just about anything to slant the case to please the person.

So there are many such experts out there. And some lawyers may think I'm one of them, but I certainly don't see myself that way --

Q. Sure.

A. -- even though I get most of my cases from defense firms.

Q. What does "validity" in a test score mean?

A. That it measures what it says it's measuring.

Q. And that's -- that and reliability are two things you're going to look for in a test result; right?

A. Yes.

Q. And reliability has to do with repeating the test --

A. Yes.

Q. -- and getting the same scores --

A. Yes.

Q. -- within the same range, so to speak?

A. Yes.

Q. Are you able to make an assessment as to the reliability of test results if the test is only taken once?

A. Yes.

Q. How is that?

Page 50

A. Well, you're not doing a test-retest reliability; you're doing how -- you're using the validity scales to assess whether -- what is the possibility that any human being in this large number of people who have taken this test could possibly have this many symptoms of all of these different types versus this many symptoms here but few over here.

So the validity scales mostly, but in conjunction with other scales, can tell you that the test is -- the person's -- how the person behaved in taking the test, or why the test was valid or invalid.

Q. So did the spit-out or the test results, the interpretive report, if you will, give an indication whether her test results were also reliable or unreliable?

A. I don't know if it said that. I mean, I can say they're reliable against Dr. Mortillaro's test results in 2012, I think, or '13 or whatever it was.

Q. And that was also the MMPI?

A. No. But the way she took these tests with complaining of everything under the sun happening at the highest possible level -- sort of like I'm in 10 out of 10 pain from head to toe -- which is sort of what she said to Dr. Mortillaro -- it's not humanly possible, but that's how she presented herself.

Page 51

She did the same exaggerated presentation on the Beck Anxiety Inventory, the Beck Depression Inventory 2, the P3, and my two objective tests, which are even better than the ones that he used -- symptom checklists and questionnaires which you can fake very easily. These actually are very difficult to fake.

So there's reliability over time, one-time test-retest reliability. Not the same test, but she presented similarly both times.

Q. And because of her results on the MMPI, you had her take the PAI?

A. I had her take the PAI in the hope that she would kind of do it better and do it more validly so that we can discuss, Here's how these test results depict you. This is what you said about yourself, here's what it says about you. Does this make sense or not?

Q. So what's the PAI?

A. It's another objective, a more recently developed objective personality test, the Personality Assessment Inventory.

Q. Does it measure similar things that the MMPI is designed to measure?

A. Yes. These overlap.

Q. Is it similar in that she filled it out, it's

Page 52

inputted into the computer, it spits out a report?

A. Yes. She has four choices to -- it's not just true/false, but false, somewhat true, usually true, always true or very true.

Q. Sure.

A. So it's a little different and it's shorter.

Q. Does that also come with a built-in interpretive section?

A. Yes.

Q. Is that something you got on hers?

A. You'll read it.

Q. Okay. You mentioned earlier -- and this is the report -- that there are a number of reasons that a test could be invalid?

A. Yes.

Q. In fact, I think there were seven that you listed -- well, there were seven and then five. There were two different sections. Do you know what I'm talking about?

A. Yes. This is right from the MMPI-2 in the Profile Validity section. It says, "She responded to the MMPI-2 items in an exaggerated manner, endorsing a wide variety of symptoms and attitudes. These results may stem from a number of factors, including indiscriminately claiming extreme psychological

Page 53

problems" -- which is what I think she did -- "a low reading level, a 'plea for help,' or severe psychological deterioration or psychosis. Her responses were probably not random because she was consistent in her item responses. The resulting MMPI-2 profile is not likely to be a valid indication of her personality and symptoms. The interpreter is cautioned against making clinical or administrative decisions on the basis of this MMPI-2 protocol without determining the reasons for the extreme responding," closed quote.

Q. Can you turn to Page 8 of your report, if you don't mind?

This has to do with probably the parallel explanation for the interpretation of invalid results of the PAI?

A. Yes.

Q. It says -- there's a quote -- do you see where it says Page 6 in parentheses, the fifth line down -- or the big, long paragraph, fifth line down, Page 6?

A. Yep. Yep.

Q. Later in that same line it says, "The PAI" -- quote, "The PAI provides a number of validity indices that are designed to provide an assessment of factors that could distort the results of testing. Such factors could include failure to complete test items properly,

Page 54

carelessness, reading difficulties, confusion, exaggeration, malingering, or defensiveness." Okay?

A. Yes.

Q. Were those factors -- did you consider those factors -- I mean, you included them in your report, so I'm presuming, but correct me if I'm wrong -- that these were factors you considered before reaching a conclusion?

A. Yes.

Q. And the conclusion that you reached was that you could rule out all but malingering; is that right?

A. I'm saying there's a possibility that she's malingering in the sense -- I should define "malingering" -- that she is consciously and purposely exaggerating the extent of her disability for secondary gain. I can't say that in court because I don't know; I don't have all the information. But I could give you -- and I did -- put all of the different reasons or evidence that could lead to that diagnosis. But I didn't have enough for me.

Q. So is it my understanding, then, that the opinion -- at least what I inferred was your opinion from the report that Ms. Fernandez is in fact malingering -- is not something that you'll be testifying to in court?

Page 55

A. You're right. That's why I couldn't rule it out.

Q. Okay.

A. That means I haven't made that decision, but it's possible.

Q. Malingering would necessarily mean being untruthful or lying; right?

A. Yes.

Q. Would -- can someone subconsciously lie, or would that mean they would have to make a conscious, knowing mistruth?

A. Great question. Yes, you can subconsciously lie; but it's not a lie, so that wouldn't be malingering.

Q. Okay.

A. And there's lots of people like that. That's a very interesting part of psychology.

Q. Okay. And presumably, if you were going to reach the conclusion that she is malingering after reviewing subsequent reports, that would be -- or subsequent information, that would be included in the subsequent report?

A. It would. And the evidence on which I based it.

Q. Did you get a sense as to whether Ms. Fernandez trusted you?

Page 56

A. You know, it's not uncommon. I've done so many of these for -- depending upon the person, the attorney, the attorney's belief about what I'm going to do. There are some people who come in here and they're so nice. I'm so happy that they were so nice. We talk about it afterwards, Oh, that was so nice. They were cordial and courteous.

And some people come in here and they would just as soon hit me across the head with a baseball bat before they even met me. And that happens too.

She was emotional, but I think we had rapport. I was nice to her. She was -- I don't remember her being, you know, critical of me or saying nasty things or calling her attorney complaining, or whatever.

Q. Sure. Now, I'm not -- I don't know hardly anything about the MMPI, so I'm going to ask questions out of ignorance, and I probably know about as much as a juror might, so --

There are a number of -- I'm going to use the wrong terminology here -- but from my research, it looks like there's different types of -- let me get the right word here -- validity measures, CNS, LF, F minus K, F-Back. Do you know what I'm talking about?

A. Yes.

Q. Is a "validity measure," is that a good

Page 57

description of those?
A. Yes.
Q. Okay. Do you have her F score?
A. I do.
Q. And what was her F score?
A. The raw F score was 23; the T score, which is the score we use to say how many standard deviations above or below of mean that score represents was 116; and --
Q. Does that mean 16 percent above the mean?
A. 116 T score.
Q. Standard deviations above the mean?
A. Well, 50 is your mean, and every 10 points is a standard deviation. So 60, 70, 80, 90, 100, 110 -- so almost seven standard deviations above the mean. And knowing statistics, as I do --
Q. It's a tiny percentage?
A. Uh-huh, one in 100,000.
Q. That was her T score for the test results?
A. Yes, on the F scale.
Q. Okay, all right. What about the F-Back scale?
A. She had 18 raw score; T score of 112 --
Q. Okay.
A. -- which is that rare also.
Q. And you're getting this information from the

Page 58

same page?
A. Yes.
Q. Is there a page number on there --
A. 2.
Q. -- to help me identify it later?
A. This is Page 2 of the Interpretative Report?
Q. Yes.
A. Yes.
Q. And the F minus K, where does she fall there?
A. It doesn't -- we don't use the F minus K. That's an old thing that's sort of been supplanted by -- yes, so go ahead. We don't use that anymore.
Q. Okay, all right. What about the FS? Is that something you guys use?
A. The superlative? Or what's the FS?
Q. From what -- the description here I have, infrequent somatic response.
A. Ahhh, that isn't -- that isn't --
Q. It might have been something only on the R, the MMPI -- the other one you talked about.
A. The 2-R.
Q. The 2-R?
A. That might be where that is. It's not on this one. But we have lots of scale measures of that, other than on the validity scales.

Page 59

Q. Okay.
A. So, yes, we can give you that information, but it's not --
MR. GOATES: It's 3:15. How long do you anticipate going further?
MR. PARRY: I think I paid for two hours.
THE WITNESS: -- usually, what happens.
MR. GOATES: Okay.
THE WITNESS: Oh, may I say something?
BY MR. PARRY:
Q. Uh-huh.
A. So I want you to look at this.
Q. Sure.
A. On the MMPI-2 when it spits out her report, it doesn't have any of these red lines. I wrote a note so that any psychologist reviewing this, I put these red lines in so that I could get a visual idea of how high or low each of these scales were. So I said, "Note for Psychologist who may review this MMPI-2." I added the red lines to the Pages 2, 4, and 5, for purposes of visual illustration, i.e., so I could see the relevant scale elevations, Lewis Etcoff, Ph.D., blah, blah, blah. So this, if you just have your psychologist reproduce by entering this into the computer, they will get hopefully the same scores. There may be a -- you

Page 60

know, the person who puts it in may do it wrong once or twice. Donna may have made a mistake or two; I hope not. But the red stuff I drew in so I can look at it, because that's how I was trained to look.
Q. To originalize it. What about these blue dots? Is that --
A. Oh, that's my pen. Just kind of -- the blue dot is a way of lining up there's the F scale, there's the FB scale. So when it says 116, I would take a ruler, and here's my ruler (indicating), and I would put 116. There's 100, 110, 120. That's about 116.
Q. So you didn't just draw those red lines; you actually plotted the graph yourself too; right?
A. Right. Yes. That's what that is.
Q. All right. I appreciate the clarification.
Other than the -- well, all right. We've talked about the MMPI and its results. I want to spend some time talking about what happened on the 19th when Ms. Fernandez came in.
A. Yes.
Q. So she came into your office on the 19th, we're assuming around 9:00 because that's when you typically do it --
A. We start at 9:00, yeah.
Q. So do you remember if Maria --

Page 61

A. May I get some water?
Q. Yeah. If you wouldn't mind referring to your notes --
(Discussion held off the record.)
BY MR. PARRY:
Q. Do you know if Maria showed up on time?
A. I don't know for a fact, but I believe she did, or I would have -- I know when someone's late.
Q. Sure. Is it something where -- well, so, walk me through it. She shows up at 9:00. Does someone give her some stuff to fill out at first, or she walks back --
A. So Donna will say, "Ms. Fernandez is in the waiting room." I'll say, "Great." I'll grab a coffee, grab my water, put my stuff on the desk. I'll say, "Dr. Kampfer," if she shows, "Let's go introduce ourselves," blah, blah, blah. We introduce ourselves and have her come back here, give her some water, some coffee, whatever she wants.
When we sit down, the first thing I do is an informed-consent spiel so that she knows who retained me -- and I can give you the spiel, if you want. You don't want it.
Q. This is in your office, isn't it?
A. It's right here.

Page 62

Q. Okay.
A. So before I actually interview her, I say, "I'm retained by Mr. Goates, who's representing the defense. I'm a psychologist licensed in the state of Nevada. This isn't confidential. I am going to ask you questions about your life before this thing and after this thing, and I want you to tell me as best you can what your symptoms and problems are that you believe are related to this accident. There's no confidentiality as opposed to when you see a psychologist regularly, because this is in court. So what you tell me -- and I'm writing it down. It can be in my report.
And then it goes into the public domain. If I ask you a question that you don't want to answer it, you don't have to. Maintain your rights. Just tell me, "Go on to the next question," and I'll do that.
At the end of this I write a report. Dr. Kampfer and I edit it, make sure it's accurate. We send it to Mr. Goates. Mr. Goates sends it to your attorney. Months later, more often than not, your attorney will come in and depose me to see why I have the opinions I have."
Q. There I am being predictable again.
A. Everybody -- well, not everybody.
And then 95 -- 98 of 100 times your case will settle, and then in the other 2 to 5 percent you'll go to court and I could be called as an expert witness by either side, depending on what my opinions are, and cross-examined by the other side.
Do you feel you can -- are we okay? Can you -- how do you feel today? Can you go through with this? Yes. Okay, here we go.
And then we start out with, Let's do simple stuff, like where do you live? Who do you live with? How old are you? What's your address? I just kind of let them warm up because they're sometimes a little freaked out about the whole thing.
Q. This is all oral?
A. Yeah.
Q. And you're taking notes?
A. Oh, yeah.
Q. And this is you, not Dr. Kampfer?
A. She's silent.
Q. But she's in the room?
A. She's just sitting and watching and listening.
Q. Okay. So you get through the warmup, you get some information about her background, and then what? Do you get into some of the more --
A. And you'll see from my notes. I literally -- my ethical obligation is to be as transparent as I possibly can be. So you will literally -- if you -- I have bad handwriting. You can ask me, if you want.
I mean, I'll literally -- the order of what I asked and how she answered is pretty obvious. And then you'll compare my notes to what's in the report, and it will be pretty darn the same thing. I may have changed a word. I mean, I don't take -- I'm not tape-recording it and putting in quotes perfectly. But when I put in a quote, it's absolutely a quote, a short one, or pretty close to it.
So it's just literally page after page of what I asked. I usually put parentheses around my question, and then what she said. And there's -- here's subject accident injuries. How you doing emotionally? What treatments have you had? You worked at the Palms, you said. Tell me about that. How is your financial situation? What were you like before the subject accident? All of these things are all in here, so you can just read everything I did and know exactly where everything came from, because that's what I'm supposed to do.
Q. And how long does that interview typically last?
A. Two to three and a half hours.
Q. And after that, what's the next step? So we're at, like, lunchtime now normally; right?

Page 65

A. Yes. And what we might do is I might interview for an hour or 50 minutes, and then I typically will take a bathroom break, or they'll need a bathroom break, and then come back and do another bunch of interviewing. And then I'll give them a break.

And in this case, I probably gave her the Personality Assessment Inventory after explaining that the other one didn't come out. Can you try this one? Sometimes I'll let her, the person -- that might take her to lunch, but she's not completely through, so then she'll go to lunch and come back and finish it, and we'll talk some more after I have those results and go over that.

And then sometime in midafternoon I run out of things to ask about. I'll review her records, because oftentimes medical records are inaccurate, or you want to see how they respond to what was in their medical records and compare consistency with what they told you versus what the records say. So all of that is involved in the interview.

Q. It sounds like fun, actually. So --

A. Sometimes.

Q. -- then the inter- -- you said sometime in the afternoon you run out of questions. Then is it over, you're done, she goes home?

Page 66

A. It's over.

Q. So the whole thing -- the whole day is pretty much one long interview, and maybe they took a test there?

A. Yes.

Q. Okay.

A. I've just got to give you an idea.

Q. Sure.

A. So I had 15 pages of handwritten notes. I've had 25 pages or 30 pages. So 15 pages, the tests, and that's that.

Q. And you indicated you have not read Dr. Pineiro's deposition transcript?

A. Not yet.

Q. Is that something that you plan on doing or at least under the discretion of Mr. Goates, you will if he'll send it to you?

A. Correct.

Q. And that's something that you would like to read?

A. Yes.

Q. Will be you offering opinions in this case related to the genuineness or extent of Maria's back pain?

A. Nope.

Page 67

Q. Beyond the scope of your expertise?

A. Yes. Well, now, I should say I could be asked -- I could be asked: Of all of her complaints, does she tend to exaggerate her pain? I would have to say yes. And there's enormous evidence of that.

But am I going to say she's exaggerating her back pain? I can't say that she's exaggerating her back pain, period. I can just say she is prone to exaggerating pain, exaggerating depression, exaggerating even symptoms that are psychotic she was endorsing.

Q. Someone who exaggerates their symptoms, what potential psychological explanations could there be for that?

A. They could have histrionic personality characteristics where they're just emotion-driven and they make mountains out of molehills.

Q. It doesn't seem like a PC term, histrionic.

A. It is actually. No, it is.

Q. Like the wandering uterus?

A. That's good. You've been doing your homework. That's very good. It used to be called hysterical, so that wasn't PC, so they changed it to histrionic.

Q. Histrionic is okay.

A. Men can be histrionic.

Q. Sure.

Page 68

A. It can be -- now I forgot the question. What was the question?

Q. What possible psychological explanations could there be for someone who exaggerates their symptomology?

A. It can be many things. It could be a cry for help. I want you to know how much I'm hurting, therefore unconsciously I'm going to just -- if there's a choice or I'm on the borderline, I'm going to say yes to I've got this, I've got that, I've got this, I've got that. It could be completely outside of awareness when -- it could be a cry for help. But in this case, she didn't want help and she had help, so I ruled that out.

Q. What do you mean she didn't want help?

A. In other words, psychological help. She wasn't, like, I'm going to complain to this extent in the hope that you tell me to go back to psychotherapy. Or I want you to -- I want you to, in your report -- this could be conscious or unconscious -- I want you to see how bad off I am so that I hope you say, Boy this person needs anti-depressants, or see a psychiatrist, or more biofeedback, or go back to Dr. Mortillaro, which I said, Go back to Dr. Mortillaro. You're feeling depressed."

Q. So you ruled out the plea for help as a --

A. I don't think that was her motivation. I'm

Page 69

inferring that's not her motivation. She didn't have a reading problem. I saw all of the stuff she had filled out for Dr. Mortillaro for us, and she couldn't have had a reading problem and done what she did legitimately or validly.

She wasn't psychotic. I don't think -- I'm not convinced that she was malingering; though if I felt like making that case, you'd have a hard time with me in court telling me I'm wrong, because I could wrap it up in 11 different packages in a pretty kind of way. But I won't do that until I really think she is. But there's stuff there for that. She's exaggerating.

Q. What about the defensiveness?

A. Oh, no, not defensive. My God. She had the exact opposite of defensiveness. Defensiveness is when you and your wife are divorcing and you have children and you're such jerks that you have to come to a psychologist to see -- you know, you're just so impossible. Like, if you're a jerk -- that's not PC.

Q. Uh-huh.

A. And then when you're at the psychologist's office and when we give you an MMPI-2, you deny any problems. Or a policeman, same thing. Airline pilot, like the guy who ran the plane into the mountain.

Q. Just the opposite?

Page 70

A. Exactly. You're defensive when there's something at risk: Your children, your job. But in this case, most plaintiffs, if anything, are the opposite, though, sometimes I see ones who are -- they're wonderful. They actually don't complain as much as they should be complaining. And I'll put that; they're worse than they're telling me they are, and so they're really credible.

Q. One of -- you mentioned a dozen different little things you can package this up with if you decided to go in that direction. And based on your report, I think I know what some of those are, if not all of them.

A. Yes.

Q. I think you mentioned the fact that she had self-diagnosed two broken toes. Do I remember that?

A. Yes.

Q. And it -- you seem to think -- and I don't want to put words in your mouth, but I'm going to, so fix them if I'm doing it wrong -- but you seem to think that the fact that she never sought any diagnosis or treatment for the broken toes belied the claim or contradict -- or at least caused a question as to whether the self-diagnosis was accurate?

A. Exactly. Show me broken toes in the medical records. I understand what she said. You know, you can't really fix broken toes anyway, so why go to the doctor? I -- a normal human being would probably want to know if they're broken, especially if they have insurance that covers it. But, you know, it was just unusual.

Page 71

Q. Did you get the sense that she's the type of person who is reluctant to go to a doctor?

A. I don't know if she's reluctant. I couldn't say that. She's been to doctors. She's had surgeries, so she's certainly not -- she goes. She'd been to Dr. Pineiro a lot; she went to her chiropractor. I just don't have the records. She's had surgeries. So I believe she's reluctant to go to a doctor.

Q. She told you that she had seen Dr. Littlefield for chiropractic care?

A. Yes.

Q. And that was one thing -- what's your opinion on -- or how does her reporting of the treatment from Dr. Littlefield, how does that affect your opinion as to the exaggeration of her symptoms, if at all?

A. Not at all.

Q. Okay. There was a part in your report where you mentioned that she wasn't sure if she had gotten X rays --

A. Yes.

Page 72

Q. -- or radiological studies --

A. Yes.

Q. -- through her treatment with Dr. Littlefield?

A. Yes.

Q. Can you explain to me what the significance of that might be?

A. As someone who's had many radiological -- if you've ever had a CT scan, you don't forget. If you've ever had an MRI, you'd damn well never forget it. X rays, you know, you've had X rays. It's hard to believe that she would forget, having diagnostic tests that are just -- X rays, everybody has X rays. I would -- it's weird to forget that you've had an X ray or a CT scan or an MRI scan of your back, or whatever is bothering you. It's unusual to forget.

Q. That's if you had it, and then you don't remember if you had it?

A. Yes.

Q. Would it be less unusual if she hadn't had it and wasn't sure if she had?

A. That would be less unusual. I'm thinking that she didn't have it. Because if she did have them, it's obvious. You know you had it.

Q. In fact, you'll see this in Dr. Littlefield's medical records and his deposition, he did not order

Page 73

X rays because he determined that the cause was muscular and had nothing to do with it.
A. That answers my question.
Q. So does that change your opinion at all with respect to her not being able to recall if she had any diagnostic --
A. Wipe that one off my report.
Q. Okay. What did Ms. Fernandez tell you about the -- well, before I ask that, can you explain the difference between a suicide attempt and suicidal ideations?
A. A suicidal ideation is you think of killing yourself, or tried the thought on and maybe think about how you would do it if you were going to do it. You assume, then, that you're pretty sad and foregone and hopeless. Suicide attempt is when you open that bottle of pills and swallow as many as you can, or drink, drink, drink, drink, drink, drink, and then open the bottle of pills and swallow them. Or run your car into a wall or off the cliff. It's a behavior. The suicidal attempt is a behavior; the suicidal ideation is thoughts.
Q. What about opening -- drinking, opening pills but then not actually taking the pills. Where would that fall in the spectrum? I mean, I don't --

Page 74

A. In between.
Q. So it wouldn't be an attempt, but it could be something more than ideation?
A. Yes.
Q. Is that something that's common -- is that a difference that most people would understand, where the line is?
A. I don't know. I could explain it easily. I think you understood it.
Q. Well, you can explain it as a doctor, and I can understand it.
A. Yes.
Q. But you treat all sorts of -- not just treat, but you examine all sorts of different people from different socioeconomic, different education levels. Is that -- would a normal person understand the difference between how much behavior had to be undertaken before it actually qualified as a suicide attempt?
A. I don't think so, because I'm not sure it would be agreed upon by mental health professionals. Though, I would be of the mind to say if she opened the bottle and didn't take the pills, that she was close to taking the pills and that would be nearly a suicide attempt.
Q. Did she discuss with you the details of what she described as a suicide attempt?

Page 75

A. I don't believe so.
Q. Did you discuss the suicide attempt with her?
A. I -- you know, I thought I went over this today. Do you know if it's in my report?
Q. I know the suicide is in your report.
A. I don't know if actually --
Q. I can help you find it real quick.
A. Yeah. It may have been nothing more than a brief discussion.
Q. It's at the bottom of Page 3.
A. Thank you. Oh. So she was very -- she was tearful. And so I said, Do you feel depressed, and she said she did and she told me she had suicidal thoughts but she wouldn't take her life because she's a Christian.
So I asked her, Have you ever attempted to take a life, and she said, "Yes, I have." I asked when. "Right after this happening," meaning the subject accident, she answered. However, she didn't actually attempt to take her life; rather, she had thoughts to take her life while sitting in her car, which she considered driving to her death. That was what she told me.
Q. So you'll see this in her deposition, but I'm going to make some representations to you to fill in

Page 76

some of these facts and get your opinion on it.
What she said here is accurate, but it's not -- or least what you report as her having said -- is accurate but not complete. My understanding of what happened is she actually got in her car; she drove down to Hoover Dam. Her plan was to take her life at Hoover Dam. She actually got to Hoover Dam and she was sitting in her car, contemplating her life, and ultimately decided not to. Got courage, chickened out, however you want to say it, but decided not to take her life.
So if the facts as I relayed them are what happened, would you find fault with her for saying that she had attempted to take her life?
A. Not at all.
Q. Okay. I want to ask you too about -- it's the same paragraph, the second section where it says --
Actually, let me follow through. So that would be more akin to opening the bottle and being about to swallow the pills; right?
A. Yes. Driving to Hoover Dam is even worse.
Q. She actually took steps?
A. Yes. That was --
Q. Okay. Ms. Fernandez also reported, quote, "I don't like -- I don't feel like having sex. My marriage

Page 77

is down the drain," closed quotes. Do you remember having this discussion with her?
A. Yes.
Q. And my interpretation of your reaction to that is based on -- well, your reaction or your opinion is your marriage can't be down the drain. Your husband was so kind to you in the waiting room, and he kissed you and told he loved you when he dropped you off. Is that ringing a bell?
A. Yes. Yes.
Q. It's the same paragraph here.
A. Yes. Which was poignant because I see plaintiffs and their spouses who they're sitting on opposite sides of the waiting room. They can't stand each other. You can tell they have a bad marriage. This guy was -- it's like I remember him. He was just so genuinely nice to her and loving. So that took me aback.
Now, I might be wrong. I might -- you can say, I'll represent to you that they're divorcing, and then I'll say, Okay. What it looked like was not what I thought it what was, what reality is.
Q. Well, I'm going to be unpredictable here. As far as I know, he is a kind, nice gentleman.
But I do have a few questions about that.

Page 78

Because if a -- would you agree that sexual intimacy is an important part of a marriage?
A. Yes.
Q. And then if a wife is unable to engage in a sexual relationship, she might feel like she's failing as a wife?
A. Correct.
Q. And these thoughts of -- or these feelings that she's failing as a wife might lead to her belief that her marriage is not going well because she's not contributing like the way she feels she should, even if the husband is okay and patient and loving?
A. Makes sense.
Q. If you can turn to Page 10. I don't know what page you're on now, but Page 10, the last paragraph on Page 10.
Referring to the reports to Dr. Pineiro. I'll just read that, so we know where we're at. It's the line -- it's a little over halfway through the last paragraph where it says "Yet."
A. Yes, "Yet."
Q. "Yet, she made no complaints of travel anxiety to Dr. Pineiro and appeared to only hint at having a traumatic event occur recently in her life, though Dr. Pineiro never again mentioned any posttraumatic

Page 79

symptoms in her medical records."
You have Dr. Pineiro's medical records; right?
A. Yes.
Q. Do you have them there with you?
A. I do.
Q. Would you mind turning to those real quick?
A. Yes. And that's incorrect. Because I looked at them today, and he still had the diagnosis of rule out PTSD on several records. What I think I was trying to say but did so inelegantly, is neither in Dr. -- there was never any meat on the bone.
In other words, Dr. Pineiro didn't comment she's been complaining of nightmares and reliving the event, or that this car went through her store. There was nothing mentioned, except -- and that's how I -- that's why I wrote it the way I did. But I know that he had written in his notes that rule-out state in his records.
Q. Well, let's look at them real quick. I do appreciate that clarification. If you could -- I don't know that yours have Bates labels. I don't think so.
A. I do.
Q. So if you could go to the May 21st, 2012 report.
A. May 21st?
Q. Yes.
A. April 17th, 2012. Okay, sorry.

Page 80

Q. That's all right.
A. Oh, no. I don't have that.
Q. You don't have the May 21st, 2012 records?
A. No. Right, that's why I was searching. My first record -- and I asked her about this, I think -- of her visit with Dr. Pineiro was 12/12/12, December 12, 2012.
Q. Okay. Well, I'll represent to you that there was a record May 21st, 2012, which was three days after the accident. There's one June 8th, 2012; there was one August 6th, 2012 -- and I'll just read you real quick some of the things that she said to Dr. Pineiro, and it sounds like it might change your opinion.
Quote, "The patient is in the clinic very anxious, stating that while she was in her office, a car drove right inside the office causing severe damage to her property. She did not have any direct trauma, but the patient had to move quickly out of the way not to be injured, and since then she has been having chest-wall-type of musculoskeletal pain."
And under the Impression, he said "anxiety, increased social stressors and possible PTSD. We discussed the use of some other anti-depression medication, but the patient states that she'll see a psychiatrist. She's very upset and stressed about the

Page 81

event that took place, where she stated that she was almost killed."

So that was May 21st, 2012, three days after the accident.

A. Okay.

Q. And then on June 8th, quote, "The patient is in the clinic, still very distraught. Stated she cannot sleep and that she has dreams about the car going into her office and she almost getting killed. Extensive discussion with the patient about her symptoms, which are consistent with PTSD. I do agree with a psychiatry evaluation, as well as a psychotherapy evaluation."

Then on August 6th, 2012, quote, "The patient is in the clinic stating she is doing better as far as her depression, but still having significant anxiety from the accident that she had. And apparently she also lost her business secondary to this accident. The patient is to follow up with psychology and psychiatry as previously instructed."

So with that added context, does that change your opinion insofar as it relates to that paragraph we just read?

A. Absolutely.

Q. And how does that change it?

A. She -- the records I don't have, but requested

Page 82

to have, given the fact that she had told me that she had seen Dr. Pineiro before -- well, before -- it's like 2010, if I recall correctly --

Q. Uh-huh.

A. -- those records clearly show that she sought treatment from him, explained the accident, had PTSD symptoms and depression, and wasn't going back to work. So, yes, that's now consistent with what she saw -- she had told Dr. Mortillaro.

Q. Okay. Did you get a copy of the EMT report? It would have been dated May 18th, 2012. The report was actually created by the fire department.

A. Let's see. Yeah.

Q. You do have it?

A. I've got the Las Vegas Metropolitan Department Traffic Accident Report. I don't have -- that's not what you're talking about?

Q. No. I'm talking about fire department, the paramedic report.

A. No, I don't have that.

Q. Is that something that would interest you?

A. Absolutely.

Q. Okay. I see Mr. Goates writing that down. I assume you'll be seeing that.

So you don't know of any treatment she might

Page 83

have received at the scene?

A. Correct.

Q. In your report, you were critical of the fact that she did not go to the hospital on the day of the accident.

A. Yeah. I'm wondering why -- with all of these problems she was having -- she was scared, her heart was palpitating, she said her blood pressure rose, her toes were broken -- she had insurance, go to somebody.

Q. So when you made that opinion, you were unaware that there were paramedics on the scene and that she did --

A. Oh, no. I knew -- she told me, I think, that she was seen by the fire department, if I recall, but I'll check my report. But I obviously didn't put two and two together until now that there was a paramedic's report that I didn't receive.

So she got help at the scene and then didn't follow up later on; but, for whatever reason, I think she just, with her toes, felt, Well, they're broken. I don't know if they're broken, but they're broken. I'm just saying I don't know. And she -- I don't know why she didn't go to an emergency room. It could have been -- I can read the answer, I guess, in the EMT report.

Page 84

Q. But now you know she did go see her family doctor within three days?

A. Yes.

Q. And that changes things?

A. Yes.

Q. You indicated too -- and I think if you looked at Dr. Pineiro's report, that the rule-out PTSD line is not only in the December 2012 report, but in every subsequent report.

A. It carried through.

Q. All right. What does "rule out" --

A. Why does it say that?

Q. Yeah. What does it mean when a doctor put in -- and you've used the same thing. What does it mean "rule out" certain, you know, whatever it is?

A. Well, it's similar to diagnostic impressions. When you see diagnostic impressions from a physician, they're saying, At this time, given what I know, here's my differential diagnoses. I'm not -- you know, they way they write it, people think, Oh, it is a myocardial infarction. Well, it may not turn out to be that, but they're thinking it could be this, it could be that, it could be that.

Rule out, I'm imagining -- and you may have asked him in his deposition -- he says, I'm not a

psychiatrist. He probably says to himself, I don't know PTSD as well as a psychiatrist or psychologist, but it looks like it to me, but I'm not trained like that, so I'm going to put "rule out." So conservative.

Q. So is "rule out" just like an asterisk on a -- it's like a -- this isn't my diagnosis, but --

A. Yeah, but it looks like --

Q. -- it looks like it.

A. That's what I do. It looks like. I'm not sure about it.

Q. Is malingering a diagnosis? Would you call it a diagnosis?

A. I mean, it's in the DSM-5 and 4. I mean, it's not a psychiatric diagnosis. It is more of an intention. It's not a -- it's not -- it's something that you can do, but it's not a psychiatric problem.

Q. So it is in the DSM-5?

A. I believe it's barely mentioned.

Q. Would you mind pulling it out? I am interested in seeing what it says.

A. Okay.

Q. DSM-5 is fairly new, isn't it?

A. Yes.

Q. DSM-4 has been around for a long time?

A. Yes. But this thing is getting some pretty bad

press.

Q. Is it really?

A. They have something like -- they've made so many mistakes. And the numbers of what these disorders are, I learned there must be six or seven pages of errors.

Q. Really? They need to put out an edition.

A. They're going to do a 5.1, 5.1. It's not perfect.

Here it is. Here is the malingering section at the bottom to here. And it's not a really -- it's a crappy section. It's not -- it's just not psychiatry's area of expertise. Psychologists do a much better job with this, but this is what the DSM-5 is.

Q. Sure. And this is under the subheading "Nonadherence to Medical Treatment." It's on Page 726, and the code is, is V65.2 (Z76.5). I'm just going to read this.

A. Sure.

Q. "The essential feature of malingering is the intentional production of false or gross exaggerated physical or psychological symptoms motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs. Under some circumstances, malingering may represent adaptive

behavior; for example, feigning an illness while captive of an enemy at wartime. Malingering should be strongly suspected if any combination of the following is noted:

"1) Medicolegal context of presentation -- for example, the individual is referred by an attorney to the clinician for examination, or the individual self-refers while litigation of criminal charges are pending.

"2) Marked discrepancy between the individual's claimed stress or disability and the objective findings and observations.

"3) Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen.

"4) The presence of anti-social personality disorder. Malingering differs from factitious disorder in that the motivation for symptom production and malingering is an external incentive, whereas in factitious disorder external disorders are absent. Malingering is differentiated from conversion disorder and" somatic --

A. Symptoms disorders.

Q. -- "symptom-related mental disorders by the intentional production of symptoms and by the obvious external incentives associated with it. Definite

evidence of feigning (such as clear evidence that loss of function is present during the examination but not at home) would suggest a diagnosis of factitious disorder if the individual's apparent aim is to assume the sick role, or malingering if it is to obtain an incentive such as money."

And I read that because I don't have a copy, but I'll have to get one. But now I have what I need.

A. Okay.

Q. So to me, this looks like kind of a definition and not really a -- it doesn't provide guidance as to factors that you would look at to diagnose someone; is that fair?

A. Yes. It's bare bones. It's accurate, but it's bare bones.

Q. Okay. There's not a test that you can administer that would -- that has the aim of detecting malingering, or is there?

A. Oh, gosh, there are lots now. I can't -- there isn't a journal article in neuropsychology that comes out that doesn't. I joke every time I open up one of my peer-review journals. I ask myself, How many malingering test articles are there going to be there?

Ten years ago, you barely saw anything. Then, it just started. It just has a life of its own, like

Page 89

autism. You know, autism was rare, and now one out of 58 people. Malingering articles, thousands; tests, lots. There are -- it's -- I could go on. Yes, there's many. I can test for malingering of all sorts of things.

Q. And these tests that you mention, are there any that are done for their express purpose to test for malingering?

A. Many.

Q. Okay. What are some of the more well-recognized or more reputable tests?

A. Okay, let's see. We've got Green, Dr. Green's Word Memory Test; the Test of Memory Malingering; The Carb, C-a-r-b; the Portland Digit Recognition Test; Rey 15-Item Test. Oh, God. The Medical Symptom Validity Test; that's another Dr. Green one. I'm -- that's plenty that I can roll off the top of my head.

Q. Sure. Did you ever --

A. And the MMPI-2 has distinct malingering scales.

Q. And that was going to be one of my next questions. The test that you mention, is that -- is the express purpose to test for malingering, or is that one of the conclusions that can be drawn from certain test results?

A. Never should you draw a conclusion that someone

Page 90

is malingering from just one test or just two tests, although there are actual formulas where if a person does poorly on these two tests that the actual statistical probability of them feigning something or exaggerating or malingering purposely is X percent.

But typically, we're all told to -- and we all do -- we never make that diagnosis unless there's -- you know, you've seen the records, collateral records; you've hopefully seen the person or someone in your field has recently seen the person and did a very competent job that you can refer to.

The tests, symptom validity tests as they're known, have been accomplished, that they've failed those tests; that there are all these symptom validity indicators within regular tests that you can use to see whether they're feigning all sorts of things that they never, not in a million years, knew that they were feigning.

So there's -- so we never just make a diagnosis of malingering based upon one symptom validity test. We always look at consistency between the test results and other test results; consistency between the test results and their presentation; consistency between the test results and how they live their life; consistency between the test results and the medical records. All

Page 91

of that.

Q. Okay. To be clear, although you believe, it's your opinion, that Maria Fernandez exaggerated her symptoms, you have not seen enough evidence or heard enough from her or gotten enough to be able to reach the opinion that she is malingering in this case?

A. Absolutely right.

Q. However, you reserve the right to reach that conclusion based upon further information that may be provided to you?

A. Yes.

Q. And based on the discussions that you and I have had, a number of these factors that you have considered might point towards or suggest malingering are no longer factors; is that right?

A. Correct.

MR. PARRY: That's all the questions I have. If we could just get a copy of that for the court reporter, then that would be --

THE WITNESS: A copy of my -- yeah, the medical records. Donna -- we never let them out of the office. Donna will do all that and get it to you. Just give your card to her, and she'll have this in a day or two to you.

MR. PARRY: Yeah, and I was going to suggest --

Page 92

MR. GOATES: I just have one question, Doctor.

EXAMINATION

BY MR. GOATES:

Q. With regards to your opinions, you're being paid for your time, not your opinions; correct?

A. Absolutely.

MR. GOATES: Thank you.

(Exhibits 1 and 2 were marked for identification.)

(The deposition concluded at 3:56 p.m.)

-oOo-

CERTIFICATE OF DEPONENT

PAGE LINE CHANGE REASON

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

* * * * *

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

_____

LEWIS M. ETCOFF, Ph.D., A.B.N., Deponent Date

CERTIFICATE OF REPORTER

STATE OF NEVADA)
) SS:
COUNTY OF CLARK)

I, Jean M. Dahlberg, a duly commissioned and licensed Court Reporter, Clark County, State of Nevada, do hereby certify: That I reported the taking of the deposition of the deponent, Lewis M. Etcoff, Ph.D., A.B.N., commencing on Tuesday, June 23, 2015, at 2:09 p.m.

That prior to being examined, the deponent was, by me, duly sworn to testify to the truth. That I thereafter transcribed my said shorthand notes into typewriting and that the typewritten transcript of said deposition is a complete, true and accurate transcription of said shorthand notes.

I further certify that I am not a relative or employee of an attorney or counsel of any of the parties, nor a relative or employee of an attorney or counsel involved in said action, nor a person financially interested in the action.

IN WITNESS HEREOF, I have hereunto set my hand in my office in the County of Clark, State of Nevada, this 29th day of June, 2015.

_____

JEAN M. DAHLBERG, RPR, CCR NO. 759, CSR 11715

EXHIBIT "2"

Miller v. Sisolak

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

August 25, 2014

WESTERN REPORTING SERVICES, INC.™
500 South Rancho Drive, Suite 8A
Las Vegas, Nevada 89106
Telephone **702.474.6255**
Facsimile 702.474.6257

www.westernreportingservices.com

1

DISTRICT COURT
CLARK COUNTY, NEVADA

ALEXANDER MILLER and STELLA MILLER,
Plaintiff,
vs
ASHLEY SISOLAK; DOES I through X, inclusive and ROE BUSINESS ENTITIES I through X, inclusive,
Defendants.

Case No. A-12-665098-C

MITSUI SUMITOMO INSURANCE USA INC.,
Plaintiff,
vs
ASHLEY LAUREN SISOLAK; STEPHEN SISOLAK; and DOES I through X, inclusive,
Defendants.

DEPOSITION OF LEWIS M. ETCOFF, PH.D., A.B.N.
Taken on Monday, August 25, 2014
At 1:58 p.m.
At 8475 South Eastern Avenue, Suite 205
Las Vegas, Nevada

Reported by: Marnita J. Goddard, RPR, CCR No. 344

2

APPEARANCES

FOR THE PLAINTIFFS:
JOSEPH L. BENSON, II, ESQ.
BENSON & BINGHAM
11441 Allerton Park Drive
Suite 100
Las Vegas, Nevada 89135

FOR PLAINTIFF MITSUI SUMITOMO INSURANCE USA INC.:
LISA A. TAYLOR, ESQ.
ATTORNEY AT LAW
5664 North Rainbow Boulevard
Las Vegas, Nevada 89130

FOR THE DEFENDANTS:

ANDREW J. VAN NESS, ESQ.
ROGERS, MASTRANGELO, CARVALHO & MITCHELL
300 South Fourth Street
Suite 710
Las Vegas, Nevada 89101

3

INDEX

EXHIBITS

4

(Upon inquiry by the reporter prior to the commencement of the proceedings, Counsel present agreed to waive the reporter requirements as set forth in NRCP 30(b)(4) or FRCP (b)(5), as applicable.)

LEWIS M. ETCOFF, PH.D., A.B.N.,
having been first duly sworn, was
examined and testified as follows:

EXAMINATION

BY MR. BENSON:

Q. It's Dr. Lewis Etcoff; correct?
A. It is.
Q. Fantastic. You have a Ph.D. in what, sir?
A. Clinical psychology.
Q. And what does the A.B.N. stand for?
A. That I am a diplomat or board certified, in other words, by the American Board of Professional Neuropsychology, and we use those initials, A.B.N.
Q. How long have you been practicing?
A. Since 1984.
Q. Has that been mostly in Nevada?
A. Completely in Nevada.
Q. And you've been licensed continuously since 1984?
A. Yes.

5

Q. And what kind of practice do you primarily run? I know you've been hired as an expert in this case, but what do you primarily do?
A. I do two different types of practices: a clinical practice and a forensic practice. The clinical practice typically involves evaluating children, doing assessments or testing, but no therapy or any kind of counseling. Most of the cases are regarding whether -- if they're having trouble at school or is that because they have learning disabilities or attentional problems or psychiatric difficulties causing that. So that's probably -- until recently, it was probably two-thirds of my practice. And now I've sort of really cut back on the clinical and see fewer clinical cases.
The other part of my practice is doing these types of evaluations for either plaintiff or defense attorneys, essentially just in the area of personal injury, to see whether someone has emotional or cognitive changes as a result of an accident or an incident.
Q. So currently you say that's about 25 percent now versus the 75 percent clinical?
A. It's switched around. It's probably -- I probably spend more time now on the forensic than on

6

the clinical as I age and kind of try to do less work.
Q. Fair enough. Just for the record, forensic, in your view, means what?
A. Working as a consultant or an expert for an insurance company or an attorney who retains me to take a look at a case they have.
Q. Currently, can you give me an estimate as to maybe how much plaintiffs' work you've done versus defendants'?
A. Typically, I don't take liens and haven't for 20, 25 years. So it's heavily retained by defense. About 90 percent defense, 10 percent plaintiff.
Q. The insinuation by that answer is that you do plaintiffs' work, but you do it on lien work?
A. No lien. If the plaintiffs retain me, they'll actually pay me for doing my evaluation.
Q. I understand. As a plaintiff, a plaintiffs' firm, they would just pay you just like they would pay any other expert; right?
A. Correct.
Q. The distinguishment between lien and expert payment really has no reason -- there's not a reason for that, is there, in terms of why you maybe do more defense?

7

A. Yes, there is. I think taking a lien essentially puts a physician or a psychologist or any expert in a conflicted position. Because if you accept a lien, you know that the only chance of you getting paid for the work you do is if the plaintiff wins the case. And, as a result, unconsciously, if not consciously, as a human being you will probably tend to side a little more with the plaintiff because you know that you're not going to get paid unless that person wins the case. Even if they do win the case, from my experience over 30 years, you are lucky if you get paid 10 to 50 cents on the dollar. Because that happens commonly. So I just decided a long time ago not to bother putting myself in a compromised ethical position. This way if I take a case, it doesn't really matter what my opinion is because I'm doing what I'm doing and getting paid for my time.
Q. Right. When's the last time you did lien work?
A. Probably the early '90s.
Q. So you have been a lien provider, though?
A. Two or three times.
Q. In 2014 how many times has the Rogers Mastrangelo law firm hired you?
A. I don't know.

8

Q. Is it more than ten?
A. I really doubt it.
Q. Can you give me your best estimate?
A. It would be a guess. I could find out specifically.
Q. I'll take a guess right now.
A. Probably less than five.
Q. That's just in 2014; correct?
A. It's a guess. Yeah. I mean, I could find out the exact answer for you by just asking my office manager.
Q. Is there a particular firm in town that you work with more than others?
A. Not to my knowledge.
Q. Who is the last plaintiffs' firm that hired you?
A. The one that comes to mind is Kravitz, Schnitzer, Johnson.
Q. You believe that's a plaintiffs' firm?
A. Yes. They do business litigation too. That was a plaintiff's case. I got a couple of plaintiff cases from that firm.
Q. When were you hired on that case?
A. How long ago?
Q. Yes.

9

A. Gosh. On the case I'm thinking about, two years ago. But it's been an ongoing case. So I've been doing work throughout the two years.
Q. Can we agree that most of your work is done for the defense?
A. Yes, we can.
Q. There's not really a reason why it's defense, in your view, because you get expert fees; correct?
A. My view is that most personal injury attorneys don't want to put out the money to hire experts unless they know they have a slam dunk case. When there is a slam dunk case, they'll pay me. But if it's a case that isn't such a hot case for them or they can't see that it's going to be a big case, they'll get someone who will accept a lien.
Q. I see. How much do you charge?
A. I think I charge like $360 an hour for my work. I have associates who I charge $265 an hour who do some of what you see in front of you, organize and review records.
Q. Understood. In this case, you were asked to review and do an IME for Alexander Miller; is that correct?
A. Yes.

10

Q. I believe his wife as well, or no?
A. No.
Q. Just Alex. Okay.
Approximately how many hours did you bill on that case so far?
A. I'd have to look it up. Let's see. In the early part of 2014, I billed for my time 28.25 hours and my staff 32.25 hours in sorting, organizing, reviewing records, and some of my staff members helped me test Mr. Miller.
Q. Okay.
A. I have more.
Q. Go ahead.
A. In May I had a telephone consultation with Mr. Ira Spector, who is a rehab counselor. I spent half an hour talking to him. Then in June of this year, I received new records regarding the case, vocational report, medical reports, a new report from Dr. Hibbard. And I spent a total of five hours. That was a bill of $2,042.75.
Q. We can all do the math, I guess. But that's pretty much the hours that you have in this?
A. And previous to doing the evaluation, I also was asked to look at Dr. Hibbard's first evaluation of Mr. Miller as a consultant before I did a forensic

11

neuropsychological evaluation. That was 11 hours and -- 11 and a half hours. That was billed in November of 2013.
Q. So have you stated all of your hours on this case so far?
A. Except for studying for today, yes.
Q. How many hours did you study for today?
A. Four.
Q. As part of your preparation today, what did you do?
A. I read my report. I looked through all of my data, the psychological tests I administered. I read through all of the newest records that I got just recently from Dr. Fazzini. I read through Dr. Fazzini's records. I looked through my billing and I looked at the photographs from the accident and a couple of Dr. Hibbard's reports.
Q. I think that was referenced somewhere when you sent a letter to their office that you had reviewed the Plaintiff's Third Supplement List of Witnesses and Documents; is that correct?
A. There's not much to review.
Q. What was in that third supplement?
A. That's probably in here. Besides that stuff where you say who is going to be testifying, which I

12

don't really spend much time looking at, there was some evaluation from Dr. Hibbard, Dr. Fazzini reports, I think an MRI report. There was -- oh, gosh, Terrence Dineen's report. I read that today.
Q. So that kind of includes what you reviewed, then, as far as the third supplement; correct?
A. Yes.
Q. The admonitions we normally give, are you comfortable with waiving those? I kind of jumped into things.
A. Waive.
Q. How many times have you had your deposition taken?
A. Couple hundred.
Q. That's fair, then. We'll skip those.
A. Unless something has changed.
Q. I think we're fine there.
So you were asked in this case to, I guess, do a records review and also do a clinical evaluation with Mr. Miller; correct?
A. Forensic evaluation. Different than a clinical evaluation.
Q. So one was in person and one was more of a records review; right?
A. Yes.

13

Q. When you were asked to do the records review side of it, was there anything in your review that struck you that Mr. Miller was a malingerer?
A. No.
Q. So it wasn't until you actually did testing that you came up with that conclusion?
A. Yes.
Q. Aside from being a malingerer, you also kind of stated that he feigned some of the results; is that correct?
A. The malingering is the cognitive part, that he was making memory -- he was trying to perform worse on memory tests than he should have been performing. So on tests that are specifically designed to catch and differentiate between people who are giving solidly optimal effort and those who are not giving -- well, they are giving good effort, but they're giving good effort to make themselves appear as if they have problems. Consistently he made an impression on those tests where his test results indicated that he was trying to do worse to show me that he had memory problems.
Q. So anything other than -- I guess except for the testing that you did, per se, was there anything in the records that you read through that indicated

14

that there was inconsistencies in him being a historian or anything that he told to his medical providers?
A. I think when I was reviewing some of it today, it occurred to me that he exaggerated the two providers who he saw for treatment the speed at which the vehicle he was a passenger in was struck. I think twice he said the vehicle was struck at 45 miles an hour, and to another doctor he said the vehicle was struck at 60 miles an hour. Clearly, he knew that wasn't the case.
Q. Do you remember where in the records that you're referring to that?
A. I could find it.
Q. Sure.
A. I think. Or could I?
Q. Are you referencing your report?
A. It will take me five or ten minutes to find it. If you want me to do it at a break or something like that, I could. It was probably in the records I reviewed and who he spoke to. It would probably be easier to get on the computer -- not that I could do this -- and look for, like, 45 miles an hour. It would come up in the report. But we can do that if you'd like.

15

Q. Here's the thing. You're testifying that that was a significant finding for you; correct?
A. It was. But not as significant as the testing. But it was consistent with his exaggerated memory disturbances.
Q. Do you believe that plaintiffs actually know how fast other cars are moving?
A. No. But you can usually -- I assume that they know if they've been hit at 40 miles an hour versus 10 or 5 or 60 miles an hour. I think any human being with a modicum of intelligence could guess within range like that.
Q. Was it the difference in range or was it the fact that he told two different stories that was significant to you?
A. I think it was the difference between the actual hit of the car into his versus what he told people who he had seen as physicians or providers, that it was so much greater.
Q. Is it your understanding that he saw the impact?
A. No. He was in the car. He felt the impact.
Q. When you did your evaluation with the records, did you end up doing any conclusions or letters to defense counsel about your review of that?

16

A. My records review was more so looking over Dr. Hibbard's work. And, yes, I did -- I was asked to prepare potential deposition questions for Dr. Hibbard based upon the enormous number of mistakes she made in administering and scoring and interpreting the tests she gave to your client.
Q. Got it. Speaking of scoring, do you score your own stuff?
A. I do.
Q. You have a staff, though; correct?
A. I do.
Q. Do they also score stuff for you?
A. They do. Sometimes computers score. Depends upon the test.
Q. In this case I think that your report was signed by yourself as well as another person?
A. Dr. Gunther, I'm guessing.
Q. How many people work for you?
A. Currently I have three associates, part time. I have Dr. Karen Kampfer, who works as a school psychologist. She works for me 20 hours a week. She was one of the first people I had ever employed back in the 1990s to do this. So she's got years and years of experience. I have a predoctoral intern, Bethany Ghali, G-H-A-L-I, who is a licensed clinical social

17

worker and just completed her dissertation for her doctorate in psychology at Capella University. She works full time, and I supervise her. I just took on a very part-time person, a retired school psychologist who is working nine hours a week and who will be doing forensic records reviews. Her name is Melinda Hauret, H-A-U-R-E-T. She was one of the supervisors of school psychologists in the Clark County School District. And I have an office manager.

Q. Fantastic. Looking at this report that you did, it's roughly 60 pages or so -- the actual report I think is more in the -- 27 pages, but the full thing I think was many pages.

A. Yes, it was.

Q. I see Karen Kampfer's name is signed on this. What did she do as part of the preparation of your report?

A. Karen Kampfer -- I can't tell you exactly what she did on this. She did some of the testing. She probably -- I can find out. She may have sat in on my interviews. I think I had like 32 pages -- yeah, she was in on the interview. I always have two people in the interview with me, me and someone else. The reason I do that is because I fully realize I am not perfect. When I'm asking questions and taking

18

notes, I'm not going to be perfect. I may not exactly understand how people answer me or be able to keep up with it, so I have a second person taking notes sometimes or just listening. Usually taking notes. And when I then dictate the part of my evaluation that is the interview of the person I've seen, the person who was in the room reads what I said and compares my recollection or the words I thought I heard to what he or she heard, and then we talk about whether I heard it correctly or not. So it allows for greater validity and accuracy.

Q. Do you know whether Karen Kampfer is expected to testify in this case?

A. No. I am the expert.

Q. So that we're clear, what did you do specifically and what did she do on this case? She sat in on the interview.

A. Yes. So I interviewed pretty much all of the questions. She may have asked a question or two. But typically she doesn't. It looks at least three hours of interviews. I interviewed his wife. Then there were a lot of tests that we gave. So I will go through the tests and tell you who did what, if that's what you're interested in.

Q. Actually, if you could just tell me what she

19

did.

A. She administered the California Verbal Learning Test. The personality tests are taken by the person themself. Whoever gives it to them just gives them the directions. The Stroop, S-T-R-O-O-P, Color and Word Test was administered by her. The Test of Memory Malingering was administered by her. The WAIS-IV, Wechsler Adult Intelligence Scale, Fourth Edition, was administered by Ms. Ghali. My doctoral intern administered the Woodcock-Johnson-III Tests of Achievement. And the other tests I administered.

Q. How long did your IME last with Mr. Miller?

A. It was over two days. So give or take six hours a day. Probably around 12 hours.

Q. Is that typically how you administer tests in your clinical practice?

A. Clinical practice, typically I get everything done in one day, especially if they're kids. They've lived fewer years and there's less to talk about. Even the teenagers I can usually start at about 8:45 and be done at around 3:30.

Q. So I'm clear, the testing itself, though, how long does the testing itself take out of the 12 hours that you saw Mr. Miller?

A. I would say -- let me see what the billing

20

says. I'm going to guess it's six, seven hours. Let's see. I would say the testing was about six, six and a half hours. On top of that you have to score the tests and interpret them. But the actual administration, six to seven hours.

Q. And it's fair to say that the tests that Karen did -- one, two, three, four, five, six -- roughly six of those tests -- how many total tests were given?

A. Thirteen.

Q. So we can reasonably assume the 13 tests were done in that six and a half hours, roughly?

A. Some of it, like the two intelligence tests, take about two and a half hours. But they're not hours that we do anything. The person is sitting in a room filling in the tests.

Q. In terms of the malingering tests, are there any tests that you performed to do that or was that all done by Karen?

A. I did the -- trying to think. There were malingering indicators on the personality tests, the MMPI-2-RF and the MMPI-2. I did a lot of the motor tests, but there were no malingering tests within there. She did the Test of Memory Malingering, the CVLT, and the -- one of the subtests from the CVLT and

21

the Reliable Digital Span that comes off of the IQ test. She administered those.
Q. So she did the majority of the malingering tests; correct?
A. Yes.
Q. You relied on her data; correct?
A. Yes, I did.
Q. Are these objective or subjective tests?
A. Objective.
Q. Completely?
A. As complete as they can be. I mean, there's literature on them and norms. Yeah, they're objective.
Q. And you are aware that Dr. Hibbard did the same tests; is that correct?
A. I wouldn't say she did the same tests. But we did a lot that overlapped. No two neuropsychologists, if you look at their test batteries, does the exact same battery of tests. But she and I did many of the same tests.
Q. If they are so objective, why redo them?
A. Well, if I don't do them, I would not be following the standards and practices of forensic neuropsychology.
Q. Which says?

22

A. That you have to try to see whether someone is malingering in a case that is a legal case.
Q. But doesn't that require some subjective part -- on your part?
A. I've been doing this for a long time. I can watch a person and tell on a subjective level, not on a test level, whether they are giving their best effort or whether they're attempting to look like they're in more pain than they are really in. Having any number of symptoms that they want me to believe they're having. So there is a subjective component. In terms of the tests themselves, those are objective signs of effort to look as if one has problems that one doesn't.
Q. Did you remember when you were -- but you didn't sit through the malingering side. So as far as you are concerned, what tests required your subjective impressions?
A. Even in my interview I could talk to him and see from being a clinical psychologist when he spoke about his -- the problems he has from the accident, his voice -- he would stutter. He would speak more slowly. He put on a way of speech that was completely different than when I asked him about his job as a bigshot in the music industry when he was voluble and

23

articulate and expressive. So if one really has brain damage, one's speech doesn't change subject to subject. So he wanted to talk about stuff that he wanted to tell me about. About his career, he sounded like a disc jockey with that mellifluous voice. He had no word finding problems. He was just normal as can be. But when he was talking about how the accident bothered him, he would be slower. That's a common sign of someone trying to look impaired.
Q. Aren't there different types of brain damage?
A. Yep.
Q. And they have different types of symptoms; correct?
A. Yes.
Q. What is your understanding, if any, of what his diagnosis is in terms of the medical side of his brain damage?
A. Well, until recently, when there were medical records showing that he has some MRI problems that were recent, I saw nothing in his medical records suggesting that there was anything wrong with his brain. At worst someone said, oh, maybe he had a postconcussion syndrome. And there is enormous research on postconcussion syndrome that shows that

24

there should be no neuropsychological abnormalities after a year. Well, a year, after several weeks they go away. So if you retest or test someone a year out, they will be normal on all the neuropsychological tests. If they are not, it's not because their brain isn't working well. It's because there's some other motivation or stresses in their lives, such anxiety, depression, drugs they're being given that cause them to perform poorly.
Q. Did you review some records at some point that have changed your mind or enlightened you to his traumatic brain injury diagnosis?
A. No.
MR. VAN NESS: Object as to form.
THE WITNESS: He doesn't have a brain injury from this accident. What really is the cause of his problems is that he got fired from a very prestigious identity -- prestigious high-paying position in the music industry that his identity was very closely tied with. That has caused him definite psychiatric and psychological problems. This car accident didn't really do anything to him.
Q. (BY MR. BENSON) Why was he fired?
A. I don't know. You'd have to talk to his boss.

25

Q. You've just given testimony here as to your opinion, that he didn't have brain damage, it was because of him being fired, but you don't know the reason for him being fired?
A. Right. But I know he doesn't have brain damage from this accident. So it couldn't be that. That's my opinion.
Q. Did you do most of the interview?
A. All of it.
Q. How do you document your conversations with a potential -- I guess not really a client but a potential patient or, in this case, an adverse witness?
A. Not an adverse witness. Just a person I'm evaluating.
Q. Well, okay. We can agree to disagree on that.
A. I'm right. More than anyone I've ever met, having reviewed so many other people's, I take voluminous notes that you can read, I hope, and it sort of tells you exactly what I asked and what they said. Then you can compare what I asked and said to what's in the report and figure out whether --
Q. Got it. So you have approximately, I don't know, half a ream of notes there. Is that a fair

26

statement?
A. 32 handwritten pages.
Q. I don't think we've got a copy of your file. I don't know if we've requested it or not. Is that something we can get?
A. Yes. I'll have my office manager give you the notes. You probably don't want all of the records you already have.
Q. Just your notes would be great. I know, looking through your report, there are a ton of quotations. That was my next question. Do you record --
A. Yes.
Q. You do. And where would those tapes be?
A. Oh, no, I record little quote marks. No, I don't ever record. Unless someone is recording me, I don't record. It would be enormously time consuming to reconstruct everything. That's why I have a second person in the room.
Q. So we've got to rely on your notes, then, as opposed to actual audio recordings?
A. Correct.
Q. So going to your report, if we can, you just did one report for Alexander Miller; is that correct?
A. Yes.

27

Q. So you've given a list here that is fairly exhaustive of the records that you reviewed and the depositions you reviewed; correct?
A. Yes.
Q. Then on page 2 of your report you indicate that you are going to remain objective and neutral during this evaluation; correct?
A. Yes.
Q. You mention in this educational history on page 3 that he recalled taking his PSATs but not his SATs. Then you put a note in here. This is likely an inaccurate recollection on his part.
A. What was unlikely was that they weren't offered.
Q. I see. Okay.
A. I think the SATs -- if he took his PSATs, I've never heard of SATs not being offered. And I said that's probably unlikely to be correct.
Q. When do the PSATs start?
A. I don't know.
Q. Do you know when the SATs started?
A. No.
Q. How do you know it's likely inaccurate, then?
A. Because I took the PSATs and SATs and I'm

28

older than him.
Q. Where did you go to school?
A. Randolph High School in Randolph, Massachusetts.
Q. So you took a history; correct?
A. Yes.
Q. During that history -- I mean, you've got a lot of pages here of history. You go into his occupational history. You cover primarily mostly his employment.
A. We talked a lot about his employment history.
Q. Marital history.
A. Marital history. It's the same type of interview I do with everybody.
Q. What's your goal when you are taking a history like this?
A. Getting to know someone, trying to figure out what they're like, personality characteristics, seeing how accurate they are, comparing what they tell me to the collateral records that substantiate or don't substantiate what they tell me. Just basically getting to know them.
Q. Behaviorally you looked at Mr. Miller and was there anything behaviorally that he showed signs

29

of that you found uncharacteristic?
A. Besides the difference in how he spoke about his perceived subject accident-related symptoms and how he spoke when he was talking about things he loved to talk about to tell you about his job, his occupation, his profession, no, nothing else. He was a very nice man. A gentleman. Respectful. Cooperative. Easy to talk to. As was his wife.
Q. Did you find him intelligent?
A. Yes.
Q. You said here his eye contact was appropriate. Seated posture was relaxed. No visible manifestation of pain.
A. Correct.
Q. Apparently you go by facial grimacing to notice that?
A. Facial grimacing, a lot of fidgetiness, restlessness, getting up, how he sits and gets up out of a chair, how he walks, whether he says, "I'm in a lot of pain" or "Ah." Verbal or nonverbal signs of pain that everybody who is human would manifest if they were in pain.
Q. And he was respectful to you?
A. Yes.
Q. You mention on page 13 here -- says,

30

"Mr. Miller was personable and rapport was easily established. His attitude towards my staff was respectful. He appeared comfortable working with me and my staff, although his emotional expression struck me as shallow." What do you mean by that?
A. Well, if you're sad, you can really be sad, or if you're happy, you can really be happy and look it. He didn't have that kind of affect of typically where he really looked whatever he was saying he was feeling, except once when he cried when he was talking about getting fired. That was the most poignant part of the interview, talking about getting fired and how terrible that was for him. In that he was not emotionally shallow. It was as if he was experiencing it again.
Q. A big part of your work is pediatrics, or used to be?
A. Still. Not as much. Yes, it has been.
Q. Is it fair to say that your range goes from pediatric to adults?
A. Yes. That's fair.
Q. You kind of go through some of the neuropsychological test results. They start on page 13.
A. Yes.

31

Q. Let's kind of go through a few of these tests that you did. The TOMM test --
A. Uh-huh.
Q. -- is that something that you administered?
A. That was administered by Dr. Kampfer.
Q. In that test, basically we got some results from three trials; is that right?
A. Yes.
Q. Can you explain to us basically what a trial means?
A. The person would be shown pictures of common objects, one after another, every three seconds. And following 50 such pictures, the person would be shown two pictures, 50 different pages containing two pictures on the page. One would be what they already saw. One would be something that they never saw. We would ask them to point to or tell us which picture they saw. You do that first, when they're first learning it, and then you do it right -- you give the test a second time. You ask them a second time to do it again. And then 20 minutes later you don't give it to them again but you ask them to try to remember which of the two pictures we're showing you you saw previously, previously twice.
Q. That's something that whoever is giving the

32

test, they're the ones who control the speed; correct?
A. Yes.
Q. You are stating that the policy should be every three seconds that they show that; right?
A. Yes.
Q. So when she's doing this test, is she manually scoring this, then?
A. Yes.
Q. And those results would be where?
A. Right here in the book.
Q. Is that part of your written notes or is that some other section?
A. That's part of the raw test data. If you want that, if you have an expert -- like if Dr. Hibbard is going to be your expert, I would be more than happy to send all of the psychological test data to her as she sent to me.
Q. Fair enough. We'll probably want to get that from you.
So that I'm clear here, the test results that you have put in your report here were less than 39 on Trial 1, less than 49, and then less than 49 on Trial 3; is that correct?
A. Yes. I could give you the exact scores on each trial, which I probably put in there.

33

Q. I'm sorry. I think that's the standard that I just read to you.
A. Yes.
Q. The actual scores, according to page 13, were 33, 44, and 46.
A. Yes.
Q. I think on the third one, that fell into the normal range?
A. It did.
Q. Can you give me the ranges, where they cut off, so we can evaluate what --
A. Forty-five for Trials 2 and 3. There's been more recent research, which I noted -- the author is Stenclik, et al., 2013 developed norms also for the TOMM, Trial 1.
Q. How off do you have to be before it's significant to you?
A. You have to be under 45 on Trials 2 and 3. On Trial 1, less than 39.
Q. Then that's when it starts making -- it's clear to you that --
A. Yes. The lower it is the more they're obviously not trying to -- they're telling you things they know to be false. This was just within the range of being significant. Not way into the range.

34

Q. Some people that you've tested have scored as low as what?
A. I've had people score as low as 20 out of 50 correct. It's rare, but it happens.
Q. And that's just a straight loser right there? You know right away they're lying?
A. Straight loser.
Q. So there is a range, though, that -- is there a margin of error in here?
A. I can't -- you know what? I don't know if there's a specific margin of error. We use cut scores. There are times when a score of 43 or 44, although it suggests the person is malingering, I'll look at the rest of the data and say you know what? I'm not going to call that person a malingerer based upon one cut score that was off. So I won't do that. The only time I'll call someone malingering is when they have several -- three, four, five -- test results that are in that range. I don't rely on just one test.
Q. Did you feel like you needed to retest this part or these three parts or you felt like these were good scores?
A. Yes. I mean, I didn't retest anything. I mean, they were all good scores.

35

Q. Did Dr. Hibbard administer the same tests?
A. I believe she did.
Q. How did you guys get such different results?
A. He tried harder for her. That's the only explanation.
Q. Do you know what the ranges were that -- of the testing that she did?
A. I'd have to look it up. I don't know it offhand.
Q. Is there any -- to do all these tests within a six-hour period, I mean, from an outsider, seems brutal. Is there any scientific background that would show that maybe you won't get the best results by cramming it all in one session?
A. Some people do it in one session. I don't. Because -- especially when people are coming out of town. It is hard. It's hard for us. I'm tired after doing a full day. So I try to break it out over two sessions so that it isn't as anxiety producing or as difficult for people. Some people do it all in one day. Some people do it over three days. It just depends upon their philosophy or where they work and how many hours they can allocate to any one person.
Q. You mention here in your conclusions -- it says, "His test result is clearly indicative of

36

feigned auditory-verbal memory dysfunction."
Is that the right adjective? It's clearly indicative?
A. Well, on the CVLT, yes.
Q. I'm sorry. I switched gears here. We're now on the CVLT?
A. We're on the other test, yes.
Q. Let's go back up. Mr. Miller's test results -- going back to the TOMM. "Mr. Miller's test results on the TOMM indicate that he was purposely performing worse than he could have in order to impress his examiners that he has memory disturbance."
So you made that conclusion just based on these numbers; is that correct?
A. I made that conclusion based on everything together.
Q. But he was normal in his third trial; correct?
A. Yes.
Q. Yet you still feel like he was trying to impress you?
A. That statement is based upon not only his TOMM results but all of the other test results in this section of the report. Had he just taken the TOMM and had I not administered any of the other tests in this

37

section, I wouldn't have said that. I would have said that it appears he may not have given his best effort.
Q. The California Verbal Learning Test is another test, CVLT. Can we call it that?
A. Yes, CVLT.
Q. He scored a 14 out of 16?
A. No, that's the cut score for whether someone is feigning memory disturbance or not. Anything under 14 is indicative of feigned memory disturbance. His score was well below that.
Q. What was his score?
A. I've got to look it up. I'm -- I think it was 10 out of 16. But I want to really be accurate, which means I have to find it. Not that. Not that. Here it is. It's 10 out of 16.
Q. Can you just explain to me like you did with the other tests how this one is performed?
A. Well, a person is given a set of 16 words five times in a row and then asked after each -- it's a memory test battery. It's really not a test specifically designed for malingering. It's just that the research has shown that the part of this test that's sensitive to malingering is the part he failed.
So I'll give you 16 words. After each trial, you tell me as many of them as you can recall.

38

And we just keep going over it. I do it a second time, you do it a second time. Third time, third time. Fourth time, fourth time. Fifth time, fifth time. Add up all the words and I get a scaled score, a score that compares you to your age and education matched peer group. Then there is a short delay. Then there is a second list of words called List B, which is all new lit words. Then I ask you after I tell you List B, what do you remember of List B? So that sort of gets you off track a little. Then I say, hey, let's go back to List A that we did five times. Tell me all of the words that you remember without cues from me. And that person just says I remember da, da, da, da, da, da, da, this many words. And then 20 minutes later I ask them for -- right afterwards I will actually say, I'm going to give you a hint. I'm going to tell you to tell me all the words that were animals -- I'm making that up -- and you would just say, oh, animals, and that's a cue. And you would try to remember all the animals to see whether when you are cued your performance improves. We do the same thing 20 minutes later. At the very end of the test, I read a list of something like 50, 60 words off, and I ask you, if the word was on the list, say yes. If it's a word that wasn't on the list, say no.

39

Thousands of people have been taking this test and they find that people who can't -- who tell you fewer than 14 of the 16 words are not -- are purposely not telling you all that they know. So when you get down to ten, that's a very rare event. After you've heard something five times and you've practiced it, it's hard to not have remembered the word "cat," for example.
Q. Are they basic words like "cat"?
A. Uh-huh.
Q. Do you know the words that you used with him?
A. Uh-huh.
Q. What were they?
MR. VAN NESS: Are you trying to get his raw data?
Q. (BY MR. BENSON) I'm just curious.
A. I'm going to give you a couple of the words. I don't want to tell you the whole list because this is sort of copyrighted material. And if you guys go out and tell your clients, hey, when you get this test, here's some of the words on it, it screws up psychology in a big way.
So there are clothing and fruit and tools.
Q. Talking about like hammer?

40

A. Yeah.
Q. Or are they more complicated than that?
A. No. No.
Q. I can imagine if you gave a hard word, right, that would be harder to remember?
A. They're common words that people with no education should be able to remember.
Q. So he got 10 out of 16 on that?
A. On that last long delay cued recall component.
Q. What about the research that females do better on that test?
A. I'm not familiar with that. On which test?
Q. On the CVLT.
A. The CVLT 1 or 2? I am unfamiliar with the research. Though I could read an article, if you have one in mind, and give you my opinion.
Q. I just printed something off the internet. Obviously it's not super science. Memorylossonline.com. It's done by Catherine Myers, which is also copyrighted by her book "Memory Loss and the Brain."
We'll attach this as Exhibit 1.
Says here that overall women tend to perform better than men on the CVLT, especially in their

41

ability to make use of category information.
I found that actually on other Web sites too. Your testimony is that you don't see a distinguishing fact between male and female?
A. Well, there are norms for males and females. In other words, if a woman takes this test, I go to the female norms and see whether her scores are indicative of normal performance for females in a certain age group or not. So, no, I don't know the research on each of the different indices on this test. But that doesn't surprise me. Women do better than men at a lot of stuff.
Q. So on this test, you're basically really testing his memory? Is that all you are testing?
A. Yes.
Q. What medications was he on when you took this test?
A. I don't remember him being on much of anything. He was on Adderall, is all I think he told me he was taking.
Q. What is Adderall?
A. It's a psychostimulant used to treat ADHD.
Q. How does that affect someone who is taking --
A. It would improve his memory.

42

Q. It should improve it?
A. Oh, yeah.
Q. But you don't know whether or not he took it? Wouldn't it be important to know that prior to doing your testing?
A. I believe I asked him, and he told me he took it.
Q. How much was he taking?
A. I think he takes 10 milligrams. It would be in my report. That was my recollection. That's a normal dosage.
Q. Is that all he was taking?
A. I believe so.
Q. What's Aricept?
A. Aricept is a medicine that's used with Alzheimer's patients to sort of improve memory to the extent that it works. It's sort of -- I don't see too many -- I don't see too many people with Alzheimer's disease. I've read about Aricept. It works a little bit maybe. But neurologists are fond of prescribing it to people with Alzheimer's disease in the hope, since it is FDA approved, that it could slow down the loss in memory functioning. So I think his neurologist gave him Aricept.
Q. Was he taking Aricept when you did his

43

testing?
A. I don't believe so. He was sort of reticent to take these medicines as he said to me and hadn't been taking them as prescribed for a while and then decided to. I can't remember. I can try to look it up.
Q. Is there any research for someone who might be taking medication how that affects the test scores?
A. He was on a very low dosage of Aricept, 5 milligrams. He can't tell if it's helping. I'd have to read it more carefully. I don't know if he took the Aricept that day.
Q. Wouldn't you want to get a baseline, I mean, with someone like this, to really truly test them? Like no medication and then test them?
A. If the world worked that way, sure. Sometimes I do that with ADHD kids. I'll have them not -- I'll have them come in, mom and dad bring the pill, I test them in the morning without the medicine and see how inattentive or impulsive they are. Then I have them take the medication over lunch and then do similar tests, measuring similar skills in the afternoon to measure whether the pill has improved their motor speed or memory functioning or attention and concentration. Handwriting. It does a lot of

44

different things.
Q. In this case, you could have done that too; correct?
A. I suppose I could have told him -- well, I could have suggested don't take any medication until I see you and then if you want your medication later, go ahead. But in forensic cases, I usually don't tell people not to take their medications.
Q. Are you allowed to tell people not to take their medications?
A. I don't think so.
Q. Can you prescribe medication?
A. No.
Q. So moving on, then, you did the Reliable Digit Span Test, the RDS?
A. Yeah. Reliable Digit Span is just a way to manipulate the data from the Digit Span Test from the IQ test battery. It's the number of digits that a person twice in a row correctly recalls. And his Reliable Digit score, which is a very big indicator of effort, was well into the he's not trying so hard range and he's not doing what he could do.
Q. So what was his score?
A. He had like a scaled score of like -- I can tell you exactly. He had forward digits, just four.

45

Backward digits, two, which is --
Q. What does that mean?
A. Miserable. I mean, you could be -- you could take an eight-year-old who could do better than that.
Q. Just tell me, what type of a test? How does it go?
A. I would say numbers to you, like 3, 4, 2, 1. And you would say 3, 4, 2, 1. Starts off at two or three or four in a row, five in a row, six in a row, to see how many numbers you can keep in working memory and recall.
Q. How do we know what questions were asked of him?
A. It's in the test.
Q. It's in the test?
A. Oh, yeah.
Q. And we have copies of all that?
A. Have everything.
Q. Did you administer the RDS test?
A. Dr. Kampfer. The Digit Span Subtest. The RDS is just a way of looking at the data.
Q. Is that an age corrected score on his? Do you know?
A. Yes.

46

Q. Why is that important?
A. Well, people -- the older you get, the less well you do on things is the general rule. So while vocabulary pretty much stays fine and unaltered until 70ish or thereabouts, things like digit span or psychomotor speed where you're measuring speed of processing or fluid intelligence where you have new data that you've never seen before and you have to manipulate it gets worse as you get older.
Q. How is it malingering versus someone who might just have a true brain damage?
A. Well, if you fail a lot of the malingering indicators, it looks like malingering. His intelligence is intact. He did well on a lot of the tests, which is common in people who are malingering. They pick and choose what they want to do poorly upon. But I think the burden of proof is on you to show me he hit his head. He was knocked unconscious for a bit of time. We've got abnormalities on the CAT scan. Abnormalities on an MRI. Abnormalities on an EEG. Posttraumatic amnesia. He wasn't lucid at the scene. None of that exists. There is absolutely no evidence that this guy hit his head, was knocked unconscious, had posttraumatic amnesia. He had a normal CT. Couple of normal MRIs. He went back to the hotel, got

47

ready for dinner, went to a show. There's nothing wrong with him. That's not a brain injury.
Q. What makes you think that you have to hit your head to have a brain injury?
A. You can have a -- you don't have to hit your head to have a brain injury. You can have an injury, like blast injury, like in war, or a terrible whiplash injury where you're having diffuse axonal problems. But there is no evidence that any of that happened here.
Q. You are basing that on what exactly?
A. All of the records I reviewed and everything that he took, the behavior, his behavior. There's just nothing there.
Q. What about the recent MRIs that Fazzini ordered?
A. I have no clue. I have no opinion about those since I'm not a physician. Why didn't -- I was -- we were talking about this beforehand. I said, you know what? If he -- if those are really there, if that's truly well read, then he's developed something in his brain three years after this accident. Had it been there before, it would have shown on the other tests.
Q. Do you know what kind of MRIs were taken

48

before and after? Excuse me, not before and after. You are saying that the MRIs were the same?
A. Every machine is different. But I'm saying the likelihood of him having suddenly -- if there's something wrong with his brain now, as his wife said, maybe he has Alzheimer's disease. Maybe he is dementing. But he showed none of the signs of brain injury.
Q. Did he show Alzheimer's in your testing?
A. Nope. Because in Alzheimer's you will see word finding problems, dysnomia. His word finding was excellent. Not only did he ace the word finding test that he did also for Dr. Hibbard but he also -- he's very articulate.
Q. And he has got no college degree; correct?
A. Correct.
Q. Did you do an IQ test?
A. It was done. Dr. Kampfer administered the IQ test.
Q. Which test is that exactly?
A. The Wechsler Adult Intelligence Scale IV.
Q. What did he score on that?
A. There's a bunch of different scores. Are you interested in all of them, the full scale IQ? There is a bunch of scores.

Q. Why don't you tell me what a normal IQ is and then we'll establish that.
A. A normal IQ would be 90 to 110. That would be two-thirds -- or make that -- hold it. Let me see. From 85 to 115 would encompass 67 percent of the human race. Ninety to 110 is considered average. 110 starts the high average. 120 starts the superior range. 89 and below to 80 is considered below average, or low average. And then below 80 is borderline until you reach below 70, which is then significantly impaired.
Q. How did Alex score on your exam?
A. The IQ test is divided into subtests or index scores. There's a verbal comprehension index score which measures his verbal facility. He earned a score of 114, which means that he did better than 82 out of a hundred people his age, or in his age group.
There's also tests that are called perceptual reasoning, which are visual reasoning tests. He earned an index score of 111, meaning that he did better than 77 out of a hundred people his age in visual reasoning. We measured his working memory, which is attention and concentration for numbers and arithmetic problems. He scored in the low average

range at the 23rd percentile with a working memory index score of 89. We measured his simple processing or information processing speed using a pencil. He scored in the average range at the 30th percentile with a processing speed index score of 92. Taking all of that together, his full scale IQ, what we call the IQ, was average, 104. 61st percentile, average range.
We also have one other score which is called the General Ability Index, which is an interesting one. A good one. It takes out the working memory and processing speed parts of the test because information processing speed and working memory are not higher level thinking skills. So the General Ability Index includes only the verbal comprehension and perceptual reasoning subtests and measure higher level reasoning skill. He did better than 82 out of a hundred people his age, earning a General Ability Index score of 114.
Q. How long does it take to perform the IQ test, though?
A. Hour and a half, give or take.
Q. He scored lowest on his math?
A. No. His math was actually better than his digit span, which makes no sense because -- he's doing mental -- he's doing word problems in his mind. A word problem in your mind where you have to remember a

couple of numbers and a bunch of words and manipulate the numbers without the use of paper tends to be a harder thing to do well upon than digit span which makes digit span much easier to perform. Because all you have to do is remember the numbers 1, 3, 6, 2, 4, 5 and repeat 1, 3, 6, 2, 4, 5. A lot easier than doing a math problem in your head. He did much better, significantly better, in mental arithmetic, 50th percentile, than he did on digital span, 9th percentile.
Q. On page 16 there's a distinction here between his reading and his math. You clearly indicate that his math was lower.
A. You are looking at achievement test, not the intelligence test. That's a whole other battery of tests we did.
Q. Gotcha. So he had a different score, then, between your IQ and then that other test; correct?
A. Let's take a look. On the Woodcock-Johnson-III test of achievement, we administered three different math tests. One's called math fluency. Math fluency is do you know seven plus one equals eight, ten minus two equals eight. It's a three-minute test that you give kids or adults and just go at it and do these one digit

addition/subtraction/multiplication problems as fast as you can.
In math fluency, he scored in the limited to average range at a 7th grade equivalent, 7.1 grade equivalent. So slower than expected. Especially in comparison when he did higher level math on calculations, fractions, division, several digit multiplication, things like that, he scored at a first year college level in the average to advanced range. Then when we gave him higher level word problems on the Applied Problems Subtest, he scored at 12.5 grade equivalent, in the average range, exactly where his peer group -- people who have that type of education should fall typically.
So his weakest was in math fluency. And math fluency is much easier than all of the rest of the math tests.
Q. I guess I'm curious on this. If you have a left brain/right brain person, you've always heard someone who might be right brained is more into math and engineering and someone left brained might be into arts and music and that kind of thing. Is there any truth to that?
A. Popular gobbledegook.
Q. So someone might be very good at math and

53

still be in the arts?
A. Yes. And doing cubism or something.
Q. Anything significant in, like, his motor skills?
A. I did his motor skills stuff, his tests. I'll look it up. Motor skills. I did all of that battery. The actual -- I want to go to my report where I actually made sense of the motor skills. Sorry. His right-handed motor test results were much superior to his left-handed motor test results.
We measured strength of grip using a hand dynamometer, finger-tapping speed using a little finger-tapping machine, and dexterity, or hand/eye dexterity, putting pegs into a pegboard as fast as you can.
I asked him, do you notice differences in the way you perform left hand to right hand? He answered my left hand and arm is not as strong and dexterous as my right. He said that he doesn't have the same level of sensation in his left upper extremity as I did prior to the auto accident. He describes sensations of numbing and tingling in his left hand at the base of his thumb and said that one of his physicians explained, quote, this is related to damaged discs in my neck, vertebrae, misalignment, and

54

pressure. He's had trigger-point injections by Dr. Kulick for this. The last a few months before. Basically that all of these problems were a result of the subject accident and didn't preexist the subject accident.
Q. So right-hand strength is usually shown when you are right-handed; is that correct?
A. Yes.
Q. So he's fairly normal on that point?
A. Below average but unimpaired. Still within normal range.
Q. Someone who has traumatic brain injury or mild traumatic brain injury or the type of brain injury that he may have or may not have, would they necessarily have a motor skill problem?
MR. VAN NESS: Object as to form of the question.
THE WITNESS: Depends upon where the brain was hurt. If it was in the motor strip or the prefrontal area or deep into the cerebellum possibly, he could have some motor coordination problems. It isn't so unusual to have lousy scores on these tests, because you have other nonbrain-related problems and your -- like I have arthritis. So if I were asked to do these tests, I would mess them up. You can have

55

had a shoulder, rotator cuff, a number of --
Q. (BY MR. BENSON) You lift weights, right.
A. Any of that.
Q. Information processing speed. This is part of the IQ test?
A. Part of it is, yes. Part of it is extra tests that aren't part of the IQ test. Different tests that measure different types of information processing.
Q. Briefly, can you tell me how he scored on the processing speed?
A. On the intelligence test processing speed, he was in the average range. On a test called the Stroop Word Subtest, which you give the person to read words, three words, red, green, and blue, that are in no particular order. You read them as fast as you can. You stop them after a certain number of seconds. He was average. He read that in average fashion. Then you have them read colors -- red, green, and blue. So not the word, but the color red is there, the color green is there, and you read the colors as fast as you can. His reading speed was quicker than his color reading speed. His color reading speed was mildly impaired. T-score of 35. Not that anyone knows what that is. That was off.

56

Then we gave him the reading fluency test from the Woodcock battery, and he was average at reading sentences at a normal rate. He was slow at the math fluency, which I already discussed. And his speech was either halting or very fast. It just sort of changed.
Q. Language skills, he did real well?
A. Good language skills.
Q. Is that something you can fake if you wanted to?
A. Oh, yeah. You can try to. I'm pretty good at catching fakers at that. But you can try.
Q. And you noticed he didn't fake that; correct?
A. Nope. Nope.
Visual organization skills, good. Attention, working memory skills, we've done some of that already. The best -- there's so many different of these tests. Page 17 at the end, I said, taken together, Mr. Miller's attentional abilities and working memory ranged from below average, 9th percentile, on the WAIS-IV Digit Span to average on WAIS-IV arithmetic. That was 50th percentile. With most of the tests falling between the 16th and 27th percentiles.

57

Q. That's good or bad?
A. It's okay. Not great. Worse than his visual thinking skills, worse than his verbal thinking skills, but not terrible.
Q. How can you tell if someone has brain damage, from your point of view, when you take all these tests and look at them?
A. That's the art of putting all of these things together and looking at all the tests, looking at the data. Is there medical evidence of brain damage? Is there not medical evidence of brain damage? Talking to the person. Do they look and sound and talk like a brain-damaged person or they don't. What are the test results? Are they consistent and say one thing or are they inconsistent and all over the place?
Q. What about the symptoms he was having right after the accident?
A. He said he was having headaches and he really had to be in a dark room for a while and he couldn't go back to work and then was going back part time. Could be, if that was a brain damage. That would be consistent with brain damage. It could be that. Could have had headache problems for whatever reason.

58

Q. Do you know if he had a history of headaches?
A. I don't think he told me he did or it would have been in my report.
Q. Anything else? I know there's a lot of stuff to cover in your report. But is there anything that is super important that you think that I would like to know about? I know that's kind of a crazy question. Is there anything that you would testify to that you think is important in the next five, six pages there?
A. I mean, I could go through his personality test results if you want.
Q. What's important about that?
A. The MMPI-2 indicated that he may be malingering cognitive symptoms. That's a very well-respected, excellent personality test that says this guy is presenting memory complaints that make no sense. So he may be malingering cognitive symptoms. Which is what I said he was doing, given all of the other test results I've been talking about.
It also suggests that a somatoform disorder, which means that if you can't substantiate his physical complaints via objective medical evidence, then they may be of psychological origin, which if you

59

are under enough stress, you'll have headaches, stomachaches, diarrhea, low back pain. All sorts of things. Because you're in stress. You lost your job, in his case. You know, all of that. These were some of the things that the MMPI-2-RF mentioned. Looks like he has some marital problems. We talked about this. I actually went through the results with him and asked him, do these results make sense or not make sense? Because I want to see if he's -- these tests bring out group norms. So just because it says something about you doesn't mean that sentence or that attribute that you seem to be high on is true. So I ask. Well, it says here that you may be having marital problems. And I listen. Well, you know, I do have marital problems and here's why or my libido is low. So I'll ask the people and say, here's what the tests say about you, given what you told the test, does this make sense to you?
Q. He's been married for a long time; right?
A. Yes.
Q. Is it -- are you diagnosing him with marital problems?
A. No. I don't know him well enough. I mean, he told me he has marital problems. I'm not --
Q. Did you get at a cause of why he has marital

60

problems?
A. I don't have any real -- I don't know enough about them to say that he has marital problems for any particular reason.
Q. And you are not blaming the fact that he got terminated from work or that he's not working based on his marital problems?
A. No opinion.
Q. The MMPI, can that be affected by his use of Adderall?
A. No. At most he would do it better. He would make careless errors, but otherwise, no. And to make this go quicker, in the summary section, I basically list out as logically as I can why I have the opinions I have. You probably want to ask me about that.
Q. So you looked at the property damage. You thought that was significant; right?
A. I thought the person who knocked into him had significant property damage.
Q. Did you look at those photos?
A. Yes.
Q. Was that part of your report? I didn't see --
A. I don't know if I -- I mentioned that I saw

61

the photos. I don't know if I had any particular -- since you would tell me, hey, you're not an accident reconstructionist. So you can't rely on it. I saw the photos.
Q. I think we can all use common sense at some degree. But you did look at both sets of photos?
A. I did.
Q. Your summary said you only looked at Mr. Marino's vehicle, which would have been the suburban?
A. Then I'm wrong. I looked at both.
Q. All the photographs are in your file?
A. In there.
Q. Can you show me them?
A. Sure. See if they're here. Yep. They're black and white. I don't know if they were black and white originally. Just whatever. There's a lot of them.
Q. Do you normally get the photographs?
A. Oh, yeah. Police reports, ambulance reports, photographs, depositions.
Q. Do you rely on police reports?
A. Oh, yeah. I think those are important. Because they are objective. And the person was there and they saw something. Just like -- looks like about

62

40 pages or so of photographs.
Q. Keep it right there. I just want to flip through what you've got. I'm just looking at what you've already got numbered as B001. There's 10. Go on to 11. Here's 12, 13, 14, 15, 16, 17, 18, 19, 20, 21.
A. Then the other car.
Q. I just wanted to keep going here. Looks like you've got C and then they start at D. What kind of car was she driving?
A. Was it a Honda? I don't remember.
Q. But her air bags went off; right?
A. It looks it, yes.
Q. Is that significant to you?
A. Yeah.
Q. Why is that significant?
A. She hit him -- the front of her car hit him at a decent enough speed that whatever that speed happens to be that makes an air bag go off.
Q. In your report you don't mention that that's being significant, do you?
A. I'm not an accident reconstructionist.
Q. But you mention that the vehicle that my client was in was minor, but you failed to mention -- how do you rate that damage to the Nissan?

63

A. Looks pretty damaged.
Q. Is that significant?
A. Significant damage.
Q. Is there anywhere in your report where you reference that?
A. I don't believe so. She wasn't the one suing for medical problems.
Q. That's your rationale?
A. I mean, maybe I just didn't think of it. I am very willing to say that her car was very damaged and his car was hardly damaged at all.
Q. Based on that, you came up that -- your diagnostic impression is V65.2, malingering, of cognitive disorder?
A. Yes.
Q. You go on to say -- here's a paragraph. I'll just kind of go through it. Maybe it's important. Evidence of -- this is on page 25, second paragraph, "Evidence of malingering during this evaluation included Mr. Miller's variable style of speaking where, as reported previously in this report, he spoke in a more halting manner, taking longer than normal to express himself, especially in the front office and waiting room situations."
In the waiting room, how do you know how

64

he's talking?
A. I imagine my office manager or anyone who is in my office who spoke to him mentioned that.
Q. Is that documented somewhere?
A. Don't know. Should be. But I don't know.
Q. It's in your report; right?
A. Yes.
Q. So you are relying on this?
A. Yes.
Q. Then you say when he's with you, he speaks in an articulate, intelligent, and eloquent manner.
A. When he's talking about the stuff he's proud about himself. The way he presented himself changed. If you have brain damage, you don't speak perfectly when you speak about something you like about yourself and then start stuttering and going slowly when you are speaking about your injuries.
Q. Did he ever speak slowly and in a halting manner when he was in front of you?
A. Oh, yeah.
Q. When?
A. During interview.
Q. But you said that he did quite well when he was doing that, articulate, intelligent, and eloquent.
A. When he was speaking about his career. When

65

he was speaking about his accident, things like that, he tended to be much slower and less exact. I think I said -- I'm pretty sure I said that.
Q. You are saying this variability in his presentation suggests that he was consciously attempting to manipulate the impressions of the examiners. You are telling me your front desk clerk is the one that you are comparing this to?
A. No. I also saw this.
Q. Who is the front desk clerk?
A. That would have been Donna Calendar.
Q. Does she take her own notes?
A. No, she doesn't.
Q. Does she have any credentials?
A. Nope.
Q. Do you claim to know what someone is thinking?
A. I don't.
Q. Out of all the tests that you gave in terms of malingering, what do you rely on the most?
A. None. I rely on -- what makes the diagnosis stick is when you have two, three, four, five different test results. The greater number the test results that the literature indicates is consistent with a malingering diagnosis the more -- that is when

66

I will give the diagnosis. If it was just the TOMM or just the MMPI-2 or just the CVLT, I would never say malingerer. Never.
Q. How do you contrast that with someone else who, like Dr. Hibbard, who is not -- not really a plaintiff's expert when she did the testing?
A. Contrast meaning what?
Q. How do you contrast, like, her results? You take a variety of results when you do this; right?
A. Yes.
Q. You are only relying on what you did or your staff did or your front desk clerk did?
A. Well, I tried to rely on what she did, but she made so many errors, it was hardly believable how many errors she made. So --
Q. Did you find out that those errors were insignificant? Because she did a rebuttal report.
A. They were significant. I mean, I wouldn't trust anything she does. I mean, seriously. If a doctoral student who I was training made that many errors, I would send that person back to their school and say don't return. That's how bad it was. It was so beneath standards. I couldn't believe it, for someone who has got a diplomate. So I place no credibility on her work. Though once upon a time she

67

was clearly competent.
Q. What happened, do you think?
A. I have no clue. She would know. But I don't know.
Q. The testing -- do you have her report in your file?
A. Somewhere. Which one?
Q. The neurological reevaluation.
A. Possibly.
Q. Looks like it's 24 pages. The date was March 14, 2014.
A. Probably in this section.
Q. Probably in that last --
MR. VAN NESS: Third supplement.
Q. (BY MR. BENSON) Third supplement.
A. I have it, I think. Yes.
Q. You reviewed that?
A. I did.
Q. Looks like you've got some highlights on that?
A. Yes.
Q. What did you highlight about that?
A. I just use highlighters. If something looks like it might be interesting, I highlight it. I highlight magazines and newspapers too.

68

Q. When you reviewed her supplement or reevaluation versus her other report, was there anything that you found significant in the reevaluation?
A. More errors.
Q. That she did more errors the second time?
A. Just fraught with errors.
Q. Let's go through them, please.
A. I'm not sure I can pick them all out at this point. I didn't bother writing a -- I wasn't asked to write up all the different errors.
Q. Generally looking at it, you apparently have come up with the conclusion that there are errors; correct?
A. Well, I looked at it back then and I picked out things that were errors, but I didn't really place any emphasis on the report as a result of her lack of competence in administering, scoring, and interpreting tests.
Q. You're looking at page 21. What on there is so glaring to you?
A. Right offhand, I can't tell you. Hold it. Hold it. Hold it. Maybe I can tell you. No, I don't think I did -- I didn't do anything. So, no, right at this point, I was just trying to figure out -- I can't

69

tell you. I am not ready at this point to tell you all the errors she made. I just found things. It would take me a good hour, hour and a half to go back and try to reconstruct the errors here. I just gave up. Since I wasn't going to give it any credence, I just said, okay, this is ridiculous. Maybe she did a better job the second time.

Q. She gives the comparisons what the testing was on October 3rd, 2011, and then she gives the scores of the retesting of March; correct?

A. But you can't rely that any of the things in here are accurate. Some are; some aren't.

Q. Right. And we are just going by what you're saying; right?

A. I mean, I can prove it, if it comes down to going on the stand. If that comes down to it, I'll be able to say this is exactly what she did and show you why it wasn't right.

Q. Everything you guys did was perfect; right?

A. Well, give my stuff to her. Have her pick out as many mistakes as you can. Good luck to you. There will be fewer. Perfect? Never.

I mean, I'm just looking. Here's a mistake. I mean, they're everywhere. A scaled score of 16, a graduate student knows it means 98th percentile. She

70

has 84th percentile. Then she says very superior. Very superior is the 98th percentile, not the 84th percentile. This is like first year of graduate school.

Here's another one. Scaled score 19, 50th percentile. 50th percentile is average. 99th percentile is very superior. The scaled score of 19 is the highest score you can get. There is nothing higher. If you get a scaled score of 19, you are unbelievable.

Q. Are you going by the old or are you going by the new?

A. What is it?

Q. What page are you referencing?

A. Page 10 of the new.

Q. You are referencing the old one. Those are the ones where she made the corrections.

A. Where did she make the corrections?

Q. They're in the new report on the last two pages.

A. Okay. I see. The last two pages. Let me see. It looks like she omitted some of the scores on the D-KEFS test that she had placed in the other test result. I don't know why she did that. She omitted two tests, the D-KEFS fill dots and empty dots from

71

2011. Don't know why she did that. She also omitted the D-KEFS 20 questions abstract and total scores from 2011 in comparing them. I don't know why she did that. She was, I guess -- she learned that she should have given a good personality test. She did that at least.

Q. What were her -- were those consistent with what you found?

A. Let me take a look. I'd have to look it up and compare all the different subtests.

Q. I know it's laborious. This is my one shot, man.

A. That's different. That's not bad.

MR. BENSON: Off the record for a second.

(Discussion off the record)

THE WITNESS: This is why I didn't spend as much time. She didn't even include the most important scales.

Q. (BY MR. BENSON) What was that?

A. Those are the higher order and reconstructed clinical scales. Those are the meat of the test. She left those out. It's just not worth the time.

Q. What do you mean she left that out?

A. It's not in here. She put in some of the validity scales. Then she went to the --

72

Q. Are you saying it's not part of her report or that she left it out?

A. She left it out of the entire chart. There are a bunch of things that she didn't put in here. God knows why. I don't know why.

Q. Do you know that for sure?

A. Swear on a stack of Bibles.

Q. That the analysis --

A. There's scales missing. I can show you the scales that are missing. It might have been just another careless error.

Q. That's primarily on the mood and personality; correct?

A. Yes. That's what I just saw on that test, the test scores. But in terms of the -- I can't give you -- besides the few things I wrote down here that were mistakes, I would have to take an hour and go through here. She made so many mistakes. I would literally have to go through every single thing that she wrote and compare it to the raw data. Now, I didn't get the raw data from this testing. There was no sense in trying to figure it out. Because without the raw data, I can't figure out whether she scored the retesting correctly or incorrectly. I mean, on the first testing, she changed things -- she changed

73

things that they told her were wrong.
Q. Same goes for her too. She would need your raw data to actually evaluate what you did?
A. I would give it to her in a heartbeat.
Q. Just looking, then, at pages 21, 22, 23, and 24 of the retesting that was done on March 14th, 2014 --
A. 21, 22, 23. Yep.
Q. So looking at those, it's kind of a summary, would you agree, of the neurological tests that she did?
A. Yes.
Q. Out of that summary, are there particular tests in there that are the malingering at least tests or the feigning tests that you would highlight?
A. There is Reliable Digit Span, Rey 15.
Q. This is on page 21?
A. That's on page 21.
Q. I'm going to star that one.
A. Dot Counting, Rey 15, Reliable Digit, and she used the CVLT recognition as I did. There he did perfectly. He gives better effort for her. This MVLT -- those are the ones I think that are specifically for malingering.
Q. So he did a 16 out of 16 both times, right,

74

with her?
A. Yes.
Q. Then with you he did a 10 out of 16? Oddly.
A. Oddly, but yes.
Q. Then the dot counting test, E-score equals 13.
A. I never use dot counting; so I can't make sense of it.
Q. Anything else that you noticed on the first page here that it goes towards the malingering or the feigning of symptoms?
A. Those -- the rest are not malingering tests.
Q. On the next page, are there any that are malingering tests?
A. Digit Span can be, but he was okay on that.
Q. In fact, that's the one where he got a nine and he got an eight there?
A. Yes.
Q. That's within the range; right?
A. That's normal.
Those -- I think the malingering tests were on the first page of that.
Q. So no other tests, then, really go to the malingering except for that first page?
A. Offhand. But I would have to look at her

75

raw data to see the real scores versus what she put in there.
Q. I have a few things to go over here.
Did your testing reveal that he was depressed?
A. Yes. Some.
Q. Is there a way of scaling that?
A. Get to that answer. I was going to say dysthymic disorder. So probably mild to moderate depression. Not severe major depressive disorder.
Q. What is PTSD?
A. Posttraumatic stress disorder.
Q. Does he have that?
A. No.
Q. Can you tell me more about what PTSD is?
A. PTSD, if you have a life-threatening event -- you're in a terrible car wreck, you're a prisoner of war, someone holds you up by gun, rape, seeing someone else die or almost die. Terrible -- you know, soldier stuff. Concentration camp. But terrible auto accidents. You can see something that's beyond the range of human experience that is life threatening and you have nightmares and you get very frightened. You have a nervous system reaction that makes you very anxious.

76

Q. On page 21 of your report, you indicate that he has got anxiety-related disorders, including PTSD.
A. Those are the rule-outs from the MMPI-2. Those are things it could be, but you look at it and see whether -- those are differential possibilities.
So I diagnosed him with an adjustment disorder with mixed anxiety and depressed mood, meaning that he's somewhat anxious and somewhat depressed. He's lost his job. He's not the breadwinner. He's trying to find himself. That all makes for an unhappy guy.
Q. You do a fair amount of personal injury; correct?
A. Yes.
Q. Do you do workers' compensation?
A. Hardly ever.
Q. Do you have any general opinions of workers' compensation doctors?
A. No.
Q. You read all the records, including Dr. Chacko in this one?
A. Yes.
Q. What kind of doctor is Dr. Chacko?
A. Was he a neurologist? Off the top of my head.

77

Q. I don't believe so, but --
A. I got to look it up. I read it over again today. Look for Chacko. If you could find when he saw him, I will find out.
Q. March 2012.
A. March 2012? Neurological. I was right. Neurological exam.
Q. You were right. You are relying on Dr. Chacko as part of your assessment?
A. All of the doctors. I read all of them. I mean, in forensic cases, you get doctors saying one thing and then doctors saying the opposite. Whatever you -- there's something for you or -- you are going to get a lot of different opinions.
Q. Have you spoken to the expert neurologist hired by the Sisolaks?
A. Nobody. I have spoken to no one.
Q. Did you rely on their reports at all, the neurology reports?
A. As much as I relied on all of the reports. I mean, I read them. They go into the equation of helping me form my opinions. I don't give greater credence necessarily to Dr. Chacko versus someone else.
Q. Have you read Dr. Chacko's deposition?

78

A. Yes.
Q. After that deposition, you still have the same opinion?
A. I don't remember his deposition. I didn't read it today.
MR. BENSON: All right. I'll pass the witness.
MS. TAYLOR: I don't have any questions at this time.
MR. BENSON: Before we end the deposition, I'd like to attach as Plaintiffs' Exhibit 2, the report, and then 3 would actually be his entire file.
MR. VAN NESS: With the exception of what he can't produce to you, which he will produce to your expert.
THE WITNESS: Let me make it easy. Entire file, billing records, interview records. I'll send the test results to Dr. Hibbard if you give me her address. So the psych data goes to Hibbard. The interview goes to you. The correspondence with attorney goes to you. The billing goes to you. In terms of the medical records, you want us to make copies of this? It will cost you an arm and a leg. I don't care. 60 cents a page.
MR. BENSON: It's not that I want that. But

79

I do need to know what you relied on. So go ahead and attach that.
THE WITNESS: You want all the medical records?
MR. BENSON: Whatever you relied on.
THE WITNESS: Oh, my God. I'm not going to be able to go through there and tell you that. That's crazy.
MR. BENSON: Is this your file here?
THE WITNESS: Yes. Two files.
MR. BENSON: It's got about four reams?
THE WITNESS: Yeah. I read everything. How much of it was --
MR. BENSON: I don't know what you relied on. If they only gave you half the medical records, and you're giving me opinions --
THE WITNESS: That should be in my report. In my report, it will say here's the records I reviewed.
MR. BENSON: I'll be fair with you. I'll skip the medical records for now. We want to make sure we have all the notes, all the testing data, the photographs that you relied on, the estimates that you relied on --
THE WITNESS: You want photos?

80

MR. BENSON: Yeah. That are part of your report today that's going to go directly to her.
THE WITNESS: Okay. You got it.
MR. BENSON: That will be 3.
THE WITNESS: If you give me Dr. Hibbard's address, or give it to Donna. Call from your office. We will send all of that stuff to her too.
MR. BENSON: It's on her report. Right at the bottom. You have a copy of her report; right?
THE WITNESS: Yes. That is the right address.
MR. BENSON: That's it.
(Exhibits 1 and 2 were marked)
(The deposition was concluded at 3:42 p.m.)
* * * * *

CERTIFICATE OF DEPONENT

I, LEWIS M. ETCOFF, PH.D., A.B.N., deponent herein, do hereby certify and declare the within and foregoing transcription to be my deposition in said action, subject to any corrections I have heretofore submitted; and that I have read, corrected, and do hereby affix my signature to said deponent.

_____
LEWIS M. ETCOFF, PH.D., A.B.N., Deponent

Subscribed and sworn to before me this _____ day of _____, _____.

STATE OF NEVADA)
ss:
COUNTY OF CLARK)

_____
Notary Public

CERTIFICATE OF REPORTER

I, Marnita J. Goddard, CCR No. 344, a Certified Court Reporter licensed by the State of Nevada, do hereby certify:

That I reported the deposition of the witness, LEWIS M. ETCOFF, PH.D., A.B.N., commencing on Monday, August 25, 2014, at the hour of 1:58 p.m.;

That prior to being examined, the witness was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth; that I thereafter transcribed my related shorthand notes into typewriting and that the typewritten transcript of said deposition is a complete, true, and accurate record of testimony provided by the witness at said time.

I further certify (1) that I am not a relative or employee of an attorney or counsel of any of the parties, nor a relative or employee of any attorney or counsel involved in said action, nor a person financially interested in the action, and (2) that pursuant to NRCP 30(e), transcript review by the witness was not requested.

IN WITNESS WHEREOF, I have hereunto set my hand in my office in the County of Clark, State of Nevada, this _____ day of _____, 2014.

_____
Marnita J. Goddard, RPR, CCR No. 344

EXHIBIT "3"

THE PRIMARY CARE COMPANION FOR CNS DISORDERS

Information for Authors
Register
About Us
Now @ PCC

Prim Care Companion CNS Disord. 2015; 17(5): 10.4088/PCC.15f01840. PMCID: PMC4732308
Published online 2015 Oct 22. doi: 10.4088/PCC.15f01840: 10.4088/PCC.15f01840 PMID: 26835164

Impact of the Doctor-Patient Relationship

Fallon E. Chipidza, BA, Rachel S. Wallwork, BA, and Theodore A. Stern, MD*

*Corresponding author.
Corresponding author: Theodore A. Stern, MD, Harvard Medical School Massachusetts General Hospital, Department of Psychiatry, Massachusetts General Hospital, Fruit St, WRN 605, Boston, MA 02114 (tstern@partners.org).

Received 2015 May 21; Accepted 2015 Jun 12.

Clinical Points

- Trust, knowledge, regard, and loyalty are the 4 elements that form the doctor-patient relationship, and the nature of this relationship has an impact on patient outcomes.
- Factors affecting the doctor-patient relationship can be patient-dependent, provider-dependent, health system–dependent, or due to patient-provider mismatch.
- Solutions to each of these factors are rooted in the 4 elements of the doctor-patient relationship.

Have you ever wondered what makes the doctor-patient relationship so powerful? Have you ever considered what you could do to strengthen it or to prevent it from crumbling? Have you thought about the consequences of unsatisfactory or adversarial relationships? If you have, then the following case vignettes and discussion should prove useful.

CASE VIGNETTE 1

Mr A, a 43-year-old man with a 20-year history of intravenous drug abuse (complicated by hepatitis C and recurrent abscesses), was admitted to the hospital for treatment of acute bacterial endocarditis. His inpatient medical team consulted the addictions consult/substance abuse team, who evaluated and enrolled him in an outpatient methadone clinic. Mr A noted that prior to this assessment he had never had a "decent" conversation about addiction treatment.

CASE VIGNETTE 2

Ms B, a 75-year-old woman with an alcohol use disorder and gastroesophageal reflux disorder, presented to the oncology clinic following her new (incidental) diagnosis of gastric carcinoma. During the visit, the oncologist explained the importance of assessing the depth of the tumor's invasion into the gastric wall (ie, to stage the tumor and to decide on treatment options). He noted that if the tumor was confined to the most

superficial layer of the stomach, it could be excised during an endoscopy. If the tumor went deeper, Ms B would need radiation and/or chemotherapy or surgery. The oncologist arranged for an immediate visit by the surgeon, who informed her that the cancer would almost certainly be invasive and that he planned to remove a large part of her stomach. He described her surgery as very serious, but necessary, because her cancer was very likely to lead to death. As the surgeon turned to write his note in the electronic medical record, Ms B began to shake her head from side to side and cry.

WHY IS THE DOCTOR-PATIENT RELATIONSHIP SO IMPORTANT?

The doctor-patient relationship involves vulnerability and trust. It is one of the most moving and meaningful experiences shared by human beings. However, this relationship and the encounters that flow from it are not always perfect.

The doctor-patient relationship has been defined as "a consensual relationship in which the patient knowingly seeks the physician's assistance and in which the physician knowingly accepts the person as a patient."[1(p6)] At its core, the doctor-patient relationship represents a fiduciary relationship in which, by entering into the relationship, the physician agrees to respect the patient's autonomy, maintain confidentiality, explain treatment options, obtain informed consent, provide the highest standard of care, and commit not to abandon the patient without giving him or her adequate time to find a new doctor. However, such a contractual definition fails to portray the immense and profound nature of the doctor-patient relationship. Patients sometimes reveal secrets, worries, and fears to physicians that they have not yet disclosed to friends or family members. Placing trust in a doctor helps them maintain or regain their health and well-being.

This unique relationship encompasses 4 key elements: mutual knowledge, trust, loyalty, and regard.[2] Knowledge refers to the doctor's knowledge of the patient as well as the patient's knowledge of the doctor. Trust involves the patient's faith in the doctor's competence and caring, as well as the doctor's trust in the patient and his or her beliefs and report of symptoms. Loyalty refers to the patient's willingness to forgive a doctor for any inconvenience or mistake and the doctor's commitment not to abandon a patient. Regard implies that the patients feel as though the doctor likes them as individuals and is "on their side." These 4 elements constitute the foundation of the doctor-patient relationship.

WHAT IS THE STRUCTURE OF THE DOCTOR-PATIENT RELATIONSHIP?

In their seminal article from 1956, Szasz and Hollender[3] outlined 3 basic models of the doctor-patient relationship.

Active-Passive Model

The active-passive model is the oldest of the 3 models. It is based on the physician acting *upon* the patient, who is treated as an inanimate object. This model may be appropriate during an emergency when the patient may be unconscious or when a delay in treatment may cause irreparable harm. In such situations, consent (and complicated conversations) is waived.

Guidance-Cooperation Model

In the guidance-cooperation model, a doctor is placed in a position of power due to having medical knowledge that the patient lacks. The doctor is expected to decide what is in the patient's best interest and to make recommendations accordingly. The patient is then expected to comply with these recommendations.

Mutual Participation Model

APP-1261

The mutual participation model is based on an equal partnership between the doctor and the patient. The patient is viewed as an expert in his or her life experiences and goals, making patient involvement essential for designing treatment. The physician's role is to elicit a patient's goals and to help achieve these goals. This model requires that both parties have equal power, are mutually interdependent, and engage in activities that are equally satisfying to both parties.

While each of these models may be appropriate in specific situations, over the last several decades there has been increasing support for the mutual participation model whenever it is medically feasible.[4]

HOW DOES THE NATURE AND QUALITY OF THE DOCTOR-PATIENT RELATIONSHIP AFFECT HEALTH OUTCOMES?

Gordon and Beresin[5] asserted that poor outcomes (objective measures or standardized subjective metrics that are assessed after an encounter) flow from an impaired doctor-patient relationship (eg, when patients feel unheard, disrespected, or otherwise out of partnership with their physicians[6]). Thus, there are many different outcome measures. However, these measures can be divided into 3 main domains: physiologic/objective measures, behavioral measures, and subjective measures. Examples of outcome measures for each of these categories are shown in Table 1.

Stewart et al[7] noted that the physician's knowledge of the patient's ailments and emotional state is associated positively with whether or not those physical ailments resolve. In this instance, the outcome measure is resolution of symptoms (ie, recovery).

In a follow-up meta-analysis of how doctor-patient communication affected outcomes, Stewart[8] noted that the quality of communication during history-taking and management also affects outcomes (eg, frequency of visits, emotional health, and symptom resolution) and that such communication extended beyond creation of the "plan." The manner in which a physician communicates with a patient (even while gathering information) influences how often, and if at all, a patient will return to that same physician.

Furthermore, the quality of communication between doctor and patient involves assessment of the doctor's willingness to include a patient in the decision-making process, to provide a patient with information programs, and to ask a patient about his or her explanatory model of illness (ie, the perception of the disease as influenced by personal customs and beliefs).[9,10]

WHAT IS PATIENT SATISFACTION AND HOW IS IT AFFECTED BY THE DOCTOR-PATIENT RELATIONSHIP?

Patient satisfaction is defined as "the degree to which the individual regards the health care service or product or the manner in which it is delivered by the provider as useful, effective, or beneficial."[11] Moreover, all 4 elements of the doctor-patient relationship impact patient satisfaction.

Trust. Bennett et al[12] found that, among patients with systemic lupus erythematosus, those who trust and "like" their physician had higher levels of satisfaction. In another study,[13] patients' perceptions of their physician's trustworthiness were the drivers of patient satisfaction.

Knowledge. When doctors discovered patient concerns and addressed patient expectations, patient satisfaction increased as it did when doctors allowed a patient to give information.[14,15]

Regard. Ratings of a physician's friendliness, warmth, emotional support, and caring have been associated with patient satisfaction.[16–18]

Loyalty. Patients feel more satisfied when doctors offer continued support; continuity of care improves patient satisfaction.[13,14]

APP-1262

WHICH FACTORS CAN ADVERSELY INFLUENCE THE DOCTOR-PATIENT RELATIONSHIP?

While the attributes and benefits of a favorable doctor-patient relationship have been characterized, few studies have provided solutions for an impaired relationship. Therefore, we propose 4 categories (patient factors, provider factors, patient-provider mismatch factors, and systemic factors) that can interfere with the doctor-patient relationship.

Tables 2–5 summarize the major factors in each of these categories, list elements of the doctor-patient relationship affected by each factor, and propose possible solutions; however, these tables are by no means an exhaustive accounting of the nuances of the doctor-patient relationship.

CASE DISCUSSION

The case of Mr A illustrates an exemplary doctor-patient interaction. He had been hospitalized on multiple occasions with complications (eg, hepatitis C, abscesses, and endocarditis) secondary to his underlying disease (intravenous drug abuse). His medical team made an effort to develop their knowledge of the patient and his disease. Consequently, the team was able to recognize and address his underlying problem. Mr A's team demonstrated regard for the patient by making him feel that they were "on his side," and they demonstrated knowledge of his disease, as well of him as a person, resulting in earning his loyalty. Recognizing the gaps in their expertise with regard to addiction management, the medicine team consulted the substance abuse team after Mr A expressed a desire to change his drug use habits in the context of motivational interviewing. Involvement of the substance abuse team is an example of using available resources to overcome the challenge of treating what is generally considered a "frustrating" disease.

Ms B's case is an example of a failure in the doctor-patient relationship. The oncologist started off well by explaining the upcoming diagnostic steps to the patient. The oncologist built trust by explaining the diagnostic procedures that should be performed to better characterize the nature of the cancer, thus demonstrating her competence and understanding of Ms B's disease. The oncologist also increased trust by recognizing her own limits by engaging the surgeon's expertise when needed. However, the interaction between the patient and the surgeon illustrated problems that can arise between the physician and the patient. Since the surgeon had never met the patient before, and the surgeon and the patient had not had a chance to establish trust, neither knew each other and neither had the opportunity to establish loyalty. While it may not be possible for a doctor to develop instant trust and loyalty with a patient (although institutional transference may provide a protective umbrella over the relationship), the doctor in the case of Ms B could have made an effort to demonstrate regard for the patient and to display a desire to know the patient. The surgeon could have started off by asking Ms B open-ended questions about her understanding of her disease, as well as of her fears and expectations regarding her health. This questioning would have allowed the surgeon to create a patient-centered interaction by recognizing and addressing Ms B's thoughts, concerns, and values. The mutual participation model would have allowed the surgeon to build knowledge of the patient as a person and show regard for her. Ms B's responses also would have provided the surgeon with information about her level of health literacy, so the surgeon would be better able to target the discussion to her level of understanding.

The surgeon and the oncologist also failed to present a consistent prognosis for Ms B, undermining her trust in the surgeon and the oncologist's competence and transparency. It is worth acknowledging that sometimes it is difficult to balance the 2 seemingly different roles of a physician: a bearer of bad news that may remove hope versus a healer who cares for and sides with the patient. Neither the surgeon nor the oncologist is necessarily inferior in this context. In fact, the surgeon's intentions were good. The surgeon was attempting to ensure that Ms B was fully informed of all the different outcomes of the suggested procedure. There are no current screening tests for esophageal/gastric cancer, except in a subpopulation of patients with known Barrett's esophagus.[44] By the time most patients present with symptoms, their disease

is well advanced, so the surgeon was right in informing Ms B of the potential severity of her disease. Delivering bad news, especially for a disease with a relatively unfavorable prognosis, will almost always upset any patient. However, the surgeon should have pointed out all the possible outcomes, including that of a superficial malignant lesion, and he should not have sounded so certain about resecting a large portion of Ms B's stomach, especially prior to endoscopic exploration and disease staging. While the oncologist's assessment could have been overly optimistic, provision of all the possible outcomes by the oncologist as well as the surgeon would have demonstrated concordance among the physicians, thus allowing Ms B to retain trust in her providers. Additionally, during the initial visit, the surgeon could have simply stated the possibility of the disease's seriousness, rather than bluntly stating that the disease would most likely be the cause of her demise. The surgeon and oncologist could then reveal more details at subsequent visits when some loyalty had been established and when more information about the extent of her disease was known. Delaying such information until the next visit would not alter staging or management of the disease. The surgeon was right to inform Ms B, but in this context, the manner and the quantity of information divulged ultimately affected the doctor-patient relationship.

Further, distance arose when the surgeon turned away from Ms B at the end of the meeting to complete the visit note. As the documentation burden increases, doctors feel increased pressure to attend to the computer during patient visits, causing face-to-face interaction to suffer. Doctors may unintentionally display a profound lack of empathy by looking at the computer screen instead of at the patient, especially when the patient is experiencing strong emotions. This act of turning away created not only a failure of regard, but also of loyalty. The physician is abandoning the patient to suffer alone despite the physician's physical presence. In this vignette, the surgeon should have fully addressed Ms B's emotions before working on the note. In other circumstances, the physician may turn note-writing into a collaborative experience with the patient and encourage the patient to correct or to fill in additional information. If the doctor is writing orders for the patient, it may be useful to explicitly explain to the patient what the physician is doing on the computer so the patient can understand that the physician is using the computer to help to provide better care.

CONCLUSION

As our vignettes intended to illustrate, the doctor-patient relationship is a powerful part of a doctor's visit and can alter health outcomes for patients. Therefore, it is important for physicians to recognize when the relationship is challenged or failing. If the relationship is challenged or failing, physicians should be able to recognize the causes for the disruption in the relationship and implement solutions to improve care.

Potential conflicts of interest:

None reported.

Funding/support:

None reported.

Author contributions:

Mss Chipidza and Wallwork contributed equally to the manuscript.

Footnotes

LESSONS LEARNED AT THE INTERFACE OF MEDICINE AND PSYCHIATRY

The Psychiatric Consultation Service at Massachusetts General Hospital (MGH) sees medical and surgical inpatients with comorbid psychiatric symptoms and conditions. During their twice-weekly rounds, Dr Stern and other members of the Consultation Service discuss diagnosis and management of hospitalized patients with

complex medical or surgical problems who also demonstrate psychiatric symptoms or conditions. These discussions have given rise to rounds reports that will prove useful for clinicians practicing at the interface of medicine and psychiatry.

Mss Chipidza and **Wallwork** are fourth-year medical students at Harvard Medical School, Boston, Massachusetts. **Dr Stern** is chief of the Avery D. Weisman Psychiatry Consultation Service at Massachusetts General Hospital and the Ned H. Cassem professor of psychiatry in the field of psychosomatic medicine/consultation at Harvard Medical School, Boston, Massachusetts.

Dr Stern is an employee of the Academy of Psychosomatic Medicine, has served on the speaker's board of Reed Elsevier, is a stock shareholder in WiFiMD (Tablet PC), and has received royalties from Mosby/Elsevier and the Massachusetts General Hospital Psychiatry Academy and McGraw Hill. **Mss Chipidza** and **Wallwork** report no conflicts of interest related to the subject of this article.

References

1. QT, Inc v. Mayo Clinic Jacksonville, 2006 US Dist. LEXIS 33668, at *10 (ND Ill May 15, 2006)

2. Ridd M, Shaw A, Lewis G, et al. The patient-doctor relationship: a synthesis of the qualitative literature on patients' perspectives. *Br J Gen Pract.* 2009;59(561):e116–e133. [PMCID: PMC2662123] [PubMed: 19341547]

3. Szasz TS, Hollender MH. A contribution to the philosophy of medicine: the basic models of the doctor-patient relationship. *AMA Arch Intern Med.* 1956;97(5):585–592. [PubMed: 13312700]

4. Kaba R, Sooriakumaran P. The evolution of the doctor-patient relationship. *Int J Surg.* 2007;5(1):57–65. [PubMed: 17386916]

5. Gordon C, Beresin EV. The doctor-patient relationship. In: Stern TA, Fava M, Wilens TE, et al., editors. *Massachusetts General Hospital Comprehensive Clinical Psychiatry.* 2nd ed. Philadelphia, PA: Elsevier Health Sciences; 2016. pp. 1–7.

6. Ong LML, de Haes JCJM, Hoos AM, et al. Doctor-patient communication: a review of the literature. *Soc Sci Med.* 1995;40(7):903–918. [PubMed: 7792630]

7. Stewart MA, McWhinney IR, Buck CW. The doctor/patient relationship and its effect upon outcome. *J R Coll Gen Pract.* 1979;29(199):77–81. [PMCID: PMC2159129] [PubMed: 480298]

8. Stewart MA. Effective physician-patient communication and health outcomes: a review. *CMAJ.* 1995;152(9):1423–1433. [PMCID: PMC1337906] [PubMed: 7728691]

9. Evans BJ, Kiellerup FD, Stanley RO, et al. A communication skills programme for increasing patients' satisfaction with general practice consultations. *Br J Med Psychol.* 1987;60(pt 4):373–378. [PubMed: 3426975]

10. Kleinman A, Eisenberg L, Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Ann Intern Med.* 1978;88(2):251–258. [PubMed: 626456]

11. Patient satisfaction. Biology online web site. http://www.biology-online.org/dictionary/Patient_satisfaction. Updated October 2, 2005. Accessed April 28, 2015.

12. Bennett JK, Fuertes JN, Keitel M, et al. The role of patient attachment and working alliance on patient adherence, satisfaction, and health-related quality of life in lupus treatment. *Patient Educ Couns.* 2011;85(1):53–59. [PubMed: 20869188]

13. Dulewicz V, Van Den Assem B. The GP-patient relationship and patient satisfaction. *Br J Healthc Manag.* 2013;19(12):596–600.

APP-1265

14. Korsch BM, Negrete VF. Doctor-patient communication. *Sci Am.* 1972;227(2):66–74. [PubMed: 5044413]

15. Inui TS, Carter WB, Kukull WA, et al. Outcome-based doctor-patient interaction analysis: I. comparison of techniques. *Med Care.* 1982;20(6):535–549. [PubMed: 7109738]

16. Korsch BM, Freemon B, Negrete VF. Practical implications of doctor-patient interaction analysis for pediatric practice. *Am J Dis Child.* 1971;121(2):110–114. 10.1001/archpedi.1971.02100130064006. [PubMed: 5542848]

17. Gesell SB, Wolosin RJ. Inpatients' ratings of care in 5 common clinical conditions. *Qual Manag Health Care.* 2004;13(4):222–227. [PubMed: 15532516]

18. Cousin G, Schmid Mast M, Roter DL, et al. Concordance between physician communication style and patient attitudes predicts patient satisfaction. *Patient Educ Couns.* 2012;87(2):193–197. [PubMed: 21907529]

19. Oakley BA. In: *Pathological Altruism.* Oakley B, Knafo A, Madhavan G, editors. New York, NY: Oxford University Press; 2012.

20. Singer PA, Martin DK, Kelner M. Quality end-of-life care: patients' perspectives. *JAMA.* 1999;281(2):163–168. [PubMed: 9917120]

21. Gawande A. *Being Mortal: Medicine and What Matters in the End.* New York, NY: Metropolitan Books; 2014.

22. Weisner C, Mertens J, Parthasarathy S, et al. Integrating primary medical care with addiction treatment: a randomized controlled trial. *JAMA.* 2001;286(14):1715–1723. [PMCID: PMC3056510] [PubMed: 11594896]

23. Groves JE, Beresin EV. Difficult patients, difficult families. *New Horiz-Sci Pract.* 1998;6(4):331–343.

24. Wallace LS, Lennon ES. American Academy of Family Physicians patient education materials: can patients read them? *Fam Med.* 2004;36(8):571–574. [PubMed: 15343418]

25. Williams MV, Davis T, Parker RM, et al. The role of health literacy in patient-physician communication. *Fam Med.* 2002;34(5):383–389. [PubMed: 12038721]

26. Ratanawongsa N, Roter D, Beach MC, et al. Physician burnout and patient-physician communication during primary care encounters. *J Gen Intern Med.* 2008;23(10):1581–1588. [PMCID: PMC2533387] [PubMed: 18618195]

27. Halbesleben JRB, Rathert C. Linking physician burnout and patient outcomes: exploring the dyadic relationship between physicians and patients. *Health Care Manage Rev.* 2008;33(1):29–39. [PubMed: 18091442]

28. Irving JA, Dobkin PL, Park J. Cultivating mindfulness in health care professionals: a review of empirical studies of mindfulness-based stress reduction (MBSR) *Complement Ther Clin Pract.* 2009;15(2):61–66. [PubMed: 19341981]

29. Krasner MS, Epstein RM, Beckman H, et al. Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *JAMA.* 2009;302(12):1284–1293. [PubMed: 19773563]

30. Kjeldmand D, Holmström I. Balint groups as a means to increase job satisfaction and prevent burnout among general practitioners. *Ann Fam Med.* 2008;6(2):138–145. [PMCID: PMC2267420] [PubMed: 18332406]

APP-1266

31. Shanafelt T, Dyrbye L. Oncologist burnout: causes, consequences, and responses. J Clin Oncol. *2012.* 30(11):1235–1241. [PubMed: 22412138]

32. Kushner RF, Kessler S, McGaghie WC. Using behavior change plans to improve medical student self-care. *Acad Med.* 2011;86(7):901–906. [PMCID: PMC3128665] [PubMed: 21617509]

33. O'Leary KJ, Wayne DB, Haviley C, et al. Improving teamwork: impact of structured interdisciplinary rounds on a medical teaching unit. *J Gen Intern Med.* 2010;25(8):826–832. [PMCID: PMC2896605] [PubMed: 20386996]

34. Baker DP, Salas E, King H, et al. The role of teamwork in the professional education of physicians: current status and assessment recommendations. *Jt Comm J Qual Patient Saf.* 2005;31(4):185–202. [PubMed: 15913126]

35. Weech-Maldonado R, Morales LS, Elliott M, et al. Race/ethnicity, language, and patients' assessments of care in Medicaid managed care. *Health Serv Res.* 2003;38(3):789–808. [PMCID: PMC1360917] [PubMed: 12822913]

36. Ferguson WJ, Candib LM. Culture, language, and the doctor-patient relationship. *Fam Med.* 2002;34(5):353–361. [PubMed: 12038717]

37. Meeuwesen L, Harmsen JAM, Bernsen RMD, et al. Do Dutch doctors communicate differently with immigrant patients than with Dutch patients? *Soc Sci Med.* 2006;63(9):2407–2417. [PubMed: 16928417]

38. Campbell A, Sullivan M, Sherman R, et al. The medical mission and modern cultural competency training. *J Am Coll Surg.* 2011;212(1):124–129. [PubMed: 21115375]

39. Wang S-M, Caldwell-Andrews AA, Kain ZN. The use of complementary and alternative medicines by surgical patients: a follow-up survey study. *Anaesth Analg.* 2003;97(4):1010–1015. [PubMed: 14500149]

40. Gordon NP, Sobel DS, Tarazona EZ. Use of and interest in alternative therapies among adult primary care clinicians and adult members in a large health maintenance organization. *West J Med.* 1998;169(3):153–161. [PMCID: PMC1305198] [PubMed: 9771154]

41. Astin JA, Marie A, Pelletier KR, et al. A review of the incorporation of complementary and alternative medicine by mainstream physicians. *Arch Intern Med.* 1998;158(21):2303–2310. [PubMed: 9827781]

42. Kimball B, Joynt J, Cherner D, et al. The quest for new innovative care delivery models. *J Nurs Adm.* 2007;37(9):392–398. [PubMed: 17823572]

43. Patel BK, Chapman CG, Luo N, et al. Impact of mobile tablet computers on internal medicine resident efficiency. *Arch Intern Med.* 2012;172(5):436–438. [PubMed: 22412110]

44. Hvid-Jensen F, Pedersen L, Drewes AM, et al. Incidence of adenocarcinoma among patients with Barrett's esophagus. *N Engl J Med.* 2011;365(15):1375–1383. [PubMed: 21995385]

Figures and Tables

Table 1.

Health Outcome Variables Related to the Doctor-Patient Relationship

Outcome Category	Outcome Variable
Objective	Blood pressure
	Frequency of visits
	Knowledge/recall
	Serum glucose level
	Serum triglyceride level
	Survival
Behavioral	Adherence to treatment
	Coping
	Emotional status
	Functional status
	Recovery
Subjective	Global health status
	Knowledge
	Pain
	Satisfaction
	Understanding

APP-1268

Table 2.

Patient Factors That Affect the Doctor-Patient Relationship and Suggested Solutions for an Impaired Relationship

Patient Factors	Strains on Relationship	Solutions
New patient	Trust: Not yet established	Regard: Maximize the patient's comfort and feeling of being liked
	Knowledge: The doctor does not know the patient and vice versa	Knowledge: Take time to get to know the patient to maximize your knowledge of the patient
	Loyalty: There has been limited opportunity to demonstrate loyalty	
Poor prognosis	Trust: Medical knowledge and interventions may be exhausted	Trust: Ensure that the patient knows you have done everything possible
	Regard: "Pathologic altruism," in which a physician may damage his or her relationship with a patient if the physician fails to recognize when treatment is futile, but continues to aggressively treat the patient, rather than focus on the patient's goals of care[19]	Loyalty: Do not abandon the patient
		Regard: Find out what is important to the patient and work with him or her to maximize the quality of his or her final days[20,21]
Afflicted with a "frustrating" disease[a]	Trust: The doctor might not trust the patient	Loyalty: Make sure the patient knows that the physician is there for him or her
	Regard: The patient and the physician might not like each other; the patient may feel judged; the doctor might have trouble being empathic	Trust: Educate oneself about the disease in question and the best ways to connect with the patient; create a dedicated team to support the treatment team for a challenging patient; in the case of substance abuse, studies have shown that patients in integrated care groups are more likely to remain abstinent compared to those in independent care groups[22]
		Regard: Use motivational interviewing techniques to evaluate a patient's current willingness to change and to keep a patient's goals central to care
"Difficult" patient	Regard: The patient might dislike the physician; the doctor may dislike the patient	Knowledge: The physician should actively evaluate his or her feelings toward the patient ("autognosis" or self-knowledge), which allows the physician to use his or her own emotional reactions toward the patient as

Open in a separate window

[a]Diseases that are generally considered difficult to treat (eg, substance abuse, substance-induced comorbidity, borderline personality disorder).
[b]Especially if the patient does not have decision-making capacity.

APP-1270

Table 3.

Provider Factors That Affect the Doctor-Patient Relationship and Suggested Solutions for an Impaired Relationship

Provider Factors	Strains on Relationship	Solutions
Physician burnout: state of detachment, emotional exhaustion, and lack of work-related fulfillment[26]	Trust: Lack of trust can lead to lower levels of patient satisfaction and to longer recovery times[27]; the behavioral consequences of burnout (eg, ineffective communication) also jeopardize trust and may damage the trust that patients have in a physician's competence Knowledge: Attentive doctors are better able to understand both verbal and nonverbal communication[28]; therefore, burnout, which hinders attentiveness, prevents physicians from appreciating the needs of their patients, thus failing to identify their ailments Regard: It is harder for emotionally exhausted physicians to show affection; when physicians are burned out, their patients are more likely to report that physicians use nonempathic statements[26] Loyalty: Patients are less likely to return to a physician who fails to recognize their needs or who fails to regard them as individuals	Trust, knowledge, regard, and loyalty: All 4 elements are dependent upon physician well-being; strategies that improve a doctor's emotional wellness will optimize the doctor-patient relationship (eg, mindfulness meditation techniques, work-hour restrictions, participation in Balint groups, and programs to promote personal health [eg, exercise, nutrition, and sleep])[27–32]
Doctors in training or in early career	Trust: Patients may not trust a doctor's competence due to his or her young appearance or apparent lack of confidence Loyalty: Patients might be reluctant to receive ongoing care from an	Trust: Take the time to explain your clinical reasoning to a patient to demonstrate competence Knowledge: Get to know your patient

APP-1271

Table 4.

Patient/Provider Mismatches That Affect the Doctor-Patient Relationship and Suggested Solutions for an Impaired Relationship

Patient/Provider Mismatches	Strains on Relationship	Solutions
Language barriers	Trust: Linguistic minorities report worse care than is provided to linguistic majorities[35]; physicians are less likely to share important medical information[36]	Trust: Print educational handouts in the patient's language
	Knowledge: Doctors and patients may have more difficulty getting to know one another due to language barriers	Knowledge: Use skilled/trained interpreters rather than family members or members of the treatment team who speak "a little" of the patient's language
	Regard: Doctors are less likely to show empathy for a patient who is not proficient in the physician's language and are less likely to establish rapport[36,37]	Regard: Encourage a greater expression of empathy
Cultural barriers	Trust: Patients may not trust Western medicine	Knowledge: Whenever possible, use interpreters who act as cultural ambassadors as well as language interpreters; use frameworks, such as Kleinman's 8 questions,[10] to elicit the patient's explanatory model; encourage physician participation in global health initiatives[38]
	Knowledge: Doctors may not understand the patient's health goals	Regard: Acknowledge and incorporate traditional practices whenever possible[39–41]
	Regard: Physicians may be judgmental about a patient who seeks complementary and alternative medical therapies	
Locus of control[a]	Knowledge: Patients may know themselves better than the doctor knows them and therefore know the best treatment	Knowledge and regard: A mutual participation model can be employed[3]

[a]Locus of control (ie, Who is ultimately making the decisions?).

APP-1272

Table 5.

Systemic Factors That Affect the Doctor-Patient Relationship and Suggested Solutions for an Impaired Relationship

Systemic Factors	Strains on Relationship	Solutions
Time constraints	Trust: Doctors may not have or make the time to explain their reasoning to engender the patient's trust Knowledge: There is less time for the physician and the patient to get to know one another Regard: There is less time to establish rapport Loyalty: Patients are less likely to be loyal to a doctor if they have not developed positive regard	Trust, knowledge, regard, and loyalty: Develop strategies to increase workplace efficiency, leaving time for physicians to explain their reasoning, to know patients, and to establish rapport; by using prescreening forms and questionnaires while the patient is in the waiting room or by using simple technologies (eg, walkie-talkies to communicate with medical assistants and other support staff), more time can be devoted to patient care[42]
Space/room	Knowledge: If the space is not private, physicians may be reluctant to ask certain questions, which limit their ability to know the patient; additionally, patients may be reluctant to confide in doctors if they do not feel the conversation is private Regard: Busy and uncomfortable clinics may make it harder for the doctor and patient to connect	Knowledge: Whenever possible, take the patient into a private room to ask questions
High patient-provider ratio[a]	Knowledge: Patients may feel like they are objects being discussed, rather than as equals participating in their own care; they may not feel as though they know all of the team members and what their roles are	Trust: Explain each team member's role and how they contribute to the patient's care
	Regard: There may be too many people with whom to establish rapport	Knowledge and regard: Whenever possible, limit the number of physicians who round on a patient at one time; in teaching hospitals, where this is not always possible, team members should introduce themselves to the patient outside of rounds to

Open in a separate window

[a]Refers specifically to teaching rounds, wherein a large team of providers visits a patient as a group.

APP-1273

Articles from The Primary Care Companion for CNS Disorders are provided here courtesy of **Physicians Postgraduate Press, Inc.**

APP-1274

EXHIBIT “4”

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 feelings[21] 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 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.

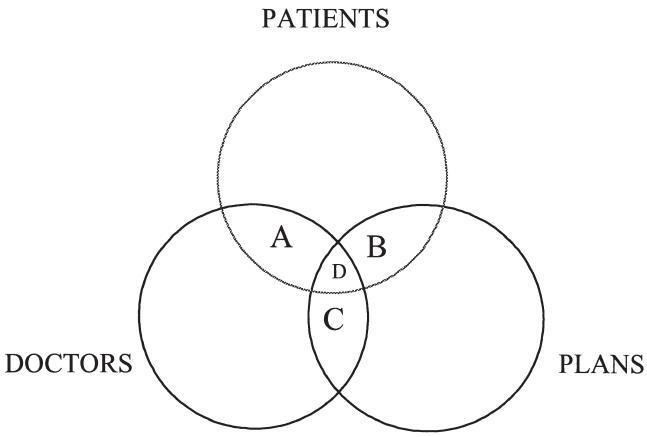

FIGURE 1. Overlapping and conflicting interests. The interests of patients (top circle), doctors (left circle), and health plans (right circle) may overlap to a greater or lesser degree, depending on the actors and the circumstances. Employers' interests are likely to be approximated by plans' interests, 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.

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 strategies[37] 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.

REFERENCES

1. Lipkin M Jr, Putnam SM, Lazare A, eds. The Medical Interview: Clinical Care, Education, and Research. New York, NY: Springer-Verlag; 1995.
2. Tessler R, Mechanic D. Factors affecting the choice between prepaid group practice and alternative insurance programs. Milbank Mem Fund Q Health Soc. 1975;53(2):149–72.
3. Garfinkel SA, Schlenger WE, McLeroy KR, et al. Choice of payment plan in the Medicare capitation demonstration. Med Care. 1986; 24(7):628–40.
4. Grazier KL, Richardson WC, Martin DP, Diehr P. Factors affecting choice of health care plans. Health Serv Res. 1986;20(6 pt 1):659–82.
5. Sofaer S, Hurwicz ML. When medical group and HMO part company: disenrollment decisions in Medicare HMOs. Med Care. 1993; 31(9):808–21.
6. Emanuel EJ, Dubler NN. Preserving the physician-patient relationship in the era of managed care. JAMA. 1995;273(4):323–9.

7. Mechanic D, Schlesinger M. The impact of managed care on patients' trust in medical care and their physicians. JAMA. 1996; 275(21):1693–7.
8. Mechanic D. Changing medical organization and the erosion of trust. Milbank Q. 1996;74(2):171–89.
9. Rodwin M. Medicine Money and Morals: Physician's Conflict of Interest. New York, NY: Oxford University Press; 1993.
10. Angell M. Cost containment and the physician. JAMA. 1985; 254: 1203–7.
11. Gordon GH, Rost K. Evaluating a faculty development course on medical interviewing. In: Lipkin M Jr, Putnam SM, Lazare A, eds. The Medical Interview: Clinical Care, Education, and Research. New York, NY: Springer-Verlag; 1995;248–53.
12. Levinson W, Roter D. The effects of two continuing medical education programs on communication skills of practicing primary care physicians. J Gen Intern Med. 1993;8:318–24.
13. Lipkin M Jr. The medical interview. In: Feldman M, Phil M, Christensen J, eds. Behavioral Medicine in Primary Care: A Practical Guide. Stamford, Conn: Appleton-Lange; 1997;1–7.
14. Lazare A, Putnam SM, Lipkin M Jr. Three functions of the medical interview. In: Lipkin M Jr, Putnam SM, Lazare A, eds. The Medical Interview: Clinical Care, Education, and Research. New York, NY: Springer-Verlag; 1995;3–19.
15. Dye NE, DiMatteo MR. Enhancing cooperation with the medical regimen. In: Lipkin M Jr, Putnam SM, and Lazare A, eds. The Medical Interview: Clinical Care, Education, and Research. New York, NY: Springer-Verlag; 1995;134–44.
16. Kaplan S. Patient activation. Presented at Royal College of Medicine symposium on Doctor Patient Communication, Washington, DC, 1997.
17. Stewart MA, Brown J, Levenstein J, McCracken E, McWhinney IR. The patient-centered clinical method: changes in residents' performance over two months of training. Fam Pract. 1986;3:164–7.
18. Carkhuff R. Art of Helping. Amherst, Mass: Human Resources Development Press; 1972.
19. Peabody FW. The care of the patient. JAMA. 1927;88:877–82.
20. Rogers C. A Way of Being. Boston, Mass: Houghton Mifflin; 1980.
21. Kaplan SH, Greenfield S, Ware JE. Assessing the effects of physician-patient interactions on the outcome of chronic disease. Med Care. 1989;27(suppl.):S110–27.
22. Orth JE, Stiles WB, Scherwitz L, Hennrikus D, Vallbona C. Patient exposition and provider explanation in routine interviews and hypertensive patients' blood pressure control. Health Psychol. 1987; 6:29–42.
23. Starfield B, Wray C, Hess K, Gross R, Birk PS, D'Lugoff BC. The influence of patient-practitioner agreement on the outcome of care. Am J Public Health. 1981;71:127–31.
24. Tuckett D, Boulton M, Olson C, Williams A. Meetings Between Experts: An Approach to Sharing Ideas in Medical Consultations. New York, NY: Tavistock Publications; 1985.
25. Egbert LD, Battit GE, Welch CE, Bartlett MK. Reduction of postoperative pain by encouragement and instruction of patients. N Engl J Med. 1964;270:825–7.
26. Hall JA, Roter DL, Katz NR. Meta-analysis of correlates of provider behavior in medical encounters. Med Care. 1988;26:657–75.
27. Roter DL. Patient participation in the patient-provider interaction: the effects of patient question asking on the quality of interaction, satisfaction, and compliance. Health Educ Monogr. 1977;5:281–315.
28. Putnam SM, Lipkin M Jr. The patient-centered interview: research support. In: Lipkin M Jr, Putnam SM, Lazare A, eds. The Medical Interview: Clinical Care, Education, and Research. New York, NY: Springer-Verlag; 1995;530–7.
29. Gerteis M, Roberts MJ. Culture, leadership and service in the patient-centered hospital. In: Gerteis M, Edgman-Levitan S, Daley J, Delbanco TL, eds. Through the Patient's Eyes. San Francisco, Calif: Jossey-Bass Publishers; 1993.
30. Brody H. The Healer's Power. New Haven, Conn: Yale University Press; 1992.
31. Arnold R, Forrow L, Barker LR. Medical ethics and doctor/patient communication. In: Lipkin M Jr, Putnam SM, Lazare A, eds. The Medical Interview: Clinical Care, Education, and Research. New York, NY: Springer-Verlag; 1995;345–67.
32. Ubel P, Goold SD. Recognizing bedside rationing: clear cases and tough calls. Ann Intern Med. 1997;126(1):74–80.
33. Eddy DM. Cost-effectiveness analysis: will it be accepted? JAMA. 1992;268:132–6.
34. Jecker NS, Pearlman RA. An ethical framework for rationing healthcare. J Med Philos. 1992;17:79–96.
35. Kleinman A, Eisenberg L, Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. Ann Intern Med. 1978;88:251–8.
36. Halpern J. Can the development of practice guidelines safeguard patient values. J Law Med Ethics. 1995;23(1):75–81.
37. Deming WE. Out of the Crisis. Cambridge, Mass: Massachusetts Institute of Technology, Center for Advanced Engineering Study; 1986.
38. Roland MO, Bartholomew J, Courtenay MJF, Morris RW, Morrell DC. The "five minute" consultation: effective time constraint on verbal communication. BMJ. 1986;292:874–6.
39. Tamblyn R, Berkson L, Dauphinee W, et al. Unnecessary prescribing of NSAIDs and the management of NSAID-related gastropathy in medical practice. Ann Intern Med. 1997;127:429–38.
40. Hjortdahl P, Laerum E. Continuity of care in general practice: effect on patient satisfaction. BMJ. 1992;304(6837):1287–90.
41. Goold SD. Allocating health care resources: cost utility analysis, informed democratic decision making, or the veil of ignorance? J Health Polit Policy Law. 1996;21(1):69–98.
42. Sofaer S, Hurwicz ML. When medical group and HMO part company: disenrollment decisions in Medicare HMOs. Med Care. 1993;31(9):808–21.
43. Lipkin M Jr. The medical interview as core clinical skill: the problem and the opportunity. J Gen Intern Med. 1987;2(5):363–5.
44. Gerteis M, Edgman-Levitan S, Daley J, Delbanco TL, eds. Through the Patient's Eyes. San Francisco, Calif: Jossey-Bass Publishers; 1993:ch. 10.
45. Daniels N. Why saying no to patients in the United States is so hard: cost containment, justice, and provider autonomy. N Engl J Med. 1986;314(21):1380–3.
46. Weber LJ. The business of ethics: hospitals need to focus on managerial ethics as much as clinical ethics. Health Prog. 1990; 71(1):76–8, 102.
47. Goold SD. Money and trust: relationships between patients, physicians and health plans. J Health Polit Policy Law. 1998;23: 687–95.
48. Ubel PA, Goold SD. Does bedside rationing violate patient's best interests? An exploration of the moral relevance of "moral hazard." Am J Med. In press.
49. Scott RA, Aiker LH, Mechanic D, Moravcsik J. Organizational aspects of caring. Milbank Q. 1995;73(1):77–95.
50. Mao Tse Tung. Quotations from Chairman Mao. San Francisco, CA: China Books; 1975.
51. Clark W, Lipkin M Jr, Graman H, Shorey J. Improving physicians' relationships with patients. J Gen Intern Med. 1999;14(suppl 1): S45–50.

EXHIBIT “5”

DISTRICT COURT

CLARK COUNTY, NEVADA

MARCO CENTENO-ALVAREZ, Plaintiff,	)	
vs.	)	CASE NO. A510230
	)	DEPT. NO. XXIV
CURTIS COE and DOES I 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

DEPOSITION OF LEWIS M. ETCOFF, Ph.D.,

taken at 8475 S. Eastern Avenue, Suite 200, Las Vegas, Nevada, on SATURDAY, SEPTEMBER 25, 2010, at 9:02 a.m., before Michelle R. Ferreyra-Marez, Certified Court Reporter, in and for the State of Nevada.

APPEARANCES:

For the Plaintiff:

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

For the Defendants:

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

I N D E X

WITNESS: LEWIS M. ETCOFF, Ph.D.

E X H I B I T S

(None marked.)

LAS VEGAS, NEVADA, SATURDAY, SEPTEMBER 25, 2010;
9:02 A.M.
-OOO-
(In an off-the-record discussion held prior to the commencement of the deposition proceedings, counsel agreed to waive the court reporter requirements under Rule 30(b)(4) of the Nevada Rules of Civil Procedure.)

Whereupon,

LEWIS M. ETCOFF, Ph.D.,

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

EXAMINATION

BY MR. VANNAH:

Q. Could you state your full name, please?

A. Lewis Marvin Etcoff.

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

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

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

A. Yes.
Q. What happened to the audiotape?
A. I have it.
Q. Is there a copy for me?
A. There is, once I dig through all of this, I think we may have an extra copy.
Q. Okay.
MR. RANALLI: Bob, if I can just interject, and I don't mean to interrupt, I think before I have it attached to the deposition, I'm going to instruct him not to give it because I think there's an issue of that whether it is even disclosable because it wasn't supposed to be videotaped according to Bixler. You weren't privy to that, but there was an issue that arose right prior to the IME, so I would like to address it to Bixler before I disclose it or have it produced.
MR. VANNAH: Well --
MR. RANALLI: He's not going to destroy it. And then if Bixler allows it, obviously he can, but I have an objection to that because it wasn't even suppose to be audiotaped.
MR. VANNAH: Well, that's a problem. I want it. I mean, whether it comes into evidence or not, I won't play it or anything for whatever reason, but

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

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

MR. VANNAH: Well, you have a copy.

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

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

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

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

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

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

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

(Off the record.)

MR. VANNAH: Back on the record.

BY MR. VANNAH:

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

A. Okay.

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

A. Sure.

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

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

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

presentation?

A. Yes.

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

A. That's met, correct.

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

A. No. I'm just --

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

A. Yes. Correct.

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

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

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

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

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

A. That's correct. Yes.

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

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

Q. So the first one is litigation --

A. Litigation.

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

What's the second one?

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

Q. Okay. Hold that thought.

What's the third?

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

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

A. He has been very cooperative during my evaluation.

Q. Was it during your evaluation or --

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

Q. What's --

A. Just -- just using this script.

Q. Sure. What's the fourth criteria?

A. The presence of antisocial personality disorder.

Q. Anti --

A. Social -- Antisocial personality disorder.

And there is no such finding anywhere of that.

Q. What is antisocial personality disorder?

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

Q. Do --

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

Q. So those are the four criteria?

A. Yeah.

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

A. Yes.

Q. Motivation possibilities; right?

A. Yes.

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

A. Yes.

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

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

Q. You made that clear.
A. So -- well, yeah.
Q. But this is DSM-IV TR; right?
A. It is.
Q. I thought it was your Bible or something?
A. It's not -- it's not my Bible. It's -- we use it to diagnose. In fact, in the DSM-V, as far as I know, malingering isn't even going to be in as a diagnosis. They are taking it out. So psychiatry who -- which is the profession that writes this, is just taking it out because they know that malingering isn't a mental disorder. So in a couple of years, you won't even be -- we won't even be referring to this book for any type of exaggerating -- purposely or exaggerated symptoms of any type.
Q. That's a good point. I mean, not necessarily a disorder, but maybe a very clever person who is malingering to get benefits. It may not be a disorder. I mean, I see your point. It may not be a disorder. It's just a purposeful effort to fool somebody?
A. Yes.
Q. Now we come down to marked discrepancy, and that's where, you know, I read what you wrote, and I'm going to have some severe disagreements with you. I don't usually have that. Usually I recognize when you

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

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

A. Okay.

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

A. Sure.

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

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

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

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

A. That's not delusional at all.

Q. So he's right about that?

A. Yes.

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

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

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

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

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

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

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

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

A. Okay.

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

A. I don't have an independent impression.
Q. Well --
A. I don't know him. I have never met him.
Q. No, no, that's okay. But I read -- you reference him in the report, and I think that you might have misunderstood Rothman's opinion, because I know what his opinion will be without even talking to him.
A. Okay.
Q. It's the same every time. Let's see where you referenced him here.
A. He might have -- I know in 2006 he did a records review.
Q. Right. But in your report here, you actually -- let me see if I can --
A. Oh --
MR. RANALLI: What page?
THE WITNESS: Page 13, bottom paragraph in the summary conclusion section, Dr. Rothman's medical opinion was that Mr. Centeno's MRI of the cervical spine did not indicate spinal trauma myomalacia.
BY MR. VANNAH:
Q. Right. Do you know what myomalacia is?
A. It's cord damage, a bruise on the cord.
Q. Right. And you know that 98 percent of the cases that you are going to be involved with, that I'm

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

A. I didn't know that.

Q. Myomalacia is a very serious condition.

A. I have that.

Q. You have that?

A. I have that.

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

A. That's what I have.

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

A. Yes.

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

A. I do.

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

agreed?

A. Agreed.

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

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

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

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

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

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

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

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

A. Sure.

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

A. Yes.

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

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

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

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

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

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

A. Yes.

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

A. I'm not saying that.

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

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

MR. VANNAH: But he talked about the videos.

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

MR. VANNAH: No, the videos.

BY MR. VANNAH:

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

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

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

MR. RANALLI: My fault. Sorry.

BY MR. VANNAH:

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

A. I got it. Got it.

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

A. That's fair to say.

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

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

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

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

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

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

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

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

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

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

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

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

BY MR. VANNAH:

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

A. That's fair to say.

Q. All right.

A. There were lots of different things.

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

A. It's not a big factor.

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

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

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

A. Okay.

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

A. Right.

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

A. I guess --

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

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

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

A. Yes.

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

A. Correct.

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

A. Okay.

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

right?

A. Right.

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

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

MR. VANNAH: Who is it?

MR. RANALLI: Helm.

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

BY MR. VANNAH:

Q. How heavy were those suitcases?

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

weight, but they didn't look light --

Q. Well --

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

Q. I -- airlines now weigh suitcases.

A. Okay.

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

A. Yeah.

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

A. Fine. Yeah.

Q. Is that fair to say?

A. I would say, yeah.

Q. So was this a big suitcase?

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

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

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

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

Q. Well --

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

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

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

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

A. Yes.

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

A. Yes.

Q. Does he read English?

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

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

A. No. They're excellent.

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

A. I believe you are right.

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

A. On occasion.

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

A. Agreed.

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

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

Q. You did read that; right?

A. I did. I did.

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

A. I agree.

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

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

Q. I know, but you brought that up.

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

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

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

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

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

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

Q. Well, think about that.

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

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

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

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

A. At what?

Q. The American with Disabilities Act.

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

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

MR. RANALLI: Object as to form.

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

BY MR. VANNAH:

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

A. Okay.

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

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

A. That makes sense.

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

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

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

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

Q. To light duty, though?

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

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

we want to help you get rehabilitated? Anything?

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

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

MR. RANALLI: Object as to form.

BY MR. VANNAH:

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

A. No.

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

A. I didn't see that.

Q. I didn't either.

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

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

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

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

A. Yes.

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

A. I think we talked about it.

Q. What did he say?

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

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

A. No.
Q. What are the other discrepancies you are talking about?
A. Well, if we go by -- we've got external -- in other words, there is -- not that he -- there is an external incentive to not go back to work because he could win a lot of money in a personal injury lawsuit.
Q. Now, see, I think that's wrong, by the way.
A. Okay.
Q. I tell every one of my clients if you can go back to work, you should go back to work because juries will be more likely to award you money if they see you are trying.
A. Okay.
Q. Wouldn't you agree that actually is true?
A. If I was juror, I would certainly agree with that.
Q. So how is that an incentive to not go back to work if, in fact, the juries are actually bothered by that and tend to be less?
MR. RANALLI: I'm going to object to the form.
BY MR. VANNAH:
Q. See, you brought that up. I actually disagree with you. I don't agree at all that a person -- well, unless a person is like blind and her legs are cut off

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

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

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

A. Okay.

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

doing their best?

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

Q. Okay.

A. -- to go back to work.

Q. Okay.

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

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

A. Yes.

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

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

Q. Okay.

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

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

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

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

A. Yeah.

Q. Okay. That's good stuff.

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

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

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

THE WITNESS: I don't remember.

BY MR. VANNAH:

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

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

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

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

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

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

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

Q. Okay. Beat that to death.

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

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

A. Okay.

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

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

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

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

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

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

A. Sure.

Q. And they exaggerate a little bit.

A. I --

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

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

THE WITNESS: No, no.

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

THE WITNESS: I --

BY MR. VANNAH:

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

A. You are right.

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

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

we know isn't true.

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

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

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

A. I understand.

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

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

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

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

Q. Oh, okay.

A. Do you see that?

Q. I see that.

A. That's it.

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

A. The point is you are cheap.

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

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

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

A. Okay.

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

A. There you go.

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

A. I'll tell that to your staff.

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

BY MR. VANNAH:

Q. That's those hierarchy of things.

A. That's it.

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

A. Tony, he goes by.

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

A. I'm in charge.

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

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

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

A. Uh-huh.
Q. -- they actually have said things that actually were just so far out there later I have read about them in the press, like wow. But saying that you have been a foreman when you are put in charge, but you don't have the -- well, you know what I am saying?
A. (Witness nods.)
Q. So beyond that, what's this other stuff, though?
A. Well --
Q. For example, here's one you write.
A. Okay.
Q. Dr. Dunn told him that he would be in danger of paralysis below the waist if he did not choose to undergo lumbar surgery. Now, did somebody diagnose him with myomalacia?
A. No. He said --
Q. That's why I'm asking you.
A. No. That's why I put that there. He said that the reason he was in such pain or that he needed lumbar surgery was because Dr. Dunn reportedly told him he would be in danger of paralysis below the waist if he didn't get it. So I said, Well, okay. Did Dr. Dunn really say that? And Dr. Dunn didn't say that.
Q. Well, let me just tell you, this is my field

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

A. Okay.

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

A. Okay.

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

A. Which -- which is part of his pain disorder. He may catrastophize, which is why he has a pain disorder diagnosis.

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

A. Oh, I know.

Q. -- these risks.

A. I know.

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

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

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

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

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

A. No. It would have been in --

Q. I wasn't sure.

A. -- yeah. So that was something.

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

A. Sure. Yeah.

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

A. Yes.

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

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

A. No. There's more.

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

A. I guess.

Q. If there's more -- okay.

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

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

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

And this guy's got GERD and gastritis. In

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

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

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

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

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

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

Q. All right.

A. He's got an alcohol problem --

Q. All right.

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

Q. Okay.

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

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

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

A. What's that?

Q. Because it doesn't come into evidence.

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

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

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

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

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

MR. RANALLI: Oh, I'm sorry.

BY MR. VANNAH:

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

A. Okay.

Q. -- twelve years ago?

A. Okay.

Q. Now if he was convicted of something --

A. Yes.
Q. -- that comes in. But I mean, the point is: Did you ever see the arrest records?
A. No.
Q. What was he arrested for exactly?
A. He said something about an altercation with his wife in the mid '90s. And there was something in his mental health records that he had been arrested on another occasion. I mean, I don't remember offhand, but it was a --
MR. RANALLI: It involved DUI.
THE WITNESS: DUI.
BY MR. VANNAH:
Q. You know, I have never had a DUI. But if I had a DUI, especially being arrested, I might not remember that as being an arrest, you know. Maybe that's -- to me, an arrest -- I suppose I have been arrested for speeding, but they didn't put me in handcuffs and take me away. But --
A. Yeah, but -- I don't know.
Q. But when you questioned him further, he brought up the other incidences?
A. So my question?
Q. So when you asked him more about it, he probably remembered it; right?

A. Yes.
Q. When you prompted him, was he candid about it?
A. Yes.
Q. Anything else?
A. Yes. The other part of this definition is, Do you have psychological evidence of symptom magnification, which I didn't have the opportunity to do any of the psychological tests. Dr. Mortillaro did, but I reviewed all of those test results, and there was -- the records were replete with very significant consistent overlapping descriptions of him as having a good possible somatization disorder, mental problems, all sorts of things, alcohol or drug problems. Dr. Mortillaro -- or Gamada actually wrote the report and left all of that out, which you undoubtedly read in my report or my records review when I went over that.

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

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

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

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

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

Q. Okay.

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

Q. All right. Now look --

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

In -- in its nutshell.

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

A. No.

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

A. It's --

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

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

Q. Right.

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

Q. All right.

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

Q. Okay. You are not --

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

Q. That diagnosis you are suggesting that the

malingering is his inability to go back to work?
A. Correct.
Q. Okay. All right.
A. And on that note, can I take a bathroom break?
MR. VANNAH: Yes. Of course, you can.
(Off the record.)
MR. VANNAH: Back on the record.
BY MR. VANNAH:
Q. Let's talk about something more interesting. I want to ask you about -- did Mortillaro do the MMPI-2?
A. No.
Q. Did you review any -- well, he did a PAI. And refresh me, that's the something --
A. Personality Assessment Inventory.
Q. Apparently there was -- and a P3, what's a P3?
A. Pain profile -- pain something profile. It's --
Q. And a BBHI-2?
A. And that would be the Brief Behavioral Health Inventory-2.
Q. On all three of those, did it come back that there was a suggestion of symptom magnification in all three?
A. I believe so. Let me -- let me answer by

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

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

Q. And -- okay.

A. Do you want me to do the others?

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

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

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

Q. Okay.

A. And then the last one was the PAI.

Q. Right.

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

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

A. Psychologically, yes.

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

A. I never gossip.

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

A. Correct.

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

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

Q. Well, he has --

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

Q. What does that mean, treatment motivation?

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

Q. Okay.

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

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

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

Q. His people?
A. -- a company. And I didn't conclude he was paranoid, but his treating docs in North Carolina have given him a diagnosis recently or in the past couple of years of schizoaffective disorder, which is a serious mental illness involving both mood disorder and unusual psychotic thinking.
MR. VANNAH: Off the record.
(Off the record.)
MR. VANNAH: Back on the record.
BY MR. VANNAH:
Q. The PAI came out with a rule out diagnosis; right?
A. Several. Several.
Q. If I understand that correctly, what it means is, Hey, these are suggestive of a possibility of these various things?
A. Yes.
Q. And you need to rule them out. I presume the way one rules them out is to do a clinical interview and go over some of these things?
A. And/or records review, yes.
Q. So I read that Dr. Mortillaro said that he actually -- either he or his assistant there or somebody -- had a conversation to rule these things

out. You saw that in his deposition; right?

A. Yes.

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

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

Q. You need to elaborate on that?

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

Q. Okay.

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

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

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

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

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

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

A. (Witness nods.)

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

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

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

Q. I like my little analysis.

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

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

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

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

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

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

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

A. Okay.

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

A. Yes.
Q. Is that a psychological disorder that's recognized under the DSM-IV?
A. Alcohol abuse, yes.
Q. I was going to ask you, then, so what -- and I always get confused on the axis, but what would be the psychological diagnosis, if any, that you reached for this individual that he had prior to the accident other than -- I assume that alcohol abuse would be one?
A. Other than that, I didn't have any pre-existing psychological diagnoses.
Q. So then I just want to get that straight. So pre-existing psychological diagnoses would include alcohol abuse, which is a recognized DSM-IV TR diagnosis; right?
A. Yes.
Q. And that's all?
A. Yes.
Q. Subsequent to the accident, he's developed a pain disorder?
A. Yes.
Q. It's your opinion that the fact that he had a pre-existing psychological disorder, that being alcohol abuse, made him more susceptible to developing the pain disorder as a result of this accident and the sequella

of treatment that he received; right?

A. Possibly, yeah.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Yes.
Q. Do you agree with that?
A. Uh-huh.
Q. That's a yes?
A. Yes.
Q. All right. Now, the major depressive disorder, he has that; right?
A. Yes.
Q. And I sure can't disagree with you.
A. Well, he's --
Q. I mean, pretty much any psychologist would have to agree that he has a major depressive disorder; right?
A. Yes.
Q. To the point that a couple of times he has attempted suicide?
A. At least once.
Q. I got the feeling that that was a serious attempt, too. Did you get that feeling or did you think it was one of those things -- and I don't understand that stuff very much, but I hear people saying, Well, the guy is just crying out help, but some people actually do it?
A. You know, I don't know about that. I have read it in different ways. I'm not sure -- I guess

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

Q. Right.

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

Q. The hospitalized one?

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

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

A. Prior proceedings?

MR. RANALLI: Correct.

BY MR. VANNAH:

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

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

A. Yes.

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

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

Q. Okay.

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

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

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

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

A. Yes.

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

A. Yes.

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

A. No.

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

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

Q. Okay.

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

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

A. They may think that he is crazy.

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

A. I would believe you.

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

A. If you meant it --

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

A. Then you are right.

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

A. Yes.

Q. So there's a fine line there?

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

he doesn't really have the thought disorder.

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

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

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

A. Correct.

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

A. Probably for years and years.

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

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

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

Q. What's NOS?

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

Q. Okay.

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