Case No. _____

IN THE SUPREME COURT OF NEVADA

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 3 OF 14

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APPENDIX TO PETITION FOR EXTRAORDINARY WRIT RELIEF
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TAB 8

TAB 8

RTRAN

DISTRICT COURT

CLARK COUNTY, NEVADA

AARON MORGAN, Plaintiff,	)	
vs.	)	CASE NO. A718679
HARVEST MANAGEMENT SUB, LLC, Defendants.	)	DEPT. VII

BEFORE THE HONORABLE LINDA MARIE BELL, DISTRICT COURT JUDGE
TUESDAY, NOVEMBER 7, 2017

TRANSCRIPT OF JURY TRIAL

APPEARANCES:

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

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

RECORDED BY: RENEE VINCENT, COURT RECORDER

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Las Vegas, Nevada, Tuesday, November 7, 2017

THE COURT: All right. Are you all ready to go? Yes? Okay. He's getting the jury in.

[Pause while jury is summoned]

THE COURT: We're missing one? Just bring them all in then, we'll --

THE MARSHAL: Please rise for the jury.

[Jury in at 10:39 a.m.]

THE MARSHAL: Please be seated.

THE COURT: All right. We're back on the record in case number A718679, Morgan versus Lujan, and we are waiting for one of our jurors, so we'll just wait for a second.

[Pause]

[Court and Marshal confer]

[Bench conference begins at 10:49 a.m.]

THE COURT: All right. So my Marshal's tried to call the juror two times and has been unsuccessful reaching him by telephone and he's now 20 minutes late. I don't know if you want to wait longer or if you would prefer just to start and --

MR. GARDNER: [Indiscernible] one of the alternates I think we can just go.

THE COURT: I won't --

MR. GARDNER: Just start.

THE COURT: -- issue an order to show cause and deal with

the juror later, so I'll excuse him from the jury, issue an order to show cause then.

MR. CLOWARD: Yeah, I think we get going.

THE COURT: I don't want to hang up everybody anymore.

MR. CLOWARD: I agree.

MR. RANDS: I think the last time I tried a case we had to use two alternates, so I think we're okay.

THE COURT: I think we'll be fine, but I'm obviously not going to let that go without some --

MR. LAWYER: Something.

THE COURT: -- something because --

MR. LAWYER: And then they file --

THE COURT: -- the Marshal gives them his phone number so if he had some sort of emergency. Obviously he was already instructed, you know, whenever they go out after the first day he gives them all his cell phone number so they have the ability to contact staff. Obviously they could contact the department. If there's ever been an emergency or somebody's running late, usually they text or call the Marshal. And the Marshal's tried to reach him twice and has been unsuccessful reaching him --

MR. GARDNER: Yeah, no problem.

MR. CLOWARD: No problem with us either, thank you.

THE COURT: All right. Great.

[Bench conference ends at 10:50 a.m.]

THE COURT: All right. So we have now waited for about 20 minutes for Mr. Appah, who is Juror Number 10, and unfortunately we've

also tried to contact him by phone and been unsuccessful in doing so, so --

UNIDENTIFIED VOICE: There he is.

THE COURT: There he is. There we go.

UNIDENTIFIED JUROR: What were you going to say?

THE COURT: I was going to issue an order to show cause.

UNIDENTIFIED JUROR: What does that mean?

THE COURT: Well, it means that he was going to have to come in and I was going to decide whether I was going to hold him in contempt, so, fine or jail, yeah. Alrighty.

Sir, if you are running late I am a hundred percent certain that my Marshal gave you contact information yesterday, because he always does, you need to let us know. My Marshal tried to reach you twice and you were not answering your phone.

So, if anybody is running late, please let us know. We understand that things happen. I mean, we prefer that nobody be late so we can get things going and not waste everybody's time. But it is really imperative that you let us know what's going on, or if you have some sort of emergency, we understand, that's happened too. We've had, you know, jurors who have come in and unfortunately have been in car accidents, who have had family emergencies arise. We understand. You really need to communicate with us. All right. With that we have now all of our parties. Mr. Cloward.

MR. CLOWARD: Yes, Your Honor, thank you. Okay. Your Honor, may I approach and pull out the monitor just a little bit?

THE COURT: Absolutely.

MR. CLOWARD: Thank you.

[Pause]

MR. CLOWARD: Can everybody see that okay? Okay. Great.

OPENING STATEMENT BY THE PLAINTIFF

BY MR. CLOWARD:

So now is the time that we actually get to talk about the case. I love this part because for the whole day prior we kind of talked cryptically and we're not allowed to talk about the facts. We get to do that now, kind of give you an overview of what the evidence in this case will be. So the purpose of trial is to find out the truth, number one, if there's a dispute, and then also to I guess restore -- it's a mechanism to restore imbalance that's been caused by one party.

So this crash took place April 1 -- and it wasn't April Fools -- it actually took place on April 1, 2004 [sic]. Very basic description of the facts: Aaron is traveling north on McCloud and the Defendant is parked kind of on a side street, a parking lot, and shoots across McCloud and doesn't give himself enough time and Aaron hits the side of the vehicle. So this is kind of an overview, Google Earth image overview. Aaron is traveling north, the Defendant is parked right here. The Defendant kind of shoots out, tries to beat traffic. This is --

MR. GARDNER: Object, argumentative, Your Honor. Just maybe a description would be better.

THE COURT: Overruled.

MR. GARDNER: Thank you.

MR. CLOWARD: I mean, this is what the evidence is going to

show. So the evidence is going to show that Aaron is traveling north. He doesn't have a stop sign, he doesn't have a yield. The Defendant, on the other hand, is pulling from a parking lot. The speed limit on that road is 35 miles an hour. And as mentioned, what the evidence in the case will show is that the Defendant pulled out in front of Aaron and the crash took place.

The police officers came and they did a report. They did kind of an investigation, talked to all the parties, and determined I guess, you know, what took place. The police officer's estimate was that Aaron was going about 25 miles an hour. Aaron will tell you from the stand that he -- when he saw what was, you know, the van pulling out in front of him, he tried to slam on his brakes and swerve. Did everything he possibly could, but he didn't have time to avoid the crash.

The officer says that the damage to his vehicle was major. And here's a photograph of the scene that shows kind of his bumper, you know, slanted. Here's another photograph later on that shows the damage to the vehicle. And, ultimately, the damage to Mr. Morgan's vehicle was about $5,000. One thing that you'll notice in discussion, Aaron will talk about this, is that the frame was bent. They had to put the frame on a special machine to kind of straighten the frame around. That took about five hours of shop time to do that.

And so you might be asking, Well, who is responsible? It seems pretty clear. Well, the evidence is going to show that at the scene of the crash the Defendant never told the police that it was not his fault. At the scene of the crash the Defendant never told the police that it was Aaron's fault. So the Defendant never said: Hey, it's not my fault, Officer. Never

said: Hey, Officer, it's his fault. That's not what took place at the scene of the crash. Never told the police officer that he looked both ways carefully before pulling onto the road. That never took place at the scene of the crash.

But something interesting happened when Mr. Lujan went back to his company the next day. The next day, 4/2/14, now both the company and the driver blame Aaron. That's what the facts and evidence will show. We're going to ask Mr. Lujan about that on the stand. Now Mr. Lujan claims, the Defendant claims, well, you know what, I stopped, I looked both ways, and I started to go and all of a sudden there was Aaron and he hit me. It was his fault. The company actually claims that it was Aaron that didn't see the Defendant, that it was Aaron that was not paying attention. Okay. Keep in mind that's not what took place at the scene of the accident.

So over one year after the crash a lawsuit was filed on behalf of Aaron. Another attorney at the firm, Adam Williams, had filed the complaint, and in the complaint there are certain allegations that are set forth. Very basic allegations like, hey, the Defendant did something wrong, you know the Defendant was at fault.

What happens in response to a complaint is that Defendants file an answer. They respond and basically say, yes, we did that, or, no, we didn't do that. Well, in answer -- so it's very, very simple. Basically says that the Defendant was negligent and it caused a collision. Very basic allegations. Well, in the answer those things are denied. Defendants deny each and every allegation.

But not only that, but now all of a sudden the finger and the

evidence will show that the Defendants claim that this was Aaron's fault. And this is from the Defense. The Defendants claim that this was completely unavoidable, that, you know, regardless of anybody's actions it just was unavoidable. And also for the first time there I guess was some third person that we still don't know who it is. We'll talk to the Defendant about who that is. But some third person is -- was responsible for causing this crash.

And so again, the timeline of events: The Defendant causes the crash by pulling onto the street in front of Aaron. Aaron does not have a stop sign, does not have a yield --

MR. GARNDER: Object, Your Honor. We're going well into argument.

MR. CLOWARD: That's what the evidence will show, Your Honor.

MR. GARDNER: Well, you're not presenting it that way. You're --

THE COURT: All right.

MR. GARDNER: -- presenting it as an argument.

THE COURT: Do you want to approach?

MR. GARDNER: Yes, please.

[Bench conference begins at 10:59 a.m.]

THE COURT: Let's not argue in front of the jury. You're both better than that.

MR. CLOWARD: I'm entitled to show what the evidence will --

THE COURT: Yeah.

MR. CLOWARD: -- to say what the evidence will show. And the fact of the matter is the evidence will show the Defendant pulled out in front of Aaron. How is that argument? How is that argument?

MR. GARDNER: It's not that. I mean, I know how the crash occurred.

THE COURT: Right. But he doesn't have to say the evidence will show before everything he says. I don't think -- I think there's a line. He's close, but not over, so I'm going to overrule the objection. Go ahead.

MR. CLOWARD: Thank you, Your Honor.

[Bench conference concluded at 10:59 a.m.]

OPENING STATEMENT BY THE PLAINTIFF CONTINUED

BY MR. CLOWARD:

So again, the timeline of events. So this is what the evidence is going to show in this case. The evidence is going to show that the Defendant pulls out in front of Aaron, that at the scene of the accident does not dispute what took place. But then that story the next day changes. And we'll talk to the Defendant about that. That is evidence that we're going to present. We're going to show the Defendant some documents that he filled out while he was back at the company. We're going to ask him some questions about those things. That's just what the evidence is going to show.

The evidence is also going to show that one year, 46 days later, the Defendant is now saying that the crash was unavoidable and that it was Aaron's fault and that it was a third party's fault. So that's the defense to I guess who caused the crash. And then there's also an argument, there's a

dispute about whether or not Mr. Morgan's injuries are -- were caused by this crash.

The very, very first thing that you're going to find out is that Aaron never had a single history of any neck or back problems his entire life. Okay. Never went to the doctor for a neck problem, never went to the doctor for a back problem, never went to the doctor for any problems associated with his spine. Gets into the accident and has a bunch of issues that start.

So in this case you're going to hear from Dr. Steven Sanders. And before we get into the medicine, I want to talk to you a little bit about Steven Sanders. The evidence is going to show Mr. -- or Dr. Sanders, he is not a spine fellowship trained surgeon. Dr. Sanders does not have privileges at any hospital here in Nevada to perform any spine surgeries. So he cannot go to a single hospital here to do a spine surgery. The evidence is going to show that he does not testify on behalf of Plaintiffs. Okay. Ninety-five percent of the time when he comes into the courtroom he testifies for the defense. That's what the evidence will show.

The evidence will show also that Dr. Sanders' routinely charges $2500 for a deposition. For a one hour deposition. He does not charge anything less than $3500 to do a report in this type of a case. The evidence will also show that there is a society called the North American Spine Society. It's basically the society that kind of governs spine surgeons here in the state of Nevada. Dr. Sanders is not a member of NASS.

There's a society that kind of governs the standards for pain management doctors called the International Spine Intervention Society. I

think they're working on changing their name because it's ISIS. I think they actually have changed it, truthfully, to like ISI or something like that. But he's not a member of that organization. And, you know, the evidence is going to show that not one time in his career has he done a neck surgery as the lead surgeon, never a time in -- never once in his career has he ever done a upper back or a lower back surgery as the lead surgeon. That's what the evidence is going to show. Dr. Sanders has testified to those things and we're going to talk to him about that. This is over a 30-year history. He's never been the lead surgeon for any type of a spine issue.

What he has done, and what he will tell you is that he has assisted in doing a couple of spine surgeries to hold things for the surgeon to do their part. That's his experience with actually doing spine treatment. Similarly, you're going to hear -- and I'm going to get into all the medicine and it'll kind of become important. You'll recognize why it's important to talk about Dr. Sanders and his qualifications right off the bat. He has never done a discography study, he's never done a steroid epidural injection, never done a medical branch block facet injection, rhizotomy, and so forth.

What you will hear from Dr. Sanders, however, is is that his partner that works at the same clinic that he works at, Hugh Selznick, he is fellowship trained and he is a spine surgeon. So, you know, there are other folks in town that you'll hear about that do have this training.

So the evidence is going to show that Dr. Sanders criticizes the treatment in this case. He criticizes Dr. Cash's treatment, criticizes Dr. Muir, his treatment, criticizes Coppel's treatment and so forth. And so I'd like to talk about I guess some of the treatment because Dr. Sanders, he does

agree, in fact, that Mr. Morgan was hurt. He says he was hurt, yeah, but I just don't think he was hurt that bad.

And so let's talk now a little bit about the injuries that Aaron did sustain in this case. So at the scene the AMR comes. Aaron tells the AMR, the ambulance folks, he says: You know, I hit my head. Initially they say: Well, do you want to go to the hospital? And he says: No, I don't want to go to the hospital, I'm okay. Then his mom shows up and, you know, kind of persuades him, look, you probably ought to go get checked out, you hit your head. And so he's taken in the ambulance to Sunrise Hospital.

Now, when he's at Sunrise Hospital, what they do for him -- you'll hear the evidence -- they do a brain CT scan. The doctors are worried enough about his complaints they do a brain CT scan, they do a neck CT scan, and then they also -- they give him a shot of morphine. And then they discharge him, they give him some -- leave him with some prescriptions for Flexeril, there's a Norco, so some pain medication, some medication for muscles, you know, muscle relaxer-type medication. They discharge him.

Now, about a week later, Aaron is still having some problems and now he's noticing that he's having some wrist problems as well. So what he does is he goes to the urgent care and the urgent care looks at his neck and they look at his wrists and the make a couple of referrals. They make a referral to a doctor by the name of Dr. Grabow, who is a hand and wrist -- Dr. Grabow kind of specializes in from the shoulder down to the hand. And then also Dr. Coppel. Dr. Coppel was a pain management doctor.

Now, although Aaron receives the initial I guess referral to

Dr. Grabow, he doesn't go to see Dr. Grabow for a couple months. He tries to do some conservative therapy, conservative modalities as in chiropractic care and so forth.

And so a couple of weeks after the urgent care visit Aaron goes to see Dr. Coppel, he sees Dr. Weisner at Las Vegas Valley Chiropractic Center, and he begins to essentially do conservative therapy, conservative treatment. And Dr. Muir will be here and Dr. Coppel and Dr. Cash and they'll go into detail with all of these things. This is just kind of a general, 30,000 foot overview of the treatment in this case.

And so now I kind of want to talk about I guess the -- what they're going to tell you about the spine. And this might be really simple for a lot of you that have had some experience, but for the benefit of everybody else I want to go into this for those folks that don't have experience with the spine. So there are generally two really major sources of pain. You can have a discogenic pain or you can have a what's called a facet or -- some folks pronounce it fassit [phonetic] -- a facet joint or fassit joint pain. And what those are is -- this white is the bone. The doctors will tell you this. This is what's called a vertebral body. And then in between the vertebral bodies you have a disc. Okay. And you have like the -- the full model shows you have discs and vertebral bodies from your neck all the way down to your coccyx or your, you know, the lower spine. And this is -- the neck is called the cervical or C spine often, the mid is called the thoracic or T spine often, and then the lumbar is the lower spine or L spine, low back, and then you also have the sacrum and so forth.

So again, within the pain generators you can have -- and the

facet joint, just for everybody's benefit, that are these -- those are these joints right here. And those joints are how the vertebral bodies move. So when you stretch back like that, when you stretch forward, there's movement in this little joint here, and the joint has a little capsule. And, again, there are two major sources of pain: discogenic versus facet. And I'm going to talk about each of those.

Because the disc, we'll talk about that one first. The disc, you can have two types of a discogenic injury. You can have what's called kind of a physical compression. That's where you might have cord compression, you might have some stenosis, you might have what's called a pinched nerve. Folks have often heard of a pinched nerve. But you can also have what's called a chemical irritation. That's an annular tear or internal disc disruption. We'll talk about that.

So the disc is kind of a material, it's like a shock absorber. It's meant to absorb stresses and pressure between the vertebral bodies. It's composed of two layers. You have the annulus fibrosis. That's the outer portion. It's kind of a tough portion. Then you have the inside, which is nucleus pulposus. You think of it kind of like a jelly donut. If you put a jelly donut on the table and you push on it -- doctors will tell you this -- you push on it the jelly sometimes will leak out into the outside portion.

And you can think of I guess a compression-type kind of like a hose. When you kink the hose, that can cause problems. So your spinal cord is protected. It goes down the middle of this, the spinal column. And at each level on both sides you have what's called a nerve root. The nerve root exits out of something called the foraminal opening. Foramen in Latin

just means hole. So nerve root comes out of the hole. And so you have a nerve root at every single level. And if you have a discogenic injury, if you have a herniated disc or, you know, a bulge or compression-type injury, sometimes that nerve root will be compressed. Sometimes you can actually have central cord compression where the herniation goes backwards and actually compresses the spinal cord itself. And that's a central canal compression-type injury.

But then the second type is an annular tear. And this just shows I guess some, you know, the different types. You can have an extrusion, protrusion, bulge and so forth. But the second type is a chemical irritation, and that's like if you had a cut on your hand and you got some lemon juice and you squeeze the lemon juice on it and it would hurt. Well it's the same principle in the neck -- or in the spine with the discs.

When the disc gets torn, the disc at each nerve root, the nerve roots have these follicles off the nerve roots and they -- it's called they innervate. So they're woven into the annulus. So they're innervated into the annulus. And so when you have a tear, when this is torn, and this material comes in contact with these follicles, that can cause pain. And that's what we call an annular tear or internal disc disruption.

Sometimes you will see on the MRI, well, that's not a -- it's not a compression but they're having these radicular problems. That's called a chemical radiculitis or a chemical irritation. Okay. So that's the discogenic pain. So keep in mind discogenic you can have two broad types of discogenic. You can have a compression, you could also have a chemical irritation.

Now, the next thing -- there are other sources of pain. The next thing is what we call facet, or fassit, joint pain. And again, that's this little joint back here. And keep in mind everybody from their head to their toe -- or from -- not to their toe -- the top of their spine to the bottom of their spine they have two of these joints on every single side, all the way down. So this is the lumbar spine. You have a joint here, joint here, joint here, joint here, joint here, all the way up. Same thing on this side, joint, joint, joint, joint, all the way up.

Now, the facet is a little bit tougher to diagnose because the joint is much smaller. Okay. And it's the same thing with a neck MRI. Neck MRIs are a little bit harder to read than lumbar MRIs just because the vertebral bodies are bigger in the lumbar spine. Well, the facet joint is a much smaller part of anatomy than, say, the disc. So it's a little bit harder to diagnose. And this is kind of a picture of the facet joint here. So this joint can become irritated. If this capsule has some strain or tearing, the joint itself can cause pain, can become painful.

But also you can have what's called a medial branch irritation. So medial branch -- and I'll go back to the spine. Out of the hole you have -- so at every level out of the hole comes the nerve root. Well, off the nerve root is the -- is a branch. It's another nerve. It's called the medial branch. So that nerve comes off of the nerve root and actually goes over across the back of the facet joint. Medial branch can cause some irritation too.

And so the way that the doctors I guess figure out -- doctors, physical therapists, chiropractors, practitioners figure out what's going on with somebody there are a couple of things that they do. First, there's

radiographic imaging, things like MRIs, CT scan, x-ray. Then there's also a physical examination. We kind of discussed that, touched on that a little bit in the jury selection process, like, you know, is there a negative -- or, I mean, excuse me, a positive orthopedic test, you know, things like that, what is the doctor feeling upon palpation. Then you have the patient reporting. So the patient comes in and they say, hey, Doctor, this is where I'm hurting, this is what it feels like, this is how I describe it, and so forth.

There are also other methods: injection therapy by pain management doctors that can help to isolate what's going on. And so let's talk about the physical examination and the patient reporting in this case. So what the doctors are looking for if it's a facet joint problem is -- let's say this is the lumbar spine. The facets can cause pain into these areas. And the doctors will tell you that. This is a -- from a journal article. They'll tell you, look, this is what you would expect when you have a facet issue. In the neck, this is what you would expect if, you know, these levels are affected. So if someone has a C3-4 facet issue, this is kind of where you would expect them to complain of the pain. This is what correlates clinically with what the patient is telling you.

But it can be difficult for practitioners, the evidence will tell you, and Dr. Muir and Dr. Coppel and the others will come in and tell you, look, it's not a perfect science. There's some trial and error involved here. And this is the reason why. Because the thoracic spine also has pain, and when you look at the patterns a lot of the patterns overlap. But not only that, the disc, when you injure the disc, the disc can also cause pain into these same areas. This is what we call a dermatomal pattern. It's a -- it's kind of a

diagram that lets doctors know, look, if it's a C6-7 problem doctors often will tell you, you know, 6-7 is probably the easiest one. The 6 nerve root is the easiest one to remember because it's like a six shooter. This is how it's going to affect you, thumb and forefinger. And so they have these ways that they're taught in medical school if a patient is complaining of pain into their pinky then it's usually this nerve root. If it's a thumb and forefinger it's this nerve root. If it's a big toe it's this nerve root. If it's the bottom of the foot it's this one, and so forth. It gives them an idea.

But the problem is, is that you have overlap. Okay. You have overlap. And so Aaron is complaining of pain in his neck, in his mid-back, and his low back and then his wrists bilaterally. And so let's talk about the neck and back injuries first. So he attend the chiropractor and Dr. Weisner, he starts to perform reasonable I guess -- not reasonable but conservative -- that's the word I'm looking for -- what we call conservative modalities. So basically stretching, does some manipulation, things of that nature. And he does that and when Aaron doesn't get better, after about two months he says, you know what, Aaron, you're still having problems in these areas, I think we need to send you off to get some MRIs to see what else is going on here.

So he sends Aaron off to get some radiographic testing. And again Aaron's complaining of neck, mid-back, low back, and wrist pain. And so -- and he had already received a neck and brain CT scan. The doctors will tell you the difference between the CT scan versus like an MRI. A CT scan is a better tool to look for a broken bone, whereas an MRI is a better tool to look for discogenic or soft tissue-type injury.

So he goes and has some MRIs, and he's had a couple of them, repeats. And the MRIs show that he's got disc protrusions at two levels in his cervical spine and that he's got a disc bulge at one level in [indiscernible], and then he -- in his mid-back he's got a disc protrusion, and then in his lumbar spine it's a little bit complicated because he has a disc bulge with foraminal narrowing. So what that means is that the bulge has caused some narrowing of the hole, okay. So where the nerve root exits it's caused a little bit of a narrowing. And it's -- I believe it's -- the radiologist called it as moderate to severe narrowing.

But he also has facet hypertrophy. So what that means is the facet joint is kind of swollen. And those are the findings that the MRI that the radiologist, the trained radiologist, finds and puts on the reports. And the radiologist measures the spine, and you can see the differences in the measurements that are provided, and that's how the radiologist -- they have special tools that kind of, you know, help them to know what the distances and so forth are. That was the -- this is the neck, the cervical spine. You can see it's 1.26, 1.08, 1.12, and then .99, .02, and then .19. And the doctors will tell you, you know, it doesn't seem like that big of a difference, .99 to maybe .26, but when you think of it as a percentage it's, you know, twenty-five percent more narrower, I guess, than the other. So it is more of a significant. Doctors will tell you that. And then also we have 1.04, 1.02, and the .87, so it's almost twenty percent smaller in the lumbar.

And the doctors will tell you that a normal healthy disc without any problems, you want it to look like this. You want it to have a -- at the bottom concave, moon, half moon-like shape. That's the shape of a normal

disc that's healthy. You have that concavity. When you have a rounded disc like that, that's the bulge. The disc is not in the normal shape like it should be.

So now let's talk about the wrist injuries that Mr. Morgan had. So Mr. Morgan was sent out for MRIs of the left wrist and the right wrist. A lot of times in -- the doctors will tell you like a frontal collision, someone's holding onto the steering wheel type of a situation, that can cause this type of an injury. So he has a 3mm by 5mm partial tear of the triangular fibrocartilage complex at the ulnar aspect. That's up here. And then that's the left wrist. And then the right wrist is 5mm by 4.5 partial tear of the same thing. So tears on both sides of the wrists there.

And we touched on this a little bit. I want to kind of go into detail now about the purposes of an injection. So the doctors will tell you an injection is kind of like going to the dentist. When you go to the dentist the dentist blows some air on your -- in your mouth if you go there with a toothache, obviously. And if the doctor says: Hey, does that hurt? And if it does hurt then the doctor puts some medication in there, and if it goes numb then the doctor knows, okay, I've got the right nerve root for this toothache, and then they go in there and they do the nerve -- or the root canal, is what it's called. They do the root canal.

Sometimes the doctor will come in there, they'll blow the air, you say: Ow, that hurts, and then the doctor puts the medication, comes back in 10 minutes later, blows some more air on there and says: Hey, does that still hurt? If it still hurts then they give you another shot, numb you up a little bit more. And they do that until you're -- you receive, you know,

complete numbness. That lets the doctors know what nerves are at issue here.

Same thing with injections. Injections are more for diagnostic purposes than they are for therapeutic. That's an injection. That will -- that's different than what we call a rhizotomy, and we'll talk about that in a moment. But an injection, the doctors, based on the clinical presentation, based on their physical examination, based on the MRIs, they kind of have an idea. They have some puzzle pieces of where they think the pain generator is.

So what they do in the wrist, the doctor went in there and the doctor injected the wrist with some medication. And if that relieves the pain, then the doctors know, ah-ha, the tear, that's what's causing the problems so we're going to go in there and we're going to repair that.

And so Aaron has a couple of injections on his left wrist and one on his right wrist. The injection on his right wrist fortunately actually helped his wrist to heal. It helped to -- it helped him to get better. That's all that he needed. However, on the left wrist, the left wrist continued to have some problems and so he had to have a surgery for the left wrist. And so they go in and they do an arthroscopic TFCC repair. So the doctor goes in there and surgically repairs that tear. And the doctor did that with Aaron and Aaron has received benefit from that.

Now, it is undisputed in this case that Aaron hurt his wrists, and there's not an issue that $40,171 has already been determined. That is not an issue that you folks will even decide. That has already been determined. It's not an issue in the case. What is in dispute are the injuries related to his

spine and the severity of those injuries.

So, again, when we talk about an injection therapy, the injection therapy is very similar to, you know, like a nerve -- I mean a root canal injection, very similar to say an injection into the shoulder or the knee or what have you. The doctors, if the suspect, okay, I think this is a facet mediated problem, I think the problem is coming from the facet joint, what they do they have a special machine that's called a radiography -- I think that's what it's called, I might be wrong on that. But it's -- the person lays down on a table and there's a big machine. It's like a big seat. And the machine actually goes over and under the person and it shoots x-rays down through the person and it gives the surgeon -- there's actually a video screen and they can in live action see what's going on.

So what they do, because you're dealing with the spine they want to be super careful, so they slowly advance the needle, and there's some dye. They'll advance a little bit of dye to give contrast on the machine, and then they'll continue to advance it. Then once they feel like they have the needle exactly where they want it, then they'll inject the medication. And they usually inject two types of medication. They'll inject a -- like a lidocaine. I think it's actually -- I'm not sure if it's lidocaine, but it's a numbing medication. And then they also will inject a steroid to kind of reduce the inflammation.

And so the doctors will do that to either the facet joint, the disc through what's a transforaminal injection where they're basically injecting the nerve root. They want to bathe the nerve root with this medication. Or they'll do what's called a medial branch block, where instead of injecting the

facet joint itself they'll advance the needle and they will inject the medial branch, that nerve.

And so over the course of Aaron's care, Aaron has had a lot of injections. He's had, you know, multiple injections. And Dr. Coppel will talk to you about that. Very first set of injections are kind of a combo of cervical and mid-back injections. The doctor's looking at the -- and Dr. Coppel will tell you, you know, why are you -- what was your thought process with administering these injections? He'll tell you, well, you know, where he's complaining of pain, where the tenderness is, and also the MRI findings. That's kind of where I thought initially they'll start to look here.

And then the next procedure is -- he says, you know what, okay, we're going to just focus in on the cervical spine this time. We're not going to do a combo of the cervical and thoracic, we're just going to do the neck. And he kind of moves through and now he's only doing the thoracic spine. He's not doing a combo of the neck and back or neck and mid-back or of just the neck, now he's kind of focusing in on the thoracic. And this -- the doctors will tell you it's not like the dentist where the dentist can come back and 15 minutes later do another injection. What they do is they go in there and they selectively pick where they're going to go, they inject the patient, and then they bring them into post-op and post-op will ask him: How you feeling? And they'll give him a pain score and then they follow up with him like a few days later to say, hey, did this help you? Did it not help you? How are you feeling, and so forth.

And so it's a little bit slower than going to the dentist where the dentist can come right back in in 15 minutes so you've -- the doctors will tell

you it's a process, and sometimes it's -- you're playing Sherlock Holmes. You're trying to figure this out. You're trying to figure out, okay, is this a disc? Is this a facet joint? If it's a facet joint is it the joint or is it the medial branch? If it's a disc is it the nerve root or is it the disc itself? And they 're, you know -- or is this a cervical problem? Well, maybe it's a thoracic problem. So they're trying to figure these things out.

And then there's some focus on the lumbar spine, some injections there, and then also some more injections back on the neck. And Dr. Coppel will come in and testify and the issue with the case, the big contention that you'll hear from the Defense, is, hey, look, none of these injections provided a hundred percent relief. Okay. And so because none of the injections provided a hundred percent relief, well, you know, it's, you know, it's too bad for Aaron.

And Dr. Muir, Dr. Coppel, Dr. Cash will all come in and testify, look, this is not something that's easy. This sometimes takes some time to figure out and we've -- these are the steps that we've done to try to figure this out for Mr. Morgan. And then the last injection performed was what we call a tessier [phonetic] transforaminal epidural steroid injection.

So what was the cause of the problems? What will the doctors tell you? The doctors will tell you pretty simply, look, here you have a young man that was 22 years old at the time of the crash. He's never gone to a single doctor visit for any neck or back problems ever in his life. He gets into this crash, he has the symptomatology, he has the objective findings on the MRIs. He has good relief from the injections, not a hundred percent. Some of the injections provided up to 70% relief. So he has relief, just not a

perfect, you know, textbook result. And they will testify that the problems were caused by the crash.

You'll hear from Dr. Muir. You'll hear that Dr. Muir he's a physical therapist. He went to physical therapy school at Stanford and then practiced physical therapy for a few years, then decide, you know what, I want to go back and I want to be a surgeon. So he goes back to medical school and becomes a surgeon. He's spine fellowship trained. You'll hear the significance from them of what that means, what it means to be spine fellowship trained, what it means to actually perform surgeries and what's involved in getting privileges at hospitals. I believe Dr. Muir currently or has been recently the director of orthopedic spine surgery at Summerlin Hospital. I think he's that -- currently that's his position right now.

Dr. Cash, you'll hear from Dr. Cash who is also a board certified orthopedic surgeon. He went to the University of North Carolina School of Medicine. He is also spine fellowship trained in spine surgery, and he has -- he routinely performs neck, mid-back, low back surgeries.

You're also going to hear from Dr. Coppel. Dr. Coppel went to Johns Hopkins School of Medicine. He is triple board certified, so he has actually -- I think -- I'm not a hundred percent, we'll ask him, but I think he might be the only person in the Valley that has these three particular board certifications. But it's in pain management, anesthesiology, addiction medicine. And Dr. Coppel routinely performs injections of both the neck and back as well as what we call rhizotomy procedures.

So in this case you're going to hear from Dr. Muir. Dr. Muir is going to talk about what's called a life care plan. It's a projected forecast of

issues that Mr. Morgan will face down the road. And Dr. Muir will tell you what that treatment entails and explain to you why he believes that Aaron will be required to have that treatment. That treatment, the -- you know, Aaron, at the time of this accident, was 22 years old. You'll also at the end of this you'll hear from Dr. Muir about the life expectancy of Mr. Morgan and how long he's going to live and so forth. This life care plan is to care for Aaron well into the future, not just a year from now, not two years from now, but 10 years from now. And we'll talk about that. Dr. Muir will talk about the treatment protocol.

The total damages in the case -- and keep in mind you're going to hear this is the evidence. The wrist surgery, that is not at issue. That's already been determined.

MR. GARDNER: I want to object. Make sure there's an objection on the record about the wrist, medicals and --

THE COURT: Counsel, approach.

[Bench conference begins at 11:35 a.m.]

MR. GARDNER: I'm sorry.

THE COURT: It's all right.

MR. GARDNER: I just want to make sure the record [indiscernible] potential of an appeal regarding that motion in limine that was [indiscernible] regarding the doctor. And that's all I wanted to do. That's all I was going to say is I objected and move on.

MR. CLOWARD: If the record's been made then --

THE COURT: All right. Okay.

MR. RANDS: We'll do it off the record out of the presence of

the jury.

THE COURT: That's fine. We can make a make a more thorough record then.

MR. CLOWARD: Thank you.

[Bench conference ends at 11:36 a.m.]

MR. CLOWARD: So, again, Ladies and Gentlemen, there is no dispute regarding the wrist. That is not an issue you will be asked to determine. And the total damages for the treatment that Mr. Morgan received in this case up to date is $173,459.60. Now, that is the past medical bills. That's not to be confused with the future medical bills that Dr. Muir will come and talk about. Now, the amount of the futures plus the past is $1,528,880.60. And you will be asked to evaluate in the case the necessity of the treatment.

And the thing that's really neat about Nevada courtrooms, individuals can ask questions, okay. So if you have questions of the witnesses, write them down and they'll answer them right there on the stand. So you guys can ask those questions and that's really your role is to determine what injuries this accident caused.

And then the pain and suffering damages, you know, that's a little bit more difficult. We'll wait to talk about that one in closing arguments when you actually have the law read to you from the Judge on that.

So the only thing I would I guess just ask you to remember is the standards that we talked about. And the purpose of trial is to find the truth, so if you're not clear on something please go ahead and ask the question because a lot of times the lawyers don't ask all the questions. We

try to get it right, but we don't. So thank you very much. Appreciate it.

THE COURT: Thank you, Mr. Cloward. Mr. Gardner.

MR. GARDNER: May I have the Court's indulgence for five minutes? I'm trying to determine whether I want to waive my opening and [indiscernible] case.

THE COURT: All right. So --

MR. GARDNER: I'm not doing that, I've just got to look at a couple slides.

THE COURT: Do you want me to -- so why don't we just take like a five-minute 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, read, 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, 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 will remind you again not to do any independent research. Don't go too far. I think we'll probably come back in about five minutes.

THE MARSHAL: Please rise for the jury.

[Jury exits courtroom.]

[Recess taken at 11:39 a.m. and resumes at 11:46 a.m.]

THE COURT: I also need to talk to you just about a couple things before we bring the jury back in and excuse them for lunch. Are any of the exhibits stipulated to? Since both of you have done trials in here

recently I kind of skipped over a couple things I normally do in the beginning. Are any of the exhibits stipulated to?

MR. GARDNER: I don't think -- you know what, we probably could.

MR. CLOWARD: I don't think we stipulated to any exhibits, but Mr. Gardner and I are in agreement that anything that I -- I told him what I was going to the Judge.

THE COURT: All right. I know, but can I admit any of the exhibits now? No? No? All right.

MR. CLOWARD: No. [Indiscernible] doesn't want to.

THE COURT: And then are -- is either side invoking the exclusionary rule? We really haven't had anyone in here to exclude, but...

MR. CLOWARD: I don't --

MR. GARDNER: You know what? I think we ought to make that decision based upon who's here. For example, Muir is coming up right now. We're not going to have our doctor here watching him or anything else like that, our loser of a doctor, Sanders, who doesn't know crap. So I'm thinking that --

MR. CLOWARD: He told me I needed counseling one time, Dr. Sanders did. He literally off the record he said: You need some counseling.

MR. GARDNER: Oh, boy.

THE COURT: That's nice. Well, I'm looking forward to this now.

MR. GARDNER: Yeah.

THE COURT: So, all right. Well, I mean, I think the experts --

MR. GARDNER: I am, too, now.

THE COURT: The experts are, you know, entitled to watch the other experts. To the extent I think we really only have --

MR. CLOWARD: We've made up by then, Judge. I don't anticipate --

THE COURT: Yeah, I know. I know. All right. So just let me know. I mean, we have Mr. Morgan's mom?

MR. RANDS: Why don't we just invoke the exclusionary rule and --

MR. CLOWARD: That's fine.

MR. GARDNER: Yeah.

MR. RANDS: -- and leave it to the parties to do it.

MR. GARDNER: Sure thing.

THE COURT: All right. So we'll invoke the exclusionary rule. If you want to have somebody come in, just let me know and we can address it at that time.

THE CLOWARD: No problem, Judge, thank you.

THE COURT: Okay. Let's bring them back in so we can excuse them for lunch. Actually, you know what, let's just -- instead of bringing them back in, let's just tell them to come back at 1:00. Does that work?

MR. GARDNER: Okay.

THE MARSHAL: You're already given them the admonishment, so...

THE COURT: Yeah. Yeah. So we'll just do it that way.

THE MARSHAL: Okay.

[Court, Counsel, and Marshal confer]

[Recess at 11:51 a.m., recommencing at 1:05 p.m.]

[Jury in at 1:05 p.m.]

THE MARSHAL: Please be seated.

THE COURT: All right. Back on the record in case number A718679, Morgan versus Lujan. Let the record reflect the presence of all of our jurors, Counsel.

MR. GARDNER: Yes, Your Honor.

MR. CLOWARD: Yes, Your Honor.

THE COURT: All right. So, Mr. Gardner, I understand that the Defense is going to defer their opening until the Defense presents its case in chief?

MR. GARDNER: That is correct, Your Honor. Thank you.

THE COURT: And, Mr. Cloward, please call your first witness.

MR. CLOWARD: The Plaintiff calls William -- Dr. William Muir.

THE MARSHAL: Right this way, Doctor.

THE COURT: Sir, come on up.

THE MARSHAL: Remain standing. Raise your right hand, face the Clerk to be sworn in, please.

[Oath administered]

THE WITNESS: I do.

THE CLERK: Thank you.

THE COURT: Good afternoon, sir.

THE WITNESS: Good afternoon.

THE COURT: Go ahead and have a seat.

THE WITNESS: Thank you. Thank you, sir.

THE MARSHAL: You're welcome.

WILLIAM MUIR, M.D.

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

THE COURT: If you could please state your name and then spell it for the record.

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

THE COURT: Thank you.

Mr. Cloward, whenever you are ready.

MR. CLOWARD: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. CLOWARD:

Q Dr. Muir, how are you doing today?

A I'm doing fine, thank you.

Q Okay, good. Let me just grab one other thing.

So, Dr. Muir, can you I guess just tell the jurors, before we get into the treatment that you've rendered, can you explain to us a little bit of your educational background. My understanding is you're a physician.

A Yes. My undergraduate study was at Brigham Young University, then I went to Stanford University in California and obtained a master's in physical therapy. I came here in the mid '70s and practiced physical therapy in the Las Vegas area for a number of years. And then I went to medical school at the University of Nevada School of Medicine. On

completion of my M.D. degree, I went to Phoenix, Arizona for my internship and orthopedic residency program, which is five years. Then I went to North Carolina for a spine fellowship and that was completed in -- around 1991, 1992. I went to Salt Lake City, practiced at the Spine Institute there and where I practiced spine surgery, also did pain management as well.

I moved here in 2005 and I'm a solo practitioner at Summerlin Hospital where I am the -- I have been the chief of orthopedic surgery and chief of spine surgery for the last six years. My practice is limited to the spine. Upon completion of my training as a spine fellowship-trained orthopedic spine surgeon I did not do general orthopedics. The practice has been limited to this, the spine, and I am board certified and recertified in orthopedic surgery.

Q Okay. Now, Doctor, can you tell us is there any significance to having a spine fellowship?

A Yes. An orthopedic residency program typically you'll get four months, maybe six months of spine. The rest is in pediatric orthopedics, trauma, different areas, total joints and hips. You get only a small portion of training in the spine. So we have spine fellowships where it's dedicated just to the spine with experts in the country that do nothing but spine so that it's -- so you get that training necessary to do spine surgery. I'm not sure any general orthopedic surgeons nowadays would do spine surgery unless they're board -- unless they're -- they have a fellowship in spine.

Q Okay. Now, one thing I wanted to I guess ask about were hospital privileges. You talked about Summerlin Hospital. You're the chief there of the spine surgery department?

A I'm chief of spine surgery and chief of orthopedic surgery at Summerlin Hospital, have been for about six years.

Q Okay. Now, does that mean that you could go in there and perform any orthopedic surgery you wanted or do you still have to have privileges, say, for instance, to do a specific type of a surgery?

A No. I -- you have to have privileges to do a specific surgery. If someone wants to do a spine surgery, they have to have evidence that they've had special training, that they've done a number of those cases, and that they haven't had problems. And I review those, and if that's the case then I'll sign them off. But if I wanted to do a total hip surgery today, even though I'm chief of orthopedic surgery at Summerlin, I can't do that because the last one I did was 27, 28 years ago.

Q Okay. And that's a way, I guess, to ensure that the most qualified individuals are doing the surgeries that they're familiar with?

A Yes.

Q Okay. Now, my understanding is, Doctor, that you have privileges to perform surgery on both the neck and the low back and other parts of the spine; is that correct?

A Yes.

Q Okay. Doctor, can you just give us a brief estimate, if you can, if you can't that's okay too, but of how many spinal surgeries you've been involved in? That can be, you know, at any level of the neck -- or I mean of the spine, neck, mid-back, low back, so forth

A I haven't counted the numbers, but over the -- my career, probably typically six spinal surgeries a week, more lately I'm 66 now, so it's

more like three or four now a week

Q Okay. And that's been pretty consistent over the course of your career?

A Yes, as well as pain management injections.

Q Okay. So you perform pain management injections as well?

A Yes. When I had my spine fellowship there was no such thing as pain management physicians, and I was training in injections of the spine and I continued to do those, and have done that for more than 25 years.

Q Okay. So fair to say the pain management field is a relatively new in comparison field to maybe other practices?

A Yes.

Q Okay.

A Definitely

Q All right. So, Doctor, before we get into the I guess the specific treatment of this case, what I want to do is spend a moment and just discuss the basic kind of foundation of the spine and maybe some education about the spine and help us to understand how the spine works and some of the things that can be painful in the spine. So if you don't mind kind of walking us through the spine and help us to understand, that would be great.

A Certainly. And I'll try to keep it relevant for this particular case.

Q Dr. Muir, I do have a small, little model if that would be helpful to you to --

A It may be helpful so I could point that out to the jurors what we're talking about.

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

THE COURT: Go head. Yeah.

MR. CLOWARD: Okay.

THE WITNESS: May I get up?

THE COURT: Sure.

THE WITNESS: Thank you. Okay. I'll try to keep this to three, four minutes. This is a model of the lower lumbar spine. The patient has a problem in the lower lumbar spine as well as the neck. The neck is fairly similar, but it's just smaller.

When patients have pain that lasts for more than a year or two in the neck or low back, the pain almost always is coming from the joints or the discs. The discs are the shock absorbers between the bones. The joints are where the bones come together. And if I can rock that back and forth, you see a little bit of motion right there. It's like shingles on a roof that slide on the top of each other and that has cartilage and it has -- and it's innervated, so it's a -- just like your knee is innervated, your shoulder, the joints are innervated. So if you have damage to those joints, that can cause pain.

BY MR. CLOWARD:

Q Just really quickly, what is the name of that joint? Is there a specific medical name or a term that those are called?

A We call them facet joints.

Q Okay.

A Pophyseal or zygomatic. Pophyseal is more a technical term, but they're called the facet joints.

Q Okay. Thank you, Doctor. You may continue.

A Okay. And the type of patient -- the disc problem the patient has is one where there's damage to the disc, not where there's disc is hitting a nerve causing leg pain. It's one where there's damage to this rubber bushing. And there's little nerves that innervate the -- this disc in the outer portion, and so when that's damaged it causes irritation, both mechanical and a chemical irritation to those little tiny nerves and causes back pain.

With the joints, they will refer pain in a certain pattern. But the key is to figure out of all these discs, the lumber and the seven in the neck, with all the joints, two on each side, where the pain is coming from. Once we know where the pain is coming from, then we can be a little more exact on treatment options if the pain continues.

Q And, Dr. Muir, one thing that I discussed in the opening statement was I guess a referral pattern. Do the facets have a specific pattern that will kind of let the physicians know sometimes, hey, this is where the problem is or give them a little bit of an idea?

A Well, if the pain is predominantly on one side, like the patient's neck pain is predominantly on the right side, that helps to eliminate the left side as the major source of the pain.

In the low back, in these joints, patient did have an injection which indicated it wasn't the low back joints, but they would tend to refer pain in a number of different areas and not a specific area. In the cervical spine, it's a little more specific, but there's still overlap.

Q Before we get to that, what I want to do, we'll keep on the lumbar. I want to just show you a diagram here. It's kind of a demonstrative diagram. And can we get the ELMO on?

THE COURT: It's on.

MR. CLOWARD: It's on? Let's see here. Or I just don't know how to work it.

[Counsel, Clerk, and Marshal confer]

THE COURT: Doctor, if you would like to have a seat you'll be able to see that from up here --

THE WITNESS: Certainly.

THE COURT: -- and you can actually write on the one up here.

THE WITNESS: Thank you.

[Pause]

MR. CLOWARD: Your Honor, I can just hold it up, if that'd be easier. Can I have the doctor come back off the stand?

THE COURT: I think the jurors will be able to see it. Can you -- just take a second and get it straightened out. It'll be fine.

[Pause]

BY MR. CLOWARD:

Q Okay. Doctor, this is an article download off of *Anesthesiology* journal. It shows some diagrams here of the lumbar facets, the pain referral patterns. Can you I guess explain to the jurors just very basically the pain that can -- the facet in the lumbar spine can cause, and then we're going to switch over to the cervical spine and then we're going to talk about disc issues. So let's focus in here on the lumbar facet.

A All right. It -- if you had a problem in your hand and you say it hurt there, that’s where the problem's going to be, right there. Not over here, not over there, it's right where you point to where the problem is. In

the low back it's not that simple because the body, the brain will interpret where the problem is and it interprets it in a broad area. And so when it's a joint problem in the low back, it's not where -- exactly where the patient feels the pain. It often causes pain down -- can cause pain down the back of the legs and actually any of the areas that I've circled there, it can cause pain in those areas.

Q Okay. So that's when we're talking about the facet joint. Now, using this diagram I guess, can you just explain what type of pain a patient could experience if they had a discogenic pain generator, where they also experience pain in those same areas?

A It's the same areas.

Q Okay. Does that often cause confusion? Can that cause confusion in -- for doctors to try and figure things out?

A It is. And often we want to know where the problem is if the problem persists, such as in this situation. And we can do that by examination by the patient's symptoms that they have and by responses to injections.

Q Okay.

A Typically an MRI scan is not very helpful for this type of a disc problem, and certainly rarely is helpful for this type of a joint problem.

Q Okay. Now, what I'd like to do is I'd like to show another diagram of the cervical facets and have you talk about that a little bit, same kind of principle.

MR. CLOWARD: And is there a way to clear that off of the screen?

MR. RANDS: You've got to make sure that your diagram corresponds with it.

[Pause]

BY MR. CLOWARD:

Q Now, Doctor, this is an individual by the name of Nikolai Bogduk, who I believe is the president of ISI, Interventional Spine International Society. And this is the *Physician Medicine and Rehabilitation Clinic of North America* journal. This is a diagram. Does this show -- and it's not coming up super clear, the [indiscernible] on this, but that's the -- what the diagram shows. Draw that in a little bit because it's not coming up super clear. But is that a -- I guess a distribution pattern of what a patient could experience if they had a cervical facet problem?

A Yes. The one on the right here -- it didn't correspond. The C5-6 would be what's on the right side.

Q Okay.

A In other words, the 5-6 joint is in the middle lower portion of the neck, but the pain goes from that area down into the upper scapular area into this area, and the 6-7 level goes down further down the back. So with -- people with joint problems often at 5-6 or 6-7 they're going to have pain in the thoracic region, so you have to figure out whether that's a separate problem of the thoracic region or whether that's coming from the neck.

Q Okay. And staying focused on the neck, can a problem with an individual's disc cause pain in those similar areas?

A Yes.

Q Okay. And specifically in regard to the 6-7 distribution here -- I

guess draw that on that there -- can an individual have a damaged thoracic spine that can also cause pain into that distribution?

A Yes.

Q Okay. And does that complicate things somewhat?

A It does, but through injections we can get a better idea whether that pain in the thoracic area in the upper scapula area whether that's from the neck or the low back. If someone has with extension of the neck if that hurts the most, as it did in this patient, that's an indication of a joint problem. And when they do that, if it causes pain in that area that's an indication that it's a referred type of pain. And then if one would have injections, you can help rule out whether there's a separate problem in that scapular region or whether it's coming from the neck.

Q Okay. And now we'll kind of shift to Mr. Morgan and the treatment and care in his case. What were some of the complaints that he had? Where was he I guess complaining of pain or to -- I guess we'll go through this in a systematic way. But let's talk about the neck and then we'll kind of shift and we'll talk about the back next. But let's stay focused here on the neck while we're here.

A Well, the neck again is predominantly on the right side, which would indicate more of a facet type of a problem than a disc problem. He had more pain with extension and flexion, which would indicate more of a joint problem. He had complaints of a sharp type of pain with certain movements, and that's consistent with a joint problem as opposed to a disc problem, which is more of an aching type of a pain. Those are the major complaints and findings on examination. Also he had pain with moving

towards the right side, which jams the joint together and indicates a problem with the joint on that side as well.

Q Now, was there -- were there any sort of diagnostic testing, not talking about the injections, but radiographic testing performed like an MRI, CT scan, x-ray, anything along those lines that kind of shed light on what was causing the problems?

A It's documented regarding a joint problem that MRI scans and CT scans are not very helpful. The patient did have a CT scan when he first came into the hospital because he hit his head, he had some complaints of the neck pain, they wanted to rule out fractures. CT scans are very good to rule out any fractures or any bleeds into that area.

Subsequently, he had an MRI scan that showed multiple I'd call relatively common changes in the MRI scan, nothing that you could put your finger on and say, ah-ha, this is where the problem is, neither in the neck or the low back. There's changes in a number of the discs, there were changes in a number of the joints.

On x-rays, bending forwards and backwards it showed a 4mm slip at C5-C6 level, and this is considered to be borderline hypermobile or unstable when you have that much of a shift at a particular level. And I'm not saying that that shift was caused by the accident or it may have been pre-existing and just predisposed him to have problems at that level. It could have been -- certainly could have been an asymptomatic finding before, but it's one level that's loose. So when you're involved in a car accident you're going to have more motion at that level and a greater chance to have trauma at that particular level, and that's at the C5-6 level.

Q Okay. And I'm going to ask a question that's somewhat not sequential, a little bit out of order, but I want to ask it while you brought up this point. What does it mean to be asymptomatic versus symptomatic?

A Symptomatic means you have complaints. You have symptoms, complaints. Asymptomatic means without complaints. For example, everybody that's sitting there in the jury if you had an MRI scan of your neck or back you'd find some disc bulges, some arthritic changes in the joints, but the vast majority of you have no pain in those areas. Those are asymptomatic findings.

Q Okay.

A Asymptomatic would be if you have some changes and you have pain.

Q Okay. So basically pain or no pain; is that fair?

A Yes.

Q Okay. Now, while we're talking about that, are you aware of any prior treatment, any prior history whatsoever of neck pain, back pain, or low -- mid-back pain, low back pain that Mr. Morgan had before this crash?

A In the medical records, and I'm referencing Dr. Cash, he indicated that there was a motor vehicle accident 10 years before this one but had -- patient had no residual problems.

Q Okay.

A There's no other details other than that.

Q Okay.

A But he had not further problems.

Q And have you -- and I guess regarding that, are you aware of

whether he even treated for that or not?

A I don't know anything of it.

Q Okay. And you've -- it's my understanding you've been an expert witness for both the plaintiff and the defense, right?

A I have.

Q And are you provided records that are -- I guess would help one side or another? Like, say, for instance, if you're retained by the defense where they provide you with certain records regarding a matter that they felt like was important?

A Typically yes.

Q Okay. And obviously I don't know if Mr. -- if you ever worked with Mr. Gardner, he's a fine lawyer, but to your knowledge has there been any record of any treatment ever provided showing any history of neck, back, or low back problems with Mr. Morgan?

A No.

Q Okay. So now let's move on to -- get back to the neck. So you were talking about these -- the findings in the neck and you talk about the hypermobility. And I guess what was your initial opinion as far as what was causing the problems that he was having in his neck and what treatment did you render?

A Well, I was most suspicious of the cervical facet joints. And in my records you'll see sometimes I'll talk about certain levels and other times other levels, depending on information that was provided to me. But it's like a big puzzle, lots of pieces of the puzzle. If you look at one piece of the puzzle it can become confusing. If you have all the pieces of the puzzle laid

out it becomes more clear where the patient's problem is. And as time went on and we obtained information from different injections, the major source of the pain became more clear.

Q Okay. And you had a chance to review all of the records in this case?

A Yes.

Q Okay. So, Dr. Muir, just as a foundational question, I'd like to go through and discuss the records that you reviewed in this matter. Okay?

A Yes.

Q Have you got a list of those or --

A I do.

Q Okay. If you could help me with those then and just let me know all the records, if you'd just read them off what you --

A Traffic accident report, MedicWest Ambulance, Sunrise Hospital Medical Center, Urgent Care, Grabow Hand and Shoulder Center, Nevada Pain -- sorry, Nevada Comprehensive Pain Center, Las Vegas Valley Chiropractic, Las Vegas Radiology, obviously my records, Pay Later Pharmacy, Nevada Comprehensive Pain Center Surgical Suites, Advanced Spine and Rehabilitation, Southern Hills Hospital, colored photographs of the vehicles, records of Steven Brown, and expert -- defense expert reports, Andrew Cash.

Q When you say expert report, Andrew Cash, that's -- he wasn't a defense expert, right?

A No.

Q He -- that was a second record that you reviewed; is that

accurate?

A Yes. He's a local orthopedic spine surgeon like myself.

Q Okay. Do you recall the name of the defense expert that -- his report that you reviewed?

A Steven Sanders.

Q Okay. Now, what I want to do is I guess talk about kind of the treatment of a problem such as the one that Mr. Morgan presented to you with and ask you I guess to help us understand how you go about treating something -- a patient when they have symptoms in their neck. What is the, you know, what do you do for folks?

A You try to treat a problem the most conservative way possible, which is give them time to heal, provide medications so they're more comfortable, physical therapy or chiropractic treatment. Then if they don't improve, then typically what's done are what we call selective injections, injections focused in a particular area, for two reasons: One, to help figure out or confirm or rule out where the major source of the pain is coming from. Also for potential therapeutic response, because injections, unlike the ones that the patient had which were medial branch block injections, injections can provide a -- can provide help for three months or so. Up to three months. If a patient does not respond to time, conservative care, the things we talked about, then often surgery is considered, depending on their particular problem.

Q Doctor, are there any sort of a maybe red flags that you might during the course of treatment that, you know, you might be on the lookout for to determine whether somebody's actually hurt or whether they're, you

know, not hurt?

A Yes. In addition to have a sense as a physician treating patients whether they're being accurate or not, we will do a test that's called the Waddell's test and it's certain physical examination maneuvers, but the patient really doesn't know why you're doing those. And depending on the response, we can figure out whether the patient is being honest, whether they're exaggerating their problem, whether they have any significant psychological factors that are affecting their medical condition. And the patient did not.

Q When you say the patient did not, meaning the patient did not exhibit any of those signs that you'd be concerned about?

A Yes.

Q Okay. So although you performed some injections, you have a practice that you perform those as well?

A Yes.

Q You also -- do you also work with pain management physicians throughout the Valley?

A Yes.

Q Do they refer you cases as the spine surgeon?

A Yes.

Q And my understanding is there was a Dr. Coppel involved in the care of Mr. Morgan?

A Yes.

Q Okay. Now, can you explain I guess how a physician such as yourself, a surgeon, a spine surgeon, would work with a pain management

physician to try and figure out what was the source or the generator of an individual's pain?

A Yes. If one is suspicious of a disc problem, then there is an injection called a transforaminal epidural injection. If one is suspicious of a joint problem, then either a medial branch block injection or a facet injection is done. In this particular case, medial branch block injections were done.

Q Okay. And what levels for the first procedure back in August of 2014, what levels were performed?

A Well, half of C5-6, C6-7, and C7-T1 and -- were done.

Q Okay.

A On those on 8/8/14.

Q Now, were there radiographic findings, meaning were there findings on the MRIs at those levels in the cervical and the thoracic spine that would not, you know, give a for sure, hey, that's where the problem is, but at least support a physician wanting to go in and do an injection at those levels?

A Well, as mentioned, a CT scan or MRI scan typically is not very helpful in pinpointing where a joint problem is. It's more by examination and by ruling out or ruling in the level through an injection.

Q Okay. Were there examination findings of those areas of the facet that would suggest, hey, those are problems, those are probably causing some pain, we probably want to go in and try and isolate that?

A Yes. The upper levels of the neck don't refer patterns down into the scapular region, as we saw on that initial diagram.

Q When you say upper levels, you're talking about like C1, C2,

C3?

A And C4 will just get the very top of the scapula. But the patient was having pain down into the central mid portion of the scapula, which is consistent with a C5-6 and C6-7 levels. So his symptoms were most consistent with those levels.

Q And what type of benefit, if any, did Mr. Morgan have from the injections that were performed on 8/8/2014?

A Again, these were -- there's two types of injections you can have for a joint. One's the medial branch block, which was done in this particular case. The advantage of that injection, it's considered more diagnostic and more accurate in figuring out whether those levels are involved or not as opposed to just putting it into the joint.

For me, a disadvantage is that even though Dr. Coppel puts a little steroid in those little nerves before they come in the joint, there's really nothing going into that joint. So often a medial branch block injection is not as therapeutic. It's more of a -- it's considered nowadays more of a diagnostic injection rather than a therapeutic injection. So the patient really didn't have much of a therapeutic benefit from any of the medial branch block injections, which is expected with that type of an injection.

Q Okay. With an analogy kind of similar using the, you know, when you go to the dentist that, yeah, the dentist can inject your hurt tooth and put some numbing medication on there, but, you know, a few hours later your toothache is going to come back unless they actually do the nerve root -- or I mean -- nerve -- root canal. I keep getting those two mixed up. The root canal. Is that kind a similar kind of analogy?

A It'd be similar. If you had three teeth and you didn't know which one's causing the pain, you could inject one after the other to see which level is the problem. So the level that you inject -- if you inject to the wrong side of the jaw it's not going to block the pain for a couple of hours. But if you inject next to the bad tooth for a couple hours, even if you don't treat it, it will feel better. At least you helped identify where the problem's coming from.

Q But I guess the point I was trying to make -- it was a terrible question. But the injection is not how you treat that. It gives you some diagnostic benefit but not a therapeutic long-term -- it's not going to solve your problem.

A No injection will alter the outcome. Even when we have successful injections that they help three months, they can give you temporary relief but they won't fix the problem.

Q Okay. Now, so there was some diagnostic value of that injection but it did not provide long-term relief; is that fair?

A Yeah. The pain went from seven out of ten before the injection to three out of ten immediately afterwards.

Q Okay.

A And the significance of that, if you have a drop in fifty percent of the pain, then that indicates that those structures that you injected are probably the major source, not necessarily the only source, but the major source where the pain and the symptoms are coming from.

Q Okay. Now, it's my understanding that there was some -- there were some additional injections after that on -- the next procedure that I

show is on 3/20 of '15. Is that the next procedure that you show?

A Yes.

Q And what procedure was that, Dr. Muir?

A These were again medial branch block injections for the C3-4 level, the 4-5 level, and the 5-6 level and half of the 7th level on the right side.

Q Now, were there any thoracic or T-level injections on that visit?

A There were some thoracic injections that didn't provide much information as far as diagnostic information, whether that's the source of the pain, there's no support that the patient had source of pain, and they were not very therapeutic.

Q Now, that was the next injection. What I mean is on that specific visit, the 3/20/15 visit, other than the cervical injections were there any other levels that were done?

A None that I recall other than those levels that I stated.

Q Okay. And then fast forward a few months until August 28th, and I think that's the -- those are the ones you're referring to where it was just the thoracic, not the cervical, now it's just focusing on the thoracic.

A Yes.

Q And those were the ones that provided no benefit you talked about?

A As I mentioned, the patient had pain into the thoracic region and this helped identify that the patient -- the problem wasn't coming from the thoracic spine itself but more likely from the neck.

Q Okay. And I believe on those injections he only had -- Mr.

Morgan only had about a twenty percent benefit?

A Right. And that's not diagnostic. You need to have at least fifty percent change.

Q Okay. Thank you, Dr. Muir. Now, what I'd like to do, so we've kind of covered the injections to the cervical, the thoracic --

A There was one more.

Q Oh, sorry. When was that? What was the --

A 5/19/16.

Q Okay. Let's hit that while we're here and then we'll shift onto the lumbar.

A That was on the right side again.

Q Okay.

A For the C5-6 and C6-7 joint, so it was more specific, just those two joints, and it was the best response. The pain went from a seven out of ten down to a two out of ten. And that indicates that the major pain generator is coming from the 5-6 and/or C6-7 level and which corresponds to the injection that he had before which covered half of the 5-6 and all the C6-7 level.

Q Okay.

A But wasn't quite as diagnostic.

Q So after -- and was that the only injection in the neck?

A Those were the only injections in the neck, yes.

Q Okay. So after I guess having the chance to review everything and take a look at the entire picture, as you sit here today what is the -- what is your opinion as to the pain generator that is causing Mr. Morgan's

symptomatology in the cervical region that, you know, kind of the scapular area?

A The C5-6 and/or C6-7 facet joints on the right.

Q Okay. And you could state that to a reasonable degree of medical probability on a more likely than not basis?

A Absolutely.

Q All right. And before I move on, that's normally a question I ask at the first of all the examination, but I would just ask that all of your opinions be to a reasonable degree of medical probability on a more likely than not basis. And if you cannot give an opinion to that standard, please just let me know. Is that fair?

A I will.

Q Okay. Now, let's shift the focus and the attention to the lumbar spine. Dr. Muir, can you walk us through a little bit of I guess the treatment that Mr. Morgan had in that area?

A Yes. The low back was problematic. His pain was about five out of ten. The neck was worse. So we were focusing more on the neck than the low back and hoping that the low back would go away with time, which it did not.

The patient on October 16, 2015, underwent these medial branch block injections which are to help identify whether it's a joint problem, and these were done for the bottom three levels of the lumbar spine. And they did not block the patient's pain, indicating that more likely than not the pain is not coming from the joints.

And as I mentioned, if you have a chronic back pain for more

than a year or two, almost always is either going to be the joints or the discs. And so if it's not the joints then it's going to be the discs of the lower lumbar spine.

Q Okay. Now, was there another injection that was performed earlier this year for the lumbar spine?

A There was one for the two bottom discs at L4-S1 on March 10th of this year. I never was able to see the response to the injection though.

Q Okay. And we can certainly have Dr. Coppel address that.

Dr. Muir, what -- I guess after reviewing the medical records, reviewing in preparation for the, you know, the testimony today you -- I'm sure you reviewed everything; is that fair?

A Yes.

Q What is your opinion as you sit here today, based on your clinical examination, based on the subjective complaints, based on the testing in the lumbar spine that Mr. Morgan did have, what do you think's causing the problems there?

A The patient's low back pain is coming from the lower lumbar discs. And I can't state at this time whether it'd be the bottom disc or the second to bottom disc or even the third to bottom disc. That can be sorted out with additional injections. This is not the type of a disc herniation where you're hitting the nerve, putting pressure in the canal or the spinal cord. This is a type where it's a rubber bushing that has innervation, there's damage to that rubber bushing causing chronic back pain.

Q Okay. Assuming Mr. Morgan did have good benefit from the injections that were performed on March 10, 2017 by Dr. Coppel -- and

when I say good response I mean greater than fifty percent -- what would your opinion be as to the generator of pain in the lumbar spine?

A Then it would be coming from the L4-5 and/or L5-S1 levels.

Q Okay. And would that opinion be to a reasonable degree of medical probability on a more likely than not basis?

A Yes.

MR. RANDS: I'm going to object to that, Your Honor. He said he didn't even know what the results were and he's testifying that they're reasonably related.

MR. CLOWARD: I asked him to base it on the assumption, which is a proper thing for him to do.

THE COURT: All right. Objection's overruled.

MR. CLOWARD: Thank you.

THE WITNESS: Sorry. I hadn't quite completed the answer, so I may have caused your confusion.

If we're looking at the injection alone, if it had greater than fifty percent reduction of pain during the first three hours then that would be diagnostic.

BY MR. CLOWARD:

Q Okay. Now, what I'd like to do, Dr. Muir, before we get into I guess -- and you were specifically retained to prepare what's called a life care plan; is that fair?

A Yes.

Q Okay. You were also retained to I guess review the treatment records of the other providers in the case to determine whether or not that

was reasonable and necessary; is that fair also?

A Yes.

Q Okay. So before we get much further, what I'd like to do is just kind of go through the past medical to talk about whether you believe that that treatment was reasonable and necessary and whether the billing was usual and customary for the Las Vegas community. So I'm just going to pull that up really quick.

Now, the -- well just -- I'm going to go down kind of the list that you have already given. So the MedicWest Ambulance bill was $1,045.92. Was it reasonable and necessary for Mr. Morgan to take the ambulance to Sunrise Hospital after this collision?

A Yes.

Q And was the charge of $1,045.92, was that usual and customary for the Las Vegas community?

A Yes.

Q Okay. Now, Mr. Morgan went to Sunrise Hospital where they performed some diagnostic testing. I believe they did a brain CT scan and a neck CT scan and some other tests, gave some medications. Was that reasonable and necessary for the injuries he sustained in the automobile crash?

A Yes.

Q And I guess I didn't even ask the preliminary foundational question. Is it your belief as you sit --

[Telephone ringing]

THE WITNESS: I'm sorry.

MR. CLOWARD: Objection, Your Honor, phone.

THE WITNESS: I thought it was on silent. I apologize.

THE COURT: That's all right. It happens to everybody.

MR. CLOWARD: I'm sorry, Dr. Muir [indiscernible].

MR. RANDS: Your Honor, I'd just like to put an objection on the record, too. I understand he's gone through these and I've got the copy of his report, but I don't think there's been any foundation laid that he's an expert on ambulance costs in the Las Vegas area and the hospital costs and he certainly --

THE COURT: All right. Counsel approach, please.

[Bench conference begins at 1:54 p.m.]

MR. CLOWARD: I'm happy to lay a foundation.

THE COURT: I would agree.

MR. CLOWARD: Thank you.

THE COURT: That was unnecessary, wasn't it? All right. They got to stand up. That's good.

[Bench conference ends at 1:54 p.m.]

BY MR. CLOWARD:

Q While my co-counsel is helping me to get that up for the -- for everybody to see, Doctor, I would like to just lay some foundation. Have you prepared life care plans before?

A Yes.

Q How many occasions -- on how many occasions have you prepared a life care plan?

A I haven't counted them but more than 50, probably close to a

hundred.

Q Okay. And in reviewing a life care plan, can you tell the jurors and tell the Court what the process is that you go through to do that? Do you review medical records? Do you review billing?

A Yes. A life care planner is one that will identify future costs related to a specific injury. What's taken into consideration, the treatments the patient's receiving, their particular problem, and what they may benefit from -- regarding that injury. As a -- life care planners can be rehab physicians. They're take a couple courses and they'll prepare life care plans. They take a certifying course. As physicians, it's under our license that we can do life care plans.

But what I did more than ten years ago is obtained books on life care planning, the same training that the rehab people would have on life care planning training, their courses, went through all those, research on the Internet, researched life care plans. And this was more than ten years ago.

Since that time, on multiple occasions I've been admitted as an expert in life care planning in the courts of Nevada, always been approved to do such. And the -- so my job is to figure out what the patient's problem is and what they may benefit in the life because of that particular problem.

Q Okay. Has a court in the state of Nevada ever precluded you from testifying as an expert witness in the area of life care planning?

A Never.

Q Okay. And you have been certified in prior courts in Nevada in this area?

A Multiple times.

Q Okay. And obviously in your training at the -- through your position at Summerlin Hospital -- sorry, it's getting late in the day -- as your position at the hospital there I'm sure that you're familiar with the charges that hospitals charge for these services?

A I do. I do and I have for more than 10 years reviewed medical records on a weekly basis. Most every weekend I'm reviewing medical records. And these are related to spine, essentially to spine.

Q Okay.

A And so I'm very familiar with the charges of the ambulances and charges of the hospitals for spine-related problems, the charges by pain management physicians, for the charges for surgeries by the hospital or the local surgeons here.

Q Okay.

A That's something that I see those charges on a weekly basis. There are books that you can look those up, but I find that they're often outdated, and included in those figures are discounted rates and it skews the accurate cost -- true costs of a particular treatment.

Q And do those books also sometimes include other geographic areas not solely limited here to Las Vegas?

A They do often. There are some that are specific for the area, but again because you throw in the discounted rates the prices are not accurate what it costs a patient to have a particular service.

Q Okay. Thank you, Dr. Muir. So what I'd like to do now is just to kind of go back through those items. Mr. Boyack's been kind enough to put this on the screen for me. Thank you.

So let's go through the charges there. Okay. So the first charge was the MedicWest and that was $1,045.92. And I believe you testified that was a reasonable and customary and that that billing was usual and customary -- reasonable and necessary and the billing was usual and customary for the Las Vegas community; is that accurate?

A Yes.

Q And then for Sunrise Hospital the charge of $9,689, was that reasonable and necessary to treat Mr. Morgan's injuries?

A Yes.

Q And were those charges usual and customary for a hospital to charge for like services here in the community of Las Vegas?

A Yes.

Q Moving on to the urgent care visit, $350, was it appropriate, reasonable and necessary treatment that Mr. Morgan received?

A Yes.

Q And was the charge of $350 usual and customary for the Las Vegas community?

A Yes.

Q Now, moving on to -- and we're going to skip Dr. Grabow. That's not an issue of the case.

A I might state in my record I have 250. That might have been a mistake on my part, either a mistake on my part or your part.

Q Let me see.

MR. RANDS: I was going to bring that up but after this.

[Pause]

BY MR. CLOWARD:

Q Well, while we get to that, let's move on to the Dr. Coppel -- Dr. Coppel's charges for the services he rendered was $30,250 for the injections that he provided. Number one, were the injections reasonable and necessary for the treatment that Dr. Coppel provided to Mr. Morgan?

A Yes.

Q And were the charges of 30,250 usual and customary for the Las Vegas community?

A Yes.

MR. CLOWARD: There is some patient information I need to white out here. Let me just --

[Pause]

[Counsel confer]

MR. CLOWARD: Okay. Your Honor, we have a stipulation the amount is $350 --

THE COURT: All right.

MR. CLOWARD: -- for the --

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

MR. CLOWARD: -- Urgent Care Extra.

BY MR. CLOWARD:

Q And, Dr. Muir, I would ask if your report does say 250 would 350 also be usual and customary as an amount to charge for an urgent care visit?

A Yes.

Q Okay. And when services are provided, I guess just -- to just

explain, are there ranges that are allowed for certain services?

A Yes.

Q And that would fall within the range that's reasonable?

A Yes.

Q Okay. Now, the Nevada Surgical Suites, I believe that's where Dr. Coppel does the surgery -- or the injection therapy, the injections. Before we talk about the charge, can you explain how you -- how a doctor goes about this type of an injection? Is that one that's, you know, it's like when you go, you know, and get an injection in your shoulder for, you know, the flu, or is there a little more to it?

A There's a lot more to it. You can't just stick a needle by the spine because you have the spinal cord and you have nerves and you have vessels. And if you inject in certain vessels you can actually cause strokes or people can die from that. So you need to know where you're putting the needles, so you use a fluoroscopy or fluoroscope, and it's like a movie camera x-ray machine so we can see exactly where the needle is and we'll look at different planes, and by looking at different directions or planes we can determine whether the needle is exactly where we want it to be or not.

Q Is that like a sterilized setting, I mean patients are brought back one by one or is it kind of a --

A Yes. I have a surgical suite in my office and you have to have EKG equipment, you have to have resuscitation equipment, you have to have all these -- this monitoring. The C-arm or the fluoroscopy that's -- I paid $200,000 for that. there's typically a half-million dollars involved economically in that room. So you have all the equipment so that that

particular procedure can be done very safely.

Q Okay. And the charge for that, for those services for those different injections, I believe five sets of injections was $38,500 for the Nevada Surgical Suites. Was that a usual and customary charge for those services rendered for Mr. Morgan?

A It's slightly lower than the community standard but it's within the normal range, yes.

Q Okay. Now, and was the treatment that Dr. Coppel provided of those injections, was that reasonable and necessary to treat the injuries that Mr. Morgan sustained?

A Yes. They were reasonable and necessary to be able to figure out where the patient's problem's coming from because it didn't go away on its own.

Q Okay. Now, the next charge is Las Vegas Radiology. I believe Mr. Morgan had two MRIs of the neck, two of the back, and that was one spaced two years apart. So there was one MRI and then --

[Defense counsel confer]

MR. CLOWARD: Oh. I see. Thank you.

BY MR. CLOWARD:

Q I'm sorry. The next one was Dr. Weisner, Las Vegas Valley Chiropractic. And how long did Dr. Weisner provide treatment to Mr. Morgan?

A I believe it was ninety -- approximately 94 treatments or 91 treatments.

Q Now, is 91 treatments, is that high? Do you -- is that a little high

for --

A It's within the range. If chiropractic provides him temporary relief and it increases the patient's ability to carry out their functions in life, then it's reasonable to go on -- go beyond this what we say two to three months of reasonable chiropractic treatment.

Q Okay. So the 91 visits was reasonable and necessary and within this -- I guess the usual and customary range here in Las Vegas?

A Yes.

Q Okay. And the charges of 18,138 were also usual and customary?

A Yes.

Q Okay. Now, the next was the Las Vegas Radiology, and my understanding was Mr. Morgan had an MRI in 2014 and then a repeat in 2016 of the cervical, and then an MRI of the lumbar in 2014, then a repeat of the 2016 -- or in 2016 and then also some wrist arthrogram tests. Is that your understanding?

A Yes.

Q Can you tell us why would it be necessary to do -- or is it necessary or not necessary to do a repeat of a test like that?

A Well, often MRI scans are repeated if it's been more than a year and patient's still symptomatic, because there -- sometimes there's changes on the MRI scan and we can see an MRI scan at a later date and say, ah, this is where the problem is. It becomes more apparent. So we often will order MRI scans periodically.

Q Okay. So was it reasonable and necessary to have two MRIs of

the neck and the low back?

A Yes.

Q And were the charges that Las Vegas Radiology made usual and customary for the Las Vegas community for like similar services?

A Yes. In my review I have a smaller number because I don't have all the imaging on that.

Q Okay. What is the number that you have?

A Seven thousand three hundred. That's just one cervical MRI and thoracic, as well as the wrist MRI scans and arthrograms.

Q So you have one set of the neck and back and then the wrists?

A Yes.

Q Okay.

[Defense counsel confer]

BY MR. CLOWARD:

Q Okay. So we're going to put a placeholder there and we're going to come back.

Now, Dr. Muir, the charges that you rendered in this case are $5,416, and you've talked to the jurors about that treatment. Is that reasonable and necessary for the services that you provided?

A Yes.

Q And is the billing that you've charged usual and customary for the Las Vegas community?

A Yes.

Q Okay. Now, the Pay Later Pharmacy, I believe that Mr. Morgan had a series of time where he was on some narcotic pain medications as

well as medication called Flexeril; is that accurate?

A Yes. He was on also Soma, muscle relaxer, and a sleeping pill.

Q Okay. Now, is it within the proper protocol to prescribe medications to patients who are having pain of sleep difficulties?

A Yes.

Q All right. And the charges that Pay Later Pharmacy has charged of $6,308, is that usual and customary for the Las Vegas community?

A Again, I have prescriptions for 7/9 -- 7/29/15, 12/2/15, and 2/8/16 totaling $4,972.

Q Okay. Four thousand seven -- what was it?

A $972.46.

Q 972.46. Okay. So we'll -- we will put a placeholder there.

Now let's go to Dr. Roger Russell. Do you have that charge in your -- I didn't see it [indiscernible] record.

A No.

Q Okay. So we'll move past that one. The Southern Hills Hospital, that's no longer an issue so we're not going to have you discuss that.

Las -- or, excuse me, Radiology Specialists, I believe that was for an x-ray, and that was $345. Is that a usual and customary charge for the Las Vegas community for that?

A Most likely it was a radiologist reading. And what was the reading of?

Q I believe it was an x-ray.

[Defense counsel confer]

BY MR. CLOWARD:

Q Do you have that one? Did you review that one?

A No.

Q Okay. If you didn't review it, I'm not going to ask you to comment on it.

Let's move on to the [indiscernible] Emergency Services. Did you review that one?

A No.

Q Okay. How about PBS Anesthesia?

A Um -- no, but that would be related to the sedation for the injections.

Q Okay. And would a charge of $1200 be usual and customary for the Las Vegas community?

A It's actually on the low side.

Q Does it fall within the usual and customary range?

A Yes.

Q Okay. And then Dr. Cash, there was a consultation there of $1,250. Is that usual and customary for the Las Vegas community?

A Yes.

Q And was -- it was my understanding Dr. Cash provided a second opinion. Is it reasonable for folks to get a second opinion?

A Yes.

Q Okay. Now, did you review the ATI Physical Therapy?

A No.

Q Okay. Dr. Muir, thank you. Should have a record of those.

[Counsel confer]

BY MR. CLOWARD:

Q Okay. Now, before we go on to the life care plan that you provided, what I would like to ask is, is it your opinion as you sit there on the stand that the injuries that Mr. Morgan sustained were caused by the motor vehicle accident of 4/1/2014?

A Yes, regarding the neck, wrist, and low back.

Q Okay. Was there any other source or cause that you think may have contributed to those injuries?

A No.

Q Okay. That's the sole cause of the problems that Mr. Morgan had was the car crash?

A Yes.

Q Okay. So now what I would like to do is finish discussing the -- I guess the future care needs that you believe Mr. Morgan will have ongoing into the future. Dr. Muir, have you got that?

A Yes.

Q Can we take just a moment and have you discuss that?

A Yes.

Q Do you believe that Mr. Morgan will have future care needs?

A Yes.

Q And what will those be?

A Again, a life care plan is based on the patient's problem, what treatment they're having, and what -- also what treatments they may benefit

from. And there's different categories. There's a physician care, there's ancillary care, diagnostic, medicines, and surgery are the major categories.

And regarding physician care it is my belief that the patient will benefit from and most likely require a follow-up of a person such as myself every five years regarding the neck and low back, that the patient would benefit from periodic visits through the pain management once a month to monitor medications and their condition, that he would most likely benefit from a treatment called radiofrequency ablation. That's similar to an injection but it's putting a needle next to the little nerves [indicating] by the -- going into the joint and cauterizing those nerves. Well, I did three of these this morning. It's burning the little nerves that go into the joint. They grow back again in a year, year and a half, sometimes faster, but you can get good relief from that procedure and it can be repeated. Most of the time it doesn't last longer than a year. And so in the life care plan I have built in here regarding the cervical spine a -- that particular treatment once a year.

Also in there is the patient has been prescribed pain medication. From my understanding, he may not be taking those at this time, but he would benefit from those. And if he's taking pain medications, he should see a family physician for some lab work to make sure his kidneys and his liver are tolerating those pain medications.

Next category is ancillary medical care. I included a life care plan that every ten years for the low back and every five years for the neck that he'll require either therapy or chiropractic treatment or at least benefit from that due to flare-ups. Also included in that category is a surgical center to perform the radiofrequency ablation. Included in this is one additional

injection before he starts the radiofrequency ablation.

Q Why would you do that?

A He had not had that yet and there's some other injections that were pending.

Q Okay.

A And I believe since the life care plan he may have had another injection.

Q Okay.

A But if he proceeded -- well, also to -- if he proceeded with the radiofrequency ablation in the near future, then that would be changed. The life care plan is not set for life, meaning that this is good for his whole life. His condition can wax or wane. And a life care plan is considered a dynamic vehicle, dynamic structure, so from time to time it needs to be updated depending on the patient's condition and how they're doing.

As far as diagnostic testing, I included that patient would most likely undergo an MRI scan of the neck every ten years and x-rays every five years.

Q And what would the purpose of that be?

A To evaluate the overall situation of the neck, to rule out other potential sources of the pain.

Q Now, assuming that this car crash never took place, okay, the Defendant never, you know, drove out onto the road and there was never a collision, is there anything to suggest that Mr. Morgan would have had to have these future care needs?

A No.

Q Okay.

A And then under medications, and I don't have that with me, but I believe I included a pain pill, muscle relaxer, and anti-inflammatory.

Q Now --

A It actually was fairly conservative, putting one pill per day for each one of those.

Q Okay.

A Next category, surgery. And what I put here is a procedure that's similar to laser discectomy. It's a procedure that I do and there's another pain management doctor that does that and apparently there's a new laser center that's here that does these type of procedures. But it's a way to address discogenic pain and not fusing the back.

If you talk to spine docs, I'm not sure if Dr. Cash comes in and says what would you do for chronic back pain, or any spine doc, and they said, well, if everything else fails you fuse it with screws and rods and cages and bone graft. It's a -- it works fairly well, most of the time, but it's a big, big procedure. I didn't include that in the life care plan on Aaron because you try to avoid a lumbar fusion, especially at that young age.

But I believe he would benefit from a plasma disc decompression. In fact, his plan, I've seen him fairly recently, we're planning to do such. And it's done percutaneously, meaning there's no incision, and essentially what it does is, like laser, it shrinks the disc. And by shrinking the disc approximately two-thirds of people are helped from that procedure and on a long-term basis approximately fifty percent

Q Okay. And is that I guess a less invasive procedure than a

fusion or are they about the same?

A It's 20, 30 times less invasive than a fusion.

Q Okay.

A It's done in the office.

Q Are there complications that a fusion could potentially have that maybe that procedure wouldn't?

A Yes. A fusion you could get -- one out of 20 people are going to get pain from loosened hardware. One out of ten the bone's not going to fuse enough and you have to go back and add more bone. You can get pain from scarring around nerves. You -- with a fusion there is a fairly high percent that will have adjacent level breakdown requiring additional treatment and even fusions, because if -- with a fusion it stiffens up a segment, puts more stress on the other levels. And all those are avoided with the procedure that I recommended.

Q Okay. So, Doctor, I guess in summary I'd like to go through each of the main categories and just restate what you've testified to. The categories that you listed: Number one, physician care; number two, ancillary medical care; number three, diagnostic testing; number four, medications; number five, surgery, lumbar; and then a summary of costs. Is that accurate?

A Yes.

Q So the physician care you have listed follow up with either an orthopedic spine surgeon or a neurosurgeon, pain management, family physician and anesthesiologist in the lifetime cost of four hundred twenty-four dollars and nine hundred and fifty-two -- four hundred -- I'm not real

good with numbers here -- $424,952. Is that accurate?

A Yes.

Q Okay. And then ancillary medical care, that's for things like physical therapy, surgery center, surgical center for radiofrequency ablations, and then surgical center for medial branch blocks; is that accurate?

A Yes.

Q And the total charge for that would $669,563; is that accurate?

A Yes.

Q And then diagnostic testing you have some radiographs and then MRI of the cervical spine repeated once every five years for the radiographs, every ten years for the cervical MRI, for a total charge of $9,922; is that accurate?

A Yes.

Q And then medications you indicated Motrin, Norco, Flexeril, and then a stool softener. What's that for?

A With pain medications they cause constipation.

Q Okay.

A And as you can see, the cost of stool softener is very, very inexpensive.

Q Okay.

A And that's to help prevent that problem.

Q And the charges for the medications was $34,493; is that accurate?

A Yes.

Q Okay. Now, the future medical needs of surgery you have listed the plasma disc decompression, the pain management discography study in the lumbar, and then surgery center for the same procedure, and then anesthesiologist charge for the same procedure and then a medical device, the wand for the plasma disc decompression.

A Yes.

Q And that's a charge of 54,000; is that accurate?

A Yes.

Q Are the charges for the future treatment, the total lifetime cost, the amount was different than what I had in the opening, the amount of $1,192,928, is that usual and customary for the services provided for those services?

A Yes.

Q And in your view, in your opinion to a reasonable degree of medical probability on a more likely than not basis, would those charges be reasonable and necessary to treat the problems that Mr. Morgan is having with his back and neck?

A Yes.

Q Okay. Dr. Muir, I believe those are all of the questions. Just a final cleanup question for the record, for appellate purposes if necessary. Have all of your opinions been stated to a reasonable degree of medical probability on a more likely than not basis?

A Yes.

Q Thank you.

THE COURT: Mr. Rands, before we start let's just take a short

break, okay?

MR. RANDS: I was going to suggest that, Your Honor.

THE COURT: Ladies and Gentlemen, we're going to take a ten minute 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 read, 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, 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 will also caution you not to do any independent research on the [indiscernible].

THE MARSHAL: Please rise for the jury.

[Jury out at 2:26 p.m.]

[Recess at 2:26 p.m., recommencing at 2:39 p.m.]

[Jury in at 2:39 p.m.]

THE MARSHAL: Please be seated.

THE COURT: Okay. We're back on the record in case number A718678, Morgan versus Lujan. Let the record reflect the presence of all jurors, counsel, and parties.

I will just remind you that you are still under oath.

And, Mr. Rands, whenever you're ready.

MR. RANDS: Thank you.

[Pause]

///

CROSS-EXAMINATION

BY MR. RANDS:

Q Good afternoon, Dr. Muir. My name is Doug Rands. I'm one of the attorneys representing the Defendant in this matter. Talked -- before we get started, you are compensated for your time here today, correct?

A Correct.

Q And if my records are correct, you bill about $6,000 for a half a day of testimony at trial?

A Yes.

Q Is that current?

A Yes.

Q Okay. And you also bill for depositions, if you were to give a deposition?

A Yes.

Q And I think in your billing rate you also bill for IMEs, if someone hires you to look at a case that you're not the treating physician on, that's an independent medical evaluation, correct?

A Yes.

Q And you do those?

A Yes.

Q And in doing an IME you would review the records, maybe evaluate or examine the patient?

A Yes.

Q For the Plaintiff. And then make a recommendation or a report --

A Yes.
Q Based on your findings, correct?
A Yes.
Q And you do that and you charge for that also, correct?
A Yes.
Q I think it you said you do $1500 not including x-ray review for an IME, at least the --
A Correct.
Q Okay. And you also testified that you've been retained or testified in court on other cases, correct?
A Correct. Approximately 30 times in 25 years.
Q I've got quite a few here. I just wanted to go down some of these. You testified that you testify for both the plaintiff, who is the one bringing the case, usually a patient, and the defense, correct?
A About once a month I'm asked to do an independent medical examination from the defense. But none of those that I know of have gone to court.
Q So I would be correct -- I've been through these. This is a list of the trials that you've been involved in or at least was provided as part of your expert designation. Part of one of the things you have to provide to the other side is a list of all the -- and I went through this. I couldn't find any that were defense cases.
A No, they're -- the vast majority are my own patients, patients that I've been asked to testify and people that I'm training -- that I treated, but there are a handful, probably less than ten, where I've testified on

patients that I have not treated.

Q Okay. But most of it's based -- most of your work where you're hired is because you've been a treating physician on a patient?

A Yes.

Q And the patient's generally the person bringing the case in a litigation situation, correct?

A Yes.

Q Okay. So the vast majority of your testimony has been for the plaintiff?

A Yes.

Q You talked a little bit about -- well, you talked in great length about your opinion that all of the treatment related to this case or to this -- to Mr. Morgan is related to this particular accident. By this accident I'm referring to the accident of April 1st. You understand that?

A I do.

Q So for purposes of, you know, so I don't have to keep repeating that every time, can we just understand that when I say "this accident" I'm referring to the April 1st accident involving --

A Yes.

Q -- that we're here to talk about today. Okay.

Now, if someone were to, say, be treating for an accident, hypothetically, and they got in a second accident during the treatment could that affect the treatment?

A Yes.

Q Could it affect the duration?

A Yes.

Q Okay. And much of your evaluation -- you said you can't rely specifically on x-rays, on CT scans, on MRI films when you're dealing with the neck and back, correct?

A In this particular case, yes.

Q Correct. Okay. So the fact that when he went to the hospital they did a CT scan while he was at the emergency room --

A They did.

Q -- and it was negative, correct?

A Correct.

Q Okay. And you talked --

A I'm sorry, it was negative for the things that they're trying to screen. It's negative for fractures, it's negative for bleeding into -- in the brain.

Q Okay. But it was negative?

A Yes, for the things they were looking for.

Q And you also have -- I think you testified earlier that of the MRI scans they show some mild -- I'll say mild, I don't know if that was your word -- but mild issues on the MRI scan but that could be just a normal MRI scan, correct?

A Yes.

Q It doesn't necessarily correlate to the effect or what he's claiming in this case?

A Does not.

Q Okay.

A Now when you --

Q And I believe -- I'm sorry, Your Honor -- or Your Honor. Sorry, Doctor.

A Sorry.

Q I respect doctors so much that I call you Your Honor. I apologize for that, Doctor.

THE COURT: I'm not sure if that's a promotion or a demotion. [Laughter]

MR. RANDS: It may be either or.

THE WITNESS: Promotion.

BY MR. RANDS:

Q You answered my question, Doctor, and I appreciate that. In fact, someone once said that disc protrusions can be a simple variation of normal.

A Yes.

Q And you would agree with that?

A Yes.

Q Okay. I have a copy of the -- both the life care plan and the report that you prepared in this case. Do you have the report in front of you?

A I have the graphs.

Q Okay. You don't have your medical record review in front of you?

A No.

Q Okay. And you said you have the graphs. What are those

graphs?

A The different categories and the breakdown of charges.

Q Oh, for the life care plan?

A Yes.

Q Okay. I'm referring to the report that you prepared, the --

A I do have that.

Q -- records review report.

A I do have that.

Q That's what I was referring to.

A Yes, I do.

Q Okay. All right. We're back on the same page. And the report I have is stated date of service July 27th, 2016, the front page, top corner.

A Yes.

Q Okay. Is that the report that you have?

A Yes.

Q And it talks patient Aaron Morgan?

A Yes.

Q And the report I have is 11 pages in length?

A Yes.

Q Okay. So we're working off the same report. It has a list of medical records reviewed, and the report I have the last one is 15, Steven Brown, M.D., correct?

A Yes.

Q Okay. Have you subsequently reviewed the Defense expert report and records from Andrew Cash?

A Yes.

Q Did you prepare a supplemental report?

A Yes, on 7 -- looks like November 28th, '16. I think there's a typo on the date of the review, but up on top date of service November 8th -- 28th, 2016.

Q And did anything in significance change in that report from the July 27th?

A The patient had an additional injection, a medial branch block at -- for the C5-6 and C6-7 levels which were diagnostic.

Q And that's what you already testified to.

A Right. I mean a change from my prior [indicating] report, but essentially the opinions remain the same.

Q Okay. So he had one more block that wasn't in your first report?

A Correct.

Q Okay. Let's go back to the first report then. Actually, this wouldn't be the report, it would be actually your medical records on the follow-up visit, date of visit 6/16/2016. Do you have that in front of you?

A What date?

Q 2016/6/16.

A 6/16 I don't.

Q Okay. You did see Mr. Morgan as a physician, a treating physician, correct?

A Yes.

Q And so in addition to performing the I -- or the records review

and the life care plan, you were also one of his treating physicians, correct?

A Correct.

Q And on your report of July 27th, 2016, on the second page, do you have that in front of you?

A Yes.

Q And this is the Urgent Care Extra we've already stipulated that the charge was actually $350, not $250?

A Yes.

Q But you, as part of going through you records and your review, you took I guess the information from the report and put it into your report, correct?

A Yes.

Q Really summarized it?

A Yes.

Q Okay. And then on the Urgent Care on the 4/8/14, you see the chief complaint there?

A Yes, neck, upper back pain, left wrist pain.

Q Okay. And that's when he went to the Urgent Care, correct?

A Correct.

Q And Sunrise Hospital, 4/1/14, up there, that is a -- the emergency room visit on the day of the accident, right?

A Correct.

Q And his complaint there was of neck pain, correct?

A Yes.

Q Did you review the Sunrise Hospital records?

A Yes.

Q And, in fact, I noted when I reviewed it that the low back wasn't an issue then. In fact, he had full range of motion and no pain in the low back on that day. Is that you recollection?

A Well, in the macro that the emergency room had it stated that he had full range of motion. But when you go into the emergency room they look at the -- they try to rule out major trauma such as fractures, bleeds in the head and the major areas. And those areas that they don't focus on they have a macro. They don't go through and change the macro. The macro just says normal for all that area.

So most likely, and I see this frequently, they were concerned about hitting his head, had a potential bleed in his head, that he may have had fractures in his neck, and ruled those out. And most likely, there was nothing written down about the back and likely the patient didn't even complain of that because that was not his major complaint at that time.

Q Yeah. If he'd have said, hey, I've got a -- my neck pain and I've got low back pain, they would have checked the low back?

A Typically if he complained of low back pain they would have --

Q Checked it.

A -- put something down.

Q All right. And in the Urgent Care the next -- or a couple days later, a week later, that was -- we've gone over that. And then he went to the Nevada Comprehensive Pain Center. And you've gone through that. I'm not going to spend a lot of time going through every detail of that report because you've gone through it already.

On the first visit, 4/21/14, you put this in your report: The patient presents with a new onset of neck pain, headaches, mid-back pain, left wrist pain that began after the motor vehicle accident on 4/1/14, correct?

A Correct.

Q And they noted decreased range of motion on the cervical and thoracic, moderate tenderness to palpation, he said, correct?

A Correct.

Q And that was the doctor that performed the evaluation or the medical provider who performed the evaluation, correct?

A Correct.

Q It says: We have received results from the cervical and thoracic MRIs and the pain -- on 7/14 he says that the pain has been moving into the low back as well on that day. That's what was in the records.

A On which date?

Q 7/14/14.

A That's what it states in that record, yes.

Q Yes, okay. And then on the same page, on the 30th of 2014, it says: The patient reports worsening of low back with standing. Correct?

A I'm sorry, which record are we looking at?

Q Same record, same page.

A Nevada Comprehensive?

Q Yes.

A On which date?

Q Page 3, 9/30/14.

A Yes, worsening of low back pain.

[Pause]

Q Okay. Now, one question. Next page, on page 4, there's a significant entry and I believe it's dated 1/19/15. And at that point he said -- it says on the top of page 4 that he had a pending orthopedic specialist with Dr. Muir. Where it talks about the lumbar, they're talking about the range of motion that we've talked about before. But it says in there that the neurological examination is normal. Does that mean he's not getting any shooting down his legs or anything like that from the lumbar area?

A Well, it means that there's no indication of the nerves being pinched. You could have a tear in the disc and have nerve irritation down the leg, but on the physical examination there's no indication of a nerve being pinched.

Q Okay. Now, I wanted to talk on the next page, going through it rather quickly, but I promised I'd get everybody out of here by 5, so. On the next page, page 5, this is where you're talking about the Las Vegas Chiropractic, and you testified that 93 visits with the chiropractor over probably close to a year is reasonable and customary in Las Vegas.

A I said it is reasonable and within the range of normal.

Q Okay.

A And that he had some temporary relief.

Q Did you review the chiropractic records, the actual SOAP notes?

A Yes.

Q And I went through those. Appeared to be, at least in the -- like the areas of May, June, that the chiropractor was putting in there -- and it

may just be something like you said that they put in there, but he wasn't getting much relief, he wasn't getting much -- making much progress. With those kind of notes would you still consider it prudent to continue with a chiropractor?

A When I reviewed all the records, it seemed reasonable what the -- because there was some temporary relief. There's certainly periods of no relief, but there was some temporary relief and, therefore, it seemed to be reasonable.

Q But you would agree with me that 93 visits to a chiropractor with the kind of relief or non-relief he was getting would be a lot?

A It's within the normal range but the upper end of the normal range.

Q Okay. We'll agree to talk about the upper end of the normal range.

A But reasonable for this patient.

Q Okay. You said you reviewed Dr. Sanders' report. In that report he puts that the patient told him the chiropractic wasn't really helping him and that's why he quit chiropractic. Did you remember reading that in Dr. Sanders' report?

[Pause]

A I don't recall at this time.

Q Okay. We'll talk to Dr. Sanders about that on Thursday.

And then on your report, the next one is Dr. William Muir, and that's you, correct?

A Correct.

Q You've talked about your treatment. You saw him several times.

A Approximately ten.

Q Approximately ten times. And during that ten times he was also treating with Dr. Coppel, correct?

A Correct.

Q Did you have him on a regular course of physical therapy during this time he was treating with you?

A The patient had chiropractic treatment. I'm trying to see if that overlapped or not. I'd have to check the dates.

Q The question I asked, though, is did you prescribe him physical therapy while he was treating with you?

A Not that I recall.

Q Okay. And, in fact, when you -- on one of the last visits with you, at least the ones in your report on page 8, it's dated 12/31/15.

A Yes.

Q Follow-up for a post-injection, as of this visit he hasn't noticed any relief from the injection, correct?

A Correct.

Q And you recommended -- let's just go down to the lumbar. You recommended treatment options of allow more time to heal, continue conservative measures. Is this the chiropractic care or the physical therapy?

A It can be therapy -- conservative therapy refers to medication and therapy, principally.

Q Okay. So the medication could be part of the conservative care?

A Yes.

Q All right. Consider repeat injections, discogram, and then discogram/plasma disc decompression. Is this -- that's the surgery that you talked about?

A Yes.

Q The less invasive surgery than a fusion?

A Yes.

Q And it says: The patient would like to move forward with the discogram and plasma disc decompression. Did you ever get that scheduled?

A Tentatively we have it -- we had it scheduled but postponed it because of the trial.

Q So you postponed the surgery because of the trial?

A Yes.

Q What would be the recovery time for a surgery like that? You said it was an in-office procedure?

A It's when a patient walks out right afterwards, meaning 30, 40 minutes after the procedure, and recovery varies from patient to patient. I've had patients that had immediate relief. Sometimes it takes three months. If they're not better by three months, then typically they're not going to get better. They're discouraged to do any heavy bending or lifting during that three-month period of time.

Q And you said in your report, this is at page 11, that without

surgical intervention that patient's symptomology will persist, requiring continued treatment.

A Yes.

Q Do you remember saying that?

A That's based upon a large study of looking at patients with chronic back pain for a year or two to see how they did over years, 25 --

Q But the answer to the question was you said that, correct?

A Yes.

Q Okay. And the surgery you were talking about there is that discectomy -- plasma discectomy?

A Plasma disc decompression.

Q Disc decompression. Sorry. Plasma disc decompression. Okay.

Now let's talk a little bit just about your life care plan. And you said you have -- don't have the actual introduction, but it appears to me the introduction's pretty much what you put in your report.

A Yes.

Q So it's not -- I couldn't see a lot different between that and the report, so.

A No.

Q But you did bring the -- I guess the charts or graphs I think you called it.

A Yes.

Q Okay. Now, let's just go through a couple of them. The first one is the physician care, correct?

A Yes.

Q And it says orthopedic spine surgeon or neurosurgeon, evaluate him every five years, and it says beginning 2016 and ending 2068. So that's -- my math is as bad as Counsel, but that's about 55 years, correct?

A [No verbal response].

Q Fifty-four and a half, actually, but.

A I get 53, but, yes.

Q Okay. You're right. My math is as bad. Fifty-three and a half or fifty-two and a half. Anyway, it's over 50 years. Let's just say that and move on.

A Yes.

Q Okay. So for the next 50 years you think -- you're saying that he's going to go see a physician once every five years for follow up?

A Yes.

Q And that for 12 times a year for the next 50 years he's going to see a pain management specialist?

A Yes.

Q And that one episode every two years to each area he's going to require pain management facet radiofrequency ablation.

A Yeah. And that's -- it's not written well. It should state -- it would be simplified saying once a year for a radiofrequency ablation.

Q And this is for the doctor, correct?

A Yes.

Q I looked through all the medical records to date, he hasn't had one of those yet, has he?

A No, but he's a candidate now.
Q Okay. But he hasn't had one to date.
A No, because you have to have two medial branch blocks, which he's had now.
Q And pain management M.D., medial -- you said he's already had the medial branch blocks but you put it in here as an item that he's going to need?
A I put as having one more before the radiofrequency, but as stated earlier he could receive the radiofrequency ablation and that would eliminate that additional injection.
Q You said he needed two, and he's had two, but then you put a third into here?
A Yes. The first one included another level, and so it's reasonable to be more specific but, as mentioned, it's optional. You could -- he could pursue the radiofrequency ablation now.
Q So may or may not need that?
A Correct.
Q Okay. Family physician. He testified in his deposition he doesn't have a family physician, he doesn't go to a family physician, but you put that in your report.
A Right. And I should, as a life care planner, because that's something he would benefit from to have those tests.
Q And the anesthesiologist is once yearly for rhizotomies?
A Yes, that's the radiofrequency ablation, another name for it.
Q Okay. And that would be the person who would have to do the

anesthesia for that procedure?

A Yes.

Q Okay. Then next on the ancillary medical care you said he's going to require physical therapy every ten years. Isn't this kind of speculative?

A Well, you can't say exactly whether it'd be -- obviously he's had more than what I am predicting, and it can change over years. But as a life care planner, you have to take what the patient has and look in the future and say this for this particular condition --

Q Doctor, I don't want to cut you off --

A -- this is what he would benefit from.

Q -- but I -- I understand.

A So --

Q The question was --

A -- is life care plan speculative? There's some speculation in it, but it's based upon medical probability with their particular problem.

Q In fact, even in your report you say the frequency and duration is quite variable --

A Uh-huh (affirmative).

Q -- on the first one, on physical therapy.

A On the therapy part, yes.

Q Yeah. So it could be more, could be less, could be none at all?

A And most likely, if anything it'd be more, but I tend to try to be on the conservative side.

Q Okay. But it could be less?

A Could be less.

Q All right. Surgical center once a year. This is for that radio ablation -- radiofrequency ablation?

A Yes.

Q $12,000 a year once a year for 50-some years?

A Yes.

Q And again, is that something that you can say as you sit here today he's going to have to do that?

A What I'm saying -- that's not a life care plan. What I'm saying is that he would benefit from that once a year for the rest of his life.

Q Okay. But you don't have a crystal ball, you can't look into the future and say he's going to do that every year for the next 50 years.

A Correct.

Q Okay. And the surgery -- surgical center once -- this is for the medial branch that he may or may not need now?

A Correct.

Q Okay. And then this last one for the surgery, this is the surgery that you're talking about that he had scheduled and -- or that you were going to schedule but never did before trial?

A Correct.

Q Okay. And when you do a life care plan, is the amounts that you're putting there is that to today's dollars or is that to present value or just what it would cost today?

A It's today's dollars.

Q Okay.

A What it'd cost today.

Q And you would agree with me, would you not, that if the jury were to give him the $1.2 million that you've put in this report, say, yeah, he's entitled to that, you don't know what he's going to do with that money, correct?

A Correct.

Q He could save it and use it for this or he could do something else with it.

A Correct.

Q Okay. And do you have a current appointment with him to see him again?

A I didn't look at the schedule book, but I believe we do.

Q Okay. But you couldn't tell us today when that is?

A No. I don't keep track of those.

MR. RANDS: Could we just have a moment, Your Honor?

THE COURT: Okay.

[Defense counsel confer]

MR. RANDS: Thank you, Your Honor. That's all I have.

THE COURT: Counsel?

REDIRECT EXAMINATION

BY MR. CLOWARD:

Q Dr. Muir, have you heard of something called a medical trust, you put money aside into a trust that protects the money for the future? Have you heard of that before?

A Yes.

Q Okay. So let's talk about some of the questions that you were asked, specifically about a CT scan. Oftentimes come to court and I hear cross-examination about a CT scan, well the CT scan was negative. If a negative CT scan means that somebody's not hurt, why don't we just stop treating people at that point? I'm -- this is a serious question.

A No, it's true. Because they have a problem that the CT scan just does not pick up their problem.

Q I mean, goodness sakes, if a CT scan that's negative is dispositive why do we even have physical therapy, chiropractic, pain management, orthopedic spine surgery, neuro spine surgery, why do we even continue to treat folks? Why don't we just say, hey, you know what, negative CT scan or positive CT scan, if it's negative they're hurt -- or I mean they're not hurt, they're okay; if it's positive then we're going to continue the treatment.

A Because the emergency rooms are looked at screening of bad things, meaning bleeding of the brain or fractures in the neck. That's -- they're not concerned about potential chronic neck pain or back pain in the emergency room. But they -- their job is to rule out the potential bad things. And that's what they're looking for. I see CT scans from ERs often saying negative, and but I can see a lot of different changes in there. They're saying negative for fractures, negative for dislocations.

Q Okay. Is it fair to suggest that a negative CT scan means that Mr. Morgan was not hurt?

A No.

Q Now, a lot of discussion about the lumbar spine. It's true, Mr.

Morgan's lumbar spine complaints did not show up until April 25th, 2014; isn't that true?

A That's the first time it was documented.

Q Okay. First time it was documented. How many visits had he had to medical providers prior to that? Had he been treating like three times a week, four times a week, five times a week?

A Well, he had the one emergency room visit, the urgent care center.

Q Okay.

A And then I don't think there's many treatments. I'd have to -- I can look. Only once to pain management. As far as the chiropractic, 4/25, indicates low back pain five out of ten.

Q Okay. Now --

A On the first visit.

Q So there were -- there was -- and the question initially was how many visits did he have prior to that. I think you said there was a Sunrise Hospital, one treatment, that was the day of the crash; a week later the urgent care, and then pain management shortly before the chiropractic. So basically three visits, three visits after the accident; is that fair?

A Yes.

Q Okay. Is it unusual for patients to have pain in other parts of their body begin to manifest in the days and weeks after a traumatic event?

A No.

Q I mean, if we look at this case, he had an MRI that proved he had tears in his wrists and he had surgery to repair that wrist; is that not

true?

A That's true.

Q But he didn't say a word about the wrist on the treatment to the Sunrise Hospital. Does that mean that --

MR. RANDS: Objection, Your Honor. He -- can we approach?

THE COURT: Sure.

[Bench conference begins at 3:13 p.m.]

MR. RANDS: [Indiscernible}.

MR. CLOWARD: I'm using it as an analogy and I think it's a fair analogy. And the pain and suffering for the wrist is a part of the case. Medical treatment is not.

THE COURT: That's fine. So can you [indiscernible]? The way I understood it was Mr. Cloward's point was that not every -- even the no medical things aren't in every single record.

MR. CLOWARD: Yeah, exactly.

THE COURT: So I'm going to overrule it on that basis.

MR. CLOWARD: Thank you, Your Honor.

[Bench conference ends at 3:14 p.m.]

BY MR. CLOWARD:

Q Okay. I don't even remember what -- the question I asked. Let me think for a minute.

A Must be time to go home then.

Q Oh, we were talking about the wrist. Okay. We were talking about the wrist. So, Mr. Morgan, he had MRIs of his wrist, true?

A True.

Q Showed a tear, true?
A Yes.
Q He had surgery to repair the tear in his left wrist?
A Yes.
Q Okay. He didn't mention the wrist at Sunrise Hospital, so does that mean that, you know, he wasn't hurt?
A No.
Q Okay. So again the question is, is it unusual for patients to have pain manifest in the days and weeks after a traumatic event?
A No, especially when there's multiple injuries.
Q Now, you were asked a lot of questions about the life care plan. And you did not include a fusion surgery in there, did you?
A Did not.
Q What, hypothetically, if he had a two-level lumbar fusion, what is the cost of a two-level lumbar fusion?
A Approximately 250,000 to $350,000.
Q So 250 to $350,000 for one surgery?
A Yes.
Q The surgery that you recommended was a plasma disc decompression was 50,000?
A Yes.
Q Why didn't you just throw in the lumbar fusion? It's a lot more money.
A It could be done. I'm in hopes that the plasma disc decompression would be sufficient. And we're dealing with medical

probability and it's slightly more probable that the plasma disc decompression will be sufficient, so I did not put that in.

Q Okay. What happens when somebody has what's called failed fusion syndrome?

A Failed fusion syndrome is one that's had fusion and they still have symptoms, either from the area of surgery or an adjacent level. And those are patients that require typically treatment such as therapy, medications, injections, or additional surgeries.

Q Isn't there actual literature that suggests that folks that have a fusion are more likely than not to have adjacent segment disease breakdown and require an additional fusion down the road? I believe this -- the probabilities are about every 17 years?

A There's different opinions and different records on that. Often what's quoted is one that says in ten years there's a twenty-nine percent chance of adjacent level breakdown, but that's with the cervical spine.

If someone has an already damaged disc above where you're fusing but it may not be bothering them, then it be -- goes into the probability of adjacent level breakdown. If they have a normal-looking disc at adjacent level, then usually you don't have adjacent level breakdown.

Q Okay. And I believe the study you probably are referring to is the Hillenbrand [phonetic] study?

A That's the one with twenty-nine percent in ten years.

Q Twenty-nine percent at ten years, over fifty percent at seventeen years; is that accurate?

A Yes.

Q That's a *Spine Journal* article, correct?

A Yes.

Q They did a comprehensive study, looked at the probabilities of fusions, outcomes, and the probability analysis of an adjacent level breaking down after a fusion; is that correct?

A Yes.

Q Okay. So if Mr. Morgan -- the life care plan that you provided, you could have easily put in there, you know what, he needs a lumbar fusion, it's 250 to $350,000, and he's going to have to have another one every 17 years. You could have done that, huh?

A Could have.

Q You didn't do that, though, did you?

A Nope.

Q Why not? It would have been a lot more money.

A I have to look at probabilities. And I believe that with the plasma disc decompression that would be sufficient. I could put -- I could have put it down as a possibility. Sometimes I do that in my life care plan, but I didn't put it down as a probability because I believe more likely than not the plasma disc decompression will be sufficient.

Q Okay. Fair enough. Now, you weren't allowed to answer this question, but you said it was -- you felt like it would be important for him to follow with a family physician even though he doesn't currently go to a family physician. Why?

A Because in the life care plan it's designed what the patient would benefit from. And he's taken these same medicines in the past. And

if you took these medicines most likely you would have some relief from pain, slight improvement in his function. And when you take pain medicine, as I mentioned before, that can cause problems in different organs and you should have periodic blood tests to make sure those organs are tolerating those medications.

Q Okay. And obviously a patient's symptoms can change over time, they can get worse?

A Yes.

Q Okay. So is it possible that the life care plan that you've outlined actually may not be sufficient to cover Mr. Morgan's needs into the future?

A Yes.

Q Is it possible that he actually may have to have that lumbar fusion into the future as he grows older?

A Yes.

Q Is there anything to suggest that without this crash he would have been a candidate for a two-level lumbar fusion without the crash?

A No.

Q Okay. Thank you, Dr. Muir. No -- and have all your opinions been stated to a reasonable degree of medical probability on a more likely than not basis?

A Yes.

Q Thank you.

THE COURT: All right. Mr. Rands?

///

RECROSS-EXAMINATION

BY MR. RANDS:

Q I didn't see anywhere in the records that you recommended a two-level fusion.

A Did not.

Q Okay. And a lot of that's due because of his age?

A His age and the likelihood of the plasma disc decompression being sufficient.

Q So you believe that in your medical opinion the plasma disc decompression would be sufficient in this case?

A Yes.

Q Okay. And counsel said that it could get worse over time. It could get better over time, too, right?

A The statistics are, because they looked at big numbers of patients like -- just like the patient, over years. Fifty percent stayed the same, twenty-five percent got worse, twenty-five percent got better. So there's a twenty-five percent chance that he would get better, seventy-five percent chance he'll stay the same or get worse.

Q Or stay the same or get better.

A That's twenty-five percent.

Q Seventy-five percent if he stays the same and gets better?

A Yes. There's a seventy-five percent chance that he'll stay the same or get better.

Q Okay. Thanks.

MR. RANDS: That's all I have.

THE COURT: All right. Are there any questions from the jury? Counsel, approach, please.

[Bench conference begins at 3:22 p.m.]

[Reading questions from jurors]

THE COURT: [Indiscernible].

MR. LAWYER: I think that would be more appropriate for the Plaintiff [indiscernible].

THE COURT: [Indiscernible].

MR. RANDS: This would just have to be crafted more to in the records that you've reviewed or your visits with him are you aware of any other intervening --

THE COURT: [Indiscernible].

MR. RANDS: [Indiscernible].

MR. CLOWARD: I'm fine with all of them; they just don't make a lot of sense. They're kind of somewhat confusing to me.

MR. RANDS: [Indiscernible].

THE COURT: That's fine.

MR. RANDS: If you want to [indiscernible].

MR. CLOWARD: Yeah, that's fine with me.

THE COURT: Okay.

MR. CLOWARD: We're fine reading them to the jury.

THE COURT: [Indiscernible].

MR. CLOWARD: I mean, asking them to --

THE COURT: They're fine [indiscernible] no objections.

MR. CLOWARD: Yeah.

MR. RANDS: Yeah.

THE COURT: Great. All right.

[Bench conference ends at 3:24 p.m.]

THE COURT: All right, sir. I'm going to ask you questions. I'm going to ask you to look at the jury, instead of me, when you answer so that they can hear you.

THE WITNESS: All right.

THE COURT: Between doctor visits, was it asked if Mr. Morgan has done any other activities besides the crash that may have or could have brought on different?

THE WITNESS: It's always a possibility. There's nothing documented in the records where -- the only documentation of anything that should be considered is Dr. Cash indicated that during his treatment he had a motor vehicle accident but it did not alter his symptoms, and the medical records didn't indicate that it altered his symptoms.

There's nothing in the records that he did to make things worse. And if you look at anybody here, say in the next two years, are you going to have problems with your neck or back from something that you do where you're going to actually need treatment, probably not. Is it possible that he had something else going on? It's possible, but not likely. There's a constant flow of the medical records of him having persistent symptomatology and there's no indication of anything, activity, that increased his symptoms or changed on his examination to any great extent.

THE COURT: Could any work or sport-type activity like lifting, pushing, or sitting for long periods of time affect Mr. Morgan or may have

been a part of what medical conditions he has now?

THE WITNESS: Again you're talking -- we're talking about possibilities. But those are activities that one can do and you wouldn't need to have -- you wouldn't have seven out of ten neck pain or five out of ten low back pain requiring medications, including narcotics and injections, even considerations of surgery. So those activities most likely did not result in any alteration of his symptoms.

THE COURT: In Mr. Morgan's condition, does he have and still have a doctor's note stating for him not to lift heavy objects as this could affect his back or neck?

THE WITNESS: Dr. Cash in his notes he had some recommendations, and I don't want to misquote him so I'll just -- I can find this right away. He said no -- he recommended no repetitive bending, twisting, stooping, crawling, climbing, squatting, or lifting more than 10 pounds or -- frequently or 20 pounds occasionally. And those are all reasonable. I try to tell patients to be as active as they can but use their common sense, don't do any -- it's not ideal to do any heavy lifting because it can aggravate that.

THE COURT: All right. Any follow up, Mr. Cloward?

MR. CLOWARD: No. Those are great questions. None for the Plaintiff.

MR. RANDS: No, Your Honor.

THE COURT: Thank you, sir. You are free to go.

THE WITNESS: Thank you, Judge.

THE COURT: Have a good evening.

[Witness excused]

THE COURT: Mr. Cloward, if you'll please call your next witness.

MR. CLOWARD: Your Honor, may we approach briefly?

THE COURT: Sure.

[Bench conference begins at 3:28 p.m.]

MR. CLOWARD: We had planned on --

THE COURT: You're not going to tell me we're going to stop an hour and a half early, right?

MR. CLOWARD: We don't --

THE COURT: You have your client here?

MR. CLOWARD: He's completely on -- we haven't even prepared for that. I didn't -- I thought that Dr. Muir would go longer than that, but we thought that we could take up the jury instruction issue so that we're still working, using the time that we have. We kind of discussed the timing with opposing counsel. I apologize, Your Honor. I thought we could use the time to iron out the jury instructions.

THE COURT: It's going to take us 15 minutes to go through the jury instructions, Mr. Cloward. I am not going to send the jury home an hour and a half early.

MR. CLOWARD: Even though we're on schedule? We're still on schedule. Because we're going to have some down time on Thursday is the problem with Dr. Sanders, so.

THE COURT: Have you had any luck getting him here sooner?

MR. GARDNER: Oh, no, he cannot. In fact, I had them call

again today and he's just -- can't do it. I'll try again.

THE COURT: He could. He doesn't --

MR. GARDNER: Well, yeah --

THE COURT: He chooses not to do it.

MR. GARDNER: I'll try again.

THE COURT: He doesn't --

MR. GARDNER: Well, yeah.

THE COURT: He chooses not to do it.

MR. GARDNER: [Indiscernible].

THE COURT: But he chooses not to. Like, he could if he really wanted to. He just chooses not to.

MR. GARDNER: It's my staff that's calling. I'll call him personally, see what we can do.

MR. CLOWARD: That's, you know -- we will -- Plaintiffs will one hundred percent finish on time, even if we finish a little early today we will never go past the time that we've given the Court, even if we don't use the hour and a half right now. I can assure the Court that we will not go over. I promise you that. So as far as the ultimate schedule that the Court's given --

THE COURT: All right, Mr. Cloward. Here's the deal. I will stop today. But --

MR. CLOWARD: He won't --

THE COURT: -- I expect that tomorrow we will have a full day.

MR. CLOWARD: Absolutely.

THE COURT: So when we finish --

MR. CLOWARD: One hundred percent.

THE COURT: -- with Dr. Cash, then I expect that your client is going to go on the stand. This is --

MR. CLOWARD: Hundred percent, Your Honor.

MR. GARDNER: Yep.

THE COURT: -- extraordinarily unacceptable to me, so...

MR. CLOWARD: Okay.

[Bench conference ends at 3:30 p.m.]

THE COURT: All right. Folks, we're just a little bit ahead of schedule, so that's good news. We're going to go ahead and wrap up for today. We have another -- because of the physician's schedule we have another doctor that's scheduled to come in at -- he's coming in at 10, right?

MR. CLOWARD: Yeah, first thing in the morning.

THE COURT: At 10:00 tomorrow morning. So we just have a little bit of a gap, but the good news is that we're running a little bit ahead of schedule. So we're going to go ahead and break for the evening. 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 read, 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, 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 will remind you again not to do any independent research. Everybody have a good evening. We'll see you tomorrow at 10.

THE MARSHAL: Please rise for the jury.

[Jury out at 3:31:45 p.m.]

[Counsel confer]

MR. GARDNER: Your Honor, may I make a record of something at this point?

THE COURT: Absolutely. Good time to do this.

MR. GARDNER: The motion in limine that granted the Plaintiff --

[Plaintiff and Defense counsel confer]

MR. GARDNER: -- summary judgment --

THE COURT: Hang on. Just one second.

Mr. Morgan, if you don't -- we're going to go over the jury instructions and make a record on this. You certainly are welcome to leave if you want. Don't feel like you are obligated to stick around.

MR. CLOWARD: We're his ride, so…

THE COURT: All right.

MR. RANDS: You can sort of walk around outside if you want.

THE COURT: Then you're just stuck here, but --

MR. GARDNER: Excuse me. As the MSJ partial summary judgment, I just want to make sure that there is a clean, clear record that we oppose that and we -- it's our position that there has not been adequate foundation laid for this hand doctor or wrist doctor reports coming in.

THE COURT: All right.

MR. CLOWARD: Your Honor, would you like to address the jury instructions now or --

THE COURT: Yes, I would. Hold on. I'm just going back to -- I

just wanted to [indiscernible].

[Pause]

THE COURT: All right. So, I mean, the issue was that there was no expert by the Defense to -- that's what I recalled as well -- that there was no expert providing any opinion about the issues related to the wrist from the Defense side.

MR. CLOWARD: But there was no genuine issue of disputed fact.

THE COURT: All right.

MR. GARDNER: Thank you, Your Honor.

THE COURT: Yeah. So let's go ahead and go through the jury instructions. So everybody should have a [indiscernible].

MR. BOYACK: Yeah, I think there was only one change that we needed to make.

MR. RANDS: Two changes that we have to make and then I --

THE COURT: Okay. So let's just start -- I want to start from the beginning.

MR. BOYACK: Okay.

MR. RANDS: Okay.

THE COURT: So the first one it is -- Number 1 will be it is my duty as judge;

2, if in these instructions any [indiscernible] or idea;

3, if during this trial I have done -- said or done anything.

MR. RANDS: You're so demonstrative we need that in here.

THE COURT: All right. Or it's the big sign that I hold up with

the arrows.

MR. GARDNER: Your Honor, I'm going to switch tables if that's okay.

MR. CLOWARD: While we were there, Judge, I actually -- I was pointing out to counsel one thing you taught me at the last trial we did was there's a new Supreme Court case or pretty recent federal -- or criminal case that -- because we were having some dialogue outside your presence about the appropriateness of asking a judge to identify an expert, and we don't do that anymore, right?

THE COURT: No. And, you know, I'm not sure that's a criminal case but I don't recall the -- I can never remember the case name. No, because it's considered vouching for the expert. So if there's some issue about the qualifications of the expert then we would take that up outside the presence of the jury, but we don't say any more like we used to. And [indiscernible] I want to say like a good four, five years old. But we don't say any more like we used to that they're qualified to testify as an expert, simply because it gives some additional perhaps unnecessary credibility to the witness. So we can say, you know, they're permitted to testify. I think generally that case actually disfavors the lawyers asking that question in front of the jury, if I'm recalling --

MR. CLOWARD: Yeah.

THE COURT: -- what the case says correctly.

MR. CLOWARD: Yeah, and I believe --

THE COURT: Of course I don't remember the name of the case.

MR. RANDS: And I believe it should be handled in a motion in limine outside the presence of.

THE COURT: Yeah, right, or outside the presence of the jury with respect to the -- and, you know, obviously whenever anybody has an expert they're going to want to establish just, you know, the foundation of the expert's opinions with the jurors. But if there's some foundational issue about the expert being able to give an opinion, that's supposed to be handled outside the presence of the jury. And if I looked for a few minutes I could find the name of the case, but. I can remember -- always remember the facts and the point but I -- the case names are --

MR. RANDS: That's what Lexus is for.

THE COURT: -- escape me completely. All right. So 4 is the evidence which you are to consider;

5, if the counsel for the parties have stipulated to any facts. Okay.

So with respect to instruction Number 6, I added the last phrase just including the Internet or other online services from what was provided to me. It's just in addition to the stock instructions.

I also -- I find the organization of the stock instructions a little bit weird and so I have reordered these two so that I go -- the general instructions, instructions about evidence, instruction about witnesses, general, then expert, instructions about the parties, instructions specific to the case -- well, instructions about burden of proof, then instructions specific to the case, and then the concluding instructions. So I've just reshuffled these a hair.

MR. RANDS: Yeah.

MR. GARDNER: That makes a lot more sense.

THE COURT: Because that's what --

MR. RANDS: I don't know about --

THE COURT: Well, I don't know if it makes more sense but it makes more sense to me.

MR. RANDS: I don't know about Counsel, but when I submit instructions to the judge usually it's just how they are in my computer, you know. This is my order, it's not --

THE COURT: Well, I mean, I think generally people give them in the order that the stock instructions are, and I don't know why they are how they are or who decided them to be on the structure. Like, for example, the last instruction that we have always given is not the last instruction in the stock instructions.

MR. RANDS: Yeah.

THE COURT: Okay. So 6, you must decide all questions of fact, with the addition of that last phrase about Internet, online;

7 are the -- though you are to consider only the evidence in the case;

8, there are two types of evidence. And Mr. Cloward submitted it with the correct punctuation. Yay for him.

MR. CLOWARD: Thanks. Good job, Bryan.

THE COURT: It's about the fifth time that's ever happened.

MR. BOYACK: We'll keep a clean set then.

THE COURT: That makes me happy.

MR. CLOWARD: Yeah, I know. I want to make sure I have that one for the future.

THE COURT: Instruction 9, in determining whether any proposition has been proved.

Instruction 10, certain testimony has read from a -- been read from a deposition. Are we anticipating using depositions?

MR. RANDS: Not at this time. Not to put testimony in. There may be some impeachment, but it wouldn't be just to do testimony.

MR. GARDNER: Right.

MR. BOYACK: So I would say for right now let's keep it in, but it may change.

MR. CLOWARD: [Indiscernible].

MR. BOYACK: The only deposition there is available is our client's deposition. And so once we get through him, we can then decide to take that out or not.

THE COURT: Do you want me to put it --

MR. RANDS: Why don't we take it out and then put it in if we need it?

THE COURT: We can put it in as an A if we need to.

MR. BOYACK: Okay.

THE COURT: All right. So I'll hang onto that one. We'll call that if we need to. All right. Then I have during the course of the trial -- have we talked about interrogatories or does anybody anticipate doing that?

MR. CLOWARD: No.

MR. GARDNER: Perhaps. Perhaps.

MR. CLOWARD: [Indiscernible].

THE COURT: Okay. So I'll hang onto that one as well. And then I have request for admissions. Anybody planning to reference any request for admissions?

MR. GARDNER: We're not, Your Honor.

MR. RANDS: Defense, no.

THE COURT: Mr. Cloward?

MR. CLOWARD: No, Your Honor.

THE COURT: All right. So we'll pull that one out.

The credibility or believability of a witness then will be instruction Number 10.

Oh, and I pulled out the gender neutral instruction. I just make the instructions gender neutral. It's just easier.

MR. BOYACK: Okay.

MR. CLOWARD: No problem.

THE COURT: Instruction -- then I have the preponderance or the weight of evidence, and that will be 11. They got switched up from the packet.

Then the next is discrepancies in a witness's testimony. That'll be 12.

Then an attorney has a right to interview a witness. Everybody wants that instruction?

MR. GARDNER: Fine.

MR. CLOWARD: Yeah.

MR. RANDS: Yep.

MR. BOYACK: Yep.

THE COURT: Okay. So that'll be 13.

A person who has special knowledge, skill, experience and training, that'll be 14.

An expert witness has testified about reliance on articles and books. Are we -- I guess we did have a little of that --

MR. RANDS: He kind of had the little thing, yeah.

THE COURT: Okay. So we're good with that one, and that will be -- the submitted instruction had just a typo -- a couple typographical errors so --

MR. RANDS: Uh-oh.

THE COURT: -- so it says: An expert witness has testified about his reliance upon article and books, and then the word "that" was omitted. So we added: that have not been admitted into evidence. Reference by the expert witness to this material is -- and a -- there -- D was missing on allowed so that the expert -- so we corrected those two things.

MR. CLOWARD: Mr. Boyack submitted that, Your Honor.

MR. RANDS: So how fleeting it -- so how fleeting your --

THE COURT: That'll be instruction 15.

MR. CLOWARD: I submitted all the good ones.

MR. RANDS: All right. Sorry.

THE COURT: A hypothetical question, that will be 16.

MR. RANDS: This is one we're going to have to change, Your Honor.

THE COURT: Okay. You are not to discuss -- okay. So what

are we doing with this?

MR. RANDS: It references loss of earnings. Loss of earnings are not a part of this particular case at this time, so.

MR. BOYACK: That's fine. We can just omit the loss of --

THE COURT: Oh, all right. So you are not to discuss or even consider whether the Plaintiff was carrying insurance to cover medical bills or any other damage?

MR. RANDS: Yeah.

THE COURT: We'll just remove loss of earnings.

MR. RANDS: Correct.

THE COURT: And -- all right. And so then with that one change, that will be Instruction Number 17.

We don't need the corporation instruction. I'm not sure how that snuck in. Oh, because you gave it to me.

MR. BOYACK: No.

MR. CLOWARD: There is a company.

MR. BOYACK: Yeah, it's a corporation.

MR. RANDS: There are two defendants.

THE COURT: Oh, right. That's why. Okay.

MR. RANDS: Individual and the corporation.

THE COURT: Got it. Forgot about that. So that'll be 18.

Nineteen. So the next instruction is whenever in these instructions -- oh, and this is -- there's a typo in this one. Oh, no, that's not right. Okay. Got it. There's not a typo. I just read it wrong. Whenever these instructions I state that the burden or burden of proof, the stock

instruction has the truth of the allegation is proved by a preponderance of the evidence, you shall find the same not to be true. I have generally added in my instruction: in other words more likely than not. Just to clarify the --

MR. CLOWARD: That's a great change.

THE COURT: -- preponderance of the evidence.

MR. RANDS: No problem.

THE COURT: Everyone's all right with that. I've added that in both paragraphs.

MR. CLOWARD: I love it.

THE COURT: Okay.

MR. RANDS: The one that I've got only has it in the second paragraph. I don't want to be --

THE COURT: It says --

MR. RANDS: Oh, more likely than not.

THE COURT: Yeah.

MR. RANDS: Okay. Got it. Thank you.

THE COURT: Okay. And so that will be 19. I wish our instructions generally -- you know, we have so many that we have to give that just don't make any sense at all to the -- our jurors. Okay. And then --

MR. RANDS: This is about the time their eyes glaze over anyway, so.

THE COURT: 20, the Plaintiffs seek to establish a claim of negligence.

Then 21, the Plaintiff has the burden to prove;

22, when I use the word negligence;

23, proximate cause of injury;

24, ordinary care;

25, the Plaintiff may not recover damages. And this should actually say his. Comparative negligence is greater.

MR. RANDS: Well, actually line 3 there's a --

THE COURT: Three actually. It's on the first line that they're lined and seventh line. We'll get that straightened out.

MR. RANDS: Yep.

THE COURT: Okay. That's otherwise all right?

MR. RANDS: Uh-huh.

THE COURT: That'll be 25. There's some weird capitalization thing going, too, here. I think it's the -- okay. So generally the Plaintiff and the Defendant are capitalized throughout, so I'm going to do that in the -- I don't know. I'm going to fix that so it's all consistent.

So 26, if you find the Plaintiff suffered injuries;

27, in determining the amount of losses.

MR. RANDS: This was another one that we're going to have strike the -- they're trying to slip in the number 3, the past [indiscernible] and vocational laws is in here.

THE COURT: All right.

MR. RANDS: I don't want to open the door on that.

THE COURT: Just to make it consistent, do you have any problem if I take out the Plaintiff's name and just put in The Plaintiff?

MR. CLOWARD: That's fine.

THE COURT: Okay. And for whatever reason it's not

capitalized in the sixth line, so I'm going to fix that. And then -- so that'll be 27;

28, no definite standard or calculation;

29, according to a table of mortality, I will leave his name in here but I'm going to just not all caps it because we don't need to do that. According to the table of mortality, so that will be 29.

Whether any of these elements of damage will be 30.

The Court has given you instructions, that'll be 31.

If during your deliberation, that'll be 32.

If -- it is your duty as jurors, that'll be 33.

When you retire, that'll be instruction 34.

And now you will listen is 35.

All right. Are we anticipating any additional instructions?

MR. RANDS: Not from the Defense, Your Honor.

MR. BOYACK: The only one that we would have is how we want the jurors to be informed about the summary judgment on the wrist. I mean, we referred to it, but do we want to do that in an instruction form?

THE COURT: It's your case.

MR. CLOWARD: We would propose a --

THE COURT: You tell me what you want.

MR. CLOWARD: We would propose a jury instruction that indicates that it is not in dispute -- there is no dispute regarding the wrist treatment which has been determined to be X-dollar amount.

THE COURT: All right. Where would you like to put that?

MR. CLOWARD: I would say after the --

MR. BOYACK: The damages?

THE COURT: Do you have something written up yet?

MR. CLOWARD: No, but I can take five seconds and do that. It'd be handwritten, if that's okay, or I can type it.

THE COURT: No. that's fine.

[Counsel confer]

MR. CLOWARD: This may be a little wordy. That's probably a little wordy.

[Pause]

MR. RANDS: Okay. I guess it says it all.

MR. CLOWARD: You're on board?

MR. RANDS: Yeah. Yeah, go ahead.

MR. CLOWARD: May I approach, Your Honor?

THE COURT: Yes.

MR. CLOWARD: I'm sure you would have some better changes than that.

THE COURT: All right.

[Pause]

THE COURT: All right. So, Mr. Cloward. So it has already been determined that Mr. Morgan injured his left and right wrist as a result of the crash on April 1st, 2014 and that the treatment he received was reasonable and necessary. And then you say and caused by the crash, but I think that's a little redundant of the first --

MR. CLOWDER: Redundant, yeah.

THE COURT: So I'm just going to take that out.

MR. CLOWDER: Okay.

THE COURT: And instead of saying, again it has already been determined, how about if I say: You are instructed the billing amounts of 40,171 for that treatment was usual and customary for the Las Vegas community?

MR. CLOWDER: Yeah.

MR. RANDS: That's fine.

MR. CLOWDER: That's fine.

THE COURT: All right. This is going to mess up my numbers.

MR. RANDS: Yeah. We'll have to do an A anyway.

THE COURT: It's all right. No, I'll just fix it right now because we haven't -- we're not -- go back.

[Pause]

THE COURT: All right. So I'm going to put this -- I'm going to make this 25.

MR. CLOWDER: Perfect.

THE COURT: And then the Plaintiff may not recover will be 26. I also took out the his and just put Plaintiff's instead.

MR. CLOWDER: That's fine.

THE COURT: Yeah. I really don't like using pronouns. It just gets confusing sometimes.

So then if you find the Plaintiff, that will be 27. I fixed the capitalization thing there.

In determining the amount of losses, I'll make that 28.

No definite standard or amount, that will be 29.

According to a table of mortality, that will be 30.

Whether any of these elements, that will be 31.

Court has given you instructions, that will be 32.

If during your deliberation, that will be 33. It is your duty as jurors, that'll be 34.

When you retire, that will be 35.

And 36 will be now you will consider. Okay.

So we should have probably by lunch tomorrow we'll have a final set for you of these, and then I'll just hang onto these couple and we'll add them in as it may, if that becomes necessary during the rest of the trial. I appreciate you all getting the instructions to us [indiscernible] trial. It helps the time because I can see that part first and obviously these were fairly straightforward but it [indiscernible]..

MR. CLOWDER: Okay.

THE COURT: And then you have a nice final set that you can use for closings, too, which is nice. Okay. Thank you, folks. I'll see you tomorrow at --

MR. BOYACK: Ten.

THE COURT: Ten.

[Proceedings adjourned at 4:00 p.m.]

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio-visual recording of the proceeding in the above-entitled case to the best of my ability.

Lee Ann Nussbaum

Lee Ann Nussbaum, Transcriber

Date: February 5, 2018