

# IN THE SUPREME COURT OF THE STATE OF NEVADA

## INDICATE FULL CAPTION:

DARELL L. MOORE and CHARLENE A.  
MOORE,  
Appellants,  
v.  
JASON LASRY, M.D., and TERRY  
BARTIMUS  
Respondents

No. 81659

Electronically Filed  
Oct 16 2020 02:17 p.m.  
Elizabeth A. Brown  
Clerk of Supreme Court  
**DOCKETING STATEMENT  
CIVIL APPEALS**

## GENERAL INFORMATION

Appellants must complete this docketing statement in compliance with NRAP 14(a). The purpose of the docketing statement is to assist the Supreme Court in screening jurisdiction, identifying issues on appeal, assessing presumptive assignment to the Court of Appeals under NRAP 17, scheduling cases for oral argument and settlement conferences, classifying cases for expedited treatment and assignment to the Court of Appeals, and compiling statistical information.

## WARNING

This statement must be completed fully, accurately and on time. NRAP 14(c). The Supreme Court may impose sanctions on counsel or appellant if it appears that the information provided is incomplete or inaccurate. *Id.* Failure to fill out the statement completely or to file it in a timely manner constitutes grounds for the imposition of sanctions, including a fine and/or dismissal of the appeal.

A complete list of the documents that must be attached appears as Question 27 on this docketing statement. Failure to attach all required documents will result in the delay of your appeal and may result in the imposition of sanctions.

This court has noted that when attorneys do not take seriously their obligations under NRAP 14 to complete the docketing statement properly and conscientiously, they waste the valuable judicial resources of this court, making the imposition of sanctions appropriate. *See KDI Sylvan Pools v. Workman*, 107 Nev. 340, 344, 810 P.2d 1217, 1220 (1991). Please use tab dividers to separate any attached documents.

1. Judicial District Eighth Judicial District Department 25  
County Clark County Judge Kathleen E. Delaney  
District Ct. Case No. A-17-766426-C

**2. Attorney filing this docketing statement:**

Attorney Matthew W. Hoffmann, Esq. Telephone 702-562-6000  
Firm Atkinson Watkins & Hoffmann, LLP  
Address 10789 W. Twain Ave., Ste. 100  
Las Vegas, NV 89135

Client(s) Darell L. Moore and Charlene A. Moore

If this is a joint statement by multiple appellants, add the names and addresses of other counsel and the names of their clients on an additional sheet accompanied by a certification that they concur in the filing of this statement.

**3. Attorney(s) representing respondents(s):**

Attorney Chelsea Hueth, Esq. Telephone 702-792-5855  
Firm McBride Hall  
Address 8329 W. Sunset Rd., Ste. 260  
Las Vegas, NV 89113

Client(s) Jason Lasry, M.D.

Attorney Alissa Bestick, Esq. Telephone 702-893-3383  
Firm Lewis Brisbois Bisgaard & Smith, LLP  
Address 6385 S. Rainbow Blvd., Ste. 600  
Las Vegas, NV 89118

Client(s) Fremont Emergency Services (Mandavia), Ltd., and Terry Bartmus, A.P.R.N.

(List additional counsel on separate sheet if necessary)

**4. Nature of disposition below (check all that apply):**

- |   |   |
|---|---|
| <input type="checkbox"/> Judgment after bench trial             | <input type="checkbox"/> Dismissal:                                     |
| <input checked="" type="checkbox"/> Judgment after jury verdict | <input type="checkbox"/> Lack of jurisdiction                           |
| <input type="checkbox"/> Summary judgment                       | <input type="checkbox"/> Failure to state a claim                       |
| <input type="checkbox"/> Default judgment                       | <input type="checkbox"/> Failure to prosecute                           |
| <input type="checkbox"/> Grant/Denial of NRCP 60(b) relief      | <input type="checkbox"/> Other (specify): _____                         |
| <input type="checkbox"/> Grant/Denial of injunction             | <input type="checkbox"/> Divorce Decree:                                |
| <input type="checkbox"/> Grant/Denial of declaratory relief     | <input type="checkbox"/> Original <input type="checkbox"/> Modification |
| <input type="checkbox"/> Review of agency determination         | <input type="checkbox"/> Other disposition (specify): _____             |

**5. Does this appeal raise issues concerning any of the following?**

- ☐ Child Custody
- ☐ Venue
- ☐ Termination of parental rights

**6. Pending and prior proceedings in this court.** List the case name and docket number of all appeals or original proceedings presently or previously pending before this court which are related to this appeal:

**7. Pending and prior proceedings in other courts.** List the case name, number and court of all pending and prior proceedings in other courts which are related to this appeal (e.g., bankruptcy, consolidated or bifurcated proceedings) and their dates of disposition:

**8. Nature of the action.** Briefly describe the nature of the action and the result below:

This is a medical malpractice action resulting from an above-the-knee amputation performed on Appellant Darell L. Moore by Respondents on or about December 25, 2016.

After trial, the Honorable Kathleen Delaney entered a Judgment on Jury Verdict in favor of Respondents on February 13, 2020.

**9. Issues on appeal.** State concisely the principal issue(s) in this appeal (attach separate sheets as necessary):

Appellants are appealing the Order on Plaintiffs' Motion for New Trial filed in district court. The relief granted by the district court was to Respondents by denying Appellants' Motion for New Trial.

Additional information is on the attached sheet.

**10. Pending proceedings in this court raising the same or similar issues.** If you are aware of any proceedings presently pending before this court which raises the same or similar issues raised in this appeal, list the case name and docket numbers and identify the same or similar issue raised:



**11. Constitutional issues.** If this appeal challenges the constitutionality of a statute, and the state, any state agency, or any officer or employee thereof is not a party to this appeal, have you notified the clerk of this court and the attorney general in accordance with NRAP 44 and NRS 30.130?

☒ N/A

☐ Yes

☐ No

If not, explain:

**12. Other issues.** Does this appeal involve any of the following issues?

☐ Reversal of well-settled Nevada precedent (identify the case(s))

☐ An issue arising under the United States and/or Nevada Constitutions

☐ A substantial issue of first impression

☐ An issue of public policy

☐ An issue where en banc consideration is necessary to maintain uniformity of this court's decisions

☐ A ballot question

If so, explain:

**13. Assignment to the Court of Appeals or retention in the Supreme Court.** Briefly set forth whether the matter is presumptively retained by the Supreme Court or assigned to the Court of Appeals under NRAP 17, and cite the subparagraph(s) of the Rule under which the matter falls. If appellant believes that the Supreme Court should retain the case despite its presumptive assignment to the Court of Appeals, identify the specific issue(s) or circumstance(s) that warrant retaining the case, and include an explanation of their importance or significance:

Pursuant to NRAP 17(b)(5) this matter is presumptively assigned to the Court of Appeals as it is in a tort case with a judgment which is lower than \$250,000.00.

Appellant believes that this matter is best addressed by the court of appeals as well settled precedent will support the arguments on appeal. However, nothing in this statement should be taken as a waiver of Appellant's rights to pursue a judgment in an amount greater than \$250,000 if and when a new trial is granted.

**14. Trial.** If this action proceeded to trial, how many days did the trial last? \_\_\_\_\_

Was it a bench or jury trial? Jury Trial

**15. Judicial Disqualification.** Do you intend to file a motion to disqualify or have a justice recuse him/herself from participation in this appeal? If so, which Justice?

No.

## TIMELINESS OF NOTICE OF APPEAL

**16. Date of entry of written judgment or order appealed from** 07/16/2020

If no written judgment or order was filed in the district court, explain the basis for seeking appellate review:

**17. Date written notice of entry of judgment or order was served** 07/16/2020

Was service by:

☐ Delivery

☒ Mail/electronic/fax

**18. If the time for filing the notice of appeal was tolled by a post-judgment motion (NRCP 50(b), 52(b), or 59)**

(a) Specify the type of motion, the date and method of service of the motion, and the date of filing.

☐ NRCP 50(b)      Date of filing \_\_\_\_\_

☐ NRCP 52(b)      Date of filing \_\_\_\_\_

☒ NRCP 59      Date of filing 04/07/2020

**NOTE: Motions made pursuant to NRCP 60 or motions for rehearing or reconsideration may toll the time for filing a notice of appeal. See AA Primo Builders v. Washington, 126 Nev. \_\_\_\_, 245 P.3d 1190 (2010).**

(b) Date of entry of written order resolving tolling motion 07/15/2020

(c) Date written notice of entry of order resolving tolling motion was served 07/16/2020

Was service by:

☐ Delivery

☒ Mail

**19. Date notice of appeal filed** 08/14/2020

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If more than one party has appealed from the judgment or order, list the date each notice of appeal was filed and identify by name the party filing the notice of appeal:

**20. Specify statute or rule governing the time limit for filing the notice of appeal, e.g., NRAP 4(a) or other**

NRAP 4(a)

---

**SUBSTANTIVE APPEALABILITY**

**21. Specify the statute or other authority granting this court jurisdiction to review the judgment or order appealed from:**

(a)

☐ NRAP 3A(b)(1)

☐ NRS 38.205

☒ NRAP 3A(b)(2)

☐ NRS 233B.150

☐ NRAP 3A(b)(3)

☐ NRS 703.376

☐ Other (specify) \_\_\_\_\_

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(b) Explain how each authority provides a basis for appeal from the judgment or order:

The Appellant's primary contention on appeal is that the District Court abused its discretion by denying a motion for new trial despite evidentiary errors which necessarily prejudiced the jury which is appealable under NRAP 3A(b)(2).

**22. List all parties involved in the action or consolidated actions in the district court:**

(a) Parties:

Darell L. Moore

Charlene A. Moore

Jason Lasry, M.D.

Terry Bartmus, RN, APRN

(b) If all parties in the district court are not parties to this appeal, explain in detail why those parties are not involved in this appeal, *e.g.*, formally dismissed, not served, or other:

Fremont Emergency Services (Mandavia), LTD. was formally dismissed on 12/18/2019.

**23. Give a brief description (3 to 5 words) of each party's separate claims, counterclaims, cross-claims, or third-party claims and the date of formal disposition of each claim.**

Professional negligence

Negligent hiring, training and supervision

Corporate negligence/vicarious liability

All claims were resolved by jury verdict on 03/10/2020. Fremont Emergency Services was previously dismissed on 12/18/2019.

**24. Did the judgment or order appealed from adjudicate ALL the claims alleged below and the rights and liabilities of ALL the parties to the action or consolidated actions below?**

☒ Yes

☐ No

**25. If you answered "No" to question 24, complete the following:**

(a) Specify the claims remaining pending below:

N/A

(b) Specify the parties remaining below:

(c) Did the district court certify the judgment or order appealed from as a final judgment pursuant to NRCP 54(b)?

☐ Yes

☐ No

(d) Did the district court make an express determination, pursuant to NRCP 54(b), that there is no just reason for delay and an express direction for the entry of judgment?

☐ Yes

☐ No

**26. If you answered "No" to any part of question 25, explain the basis for seeking appellate review (*e.g.*, order is independently appealable under NRAP 3A(b)):**

**27. Attach file-stamped copies of the following documents:**

- The latest-filed complaint, counterclaims, cross-claims, and third-party claims
- Any tolling motion(s) and order(s) resolving tolling motion(s)
- Orders of NRCP 41(a) dismissals formally resolving each claim, counterclaims, cross-claims and/or third-party claims asserted in the action or consolidated action below, even if not at issue on appeal
- Any other order challenged on appeal
- Notices of entry for each attached order

## VERIFICATION

I declare under penalty of perjury that I have read this docketing statement, that the information provided in this docketing statement is true and complete to the best of my knowledge, information and belief, and that I have attached all required documents to this docketing statement.

Darell E. Moore & Charlene A. Moore  
Name of appellant

Matthew W. Hoffmann, Esq.  
Name of counsel of record

10/16/2020  
Date

/s/ Matthew W. Hoffmann, Esq.  
Signature of counsel of record

Nevada, County of Clark  
State and county where signed

## CERTIFICATE OF SERVICE

I certify that on the 16th day of October, 2020, I served a copy of this completed docketing statement upon all counsel of record:

☐ By personally serving it upon him/her; or

☒ By mailing it by first class mail with sufficient postage prepaid to the following address(es): (NOTE: If all names and addresses cannot fit below, please list names below and attach a separate sheet with the addresses.)

Robert C. McBride, Esq.  
Nevada Bar No. 7082  
Chelsea Hueth, Esq.  
Nevada Bar No. 10904  
MCBRIDE HALL  
8329 W. Sunset Road, Suite 260  
Las Vegas, NV 89113  
Attorneys for Respondent Jason Lasry, M.D.

Dated this 16th day of October, 2020

/s/ Erika Jimenez  
Signature

**ADDITIONAL SHEET**



IN THE SUPREME COURT OF THE STATE OF NEVADA

DARELL L. MOORE and CHARLENE A.	)	
MOORE, individually and as husband and	)	
wife,	)	
Appellants;	)	
v.	)	No. 81659
	)	
JASON LASRY, M.D., individually;	)	DOCKETING STATEMENT
TERRY BARTMUS, RN, APRN,	)	CIVIL APPEALS
	)	
Respondents.	)	
_____	)	

**SEPARATE SHEET WITH ADDITIONAL INFORMATION**

**2. Attorney Filing This Docketing Statement**

In addition to Matthew W. Hoffmann, Esq., the following attorneys serve as co-counsel for the Appellants:

E. Breen Arntz, Esq.  
Nevada Bar No. 3853  
5545 Mountain Vista, Ste. E  
Las Vegas, NV 89120

I, E. Breen Arntz., Esq. concur in the filing of this Docketing Statement.  
/s/ E. Breen Arntz, Esq. DATE: 10/16/2020

**9. Issues on Appeal:**

Failure to grant Plaintiffs' NRCP 59 Motion for New Trial after entering Judgment on Jury Verdict in favor of Respondents. This appeal is based on two instances of error by the district court and the attorney misconduct of Keith Weaver, Esq., counsel for Respondent/Defendant Terri Bartmus.

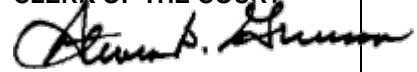
The district court erred when, over Plaintiffs' counsel's objections, it allowed defense counsel, Mr. Weaver, to question Plaintiffs' expert witness about a document that had not been disclosed pursuant to NRCP 16.1. The document went only to the witness' reputation and did not relate to the treatment at issue. Defense counsel misrepresented the substance of the document to the jury in a clear attempt to misinform. The district court did not require production of the document, making it impossible for Plaintiffs' counsel to rehabilitate their witness.

The district court further erred when it excluded Dr. Wiencek when Plaintiffs' counsel called him as a witness even though Defendant Lasry's counsel had referenced Dr. Wiencek as a potential witness during his introduction to the case and Dr. Wiencek was identified as a witness in all thirteen (13) supplemental disclosures pursuant to NRCP 16.1 with the appropriate description of his anticipated testimony as a treating physician. The notes, records and treatment by Dr. Wiencek became such a focal point of the evidence at trial that to preclude him from testifying under the circumstances was an abuse of the district court's discretion.

**Additional addresses for the Certificate of service:**

Keith A. Weaver, Esq.  
Nevada Bar No. 10271  
Alissa Bestick, Esq.  
Nevada Bar No. 14979C  
LEWIS BRISBOIS BISGAARD & SMITH LLP  
6385 S. Rainbow Blvd., Suite 600  
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*Attorneys for Respondents Fremont Emergency Services (Mandavia), Ltd.  
And Terry Bartmus, A.P.R.N.*

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*Co-Counsel for Appellants*



SAC  
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Facsimile: 702-562-6066  
*Attorneys for Plaintiffs*

**DISTRICT COURT**  
**CLARK COUNTY, NEVADA**

DARELL L. MOORE and CHARLENE A.  
MOORE, individually and as husband and  
wife;

Plaintiffs,

v.

JASON LASRY, M.D., individually;  
FREMONT EMERGENCY SERVICES  
(MANDAVIA), LTD.; TERRY BARTMUS,  
RN, APRN; and DOES I through X, inclusive;  
and ROE CORPORATIONS I through V,  
inclusive;

Defendants.

CASE NO.: A-17-766426-C

DEPT. NO.: Dept. 25

**SECOND AMENDED COMPLAINT**  
**MEDICAL MALPRACTICE**

**EXEMPT FROM ARBITRATION**

COME NOW, Plaintiffs, DARELL L. MOORE and CHARLENE A. MOORE, individually  
and as husband and wife, by and through their attorneys of record, MATTHEW W. HOFFMANN,  
ESQ., of the law firm of ATKINSON WATKINS & HOFFMANN, LLP, and for their complaint  
on file herein allege as follows:

...

...

...

...

**I.**

## **GENERAL ALLEGATIONS**

1  
2           1.       Plaintiff, DARELL L. MOORE, individually (hereinafter referred to as  
3 “DARELL”), is, and at all times mentioned herein was a resident of the County of Clark, State of  
4 Nevada.

5           2.       Plaintiff, CHARLENE A. MOORE, individually (hereinafter referred to as  
6 “CHARLENE”), is, and at all times mentioned herein was a resident of the County of Clark, State  
7 of Nevada.

8           3.       Defendant, JASON LASRY, M.D. (hereinafter referred to as “Defendant LASRY”),  
9 individually, is and was at all times relevant hereto, a physician licensed to practice medicine in the  
10 State of Nevada pursuant to NRS Chapters 630 and 449.

11           4.       Defendant, FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.  
12 (hereinafter referred to as “Defendant FREMONT”), is and was at all times hereto, a Nevada  
13 Corporation duly authorized to conduct business in the State of Nevada and was responsible for the  
14 actions of their employees and/or agents, including but not limited to Defendant LASRY, and was  
15 further responsible for the hiring, training, and supervision of said employees and/or agents,  
16 including but not limited to Defendant LASRY, at all times relevant hereto.

17           5.       Defendant, TERRY BARTMUS, RN, APRN (hereinafter referred to as “Defendant  
18 BARTMUS”), individually, is and was at all times relevant hereto, a Registered Nurse and Advance  
19 Practice Registered Nurse employed by Defendants FREMONT and/or a presently unknown  
20 nursing company, and licensed to practice nursing pursuant to NRS Chapter 449.

21           6.       At all relevant times the Defendants, DOES I through X, inclusive, were and are  
22 now physicians, surgeons, registered nurses, licensed occasional nurses, practical nurses, registered  
23 technicians, psychologists, aides, technicians, attendants, physician assistants, pharmacists,  
24 pharmacy technicians, or paramedical personnel holding themselves out as duly licensed to practice  
25 their professions under and by virtue of laws of the State of Nevada and are now engaged in the  
26 practice of their professions in the State of Nevada; the true names and capacities, whether  
27 individual, corporate, associate, or otherwise of Defendants DOES I through X, inclusive, and ROE  
28 CORPORATIONS I through X, inclusive, are presently unknown to the Plaintiffs, who therefore

1 sue those Defendants by such fictitious names; the Plaintiffs are informed and do believe, and  
2 thereupon allege that each of the Defendants sued herein as DOES I through X are responsible in  
3 some manner for the events and happenings herein referred to, which thereby proximately caused  
4 the injuries and damages to the Plaintiffs as alleged herein; that when the true names and capacities  
5 of such Defendants become known, Plaintiffs will ask leave to amend this Complaint to insert the  
6 true names, identities and capacities, together with proper charges and allegations.

7 7. At all relevant times, Defendants, ROE CORPORATIONS, I through X, were and  
8 now are corporations, firms, partnerships, associations, or other legal entities, involved with the  
9 employment of the Defendant doctors and nurses named herein, including but not limited to the  
10 employment of Defendant BARTMUS, and were further involved with the care, treatment,  
11 diagnosis, surgery and/or other provision of medical care to the Plaintiffs herein; that the true  
12 names, identities or capacities whether individual, corporate, associate or otherwise of the  
13 Defendants, ROE CORPORATIONS I through X, inclusive are presently unknown to Plaintiffs,  
14 who therefore sue said Defendants by such fictitious names; that the Plaintiffs are informed and do  
15 believe and thereupon allege that each of the Defendants sued herein as ROE CORPORATIONS I  
16 through X are responsible in some manner for the events and happenings herein referred to, which  
17 thereby proximately caused the injuries and damages to the Plaintiffs alleged herein; that when  
18 their true names and capacities of such Defendants become known, Plaintiffs will ask leave of this  
19 Court to amend this Complaint to insert the true names, identities and capacities, together with  
20 proper charges and allegations.

21 8. At all relevant times, Defendants, and each of them, were the agents, ostensible  
22 agents, servants, employees, employers, partners, co-owners and/or joint venturers of each other  
23 and of their co-defendants, and were acting within the color, purpose and scope of their  
24 employment, agency, ownership and/or joint ventures.

25 9. Plaintiffs' claims arise out of errors and omissions by Defendant LASRY, while in  
26 the course and scope of his employment with Defendant FREMONT; Defendant BARTMUS, while  
27 in the course and scope of her employment with Defendant FREMONT and/or a presently unknown  
28 nursing company; Defendant FREMONT and/or its employees, agents and/or servants, and their

1 failure to appropriately monitor, inform, document, and/or implement appropriate medical  
2 treatment to Plaintiff DARELL MOORE.

3 10. The combined failures of the Defendants proximately led to Plaintiff DARELL  
4 MOORE requiring an above-the-knee amputation of the left lower extremity.

5 11. On or about December 25, 2016, DARELL presented to the emergency department  
6 at Dignity Health dba St. Rose Hospital - San Martin (hereafter, "St. Rose") with a one day history  
7 of pain in the calf area of his left leg. He was noted to have a prior history of deep vein thrombosis  
8 and a prior femoral and/or popliteal artery bypass surgery on December 11, 2014.

9 12. The evaluation at the emergency department consisted of routine laboratory studies  
10 and a venous duplex ultrasound of the left leg.

11 13. The ultrasound showed occlusion of the left femoral-popliteal arterial bypass graft.

12 14. No further treatment was recommended in response to the left arterial occlusion and  
13 the differential diagnosis did not include arterial occlusion despite DARELL's history of a prior  
14 femoral-popliteal bypass and despite the fact DARELL reported pain increased with walking.

15 15. DARELL was discharged with aftercare instructions for musculoskeletal pain as  
16 well as hypertension.

17 16. On December 28, 2016, DARELL returned to the emergency department at St. Rose.

18 17. At that time, DARELL reported persistent and increasing left leg pain. An arterial  
19 duplex ultrasound of the left leg was performed and once again showed occlusion of the left leg  
20 graft vasculature with no flow detected in the left posterior tibial anterior tibial or dorsalis pedis  
21 arteries.

22 18. DARELL was noted to have an ischemic lower extremity and started on  
23 anticoagulants including heparin and tissue plasminogen activator.

24 19. DARELL was eventually admitted to the Intensive Care Unit in critical condition.

25 20. On January 2, 2017, DARELL underwent an above-the-knee amputation of his left  
26 lower extremity under the care of Holman Chan, M.D. He was discharged on January 5, 2017.

27 21. DARELL's injuries and medical treatment were preventable. The venous ultrasound  
28 performed at the emergency department at St. Rose on December 25, 2016 showed an occlusion of

1 the left femoral-popliteal arterial bypass graft, despite being the incorrect ultrasound to order.  
2 Defendants LASRY and BARTMUS failed to recognize the obvious occlusion recognized by the  
3 Radiologist and failed to properly address DARELL's condition, thus leading to above-the-knee  
4 amputation of his left lower extremity.

5 22. Furthermore, Defendant FREMONT EMERGENCY SERVICES (MANDAVIA),  
6 LTD., failed to properly hire, train, and supervise their employees and/or agents and failed to  
7 provide adequate, sufficient and reasonable staffing protocols and procedures.

8 23. As a direct and proximate result of Defendants' combined negligence, DARELL  
9 experienced pain, suffering, and medical treatment, with said suffering and medical treatment  
10 continuing at the present time.

11 24. In support of Plaintiffs' allegations of medical malpractice, Plaintiffs submit the  
12 merit affidavit/report of R. Scott Jacobs, M.D., attached hereto as **Exhibit 1** and R. Scott Jacobs,  
13 M.D.'s supplement to that report attached hereto as **Exhibit 2**.

14 **SPECIFIC ALLEGATIONS OF NEGLIGENCE**

15 **1st CAUSE OF ACTION**  
16 **PROFESSIONAL NEGLIGENCE**  
**(As Against JASON LASRY, M.D.)**

17 25. Plaintiffs hereby adopt and incorporate by reference Paragraphs 1 through 24 of this  
18 complaint and make them a part of the instant cause of action as though fully set forth herein.

19 26. Defendant, JASON LASRY, M.D., fell below the standard of care of health care  
20 providers who possess the degree of professional learning, skill and ability of other similar health  
21 care providers by negligently failing to order appropriate testing, failing to follow-up on ultrasound  
22 results, failing to recognize and treat DARELL's presenting medical condition, and discharging  
23 DARELL without addressing his presenting medical condition.

24 27. Defendant, JASON LASRY, M.D., fell below the standard of care by falling below  
25 his respective professional degree of learning, skill and exercise of good judgment.

26 28. At all times mentioned herein, said Defendant knew, or in the exercise of reasonable  
27 care should have known, that the providing of medical care, treatment and advice was of such a  
28 nature that, if it was not properly given, it was likely to injure the person to whom it was given.

29. As a proximate result of the negligence of said Defendant, by failing to appropriately evaluate, diagnose, care, treat and respond to DARELL's condition, it was allowed to proceed and progress to such a stage as to place him at risk and caused him to suffer.

30. As a proximate result of the negligence of said Defendant, by failing to appropriately care and treat DARELL, he had to endure extreme pain and suffering.

31. As a proximate result of the negligence of said Defendant, DARELL incurred medical and hospital expenses, the full extent of said expenses are not known to Plaintiffs, and leave is requested of this Court to amend this complaint to conform to proof at time of trial.

32. As a further proximate result of the negligence of said Defendant, Plaintiffs, as husband and wife, have and will experience a loss of consortium, and Plaintiffs seek compensatory damages therefor.

33. That as a further proximate result of said Defendant's negligent acts and/or omissions, Plaintiffs were forced to retain the services of attorneys in this matter and therefore seek reimbursement for attorneys' fees and costs.

**2nd CAUSE OF ACTION**  
**(NEGLIGENT HIRING, TRAINING AND SUPERVISION**  
**(As Against FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.)**

34. Plaintiffs hereby adopt and incorporate by reference Paragraphs 1 through 33 of this complaint and make them a part of the instant cause of action as though fully set forth herein.

35. Defendant FREMONT's employees, agents and/or servants were acting in the scope of their employment, under Defendant's control, and in furtherance of said Defendant's interest, and at all times their actions caused DARELL's injuries.

36. Defendant FREMONT is vicariously liable for damages resulting from its agents' and/or employees' and/or servants' negligent actions and omissions regarding DARELL. Said Defendant's conduct in negligently hiring, and failing to train, supervise and/or correct the negligence of its employees and/or agents demonstrated disregard for the safety of its patients.

37. Defendant FREMONT failed to adequately hire, train, and/or supervise their agents and/or employees, including but not limited to Defendants LASRY and BARTMUS, and failed to provide adequate, sufficient and reasonable staffing protocols and procedures.



38. As a direct result of said Defendant's acts and/or omissions, DARELL's condition was left undiagnosed and untreated leading to the above-the-knee amputation of his left lower extremity.

39. As a proximate result of the negligence of said Defendant, DARELL had to endure extreme pain and suffering.

40. As a proximate result of the negligence of said Defendant, DARELL incurred medical and hospital expenses, the full extent of said expenses are not known to Plaintiffs, and leave is requested of this Court to amend this complaint to conform to proof at time of trial.

41. As a further proximate result of the negligence of said Defendant, Plaintiffs, as husband and wife, have and will experience a loss of consortium, and Plaintiffs seek compensatory damages therefor.

42. That as a further proximate result of said Defendant's negligent acts and/or omissions, Plaintiffs were forced to retain the services of attorneys in this matter and therefore seek reimbursement for attorneys' fees and costs.

**3rd CAUSE OF ACTION**  
**CORPORATE NEGLIGENCE/VICARIOUS LIABILITY**  
**(As Against FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.)**

43. Plaintiffs hereby adopt and incorporate by reference Paragraphs 1 through 42 of this complaint and make them a part of the instant cause of action as though fully set forth herein.

44. Defendant FREMONT had a duty to exercise due care in the selection, training, supervision, oversight, direction, retention and control of its employees and/or agents, retained by it to perform and provide services.

45. Defendant FREMONT breached the above-referenced duty when they negligently, carelessly, and recklessly hired, trained, supervised, oversaw, directed and/or retained their personnel.

46. As a proximate result of the negligence of said Defendant's employees and/or agents, by failing to appropriately care and treat DARELL, he had to endure extreme pain and suffering.

47. As a proximate result of the negligence of said Defendant, DARELL incurred

1 medical and hospital expenses, the full extent of said expenses are not known to Plaintiffs, and  
2 leave is requested of this Court to amend this complaint to conform to proof at time of trial.

3 48. As a further proximate result of the negligence of said Defendant, Plaintiffs, as  
4 husband and wife, have and will experience a loss of consortium, and Plaintiffs seek compensatory  
5 damages therefor.

6 49. That as a further proximate result of said Defendant's negligent acts and/or  
7 omissions, Plaintiffs were forced to retain the services of attorneys in this matter and therefore seek  
8 reimbursement for attorneys' fees and costs.

9 **4th CAUSE OF ACTION**  
10 **PROFESSIONAL NEGLIGENCE**  
**(As Against TERRY BARTMUS, RN, APRN)**

11 50. Plaintiffs hereby adopt and incorporate by reference Paragraphs 1 through 49 of this  
12 complaint and make them a part of the instant cause of action as though fully set forth herein.

13 51. Defendant, TERRY BARTMUS, RN, APRN, fell below the standard of care of  
14 health care providers who possess the degree of professional learning, skill and ability of other  
15 similar health care providers by negligently failing to ensure appropriate testing was ordered;  
16 failing to properly report and follow-up on ultrasound results; failing to recognize and ensure  
17 DARELL'S presenting medical condition was brought to the attention of other medical providers  
18 for treatment; and allowing DARELL to be discharged without addressing his presenting medical  
19 condition.

20 52. Defendant, TERRY BARTMUS, RN, APRN, fell below the standard of care by  
21 falling below her respective professional degree of learning, skill and exercise of good judgment.

22 53. At all times mentioned herein, said Defendant knew, or in the exercise of reasonable  
23 care should have known, that the providing of medical care, treatment and advice was of such a  
24 nature that, if it was not properly given, it was likely to injure the person to whom it was given.

25 54. As a proximate result of the negligence of said Defendant, by failing to appropriately  
26 evaluate, diagnose, care, treat, report, monitor, and respond to DARELL's condition, it was allowed  
27 to proceed and progress to such a stage as to place him at risk and caused him to suffer.

28 55. As a proximate result of the negligence of said Defendant, by failing to appropriately

1 care and treat DARELL, he had to endure extreme pain and suffering.

2 56. As a proximate result of the negligence of said Defendant, DARELL incurred  
3 medical and hospital expenses, the full extent of said expenses are not known to Plaintiffs, and  
4 leave is requested of this Court to amend this complaint to conform to proof at time of trial.

5 57. As a further proximate result of the negligence of said Defendant, Plaintiffs, as  
6 husband and wife, have and will experience a loss of consortium, and Plaintiffs seek compensatory  
7 damages therefor.

8 58. That as a further proximate result of said Defendant's negligent acts and/or  
9 omissions, Plaintiffs were forced to retain the services of attorneys in this matter and therefore seek  
10 reimbursement for attorneys' fees and costs.

11 WHEREFORE, Plaintiffs pray for judgment against Defendants, and each of them, as  
12 follows:

- 13 1. For medical special damages and compensatory damages against Defendants, for an  
14 amount in excess of \$15,000, plus pre-judgment and post-judgment interest thereon  
15 at the highest legal rate;
- 16 2. For an award of Plaintiffs' attorneys' fees and costs;
- 17 3. For such other and further relief as this Court deems just and proper.

18 DATED this 29<sup>th</sup> day of October, 2019.

20 ATKINSON WATKINS HOFFMANN LLP

21 By: /s/ Matthew W. Hoffmann, Esq.  
22 MATTHEW W. HOFFMANN, ESQ.  
23 Nevada Bar No. 009061  
24 10789 W. Twain Avenue, Suite 100  
25 Las Vegas, NV 89135  
26 *Attorneys for Plaintiffs*  
27  
28

**CERTIFICATE OF SERVICE**

I hereby certify that I am an employee of ATKINSON WATKINS & HOFFMANN, LLP and that on the 29<sup>th</sup> day of October, 2019, I caused to be served via Odyssey, the Court's mandatory efilings/eservice system, a true and correct copy of the document described herein.

**Document Served:**        **SECOND AMENDED COMPLAINT**  
   **MEDICAL MALPRACTICE**

Chelsea Hueth, Esq.  
Nevada Bar No. 10904  
Anna Karabachev, Esq.  
Nevada Bar No. 14387  
CARROLL, KELLY, TROTTER, FRANZEN,  
MCBRIDE & PEABODY  
8329 W. Sunset Road, Suite 260  
Las Vegas, NV 89113  
*Attorneys for Defendant Jason Lasry, M.D.*

Keith A. Weaver, Esq.  
Nevada Bar No. 10271  
Bianca Gonzalez, Esq.  
Nevada Bar No. 14529  
LEWIS BRISBOIS BISGAARD & SMITH LLP  
6385 S. Rainbow Blvd., Suite 600  
Las Vegas, NV 89118  
*Attorneys for Defendants Fremont Emergency Services (Mandavia), Ltd.  
and Terry Bartmus, A.P.R.N.*

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Las Vegas, NV 89120  
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*Co-Counsel for Plaintiffs*

/s/ Erika Jimenez

An Employee of ATKINSON WATKINS & HOFFMANN, LLP

# EXHIBIT 1

**R. SCOTT JACOBS, M.D. FAAEM**  
**1669 TORRANCE STREET**  
**SAN DIEGO, CALIFORNIA 92103**  
**DECEMBER 8, 2017**

Matthew Hoffman  
Atkinson & Watkins, LLP  
10789 W. Twain Avenue, Suite 100  
Las Vegas, NV 89135

Dear Mr. Hoffman:

I have reviewed the records, reports and other materials that your office supplied to me regarding Darell Moore. This letter is a summary of my qualifications, opinions, and conclusions.

I am a physician and have been licensed to practice medicine in California since 1975. I am board certified in Emergency Medicine and have been since 1983. I have practiced Emergency Medicine for over thirty years and since 1984 have been at Sharp Memorial Hospital in San Diego, California. I am very familiar with the pathophysiology involved in this case and am qualified to render an expert opinion. My current curriculum vitae is attached hereto.

The cases in which I have given testimony during the past four years are:

2013	Charles Thiede v. Stephen Johnson, et al.	Huron County, MI
2013	Ford Cutler v. Ronald A. Sparschu et al.	Genesee County, MI
2013	Lydell Burt v. Sheriff Paul Bailey et al.	U.S. Southern MI
2013	Rachel Hegler v. Port Huron Hospital et al.	St. Clair County, MI
2014	Nancy Warner v. Henry Ford Health System et al.	Wayne County, MI
2014	Jeffrey Frampton v. Northland Pain Consultants et al.	Clay County, MO
2015	Julie Szatkowski v. Metropolitan Hospital et at.	Kent County, MI
2015	Sharon Geisler v. Specialized Assistance Services	Cook County, IL
2015	Joseph Cartwright v. Dr. Sinem Sherifali	Wayne County, MI
2015	Kimberly Shaver v. Dignity Health et al.	Clark County, NV
2016	Taylor-Laryea v. Genesis Regional Medical Center et al.	Genesis County, MI
2016	Terrance McClellan v. William Backus Hospital et al.	New London, CT

My fees for consulting services are as follows:

Review of materials	\$400.00 per hour
Deposition testimony	\$600.00 per hour
Trial testimony	\$600.00 per hour

There is a two hour minimum charge for deposition or trial testimony

As basis for forming my opinions, I have reviewed the following materials:

Records of Darell Moore from St. Rose Dominican Dec. 25, 2016

Records of Darell Moore from St. Rose Dominican Dec. 28, 2016 to Jan. 5, 2017

Records of Darell Moore from Advanced Orthotics and Prosthetics

My review of the records indicates that Mr. Moore presented to the Emergency Department at St. Rose Dominican Hospital on Dec. 25, 2016. He was seen by Dr. Jason Lasry and/or Terry Bartmus and was found to have a one day history of pain in the calf area of his left leg. He was noted also to have been walking more than usual in the prior two days and to have a past history of deep vein thrombosis and to be taking the anticoagulant Xarelto. Additionally, Amee Kuchinsky R.N. documented that Mr. Moore had a history of femoral and/or popliteal artery bypass on Dec. 11, 2014 and to have a history of an abdominal aortic aneurysm.

Mr. Moore's evaluation in the Emergency Department that day consisted of routine laboratory studies and a venous duplex ultrasound of the left leg. The laboratory studies were non-diagnostic and the venous ultrasound demonstrated no venous occlusion, but did show occlusion of the left femoral-popliteal arterial bypass graft. Nonetheless, Dr. Lasry and/or Terry Bartmus apparently felt comfortable that this study did not merit further immediate treatment and discharged Mr. Moore with aftercare instructions on musculoskeletal pain as well as hypertension. Of note, the differential diagnosis included deep vein thrombosis, arthritis, sprain, and strain, but did not include arterial occlusion despite Mr. Moore's history of a prior femoral-popliteal bypass and despite the fact that Mr. Moore reported pain increased with walking.

Mr. Moore returned to the Emergency Department at St. Rose Dominican on Dec. 28, 2016 at which time he was seen by Dr. Stan Liu. He complained of persistent and increasing left leg pain and was evaluated with studies that included an arterial duplex ultrasound of the left leg which again showed occlusion of the left leg graft vasculature with no flow detected in the left posterior tibial anterior tibial or dorsalis pedis arteries. He was noted to have an ischemic lower extremity and started on anticoagulants including heparin and tissue plasminogen activator (TPA). He was seen by interventional radiology for placement of an arterial catheter above the occlusion. This was done so that the TPA could be administered directly to the occluded area. Mr. Moore was subsequently admitted to the ICU in critical condition. Despite these measures, his leg was too ischemic to be salvaged and he eventually required an above the knee (AK) amputation of the lower extremity. He had some post-operative complications, and was eventually discharged January 5, 2017.

It is my professional opinion that Dr. Jason Lasry and/or Terry Bartmus were negligent in the care of Darell Moore in several respects. The history as documented does not convincingly



demonstrate that they were aware that Mr. Moore had undergone a previous femoral popliteal arterial bypass. Although they did document Mr. Moore's history of prior deep venous thrombosis and history of taking Xarelto, they made no comment about his past bypass. In addition, Dr. Lasry and/or Terry Bartmus documented a differential diagnosis that included deep vein thrombosis, arthritis, sprain and strain, but importantly, did not include the possibility of arterial insufficiency. Mr. Moore described pain with increased walking and this is often from muscle ischemia or claudication which is a classic symptom of arterial vascular insufficiency.

This erroneous thought process was further compounded by ordering a venous ultrasound and excluding an arterial study. Both arterial and venous studies can be performed ultrasonically and can be very easily combined when the patient is having an ultrasound. An arterial ultrasound was, in fact, the study that diagnosed Mr. Moore when he returned with an ischemic limb on December 28. Had an arterial ultrasound been performed on Dec. 25, 2016, certainly the diagnosis of acute arterial occlusion should have been made and hospitalization and appropriate therapy undertaken.

Even more perplexing, however, is Dr. Lasry's and/or Terry Bartmus' failure to act upon the findings that were present on the venous ultrasound performed Dec. 25. Although the study does demonstrate no evidence of venous occlusion or DVT, the radiologist comments specifically that the left femoral-popliteal graft appears occluded. This finding should have been alarming enough to cause Dr. Lasry and/or Terry Bartmus to either order further diagnostic studies such as an arterial ultrasound or arteriogram or to admit Mr. Moore for attempts at revascularization. Dr. Lasry in his medical teaching addendum commented that the ultrasound showed arterial occlusion with good distal perfusion. However, it should be noted, that the radiologist did not comment on distal perfusion and it would be unlikely that a venous ultrasound would demonstrate distal perfusion. If "good distal perfusion" was meant as a clinical assessment, the standard of care requires the physician to document the clinical assessment including, at least, extremity warmth and pulses.

Dr. Lasry's and/or Terry Bartmus' incomplete assessment and lack of understanding of Mr. Moore's disease process led to Mr. Moore being discharged on Dec. 25 with limited and inadequate follow-up. He was diagnosed with "musculoskeletal leg pain" and given instructions to make a routine follow-up appointment with his primary care provider.

Mr. Moore was clearly suffering from an ischemic lower extremity at the time he presented to the Emergency Department at St. Rose on December 25, 2016. He had a history of a femoral-popliteal bypass and it should have been apparent to any reasonable and prudent physician that re-occlusion was a real possibility. In fact, the radiologist's reading on the ultrasound performed that day literally spells out the diagnosis. Despite that, Mr. Moore was discharged on Dec. 25, and never advised that he had a condition that required emergent or urgent treatment.



Finally, it is also my opinion that the delay in the treatment of Mr. Moore caused by his being discharged on Dec. 25, led directly to the progressive ischemia of his left leg and ultimately to his subsequent need for an above the knee amputation of his leg. It is well known that an acutely ischemic limb needs to have its blood supply restored within six hours in order to preserve an intact limb. Although this time frame is somewhat looser in the circumstance of subacute arterial occlusion or partial occlusion one principle remains constant. The sooner that revascularization is preformed the better the results and the less disability ensues.

The fact that there was a three day delay in diagnosing and treating Mr. Moore meant that his leg was significantly more ischemic and that there was substantially more devitalized and necrotic tissue. Areas that would have been amenable to restored blood flow on Dec. 25 were no longer viable on Dec. 28, because the tissue had died in the intervening three days. Had the treatment including heparin and TPA that was administered on Dec. 28 been initiated on Dec. 25, it is my opinion that Mr. Moore's leg could have been salvaged and that certainly he would not have required an above the knee amputation.

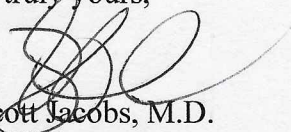
In summary, it is my opinion that Dr. Lasry, Terry Bartmus, and the staff at St. Rose Dominican Hospital were negligent in the treatment of Mr. Moore in several respects. Dr. Lasry's and/or Terry Bartmus' initial error was in fixating on venous vascular problem as the cause of Mr. Moore's symptoms. They appear to have excluded the fact that he had had a previous femoral-popliteal bypass as increasing the possibility that he had an arterial occlusion. Their differential diagnosis included deep vein thrombosis, but excluded arterial occlusion. This error was then compounded by ordering only a venous ultrasound study and not an arterial study. Even with these errors, however, they should have realized the diagnosis was arterial occlusion, because the venous ultrasound demonstrated complete occlusion of the popliteal artery graft. The fact that this significant finding was ignored again demonstrates Dr. Lasry's and/or Terry Bartmus tunnel vision in only considering venous problems as the etiology of Mr. Moore's symptoms.

Finally, it is my opinion that had Mr. Moore been diagnosed with arterial occlusion and started on treatment December 25, 2016 that his outcome would have been significantly improved. It is likely that his leg could have been successfully revascularized and that he would not have required an amputation of the leg. It is also certain that had appropriate treatment been initiated on December 25, that any procedure required in treating Mr. Moore would not have been as invasive nor as drastic.

I reserve the right to amend and supplement my findings and opinions in this report based on any additional, testing, or information which may provided to me hereafter. All of the opinions expressed herein are stated to a reasonable degree of medical certainty. Further, I base these conclusions not only on the aforementioned documentation, but also on my education, training and over thirty years of experience in the active practice of Emergency Medicine in an

acute care setting. During that time, I have cared for perhaps 100,000 patients including thousands with ischemia and hundreds with ischemic limbs.

Very truly yours,


A handwritten signature in dark ink, appearing to be 'R. Scott Jacobs', with a long, sweeping horizontal line extending to the right.

R. Scott Jacobs, M.D.



**CALIFORNIA JURAT WITH AFFIANT STATEMENT****GOVERNMENT CODE § 8202**

- ☒ See Attached Document (Notary to cross out lines 1–6 below)  
☐ See Statement Below (Lines 1–6 to be completed only by document signer[s], *not* Notary)

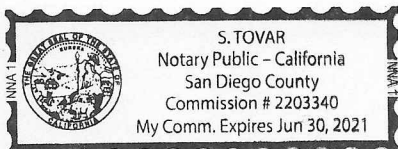
  
Signature of Document Signer No. 1\_\_\_\_\_  
Signature of Document Signer No. 2 (if any)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California

County of San Diego

Subscribed and sworn to (or affirmed) before me

on this 11<sup>th</sup> day of December, 2017,  
by                      Date                      Month                      Year(1) Russell Scott Jacobs(and (2) \_\_\_\_\_),  
Name(s) of Signer(s)proved to me on the basis of satisfactory evidence  
to be the person(s) who appeared before me.Signature \_\_\_\_\_  
Signature of Notary Public

Seal  
Place Notary Seal Above

**OPTIONAL**

Though this section is optional, completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

**Description of Attached Document**

Title or Type of Document: \_\_\_\_\_ Document Date: \_\_\_\_\_

Number of Pages: \_\_\_\_\_ Signer(s) Other Than Named Above: \_\_\_\_\_

**R. Scott Jacobs, M.D. FAAEM**

1669 Torrance Street  
San Diego, California 92103

**Curriculum Vitae**

**EDUCATION**

**Premedical Education**

University of Michigan Ann Arbor, Michigan	A.B. Degree	1970
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**Medical Education**

University of Michigan Ann Arbor, Michigan	M.D. Degree	1974
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**Postgraduate Education**

Rotating Internship Mercy Hospital and Medical Center San Diego, California	1974 - 1975
---	-------------

General Surgery Residency Mercy Hospital and Medical Center San Diego, California	1975 -1976
---	------------

**MEDICAL LICENSURE**

State of California	1975 - current
---------------------	----------------

**CERTIFICATION**

American Board of Emergency Medicine	1983 - current
Pediatric Advanced Life Support	1992
Advanced Trauma Life Support	1982
Advanced Cardiac Life Support	1976
ACEP Base Station Physician Symposium	1985
National Board of Medical Examiners	1975

**PROFESSIONAL PRACTICE**

Emergency Physician	Sharp Memorial Hospital San Diego, California	1984 - present
Emergency Department Director	Director of Risk Management	2002 - 2012
Emergency Department Supervisor	Supervisory Committee	2012 - present
Medical Director	Care Medical Transportation San Diego, California	1996 - present
Medical Director	Care Medical Transportation National City, California	1992 - 1993
Emergency Physician	Grossmont Hospital La Mesa, California	1983 - 1984
Emergency Physician	Valley Medical Center El Cajon, California	1980 - 1983
Emergency Physician	Pomerado Hospital Poway, California	1979 - 1980
Industrial Medicine	Kearny Mesa Industrial Medical Center San Diego, California	1978 - 1979
Emergency Physician	Clairemont Community Hospital San Diego, California	1976 - 1979
Emergency Physician	San Clemente General Hospital San Clemente, California	1976 - 1978

**EMERGENCY MEDICAL SERVICES ADMINISTRATION**

Base Hospital Medical Director	Sharp Memorial Hospital	1986 - 1989
San Diego County Base Station Physicians Committee		1986 - 1989
San Diego County Trauma System Medical Audit Committee		1986 - 1989
San Diego County Shared Helicopter Services Committee		1986 - 1989
San Diego County Pre-hospital Audit Committee		1987 - 1989
Chairman	1989	

**CONFERENCE PARTICIPATION**

Trauma Management	1989
San Diego, California	
Topic:	Pre-hospital Quality Assurance

## **PUBLICATIONS**

Chernof, D., Pion, R., et al. Self-Care Advisor. Time Health Inc. 1996. Advisor to author of Emergency and First Aid section pp13-48.

Kaufman I.A., Stonecipher J., Kitchen L., Haubner L.M., Jacobs, R.S.  
Children's Trauma Tool. As published in Guidelines for the Triage of Pediatric Trauma Patients. Journal of Emergency Nursing, 1989. Vol 15, No.5 pp414-415.

## **PROFESSIONAL AFFILIATIONS**

American Academy of Emergency Physicians  
American College of Emergency Physicians  
National Association of EMS Physicians

**R. Scott Jacobs, M.D. FAAEM**  
**1669 Torrance Street**  
**San Diego, California 92103**  
**Cell: 619-750-7651**  
**E-Mail: [rsjacobsmd@gmail.com](mailto:rsjacobsmd@gmail.com)**  
**2017**

## **FEE SCHEDULE**

**My hourly fees for consulting services are as follows:**

<b>Review of materials</b>	<b>\$400.00</b>
<b>Deposition testimony</b>	<b>\$600.00</b>
<b>Two hour minimum</b>	
<b>Trial testimony</b>	<b>\$600.00</b>
<b>Two hour minimum</b>	

# EXHIBIT 2



**R. SCOTT JACOBS, M.D. FAAEM  
1669 TORRANCE STREET  
SAN DIEGO, CALIFORNIA 92103  
APRIL 12, 2019**

Matthew Hoffman  
Atkinson & Watkins, LLP  
10789 W. Twain Avenue, Suite 100  
Las Vegas, NV 89135

Dear Mr. Hoffman:

I have reviewed the additional records that your office supplied to me regarding Darell Moore. This letter is a represents opinions that I have formed after review of the additional records.

Additional records reviewed:

Deposition of Darell Moore  
Deposition of Charlene Moore  
Deposition of Christopher Moore  
Deposition of Terry Bartmus, APRN  
Deposition of Jason Lasry, M. D.  
Chart audit timeline for Darell Moore

My general opinions are fundamentally unchanged from those outlined in my report dated December 8, 2017. I feel that when Mr. Moore presented to the Emergency Department at St. Rose Dominican Hospital on Dec. 25, 2016 his symptoms were suggestive of arterial ischemia of the left leg. A venous but not arterial ultrasound was performed and was negative for venous thrombosis or DVT. The radiologist did, however, comment that the femoral-popliteal bypass graft appeared occluded.

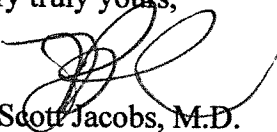
In their depositions, both Dr. Lasry and Nurse Bartmus concede that the comment of graft occlusion on the ultrasound would have necessitated further evaluation if Mr. Moore had shown signs of inadequate perfusion of the lower leg. Neither felt that to be the case, however, and Mr. Moore was discharged from the Emergency Department without definitive studies having been performed. Mr. Moore's presenting history of leg pain increased with walking is suggestive of arterial ischemia and even in the absence of other signs or symptoms should have led to further evaluation of his leg perfusion. Importantly, no Dopler studies were performed to quantify pulses and there appears to have been no reevaluation of Mr. Moore's circulatory status following the report of the occluded arterial graft.

There is also controversy regarding the actual examination of Mr. Moore. Both Darell and Christopher Moore in their depositions are adamant that no male ever performed an examination of Mr. Moore's legs. Ms. Bartmus is a nurse practitioner and, as such, is able to practice independently although she would have a supervising physician. Importantly, the chart audit timeline demonstrates that Dr. Lasry did not access Mr. Moore's chart at all on December 25, and his first interaction with the chart was not until 0910 on December 26th. It is extremely unlikely that a medical provider would evaluate a patient and not access the chart contemporaneously. As such, it is hard to imagine the Dr. Lasry actually examined Mr. Moore on December 25, 2016.

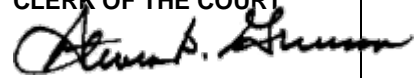
In any case, it is my opinion that the evaluation of Mr. Moore was woefully inadequate and the failure of Ms. Bartmus and Dr. Lasry to order the appropriate studies and to make an accurate diagnosis on December 25, resulted in Mr. Moore requiring above the knee amputation of his leg.

My criticisms of the care provided to Mr. Moore involve only Dr. Lasry and Ms. Bartmus who appear to be contracted to Fremont Emergency Services. I have no criticisms of the nursing care provided, therefore, am not critical of the employees of St. Rose Hospital. My opinion that the care provided by Dr. Lasry and Ms. Bartmus to Mr. Moore was negligent as outlined in my original report remains unchanged and is, in fact, strengthened by the additional materials you provided.

Very truly yours,



R. Scott Jacobs, M.D.



**MNTR**  
MATTHEW W. HOFFMANN, ESQ.  
Nevada Bar No. 009061  
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Telephone: 702-562-6000  
Facsimile: 702-562-6066  
Email: [mhoffmann@awhlawyers.com](mailto:mhoffmann@awhlawyers.com)  
*Attorneys for Plaintiffs*

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Email: [breen@breen.com](mailto:breen@breen.com)  
[bartnz@ggrmlawfirm.com](mailto:bartnz@ggrmlawfirm.com)  
*Attorneys for Plaintiffs*

**DISTRICT COURT**  
**CLARK COUNTY, NEVADA**

DARELL L. MOORE and CHARLENE A.  
MOORE, individually and as husband and  
wife;

Plaintiffs,

v.

JASON LASRY, M.D., individually;  
FREMONT EMERGENCY SERVICES  
(MANDAVIA), LTD.; TERRY BARTMUS,  
RN, APRN; and DOES I through X, inclusive;  
and ROE CORPORATIONS I through V,  
inclusive;

Defendants.

CASE NO.: A-17-766426-C

DEPT. NO.: Dept. 25

**PLAINTIFFS' NRCP 59 MOTION**  
**FOR NEW TRIAL**

**HEARING REQUESTED**

COME NOW, Plaintiffs, DARELL L. MOORE and CHARLENE A. MOORE, individually  
and as husband and wife, by and through their attorneys of record, MATTHEW W. HOFFMANN,  
ESQ., of the law firm of ATKINSON WATKINS & HOFFMANN, LLP, AND E. BREEN  
ARNTZ, CHTD., and hereby submit their Motion for a New Trial.

1 **I. FACTUAL BACKGROUND**

2 This is a medical malpractice action resulting from an above-the-knee amputation that  
3 occurred on or about December 25, 2016. On that date, Plaintiff Darell presented to the emergency  
4 department at Dignity Health dba St. Rose Hospital- San Martin (hereafter, "St. Rose") with a one-  
5 day history of pain in the calf area of his left leg. He was noted to have a prior history of deep vein  
6 thrombosis and a prior femoral and/or popliteal artery bypass surgery on December 11, 2014. The  
7 previous procedure of putting a bypass and graft was performed at the same hospital as the visit  
8 on December 25, 2016. An ultrasound was ordered to rule out DVT in the left leg, which was  
9 negative, but which also showed an occlusion of the left femoral-popliteal arterial bypass graft.  
10 No further treatment was recommended in response to the left arterial occlusion and the differential  
11 diagnosis did not include arterial occlusion despite Darell's history of a prior femoral-popliteal  
12 bypass and despite the fact Darell reported pain increased with walking. Plaintiff Darell was  
discharged with aftercare instructions for musculoskeletal pain as well as hypertension.

13 On December 28, 2016, Plaintiff Darell returned to the emergency department at St. Rose.  
14 At that time, Darell reported persistent and increasing left leg pain. An arterial duplex ultrasound  
15 of the left leg was performed and once again showed occlusion of the left leg graft vasculature  
16 with no flow detected in the left posterior tibial anterior tibial or dorsalis pedi arteries. Darell was  
17 noted to have an ischemic lower extremity and started on anticoagulants including heparin and  
tissue plasminogen activator.

18 Plaintiff Darell was eventually admitted to the Intensive Care Unit in critical condition. On  
19 January 2, 2017, Plaintiff Darell underwent an above-the-knee amputation of his left lower  
20 extremity under the care of Holman Chan, M.D. He was discharged on January 5, 2017.

21 **II. ARGUMENT**

22 The subject motion is based on two instances of error by this court and the attorney  
23 misconduct of Mr. Keith Weaver, counsel for Nurse Practitioner Terri Bartmus. First, during the  
24 trial Plaintiffs' called Dr. Alexander Marmureanu, a board certified cardiovascular surgeon who  
25 was qualified to discuss the standard of care of the Defendants and the causation of the injury of  
26 the Plaintiff, the loss of his leg above the knee, due to the malpractice of the Defendants. During  
27 the direct examination of Dr. Marmureanu, he was examined on his qualifications, the scope of his  
28 opinions and the foundation he possessed as an expert witness to address those issues and form the  
testimony that he had. Nothing unusual was discussed during the qualifications phase of direct  
testimony and no objections were made regarding the scope of that questioning. During the cross-

1 examination of Dr. Marmureanu, over the objection of counsel grounded in a number of different  
2 bases, Mr. Weaver was permitted to question Dr. Marmureanu regarding an article in a magazine  
3 that related only to his reputation as a cardiovascular surgeon. More specifically, the article didn't  
4 even relate to treatment that was the subject of the subject case; rather, it concerned a study from  
5 California that tracked the number of deaths in the first thirty days following cardiac bypass  
6 surgery. The manner in which Mr. Weaver confronted Dr. Marmureanu was designed to merely  
7 impugn the reputation of the Plaintiffs' expert, not to challenge him on the medicine related to the  
8 case.

9 One of the objections made to the cross-examination was that the article that was being  
10 used for impeachment was not disclosed pursuant to NRCP 16.1. This court summoned counsel  
11 to the bench for a discussion during which this objection and others were made. This court ruled  
12 that Mr. Weaver was not required to produce impeachment evidence before trial and ruled that "so  
13 long as Mr. Weaver acted in good faith" he was permitted to pursue the line of questioning. Not  
14 only does such a ruling contradict the specific language of NRCP 16.1(a)(3) which does require  
15 impeachment evidence to be produced, but, Mr. Weaver did not act in good faith as he  
16 misrepresented a number of different aspects of the article. The cross-examination should have  
17 been disallowed for a number of reasons. First, NRCP 16.1 does require the parties to produce  
18 evidence one intends to use for impeachment. Defendants did not produce the article in question.  
19 In fact, the rule couldn't be clearer. Second, the evidence presented went only to Dr.  
20 Marmureanu's reputation as it concerned information Mr. Weaver suggested demonstrated that  
21 Dr. Marmureanu was one of seven worst doctors in California. And, finally, Mr. Weaver  
22 misrepresented the substance of the article in a clear attempt to misinform the jury regarding Dr.  
23 Marmureanu's reputation as a surgeon. Because this court didn't even require production of the  
24 article, it was impossible to afford Plaintiffs the opportunity to rehabilitate their witness.

25 A second instance of reversible was this court's ruling to exclude Dr. Wiencek as a witness  
26 when called by Plaintiffs. Mr. Robert McBride, counsel for Dr. Lasry, had referenced Dr. Wiencek  
27 as a potential witness during his introduction to the case, Dr. Wiencek was identified as a witness  
28 in all thirteen (13) supplemental disclosures pursuant to NRCP 16.1 with the appropriate  
description of his anticipated testimony as a treating physician, and, perhaps most critical, the notes  
and records and treatment by Dr. Wiencek became such a focal point of the evidence at trial that  
to preclude him from testifying under the circumstances was an abuse of this court's discretion.

1     **A.     The Contents of the Article at Issue**

2             On July 17, 2017, Kaiser Health News published an article featured on the website Fierce  
3     Health Care entitled “California hits nerve by singling out cardiac surgeons with higher patient  
4     death rates”. ([https://www.fiercehealthcare.com/practices/calif-hits-nerve-by-singling-out-](https://www.fiercehealthcare.com/practices/calif-hits-nerve-by-singling-out-cardiac-surgeons-higher-patient-death-rates)  
5     [cardiac-surgeons-higher-patient-death-rates](https://www.fiercehealthcare.com/practices/calif-hits-nerve-by-singling-out-cardiac-surgeons-higher-patient-death-rates) – *attached hereto as Exhibit 1*). The article’s topic  
6     was the controversy surrounding a public database which listed California heart surgeons with a  
7     higher-than-average death rate for patients who underwent a common bypass procedure. *Id.* “The  
8     practice is controversial: Proponents argue transparency improves quality and informs consumers.  
9     Critics say it deters surgeons from accepting complex cases and can unfairly tarnish doctors’  
10    records”. *Id.*

11            The article uses a report, released in May 2017 by California’s Office of Statewide Health  
12    Planning and Development, based on surgeries performed in 2013 and 2014. *Id.* Dr. Marmureanu  
13    was listed, along with several other veteran cardiac surgeons, as having an above-average death  
14    rate for patients undergoing the procedure during that two-year time period. *Id.* While some of the  
15    doctors interviewed stated that they supported public reporting, they also criticized the database,  
16    pointing out that the calculation of deaths did not fully take the varying complexity of the cases  
17    into account and that the results could be easily skewed by only a few bad results depending upon  
18    the overall number of surgeries a particular doctor performed. *Id.*

19            The death rates included those occurring during hospitalization, regardless of how long the  
20    stay, or anytime within 30 days after the surgery, regardless of the venue. *Id.* Holly Hoegh,  
21    manager of the clinical data unit at the Office of Statewide Health Planning and Development,  
22    which issued the report, acknowledged that “a risk model can never capture all the risk”, which  
23    critics pointed out does not adequately take into account the number of complex and challenging  
24    cases a surgeon has accepted. *Id.* The article noted that officials in Massachusetts, who had been  
25    reporting bypass outcomes for individual doctors, stopped doing it in 2013 because, while surgeons  
26    supported reporting to improve outcomes, they were concerned that they were being identified  
27    public as “outliers” when they really were just taking on difficult cases, which could lead to  
28    surgeons turning away high-risk patients in order to protect their death rate percentages. *Id.* Dr.  
29    Marmureanu, who takes on some of the most difficult cases and the sickest patients, was assigned  
30    a mortality rate of 18.04 based on three deaths among 22 cases in the two-year time period covered  
31    by the report. *Id.* One of those deaths was due to a traffic accident which occurred within the 30-

1 day period after the patient had undergone the bypass procedure, illustrating the problematic nature  
2 of the report's death rate calculation method. *Id.*

3 **B. The Misleading Line of Questioning at Trial Concerning the Article at Issue and the**  
4 **Court's Response to Plaintiffs' Counsel's Objection**

5 During trial, Mr. Weaver questioned Dr. Marmureanu about the article in a manner that  
6 completely misrepresented its contents, making it appear that Dr. Marmureanu had been singled  
7 out as one of the "worst" surgeons in the state, in an apparent attempt to undermine his credibility  
8 with the jury.

9 "Q: In 2017, the State of California declared that you are one of the seven worst  
10 cardiovascular surgeons in the entire state out of hundreds; correct?

11 A: Incorrect, sir. I would like to see that.

12 Q: So is it your testimony, Dr. Marmureanu, that the office of – the California Office of  
13 Statewide Health Planning and Development didn't issue a report that listed you in the  
14 top 3 percent of the worst cardiovascular surgeons in California?

15 A: You're untruthful and incorrect, again, sir.

16 Q: Okay. So what would you need to be convinced that that report exists?

17 A: Show it.

18 Q: Okay. We'll come back to that"

19 A: Go ahead.

20 Q: Let me do what's called "lay a little foundation". So do you know what the  
21 "California Society of Thoracic Surgeons" is?

22 A: Very well.

23 Q: Okay. And you don't believe that the president of the California Society of Thoracic  
24 Surgeons supported a report that identified you as one of the top seven worst  
25 cardiovascular surgeons in California; correct?

26 A: Not only do I don't believe, I'm saying you're wrong.

27 Q: And I would also be wrong if you told a reporter for Kaiser News that, in effect,  
28 hospital patients don't care if they're, in your case, nine times more likely to die under  
your care?

A: That's not what I said. You're not telling the truth again.

1 Q: Did you say something to that effect, that hospital patients don't care about that  
2 report; the only people who care about the data are the journalists?

3 A: That could be.

4 Q: But it's in the context of the report that, out of 271 cardiovascular surgeon (sic) in  
5 California, found you one of the worst seven?

6 A: It's absolutely not true. And, I mean, I don't want to judge upset, but I think it's  
7 despicable what you're saying.

8 Q: And would it also be despicable if Hollywood Presbyterian Hospitals got one of the  
9 worst rankings as a hospital because of your ranking by the State of California's Office of  
Statewide Health Planning and Development?

10 A: That's not true again, sir. You will have to show me.

11 Q: Okay. We'll come back to that. Sir, you're saying no such report exists; right?

12 A: Well, not what you said. What you said doesn't exist. You are wrong about the year;  
13 you are wrong about the report; you are wrong what the report says, and I'm not sure if  
14 you're doing it on purpose or just you don't know enough about it."

15 *(Reporters Transcript of Proceedings of Jury Trial P.M. Session Testimony of Alexander*  
16 *Marmureanu, M.D. Before the Honorable Kathleen E. Delaney, Friday, January 31, 2020,*  
17 *29:1-31:10, attached hereto as Exhibit 2).*<sup>1</sup> Mr. Weaver clearly misrepresented the contents of  
18 the article during cross examination. When Dr. Marmureanu asked to see the article on two  
19 separate occasions, his request was disregarded. Plaintiffs' counsel objected as to foundation, but  
20 his objection was overruled and Mr. Weaver was allowed to continue with his line of misleading  
questioning. (*Id.*, 31:14-15, 20-21).

21 Mr. Weaver repeatedly and incorrectly stated that the article categorized Dr. Marmureanu  
22 as one of the "worst" cardiovascular surgeons in California. (*Id.*, 32:6-13, 22-23; 37:17-19);  
23 ("The state put you in a category that they labeled you as "worst.") (*Id.*, 32:16-17); ("Q:...It  
24 doesn't say I'm the worst surgeon than the guy who did only three cases and nobody died. A: It

25  
26 <sup>1</sup> In fact, Hollywood Presbyterian Hospital Medical Center received an "average" (as opposed to "worse", "low" or  
27 "acceptable") rating for Isolated CABG Operative Mortality in the 2013, 2014 and 2015 time periods and for CABG  
28 + Valve Operative Mortality for 2012-13, 2013-14, 2014-15 time periods. (*California Hospital Performance*  
*Ratings for Coronary Artery Bypass Graft (CABG) Surgery by Region, 2013, 2014, 2015, attached hereto as*  
*Exhibit 3).*



1 does.”) (*Id.*, 39:2-5). The witness again asked to see the article and was told by Mr. Weaver: “I  
2 don’t have it with me.” (*Id.*, 36:15).

3 The Court recapped the bench discussion on the record following Plaintiffs’ counsel’s  
4 objection in pertinent part as follows:

5 “The Court: [T]he argument was that Mr. Weaver was not actually confronting the  
6 witness with these reports, that he would be required to do so, and that it would not be  
7 appropriate; it was not an appropriate line of questioning.

8 The Court disagreed, respectfully, with that assessment, that when there was testimony  
9 obviously by the doctor regarding his qualifications and this information called into  
10 question that testimony, that the proper impeachment is to ask certain things – obviously,  
11 you have to have your ethical obligations fulfilled that you have a good faith belief to ask  
12 the question and that ultimately there was no reason to believe otherwise – certainly Mr.  
13 Weaver was able to do so without actually requiring confrontation with documentation,  
14 to this Court’s opinion, would be akin to impeachment with extrinsic evidence; and that  
15 is something that is not allowed, other than in certain circumstances, really more things  
16 go towards credibility of testimony, that’s not what this would have been.

17 So the Court indicated that, although the Plaintiffs’ counsel may wish to challenge if Mr.  
18 Weaver was misrepresenting any such reports and could potentially do so on redirect, that  
19 it was not required of Mr. Weaver to confront the witness with actual reports. Although,  
20 I do think it was fair for Mr. Arntz to ask to be given a reference to or copy of or citation  
21 to what reports he was referring to; and I believe Mr. Weaver agreed, when he left the  
22 bench, to do so. He indicated it was all online and there was a website that could be  
23 given. So, again, that inquiry continued.”

24 (*Id.*, 65:9-66:17). The Court’s response to Mr. Arntz’s objection represents reversible error, as  
25 discussed, below.

### 26 **C. Violation of Rules of Civil Procedure - NRC 16.1**

27 Mr. Weaver misrepresented the substance of the article in an attempt to impeach Dr.  
28 Marmureanu. Yet, he never produced the article, either before or during trial. Although the Court  
found no impropriety, this failure to produce is contrary to the mandate of Rule 16.1, which says  
just the opposite.

Nevada Rule of Civil Procedure 16.1 states:

“Except as exempted by Rule 16.1(a)(1)(B) or as otherwise stipulated or ordered by the  
court, a party **must**, without awaiting a discovery request, provide to the other parties:  
...(ii) a copy – or a description by category and location – of **all documents,**  
**electronically stored information,** and tangible things that the disclosing party has in its  
possession, custody, or control and may use to support its claims or defenses, **including**  
**for impeachment** or rebuttal, and, unless privileged or protected from disclosure, any

1 record, report, or witness statement, in any form, concerning the incident that gives rise to  
2 the lawsuit.”

3 NRCP 16.1(a)(1)(A)(ii) (emphasis added).

4 NRCP 16.1 further states:

5 “[A] party must provide to other parties the following information regarding the evidence  
6 that it may present at trial, including impeachment and rebuttal evidence:...(C) An  
7 appropriate identification of each document or other exhibit, including summaries of  
8 other evidence, separately identifying those which the party expects to offer and those  
9 which the party may offer if the need arises.”

10 NRCP 16.1(a)(3). The policy underlying NRCP 16.1 “serves to place all parties on an even playing  
11 field and to prevent trial by ambush or unfair surprise.” *Sanders v. Sears-Page*, 131 Nev. Adv.  
12 Op. 50, 354 P.3d 201, 212 (Nev. Ct. App. 2015).

13 If a party fails to disclose a document or exhibit before trial as so required, the trial court  
14 “shall” impose certain sanctions, including prohibiting the use of that document or exhibit. NRCP  
15 16.1(e)(3)(B) permits exclusion of evidence not produced in compliance with disclosure deadlines.  
16 Moreover, NRCP 37(c)(1) provides that “[a] party that without substantial justification fails to  
17 disclose information required by Rule 16.1...is not, unless such failure is harmless, permitted to  
18 use as evidence at a trial...any witness or information not so disclosed.” NRCP 37(c)(1).

19 The rules and their applicability to the instant issue is clear. The Court was in error to rule  
20 otherwise. See, e.g. *Cooter & Gell v. Hartmarx Corp.*, 496 U.S. 384, 405 (1990) (“A district court  
21 would necessarily abuse its discretion if it based its ruling on ...a clearly erroneous assessment of  
22 the evidence.”), superseded by rule on other grounds, Fed. R. Civ. P. 11; *Finner v. Hurless*, No.  
23 70656, \*\*6-7 (Nev. App. 2018) (unreported) (district court correctly prohibited use of undisclosed  
24 deposition transcript for impeachment purposes in cross examination of medical expert).

25 Sanctions are warranted for failure to comply with discovery obligations unless the delayed  
26 disclosures are substantially justified or harmless. *JPMorgan Chase Bank, N.A. v. SR Investments*  
27 *Pool 1, LLC*, No. 76952 (Nev., March 2, 2020), citing NRCP 37(c)(1). A party cannot use at trial  
28 any witness or information not disclosed unless one of these terms are met. *Capanna v. Orth*, 134  
Nev. 888, 894, 432 P.3d 726, 733 (2018). In *JPMorgan*, the Nevada Supreme Court upheld the  
district court’s decision to strike evidence that was not properly disclosed before trial where such  
evidence related to a “pivotal and dispositive” issue in the case and the failure to timely disclose  
was not substantially justified or harmless. *Id.*, at \*2.

1 Here, the Court failed in its duty to ensure Plaintiffs' case was not prejudiced by  
2 Defendant's failure to abide by the discovery rules. Its failure to do so was prejudicial error,  
3 requiring reversal and remand for a new trial. See, i.e. *Wiggins v. State of Mississippi*, 733 So. 2d  
4 872, 874 (Miss. App. 1999) (trial court committed reversible error when it allowed testimony to  
5 continue after counsel objected that the opposing party had failed to produce the document at  
6 issue).

6 **D. Violation of Rules of Evidence - NRS 50.085**

7 In addition, the Court allowed reputation evidence – which this plainly was, as the topic of  
8 the article was not at issue nor was it discussed other than to attempt to wrongfully paint Dr.  
9 Marmureanu one of the “worst” surgeons in California – for impeachment purposes, even though  
10 NRS 50.085 specifically excludes evidence of reputation to show “truthfulness or untruthfulness”.  
11 NRS 50.085(2) (“Evidence of the reputation of a witness for truthfulness or untruthfulness is  
12 inadmissible.”)

12 Further, NRS 50.085(3) states that “[s]pecific instances of the conduct of a witness, for the  
13 purpose of attacking or supporting the witness's credibility, other than conviction of crime, may  
14 not be proved by extrinsic evidence”. NRS 50.085(3). Such conduct may be inquired into on  
15 cross-examination of a witness only if relevant to truthfulness.<sup>2</sup> See, i.e. *Collman v. State*, 116  
16 Nev. 687, 7 P.3d 426, 436 (2000); *McKee v. State*, 112 Nev. 642, 646, 917 P.2d 940, 943 (1996)  
17 (it is error to allow impeachment of a witness with extrinsic evidence relating to a collateral  
18 matter). “Collateral facts are by nature outside the controversy or are not directly connected with  
19 the principal matter or issue in dispute.” *Lobato v. State*, 120 Nev. 512, 518, 96 P.3d 765, 770  
20 (2004).

20 Mr. Weaver's attempt to use the article reporting prior negative surgical outcomes in  
21 coronary bypass procedures – which is not the procedure at issue in this case – to attack Dr.  
22 Marmureanu's credibility was improper. The article was extrinsic evidence, the matter was  
23 collateral and truthfulness/untruthfulness was not the subject of inquiry. Dr. Marmureanu's skill  
24 as a coronary bypass surgeon is absolutely irrelevant to his credibility as an expert witness in this  
25 matter. This irrelevancy is compounded by the fact that the article's contents were misrepresented

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26 <sup>2</sup> “Specific instances of the conduct of a witness, for the purpose of attacking or supporting the witness's credibility,  
27 other than conviction of crime, may not be proved by extrinsic evidence. They may, however, if relevant to  
28 truthfulness, be inquired into on cross-examination of the witness or on cross-examination of a witness who testifies  
to an opinion of his or her character for truthfulness or untruthfulness, subject to the general limitations upon relevant  
evidence and the limitations upon interrogation and subject to the provisions of NRS 50.090.” NRS 50.085(3).

1 by defense counsel during questioning. This is precisely the type of collateral issue that the rules  
2 deem inadmissible.

3 **E. Motion for a New Trial Standard – NRCP 59**

4 Nevada Rule of Civil Procedure 59 states in pertinent part that:

5 “The court may, on motion, grant a new trial on all or some of the issues – and to any  
6 party – for any of the following causes or grounds materially affecting the substantial  
7 rights of the moving party: (A) irregularity in the proceedings of the court, jury, master,  
8 or adverse party or in any order of the court or master, or any abuse of discretion by  
which either party was prevented from having a fair trial; (B) misconduct of the jury or  
prevailing part; (C) accident or surprise that ordinary prudence could not have guarded  
against...”

9 NRCP 59(a)(1)(A)-(C).

10 Here, Mr. Weaver cross-examined Dr. Marmureanu with an article that had not been  
11 produced or made known to Plaintiffs’ counsel before the cross-examination occurred. Mr.  
12 Weaver misrepresented the contents of the article during his questioning of Dr. Marmureanu in  
13 order to diminish the doctor’s credibility with the jury. He then failed to produce the article even  
14 after Dr. Marmureanu repeatedly asked to see it from the stand. The Court overruled Plaintiffs’  
15 counsel’s objection and failed to admonish Mr. Weaver or the jury. Instead, the Court allowed  
16 Mr. Weaver to continue with the improper line of questioning, declined to order production of the  
17 article, and suggested that Plaintiffs’ counsel could simply find the article on-line himself at a later  
18 time. This was an erroneous response in violation of the rules. The elements of irregularity in  
19 proceedings by the court and by the adverse party, misconduct of the prevailing party and unfair  
20 surprise have been met in accordance with NRCP 59.

21  
22 Dr. Marmureanu was Plaintiffs’ expert witness for purposes of vascular surgery and  
23 emergency medicine. He was Plaintiffs’ only testifying expert witness in a complex medical  
24 malpractice claim. Such cases are dependent upon expert testimony. NRS 41A.100; *Fernandez*  
25 *v. Admirand*, 108 Nev. 963, 969, 843 P.2d 345, 358 (1992) (expert testimony is necessary in a  
26 medical malpractice case “unless the propriety of the treatment, or lack of it, is a matter of common  
27  
28

1 knowledge of laymen”). Plaintiffs’ only medical expert which supported their claims was  
2 wrongfully discredited on the stand without means for rehabilitation resulting in prejudicial error.  
3 See, i.e. *Las Vegas Paving Corp. v. Coleman* (affirming district court’s grant of a new trial where  
4 admission of improper testimony “almost certainly prejudiced the jury because it was the only  
5 evidence that supported (plaintiff’s) contention – one that played a significant role in its closing  
6 argument to the jury”, as but for the error, a different result might reasonably have been expected).  
7 As the article was never produced or entered into evidence as an exhibit, it was impossible for the  
8 jury to understand the substantial misrepresentations which had occurred. Due to the irregularity  
9 in the proceedings occasioned by Mr. Weaver’s conduct and the subsequent ruling by the Court,  
10 which abused its discretion by overruling Plaintiffs’ counsel’s objections to such conduct,  
11 Plaintiffs’ substantial rights were materially affected, which prevented them from having a fair  
12 trial and resulted in a defense verdict.  
13

14  
15 See, i.e. *Lioce v. Cohen*, 124 Nev. 1, 174 P.3d 970, 981 (2008) (where party moving for  
16 new trial based on purported attorney misconduct demonstrates that the district court erred by  
17 overruling the party’s objection and an admonition to the jury would likely have affected the  
18 verdict in favor of the moving party, a new trial is warranted). “In this, the court must evaluate  
19 the evidence and the parties’ and the attorneys’ demeanor to determine whether a party’s  
20 substantial rights were affected by the court’s failure to sustain the objection and admonish the  
21 jury.” *Id.* Where an attorney encourages jurors to look beyond relevant facts in deciding the case,  
22 misconduct has occurred. *Id.*, at 6, 973. When an attorney commits misconduct and the opposing  
23 party objects, the district court should sustain the objection and admonish the jury and counsel,  
24 respectively, by advising the jury about the impropriety of counsel’s conduct and reprimanding or  
25 cautioning counsel against such misconduct. *Id.*, at 17, 980.  
26

27 ...  
28

1 Error is unfairly prejudice where the aggrieved party demonstrates from the record that but  
2 for the error, a different result “might reasonably have been expected”. *Hallmark v. Eldridge*, 124  
3 Nev. 492, 505, 189, P.3d 646, 654 (2008). Had Dr. Marmureanu not been unfairly confronted  
4 with an unproduced article regarding a collateral issue, the contents of which Mr. Weaver grossly  
5 misrepresented before the jury, the outcome may very well have been different. Had the Court  
6 sustained Plaintiffs’ counsel’s objection, prohibited the use of the article in question – or in the  
7 alternative, ordered production of the article - and admonished the jury, the outcome may very  
8 well have been different. A new trial is warranted.

10 Moreover, Plaintiffs were unavoidably unfairly surprised to their detriment when Mr.  
11 Weaver began cross-examining Dr. Marmureanu about an article which was never disclosed,  
12 produced or made available to the witness or Plaintiffs’ counsel at trial. In the exercise of ordinary  
13 prudence or otherwise, Plaintiffs’ counsel could not have guarded against this occurrence  
14 beforehand and once his objection was overruled, the harm was complete. The Nevada Supreme  
15 Court has explained that surprise materially affects the substantial rights of an aggrieved party  
16 where it “result[s] from some fact, circumstance, or situation in which a party is placed  
17 unexpectedly, to his injury, without any default or negligence of his own, and which ordinary  
18 prudence could not have guarded against. *Havas v. Haupt*, 94 Nev. 591, 593, 583 P.2d 1094, 1095  
19 (1978). This was not a situation where Plaintiffs knew in advance of trial that the article would be  
20 used by defense counsel and failed to take action to protect their interests. Its use during Dr.  
21 Marmureanu’s cross-examination was completely unexpected, the unfairness of which was  
22 compounded by Mr. Weaver’s refusal to produce the article to the witness or Plaintiffs’ counsel  
23 during questioning and the Court’s refusal to correct the situation. Therefore, a claim of unfair  
24 surprise under the rule will lie. *Id.*, at 593, 1095-96.

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DATED this 7<sup>th</sup> day of April, 2020.

*/s/ E. Breen Arntz, Esq.*  


---

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1 **CERTIFICATE OF SERVICE**

2 I hereby certify that I am an employee of ATKINSON WATKINS & HOFFMANN, LLP  
3 and that on the 7<sup>th</sup> day of April, 2020, I caused to be served via Odyssey, the Court's mandatory  
4 efilng/eservice system a true and correct copy of the document described herein.

5 **Document Served: PLAINTIFFS' NRCP 59 MOTION FOR NEW TRIAL**

6  
7 **Person(s) Served:**

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# EXHIBIT 1

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## Practices

### California hits nerve by singling out cardiac surgeons with higher patient death rates

by [Anna Gorman, Kaiser Health News](#) | Jul 17, 2017 11:42am



*A public database of California heart surgeons identified physicians who had a higher-than-average death rate for patients who underwent a common bypass procedure.*

Michael Koumjian, M.D., a heart surgeon for nearly three decades, said he considered treating the sickest patients a badge of honor. The San Diego doctor was frequently called upon to operate on those who had multiple illnesses or who'd undergone CPR before arriving at the hospital.

Recently, however, Koumjian received some unwelcome recognition: He was identified in a public database of California heart surgeons as one of seven with a higher-than-average death rate for patients who underwent a common bypass procedure.

"If you are willing to give people a shot and their only chance is surgery, then you are going to have more deaths and be criticized," said Koumjian, whose risk-adjusted death rate was 7.5 per 100

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surgeries in 2014-15. “The surgeons that worry about their stats just don’t take those cases.”

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Now, Koumjian said he is reconsidering taking such complicated cases because he can’t afford to continue being labeled a “bad surgeon.”

California is one of a handful of states—including New York, Pennsylvania and New Jersey—that publicly reports surgeons’ names and risk-adjusted death rates on a procedure known as the “isolated coronary artery bypass graft.” The practice is controversial: Proponents argue transparency improves quality and informs consumers. Critics say it deters surgeons from accepting complex cases and can unfairly tarnish doctors’ records.

“This is a hotly debated issue,” said Ralph Brindis, M.D., a cardiologist and professor at UC-San Francisco who chairs the advisory panel for the state report. “But to me, the pros of public reporting outweigh the negatives. I think consumers deserve to have a right to that information.”

Prompted by a state law, the Office of Statewide Health Planning and Development began issuing the reports in 2003 and produces them every two years. Outcomes from the bypass procedure had long been used as one of several measures of hospital quality. But that marked the first time physician names were attached—and the bypass is still the only procedure for which such physician-specific reports are released publicly in California.

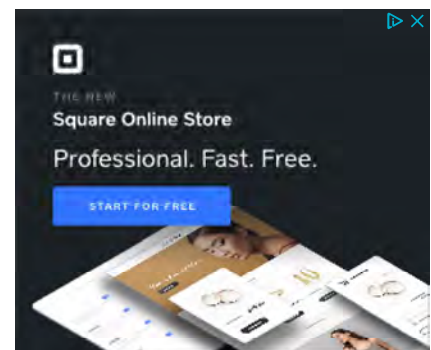
California’s law was sponsored by consumer advocates, who argued that publicly listing the names of outlier surgeons in New York had appeared to bring about a significant drop in death rates from the bypass procedure. State officials say it has worked here as well: The rate declined from



#### About the Author



**Anna Gorman, Kaiser Health News**  
*Senior correspondent, Kaiser Health News*



2.91 to 1.97 deaths per 100 surgeries from 2003 to 2014.

“Providing the results back to the surgeons, facilities and the public overall results in higher quality performance for everybody,” said Holly Hoegh, manager of the clinical data unit at the state’s health planning and development office.

Since the state began issuing the reports, the number of surgeons with significantly higher death rates than the state average has ranged from six to 12, and none has made the list twice. The most recent **report**, released in May, is based on surgeries performed in 2013 and 2014.

In this year’s report, the seven surgeons with above-average death rates—out of 271 surgeons listed—include several veterans in the field. Among them were Daniel Pellegrini, M.D., chief of inpatient quality at Kaiser Permanente San Francisco and John M. Robertson, M.D., director of thoracic and cardiovascular surgery at Providence Saint John’s Health Center in Santa Monica. Most defended their records, arguing that some of the deaths shouldn’t have been counted or that the death rates didn’t represent the totality of their careers. (Kaiser Health News, which produces California Healthline, is not affiliated with Kaiser Permanente.)

“For the lion’s share of my career, my numbers were good and I’m very proud of them,” said Pellegrini. “I don’t think this is reflective of my work overall. I do think that’s reflective that I was willing to take on tough cases.”

During the two years covered in the report, Pellegrini performed 69 surgeries and four patients died. That brought his risk-adjusted rate to 11.48 deaths per 100, above the state average of 2.13 per 100 in that period.

Pellegrini said he supports public reporting, but he argues the calculations don’t fully take the varying complexity of the cases into account and that a couple of bad outcomes can skew the rates.

Robertson said in a written statement that he had three very “complex and challenging” cases involving patients who came to the hospital with “extraordinary complications and additional unrelated conditions.” They were among five deaths out of 71 patients during the reporting period, giving him an adjusted rate of 9.75 per 100 surgeries.

"While I appreciate independent oversight, it's important for consumers to realize that two years of data do not illustrate overall results," Robertson said. "Every single patient is different."

The rates are calculated based on a nationally recognized method that includes deaths occurring during hospitalization, regardless of how long the stay, or anytime within 30 days after the surgery, regardless of the venue. All licensed hospitals must report the data to the state.

State officials said that providing surgeons' names can help consumers make choices about who they want to operate on them, assuming it's not an emergency.

"It is important for patients to be involved in their own health care, and we are trying to work more and more on getting this information in an easy-to-use format for the man on the street," said Hoegh, of the state's health planning and development office.

No minimum number of surgeries is needed to calculate a rate, but the results must be statistically significant and are risk-adjusted to account for varying levels of illness or frailty among patients, Hoegh said.

She acknowledged that "a risk model can never capture all the risk" and said her office is always trying to improve its approach.

Surgeons sometimes file appeals—arguing, for example, that the risk was improperly calculated or that the death was unrelated to the surgery. The appeals can result in adjustments to a rate, Hoegh said.

Despite the controversy it generates, the public reporting is supported by the California Society of Thoracic Surgeons, the professional association representing the surgeons. No one wants to be on the list, but "transparency is always a good thing," said Junaid Khan, M.D., president of the society and director of cardiovascular surgery at Alta Bates Summit Medical Center in the Bay Area.

"The purpose of the list is not to be punitive," said Khan. "It's not to embarrass anybody. It is to help improve quality."

Khan added that he believes outcomes of other heart procedures, such as angioplasty, should also be publicly reported.

Consumers Union, which sponsored the bill that led to the cardiac surgeon reports, supports expanding doctor-specific reporting to include a variety of other procedures — for example, birth outcomes, which could be valuable for expectant parents as they look for a doctor.

“Consumers are really hungry for physician-specific information,” said Betsy Imholz, the advocacy group’s special projects director. And, she added, “care that people receive actually improves once the data is made public.”

But efforts to expand reporting by name are likely to hit opposition. Officials in Massachusetts, who had been reporting bypass outcomes for individual doctors, stopped doing it in 2013. Surgeons supported reporting to improve outcomes, but they were concerned that they were being identified publicly as outliers when they really were just taking on difficult cases, said Daniel Engelman, M.D., president of the Massachusetts Society of Thoracic Surgeons.

“Cardiac surgeons said, ‘Enough is enough. We can’t risk being in the papers as outliers,’” Engelman said.

Engelman said the surgeons cited research from New York showing that public reporting may have led surgeons to turn away high-risk patients. Hoegh said research has not uncovered any such evidence in California.

In addition to Koumjian, Robertson and Pellegrini, the physicians in California with higher-than-average rates were Philip Faraci, Eli R. Capouya, Alexander R. Marmureanu, Yousef M. Odeh. Capouya declined to comment.

Faraci, 75, said his rate (8.34 per 100) was based on four deaths out of 33 surgeries, not enough to calculate death rates, he said. Faraci, who is semi-retired, said he wasn’t too worried about the rating, though. “I have been in practice for over 30 years and I have never been published as a below-average surgeon before,” he said.

Odeh, 45, performed 10 surgeries and had two deaths while at Presbyterian Intercommunity Hospital in Whittier, resulting in a mortality rate of 26.17 per 100. “It was my first job out of residency, and I didn’t have much guidance,” Odeh said. “That’s a recipe for disaster.”

Odeh said those two years don't reflect his skills as a surgeon, adding that he has done hundreds of surgeries since then without incident.

Marmureanu, who operates at several Los Angeles-area hospitals, had a mortality rate of 18.04 based on three deaths among 22 cases. "I do the most complicated cases in town," he said, adding that one of the patients died later after being hit by a car.

"Hospital patients don't care" about the report, he said. "Nobody pays attention to this data other than journalists."

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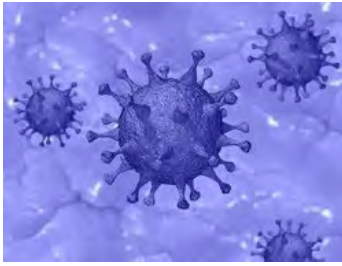
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# EXHIBIT 2

1	IN THE EIGHTH JUDICIAL DISTRICT COURT	
2	CLARK COUNTY, NEVADA	
3		
4	DARELL L. MOORE and CHARLENE A. )	
5	MOORE, individually and as )	
6	husband and wife, )	
7	Plaintiffs, )	
8	vs. )	CASE NO.
9	JASON LASRY, M.D., )	A-17-766426-C
10	individually; FREMONT EMERGENCY )	
11	SERVICES (MANDAVIA), LTD.; )	DEPT. NO. 25
12	TERRY BARTMUS, RN, APRN; and )	
13	DOES I through X, inclusive; )	
14	and ROE CORPORATIONS I )	
15	through V, inclusive, )	
16	Defendants. )	
17	<hr/>	
18	REPORTER'S TRANSCRIPT OF PROCEEDINGS OF JURY TRIAL	
19	P.M. SESSION TESTIMONY OF ALEXANDER MARMUREANU, M.D.	
20	BEFORE THE HONORABLE KATHLEEN E. DELANEY	
21	FRIDAY, JANUARY 31, 2020	
22	APPEARANCES:	
23	For the Plaintiffs:	
24	E. BREEN ARNTZ, ESQ.	
25	HANK HYMANSON, ESQ.	
26	PHILIP M. HYMANSON, ESQ.	
27	For the Defendants:	
28	ROBERT C. McBRIDE, ESQ.	
29	KEITH A. WEAVER, ESQ.	
30	ALISSA BESTICK, ESQ.	
31	REPORTED BY: DANA J. TAVAGLIONE, RPR, CCR No. 841	

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## I N D E X

### WITNESSES

### PAGE

ALEXANDER MARMUREANU

Cross-Examination by Mr. Weaver

3

Redirect Examination by Mr. Arntz

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Redirect Examination by Mr. Arntz

53

Cross-Examination by Mr. McBride

57

Cross-Examination by Mr. Weaver

59

## E X H I B I T S

### JOINT EXHIBIT

### MARKED

### ADMITTED

104

Admitted

40

1 LAS VEGAS, NEVADA, FRIDAY, JANUARY 31, 2020

2 1:57 P.M.

3 \* \* \* \* \*

4 Thereupon --

5 ALEXANDER MARMUREANU, M.D.,  
6 having been previously sworn to testify to the  
7 truth, was examined and testified as follows:

8  
9 CROSS-EXAMINATION

10 BY MR. WEAVER:

11 Q. Good afternoon, Doctor.

12 A. Good afternoon, Mr. Weaver.

13 Q. Welcome to Las Vegas.

14 A. Thank you, sir. Much appreciated.

15 Q. I want to start off with a little bit of  
16 apology in response to counsel earlier this morning.  
17 You had mentioned that you were coming out of the  
18 bathroom, I was going in. We shook hands. But I  
19 didn't stop and chitchat. I did not mean it as any  
20 slight. It's not my style, when I'm in trial, to  
21 talk with the other side's expert. Fair enough?

22 A. Apology accepted.

23 Q. Thank you. Also, just to clarify something,  
24 I'm sure would have got clarified later, but I can  
25 just do it quick and easily.

1                   When we were leaving off, before the lunch  
2 break, I think you misspoke on the record, and I just  
3 wanted to potentially clear it up so that the jury  
4 might not get the wrong impression.

5                   You mentioned that, at your deposition,  
6 which was taken in my firm's downtown Los Angeles  
7 office; correct?

8           A.     I believe so. Yes, you're correct.

9           Q.     And there was an attorney from Mr. McBride's  
10 office there, Chelsea Hueth. Do you remember that?

11          A.     That's correct.

12          Q.     And do you remember what Ms. Hueth actually  
13 said, which was not --

14                   MR. ARNTZ: Well, hold on. Before you  
15 start to ask this question, we need to approach the  
16 bench.

17                   THE COURT: Okay.

18                                 (Bench conference.)

19                   THE COURT: You didn't get too comfortable,  
20 did you, folks? In all seriousness, once a bench  
21 conference goes a little bit longer and we're really  
22 trying to flesh some things out, it's just much  
23 easier to do it without you all present. So if  
24 you'll indulge us. You know your admonishment.  
25 we'll note it on the record. I'm not going to read

1 it again. If you could just step outside for a few  
2 minutes, we'll have you right back in. Okay?

3 THE MARSHAL: All rise for the jury.

4 (Jury exits the courtroom.)

5 THE COURT: Doctor, can I ask you to please  
6 step back to --

7 THE WITNESS: Of course. Go outside?

8 THE COURT: Into the alcove. There's a  
9 little waiting room.

10 THE WITNESS: Thank you.

11 THE COURT: Okay. As is my practice, just  
12 indulge me. I would like to, you know, summarize  
13 the bench conference.

14 So what Mr. Arntz' concern expressed, when  
15 he asked to approach, was that he believed that  
16 Mr. Weaver was going to get into details, but also  
17 just identification of potentially that what had  
18 come out in the deposition was that Dr. Marmureanu  
19 had been represented by Mr. McBride's law firm, not  
20 that Mr. McBride's law firm had used him as an  
21 expert, and that Mr. Weaver indicated that that  
22 clarity was necessary because Dr. Marmureanu had  
23 testified that it had come out in the deposition  
24 that he had been used as an expert by Mr. McBride's  
25 law firm.

1 I distinctly, from my personal  
2 recollection, recall Dr. Marmureanu testifying and  
3 going out of his way, in all candor, to testify to  
4 your firm and "you've used me" and clearly leaving  
5 this jury with the impression that Mr. McBride's law  
6 firm had used him as an expert at least once, if not  
7 more, in the past.

8 So my indication at the bench initially, as  
9 we were talking but before the conversation got more  
10 detailed and concerns expressed about the level in  
11 which Mr. Weaver might inquire on this subject,  
12 that's when I excused the jury so we could have a  
13 better discussion. But Mr. Weaver's response was,  
14 you know, the clarity is necessary and that he was  
15 not going to inquire into details of the  
16 representation, but that he should be able to  
17 clarify that there was representation.

18 Obviously, that's a very fine line to walk  
19 if these jurors are connecting to, and I don't know  
20 why they wouldn't be, that these attorneys represent  
21 doctors in medical malpractice cases and then cast  
22 aspersions indirectly that way on this witness.

23 So we are going to have to figure out how  
24 we're going to address this, but my inclination is  
25 still, at this moment, to indicate that there must

1 be some clarity because the doctor did volunteer  
2 that information. I don't think it was responsive  
3 to an inquiry of Mr. McBride, and he did appear to  
4 leave the jury with the impression that his firm had  
5 hired him as an expert, and if that's not the case,  
6 we need to figure out how to get some clarification.  
7 But, Mr. Arntz, let me let you flesh out your  
8 argument, and then I'll hear from Mr. Weaver.

9 MR. ARNTZ: Look, I wasn't -- in fact, at  
10 lunch, I cautioned him not to get cute volunteering  
11 statements like that. But his statement was not in  
12 the context of what was discussed in the deposition.  
13 His statement was just a gratuitous, "Oh, and by the  
14 way, you guys have hired me too." And this was  
15 being discussed when he was talking about how much  
16 things cost and so forth.

17 I don't have any recollection of it being  
18 in the context of that being discussed in the  
19 deposition. I agree that the only thing that was  
20 discussed in the deposition was a disclosure by  
21 Ms. Hueth that her firm had represented him before.  
22 And she wanted to make sure it wasn't going to be a  
23 conflict. But that statement that he made was just  
24 a gratuitous statement of "Oh, and by the way, your  
25 firm has hired me too."



1           THE COURT: Right. Gratuitous.  
2       Problematic in that way.

3           MR. ARNTZ: I don't disagree that some  
4       clarity brought on by saying "But you represent  
5       plaintiffs and/or you testified for plaintiffs, and  
6       you've testified for defendants and so forth." I  
7       don't see it opening the door to something that  
8       happened at deposition where a disclosure was made  
9       just so he would be comfortable having one of his  
10      attorneys there.

11          THE COURT: Let's role play here a second.  
12      So if I were to limit Mr. Weaver's followup to  
13      something along the lines of, you know, "Doctor, you  
14      testified earlier that you believed or remembered  
15      that Mr. McBride's law firm had hired you as an  
16      expert, if I were to indicate to you that there does  
17      not appear to be any record of that being the case,  
18      would" --

19          MR. ARNTZ: I don't know if that's true. I  
20      don't think that's true.

21          THE COURT: Have you hired him as an  
22      expert?

23          MR. MCBRIDE: Our firm?

24          THE COURT: I know you said you hadn't met  
25      him. Has your firm? I mean, I know your firm is

1 pretty big.

2 MR. MCBRIDE: I honestly don't know because  
3 we have our firm --

4 THE COURT: But it never came out in the  
5 depo, so.

6 MR. MCBRIDE: It never came out in the  
7 depo, yeah.

8 MR. ARNTZ: The only thing that came out in  
9 the depo was a disclosure.

10 THE COURT: Mr. Arntz, okay, but I wasn't  
11 finished. But, okay, fair enough. I'm trying to  
12 figure out a way, because this clarity will occur,  
13 how we do it. So I was trying to throw out an  
14 option so you can shoot it down, if you want, but  
15 then what's your alternative?

16 MR. ARNTZ: Well, if I had asked  
17 Dr. Marmureanu, "Have you ever worked for any of the  
18 defense firms" and he said yes, would that require  
19 clarity? Because all he did was volunteer a  
20 statement that wasn't responsive to a question that  
21 still is true.

22 THE COURT: In Dr. Marmureanu's  
23 testimony, I think it's more problematic because it  
24 was gratuitous, volunteered, and it appeared to be  
25 designed for exactly the effect that counsel is now

1 concerned about and wants clarity on.

2 Had you asked, would they be able to  
3 clarify? You know, again, I mean, as we sit here  
4 today, we can't be certain that he hasn't been used  
5 by them as an expert. But, again, it never came up.  
6 I would think that we would have that information,  
7 if he had, but I guess we can't rule it out. But at  
8 this point, you know, what he was talking about  
9 appeared to be in the context -- because he said it  
10 himself, "In the deposition, it came out."

11 He's very prone to want to say what he  
12 thinks is in there, that he thinks is being kept  
13 from the jury. I tried to admonish him, but he's  
14 still doing it. And he made it clear that, in the  
15 deposition, this is what it says. So maybe that's  
16 how we clarify that, you know, "If I were to tell  
17 you that there's no statement in the deposition that  
18 this firm hired you as an expert, would you have  
19 reason to question that at this time?"

20 MR. ARNTZ: How about striking that from  
21 the record and just telling the jury --

22 THE COURT: They heard it. You can't  
23 unring the bell. There needs to be clarity.

24 MR. ARNTZ: But my point is let's assume  
25 for a minute that it's true that he's been hired by

1 Mr. McBride's firm to act as an expert. How does  
2 the fact that, during the deposition, a disclosure  
3 was made by Ms. Hueth that her firm had represented  
4 him in the past clarify that? It doesn't clarify  
5 that. If it's true that he has been retained by  
6 them, talking about the fact that he's been  
7 represented by that firm doesn't clarify that point.

8 THE COURT: I don't perceive that to be the  
9 issue. I perceive the issue to be that there's no  
10 evidence, from what they're telling me, from his  
11 deposition which, by all accounts, was lengthy and  
12 his C.V. and anything else to indicate that they had  
13 hired him as an expert; although, again, we can't  
14 completely rule it out, all that came up in the depo  
15 was this other issue. He's referring to the depo.

16 So in the end of the day, you know, he's  
17 talking about something that was in the depo that  
18 wasn't there. Why is that clarity not appropriate?

19 MR. ARNTZ: Okay. I don't remember it that  
20 way.

21 THE COURT: You remember which part?

22 MR. ARNTZ: I don't remember his gratuitous  
23 comment being made in the context of this coming up  
24 in the depo.

25 THE COURT: I heard it.

1 MR. ARNTZ: Okay. I don't remember it that  
2 way, but I still don't see how --

3 THE COURT: Respectfully, I remember it.  
4 You don't. We agree to disagree.

5 MR. ARNTZ: Yeah, no, that's fine. That's  
6 not really relevant to the other point, which is I  
7 don't see how him asking questions about having been  
8 represented by that firm, just because that's what  
9 came up in the depo sheds clarity on the statement  
10 he made. If he asks that question and then I  
11 follow-up by saying, "well, Dr. Marmureanu, have you  
12 been retained by Mr. McBride's firm?" Because then  
13 that would clarify even further.

14 THE COURT: Maybe the better way to do it,  
15 go about this, Mr. Arntz, and we need to get to  
16 this, but I'm assuming your angst over this is  
17 because you don't want it coming out these attorneys  
18 who represent doctors in medical malpractices might  
19 have represented him.

20 MR. ARNTZ: Right. So I'm giving you an  
21 alternative where I'm limiting Mr. Weaver to just  
22 asking the witness -- at least for now, we'll see  
23 what his answer is -- but just asking the witness,  
24 "You testified earlier that you believed it came out  
25 in the deposition that Mr. McBride's firm had hired

1 you as an expert. If I were to tell you that we  
2 reviewed this over the break and there doesn't  
3 appear to be any indication in the deposition that  
4 that is the case or that the dialogue in the  
5 deposition was related to not that, you know, would  
6 you have any reason to doubt that? Do you have any  
7 better recollection of that at this time?"

8 something so that it doesn't come up that  
9 he was represented, but it comes up that there's  
10 nothing in evidence that he was retained by them as  
11 an expert. Because he clearly gave testimony to the  
12 jury that sounded like he had been retained by them  
13 as an expert.

14 MR. ARNTZ: Right. So I guess maybe the  
15 reason I focus on what I have is because that seems  
16 to be the focal point, has he been retained by this  
17 firm, not whether it came up in the depo. But your  
18 solution is fine with me, so long as they don't get  
19 into representations.

20 THE COURT: I think there's a way.

21 Mr. Weaver, can you tell us, do you think  
22 there's a way that you can inquire without --

23 MR. WEAVER: I think, well, two things. I  
24 think that there is a way I can inquire as long as  
25 it's clear that it's not just whether he has been

1 retained as an expert by Mr. McBride's firm, that he  
2 has not, but the context of what he said in the  
3 deposition is he had it wrong, No. 1.

4 But, No. 2, the Motion in Limine with  
5 regard to lawsuits only applies to defendants. So  
6 if I ask him, I'm not intending to ask him questions  
7 about Mr. McBride's representation any more than  
8 Mr. McBride was obviously, at the end, going to get  
9 into his firm's representation. I could get into  
10 questions about lawsuits that he's had, and there  
11 have been plenty. But I certainly was not intending  
12 to get into questions about Mr. McBride's firm  
13 representation.

14 The only thing that I can't live with is he  
15 gratuitously offered, implying that it was brought  
16 up that he is an expert of Mr. McBride's firm when  
17 the only thing that was brought up was not that, but  
18 representation.

19 THE COURT: All right. So, you know, my  
20 thought is that we do need to clarify his testimony.  
21 The same, whether or not the Motion in Limine was  
22 brought by a particular party on behalf of  
23 particular parties, it's still the same concept  
24 which is, you know, is it relevant and does it, is  
25 it substantially outweighed by prejudice -- I

1     suppose, to some degree -- analysis, and I don't  
2     think it should be revealed here that he was  
3     represented by Mr. McBride's firm.

4             But the issue, I think by the way I'm  
5     suggesting it be done, I think is resolved because  
6     if you say and very clear, you know, "We reviewed  
7     this over the break, and we see no indication of  
8     that testimony being had or no indication of any,  
9     you know, evidence in the deposition of them having,  
10    you know, retained you as an expert. So, you know,  
11    what you were testifying about does not appear to be  
12    accurate in that regard, you know, would you agree  
13    with that, or would you have some reason to doubt  
14    that?"

15            Now, the issue is if he says something like  
16    "well, it may have been something different" or "I  
17    may have been mistaken" or whatever, we can move on.  
18    If he doubles down on it, then where do we go?

19            MR. ARNTZ: I'll tell him to just take his  
20    medicine and we move on.

21            MR. MCBRIDE: And, Your Honor, just for  
22    clarification too, you asked the question if I knew  
23    if our firm has retained him, again, I don't know  
24    specifically. At least from the deposition list  
25    that he provided and trial testimony, I went through



1     that just now, that he attached from 2009 up to  
2     2019, I don't see any reference to our firm as  
3     being, representing him in those depositions or him  
4     acting on behalf of our firm or any of the trials or  
5     mediations that he's worked on. So just for that --

6             THE COURT: Right. I mean, it doesn't  
7     drive the train.

8             MR. MCBRIDE: Right.

9             THE COURT: The whole thing boils down to  
10    me, and I understand Mr. Arntz and I remember this  
11    differently, and maybe the other counsel do as  
12    well -- you know, various people in the setting can  
13    hear things differently -- is the whole conversation  
14    was what was in the depo and what came out in the  
15    depo. And I think if we limit it to what's in the  
16    depo, we can solve this problem.

17            I think actually makes it worse, Mr. Arntz,  
18    if it's not the case that it was him talking about  
19    what's in the depo because then it's a little bit  
20    more broad-based about how we can inquire. But I  
21    think it can be corrected.

22            I think it can be corrected by "There's  
23    nothing in the depo that would support your  
24    recollection of you having a discussion about being  
25    retained by Mr. McBride's firm." So, you know, "or

1     you being retained as an expert by Mr. McBride's  
2     firm.  so if we indicate that to you, you know,  
3     would you stand corrected on that point, or could  
4     you have possibly misremembered?" or something along  
5     those lines.  And, again, if he agrees, yes.  If he  
6     says "I don't remember" or "maybe I misremembered,"  
7     then we can move on.  But like I said if he doubles  
8     down and says "No, I'm quite certain I testified  
9     that they represent," then we might have to allow  
10    some clarification.

11                 MR. ARNTZ:  Like I said, I don't think that  
12    the prejudice that Mr. Weaver is talking about is  
13    that it came up in the depo.  He's talking about  
14    whether or not he's been hired by a defense firm,  
15    and so I don't know -- I don't know how I see the  
16    relevance of the depo.  But I'm perfectly happy with  
17    your solution, and I will tell him to --

18                 THE COURT:  No.

19                 MR. ARNTZ:  Because I don't think it's in  
20    the depo either.  So I'm happy --

21                 THE COURT:  We're not going to have that  
22    issue again where we've had a dialogue about his  
23    testimony.  We're, you know, just going to have to  
24    live with the answer and go from there.

25                 But, Mr. Weaver, do you think you can make

1     that line of inquiry?

2                 MR. WEAVER:   Sure.   I think that's the  
3     perfect solution.

4                 THE COURT:   I hope.   We'll see.   Let's get  
5     Dr. Marmureanu up in, Dr. "Marmureanu" here first.  
6     I don't want to do an outside-the-presence voir dire  
7     with him because it's just going to make it worse.

8                 MR. P. HYMANSON:   Your Honor, before we go,  
9     if I could, Phil Hymanson.   Very quickly, Your  
10    Honor.   So the representation from Mr. McBride's  
11    firm is he can't say specifically whether they have  
12    or have not, they're just -- at this point, they  
13    don't know?   Is that the understanding?

14                THE COURT:   I mean, I think that's true.

15                MR. MCBRIDE:   Yeah, I think that's true,  
16    and I'm just going off also the top of that, what he  
17    had listed.

18                MR. P. HYMANSON:   When asking questions,  
19    we'll hopefully move through it and move on, but if  
20    we don't, then there's Step 2.

21                THE COURT:   I mean, I think we've said that  
22    a couple of times, but I appreciate you clarifying,  
23    Mr. Hymanson, that we can't be certain, as we sit  
24    here today, that he hasn't been retained by his firm  
25    as an expert.   We know he hasn't been retained by

1 Mr. McBride as an expert. But by his firm, no.

2 But what we can also be certain of is that  
3 it does not appear to be what was discussed in the  
4 depo; and when he testified, from his recollection,  
5 that what was in the depo was that fact, that's what  
6 we need to clarify.

7 MR. P. HYMANSON: Thank you.

8 MR. WEAVER: I'll limit it to that.

9 Thank you.

10 THE COURT: Ask to approach if it goes  
11 south.

12 (Jury enters the courtroom.)

13 THE COURT: All right. Thank you, ladies  
14 and gentlemen. Have a seat. I'll invite everybody  
15 else to have a seat as well. We have resolved the  
16 bench conference issue, and everybody in the jury  
17 appears to be ready to proceed.

18 Dr. Marmureanu, could you please also,  
19 again, acknowledge you understand you're still under  
20 oath.

21 THE WITNESS: Yes, I do.

22 THE COURT: Thank you. And, Mr. Weaver,  
23 whenever you're ready to resume.

24 MR. WEAVER: Thank you, Your Honor.

25 / / /

1 BY MR. WEAVER:

2 Q. Dr. Marmureanu, I think I just want to cut  
3 through the chase on something. Over the break, I  
4 reviewed the deposition that you and I attended and  
5 have refreshed my recollection that I don't believe  
6 there's anything in your deposition that indicated  
7 Mr. McBride's office has retained you as an expert,  
8 which I think you said just before we went on the  
9 lunch break.

10 would it be fair to say that you just  
11 misspoke when you said that and that it didn't come  
12 up in the deposition, that that was the case?

13 A. It is unfair, sir. May I explain?

14 Q. So let me just stop you there for a minute.

15 So your recollection of the deposition is  
16 there was a discussion about Mr. McBride's firm  
17 retaining you as an expert? That's your recollection  
18 of the deposition?

19 A. I don't have much of a recollection of the  
20 issue that you brought up. That's not what I  
21 referred to when I --

22 Q. Well, I'm just asking you because the  
23 testimony that you volunteered to Mr. McBride was  
24 that, in the deposition, it came up that there was  
25 something that related to comments on the record

1 about you being retained by Mr. McBride's firm as an  
2 expert. Is it your recollection that that  
3 conversation took place or not in the deposition?

4 A. I don't remember about talking about this  
5 during the deposition. May I explain what I was  
6 referring to?

7 MR. WEAVER: No. May we approach.

8 THE COURT: Yes.

9 (Bench conference.)

10 THE COURT: All right. Thank you,  
11 Mr. Weaver. You can move on to another line of  
12 questioning.

13 MR. WEAVER: Thank you, Your Honor.

14 THE COURT: I think we have that clear.

15 BY MR. WEAVER:

16 Q. Dr. Marmureanu, I forget whether you said  
17 you reviewed the deposition of your co-expert in this  
18 case, Dr. Jacobs. Have you or not?

19 A. I did review it, sir. Yes.

20 Q. Do you recall seeing in his deposition where  
21 he said the exact opposite of you this morning when  
22 you said: "The standard of care doesn't require the  
23 Five Ps; nobody does that anymore, that the standard  
24 of care requires a CT angiogram," and he said the  
25 exact opposite?

1           Do you recall him saying nobody would have  
2       done a CT angiogram in this case?

3           A.    I do not recall that, sir.  No absolutely  
4       not.

5           Q.    would it shock you?

6           A.    wouldn't shock me.  I just said I don't  
7       remember.

8           Q.    why wouldn't -- if that is his testimony,  
9       why wouldn't it shock you that your co-expert in this  
10      case says the exact opposite that you do, given that  
11      in response to Mr. Arntz' questioning, you said  
12      there's one standard of care when it comes to the  
13      emergency medicine in this case?

14          A.    Because I truly believe you take it out of  
15      context, and I would like you to show us exactly  
16      what we're talking about before we make those  
17      statements.

18          Q.    well, it's a statement that you made.

19                You testified this morning that you're  
20      qualified to offer opinions in emergency medicine,  
21      even though you haven't been trained in emergency  
22      medicine, because there's one standard of care.

23                So if there's one standard of care for you,  
24      if there's one standard of care for Dr. Jacobs, if  
25      there's one standard of care for Nurse Practitioner

1 Bartmus, if there's one standard of care for  
2 Dr. Lasry, everybody should be on the same page, or  
3 at least you and Dr. Jacobs should be on the same  
4 page; correct?

5 MR. ARNTZ: Your Honor, I have an objection  
6 as to this line of questioning regarding Dr. Jacobs'  
7 deposition. It's hearsay, and we've had a motion on  
8 this before trial started.

9 THE COURT: Mr. Weaver, do you want to  
10 respond?

11 MR. WEAVER: Yes. What I respond to that  
12 is he said he's reviewed that experts are able to  
13 rely on anything of a serious matter, and I think  
14 that given that the testimony that there's already  
15 been, I think it's fair game.

16 MR. ARNTZ: Okay. He hasn't testified  
17 here, and his deposition hasn't been read into the  
18 record here.

19 THE COURT: Maybe you all get to have your  
20 exercise. So come on up to the bench.

21 (Bench conference.)

22 THE COURT: All right. Thank you. We got  
23 right up on that moment of having to start fresh.

24 But go ahead. Mr. Weaver, I think we have  
25 an understanding of how to proceed with this line of



1 questioning.

2 MR. WEAVER: Thank you, Your Honor.

3 BY MR. WEAVER:

4 Q. Dr. Marmureanu, you said that you reviewed  
5 Dr. Jacobs' deposition. When did you last review it?

6 A. Probably last week.

7 Q. All right. And you reviewed it obviously in  
8 preparation for being here today; correct?

9 A. That's correct.

10 Q. And you reviewed it because it was material  
11 sent to you by plaintiffs' counsel's office for you  
12 to prepare for your deposition -- I'm sorry -- for  
13 you to prepare for your trial testimony today;  
14 correct?

15 A. No. Not correct. That was sent to me way  
16 before the trial. So I review it because I felt I  
17 need to review it.

18 Q. Why did you feel it would be helpful to  
19 review it in preparation for your testimony today?

20 A. That's who I am. I need to review every  
21 piece of document that I can in order to formulate  
22 what I believe is the right opinion.

23 Q. Okay. So you wanted to review all the  
24 materials that were provided to you in order to  
25 support the opinions for which you're prepared to

1 testify to today, and that included Dr. Fish's (sic)  
2 deposition; correct?

3 MR. ARNTZ: Not Dr. Fish. Dr. Jacobs.

4 BY MR. WEAVER:

5 Q. I'm sorry. Dr. Jacobs' deposition?

6 A. No, not really. I didn't review it in  
7 order to help me support my opinions. I review it  
8 in order to basically understand what was his  
9 thought on the whole process. So then I decide  
10 where it goes from there, but I don't review  
11 documents -- I don't know ahead of time what's going  
12 to happen with that review. Make sense?

13 Q. Do you agree with me that Dr. Jacobs'  
14 opinions with regard to the violations of the  
15 standard of care in this case are different from  
16 yours?

17 A. No. I disagree with you.

18 Q. Okay. Is it your opinion, based on your  
19 review of Dr. Jacobs' deposition, that your opinions  
20 fit those of Dr. Jacobs?

21 A. By and large, yes, that's my opinion.

22 Q. In what ways don't they, other than that he  
23 testified that there did not need to be a CT  
24 angiogram? What additional ways don't they match, or  
25 would we need to go through them all?

1           A.    We will probably need to go through. If I  
2    may explain, I do not believe that he said that  
3    there is no need for a CT angiogram. I think you're  
4    taking it out of context. What I believe he said,  
5    he would follow-up with an arterial duplex  
6    immediately after venous duplex, and he will decide  
7    from there other ways of discovering if this graft  
8    is open or not. In other words, by no means, when  
9    we talk about Five Ps, that's historical medicine.  
10   That address to physical exam, which is part of the  
11   standard of care, but by itself, doesn't represent  
12   the standard of care.

13                 Standard of care, it's part of the  
14    compilation. It's the physical exam, which you  
15    could put the Five Ps in there. There are the  
16    studies, and there is the management.

17           Q.    Right. But Dr. Jacobs testified that no  
18    reasonable practitioner in the emergency department  
19    on December 25th, 2016, would have done a CT  
20    angiogram. That's the exact opposite of what you're  
21    saying; correct?

22           A.    I do not believe you're truthful, sir. I  
23    would like to see that.

24           Q.    Okay. So you don't just think I'm wrong.  
25    You think I'm not telling the truth --

1           A.     Either way.

2           Q.     -- about Dr. Jacobs?

3           A.     Yeah, I would like to see that.

4           Q.     So but you don't really need to see it  
5 because you're sure I'm just not telling the truth  
6 about what he testified to; right?

7           A.     Well, to the best of my recollection, I  
8 remember you and him talking about it. I truly  
9 believe that he said that perhaps, to the best of my  
10 recollection, as an initial step, he wouldn't have  
11 ordered it. He would have perhaps ordered it after.  
12 It's not about CT angiogram. It's any sort of  
13 angiogram. I would like to see that, if possible.

14          Q.     Right. But that's my point. Dr. Jacobs  
15 said that in the emergency department, nobody had a  
16 duty to order a CT angiogram. This morning, what you  
17 testified to to the jury is that: The standard of  
18 care isn't to do Five Ps; nobody does that anymore;  
19 the standard of care was to do a CT angiogram.

20          A.     Correct. I'm saying the same thing.  
21 That's, standard of care, it's Five Ps, forward  
22 slash, physical exam and angiograms. MR angiograms,  
23 CT angiograms, or real angiogram. And I think, if I  
24 recall correct, that's what the E.R. doctor said. I  
25 would like --

1 THE REPORTER: Was that "real" angiogram?

2 THE WITNESS: Or "regular" angiogram.

3 BY MR. WEAVER:

4 Q. Dr. Marmureanu, do you have an opinion of  
5 how many cardiovascular surgeons there are in  
6 California, roughly?

7 A. No, sir.

8 Q. A few hundred?

9 A. Probably. Could be.

10 Q. Your understanding?

11 Okay. And you testified this morning that  
12 anytime you're doing heart surgery, it includes  
13 vascular. So if you're doing heart surgery, the  
14 cardiac part, it also includes vascular. So that  
15 it's cardiovascular; correct?

16 A. That's right. It's -- yes, sir.

17 Q. And, Dr. Marmureanu, have you heard the term  
18 "Pot calling the kettle black"?

19 A. I'm sorry. What did you say?

20 Q. Do you know what the term "Pot calling the  
21 kettle black" means?

22 A. No, sir.

23 Q. How about the term "People who live in glass  
24 houses shouldn't throw stones"? Ever heard of that?

25 A. No, sir.

1           Q.    In 2017, the State of California declared  
2   that you are one of the seven worst cardiovascular  
3   surgeons in the entire state out of hundreds;  
4   correct?

5           A.    Incorrect, sir. I would like to see that.

6           Q.    So is it your testimony, Dr. Marmureanu,  
7   that the office of -- the California Office of  
8   Statewide Health Planning and Development didn't  
9   issue a report that listed you in the top 3 percent  
10   of the worst cardiovascular surgeons in California?

11          A.    You're untruthful and incorrect, again,  
12   sir.

13          Q.    Okay. So what would you need to be  
14   convinced that that report exists?

15          A.    Show it.

16          Q.    Okay. We'll come back to that.

17          A.    Go ahead.

18          Q.    Let me do what's called "lay a little  
19   foundation." So do you know what the "California  
20   Society of Thoracic Surgeons" is?

21          A.    Very well.

22          Q.    Okay. And you don't believe that the  
23   president of the California Society of Thoracic  
24   surgeons supported a report that identified you as  
25   one of the top seven worst cardiovascular surgeons in

1 California; correct?

2 A. Not only do I don't believe, I'm saying  
3 you're wrong.

4 Q. And I would also be wrong if you told a  
5 reporter for Kaiser News that, in effect, hospital  
6 patients don't care if they're, in your case, nine  
7 times more likely to die under your care?

8 A. That's not what I said. You're not telling  
9 the truth again.

10 Q. Did you say something to that effect, that  
11 hospital patients don't care about that report; the  
12 only people who care about the data are the  
13 journalists?

14 A. That could be.

15 Q. But it's in the context of the report that,  
16 out of 271 cardiovascular surgeon in California,  
17 found you one of the worst seven?

18 A. It's absolutely not true. And, I mean, I  
19 don't want to judge upset, but I think it's  
20 despicable what you're saying.

21 Q. And would it also be despicable if Hollywood  
22 Presbyterian Hospitals got one of the worst rankings  
23 as a hospital because of your ranking by the State of  
24 California's Office of Statewide Health Planning and  
25 Development?

1           A.    That's not true again, sir.  You will have  
2   to show me.

3           Q.    Okay.  We'll come back to that.

4                    Sir, you're saying no such report exists;  
5   right?

6           A.    Well, not what you said.  What you said  
7   doesn't exist.  You are wrong about the year; you  
8   are wrong about the report; you are wrong what the  
9   report says, and I'm not sure if you're doing it on  
10   purpose or just you don't know enough about it.

11          Q.    Well, I read the report.  What does it say?  
12   well, you're familiar --

13          A.    Allow me to explain.  I can explain.

14                   MR. ARNTZ:  Your Honor, he's not laying the  
15   proper foundation.

16                   THE COURT:  Hold on.  There's an objection  
17   posed, and I'm going to have counsel back at the  
18   bench so we can try to resolve it more quickly.

19                               (Bench conference.)

20                   THE COURT:  The objection is overruled.  
21   You may proceed, Mr. Weaver.

22   BY MR. WEAVER:

23          Q.    Dr. Marmureanu, you were quoted, weren't  
24   you, after the report came out, by a reporter from  
25   Kaiser Health News where you were identified in a



1 news report based on the California Office of  
2 Statewide Health Planning and Development where you  
3 were asked questions about your ranking in that  
4 report; correct?

5 A. Can you repeat the question.

6 Q. Sure. Tell me what your understanding is of  
7 the report that came out in 2017, from the California  
8 Office of Statewide Health Planning and Development,  
9 that identified you in the "worst" category.

10 There were 265 cardiovascular surgeons in  
11 one category, and you and six others were in a  
12 category that was labeled "worst." A California  
13 state document. Are you denying that?

14 A. Can you, when you say "worst," what are you  
15 referring to?

16 Q. The state put you in a category that they  
17 labeled you as "worst." Do you admit that or deny  
18 that?

19 A. I'm asking you when you say "worst,"  
20 "worst" in which? what kind of "worst"? what  
21 category of "worst"?

22 Q. "Worst" in the context of you having nine  
23 times the state average of deaths following CABGs.  
24 Tell the jury what a "CABG" is.

25 A. All right. May I explain, sir?

1 Q. Sure. Tell the jury what a "CABG" is.

2 A. So first of all, I truly believe you're  
3 totally incorrect, or I'm not sure. Maybe you don't  
4 even know what you're saying. We have to look at  
5 the report. But here is what he's trying to say.  
6 "CABG" means "coronary artery bypass grafting."  
7 Most of the people -- people have heart attacks.  
8 Instead of having a clotted graft, they have a  
9 clotted artery. They get rushed to the hospital.  
10 We talk this called "STEMI" --

11 (Reporter request.)

12 THE WITNESS: It's called a "STEMI,"  
13 S-T-E-M-I.

14 THE REPORTER: Please begin the sentence  
15 again, and speak more slowly. I apologize.

16 THE WITNESS: Sure. S-T-E-M-I. I don't  
17 remember. It's about STEMI.

18 So people whose heart attacks come to the  
19 hospital, they're being brought by the ambulance to  
20 the hospital; and at that point, we talked about the  
21 committees that address the fact that this is an  
22 emergency. We have to operate on those patients or  
23 do some sort of percutaneous intervention on them  
24 within 30 to 90 minutes. The operation that they  
25 usually get is called "coronary artery bypass

1 grafting." Sounds "CABG." It's not a fancy, but  
2 that side the way it is.

3 So the report is from 2013 and not 2017.  
4 I've actually had zero mortalities the last seven  
5 years. That's a zero. In that year, in 2013,  
6 because I cover nine hospital, and most of the busy  
7 doctors and the best doctors in town tend to address  
8 and to operate on the sickest patients. We don't  
9 pick and choose, but we are the first and the last  
10 line of defense. We are the one operating on people  
11 with chest pain, with the heart being almost dead,  
12 with the vessels be blocked with the balloon pumps  
13 in them.

14 The family is there. The cardiologist said  
15 "It's nothing that you can do." The easiest thing  
16 to do is to deny the case and go and play golf, or  
17 you do the case, you spend 18 hours there, and you  
18 try to save his life. So in 2013, they decide to  
19 look at 30 days mortality. 30 days mortality is, by  
20 California, S-T-S, means any patient that died  
21 within 30 days for any cause.

22 I've had a patient that was hit by a bus.  
23 I had a patient that had a stroke post update 25  
24 because of anticoagulation. I had a few patients  
25 that died before dissection. The whole heart

1 exploded. The whole aorta exploded, torn apart. So  
2 during that procedure, because every I have to  
3 reconstruct, I actually put a graft from the aorta  
4 to the heart, and suddenly went into this category  
5 of CABG. So my mortality that year was in 30 days.  
6 No patient ever died on the O.R. table. They were  
7 always in 15 days to 30 days.

8           we had an issue with California Society of  
9 Cardiothoracic Surgery, it's plain stupid to blame a  
10 surgeon -- and nobody blamed the surgeon. The data  
11 is not blaming surgeon. It's that surgeon, in that  
12 year, had a higher mortality than his colleagues  
13 with they not taking call the way I do in three very  
14 busy hospitals. And there was all those sick  
15 patients.

16           So that happens. I gave them an interview.  
17 Some of the best cardiac surgeons in Los Angeles,  
18 the busiest guy are part of this group, and we're  
19 happy because we don't turn patient down. We know  
20 they will die if we don't do them. If we do them,  
21 they had a chance. Nobody died on the O.R. table,  
22 died weeks after. And currently there is a big  
23 issue with covering this kind of data because the  
24 public has to be informed.

25           This is not a blame on the surgeons,

1 otherwise nobody would operate, because misinformed  
2 people will take those tables that they don't know  
3 what "worst" is about. So it's about, in 2013, I  
4 had a few more mortalities, 20 to 30 days postop.  
5 Those are patients that are home. One of them got  
6 hit by a bus in Vegas, and those death within  
7 30 days. So no, I don't think I'm a bad surgeon,  
8 no.

9 BY MR. WEAVER:

10 Q. Dr. Marmureanu, the study was not in 2013.

11 A. 2013.

12 Q. No, it wasn't. The surgeries were in 2014  
13 and 2015, and the report was in 2017.

14 A. May I see it?

15 Q. I don't have it with me. I have the  
16 reports. You know why I don't have it with me  
17 because it's all online, and it's all online for the  
18 world to see, and it's never had to be corrected  
19 because this is the first time you've ever claimed  
20 that one of your patients is included in that  
21 mortality rate by being hit by a bus.

22 That's not true, is it?

23 A. It's -- no, it's been -- I actually claimed  
24 this before, even during the interview.

25 Q. You claimed somebody got hit buy a car. Now

1     you're claiming they got hit by a bus in Las Vegas?

2           A.     It's the same thing.  It's car or a bus,  
3     yes.

4           Q.     Okay.  So the people who compile -- the  
5     state employees whose job it is, at the Office of  
6     Statewide Health Planning and Development, you agree,  
7     don't you, that they didn't just calculate all the  
8     deaths from patients by surgeons like you who do the  
9     coronary artery bypass surgery.  You know that they  
10    risk stratified them so that it's apples for apples;  
11    correct.

12          A.     More or less, but you can't really  
13    re-stratify a death.  A death is a death.

14          Q.     Right.  But my point is when you're trying  
15    to tell the jury that you're actually one of the best  
16    cardiovascular surgeons in Los Angeles, but the  
17    reason you got tagged as being one of the worst seven  
18    in the entire state out of hundreds is because you  
19    take harder cases.

20                 The report risk-stratified the cases so that  
21    it took into account these extra sick patients that  
22    you're talking about you're getting labeled as being  
23    in the worst category for.

24          A.     Absolutely incorrect, sir.

25          Q.     Okay.  What's incorrect about the report

1 risk-stratifying and risk-adjusting so it's apples to  
2 apples and not just your claim you had more  
3 mortalities because of people who got hit by a bus or  
4 who were sicker to start?

5 A. Well, it was restratified, but you cannot  
6 restratify mortality. Those are not my mortalities.  
7 Those are hospital patients that came in very sick  
8 that I've operated on them and within two, three,  
9 four weeks, they died from -- not from surgical  
10 issues. They have nothing to do with me.

11 Q. Okay.

12 A. Nothing. And that's what the report says.  
13 Unfortunately, you interpret the wrong way.

14 Q. Wait. The report does not say it has  
15 nothing to do with you. It says the opposite. It  
16 says it's all about you.

17 A. No, you're incorrect again. Absolutely  
18 not. The report deals with 30 days mortality after  
19 surgery, and it turns that some -- I had more  
20 patients than the average. I do 3 to 500 cases  
21 per year, sir. So I do more complicated cases than  
22 the average surgeon.

23 So that's three weeks mortality, somebody  
24 dies from a stroke or falls down in the bathroom.  
25 This is not attributed to the surgeon. It deals

1 with the mortality after surgery, and some of those  
2 are my patients. But it doesn't say I'm the worst  
3 surgeon than the guy who did only three cases and  
4 nobody died.

5 Q. It does.

6 A. No, it doesn't.

7 Q. Because it takes the -- it says, out of  
8 100 patients who get surgery, 100 patients who get  
9 surgery, you have nine times the rate of patients who  
10 die.

11 A. I will need to see that. But, again, those  
12 are not my patients. Sir, those are hospital  
13 patients, yes, that I operate on; and then they go  
14 back to other facilities, and for whatever reason,  
15 they aspirate, they get pulmonary embolus; they get  
16 a stroke, or they get hit by a car. I said car or a  
17 bus. I think it was a bus actually. So I did say  
18 before that. So this has nothing to do with the  
19 surgical skill.

20 MR. WEAVER: Okay. I don't have any  
21 additional questions. Thank you, sir.

22 THE COURT: Thank you. Mr. Arntz.

23 MR. ARNTZ: Thank you, Your Honor.

24 What exhibit is that? Is that 104? I  
25 don't think it's in. I'd like to move for the



1 admission of Exhibit 104.

2 THE COURT: Joint Exhibit 104 is being  
3 moved for admission. Any objection?

4 MR. WEAVER: One moment, Your Honor,  
5 please.

6 THE COURT: That's fine. Can you identify  
7 generally what it is, Mr. Arntz.

8 MR. ARNTZ: I'm only going to use one  
9 letter from it.

10 THE COURT: Whose records they are, what it  
11 is so that they can get --

12 MR. WEAVER: It's Dr. Irwin.

13 MR. ARNTZ: Dr. Irwin.

14 THE COURT: Thank you. Any objection?

15 MR. MCBRIDE: No objection.

16 MR. WEAVER: No objection, Your Honor.

17 THE COURT: Exhibit, Joint Exhibit 104 is  
18 admitted. You may inquire.

19 (Whereupon Joint Exhibit No. 104 was  
20 admitted into evidence.)

21

22 REDIRECT EXAMINATION

23 BY MR. ARNTZ:

24 Q. Dr. Marmureanu, I'm going to put up a letter  
25 here. Have you seen this letter?

1           A.    Yes, sir. I think it's from Dr. Wienczek,  
2    yeah.

3           Q.    Okay. And I'll refresh your memory that in  
4    December of 2014, Mr. Moore was hospitalized for a  
5    blood clot, and so this is probably three or four  
6    weeks after that hospitalization, maybe a month.  
7    And I'd like to draw your attention specifically  
8    to -- it seems as though I was wrong about the DVT,  
9    the emphasis I put on that.

10                But let me ask you something: First of all,  
11    what is the importance of the fact that the DVT was  
12    the primary differential diagnosis?

13           A.    Well, like I said, DVT should have been  
14    part of differential diagnosis, but it should have  
15    never been the first thing. A DVT, or a deep vein  
16    thrombosis, below the knee, more likely than not  
17    will not kill a patient or make him lose a leg.  
18    Arterial insufficiency, ischemia, it will do that.

19                In other words, there is a differential  
20    diagnosis. There are things that you have in your  
21    mind when you work out a patient. The standard of  
22    care in this patient, because of his prior arterial  
23    insufficiency history, should have been, the No. 1  
24    should have been leg ischemia. Not only wasn't  
25    No. 1, not only wasn't No. 2, wasn't 3, wasn't on

1 the list.

2 So even though I don't believe there was a  
3 problem ruling out -- actually, I think it's good to  
4 rule out the deep vein thrombosis, my issue is that  
5 there was nothing done.

6 Q. And once the ultrasound came back with a  
7 blocked arterial graft, what does the standard of  
8 care indicate that they should have done at that  
9 point?

10 A. At that point, they need to continue the  
11 workup. It's not the Five Ps. It's not the  
12 physical exam only. It's something needs to be  
13 done. All his symptoms, all his complaints lead  
14 toward an arterial problem, not the venous problem.  
15 And at that point, you know that basically, again,  
16 it's impossible to have normal pulses.

17 He never had pulses before the bypass. And  
18 the bypass is done, according to that ultrasound, he  
19 definitely didn't have pulses by Doppler, definitely  
20 not palpable. So at that point, you will need to do  
21 some sort of an imaging study. You can't -- would  
22 be fair to say, you have a venous duplex for the  
23 veins. You want to get an arterial duplex for the  
24 arteries, which will show it's blocked.

25 And at that point, you need to get an

1 angiogram, which will basically be as a roadmap,  
2 clearly will show you where the blockage is, what's  
3 blocked, how deep, et cetera. And then obviously  
4 you have to treat it, start medical management,  
5 medication, Heparin. That stops the more clot from  
6 being formed versus TPA, which is a clot buster.  
7 Call intervention radiology to start those. Call  
8 vascular to hopefully try the percutaneous open or  
9 do any sort of procedures.

10 Q. You saw other letters from Dr. Wiencek where  
11 he talks about good pulses.

12 what was significant by what you read in  
13 those records about those pulses?

14 A. It's very interesting because his own  
15 surgeon who knows him the best -- he evaluated him,  
16 he done the bypasses -- never used the word  
17 "palpable." Never. Because the pulses were never  
18 palpable. He used "very good pulses," which we're  
19 happy to have them, by Doppler. You put it. You  
20 find it where you do it, and then you hear (witness  
21 makes sound). They're palpable -- well, they're  
22 Dopplerable pulses.

23 so his surgeon is saying that, before the  
24 bypass, there were no pulses, Doppler or palpable.  
25 After the bypass, we've looked at the report, there

1 was Dopplerable in one area. And I think in this  
2 letter, if I recall correct, he's saying that  
3 they're good pulses by Doppler while the graft is  
4 open. While the graft is closed -- it's right  
5 here -- he had excellent pulses in the foot, current  
6 by Doppler. In other words, they're not palpable.  
7 Nobody uses the machine if you can feel them.

8           So it's very difficult for me to understand  
9 or actually it's impossible to say that even after  
10 the bypass, there were only pulses by Doppler, and  
11 before the bypass, there were no pulses at all.  
12 Once a bypass is down, and we know from the venous  
13 duplex that the bypass is closed, there are no  
14 pulses. They can't be.

15           The blood -- there's no way that you can  
16 get blood in that area to have pulses, even by  
17 Doppler. So go a step further to have palpable  
18 pulses, this patient never had palpable pulses.  
19 Obviously it's wrong. It's impossible.

20           Q. All right. Anything discussed during your  
21 cross-examination change any of your opinions?

22           A. Other than his statements are wrong in  
23 regards to study. The study doesn't say that my  
24 mortalities is nine times more. That's incorrect.  
25 It's not truthful, and everything else, I disagree

1 with all his statement. I don't have anything else.

2 Q. In regards to your opinions, have your  
3 opinions changed in any way?

4 A. Absolutely not.

5 MR. ARNTZ: Okay. That's all I have.

6 MR. MCBRIDE: No questions.

7 MR. WEAVER: No questions.

8 THE COURT: May I see, by a show of hands,  
9 if there are any jurors who have questions for this  
10 witness. I believe that there was a reference made  
11 on the lunch break that there might be a question  
12 for this witness. Then we'd ask the marshal to make  
13 sure that you write it down and have it ready.

14 If there are questions, please prepare  
15 them. I'm just going to remind you to make sure  
16 your name and badge number, for the current seat you  
17 are in, is on the question and that you use the  
18 entire piece of paper.

19 Can I just see a show of hands right now  
20 how many questions we have. Two. Looks like two  
21 people have questions. Okay. Finish them up, and  
22 whenever you're ready to hand them in, you'll give  
23 them to the marshal. She'll bring them forward.

24 I don't know if you notice, our marshal  
25 shrunk a little bit.

1 MR. MCBRIDE: She's probably just as strong  
2 though.

3 THE COURT: Oh, my money is on her.  
4 Did you get the one that --

5 THE MARSHAL: Yeah, she's still writing.

6 THE COURT: She's still writing.

7 You getting close there, Juror No. 8?

8 Thank you. All right. May I have counsel at the  
9 bench to read the questions.

10 (Bench conference.)

11 THE COURT: All right. Doctor, we do have  
12 some questions from the jurors. There are multiple  
13 questions on the sheet, and I think that they're  
14 sort of standalone. So here's how this process is  
15 going to work, if you're not familiar:

16 I'm going to read the question exactly as  
17 written. I'm not at liberty, nor are the jurors, to  
18 respond and have a dialogue like the counsel would  
19 have. What you do is you answer the question, to  
20 the best of your ability, and then the counsel will  
21 have an opportunity to follow-up and flesh out those  
22 answers, if need be.

23 Okay. First question: "Are there  
24 instances when an occlusion in a graft dissolves or  
25 otherwise goes away without medicine or surgery?"

1 THE WITNESS: Never.

2 THE COURT: "Will or can blood flow from  
3 collaterals demonstrate a pulse in the foot?"

4 THE WITNESS: No. Not in this case, no.

5 THE COURT: "In your opinion, does the  
6 standard of care mandate the administration of  
7 medicine, like Heparin, if a graft appears occluded  
8 or possibly has an occlusion?"

9 THE WITNESS: 100 percent, yes. Very good  
10 question. Immediately. There is no downside. It's  
11 better safe than sorry.

12 THE COURT: "Can you clarify what you meant  
13 when you stated that it is impossible for PT pulses  
14 to have been detected on 12/25/16, due to the 2012  
15 fem-pop."

16 THE WITNESS: Repeat the question.

17 THE COURT: Yes. "Can you clarify what you  
18 meant when you stated that it is impossible for  
19 PT pulses to have been detected on 12/25/16, due to  
20 the 2012 fem-pop."

21 THE WITNESS: I'm sorry I'm having  
22 repeating it. 12? Which one was the last date?  
23 12/26? 12/25? 12/28?

24 THE COURT: I'll read it again, as it's  
25 written, and I'll state the date in not number



1 terms. Okay? "Can you clarify what you meant when  
2 you stated that it is impossible for PT pulses to  
3 have been detected on December 25th, 2016, due to  
4 the 2012 fem-pop."

5 THE WITNESS: Yes. May I show?

6 THE COURT: You may.

7 THE WITNESS: Very good question. Let's  
8 look at the facts.

9 (Reporter request.)

10 THE WITNESS: Okay. Very good question.  
11 Let's look at the facts.

12 THE COURT: So let me first interrupt,  
13 Doctor. You can't illustrate this answer from the  
14 sheet that you already have.

15 THE WITNESS: I cannot do new ones?

16 THE COURT: Okay. I would like you to  
17 return to your seat. I would like you to answer the  
18 question, to the best of your ability, if you may;  
19 and then, as I mentioned, counsel will have an  
20 opportunity to follow-up, and they can determine how  
21 they wish to proceed in that regard.

22 THE WITNESS: Thank you.

23 The medical documents show that, before the  
24 bypass in 2012, there are no pulses. That's what  
25 the surgeon said. We looked at it. After the

1 bypass, he documented he was happy that, by Doppler,  
2 he was able to obtain a PT pulse, and he also  
3 document in that note that that pulse wasn't present  
4 before the bypass. So the bypass that he clearly  
5 said he had very good flow brought, allowed him to  
6 detect a Doppler, a PT pulse, a foot pulse, with the  
7 Doppler, not palpable.

8           The reason I said it's impossible to have  
9 the same PT pulse, on 12/25, is that the bypass is  
10 gone. There is no more bypass. It's simple.  
11 Before the bypass, he said there was no PT pulse.  
12 He did a bypass, and he got a PT pulse.

13           That bypass in December 25 is gone. And  
14 the reason we know it's gone, No. 1, the study show  
15 that it's occluded, and we also know he lost his leg  
16 three days after. So if the bypass is gone, it's  
17 very simple that there was no pulse because only the  
18 bypass allows him to bring the flow in there to  
19 create the same PT.

20           So no PT pulse or no foot pulse before the  
21 bypass in 2012. If, after the bypass, there is a  
22 foot pulse, if you take the bypass away, there is --  
23 you're not going to get that pulse in there, and  
24 that's the way it is. 100 percent, you're not going  
25 to have a palpable pulse. Impossible because he

1 never had a palpable pulse. Nowhere in any medical  
2 record it says that there is a palpable pulse.

3 I will actually guarantee you, which we can  
4 look in the records, the surgeon says before the  
5 bypass, he had no pulses at all. But even in 2012,  
6 he had no pulses, mean no palpable pulses, no pulses  
7 by Doppler. After a bypass, only by Doppler, for  
8 some time. And when the graft goes bad, that  
9 Doppler pulse is gone because only the --

10 If I can show -- can I show the old  
11 picture?

12 THE COURT: That's fine. Just remember the  
13 reporter needs to hear you.

14 THE WITNESS: I'm sorry? I didn't hear you.

15 THE COURT: Just remember the reporter  
16 needs to hear you.

17 THE WITNESS: This bypass is what brings  
18 the blood down to the foot pulses where the PT is.  
19 Surgeon says, before he did this, there was nothing  
20 here. After he did this, he said he had a PT pulse  
21 by Doppler. All what you need to do, if you take  
22 this away, this is gone, (indicating). There is no  
23 pulse in here by Doppler, and that's what I mean.  
24 That's why it was impossible.

25 THE COURT: Okay. One additional question:

1 "On February 8, 2016, Dr. Wiencek state the showed  
2 good pulses on both lower extremities. Was this  
3 only by Doppler?"

4 If that's what you were just talking about,  
5 or can you clarify?

6 THE WITNESS: Very good question, and I  
7 actually looked in the records.

8 THE COURT: There's a reference, by the  
9 way, to Exhibit 109, page 36.

10 THE WITNESS: I've looked at this. Can we  
11 put back the letter?

12 Surgeons are happy to say "Very good  
13 pulses. By Doppler, we can see there are still good  
14 pulses, better than no pulses. In his notes --  
15 actually, the two notes that he's talking, he just  
16 said "very good pulses." He didn't say "palpable,"  
17 but he didn't say "by Doppler" either.

18 In the letter -- first of all, in the O.R.,  
19 he's describing Doppler. In the letter, he's  
20 describing "very good pulses by Doppler." Nowhere  
21 he's saying "palpable pulses." The word "palpable"  
22 is not being used.

23 So now what I look at, more likely than  
24 not, when the bypass, I know that he never said  
25 "palpable." Usually, it's not enough load to create

1 bounding pulses the way you take your pulse here.  
2 That's palpable. He's talking about --

3 That was good before. Bring it back.

4 MR. ARNTZ: Oh, you want that letter?

5 THE WITNESS: Yeah.

6 MR. ARNTZ: Oh, I'm sorry. I thought you  
7 wanted the February letter.

8 THE WITNESS: No.

9 "He has excellent pulses in the foot  
10 currently by Doppler." In the note, he said, "very  
11 good pulses." He didn't say "Doppler"; he didn't  
12 say "palpable." So, to me, seems that more likely  
13 than not, more often than not, he's talking about  
14 pulses, and he adds the word "Doppler."

15 I can tell you that there were no palpable  
16 pulses based on the fact that there was no blood  
17 coming on the 25th. This was gone. This is gone.  
18 There is no, nothing here. Three days after, he  
19 losses his leg. People who has palpable pulses  
20 don't lose leg three days. It just doesn't happen.  
21 They don't go home and lose their legs.

22 THE COURT: I'll start with Mr. Arntz.

23 Do you have any followup questions to the  
24 jurors' questions?

25 / / /

## 1 FURTHER REDIRECT EXAMINATION

2 BY MR. ARNTZ:

3 Q. why do you keep grabbing a pen whenever  
4 you're talking about a Doppler?5 A. That's how a Doppler probe looks, just like  
6 this. There's a transducer in here, and it's got a  
7 wire, and it goes to a speaker. And when you do an  
8 arterial duplex study, you actually have a screen.  
9 You see the flow. It's red and blue, coming towards  
10 you and going away from you, and you look.11 when the basic one, it just says (witness  
12 makes sound). So you actually going to move it  
13 around until you find where the flow is, if there is  
14 a flow. And when you hear only (witness makes  
15 different sound), those are not good pulses by  
16 Doppler. Systole and diastole, that's a good pulse  
17 by Doppler.18 Q. In a person who has a blocked graft, like  
19 Mr. Moore, but has collateral source of blood, will  
20 that person have a detectable pulse, by any means,  
21 Doppler or otherwise?22 A. Definitely impossible to have a palpable  
23 pulse. The collateral will not give you that.  
24 Highly unlikely, because the collaterals are very  
25 low here. The collaterals can be here (indicating).

1 highly unlikely that you will have a Doppler pulse  
2 because the main source is shut down.

3 Remember, before surgery, there was no  
4 pulse here. They did say that. After they put the  
5 graft, they found the pulse. They could be some  
6 collaterals, and they were collaterals because he  
7 lasted three days. So whatever collaterals he had,  
8 they were okay. They start clotting right away.  
9 But it took a few days for this leg to basically  
10 die.

11 Q. In counsel for Nurse Practitioner Bartmus's  
12 opening, he made an analogy --

13 MR. MCBRIDE: Well, again, this goes beyond  
14 the question, Your Honor.

15 MR. ARNTZ: No, it doesn't.

16 MR. MCBRIDE: It does. We're talking  
17 about --

18 THE COURT: Can you make a proffer what  
19 you're tying it into, which of the questions,  
20 Mr. Arntz, before you ask the --

21 MR. ARNTZ: The discussion about  
22 collaterals.

23 MR. MCBRIDE: That wasn't the question that  
24 was read.

25 THE COURT: There was a question with

1 regard to collaterals. I'll allow it.

2 BY MR. ARNTZ:

3 Q. He made an analogy to being on a freeway and  
4 the freeway coming to a stop and having to get off  
5 the freeway and you go around to get to where you're  
6 going. Is that a good analogy for collaterals, that  
7 it's just merely bypassing and finding another route  
8 to the foot? Tell the jury how collaterals work.

9 A. When you have blockages and stenosis, so  
10 total blockage and stenosis, just like traffic, the  
11 cars tend to go different areas to get down. A lot  
12 of time, you're unsuccessful. Like you drive, and  
13 there is a cul-de-sac or there are blockages or you  
14 can't get that street or it's a one way. That's  
15 exactly what happened here.

16 THE COURT: And, Doctor, I don't mean to  
17 interrupt you, but I do want to make sure you put  
18 this follow-up question in the context of the  
19 question you were asked. The question you were  
20 asked was: "Will or can blood flow from collaterals  
21 demonstrate a pulse in the foot?"

22 I believe your answer was no.

23 THE WITNESS: No. Not in Mr. Moore case.

24 THE COURT: So can you answer this question  
25 in relation to that question. I know the question



1 from counsel was very broad. But I don't know that  
2 we need that broad of a response.

3 BY MR. ARNTZ:

4 Q. Yeah, let me narrow it a little bit.

5 Mainly, what I want to do is I want to take  
6 this opportunity, since the question has to do with  
7 collaterals, to educate the jury on exactly what it  
8 means to have a collateral source of blood flow so  
9 they can understand the context of that question.

10 A. If you have a good source of blood up here  
11 (indicating) and it goes here, from the groin, where  
12 the femoral artery goes to your foot, which is here,  
13 and you have a blockage right in here, the blood  
14 tends to avoid this area and then create what's  
15 called "collaterals." You see them on the  
16 angiogram. Goes around, and then it's called  
17 "reconstitutes," and go down here.

18 That's not the case. He never had a source  
19 of blood because the graft was gone, and nothing was  
20 coming from above. So you don't have enough  
21 collaterals to create enough blood flow and the  
22 pulse, definitely not a palpable pulse. The leg  
23 died. There was not enough blood in there because  
24 there is nothing to create what's called an  
25 "inflow." "Inflow and outflow."

1           There was no inflow in this patient. The  
2           graft is gone. Nothing is coming. The iddy-biddy  
3           tiny collaterals that I actually explained earlier  
4           with my pen here, they're not enough to carry the  
5           foot, and that's why this leg died on the 28th.

6           MR. ARNTZ: Nothing else.

7           THE COURT: Mr. McBride.

8           MR. MCBRIDE: Sure. Thank you, Your Honor.

9  
10                           CROSS-EXAMINATION

11          BY MR. MCBRIDE:

12           Q.     Doctor, just a couple of follow-up  
13           questions. So you looked at that note that was just  
14           up on the screen, Dr. Simon's records, for the first  
15           time this afternoon while at the lunch break with  
16           counsel; right?

17           A.     I don't think so. I remembered it. I  
18           remember seeing it at some point.

19           Q.     Okay. And, again, I'm happy to go back  
20           through your list of documents that you reviewed that  
21           you told me about. You still have that in front of  
22           you; right?

23           A.     Well, I have -- the answer is I have a list  
24           of documents that I reviewed before the depo, and  
25           then I got further records after the depo, just the

1 way -- so it could have been one of those. I  
2 remember the letter actually.

3 Q. Okay. Doctor, you would agree with me, it's  
4 not listed there; right?

5 A. It's not listed? well, actually, I'm not  
6 sure.

7 Q. Go ahead and look for it, yeah.

8 A. I have like 50 things listed.

9 Q. Sure. Just take a minute to look through  
10 it. See if you have Dr. Simon's records there.

11 A. well, I didn't write Dr. Simon's records.  
12 I mean, I have a lot of records here. I'm not sure  
13 if it's listed or not here.

14 Q. Exactly. I didn't see it, and I can  
15 represent to you that in the materials we've been  
16 provided from your office that you did review, it's  
17 not listed. And neither are the records from  
18 Nevada Pain Center. Remember I had asked you about  
19 those, where he went to, Mr. Moore went on  
20 12/21/2016, four days before this hospitalization  
21 we're talking about? You hadn't seen those records  
22 either; right?

23 A. I think I did. I told you I don't  
24 remember. I received two links to medical records  
25 in the last few weeks, thousand and thousands of

1 pages.

2 Q. You weren't familiar with -- when I asked  
3 you those question, Doctor, you weren't familiar with  
4 any of that information from that, is it true?

5 A. I said I don't remember.

6 MR. MCBRIDE: Okay. And that's all the  
7 questions I have. Thank you.

8 THE WITNESS: Thank you.

9 THE COURT: Mr. Weaver.

10

11 FURTHER CROSS-EXAMINATION

12 BY MR. WEAVER:

13 Q. Dr. Marmureanu, I'm just going to ask you a  
14 question to see if you agree with this.

15 A. Sure.

16 Q. Do you agree that this morning, in response  
17 to questions from Mr. Arntz, you said, no fewer than  
18 five times, that it is impossible that there were  
19 pulses in Mr. Moore's foot after 2012. And then  
20 after Mr. McBride showed you over and over and over  
21 and over in instances of the records, including  
22 wiencek's, where pulses are documented, then after  
23 the lunch break, you came back and said, "well, what  
24 I really meant is, okay, there are pulses, they're  
25 just not palpable."

1 Do you agree with that?

2 A. We're both saying the same thing. I can  
3 tell what I referred to, most of it, and the most  
4 important part, there were no palpable pulses.  
5 Impossible to have palpable pulses on 12/25. In  
6 other words, when the patient show up to the E.R.,  
7 it's absolutely impossible to have palpable pulses.

8 Q. What I'm talking about is you do agree,  
9 don't you -- I'm not talking about 12/25/2016, which  
10 is where you keep going to, you told this jury --  
11 over and over and over and over and over, at least my  
12 notes say five times -- that after 2012, it was  
13 impossible for Mr. Moore to have pulses in his foot.  
14 You said that to this jury, didn't you?

15 A. I did say that, yes.

16 MR. WEAVER: Thank you.

17 THE COURT: Anything further? Mr. Weaver?  
18 That's it?

19 MR. WEAVER: Sorry, Your Honor. No more.

20 THE COURT: Okay. Dr. Marmureanu, you are  
21 excused at this time.

22 THE WITNESS: Thank you very much.

23 THE COURT: Take your paperwork, if you  
24 would.

25 THE WITNESS: Sure. Thank you very much.

1           THE COURT: We're going to take a 15  
2 minute -- we're going to take a 15 minute recess,  
3 return at 3:30, please.

4           During this 15 minute recess, you're  
5 admonished not to talk or converse among yourselves  
6 or with anyone else on any subject connected with  
7 this trial or read, watch, or listen to any report  
8 of or commentary on the trial or any person  
9 connected with the trial by any medium of  
10 information including, without limitation,  
11 newspapers, television, radio, or Internet. Please  
12 don't not attempt to undertake any independent  
13 investigations. No independent research, no  
14 Internet searches of any kind. Please do not engage  
15 in any social media communications, and please do  
16 not form or express any opinion on any subject  
17 connected with the trial until the case is finally  
18 submitted to you. See you back at 3:30.

19           THE MARSHAL: All rise for the jury.

20           (Out of the presence of the jury.)

21           THE COURT: All right. I have a couple of  
22 records to make with regards to bench conferences,  
23 trying to do this quickly so we can get a little  
24 comfort break too.

25           Bench conference, first, it has not been

1 yet recorded. In this later part of the testimony  
2 was when Mr. Weaver began inquiring of  
3 Dr. Marmureanu about having reviewed the Deposition  
4 of Dr. Jacobs, Mr. Arntz objected, and then we had a  
5 bench conference that ensued that because the bench  
6 conference -- I'm sorry -- because the deposition  
7 was not in evidence, that there ultimately should  
8 not be able to be any inquiry about this, that it  
9 was a hearsay concern as well as, again, just that  
10 evidence not being in the record.

11 The response was that, of course, the flow  
12 of things with Dr. Jacobs was a later revelation  
13 closer to trial that he was not appearing, then a  
14 determination or request to perhaps use deposition,  
15 and then ultimately because of the stated objection,  
16 we already have much record of this in the case  
17 already based on the discussion about whether or not  
18 opening statements could include references to  
19 Dr. Jacobs' deposition.

20 This is sort of a continuance of that  
21 discussion that ultimately it was determined by the  
22 Court regarding opening statements, and it was  
23 determined again by the Court this time that, yes,  
24 the information by Dr. Jacobs or from Dr. Jacobs, to  
25 the extent that it was in fact relied on by

1 Dr. Marmureanu, that that could be inquired about by  
2 counsel without otherwise being in evidence.

3 At the bench conference, Mr. McBride  
4 mentioned in references a "Baxter vs. Eighth  
5 Judicial District Court" case, I sent a note out to  
6 my law clerk to find it, and it turns out actually  
7 it's not the "Baxter" case. It's the "Bhatia" case,  
8 B-H-A-T-I-A, that was in front of Judge Jones. It  
9 is unpublished decision, but it is within the time  
10 frame to be able to be cited and considered. And  
11 the reference that I believe you made there is  
12 what's cited in the case, which is there had been no  
13 experts who opined on certain information at the  
14 time of trial.

15 The quote was: "The courts repeatedly  
16 observe that once a party has given testimony  
17 through deposition or expert reports, those opinions  
18 do not belong to one party or another but rather are  
19 available for all parties to use at the time of  
20 trial." And that was the reference you were making.

21 The Court ultimately did rule that further  
22 inquiry regarding -- and that we asked Mr. Weaver to  
23 make sure he laid a foundation -- but that further  
24 inquiry of the doctor of his review of Dr. Jacobs'  
25 reports and whether he agreed or disagreed with



1 those opinions could be had, and there was.

2 Mr. Arntz, anything further you want to  
3 state as far as this bench conference record?

4 MR. ARNTZ: No. Although I will state, for  
5 the record, that I am having to reconsider whether I  
6 read Dr. Jacobs' deposition because it's been  
7 referenced so much, I might as well get the context  
8 of it all in.

9 THE COURT: And that's still an option, and  
10 the Court indicated earlier and certainly respects  
11 your decision, one way or the other, whether or not  
12 you wish to do that; and whether or not it's the  
13 whole depo or whether or not you have experts, as  
14 long as the parties communicate about that and  
15 whether they can agree or not on what to read, if  
16 there's some dispute, the Court has a reasonable  
17 opportunity to resolve that dispute, that's still  
18 your choice.

19 But anything further to that bench  
20 conference, Mr. McBride?

21 MR. MCBRIDE: No, Your Honor.

22 THE COURT: Mr. Weaver.

23 MR. WEAVER: No, Your Honor.

24 THE COURT: Okay. The second bench  
25 conference arose when Mr. Weaver was inquiring of

1 Dr. Marmureanu about reports that would indicate or  
2 question his abilities as a surgeon or his rankings  
3 related to his practice. I'll sort of, for just  
4 purposes of discussion, give it the title of, you  
5 know, "bad press," so to speak.

6 And he was denying these things, and  
7 Mr. Weaver was referencing them. Then Mr. Arntz  
8 objected at some point during that inquiry, and when  
9 we came to the bench conference, the argument was  
10 that Mr. Weaver was not actually confronting the  
11 witness with these reports, that he would be  
12 required to do so, and that it would not be  
13 appropriate; it was not an appropriate line of  
14 questioning.

15 The Court disagreed, respectfully, with  
16 that assessment, that when there was testimony  
17 obviously by the doctor regarding his qualifications  
18 and this information called into question that  
19 testimony, that the proper impeachment is to ask  
20 certain things -- obviously, you have to have your  
21 ethical obligations fulfilled that you have a good  
22 faith belief to ask the question and that ultimately  
23 there was no reason to believe otherwise --  
24 certainly Mr. Weaver was able to do so without  
25 actually requiring confrontation with documentation,

1 to this Court's opinion, would be akin to impeachment  
2 with extrinsic evidence; and that is something that  
3 is not allowed, other than in certain circumstances,  
4 really more things that go towards credibility of  
5 testimony, that's not what this would have been.

6 So the Court indicated that, although the  
7 plaintiffs' counsel may wish to challenge if  
8 Mr. Weaver was misrepresenting any such reports and  
9 could potentially do so on redirect, that it was not  
10 required of Mr. Weaver to confront the witness with  
11 actual reports. Although, I do think it was fair  
12 for Mr. Arntz to ask to be given a reference to or  
13 copy of or citation to what reports he was referring  
14 to; and I believe Mr. Weaver agreed, when he left  
15 the bench, to do so. He indicated it was all online  
16 and there was a website that could be given. So,  
17 again, that inquiry continued.

18 Mr. Arntz, do you have anything you want to  
19 add to this bench conference?

20 MR. ARNTZ: No, Your Honor.

21 THE COURT: Mr. McBride?

22 MR. MCBRIDE: Nothing, Your Honor.

23 THE COURT: Mr. Weaver, this was more your  
24 inquiry.

25 MR. WEAVER: No, Your Honor.

1           THE COURT: No. All right. Thank you. We  
2 get a little more time. Just whenever you all are  
3 ready, come on back, but I'd like to aim for 3:30.  
4 I guess I should ask scheduling question now too  
5 while we're at it. Who's the second witness  
6 tonight, today?

7           MR. ARNTZ: Dr. Fish.

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9           (The proceedings concluded at 3:23 p.m.)

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C E R T I F I C A T E

STATE OF NEVADA     )  
                                  )SS:  
COUNTY OF CLARK    )

I, Dana J. Tavaglione, RPR, CCR 841, do  
hereby certify that I reported the foregoing  
proceedings; that the same is true and correct as  
reflected by my original machine shorthand notes  
taken at said time and place, and prepared in daily  
copy, before the Hon. Kathleen E. Delaney,  
District Court Judge, presiding.

Dated at Las Vegas, Nevada, this 27th day  
of February 2020.

/S/Dana J. Tavaglione

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Dana J. Tavaglione, RPR, CCR NO. 841  
Certified Court Reporter  
Las Vegas, Nevada

# EXHIBIT 3





# California Hospital Performance Ratings for Coronary Artery Bypass Graft (CABG) Surgery by Region, 2013

Region	Hospital	Isolated CABG Operative Mortality <sup>1</sup> 2013	CABG + Valve Operative Mortality <sup>2</sup> 2012-2013	Post-Operative Stroke <sup>3</sup> 2012-2013	30-Day Readmission <sup>4</sup> 2013	Internal Medicine Artery Use <sup>5</sup> 2013
		Cases (Denom) Risk-Adjusted Rate Performance Rating	Cases (Denom) Risk-Adjusted Rate Performance Rating	Cases (Denom) Risk-Adjusted Rate Performance Rating	Cases (Denom) Risk-Adjusted Rate Performance Rating	Cases (Denom) Risk-Adjusted Rate Performance Rating
Statewide		11,940 (273) 2.29	5,150 (309) 6.00	23,860 (532) 1.49	10,740 (1,253) 11.66	10,767 (96.6)
San Francisco Bay Area & San Jose	San Ramon Regional Medical Center	19 (0) 0.00 Average	6 (1) 28.09 Average	52 (0) 0.00 Average	17 (1) 8.74 Average	16 (100) Acceptable
	Santa Clara Valley Medical Center	68 (0) 0.00 Average	23 (2) 12.96 Average	155 (0) 0.00 Average	83 (9) 17.69 Average	86 (98.63) Acceptable
	Santa Rosa Memorial Hospital – Montgomery	73 (2) 2.97 Average	24 (1) 4.92 Average	134 (0) 0.00 Average	69 (2) 3.51 Average	63 (99.41) Acceptable
	Sequoia Hospital	45 (2) 2.89 Average	62 (1) 1.33 Average	97 (1) 1.04 Average	42 (4) 8.52 Average	39 (97.44) Acceptable
	Seron Medical Center	57 (2) 2.52 Average	9 (0) 0.00 Average	95 (5) 4.15 Average	49 (5) 9.28 Average	50 (94.00) Acceptable
	Stanford Hospital	87 (1) 1.74 Average	60 (6) 9.94 Average	158 (5) 4.24 Average	74 (0) 0.00 Better	83 (97.99) Acceptable
	Sutter Medical Center of Santa Rosa	54 (2) 6.25 Average	32 (1) 3.83 Average	120 (2) 2.65 Average	50 (5) 13.22 Average	44 (75.00) Low
	UC San Francisco Medical Center	76 (1) 1.92 Average	29 (3) 10.10 Average	135 (4) 3.17 Average	65 (7) 12.05 Average	75 (100) Acceptable
	Valleycare Medical Center	23 (0) 0.00 Average	13 (1) 5.76 Average	61 (0) 0.00 Average	18 (2) 9.43 Average	20 (100) Acceptable
	Washington Hospital – Fremont	112 (3) 2.30 Average	11 (3) 22.93 Average	108 (5) 2.28 Average	93 (12) 11.88 Average	107 (95.05) Acceptable
Central California	Bakersfield Heart Hospital	79 (3) 4.11 Average	27 (1) 4.26 Average	159 (5) 3.40 Average	70 (8) 11.82 Average	75 (94.87) Acceptable
	Bakersfield Memorial Hospital	128 (2) 1.24 Average	48 (3) 6.44 Average	251 (2) 0.72 Average	124 (16) 11.03 Average	111 (94.59) Acceptable
	Community Regional Medical Center – Fresno	213 (4) 1.75 Average	48 (6) 14.96 Average	447 (3) 0.65 Average	194 (24) 12.00 Average	187 (98.47) Acceptable
	Dameron Hospital	44 (2) 4.30 Average	9 (1) 7.30 Average	87 (1) 0.78 Average	38 (4) 10.42 Average	40 (97.50) Acceptable
	Doctors Medical Center	190 (7) 2.72 Average	81 (4) 3.67 Average	412 (6) 1.27 Average	165 (24) 12.67 Average	185 (96.15) Acceptable
	Emanuel Medical Center	47 (0) 0.00 Average	4 (1) 19.59 Average	82 (0) 0.00 Average	46 (9) 17.40 Average	41 (95.12) Acceptable
	Fresno Heart and Surgical Hospital	135 (5) 2.99 Average	51 (4) 7.90 Average	322 (3) 0.98 Average	129 (10) 7.98 Average	120 (95.93) Acceptable
	Kaweah Delta Medical Center	162 (3) 2.13 Average	36 (4) 11.37 Average	303 (6) 2.03 Average	150 (16) 10.70 Average	154 (98.05) Acceptable
	Marian Regional Medical Center	52 (0) 0.00 Average	15 (0) 0.00 Average	114 (2) 1.60 Average	49 (1) 1.93 Better	49 (100) Acceptable
	Memorial Hospital Medical Center – Modesto	156 (4) 2.28 Average	59 (7) 9.11 Average	289 (4) 1.48 Average	148 (17) 12.01 Average	140 (87.88) Low
Santa Barbara Valley, Antelope Valley, Ventura and San Fernando	Saint Agnes Medical Center	217 (2) 1.08 Average	81 (7) 9.55 Average	457 (4) 0.89 Average	177 (14) 8.29 Average	207 (99.00) Acceptable
	Saint Joseph's Medical Center of Stockton	180 (7) 3.10 Average	68 (7) 6.61 Average	369 (3) 0.61 Average	178 (22) 10.62 Average	173 (98.84) Acceptable
	San Joaquin Community Hospital	89 (1) 1.43 Average	14 (1) 7.86 Average	127 (2) 1.40 Average	61 (5) 8.28 Average	59 (93.22) Acceptable
	Antelope Valley Hospital	20 (2) 5.93 Average	1 (1) N/A	40 (1) 2.41 Average	18 (4) 25.85 Average	17 (82.35) Low
	Community Memorial Hospital – San Buenaventura	70 (1) 1.08 Average	31 (2) 4.78 Average	165 (1) 0.61 Average	85 (7) 10.55 Average	81 (100) Acceptable
	French Hospital Medical Center	89 (1) 1.33 Average	62 (5) 8.76 Average	153 (4) 2.42 Average	80 (12) 17.23 Average	78 (98.72) Acceptable
San Francisco Bay Area & San Jose	Glendale Adventist Medical Center – Wilson Terrace	127 (5) 5.09 Average	28 (2) 9.51 Average	242 (4) 2.11 Average	110 (17) 18.72 Average	117 (84.87) Acceptable
	Glendale Memorial Hospital and Medical Center	108 (3) 2.84 Average	33 (2) 7.40 Average	225 (5) 2.28 Average	95 (16) 17.14 Average	103 (100) Acceptable



# California Hospital Performance Ratings for Coronary Artery Bypass Graft (CABG) Surgery by Region, 2013

Region	Hospital	Isolated CABG Operative Mortality <sup>2</sup> 2013			CABG + Valve Operative Mortality <sup>2</sup> 2012-2013			Post-Operative Stroke <sup>3</sup> 2012-2013			30-Day Reoperation <sup>4</sup> 2013			Internal Mammary Artery Use <sup>5</sup> 2013		
		Cases (Deaths)	Risk-Adjusted Rate	Performance Rating <sup>1</sup>	Cases (Deaths)	Risk-Adjusted Rate	Performance Rating <sup>1</sup>	Cases (Strokes)	Risk-Adjusted Rate	Performance Rating <sup>1</sup>	Cases (Reoperation)	Risk-Adjusted Rate	Performance Rating <sup>1</sup>	Cases (Risk)	Performance Rating <sup>1</sup>	
San Fernando Valley, Antelope Valley, Ventura and Santa Barbara	Statewide	11,940 (273)	2.29	Average	5,150 (309)	8.00	Average	23,660 (352)	1.49	Average	10,740 (1,232)	11.66	Average	10,767 (95.6)	Average	
	Los Robles Hospital and Medical Center	74 (0)	0.00	Average	38 (3)	7.95	Average	125 (4)	3.19	Average	68 (10)	15.13	Average	62 (98.39)	Acceptable	
	Northridge Hospital Medical Center	63 (2)	2.69	Average	15 (2)	11.76	Average	122 (5)	3.55	Average	55 (10)	16.37	Average	59 (100)	Acceptable	
	Palmdale Regional Medical Center	10 (0)	0.00	Average	1 (0)	0.00	Average	21 (0)	0.00	Average	8 (0)	0.00	Average	10 (80.00)	Low	
	Providence Holy Cross Medical Center	40 (1)	2.23	Average	15 (2)	19.94	Average	102 (2)	1.89	Average	33 (9)	24.02	Average	37 (100)	Acceptable	
	Providence Saint Joseph Medical Center	48 (0)	0.00	Average	16 (1)	9.40	Average	96 (1)	1.39	Average	46 (5)	13.43	Average	48 (100)	Acceptable	
	Providence Tarzana Medical Center	52 (1)	1.61	Average	24 (3)	0.00	Average	91 (1)	1.29	Average	47 (3)	7.29	Average	47 (100)	Acceptable	
	Saint John's Regional Medical Center	56 (1)	1.56	Average	32 (2)	4.11	Average	120 (4)	2.82	Average	50 (6)	11.16	Average	54 (95.15)	Acceptable	
	Santa Barbara Cottage Hospital	77 (0)	0.00	Average	30 (1)	4.24	Average	169 (3)	1.83	Average	73 (9)	8.59	Average	71 (92.56)	Acceptable	
	Valley Presbyterian Hospital	41 (2)	6.35	Average	6 (0)	0.00	Average	90 (2)	2.37	Average	34 (5)	18.17	Average	38 (100)	Acceptable	
	West Hills Hospital and Medical Center	44 (0)	0.00	Average	15 (0)	0.00	Average	85 (0)	0.00	Average	41 (4)	9.83	Average	33 (98.97)	Acceptable	
	Beverly Hospital	28 (1)	3.43	Average	4 (0)	0.00	Average	48 (1)	1.69	Average	26 (3)	9.49	Average	28 (95.15)	Acceptable	
	California Hospital Medical Center - Los Angeles	32 (0)	0.00	Average	- (-)	-	N/A	40 (1)	1.64	Average	27 (2)	5.61	Average	29 (95.55)	Acceptable	
	Cedars Sinai Medical Center	130 (1)	1.03	Average	98 (7)	9.13	Average	241 (1)	0.57	Average	146 (18)	16.91	Average	116 (99.14)	Acceptable	
Greater Los Angeles	Centinela Hospital Medical Center	25 (3)	10.42	Average	5 (0)	0.00	Average	51 (1)	1.48	Average	19 (4)	11.13	Average	21 (95.24)	Acceptable	
	Citrus Valley Medical Center - Inter Community Campus	89 (2)	1.99	Average	33 (2)	5.36	Average	202 (7)	2.83	Average	84 (11)	10.99	Average	80 (95.00)	Acceptable	
	Dorsey Regional Medical Center	63 (1)	1.99	Average	5 (0)	0.00	Average	102 (0)	0.00	Average	53 (7)	14.42	Average	56 (94.83)	Acceptable	
	Garfield Medical Center	107 (1)	1.33	Average	35 (0)	0.00	Average	243 (4)	1.38	Average	70 (11)	15.71	Average	104 (87.53)	Low	
	Good Samaritan Hospital - Los Angeles	88 (2)	2.27	Average	35 (1)	3.80	Average	173 (3)	1.53	Average	64 (9)	13.67	Average	75 (94.87)	Acceptable	
	Henry Mayo Newhall Memorial Hospital	13 (0)	0.00	Average	8 (1)	10.05	Average	15 (1)	9.64	Average	12 (5)	39.29	Worse	11 (100)	Acceptable	
	Hollywood Presbyterian Medical Center	47 (2)	3.93	Average	2 (0)	0.00	Average	99 (0)	0.00	Average	43 (10)	21.70	Average	39 (92.31)	Acceptable	
	Huntington Memorial Hospital	66 (0)	0.00	Average	48 (1)	2.05	Average	131 (1)	0.74	Average	64 (11)	15.35	Average	64 (100)	Acceptable	
	Kaiser Foundation Hospital - Sunset	502 (9)	2.33	Average	252 (12)	5.17	Average	1014 (11)	1.13	Average	488 (47)	9.96	Average	476 (95.95)	Acceptable	
	Koch Hospital of University of Southern California	62 (3)	5.70	Average	67 (4)	5.19	Average	117 (1)	0.89	Average	53 (7)	12.95	Average	53 (94.34)	Acceptable	
	Lakewood Regional Medical Center	79 (4)	3.93	Average	19 (4)	13.73	Average	160 (1)	0.48	Average	70 (11)	12.76	Average	71 (88.73)	Acceptable	
	Long Beach Memorial Medical Center	157 (7)	3.86	Average	38 (3)	7.25	Average	311 (4)	1.16	Average	137 (13)	8.67	Average	144 (95.14)	Acceptable	
	Los Angeles County Harbor - UCLA Medical Center	82 (4)	7.90	Average	19 (0)	0.00	Average	150 (4)	2.86	Average	67 (15)	22.59	Worse	80 (100)	Acceptable	
	Los Angeles County/ University of Southern California Medical Center	97 (0)	0.00	Average	31 (1)	4.82	Average	209 (2)	1.24	Average	79 (15)	22.27	Worse	92 (94.57)	Acceptable	
	Methodist Hospital of Southern California	45 (0)	0.00	Average	17 (1)	5.17	Average	93 (0)	0.00	Average	43 (4)	9.69	Average	42 (97.82)	Acceptable	







# California Hospital Performance Ratings for Coronary Artery Bypass Graft (CABG) Surgery by Region, 2013

Region	Hospital	Isolated CABG Operative Mortality <sup>1</sup> 2013			CABG + Valve Operative Mortality <sup>2</sup> 2012-2013			Post-Operative Stroke <sup>3</sup> 2012-2013			30-Day Readmission <sup>4</sup> 2013			Internal Mortality: Aortic Use <sup>5</sup> 2013
		Cases (Denom)	Risk-Adjusted Rate	Performance Rating <sup>6</sup>	Cases (Denom)	Risk-Adjusted Rate	Performance Rating <sup>6</sup>	Cases (Stroke)	Risk-Adjusted Rate	Performance Rating <sup>6</sup>	Cases (Readmission)	Risk-Adjusted Rate	Performance Rating <sup>6</sup>	Cases (Aortic)
Statewide		11,940 (273)	2.29	Average	5,160 (309)	6.00	N/A	23,660 (352)	1.49	Average	10,740 (1,252)	11.66	Average	10,767 (96.6)
	West Anaheim Medical Center	26 (2)	8.38	Average	(1)	-	N/A	47 (0)	0.00	Average	19 (5)	22.16	Average	24 (91.67)
	Western Medical Center - Anaheim	56 (1)	2.10	Average	16 (1)	4.13	Average	112 (0)	0.00	Average	51 (4)	8.08	Average	48 (100)
Orange County	Western Medical Center - Santa Ana	75 (1)	1.40	Average	16 (0)	0.00	Average	120 (0)	0.00	Average	68 (10)	15.33	Average	67 (100)
	Avalencia Hospital	37 (2)	5.50	Average	13 (2)	17.04	Average	69 (1)	1.33	Average	29 (3)	10.76	Average	34 (100)
	Grossmont Hospital	123 (6)	4.11	Average	96 (5)	7.33	Average	261 (10)	2.79	Average	106 (22)	16.95	Worse	112 (100)
	Palomar Health Downtown Campus	44 (1)	2.13	Average	17 (1)	7.89	Average	91 (2)	2.18	Average	42 (4)	8.36	Average	39 (100)
	Scripps Green Hospital	31 (0)	0.00	Average	46 (2)	6.00	Average	92 (2)	4.68	Average	28 (2)	10.25	Average	26 (100)
	Scripps Memorial Hospital - La Jolla	203 (1)	0.45	Average	150 (1)	0.66	Better	436 (5)	1.28	Average	225 (20)	9.96	Average	216 (88.07)
	Scripps Mercy Hospital	124 (1)	1.06	Average	44 (6)	11.34	Average	255 (6)	2.32	Average	115 (19)	17.31	Average	115 (100)
	Sham Chula Vista Medical Center	78 (4)	6.63	Average	56 (5)	5.67	Average	164 (5)	2.24	Average	68 (12)	16.32	Average	73 (100)
	Sham Memorial Hospital	119 (2)	2.45	Average	89 (2)	2.25	Average	185 (6)	3.34	Average	110 (13)	13.19	Average	108 (84.59)
	Tri-City Medical Center - Oceanside	50 (3)	6.55	Average	32 (4)	14.42	Average	139 (1)	0.71	Average	54 (1)	2.09	Better	52 (91.68)
Greater San Diego	UC San Diego Health - Suijizo Cardiovascular Center	81 (2)	3.33	Average	44 (2)	5.02	Average	150 (0)	0.00	Average	71 (9)	12.36	Average	75 (97.33)

<sup>1</sup> Isolated CABG Operative Mortality is defined as patient death occurring in the hospital after isolated CABG surgery, regardless of length of stay, or death occurring anywhere after hospital discharge but within 30 days after the isolated CABG surgery. Hospital ratings are risk-adjusted using a statistical technique that allows for fair comparison of hospital outcomes even though some hospitals have sicker patients than average.

<sup>2</sup> CABG + Valve Operative Mortality is defined as patient death occurring in the hospital after CABG with Valve surgery (Aortic Valve Replacement, Mitral Valve Replacement or Repair or a combination of these), regardless of length of stay, or death occurring anywhere after hospital discharge but within 30 days after the surgery. Hospital ratings are risk-adjusted using a statistical technique that allows for fair comparison of hospital outcomes even though some hospitals have sicker patients than average.

<sup>3</sup> Post-Operative Stroke is defined as a post-operative, central neurologic deficit persisting for more than 24 hours after isolated CABG surgery while in the operating hospital.

<sup>4</sup> 30-Day Readmission is defined as an isolated CABG surgery patient being readmitted to an acute care hospital within 30 days of being discharged to home or a non-acute care setting within a principal diagnosis indicating a heart-related condition, or an infection or a complication that was likely related to the CABG surgery.

<sup>5</sup> Internal Mortality Aortic (IMA) usage in CABG surgery is an evidence-based indicator of surgery quality. Most first-time CABG surgery patients are eligible to receive an IMA bypass. Clinical research shows that IMA grafts used in CABG surgery are associated with lower mortality and longer survival. Very low hospital utilization rates may be associated with poorer care. Those hospitals with IMA usage rates below 85.1% (two standard deviations below the state average [85.6%]) are labeled as "Low", those with rates above 88.1% are labeled as "Acceptable", and those with rates above 90.1% are labeled as "Better". Hospitals are not assessed for very high IMA usage rates because there is no consensus on what constitutes an optimal rate.

<sup>6</sup> The performance rating is based on a comparison of each provider's risk-adjusted mortality/stroke/readmission rate to the California observed mortality/stroke/readmission rate. A provider is classified as "Better" if the upper 95% confidence limit of its risk-adjusted mortality/stroke/readmission rate falls below California's observed mortality/stroke/readmission rate. A provider is classified as "Average" if the California observed mortality/stroke/readmission rate falls within the confidence interval of the provider's risk-adjusted mortality/stroke/readmission rate.

<sup>7</sup> Hospital submitted letter in response to the 2013 CABG surgery performance ratings. Click on hospital name to view the letter.

IMA/Not Applicable: Hospital results are not shown for one of the following reasons: 1) data necessary to confirm deaths or IMA use were not available; 2) CABG case(s) performed did not meet the criteria for a specific measure.



# California Hospital Performance Ratings for Coronary Artery Bypass Graft (CABG) Surgery by Region, 2014

Region	Hospital	Isolated CABG Operative Mortality <sup>1</sup> 2014			CABG + Valve Operative Mortality <sup>2</sup> 2013-2014			Post-Operative Stroke <sup>3</sup> 2013-2014			Internal Mammary Artery Use <sup>4</sup> 2014		
		Cases (Deaths)	Risk-Adjusted Rate	Performance Rating <sup>*</sup>	Cases (Deaths)	Risk-Adjusted Rate	Performance Rating <sup>**</sup>	Cases (Stroke)	Risk-Adjusted Rate	Performance Rating <sup>*</sup>	Cases (Rate)	Performance Rating <sup>*</sup>	
Statewide		12,152 (239)	1.97	Average	5,239 (293)	5.59	Average	24,092 (308)	1.28	Average	11,043 (97.1)	Acceptable	
Sacramento Valley & Northern California Region	Enloe Medical Center – Esplanade Campus	130 (2)	1.30	Average	35 (2)	10.50	Average	251 (4)	1.71	Average	112 (96.43)	Acceptable	
	Mercy General Hospital	413 (3)	0.80	Average	376 (10)	2.93	Better	849 (10)	1.21	Average	396 (99.75)	Acceptable	
	Mercy Medical Center – Redding	128 (4)	2.04	Average	33 (4)	13.98	Average	228 (1)	0.40	Average	91 (100)	Acceptable	
	Mercy San Juan Hospital	85 (1)	1.33	Average	51 (2)	4.18	Average	165 (2)	1.37	Average	79 (100)	Acceptable	
	Rideout Memorial Hospital	91 (4)	3.57	Average	28 (2)	8.37	Average	165 (6)	3.19	Average	76 (100)	Acceptable	
	Shasta Regional Medical Center	55 (1)	1.78	Average	17 (0)	0.00	Average	136 (5)	4.36	Worse	52 (80.77)	Low	
	St. Joseph Hospital – Eureka	17 (1)	4.73	Average	15 (1)	10.67	Average	37 (0)	0.00	Average	15 (100)	Acceptable	
	Sutter Memorial Hospital	315 (2)	0.64	Average	198 (13)	5.88	Average	646 (7)	1.17	Average	280 (98.28)	Acceptable	
	UC Davis Medical Center	80 (2)	3.84	Average	65 (7)	10.59	Average	196 (5)	3.02	Average	78 (100)	Acceptable	
	Alta Bates Summit Medical Center – Summit Campus – Hawthorne	115 (0)	0.00	Average	56 (6)	9.66	Average	236 (0)	0.00	Average	114 (100)	Acceptable	
	California Pacific Medical Center – Pacific Campus	57 (1)	1.19	Average	28 (1)	3.51	Average	125 (2)	1.47	Average	53 (96.23)	Acceptable	
	Community Hospital of the Monterey Peninsula	89 (2)	2.04	Average	50 (0)	0.00	Average	161 (2)	1.74	Average	81 (100)	Acceptable	
	Dominican Hospital – Santa Cruz/Soquel	63 (0)	0.00	Average	36 (5)	18.68	Worse	127 (1)	0.84	Average	62 (100)	Acceptable	
	El Camino Hospital	85 (1)	0.96	Average	45 (2)	4.92	Average	151 (0)	0.00	Average	79 (96.2)	Acceptable	
	Good Samaritan Hospital – San Jose	71 (3)	3.63	Average	37 (2)	6.30	Average	138 (5)	3.45	Average	66 (100)	Acceptable	
	John Muir Medical Center – Concord Campus	206 (1)	0.46	Average	60 (5)	8.72	Average	413 (2)	0.48	Average	188 (100)	Acceptable	



San Francisco Bay Area & San Jose

John Muir Medical Center – Walnut Creek Campus	(.)	N/A	N/A	(.)	N/A	N/A	(.)	N/A	(.)	N/A	(.)	N/A
Kaiser Foundation Hospital – San Francisco	305 (3)	1.51	Average	130 (0)	0.00	Better	643 (12)	Average	267 (98.61)	Acceptable	(.)	N/A
Kaiser Foundation Hospital – Santa Clara	263 (6)	2.12	Average	147 (5)	5.34	Average	512 (5)	Average	245 (99.59)	Acceptable	(.)	N/A
Marrin General Hospital	32 (0)	0.00	Average	11 (0)	0.00	Average	64 (1)	Average	30 (96.67)	Acceptable	(.)	N/A
North Bay Medical Center	35 (1)	2.31	Average	6 (2)	31.87	Average	84 (0)	Average	34 (100)	Acceptable	(.)	N/A
O'Connor Hospital – San Jose	40 (1)	1.96	Average	12 (1)	6.87	Average	70 (1)	Average	32 (100)	Acceptable	(.)	N/A
Peninsula Medical Center	46 (0)	0.00	Average	21 (1)	5.92	Average	84 (0)	Average	45 (97.78)	Acceptable	(.)	N/A
Queen of the Valley Hospital – Napa	36 (1)	2.85	Average	14 (2)	12.10	Average	87 (2)	Average	31 (100)	Acceptable	(.)	N/A
Regional Medical of San Jose	66 (0)	0.00	Average	25 (0)	0.00	Average	137 (2)	Average	62 (98.39)	Acceptable	(.)	N/A
Salinas Valley Memorial Hospital	103 (0)	0.00	Average	20 (1)	5.62	Average	188 (5)	Average	92 (98.91)	Acceptable	(.)	N/A
San Ramon Regional Medical Center	24 (0)	0.00	Average	8 (2)	26.57	Average	43 (0)	Average	21 (100)	Acceptable	(.)	N/A
Santa Clara Valley Medical Center	69 (1)	1.84	Average	28 (3)	11.45	Average	137 (0)	Average	67 (100)	Acceptable	(.)	N/A
Santa Rosa Memorial Hospital – Montgomery	71 (0)	0.00	Average	21 (1)	4.23	Average	144 (1)	Average	57 (96.49)	Acceptable	(.)	N/A
Sequoia Hospital	55 (2)	2.88	Average	57 (0)	0.00	Better	100 (2)	Average	50 (98)	Acceptable	(.)	N/A
Seton Medical Center	51 (2)	2.87	Average	12 (1)	6.02	Average	108 (5)	Average	48 (91.3)	Acceptable	(.)	N/A
St. Helena Hospital	82 (0)	0.00	Average	30 (4)	13.24	Average	151 (0)	Average	75 (96)	Acceptable	(.)	N/A
St. Mary's Medical Center, San Francisco	22 (0)	0.00	Average	6 (1)	14.21	Average	39 (1)	Average	18 (100)	Acceptable	(.)	N/A
Stanford Hospital	97 (1)	0.86	Average	61 (4)	7.14	Average	184 (4)	Average	89 (96.63)	Acceptable	(.)	N/A
Sutter Santa Rosa Regional Hospital	52 (0)	0.00	Average	22 (1)	5.77	Average	108 (2)	Average	46 (95.65)	Acceptable	(.)	N/A
UC San Francisco Medical Center	66 (0)	0.00	Average	23 (3)	9.81	Average	142 (3)	Average	63 (100)	Acceptable	(.)	N/A
Valleycare Medical Center	25 (0)	0.00	Average	13 (1)	6.31	Average	48 (0)	Average	20 (100)	Acceptable	(.)	N/A





San Fernando Valley, Antelope Valley	Palmdale Regional Medical Center	8 (1)	16.88	Average	.	N/A	N/A	18 (0)	0.00	Average	8 (37.5)	Low
	Providence Holy Cross Medical Center	39 (2)	5.85	Average	18 (0)	0.00	0.00	78 (1)	1.27	Average	34 (100)	Acceptable
	Providence Saint Joseph Medical Center	46 (0)	0.00	Average	21 (1)	7.35	7.35	94 (1)	1.48	Average	45 (97.78)	Acceptable
	Providence Tarzana Medical Center	62 (3)	4.45	Average	21 (2)	7.80	7.80	114 (2)	1.94	Average	50 (96)	Acceptable
	Santa Barbara Cottage Hospital	90 (3)	3.89	Average	32 (0)	0.00	0.00	167 (2)	1.32	Average	83 (100)	Acceptable
	St. John's Regional Medical Center	83 (2)	2.20	Average	27 (5)	9.95	9.95	139 (5)	3.15	Average	80 (97.5)	Acceptable
	Valley Presbyterian Hospital	42 (0)	0.00	Average	3 (0)	0.00	0.00	83 (1)	1.35	Average	40 (100)	Acceptable
	West Hills Hospital and Medical Center	51 (2)	2.48	Average	12 (0)	0.00	0.00	95 (2)	1.39	Average	43 (100)	Acceptable
	Beverly Hospital	13 (0)	0.00	Average	1 (0)	0.00	0.00	41 (0)	0.00	Average	11 (100)	Acceptable
	California Hospital Medical Center – Los Angeles	19 (0)	0.00	Average	3 (0)	0.00	0.00	51 (3)	3.35	Average	19 (94.74)	Acceptable
	Cedars Sinai Medical Center	129 (0)	0.00	Average	93 (3)	4.04	4.04	259 (2)	1.08	Average	117 (98.26)	Acceptable
	Centinelia Hospital Medical Center	28 (3)	8.99	Average	7 (1)	8.15	8.15	53 (0)	0.00	Average	27 (96.3)	Acceptable
	Citrus Valley Medical Center – Inter Community Campus	110 (3)	1.95	Average	25 (2)	7.88	7.88	199 (2)	0.82	Average	103 (96.12)	Acceptable
	Downey Regional Medical Center	46 (0)	0.00	Average	3 (0)	0.00	0.00	109 (0)	0.00	Average	45 (88.89)	Acceptable
	Garfield Medical Center	102 (1)	0.95	Average	33 (0)	0.00	0.00	209 (1)	0.49	Average	96 (95.83)	Acceptable
	Good Samaritan Hospital – Los Angeles	87 (2)	2.22	Average	32 (2)	5.88	5.88	175 (3)	1.77	Average	77 (100)	Acceptable
	Henry Mayo Newhall Memorial Hospital	35 (1)	2.14	Average	12 (1)	7.81	7.81	48 (1)	1.93	Average	31 (93.55)	Acceptable
	Hollywood Presbyterian Medical Center	42 (1)	2.78	Average	3 (1)	41.95	41.95	89 (1)	1.15	Average	41 (97.56)	Acceptable
	Huntington Memorial Hospital	65 (0)	0.00	Average	44 (2)	5.26	5.26	131 (1)	0.79	Average	61 (96.36)	Acceptable
	Kaiser Foundation Hospital – Sunset	583 (7)	1.21	Average	272 (11)	3.91	3.91	1085 (10)	0.91	Average	539 (99.07)	Acceptable
	Keck Hospital of University of Southern California	73 (4)	4.76	Average	94 (5)	5.48	5.48	135 (1)	0.71	Average	61 (98.36)	Acceptable

Antelope Valley, San Fernando Valley



Greater Los	Los Angeles County/Harbor – UCLA Medical Center	64 (0)	0.00	Average	15 (1)	5.98	Average	146 (3)	2.14	Average	64 (98.44)	Acceptable
	Los Angeles County/University of Southern California Medical Center	80 (1)	2.64	Average	28 (1)	4.64	Average	177 (1)	0.81	Average	78 (98.72)	Acceptable
	Lakewood Regional Medical Center	89 (3)	2.22	Average	28 (3)	8.44	Average	168 (0)	0.00	Average	81 (91.36)	Acceptable
	Long Beach Memorial Medical Center	159 (4)	2.13	Average	42 (3)	5.25	Average	316 (6)	1.83	Average	146 (95.21)	Acceptable
	Methodist Hospital of Southern California	54 (4)	5.94	Average	17 (0)	0.00	Average	99 (3)	3.00	Average	49 (93.88)	Acceptable
	Presbyterian Intercommunity Hospital	51 (2)	4.29	Average	111 (2)	1.20	Better	118 (1)	0.77	Average	49 (97.96)	Acceptable
	Providence Little Company of Mary Medical Center – Torrance	92 (3)	2.29	Average	59 (6)	11.68	Average	171 (1)	0.53	Average	86 (94.19)	Acceptable
	Ronald Reagan UCLA Medical Center	137 (6)	4.48	Average	99 (7)	7.45	Average	246 (1)	0.51	Average	96 (95.83)	Acceptable
	Saint John's Health Center	41 (2)	5.14	Average	23 (1)	4.09	Average	82 (2)	2.51	Average	37 (97.3)	Acceptable
	St. Francis Medical Center	28 (1)	5.45	Average	9 (0)	0.00	Average	53 (0)	0.00	Average	23 (86.96)	Acceptable
	St. Mary Medical Center – Long Beach	36 (0)	0.00	Average	13 (0)	0.00	Average	88 (3)	2.64	Average	32 (96.88)	Acceptable
	St. Vincent Medical Center	48 (1)	2.41	Average	13 (0)	0.00	Average	113 (2)	1.85	Average	46 (100)	Acceptable
	Torrance Memorial Medical Center	47 (0)	0.00	Average	36 (3)	10.59	Average	85 (0)	0.00	Average	46 (100)	Acceptable
	White Memorial Medical Center	39 (2)	6.93	Average	8 (0)	0.00	Average	86 (3)	3.48	Average	37 (100)	Acceptable
Riverside & San Bernardino	Desert Regional Medical Center	112 (7)	7.72	Worse	33 (3)	8.94	Average	215 (0)	0.00	Average	104 (96.15)	Acceptable
	Desert Valley Hospital	34 (3)	9.14	Average	10 (1)	15.15	Average	65 (3)	4.19	Average	33 (100)	Acceptable
	Eisenhower Medical Center	122 (0)	0.00	Average	49 (0)	0.00	Better	254 (3)	1.13	Average	111 (100)	Acceptable
	Kaiser Foundation Hospital – Fontana	51 (0)	0.00	Average	10 (0)	0.00	Average	51 (0)	0.00	Average	49 (97.96)	Acceptable
	Loma Linda University Medical Center	161 (8)	3.47	Average	53 (8)	7.12	Average	340 (1)	0.25	Average	145 (98.62)	Acceptable
	Loma Linda University Medical Center – Murrieta	115 (1)	0.77	Average	12 (0)	0.00	Average	210 (2)	0.87	Average	95 (95.79)	Acceptable
	Pomona Valley Hospital Medical Center	131 (0)	0.00	Average	31 (1)	4.63	Average	234 (6)	2.51	Average	118 (98.31)	Acceptable



Inland Empire, CA	Riverside Community Hospital	162 (2)	1.30	Average	66 (1)	1.72	Average	322 (5)	1.58	Average	142 (97.18)	Acceptable
	San Antonio Community Hospital	130 (6)	4.40	Average	58 (5)	6.95	Average	289 (3)	1.08	Average	110 (97.27)	Acceptable
	St. Bernardine Medical Center	428 (3)	0.77	Average	47 (4)	7.32	Average	886 (3)	0.37	<b>Better</b>	412 (99.03)	Acceptable
	St. Mary Medical Center – Apple Valley	80 (0)	0.00	Average	37 (2)	6.22	Average	194 (3)	1.79	Average	63 (100)	Acceptable
	Temecula Valley Hospital	15 (0)	0.00	Average	.	N/A	N/A	15 (0)	0.00	Average	15 (93.33)	Acceptable
Orange County	AHMC Anaheim Regional Medical Center	129 (0)	0.00	Average	49 (2)	4.23	Average	245 (4)	1.69	Average	123 (97.56)	Acceptable
	Fountain Valley Regional Hospital and Medical Center – Euclid	118 (5)	3.49	Average	14 (3)	25.05	Average	215 (7)	3.00	Average	110 (89.09)	Acceptable
	Hoag Memorial Hospital Presbyterian	135 (0)	0.00	Average	103 (6)	6.66	Average	287 (0)	0.00	Average	122 (100)	Acceptable
	Mission Hospital Regional Medical Center	113 (2)	1.42	Average	44 (5)	9.37	Average	221 (4)	1.75	Average	104 (99.04)	Acceptable
	Orange Coast Memorial Medical Center	59 (0)	0.00	Average	18 (1)	7.84	Average	133 (0)	0.00	Average	57 (100)	Acceptable
	Saddleback Memorial Medical Center	67 (0)	0.00	Average	27 (2)	6.27	Average	149 (4)	3.22	Average	65 (100)	Acceptable
	St. Joseph Hospital – Orange	61 (3)	4.31	Average	52 (6)	9.93	Average	147 (3)	2.30	Average	22 (100)	Acceptable
	St. Jude Medical Center	79 (0)	0.00	Average	28 (0)	0.00	Average	156 (4)	2.33	Average	72 (100)	Acceptable
	UC Irvine Medical Center	71 (4)	4.36	Average	11 (0)	0.00	Average	117 (1)	0.79	Average	66 (97.06)	Acceptable
	West Anaheim Medical Center	22 (0)	0.00	Average	1 (1)	92.28	Average	48 (0)	0.00	Average	19 (100)	Acceptable
	Western Medical Center – Anaheim	30 (2)	5.52	Average	9 (0)	0.00	Average	66 (1)	0.95	Average	30 (100)	Acceptable
	Western Medical Center – Santa Ana	82 (1)	0.91	Average	18 (0)	0.00	Average	157 (1)	0.60	Average	82 (100)	Acceptable
San Diego	Alvarado Hospital	28 (1)	3.14	Average	13 (2)	19.78	Average	65 (0)	0.00	Average	24 (100)	Acceptable
	Grossmont Hospital	115 (3)	2.18	Average	43 (1)	2.30	Average	238 (4)	1.32	Average	103 (100)	Acceptable
	Palomar Health Downtown Campus	44 (0)	0.00	Average	21 (2)	7.71	Average	88 (1)	1.18	Average	41 (90.24)	Acceptable
	Scripps Green Hospital	49 (0)	0.00	Average	42 (1)	3.02	Average	80 (1)	2.11	Average	44 (100)	Acceptable



Scripps Memorial Hospital – La Jolla	249 (3)	1.18	Average	175 (1)	0.65	Better	482 (2)	0.46	Average	235 (100)	Acceptable
Scripps Mercy Hospital	99 (4)	3.42	Average	27 (4)	10.58	Average	223 (4)	1.76	Average	92 (100)	Acceptable
Sharp Chula Vista Medical Center	84 (0)	0.00	Average	54 (6)	8.48	Average	162 (3)	1.80	Average	79 (100)	Acceptable
Sharp Memorial Hospital†	107 (2)	2.52	Average	101 (4)	5.38	Average	226 (8)	4.27	Worse	97 (97.94)	Acceptable
Tri-City Medical Center – Oceanside	89 (2)	1.84	Average	25 (3)	12.37	Average	149 (1)	0.66	Average	74 (97.3)	Acceptable
UC San Diego Health – Sulpizio Cardiovascular Center	89 (1)	1.37	Average	61 (1)	2.03	Average	170 (0)	0.00	Average	88 (100)	Acceptable

<sup>1</sup> Isolated CABG Operative Mortality is defined as patient death occurring in the hospital after isolated CABG surgery, regardless of length of stay, or death occurring anywhere after hospital discharge but within 30 days after the isolated CABG surgery. Hospital ratings are risk-adjusted using a statistical technique that allows for fair comparison of hospital outcomes even though some hospitals have sicker patients than average.

<sup>2</sup> CABG + Valve Operative Mortality is defined as patient death occurring in the hospital after CABG with Valve surgery (Aortic Valve Replacement, Mitral Valve Replacement or Repair or a combination of these), regardless of length of stay, or death occurring anywhere after hospital discharge but within 30 days after the surgery. Hospital ratings are risk-adjusted using a statistical technique that allows for fair comparison of hospital outcomes even though some hospitals have sicker patients than average.

<sup>3</sup> Post-Operative Stroke is defined as a post-operative, central neurologic deficit persisting for more than 24 hours after isolated CABG surgery while in the operating hospital.

<sup>4</sup> Internal Mammary Artery (IMA) Usage in CABG surgery is an evidence-based indicator of surgery quality. Most first-time CABG surgery patients are eligible to receive an IMA bypass. Clinical research shows that IMA grafts used in CABG surgery stay open longer and increase patients' survival. Very low hospital utilization rates may be associated with poorer care. Those hospitals with IMA usage rates below 84.21% (two standard deviations below the state average [87.1%]) are labeled as "Low"; those with rates above 84.21% are labeled as "Acceptable." Hospitals are not assessed for very high IMA usage rates because there is no consensus on what constitutes an optimal rate.

<sup>5</sup> The performance rating is based on a comparison of each provider's risk-adjusted mortality/stroke/readmission rate to the California observed mortality/stroke/readmission rate. Providers are classified as "Better" if the upper 95% confidence limit of their risk-adjusted mortality/stroke/readmission rates fall below the California observed mortality/stroke/readmission rate. Providers are classified as "Worse" if the lower 95% confidence limit of their risk-adjusted mortality/stroke/readmission rates are higher than the California observed mortality/stroke/readmission rate. A provider is classified as "Average" if the California mortality/stroke/readmission rate falls within the confidence interval of the provider's risk-adjusted mortality/stroke/readmission rate.

<sup>†</sup> Hospital submitted letter in response to the 2014 CABG surgery performance ratings. Click on hospital name to view the letter.

N/A-Not Applicable: Hospital results are not shown for one of the following reasons: 1) data necessary to confirm deaths or IMA use were not available, 2) CABG case(s) performed did not meet the criteria for a specific measure



# California Hospital Performance Ratings for Coronary Artery Bypass Graft (CABG) Surgery by Region, 2015

Region	Hospital	Isolated CABG Operative Mortality <sup>1</sup> 2015				CABG + Valve Operative Mortality <sup>2</sup> 2014-2015				Post-Operative Stroke <sup>3</sup> 2014-2015				30-Day Re-Admission <sup>4</sup> 2014-2015				Inferior Myocardial Infarction <sup>5</sup> 2014-2015			
		Cases (Discharge)	Risk-Adjusted Rate	Performance Rating <sup>6</sup>		Cases (Discharge)	Risk-Adjusted Rate	Performance Rating <sup>6</sup>		Cases (Stroke)	Risk-Adjusted Rate	Performance Rating <sup>6</sup>		Cases (Readmission)	Risk-Adjusted Rate	Performance Rating <sup>6</sup>		Cases	Percent MIA Rate	Performance Rating	
Statewide		12,498 (313)	2.50	Average		5,058 (274)	5.42	Average		24,727 (323)	1.31	Average		21,680 (2,494)	11.50	Average		11,664	97.49%		
Northern California Valley & Sacramento Valley Region	Enloe Medical Center - Esplanade Campus	148 (8)	4.00	Average		32 (4)	12.04	Average		276 (5)	1.88	Average		257 (32)	12.93	Average		138	95.65%	Acceptable	
	Mercy General Hospital	457 (5)	0.99	Better		308 (10)	3.76	Average		870 (14)	1.67	Average		780 (88)	8.54	Better		424	98.35%	Acceptable	
	Mercy Medical Center - Redding	117 (4)	2.61	Average		48 (8)	11.38	Average		245 (2)	0.75	Average		225 (23)	10.18	Average		100	98.00%	Acceptable	
	Mercy San Juan Hospital	72 (0)	0.00	Average		42 (0)	0.00	Average		157 (2)	1.43	Average		146 (19)	13.20	Average		89	96.65%	Acceptable	
	Rideout Memorial Hospital	111 (8)	6.33	Worse		28 (5)	13.74	Average		202 (2)	0.80	Average		189 (28)	13.71	Average		99	100.00%	Acceptable	
	Shasta Regional Medical Center	70 (0)	0.00	Average		19 (0)	0.00	Average		125 (2)	1.59	Average		117 (12)	10.18	Average		64	98.44%	Acceptable	
	St. Joseph Hospital - Eureka	20 (0)	0.00	Average		9 (1)	8.54	Average		37 (0)	0.00	Average		34 (2)	5.24	Average		17	100.00%	Acceptable	
	Sutter Memorial Hospital	295 (5)	1.36	Average		201 (8)	3.28	Average		610 (7)	1.16	Average		540 (54)	10.54	Average		288	99.53%	Acceptable	
	UC Davis Medical Center	97 (3)	3.30	Average		54 (8)	13.99	Average		177 (5)	3.46	Average		154 (17)	11.71	Average		94	98.04%	Acceptable	
	Alta Bates Summit Medical Center - Summit Campus	108 (3)	2.23	Average		39 (2)	3.91	Average		223 (0)	0.00	Average		199 (23)	11.05	Average		105	100.00%	Acceptable	
San Francisco Bay Area & San Jose	California Pacific Medical Center - Pacific Campus	88 (2)	2.22	Average		26 (1)	5.01	Average		125 (2)	1.49	Average		107 (17)	15.41	Average		81	98.36%	Acceptable	
	Community Hospital Monterey Peninsula	93 (0)	0.00	Average		46 (0)	0.00	Average		192 (1)	0.82	Average		166 (14)	8.98	Average		84	100.00%	Acceptable	
	Dominican Hospital - Santa Cruz/Soquel	75 (3)	3.51	Average		55 (7)	11.26	Average		138 (1)	0.74	Average		113 (9)	8.41	Average		67	100.00%	Acceptable	
	El Camino Hospital	85 (3)	2.34	Average		44 (1)	1.89	Average		170 (1)	0.63	Average		133 (15)	11.43	Average		77	100.00%	Acceptable	
	Good Samaritan Hospital - San Jose	76 (3)	3.02	Average		29 (2)	6.06	Average		147 (5)	2.89	Average		134 (22)	16.85	Average		60	100.00%	Acceptable	
	John Muir Medical Center - Concord Campus	188 (3)	1.81	Average		65 (1)	1.77	Average		392 (7)	1.88	Average		345 (38)	11.37	Average		170	98.24%	Acceptable	
	Kaiser Foundation Hospital - San Francisco	373 (3)	1.11	Average		120 (2)	2.57	Average		678 (5)	0.97	Average		660 (44)	7.52	Better		363	99.17%	Acceptable	
	Kaiser Foundation Hospital - Santa Clara	233 (6)	2.61	Average		181 (10)	6.85	Average		546 (6)	1.08	Average		518 (41)	7.76	Better		263	100.00%	Acceptable	
	Marin General Hospital	28 (1)	2.78	Average		18 (0)	0.00	Average		60 (1)	1.76	Average		52 (5)	11.64	Average		27	100.00%	Acceptable	
	North Bay Medical Center	53 (2)	5.16	Average		3 (2)	53.00	Worse		88 (0)	0.00	Average		85 (14)	15.93	Average		53	100.00%	Acceptable	
San Francisco Bay Area & San Jose	O'Connor Hospital - San Jose	35 (0)	0.00	Average		9 (0)	0.00	Average		73 (1)	1.21	Average		80 (7)	11.90	Average		34	100.00%	Acceptable	
	Peninsula Medical Center	58 (0)	0.00	Average		18 (0)	0.00	Average		104 (1)	1.18	Average		91 (11)	13.52	Average		55	100.00%	Acceptable	
	Queen of the Valley Hospital - Napa	43 (0)	0.00	Average		11 (3)	17.47	Average		79 (3)	3.95	Average		63 (5)	9.34	Average		41	100.00%	Acceptable	
	Regional Medical of San Jose	77 (3)	3.54	Average		21 (0)	0.00	Average		143 (0)	0.00	Average		128 (24)	17.11	Average		75	100.00%	Acceptable	
	Sallinas Valley Memorial Hospital	90 (3)	4.87	Average		21 (1)	4.14	Average		193 (7)	3.83	Worse		176 (19)	11.47	Average		86	98.84%	Acceptable	
	San Ramon Regional Medical Center	23 (0)	0.00	Average		6 (1)	19.19	Average		47 (0)	0.00	Average		44 (7)	17.47	Average		18	100.00%	Acceptable	
	Santa Clara Valley Medical Center	72 (0)	0.00	Average		28 (3)	10.55	Average		141 (2)	1.76	Average		121 (11)	9.00	Average		72	95.83%	Acceptable	
	Santa Rosa Memorial Hospital - Montgomery	90 (0)	0.00	Average		22 (1)	3.84	Average		161 (1)	0.89	Average		141 (10)	7.23	Average		86	94.19%	Acceptable	
	Sequoia Hospital	45 (1)	3.17	Average		66 (0)	0.00	Better		100 (1)	1.12	Average		82 (4)	5.29	Average		41	100.00%	Acceptable	
	Solon Medical Center	45 (1)	1.67	Average		8 (1)	12.00	Average		98 (5)	4.70	Worse		83 (5)	5.64	Average		39	100.00%	Acceptable	



Central California	St. Helena Hospital	94 (6)	4.08	Average	37 (4)	11.65	Average	176 (0)	0.00	Average	157 (15)	9.87	Average	84	95.43%	Acceptable
	St. Mary's Medical Center, San Francisco	22 (1)	3.54	Average	4 (0)	0.00	Average	44 (1)	2.11	Average	37 (5)	13.82	Average	18	100.00%	Acceptable
Central California	Stanford Hospital	96 (1)	1.12	Average	76 (4)	6.47	Average	193 (5)	2.76	Average	156 (20)	12.69	Average	64	98.81%	Acceptable
	Sutter Santa Rosa Regional Hospital	49 (2)	5.28	Average	23 (2)	11.82	Average	101 (1)	1.38	Average	90 (3)	4.39	Average	43	90.70%	Acceptable
	UC San Francisco Medical Center	89 (0)	0.00	Average	21 (0)	0.00	Average	155 (2)	1.56	Average	124 (13)	11.15	Average	85	98.92%	Acceptable
	Valleycare Medical Center	17 (1)	5.79	Average	12 (0)	0.00	Average	42 (1)	2.50	Average	39 (5)	13.12	Average	17	100.00%	Acceptable
	Washington Hospital - Fremont	79 (0)	0.00	Average	15 (1)	5.74	Average	165 (0)	0.00	Average	141 (18)	13.01	Average	76	97.37%	Acceptable
	Bakersfield Heart Hospital	49 (6)	17.56	Worse	10 (1)	20.83	Average	99 (3)	3.50	Average	82 (19)	25.63	Worse	47	85.11%	Low
	Bakersfield Memorial Hospital	87 (1)	1.05	Average	34 (2)	7.82	Average	206 (5)	2.68	Average	191 (26)	12.97	Average	77	100.00%	Acceptable
	Community Regional Medical Center - Fresno	184 (3)	1.13	Average	45 (4)	8.38	Average	404 (6)	1.19	Average	370 (72)	17.07	Worse	168	98.79%	Acceptable
	Dameron Hospital	54 (0)	0.00	Average	8 (0)	0.00	Average	111 (1)	0.72	Average	79 (10)	10.59	Average	42	90.48%	Acceptable
	Doctors Medical Center	231 (5)	1.65	Average	95 (11)	9.42	Average	475 (7)	1.25	Average	420 (42)	9.47	Average	205	96.65%	Acceptable
	Emanuel Medical Center	58 (4)	5.64	Average	5 (0)	0.00	Average	131 (2)	1.28	Average	101 (14)	11.89	Average	51	100.00%	Acceptable
	Fresno Heart and Surgical Hospital	81 (2)	2.23	Average	47 (1)	1.88	Average	297 (1)	0.33	Average	217 (20)	9.26	Average	143	97.90%	Acceptable
	Kaweah Delta Medical Center	191 (2)	1.01	Average	39 (2)	5.23	Average	357 (3)	0.80	Average	333 (38)	10.76	Average	181	98.90%	Acceptable
	Marian Regional Medical Center	70 (1)	1.57	Average	27 (1)	4.09	Average	129 (2)	1.37	Average	120 (13)	9.63	Average	60	100.00%	Acceptable
	Memorial Hospital Medical Center - Modesto	135 (4)	2.54	Average	65 (4)	5.69	Average	286 (4)	1.32	Average	271 (31)	10.44	Average	126	85.24%	Acceptable
Santa Barbara	Saint Agnes Medical Center	221 (3)	1.41	Average	92 (4)	4.10	Average	466 (3)	0.70	Average	403 (33)	6.84	Average	201	88.00%	Acceptable
	San Joaquin Community Hospital	81 (1)	1.57	Average	24 (2)	8.34	Average	165 (3)	2.13	Average	129 (16)	12.09	Average	74	97.30%	Acceptable
	St. Joseph's Medical Center of Stockton	215 (9)	2.49	Average	75 (6)	8.25	Average	440 (8)	1.42	Average	375 (46)	10.91	Average	191	96.48%	Acceptable
	Antelope Valley Hospital	13 (1)	10.80	Average	2 (0)	0.00	Average	30 (1)	3.64	Average	26 (6)	24.87	Average	13	69.23%	Low
	Community Memorial Hospital - San Buenaventura	79 (4)	3.79	Average	35 (2)	6.70	Average	154 (2)	1.31	Average	129 (13)	11.34	Average	73	98.63%	Acceptable
	French Hospital Medical Center	82 (5)	5.37	Average	39 (1)	3.28	Average	159 (2)	1.34	Average	146 (8)	6.68	Average	69	98.55%	Acceptable
	Glendale Adventist Medical Center - Wilson Terrace	129 (5)	4.33	Average	31 (2)	8.42	Average	225 (2)	0.97	Average	180 (32)	18.44	Worse	121	99.17%	Acceptable
	Glendale Memorial Hospital and Health Center	95 (2)	1.97	Average	35 (3)	7.39	Average	216 (4)	2.08	Average	192 (27)	14.18	Average	91	97.80%	Acceptable
	Los Robles Hospital and Medical Center	55 (4)	4.92	Average	35 (4)	13.67	Average	121 (3)	1.72	Average	99 (14)	11.79	Average	54	94.44%	Acceptable
	Northridge Hospital Medical Center	67 (3)	3.41	Average	12 (2)	16.83	Average	162 (5)	3.55	Average	137 (19)	13.80	Average	60	96.67%	Acceptable
	Palmcote Regional Medical Center	8 (0)	0.00	Average	( )	N/A	N/A	18 (0)	0.00	Average	13 (1)	6.67	Average	8	82.50%	Low
	Providence Holy Cross Medical Center	43 (2)	4.25	Average	18 (0)	0.00	Average	82 (0)	0.00	Average	89 (5)	7.30	Average	34	100.00%	Acceptable
	Providence Saint Joseph Medical Center	50 (3)	6.39	Average	21 (1)	6.55	Average	98 (1)	1.24	Average	37 (9)	11.45	Average	46	95.65%	Acceptable
	Providence Tarzana Medical Center	51 (1)	1.79	Average	14 (2)	15.04	Average	113 (2)	1.74	Average	99 (14)	14.08	Average	44	95.45%	Acceptable
	Santa Barbara Cottage Hospital	81 (0)	0.00	Average	36 (1)	3.78	Average	171 (1)	0.67	Average	164 (7)	4.61	Better	79	98.73%	Acceptable
San Fernando Valley, Antelope Valley, Ventura &	St. John's Regional Medical Center	84 (1)	1.23	Average	30 (0)	25.95	Worse	147 (7)	4.34	Worse	128 (14)	10.51	Average	61	96.72%	Acceptable
	Valley Presbyterian Hospital	20 (0)	0.00	Average	1 (1)	61.46	Average	62 (0)	0.00	Average	54 (15)	27.84	Worse	19	100.00%	Acceptable
	West Hills Regional and Medical Center	45 (1)	1.85	Average	15 (1)	5.21	Average	98 (3)	2.31	Average	76 (11)	13.51	Average	41	97.66%	Acceptable
	Beverly Hospital	28 (0)	0.00	Average	4 (0)	0.00	Average	41 (1)	2.12	Average	36 (6)	15.31	Average	28	100.00%	Acceptable



Hospital	23 (0)	0.00	Average	8 (1)	13.37	Average	42 (3)	4.33	Average	29 (10)	24.27	Worse	22	100.00%	Acceptable
California Hospital Medical Center - Los Angeles	101 (4)	3.42	Average	88 (4)	6.05	Average	290 (3)	1.25	Average	238 (28)	13.86	Average	149	100.00%	Acceptable
Cedars Sinai Medical Center	35 (3)	6.36	Average	6 (1)	12.89	Average	63 (0)	0.00	Average	43 (10)	19.56	Average	33	100.00%	Acceptable
Centennial Hospital Medical Center	121 (2)	1.40	Average	24 (1)	5.37	Average	231 (3)	1.29	Average	195 (25)	11.47	Average	113	94.85%	Acceptable
Citrus Valley Medical Center Inner Community Campus	28 (0)	0.00	Average	5 (0)	0.00	Average	74 (1)	1.37	Average	70 (6)	9.53	Average	25	96.00%	Acceptable
Downey Regional Medical Center	124 (5)	4.70	Average	32 (0)	0.00	Average	226 (3)	1.41	Average	147 (18)	12.33	Average	114	95.61%	Acceptable
Garfield Medical Center	87 (4)	5.31	Average	30 (1)	3.17	Average	164 (3)	1.85	Average	91 (9)	9.09	Average	58	96.26%	Acceptable
Good Samaritan Hospital - Los Angeles	29 (0)	0.00	Average	13 (2)	17.74	Average	84 (0)	0.00	Average	55 (7)	11.76	Average	25	96.00%	Acceptable
Henry Mayo Newhall Memorial Hospital	51 (3)	3.85	Average	2 (1)	103.02	Average	93 (2)	1.74	Average	68 (17)	20.01	Worse	45	95.56%	Acceptable
Hollywood Presbyterian Medical Center	84 (1)	1.47	Average	35 (1)	3.39	Average	149 (3)	2.30	Average	139 (19)	13.87	Average	83	97.59%	Acceptable
Huntington Memorial Hospital	587 (7)	1.39	Average	297 (8)	2.95	Average	1170 (18)	1.80	Average	1134 (126)	10.32	Average	569	99.82%	Acceptable
Kaiser Foundation Hospital - Sunset	65 (0)	0.00	Average	85 (2)	2.05	Average	138 (1)	0.68	Average	102 (16)	16.13	Average	57	96.25%	Acceptable
Keck Hospital of University of Southern California	75 (3)	2.78	Average	30 (3)	12.13	Average	165 (1)	0.50	Average	140 (13)	7.30	Average	75	98.67%	Acceptable
Lakewood Regional Medical Center	165 (7)	2.87	Average	33 (2)	5.37	Average	324 (8)	1.64	Average	262 (43)	14.98	Average	148	95.95%	Acceptable
Long Beach Memorial Medical Center	59 (1)	2.08	Average	11 (1)	8.30	Average	123 (1)	0.87	Average	91 (17)	17.42	Average	54	95.15%	Acceptable
Los Angeles County Harbor UCLA Medical Center	55 (0)	0.00	Average	24 (1)	5.05	Average	135 (0)	0.00	Average	104 (10)	12.18	Average	55	100.00%	Acceptable
Los Angeles County University of Southern California Medical Center	53 (0)	0.00	Average	10 (0)	0.00	Average	107 (3)	2.77	Average	101 (16)	16.00	Average	52	96.15%	Acceptable
Methodist Hospital of Southern California	55 (1)	1.20	Average	81 (5)	4.00	Average	107 (0)	0.00	Average	95 (9)	8.63	Average	50	95.00%	Acceptable
Presbyterian Intercommunity Hospital	112 (5)	4.85	Average	69 (7)	10.43	Average	204 (1)	0.46	Average	180 (30)	15.23	Average	110	93.64%	Acceptable
Providence Little Company of Mary Medical Center - Torrance	156 (1)	0.61	Average	90 (6)	5.59	Average	293 (5)	1.86	Average	250 (40)	16.23	Worse	135	100.00%	Acceptable
Ronald Reagan UCLA Medical Center	21 (0)	0.00	Average	12 (0)	0.00	Average	62 (1)	1.83	Average	59 (11)	22.39	Average	19	100.00%	Acceptable
Saint John's Health Center	26 (1)	7.35	Average	8 (0)	0.00	Average	54 (0)	0.00	Average	49 (11)	25.26	Worse	25	84.00%	Low
St. Francis Medical Center	59 (3)	3.88	Average	14 (0)	0.00	Average	95 (1)	0.82	Average	83 (16)	16.83	Average	55	96.36%	Acceptable
St. Mary Medical Center - Long Beach	38 (1)	3.30	Average	7 (1)	26.44	Average	86 (0)	0.00	Average	73 (4)	5.89	Average	38	97.37%	Acceptable
St. Vincent Medical Center	83 (1)	1.87	Average	43 (1)	3.38	Average	130 (1)	0.83	Average	113 (10)	9.42	Average	82	100.00%	Acceptable
Torrance Memorial Medical Center	86 (2)	2.38	Average	14 (0)	0.00	Average	105 (4)	3.82	Average	87 (6)	6.20	Average	64	96.86%	Acceptable
White Memorial Medical Center	123 (10)	5.80	Worse	26 (5)	15.06	Worse	235 (1)	0.42	Average	206 (16)	8.40	Average	110	98.16%	Acceptable
Desert Regional Medical Center	26 (1)	2.82	Average	4 (0)	0.00	Average	60 (0)	0.00	Average	56 (7)	10.84	Average	25	96.00%	Acceptable
Desert Valley Hospital	187 (5)	2.18	Average	27 (0)	0.00	Average	309 (4)	1.19	Average	272 (35)	12.24	Average	175	96.86%	Acceptable
Eisenhower Medical Center	253 (2)	0.83	Average	55 (1)	2.55	Average	304 (0)	0.00	Average	292 (23)	7.89	Average	248	98.79%	Acceptable
Kaiser Foundation Hospital - Fontana	188 (7)	2.61	Average	68 (4)	4.14	Average	340 (6)	1.38	Average	306 (34)	9.74	Average	176	97.73%	Acceptable
Loma Linda University Medical Center	125 (4)	2.99	Average	20 (0)	0.00	Average	240 (4)	1.54	Average	215 (22)	10.13	Average	112	98.11%	Acceptable
Loma Linda University Medical Center - Murreleta	135 (0)	0.00	Average	33 (0)	0.00	Average	288 (2)	0.78	Average	241 (27)	11.81	Average	128	98.44%	Acceptable
Pomona Valley Hospital Medical Center	156 (2)	1.23	Average	44 (1)	2.63	Average	318 (2)	0.82	Average	278 (39)	14.37	Average	141	99.29%	Acceptable
Riverside Community Hospital	132 (4)	1.89	Average	54 (4)	6.11	Average	282 (4)	1.34	Average	218 (28)	12.75	Average	116	100.00%	Acceptable
San Antonio Community Hospital	272 (17)	4.67	Worse	90 (8)	7.68	Average	701 (8)	1.18	Average	553 (75)	13.81	Average	254	98.43%	Acceptable
St. Bernardino Medical Center															

Greater Los Angeles

Bernardino  
Riverside & San



Orange County	St. Mary Medical Center - Apple Valley	85 (1)	0.93	Average	35 (2)	6.06	Average	165 (1)	0.65	Average	156 (24)	16.22	Average	76	97.37%	Acceptable
	Temecula Valley Hospital	50 (2)	4.38	Average	5 (1)	25.83	Average	65 (0)	0.00	Average	57 (11)	10.67	Average	47	100.00%	Acceptable
	A-HMC Anaheim Regional Medical Center	120 (2)	2.08	Average	57 (0)	0.00	Average	249 (3)	1.26	Average	203 (17)	8.09	Average	114	96.49%	Acceptable
	Fountain Valley Regional Hospital and Medical Center - Euclid	115 (1)	0.76	Average	11 (3)	35.92	Worse	233 (4)	1.42	Average	195 (22)	10.28	Average	110	92.13%	Acceptable
	Heag Memorial Hospital Presbyterian	131 (3)	1.98	Average	90 (5)	5.80	Average	266 (1)	0.40	Average	244 (15)	7.56	Average	115	100.00%	Acceptable
	Mission Hospital Regional Medical Center	97 (1)	1.40	Average	37 (3)	9.00	Average	210 (5)	2.75	Average	184 (19)	11.26	Average	93	100.00%	Acceptable
	Orange Coast Memorial Medical Center	75 (3)	4.95	Average	19 (1)	6.73	Average	134 (2)	1.71	Average	123 (14)	12.63	Average	89	100.00%	Acceptable
	Saddleback Memorial Medical Center	85 (4)	4.15	Average	22 (1)	4.00	Average	152 (3)	2.30	Average	140 (14)	11.26	Average	77	97.40%	Acceptable
	St. Joseph Hospital - Orange	92 (1)	1.20	Average	46 (5)	8.28	Average	163 (3)	2.06	Average	139 (22)	15.86	Average	88	96.56%	Acceptable
	St. Jude Medical Center	81 (1)	1.12	Average	29 (0)	0.00	Average	160 (2)	1.34	Average	148 (9)	6.16	Average	75	98.67%	Acceptable
	UC Irvine Medical Center	59 (3)	5.43	Average	12 (3)	21.71	Average	130 (1)	0.72	Average	100 (11)	9.57	Average	57	98.25%	Acceptable
	West Anaheim Medical Center	31 (2)	6.01	Average	3 (1)	49.80	Average	53 (1)	1.86	Average	38 (6)	16.38	Average	31	93.55%	Acceptable
	Western Medical Center - Anaheim	15 (1)	5.04	Average	6 (0)	0.00	Average	45 (1)	1.87	Average	37 (2)	4.70	Average	15	100.00%	Acceptable
	Western Medical Center - Santa Ana	51 (1)	1.30	Average	15 (0)	0.00	Average	133 (2)	1.32	Average	107 (13)	11.83	Average	48	95.83%	Acceptable
	Alvarado Hospital	26 (0)	0.00	Average	13 (2)	8.73	Average	54 (0)	0.00	Average	46 (9)	18.10	Average	25	100.00%	Acceptable
	Grossmont Hospital	106 (4)	2.86	Average	54 (3)	3.37	Average	221 (3)	1.11	Average	190 (28)	13.44	Average	94	100.00%	Acceptable

1 Isolated CABG Operative Mortality is defined as patient death occurring in the hospital after isolated CABG surgery, up to 90 days, death occurring anywhere after hospital discharge but within 30 days after the isolated CABG surgery or all deaths after transfer to another acute care center up to 90 days.

2 CABG + Valve Operative Mortality is defined as patient death occurring in the hospital after CABG with valve surgery (Aortic Valve Replacement, Mitral Valve Replacement or Repair or a combination of these), up to 90 days, or death occurring anywhere after hospital discharge but within 30 days after the surgery, or all deaths after transfer to another acute care center up to 90 days. Hospital ratings are risk-adjusted using a statistical technique that allows for fair comparison of hospital outcomes even though some hospitals have sicker patients than average.

3 Post-Operative Stroke is defined as a post-operative, central neurologic deficit persisting for more than 24 hours after isolated CABG surgery while in the operating hospital.

4 30-Day Readmission is defined as an isolated CABG surgery patient being readmitted to an acute care hospital within 30 days of being discharged to home or a non-acute setting with a principle diagnosis indicating a heart-related condition, or an infection or a complication that was likely related to CABG surgery. Study population includes patients discharged alive that could be followed-up via hospital patient discharge data.

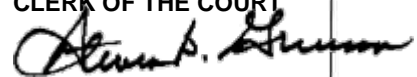
5 Internal Mammary Artery (IMA) Usage in CABG surgery is an evidence-based indicator of surgery quality. Most first-time CABG surgery patients are eligible to receive an IMA bypass. Clinical research shows that IMA grafts used in CABG surgery stay open longer and increase patients' survival. Very low hospital utilization rates may be associated with poorer care. Those hospitals with IMA usage rates below 65.89% (i.e. two standard deviations below the statewide average [67.49%]) are labeled as "Low"; those with rates above 85.89% are labeled as "Acceptable." Hospitals are not assessed for very high IMA usage rates because there is no consensus on what constitutes an optimal rate.

6 The performance rating is based on a comparison of each provider's risk-adjusted mortality rate and the California observed mortality rate. This is a test of statistical significance. A provider is classified as "Better" if the upper 95% confidence limit of its RAMR falls below the California observed mortality rate. A provider is classified as "Worse" if the lower 95% confidence limit of its RAMR is higher than the California observed mortality rate. A provider is classified as "Average" if the California mortality rate falls within the confidence interval of the provider's risk-adjusted mortality rate.

\* Hospital submitted letter in response to the 2014-2015 CABG surgery performance ratings. Click on hospital name to view the letter.

† Fresno Heart and Surgical Hospital report for isolated CABG Operative Mortality is based on cases from January to July of 2015 and for CABG+VALVE Hospital Operative Mortality is based on cases from January to December 2014 and January to July of 2015. Post-operative Stroke is based on cases from January to December 2014 and January to December of 2015.

N/A-Not Applicable: Hospital results are not shown for one of the following reasons: 1) data necessary to confirm deaths or IMA use were not available, 2) CABG case(s) performed did not meet the criteria for a specific measure



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8  
9 DISTRICT COURT  
CLARK COUNTY, NEVADA

11 DARELL L. MOORE and CHARLENE A.  
12 MOORE, individually and as husband and  
wife;

13 Plaintiffs,

14 vs.

15 JASON LASRY, M.D., individually;  
16 FREMONT EMERGENCY SERVICES  
(MANDAVIA), LTD.; TERRY BARTMUS,  
17 RN, APRN; and DOES I through X,  
inclusive; and ROE CORPORATIONS I  
18 through V, inclusive;

19 Defendants.

CASE NO. A-17-766426-C  
Dept. No.: XXV

**ORDER ON PLAINTIFFS' MOTION FOR  
NEW TRIAL**

20  
21 Plaintiffs' Motion for New Trial came on for hearing before this Court on June 11,  
22 2020. This Court issued its decision on June 16, 2020. Keith Weaver, Esq. appeared for  
23 Defendant Terry Bartmus, A.P.R.N.; Chelsea Hueth, Esq. and Robert McBride, Esq.  
24 appeared for Defendant Jason Lasry, M.D.; Breen Arntz, Esq. and Phil Hymanson, Esq.  
25 appeared for Plaintiffs.

26 The Court, having reviewed the pleadings and paper filed by the parties and  
27 hearing oral arguments relating thereto, and good cause appearing, finds as follows:

28  
07/01/2020

1 IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the Court did not err  
2 in precluding Dr. Wiencek from testifying at trial. The Court finds that Dr. Wiencek's  
3 testimony was unnecessary. The Court further finds that Plaintiffs did not provide  
4 sufficient notice that Plaintiffs sought to call Dr. Wiencek to testify at trial. The Court  
5 further finds that Plaintiffs were not substantially prejudiced by the Court's decision to  
6 preclude Dr. Wiencek from testifying.

7 IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the Court finds that  
8 it may have erred in allowing the impeachment of Dr. Marmureanu using the article titled  
9 "CA Hits Nerve By Singling Out Cardiac Surgeon with Higher Patient Death Rates," and  
10 corresponding State of California report upon which the article is based. However, the  
11 Court finds that any potential error in allowing the impeachment of Dr. Marmureanu did  
12 not substantially prejudice Plaintiffs in their right to a fair trial.

13  
14 Plaintiffs' Motion for New Trial is hereby DENIED.

15  
16 DATED this the 10<sup>th</sup> day of July, 2020.

17  
18   
DISTRICT COURT JUDGE  
JG

19 Respectfully Submitted by:

20 LEWIS BRISBOIS BISGAARD & SMITH LLP

21 /s/ Alissa N. Bestick

22 KEITH A. WEAVER

Nevada Bar No. 10271

23 ALISSA N. BESTICK

Nevada Bar No. 14979C

24 6385 S. Rainbow Boulevard, Suite 600

Las Vegas, Nevada 89118

25 Attorneys for Defendant Terry Bartmus,  
A.P.R.N.

26 ///

27 ///



1 APPROVED AS TO CONTENT:

2 Dated: July 1, 2020

3 ATKINSON WATKINS & HOFFMAN,  
4 LLP

5 SUBMITTING COMPETING ORDER

6 MATTHEW W. HOFFMAN  
7 Nevada Bar No.: 9601  
8 10789 W. Twain Avenue, Ste. 100  
9 Las Vegas, NV 89135

10 And

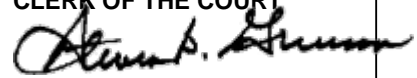
11 BREEN ARNTZ  
12 Nevada Bar No.: 3853  
13 5545 Mountain Vista, Suite E  
14 Las Vegas, NV 89120  
15 *Attorneys for Plaintiffs*

Dated: July 1, 2020

MCBRIDE HALL

*/s/ Chelsea R. Hueth*

ROBERT MCBRIDE,  
Nevada Bar No.: 7082  
CHELSEA R. HUETH,  
Nevada Bar No.: 10904  
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M.D.*



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5 Las Vegas, Nevada 89118  
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*Attorneys for Defendant Terry Bartmus,*  
7 *A.P.R.N.*

8  
9 DISTRICT COURT  
CLARK COUNTY, NEVADA

11 DARELL L. MOORE and CHARLENE A.  
12 MOORE, individually and as husband and  
13 wife;

14 Plaintiffs,

15 vs.

16 DIGNITY HEALTH d/b/a ST. ROSE  
DOMINICAN HOSPITAL-SAN MARTIN  
17 CAMPUS; JASON LASRY, M.D.,  
individually; FREMONT EMERGENCY  
18 SERVICES (MANDAVIA), LTD.; TERRY  
BARTMUS, RN, APRN; and DOES I  
19 through X, inclusive; and ROE  
CORPORATIONS I through V, inclusive;

20 Defendants.

CASE NO. A-17-766426-C  
Dept. No.: XXV

NOTICE OF ENTRY OF ORDER ON  
PLAINTIFFS' MOTION FOR NEW TRIAL

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1 PLEASE TAKE NOTICE that the Order was entered into this matter on July 16,  
2 2020, a true and correct copy of which is attached hereto.

3 DATED this 16th day of July, 2020

4  
5 LEWIS BRISBOIS BISGAARD & SMITH LLP

6  
7 By /s/ Alissa Bestick  
8 KEITH A. WEAVER  
9 Nevada Bar No. 10271  
10 ALISSA N. BESTICK  
11 Nevada Bar No. 14979C  
12 6385 S. Rainbow Boulevard, Suite 600  
13 Las Vegas, Nevada 89118  
14 Tel. 702.893.3383  
15 *Attorneys for Defendants Fremont Emergency*  
16 *Services (Mandavia) and Terry Bartmus,*  
17 *A.P.R.N.*  
18  
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CERTIFICATE OF SERVICE

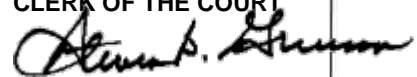
I hereby certify that on this 16<sup>th</sup> day of July, 2020, a true and correct copy of  
NOTICE OF ENTRY OF ORDER ON PLAINTIFFS' MOTION FOR NEW TRIAL was  
served electronically with the Clerk of the Court using the Wiznet Electronic Service  
system and serving all parties with an email-address on record, who have agreed to  
receive Electronic Service in this action.

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*Attorneys for Plaintiffs*

By /s/ Emma L. Gonzales  
An Employee of  
LEWIS BRISBOIS BISGAARD & SMITH LLP



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702.893.3383  
6 FAX: 702.893.3789  
*Attorneys for Defendant Terry Bartmus,*  
7 *A.P.R.N.*

8  
9 DISTRICT COURT  
CLARK COUNTY, NEVADA

11 DARELL L. MOORE and CHARLENE A.  
12 MOORE, individually and as husband and  
13 wife;

14 Plaintiffs,

15 vs.

16 JASON LASRY, M.D., individually;  
FREMONT EMERGENCY SERVICES  
(MANDAVIA), LTD.; TERRY BARTMUS,  
17 RN, APRN; and DOES I through X,  
inclusive; and ROE CORPORATIONS I  
18 through V, inclusive;

19 Defendants.

CASE NO. A-17-766426-C  
Dept. No.: XXV

**ORDER ON PLAINTIFFS' MOTION FOR  
NEW TRIAL**

20  
21 Plaintiffs' Motion for New Trial came on for hearing before this Court on June 11,  
22 2020. This Court issued its decision on June 16, 2020. Keith Weaver, Esq. appeared for  
23 Defendant Terry Bartmus, A.P.R.N.; Chelsea Hueth, Esq. and Robert McBride, Esq.  
24 appeared for Defendant Jason Lasry, M.D.; Breen Arntz, Esq. and Phil Hymanson, Esq.  
25 appeared for Plaintiffs.

26 The Court, having reviewed the pleadings and paper filed by the parties and  
27 hearing oral arguments relating thereto, and good cause appearing, finds as follows:

28  
07/01/2020

1 IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the Court did not err  
2 in precluding Dr. Wiencek from testifying at trial. The Court finds that Dr. Wiencek's  
3 testimony was unnecessary. The Court further finds that Plaintiffs did not provide  
4 sufficient notice that Plaintiffs sought to call Dr. Wiencek to testify at trial. The Court  
5 further finds that Plaintiffs were not substantially prejudiced by the Court's decision to  
6 preclude Dr. Wiencek from testifying.

7 IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the Court finds that  
8 it may have erred in allowing the impeachment of Dr. Marmureanu using the article titled  
9 "CA Hits Nerve By Singling Out Cardiac Surgeon with Higher Patient Death Rates," and  
10 corresponding State of California report upon which the article is based. However, the  
11 Court finds that any potential error in allowing the impeachment of Dr. Marmureanu did  
12 not substantially prejudice Plaintiffs in their right to a fair trial.

13  
14 Plaintiffs' Motion for New Trial is hereby DENIED.

15  
16 DATED this the 10<sup>th</sup> day of July, 2020.

17  
18   
DISTRICT COURT JUDGE  
JG

19 Respectfully Submitted by:

20 LEWIS BRISBOIS BISGAARD & SMITH LLP

21 /s/ Alissa N. Bestick

22 KEITH A. WEAVER

Nevada Bar No. 10271

23 ALISSA N. BESTICK

Nevada Bar No. 14979C

24 6385 S. Rainbow Boulevard, Suite 600

Las Vegas, Nevada 89118

25 *Attorneys for Defendant Terry Bartmus,*  
*A.P.R.N.*

26 ///

27 ///

1 APPROVED AS TO CONTENT:

2 Dated: July 1, 2020

3 ATKINSON WATKINS & HOFFMAN,  
4 LLP

5 SUBMITTING COMPETING ORDER

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7 Nevada Bar No.: 9601  
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10 And

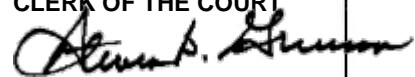
11 BREEN ARNTZ  
12 Nevada Bar No.: 3853  
13 5545 Mountain Vista, Suite E  
14 Las Vegas, NV 89120  
15 *Attorneys for Plaintiffs*

Dated: July 1, 2020

MCBRIDE HALL

*/s/ Chelsea R. Hueth*

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FAX: 702.893.3789  
8 *Attorneys for Defendants Fremont  
Emergency Services (Mandavia) and Terry  
9 Bartmus, A.P.R.N.*

10 DISTRICT COURT  
11 CLARK COUNTY, NEVADA  
12

13 DARELL L. MOORE and CHARLENE A.  
14 MOORE, individually and as husband and  
wife;

15 Plaintiffs,

16 vs.

17 JASON LASRY, M.D., individually;  
18 FREMONT EMERGENCY SERVICES  
(MANDAVIA), LTD.; TERRY BARTMUS,  
19 RN, APRN; and DOES I through X,  
inclusive; and ROE CORPORATIONS I  
20 through V, inclusive;

21 Defendants.  
22

CASE NO. A-17-766426-C  
Dept. No.: XXV

**STIPULATION AND ORDER TO DISMISS  
DEFENDANT FREMONT EMERGENCY  
SERVICE (MANDAVIA), LTD ONLY WITH  
PREJUDICE**

23 ///

24 ///

25 ///

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27 ///

28



1 IT IS HEREBY STIPULATED by and between the parties through undersigned  
2 counsel of record that:

3 FIRST, all claims against Defendant Fremont Emergency Services (Mandavia),  
4 Ltd. are to be dismissed with prejudice.

5 SECOND, each party shall bear their own attorneys' fees and costs incurred in this  
6 action associated with the claims against Defendant Fremont Emergency Services  
7 (Mandavia), Ltd.

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1 THIRD, the hearing on the Motion for Summary Judgment regarding the negligent  
2 hiring, training and supervision claim against Defendant Fremont Emergency Services  
3 (Mandavia), Ltd. set for December 10, 2019 at 9:00 a.m. is vacated as moot.

4 Dated: December 9<sup>th</sup>, 2019

Dated: December \_\_\_\_, 2019

5 ATKINSON WATKINS & HOFFMAN, LLP

CARROLL, KELLY, TROTTER,  
FRANZEN & MCBRIDE

7   
8 Matthew W. Hoffman, Esq.  
9 Nevada Bar No.: 9061  
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M.D.*

11 Breen Arntz, Esq.  
12 Nevada Bar No.: 3853  
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14 Las Vegas, NV 89120  
15 *Attorneys for Plaintiffs*

14 Dated: December \_\_\_\_, 2019

16 LEWIS BRISBOIS BISGAARD &  
17 SMITH LLP

18 KEITH A. WEAVER  
19 Nevada Bar No. 10271  
20 DANIELLE WOODRUM  
21 Nevada Bar No. 12902  
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26 *Attorneys for Defendants Fremont  
27 Emergency Services (Mandavia) and Terry  
28 Bartmus, A.P.R.N.*

1 THIRD, the hearing on the Motion for Summary Judgment regarding the negligent  
2 hiring, training and supervision claim against Defendant Fremont Emergency Services  
3 (Mandavia), Ltd. set for December 10, 2019 at 9:00 a.m. is vacated as moot.

4 Dated: December \_\_\_\_, 2019

Dated: December 11, 2019

5 ATKINSON WATKINS & HOFFMAN, LLP  
6

CARROLL, KELLY, TROTTER,  
FRANZEN & MCBRIDE

8 Matthew W. Hoffman, Esq.  
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M.D.*

10 Breen Arntz, Esq.  
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5545 Mountain Vista, Suite E  
12 Las Vegas, NV 89120  
*Attorneys for Plaintiffs*

14 Dated: December \_\_\_\_, 2019

16 LEWIS BRISBOIS BISGAARD &  
SMITH LLP

18 KEITH A. WEAVER  
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20 Nevada Bar No. 12902  
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22 Las Vegas, Nevada 89118  
*Attorneys for Defendants Fremont  
23 Emergency Services (Mandavia) and Terry  
24 Bartmus, A.P.R.N.*

1 THIRD, the hearing on the Motion for Summary Judgment regarding the negligent  
2 hiring, training and supervision claim against Defendant Fremont Emergency Services  
3 (Mandavia), Ltd. set for December 10, 2019 at 9:00 a.m. is vacated as moot.

4 Dated: December \_\_\_\_, 2019

Dated: December \_\_\_\_, 2019

5 ATKINSON WATKINS & HOFFMAN, LLP  
6

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FRANZEN & MCBRIDE


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*Attorneys for Defendant, Jason Lasry,  
M.D.*

14 Dated: December 9, 2019

15  
16 LEWIS BRISBOIS BISGAARD &  
SMITH LLP

17   
18 KEITH A. WEAVER  
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DANIELLE WOODRUM  
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22 Las Vegas, Nevada 89118  
23 *Attorneys for Defendants Fremont  
Emergency Services (Mandavia) and Terry  
24 Bartmus, A.P.R.N.*



ORDER

Based on the foregoing stipulation, IT IS HEREBY ORDERED that the Defendant Fremont Emergency Services (Mandavia), Ltd. is hereby DISMISSED WITH PREJUDICE and that each party shall bear their own attorneys' fees and costs associated with the claims against Defendant Fremont Emergency Services (Mandavia), Ltd. in this matter.

IT IS ALSO HEREBY ORDERED that the hearing on the Motion for Summary Judgment regarding the negligent hiring, training and supervision claim against Defendant Fremont Emergency Services (Mandavia), Ltd. set for December 10, 2019 at 9:00 a.m. is vacated as moot.

DATED this the 11<sup>th</sup> day of December, 2019.

  
DISTRICT COURT JUDGE

Respectfully Submitted by:

LEWIS BRISBOIS BISGAARD & SMITH LLP

  
KEITH A. WEAVER

Nevada Bar No. 10271

DANIELLE WOODRUM

Nevada Bar No. 12902

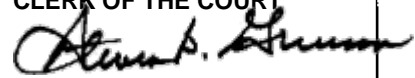
ALISSA N. BESTICK

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*Attorneys for Defendants Fremont  
Emergency Services (Mandavia) and Terry  
Bartmus, A.P.R.N.*



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8 *Attorneys for Defendants Fremont  
Emergency Services (Mandavia) and Terry  
9 Bartmus, A.P.R.N.*

10 DISTRICT COURT  
11 CLARK COUNTY, NEVADA  
12

13 DARELL L. MOORE and CHARLENE A.  
14 MOORE, individually and as husband and  
wife;

15 Plaintiffs,  
16

17 vs.  
18

JASON LASRY, M.D., individually;  
18 FREMONT EMERGENCY SERVICES  
(MANDAVIA), LTD.; TERRY BARTMUS,  
19 RN, APRN; and DOES I through X,  
inclusive; and ROE CORPORATIONS I  
20 through V, inclusive;

21 Defendants.  
22

CASE NO. A-17-766426-C  
Dept. No.: XXV

NOTICE OF ENTRY OF STIPULATION  
AND ORDER TO DISMISS DEFENDANT  
FREMONT EMERGENCY SERVICES  
(MANDAVIA), LTD ONLY

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1 PLEASE TAKE NOTICE that the Stipulation and Order to Dismiss Defendant  
2 Fremont Emergency Services (Mandavia), Ltd. only was entered on December 18, 2019,  
3 a true and correct copy of which is attached hereto.

4 DATED this 18<sup>th</sup> day of December, 2019

5 LEWIS BRISBOIS BISGAARD & SMITH LLP

6  
7  
8 By Ami Bestick  
9 KEITH A. WEAVER  
10 Nevada Bar No. 10271  
11 DANIELLE WOODRUM  
12 Nevada Bar No. 12902  
13 ALISSA N. BESTICK  
14 Nevada Bar No. 14979C  
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16 Las Vegas, Nevada 89118  
17 *Attorneys for Defendants Fremont Emergency*  
18 *Services (Mandavia) and Terry Bartmus,*  
19 *A.P.R.N.*  
20  
21  
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CERTIFICATE OF SERVICE

I hereby certify that on this 18th day of December, 2019, a true and correct copy of NOTICE OF ENTRY OF STIPULATION AND ORDER TO DISMISS DEFENDANT FREMONT EMERGENCY SERVICES (MANDAVIA), LTD ONLY was served electronically with the Clerk of the Court using the Wiznet Electronic Service system and serving all parties with an email-address on record, who have agreed to receive Electronic Service in this action.

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*Attorneys for Plaintiffs*

By



An Employee of  
LEWIS BRISBOIS BISGAARD & SMITH LLP





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8 *Attorneys for Defendants Fremont  
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9 Bartmus, A.P.R.N.*

10 DISTRICT COURT  
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13 DARELL L. MOORE and CHARLENE A.  
14 MOORE, individually and as husband and  
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17 JASON LASRY, M.D., individually;  
18 FREMONT EMERGENCY SERVICES  
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inclusive; and ROE CORPORATIONS I  
20 through V, inclusive;

21 Defendants.  
22

CASE NO. A-17-766426-C  
Dept. No.: XXV

STIPULATION AND ORDER TO DISMISS  
DEFENDANT FREMONT EMERGENCY  
SERVICE (MANDAVIA), LTD ONLY WITH  
PREJUDICE

23 ///

24 ///

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27 ///

28

LEWIS  
BRISBOIS  
BISGAARD  
& SMITH LLP  
ATTORNEYS AT LAW

4852-4838-2382.1

DEC 11 2019

1 IT IS HEREBY STIPULATED by and between the parties through undersigned  
2 counsel of record that:

3 FIRST, all claims against Defendant Fremont Emergency Services (Mandavia),  
4 Ltd. are to be dismissed with prejudice.

5 SECOND, each party shall bear their own attorneys' fees and costs incurred in this  
6 action associated with the claims against Defendant Fremont Emergency Services  
7 (Mandavia), Ltd.

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1 THIRD, the hearing on the Motion for Summary Judgment regarding the negligent  
2 hiring, training and supervision claim against Defendant Fremont Emergency Services  
3 (Mandavia), Ltd. set for December 10, 2019 at 9:00 a.m. is vacated as moot.

4 Dated: December <sup>gth</sup>\_\_\_\_, 2019

Dated: December \_\_\_\_, 2019

5 ATKINSON WATKINS & HOFFMAN, LLP

CARROLL, KELLY, TROTTER,  
FRANZEN & MCBRIDE

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8 Matthew W. Hoffman, Esq.  
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Las Vegas, NV 89113  
*Attorneys for Defendant, Jason Lasry,  
M.D.*

17 Dated: December \_\_\_\_, 2019

18 LEWIS BRISBOIS BISGAARD &  
19 SMITH LLP

20 KEITH A. WEAVER  
21 Nevada Bar No. 10271  
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Bartmus, A.P.R.N.*

1 THIRD, the hearing on the Motion for Summary Judgment regarding the negligent  
2 hiring, training and supervision claim against Defendant Fremont Emergency Services  
3 (Mandavia), Ltd. set for December 10, 2019 at 9:00 a.m. is vacated as moot.

4 Dated: December \_\_\_\_, 2019

Dated: December 11, 2019

5 ATKINSON WATKINS & HOFFMAN, LLP  
6

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M.D.*

10 Breen Arntz, Esq.  
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12 Las Vegas, NV 89120  
13 *Attorneys for Plaintiffs*

14 Dated: December \_\_\_\_, 2019

15  
16 LEWIS BRISBOIS BISGAARD &  
SMITH LLP

17  
18 KEITH A. WEAVER  
19 Nevada Bar No. 10271  
DANIELLE WOODRUM  
20 Nevada Bar No. 12902  
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23 *Attorneys for Defendants Fremont  
Emergency Services (Mandavia) and Terry  
24 Bartmus, A.P.R.N.*

1 THIRD, the hearing on the Motion for Summary Judgment regarding the negligent  
2 hiring, training and supervision claim against Defendant Fremont Emergency Services  
3 (Mandavia), Ltd. set for December 10, 2019 at 9:00 a.m. is vacated as moot.

4 Dated: December \_\_\_\_, 2019

Dated: December \_\_\_\_, 2019

5 ATKINSON WATKINS & HOFFMAN, LLP  
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14 Dated: December 9, 2019

15  
16 LEWIS BRISBOIS BISGAARD &  
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17   
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24 Bartmus, A.P.R.N.*

ORDER

Based on the foregoing stipulation, IT IS HEREBY ORDERED that the Defendant Fremont Emergency Services (Mandavia), Ltd. is hereby DISMISSED WITH PREJUDICE and that each party shall bear their own attorneys' fees and costs associated with the claims against Defendant Fremont Emergency Services (Mandavia), Ltd. in this matter.

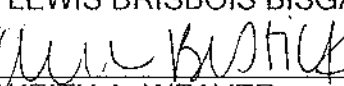
IT IS ALSO HEREBY ORDERED that the hearing on the Motion for Summary Judgment regarding the negligent hiring, training and supervision claim against Defendant Fremont Emergency Services (Mandavia), Ltd. set for December 10, 2019 at 9:00 a.m. is vacated as moot.

DATED this the 11<sup>th</sup> day of December, 2019.

  
DISTRICT COURT JUDGE

Respectfully Submitted by:

LEWIS BRISBOIS BISGAARD & SMITH LLP

  
KEITH A. WEAVER

Nevada Bar No. 10271

DANIELLE WOODRUM

Nevada Bar No. 12902

ALISSA N. BESTICK

Nevada Bar No. 14979C

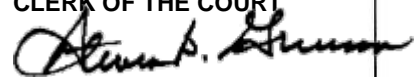
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*Attorneys for Defendants Fremont*

*Emergency Services (Mandavia) and Terry  
Bartmus, A.P.R.N.*





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7 702.893.3383  
FAX: 702.893.3789  
8 *Attorneys for Defendant Terry Bartmus,*  
*A.P.R.N.*

10 DISTRICT COURT  
11 CLARK COUNTY, NEVADA

13 DARELL L. MOORE and CHARLENE A.  
14 MOORE, individually and as husband and  
wife;

15 Plaintiffs,

16 vs.

17 JASON LASRY, M.D., individually and  
18 TERRY BARTMUS, RN, APRN;

19 Defendants.

CASE NO. A-17-766426-C  
Dept. No.: XXV

JUDGMENT ON JURY VERDICT

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<input type="checkbox"/> Non-Jury Judgment Reached before Trial	<input type="checkbox"/> Jury Verdict Reached after Trial Start
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LEWIS  
BRISBOIS  
BISGAARD  
& SMITH LLP  
ATTORNEYS AT LAW

4832-7379-8325.1

MAR 05 2020

1 This action came on for trial before the Honorable Kathleen Delaney, and a jury  
2 beginning on January 27, 2020, Plaintiffs and Defendants appearing by and through  
3 counsel, and the Court having submitted the case to the jury and the jury having entered  
4 a verdict on February 13, 2020, and in accordance with the verdict of the jury:

5 IT IS HEREBY ORDERED, ADJUDGED AND DECREED that Judgement is  
6 hereby entered in favor of Defendant JASON LASRY, M.D. and TERRY BARTMUS,  
7 A.P.R.N. and against Plaintiffs DARELL L. MOORE and CHARLENE A. MOORE.

8 DATED this 6<sup>th</sup> day of MARCH, 2020.

9  
10   
11 DISTRICT COURT JUDGE  
12 JG

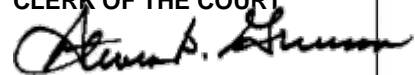
12 Respectfully Submitted by:

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9 *Bartmus, A.P.R.N.*

10 DISTRICT COURT  
11 CLARK COUNTY, NEVADA  
12

13 DARELL L. MOORE and CHARLENE A.  
14 MOORE, individually and as husband and  
15 wife;

16 Plaintiffs,

17 vs.

18 JASON LASRY, M.D., individually and  
TERRY BARTMUS, RN, APRN;

19 Defendants.  
20

CASE NO. A-17-766426-C  
Dept. No.: XXV

NOTICE OF ENTRY OF JUDGMENT ON  
JURY VERDICT

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1 PLEASE TAKE NOTICE that the Judgment on Jury Verdict was entered on March  
2 10, 2020, a true and correct copy of which is attached hereto.

3 DATED this 10<sup>th</sup> day of March, 2020

4 LEWIS BRISBOIS BISGAARD & SMITH LLP

5

6

7

By Alissa Bestick

8

KEITH A. WEAVER

Nevada Bar No. 10271

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DANIELLE WOODRUM

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Las Vegas, Nevada 89118

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*A.P.R.N.*

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1 CERTIFICATE OF SERVICE

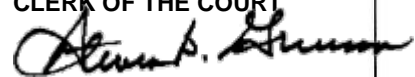
2 I hereby certify that on this 10<sup>th</sup> day of March, 2020, a true and correct copy  
3 of NOTICE OF ENTRY OF JUDGMENT ON JURY VERDICT was served electronically  
4 with the Clerk of the Court using the Wiznet Electronic Service system and serving all  
5 parties with an email-address on record, who have agreed to receive Electronic Service in  
6 this action.

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19 *Attorneys for Plaintiffs*

20 By /s/ Emma L. Gonzales  
21 An Employee of  
22 LEWIS BRISBOIS BISGAARD & SMITH LLP  
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19 Defendants.

CASE NO. A-17-766426-C  
Dept. No.: XXV

JUDGMENT ON JURY VERDICT

<input type="checkbox"/> Non-Jury Disposed After Trial Start	<input type="checkbox"/> Jury Disposed After Trial Start
<input type="checkbox"/> Non-Jury Judgment Reached	<input checked="" type="checkbox"/> Jury Verdict Reached
<input type="checkbox"/> Transferred before Trial	<input type="checkbox"/> Other - _____

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2 beginning on January 27, 2020, Plaintiffs and Defendants appearing by and through  
3 counsel, and the Court having submitted the case to the jury and the jury having entered  
4 a verdict on February 13, 2020, and in accordance with the verdict of the jury:

5 IT IS HEREBY ORDERED, ADJUDGED AND DECREED that Judgement is  
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7 A.P.R.N. and against Plaintiffs DARELL L. MOORE and CHARLENE A. MOORE.

8 DATED this 6<sup>th</sup> day of MARCH, 2020.

9  
10   
11 DISTRICT COURT JUDGE  
12 JG

12 Respectfully Submitted by:

13 LEWIS BRISBOIS BISGAARD & SMITH LLP

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