Case No. _____

IN THE SUPREME COURT OF NEVADA

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HARVEST MANAGEMENT SUB LLC,
Petitioner,

vs.

EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF CLARK, THE HONORABLE LINDA MARIE BELL, DISTRICT COURT CHIEF JUDGE,
Respondent,

- and -

AARON M. MORGAN and DAVID E. LUJAN,
Real Parties in Interest.

District Court Case No. A-15-718679-C, Department VII

APPENDIX TO PETITION FOR EXTRAORDINARY WRIT RELIEF VOLUME 7 OF 14

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VOLUME 7 OF 14

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TAB 13

RTRAN

DISTRICT COURT

CLARK COUNTY, NEVADA

AARON MORGAN, Plaintiff, vs. DAVID LUJAN Defendant.	CASE#: A-15-718679-C DEPT. VII

BEFORE THE HONORABLE **LINDA MARIE BELL**, DISTRICT COURT JUDGE

WEDNESDAY, APRIL 4, 2018

RECORDER'S TRANSCRIPT OF HEARING
CIVIL JURY TRIAL

APPEARANCES:

For the Plaintiff: DOUGLAS GARDNER, ESQ.
DOUGLAS RANDS, ESQ.

For the Defendant: BRYAN BOYACK, ESQ.
BENJAMIN CLOWARD, ESQ.

RECORDED BY: RENEE VINCENT, COURT RECORDER

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Las Vegas, Nevada, Wednesday, April 4, 2018

MR. CLOWARD: The first thing is the prior trial, in the event that that comes up, we feel like there should be some sort of an instruction that you could give the jurors now. Just, hey, there was a prior trial, you know, that something happened and, you know, this is the second time or something. I mean, we don't want to indicate that there was anything negative.

THE COURT: Generally, how I have handled that in the past on the few occasions this has come up is to just simply say you previously testified in this matter. I mean, we have got this [indiscernible] testimony as well, and so we treat it really kind of like deposition testimony because obviously you're entitled to impeach someone if they something different than they did in their testimony in the first trial. But if you just say you testified in this matter previously, I don't think that it is necessary to get into any particular detail about that further than that.

MR. CLOWARD: Yeah. I guess a concern that we would have is that if the jurors think that, you know, Aaron's already collected on this and that this is just a second lawsuit kind of a thing which, you know, that wouldn't be accurate. And so we'd hoped to get just a simple instruction that, you know, we had a -- there's a reason we give these instructions. In that case, there was an issue -- or in that trial there was an issue and so this is the second trial on this matter, it's still not complete, and that's it.

And then, if we get into the whole prior trial thing, there won't be the jurors thinking that there was some sort of conclusion for one side or the other.

THE COURT: Well I just don't know why we could into the whole prior trial thing at all, Mr. Cloward. I mean, can't we just --

MR. GARDNER: I don't -- yeah. In fact, I don't mean to bring up the prior trial. We could call it sworn testimony if we want to refer to the trial transcript -- just as sworn testimony.

THE COURT: It would be very similar to the way that we handle it when somebody makes a sworn statement to an insurance adjuster. We don't say it's a sworn statement to an insurance adjuster, we just say you gave a statement in this case previously.

MR. BOYACK: It was brought up yesterday.

UNIDENTIFIED SPEAKER: Yeah, twice yesterday, they said --

MR. CLOWARD: Yeah, it was brought up, plus --

UNIDENTIFIED SPEAKER: -- prior trial.

MR. CLOWARD: -- I believe that it's possible --

THE COURT: All right. Well if you want to draft an instruction, I'm happy to look at Mr. Cloward.

MR. CLOWARD: Okay. Will you do that, Bryan.

MR. BOYACK: Yep.

MR. CLOWARD: Thanks. And thank you, Your Honor, for that consideration.

And a couple of other things. The first trial that we had, there was no discussion of liens or health insurance. I just assumed that that was because the case law, the *Pizarro* case at 133 Nev. Adv. Op., talks about how, you know, if a lien is recourse versus non-recourse, the relevance is really minimal.

And so I assume that that's why we didn't talk about it last time is because that's what this case stands for. But it now appears that Mr. -- so we didn't file anything on that.

THE COURT: Okay. So generally, and I think, Mr. Cloward, you've probably had enough cases in here that you know this. I mean, generally, my ruling on if I had that in front of me as a motion in limine, is that Defense counsel is permitted to ask about liens if the physician is currently holding a lien because it potentially goes to bias which I think is in keeping with the case law.

If the physician has sold the lien, does not currently hold the lien, then I think it is completely irrelevant. I'm also happy to give a limiting instruction that that can be considered only for the purpose of determining bias. So that's generally how I would handle that issue. I know there was some mention of it in opening yesterday.

MR. CLOWARD: Yeah, I mean, just for the record so that we have a clean record. In *Pizzaro vs. Christian Cervantes-Lopez*, 133 Nev. Adv. Op. 37 (2017), the court indicated, this court recently recognized in *Khoury v. Seastrand*, that the degree of relevance is limited, particularly when medical liens indicate the Plantiff will be responsible for his or her medical bills if he or she does not obtain a favorable judgment.

And then the court goes on to indicate here, and despite not having the benefit of the subsequently issued *Khoury* decision, the district court determined the liens would be of limited relevance for the same reason put forth in *Khoury*. Additionally, the district court believed the introduction of medical liens would not simply show that the treating doctors were

biased, but that they would have a motivation to lie. Thus, the district court excluded evidence of medical liens based on the court's belief that the limited probative of the liens would be substantially outweighed by the unfairly prejudicial effect of coloring respondent's doctors as liars. *See* N.R.S. 48.035(1).

And then I skip one sentence, thus in light of the medical lien's limited relevance and appellant's failure to address the district court's basis for determining the liens would be unfairly prejudicial, we are not persuaded the district court necessarily abused its discretion in excluding that evidence particularly when the district court did not have the full benefit of this court's *Khoury* opinion at the time it made the decision.

And in this case, Mr. Gardner, from his opening statement, that's exactly what he's suggesting. He's suggesting the doctors are going to lie, that they're trying to pad their pockets. It goes a lot more to -- I mean those are words he actually used. They're going to pad their pockets. You know, these liens are a way for them to pad their pockets. That goes a lot more than just, hey they might be biased one way or another.

And another issue --

THE COURT: So what are you asking me to do?

MR. CLOWARD: So I'm asking for the Court to look at it more from a probative versus prejudicial. The way that he's arguing this is way too prejudicial. The other problem is is that there is some treatment that was on health insurance. And so, are we going to get into the weeds of, you know, one of the doctors tried to bill health insurance and the health insurance denied it and said, sorry, we're secondary to auto which is

primary, so we're not paying.

Do I get to go into that? If the door's opened, I'll be happy to discuss why some of the treatment was put on a lien. I would love it because we have statements from the health insurance that says, we're denying this, we're not primary. And so, you're getting into -- so first off, you take this issue of relevance as minor. The court in *Pizarro* said it's limited relevance.

THE COURT: All right. So it's limited to the issue of bias under *Khoury*?

MR. CLOWARD: Yeah. And the point I'm trying to make, Your Honor, is that first off, it's limited, and then when you add these other issues, now when you look at it from a 403(b) analysis of probative versus prejudicial, prejudicial effect outweighs any limited relevance that it may have. And so I'm asking that we just exclude the liens altogether.

And another issue is, this is another bite at the apple. They didn't bring up a lien with a single doctor the first time. Not one doctor was asked a single question about liens, and it's not fair. It's not fair to come in and reinvent the case because you cause a mistrial. And I have the transcripts for the Court to review.

THE COURT: All right. No, I understand what you're saying. I mean, I don't think -- you know, when there's a retrial, I don't think it's limited to only what was presented in the first trial. I am happy though to have with each doctor, if there's an intent for the Defense to bring up the issue to have, you know, a hearing outside the presence to make sure they still hold the lien, and the only thing that I will allow questions about with respect to the

lien is basically, do they have a lien.

Now, if you want to ask why, you know, physicians take cases on liens or those sorts of questions, I think that's completely appropriate.

MR. CLOWARD: Well, I think -- can I get into the treatment of the medical provider that, you know, they tried to submit it to health insurance and health insurance rejected it and that's why it was put on a lien? Can I go into that? I mean, if -- you know, because that's the truth of it. And that's why it's not -- it's unfair to only allow one side of the coin to be told.

MR. GARDNER: Your Honor, that only tells one part of the story, too. It would actually raise another issue that might need to be tried because the policy itself might have been not eligible, but the Med-Pay for the automobile accident is primary, if there was Med-Pay. I don't think we want to get into insurance in front of the jury. But I will tell you that this is an important part of our case because it deals with the timing and the treatment, when it was done, why it was done. So we're looking very closely at that.

In fact, I'm a little gun shy from last time, so let me just ask you this. I intend to ask the doctor -- and I know what they'll say. I'm going to say, have you collected your fees, and they'll say, no. I'll say, what are they. I don't know. And so what I'm going to do is, I'm going to then ask the Plaintiff, have you been sued by any of these doctors. And the answer's no.

THE COURT: Well that's not -- I don't know how that is relevant at all. I mean, so under *Proctor vs. Castelletti*, Mr. Cloward, I can't admit -- allow collateral source evidence to be admitted for any purpose. They say,

no matter how probative the evidence of a collateral source may be, it will never overcome the substantially prejudicial danger of the evidence.

I do think, though, if the Defense is using evidence of a lien for bias, that it is appropriate for you to ask generally, not specifically in this case, but generally, why doctors take cases on liens in response to their, you know, raising the issue of bias.

MR. GARDNER: And if he does that, Your Honor, what am I allowed to do? I mean, we're familiar with the collateral source rule that --

THE COURT: Nothing.

MR. GARDNER: I think that bias is a big part of this.

THE COURT: Right. So you're allowed to raise the issue of a lien with respect to bias, did they treat on a lien, do they still hold the lien, and Mr. Cloward is allowed to ask generally why, you know, doctors treat on a lien and kind of how that works without getting into any specific collateral source payment in this case. But there wouldn't be anything else for the Defense to do at that point. And I, again, will be happy to give a limiting instruction that it is for the purpose of bias only.

MR. CLOWARD: Okay. And then two other discussions, Your Honor.

One, the mistrial last time was about a DUI that was, basically, Aaron caused a crash. The police officer asked him hey, you know, what's going on? And he said, well, you know, I don't know what happened. Then the guy asked him, do you got any, you know, are you high or anything like that? And he said no, but I've -- you know, I do take prescription medication. I have taken my prescription medication.

So they issued him a, basically -- a DUI that's, you know, it's just a per se. It's a per se DUI. As a result of that, Aaron's license has lapsed and he's not gotten a new license. And so I think any discussion about his driver license, you know, why don't you have a driver license, anything like that would --

THE COURT: That's totally irrelevant to whether he was injured in an accident in 2014 or whenever that was.

MR. GARDNER: But, Your Honor, though that -- I mean, that goes to the heart of this. He was driving under the influence of his prescription medication --

THE COURT: After this accident.

MR. GARDNER: After this incident. But still, I'm entitled to ask him why he doesn't have a license.

THE COURT: No. He had a license when this accident happened. It's not relevant. This trial is about whether he was injured in this accident, you know, whether he was at fault, or who was at fault, and whether he was injured. That's it. That's it.

A subsequent accident is only relevant to the extent that you have a doctor that's going to come in and say he had some injuries in the subsequent accident that somehow have, you know -- hold on -- that he was injured in a subsequent accident and some of the damages would be appropriately apportioned to that subsequent accident.

If you have a physician that will come in and say that, that's appropriate. Otherwise, the subsequent accident is really not relevant at all. And whether he was drunk or at fault or not having a driver's license in a

subsequent accident has no relevance to the case that we are here to try. So I will not permit questions about that at all.

MR. CLOWARD: Thank you. And one final matter.

There will be testimony about a hospitalization. Aaron, one time, dealing with this issue, drank an entire bottle of whiskey and landed in the hospital for that. He was acting crazy and the people were -- you know, the folks were asking him, Aaron, hey what's going on, and his mom said, well, you know, he took some acid like four months ago and he's never been the same way. So that's in the record.

But all of the testimony from the witnesses will be that he drank an entire bottle of whiskey, it had nothing to do with acid. But that is --

THE COURT: What is any of that relevant to, Mr. Cloward?

MR. CLOWARD: Well, I do want to talk about the hospitalization because he was drinking to cope with the issues. But the acid didn't really have anything to do with anything. I'm happy if they talk -- you know, they're fine to talk about the hospitalization and the alcohol. But a reference in a record to something that he did four or five months before is too -- doesn't have anything to do with anything.

It'd be like, if he said, hey, four months ago, I was, you know, beating my girlfriend or something -- just something weird like that. It just found its way into the record. I just don't want Mr. Gardner to say, well isn't it true that they were asking you whether you were taking acid because it didn't -- there's no testing done that he was taking acid. His girlfriend was with him. She'll testify he drank an entire bottle of whiskey. They went to the store, they bought it, he chugged it, and then he went -- basically, the

next thing he remembers is he woke up in the mental hospital.

MR. GARDNER: Well, Your Honor, this case is about character, it's about truth, it's about what kind of a young man this is. I think that those things are very relevant. He drinks a whole bottle of whiskey and drives. Was he driving, Counsel?

MR. CLOWARD: No, he was not driving. His girlfriend was driving.

MR. GARDNER: Okay.

MR. CLOWARD: And I'm happy to talk about the whiskey drinking. We're going to talk about that. We would like to talk about that. What I don't think is -- it's too prejudicial is to talk about acid, a reference to using. They're given the history. Well, do you take this, do you do that? He said four months ago, I took acid once and it -- you know, never been the same. But that's not why he was there that day. It has zero relevance to why he was there that day.

MR. RANDS: True. But Your Honor, it does have some relevance to they're trying to portray him as the kind of person that he is and was and now that it's worse. And I think it certainly has some relevance if they're going to try and put him on a pedestal and say this is a fine young man who never did anything wrong till this happened.

MR. CLOWARD: We're not. My heavens, we're saying he drank an entire bottle of whiskey and wound up in a psyche hospital. That's not portraying him as this kid up on a pedestal. That is not portraying him as Saint Peter. That's saying, look, this had some problems and he started to drink and he was drinking every single day because of it.

But what they're trying to do is portray him as, look, this accident happened and this slug, this no Einstein -- using his words -- this no Einstein sat around on his couch and did nothing. And that's not what happened. He did give up and he did lose hope for a period of time, and we own that. And we own that. And we're not running from that. We're embracing that. But a reference to taking drugs four years before -- or I mean, four months before, doesn't have anything to do with that hospitalization.

MR. GARDNER: Well, it's in the record, Your Honor, and we just -- you know, the whole thing about this case right now is a he said, she said type of a circumstance and so I think the credibility of the witness should be relevant in this case, and we should be able to talk about those things because right now, when I'm looking at the jury, I'm thinking --

THE COURT: Hold on. So how does that go to credibility?

MR. GARDNER: Well, if he -- well, what we're doing is, his character is on notice. His character is what is going to make or break this case for him. And if somebody's --

THE COURT: Right. But specific instances of conduct are generally not admissible unless they go to truthfulness, yes? So that's my question. I don't think that substance use -- and in fact, you know, I mean, I frankly would not -- I would assume, Mr. Cloward, you're, you know, entitled to get into whatever you get into, but I mean, I wouldn't generally allow any of that.

MR. GARDNER: And also, Your Honor, maybe it -- you don't need to rule right now. Maybe after he has testified, they will bring

something up that maybe contradicts what they're saying right now and I'll want to be able to talk about that on cross examination. So if we could -- I mean, it really depends on how they present him.

If they present him as an angel, then --

THE COURT: Well, I'm just going to say -- and I don't know how testimony is going to go and I suppose there is some impeachment scenario that could exist here. But generally, substance use that is not relevant to the case -- so it's not like we're talking about substance use prior to the accident, that he was impaired at the time of this accident -- would be a specific instance of conduct that is not admissible under our rules of evidence. So I am not going to allow that.

Now if something changes and you think that that, because of whatever testimony makes it appropriate to bring it in, then I will ask you to please bring that up to me outside the presence of the jury and I will happily consider that at that time because obviously, any evidentiary ruling can change depending on what happens with regard to testimony.

MR. GARDNER: And Your Honor, I'm going to tread lightly. I know what happens when I don't.

THE COURT: All right.

MR. GARDNER: You know, I do have a certain way of dealing with credibility without exactly saying I'm doing that, but I would like to see what they do.

THE COURT: Well, but you have to understand. I mean, our evidentiary rules do not allow the use of specific instances of conduct unless they go to the issue of credibility.

MR. CLOWARD: And also *Holder [phonetic] v. Aetna* discusses that drug use in particular is an inflammatory sensitive subject versus --

THE COURT: Right. It is also more prejudicial than probative, I think. So I mean for both of those reasons.

MR. CLOWARD: Yeah. Lots of people use alcohol, not lots of people, you know --

THE COURT: Well, like I said, I wouldn't -- that's obviously your choice to open the door on that issue, but I don't think -- and I know you have reasons for doing that. I just, you know, I don't know that the Defense could get into that unless you chose to first.

MR. CLOWARD: Okay.

MR. RANDS: Since we're dealing with things outside the presence of the jury also, Dr. Muir is going to be testifying and then he was their expert witness who prepared a report. And in Counsel's opening, he referenced that Dr. Muir would be talking about several articles from different medical journals that weren't included in the report.

And I believe as an expert witness, we're entitled to at least have his opinions and such in the reporting that's provided with the expert disclosure. And that whole area was not in that report and neither were those issues regarding those articles, at least not that I could find. I may be wrong, but I don't think so.

MR. CLOWARD: I don't need to talk about the specific articles. I can talk about his experience. And I'll discuss the articles with Dr. Sanders on direct -- or on cross.

THE COURT: All right. So I suppose that resolves that.

MR. CLOWARD: Okay. Thank you. I just want to confer with Dr. Muir, make sure that he doesn't say anything about, you know, health insurance or anything that -- based on the Court's ruling on the lien issue.

THE COURT: Okay. How long do you anticipate Dr. Muir's testimony will be?

MR. CLOWARD: At least -- I mean, a while.

THE COURT: Okay. So after lunch for sure.

MR. CLOWARD: Oh, yeah.

THE COURT: Okay. Good.

MR. GARDNER: One more thing. I am going to ask for an accommodation. I've got a witness that's living in the east. If I could get him either by telephone or by video link so they could see him --

THE COURT: Mr. Gardner, that's something that has to be -- I mean, by our rules, that's something that you have to ask for well prior to trial.

MR. CLOWARD: Who?

MR. GARDNER: Well, I didn't know that the trial was going to go as long as it did -- it is. I've never been through a two-day voir dire. Not saying there's a problem with that --

THE COURT: Okay. Well, when is your witness coming?

MR. CLOWARD: That's what it was last time.

THE COURT: We can take the witness out of order. And it was also two days last time, so I'm not sure why that would be surprising. So, I mean, is your witness here? Is your witness --

MR. GARDNER: No, he's not here. I don't know when to tell him to be here.

MR. CLOWARD: Who is it?

MR. GARDNER: The Voc Rehab [indiscernible].

THE COURT: Well, I mean, get the witness here, you know, Friday morning or something, and we'll --

MR. CLOWARD: Well, that solves the problem there is he says it a Voc Rehab. We dropped the wage loss last time before the last trial.

MR. GARDNER: All right. So the way I understand it is, the Voc Rehab and the CPA, they're not necessary because we're not going to deal with wages. But I thought that in the opening, there were some discussions about a wage loss. If that's off, then that's off.

MR. CLOWARD: We abandoned that a long time ago.

THE COURT: I don't recall a discussion about wage loss. I recall a discussion about employment.

MR. CLOWARD: We're not making a wage-loss claim. We abandoned that last time.

MR. RANDS: Yeah. And I remember that and agree with that. The only thing was, at the end of pretrial report, they still did have some wage losses that were [indiscernible].

THE COURT: All right. So we're clear that there's no wage loss.

MR. RANDS: If we're abandoning that, that's not an issue.

MR. CLOWARD: Yeah, that was a mistake, then.

MR. GARDNER: Okay.

MR. CLOWARD: It just was carryover from the template.

MR. RANDS: I figured as much. I mean, I didn't -- I wasn't trying to say that you did anything inappropriate. I just pointed that out because that would be -- just to get it on the record.

MR. CLOWARD: Okay.

THE COURT: All right.

MR. CLOWARD: Thanks, Judge.

Sorry, I'm always causing problems.

THE COURT: Nope, you're fine.

Anything else?

MR. CLOWARD: No, Your Honor.

MR. GARDNER: Can we talk about his employment, then? About what he's done and when he's done it and things like that?

MR. CLOWARD: Sure.

THE COURT: Employment is obviously relevant to his ability to function, pain and suffering, that sort of thing. So yeah, I think his, you know -- and Mr. Cloward, I think, has every intention of bringing it up because he certainly talked about plenty in his opening. So I think that's not an issue at all.

They're not making a wage-loss claim, but I do think, you know, it goes to the extent of his injuries and that sort of thing. What he's able to do and not able to do.

MR. RANDS: I think we cleared it up last time, but the wage-loss claim would also encompass future loss of --

MR. CLOWARD: Yeah, we're not claiming loss of earning

capacity --

MR. RANDS: -- earning capacity.

MR. CLOWARD: -- loss of future wages --

THE COURT: Right.

MR. CLOWARD: -- a loss or work life expectancy, nothing along those lines.

MR. GARDNER: I'm sure you can understand why I'm going through a couple of these things just to make sure because I --

THE COURT: I do, Mr. Gardner. I'm just -- you know, partly my fault --

MR. CLOWARD: We've got a jury waiting.

THE COURT: -- but the jury's now been waiting for more than an hour, so I'm a little -- I'm just anxious about that. But no. I mean, you guys need to make whatever record and get whatever rulings you need to get, so.

MR. GARDNER: Thank you.

THE COURT: If I seem a little frustrated, it's only because of the time, it's sure not because of you.

Oh, yes. Let's get them in.

THE BAILIFF: Please rise for the jury.

Please be seated.

[In the presence of the jury]

THE COURT: Back on the record in Case Number A-718679, Morgan versus Lujan. Let the record reflect the presence of all of our jurors, counsel, and parties.

Ladies and gentlemen, good morning. I am so sorry for the delay this morning. So let me just tell you what was going on.

On Wednesday mornings, I have a veteran's treatment court so people who have served in the military who get into trouble in our legal system, we have a special statute that allows them to go through a treatment program potentially to have their charges dropped. Not always, but generally. And usually it's issues that are related to their service, like post-traumatic stress. So I have that on Wednesday mornings.

I make the best guess I can about how long that's going to take, but because it's a very fluid thing, like, you know, we might have somebody who tested positive for using drugs yesterday, and I have to deal with those issues. I never know exactly how long that's going to take. It took a really long time this morning.

So we had that, and then we had a couple of legal issues that I had to sort out with the attorneys before we get going with the testimony. I really apologize because I know you were waiting for a very long time. So I'm sorry about that. Okay.

Mr. Cloward, please call your first witness.

MR. CLOWARD: Dr. William Muir will be the first witness.

DR. WILLIAM MUIR

[having been called as a witness and being first duly sworn testified as follows:]

THE COURT: Good morning, sir.

THE WITNESS: Good morning.

THE COURT: Go ahead and have a seat.

THE WITNESS: Thank you.

THE COURT: Could please state your name and then spell it for the record.

THE WITNESS: Yes. William Muir, M.D., M-U-I-R.

THE COURT: Thank you.

Mr. Cloward, whenever you are ready.

MR. CLOWARD: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. CLOWARD:

Q How are you doing today, Dr. Muir?

A I'm doing fine, thank you.

Q Okay. Dr. Muir, can you -- I guess we'll first start out and just -- are you a physician in this case?

A Yes.

Q Are you a treating physician for Mr. Morgan?

A Yes.

Q Okay. Why don't we go through and kind of tell the jurors a little bit about you and what kind of physician you are and what's your training and so forth? Do you mind telling them that?

A Certainly. I'm a orthopedic spine surgeon. My undergraduate was at Brigham Young University and then I went to Stanford University and received master's in physical therapy. I then came to Las Vegas in the '70s and established a physical therapy practice for a few years.

I then went to University of Nevada School of Medicine where I received my M.D. degree. And then I went to Arizona for my orthopedic

residency, which is a five-year program. Upon completion of my orthopedic residency program, I went to North Carolina and completed a spine fellowship, and that's where you receive additional treatments and different training for a specific area with people that are experts in the area -- that particular area.

Upon completion of that in 1991, '92, I went to Salt Lake City. I was part of a -- approximately ten-member team that we -- at the Intermountain Spine Institute where we treated nothing but the spine.

In 2005, I came to Las -- returned to Las Vegas, and I'm in private practice -- in solo practice at Summerlin Hospital. I'm attached to the hospital. And there I am -- for the last seven years, have been the chief of orthopedic surgery and the chief of spine surgery at the Summerlin Hospital.

And my practice is essentially limited to spine surgery and innovative pain management. Innovative pain management refers to injections.

Q Okay. Now just a couple of follow-up questions. Are you a member of any societies, like, say for instance, the North American Spine Society?

A I am, and Orthopedic Society, Clark County Society, the Nevada Orthopedic Society, Life Care Planners Rehabilitation Society. And those last two have to do with life-care planning. Those are some of the societies.

Q Okay. Now do some of these societies have, for instance, articles and magazines, periodicals that they produce?

A Yes.

Q Okay. Is the Spine Journal an example of one of those articles?

A That's probably the most recognized and admired journal is the Spine Journal in spine surgery.

Q And is that the official journal of the North American Spine Society?

A Yes, and for the American Academy of Orthopedics regarding the spine.

Q Okay. And then, what about -- so is that I guess a reputable medical source?

A Probably the best.

Q Okay. And then, have you heard of another one called the New England Journal of Medicine?

A Yes.

Q Is that reputable?

A Yes.

Q Okay. So another thing I want to follow-up on is you mentioned you were a solo practitioner.

A Yes.

Q Has that always been the case?

A No, in Salt Lake City, I had a -- a number of partners. And then, when I came down to Las Vegas, for the first year and a half, I had a -- a partner. And then, a couple of years ago, for approximately two years, I had a -- another partner who is my son who is a pain management specialist.

Q And what was his name?

A Jeffrey Muir.

Q Tell us where did he go to school, what did he do?

A He did his residency at Mayo Clinic back in Rochester. And then he -- he -- upon completion of his residency went to Dartmouth and received his training in -- in pain management and he's board certified both in physical medicine, rehabilitation, and pain management. So he's at the same program my -- where my other son is doing the same thing.

Q Okay. Now, Dr. Muir, can you tell us what is the difference between a board certification and a spine fellowship?

A Well board certification typically is required by hospitals to practice. And -- and we need to be certified in -- if you're an orthopedic surgeon or spine surgeon, it'd be either orthopedic surgery or neurosurgery boards. And then the -- for a spine fellowship, that's additional training. There's no recognized or established board certification for the spine surgery. It's within our teaching. It's within the orthopedic residency or neurosurgery residency boards.

Q Okay. Now can you tell us what it means to have hospital privileges?

A Hospital privileges allows one to do certain procedures. That's the short of it. And you need to show that you've been -- had adequate training, that you've done a -- a number of supervised cases, and that you haven't had any significant complications during those cases.

Q All right. So the fact that you're a spine surgeon, does that mean that you could go in and, say, perform an open-heart surgery?

A No. Just by being chief of orthopedics and chief of spine surgery, if I wanted to even do some type of a spine surgery that I don't

normally do, I can't do that unless I show I've had the -- the training, and I've done a number of those without complications.

Q Okay. What privileges do you have currently?

A I have privileges to do spine surgery.

Q And that's at Summerlin Hospital?

A Yes.

Q How does one go about getting privileges? Say for instance, could I go and apply?

A You could apply but you'd be rejected for it. You -- you -- it's about a six-month process where they -- they look at your credentials, make sure you've -- you don't have -- you're not a felon, that you have gone to and graduated from a legitimate medical school, from a legit residency program, that you have documentations of doing specific types of -- of treatments. And then -- and then the committee will look at that and then those are presented to me such as, I believe it's Dr. Sanderson [*sic*] who is an orthopedic surgeon that's the -- on the Defense. For him to practice at Summerlin, I had to look at his credentials and sign him off.

Q Okay. So fair to say, you're the one that approved Dr. Sanders to have privileges at Summerlin Hospital?

A I am the one, yes.

Q Okay. Now does he have privileges to do spine surgery?

A No, he did not request to do any, nor did he have any training that would allow him to do such.

Q Okay. So now that we've kind of talked about the training and education that you've had, you touched very briefly on physical therapy.

You received a physical therapy degree at Stanford. Did you practice as a physical therapist ever?

A I -- I did. As I stated, when I completed my master's degree in physical therapy and my credentials and certification, I came here to Las Vegas and -- and practiced in -- at a private practice. Some may know Kelly Hawkins Physical Therapy, which is a chain of therapists -- therapy practices in -- here locally. I'm the one that started that. And then when I decided to go to medical school, I brought Kelly from Utah to take over that practice.

Q Okay. So why don't we talk a little bit about now, just general principals regarding the spine? And then once we discuss that, then we can transition into the specific care and treatment for Mr. Morgan. Is that fair?

A Yes.

Q Okay. So, Dr. Muir, what are some basic, I guess in your practice, when folks come in, what is the treatment that you provide to them and tell us a little bit about your practice itself.

A What I provide for them will somewhat vary depending on how soon they -- they'd had their -- their injury. But my goal is to figure out what the patient's problem is and then provide options to -- to treat that problem. And we try to treat it the most conservative way possible.

Q Okay. When you're trying to figure out the issue, the underlying problem, how do you go about doing that? What are some things that you do?

A Well, you could think of it as a puzzle. That to recognize the picture of the puzzle, you need to have a number of -- of pieces of that

puzzle. And sometimes it's easy to get a few pieces of the puzzle. You go, I know what that -- that picture is. Other times, you -- you have to have more and more pieces to become more and more comfortable with what that -- that picture is. And it's the same thing with medicine. And we -- we obtain that from their physical examination, their complaints, the imaging, responses to injections.

Q Now there was a lot of discussion during jury selection about the differences between objective versus subjective complaints and testing and so forth. Can you give us an overview of what those things mean?

A Subjective would be what the patient tells you. It's not treated, it's not observed. It'd be like if I'm talking on the phone and they tell me what's going on, that would be subjective information.

Objective information would be anything that's tested, such as physical examination, imaging, responses to injections, responses to certain treatments. Those would be considered to be objective information.

Now sometimes there's some subjective sprinkled in with the objective information, but those are -- that's considered -- it's considered to be objective if it's something that's observable or something that you can test.

Q Can you give us some examples of, I guess, some objective testing that you would perform on a patient to determine whether what they're telling you is accurate or whether they're in there just trying to get, you know, some medicine or something along those lines?

A Well, an example?

Q Yeah.

A Okay. One example would be if you think it's a disc problem and a discogram is done. A discogram is a -- a study where a needle is placed within the -- the disc and some -- the disc is pressurized with a -- a dye material. You do not only the suspected disc, but typically two other additional discs. And the patient doesn't know which disc is being pressurized or which isn't. And the patient's asked does the pressurization result in the same type of pain. And so, it's an objective test where you're getting your information back from the patient, but they don't know which disc.

Also you're looking under a movie camera x-ray machine the spread of the dye to see if that's a normal spread, having normal anatomy, or whether there's some damage to that particular disc. And then, often the patient will be sent for a CAT scan to -- to have a better visualization or additional information of the damage to the -- to the disc. And so the -- those are both considered objective information and -- well that'd be an example of objective.

And they're very important. In medical schools, often they say if you really listen to the patient that subjective may be more important than the objective findings.

Q Okay. I mean, without the pain, generally speaking, people wouldn't be going to the doctor, to the hospital, or to a medical provider to begin with?

A Correct.

Q Okay. So why don't we talk a little bit about the spine itself?

MR. CLOWARD: And Your Honor, if I may have Dr. Muir come

off the stand.

THE COURT: Certainly.

BY MR. CLOWARD:

Q I'd like to just have you come and explain the basic anatomy, explain whether there are different things that can cause pain in the back, and what those things might be.

A All right. I have the flu, so I'll stand back just a little bit so I don't get people sick.

This is a basic model of -- of one segment. The white represents the bone. The red represents the disc. The disc is like a shock absorber. So this is an enlargement of a -- a lower vertebrae in the low back. The ones in the neck are quite similar, but they're much, much smaller than the ones in the -- in the low back, but essentially, it's the same structures.

After three or four months, if a patient still hurts, it's typically going to be either from the disc -- damage to the disc, or damage to the joints. In the back, there's like a knuckle joint. You can see the two bones move, come together. It's like a joint in the -- in the hand. And just as in the hand, you have cartilage, we have nerves, and you have ligaments around that. You have the same thing in -- in the joints.

So typically, in the spine, if they're still hurting after a few months, it's either a problem with the -- the joint damage to the -- to the joint or the disc. And the disc can be -- you've heard of herniations where the disc is torn, it pushes against the nerve. That's not what we're talking about in this case.

Also if the disc -- the disc is innervated, it means it has little nerves around that, if you get a split in that disc, that often is painful, and then the body tries to heal that split, and that can cause additional pain. And so we're dealing with disc problems or -- or joint problems. Another one that you can have is a narrow canal, especially in the elderly, pinching nerves with a -- with a [indiscernible] spinal cord, but that's not this case at all.

Q Okay. Now you said, a split in the disc. Is that the same thing as like an annular tear or an annular fissure?

A Yeah, the -- the disc is comprised of the outer portion which is annulus, which means ring. And then the inner portion is kind of like a rubbery crab meat that gives more of the -- the bounce. The outer portion is to hold the inner portion intact. And the disc off of the major nerves, there's little a nerve that's called sinuvertebral nerves that innervate the back portion of the -- the disc.

Q Okay. How is it that, say for instance, a pinched nerve, in say in the neck, or a tear in the neck, could cause problems down into your hands or down into your feet? How does that work?

A If a nerve -- the -- the nerves -- if you're talking about the -- the neck, for example, the nerves that come out of the neck, most of them go down into the arm and -- and some into the hands and the fingers. So if you -- if you're pinching some of those nerves up at the neck, you can get numbness, pain, or weakness down the arm. Same thing for the -- for the low back.

This is not this type of situation, but if you have a tear in the disc, there's a chemical irritation that's around the major nerve so you can

get numbness and tingling. In addition to this, when -- any time you have an injury, the muscles are going to tighten up around the area of that -- of that injury, and the nerves have to go through the muscles. So sometimes just the tight muscles can cause some tingling sensation in the leg or the -- or the arm.

Q Okay. Can you explain to the jurors what a dermatome pattern is?

A Certainly.

MR. CLOWARD: And I have diagram. [Indiscernible] the box. It's the plastic one that makes the noise.

THE WITNESS: As mentioned, as the -- the nerves come off the spine, they head towards areas. And here a fairly specific. They're not always 100 percent to the same areas. But let me give you an example.

This particular patient had significant hypermobility, close to instability at C5, 6 level of the neck. Well that is -- that nerve that would be effected principally would be the six nerve root off of that level. That goes down the arm into the thumb and to the index, I think of the six shooter because it's these -- mainly these two fingers. Sometimes, it goes over here, but mainly these fingers.

So if somebody comes in and says, gosh I'm -- I'm numb in my thumb and index, then you're thinking, okay, it's a -- a pinch coming off the C5, 6 level.

BY MR. CLOWARD:

Q Okay. Now I guess you've explained it. Here's this. I don't know if you need it or not. But are there also --

A Well, and for the six nerve root for example, this shows C6 coming down here in the thumb and then the index. And there's some variation. They -- they say it goes -- 7 goes partially in the index and there's some -- some minor variability, but the same thing holds true with the -- the spine. If someone has, say, numbness in the outer portion of the foot, that's the S1 nerve root, the big toe, it's the L5 nerve root. Just different nerves.

Q Now is -- I'm trying to think of the correct grammatical way to say it. Is everyone's body the same? Meaning, will everyone have an exact distribution of their C6 nerve root that follows this progression exactly?

A There are some variations.

Q Okay. And then similarly, are there also referral patterns for pain originating from damage to the joint there, the facet joint?

A Yes. It's not as specific as a nerve, but the joints will refer pain in certain areas. For example, if you had a joint problem at the very top of the neck, you're not going to get referred pain down into the scapular region. Whereas, this patient had pain down the scapular region. Whereas, the 5, 6, and the 6, 7 joints will cause pain into this scapular region. It refers pain. And in fact, 60 percent of the injuries are at the 5, 6 level.

But -- so if someone says, I've got this neck pain that goes down into my scapular region, if it's the upper scapular, I'm thinking C5, maybe C4. If it's the lower scapular region, then I'm seeking C6 or a combination of 5, 6 and 6, 7. But if -- if -- if they have pain in that area, I'm not thinking of an upper cervical facet being the major source of the patient's pain. So the -- so the facet joints will refer pain in a certain -- somewhat in a certain pattern in the cervical spine. Low back not so much.

Q Okay. Now based on, I guess, the different presentations of pain, how do you go about as a clinician, as a doctor, how do you try and figure it out? I mean, if you -- you mentioned something about the injections. What do you do to try and figure it out?

A Well you have the patient's symptoms. If the patient, such as patient says my pain is kind of a sharp pain in the neck. That's consistent with a joint pain, as opposed to aching pain would be more of a disc. If they have more pain in extension than flexion, particularly in the cervical spine, that would indicate more of a joint problem because you're jamming that joint together.

Q Can you -- and I always get these two confused. What is -- which one is flexion? Is that this one? Or is it --

A Flexion is chin towards the chest.

Q Chin towards the chest is flexion.

A And -- and extension is bringing the head up or the back backwards.

Q Okay. And so just doing those different tests can give you a little bit of information?

A Right. And this particular patient with the sharp pain in the neck, pain off to one side which is often more of a facet mediated problem, pain with extension, and then pain into the scapular region. I think all the providers from the beginning were most suspicious in the neck as being because of those factors being a facet mediated problem. And so the next step would be injections to provide more information, confirmation, or rule it out.

Q Is there also the use of -- you talked a little bit a moment ago about the discography test, but are there other tests such as that radio graphic test that can be done to help doctors know where they should be looking?

A As far as objective findings on the MRI scans, if you have -- you can have disc protrusions which can be a source of pain. It can be trauma or be just degenerative, and may not have any pain. Mostly, we'd have some disc bulges and you don't hurt. So those are -- are common. But the MRI scan sometimes gives some evidence.

If there's a tear in the disc, that can provide -- usually a tear means it's going to be associated with pain. You can have a tear that's degenerative, that's not traumatic, that -- that doesn't -- doesn't hurt. That's not unusual. But typically, it will be associated with pain.

So if you see a tear in a particular disc, you become a little more suspicious that that disc may be the major pain generator. And sometimes we do injections to see if -- if that confirms it. It'd be like if you had a bad tooth on your right side and you go into the dentist and they put some numbing medicine next to that tooth. Well for a couple of hours, that feels great. You know, that's the problem. If they do the injection on the wrong side or the wrong area, this tooth is still going to hurt because you haven't done anything to the source of the pain.

And so we use injections in that way, putting a little bit of numbing -- that medicine next to certain structures and then to see if the pain is reduced at least by 50 percent immediately after the injection for a couple of hours. And that can tell us whether that's the problem or not.

And then we have the discogram where you put a needle inside the disc, you pressurize that -- that disc. And the newer literature would say that this is at least 90 percent accurate. And under well controls and under small amount of pressurization that's in the high 90s as far as being an accurate tool to tell us whether a particular disc is torn and is the source of the -- of the patient's pain.

Q Okay. Let me ask a question about like, say for instance, an MRI. If someone had an MRI and it showed a protrusion or a herniation or whatever you call it, why wouldn't you just go in right then and there and do surgery? Why would you do the injections?

A If a -- if a problem's not a dangerous problem, if you're not in risk -- at risk of damaging a nerve permanently or being -- or being paralyzed, you want to treat something the most conservative way possible because often these type of injuries will -- will heal.

If they don't heal by a year or two, typically, the literatures indicate they're not going to heal on -- on their own. So a lot of time, we -- we're -- we want the patients to let time pass to see how they do, to -- to give them some medicines to make them feel comfortable. That doesn't help the -- the healing that we know of.

So therapy or chiropractic treatment, and there's not a lot of evidence, especially for physical therapy, that makes -- alters the outcome, especially for these type of problems, but sometimes it can and sometimes it keeps the patient going with -- with treatment and a less aggressive type of treatment.

If they don't respond and depending on the degree of pain they

have, then often injections are often offered to the patient for two reasons. One, it can tell us where the problem is. Two, it may provide -- may provide some significant relief for a -- a few months. Now the injections that the patient had up in the neck for the joint were called medial branch block injections which are done here and here. I do these injections also. And they're not so much for a therapeutic response, but it's more of a diagnostic response.

Q To try and figure out whether that's the issue? Is that fair?

A Yes. Because if it is, then you can do what's called radio frequency ablation which is putting a -- a needle next to those little nerves that go into the joint above and below at each level of that particular joint or joints, and burning that nerve, cauterizing that nerve. And it grows back again, but sometimes it doesn't grow back again for a year, year and a half, so you can get good relief by a -- a simple procedure as opposed to -- I mean, I can surgically fuse that joint, that takes care of the problem. But you want to treat something the most conservative way possible in most instances.

Q Like, you don’t' want to use a jack hammer when you can use a little finishing --

A Yes.

Q Okay. That's the kind of principle there?

A Yes.

Q Okay. Well I appreciate it, Dr. Muir. We can have you probably take the stand.

MR. CLOWARD: Your Honor, it's noon. Do you want me to

just keep going until you tell me? I'm happy to do whatever you want.

THE COURT: Yeah. I think we need to go like another 15 minutes or so.

MR. CLOWARD: You've got it.

THE COURT: Okay.

BY MR. CLOWARD:

Q Okay. Now, Dr. Muir, does one injection usually figure out what's going on with somebody?

A Everybody's different. And if the -- when there are multiple -- potential multiple structures involved, then it becomes more tricky and often you need additional injections to sort out which levels are the ones that are involved.

So sometimes, we do one injection and you can get a great response, and -- and you're comfortable with that. With that radio frequency ablation, what's -- the standard of care is to do -- before you did the cauterizing of the nerve, is to have two of those -- two diagnostic injections before doing that procedure.

Q Two of the medial branch injections?

A Right. On other types of problems, there's not -- multiple injections are not required, but they're often done in figuring out the problem or giving the patient some relief.

Q Okay. Now, Dr. Muir, you're here today as a treating physician. We also retained you as an expert to, I guess, address the long-term care needs of Mr. Morgan; is that correct?

A Yes.

Q Okay. So what I would like to do is let's first talk about your treatment that, you know, when Aaron came to you. We'll go through that treatment, and then what we'll do is we'll circle back and we'll start -- because you reviewed all the records in the case, too. Is that fair?

A Yes.

Q So then we'll go back and we'll go through your records review of what the other provider's treatment was.

A Yes.

Q So when, I guess, did Aaron come and see you first?

A On January 15th, 1915 -- sorry, 2015.

Q Wow.

A I'm not that old. I'm old, but not that old. That -- which is approximately eight months after the injury.

Q Now is it -- is it abnormal for somebody to see you eight months after? Is that an unusual length of time?

A Not at all being a -- a specialist. Sometimes, I'll see patients right away and -- and direct their initial care. But sometimes, I don't see patients for years after having an issue.

Q Okay. And when you treated Aaron, I guess, what was your understanding of his course of care before he got to you?

A Well, at the injury, he was taken by ambulance to the Sunrise Hospital where they evaluated him and mainly concerned about his neck pain, potential fractures, and the head if he had any bleeding in the skull. Then within four or five days later, he went to an Urgent Care center.

And then he -- at approximately three weeks later, he went to --

he was referred to pain management, which is Dr. Coppel. And about the same time, he started chiropractic treatment. He started that at three weeks, two days after the -- the injury.

And so he had had chiropractic treatment from the end of April until when I saw him. He had seen Dr. Coppel that did a -- a number of injections trying to figure out exactly what was the structure that was the source of the patient's pain. And that was the -- the -- and he had MRI scan before I saw him as well.

Q Okay. Now while we're at the treatment for the Urgent Care, one thing I wanted to have you do, Doctor. Behind you --

MR. CLOWARD: Your Honor, may I approach the witness?

THE COURT: Go ahead.

MR. CLOWARD: Okay.

BY MR. CLOWARD:

Q Okay. Dr. Muir, you indicated your understanding was that Aaron went from the ambulance to Sunrise; is that accurate?

A Yes.

Q And then from Sunrise, a week later, he went to an Urgent Care; is that accurate?

A Yes.

Q Now were there any referrals made by the Urgent Care to any physicians?

A Yes. I believe the Urgent Care referred the patient to Dr. Grabow for his wrist, and I think he also sent the patient to pain management.

Q Okay. So the Urgent Care made the referral to Dr. Coppel, and that's UCE 000007; is that correct?

A Yes.

MR. CLOWARD: Your Honor, move to admit Plaintiff's Exhibit 7.

MR. GARDNER: No objection, Your Honor.

THE COURT: 7 will be admitted.

[Plaintiff's Exhibit 7 is admitted into evidence]

MR. CLOWARD: May I publish?

THE COURT: Go ahead.

BY MR. CLOWARD:

Q Okay. So here, it says Dr. Coppel referral information, and then this is the location of the Urgent Care extra. Is that accurate?

A Yes.

Q Okay. And then the next page, UCE 00008. I'm trying to blow this one up. [Indiscernible]?

A Mm-hmm. I got it.

Q Okay. Here at the top we have Urgent Care extra again; is that correct?

A Yes.

Q And then, did I read that -- it says referral to Grabow Hand to Shoulder center?

A Yes.

Q Okay. So Mr. Morgan was referred by the Urgent Care to Grabow and Dr. Coppel; is that accurate?

A That is my understanding, yes.

Q Okay. Now moving along. So at some point, Mr. Morgan, he sees Dr. Coppel and then, about eight months later, he sees you. Tell me about your first visit. What were his complaints? What did you -- what were your initial suspicions? What were your thoughts?

A Sure. I mean, this is again in January 2015. The patient's chief complaints were -- were neck pain, mid-back pain, kind of the scapular region, low back pain, and then, a pain in his wrist.

He described the -- the neck pain as a sharp shooting pain and a stabbing pain which is consistent with a joint type of problem. The low back, more of an aching pain which is consistent with a discogenic problem.

When I first saw him, his neck pain was greater than the low back pain, and that somewhat reversed with -- with time.

Q And -- I'm sorry, go ahead.

A Yes. And he -- his -- this is subjective. This is his interpretation when asking him on -- on a scale of zero to ten, zero being no pain, ten being the worst, where are you with your pain, he -- he described it as nine out of ten. So he described it as a -- a severe pain.

Q Now through the course of your treatment, has the pain complaint always been a nine out of a ten, or are there times when it's less?

A No. Typically pain's going to wax and wane depending on treatments, depending on a particular day, depending on medications, when you had medications. But his pain is fairly consistent of -- of being above six out of ten, seven out of ten up to nine out of ten.

Q Why does pain -- did you say "wax and wane"?

A It does.

Q Why does pain wax and wane?

A Well, just as if you had a bad knee, you could twist it a certain way, get up and oh, that -- that hurts, and it takes a while to settle down and -- and sometimes it doesn't hurt as bad. It depends on the -- the stress you put on that particular structure that's damaged, and it depends on the degree of inflammation that's going on.

The -- the way the body tries to heal injury is it -- there's inflammation which results in a -- a number of -- of tissues coming together or cells coming together to try to heal a particular injury. And in doing that, it -- the inflammatory response causes pain because some of those cells are -- are painful to the structures that are -- are released. And in trying to heal that, some chemicals are released that are -- it -- an irritation that results in pain.

Q Okay. Now, I mean in, I guess, just general terms, pain waxing and waning, would that be like, sometimes my knee wakes me up in the middle of the night, sometimes it doesn't?

A Yes. Or if you had a toothache, sometimes it's annoying and sometimes it can be overwhelming.

Q Okay. So at the first visit you see Mr. Morgan and you, I guess, evaluate him, you have some initial thoughts. At that point, had there been any MRIs taken that you were also looking at?

A Yes. There's an MRI scan that -- in the -- in the neck, it wasn't too helpful for his diagnosis because if you have a joint problem, it's not something you pick up typically from an MRI scan. It's by the examination,

the -- the symptoms and responses to injections. So there's a couple of small disc bulges in the neck. In the low back, there is multiple disc bulges in the lumbar spine.

So just from the MRI scan, we talked about pieces of the puzzle. If you just take that one piece of the puzzle by itself, it's not going to give me the diagnosis, yes, he damaged some joints in the neck, and, yes, he damaged some particular discs in his -- his low back.

In addition, we did some x-rays on -- in my office, and it showed that 5, 6 level with flexion extension, moving forwards and backwards, that at 5, 6 level, he had significant amount of motion almost considered to be unstable. And so that's going to put more trauma on this particular joint and particular disc level.

I'm not saying that that was caused by the accident, may or may not, I'm not -- I'm not sure. But he had -- some people would consider fussing the neck just because of the hyper -- that degree of hypermobility.

Q What is hypermobility as far as what causes it? Is it a --

A When you bend forwards or backwards, or side by side, there's supposed to be a -- there's an acceptable amount of integrity or motion within a particular joint. If -- if there's too much motion, then that's considered hypermobile, or unstable, and that's going to put more stress on that particular disc and that particular joint.

Q Okay. Could, say for instance, being jammed forward and hitting your head on a -- the part of a car and jamming your neck backward, could that cause hypermobility?

A Yes.

Q And is it basically, as I understand it, the joints can move a certain tolerance or a certain range. But when you take them outside of that range, it stretches and that's what causes it; is that accurate?

A Yes.

Q Okay. And it's kind of like having maybe a pair of socks that you stretch out too much and now the pair of socks won't stay up on your leg?

A It'd be like a pencil if you're -- you can actually bend a pencil and often let it go and it's fine. But you can -- there's a certain point where it -- it's actually going to break.

Q Okay.

A It would be damaged.

Q Okay.

THE COURT: Is it a good spot?

All right. Folks, we're going to go ahead and break for lunch.

During this break, you're admonished not to talk or converse among yourselves or with anyone else on any subject connected with this trial, read or watch or listen to any report of or commentary on the trial or any person connected with this trial by any medium of information, including without limitation, newspapers, television, internet, radio, or form or express any opinion on any subject connected with the trial until the case is finally submitted to you. I remind you not to do any independent research, and we will see you back at 1:30.

THE BAILIFF: Please rise for the jury.

[Jury out]

1150

THE COURT: I have at least an initial draft set of instructions. I still don't have any instructions from the Defense. Mr. Rands?

MR. RANDS: Your Honor, in the last trial, I think we settled the instructions.

THE COURT: I understand, but I don't have them. I didn't keep them from the last trial.

MR. BOYACK: Yeah, we're working on them.

THE COURT: And I don't have them. As I mentioned the first day, my assistant retired and so I don't have access to her [indiscernible] so I don't have them.

MR. RANDS: Counsel gave me his set. I'm going to compare it with mine. I think we've got it pretty much settled.

THE COURT: Well the set you provided me was missing some, like, critical instructions, so.

MR. BOYACK: We know. We know, and I understand. The copies that were emailed were incorrect.

THE COURT: Okay. Well just get me whatever because I would like to get those finalized.

MR. RANDS: I got his set this morning. I'll compare it with ours --

THE COURT: That's the draft that I have currently.

MR. RANDS: -- and I think we've got them settled.

THE COURT: Okay. Well, great.

MR. RANDS: So rather than give you ours and then have to deal with --

THE COURT: Well, if there's any -- the other thing is if there are any that there were objections to or whatever last time, they're not going to be in the record. So if there's any that you want that you are not agreeing on, I need those, too.

MR. RANDS: Okay.

THE COURT: So we basically just need to redo it.

MR. RANDS: Will do.

[Recess at 12:16 p.m.]

THE MARSHAL: Please rise for the jury.

[Jury in at 1:47 p.m.]

THE MARSHAL: Please be seated.

THE COURT: We're back on the record in Case number A718679, Morgan versus Lujan. Let the record reflect the presence of all of our jurors, counsel, and parties.

Mr. Cloward, I'm sorry, go ahead, please.

MR. CLOWARD: No problem. Thank you, Your Honor.

BY MR. CLOWARD:

Q So, Dr. Muir, if you'll kind of I guess just kind of we'll go through -- I think the last question was kind of the thought process in arriving to the ultimate conclusions that you have today and so forth.

A Certainly. On the cervical spine, in summary, based upon the patient's symptoms of a sharp stabbing pain, which is consistent with joint, based upon the hypermobility at C5-C6, based upon the physical examination of extension being more painful than flexion, which is consistent with a joint problem, based upon the symptoms of -- of referred pain in the

thoracic spine -- in fact, Dr. Gabell did an injection in the thoracic spine, which is below the neck, to see if maybe it was coming from -- from that area. And the injection indicated it did not, yet the injection in the neck indicated that that pain that the patient had in the scapular region is a referred pain, and that's consistent with 5-6 and 6-7 level.

Based upon all those findings, I'm -- I'm comfortable that the patient's major pain generally is coming from the C5-6 and the C6-7 level. We at one point somewhat put the treatment of the neck to the side because the low back became more of a predominant complaint. But where the patient is at this time, they're essentially ready for the radio frequency ablation in the neck. There is some hypermobility at the level above at C4-5 level, and so I wanted to do a stage -- one last thing is a stage medial branch block of the 5-6 and the 4-5 just to see whether the 4-5 should be included in the radio frequency ablation. So that's where the patient is at this point.

Regarding the lumbar spine, the -- the patient underwent an injection for the joints in the low back and that was not diagnostic, helping to rule out that the problem was from the -- from the joints. And, typically, as I stated, it's either going to be from the joint or the disc with pain that's lasting more than a few months.

So the patient did undergo a different type injection from -- from Dr. Coppel. The patient underwent what's called a discogram, and that's where a needle's placed within the disc at the suspected level and then two adjacent levels. And doing the discogram, it was done by a different pain management doctor, it was a clear good discogram in that to have a positive

discogram, you need to have two things: one, abnormal anatomy and the second is reproduction of the pain with pressurization. And that needs to be a reasonable amount of pressurization. And she was found -- he was found to have two discs that were pain generators. One was with the bottom level at the L5-S1, which was to nobody's surprise. It was somewhat of a surprise the patient had an abnormal disc at L2-3, which is the fourth from the bottom of the level. That's not a real common level to have problems with.

And the damage was a little bit different in that rather than having a torn disc in the back where the dye came out the back, it was more from the -- the front. And there's -- there's no disc herniation seen. There's a bulge seen at that level. But the upper level or the 2-3 level was involved as well as the L5-S1 level.

There was some potential minor problems with the other two discs in between and the one above. However, they were -- they were negative as far as being a pain generator. So I felt very comfortable that the major pain generator was coming from the L5-S1 and the L2-3 discs. And we -- we had seen before that the disc had a tear at the bottom level. The upper level, we did not see that because we're looking on a posterior aspect and with the discogram, it showed the tear was in the front of the disc.

So the patient underwent plasma disc decompression which is like laser discectomy, and I did that. It's a procedure that's probably 30 times less invasive than the standard treatment, which is a lumbar fusion, fusing one level to the other. It's done through a needle. And, essentially, what's -- what's done is the portion of the disc, about one cc of disc is vaporized and shrinking the -- and shrinking the disc. And that's not as

effective as a lumbar fusion, but for about half of the patients on a long-term basis, that can make a difference if you have a single disc that's involved.

So the patient underwent recently, meaning the 20th of -- of March of this last month, so approximately two weeks ago -- two or three weeks ago underwent the plasma disc decompression which is like laser discectomy at those two levels. And patient returned and noted about 90 percent improvement in his low back pain, which it would have been nicer to have 100 percent but 90 percent, I -- I would take that any day. We're still not out of the woods though because it's a relatively short time since the treatment.

Q Okay. So, Dr. Muir, what I want to do is have you look at Exhibit 30.

MR. CLOWARD: Your Honor, may I approach? Thank you.

[Pause in proceedings]

BY MR. CLOWARD:

Q Okay. I would like to just spend a moment, Dr. Muir -- I almost called you Your Honor. This is the discography study, the post disco-CT scan, Exhibit 30.

MR. CLOWARD: We'd move to admit that, Your Honor.

THE COURT: Mr. Gardner or Mr. Rands?

MR. RANDS: No objection.

THE COURT: 30 will be admitted.

[Plaintiff's Exhibit 30 admitted]

MR. CLOWARD: Your Honor, may I publish?

THE COURT: Go ahead.

MR. CLOWARD: Okay.

BY MR. CLOWARD:

Q So, Dr. Muir, what I'd like to do is have you come off the stand, if you would, and Dr. Kittusamy is going to be here tomorrow, so she's going to go into greater detail on this. But just kind of give us a very brief -- because, you know, Doctor, I don't want to waste time because she's going to come in tomorrow. But why don't you just talk to us a little bit about what this test is and what you can read from it. There's the TV screen here.

MR. CLOWARD: If I can use -- Your Honor, can I move the TV over a little?

THE COURT: That's fine. Just --

MR. CLOWARD: Okay.

THE COURT: -- be careful.

[Pause in proceedings]

THE WITNESS: So a discogram is not a treatment. It's to determine whether a disc is the major pain generator or not. And to have a positive finding, meaning that that's a generator of the pain, you must have two aspects: one, abnormal morphology, which means there's some change in the -- this disc itself, some damage to the disc, which in itself can be asymptomatic. As we get older, we all have changes in -- in the disc. And with Aaron's age being young, I'll show you a normal disc. It's like the cloud, and that's a very -- that's a normal finding, what we expect especially at his age.

BY MR. CLOWARD:

Q And, Dr. Muir, I want to ask --

A So the needle's injected in the middle of the disc, and there's an outer portion which is like the ring and the inner portion. So here's the outer portion, and here's the inner portion here. And so the needle's placed right into -- to here. And so there's some dye that's -- that's injected, so you can see the dye. You can see it right during the discogram or in a CAT scan like this. You can see it afterwards, but there's some time lag so it's kind of nice to see it right when you're doing the procedure that the discographer can see.

And this is the dye, and this is the middle of the -- the disc. And this -- this is this portion that's here, and that's completely normal.

Q So let me just make sure I understand. If it stays contained in that area, does that mean that there's not any fissures or tears that's leaking out?

A Well, you can have often [indiscernible] tear from the -- the back side. They can tear here, and they can year here. And if you pressurize, if there's a tear that goes all the way through, then you would see the dye sometimes coming out and then into the space here.

Q Okay.

A Or this tear in the front, you would see the dye coming out and then tracking along the side there. And in a normal disc, the dye, you're going to outline the -- the disc as like a cloud. And that's what we're seeing here and we're seeing here. And this is the fourth and the third disc.

Q How do you tell whether the other ones are torn?

A Well, you can see the difference here that this is an abnormal -- it's not like a puffy cloud. You can see changes in this one, see changes in

this one in the L1, L2, and L5.

Q Okay.

A So if you said which disc looked abnormal as far as damage within the disc, it's this one, this one, and this one. Now when these discs were pressurized, the only ones that reproduced typical pain at a relatively low pressure, which increases the validity of a discogram, was this level here and this level. This had a posterior tear in the disc. This one had an anterior tear in the disc.

Q And now you said that the one up, the higher one up was a little bit of a surprise. I think that's what you said.

A This was because, typically [indiscernible] many levels, meaning where it typically is going to be is going to be the bottom two levels. If you tell me your low back hurts, I could tell you and be about 90 percent accurate saying, well, it's either at your 4-5 or your 5-1 level. Those are typical levels to -- to have damage and have problems.

Q Okay.

A So the upper levels are not as -- as common. And this level here, you might say, well, this one looks really a damaged disc too. Well, it was, but it didn't reproduce typical pain, so it's not a source of his pain. It might be down the road, but it's not now.

Q Okay. So after you perform this -- the disc --

A Plasma disc decompression.

Q -- discogram and then you get the CT images, you decided to do the plasma disc decompression?

A Yes.

Q And which levels, just pointing out there, did you do that on?

A Right. When you have a positive discogram, I mean you can leave it alone, you could have a lumbar fusion, or you could do a simple procedure like laser discectomy or plasma disc decompression. So I treated this level and this level, the L2-L5. And the levels are named by the adjacent bones, so this is the first sacrum, so you might hear L5-S1. And if you want to drop the second part, you call it L5. We're talking about the same level. So this would be the fourth vertebrae and the fifth vertebrae, so this would be the L4-5 disc. Sometimes we just drop the second number and call it L4.

Q Okay. Now can you just explain, I guess, using your pen what the plasma disc decompression or the laser treatment that you --

A It's a magic treatment.

Q A magic treatment.

A The wand is placed in the middle, and both the laser and the plasma disc decompression, what it does is it shrinks the disc. And whether that alters the -- it alters the disc chemically. It can help the disc heal. The exact mechanism is not well worked out other than it's been proven to -- to help by doing that treatment. The difference is laser will vaporize at about 2700 degrees this area as opposed to the plasma disc decompression at 100 degrees. So the plasma disc decompression is a little bit more directed. It's more pinpoint.

And the laser discectomy is like putting a needle -- knitting needle into the disc. And the plasma disc decompression is just a small needle, so there's no incision made. Like you see on TV, the -- the band-aid

therapy of laser discectomy, they have to make an incision because it's -- it's large enough. With plasma discs, you don't have to.

Q Okay.

A The literature would say support both of those. There's more laser literature, but the plasma disc decompression may be slightly better, but they're probably comparable --

Q Okay.

A -- as far as the degree of being effective.

Q Okay. Thank you, Dr. Muir.

[Pause in proceedings]

BY MR. CLOWARD:

Q Okay. Now, this was recently performed about -- the discography a couple of weeks ago and then the next day after that or two days after that was the plasma disc decompression. How long have you kind of suspected that maybe this is what should be done and this was your recommendation?

A Well, it's -- it's been more than a year. In fact, Dr. Coppel, who I think is coming tomorrow also, recommended this at one point after he did the injections for the joints and didn't see that that was the problem, then he also was more suspicious of the disc and saying the next step would be see Dr. Muir and consider the discogram followed by the plasma disc decompression.

Q Okay. How come, if you have an understanding, why didn't Aaron rush into that?

A My understanding is that a number of factors. One, he was

somewhat fearful even in injections. These -- these are potentially painful, and they're sometimes scary to have done. And especially with surgery, he was very fearful of having any surgery done. And the surgery other than the plasma disc decompression, the lumbar fusion would be a very large procedure. So I allowed about a year approximately. He must have gone back and forth in his mind does he want to have this done or not and finally got to the point where enough was enough and he said let's go ahead with this treatment.

Q Okay. Now what would it say to you if a patient was pushing for a certain treatment and was trying to rush in and have things done? Would that cause you any concerns as far as, you know --

A Well, patients want to have their problem taken -- take care of. I mean I understand that. But you need to wait a reasonable amount of time to see if conservative care is going to help and particularly time because sometimes the body will heal our injuries. And you don't want to have a procedure when you could have been a little more patient and let the body just heal that on its own.

Q Okay. If the -- you know, if you performed this last month, do you believe that had -- had you not performed this procedure, that Aaron's disc on a more-likely-than-not basis -- or Aaron's discs on a more-likely-than-not basis would have healed themselves after four years?

A No.

Q Okay.

A And that's from the not just my experience but the literature would indicate that if you have a chronic back problem particularly lasting

two years and that the likelihood is it's going to continue to bother the patient.

Q Okay. So Aaron's doing well now, 90 percent reduction, but as you say, we're not out of the woods. Let's talk about, I guess, what the future holds for Aaron and kind of where your thought process is as far as moving forward. Now, at the time when we retained you, we asked you to prepare a life care plan. Let's first go off and go through the life care plan and then we'll talk about if anything changed based on this recent test.

Do you have the life care plan up there with you, Dr. Muir?

A Yes.

Q Okay. So let's go through that while I go through my notes. When did you formulate your opinions with regard to future care?

A The life care plan was created on or finished on July 31st, 2016.

Q Okay. And so July 31st of 2016, what were you recommending or what was your belief as far as the future care for Aaron?

A Regarding the cervical spine, it's the same opinion that I have now that the pain -- the major pain generators in the neck were coming from the C5-6 and C6-7 joint on the right side. And, as mentioned, if you have that on an ongoing basis, typically it does not get better and typically you continue to require treatment or at least benefit from treatment. It's always the patient's choice whether they want to have the treatment or not, if they would benefit from the treatment.

So what the life care plan, what it is, is a device to determine the best you can what the patient would benefit in the future based upon their present injuries. And a life care plan is a dynamic vehicle, meaning

that it can change in five years or ten years. For example, if Aaron had a great result of 90 percent at that state and -- and he did really well, then you need to modify the life care plan accordingly. If things got worse, the plasma disc decompression didn't help and he needed a lumbar fusion, then the life care plan would typically be modified.

So in July, I was asked as a life care planner to -- to perform the life care plan, which is a prediction of treatment in the future that will be required or at least the patient would benefit from based upon those injuries. And so my opinion at that time was the pain was coming from the -- the neck and those two joints. Regarding the lumbar spine, we hadn't had the discogram, so my opinion was the patient most likely would benefit from a discogram and subsequent plasma disc decompression which Aaron did have. And I was most suspicious of the lower lumbar levels and it turned out to be the L5-S1 disc and the L2-3 discs were the -- the pain generators.

Q Now how does -- does it change? You mentioned early on that there was the surprise with the L2-3. Does that change the prognosis moving forward for Aaron now that he's had the plasma disc decompression? At that point, it was -- that you generated that, you felt like that was the only thing that he would need. Does that change for you?

A Yes. I published and presented a paper I think it was 2007-2008 a number of conferences of 100 patients that I did plasma disc decompression on. And it helped almost two-thirds of those patients by one year at one-year follow-up on an average. And since that time, some of those patients that have -- were considered as successes have returned and said my pain came back again and they ended up having lumbar fusions.

So now I tell patients that on a long-term basis, it's similar to the laser literature, is that it's going to help about 50 percent if you have one -- one disc.

And so you might say, well, you flip a coin and half the time it's going to be heads and half the time it's going to be tails. But the more discs that are involved, you're flipping more coins. And so he had a 90 percent reduction so far, and there's about a 50 percent chance that it would solve one disc problem. But if you say, well, is it going to solve both of the disc in the long term, then it becomes less than 50 percent because of the multiple discs involved.

Q Okay. So as you sit here today to a reasonable degree of medical probability on a more-likely-than-not basis, do you believe that Aaron will require a lumbar fusion at some point in the future?

A The literature would indicate that -- that he will be a candidate for lumbar fusion.

Q Okay. And what is the cost of, say, a lumbar fusion?

A Geographically, meaning in this area, it would be -- it depends on how it's done because there's a couple of ways it can be done. And some surgeons like one way. Some surgeons like to do it another way, and so it depends on -- on the approach. But it's somewhere between approximately $250,000 to $350,000, and that's for the hospital which is the vast majority of that: the surgeon, the anesthesiologist, the assistant, the spinal cord monitoring. Those would be the major categories and some therapy after the fusion.

Q What would the surgeon and anesthesiology and those

charges, what would those be, or was it 250 to 350 for everything?

A For everything.

Q Oh, okay. Now you mentioned earlier, I guess surgeons like different approaches. So what I'd like to do is we've got some boards here. You can kind of walk through the different approaches and have you talk about that. Can we have you do that?

A Yes.

Q Okay.

MR. CLOWARD: Your Honor, could we get the easel? Is that better?

THE COURT: It's right there.

[Pause in proceedings]

THE WITNESS: Are you saying that I may explain to the model first, what we're looking at?

MR. CLOWARD: Yeah.

THE WITNESS: Okay. So, again, this is the front of the vertebrae, and this is the back. These are the bones that you feel when you touch the back, the backend. So when you do a fusion, you're trained to do two things: one, to create a bony bridge between one level and the other so it doesn't move, and the other is to remove the damaged inner portion of the disc.

So there's two approaches. One is to go from the front, move the intestines to the side, remove the disc, place a large -- a large ring, what you call a cage, that would be the size of a disc filled with some type of calcium in the middle to form a bony bridge here and then flip the patient

over and make an incision and put a screw in the bones with a connecting rod and then add additional bone graft on the side to have a solid fusion. Or it can be done from posteriorly just going -- making an incision, taking out all of the bone between the joint here and here and then moving the nerves to the side, taking out the disc, put a cage in one side, put a cage in the other side and then the screws with the rods and the bone graft. And so it could be posterior alone or anterior-posterior, and there's preferences for -- pros and cons for each one.

So this diagram here is just to show exposing the disc here and make a cut through the disc and clean out the disc here and put some type of graft in between and then typically some type of a cage in the front to add stability so the cage doesn't come out. So that's an anterior approach.

BY MR. CLOWARD:

Q Have you done these?

A Yes.

Q Okay. And then this?

A The posterior approach is to, again, expose the bone which is exposed here, and that's what we're looking at here, and then removing the structure here, which they did here. The spinal cord actually ends up here, so these are just a -- this is a sac of nerves so you can pull it to the side, clean out the disc, put a cage in, do the other on the opposite side, and then put in the screws with the connecting rods. And, typically, the screws and rods are done whether you do front or just everything from the back.

And then bone is -- the bone that you remove here is mixed with some calcium or some type of an extender and that's placed here just so

you can get a solid bony connection between on level and the other. And that's a posterior approach.

Q Okay. Now given that Aaron had the plasma, I guess, more than one level affected, would it be fair to say that the fusion would also be more than one level?

A I'd -- I'd say statistically you're talking about one level. So you're saying that probably at one level you get away with the plasma disc decompression and one you won't.

Q That was a bad question on my part. I'm sorry. What I meant to say is given the fact that you did the plasma disc decompression at two levels, does that suggest to you how many levels he would have when he had the fusion? Is he going to be one or two level -- you see what I mean?

A It's either zero, one or two, and it just depends on the response to the plasma disc decompression. And the numbers would indicate that by doing the two that at least one level would need to be done. And we don't have a crystal ball, but we have literature that shows what numbers to expect, and we would expect one of the two.

Q Okay. Thank you, Dr. Muir.

[Pause in proceedings]

BY MR. CLOWARD:

Q All right. Now let's go over -- you were retained to give some analysis regarding the medical bills, review the medical records, and also the billing charges. So can we go over the billing charges at this point?

A Yes.

Q Okay. Now the past medical bills to this point are $248,650.60.

Is that accurate?

A Yes.

Q Now let's go through each one of these and let us know whether they are what's called reasonable and necessary and usual and customary for the Las Vegas community. Was the charge of $1,045.92 for MedicWest Ambulance usual and customary and reasonable?

A Yes.

Q And necessary?

A Yes.

Q Okay. Was the Sunrise Hospital charge of $9,689 reasonable and necessary and usual and customary?

A Yes.

Q Was the Urgent Care visit of $350 usual and customary and reasonable and necessary?

A Yes.

Q And so that I don't have to keep repeating those words, I'm just going to go through each one and if it is not usual and customary and reasonable and necessary, then please let me know, okay?

A Yes.

Q So the charge of $11,267 for Grabow Hand to Shoulder Center?

A Yes, for the wrist.

Q And for Dr. Coppel's charges of $30,250?

A Yes. These are all the injections that he did plus the office visits.

Q Okay. And he'll be here tomorrow to talk about that. The

Nevada Surgical Suites of 38,500?

A These are the surgical suites required to do the injections. Yes, they are.

Q Okay. Now the chiropractic of 18,138?

A Yes. That's -- and that's been some discussion whether the chiropractors over -- over treatment. There's 91, 93 treatments. And it's -- it's within the customary number in Las Vegas. It's certainly at the upper end of normal. Even though there's a lot of visits there, my opinion that it was reasonable because at least give the patients some temporary relief.

Q Okay. Now the Las Vegas Radiology of 16,650, and that is essentially, I think two MRIs of the cervical, two MRIs of the lumbar, I believe there was a thoracic MRI in there, a wrist arthrogram of the right -- or the left wrist, a wrist arthrogram of the right wrist. Were there any other --

A Not that I recall unless the disc -- the CAT scan. I'm not sure if that was --

Q The post-disc -- okay. The post-discogram CT scan of 16?

A Yeah.

Q Okay. So were those charges reasonable and necessary and usual and customary for the Las Vegas community?

A Yes.

Q Okay. Now your bills, 74,787, can you tell the jurors what that comprised of?

A Yes. The -- the vast majority of that, it has to do with the plasma disc decompression and the surgical center associated with that. That probably counts for about approximately 60,000 of that. The other

14,000 would be all the office visits that I did.

Q Okay.

A And x-rays.

Q Now, the pharmacy bills of $6,308.60, is that reasonable for the prescriptions that he was receiving?

A Yes.

Q Now Advance Spine, I think that was a one-time second opinion from Dr. Russell of 737. Is that reasonable for a one-time visit?

A It is. I don't believe I reviewed that, but that's -- I mean that's a typical charge for the one-time [indiscernible].

Q Okay.

MR. RANDS: I'll object then if he didn't review it.

MR. CLOWARD: That's fair enough. We'll --

MR. GARDNER: You'll strike that 700.

MR. CLOWARD: We'll withdraw that one and if we need to bring Dr. Russell in, we can do that. So we'll just put a little note there on that one.

BY MR. CLOWARD:

Q Now Southern Hills Hospital of 29,1-- --

A I'm sorry. I did see that. It was the number 12 in my medical report, so I do have -- I do have that.

Q Okay. So you did review --

A That is reasonable.

Q Okay. So you did review that?

A I've reviewed that.

Q Okay.

A I just didn't recognize his name as opposed to Advanced Spine and Rehab.

Q I understand. Southern Hills Hospital, I believe that's where the wrist surgery was performed, 29,119?

A Yes.

Q Okay. And then Radiology Specialists of 345, I believe that was for a single x-ray?

A Yes.

Q And then Fremont Emergency Services, $1,233, what would that be, Fremont Emergency? Is that like an emergency room physician's group type of a situation?

A Yes. That would be the emergency room physicians that evaluated the patient at the Sunrise Hospital.

Q Okay. And then PBS Anesthesia, a charge of 1,200, what would that be for?

A That's for the anesthesia for the injections.

Q Okay. And then Dr. Cash, there was a second opinion of 1,250. Dr Cash will be here, I think, tomorrow. Is that reasonable and usual and customary for the Las Vegas community?

A It is. It's the higher end of customary for an evaluation, but he's not alone in charging that.

Q Okay. And then ATI Physical Therapy, that's the physical therapy that Aaron received for the left wrist, a charge of $1,881.08. Is that usual and customary and reasonable and necessary?

A Yes.

Q Okay. And then Epion Institute for Spine and Joint Pain, 5,900, that's for Dr. --

A Discogram.

Q -- okay, Dr. Gallagher. Is that reasonable and necessary and usual and customary for the Las Vegas community for a discogram?

A Yes.

Q Okay. Now have you had a chance -- well, before we get there, let me go here. I'll keep this one out. So now the future, this is for the past medical of 248,650. Now the future medical, you also prepared a summary for that; is that correct?

A Yes.

Q And we've kind of discussed that. Now this needs to be changed somewhat because you've already performed the discogram for the lumbar so that is now a past med rather than a future; is that correct?

A Yeah. So I would eliminate the $54,000 now.

Q Okay. So we remove that, but in place, you believe that now that you've kind of got a better image of them being two tears that are painful, Aaron would more likely than not require a lumbar surgery in the future at the cost of 250 to 350?

A Yeah.

MR. RAND: Your Honor, I'm going to object to this. This wasn't something that was provided prior to trial, and this is the first we're hearing about it. It's an expert witness.

THE COURT: Counsel, approach.

MR. RAND: Excuse me?

THE COURT: Can counsel approach for a second?

[Bench conference begins at 2:27 p.m.]

THE COURT: Great. I need to take a break anyway because I got to do a hearing next door real fast. So we're just going to break and then we'll deal with it. All right?

Mr. Cloward?

MR. CLOWARD: Okay. Fair enough.

[Bench conference ends at 2:27 p.m.]

THE COURT: All right, folks, we're going to take a short break. During this break, you are admonished not to talk or converse among yourselves or with anyone else on any subject connected with this trial; or to read, watch, or listen to any report of, or commentary on, the trial or any person connected with the trial by any medium of information including, without limitation, newspapers, television, the Internet, and radio; or form or express any opinion on any subject connected with the trial until the case is finally submitted to you. I'll remind you not to do any independent research. And we'll, let's say ten minutes.

THE MARSHAL: Please rise for the jury.

[Jury out at 2:27 p.m.]

[Outside the presence of the jury.]

THE COURT: All right, gentlemen, I'm going to run next door and I'll be right back.

[Recess taken at 2:28 p.m.]

[Outside the presence of the jury]

THE COURT: Mr. Cloward, I'm going to ask you a favor. I know you didn't mean anything by it. If you can please not walk up onto the witness stand. You did -- I know you were just trying to help get an exhibit, but I just have a thing about it. It's not --

MR. CLOWARD: Sure.

THE COURT: It's --

MR. CLOWARD: Okay.

THE COURT: -- just I don't know. I think I inherited it from the judge that I clerked for. Hopefully, I didn't inherit too many other habits of hers.

MR. CLOWARD: On this issue -- well, I guess it's his --

MR. RANDS: Well, it's my issue, Your Honor.

THE COURT: Yeah.

MR. RANDS: Your Honor, as you know and recall, the -- I believe it was the Supreme Court or it might have been the Court of Appeals, but I believe it was the Supreme Court, in 2007 came out with the Pizzaro-Ortego versus Cervantes-Lopez matter found at 133 Nev. Adv. Op. 37 (2017), which is directly on point with what's happening here.

They have a responsibility to give us prior to trial their computation of damages. And in that case, it was exactly the same as here. The doctor's on the stand and didn't give a computation of the future damages. The defense at that point made an objection and actually made a motion for a new trial. They didn't get the new trial, but the court did say that they're required to give us prior to trial the computation of damages, and it's exactly the same situation.

In that case, the orthopedic surgeon said a future surgery was going to cost $250,000 for a cervical -- or lumbar fusion in the Las Vegas area, and the defense doctor said maybe 120. There was a dispute. But, you know, the court said that the 16.1 (C) requires computation of damages and that includes future medical damages. It's exactly the same thing that happened in this case. We would move to strike the future damages that were not previously disclosed.

MR. CLOWARD: Two things, Judge, number one, the bell's already been rung. The opinion was given. It was already given with no objection. I came back to this in the form of adjusting, to be reasonable to them, adjusting the future damages to remove out the discogram, and that's when the objection came. But the fact of the matter is this is already an opinion that was given with no objection. So they've waived it.

And even if the Court -- so the Court would have to, I guess -- you know, I mean think about that conceptually. Does that mean that if a party doesn't like the testimony after reflection, can I come back tomorrow and say, hey, Judge, guess what, you know, this case says this, so I want you to strike that testimony that took place yesterday. That's essentially what they're asking you to do is to object testimony that was already given that Dr. Muir gave with no objection.

Number two, Pizzaro indicated that when it can't be cured, then it's potentially a 16.1 type of a sanction. They have Dr. Sanders coming on Friday. Dr. Sanders can state whether he thinks that 250 or 250 is high. And if he thinks it is, then, you know, they can determine who they believe, whether that be Dr. Muir or whether that be Dr. Sanders.

But we've produced -- and here's the other issue to it is this treatment took place within the last 30 days. This is something that Dr. Muir talked about the last trial was going to happen, and there was a surprise. The surprise was that the 2-3 disc was painful where nobody had suspected that prior to that, so it is a change in circumstances. It is an unusual circumstance. It is not like, hey, all of a sudden we want to sandbag these guys and put a whole bunch of new stuff up in there. This is a change in medical condition, in Aaron's medical condition, that was previously unknown.

And so for all of those -- and so that would be good cause if the Court decided, number one, to strike the testimony that was given with no objection. You know, so we think that they waived it. We think that even if the Court determines that, you know, that they can lodge an objection after the fact to strike testimony that's already been given, then we believe that there's good cause to the opinion and we believe that it's harmless because Dr. Sanders will be here on Friday.

MR. RANDS: Your Honor, I didn't waive any objection. The witness is still on the stand, for [indiscernible] sake. The objection is relevant. It is a specific Supreme Court case. It's directly on point saying they have an affirmative duty to supplement their 16.1 report. We got a -- we had a supplement of their -- of the doctor's records on Friday, last Friday, the day before trial, with the doctor's records. It was the first I [indiscernible] this surgery had even taken place or at least I did. I won't speak for Mr. Gardner, but it's the first time I heard of it was Friday when we got the supplement.

So to allow them to just willy-nilly avoid their duties under 16.1 because I didn't make the objection until he actually put the number on the -- or tried to put the number on the board is -- I mean, I think the objection's well-founded and you should strike that amount.

THE COURT: All right. So, Mr. Cloward, what was provided pursuant to 16.1?

MR. CLOWARD: The discogram --

MR. BOYACK: It's the past --

MR. CLOWARD: Huh?

MR. BOYACK: It's the past, the past and then just this chart. Those are, according to 16.1, it's that number plus this past.

MR. CLOWARD: Yeah. The future medical bills and the past medical bills were given. Then difference is that the discography study with the post-disco CT scan just took place, you know, within the last three, four weeks. That's what we've been establishing. And those were provided.

THE COURT: Can I just see the charge because I know I saw it up there, but we crossed something out, and I -- I just want to make sure that I'm understanding what the record is correctly.

MR. CLOWARD: Yes. Let me -- let me see where --

MR. RANDS: It's the one that you had writing on it.

MR. CLOWARD: Yeah. That's the one I'm trying to find. Okay. There we go. This -- oh, wait. Do you want me to bring it up? I'm sorry.

THE COURT: Thank you.

MR. RANDS: Put it on the screen.

MR. BOYACK: You can't touch it.

THE COURT: I can't really see it that well up there either, so. If I'm lucky, I get it up here and it's --

MR. CLOWARD: Another point that's worth noting is Dr. Sanders says that none of the treatment is related, so he could come in and give that opinion. That doesn't change the amount of anything. He says nothing's related past the strained sprain.

THE COURT: So --

MR. RANDS: but they're going to argue that Dr. Sanders is unqualified to make those opinions anyway, so. So it doesn't --

THE WITNESS: I'll second that.

MR. RANDS: Excuse me.

THE WITNESS: I'll second that.

THE COURT: With respect to the -- so this is what was provided. That's what you have?

MR. RANDS: That's with your handwriting on the bottom.

THE COURT: Right.

MR. CLOWARD: Yeah.

THE COURT: And there wasn't a supplement to this?

MR. CLOWARD: Not with the dollar number but with the medical records, yes.

MR. RANDS: Yeah. The medical records we provided Friday prior to trial, but there was no supplement to the computation of damages, at least the future. I don't know if they computated the past [indiscernible].

MR. CLOWARD: And, you know, the test is harmless or substantially justified. In this situation, you know, this isn't something that

the discogram happened six months ago and we waited. I mean this just barely happened. If anything, that is substantially justified. And it's harmless because they have Dr. Sanders that's testifying on Friday --

THE COURT: All right.

MR. CLOWARD: -- that can address it directly. They have --

THE COURT: So, here, I'm going to give these back, Mr. Cloward. It's different from -- what's that Cervantes-Ortega -- yeah, Cervantes-Ortega, different -- or Pizzaro-Ortega. I'm mixing up the name completely. There we go, Pizzaro-Ortega, different from that case. There was actually no future computation of damages provided in that case whatsoever as opposed to this case where there was a relatively detailed estimated computation of future damages that was provided.

And the case does not require it to be precise. Let me see what that last little language said, but to give the -- something about giving the defense the contours of the potential exposure.

MR. RANDS: My argument to that would be the contours of a million dollars versus $1.4 million dollars are significantly different.

MR. CLOWARD: Well, it's actually 1.2, and then you reduce because that's another thing I was going to establish is of the 1.19, 110 of that, which I'm going to go over with Dr. Muir, is injection therapy that was provided. So this was done in July of '16. At the time this was done in July of '16, the medical bills were, I think, 100 and -- where's that paper, Bryan?

MR. BOYACK: Which one?

MR. CLOWARD: Where you calculated that.

MR. BOYACK: Right here.

MR. CLOWARD: They were around 112, 113,000. Now they're 250 --

MR. BOYACK: [Indiscernible].

MR. CLOWARD: Huh?

MR. BOYACK: Yeah, 250.

MR. CLOWARD: -- 250. So I was actually going to go -- this 119 is reduced by $120,000 because it's basically gone from future medical to it's past now. So this number will actually be reduced. So the total exposure is pretty much at sixes.

The other thing is, is that Dr. Muir recommended a plasma -- or I mean a plasma disc decompression of the cervical spine. That's not -- that's no longer an opinion that he has of the cervical spine. So that's actually been reduced, too, because he believes that it's facet-mediated versus --

THE COURT: All right. So --

MR. CLOWARD: -- discogenic. So it's --

THE COURT: I understand the Defense objection, and I think the best practice would have been to the case supplement under 16.1 given -- well, I mean, right?

MR. RANDS: Well, the Court says he has to.

THE COURT: Given that -- right, but this is an evolving situation as well. I mean that's one of the issues, right, is that this physician is still treating this patient, which makes it more complicated than a situation where the treatment was provided two years ago, right, that it's a fluid situation.

Given that and given that there was a relatively detailed computation of future damages provided, I don't think that there is -- that any failure to disclose is harmful. So I'm going to find that it is harmless and overrule the objection.

MR. CLOWARD: Thank you.

MR. RANDS: But the record is made?

THE COURT: Absolutely. And the Supreme Court can decide if they want to get more specific [indiscernible] give us some guidance.

All right.

THE MARSHAL: Please rise for the jury.

[Jury in at 3:13 p.m.]

THE COURT: Back on the record in Case Number A-718679, Morgan vs. Lujan. Let the record reflect the presence of all of our jurors, parties, and counsel.

Mr. Cloward, go ahead.

MR. CLOWARD: Thank you.

BY MR. CLOWARD:

Q Dr. Muir, would you please turn to Exhibit 12? We were going over the future medical charges. And I just want to move through those so that we can keep with the timeframe that we promised the jurors at the outset of trial. So if you'll turn to Exhibit 12 in the book up there, you're going to go to page 144.

And you gave some broad categories of damages, basically physician care, ancillary medical care, diagnostic testing, medications, lumbar surgery, but then -- and it's page 146 in that exhibit. Then you break

down those categories into even more specific events. Are you there with me?

A Yes.

Q Okay. So let's start off with the physician care. Now you've evaluated individuals with spine care and you treated them over long periods of time; is that accurate?

A Yes.

Q And you also have taken some specialized training on life care planning; is that also true?

A Yes.

Q Okay. And what does that training help you do basically forecast in the future; is that what it's for?

A It's to -- to determine what the patient would benefit in the future for a particular injury or injuries.

Q Okay. So for the physician care, what are some types of treatments that you list out -- well, I guess they're pretty fairly well listed out, but of the 424,952 for physician care, what are some examples of that? How is that broken down? Let's get into the details, I guess, if you will.

A Certainly. Category 1 is an orthopedic surgeon or a neurosurgeon, and that's to evaluate a follow-up visit every five years for the neck and the low back. And actually that's probably too conservative because it's certainly much more than that. And that --

Q I mean let's say in the last four years, have you followed up with Mr. Morgan more than just one time?

A Yes.

Q Okay.
A More than -- I mean closer to ten times.
Q Okay. Well, let's -- we don't want to -- you know, let's stay with this.
A Okay.
Q Let's, you know --
A Then our next pain management, 12 times yearly, that's to prescribe medications and -- and potential rehabilitation. The patient is taking a couple of pain pills a day and a muscle relaxer, antiinflammatory, and I actually cut that in half. But, nevertheless, that patient would need to be seen on a monthly basis for that to prescribe medication.
Q Okay.
A Next would be the radio frequency ablation, and that's poorly worded there but it essentially should say once a year. And if you get a year's response from a radio frequency ablation, that's actually good. You could get more, but [indiscernible].
Q What is the, I guess, the standard length of time -- what does the literature say that those are effective? Is there like a time range like --
A Less than a year.
Q Okay. And for the patients that have a good outcome, what is the highest that it can be?
A Two years.
Q Okay. So roughly less than a year, up to two years of benefit; is that fair?
A Yes.

Q Okay.

A That's for the neck.

Q Okay. Now let's move to the medial branch. Now --

A Yeah. This is a single episode, and that's just to better pinpoint the -- the levels. And I would modify this a little bit from the C-5 to T-1 to C4 to C5.

Q Okay.

A And that's just to rule out that -- the additional level beyond the 5-6 and 6-7. A family physician, this isn't something he's been doing, but he -- he would -- he would benefit from this. Because of taking long-term anti-inflammatories and pain medications, he should see a family physician probably about twice a year to make sure that it's not doing any harm to his body.

The last one is the anesthesiologist to provide the sedation to do the radio frequency ablation on a yearly basis.

Q Okay. And, again, that could give longer benefit but it could be shorter?

A Yes.

Q So that's why you estimated a year; is that fair?

A Yes.

Q Okay. Now let's go through the ancillary medical care. Can you tell us -- that number's kind of high. What is that for?

A Well, it's kind of high because of the surgical center and the patient's young age, relatively young age. Of the 669, 630,000 is associated with the radio frequency being done once a year.

Q Okay.

A And then the -- the other small portions are the -- the one time where the radio -- the very bottom one, the surgical center for the single injection. And then the top is physical therapy or you can put chiropractic treatment here, either one. And I put that we anticipated that he'd be having therapy at least once every ten years for the low back and maybe five years for the neck where they'd have up to ten or approximately ten treatments during that -- that flare-up.

Q Now I want to kind of go back a little bit in time, talk about the surgical center because that is high, $630,000. Can you do the radio frequency ablation? Is that something that can be done just in the in-office setting?

A No. It has to be done at a surgical center.

Q Why? Help us to understand why.

A Because the patient's under sedation, and so you need to -- it needs to be a state-approved surgical center to -- to legally do this type. And so, in other words, you could not perform this out of a -- outside of a state-approved surgical center. It would be against the law.

Q Okay. Thank you. Now let's move to the diagnostic testing x-rays of MRIs. I'll be honest with you, Dr. Muir, that seems a little low, the 7,350 -- but we're not going to deviate from that -- 7,350 for the MRIs. I mean in the last four years, Aaron has had about six, seven MRIs between the neck and the back and a total charge of 16,000.

A And this is one the conservative side. Nevertheless, we now have a better idea of what the -- we have a very good idea of what the

problem is, the source of the pain so we don't need the MRI scan to -- to search that out. And if you ask, well, why have that at all if you already know what's going on, is that traditionally, a patient will have a flare-up. Say if Aaron has one in five years, he sees some physician, and they're going to want to get an MRI scan or I'd want to get an MRI scan to make sure it's not a new problem or that it's not a herniated disc or something different than this.

Q Okay. Fair enough. And radiograph, cervical AP, lateral, flexion, extension, those are basically x-rays?

A Right.

Q And that's the same kind of principle?

A For the same reason.

Q Okay. Next, Doctor, we'll go to the medications. And you've listed Norco. Aaron discontinued the Norco, I believe. He continues to take the Motrin. So in the event that Aaron took out the Norco, then we would want to reduce that?

A No, not necessarily, and I'll tell you why. The life care plan, you do look at what the patient's taking, but it's really to design what the patient would benefit from. You may have cancer and you're a candidate for chemotherapy, but you may choose not to have that chemotherapy. With -- with -- with Aaron's condition, I believe he would benefit from having a pain pill just to help him be more active, one a day, which is not much. He was taking -- taking two. So even though he's not taking it, I would still stand by the life care plan that he would benefit from that.

Q Okay. Fair enough. And you also have Motrin, one a day, and

then Flexeril. What is that? What is Flexeril?

A It's a muscle relaxer.

Q Why would that be something that you would believe he would need?

A It was something that he has taken in the past and that's, again, to decrease the muscle tightness and the associated pain.

Q Okay. And then the last line item on there is a stool softener of $700, 767. What's that for?

A When one takes narcotics, you almost always have some problems with -- with the bowel or constipation. And this is to help prevent that, and this is very inexpensive. It's four cents a pill, that you take once a day.

Q Okay. Now at the time that you generated this report, your future estimated amount was 1,192,928. But there are some adjustments that need to be made because at the time that you gave this opinion, Aaron's medical bills at the time -- this is back in August of '16, August 2016 -- were 136,145.38. As of today, we just went over the medical, are 248,000. So Aaron has essentially had some of the treatment that you've recommended, so this needs to be reduced by the treatment that he's already had but then we need to add in the lumbar fusion, which is a new finding due to the recent testing.

So the amount is 1.330 to 1.430 with 442 and 78. Do you see where I'm going there?

A Yes. And, also, he's almost two years older.

Q Uh-huh.

A So on these -- under physician care, his life expectancy was about 55 years, and nearly two years had passed or at least a year and a half. So you'd reduce the physician's care -- I mean we're talking about small numbers, like 3 percent or so.

Q Approximately --

A The same thing with the ancillary, and the same with the diagnostic and the medications.

Q So physician care, ancillary, diagnostic, and medications should be reduced by 3 percent?

A Yes.

Q Okay. So we'll just do a negative 3 percent, and we can calculate that.

A Because he's a little bit older than that.

Q That makes sense. Okay. Dr. Muir, now moving on, I would like to talk about some of the opinions that you have formulated in this specific case. As the Plaintiff, Aaron has the burden of proving that the damages that he sustained were caused by the actions of the Defendants. And so I would like to ask you some questions about causation and whether you believe the motor vehicle crash that took place on April 1, 2014, was the cause of Aaron's injuries or whether there was something else that might have contributed.

So have you formulated opinions in that regard?

A Yes.

Q Okay. So what is your belief?

A Both the damage to the facet joints in the neck and the -- and

the low back is directly due to the motor vehicle accident. The patient was asymptomatic before the car accident. He had immediate neck pain at the time of the accident. He had, according to the patient's, the medical records that the patient presented is that his back pain began after the emergency room visit later that -- that night. There were two providers, the urgent care, which has very, very brief notes that says one place midback pain. One does say back pain, so it's not very clear.

Q The urgent care was about a week later?

A Within a week.

Q Okay.

A Dr. Coppel saw the -- and then the chiropractor on the 25th of that same month, yeah, he has low back pain. He had multiple areas of the neck pain, headaches, midback pain, wrist that were more painful than the low back. The low back at that time was 5 out of 10, and that was the first time it was -- it was documented.

Now, Dr. Coppel saw him a couple of days before the chiropractors, and he focused in on the neck but nothing was said on the low back. But there's no argument saying that there's some trauma, something happened between those three weeks of the accident and when it was documented actually by the chiropractor that something else happened that caused his back pain or that just happened on its own.

Q That it just --

A That would be very unlikely.

Q That it just spontaneously happened --

A Yeah.

Q -- during that time period.

A And I'm asked to deal with probability, and the high probability is that that low back pain was directly related to that motor vehicle accident. Also, with a torn disc, part of the pain can come from the tear, but a lot of times a majority of the pain's coming by the inflammatory response to that tear. And that is -- is delayed somewhat.

Q Okay. Now the other question that I had was have you -- I guess have you -- the Defense attorneys that are involved, they've been involved from the beginning and been able to depose Aaron, been able to depose you, and do a lot of discovery, discover whatever they wanted. Is there anything to suggest that Aaron had ongoing problems before this event with his back, neck, wrist, anything along those lines?

A No.

Q Okay. So there's no evidence of any prior doctor for a neck problem, true?

A Correct.

Q No evidence of any prior problem for a midback problem, true?

A Correct.

Q No evidence of any problem for a low back issue, true?

A Correct.

Q And then no evidence of wrist injuries prior to this?

A Correct.

Q Okay. How does that play into your decision? Is that important or not important or --

A That is important. Obviously, if you're seeing doctors ahead of

time and had problems with his back or neck, then that needs to be taken into consideration of how much the action made that condition worse. But we -- that's not this situation. He doesn't have any history of prior problems in those areas.

Q Okay. And then with regard to the wrist, that's something that the judge has already talked about. That's a decision that has already been made -- or, excuse me, a decision that's already been made, pardon me. But is it your opinion that he had wrist injuries as well?

MR. RANDS: Objection, Your Honor. That wasn't part of his expert report.

MR. CLOWARD: That's fine. It's already been -- I don't need -- I don't even need to go there.

THE COURT: All right. Question's withdrawn?

MR. CLOWARD: Yeah, that's fine.

BY MR. CLOWARD:

Q Let me see. So, now I have to say particular words due to the record. So, Doctor, is it your opinion to a reasonable degree of medical probability on a more-likely-than-not standard that the injuries sustained by Aaron Morgan on April 1, 2014 were caused by the motor vehicle collision?

A Yes.

Q And using that same standard, was the treatment reasonable and necessary based on those injuries?

A Yes.

Q And using that same standard, was the medical billing usual and customary for the Las Vegas community?

A Yes.

Q And all of those opinions -- are all of your opinions, unless stated otherwise today, have been given to a reasonable degree of medical probability on a more-likely-than-not basis?

A Yes.

Q Okay. Now I want to address a couple of other things before I let you off the -- or before the Defense can question you. I want you to address something that Dr. Sanders said. Have you seen his report?

A Yes.

Q Okay. Now Dr. sanders was critical of the physical -- or, excuse me, the chiropractic care that Aaron received and is of the opinion that physical therapy is better than chiropractic. Now you're a physical therapist?

A Yes.

Q Are you biased toward one or the other because you went to school for physical therapy?

A The literature actually would show that there's stronger evidence for chiropractic treatment than physical therapy. They've -- they've looked at the effectiveness of both. I think it comes down to the provider, but just as this chiropractor, as he outlined in his plan that physiotherapy would be included. Nowadays, physical therapists pop joints like the chiropractors used to be the only ones. Nowadays the chiropractors do physiotherapy, physical therapy in the office as well. And part of that plan was to do modalities, which they did. I believe it was electrical stimulation and some traction. And the patient was given home exercises.

Q Okay. So did Aaron do anything wrong by getting physical -- or,

excuse me, getting chiropractic rather than physical therapy for his neck and back?

A No.

Q Would having had physical therapy instead of chiropractic made all the problems go away?

A Most likely, no. That would be unlikely.

Q Okay. Would -- I guess so do you agree or disagree with Dr. Sanders that, you know, physical therapy, had he just done that, everything would have been better?

A Well, you'd like to do some physical therapy, though it hasn't -- therapy for this problem hasn't been shown in the literature to actually alter the outcome. We still tried anyhow. And the patient did have physiotherapy but under the direction of the chiropractor.

Q Okay. And can you explain what physiotherapy is?

A It's a combination of instructions to the patient, modalities, which means like [indiscernible] electrical stem [indiscernible] or ultrasounds, those are common modalities, and then treatments such as traction and exercise.

Q Okay. Now we've talked about the other opinion of Dr. Sanders, the delay in onset of the documented back pain. We've talked about that. One final thing that was addressed in the opening yesterday was a lien. Can you explain to the jurors what a lien is?

A When a patient's involved in a motor vehicle accident, they -- they obviously seek care, and there's a -- either they pay money, which most people don't, or there's a promise to -- or a commitment to -- a legal

commitment saying I will pay for this at a later time. And it's common with motor vehicle accidents for patients to choose to be treated under a lien where payments are delayed until after settlements.

Q Okay. Now the fact that Mr. Morgan signed a lien, does that relieve him of the obligation to pay the medical bills that you charged him for?

A No. Let's say you decided that you aren't going to award anything to the -- to Aaron for whatever reason. He's still going to receive a bill from my office and if he doesn't pay that or make some arrangements, then he -- the bill would be turned over to a collection agency.

Q Okay. Thank you, Dr. Muir.

MR. CLOWARD: No further questions.

THE COURT: Mr. Rands?

CROSS-EXAMINATION

BY MR. RANDS:

Q Good afternoon, Doctor.

A Good afternoon.

Q Aaron, the Plaintiff, in this case, Mr. Morgan he was referred to your office by the attorneys; is that correct?

A My understanding is Dr. Coppel.

Q Okay. Have you worked with this group of attorneys before?

A I have.

Q How many times?

A I don't know.

Q More than one?

A Yes.
Q More than ten?
A Yes.
Q More than 20?
A Over the last 14 years, yes, 13 years, yes.
Q Okay. And we understand you're an expert and you've come here to court to give your opinion. And you're not in your office or you're compensated for that opinion. How much are you charging today for your testimony?
A $6,000.
Q Is that a flat rate or a per-hour?
A That's a flat rate.
Q You looked at a lot of documents in preparation for the report that you filed, correct? You've reviewed all the medical records?
A Yes.
Q Okay. And so you're familiar with the medical treatment that he received from other doctors also?
A Yes.
Q One of the things you also looked at was -- I think it's on 14 -- colored photographs of the vehicles. Did you review those?
A I did.
Q Would you look in the binder behind you? There's an Exhibit 4.
A Yes.
Q Are those the photographs you looked at?
A Yes.

MR. RANDS: I'd move to have those admitted, Your Honor.

THE COURT: Mr. Cloward?

MR. CLOWARD: No objection.

THE COURT: 4 will be admitted.

[Defendant's Exhibit 4 ADMITTED]

MR. RANDS: Could I have them published also?

THE COURT: You can publish them.

MR. CLOWARD: No objection.

BY MR. RANDS:

Q Have you had a chance to look at those?

A I have.

THE COURT: Do you have your own copy, so you don't [indiscernible]. Just --

MR. RANDS: I have it on my computer.

THE COURT: -- don't take them out of the book.

MR. RANDS: Okay.

MR. CLOWARD: He can use my side, Your Honor.

THE COURT: That's fine. He can use the book. He just can't take it them out of the book.

MR. CLOWARD: Oh, okay.

BY MR. RANDS:

Q And these are the photographs you looked at, correct?

A Yes.

Q Showing a Mustang?

A Yes.

Q And this was what was represented as the car driven by Mr. Morgan, correct?

A Yes.

Q All right. Let's talk a little bit about kind of moving backwards, your -- working backwards a little bit from your life care plan that you've prepared. Physician care, that was one of the sections, correct?

A Yes.

Q And you have a copy of it, but there was also an exhibit to -- but you do have a copy?

A I do.

Q Okay. On the physician care, it's broken down among several different items, correct?

A Correct.

Q And you said pain management facet radio frequency ablation.

A Yes.

Q When was the first time he had that done?

A He has not had that yet.

Q He hasn't had it yet?

A No.

Q Okay. It looks like here, it says every year beginning in 2016, correct?

A Right. So as we talked about before, the two years should be -- or the year and a half should be backed out --

Q Okay.

A -- which is about 3 percent.
Q Your opinion is that he needs it every year, correct?
A My opinion is that he would benefit, most likely benefit from that every year because typically he doesn't last longer than a year.
Q And on the next page under ancillary medical care, the $630,000, which is, you know, frankly, almost -- well, not quite half now, but when we first got the report, it was half of the total was that $600,000 for the surgery center.
A Yes.
Q And that's for the yearly radio frequency ablations, correct?
A Yes.
Q And beginning in 2016?
A Yes, of July of 2016, which is nearly two years ago.
Q Okay. But he hasn't had any of those yet?
A No.
Q Would those be something that you would do in your office or not in your office. I think we established you have to do it in a surgery center, but is that something you do?
A Yes.
Q Okay. And has he scheduled one?
A We're scheduling the final medial branch block to completely rule out the level above before doing the radio frequency, so that is not scheduled, no.
Q I don't want to interrupt you, but I asked you if he'd scheduled a radio frequency ablation?

A No.

Q Okay. And I know we talked -- generally when I'm looking at a plan like that, there's a little bit of -- or quite a bit of speculation involved in this, correct?

A Well, it's based upon the patient's problem, his patient's problem, and the literature. So it's not a crystal ball, so it's not 100 percent accurate. For example, what I predicted two years ago, it's probably understated his medical treatments during the last two years. But it's based upon the literature as well.

Q In some areas understated and others overstated, correct?

A Yes, such as physical therapy is probably the most difficult one to -- to determine or to -- to -- of how often and that's why the comment says the frequency and duration is quite variable under that one.

Q And you put it, in your own words, there's no crystal ball. As you sit here today, you can't tell the jury that if Aaron gets a million dollars for future medical care, that all these things are going to be checked off?

A I can state -- I can't tell you 100 percent, so I don't have a crystal ball that's 100 percent, but I do have -- can state things to a reasonable degree of medical probability based upon the patient's problem and what the literature would say the prognosis of that problem is.

Q Some of the things you said he needed he hasn't had yet, correct?

A Correct.

Q Okay. And many of these things assume that he never gets better, correct? I mean if he got better and didn't need the -- if the two-level

disc compression, radial disc compression you did in his back, if that works and he stays at 90 percent and chooses not to have the other treatment, a lot of this would go away?

A But, again, we have to go by probability and what the literature would -- would suggest what will happen in the future.

Q But the question is a yes or no question. It would go away, correct?

A Yes. That's correct. It's possible.

Q Okay. Let's go through some of the records that you reviewed. Now we talked a little bit with the jury, quite a bit with the jury the last couple of days about subjective versus objective. And you talked a little bit about that, too. A lot of what, as a doctor, you have to accept your patient as a historian, correct?

A We do count on patients being honest --

Q Yeah.

A -- to help us form a diagnosis. Sometimes it's very important. Sometimes it's not, and you can still make it --

Q Sure.

A -- without the patient.

Q But a lot of what you do is if I come into your office and say, hey, my neck hurts, you would have no reason to doubt that?

A I would do probably some -- what I do is I do some -- on the physical examinations, some tests to see if you're exaggerating and if things are out of proportion.

Q Including range of motion, you'd have me move my head

around or move my head around, right?

A These are -- these are specifically for the low back.

Q Sure. But range of motion on -- say my low back's sore. You'd do range of motion. Would you push on it to see if there's any pain in the --

A That's part of the examination --

Q Sure.

A -- yes.

Q Okay. And you've talked a little bit about MRIs. You would agree with me that as far as disc protrusions as an MRI, there are many times you take an MRI with an asymptomatic disc protrusion?

A Yes.

Q Okay. Let's go through the medical records with you that you've performed. On page 2 of that review, there's a Sunrise Hospital and Medical Center; do you see that?

A Yes.

Q And you notice that this was the emergency room, correct?

A Correct.

Q And the date of the accident was 4/1/14, which was the day he went to the emergency room?

A Correct.

Q Is that your understanding?

A Yes.

Q Okay. And there was an examination, pain to palpation of the right trapezius. That's up in the kind of the shoulder area, correct?

A That's included. There's another place where it says that there

was no pain whatsoever, but that's included, yes.

Q Okay. And there was a CT scan of his head and cervical x-rays, correct?

A Correct.

Q There was no lumbar x-rays taken at that time; was there?

A No.

Q And do you think if someone went in -- you're a physician. You've dealt with emergency room situations. Do you think if somebody went into the emergency room and said, hey, my low back is sore, they would probably at least take an x-ray?

A Well, I -- I have dealt and have worked in emergency rooms in my training and -- and you're looking to rule out the major problems. You're looking at is there a bleed in the head that -- that can be life-threatening, is there a fracture or dislocation in the neck. That's what you focus on. And when there's multiple problems, you focus on the major problems. If he complained enough of his low back, however patient indicated it was later that night that he felt the back pain, but if he went to the emergency room or the urgent care center seven days later, if he complained enough of one particular area, then typically they would get an x-ray.

Now my understanding that the other areas were the major pain generators, and the back was a lesser degree at that time.

Q In fact, the back was never mentioned in the records?

A In the records, it was not mentioned until three weeks later at the chiropractor's.

Q We'll get to that, Doctor, but in the back, it was not -- when he

went to the emergency room, the back was not mentioned, correct?

A Well, it was not documented --

Q Correct.

A -- at least.

Q So then next he goes to the -- well, let's look at the -- back in the exhibit binder, Exhibit 6. These were the records of the hospital, correct?

A Yes, they are. Which page?

Q I believe it's page -- in the bottom corner, there's what we call Bates numbers. Do you see those?

A Yes.

Q It would be 24. There's a lot of zeros, but it would be 24.

A I'm there.

Q And this is the -- you're there quicker than I am.

A The CT scan of the neck.

Q Okay.

MR. BOYACK: I have it right here, if you'd like.

MR. RANDS: that's okay. I got it.

BY MR. RANDS:

Q And what were the results of the CT scan?

A There was no fractures and no dislocations in the neck.

Q Okay. And there's no evidence that any kind of radiology was performed for the low back at that time, correct?

A Correct.

Q Okay. Then, next, they went to urgent care, correct?

A Yes.
Q And, again would you look at Exhibit 7, please?
A Certainly. Which page?
Q It would be Number 2.
A Yes.
Q And this is a medical record, correct?
A Yes.
Q And general medical record, it says "CC". What is that, chief complaint?
A Yes.
Q And it says "neck, upper back pain," correct?
A Yes.
Q Let's go back to Exhibit 6. I apologize I'm jumping around a little bit, but.
A Yes, which page?
Q It's on page 2 of 6 of the --
MR. CLOWARD: Which one?
MR. RANDS: It's the report, the --
MR. CLOWARD: What exhibit?
MR. RANDS: -- findings?
MR. CLOWARD: What exhibit, though?
THE WITNESS: Right. I have --
MR. RANDS: Exhibit 6.
THE WITNESS: -- category [indiscernible] which is Bates stamped.

MR. RANDS: Uh-huh.

BY MR. RANDS:

Q I thought it would be quicker to do it on the computer, and it's turning out not to be. But in any event, it is the Bates stamp number is --

A 9.

Q -- 10.

A 10.

Q I'm sorry, 2 of 6.

A Yes.

Q And it goes down, it says constitutional. They're going through an ENT, respiratory, cardiovascular. It gets down to musculoskeletal. Can you see that?

A I do.

Q And it says "denies lumbar pain," correct?

A Well, this is a macro, but on this macro that was not updated, it says -- it says "back atraumatic normal."

Q It says "denies lumbar pain"; doesn't it?

A On Bates 11?

Q No, 10.

A Oh, 10. I'm sorry.

MR. CLOWARD: Are you on 6 of 6 or 3 of 6?

MR. RANDS: I am on 2 of 6, but it's number 10.

MR. CLOWARD: Oh.

MR. RANDS: Bates number 10.

BY MR. RANDS:

Q Page 2 of 6.
A Yes.
Q Are you there?
A Yes.
Q Do you see where it says "musculoskeletal"?
A I do.
Q And it says "denies lumbar pain," correct?
A Yes.
Q And then the next page, as you said, it does say the back is atraumatic, correct?
A Yes, on the macro that they did not update --
Q Yeah.
A -- because the neck, it says atraumatic, non-tender, but that's the reason he came into the hospital.
Q All right. Let's move on then, back to your report. This is where he went to the Nevada Comprehensive Pain Center. Is that Dr. Coppel?
A Yes.
Q And on the first visit there, this is back to your note, page 3 of your review of the records.
A Yes.
Q It said that: "Patient presents with new onset of neck pain, headaches, midback pain, left wrist pain that began after a motor vehicle accident," correct?
A Correct.
Q And there was a cervical exam and a thoracic exam taken that

day, correct?

A Yes.

Q And then on the 14th of July, about three months later, and this is Dr. Coppel's records, correct?

A Yes.

Q It says: "We have received the results" -- and this is in your notes -- "we have received the results from the cervical and thoracic MRI scans. The patient reports that over the past month, his midback pain has begun moving into the low back as well." Do you see that?

A Yes.

Q And Dr. Coppel put that record in his record, correct?

A Yes, which is not accurate but, yes, he did put that in there. That's why I included it.

Q So we'll talk to Dr. Coppel about that about you saying these records aren't accurate.

A Right, because in 4/25/14, it clearly points out low back pain by the chiropractor.

Q And how about if those records aren't accurate? All right. Then Dr. Coppel performed injections, correct?

A Yes, he did.

Q And then on 9/30/2014, notes a worsening of the low back pain, correct?

A Well, in August he did the cervical injections.

Q Uh-huh.

A And then what --

Q But the question was --
A What was the question? I'm sorry.
Q The question was on 9/30/2014, according to your notes, he noted a worsening of the low back pain?
A Yes, withstanding.
Q Uh-huh. If somebody was injured according to what you have opined the Plaintiff was injured in this accident, you said that it wouldn't be unusual to have some delay in presentation of low back pain, but if somebody did a palpation of the low back after this accident, would it produce pain?
A Not always for an annular tear because a lot of the pain has to do within the inflammatory response, and that takes at least several days to have that inflammatory response.
Q On page 24, it's talking about the lumbar area again, and it says the neurological examination is normal, and this is in 2015, I believe.
A I'm sorry. Where are we -- where are we looking at?
Q On your page 4 of your report.
A Okay. Page 4, yes. What's the date?
Q It comes over from the prior page, which is the 15 -- 1/19/15.
A Yes. I'm with you now. Thank you.
Q Okay. And this says: "The neurological examination is normal in his lumbar spine." Does that mean it's not going into his legs?
A Well, this would be expected with this particular problem, and it indicates on the exam it doesn't show that there's loss of sensation, loss of strength.

Q Yeah. I understand that, Doctor, but the question was does the fact that this says there's no neurological -- or the neurological examination is normal mean that he's not going into his legs pain?

A No. This has to do with the objective findings as opposed to subjective.

Q Okay. But there were no objective findings then on that particular issue?

A As expected, yes. That's correct.

Q And then you already said you reviewed the records from Las Vegas Chiropractic and you said that 93 chiropractic treatments over that period of time was normal and expected?

A I didn't say normal. I said the upper limits of customary.

Q Okay. And you said that you've reviewed Dr. Sanders' report. Did you see where the Plaintiff told Dr. Sanders that the chiropractic really didn't help him?

A Yes.

Q Okay. He initially saw you -- now we're getting on to your records. He initially saw you on the 15th of January, 2015, correct?

A Correct.

Q And you saw him for two or three, maybe four times in 2015, five maybe?

A Six times.

Q Uh-huh. And in December 23rd -- or 21st -- or 31st, I'm sorry, 2015, you indicated in your records that the patient would like to move forward with the discogram and plasma disc decompression. Is that right?

A Yes.
Q And is that the procedure that you just performed last week?
A Yes.
Q And was it your opinion or is it your opinion or, I guess, it's proven that that would provide some relief for the patient. You were recommending it, correct?
A As an option, yes.
Q Okay.
A And it did.
Q So do you have any reason to believe that if he'd had it in December, he wouldn't have had the same result?
A No.
Q Okay. Now I just wanted to -- you were talking about reporting and such, on the summary of your report, page 10 --
A Yes.
Q -- and you pointed out that there were chief complaints at that time at the urgent care of neck, low back, and wrist pain, correct?
A At the emergency room?
Q At the urgent care.
A At the urgent care? Of neck, back, and wrist pain.
Q It says neck, low back, and wrist pain.
A Right. That was -- I think it's been edited and the "low" is taken out.
Q Okay. It wasn't taken out of mine, but. And then the next page on 31, you said "Most likely without surgical intervention, the patient

symptomology will persist" -- I'm sorry, page 11 -- "Most likely without surgical intervention, the patient symptomology will persist, requiring continued treatment," correct?

A Yes.

Q And was the surgery that you were talking about there, the procedure that was performed?

A Yes.

Q Just one more thing, we were provided recently a group of records from your practice. And I think I know the answer, but it appears that there were two signatures on these, one from Gerald Rodriguez, who's your PA --

A Yes.

Q -- and then one from you?

A Yes.

Q Did you see him or Mr. Rodriguez see him or did you both?

A I saw him as well.

Q Okay. In the front page there, the first follow-up visit, it says --

A I'm sorry. What page? Where are we looking at?

Q I've got it at 220 in the Exhibit 12.

A Yes.

Q Do you see the present problems?

A It's under Category 22?

Q It's Exhibit 12. It's your --

A Oh, I'm sorry. Okay.

Q You can look at 22 if you want, but we're looking at 12.

A What Bates number?

Q It's toward the end. It's 220 is the Bates number I have on it. It's your most recent, or at least I presume, your most recent visit since it was the 29th.

A 220. Yes, I have it now.

Q Do you see where it says "Present Problems"?

A Yes. This refers to his initial problems, not present.

Q That's my question because I compared that with the present --

A Yes.

Q -- problems that were on your --

A We need to change -- it's misleading. We need to change the macro because it should say initial evaluation problems, and that's included so I can compare that with the -- with which is the present ones which is under "Interval History".

Q Well, that was my confusion because as I was reading through the records, I noticed that those were the same every time.

A Yes.

Q And it says that his current pain severity is 9 out of 10 but further in your report, it says 4 out of 10.

A Right. The present problem should be listed, it should state, to clarify that, initial problems or problems at initial visit.

Q Okay. And then it says on the next page, which is 221, the second page of your report, 2 of 6, it says, "The patient reports his pain has decreased by approximately 90 percent in the lumbar spine."

A Correct.

Q And that's what he told you last week?
A Yes.
Q So that's a good result?
A Yes.
MR. RANDS: Can I have just a moment, Your Honor?
THE COURT: Sure.
[Pause in proceedings]
MR. RANDS: Thank you.
THE COURT: Mr. Cloward?

REDIRECT EXAMINATION

BY MR. CLOWARD:

Q Doctor, have you ever bought eggs before?
A Buy eggs?
Q Yeah.
A Yes.
Q So the first thing you do when you buy a carton of eggs?
A Open it up to make sure there's not -- I mean I should open them up to make sure they're not broken, but I can't say I always do that.
Q I mean if you wanted to know the eggs were broken, why don't you just look at the outside of the carton?
A Because you can't tell from the outside.
Q Okay. Do you think that people are any different, meaning do you think you can look at, say, a bumper and determine whether someone on the inside was hurt?
A No, typically not.

Q Okay. Same thing, can you tell from looking at a few questions what actual damage to the vehicle took place?

A From a what?

Q Can you tell from looking at a few photographs what damage was done to an actual vehicle?

A Typically not.

Q Okay. I'd like to turn -- have you just turn to page 3, or excuse me, paragraph -- or exhibit, whatever it is, 3 -- 3 something. Just turn to page -- just turn to a 3.

A Section 3?

Q No.

THE COURT: Tab 3, no?

MR. CLOWARD: I'm sorry. It's Exhibit 3, Tab 3. Thank you, Judge. It's a long day.

THE WITNESS: Yes.

MR. CLOWARD: We're getting close.

BY MR. CLOWARD:

Q This is the property damage estimate?

A Yes.

MR. CLOWARD: I'd move to admit this, Judge?

THE COURT: Exhibit 3?

MR. CLOWARD: Yeah.

THE COURT: Any objection?

MR. RANDS: No. No objection, Your Honor.

THE COURT: 3 will be admitted.

BY MR. CLOWARD:

Q Okay. Do you know -- I mean I know that you're not like a biomechanical expert or anything, but do you know how much force it takes to bend the frame of a vehicle, especially a frame that's a unibodied diamond frame?

A I don't, but I imagine it would be significant --

Q Okay.

A -- enough.

Q Do you see on page 2 here where it says that there actually was in the repair estimate five hours estimated for frame damage repair? Do you see that?

A Yes.

Q Okay. Now the other question that I had that I just wanted to know, is the spine condition that Aaron has with these Grade 4 and Grade 5 tears in the lumbar spine, is that something that a normal 20-something-year-old would have?

A No.

Q Okay. And with the protrusion in the neck and the protrusion in the thoracic spine, is that something that you normally see with a 20-year-old kid?

A Most would not.

Q Okay. Have any of your opinions changed, Dr. Muir?

A No.

Q You're still of the opinion that the automobile collision caused by the Defendant running a red -- a stop sign without looking both ways is the

cause of the injuries?

A Yes.

Q Okay. Thank you.

THE COURT: Anything else?

MR. RANDS: Nothing further, Your Honor.

THE COURT: Any questions from the jury? No. Thank you, sir. You're free to go.

THE WITNESS: Thank you.

THE COURT: Mr. Cloward, please call your next witness.

THE MARSHAL: Judge?

MR. CLOWARD: I'm sorry.

THE COURT: I'm sorry, did anyone have a question?

THE MARSHAL: He has a question, yes.

THE COURT: Whoops, sorry, sir. Doctor, if you could just hang on a second. We let you go a little --

THE WITNESS: Yeah. Sorry.

THE COURT: -- a little too soon.

Counsel, approach, please.

[Bench conference begins at 4:11 p.m.]

MR. CLOWARD: I like the questions.

UNIDENTIFIED SPEAKER: I don't think we could do 1 but the rest of them, I don't [indiscernible].

THE COURT: All right. Okay. Any objection other than the two?

MR. CLOWARD: I'm sorry. It's a really long day, Judge. What

was the question?

MR. RANDS: Do you have an objection?

THE COURT: Do you have an objection other than to number 1, which obviously cannot --

MR. CLOWARD: No.

THE COURT: Okay.

MR. CLOWARD: No.

[Bench conference ends at 4:12 p.m.]

THE COURT: Thank you, sir. I'm going to ask you a couple of questions. I'm going to ask that you look at the jury when you answer so they can hear you.

THE WITNESS: Yes.

THE COURT: How many cases do you do in a day or in a week?

THE WITNESS: Over my last 25, 27 years, typically, I will do about five, approximately five cases of surgery a week.

THE COURT: Do patients fully recover from spine surgery?

THE WITNESS: Yes.

THE COURT: Have you encountered a patient free of pain after --

THE WITNESS: Plasma disc decompression?

THE COURT: Sure. After the anterior, posterior laminectomy or any spine surgery?

THE WITNESS: Yes.

THE COURT: Any follow-up?

THE WITNESS: Most patients are not 100 percent improved, but that's still not unusual.

MR. RANDS: A little follow-up, Your Honor.

MR. CLOWARD: I do. I have some.

BY MR. CLOWARD:

Q Dr. Muir, when you treated patient on a lien, does the level of care change?

A No.

Q Does the level of care change if a patient comes in and pays cash?

A No.

Q Okay. Now I did want to follow up because those were come good questions on what the future might hold if Aaron does have the surgery, the lumbar surgery. Is that a guaranteed fix?

A No.

Q You have had patients that have done well with that. Tell us the other side of that coin?

A Are we talking about which, the plasma disc or the fusion?

Q The fusion.

A Fusion? I tell patients that, generally speaking, 80 percent are going to be happy with the procedure and 20 percent are not. And of the 80 percent that are happy with the procedure, typically, they're about 75 percent improved, somewhere between 50 percent and 100 percent. So most patients are not completely pain -- pain-free after that.

Q And what about the folks in that other category, the 20 percent?

What about those folks?

A It's somewhat of a disaster. They just don't do well with surgery, and that could be due to loosening of hardware, maybe the bone didn't fuse, which would require additional surgeries. And if all else fails and they have enough pain, they could consider a spinal cord stimulator, which is an electrode that's implanted over the spinal cord with a little battery pack and a computer that's planted over the buttocks with a connecting wire. And we have a remote control that will give a little tingling sensation over the spine to decrease -- decrease spine. And that's our -- if all else fails, that's what we typically go to.

Q And if an individual does have a level fused where you insert the plating and the hardware and everything that you've talked about, are there problems that can come down the road from the fusion itself?

A Yes. With a fusion, if all goes well, it fuses properly, there's still an added stress placed on the adjacent level. It would be like if you put something heavy over your -- in your trunk or your back right tire, that tire probably is going to wear out faster. And so you're putting with a fusion, you've stopped that one link in the chain, so it puts more stress on the level above and below.

And research that's often quoted is Hillebrand that says that in ten years, there's a 29 percent chance if you have a fusion, that you'll need one in an adjacent level.

Q Okay. Now that's kind of where you get into the point of you're starting to speculate somewhat about whether they'll need that; is that fair?

A Well, you go by the statistics, and that's the best you can go by.

Q Okay. But, for instance, you don't think that Aaron would have the fusion and then have the adjacent level break down and have to have another fusion, right?

A That gets a little bit speculative. At L-5/S-1, I'd say most likely not. If he required fusion at the L2-3, most likely he would because the adjacent level above showed quite a bit of damage to that disc, so it's already a compromised disc, more likely to break down.

Q Okay. And tell us a little bit about your patients, the patient population that doesn't have a good outcome from the surgery. What are their lives like?

A It's a whole spectrum to putting up with maybe mild to moderate degree of pain to severe -- severe pain. So it just -- it varies, and they're treated with conservative care and injections and if that doesn't help, then often the spinal cord stimulator.

Q Okay. Doctor, thank you.

RECROSS-EXAMINATION

BY MR. RANDS:

Q As you said, Doctor, when you get to that point, though, you're really in the area of speculation, correct?

A Yes.

Q And would -- many things are considered in surgery and in results of surgery. But would a young otherwise healthy person be more apt to get a better result than say an 80-year-old person who has arthritis and other issues in the back?

A Yes and no. Yes, because you're younger. You can heal a

little bit better. No in that you've got more years to have adjacent level breakdown.

Q Sure. But the initial surgery is what I'm talking about. You generally get a better result if your patient's younger and healthier; would you agree with me?

A Fairly so, yes.

Q Okay. Thanks.

THE COURT: Anything else?

MR. CLOWARD: No.

THE COURT: All right. Thank you, sir. You are really free to go now.

THE WITNESS: Thank you.

MR. CLOWARD: Your Honor, may we approach?

THE COURT: Sure.

[Bench conference begins at 4:18 p.m.]

MR. CLOWARD: I know you don't like to end early. I had hoped -- I had planned on putting my client on the stand today, but I don't think we can get the direct and the cross done, and I don't --

THE COURT: No, it's fine.

MR. CLOWARD: -- think it would be fair to put him on and stop and then --

MR. RANDS: I'd prefer that.

MR. CLOWARD: Huh?

MR. RANDS: I'd prefer that, too.

MR. CLOWARD: Tomorrow.

THE COURT: [Indiscernible]. We're running behind. [Indiscernible] Mr. Cloward. We'll be fine. He'll be fine.

MR. CLOWARD: Can we have a few minute break then?

THE COURT: Well, we just had like a break for like an hour.

MR. CLOWARD: That's fine.

[Bench conference ends at 4:19 p.m.]

MR. CLOWARD: Mr. Morgan will take the stand.

THE COURT: All right. Sir, come on up.

THE MARSHAL: If you would remain standing, face the Clerk,

AARON MORGAN

[having been called as a witness and being first duly sworn testified as follows:]

THE COURT: All right. Sir, go ahead and have a seat. And if you could state your name and then spell it for the record please.

THE WITNESS: Aaron Morgan, A-A-R-O-N M-O-R-G-A-N.

MR. CLOWARD: Thank you, Your Honor.

DIRECT-EXAMINATION

BY MR. CLOWARD:

Q How are you doing today?

A Okay.

Q That's good. You've been looking forward to this?

A Not really.

Q Super excited.

A No.

Q I'm joking. Aaron, why don't we first start off. Why don't you tell the jurors a little bit about are you -- were you born here?

A Yeah. Born and raised, actually.

Q And where did you go to school?

A I went to school at Del Sol in Coronado for High School.

Q And tell us a little bit about your family. You got brothers, sisters?

A Yeah. I have one older sister, one younger brother.

Q And what are -- what do your parents do?

A My dad is an engineer at The Valleys, he's a senior watch. And my mom is a manager at Smith's Food and Drug.

Q And how long has she worked at Smith's for?

A She's been there for about 28 years or so.

Q So she must like it?

A Yeah.

Q Been there for a while. What does she do there?

A She manages, she just kind of looks over everything.

Q Okay. And how long has your father been at the position he's at?

A He's been an engineer for about 30 years now, but I think that position about 12 years or so.

Q All right. And what is your brother's name?

A His name is Zachary.

Q And he's younger than you?

A Uh-huh (affirmative response).

Q And what does he do?

A He's going to school full-time right now.

Q What does he want to do?

A Something in biology.

Q And what about your sister, what is her name?

A Her name is Hannah.

Q And what does she do?

A She's actually an engineer. She does what my dad does to an extent.

Q Okay. So let's walk through and talk a little bit about the crash itself?

A Okay.

Q Why don't we walk through the crash. First off, why don't you let the jurors know where were you coming from, where were you going?

A I was coming from Southern -- or College of Southern Nevada. I was going with my girlfriend to take her to go pick up her car. She had some auto work being done on her car, and we were going to school at the time at that point.

Q Did you guys have class together?

A I think we had one of the three classes we were each taking at the time together.

Q Okay. And what is her name?

A Her name is Alyssa Baker.

Q And how long have you guys been going together?

A We're going on seven years now.

Q Okay. Now, I just had to ask you a question. What's it like living in your basement?

A I don't have a basement.

Q Okay. So you don't have a basement in your house?

A No.

Q Okay. Why don't you tell the jurors -- so you're following her. You dropped her off at the repair store, the repair shop, and then what were your plans then?

A To go home and study, do our homework.

Q And what happened?

A We both got on the freeway. I was driving towards Tropicana on the 215. Look in the rearview mirror; my girlfriend's behind me. We get off the freeway. We make a left, we're going up Tropicana. We make it to about Pecos or so and I end up making the light. She didn't make the light.

I'm proceeding to Harmon, make a right on Harmon; get to the park or going down towards the park. I'm driving towards McLeod, and right before I'm approaching Tompkins I notice there's a bus in the parking lot. I don't really think much of it. I continue down and then, all of a sudden, this giant metal object pulls in front of me. I slam on my brake, try to turn my wheel to avoid the accident and just next thing I know just that was the impact.

Q Okay. Now, how many lanes were there on McLeod?

A I want to say there's three on each side.

Q Okay. Now, do you remember which lane you were in?

A I wasn't in the furthest right one, I was in the one right next to the furthest right lane.

Q Okay. And I believe at your deposition you told Mr. Gardner that you were in the furthest right lane?

A Uh-huh.

Q Is that accurate?

A No. I kind of thought about it some more and because of whenever the impact happened it totally whipped me around. And I would have gotten chewed up between the bus and curb, so thankfully I wasn't in the far-right lane.

Q And you didn't hit the curb?

A No.

Q Okay. So what happens after the impact? What happens next? Does Mr. Lujan stop right then and there in the intersection or does he continue driving?

A I remember after I kind of recollected myself and got out of my dazed state I noticed he was still proceeding up the street. I didn't know what he was doing at that point. He made his way pretty far down the street and stopped.

Q What was your initial thought during that process?

A I didn't know if he was going to stop. I mean, the impact happened, and he was still going. He seemed -- so.

Q Okay. But he ended up stopping.

A Yeah.

Q So he didn't flee the scene. He stopped.

A Yeah.

Q Right?

A Right.

Q Okay. So does he come and talk to you. Do you go and talk to him? What happened?

A He had come over to my car and said, I called 9-1-1. Just that.

Q Okay. And did 9-1-1 come?

A They did.

Q And what happened there?

A The paramedics came. They basically asked me how I was feeling. I told them I was really confused. I didn't know if I lost consciousness for a moment. I told them that my neck hurt. Whenever it happened I ended bracing the wheel. And then, on the impact I ended up going sideways and smashing my head on the -- I believe it's called an A-pillar on the side of my car and I heard my neck pop. So at that point, I didn't know what was going on, so they took me to the ER.

Q And how did they do that?

A They actually had me lay down on a stretcher. They put the supports all around me. I think it's 6-points or so, just to kind of stabilize me, so I wasn't moving just in case anything was seriously hurt.

Q Okay. And then, did you end up going to the hospital?

A I did.

Q Did your -- and they took you in the ambulance?

A Uh-huh. My girlfriend actually came with us, too.

Q Was she in the ambulance with you?

A She was in the front seat, but she came with me.

Q Okay. So she missed the light, how is it that she connects back?

A She actually ended up driving past Tompkins and she was like, oh, wow a bus accident. Oh, my God, that's my boyfriend, and pulled over.

Q Okay. And how far away from the crash site did you live? Were you close to home?

A Yeah. Like very close, like, a minute away.

Q As a matter of fact your parents live on McLeod. Right?

A Uh-huh (affirmative response).

Q Is that true?

A Yeah.

Q We have to say yes or no.

A Yes.

Q Okay. And how long have they lived in that home?

A For about 30 years now or so.

Q So you were very familiar with this area?

A Yes.

Q You've been up and down that road a lot?

A Yes. Tons of times.

Q Okay. Now, so you go to the hospital and you're complaining of pain to them. And then after the hospital, what did they tell you to do?

A They told me just to try to rest, not do any heavy lifting or

anything. And basically, if the pain perceeded (sic) check back in a week with a physician.

Q Okay. Did you do that?

A I did.

Q Who did you follow up with?

A I believe I went to Urgent Care.

Q Okay. And was that on April 7th?

A That sounds right.

Q Okay. Now, why did you go to the Urgent Care?

A I didn't have a primary doctor that I was seeing at that point, so that was -- I just thought it was appropriate.

Q Were you still having problems?

A I was.

Q Okay. Now, during your deposition you were asked by Mr. Gardner who referred you to Dr. Coppel? Who referred you to Dr. Muir? Who referred you to Dr. Grabow? And initially, you indicated I don't remember. Do you remember that?

A I do.

Q And then, Mr. Gardner continued to ask, and continued to ask you questions and say, well, did your lawyer refer you there? Do you remember that?

A I do.

Q Did you tell Mr. Gardner that your lawyer referred you to Dr. Coppel?

A I did.

Q Okay. I would like to show you something. First off, in the deposition do you remember Mr. Gardner telling you specifically I have your medical records, I already know the answers to the questions I'm asking.

A Yes. I do.

Q Okay. Did he show you any medical records during your deposition?

A No. I don't believe so.

Q All right. Well, I'm going to show you some medical records.

A Okay.

MR. CLOWARD: Your Honor, may I approach?

THE COURT: (Inaudible.)

MR. MR. GARDNER: Do we know what he's showing?

MR. CLOWARD: It's Exhibit 6, Urgent Care records.

And I just need to grab a binder. Can I get the binder --

THE COURT: Yep. Absolutely.

MR. CLOWARD: -- without stepping on the steps?

THE COURT: That's fine.

MR. BOYACK: It's actually Exhibit 7.

THE COURT: Which has been -- 7 has been admitted. 6 has not.

MR. BOYACK: Correct. That's why I said it Number 7.

BY MR. CLOWARD:

Q Okay. So I just pointed out, at the bottom there are some numbers. Do you see that, Aaron, where it says UCE00001?

A I sure do.

Q Okay. So what I want you to do is I want to flip forward to UCE000007.

A Okay.

Q Do you see where I'm referring there?

A Were you looking at the referral type?

Q Yes.

A New patient consult and treat.

Q Okay. So does this document refresh your recollection as to who referred you to Dr. Coppel?

A Yes.

Q Was that in fact the Urgent Care Center?

A Yes.

Q All right. Now, the next thing I'd like to do is show you the referral to Grabow Hand to Shoulder Center, Dr. Ryan Grabow, bilateral wrist sprain.

Does that refresh your recollection as to who referred to Dr. Grabow?

A Yes.

Q And who was that?

A The Urgent Care.

Q Okay. So it wasn't your lawyer that referred you to those doctors, was it?

A What was that?

Q It wasn't your lawyer that --

A No.

Q -- that referred you to those doctors, was it?

A No.

Q Do you know why Mr. Gardner didn't show you these records when he had these records at the time of your deposition?

A I'm not sure.

Q Do you think he was trying to set you up for trial?

A Yes.

Q Okay. Now, so you go, and you see the Urgent Care and you treat there and at some point you retain a lawyer. You retain our firm. Correct?

A Yes.

Q We did refer you to chiropractic. Isn't that true?

A Yes. It is.

Q Okay. And did at some point you go and see the doctor -- Dr. Wiesner?

A Yes.

Q Okay. Why don't you tell the jurors some of the treatment. We're not going to go into super great detail like we did with Dr. Muir and take six hours. But why don't you talk to the jurors and tell them a little bit about the treatment that you had.

What was it like?

A It helped me whenever I was doing it. Long term it didn't really help, but they would do things like back rollers, they did this one machine that would kind of stretch and decompress my neck. That

helped a lot. They would do the electric stim packs, hot and cold packs, and then they would -- obviously adjustments too.

Q And you say that it didn't help long term.

What do you mean by that?

A I mean after I stopped doing it the pain went back to where it was at. Whenever I was doing it frequently it did help me. It did give me some sort of relief.

Q Okay. It didn't cure the problems?

A No.

Q Okay. At some point did you -- you had some injections from Dr. Coppel?

A Yes.

Q Why don't you talk to us about that? What was the -- I guess what was going through your mind when Dr. Coppel and others said, hey Aaron, we want to do an injection.

A It was very alarming. I never had to do anything like that in my life, so -- I'm afraid of needles. I wasn't very excited about it.

Q Okay. What was that like? Walk us through one of those -- when you'd go and get an injection how do they do that?

A Well, they'd have to put you under and they'd have to sedate you and do it. It's very painful. You're sore for about a week afterwards and it's no fun.

Q Okay. Did the injections make your pain go away?

A I got varying degrees of relief from it, but it didn't solve the problem forever.

Q Can you estimate, or do you know how many injections you've had let's say in your neck?

A Maybe four to six --

Q At --

A -- treatments, not just injections. I think they did more levels than just one at once, so I think somewhere around there.

Q Okay. And what about in your lower back?

A Probably about the same. I'm not too sure.

Q All right. Why don't you talk to us a little bit about the -- this test that Dr. Muir talked about the discography.

What was that like?

A It was very painful. They have to keep you awake whenever they inject this dye into your back, because if you're asleep they can't really test the discs to know where the problem is. You have to be fully awake. It's very scary. It's no fun and it hurts immensely.

Q Let's walk through it. Let's go there. I mean, take us to the location that you had this. You arrive in the parking lot, who brings you there? Do you have --

A My mom. You need a ride home.

Q You need a ride home. You go into the waiting room and then what?

A And then, they brought me back. I waited for a moment and then they strap me down, they strap my back down. They gave me some sort of sedative that put me to sleep. I -- and then they would wake me up after they injected the dye just to see how the pain felt or what -- if I

was getting a positive -- if I was getting pain results from the levels they were doing. So they had to put me under, wake me up, put me under, wake up I think three or four times. It was really scary, so.

Q Was it painful?

A Yeah. Really painful, too.

Q Okay.

A Because they're trying to induce the pain to, you know, recreate where the problem is to tell where the problem is, so.

Q Now, Dr. Muir suggested that you have that procedure done in 2016.

Why didn't you go in and have that done in 2016?

A Because I'm very scared of surgery and I'm young and just really fearful. I was fearful about going through all that. Maybe I don't -- maybe I don't get any relief from it. You know, what if I went through all that and didn't get any relief? It's just really scary --

Q Okay.

A -- as a young person.

Q Okay. How old are you right now?

A I am 26.

Q How old were you at the time of the crash?

A Twenty-two.

Q Prior to this crash, have you ever had any problems in your neck?

A No.

Q Did you ever go see a doctor for neck pain?

A No.

Q Did you ever go see a doctor for the trapezius or scapula pain?

A No.

Q Did you ever get an MRI of your neck?

A No.

Q Did you ever get a CT scan of your neck?

A No.

Q What about your mid-back? Did you ever have any doctor appointments for your mid-back?

A No.

Q What about your low-back? Did you ever go see a doctor for your low-back before this crash?

A No.

Q Did you ever get an MRI?

A I don't think so.

Q You don't think so?

A An MRI? I don't think so. No.

Q Okay. Tell us, I guess, what the pain is like now after the plasma disc decompression when you compare that with the pain -- let's say you're walking into the surgery center the day you have the PDD, what has it been -- what's the difference been for you? Has it been good, bad?

A An immense difference. It's actually way more manageable now.

Q Okay. What is your understanding of what the future holds for your low-back?

A I understand that that treatment is kind of a band-aid and it's not a permanent solution. So even though I'm getting great relief now that's not promised down the road, so.

Q How does that make you feel?

A It makes me really worried about my future. It makes me unsure.

Q Okay. Let's talk a little bit now -- let's kind of go back in time and talk about I guess your evolution during this crash. I want you to level with these jurors. Okay? Be brutally honest with them.

A Okay.

Q Have you always handled this with this awesome attitude?

A No.

Q Were there times during this that, you know, this kind of got the best of you?

A Yes.

Q Okay. So we're going to talk about those things. Let's set the scene before the crash, so that the jurors get a little bit of an idea of what your childhood, what your upbringing was like.

Is your home life -- is your father -- do you guys have the best relationship?

A No.

Q Okay. Without getting into a whole bunch of details tell us a little bit about that relationship and what it was like growing up.

A My dad was always really judgmental. He's very OCD about stuff. He's very meticulous. You can never do anything right in his eyes. He's got anger problems. He's physically and mentally abusive.

Q And was there a point that you were in high school that actually led you want to get out from the household?

A Yes.

Q And did you do that?

A Yes.

Q And where did you go?

A The first time I went and lived with a friend for half a year. And the second time I actually lived with my grandmother.

Q Did you moving out have any sort of an impact on your father? Did he kind of realize that hey I got to change a little bit?

A He did.

Q And did he -- did your relationship get a little bit better after that?

A It did for a while.

Q Okay. Now, when you moved out and you were living with your friend, is that when you met Alyssa?

A It was around that time.

Q Where did you meet her?

A I actually met her at church at a youth group.

Q Okay. Now, did you have a girlfriend then?

A I did.

Q Did she have a boyfriend?

A I believe so.

Q So you guys didn't -- you kind of just saw each other. Did you have a crush on her?

A I did.

Q Did she have a crush on you?

A Yes.

Q All right. You didn't start dating right then and there though. Right?

A No.

Q When was it that you started dating Alyssa?

A In my junior year of high school.

Q Okay. And, you know, the suggestion in opening statement was, you know, you got in this crash and basically loafed around and, you know, you're just waiting for a pay day, and that you don't work. That's kind of the implication.

I mean, have you worked before?

A Yes.

Q Okay. What was your first job?

A My first job was actually being a bagger at Smiths.

Q And your mom help you get that job?

A Yes. She did.

Q All right. How much were you making when you started that job?

A Probably about $ 8.00, 8.50.

Q Did you get promoted?

A I did.

Q How many times did you get promoted?

A Three times.

Q And how much was it that you were making at the end of that?

A Close to 15 an hour.

Q So why do you think you were promoted?

A I always tried to be a hard worker. Come in and do the best I could with the time that I had there.

Q Okay. And how long did you work there?

A About three-and-a-half years or so.

Q Okay. Was there at some point that you decided you wanted to kind of try and focus on school?

A Yes. There was.

Q Okay. And then you did focus on school and you started attending where was it?

A It was CSN.

Q Okay. So and you were at CSN, as a matter of fact, at the time that the crash took place. Is that --

A I was.

Q Okay. So you're going to school. You're no longer working at Smiths. You're kind of focusing on school.

What did you want to do at -- in school?

A At the time, I wanted to do something in criminal justice. I wasn't sure though. I just kind of -- that was the reason of going to school was to kind of figure that out, kind of test the waters and see.

Q Okay. After the crash takes place, did you finish that semester?

A I did.

Q Now, during your deposition I believe that you indicated that you actually withdrew from that semester. Is that accurate?

A I believe I did say that in my deposition.

Q Okay. But what I meant is, is it accurate? Did you actually withdraw from that semester or did you finish that semester?

A No. That's not accurate. I did finish that semester.

Q Okay. So you finished that semester and then, did you start another semester?

A Yeah. I did a class over online over the summer.

Q Okay. And did you withdraw from that?

A No.

Q Okay. What about the fall semester?

A In the fall I signed up for classes.

Q And did you finish those?

A No.

Q You withdrew from those?

A Yes. I did.

Q Okay. At some point after the crash you actually got a job. Right?

A Yes. I did.

Q So you're not sitting at home waiting for the --

MR. GARDNER: Objection, Your Honor. It's leading.

MR. CLOWARD: I'll withdraw. I'll rephrase.

THE COURT: All right. Thank you.

MR. GARDNER: Thank you.

BY MR. CLOWARD:

Q You got a job. Right?

A Yes.

Q And where was that?

A It was at LVAC, the athletic center that we have around town.

Q And what were you hired to do initially?

A A front-desk person.

Q Did you get promoted within that job as well?

A I did.

Q What was your ultimate end position at the time at LVAC

A I became a club manager. I actually skipped just doing sales and I was doing managing actually the whole club at one point, overseeing all the employees and everything.

Q Okay. And how did that happen if you're this -- I mean, you're no Einstein, Aaron. Right? That's what --

A Yes.

Q You got promoted to store manager position.

A Yeah.

Q Aaron, at some point though, did this accident, did this crash start to have some psychological problems?

A Yes. It did.

Q Why don’t you talk about that?

A Well, you have me working at the gym now, seeing all these people come in doing the things I used to love to do, things I can't do anymore. I used to love working out. That used to be my passion. I'd out three to five days a week and it was liking seeing a shell of myself. And here I am having trouble drafting legible contracts because my hand's so messed up. And here these people are, you know, doing what I was aspiring to do.

Q What did you start to -- how did you start to handle that?

A I got really depressed.

Q Were there things that you were doing to try and push those feelings down?

A Yes.

Q What were you doing?

A I turned to alcohol.

Q And tell us about that.

A It hurt -- it helped short term, but it just made the matters worse, because once I started drinking I was just drinking to not be anxious. It made my anxiety way worse. It made my depression way worse and just felt physically sick all the time. Stomach pains constantly, I just felt horrible.

Q Now, at some point did that affect your employment?

A It did.

Q Did you -- technically you quit.

A Technically, I quit, but I think they might have let me go if I didn’t quit.

Q Okay. And was that due to your alcohol use?

A Yes.

Q Did anything else happen as a result of that? Did you wind up in the hospital?

A I did.

Q Why don't you tell the jurors about that?

A One night I had to go return a pair of shoes that my girlfriend got me. And at that point I was really anxious about leaving the house, so she took me to the store. I ended up chugging a whole bottle of whiskey and the next thing I know I'm waking up in the psychiatric ward with eight to ten people hovering over me and just wondering how did I get here? What's going on?

Q Was that a moment that you kind of they say, hit rock bottom?

A Definitely. Yes.

Q Tell us about that. I mean, what happened when you got home? Why did you hit rock bottom then?

A I just remember waking up and being so confused. And they ended up letting me go. And whenever I got home I remember my dad came up to me and just hugged me and he just started crying. And I've never seen my dad cry in my whole life. I -- it just really -- that was the point when I realized that I started to become a burden to the people around me. It wasn't about me it was about the people around me. I didn't want my problem to get worse and then my family to have to worry what they're going to do with my body, you know? I got to the point where I saw what was happening outside of me.

Q You say you didn't want your family to have to worry about your body.

What do you mean by that?

A I mean, turn up dead. I didn't want to worry about killing myself and then having my family have to worry about that burden.

Q Talk to us about what it was like when you came home, and you saw your father and he's probably not generally like that. Is he?

A No,

Q What were your feelings at that time?

A It just really hurt me, because I'd never seen my dad lose his composure like that before, so it really showed me that my actions are starting to affect people around me. And that he does care about me and he does want me to do good for myself.

Q Okay. Now, you had been deposed I think about three months before that, August of '16. Does that sound about -- or August of -- it was the --

MR. CLOWARD: One moment, Your Honor.

THE COURT: Sure.

BY MR. CLOWARD:

Q Okay. I'm getting ahead of myself. Okay. So you are hospitalized in about November of '15. Does that sound right?

A Yes.

Q Okay. So did you feel like at that point you've got to kind of figure --

MR. GARDNER: Object. Leading.

MR. CLOWARD: I'll withdraw. That's fine.

THE COURT: Okay.

MR. CLOWARD: I'll restate.

BY MR. CLOWARD:

Q Did you come to a realization at that point?

A Yes. I did.

Q All right. And with regard to your physical condition what were some realizations that you had?

A That maybe I should proceed with the surgeries. Maybe I should try to do more to better myself.

Q Were you realizing that you had kind of been letting this define you?

A Yes. I -- unfortunately, I did let it define me instead of overcoming it.

Q Okay. So the next month you had the surgery?

A Yes. I did.

Q Now, did you have a good benefit from the surgery?

A Not entirely.

Q What was that like? So you have this kind of realization that you've got to move forward. You go and actually have the surgery and it doesn't give you the benefit that you thought.

A It was very upsetting. It made me feel like maybe before I was right not wanting to get the surgery. It made me kind of --

Q Validate some of your fears?

A Yes.

Q Did you give up?

A Yes. I did. I gave up a little bit, but I had to keep moving forward. So I mean --

Q So at some point did you continue to go to the physicians? Did you continue to try and figure out what was going on?

A Yes. I did.

Q All right. Now, after the surgery did you at some point start to go back to work, realize that look, I've got to pick myself up from this?

A I did.

Q And so, you started working again. When was that?

A It was late April of 2017.

Q Okay. And where do you work?

A Right now I am employed at Subway.

Q And what do you do there?

A Make sandwiches pretty much.

Q How long have you been doing that?

A For a year now, little bit over a year.

Q Okay. Do you work, like, five hours a week? Do you work, like, 10 hours a week?

A 35 to 40.

Q Okay. So basically, full-time employment?

A Yes.

Q So you haven't been sitting around on your couch?

A No.

Q You were asked I think one question in your deposition about

whether you mowed the lawn. Why don't you mow the lawn, Aaron?

A My dad would never let me mow his lawn. He's so meticulous and OCD about stuff he -- that would be a bad idea.

Q Would he get mad at you if you did it?

A Yes. Yeah. He would.

Q Okay. So how are you feeling now? How are feeling emotionally moving forward? Are you hopeful?

A Way better.

Q Has the pain relief you've had has that helped?

A It has.

Q Tell us a little bit about Alyssa. She never gave up on you?

A No. She's one of the reasons why I was able to get out of the hole that I'm in -- or was in.

Q And what is she doing right now?

A She's actually an architect right now. She works at RAFI Architecture.

Q And is she doing anything cool right now?

A Oh, yeah definitely. She's got all these cool jobs going on.

Q Like what?

A One in particular is on the 19th she's actually going to NASA. They help design air-force hangers and optimize things that NASA has, so she's going to go down there and get a tour and kind of see what her project's going to be, what her jobsite's like.

Q Is she pretty excited?

A Oh, yeah. Oh, yeah. She loves it.

Q Cool.

MR. CLOWARD: Okay. Your Honor, may I have one moment?

THE COURT: Sure.

(Plaintiff's Counsel Confer.)

BY MR. CLOWARD:

Q I just wanted to clarify, the surgery that you had in December of '15, that was on your left wrist?

A Yes. It was.

Q And that's the surgery you didn't have great relief from initially?

A Yes.

Q Okay. Were you able at some point to do some physical therapy on the wrist?

A I was.

Q And how long after the surgery was that?

A I can't recall the exact time frame, but it was a significant amount of time afterward.

Q About a year?

A That sounds right.

Q And did that help with the --

A It helped with the mobility.

Q Okay.

A It helped a lot.

Q Okay. Now, you also hurt your right wrist?

A Yes. I did.

Q Did you have to have surgery on your right wrist?

A No.

Q What did they do for your right wrist?

A They did some sort of injections and over time it just healed.

Q Okay. So now, Aaron, what I'd like to do is ask you a couple of questions about Dr. Sanders and the independent medical exam.

A Okay.

Q Dr. Sanders, do you remember who he is?

A Yes.

Q And he's a doctor that was hired by the Defense.

Did he tell you that?

A Yes. He did.

Q Okay. Now, during the examination that he performed, were there times during that when you -- he would ask you a question and then you would give an answer and then he would ask you -- that he would explain something a little further?

A I think so.

Q Okay. I'm going just read to you -- I want to read to you part of the examination that he performed. He says, when asked if there was any distribution --

MR. GARDNER: Your Honor, this might not be an appropriate way to use that deposition. He'd been asked if he --

THE COURT: Counsel approach. Approach.

[Bench conference begins at 5:00:41 p.m.]

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MR. CLOWARD: I'm just asking if this happened. I'm asking him to confirm what happened in the independent medical exam.

THE COURT: It -- has the deposition been published?

MR. CLOWARD: It's not a deposition. It's Dr. Sanders's --

THE COURT: Oh, I it's -- I thought you said the deposition.

MR. CLOWARD: -- medical --

THE COURT: Okay.

MR. CLOWARD: It's his medical --

MR. GARDNER: It's an IME.

MR. CLOWARD: -- examination report. And he basically says, and so it's not hearsay because it's a party admission. It's what the Dr. Sanders is saying that Aaron said.

THE COURT: Well --

MR. CLOWARD: He basically says --

THE COURT: -- right. But it's your own party. So if it's the opposing party it's not hearsay.

MR. CLOWARD: But the opposing party on this said that --

MR. GARDNER: No, I didn't.

MR. CLOWARD: -- Sanders elicited this information.

THE COURT: I understand what you're saying. But if it's a statement of your own client, that -- it's a complete exclusion from the hearsay rule, but it's only a test of the party on the other side. It's not as to your client.

MR. CLOWARD: Well, it would be a statement for medical examination then, a statement for medical diagnosis.

THE COURT: Mr. Gardner?

MR. GARDNER: I don't know. I think that it's --

Do you want to admit the whole report then?

MR. CLOWARD: No. I'm asking him to confirm that this took place. That's it.

MR. GARDNER: So you can't refer to it --

THE COURT: Can I -- do you mind if I look at what you have?

MR. GARDNER: -- and then --

MR. CLOWARD: Sure.

THE COURT: Just make it a little easier for me.

MR. CLOWARD: Yep. Also, how much longer do you want me to --

THE COURT: You know what? Why don't we just go ahead and break for the evening and we can sort this out.

MR. CLOWARD: Okay. Thanks, Judge.

MR. GARDNER: Fair enough.

THE COURT: All right.

MR. CLOWARD: Thank you.

[Bench conference ended 5:02 p.m.]

THE COURT: All right, folks, we're going to go ahead and break for the evening. We will come back tomorrow at 10:30. During this break you are admonished not to talk or converse among yourselves or with anyone else on any subject connected with the trial; or read, watch, or listen to any report or commentary on the trial, or any person connected with this trial by any medium of information including, without

limitation; newspapers, television, internet, and radio; or form or express any opinion on any subject connected with the trial until the case is finally submitted to you. I remind you not to do any independent research.

Tomorrow just to make sure that we're getting through everything that we need to we're going to have a little bit shorter lunch, but we're going to bring lunch for all of you. It will be something like pizza and salad. So if you have some sort of special dietary concern you may want to bring your lunch, because I can't promise we'll be able to accommodate any particular dietary issues. I apologize for that, but we'll probably only take about 30 minutes for lunch tomorrow, and we'll bring lunch in for all of you.

THE MARSHAL: Please rise for the jury.

[Jury exits at 5:04 p.m.]

THE COURT:

Mr. Morgan, you can go ahead and step down.

THE WITNESS: Thank you.

THE COURT: All right. So, Mr. Cloward, let's for the record maybe read that little percent there.

MR. CLOWARD: You got it, Judge. I wanted to just simply read, quote, "When asked if there was any distribution of the pain beyond those sites he had already told me," -- this, of course, getting to the issue of any radiating pain, initially he stated no. When given more explanation as to what might constitute radiating pain he then stated he had bi-lateral numbness going down to the wrists.

THE COURT: Okay.

MR. GARDNER: I don't understand what he's trying to do. I don't think it's a good way of refreshing someone's recollection to read off a report that he doesn't know anything about. I don't know if he's -- but for the most part I don't think --

THE COURT: Okay. Listen. He wasn't refreshing recollection. That -- you're right. It wouldn't be appropriate to refresh his recollection. He was --

MR. CLOWARD: I'm asking him to confirm whether that happened.

MR. GARDNER: But he was going --

MR. RANDS: My issue is he was reading off a report that's not in evidence.

MR. GARDNER: Yeah. Yeah. And that's why I asked does he want to admit the whole report? I mean it could speed things up a little bit if --

MR. CLOWARD: It doesn't need to be admitted into evidence to refer to it. You don't need to admit every document that you refer to into evidence. That's not the way evidence works.

THE COURT: All right. So the objection was hearsay?

MR. GARDNER: Yeah. Initially hearsay and also an improper way of referring to something that's not in evidence.

MR. CLOWARD: And could I just for my edification what rule would that be? So that the record's clear, what rule specifically does this -- are you referring to, Mr. Gardner that it's not --

MR. GARDNER: I'm not on trial, buddy.

MR. CLOWARD: Just wondering.

THE COURT: Mr. Gardner?

MR. GARDNER: Yes?

THE COURT: So I have the same question Mr. Cloward has though because obviously there has to be some rule that has been violated and it is not uncommon, for example, police accident, traffic accident reports generally do not come in, but there may be a case occasion to refer to them during the course of a trial. That's fairly common. So I'm just looking for a court rule, a statute or something?

MR. GARDNER: And that's fine. What I'm going to do is I'm going to read the whole report to him and see if he's ever seen that before. That's what it opens the door to do. I just go up, hey, do you remember this and read that.

THE COURT: Mr. Gardner, this was your objection. I'm just asking you the legal foundation for your objection, so I can make a ruling on it. I can't just guess what your objection is.

MR. GARDNER: Hearsay and irrelevant.

THE COURT: Okay.

So, Mr. Cloward, what is your response to the irrelevance and hearsay objections raised by Mr. Gardner?

MR. CLOWARD: The standard for irrelevance is very minimal, number 1. Number 2, the hearsay -- this is a -- this is medical -- this is a statement given to a medical provider. There's a specific exception for that. I mean, it's right in the -- as a matter of fact, I think that a statement given to a medical provider is consider non-hearsay. It's

not even an exception; it's considered non-hearsay. So it's -- I don't even need an exception for it. It's non-hearsay because the, you know, hearsay are statements that potentially could be considered not --

What was it?

Oh, sorry. I lost my train of thought. Hearsay statements are statements that should be considered with caution. Then there are certain exceptions that are given. And then there are statements that are considered non-hearsay because they're not statements that ordinarily would be considered with caution. This is a -- I believe it's a non-hearsay statement. And the relevance it goes to -- it is relevant. It's relevant for what happened at the medical examination which we're going to get into.

MR. GARDNER: Well, why didn't you just ask him what happened?

THE COURT: Wait. Could you two just talk to me and not to each other? I would really appreciate that.

MR. CLOWARD: Yes, Your Honor. We will.

THE COURT: All right. So 51.115 statements made for purposes of medical diagnosis or treatment and describing medical history or past or present symptoms, pain or sensations or the inception of general character of the cause or external source thereof are not inadmissible under the hearsay rule in so far as they were reasonably pertinent to diagnosis or treatment.

MR. GARDNER: I'll withdraw the objection, Your Honor.

THE COURT: That's the relevant statute.

MR. GARDNER: I'll withdraw the objection.

THE COURT: All right. And obviously, Mr. Gardner, to be extent that you think that Mr. Cloward has not provided the entire picture under the doctrine of completeness, you could either request him to or yourself read -- you know, if he's referring to a particular area of the document you don't think he's gotten any -- everything or that he's sort of omitted something that's important to that point you are entitled to have the whole --

MR. GARDNER: Thank you, Your Honor.

THE COURT: -- perhaps not the whole document, but the whole concept.

MR. CLOWARD: Your Honor, one other thing on a collateral or not a collateral, but another issue that I feel that it's appropriate to make the record because it happened today. Dr. Cash last trial testified on page 83 lines 8 through 19, that if Aaron needed a PDD, the plasma disc decompression, he was a candidate for the fusion and at lines 89 -- or excuse me, page 89 lines 14 through 18, the charges for the lumbar fusion were $300 to $350,000. So that's something that was discussed last time. I think that further supports Your Honor's ruling. I just felt that it would be appropriate --

THE COURT: All right.

MR. CLOWARD: -- to have that here right now. Thank you.

THE COURT: All right. Anything else that we need to take care of tonight?

MR. CLOWARD: No. Thank you. What time tomorrow?

THE COURT: 10:30. I have a horrible calendar tomorrow.

I'm hoping not to have everybody waiting today -- like they were today. So I did find the --

MR. CLOWARD: Instructions?

THE COURT: Yeah. I did find those, so I'll go through those again and get you a new -- you can just recycle whatever I gave you. I'll go through and give you a new set.

MR. GARDNER: Your Honor, I hope I didn't make a big mistake. I've been telling a couple of my witnesses Monday. Should I not do that?

THE COURT: My hope was to finish this by Friday, but I know that we are behind. So I don't know the answer to that. I mean, we'll see. We have Dr. Cash --

And how long is Dr. K -- I'm never going to get her name.

MR. CLOWARD: Kittusamy.

THE COURT: Yeah. Never going to get it.

MR. CLOWARD: Well, the concern is, is that we were -- we wanted to get Dr. Coppel yesterday.

THE COURT: Right.

MR. CLOWARD: So he got pushed 'til tomorrow. We're going to -- it's going to be a heavy, heavy lift, but we're going to try to get all three of those doctors done.

THE COURT: Okay.

MR. CLOWARD: Which will mean that we'll have to finish Aaron on Friday.

THE COURT: Okay.

MR. CLOWARD: We had hoped to close evidence Thursday, which I don't think that we would finish --

THE COURT: Nope. I don't think so.

MR. CLOWARD: -- Aaron Thursday. So --

THE COURT: But we may be done with you by Friday morning?

MR. CLOWARD: Hopefully.

MR. BOYACK: Yes. We'll be done then.

MR. CLOWARD: Yeah. That's what we're going to aspire to.

THE COURT: So I'd look at Friday afternoon.

MR. CLOWARD: Thank you.

MR. GARDNER: All right.

[Proceedings adjourned]

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio-visual recording of the proceeding in the above-entitled case to the best of our ability.

Dipti Patel

Dipti Patel
Transcriber

Karen Watson

Liesl Springer
Transcriber

Deborah Anderson

Deborah Anderson
Transcriber

Date: May 4,2018

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