

**IN THE SUPREME COURT OF THE STATE OF NEVADA**

DARELL L. MOORE; AND CHARLENE )  
A. MOORE, INDIVIDUALLY AND AS )  
HUSBAND AND WIFE, )  
Appellants, )  
vs. )  
JASON LASRY, M.D. INDIVIDUAL; )  
AND TERRY BARTIMUS, RN, APRN, )  
Respondents. )

Electronically Filed  
Jul 21 2021 05:20 p.m.  
Elizabeth A. Brown  
Clerk of Supreme Court

Supreme Court No. 81659

**APPEAL**

From the Eighth Judicial District Court, Clark County  
The Honorable Kathleen E. Delaney, District Judge  
District Court Case No.: A-17-766426-C

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**APPELLANT'S APPENDIX VOLUME XI**

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## CERTIFICATE OF SERVICE

Pursuant to NRAP 25(b), I certify that I am an employee of the law firm and that on this 21<sup>st</sup> day of July, 2021, I served a true and correct copy of the foregoing **APPELLANT'S APPENDIX VOLUME XI** as follows:

- ☐ by placing same to be deposited for mailing in the United States Mail, in a sealed envelope upon which first class postage was prepaid in Las Vegas, Nevada; and/or
- ☐ to be sent via facsimile (as a courtesy only); and/or
- ☐ to be hand-delivered to the attorneys at the address listed below:
- x to be submitted to the above-entitled Court for electronic filing and service upon the Court's Service List for the above-referenced case.

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Las Vegas, NV 89113

Keith A. Weaver, Esq.  
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Las Vegas, NV 89118

By: /s/ E. Breen Arntz  
An employee of E. Breen Arntz, Chtd.

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IN THE EIGHTH JUDICIAL DISTRICT COURT  
CLARK COUNTY, NEVADA

DARELL MOORE, ET AL,	)	
	)	
Plaintiffs,	)	
	)	
vs.	)	Case No. A-17-766426-C
	)	Dept. No. 25
JASON LASRY, M.D., ET AL,	)	
	)	
<u>Defendants.</u>	)	

JURY TRIAL  
  
Before the Honorable Kathleen Delaney  
  
Friday, January 31, 2020, 9:00 a.m.  
  
Reporter's Transcript of Proceedings

REPORTED BY:  
  
BILL NELSON, RMR, CCR #191  
CERTIFIED COURT REPORTER

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APPEARANCES:

For the Plaintiffs: Breen Arntz, Esq.  
Philip Hymanson, Esq.  
Joseph Hymanson, Esq.

For the Defendants: Robert McBride, Esq.  
Keith Weaver, Esq.  
Alissa Bestick, Esq.

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I N D E X

WITNESS	DR	CR	RDR	RCR
Dr. Alexander Marmureanu	9	48		

1 Las Vegas, Nevada, Friday, January 31, 2020

2 \* \* \* \* \*

3  
4 (Thereupon, the following proceedings were  
5 had out of the presence of the jury.):

6 THE COURT: I understand one of the Defense  
7 counsel has something to put on the record.

8 MR. WEAVER: Good morning, Your Honor.

9 I brought this to Mr. Arntz's attention  
10 this morning, but I was waiting for the transcript,  
11 just to be sure, and I'm sure we'll get it soon, but  
12 the issue is the Defense believes yesterday Mr.  
13 Arntz's opening he he said to the jury there were one  
14 or more items on the lifecare plan, I think the  
15 example was wheelchairs, but I think there was other  
16 things that Mr. Moore, quote, unquote, could not  
17 afford, that Dr. Fish, who is testifying this  
18 afternoon testified in his deposition the medical --  
19 necessary medically indicated items on the lifecare  
20 plan would be covered by Medicare, and especially  
21 with regard to one wheelchair, not that there was  
22 payment issued, not there wasn't Medicare issued.  
23 The only reason Mr. Moore doesn't have the  
24 electric wheelchair is because as of a few months ago  
25 he hasn't been fitted for it.

1           So I could be wrong, but I think the case  
2 law is very clear that when a party in opening  
3 statements quotes why it's widely recognized that a  
4 party who raises a subject in an opening statement  
5 opens the door to admission of evidence on that same  
6 subject by the opposing party.

7           So I believe the opening statement, and  
8 again we'll have to get the transcript, I don't have  
9 it, I want to be careful we quote exactly what was  
10 said, but I'm pretty sure what I heard was, there  
11 were items that Dr. Fish wanted to testify to this  
12 afternoon that Mr. Moore can't afford, which leaves  
13 the jury with the impression that if there was a way,  
14 he would have them, by now he would.

15           So I would agree that it's a general  
16 proposition, while in medical malpractice cases under  
17 NRS 42.021 Nevada says the collateral source rule  
18 doesn't apply that aren't Medicare, that because it's  
19 a general proposition that is Medicare, the  
20 collateral source would typically, but I think it  
21 would be unfair to the Defense for the jury to be  
22 left with the impression that the reason Mr. Moore  
23 after three years doesn't have these items that he  
24 could have already received through Medicare is  
25 because he can't afford them.

1           So if he gets two million dollars from the  
2   lifecare plan, Mr. Arntz asks the jury to consider it  
3   eventually I think it leaves them the wrong  
4   impression.

5           THE COURT:   Okay.

6           So let's wait until we get the transcript.

7           MR. WEAVER:   They are really quick in  
8   getting it to us normally, it's been the evening.

9           THE COURT:   I didn't know, you have been  
10   told that --

11          MR. WEAVER:   This morning.

12          THE COURT:   We'll see what happens when  
13   they come in, and we can address it then.

14          Mr. Arntz, anything you want to say in  
15   response to the record now?

16          MR. ARNTZ:   Yeah, was very careful in my  
17   opening to for example modifications to the home, a  
18   specific vehicle, and a specific wheelchair Medicare  
19   won't cover, and Mr. Moore can go in to why it's  
20   necessary, but it's a much lighter motorized  
21   wheelchair, and the one Medicare will pay for is  
22   extremely heavy and very unmanageable for them.

23                So I don't think I opened the door by  
24   referencing things that Medicare won't pay for.

25                I didn't say that he can't afford this,

1 Medicare will pay for it, but this particular  
2 wheelchair Medicare won't pay for.

3 THE COURT: So we'll get the final wording  
4 and then have a final conversation on the subject and  
5 go from there.

6 MR. WEAVER: Thank you, Your Honor.

7 THE COURT: Anything else before we bring  
8 the jurors in?

9 Just one housekeeping matter, I know you  
10 mentioned you're going to call the experts now.

11 Do you anticipate any other witnesses  
12 today?

13 MR. ARNTZ: I think that will take up the  
14 day.

15 We can go with their son.

16 THE COURT: All right.

17 We'll see where we are at.

18 We'll still take our lunch break somewhere  
19 in that 12 to 1:30 range and see how we are doing.

20 (Thereupon, the following proceedings were  
21 had in open court and in the presence of the jury.):

22 THE COURT: Thank you.

23 The jury's now present in the courtroom.

24 And make sure the cell phones are off  
25 and/or silent.

1                   We're going to ask Mr. Arntz at this time,  
2                   who is your next witness, please?

3                   MR. ARNTZ: I call Dr. Alexander  
4                   Marmureanu.

5                   THE COURT: Come straight through the  
6                   courtroom, come all the way to the witness stand,  
7                   please.

8                   Stand right here, and put your things down,  
9                   stand in the front of the chair, and please stand for  
10                  my clerk to swear you in.

11

12                   **DR. ALEXANDER MARMUREANU,**

13

14                   who, being first duly sworn to tell  
15                   the truth, the whole truth, and  
16                   nothing but the truth, was examined  
17                   and testified as follows:

18                   THE CLERK: Please be seated.

19                   Please state your full name, spelling both  
20                   your first and last name for the record.

21                   THE WITNESS: Sure.

22                   Dr. Alexander Marmureanu,  
23                   M-a-r-m-u-r-e-a-n-o.

24                   THE COURT: Thank you.

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DIRECT EXAMINATION OF DR. ALEXANDER MARMUREANU

BY MR. ARNTZ:

Q. We've all agreed with Dr. M, is that okay?

A. I didn't know this, but I'm okay.

Q. Dr. Marmureanu, where you are from?

A. It's a loaded question.

I am from Los Angeles, I live in Hollywood.

I'm originally from Romania, grew up in Romania, went to medical school there.

I did my general surgery, cardiac surgery training, moved to New York in the '90s, went to New York University, Mt. Sinai, UCLA, and like everybody else in LA we never leave, so I'm in Los Angeles now.

Q. So Romania, but you live in Los Angeles?

A. On Hollywood Boulevard.

Q. Hollywood Boulevard.

And explain for the juryt what is your expertise or specialty?

A. I'm a cardio-thoracic surgeon, so I practice what is called -- I'm board-certified in general surgery, which covers surgery on the whole body, and then I'm super-specialized in what is called thoracic and cardiovascular, which is about the heart, about the chest, heart surgery, lung

1 surgery, vascular surgery.

2 Q. You have had a chance to review all the  
3 materials involving Mr. Moore's case, his past  
4 medical treatment, and treatment associated with his  
5 care on the 25th of December 2016?

6 A. Yes, sir.

7 Q. Let's go through your qualifications.

8 The Defense went on for some time about Dr.  
9 Samuel Wilson.

10 Do you know Dr. Wilson?

11 A. No, sir.

12 I know from reading his reports, and that's  
13 it.

14 Q. Okay.

15 Currently what are your positions you hold?

16 A. I'm the president and CEO of California  
17 Heart And Lung Surgery Center, which is my company.

18 We practice in nine hospitals heart  
19 surgery, lung surgery, vascular surgery.

20 I'm the chief of cardio-thoracic surgery  
21 and in two other private practice hospitals.

22 And I'm on the medical executive committee,  
23 as well as the retro-contract review committee for  
24 one of the major hospitals where I practice  
25 cardiovascular and thoracic surgery.

1 Q. What types of past positions have you held?

2 A. Well, I think you have it better than I do,  
3 it's a long CV there, 25 pages.

4 Q. I can --

5 A. Let me answer the best way I can.

6 I came in Los Angeles in 2000, started  
7 UCLA, did my fellowship in cardio-thoracic surgery,  
8 stayed on faculty for a while, then I became the  
9 director of Century City Hospitals, which is for  
10 cardio-thoracic surgery.

11 Then I've been to many hospitals, built  
12 several, perhaps that deal with cardio-thoracic  
13 surgery, Broadman (Phonetic) Hospital, St. Aneela  
14 (Phonetic) Medical Center, California Hospital,  
15 Valley Presbyterian Hospital, and so on.

16 Q. Are you board-certified?

17 A. Yes.

18 Q. What are you board-certified in?

19 A. In general surgery, covers the surgery of  
20 the whole body, and then board-certified in  
21 cardio-thoracic surgery.

22 Q. Explain for the jury what it means to be  
23 board-certified.

24 A. Board certification is a very rigorous  
25 process, and a lot of society and a lot of hospitals

1 want you to be, and a lot of patients by the way want  
2 you to be board-certified, due to to fact you have to  
3 pass exams every few years, you have to go to  
4 meetings, you have to get what is called CMEs,  
5 continuing medical education.

6 In other words, you have to be up to date,  
7 you don't just move somewhere and practice medicine  
8 like the way you did for the last 30 years, things  
9 change over time.

10 Q. Let's talk about what it means to be  
11 fellowship-trained.

12 You are fellowship-trained?

13 A. Yes, sir.

14 Q. That is different than being  
15 board-certified?

16 A. That's correct.

17 So for the jury, you go to medical school,  
18 finish medical school, you do what is called a  
19 residency, you do it for general surgery, it's five  
20 years you train, and then I've done academic medicine  
21 and research, like I've done -- you have to do some  
22 research during your training, so I've done a year of  
23 research in New York University in New York, and then  
24 you move from there, pass your general surgery  
25 boards, and that is a requirement to be

1 board-certified in cardio-thoracic surgery, so heart  
2 and lung surgery.

3 Then you do a fellowship, two years of  
4 training in heart and lung and vascular surgery.

5 Q. Okay.

6 What faculty positions have you held over  
7 the years?

8 A. Well, I've been a teaching assistant on a  
9 faculty during my tour at New York University and Mt.  
10 Sinai New York, and been a junior faculty at UCLA  
11 while I worked for time with staff with faculty, and  
12 I belong to different societies and organizations as  
13 well.

14 Q. Are you currently in a formal position  
15 where you're doing teaching?

16 A. We do teaching every day, and if you see my  
17 CV, I've had hundreds of talks, as well as at  
18 probably close to a hundred places over the world,  
19 from Uzbekistan, to Mongolia, to China, to Africa, to  
20 London where you teach younger surgeons, that is  
21 international.

22 At a local level the same thing in the  
23 hospital, basically you teach residents, nurses, as  
24 well as other doctors.

25 Q. You have been on a number of different

1 medical school committees.

2 What does that involve?

3 A. It's an honor, privilege, and a lot of work  
4 to be on a committee. They basically want your  
5 opinion in regards to the current status of that  
6 issue and what should we do with it.

7 In other words, the committee is about  
8 critical care, about working for example with the  
9 myocardial infarction, how fast that is to work-up  
10 when we do operate.

11 In other words, a lot of committees that --  
12 medical executive committees where issues in the  
13 hospital come up and have to be decided a bit like  
14 here.

15 Q. Okay.

16 I'm not going to go through every single  
17 thing on your CV, but what is the significance of  
18 different advisory boards you have been on?

19 A. Advisory boards, companies come up with a  
20 new product, and a new stent, or device perhaps, a  
21 new device that is more or less like Crazy Glue,  
22 using humans, called Bio Glue, that helps us seal the  
23 vascular procedures, so a patient don't bleed to  
24 death.

25 So all those companies coming out, they

1 want physicians advice in regards to can we improve  
2 this product and what we're going to do.

3 So that comes from general medication to  
4 body devices that we operate.

5 The surgeon could be in Vegas, and the  
6 patient to be in Los Angeles for example.

7 Q. The different lectures you gave around the  
8 world, do some of them involve the issues -- Maybe we  
9 can talk specifically about presentations you have  
10 given involving issues that might be dealt with in  
11 this case, given lectures on those types of things?

12 A. The answer is, yes.

13 The issue we have here is not about  
14 medicine, it's about the proper work-up, the patient  
15 having the proper work-up promptly and timely,  
16 realizing it, and making the proper diagnosis, and  
17 doing the proper work-up, which means a battery of  
18 tests that we need to do to figure out what is going  
19 on, and then I like to say, it's like in the Army, it  
20 has to be done by the book.

21 Once you figure the diagnosis and  
22 treatment, and then you hope for the best outcome.

23 So medicine is not separate.

24 So to summarize your question, the answer  
25 is, yes, a lot of vascular issues come into play and

1 in to my area.

2 Q. Are you familiar with the standard of care,  
3 would it be appropriate for the health care providers  
4 and Defendants in this case, and Nurse Practitioner  
5 Bartmus and Dr. Lasry?

6 A. Yes, sir.

7 There's only one standard of care.

8 In other words, any practitioner that deals  
9 with an issue in ER, on the floor, on an out-patient  
10 basis, if you deal with that issue, there's only one  
11 thing to do, the right thing to do, but that is  
12 follow a certain sequence, pathway, certain rules  
13 need to be applied, so I'm very familiar with that  
14 standard.

15 Q. Did you treat patients similar to Mr.  
16 Moore?

17 A. Every day, sir.

18 Q. Okay.

19 Did you develop a number of different  
20 opinions in this case?

21 A. Yes.

22 Q. Do you have an opinion specifically in  
23 regards to the standard of care, and whether that  
24 standard of care was breached by the Nurse  
25 Practitioner Bartmus and Dr. Lasry?

1           A.     Yes, sir.

2                     The standard of care was breached by both  
3 of them.

4           Q.     Give me the information and foundation for  
5 your opinion regarding the breach of standard of  
6 care.

7           A.     It's going to be a very long answer because  
8 I think we have to talk about, the whole case.

9           Q.     Right.

10          A.     The reality is, there's a patient, which is  
11 Mr. Moore, that comes into the emergency room on a  
12 Christmas day.

13                    So the reality is, nobody really wants to  
14 go to the emergency room on Christmas day, even the  
15 doctors on call, nobody wants to be there, so  
16 obviously there's something that brings this patient  
17 to the ER.

18                    The time of the admission he complains  
19 first of all of problems with his left calf.

20                    Now, there are certain key words.

21                    If you look if somebody tells you, a  
22 Corvette, you probably think about the fast car.

23                    Vascular surgeons, when somebody tells you  
24 there's a problem with the patient walking, and that  
25 problem is pain in the left calf, or a calf, that is

1     vascular arterial insufficiency, that's the way we've  
2     been taught.

3             So years ago, once we asked residents and  
4     students on the exam, is that somebody's running  
5     behind the box in the morning to go to work, and  
6     suddenly develops pain in the left calf, what are you  
7     thinking of, and what we want them to say is,  
8     arterial insufficiency, the fact the arteries don't  
9     work well, not much blood flow.

10            Now, today we can't ask that question  
11     anymore, but we're still thinking about that being an  
12     issue.

13            Living in Vegas, patients do certain  
14     things, walking in the casino, so you walk more, you  
15     create more activity on the lung, you run, there's  
16     not enough blood flow to go down to your foot, and  
17     you end up with pain here, especially in him, number  
18     one being what is called a vascular path, not a  
19     healthy patient, he's got problems before in 2012 he  
20     had a by-pass, and at some point -- Perhaps I can, if  
21     you allow me to draw something, I can better explain,  
22     but in 2012 he had a --

23            MR. ARNTZ:   Can I use this?

24            THE WITNESS:  Your Honor, I'd like to draw  
25     something quick.

1 THE COURT: I understand.

2 We need counsel, in addition to the jury,  
3 to be able to see it.

4 So we have an easel here.

5 MR. MC BRIDE: I'm sorry to interrupt, but  
6 can we also have a question and answer, as opposed to  
7 a straight narrative?

8 THE COURT: I think we're getting there,  
9 and obviously have whatever illustration it's going  
10 to be, but yes, doctor, we appreciate very much you  
11 have a lot of information to provide, but this is  
12 direct examination, so just not a narrative dialogue.

13 THE WITNESS: I fully agree with you.

14 THE COURT: Is it time to do the  
15 illustration now?

16 MR. ARNTZ: Yes.

17 There's some markers there.

18 BY MR. ARNTZ:

19 Q. What is it you want to show the jury?

20 A. May I show --

21 THE COURT: You will have to turn it that  
22 way, so the jurors can see it.

23 Counsel can relocate to see what you are  
24 doing.

25 Mr. Arntz, can you help him, so the jurors

1 can see it?

2 I'm not worried, I can see it afterwards.

3 I want them to see it.

4 MR. ARNTZ: You bet.

5 THE COURT: Okay.

6 THE WITNESS: So he comes to the ER

7 basically with this pain.

8 We know he's not a normal patient.

9 In 2012 -- Let me draw this quick.

10 This is the aorta, the biggest blood vessel  
11 in the body.

12 At this point it comes down, that's the  
13 chest here, that's the belly, those are the legs.

14 His blood comes down, bifurcates, the big  
15 blood vessel bifurcates.

16 BY MR. ARNTZ:

17 Q. Splits?

18 A. Splits.

19 It comes in, and I'm not going to focus  
20 more on definition, so this is the left side, this is  
21 the right side.

22 We know from the previous notes that we had  
23 a lot of this here, in 2012 he had a graft, this  
24 wasn't able to extend, if you have surgery in here,  
25 not to focus on the left leg, but the left leg here,

1 and that's where it is.

2 This area was below the femoral, there was  
3 no blood flow going toward the knee, barely blood  
4 flow below the knee, sort of by-passing like a car  
5 driving down the highway, the highway stops here and  
6 it goes away, here the surgeon created --

7 THE COURT: Doctor, it's not really where  
8 you're speaking -- you're speaking very quickly.

9 If you could slow down, and pick up the  
10 volume, I'm sure my reporter will be fine.

11 The most important thing is that the jurors  
12 hear.

13 So you can relocate where you were, just  
14 slow down and speak up.

15 THE WITNESS: There's a lot of information  
16 I want to get.

17 THE COURT: I know.

18 Slow down, and speak up.

19 THE WITNESS: So this is the knee here.

20 This is the groin.

21 This is the femoral artery.

22 Mr. Moore did not have -- Here in 2012 he  
23 had what is called a by-pass.

24 Why it's important is because this is the  
25 history when he showed up to the emergency room, he

1 had a by-pass, and they've seen there was -- before  
2 the by-pass there was no flow, its very, very  
3 important here --

4 THE COURT: Doctor, the jurors can't see  
5 the board the way it's facing now.

6 Take your time, and speak up.

7 BY MR. ARNTZ:

8 Q. Let's go step-by-step, and then can you  
9 turn it more for them to see it.

10 A. A lot of information.

11 So the blood comes down from the by-pass,  
12 this is the circulation at that time was his left  
13 leg, there was blockages there, so due to the fact  
14 the blood cannot come down through the circulation,  
15 there was a need for an eight millimeter hose by-pass  
16 graft brings the blood down below the knee.

17 This is called the femoral artery, and you  
18 will hear the term fem pop (Phonetic). Fem pop is  
19 the by-pass.

20 While the fem pop is done, it's not as good  
21 as God made it, but it really brings some blood into  
22 the foot.

23 Before the fem pop in 2012 there was no  
24 blood here, it was extremely poor.

25 After the fem pop he had signals in one of

1 the arteries, two arteries, one comes on top of your  
2 foot, one comes down here.

3 The artery here has a flow, but not  
4 palpable. When you check for pulses the way we all  
5 check for pulses here, you feel it.

6 Here it could be tricky, but you should  
7 feel it plus one, plus two, those are pulses.

8 When we can can't feel it, we use what is  
9 called a Doppler probe, just like this, a transducer,  
10 put it on the vessel, and you're going to hear that  
11 is flowing systole and diastole, so we know there's a  
12 flow.

13 So after those kind of operations I put an  
14 X, and I tell the nurse every hour, you go in, and  
15 you check that pulse in there.

16 This is going to be extremely important for  
17 this trial.

18 So he had this by-pass done in 2012.

19 In 2014 he didn't have any blood coming  
20 down here.

21 He went to the ER, he complained, and they  
22 opened it, they dripped medication, just like in your  
23 pipe at home or sink gets clogged, you put some stuff  
24 in there, clog buster, it opens, he went home.

25 So now we're going back -- I want you to

1 understand what the issue is.

2 He goes back to the ER in 2016 complains of  
3 pain here when he walks, and we know all his history.

4 So somebody would think that he have  
5 another problem here. Once they start clotting,  
6 chances are they would continue to clot.

7 So once he gets to the ER, it's been  
8 documented he has a history of fem pop grafts, and  
9 the first thing that is being done is a test to look  
10 if there's a clot in his veins, which is actually a  
11 good idea.

12 Q. Before you go to the ultrasound, Nurse  
13 Practitioner Bartmus was here yesterday, testified  
14 she did two physical exams of Mr. Moore where she was  
15 able to detect a normal pulse in the top of the foot  
16 and the ankle, and she was able to determine from  
17 getting a normal pulse that she -- or he had no  
18 peripheral perfusion.

19 Explain to the jury whether or not that is  
20 even possible in Mr. Moore.

21 A. First of all, what you heard yesterday is  
22 absolutely impossible.

23 That is not true and impossible, and I'll  
24 show you why, and you will understand immediately.

25 First of all, the gentleman never had, for

1 the last many years at least, we know for a fact that  
2 since 2012 or before he did not have a normal exam.

3 People with normal exams there's probable  
4 pulses, like us here, they don't get fem pop grafts,  
5 nobody that is normal gets a graft, so if he had a  
6 graft, he was abnormal.

7 The surgeon said in 2012 that before his  
8 operation he had no pulse.

9 He also said in his op note once he  
10 finishes the operation in 2012, there was only one of  
11 the arteries has a pulse, and it was done only by  
12 Doppler.

13 In other words, what the surgeon in 2012,  
14 when the graft was new, checked here, and he was  
15 happy with that only one of the arteries in the foot,  
16 which is the PT, was very faint, couldn't feel it,  
17 couldn't feel it.

18 That graft was open, and he couldn't feel  
19 the pulse after he did it in 2012.

20 Q. Doctor, just a second --

21 I'd like to move the admission of Joint  
22 Exhibit 101.

23 THE COURT: Any objection?

24 MR. MC BRIDE: No, Your Honor.

25 THE COURT: We understand that to be

1 multiple binders as well.

2 MR. ARNTZ: Actually, I think it's just the  
3 last section of one binder, I think number 6.

4 THE COURT: I could stand corrected.

5 I just remember being informed by my clerk  
6 when we first started the trial that the Exhibit 100  
7 was six binders, and 102 took up a couple additional  
8 binders.

9 MR. ARNTZ: Okay.

10 You're right.

11 I apologize.

12 THE COURT: So binder 6 and 7 are the  
13 Exhibit 101.

14 MR. ARNTZ: Okay.

15 THE COURT: Any objection to the admission?

16 MR. MC BRIDE: No, Your Honor.

17 THE COURT: All right.

18 101 is admitted.

19 BY MR. ARNTZ:

20 Q. Doctor, I understand I actually gave you  
21 the sheets from the op report.

22 Could you read for us what the numbers on  
23 the bottom, the Bate's number is?

24 A. SRDSMR-00081.

25 Q. We're going to bring that up on the screen.

1 Explain to the jury what is it you're  
2 reading in this op report that gives you this  
3 information?

4 A. Do you have a laser pointer, or a stick, or  
5 something?

6 I got one that works.

7 MR. J. HYMANSON: Your Honor, may I  
8 approach?

9 THE COURT: Yes.

10 THE WITNESS: 2012ish clinically no blood  
11 flow.

12 We have arteries going down, veins bring  
13 the blood up, ischemic left leg with left iliac  
14 artery.

15 So in 2012 he had that procedure. Normal  
16 people don't get a by-pass, and somebody has normal  
17 pulses.

18 People with normal pulses also don't lose  
19 their leg. Nobody here is going to lose their leg by  
20 Monday.

21 So this is the diagnosis for surgery.

22 What did they do?

23 Well the artery up here, you remember  
24 before the femoral has a big aneurysm, and they put a  
25 stent in there, and for lack of a better term,

1 there's a lot of junk in there, which means the blood  
2 is not going down, there's so much plaque, so they  
3 open the artery and scoop the plaque out, clean  
4 everything out, and put a patch.

5 That is how bad this initial area was down  
6 here.

7 Femoral by-pass below the knee, 8  
8 millimeter Gore-Tex reported.

9 So you understand, that is where the  
10 surgeon is starting with -- he finishes the diagnosis  
11 with and what he did.

12 Can I have page two?

13 Q. Yes.

14 A. We're all happy when we finish the surgery.

15 We have to be sure that that foot, which is  
16 here, you need circulation down here.

17 All this hope is in this graft.

18 So if you need to document for the patient  
19 to do well, and for us to claim success, feel better  
20 as a surgeon that there's blood flow going down, how  
21 you do this, you can fill the pocket if you are  
22 there, you feel them, may not be there, then you have  
23 to redo your work or use a Doppler, which is a  
24 Doppler.

25 So let's see what he did.

1           He checked the flow, finished the  
2           operation, don't worry about that, that tells you how  
3           he did the graft from the top femoral artery to here,  
4           and excellent blood flow was obtained, you have the  
5           graft, close.

6           Then Doppler.

7           Why Doppler?

8           Because he wanted to feel it.

9           Then an examination of the posterior tibial  
10          pulse, you remember we talked about that right here,  
11          one of the arteries, not both.

12          He had the Doppler pulse, which is a weak  
13          pulse, in one of the arteries, only he's telling you  
14          here in 2012.

15          He's also telling you why it's so important  
16          that this pulse that he felt by Doppler was not  
17          present pre-op, but now it's present.

18          So he's saying, which makes a lot of sense,  
19          that is the way it is, there was not blood flow  
20          moving through this circulation, blood flow was  
21          coming here, and now there's blood going down.

22          So let me say this one more time.

23          We have the by-pass.

24          Before he did the by-pass there was no  
25          pulse.

1           After the by-pass he has fusion here,  
2   saying good flows were measured through this portion  
3   of the graft, and before this he has flow in one  
4   artery by Doppler only.

5           So the best this gentleman can have, four  
6   years after after this graft has been closed, once in  
7   2014 or 2015 reopened, so it's not as good as new.

8           So in the best scenario he can have, why  
9   his graft is open, it's here is a Doppler PT pulse  
10   present.

11           But now in 2016 the graft is closed, which  
12   we have a study that shows that graft is closed.

13           So not only he doesn't have this, because  
14   this the posterior tibial pulse is gone, because that  
15   comes from the graft, and the graft is done, he got  
16   no pulse, so if anybody tells you they felt normal  
17   pulses, pounding pulses by hand, it's just not true,  
18   it's impossible.

19           It's also impossible that even if the graft  
20   would be open, he wouldn't have palpable pulses. He  
21   never had palpable pulses in the last five, six, or  
22   seven years, that's why he got a by-pass.

23           Once they have a by-pass -- or before they  
24   have a by-pass, you have to be sure they don't have  
25   palpable pulses, so once the by-pass is done there

1 are no pulses, they can't be normal, this thing is  
2 done, blood is not coming off of here.

3 How can you have normal blood flowing here?  
4 Impossible.

5 Q. Didn't he lose his leg sometime sooner?  
6 Did you -- Let me ask this question.

7 Did you make a determination whether or not  
8 the occlusion was seen on the ultrasound on 2016,  
9 whether that was a chronic occlusion?

10 A. Acute, the definition of acute is less  
11 than -- We don't know that much about this  
12 gentleman's history, but we know enough to say, more  
13 likely than not.

14 We know he had a fem pop graft.

15 We know that the leg, the graft was open  
16 after it was open.

17 We know that he developed symptoms, pain  
18 while walking into the casino the day before, then  
19 thereafter going to the emergency room on Christmas  
20 day, and they do a study which showed the graft is  
21 closed.

22 So this goes together with the fact the  
23 graft just closed because that's when he started  
24 having pain, there's no more blood going there.

25 Now, you close the graft.

1           The reality that there's some itty bitty  
2 small things included here -- so even if it's closed,  
3 the leg doesn't die within six hours.

4           If you take a normal guy on a motorcycle,  
5 has an accident, the artery gets torn apart, that guy  
6 has a vascular ischemia in six hours.

7           The problem is that the collaterals, there  
8 is still absolutely no pulse, not enough to give you  
9 a pulse.

10          He never had pulses there with the graft  
11 open.

12          With the graft closed four years after it's  
13 impossible to have palpable pulses.

14          However, here's what happens:

15          The clot creates clots.

16          So the first thing you do as a doctor, you  
17 start giving Heparin, and a lot of it. It will not  
18 prevent -- it will not bust the clot, but will  
19 prevent further clot from coming back in.

20          Here is the problem, you create some clots,  
21 now the clots are going up, and now up and up, so  
22 this gentleman did not have that kind of Heparin  
23 given to him, which is an IV dripper, and the next  
24 best thing is to do exactly what they've done here  
25 before, to go into this tube here, and then give what

1 is called TPA, which is a clot buster.

2 So he had this done in 2015 and also had  
3 this done in 2018 -- or I'm sorry, in 2015 when he  
4 clotted was in June I think, and then in 2016 three  
5 days after.

6 In other words, this happened before he  
7 showed up to the ER approximately a year, and they  
8 opened the graft, and it happened again three days  
9 after.

10 He went home, everything became ischemic,  
11 and at that point they did what they are supposed to  
12 do.

13 The PA was here, and he did Heparin, but  
14 none of those things happened.

15 So to summarize, I'm sure there will be  
16 more questions, but he comes to the ER, differential  
17 diagnosis is why, so this patient's in the ER.

18 What brings him here?

19 He will tell you he's got pain and got his  
20 history.

21 The ER team wants to rule out a clot in his  
22 veins, which is actually a good idea, but then they  
23 stopped.

24 Differential diagnosis means -- which are  
25 the top five problems, what could give him the pain.

1           They sent him home with no answer.

2           The number one is arterial insufficiency  
3 because it happened before he has a history that is  
4 the cure, it tells you claudication as the name, you  
5 know the graft is closed, so the work-up was done for  
6 the vein, which should be there.

7           Nowhere in the documentation from the  
8 hospital it says that anybody with suspicion of this  
9 issue, which is the ischemic leg due to closure of  
10 the graft, even now the radiologist clearly said,  
11 hey, the graft is closed, do more work-up one it, do  
12 surgery if you want to get more blood.

13           None of those things were done, and the  
14 patient went home, and that's it.

15           Q.    Go ahead and have a seat.

16           A.    Thank you.

17           Q.    Okay.

18           So you're not critical of Nurse  
19 Practitioner Bartmus or Dr. Lasry for the ultrasound  
20 that should have been done?

21           A.    Not only not critical, I'm in agreement it  
22 should be done.

23           Q.    When there are signs or symptoms to support  
24 a differential diagnosis of DVT?

25           A.    DVT, deep vein thrombosis, could be in the

1 calf, but it should be ruled out.

2 Not only did I agree with that study, but a  
3 duplex, a vascular duplex arterial or venous, it's  
4 that transducer, the same Doppler, is a fancier one  
5 that goes around the leg artery and veins and checks  
6 the flows.

7 They checked the veins, but they never  
8 checked the arteries.

9 They should have been done together.

10 There's no downside in using that, they  
11 travel together.

12 Q. How could you have blood flow in the vein,  
13 but not have it in the artery?

14 Where is that blood coming from?

15 A. Well, they didn't look for blood flow in  
16 the veins, they looked for clots.

17 There was flow in the vein.

18 He didn't find deep vein thrombosis that  
19 could give you pain in the calf and should be  
20 evaluated.

21 The problem is, during -- or not a problem,  
22 it's just a good problem during the study, the  
23 technician who apparently throughout the history  
24 decided to move the transducer up a little bit and  
25 saw the graft being closed, so at that point the

1 radiologist who read the study, he said, hey, your  
2 graft is closed, follow-up with different studies.

3 And what we usually do as a vascular  
4 surgeon, we get what is called an angiogram, even a  
5 CAT scan, CT, Charlie Thomas, angiogram on, or just  
6 plain and simple you put a catheter and insert  
7 contrast and see is -- if there's no flow.

8 This is an emergency, somebody will lose  
9 their leg if you don't establish flow.

10 If there's no flow coming down, the leg  
11 will not die in six hours, but the leg more likely  
12 than not will die in a few days.

13 That is exactly what happened.

14 Q. So in addition to the ultrasound -- Let me  
15 ask you something.

16 I've been telling this jury, because I'm  
17 not aware of this, are you aware of an issue where he  
18 had a prior DVT?

19 A. I'm not sure it was documented.

20 Now, the truth is, even if he didn't have a  
21 prior DVT, it should be ruled out, I don't think it's  
22 a problem, and the fact they were ordering this kind  
23 of study was actually good, but it wasn't enough  
24 because not only they rule out the DVT, but now it  
25 showed you -- the arterial pathology shows you the

1 graft is there. This study is the one.

2           Unfortunately, the study was read as being  
3 normal. Absolutely, it's not normal, shows the graft  
4 is closed.

5           You don't walk, you don't run, you jump on  
6 those patients because again if you don't open that  
7 graft, the leg will go away, and let me re-emphasize  
8 one more time, in 2012, '14, '15, '16 there's  
9 absolutely no way, impossible to have palpable pulses  
10 in this patient just because there's no blood going  
11 down there.

12           Q.    What is the first thing Nurse Practitioner  
13 Bartmus and Dr. Lasry should have done once they  
14 recognized the presence of the clot?

15           A.    Well, a few things.

16           Q.    Let me ask you one thing.

17                   Are you able to tell by looking at the  
18 ultrasound whether the clot is a chronic clot, or  
19 acute clot?

20           A.    Absolutely not.

21                   Even looking at the angiogram, you put  
22 contrast in there, and at that point -- so the  
23 ultrasound will give you some sort of vague view of  
24 what's inside.

25                   The angiogram is done with contrast, and

1 you see, and then you don't see, but can see this  
2 blank because there's a blockage.

3 So the first thing when he sees this number  
4 one odd arterial duplex, versus vascular duplex, the  
5 same thing should have been ordered from the  
6 beginning, have the transducer, the doctor go in the  
7 arteries, in the veins, you will see that close.

8 Next, call a vascular surgeon, call an  
9 interventional radiologist, so they can look, do an  
10 angiogram and start squirting TPA clot busters, start  
11 medical management, start the Heparin, to prevent  
12 further clotting because once you have this classic  
13 up, up, up, and even as patients will eventually --  
14 there is no way to say impossible, say he would have  
15 needed the amputation, all is possible, but they  
16 would have a lower level amputation if this area is  
17 viable.

18 If the clot keeps on going up, the only  
19 thing remaining is called AK, above the knee  
20 amputation, versus BK, a below the knee amputation,  
21 so Heparin to stop the clot from moving, AKA surgery,  
22 we put the balloons in there, inflate the balloon,  
23 and pull the balloon towards you, fish all the clot  
24 out, and return the flow.

25 So there are many options that can be used

1 many times, Rotor Rooter, to clean the gentleman's  
2 graft.

3 We have devices, we put them in and suck  
4 the clot out.

5 So that's where we're at.

6 Q. Is redoing the graft an option?

7 A. Absolutely, called a graft revision. I  
8 probably wouldn't start there, we would first start a  
9 Heparin IV drip, a lot of it, to prevent further  
10 clotting, shoot the clot buster, pull the device to  
11 suck the clot out, or even going surgically, do an  
12 incision in the groin, the same area here, cut, you  
13 have the graft, and start fishing it all out, and  
14 then we re-establish the pulses down here to a  
15 Doppler level, never to a palpable level.

16 Q. What do you make of the finding that Nurse  
17 Practitioner Bartmus testified to yesterday when she  
18 said she found normal peripheral perfusion, normal  
19 pulse, and normal cap refill?

20 A. Not true, it's absolutely impossible in any  
21 patient that has a vascular path, that has a graft  
22 that is closed.

23 In this patient, Mr. Moore, he never had  
24 this kind of exam, even in 2012 before and after the  
25 surgery is what his surgeon said, he couldn't feel

1 pulses when the graft was new, so to me I have to say  
2 it's absolutely impossible four years after to have a  
3 normal exam when the graft is closed.

4 Where is the blood coming from?

5 Impossible.

6 Q. Doctor, one of that things brought up  
7 yesterday in counsel's opening was that you have  
8 testified that after three occlusions, two or three  
9 clots, then you're going to lose your leg?

10 A. Absolutely not true.

11 I never said this.

12 I challenge them to show me that.

13 I actually brought my depo expert report,  
14 checked them. It's nowhere there I don't believe in  
15 that, and even if it would be true, which it's not  
16 true, this is his second one.

17 What is true is, the fact that once he  
18 starts clotting, it will continue to clot, that  
19 graft.

20 That is why you have to be very cognizant,  
21 that is why you have to be very diligent and timing  
22 his leg, so you have to be sure you establish flow as  
23 fast as you can, so I actually said in my deposition,  
24 which I have it here, that you can go in -- it don't  
25 even mean if he clots four times he's going to lose

1 his leg, I said the opposite, I have the page  
2 numbers, you can go as many times as you can and fix  
3 it.

4 It might not be possible at some point, but  
5 there's no way to know if you will ever clot again or  
6 not while on anti-coagulation.

7 Q. Was sending him home with Xarelto, was that  
8 a good thing to do?

9 A. No.

10 First of all, he shouldn't have gone home.

11 Second, the only recognized way to treat  
12 this issue is Heparin IV drip.

13 You usually have 5,000 units, you run, and  
14 you check labs on him every four to six hours to be  
15 sure that the blood is extremely thin, and that is  
16 the standard of care in this kind of problem.

17 Q. So in addition to the ultrasound of the  
18 vein, also of the artery?

19 A. Yes.

20 Q. They should have done a Doppler of the  
21 artery?

22 A. Let me interrupt you for a second.

23 They done had an ultrasound of the artery  
24 because the transducer moved, and the radiologist  
25 says, hey, your graft is closed, so they have enough

1 information even to go to the next step, to get an  
2 angiogram.

3           They didn't have a perfect duplex of the  
4 arteries, which they weren't open, but they knew they  
5 had enough to move to the next step, calling a  
6 vascular surgeon, calling an interventional  
7 radiologist, asking for a CT, computerized angiogram,  
8 a regular angiogram, nothing fancy, just squirt  
9 contrast in through the graft, it's closed, then do  
10 something to fix that.

11           The way it's been done before, one year  
12 before, the way it's been done three days after when  
13 actually the leg was dead.

14           So three days after they have done the  
15 right thing in the ER, done what they were supposed  
16 to do, so he's been in the ER three times.

17           The first time they had done the right  
18 thing, opened the graft.

19           The second time they didn't.

20           The third time they did the right thing.

21           The leg was dead, called outflow.

22           If everything gets clotted here, you can  
23 try to open this graft as much as you can. It's not  
24 because the graft or clot is old, there's nowhere  
25 nobody can prove this graft was closed chronically,

1 just not true.

2           However, if everything here gets clotted,  
3 and all those small vessels, it doesn't matter,  
4 there's no blood going -- it has nowhere to go, and  
5 that is what happened on the 28th when he came back  
6 three days after, the leg was cold, numb, blue, this  
7 vein is gone, and unfortunately because the clotting  
8 went up, he couldn't have the BKA, he had to have the  
9 AKA.

10           Q.    Do you have an opinion as to whether  
11 ultimately the amputation was due to the breach in  
12 the standard of care?

13           A.    Yes, sir.

14           Q.    What does that mean?

15           A.    It means, that due to the fact the  
16 emergency team, Dr. Lasry and Miss Bartmus, fell  
17 below the standard of care.

18                   In other words, they didn't do their job.

19                   The gentleman ended up with an amputation.

20           Q.    Was the amputation a direct result of their  
21 failure to focus on the standard of care?

22           A.    Yes, sir.

23           Q.    Do you have an opinion whether or not that  
24 leg could have been saved on the 25th?

25           A.    Yes, sir, it could have been saved.

1           Q.    Is that opinion to a reasonable degree of  
2 medical probability?

3           A.    Yes, sir.

4           Q.    In other words, you believe more likely  
5 than not that had that treatment taken place on the  
6 25th, he would have kept his leg?

7           A.    Yes, sir.

8           Q.    Okay.

9                   What is the customary treatment for someone  
10 had to have an amputation above the knee after?

11                   You treat patients for that?

12           A.    I do amputations.

13                   Obviously above the knee amputation is  
14 worse.

15                   First of all, any amputation is worse than  
16 not having an amputation, but above the knee, it's  
17 more intrusive toward his lifestyle than below the  
18 knee, which is a shorter prosthesis, and people tend  
19 to walk around and function.

20                   You know, somebody ran in the Olympics.

21                   But below the knee is an easier prosthesis  
22 to fit, and patients do better than above the knee.

23                   In regards to follow-up, there's a lot of  
24 physical therapy, occupational therapy, and what have  
25 you.

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Q. Okay.

Have all the opinions you have given here today been to a reasonable degree of medical probability?

A. Yes, sir.

MR. ARNTZ: That's all I have.

THE COURT: Let's go ahead, take a brief recess before we resume the questioning with the doctor.

We'll return at 10:20.

(Jury admonished by the Court.)

THE COURT: Go ahead take a break.

We'll see you in 10.

(Thereupon, a recess was had.)

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(Thereupon, the following proceedings were  
had out of the presence of the jury.):

THE COURT: See you guys in about ten  
minutes.

(Thereupon, a recess was had.)

1                   (Thereupon, the following proceedings were  
2 had out of the presence of the jury.):

3                   THE COURT: Anything before we bring the  
4 jury in?

5                   MR. MC BRIDE: I was just going to say,  
6 we're going to go until 12:30, is that still the  
7 plan?

8                   THE COURT: It depends how long you think  
9 you're going to take.

10                  I can break whenever in the morning, I just  
11 can't start again until 1:30.

12                  So if we go a little later in the afternoon  
13 -- but the later we take the morning it creates the  
14 imbalance again.

15                  So the goal is to aim for 12 and 12:30, but  
16 ultimately be sure they have more time in the morning  
17 to get their stuff together, than afternoon people.

18                  I wouldn't want to go much later than  
19 12:30.

20                  MR. MC BRIDE: I don't think it's going to  
21 be that.

22                  THE COURT: Okay.

23

24

25

1           (Thereupon, the following proceedings were  
2 had in open court, and in the presence of the jury.):

3           THE COURT: Go ahead and have your seats.  
4           Everyone else can have a seat as well.

5           I just want to ask you for the record, you  
6 understand you're still under oath?

7           THE WITNESS: Yes, I do.

8                               - - - -

9           **CROSS-EXAMINATION OF DR. ALEXANDER MARMUREANU**

10 BY MR. MC BRIDE:

11           Q. Good morning, Dr. Marmureanu.

12                       I have to apologize because yesterday I  
13 think I absolutely butchered your name in my opening  
14 statement. I want to apologize for it in advance.

15           A. Apologies accepted.

16                       And let me assure you, it's not the first  
17 time it happened.

18           Q. May I call you Dr. M, just to make it  
19 easier for the jury to remember, if that's okay?

20           A. Okay.

21           Q. Now, doctor, you remember your deposition  
22 in this case was taken a few months ago back in  
23 October of 2019, do you recall that?

24           A. Yes, I do, sir.

25                       I have it right here, sir.

1 Q. Do you have it in front of you?

2 You reviewed that deposition before today  
3 to check for any completion or inaccuracies, is that  
4 correct?

5 A. I think I did.

6 I don't remember, I probably did.

7 I usually do.

8 I don't remember about this one.

9 Q. In fact, you did not make any changes to  
10 any part of your deposition transcript, is that true?

11 A. That's correct.

12 Q. And --

13 A. Let me say, I don't remember reviewing it,  
14 but obviously, because I did review it, I didn't make  
15 any changes, so you are correct.

16 Q. And you have been deposed numerous times  
17 over the years as an expert witness and as a treating  
18 physician, right?

19 A. Yes, sir.

20 Q. Well over 30 times?

21 A. Yes, sir.

22 Q. Approximately over a hundred times over  
23 your career?

24 A. Approximately less than 50.

25 Q. Less than 50, but more than 30?

1           A.    Yes, sir.

2           Q.    All right.

3                   And now, doctor, I want to go through some  
4 of your qualifications that you mentioned you went  
5 over with Mr. Arntz before in his questioning.

6                   You stated that your specialty is thoracic  
7 and cardio-vascular surgery, correct?

8           A.    Correct, sir.

9           Q.    Is it fair to say that you would be  
10 considered a heart surgeon?

11          A.    Well, I hope so, but not only heart  
12 surgeon, heart surgeon, lung surgeon, vascular  
13 surgeon.

14          Q.    But your primary area of expertise,  
15 specialty included on the CV that you provided to us  
16 is in the area of cardiac surgery and cardio-thoracic  
17 surgery, correct?

18          A.    No, sir, it covers everything.

19                   Let me explain.

20                   Every cardiac case has vascular in it.

21                   When I do cardiac surgery by-pass surgery  
22 for blockages, instead of having a fem pop, you have  
23 a by-pass on the heart, take a vein from the leg,  
24 from here, and you see it on top of the heart, which  
25 leads from the aorta, the big blood vessel, all the

1 way to the coronary arteries, so every cardiac --be  
2 cause I do it -- it's vascular in terms of we work on  
3 vascular structures every single time.

4 Q. I don't mean to downplay any significance  
5 of the vascular system because that is all part of  
6 your practice, correct?

7 A. Yes.

8 Q. But you were not an emergency medicine  
9 physician, correct?

10 A. Well, somewhat.

11 I mean, I don't know how you define  
12 emergency room physician, but I'm not the doctor like  
13 Mr. Lasry, but I'm on call for vascular surgery for  
14 the ER just to see patients like Mr. Moore when the  
15 ER doctor asks me to see those kind of patients, so I  
16 see them in the ER, which some people would say,  
17 well, you have seen him in the ER, you provided care  
18 in the emergency room.

19 Q. Certainly.

20 But you are a cardio-thoracic and  
21 cardio-vascular surgeon on call, or gets consulted on  
22 occasion by the emergency department, correct?

23 A. True.

24 Q. All right.

25 You are not an emergency room physician, a

1 board-certified emergency room physician, like Dr.  
2 Lasry, correct?

3 A. True.

4 Q. You don't spend your full day practicing  
5 emergency medicine, who would treat all sorts of  
6 different types of complaints from a heart attack, to  
7 a common cold, to a trauma case in the emergency  
8 department, true?

9 A. True.

10 Q. All right.

11 In fact, you did not perform an internship  
12 or residency specifically in emergency medicine,  
13 correct?

14 A. Pretty much.

15 When we do our general surgery residency,  
16 we will go through all the services, including  
17 emergency room, so I spent months in the emergency  
18 room during my training, but that is the extent of me  
19 spending months in the ER.

20 Q. Right.

21 A. That's not what I'm looking for.

22 Q. So as a surgery resident, you're going to  
23 spend time in the emergency department as part of  
24 your rotation, right?

25 A. Correct.

1 Q. And you do that as well as part of your  
2 internship, correct?

3 A. Yes, sir.

4 Q. And that internship was actually back in  
5 New York, and back in 1994 to 1995, correct?

6 A. Correct, sir.

7 Q. All right.

8 So that is the last time you would have  
9 actually spent a significant amount of time rotating  
10 through the emergency department as part of your  
11 internship or residency, correct?

12 A. Let me repeat this.

13 You are a hundred percent correct.

14 This is the last time I've been in training  
15 in the emergency room spending time.

16 Part of my -- Actually, I would say, every  
17 day I go to the emergency room to see patients.

18 Just because some of my old patients come  
19 back in, new consults come back in, and I go to nine  
20 hospitals, so I spend a fair amount, but that is the  
21 extent, as a surgeon.

22 Q. You're specifically treating your prior  
23 patients who might return to the emergency department  
24 because of a vascular issue, right?

25 A. Or cardiac or thoracic, yes.

1           Q.    You're not treating other patients in an  
2 emergency department on a regular basis for every  
3 other type of ailment, or potential complaint, a  
4 broken arm, any of those things, true?

5           A.    True, sir.

6           Q.    All right.

7                   In fact, you're not board-certified in  
8 emergency medicine, right?

9           A.    True, sir.

10          Q.    You're not a member of any  
11 nationally-recognized emergency medicine  
12 organizations, true?

13          A.    Correct.

14          Q.    You're also not a member of the American  
15 College Of Emergency Physicians, correct?

16          A.    True.

17          Q.    You are a member of separate  
18 cardio-thoracic surgery associations, right?

19          A.    And vascular, sir.

20          Q.    As well as American College Of Surgeons,  
21 right?

22          A.    Yes.

23                   Well, I have my application in there, and I  
24 understand it's been approved, so I have a different  
25 title, about American College Of Surgeons, so I'm not

1       sure exactly how they call me.

2                   I just applied a year ago, so to be  
3       precise, yes, I'm some sort of a member, but didn't  
4       get my membership, I'm ongoing, my application is  
5       there for the American College Of Surgeons, which  
6       deals with general surgery.

7                   I am a member of the Society Of Thoracic  
8       Surgeons, International Society For Cardiac Surgery,  
9       so a member of a lot of societies, international  
10      vascular surgeons deal with what I currently  
11      practice, and because I practice some general  
12      surgery, I recently applied to the American College  
13      Of Surgeons.

14           Q.     All right.

15                   In looking at your CV that you provided to  
16      us before your deposition, I noted too that you have  
17      not conducted any research specifically in the area  
18      of emergency medicine, correct?

19           A.     Correct, sir.

20           Q.     And you're not on any specific committees  
21      that specifically deal with diagnosis and treatment  
22      in the emergency room, true?

23           A.     It's untrue, but let me explain why.

24                   I'm a member -- We spoke earlier called  
25      systemic, is on the EKG waives, that's the elevation,

1 myocardial infarction.

2           So there's a patient comes up as an  
3 emergency comes up with a heart attack, he needs to  
4 go do the cardiac catheterization, a blockage around  
5 the heart needs an angiogram, then they need to go  
6 upstairs, and then need to be treated by the balloon  
7 -- or by surgery it's called systemic, so it's very  
8 important to do this within 30 minutes to 90 minutes,  
9 it's called door to balloon, walks through the door  
10 to the balloon, so I'm part of that committee and  
11 covers the emergency room in regards to being sure  
12 that things are being done in a timely fashion.

13           Q.    That specifically would relate to an area  
14 of -- your area cardio-vascular -- and  
15 cardio-vascular surgery, correct?

16           A.    It covers the ER people say, come to the  
17 ER, and then we get called, so we have to be  
18 available.

19           Q.    Going back to your CV, doctor, you have not  
20 offered any manuscripts for that?

21           A.    Correct.

22           Q.    For that matter, specifically in the area  
23 of the diagnosis or treatment of acute limb ischemia,  
24 correct?

25           A.    Well --

1 Q. Is that correct?

2 A. Can you repeat the question?

3 Q. Sure.

4 Isn't it true -- I looked through your CV,  
5 looked through all your manuscripts you provided us  
6 all, the other the publications you listed, and I  
7 think even in your deposition you told us you have  
8 not specifically authored any publications that deal  
9 with the diagnosis of and treatment of acute limb  
10 ischemia, true?

11 A. Somewhat.

12 We spoke in the depo and here, but I think  
13 over all you are correct, but for the record there is  
14 one paper I presented to the International  
15 Association Of Vascular Surgeons in 1998 we went over  
16 in the depo in regards to I think it was venous  
17 ulcers, and he had a venous ulcer, and in the paper  
18 it addresses actually certain issues in regards to  
19 chronic, acute ischemia, as well as venous disease,  
20 so that is one paper.

21 Q. That was 18 years before this presentation  
22 by Mr. Moore to the emergency room, correct?

23 A. Yes, sir.

24 Q. It wasn't specifically on the diagnosis or  
25 treatment of acute limb ischemia in the emergency

1 room, true?

2 A. True.

3 Q. Now, let's get to your deposition because I  
4 want to clear that up, so we can be on the same page  
5 here.

6 Do you have your deposition?

7 A. Which page?

8 MR. MC BRIDE: Your Honor, I'd like to move  
9 to publish the deposition of Dr. M.

10 THE COURT: Go ahead, make the formality  
11 and publish it, then we'll get back to the  
12 questioning.

13 You just want that version for now?

14 MR. MC BRIDE: He -- actually if he has a  
15 copy.

16 THE WITNESS: I have a copy.

17 MR. MC BRIDE: Can I approach to make sure  
18 we're on the same page?

19 THE COURT: Yes, you may.

20 THE COURT: Okay.

21 BY MR. MC BRIDE:

22 Q. All right.

23 Doctor, in terms of your deposition, there  
24 was a lot of questions, you remember Mr. Weaver was  
25 present and actually took the lead on asking a lot of

1 those questions of you at your deposition?

2 A. I remember very well.

3 Q. Okay.

4 And, in fact, do you remember there was  
5 some questions that related to the medical literature  
6 that you provided to us, or at least included as part  
7 of your file you had done research on prior to your  
8 deposition, you remember that?

9 A. That's correct.

10 And I explained to him, it's again not  
11 about him, but we did have a fair discussion about  
12 literature, which is different than the patient's  
13 case.

14 I made it very clear that the literature or  
15 the guidelines don't represent the standard of care.

16 I have the page.

17 I understand standard of care is  
18 individual.

19 Q. Let's talk about that.

20 I'll direct you actually to your testimony.

21 You would agree with me in your deposition  
22 you testified --

23 A. Which page?

24 Q. -- under oath, on page 48 where you already  
25 had it.

1 A. 48?

2 Q. Yeah, for -- Actually go back.

3 I think there was some question that you  
4 were going back and forth, and I think there was some  
5 stepping on the toes where you were talking over each  
6 other, Mr. Weaver and you, so there was this little  
7 interaction that you had, so it actually starts at  
8 page --

9 A. Sorry to interrupt you, but they went on  
10 for three hours, so you have to be more precise than  
11 that.

12 THE COURT: I assure you, counsel will be  
13 very professional.

14 THE WITNESS: I can't wait.

15 BY MR. MC BRIDE:

16 Q. Go to page 47, if you will.

17 A. I'm here.

18 Q. It's line 7, this is 7 through 14, and then  
19 we'll go through the next page too.

20 A. Line 7?

21 Q. Line 7.

22 And, doctor, you would agree with me at the  
23 time of your deposition you specified that given Mr.  
24 Moore's chronic peripheral vascular disease, and  
25 chronic occlusion to his fem pop by-pass graft, he

1 would ultimately require an amputation of his left  
2 leg, would you agree what that?

3 A. No, sir.

4 Where are you reading?

5 Q. I'm not reading from the deposition now.

6 A. I disagree with that.

7 Q. So let's get to your you disagree with  
8 that.

9 Let's go to page 47, and you read line 7  
10 through 14, all right?

11 A. Well, you might want to read for the jury,  
12 that's the question for Mr. Weaver.

13 Q. I'm asking if you could read it to  
14 yourself?

15 A. I already did, sir.

16 Q. So you read it to yourself.

17 Now, let me read it, so the jury  
18 understands what the question was.

19 But the literature that you have in front  
20 of you, unless I read it wrong, which I may have very  
21 easily, the question from Mr. Weaver is, that after  
22 more than two failed -- after the by-passes failed  
23 more than two times, even after re-vascularization,  
24 more likely than not the end result is going to be  
25 amputation, do you disagree that is what the

1 literature says?

2 And your answer was, yeah, well the  
3 literature or the guidelines don't represent the  
4 standard of care.

5 Was that your answer, sir?

6 A. Yes, that's I said.

7 I disagree with it.

8 And then the literature or the guidelines  
9 don't represent the standard of care, I said that,  
10 yes.

11 Q. So you disagree that's what the literature  
12 said?

13 A. Well, I think we're talking about Mr. Moore  
14 at the time.

15 This, you're taking this out of context.  
16 We have two lawyers, I just agreed in regards to Mr.  
17 Moore, and I have it all over, clotting two or three  
18 times with amputation.

19 Actually on line 4 I'm saying that, if it  
20 continues to clot, it doesn't not mean he is going to  
21 need an amputation, this is line 4.

22 Q. Right.

23 Doctor, I understand.

24 Let me get to the questions, and you can  
25 feel free to answer however you want, or disagree

1 with me.

2 I'm trying to get to your deposition  
3 testimony and what was testified there.

4 Now, so continuing on, page 48, line 2 --

5 MR. P. HYMANSON: Your Honor, may we  
6 approach, please?

7 THE COURT: Sure.

8 (Thereupon, a discussion was had between  
9 Court and counsel at sidebar.)

10 MR. P. HYMANSON: Thank you.

11 THE COURT: All right.

12 Thank you.

13 With that clarification, maybe I can assist  
14 as we get started.

15 So, doctor, there's a particular format  
16 about how we inquire of someone whose previously  
17 given a deposition.

18 I would ask that you please pause and let  
19 counsel give you the directions, rather than trying  
20 to also direct the process. It will be easier in the  
21 long run.

22 What he's doing now when he asks you to  
23 look at portions of your deposition is simply to read  
24 those portions to yourself to potentially refresh  
25 your recollection of your testimony, and then there

1 will be a line of inquiry.

2 All right?

3 THE WITNESS: Yes.

4 BY MR. MC BRIDE:

5 Q. Now, doctor, let me refer you actually to  
6 the question and answer at lines 5 through 11.

7 Read those to yourself if you could.

8 A. Page 48, sir?

9 Q. Page 48.

10 Actually, start at line 2, and go down to  
11 line 11.

12 A. I did, sir.

13 Q. Perfect.

14 So, doctor, isn't it true that you  
15 testified at your deposition that if the graft failed  
16 two times, three times, it's a possibility, or more  
17 likely than not, it will continue to fail in this  
18 patient, or a patient will require an amputation, and  
19 we agree on that, that was your testimony, correct,  
20 sir?

21 MR. ARNTZ: Excuse me.

22 THE COURT: Hold on, there's an objection.

23 Mr. Arntz.

24 MR. ARNTZ: The same objection, that is not  
25 the proper use of the deposition, reading it into the

1 record.

2 THE COURT: At this point in time I think  
3 we are trying to sort of get to the heart of what's  
4 here.

5 I'm going to give a little bit of leeway.  
6 Let's see if we can make this work. I'm not quite  
7 sure how else to get at it, unless we highlight some  
8 things.

9 Maybe Mr. McBride, ask the question, get  
10 his answer. If it doesn't match, come back to the  
11 deposition.

12 MR. MC BRIDE: That's what I did earlier,  
13 so I was trying to short-circuit it.

14 THE COURT: But what I think we want the  
15 clarity is, just because you ask the doctor to read a  
16 portion to refresh his recollection, you still have  
17 to ask the question and then get his answer, and if  
18 it doesn't match, then you can go back to the depo  
19 and look at it.

20 If we have to go through that type of  
21 formality, that is fine, it is typically how it's  
22 done.

23 Sometimes more familiarity with each other  
24 makes it short-cut some of those things, but I'm  
25 going to sustain Mr. Arntz's objection, and let's try

1 to keep it to the formality here.

2 BY MR. MC BRIDE:

3 Q. Okay.

4 Doctor, do you recall that testimony when I  
5 asked you, given Mr. Moore's chronic peripheral  
6 vascular disease, and prior occlusions, you would  
7 agree he would ultimately require an amputation of  
8 his left leg, correct?

9 A. I disagree to that, sir.

10 Q. Okay.

11 And, again, does paragraph 2 through --  
12 lines 2 through 11, does that refresh your  
13 recollection as to what you testified in your  
14 deposition in that regard?

15 A. Yes, it reflects I'm right, and you are  
16 wrong, and if possible we can put it here, let the  
17 jury be the jury.

18 You're reading it wrong, sir.

19 Allow me to finish my answer for the Judge  
20 and the jury.

21 Q. Sure.

22 A. You want me to be silent, but can I read  
23 aloud?

24 Q. I don't want you to be silent, you can  
25 answer your questions.

1           A.     You're wrong, sir.

2           THE COURT:   We're going to take a little  
3 break, about five minutes, let the jurors step out  
4 for about five minutes.

5           (Jury admonished by the Court.)

6           THE COURT:   See you back when we see you  
7 back.

8           (Jury excused from the courtroom.)

9  
10           (Thereupon, a recess was had.)

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1           (Thereupon, the following proceedings were  
2 had out of the presence of the jury.):

3           THE COURT: Go ahead, everybody have a  
4 seat.

5           Doctor, I didn't want to admonish you for  
6 the first time in front of jury, but that type of  
7 editorializing and trying to direct the process is  
8 exactly what I just told you not to do.

9           THE WITNESS: I'm sorry.

10          THE COURT: I will ask you to please not do  
11 that again.

12          We have a process.

13          Back to counsel, Mr. McBride, we were  
14 already in that area, so I really didn't have a  
15 problem with you going back to the depo and saying  
16 that, but you read this, and I said this, we have to  
17 get off that because the two of you are going to sit  
18 here and keep going at it, and I'm not going to have  
19 it.

20          So I don't know how to resolve this one,  
21 but doctor, I will in the future admonish you in  
22 front of the jury if you continue to try to direct  
23 the testimony.

24          Counsel's going to ask the questions, he's  
25 going to ask you what to read, going to ask your

1 answers, and I ask you to answer them.

2 Don't forget, your counsel's going to have  
3 the opportunity to redirect and examine you as well,  
4 but we cannot be here all day with that kind of  
5 gamesmanship.

6 Mr. Arntz.

7 MR. ARNTZ: I think the problem in this  
8 particular instance was, he wasn't allowed his right  
9 to look and reference the entire answer.

10 In fact, he says at line 13, I'm not done,  
11 please.

12 So there's more to his answer.

13 THE COURT: That is not the problem.

14 Listen to this, doctor, listen to me before  
15 you think you know what to tell me.

16 That's not the problem, Mr. Arntz.

17 Counsel's allowed to say, look at whatever,  
18 if you think there's something else, you deal with  
19 that on direct, but if he has a different answer,  
20 he's welcome to give it, but we are not going to sit  
21 here and tell the jury, oh well, you need to let the  
22 jury read this, that's not how it works, doctor.  
23 This deposition doesn't go in front of the jury.

24 You let him ask the questions.

25 If you think there's something else you can

1 respectfully say, I believe there's more to my  
2 answer.

3 I'm not trying to direct your testimony  
4 either, but I'm not having this.

5 What is your question?

6 THE WITNESS: Thank you for allowing me to  
7 speak, and I really apologize.

8 I'm not saying I know. Actually, I don't  
9 know what to do.

10 With all due respect, what he's reading  
11 here is my testimony, it's clearly he's not saying  
12 what it is supposed to say.

13 I'm saying, let me repeat the question.

14 I'm repeating Mr. Weaver's question, and  
15 he's saying that was my testimony, when clearly at  
16 line 6 -- so what are you saying, let me repeat the  
17 question, and I repeat the question, and he's saying  
18 that that is what I said.

19 THE COURT: Doctor, how many times have you  
20 given testimony in court?

21 THE DEFENDANT: Between five to ten times.

22 THE COURT: Then you know how this works.

23 THE DEFENDANT: I don't know about this.

24 THE COURT: You know how this works.

25 He's cross-examining you.

1           If you don't believe what he's indicating  
2       is complete or accurate testimony, you will have the  
3       opportunity to correct it.

4           It's not a fight over what is in the depo,  
5       it's a dialogue about what the testimony is or is  
6       not.

7           THE WITNESS: I'm sorry.

8           Thank you.

9           THE COURT: Can we get this back on track?

10          MR. MC BRIDE: Yes.

11          Thank you.

12          THE COURT: All right.

13          Thank you.

14          (Thereupon, the following proceedings were  
15       had in open court and in the presence of the jury.):

16          THE COURT: Please have your seats.

17          Even though it was just a short recess, Dr.  
18       Marmureanu, please acknowledge for the record you  
19       understand you are still under oath.

20          THE WITNESS: Yes, I do.

21          THE COURT: Thank you.

22       BY MR. MC BRIDE:

23           Q. I'm actually going to veer off of the  
24       deposition transcript for a minute, doctor.

25           I want to ask you a couple of other

1 questions first of all.

2 A. Okay.

3 Q. On the break, not this last one, the short  
4 one, but on the prior break you had an opportunity to  
5 step outside and speak to Mr. Arntz and other  
6 counsel, correct?

7 A. Yes, sir.

8 Q. And what did you talk about?

9 A. I told them that I found it -- I was  
10 pleasantly surprised you were here, I think it's  
11 going to go very well, and somewhat surprised when I  
12 was shaking Mr. Weaver's hand, he was unhappy and  
13 didn't look at me, and I was disappointed.

14 Q. That's the only thing you talked about  
15 during that break with Mr. Arntz?

16 A. That's what I remember.

17 I went to the bathroom.

18 I asked him where was the bathroom.

19 And I asked if I could get more water.

20 Q. You also talked about your testimony you  
21 gave previously, right, when Mr. Arntz was  
22 questioning you?

23 A. I don't remember, perhaps we did.

24 I don't --

25 Q. I don't mean to interrupt.

1                   Were you done?

2           A.     Actually, I don't remember.

3                   I said that -- I don't remember if we did  
4 talk, perhaps we did.

5           Q.     All right.

6                   Now, getting back to the facts of this  
7 case, in terms of your deposition at the time of your  
8 deposition you made some conclusions based on the  
9 timing of the last time that any sort of thrombolytic  
10 -- TPA therapy, or Drano therapy, would have worked  
11 in Mr. Moore's case, do you remember that testimony  
12 you gave then?

13          A.     I'm not sure I understand your question.

14                   Can you be more precise?

15          Q.     Sure.

16                   Were you able to determine the period of  
17 time is, the absolute last time that the thrombolytic  
18 therapy he received previously in your opinion that  
19 would have been able to have been used in his case on  
20 the 25th or 26th, when was the last time it would  
21 have been able to have been used in order to save his  
22 leg?

23          A.     I remember that.

24                   We talked in the depo about it, and the  
25 best of my recollection I wasn't able to come -- I

1 said it in my expert report, obviously I said, should  
2 have dealt promptly, and with this patient, and I  
3 believe Mr. Weaver said, how many hours, and I said,  
4 well, it's never by the hour because you will have to  
5 call the surgeon, you will have to call the  
6 interventional radiologist, chances are he would have  
7 gone into the 26th, and this is not a one-shot deal.

8 This is an infusion first of Heparin that  
9 will preclude further clotting form, and then a TPA  
10 you keep dripping into the legs and hope the clot  
11 will dissolve, so this is not an hour or two.

12 I again said, that should have been  
13 promptly started once the issue was recognized, and  
14 then would have more likely than not continued into  
15 the 26th.

16 Q. In your opinion would you agree with me  
17 that thrombolytic therapy is not indicated for a  
18 patient with chronic or limited ischemia?

19 A. Yeah.

20 Q. You would agree in terms of the timing of  
21 when the thrombolytic therapy would have been  
22 helpful, or prevented the ultimate outcome in Mr.  
23 Moore's case, you really don't know when that time  
24 line is, you're speculating to that, right?

25 A. I don't understand your question.

1           I can try to answer, but if you can  
2 reformulate it.

3           Q.     Sure.

4           You would agree there's a number of factors  
5 would have to take place in order for the  
6 thrombolytic therapy to be successful, true?

7           A.     Not necessarily.

8           You have to -- I mean, first of all, that  
9 was discussed in the depo, and let me -- I'm trying  
10 not to confuse the depo.

11           On one hand there was normal pulses, but on  
12 the other hand I think your expert said that he would  
13 have needed amputation anyhow, even with normal  
14 pulses, so there was -- we had a little battle there  
15 because you can't have it both ways, but regards to  
16 the acute versus chronic, when you have a patient  
17 that has limb ischemia, no blood in his foot, and you  
18 believe that it one hour, one day, or one week, you  
19 do it because you most likely will save that leg.

20           Nobody is going to look at the clock, say  
21 well, we believe we're not going to do this thing,  
22 we're going to cut his leg, so I disagree with that.

23           In other words, if a patient shows up, he  
24 will get TPA.

25           Q.     Let me try to simplify it for you, doctor.

1           You would agree with me, doctor, when Mr.  
2 Moore returned to the hospital on December 28th,  
3 thrombolytic therapy was initiated with the IV  
4 Heparin, correct?

5           A.     Incorrect, and I can explain that.

6           Q.     You know what, your counsel --

7           A.     I can explain that to the jury.

8                     Let me clarify.

9                     Heparin is not a thrombolytic. You said IV  
10 thrombolytic.

11          Q.     Let me clarify the question, so we can be  
12 on the same page then, doctor.

13                     You agree with me though that when Mr.  
14 Moore returned on the 28th, he was eventually put on  
15 thrombolytic therapy, correct?

16          A.     It's not eventually.

17                     You are started promptly.

18                     He was started on thrombolytic and Heparin,  
19 two different things here.

20          Q.     That's what I'm getting at, he was started  
21 as soon as he was diagnosed in the emergency room on  
22 December 28th, correct?

23          A.     Yes.

24          Q.     And you would agree with me that even after  
25 24 hours of thrombolytic therapy and Heparin, the

1 clot was unable to be resolved, correct?

2 A. Incorrect.

3 Q. Well, your counsel can follow-up with those  
4 answers.

5 I'm trying to get like a yes or no from  
6 you.

7 A. I --

8 Q. So if I can follow up with my next  
9 question, doctor.

10 The thrombolytic therapy initiated on the  
11 28th ultimately proved to be unsuccessful, correct?

12 A. Correct.

13 Q. Ultimately, Mr. Moore required to have his  
14 leg amputated, right?

15 A. Correct.

16 Q. Hypothetically, if Mr. Moore had been  
17 started on thrombolytic therapy on December 25, and  
18 it was unsuccessful, can you listen to me, you would  
19 agree with me that he would have ultimately required  
20 an amputation, correct?

21 A. Incorrect.

22 Q. Okay.

23 Now, in this particular case you were first  
24 contacted to review this case by counsel, Plaintiff's  
25 counsel, a few years back, right?

1           A.     Correct.

2           Q.     And at the time you knew the end result of  
3 what happened to Mr. Moore, right?

4           A.     Wrong.

5           Q.     You weren't provided with information about  
6 what the case was about, and the fact that Mr. Moore  
7 had had to have his leg amputated as a result of an  
8 arterial occlusion?

9           A.     No, sir.

10                  When he first contacted me, I didn't know  
11 anything about the case.

12           Q.     Okay.

13                  But after reviewing the case, you came to  
14 the -- you were provided with additional medical  
15 records, right?

16           A.     Correct.

17           Q.     Including the records from December 28th,  
18 correct?

19           A.     Correct, sir.

20           Q.     And records following December 28th for  
21 other hospitalizations, right?

22           A.     Yes, sir.

23           Q.     When you went and started your review, you  
24 didn't just stop at December 25th, correct, in your  
25 review?

1           A.     Correct.

2           Q.     You had those other records that you  
3 followed up and found out what happened to him,  
4 right?

5           A.     Correct.

6           Q.     All right.

7                 So you knew there was an amputation  
8 ultimately occurred, correct?

9           A.     Ultimately, yes.

10          Q.     Now, in regards to the records that you  
11 were provided, you would agree with me you have a  
12 list at the time of your deposition, you would agree  
13 with me you did not review all of Mr. Moore's prior  
14 treating physician records, correct?

15          A.     I'm not sure how to answer.

16                 The review I was given to me, I have a  
17 list.

18          Q.     Right.

19                 According to the list, I don't know if you  
20 have your actual file materials with you, based on  
21 one of the invoices attached as an exhibit in this  
22 case you were provided with records from St. Rose  
23 Hospital that were approximately 995 pages, do you  
24 recall that?

25          A.     I don't, but if I billed for it, I reviewed

1       those records.

2             Q.     All right.

3                    Are you aware that -- again, we can verify  
4       because he have numerous volumes of medical records  
5       behind you -- that in fact there 2,865 pages just  
6       from St. Rose lose alone, are you aware of that?

7             A.     I'm not sure I understand the question,  
8       sir.

9                    I have a list, if I can help with  
10      everything here.

11            Q.     I know you have listed St. Rose Hospital,  
12      right, you have it listed there how many pages were  
13      part of the St. Rose records?

14            A.     I don't know, whatever you gave me, that's  
15      what I reviewed.

16            Q.     I'll represent to you -- Do you have any  
17      reason to disagree if it was in your invoice, there  
18      was a total of 985 pages that you indicated that you  
19      had read and billed for, do you recall that?

20            A.     I don't recall, but if it's on the invoice,  
21      that is what I've done, yes.

22            Q.     And again, my question now is, are you  
23      aware there are actually 2,865 pages of records just  
24      from St. Rose Hospital alone?

25            A.     Well, if you tell me, you're probably

1 correct.

2 I wasn't aware, no.

3 Q. Did you ever ask Mr. Arntz or prior counsel  
4 as to whether or not you had been provided with  
5 everything that you needed to review in this case  
6 before coming and giving your deposition and coming  
7 to court?

8 A. No, sir.

9 Q. And you would agree with me, you have done  
10 expert work for some time, right, over the past 10,  
11 15 years?

12 A. 10 years, sir.

13 Q. All right.

14 And you have given 50 depositions, right?

15 A. Less than 50.

16 Q. And you testified in trial or mediation 5  
17 to 10 times, right?

18 A. Yes.

19 Q. And you agree with me, it's your role as an  
20 expert witness, it's important that any expert  
21 witness who is going to come in and criticize the  
22 care and treatment provided by any physician, that it  
23 is important that you have all of the available  
24 records in order the make sure you didn't miss  
25 anything, right?

1           A.     That is wrong.

2           Q.     That's wrong, you don't think you need all  
3 the records?

4           A.     No, you need enough to make your opinion,  
5 if I may explain.

6           Q.     Well, Mr. Arntz can follow-up with that.

7                   Well, in this particular case you also were  
8 provided with deposition transcripts, right?

9           A.     Yes, sir.

10          Q.     And you read Mr. Moore's transcript, right?

11          A.     Yes.

12          Q.     His wife, right?

13          A.     Yes, sir.

14          Q.     His son, Christopher?

15          A.     Yes.

16          Q.     Do -- You weren't provided with the  
17 records, I didn't see it listed -- tell me if I'm  
18 wrong -- you weren't provided with the medical  
19 records from St. Rose Stanford Clinic, true?

20          A.     I don't remember, sir.

21          Q.     Those are Dr. Wiencek's records. Do you  
22 recall seeing his office records?

23          A.     I don't remember.

24          Q.     Do you know who Dr. Wiencek was?

25          A.     I don't remember.

1 Q. Okay.

2 I'll represent -- or Wiencek, the vascular  
3 surgeon?

4 Q. Maybe it's a Romanian pronunciation, I'm  
5 mispronouncing.

6 A. Wiencek.

7 Q. You have read those office notes he has  
8 from St. Rose Stanford Clinic?

9 A. I do not remember, sir.

10 Q. Right.

11 I didn't see it.

12 I'll represent to you -- Do you want to  
13 take a look at the list?

14 Take a look at the list.

15 A. If it's not here, I didn't see it, sir.

16 Q. As the treating cardiovascular surgeon, Dr.  
17 Wiencek, those records would be important to you in  
18 order to see if they provide any additional  
19 information, or if they contradict any other  
20 information that you were provided in the records,  
21 right?

22 A. Wrong, sir.

23 Q. Okay.

24 Are you aware Dr. Wiencek diagnosed the  
25 Plaintiff as suffering from chronic venous

1 insufficiency?

2 A. I remember reading that, and actually I did  
3 say he had a venous ulcer, yes.

4 Q. So you are aware that Mr. Moore had been  
5 diagnosed and had suffered from chronic venous  
6 insufficiency for many years, right?

7 A. I'm aware of that.

8 Q. And, in fact, you said you weren't aware  
9 specifically of records reflecting a DVT diagnosis,  
10 but you're aware it was mentioned in the records  
11 somewhere, right?

12 A. Correct, sir.

13 Q. All right.

14 Now, if I can refer you to --

15 MR. MC BRIDE: At this time I'd like to  
16 move for the introduction of Joint Exhibit 109, which  
17 is Dr. Wiencek's records.

18 MR. ARNTZ: No objection.

19 MR. WEAVER: No objection.

20 THE COURT: 190 is admitted.

21 You may inquire.

22 MR. MC BRIDE: Thank you.

23

24

25

1 BY MR. MC BRIDE:

2 Q. Doctor, I just wanted to kind of refer you  
3 to a couple of notes from there. We're going to show  
4 it up on the screen.

5 I think we're switched over.

6 If we could look at -- Are you aware Dr.  
7 Wiencek saw Mr. Moore in his office on February -- in  
8 February of 2016, February 8, 2016, it's SRSC-36,  
9 Exhibit 109, which has been admitted, and they will  
10 show it.

11 In fact, doctor, it should show up on your  
12 screen now.

13 A. Thank you.

14 Q. Actually, there we go.

15 Do you see that record, have you seen that  
16 before?

17 A. I might, just don't remember, sir.

18 Q. Okay.

19 Well, you are aware that Dr. Wiencek  
20 reported that he had been -- Mr. Moore had been doing  
21 well, was ambulating with the aid of a cane, and  
22 approximately five percent of the time he uses the  
23 wheelchair, are you aware of that?

24 A. I --

25 Q. Do you see that in the history of present

1 illness section?

2 A. I see that sir, yes.

3 Q. And then you note here, Dr. Wiencek notes  
4 he has good pulses above and lower extremities on the  
5 femoral on the left and tibial on the right, you see  
6 that?

7 A. I agree, sir.

8 Q. As of February 8th of 2016, good pulses  
9 were noted in both lower extremities?

10 A. That is what is documented, and I believe  
11 the graft was open at that time.

12 Q. Okay.

13 This is ten months before, ten months  
14 before he presented to St. Rose emergency room?

15 A. Correct.

16 So I believe the graft was open, so that is  
17 right, he had pulses.

18 Q. And, in fact, are you aware he was supposed  
19 to return to Dr. Wiencek's office on a regular basis  
20 every six months to have regular checks on his pulses  
21 and see how he was doing?

22 A. That sounds fair, yeah.

23 Q. He was also using compression stockings,  
24 and that was appropriate, right?

25 A. Sure.

1           Q.     Compression stockings, do they assist with  
2 maintaining blood flow as best as possible, as well  
3 as to prevent DVT?

4           A.     Somewhat correct, somewhat incorrect.

5                     Basically, the venous part of the disease  
6 it assists with, doesn't promote the blood glow, just  
7 takes care of the venous insufficiency part.

8           Q.     Right.

9                     That was something that was appropriate,  
10 given Mr. Moore's prior venous insufficiency, right?

11          A.     Yes, sir.

12          Q.     And I'll represent to you -- Have you seen  
13 the records from Dr. Irwin Simon?

14          A.     I seen pages, don't remember all of them,  
15 but can you refresh my memory.

16          Q.     Sure.

17                     I'll show you that page in a second.

18                     But are you aware that in that particular  
19 letter being written by Dr. Wiencek to Dr. Simon,  
20 acknowledging he had been diagnosed with a prior DVT,  
21 have you seen that document before?

22          A.     I've seen it and agree with it.

23                     I'm not disagreeing, it's correct.

24          Q.     The only reason I'm going over this is  
25 because there was a lot of times yesterday by Mr.

1 Arntz with Terry Bartmus, who was on the stand, about  
2 where that came from, so I just wanted to make sure  
3 we're on the same page.

4 You have seen that?

5 A. Yes, sir.

6 And I truly believe I actually said earlier  
7 there was an indication to look for DVT.

8 Q. In fact, the reason why you recall Dr.  
9 Wiencek actually prescribed the patient with the  
10 Xarelto is in an effort to help deal with the  
11 potential -- as a prophylactic to deal with potential  
12 DVTs, right?

13 A. And also the graft.

14 Q. Also the graft.

15 I think you said in the deposition the  
16 Xarelto in your opinion does not really work for  
17 arterial insufficiency, is that your testimony?

18 A. Yes and no.

19 In a steady-staged patient it's better than  
20 nothing.

21 In a patient comes to the ER with the graft  
22 being closed, and again I don't believe he had any  
23 pulses because the pulses were coming from the graft  
24 that shows my point, but you have to move to what you  
25 read the way they've done it on the 28th to

1 thrombolytics and Heparin, so Xarelto is not good  
2 anymore, it's good for a patient that does it at  
3 home, but once it's in trouble, Xarelto is not enough  
4 anymore.

5 Q. You're aware Xarelto has been actually  
6 recommended and previously was used as an off-label  
7 use to assist in blood flow, arterial blood flow as  
8 well?

9 A. We're saying the same thing.

10 I agree, if the patient's home, he benefits  
11 better than nothing.

12 What I'm saying is, that on the 25th when  
13 he showed up with the graft being closed, and again  
14 at that time all this was gone because there no blood  
15 flow was coming from anywhere, Xarelto doesn't do it,  
16 it's all thrombolytics and Heparin, like you just  
17 said.

18 Q. And one of the blood tests that is done in  
19 a particular patient to determine if a blood thinning  
20 medication such as Xarelto is working properly, they  
21 order a PT, a prothrombotic, as well as an INR,  
22 correct?

23 A. May I explain?

24 Q. Sure.

25 A. You are somewhat correct, but mainly

1 incorrect.

2 Q. Okay.

3 That seems to be happening quite a bit.

4 A. You are correct in terms of the order,  
5 those are called coagulation studies.

6 Heparin, we talked earlier, once you give  
7 it, Heparin, the drip, that you provoke -- preclude  
8 the clot from being formed, you can measure PT/PTT or  
9 RNR, so that is when you give Heparin, the only way  
10 to flow, if it works, you measure that.

11 So to answer your question, the studies are  
12 being ordered, the Xarelto does not, it's not  
13 measured by PT/PTT, so you are incorrect by nobody  
14 measured Xarelto, that is done for Heparin.

15 I'm sorry, Xarelto, you give it, it's a  
16 certain dose, and patients live with it.

17 So you are correct to give Xarelto, but the  
18 PT/PTT is not for Xarelto, it's for the Heparin.

19 Q. Are there medications in your experience,  
20 doctor, as a cardio-vascular surgeon such as Dr.  
21 Wiencek, could prescribe in advance, or could have  
22 given to Mr. Moore in an effort to attempt to -- a  
23 stronger blood thinner, such as Coumadin or Warfarin,  
24 to be able to help deal with the potential issue of  
25 an arterial occlusion in the future?

1           A.     Well, you bring up a very good point.

2                   Coumadin is what he's talking about, it's  
3 the same thing, this is a pill, and for coagulation.

4                   Xarelto, I'm actually not saying that Dr.  
5 Wiencek did anything wrong, his decision was to start  
6 Xarelto, I don't think it's bad, rules out the DVT,  
7 makes the blood thinner to flow better through this  
8 graft, hopefully it doesn't clot.

9                   You can make an argument why don't we make  
10 the medicine stronger.

11                   Coumadin, which is actually rat poison,  
12 that is what Coumadin is, so you measure what is  
13 called RNR, different ways to measure, that you get  
14 what you pay for.

15                   That Coumadin will make the blood really  
16 thin, and people can bleed through their hands, or if  
17 they fall, they get hit by a car, die from a  
18 subdural, so you don't want to go on that side.

19                   So yes, he could have done Aspirin or  
20 Plavix, could have done Coumadin.

21                   He said it, with Xarelto I don't think it's  
22 a problem until he gets in trouble and shows up at  
23 the ER.

24           Q.     And I guess what I'm getting at is, the  
25 fact Dr. Wiencek now that I understand you're not

1 critical of him, and neither are we, but Dr. Wiencek  
2 had an understanding of Mr. Moore's prior fem pop  
3 occlusions, correct?

4 A. First of all, let me re-emphasize even  
5 more, even if you will not have had an occlusion,  
6 it's beneficial for him to be on some sort of blood  
7 thinner because this fem pop is unnatural, it's  
8 plastic tubing, so you want to give them something  
9 anyhow because we know God didn't make them perfect,  
10 so at some point they will clot.

11 So you are correct, sir.

12 Q. In fact, the fem pop, if I can approach  
13 real quick the photo or the drawing, just so the jury  
14 understands, your drawing here of this tube,  
15 obviously you're giving it a reference point, but  
16 it's ultimately inside the patient's leg?

17 A. Yes, everything is inside.

18 Q. I just wanted to make sure that was clear.

19 It's not something that is attached to the  
20 exterior of the leg he's wearing around?

21 A. That would have been easy to declot then.

22 Q. Right.

23 So again going back -- or you aware then of  
24 the visit -- this is the same, it's 14, the page  
25 number.

1                   Mr. Moore returned on May 9, 2016 to Dr.  
2                   Wienczek.

3                   Have you seen that record before?

4           A.     I don't remember.

5           Q.     Okay.

6                   Again, this is for a three-month follow-up  
7                   for a pulse check, right?

8           A.     Yes, sir.

9           Q.     That specifically is for a pulse check,  
10           that's what it says, yes?

11          A.     Yes, sir.

12          Q.     It says, he's been doing well, still able  
13           to walk for a few blocks, and then gets tired of the  
14           bilateral legs.

15                   He's talking about both of his legs causing  
16           the problems, right?

17          A.     Yes, sir.

18          Q.     Not just the left leg?

19          A.     Yes, sir.

20          Q.     Again, he reported the use of a cane and a  
21           wheelchair when in a casino, and again noted he has  
22           good pulses in both lower extremities, and on the  
23           right, you see that?

24          A.     Yes, sir.

25          Q.     No reason to disagree with that?

1           A.     No.

2           Q.     Right?

3           A.     No.

4           Q.     Again, the graft was open at that time and  
5 reflects into the pulse?

6           A.     That is the reason he's checking pulses, he  
7 wants to see if the graft is open?

8           Q.     Sure is.

9                   Then he reports that he was doing -- if you  
10 look at the assessment and plan portion at the very  
11 end, and it says, assessment of plan.

12                   And it says, he will continue on Xarelto  
13 and will continue that.

14                   He will continue to do his walking  
15 elevation and compression stockings, and I will plan,  
16 next page, to see him again in six months to a year  
17 for a pulse check.

18                   Currently he has a strong anterior tibial  
19 pulse and good capillary refill by physical  
20 examination.

21                   You see that?

22           A.     Actually, it's different than what he's  
23 saying earlier, but in essence kind of saying the  
24 same thing, he has pulses.

25           Q.     You have no reason to disagree with that?

1           A.     No.

2           Q.     And are you aware, have you seen any  
3 records from on Mr. Moore that in fact Mr. Moore on  
4 December 21, 2016, four days before he arrived in the  
5 emergency room department, he was seen at the Nevada  
6 Spine -- or excuse me, the Nevada Pain Clinic?

7           A.     I'm sorry.

8                   Is that a question?

9           Q.     Yeah.

10                  Have you seen any of those records?

11          A.     I don't remember.

12                  A few years went by perhaps.

13          Q.     And do you know if based on your review of  
14 the records from whatever source, do you know if Mr.  
15 Moore had actually been treated on a regular basis  
16 for chronic back pain?

17          A.     I think he did.

18          Q.     And do you know if any of those times he  
19 was also reporting leg pain as well, and calf pain?

20          A.     Could be.

21          Q.     And do you know what was done on any of  
22 those occasions by the physicians there to determine  
23 whether or not there was any sort of vascular  
24 insufficiency, or arterial insufficiency?

25          A.     I don't remember.

1 I'm not sure.

2 It's a spinal, probably not a vascular  
3 point of view.

4 Q. Okay.

5 Were you aware -- Have you seen any of the  
6 medical records from Walgreen's, the pharmacy that  
7 Mr. Moore received his prescriptions from?

8 A. Perhaps. I mean, a few years back.

9 I don't remember.

10 Q. I know you don't remember reviewing Dr.  
11 Wiencek's chart, ever going through it, but do you  
12 recall from either the Walgreen's records or Dr.  
13 Wiencek's records the fact that on December 27, 2016  
14 a phone call was placed to refill his prescription  
15 for Xarelto?

16 A. It's possible.

17 He was discharged on Xarelto.

18 Q. And a call was made to Dr. Wiencek's  
19 office, and Dr. Wiencek called in the prescription  
20 for Xarelto, were you aware of that?

21 A. I'm not aware, number one.

22 Number two, I'm not sure if Dr. Wiencek did  
23 it on the 27th.

24 This is an automatic refill. My office  
25 does them all the time. Sometimes I don't even know

1 about it so --

2 Q. And you have not seen any records to  
3 indicate that that was an automatic refill, did you?

4 A. I don't remember, but also I don't see any  
5 records that Dr. Wiencek personally called the  
6 pharmacy and said, we need to do it.

7 Q. Right.

8 Because you have not seen those records?

9 A. I don't remember.

10 So perhaps we can put them on the screen.

11 Q. Sure.

12 Let's look at page 18.

13 This is Dr. Wiencek's records still,  
14 Exhibit 109.

15 It's is RC-18, and right up at the top, go  
16 right there, and zero in. You see that is December  
17 27, 2016, right?

18 You ever seen this record before?

19 A. Perhaps.

20 I don't remember.

21 Q. Okay.

22 You see where it says fax refill to  
23 Walgreen's with refill per Dr. Wiencek?

24 It doesn't say that was an automatic  
25 refile, right?

1           A.     The patients call says, if run out of  
2 medication, call my office, and as per Dr. Wiencek  
3 the office or nurse says, hey, John Doe ran out,  
4 should we just refill that, and I say, sure, go ahead  
5 and give him two months or three months, and then  
6 they faxed for Xarelto as per Dr. Wiencek, which is  
7 right.

8           Q.     Sure.

9                   What I'm getting at isn't one of your  
10 criticisms, doctor.

11                  You mentioned in your deposition there was  
12 an inadequate follow-up by Dr. Lasry, as well as  
13 Nurse Practitioner Bartmus, they didn't give proper  
14 instructions for him to follow-up with his vascular  
15 surgeon, isn't that what you stated in your report  
16 and testified at your deposition?

17          Q.     It's different.

18                  May I explain?

19          Q.     Your counsel can explain that.

20                  But this --

21          A.     You're correct, I had an issue with that,  
22 and I continue to have an issue.

23                  I don't think I agree.

24          Q.     You would agree with me that this  
25 documentation suggests Mr. Moore would have called in

1 a prescription on December 27th before he returned,  
2 the day before he returned to the hospital with the  
3 complaints of the severe pain and discoloration to  
4 his leg, correct?

5 A. I'm not sure I understand the question.

6 Q. Sure.

7 December 27 was the day before he went into  
8 the emergency department again, right?

9 A. Yes, sir.

10 Q. This would reflect a phone call was placed  
11 to Dr. Wiencek to refill his Xarelto, correct?

12 A. A hundred percent correct, that's all it  
13 shows.

14 Q. Okay.

15 And we don't know what was explained to Dr.  
16 Wiencek about whether the patient informed him what  
17 had happened in the hospital, or whether he needed to  
18 make an appointment, we don't know any of that  
19 information, right?

20 A. Although, we know what is written here.

21 You are correct.

22 Q. Okay.

23 Now, I think we talked about, you don't  
24 have an issue with the fact he had been diagnosed  
25 with a DVT previously, and we cleared that whole

1 situation based on the visit on December 25.

2 I want to go back now to the December 25th  
3 visit, okay?

4 You don't have a problem with the fact that  
5 Nurse Practitioner Bartmus had indicated in her  
6 records that a prior history of DVT had been  
7 reported?

8 A. I don't have a problem with that, sir.

9 I think it's correct.

10 Q. Do you recall from reading Christopher  
11 Moore's deposition, that Christopher Moore testified  
12 that that is what was conveyed to the hospital  
13 personnel, he had a prior history of DVT, you're  
14 aware of that testimony?

15 A. Yes, but there -- First of all, let me  
16 simplify this.

17 I'm not in any way, shape, or form critical  
18 of her ordering an ultrasound for the DVT, but it was  
19 communicated to the emergency room team he had a  
20 prior history of clot in the leg, which is my  
21 understanding they totally thought there was only a  
22 DVT, versus a clot in the the leg, being the clot in  
23 the leg after the graft.

24 Q. We'll get to that, and now we'll pull the  
25 actual records.

1           These are the records from St. Rose on  
2   December 25, Exhibit 100, and it's starting at 1331.

3           Now, doctor, you have those in front of  
4   you?

5           A.    Yes, sir.

6           Q.    You have seen these records before, right?

7           A.    Yes.

8           THE COURT:   Previously admitted.

9           MR. MC BRIDE:   Thank you, Your Honor.

10          BY MR. MC BRIDE:

11           Q.    And, in fact, this would indicate that one  
12   of the things -- First of all, in terms of Mr.  
13   Moore's past medical history, which was significant,  
14   I think you agreed in your deposition with the fact  
15   Mr. Moore was a long-time smoker?

16           A.    Correct, sir.

17           Q.    And I think you stated pretty clearly that  
18   smoking is not good for your arterial perfusion,  
19   right?

20           A.    Correct, sir.

21           Q.    In fact, it's something that you would  
22   advise every one of your patients, they should do  
23   their best to try to quit smoking, especially if they  
24   have a condition and surgery that Mr. Moore had in  
25   2012, right?

1           A.     Correct, sir.

2           Q.     And that would be something you would  
3 repeat to a patient every time you saw that patient  
4 in follow-up for a pulse check or other visits in the  
5 hospital, that they -- you would advise them to stop  
6 smoking, right?

7           A.     Yes, sir.

8           Q.     And is part of the reason because that can  
9 -- smoking has been proven to actually affect the  
10 arterial and vascular system in human beings?

11          A.     Yes, sir, you're correct.

12          Q.     And it would have some effect on his  
13 arterial occlusive disease,, correct?

14          A.     Yes, correct.

15          Q.     You're aware that despite -- and again, I'm  
16 sure you had patients who despite your best effort to  
17 try to advise them to stop smoking, it's a difficult  
18 habit to break, and they continue to smoke, right?

19          A.     Most of them, yes.

20          Q.     And a lot of those patients still continue  
21 to have problems with arterial occlusion, as long as  
22 they keep smoking, right?

23          A.     Well, some do, some don't.

24                   I can explain that.

25                   In other words, smoking is not good for the

1 blood vessels.

2 People, they don't smoke, end up with bad  
3 occlusive disease, and people that smoke, they don't  
4 have it that bad, but over all it's not -- it's good  
5 for them not to smoke, but it's not a great limited  
6 step, we advise them not to smoke.

7 Q. Gotcha.

8 You're aware in this case Mr. Moore  
9 continued to smoke, and even at the time of his  
10 deposition I believe, unless he's been able to stop  
11 that at the time of his deposition, I took that he  
12 continued to smoke one or two packs a day, do you  
13 remember that?

14 A. Yes, sir.

15 Q. Now, with regard to this note, and in  
16 particular the information that was provided, did you  
17 say that there was no indication that Dr. Lasry and  
18 Nurse Practitioner Bartmus were aware of any history  
19 of prior occlusions?

20 A. Actually, I said the opposite.

21 I said, two things.

22 I said, in their differential diagnosis,  
23 which I don't have to look at your screen because I  
24 know it by heart, there's nowhere mentioned the  
25 possibility of arterial insufficiency, like not

1 enough blood flow to the arteries to the foot.

2           There's a note from Miss Bartmus there was  
3 an old graft, and some history of clot could be  
4 computer-generated, but it's there, and again in the  
5 differential diagnosis this part is missing, but  
6 somewhere in the history it shows to be present.

7           Q.     Okay.

8           And I want to get to, you would agree with  
9 me that in terms of the gold standard to diagnose  
10 acute limb ischemia, would be to use the five Ps, you  
11 heard of that?

12          A.     It's not the gold standard.

13                     A gold standard is an angiogram.

14                     Five Ps is part of the physical exam. It's  
15 very objective. We have a screen there, subjective  
16 is perhaps not, so five Ps, this is going a hundred  
17 years back when our old doctors didn't really have  
18 all the tools we have.

19                     So no, I disagree.

20                     The five Ps are a basically -- actually not  
21 being used anymore.

22          Q.     So you're saying five Ps are irrelevant to  
23 a clinical examination of the patient in the  
24 emergency department?

25          A.     I'm not saying they are irrelevant.

1 I'm saying, they do not represent the  
2 standard of care.

3 The standard of care is done, actually not  
4 even the arterial duplex, the standard of care is an  
5 angiogram where the radiologist and vascular surgeon  
6 shoot contrast to make the circulation of the graft  
7 and see if the graft is open or closed.

8 This is 2020, we look at the screen, and we  
9 see it's not.

10 Five Ps refers to touching the leg and  
11 feeling if it's warm, if it's cold, if the patient  
12 can move it, those are usually not being done  
13 anymore.

14 Q. Okay.

15 Really.

16 Do you know why in terms of why the medical  
17 records we have from Dr. Wiencek after December 2016  
18 and other records from the hospitals that Mr. Moore  
19 treated as after the December of 2016, why they would  
20 then continue to use the five Ps?

21 A. Well, they are not using the five Ps.

22 They are using -- not really going to five  
23 Ps.

24 A physical exam you look at the leg, you  
25 touch the leg, you check the pulse, see if you feel

1 it, you ask them to move their leg, see if they are  
2 able to because a lot of ischemia, they don't move it  
3 very well.

4 There's a lot of issues. Scratch it, take  
5 a car key, scratch the toes, do you feel this, do you  
6 feel anything, and they tell you, the foot feels  
7 cold, the foot feels numb, they cannot move.

8 You tell them to press your foot like you  
9 press the gas pedal in, so indirectly it's physical  
10 exam, not really the five Ps, and you decide from  
11 there which way you're going to go.

12 Q. So in this particular case if you could  
13 just encourage me for a second on the five Ps, the  
14 five Ps would indicate pain, right?

15 A. Correct.

16 Q. Color?

17 A. Pain, yeah.

18 Q. And then that would be color, if it's  
19 colored, and pulselessness, right?

20 A. Pulselessness, pulse, or pulselessness,  
21 yeah.

22 Q. And paraesthesia, which is numbness, right?

23 A. Yeah.

24 Q. Are you aware from the medical records in  
25 fact Mr. Moore had reported at least to Dr. Wiencek

1 when he diagnoses some elements of neuropathy he  
2 developed in his lower left legs?

3 A. He did not have diabetes, but he might have  
4 had neuropathy.

5 I'm not sure.

6 Q. Neuropathy in short, that can cause  
7 numbness, right?

8 A. It could.

9 Q. And then paralysis, right, if you are not  
10 able to move or ambulate, then you're paralyzed,  
11 right?

12 A. Well, we go back to the five Ps, which is  
13 part of the physical exam.

14 It's not totally paralyzed -- Well, if it's  
15 paralyzed, that is what happened the 28th. Usually  
16 it's the lack of movement, hey, press the gas pedal,  
17 or press the clutch, and they can't do it, so it's  
18 lack of movement.

19 Nobody puts the five Ps, and then makes  
20 notes on them, but indirectly that is part of the  
21 physical exam, you look for things, yeah, and  
22 document that.

23 Q. So based on you comparing the physical  
24 examination performed on Mr. Moore in the emergency  
25 department when he was admitted back in 2014 for one

1 prior occlusion, right, you looked at those records?

2 A. When he got the graft initially?

3 Q. Yes.

4 A. Correct, yes.

5 Q. And then you also looked at the records  
6 from June 2015 where he had another occlusion,  
7 correct?

8 A. Yes, sir.

9 Q. You seen the medical records and what was  
10 documented under the five Ps by the physicians on  
11 both of those visits, right?

12 A. Yeah, well, was documented.

13 I mean, there's a discrepancy regards to  
14 him being or not being evaluated.

15 Q. In June you're talking about?

16 A. I'm talking when he came in, he -- no,  
17 December.

18 Q. I'm talking about you have seen those other  
19 visits where it was documented about what his  
20 presentation was under those five Ps from 2014 and  
21 2015, right?

22 A. Correct.

23 Q. And now you have seen additional  
24 documentation too from Dr. Wiencek, at least today,  
25 in terms of the adequate perfusion, at least no

1 reports of pain, those sorts of things would indicate  
2 Dr. Wiencek was doing a physical examination using  
3 that method, right?

4 A. Yeah, correct.

5 Q. So, in fact, you agree with me that on  
6 those other visits to the emergency department where  
7 an occlusion required the thrombolytic therapy, he  
8 was admitted for that purpose, you would agree with  
9 me his presentation on each of those two occasions  
10 was actually significantly different than what it was  
11 on December 25, 2016?

12 A. Not necessarily.

13 I mean --

14 Q. Well --

15 A. -- it's never the same.

16 It's like looking at two cars, two people,  
17 they are never the same, but it's sometimes -- I can  
18 only talk about what I think is important at the  
19 presentation on the 25th was generated, the  
20 amputation, or lack of treatment generated  
21 amputation.

22 As far as his depo, he complained that leg  
23 being a bit more cool and numb, and he shows up to  
24 the ER complaining of what is called claudication,  
25 which is clearly to represent vascular arterial

1 ischemia, so if somebody comes to the ER on the 25th,  
2 and that is what is important, it's not important  
3 what happened a year or two or six months before,  
4 it's important what happened the 25th, was that kind  
5 of issue, a different diagnosis should be generated  
6 including the DVT, but mainly including the arterial  
7 insufficiency, knowingly somewhere in those notes  
8 they document there was a fem pop graft that failed  
9 the year before, but you don't see it anywhere.

10 This was a working diagnosis, and in other  
11 words, is this graft op or not, can we do anything if  
12 it's closed to open?

13 That was never taken into consideration on  
14 the 25th.

15 Q. Okay.

16 Doctor, you would agree with me the  
17 presentation was different on those prior two visits  
18 where he required admission and thrombolytic therapy,  
19 you agree with that?

20 A. No.

21 Q. We could go back.

22 A. We can -- should go back.

23 I think it's fairly similar.

24 Q. You would agree that there was  
25 discoloration noted in 2015, right?

1           A.     I think there was, if I recall correct,  
2     yeah.

3           Q.     You would agree with me, there's no note of  
4     any discoloration at the visit in December of 2016,  
5     correct?

6           A.     The 25th.  
7                   The 28th there was discoloration.

8           Q.     The 25th I'm talking about. You would  
9     agree no discoloration, right?

10          A.     Correct, yes.

11          Q.     In fact, you remember reading Mr. Moore's  
12     deposition testimony where he said in fact that his  
13     leg looked normal, you remember that?

14          A.     Yes.

15          Q.     And do you remember what he said about his  
16     leg on the 26th and the 27th, you remember what he  
17     said?

18                   He said his leg looked normal, didn't it?

19          A.     Yeah.

20                   I one hundred percent agree with you.

21                   Unfortunately, he's not a doctor.

22          Q.     So let me ask my next question.

23                   It wasn't until December 28th when he noted  
24     severe cold, causing excruciating pain, and his foot  
25     and leg was black and blue or mottled, right?

1           A.     Mottled, that is dead.

2           Q.     Right.

3                     And that didn't have mottled presentation  
4 on the 25th, right?

5           A.     He didn't, correct.

6           Q.     Right.

7                     His leg --

8           A.     It was still salvageable at that time, the  
9 leg.

10          Q.     The leg was described within normal limits,  
11 right?

12          A.     By the ER team?

13          Q.     I'm talking about every source that you  
14 looked at from his own deposition testimony, his  
15 son's testimony, as well as the depositions also of  
16 Dr. Lasry and Nurse Practitioner Bartmus, as well as  
17 the medical records from St. Rose Hospital on  
18 December 25, they all indicated that his skin and  
19 appearance and the condition of his leg was otherwise  
20 normal, with the exception of a report of pain and  
21 numbness, correct?

22          A.     Well, somewhat incorrect.

23                     You are correct that the ER team, Dr. Lasry  
24 and Miss Bartmus, documented as normal.

25                     You are also correct he complained of pain

1 and numbness.

2           You forgot to bring up again the  
3 claudication, which is a clear sign of vascular  
4 ischemia.

5           And like I previously said, we're going to  
6 get there, it's the result of the ultrasound that is  
7 not normal, the ultrasound clearly shows the graft  
8 was closed, and that is highly abnormal.

9           So that is not a normal patient.

10          Q.    Okay.

11                Actually, now we're on that subject, that  
12 is a good segway, you talked about the ultrasound  
13 report, the venous Doppler ultrasound done by the  
14 radiologist at St. Rose, do you recall that?

15          A.    Yeah, it was done by the tech, not the  
16 radiologist.

17          Q.    Right, by the tech.

18                In that particular case, in fact, that is  
19 interpreted by a radiologist subsequently, right?

20          A.    Correct, by the tech initialing it, then by  
21 the radiology.

22          Q.    So you have two people looking at it, and  
23 in this case we were fortunate, as you indicated the  
24 tech actually went farther up to actually check out  
25 the arterial system and found a possible occlusion,

1 you remember him saying that in his report?

2 A. Appeared an occlusion, correct.

3 Q. Now, I think you -- Let me get to that  
4 page.

5 Here it is, it's 1411.

6 It's St. Rose Exhibit 100?

7 Doctor, I think you testified from  
8 questions from Mr. Arntz the radiologist who  
9 interpreted this and looked at the arterial and saw  
10 the evidence of the possible occlusion, that that  
11 radiologist stated, do something now, instructed the  
12 ER physicians to take action immediately, call a  
13 vascular surgeon, do more studies, clinical  
14 correlation if necessary, isn't that sort of what you  
15 -- to paraphrase what you said in response to Mr.  
16 Arntz?

17 A. Well, not exactly, but similar.

18 So the impression is, no evidence of DVT,  
19 so no clot in the foot, in the left lower extremity,  
20 left femoral graft appears occluded.

21 If you would be in a submarine, you would  
22 see a red light and a sound, this cannot be more of  
23 an emergency, those words here, those six words there  
24 represent flags, alarms, red lights, all over.

25 When a patient walks in, a patient who has

1 a history of clot, the fem pop -- has been clotted  
2 before, comes in with pain, comes in with basically  
3 being numb, and foot pain, the first thing you do,  
4 you rule out that the graft has to be open, and there  
5 was not part of the working diagnosis for them, so  
6 then the physician says, hey, that is what I think,  
7 at that point automatically if a computer would be  
8 available to have done it, an arterial duplex gets in  
9 right away, your arterial part, and generate an  
10 angiogram to follow, you would hope, so -- but that  
11 wasn't done, that's my point.

12 Q. My point was really more to what you  
13 testified earlier where you said that the -- I'll let  
14 the jury decide what you actually testified to, but I  
15 had in my note that you said the radiologist reported  
16 that something needs to be done, a vascular surgeon  
17 needs to be consulted, or an arteriogram needed to be  
18 performed.

19 That is not what it says in that report,  
20 correct?

21 A. Not directly, no.

22 That is my interpretation of those words.

23 Q. Right.

24 In fact, you have seen reports that have  
25 come back from a radiologist when they happened upon

1 a finding that wasn't maybe something that they  
2 expect to find or not the main purpose of the exam,  
3 where they've actually used the term further clinical  
4 correlation is recommended or suggested, correct?

5 A. I've seen that, yes.

6 Q. And it happens quite often, right?

7 A. It's up to the radiologist.

8 Q. Sure.

9 A. It's not up to the radiologist who reads  
10 the film to tell the ER physician or vascular surgeon  
11 what needs to be done.

12 All they need to say is, whatever they  
13 said, this seems to be occluded, and I figure out, or  
14 the ER physician or Nurse Practitioner, what needs to  
15 be done.

16 Unfortunately, because they were never  
17 looking at this issue, they have done nothing about  
18 it.

19 Q. But this is something you would agree with  
20 me the purpose of this study was to rule out a DVT,  
21 right?

22 A. A hundred percent.

23 Q. So in the context of that you'd say the  
24 radiologist actually found is this additional, quote,  
25 unquote, abnormal finding, right?

1           A.    I don't need quote, unquote.

2                   It's definitely abnormal.

3           Q.    In that particular case you would agree  
4 with me that since this wasn't the specific test for  
5 it, that the language that the radiologist, if he was  
6 concerned about it, would be to recommend further  
7 clinical correlation with other studies, that's the  
8 language that is used all the time by radiologists,  
9 right?

10          A.    Not all the time.

11                   It's used at times.

12                   But it's not the radiologist's job to be  
13 concerned, it's the ER job to be concerned.

14                   So all what he said, he reads films, he's  
15 objective, looks there, sees what it says, and he  
16 reports it.

17                   It's up to the doctor who cares for the  
18 patient what to do.

19                   He could call the ER, he could be -- he as  
20 a vascular surgeon -- he could start the Heparin, he  
21 could do a lot of things, or do anything. It's their  
22 responsibility, not the radiologist's responsibility.

23          Q.    I understand you don't have any criticisms  
24 of any of the hospital personnel or the nurses who  
25 actually cared for Mr. Moore on December 25th, isn't

1     that right?

2             A.     You are correct.

3             Q.     So you have no criticism of the exam that  
4     Nurse Kuchinsky did initially, which demonstrated  
5     that the patient's leg was normal and warm, and not  
6     cold or blue, you don't have any disagreement or  
7     concerns with her examination that night?

8             A.     Actually, I agree with the examination.

9                     I don't think there's anything unusual.  I  
10    think she done the right thing, yeah.

11            Q.     Now, in this particular case on the  
12    ultrasound it demonstrated the venous flow was shown  
13    to be normal, right?

14            A.     Correct.

15            Q.     So in order -- You agree with me, in order  
16    for there to be normal flow in the veins against  
17    gravity towards the heart, back up to the heart,  
18    there has to be sufficient blood flow down the  
19    arteries, true?

20            A.     There has to be some flow, which I earlier  
21    spoke about the collaterals, so this leg didn't die  
22    in six hours, that is where the leg was warm, the leg  
23    never had a pulse, but there were collateral enough  
24    to keep it going for three days until everything  
25    clotted, and they had to amputate it, and that's all

1 based on the small collaterals he had for years.

2 Q. Did you see anything -- I wanted to talk  
3 about that.

4 Do you see any reference in the 12/25 visit  
5 that any examination demonstrated -- or a complaint  
6 by Mr. Moore of coldness into the toes specifically?

7 A. I don't remember.

8 He did complain of a cool leg, cold leg,  
9 colder leg, but that is exactly what happened.

10 Q. And I'm just trying to limit it.

11 I know what he testified in his deposition.

12 I'm talking about specifically, did you see  
13 a reference to cold toes?

14 A. I don't remember.

15 Q. Are you aware that one of the visits that  
16 he had in the emergency department, I believe it was  
17 either in the 2014 or 2015 visit, that one of his  
18 reports of complaints was cold toes and calf, do you  
19 remember reading that?

20 A. I don't remember.

21 It's possible.

22 He can have those symptoms, yeah.

23 Q. So one of the articles you provided to us  
24 at the time your deposition is the Hanky article, you  
25 remember that?

1           A.     I provided 11 articles.

2                     I don't remember.

3           Q.     The Hanky article that talks about acute  
4 limb ischemia, do you remember that?

5           A.     Would you mind showing it to us?

6           Q.     We can't unfortunately, that is part of the  
7 rules of evidence, but do you recall reviewing an  
8 article on acute limb ischemia from Hanky?

9           A.     11 articles I brought, that's correct.

10                   MR. WEAVER: I'm sorry.

11                   I didn't hear what he said?

12                   THE WITNESS: 11 articles, 10 or 11.

13 BY MR. MC BRIDE:

14           Q.     Okay.

15                   And in that article, are you aware of that,  
16 that article, you agree with me it does not discuss  
17 the diagnosis and treatment of chronic limb ischemia,  
18 true?

19           A.     Actually, I don't remember right now as I  
20 sit here.

21                   The articles were just looked at are again  
22 data likely previously said, the articles don't  
23 represent the standard of care, either the guidelines  
24 don't necessarily represent the standard of care for  
25 a patient.

1           I truly believe if I can help you, that  
2   this was not -- Well, there was chronic -- in terms  
3   of he had vascular disease for many years, and there  
4   was an acute presentation, which is a definition less  
5   than two weeks that got him on the Christmas day in  
6   the emergency room.

7           So I'm more concerned about the acute part  
8   of the presentation.

9           Q.    In particular I just wanted to talk very  
10   quickly about the article that mentions the  
11   classification system.

12           Are you aware of that classification system  
13   to determine a viable limb?

14          A.    Yes.

15          Q.    And --

16          A.    12 and --

17          Q.    Type one is a viable limb, not immediately  
18   threatened, no sensory or muscle weakness?

19          A.    Correct.

20          Q.    And then you have it progressively gets  
21   worst, up to the point of amputation is the only way,  
22   right?

23          A.    Correct.

24                1 is -- we all have a 1.

25                3 is dead on the 28th, and there's 2-A,

1 2-B, 2-A marginally threatened, 2-B seriously  
2 threatened, so when he showed up, he was a 2-A, 2-B,  
3 that's why the leg didn't die within six hours  
4 because you're giving out, the collaterals were good  
5 enough to support a leg for that long.

6 Q. A 2-A.

7 That particular article also talks about  
8 the five Ps?

9 A. You could talk --

10 Q. I'm asking you this question:

11 Do you agree with me that article discusses  
12 the five Ps as a way to diagnose acute limb ischemia,  
13 using that classification --

14 MR. P. HYMANSON: Excuse me.

15 May we approach, Your Honor?

16 THE COURT: Yes.

17 (Thereupon, a discussion was had between  
18 Court and counsel at sidebar.)

19 THE COURT: Thank you.

20 All right. You may proceed with further  
21 questioning.

22 BY MR. MC BRIDE:

23 Q. All right.

24 Now, Dr. Wilson, you asked a question, if  
25 you know the expert on behalf of the Defense in this

1 case, Dr. Samuel Wilson, and you said that you did  
2 not know him, right?

3 A. Correct.

4 Q. Do you know -- Have you done any  
5 investigation into his background, or training, or  
6 experience based on reviewing his expert reports, or  
7 anything like that?

8 A. I Googled him.

9 Q. Okay.

10 Are you aware of what sort of reputation he  
11 owns as a physician in the California community as a  
12 vascular surgeon?

13 A. I don't know, sir.

14 Q. Are you aware of the textbook that Dr.  
15 Wilson has authored, and other textbooks he's  
16 authored over his career, in the field of vascular  
17 surgery?

18 A. I'm not aware.

19 Q. Doctor, would you agree that physicians can  
20 disagree on recommendations of treatment for any  
21 given patient?

22 A. I do.

23 Q. And just because they disagree, that does  
24 not mean there was negligence on the part of a  
25 particular physician, correct?

1           A.     I agree.

2           Q.     Now, just very quickly -- Actually, I may  
3 be quicker than I thought.

4                    You have had your deposition taken, like we  
5 talked about, over 50 times, or close to 50, lower  
6 than 50?

7           A.     Yes.

8           Q.     And --

9                    THE COURT: Not in this particular case.

10                   MR. MC BRIDE: Right.

11 BY MR. MC BRIDE:

12           Q.     And, doctor, you provided us with a list of  
13 your testimony at trial and depositions before today,  
14 and I think it went back to 2015.

15                    Do you recall reviewing that particular  
16 publication?

17           A.     I --

18           Q.     You listed all the trials you testified in?

19           A.     My own list.

20           Q.     Yes.

21           A.     Yeah, I made the list.

22           Q.     So at least since 2015 by my count there  
23 were at least 18 depositions, and I think three  
24 trials, one mediation.

25                    Does that sound about, right?

1           A.     Probably more than that I think, but it's  
2     probably right.

3           Q.     Okay.

4                     You charge a flat rate \$1,000 for  
5     deposition, with a two-hour minimum, right?

6           A.     That's correct.

7           Q.     And in this particular case your deposition  
8     took three hours, so you were given a check for  
9     \$1500, right?

10          A.     I believe so.

11          Q.     And then you charged \$650 an hour, it's  
12     \$650 an hour?

13          A.     It should be more than that.

14                     I think he needs to write me a check then.

15          Q.     \$650 an hour for review of records, is that  
16     right?

17          A.     That's correct, sir.

18          Q.     \$650 an hour for review of the literature,  
19     correct?

20          A.     Yes, that's correct.

21          Q.     Let me ask you, do you have any idea -- and  
22     that is \$650 an hour for report preparation, right?

23          A.     That's correct.

24          Q.     As you sit here, do you have an estimate of  
25     the total amount of time that you have spent

1 reviewing the records in this case, preparing your  
2 report, and preparing for trial here today?

3 A. No, I do not, sir.

4 Q. Is it more than 20 hours?

5 A. Yes, definitely overall for the last few  
6 years.

7 Q. Yes?

8 A. I hope so, yeah.

9 Q. More than 30 hours?

10 A. I just don't know.

11 This was two years I think, yeah.

12 Q. Do you keep track of the amount of time you  
13 spend, in order to bill to the Plaintiff's attorney?

14 A. I do, and you have my bills, you have my  
15 invoices, so I think you know better than I do.

16 Q. You don't have those with you?

17 A. No, I provided them to you at the  
18 deposition.

19 Q. In terms of whatever those invoices reflect  
20 in terms of the amount of time that you have spent up  
21 to the time of your deposition, that would be  
22 accurate, right?

23 A. That's correct.

24 Q. And then how about since your deposition  
25 October of 2019, to today, how much time, additional

1 time, have you spent reviewing and preparing for your  
2 trial testimony?

3 A. I'm not sure.

4 I spent a fair amount of time just looking  
5 through records and so on, so I'm not sure.

6 Q. So those bills we don't have.

7 So that's why I am trying to get your best  
8 estimate.

9 Can you estimate, was it more than 20  
10 hours?

11 A. I would have to check.

12 More than 10 for sure.

13 Q. Is it fair to stay 10 to -- 10 to 20 hours?

14 A. Perhaps.

15 Q. Then you also charge 10,000 a day for trial  
16 testimony?

17 A. That's correct.

18 Q. Not including travel expenses, right?

19 A. That's correct.

20 Q. Did you come up last night or today?

21 A. Last night.

22 Q. Did you have a meeting with counsel to go  
23 over your testimony here today?

24 A. No, I had a meeting for dinner.

25 Q. For dinner.

1 Did you talk about your testimony?

2 A. A little bit, yeah.

3 Q. You also advertise your services as an  
4 expert in several publications, right?

5 A. Well, depends how you perhaps -- I don't  
6 call it advertising, but I'm listed, could be for  
7 advertising, I'm listed in a certain directories, my  
8 office is, that's correct.

9 Q. And so you recall testifying in your  
10 deposition that there's several advertising -- or  
11 services that you have in your name listed as a  
12 potential expert, do you have your name listed as a  
13 potential expert in emergency medicine in any of  
14 those advertisements?

15 A. No, sir.

16 Q. You said you paid a couple of thousand  
17 dollars a year for advertising, is that right?

18 A. Mr. Weaver said that, and I actually agreed  
19 with him.

20 I wasn't sure, I think it's possible, yes.

21 Q. Do you know what the amount you spent for  
22 advertising was?

23 A. No, sir, but it sounds right.

24 Q. Let me check my notes.

25 A. I think your firm is probably one of the

1 advertised in, I've been one of your experts a few  
2 years ago.

3 Q. One of my experts?

4 A. Yeah, your law firm you work for.

5 Q. Well, I've met you before today, right?

6 A. No, I'm saying the law firm, I've been an  
7 expert for you guys as a Defense expert, and they  
8 said they found me --

9 Q. I don't know how it turned out because I  
10 never met you before today, and so at any rate I'm  
11 glad you were happy.

12 Are you aware, you have read Dr. Jacobs,  
13 the expert emergency room physician for the  
14 Plaintiff, you read his report and deposition?

15 A. I did, two reports actually, and a  
16 deposition, yes.

17 Q. Are you aware of Dr. Jacobs' testimony  
18 where he stated that it was irrelevant if Dr. Lasry  
19 even seen the patient, since he reviewed the case  
20 with Nurse Practitioner Bartmus.

21 Q. Can you repeat the question?

22 A. Sure.

23 Were you aware of Dr. Jacobs' testimony  
24 where he said it was irrelevant whether or not Dr.  
25 Lasry even saw the patient on December 25, as long as

1 he discussed the case with Nurse Practitioner  
2 Bartmus?

3 A. You asked me if I seen, or agree with his  
4 statement.

5 Q. I'm asking, have you seen that?

6 A. I don't remember that.

7 I think it's relevant.

8 If he said he did, and didn't do it, it's  
9 very relevant.

10 Q. And I think you testified too that you're  
11 not making any specific judgment on Dr. Lasry and  
12 whether he personally evaluated the patient, and you  
13 would leave that to the jury to decide, right?

14 A. I did say that.

15 MR. MC BRIDE: Thank you, doctor.

16 That's all I have.

17 THE WITNESS: Thank you, sir.

18 THE COURT: So we're going to go ahead and  
19 take our lunch recess now, then resume with Mr.  
20 Weaver's questioning and any redirect from counsel,  
21 but rather than be too far into the lunch hour, I  
22 think it's a good time to take a lunch break now.

23 We'll return at 1:30.

24 It's a little after 12 now, so that gives  
25 you enough time to find a place to eat.

1                   (Jury admonished by the Court.)  
2                   THE COURT: Have a good lunch.  
3                   See you at 1:30.  
4                   (Jury excused from the courtroom.)  
5                   (Thereupon, the following proceedings were  
6 had out of the presence of the jury.):  
7                   THE COURT: Just to make a record --  
8 Doctor, you may step down.  
9                   Actually, probably just leave them there.  
10 We're coming back after lunch with your testimony.  
11                   There was a brief bench conference seeking  
12 to discuss -- or raising an objection --  
13                   THE MARSHAL: One of the jurors said they  
14 have a question.  
15                   MR. MC BRIDE: Let's wait.  
16                   THE COURT: Find out what it is, and they  
17 can write a note.  
18                   Assuming it's related to the trial or  
19 witness?  
20                   THE MARSHAL: To the witness.  
21                   THE COURT: Remind them it's at the end of  
22 the questioning of the witness, but they can  
23 certainly write their question down to have it read.  
24                   Back to the bench conference.  
25                   So Mr. Hymanson had posed an objection

1 because Mr. McBride was discussing an article with  
2 the doctor, and some specific article component, and  
3 of course the doctor had indicated he reviewed up to  
4 10 or 11 articles, and so Mr. Hymanson was concerned  
5 that way of questioning would continue, it would be  
6 imperative to have the specific article referenced  
7 shown to refresh the recollection of the doctor.

8 Mr. McBride indicated he thought he had  
9 given sufficient specifics to that article,  
10 specifically he did not intend to have further  
11 inquiry about other articles, so I think the  
12 questioning went on to another path after that.

13 Mr. Hymanson or Mr. Arntz, anything you  
14 want to add to the bench conference?

15 MR. P. HYMANSON: No, Judge.

16 MR. ARNTZ: No.

17 THE COURT: Mr. McBride?

18 MR. MC BRIDE: No, Your Honor.

19 THE COURT: I did instruct counsel if he  
20 was going to continue to inquire about particular  
21 articles, he should either have that article itself,  
22 or as much as possible, so to attempt to refresh the  
23 recollection of the witness, but it wasn't necessary.

24 We'll see you all back, get started at  
25 1:30.

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MR. WEAVER: Thank you, Your Honor.  
(Thereupon, a luncheon recess was had.)

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REPORTER'S CERTIFICATE

I, Bill Nelson, a Certified Court Reporter  
in and for the State of Nevada, hereby certify that  
pursuant to NRS 2398.030 I have not included the  
Social Security number of any person within this  
document.

I further Certify that I am not a relative  
or employee of any party involved in said action, not  
a person financially interested in said action.

          /s/ Bill Nelson          

Bill Nelson, RMR, CCR 191

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) SS .

I, Bill Nelson, RMR, CCR 191, 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.

/s/ Bill Nelson

Bill Nelson, RMR, CCR 191  
Certified Court Reporter  
Las Vegas, Nevada

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TRAN

IN THE EIGHTH JUDICIAL DISTRICT COURT  
CLARK COUNTY, NEVADA

DARELL MOORE, ET AL,	)	
	)	
Plaintiffs,	)	
	)	
vs.	)	Case No. A-17-766426-C
	)	Dept. No. 25
JASON LASRY, M.D., ET AL,	)	
	)	
<u>Defendants.</u>	)	

JURY TRIAL

Before the Honorable Kathleen Delaney  
Friday, January 31, 2020, 9:00 a.m.  
Reporter's Transcript of Proceedings

REPORTED BY:  
  
BILL NELSON, RMR, CCR #191  
CERTIFIED COURT REPORTER

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APPEARANCES:

For the Plaintiffs: Breen Arntz, Esq.  
Philip Hymanson, Esq.  
Joseph Hymanson, Esq.

For the Defendants: Robert McBride, Esq.  
Keith Weaver, Esq.  
Alissa Bestick, Esq.

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I N D E X

WITNESS	DR	CR	RDR	RCR
Dr. Alexander Marmureanu	9	48		

1 Las Vegas, Nevada, Friday, January 31, 2020

2 \* \* \* \* \*

3  
4 (Thereupon, the following proceedings were  
5 had out of the presence of the jury.):

6 THE COURT: I understand one of the Defense  
7 counsel has something to put on the record.

8 MR. WEAVER: Good morning, Your Honor.

9 I brought this to Mr. Arntz's attention  
10 this morning, but I was waiting for the transcript,  
11 just to be sure, and I'm sure we'll get it soon, but  
12 the issue is the Defense believes yesterday Mr.  
13 Arntz's opening he he said to the jury there were one  
14 or more items on the lifecare plan, I think the  
15 example was wheelchairs, but I think there was other  
16 things that Mr. Moore, quote, unquote, could not  
17 afford, that Dr. Fish, who is testifying this  
18 afternoon testified in his deposition the medical --  
19 necessary medically indicated items on the lifecare  
20 plan would be covered by Medicare, and especially  
21 with regard to one wheelchair, not that there was  
22 payment issued, not there wasn't Medicare issued.  
23 The only reason Mr. Moore doesn't have the  
24 electric wheelchair is because as of a few months ago  
25 he hasn't been fitted for it.

1           So I could be wrong, but I think the case  
2 law is very clear that when a party in opening  
3 statements quotes why it's widely recognized that a  
4 party who raises a subject in an opening statement  
5 opens the door to admission of evidence on that same  
6 subject by the opposing party.

7           So I believe the opening statement, and  
8 again we'll have to get the transcript, I don't have  
9 it, I want to be careful we quote exactly what was  
10 said, but I'm pretty sure what I heard was, there  
11 were items that Dr. Fish wanted to testify to this  
12 afternoon that Mr. Moore can't afford, which leaves  
13 the jury with the impression that if there was a way,  
14 he would have them, by now he would.

15           So I would agree that it's a general  
16 proposition, while in medical malpractice cases under  
17 NRS 42.021 Nevada says the collateral source rule  
18 doesn't apply that aren't Medicare, that because it's  
19 a general proposition that is Medicare, the  
20 collateral source would typically, but I think it  
21 would be unfair to the Defense for the jury to be  
22 left with the impression that the reason Mr. Moore  
23 after three years doesn't have these items that he  
24 could have already received through Medicare is  
25 because he can't afford them.

1           So if he gets two million dollars from the  
2   lifecare plan, Mr. Arntz asks the jury to consider it  
3   eventually I think it leaves them the wrong  
4   impression.

5           THE COURT:   Okay.

6           So let's wait until we get the transcript.

7           MR. WEAVER:   They are really quick in  
8   getting it to us normally, it's been the evening.

9           THE COURT:   I didn't know, you have been  
10   told that --

11          MR. WEAVER:   This morning.

12          THE COURT:   We'll see what happens when  
13   they come in, and we can address it then.

14          Mr. Arntz, anything you want to say in  
15   response to the record now?

16          MR. ARNTZ:   Yeah, was very careful in my  
17   opening to for example modifications to the home, a  
18   specific vehicle, and a specific wheelchair Medicare  
19   won't cover, and Mr. Moore can go in to why it's  
20   necessary, but it's a much lighter motorized  
21   wheelchair, and the one Medicare will pay for is  
22   extremely heavy and very unmanageable for them.

23                 So I don't think I opened the door by  
24   referencing things that Medicare won't pay for.

25                 I didn't say that he can't afford this,

1 Medicare will pay for it, but this particular  
2 wheelchair Medicare won't pay for.

3 THE COURT: So we'll get the final wording  
4 and then have a final conversation on the subject and  
5 go from there.

6 MR. WEAVER: Thank you, Your Honor.

7 THE COURT: Anything else before we bring  
8 the jurors in?

9 Just one housekeeping matter, I know you  
10 mentioned you're going to call the experts now.

11 Do you anticipate any other witnesses  
12 today?

13 MR. ARNTZ: I think that will take up the  
14 day.

15 We can go with their son.

16 THE COURT: All right.

17 We'll see where we are at.

18 We'll still take our lunch break somewhere  
19 in that 12 to 1:30 range and see how we are doing.

20 (Thereupon, the following proceedings were  
21 had in open court and in the presence of the jury.):

22 THE COURT: Thank you.

23 The jury's now present in the courtroom.

24 And make sure the cell phones are off  
25 and/or silent.

1                   We're going to ask Mr. Arntz at this time,  
2                   who is your next witness, please?

3                   MR. ARNTZ: I call Dr. Alexander  
4                   Marmureanu.

5                   THE COURT: Come straight through the  
6                   courtroom, come all the way to the witness stand,  
7                   please.

8                   Stand right here, and put your things down,  
9                   stand in the front of the chair, and please stand for  
10                  my clerk to swear you in.

11

12                   **DR. ALEXANDER MARMUREANU,**

13

14                   who, being first duly sworn to tell  
15                   the truth, the whole truth, and  
16                   nothing but the truth, was examined  
17                   and testified as follows:

18                   THE CLERK: Please be seated.

19                   Please state your full name, spelling both  
20                   your first and last name for the record.

21                   THE WITNESS: Sure.

22                   Dr. Alexander Marmureanu,  
23                   M-a-r-m-u-r-e-a-n-o.

24                   THE COURT: Thank you.

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DIRECT EXAMINATION OF DR. ALEXANDER MARMUREANU

BY MR. ARNTZ:

Q. We've all agreed with Dr. M, is that okay?

A. I didn't know this, but I'm okay.

Q. Dr. Marmureanu, where you are from?

A. It's a loaded question.

I am from Los Angeles, I live in Hollywood.

I'm originally from Romania, grew up in  
Romania, went to medical school there.

I did my general surgery, cardiac surgery  
training, moved to New York in the '90s, went to New  
York University, Mt. Sinai, UCLA, and like everybody  
else in LA we never leave, so I'm in Los Angeles now.

Q. So Romania, but you live in Los Angeles?

A. On Hollywood Boulevard.

Q. Hollywood Boulevard.

And explain for the juryt what is your  
expertise or specialty?

A. I'm a cardio-thoracic surgeon, so I  
practice what is called -- I'm board-certified in  
general surgery, which covers surgery on the whole  
body, and then I'm super-specialized in what is  
called thoracic and cardiovascular, which is about  
the heart, about the chest, heart surgery, lung

1 surgery, vascular surgery.

2 Q. You have had a chance to review all the  
3 materials involving Mr. Moore's case, his past  
4 medical treatment, and treatment associated with his  
5 care on the 25th of December 2016?

6 A. Yes, sir.

7 Q. Let's go through your qualifications.

8 The Defense went on for some time about Dr.  
9 Samuel Wilson.

10 Do you know Dr. Wilson?

11 A. No, sir.

12 I know from reading his reports, and that's  
13 it.

14 Q. Okay.

15 Currently what are your positions you hold?

16 A. I'm the president and CEO of California  
17 Heart And Lung Surgery Center, which is my company.

18 We practice in nine hospitals heart  
19 surgery, lung surgery, vascular surgery.

20 I'm the chief of cardio-thoracic surgery  
21 and in two other private practice hospitals.

22 And I'm on the medical executive committee,  
23 as well as the retro-contract review committee for  
24 one of the major hospitals where I practice  
25 cardiovascular and thoracic surgery.

1 Q. What types of past positions have you held?

2 A. Well, I think you have it better than I do,  
3 it's a long CV there, 25 pages.

4 Q. I can --

5 A. Let me answer the best way I can.

6 I came in Los Angeles in 2000, started  
7 UCLA, did my fellowship in cardio-thoracic surgery,  
8 stayed on faculty for a while, then I became the  
9 director of Century City Hospitals, which is for  
10 cardio-thoracic surgery.

11 Then I've been to many hospitals, built  
12 several, perhaps that deal with cardio-thoracic  
13 surgery, Broadman (Phonetic) Hospital, St. Aneela  
14 (Phonetic) Medical Center, California Hospital,  
15 Valley Presbyterian Hospital, and so on.

16 Q. Are you board-certified?

17 A. Yes.

18 Q. What are you board-certified in?

19 A. In general surgery, covers the surgery of  
20 the whole body, and then board-certified in  
21 cardio-thoracic surgery.

22 Q. Explain for the jury what it means to be  
23 board-certified.

24 A. Board certification is a very rigorous  
25 process, and a lot of society and a lot of hospitals

1 want you to be, and a lot of patients by the way want  
2 you to be board-certified, due to to fact you have to  
3 pass exams every few years, you have to go to  
4 meetings, you have to get what is called CMEs,  
5 continuing medical education.

6 In other words, you have to be up to date,  
7 you don't just move somewhere and practice medicine  
8 like the way you did for the last 30 years, things  
9 change over time.

10 Q. Let's talk about what it means to be  
11 fellowship-trained.

12 You are fellowship-trained?

13 A. Yes, sir.

14 Q. That is different than being  
15 board-certified?

16 A. That's correct.

17 So for the jury, you go to medical school,  
18 finish medical school, you do what is called a  
19 residency, you do it for general surgery, it's five  
20 years you train, and then I've done academic medicine  
21 and research, like I've done -- you have to do some  
22 research during your training, so I've done a year of  
23 research in New York University in New York, and then  
24 you move from there, pass your general surgery  
25 boards, and that is a requirement to be

1 board-certified in cardio-thoracic surgery, so heart  
2 and lung surgery.

3 Then you do a fellowship, two years of  
4 training in heart and lung and vascular surgery.

5 Q. Okay.

6 What faculty positions have you held over  
7 the years?

8 A. Well, I've been a teaching assistant on a  
9 faculty during my tour at New York University and Mt.  
10 Sinai New York, and been a junior faculty at UCLA  
11 while I worked for time with staff with faculty, and  
12 I belong to different societies and organizations as  
13 well.

14 Q. Are you currently in a formal position  
15 where you're doing teaching?

16 A. We do teaching every day, and if you see my  
17 CV, I've had hundreds of talks, as well as at  
18 probably close to a hundred places over the world,  
19 from Uzbekistan, to Mongolia, to China, to Africa, to  
20 London where you teach younger surgeons, that is  
21 international.

22 At a local level the same thing in the  
23 hospital, basically you teach residents, nurses, as  
24 well as other doctors.

25 Q. You have been on a number of different

1 medical school committees.

2 What does that involve?

3 A. It's an honor, privilege, and a lot of work  
4 to be on a committee. They basically want your  
5 opinion in regards to the current status of that  
6 issue and what should we do with it.

7 In other words, the committee is about  
8 critical care, about working for example with the  
9 myocardial infarction, how fast that is to work-up  
10 when we do operate.

11 In other words, a lot of committees that --  
12 medical executive committees where issues in the  
13 hospital come up and have to be decided a bit like  
14 here.

15 Q. Okay.

16 I'm not going to go through every single  
17 thing on your CV, but what is the significance of  
18 different advisory boards you have been on?

19 A. Advisory boards, companies come up with a  
20 new product, and a new stent, or device perhaps, a  
21 new device that is more or less like Crazy Glue,  
22 using humans, called Bio Glue, that helps us seal the  
23 vascular procedures, so a patient don't bleed to  
24 death.

25 So all those companies coming out, they

1 want physicians advice in regards to can we improve  
2 this product and what we're going to do.

3 So that comes from general medication to  
4 body devices that we operate.

5 The surgeon could be in Vegas, and the  
6 patient to be in Los Angeles for example.

7 Q. The different lectures you gave around the  
8 world, do some of them involve the issues -- Maybe we  
9 can talk specifically about presentations you have  
10 given involving issues that might be dealt with in  
11 this case, given lectures on those types of things?

12 A. The answer is, yes.

13 The issue we have here is not about  
14 medicine, it's about the proper work-up, the patient  
15 having the proper work-up promptly and timely,  
16 realizing it, and making the proper diagnosis, and  
17 doing the proper work-up, which means a battery of  
18 tests that we need to do to figure out what is going  
19 on, and then I like to say, it's like in the Army, it  
20 has to be done by the book.

21 Once you figure the diagnosis and  
22 treatment, and then you hope for the best outcome.

23 So medicine is not separate.

24 So to summarize your question, the answer  
25 is, yes, a lot of vascular issues come into play and

1 in to my area.

2 Q. Are you familiar with the standard of care,  
3 would it be appropriate for the health care providers  
4 and Defendants in this case, and Nurse Practitioner  
5 Bartmus and Dr. Lasry?

6 A. Yes, sir.

7 There's only one standard of care.

8 In other words, any practitioner that deals  
9 with an issue in ER, on the floor, on an out-patient  
10 basis, if you deal with that issue, there's only one  
11 thing to do, the right thing to do, but that is  
12 follow a certain sequence, pathway, certain rules  
13 need to be applied, so I'm very familiar with that  
14 standard.

15 Q. Did you treat patients similar to Mr.  
16 Moore?

17 A. Every day, sir.

18 Q. Okay.

19 Did you develop a number of different  
20 opinions in this case?

21 A. Yes.

22 Q. Do you have an opinion specifically in  
23 regards to the standard of care, and whether that  
24 standard of care was breached by the Nurse  
25 Practitioner Bartmus and Dr. Lasry?

1           A.     Yes, sir.

2                     The standard of care was breached by both  
3 of them.

4           Q.     Give me the information and foundation for  
5 your opinion regarding the breach of standard of  
6 care.

7           A.     It's going to be a very long answer because  
8 I think we have to talk about, the whole case.

9           Q.     Right.

10          A.     The reality is, there's a patient, which is  
11 Mr. Moore, that comes into the emergency room on a  
12 Christmas day.

13                    So the reality is, nobody really wants to  
14 go to the emergency room on Christmas day, even the  
15 doctors on call, nobody wants to be there, so  
16 obviously there's something that brings this patient  
17 to the ER.

18                    The time of the admission he complains  
19 first of all of problems with his left calf.

20                    Now, there are certain key words.

21                    If you look if somebody tells you, a  
22 Corvette, you probably think about the fast car.

23                    Vascular surgeons, when somebody tells you  
24 there's a problem with the patient walking, and that  
25 problem is pain in the left calf, or a calf, that is

1     vascular arterial insufficiency, that's the way we've  
2     been taught.

3             So years ago, once we asked residents and  
4     students on the exam, is that somebody's running  
5     behind the box in the morning to go to work, and  
6     suddenly develops pain in the left calf, what are you  
7     thinking of, and what we want them to say is,  
8     arterial insufficiency, the fact the arteries don't  
9     work well, not much blood flow.

10            Now, today we can't ask that question  
11     anymore, but we're still thinking about that being an  
12     issue.

13            Living in Vegas, patients do certain  
14     things, walking in the casino, so you walk more, you  
15     create more activity on the lung, you run, there's  
16     not enough blood flow to go down to your foot, and  
17     you end up with pain here, especially in him, number  
18     one being what is called a vascular path, not a  
19     healthy patient, he's got problems before in 2012 he  
20     had a by-pass, and at some point -- Perhaps I can, if  
21     you allow me to draw something, I can better explain,  
22     but in 2012 he had a --

23            MR. ARNTZ:   Can I use this?

24            THE WITNESS:  Your Honor, I'd like to draw  
25     something quick.

1 THE COURT: I understand.

2 We need counsel, in addition to the jury,  
3 to be able to see it.

4 So we have an easel here.

5 MR. MC BRIDE: I'm sorry to interrupt, but  
6 can we also have a question and answer, as opposed to  
7 a straight narrative?

8 THE COURT: I think we're getting there,  
9 and obviously have whatever illustration it's going  
10 to be, but yes, doctor, we appreciate very much you  
11 have a lot of information to provide, but this is  
12 direct examination, so just not a narrative dialogue.

13 THE WITNESS: I fully agree with you.

14 THE COURT: Is it time to do the  
15 illustration now?

16 MR. ARNTZ: Yes.

17 There's some markers there.

18 BY MR. ARNTZ:

19 Q. What is it you want to show the jury?

20 A. May I show --

21 THE COURT: You will have to turn it that  
22 way, so the jurors can see it.

23 Counsel can relocate to see what you are  
24 doing.

25 Mr. Arntz, can you help him, so the jurors

1 can see it?

2 I'm not worried, I can see it afterwards.

3 I want them to see it.

4 MR. ARNTZ: You bet.

5 THE COURT: Okay.

6 THE WITNESS: So he comes to the ER

7 basically with this pain.

8 We know he's not a normal patient.

9 In 2012 -- Let me draw this quick.

10 This is the aorta, the biggest blood vessel  
11 in the body.

12 At this point it comes down, that's the  
13 chest here, that's the belly, those are the legs.

14 His blood comes down, bifurcates, the big  
15 blood vessel bifurcates.

16 BY MR. ARNTZ:

17 Q. Splits?

18 A. Splits.

19 It comes in, and I'm not going to focus  
20 more on definition, so this is the left side, this is  
21 the right side.

22 We know from the previous notes that we had  
23 a lot of this here, in 2012 he had a graft, this  
24 wasn't able to extend, if you have surgery in here,  
25 not to focus on the left leg, but the left leg here,

1 and that's where it is.

2 This area was below the femoral, there was  
3 no blood flow going toward the knee, barely blood  
4 flow below the knee, sort of by-passing like a car  
5 driving down the highway, the highway stops here and  
6 it goes away, here the surgeon created --

7 THE COURT: Doctor, it's not really where  
8 you're speaking -- you're speaking very quickly.

9 If you could slow down, and pick up the  
10 volume, I'm sure my reporter will be fine.

11 The most important thing is that the jurors  
12 hear.

13 So you can relocate where you were, just  
14 slow down and speak up.

15 THE WITNESS: There's a lot of information  
16 I want to get.

17 THE COURT: I know.

18 Slow down, and speak up.

19 THE WITNESS: So this is the knee here.

20 This is the groin.

21 This is the femoral artery.

22 Mr. Moore did not have -- Here in 2012 he  
23 had what is called a by-pass.

24 Why it's important is because this is the  
25 history when he showed up to the emergency room, he

1 had a by-pass, and they've seen there was -- before  
2 the by-pass there was no flow, its very, very  
3 important here --

4 THE COURT: Doctor, the jurors can't see  
5 the board the way it's facing now.

6 Take your time, and speak up.

7 BY MR. ARNTZ:

8 Q. Let's go step-by-step, and then can you  
9 turn it more for them to see it.

10 A. A lot of information.

11 So the blood comes down from the by-pass,  
12 this is the circulation at that time was his left  
13 leg, there was blockages there, so due to the fact  
14 the blood cannot come down through the circulation,  
15 there was a need for an eight millimeter hose by-pass  
16 graft brings the blood down below the knee.

17 This is called the femoral artery, and you  
18 will hear the term fem pop (Phonetic). Fem pop is  
19 the by-pass.

20 While the fem pop is done, it's not as good  
21 as God made it, but it really brings some blood into  
22 the foot.

23 Before the fem pop in 2012 there was no  
24 blood here, it was extremely poor.

25 After the fem pop he had signals in one of

1 the arteries, two arteries, one comes on top of your  
2 foot, one comes down here.

3 The artery here has a flow, but not  
4 palpable. When you check for pulses the way we all  
5 check for pulses here, you feel it.

6 Here it could be tricky, but you should  
7 feel it plus one, plus two, those are pulses.

8 When we can can't feel it, we use what is  
9 called a Doppler probe, just like this, a transducer,  
10 put it on the vessel, and you're going to hear that  
11 is flowing systole and diastole, so we know there's a  
12 flow.

13 So after those kind of operations I put an  
14 X, and I tell the nurse every hour, you go in, and  
15 you check that pulse in there.

16 This is going to be extremely important for  
17 this trial.

18 So he had this by-pass done in 2012.

19 In 2014 he didn't have any blood coming  
20 down here.

21 He went to the ER, he complained, and they  
22 opened it, they dripped medication, just like in your  
23 pipe at home or sink gets clogged, you put some stuff  
24 in there, clog buster, it opens, he went home.

25 So now we're going back -- I want you to

1 understand what the issue is.

2 He goes back to the ER in 2016 complains of  
3 pain here when he walks, and we know all his history.

4 So somebody would think that he have  
5 another problem here. Once they start clotting,  
6 chances are they would continue to clot.

7 So once he gets to the ER, it's been  
8 documented he has a history of fem pop grafts, and  
9 the first thing that is being done is a test to look  
10 if there's a clot in his veins, which is actually a  
11 good idea.

12 Q. Before you go to the ultrasound, Nurse  
13 Practitioner Bartmus was here yesterday, testified  
14 she did two physical exams of Mr. Moore where she was  
15 able to detect a normal pulse in the top of the foot  
16 and the ankle, and she was able to determine from  
17 getting a normal pulse that she -- or he had no  
18 peripheral perfusion.

19 Explain to the jury whether or not that is  
20 even possible in Mr. Moore.

21 A. First of all, what you heard yesterday is  
22 absolutely impossible.

23 That is not true and impossible, and I'll  
24 show you why, and you will understand immediately.

25 First of all, the gentleman never had, for

1 the last many years at least, we know for a fact that  
2 since 2012 or before he did not have a normal exam.

3 People with normal exams there's probable  
4 pulses, like us here, they don't get fem pop grafts,  
5 nobody that is normal gets a graft, so if he had a  
6 graft, he was abnormal.

7 The surgeon said in 2012 that before his  
8 operation he had no pulse.

9 He also said in his op note once he  
10 finishes the operation in 2012, there was only one of  
11 the arteries has a pulse, and it was done only by  
12 Doppler.

13 In other words, what the surgeon in 2012,  
14 when the graft was new, checked here, and he was  
15 happy with that only one of the arteries in the foot,  
16 which is the PT, was very faint, couldn't feel it,  
17 couldn't feel it.

18 That graft was open, and he couldn't feel  
19 the pulse after he did it in 2012.

20 Q. Doctor, just a second --

21 I'd like to move the admission of Joint  
22 Exhibit 101.

23 THE COURT: Any objection?

24 MR. MC BRIDE: No, Your Honor.

25 THE COURT: We understand that to be

1 multiple binders as well.

2 MR. ARNTZ: Actually, I think it's just the  
3 last section of one binder, I think number 6.

4 THE COURT: I could stand corrected.

5 I just remember being informed by my clerk  
6 when we first started the trial that the Exhibit 100  
7 was six binders, and 102 took up a couple additional  
8 binders.

9 MR. ARNTZ: Okay.

10 You're right.

11 I apologize.

12 THE COURT: So binder 6 and 7 are the  
13 Exhibit 101.

14 MR. ARNTZ: Okay.

15 THE COURT: Any objection to the admission?

16 MR. MC BRIDE: No, Your Honor.

17 THE COURT: All right.

18 101 is admitted.

19 BY MR. ARNTZ:

20 Q. Doctor, I understand I actually gave you  
21 the sheets from the op report.

22 Could you read for us what the numbers on  
23 the bottom, the Bate's number is?

24 A. SRDSMR-00081.

25 Q. We're going to bring that up on the screen.

1 Explain to the jury what is it you're  
2 reading in this op report that gives you this  
3 information?

4 A. Do you have a laser pointer, or a stick, or  
5 something?

6 I got one that works.

7 MR. J. HYMANSON: Your Honor, may I  
8 approach?

9 THE COURT: Yes.

10 THE WITNESS: 2012ish clinically no blood  
11 flow.

12 We have arteries going down, veins bring  
13 the blood up, ischemic left leg with left iliac  
14 artery.

15 So in 2012 he had that procedure. Normal  
16 people don't get a by-pass, and somebody has normal  
17 pulses.

18 People with normal pulses also don't lose  
19 their leg. Nobody here is going to lose their leg by  
20 Monday.

21 So this is the diagnosis for surgery.

22 What did they do?

23 Well the artery up here, you remember  
24 before the femoral has a big aneurysm, and they put a  
25 stent in there, and for lack of a better term,

1 there's a lot of junk in there, which means the blood  
2 is not going down, there's so much plaque, so they  
3 open the artery and scoop the plaque out, clean  
4 everything out, and put a patch.

5 That is how bad this initial area was down  
6 here.

7 Femoral by-pass below the knee, 8  
8 millimeter Gore-Tex reported.

9 So you understand, that is where the  
10 surgeon is starting with -- he finishes the diagnosis  
11 with and what he did.

12 Can I have page two?

13 Q. Yes.

14 A. We're all happy when we finish the surgery.

15 We have to be sure that that foot, which is  
16 here, you need circulation down here.

17 All this hope is in this graft.

18 So if you need to document for the patient  
19 to do well, and for us to claim success, feel better  
20 as a surgeon that there's blood flow going down, how  
21 you do this, you can fill the pocket if you are  
22 there, you feel them, may not be there, then you have  
23 to redo your work or use a Doppler, which is a  
24 Doppler.

25 So let's see what he did.

1           He checked the flow, finished the  
2 operation, don't worry about that, that tells you how  
3 he did the graft from the top femoral artery to here,  
4 and excellent blood flow was obtained, you have the  
5 graft, close.

6           Then Doppler.

7           Why Doppler?

8           Because he wanted to feel it.

9           Then an examination of the posterior tibial  
10 pulse, you remember we talked about that right here,  
11 one of the arteries, not both.

12           He had the Doppler pulse, which is a weak  
13 pulse, in one of the arteries, only he's telling you  
14 here in 2012.

15           He's also telling you why it's so important  
16 that this pulse that he felt by Doppler was not  
17 present pre-op, but now it's present.

18           So he's saying, which makes a lot of sense,  
19 that is the way it is, there was not blood flow  
20 moving through this circulation, blood flow was  
21 coming here, and now there's blood going down.

22           So let me say this one more time.

23           We have the by-pass.

24           Before he did the by-pass there was no  
25 pulse.

1           After the by-pass he has fusion here,  
2   saying good flows were measured through this portion  
3   of the graft, and before this he has flow in one  
4   artery by Doppler only.

5           So the best this gentleman can have, four  
6   years after after this graft has been closed, once in  
7   2014 or 2015 reopened, so it's not as good as new.

8           So in the best scenario he can have, why  
9   his graft is open, it's here is a Doppler PT pulse  
10   present.

11           But now in 2016 the graft is closed, which  
12   we have a study that shows that graft is closed.

13           So not only he doesn't have this, because  
14   this the posterior tibial pulse is gone, because that  
15   comes from the graft, and the graft is done, he got  
16   no pulse, so if anybody tells you they felt normal  
17   pulses, pounding pulses by hand, it's just not true,  
18   it's impossible.

19           It's also impossible that even if the graft  
20   would be open, he wouldn't have palpable pulses. He  
21   never had palpable pulses in the last five, six, or  
22   seven years, that's why he got a by-pass.

23           Once they have a by-pass -- or before they  
24   have a by-pass, you have to be sure they don't have  
25   palpable pulses, so once the by-pass is done there

1 are no pulses, they can't be normal, this thing is  
2 done, blood is not coming off of here.

3 How can you have normal blood flowing here?  
4 Impossible.

5 Q. Didn't he lose his leg sometime sooner?  
6 Did you -- Let me ask this question.

7 Did you make a determination whether or not  
8 the occlusion was seen on the ultrasound on 2016,  
9 whether that was a chronic occlusion?

10 A. Acute, the definition of acute is less  
11 than -- We don't know that much about this  
12 gentleman's history, but we know enough to say, more  
13 likely than not.

14 We know he had a fem pop graft.

15 We know that the leg, the graft was open  
16 after it was open.

17 We know that he developed symptoms, pain  
18 while walking into the casino the day before, then  
19 thereafter going to the emergency room on Christmas  
20 day, and they do a study which showed the graft is  
21 closed.

22 So this goes together with the fact the  
23 graft just closed because that's when he started  
24 having pain, there's no more blood going there.

25 Now, you close the graft.

1           The reality that there's some itty bitty  
2 small things included here -- so even if it's closed,  
3 the leg doesn't die within six hours.

4           If you take a normal guy on a motorcycle,  
5 has an accident, the artery gets torn apart, that guy  
6 has a vascular ischemia in six hours.

7           The problem is that the collaterals, there  
8 is still absolutely no pulse, not enough to give you  
9 a pulse.

10          He never had pulses there with the graft  
11 open.

12          With the graft closed four years after it's  
13 impossible to have palpable pulses.

14          However, here's what happens:

15          The clot creates clots.

16          So the first thing you do as a doctor, you  
17 start giving Heparin, and a lot of it. It will not  
18 prevent -- it will not bust the clot, but will  
19 prevent further clot from coming back in.

20          Here is the problem, you create some clots,  
21 now the clots are going up, and now up and up, so  
22 this gentleman did not have that kind of Heparin  
23 given to him, which is an IV dripper, and the next  
24 best thing is to do exactly what they've done here  
25 before, to go into this tube here, and then give what

1 is called TPA, which is a clot buster.

2 So he had this done in 2015 and also had  
3 this done in 2018 -- or I'm sorry, in 2015 when he  
4 clotted was in June I think, and then in 2016 three  
5 days after.

6 In other words, this happened before he  
7 showed up to the ER approximately a year, and they  
8 opened the graft, and it happened again three days  
9 after.

10 He went home, everything became ischemic,  
11 and at that point they did what they are supposed to  
12 do.

13 The PA was here, and he did Heparin, but  
14 none of those things happened.

15 So to summarize, I'm sure there will be  
16 more questions, but he comes to the ER, differential  
17 diagnosis is why, so this patient's in the ER.

18 What brings him here?

19 He will tell you he's got pain and got his  
20 history.

21 The ER team wants to rule out a clot in his  
22 veins, which is actually a good idea, but then they  
23 stopped.

24 Differential diagnosis means -- which are  
25 the top five problems, what could give him the pain.

1           They sent him home with no answer.

2           The number one is arterial insufficiency  
3 because it happened before he has a history that is  
4 the cure, it tells you claudication as the name, you  
5 know the graft is closed, so the work-up was done for  
6 the vein, which should be there.

7           Nowhere in the documentation from the  
8 hospital it says that anybody with suspicion of this  
9 issue, which is the ischemic leg due to closure of  
10 the graft, even now the radiologist clearly said,  
11 hey, the graft is closed, do more work-up one it, do  
12 surgery if you want to get more blood.

13           None of those things were done, and the  
14 patient went home, and that's it.

15           Q.    Go ahead and have a seat.

16           A.    Thank you.

17           Q.    Okay.

18           So you're not critical of Nurse  
19 Practitioner Bartmus or Dr. Lasry for the ultrasound  
20 that should have been done?

21           A.    Not only not critical, I'm in agreement it  
22 should be done.

23           Q.    When there are signs or symptoms to support  
24 a differential diagnosis of DVT?

25           A.    DVT, deep vein thrombosis, could be in the

1 calf, but it should be ruled out.

2 Not only did I agree with that study, but a  
3 duplex, a vascular duplex arterial or venous, it's  
4 that transducer, the same Doppler, is a fancier one  
5 that goes around the leg artery and veins and checks  
6 the flows.

7 They checked the veins, but they never  
8 checked the arteries.

9 They should have been done together.

10 There's no downside in using that, they  
11 travel together.

12 Q. How could you have blood flow in the vein,  
13 but not have it in the artery?

14 Where is that blood coming from?

15 A. Well, they didn't look for blood flow in  
16 the veins, they looked for clots.

17 There was flow in the vein.

18 He didn't find deep vein thrombosis that  
19 could give you pain in the calf and should be  
20 evaluated.

21 The problem is, during -- or not a problem,  
22 it's just a good problem during the study, the  
23 technician who apparently throughout the history  
24 decided to move the transducer up a little bit and  
25 saw the graft being closed, so at that point the

1 radiologist who read the study, he said, hey, your  
2 graft is closed, follow-up with different studies.

3 And what we usually do as a vascular  
4 surgeon, we get what is called an angiogram, even a  
5 CAT scan, CT, Charlie Thomas, angiogram on, or just  
6 plain and simple you put a catheter and insert  
7 contrast and see is -- if there's no flow.

8 This is an emergency, somebody will lose  
9 their leg if you don't establish flow.

10 If there's no flow coming down, the leg  
11 will not die in six hours, but the leg more likely  
12 than not will die in a few days.

13 That is exactly what happened.

14 Q. So in addition to the ultrasound -- Let me  
15 ask you something.

16 I've been telling this jury, because I'm  
17 not aware of this, are you aware of an issue where he  
18 had a prior DVT?

19 A. I'm not sure it was documented.

20 Now, the truth is, even if he didn't have a  
21 prior DVT, it should be ruled out, I don't think it's  
22 a problem, and the fact they were ordering this kind  
23 of study was actually good, but it wasn't enough  
24 because not only they rule out the DVT, but now it  
25 showed you -- the arterial pathology shows you the

1 graft is there. This study is the one.

2           Unfortunately, the study was read as being  
3 normal. Absolutely, it's not normal, shows the graft  
4 is closed.

5           You don't walk, you don't run, you jump on  
6 those patients because again if you don't open that  
7 graft, the leg will go away, and let me re-emphasize  
8 one more time, in 2012, '14, '15, '16 there's  
9 absolutely no way, impossible to have palpable pulses  
10 in this patient just because there's no blood going  
11 down there.

12           Q.    What is the first thing Nurse Practitioner  
13 Bartmus and Dr. Lasry should have done once they  
14 recognized the presence of the clot?

15           A.    Well, a few things.

16           Q.    Let me ask you one thing.

17                   Are you able to tell by looking at the  
18 ultrasound whether the clot is a chronic clot, or  
19 acute clot?

20           A.    Absolutely not.

21                   Even looking at the angiogram, you put  
22 contrast in there, and at that point -- so the  
23 ultrasound will give you some sort of vague view of  
24 what's inside.

25                   The angiogram is done with contrast, and

1 you see, and then you don't see, but can see this  
2 blank because there's a blockage.

3 So the first thing when he sees this number  
4 one odd arterial duplex, versus vascular duplex, the  
5 same thing should have been ordered from the  
6 beginning, have the transducer, the doctor go in the  
7 arteries, in the veins, you will see that close.

8 Next, call a vascular surgeon, call an  
9 interventional radiologist, so they can look, do an  
10 angiogram and start squirting TPA clot busters, start  
11 medical management, start the Heparin, to prevent  
12 further clotting because once you have this classic  
13 up, up, up, and even as patients will eventually --  
14 there is no way to say impossible, say he would have  
15 needed the amputation, all is possible, but they  
16 would have a lower level amputation if this area is  
17 viable.

18 If the clot keeps on going up, the only  
19 thing remaining is called AK, above the knee  
20 amputation, versus BK, a below the knee amputation,  
21 so Heparin to stop the clot from moving, AKA surgery,  
22 we put the balloons in there, inflate the balloon,  
23 and pull the balloon towards you, fish all the clot  
24 out, and return the flow.

25 So there are many options that can be used

1 many times, Rotor Rooter, to clean the gentleman's  
2 graft.

3 We have devices, we put them in and suck  
4 the clot out.

5 So that's where we're at.

6 Q. Is redoing the graft an option?

7 A. Absolutely, called a graft revision. I  
8 probably wouldn't start there, we would first start a  
9 Heparin IV drip, a lot of it, to prevent further  
10 clotting, shoot the clot buster, pull the device to  
11 suck the clot out, or even going surgically, do an  
12 incision in the groin, the same area here, cut, you  
13 have the graft, and start fishing it all out, and  
14 then we re-establish the pulses down here to a  
15 Doppler level, never to a palpable level.

16 Q. What do you make of the finding that Nurse  
17 Practitioner Bartmus testified to yesterday when she  
18 said she found normal peripheral perfusion, normal  
19 pulse, and normal cap refill?

20 A. Not true, it's absolutely impossible in any  
21 patient that has a vascular path, that has a graft  
22 that is closed.

23 In this patient, Mr. Moore, he never had  
24 this kind of exam, even in 2012 before and after the  
25 surgery is what his surgeon said, he couldn't feel

1 pulses when the graft was new, so to me I have to say  
2 it's absolutely impossible four years after to have a  
3 normal exam when the graft is closed.

4 Where is the blood coming from?

5 Impossible.

6 Q. Doctor, one of that things brought up  
7 yesterday in counsel's opening was that you have  
8 testified that after three occlusions, two or three  
9 clots, then you're going to lose your leg?

10 A. Absolutely not true.

11 I never said this.

12 I challenge them to show me that.

13 I actually brought my depo expert report,  
14 checked them. It's nowhere there I don't believe in  
15 that, and even if it would be true, which it's not  
16 true, this is his second one.

17 What is true is, the fact that once he  
18 starts clotting, it will continue to clot, that  
19 graft.

20 That is why you have to be very cognizant,  
21 that is why you have to be very diligent and timing  
22 his leg, so you have to be sure you establish flow as  
23 fast as you can, so I actually said in my deposition,  
24 which I have it here, that you can go in -- it don't  
25 even mean if he clots four times he's going to lose

1 his leg, I said the opposite, I have the page  
2 numbers, you can go as many times as you can and fix  
3 it.

4 It might not be possible at some point, but  
5 there's no way to know if you will ever clot again or  
6 not while on anti-coagulation.

7 Q. Was sending him home with Xarelto, was that  
8 a good thing to do?

9 A. No.

10 First of all, he shouldn't have gone home.

11 Second, the only recognized way to treat  
12 this issue is Heparin IV drip.

13 You usually have 5,000 units, you run, and  
14 you check labs on him every four to six hours to be  
15 sure that the blood is extremely thin, and that is  
16 the standard of care in this kind of problem.

17 Q. So in addition to the ultrasound of the  
18 vein, also of the artery?

19 A. Yes.

20 Q. They should have done a Doppler of the  
21 artery?

22 A. Let me interrupt you for a second.

23 They done had an ultrasound of the artery  
24 because the transducer moved, and the radiologist  
25 says, hey, your graft is closed, so they have enough

1 information even to go to the next step, to get an  
2 angiogram.

3           They didn't have a perfect duplex of the  
4 arteries, which they weren't open, but they knew they  
5 had enough to move to the next step, calling a  
6 vascular surgeon, calling an interventional  
7 radiologist, asking for a CT, computerized angiogram,  
8 a regular angiogram, nothing fancy, just squirt  
9 contrast in through the graft, it's closed, then do  
10 something to fix that.

11           The way it's been done before, one year  
12 before, the way it's been done three days after when  
13 actually the leg was dead.

14           So three days after they have done the  
15 right thing in the ER, done what they were supposed  
16 to do, so he's been in the ER three times.

17           The first time they had done the right  
18 thing, opened the graft.

19           The second time they didn't.

20           The third time they did the right thing.

21           The leg was dead, called outflow.

22           If everything gets clotted here, you can  
23 try to open this graft as much as you can. It's not  
24 because the graft or clot is old, there's nowhere  
25 nobody can prove this graft was closed chronically,

1 just not true.

2           However, if everything here gets clotted,  
3 and all those small vessels, it doesn't matter,  
4 there's no blood going -- it has nowhere to go, and  
5 that is what happened on the 28th when he came back  
6 three days after, the leg was cold, numb, blue, this  
7 vein is gone, and unfortunately because the clotting  
8 went up, he couldn't have the BKA, he had to have the  
9 AKA.

10           Q.    Do you have an opinion as to whether  
11 ultimately the amputation was due to the breach in  
12 the standard of care?

13           A.    Yes, sir.

14           Q.    What does that mean?

15           A.    It means, that due to the fact the  
16 emergency team, Dr. Lasry and Miss Bartmus, fell  
17 below the standard of care.

18                   In other words, they didn't do their job.

19                   The gentleman ended up with an amputation.

20           Q.    Was the amputation a direct result of their  
21 failure to focus on the standard of care?

22           A.    Yes, sir.

23           Q.    Do you have an opinion whether or not that  
24 leg could have been saved on the 25th?

25           A.    Yes, sir, it could have been saved.

1           Q.    Is that opinion to a reasonable degree of  
2 medical probability?

3           A.    Yes, sir.

4           Q.    In other words, you believe more likely  
5 than not that had that treatment taken place on the  
6 25th, he would have kept his leg?

7           A.    Yes, sir.

8           Q.    Okay.

9                   What is the customary treatment for someone  
10 had to have an amputation above the knee after?

11                   You treat patients for that?

12           A.    I do amputations.

13                   Obviously above the knee amputation is  
14 worse.

15                   First of all, any amputation is worse than  
16 not having an amputation, but above the knee, it's  
17 more intrusive toward his lifestyle than below the  
18 knee, which is a shorter prosthesis, and people tend  
19 to walk around and function.

20                   You know, somebody ran in the Olympics.

21                   But below the knee is an easier prosthesis  
22 to fit, and patients do better than above the knee.

23                   In regards to follow-up, there's a lot of  
24 physical therapy, occupational therapy, and what have  
25 you.

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Q. Okay.

Have all the opinions you have given here today been to a reasonable degree of medical probability?

A. Yes, sir.

MR. ARNTZ: That's all I have.

THE COURT: Let's go ahead, take a brief recess before we resume the questioning with the doctor.

We'll return at 10:20.

(Jury admonished by the Court.)

THE COURT: Go ahead take a break.

We'll see you in 10.

(Thereupon, a recess was had.)

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(Thereupon, the following proceedings were  
had out of the presence of the jury.):

THE COURT: See you guys in about ten  
minutes.

(Thereupon, a recess was had.)

1           (Thereupon, the following proceedings were  
2 had out of the presence of the jury.):

3           THE COURT: Anything before we bring the  
4 jury in?

5           MR. MC BRIDE: I was just going to say,  
6 we're going to go until 12:30, is that still the  
7 plan?

8           THE COURT: It depends how long you think  
9 you're going to take.

10          I can break whenever in the morning, I just  
11 can't start again until 1:30.

12          So if we go a little later in the afternoon  
13 -- but the later we take the morning it creates the  
14 imbalance again.

15          So the goal is to aim for 12 and 12:30, but  
16 ultimately be sure they have more time in the morning  
17 to get their stuff together, than afternoon people.

18          I wouldn't want to go much later than  
19 12:30.

20          MR. MC BRIDE: I don't think it's going to  
21 be that.

22          THE COURT: Okay.

23

24

25

1           (Thereupon, the following proceedings were  
2 had in open court, and in the presence of the jury.):

3           THE COURT: Go ahead and have your seats.  
4           Everyone else can have a seat as well.

5           I just want to ask you for the record, you  
6 understand you're still under oath?

7           THE WITNESS: Yes, I do.

8                               - - - -

9           **CROSS-EXAMINATION OF DR. ALEXANDER MARMUREANU**

10          BY MR. MC BRIDE:

11           Q. Good morning, Dr. Marmureanu.

12                   I have to apologize because yesterday I  
13 think I absolutely butchered your name in my opening  
14 statement. I want to apologize for it in advance.

15           A. Apologies accepted.

16                   And let me assure you, it's not the first  
17 time it happened.

18           Q. May I call you Dr. M, just to make it  
19 easier for the jury to remember, if that's okay?

20           A. Okay.

21           Q. Now, doctor, you remember your deposition  
22 in this case was taken a few months ago back in  
23 October of 2019, do you recall that?

24           A. Yes, I do, sir.

25                   I have it right here, sir.

1 Q. Do you have it in front of you?

2 You reviewed that deposition before today  
3 to check for any completion or inaccuracies, is that  
4 correct?

5 A. I think I did.

6 I don't remember, I probably did.

7 I usually do.

8 I don't remember about this one.

9 Q. In fact, you did not make any changes to  
10 any part of your deposition transcript, is that true?

11 A. That's correct.

12 Q. And --

13 A. Let me say, I don't remember reviewing it,  
14 but obviously, because I did review it, I didn't make  
15 any changes, so you are correct.

16 Q. And you have been deposed numerous times  
17 over the years as an expert witness and as a treating  
18 physician, right?

19 A. Yes, sir.

20 Q. Well over 30 times?

21 A. Yes, sir.

22 Q. Approximately over a hundred times over  
23 your career?

24 A. Approximately less than 50.

25 Q. Less than 50, but more than 30?

1           A.     Yes, sir.

2           Q.     All right.

3                     And now, doctor, I want to go through some  
4 of your qualifications that you mentioned you went  
5 over with Mr. Arntz before in his questioning.

6                     You stated that your specialty is thoracic  
7 and cardio-vascular surgery, correct?

8           A.     Correct, sir.

9           Q.     Is it fair to say that you would be  
10 considered a heart surgeon?

11           A.     Well, I hope so, but not only heart  
12 surgeon, heart surgeon, lung surgeon, vascular  
13 surgeon.

14           Q.     But your primary area of expertise,  
15 specialty included on the CV that you provided to us  
16 is in the area of cardiac surgery and cardio-thoracic  
17 surgery, correct?

18           A.     No, sir, it covers everything.

19                     Let me explain.

20                     Every cardiac case has vascular in it.

21                     When I do cardiac surgery by-pass surgery  
22 for blockages, instead of having a fem pop, you have  
23 a by-pass on the heart, take a vein from the leg,  
24 from here, and you see it on top of the heart, which  
25 leads from the aorta, the big blood vessel, all the

1 way to the coronary arteries, so every cardiac --be  
2 cause I do it -- it's vascular in terms of we work on  
3 vascular structures every single time.

4 Q. I don't mean to downplay any significance  
5 of the vascular system because that is all part of  
6 your practice, correct?

7 A. Yes.

8 Q. But you were not an emergency medicine  
9 physician, correct?

10 A. Well, somewhat.

11 I mean, I don't know how you define  
12 emergency room physician, but I'm not the doctor like  
13 Mr. Lasry, but I'm on call for vascular surgery for  
14 the ER just to see patients like Mr. Moore when the  
15 ER doctor asks me to see those kind of patients, so I  
16 see them in the ER, which some people would say,  
17 well, you have seen him in the ER, you provided care  
18 in the emergency room.

19 Q. Certainly.

20 But you are a cardio-thoracic and  
21 cardio-vascular surgeon on call, or gets consulted on  
22 occasion by the emergency department, correct?

23 A. True.

24 Q. All right.

25 You are not an emergency room physician, a

1 board-certified emergency room physician, like Dr.  
2 Lasry, correct?

3 A. True.

4 Q. You don't spend your full day practicing  
5 emergency medicine, who would treat all sorts of  
6 different types of complaints from a heart attack, to  
7 a common cold, to a trauma case in the emergency  
8 department, true?

9 A. True.

10 Q. All right.

11 In fact, you did not perform an internship  
12 or residency specifically in emergency medicine,  
13 correct?

14 A. Pretty much.

15 When we do our general surgery residency,  
16 we will go through all the services, including  
17 emergency room, so I spent months in the emergency  
18 room during my training, but that is the extent of me  
19 spending months in the ER.

20 Q. Right.

21 A. That's not what I'm looking for.

22 Q. So as a surgery resident, you're going to  
23 spend time in the emergency department as part of  
24 your rotation, right?

25 A. Correct.

1           Q.    And you do that as well as part of your  
2 internship, correct?

3           A.    Yes, sir.

4           Q.    And that internship was actually back in  
5 New York, and back in 1994 to 1995, correct?

6           A.    Correct, sir.

7           Q.    All right.

8                    So that is the last time you would have  
9 actually spent a significant amount of time rotating  
10 through the emergency department as part of your  
11 internship or residency, correct?

12          A.    Let me repeat this.

13                    You are a hundred percent correct.

14                    This is the last time I've been in training  
15 in the emergency room spending time.

16                    Part of my -- Actually, I would say, every  
17 day I go to the emergency room to see patients.

18                    Just because some of my old patients come  
19 back in, new consults come back in, and I go to nine  
20 hospitals, so I spend a fair amount, but that is the  
21 extent, as a surgeon.

22          Q.    You're specifically treating your prior  
23 patients who might return to the emergency department  
24 because of a vascular issue, right?

25          A.    Or cardiac or thoracic, yes.

1           Q.    You're not treating other patients in an  
2 emergency department on a regular basis for every  
3 other type of ailment, or potential complaint, a  
4 broken arm, any of those things, true?

5           A.    True, sir.

6           Q.    All right.

7                   In fact, you're not board-certified in  
8 emergency medicine, right?

9           A.    True, sir.

10          Q.    You're not a member of any  
11 nationally-recognized emergency medicine  
12 organizations, true?

13          A.    Correct.

14          Q.    You're also not a member of the American  
15 College Of Emergency Physicians, correct?

16          A.    True.

17          Q.    You are a member of separate  
18 cardio-thoracic surgery associations, right?

19          A.    And vascular, sir.

20          Q.    As well as American College Of Surgeons,  
21 right?

22          A.    Yes.

23                   Well, I have my application in there, and I  
24 understand it's been approved, so I have a different  
25 title, about American College Of Surgeons, so I'm not

1       sure exactly how they call me.

2                   I just applied a year ago, so to be  
3       precise, yes, I'm some sort of a member, but didn't  
4       get my membership, I'm ongoing, my application is  
5       there for the American College Of Surgeons, which  
6       deals with general surgery.

7                   I am a member of the Society Of Thoracic  
8       Surgeons, International Society For Cardiac Surgery,  
9       so a member of a lot of societies, international  
10      vascular surgeons deal with what I currently  
11      practice, and because I practice some general  
12      surgery, I recently applied to the American College  
13      Of Surgeons.

14           Q.     All right.

15                   In looking at your CV that you provided to  
16      us before your deposition, I noted too that you have  
17      not conducted any research specifically in the area  
18      of emergency medicine, correct?

19           A.     Correct, sir.

20           Q.     And you're not on any specific committees  
21      that specifically deal with diagnosis and treatment  
22      in the emergency room, true?

23           A.     It's untrue, but let me explain why.

24                   I'm a member -- We spoke earlier called  
25      systemic, is on the EKG waives, that's the elevation,

1 myocardial infarction.

2           So there's a patient comes up as an  
3 emergency comes up with a heart attack, he needs to  
4 go do the cardiac catheterization, a blockage around  
5 the heart needs an angiogram, then they need to go  
6 upstairs, and then need to be treated by the balloon  
7 -- or by surgery it's called systemic, so it's very  
8 important to do this within 30 minutes to 90 minutes,  
9 it's called door to balloon, walks through the door  
10 to the balloon, so I'm part of that committee and  
11 covers the emergency room in regards to being sure  
12 that things are being done in a timely fashion.

13           Q.    That specifically would relate to an area  
14 of -- your area cardio-vascular -- and  
15 cardio-vascular surgery, correct?

16           A.    It covers the ER people say, come to the  
17 ER, and then we get called, so we have to be  
18 available.

19           Q.    Going back to your CV, doctor, you have not  
20 offered any manuscripts for that?

21           A.    Correct.

22           Q.    For that matter, specifically in the area  
23 of the diagnosis or treatment of acute limb ischemia,  
24 correct?

25           A.    Well --

1 Q. Is that correct?

2 A. Can you repeat the question?

3 Q. Sure.

4 Isn't it true -- I looked through your CV,  
5 looked through all your manuscripts you provided us  
6 all, the other the publications you listed, and I  
7 think even in your deposition you told us you have  
8 not specifically authored any publications that deal  
9 with the diagnosis of and treatment of acute limb  
10 ischemia, true?

11 A. Somewhat.

12 We spoke in the depo and here, but I think  
13 over all you are correct, but for the record there is  
14 one paper I presented to the International  
15 Association Of Vascular Surgeons in 1998 we went over  
16 in the depo in regards to I think it was venous  
17 ulcers, and he had a venous ulcer, and in the paper  
18 it addresses actually certain issues in regards to  
19 chronic, acute ischemia, as well as venous disease,  
20 so that is one paper.

21 Q. That was 18 years before this presentation  
22 by Mr. Moore to the emergency room, correct?

23 A. Yes, sir.

24 Q. It wasn't specifically on the diagnosis or  
25 treatment of acute limb ischemia in the emergency

1 room, true?

2 A. True.

3 Q. Now, let's get to your deposition because I  
4 want to clear that up, so we can be on the same page  
5 here.

6 Do you have your deposition?

7 A. Which page?

8 MR. MC BRIDE: Your Honor, I'd like to move  
9 to publish the deposition of Dr. M.

10 THE COURT: Go ahead, make the formality  
11 and publish it, then we'll get back to the  
12 questioning.

13 You just want that version for now?

14 MR. MC BRIDE: He -- actually if he has a  
15 copy.

16 THE WITNESS: I have a copy.

17 MR. MC BRIDE: Can I approach to make sure  
18 we're on the same page?

19 THE COURT: Yes, you may.

20 THE COURT: Okay.

21 BY MR. MC BRIDE:

22 Q. All right.

23 Doctor, in terms of your deposition, there  
24 was a lot of questions, you remember Mr. Weaver was  
25 present and actually took the lead on asking a lot of

1 those questions of you at your deposition?

2 A. I remember very well.

3 Q. Okay.

4 And, in fact, do you remember there was  
5 some questions that related to the medical literature  
6 that you provided to us, or at least included as part  
7 of your file you had done research on prior to your  
8 deposition, you remember that?

9 A. That's correct.

10 And I explained to him, it's again not  
11 about him, but we did have a fair discussion about  
12 literature, which is different than the patient's  
13 case.

14 I made it very clear that the literature or  
15 the guidelines don't represent the standard of care.

16 I have the page.

17 I understand standard of care is  
18 individual.

19 Q. Let's talk about that.

20 I'll direct you actually to your testimony.

21 You would agree with me in your deposition  
22 you testified --

23 A. Which page?

24 Q. -- under oath, on page 48 where you already  
25 had it.

1 A. 48?

2 Q. Yeah, for -- Actually go back.

3 I think there was some question that you  
4 were going back and forth, and I think there was some  
5 stepping on the toes where you were talking over each  
6 other, Mr. Weaver and you, so there was this little  
7 interaction that you had, so it actually starts at  
8 page --

9 A. Sorry to interrupt you, but they went on  
10 for three hours, so you have to be more precise than  
11 that.

12 THE COURT: I assure you, counsel will be  
13 very professional.

14 THE WITNESS: I can't wait.

15 BY MR. MC BRIDE:

16 Q. Go to page 47, if you will.

17 A. I'm here.

18 Q. It's line 7, this is 7 through 14, and then  
19 we'll go through the next page too.

20 A. Line 7?

21 Q. Line 7.

22 And, doctor, you would agree with me at the  
23 time of your deposition you specified that given Mr.  
24 Moore's chronic peripheral vascular disease, and  
25 chronic occlusion to his fem pop by-pass graft, he

1 would ultimately require an amputation of his left  
2 leg, would you agree what that?

3 A. No, sir.

4 Where are you reading?

5 Q. I'm not reading from the deposition now.

6 A. I disagree with that.

7 Q. So let's get to your you disagree with  
8 that.

9 Let's go to page 47, and you read line 7  
10 through 14, all right?

11 A. Well, you might want to read for the jury,  
12 that's the question for Mr. Weaver.

13 Q. I'm asking if you could read it to  
14 yourself?

15 A. I already did, sir.

16 Q. So you read it to yourself.

17 Now, let me read it, so the jury  
18 understands what the question was.

19 But the literature that you have in front  
20 of you, unless I read it wrong, which I may have very  
21 easily, the question from Mr. Weaver is, that after  
22 more than two failed -- after the by-passes failed  
23 more than two times, even after re-vascularization,  
24 more likely than not the end result is going to be  
25 amputation, do you disagree that is what the

1 literature says?

2 And your answer was, yeah, well the  
3 literature or the guidelines don't represent the  
4 standard of care.

5 Was that your answer, sir?

6 A. Yes, that's I said.

7 I disagree with it.

8 And then the literature or the guidelines  
9 don't represent the standard of care, I said that,  
10 yes.

11 Q. So you disagree that's what the literature  
12 said?

13 A. Well, I think we're talking about Mr. Moore  
14 at the time.

15 This, you're taking this out of context.  
16 We have two lawyers, I just agreed in regards to Mr.  
17 Moore, and I have it all over, clotting two or three  
18 times with amputation.

19 Actually on line 4 I'm saying that, if it  
20 continues to clot, it doesn't not mean he is going to  
21 need an amputation, this is line 4.

22 Q. Right.

23 Doctor, I understand.

24 Let me get to the questions, and you can  
25 feel free to answer however you want, or disagree

1 with me.

2 I'm trying to get to your deposition  
3 testimony and what was testified there.

4 Now, so continuing on, page 48, line 2 --

5 MR. P. HYMANSON: Your Honor, may we  
6 approach, please?

7 THE COURT: Sure.

8 (Thereupon, a discussion was had between  
9 Court and counsel at sidebar.)

10 MR. P. HYMANSON: Thank you.

11 THE COURT: All right.

12 Thank you.

13 With that clarification, maybe I can assist  
14 as we get started.

15 So, doctor, there's a particular format  
16 about how we inquire of someone whose previously  
17 given a deposition.

18 I would ask that you please pause and let  
19 counsel give you the directions, rather than trying  
20 to also direct the process. It will be easier in the  
21 long run.

22 What he's doing now when he asks you to  
23 look at portions of your deposition is simply to read  
24 those portions to yourself to potentially refresh  
25 your recollection of your testimony, and then there

1 will be a line of inquiry.

2 All right?

3 THE WITNESS: Yes.

4 BY MR. MC BRIDE:

5 Q. Now, doctor, let me refer you actually to  
6 the question and answer at lines 5 through 11.

7 Read those to yourself if you could.

8 A. Page 48, sir?

9 Q. Page 48.

10 Actually, start at line 2, and go down to  
11 line 11.

12 A. I did, sir.

13 Q. Perfect.

14 So, doctor, isn't it true that you  
15 testified at your deposition that if the graft failed  
16 two times, three times, it's a possibility, or more  
17 likely than not, it will continue to fail in this  
18 patient, or a patient will require an amputation, and  
19 we agree on that, that was your testimony, correct,  
20 sir?

21 MR. ARNTZ: Excuse me.

22 THE COURT: Hold on, there's an objection.

23 Mr. Arntz.

24 MR. ARNTZ: The same objection, that is not  
25 the proper use of the deposition, reading it into the

1 record.

2 THE COURT: At this point in time I think  
3 we are trying to sort of get to the heart of what's  
4 here.

5 I'm going to give a little bit of leeway.  
6 Let's see if we can make this work. I'm not quite  
7 sure how else to get at it, unless we highlight some  
8 things.

9 Maybe Mr. McBride, ask the question, get  
10 his answer. If it doesn't match, come back to the  
11 deposition.

12 MR. MC BRIDE: That's what I did earlier,  
13 so I was trying to short-circuit it.

14 THE COURT: But what I think we want the  
15 clarity is, just because you ask the doctor to read a  
16 portion to refresh his recollection, you still have  
17 to ask the question and then get his answer, and if  
18 it doesn't match, then you can go back to the depo  
19 and look at it.

20 If we have to go through that type of  
21 formality, that is fine, it is typically how it's  
22 done.

23 Sometimes more familiarity with each other  
24 makes it short-cut some of those things, but I'm  
25 going to sustain Mr. Arntz's objection, and let's try

1 to keep it to the formality here.

2 BY MR. MC BRIDE:

3 Q. Okay.

4 Doctor, do you recall that testimony when I  
5 asked you, given Mr. Moore's chronic peripheral  
6 vascular disease, and prior occlusions, you would  
7 agree he would ultimately require an amputation of  
8 his left leg, correct?

9 A. I disagree to that, sir.

10 Q. Okay.

11 And, again, does paragraph 2 through --  
12 lines 2 through 11, does that refresh your  
13 recollection as to what you testified in your  
14 deposition in that regard?

15 A. Yes, it reflects I'm right, and you are  
16 wrong, and if possible we can put it here, let the  
17 jury be the jury.

18 You're reading it wrong, sir.

19 Allow me to finish my answer for the Judge  
20 and the jury.

21 Q. Sure.

22 A. You want me to be silent, but can I read  
23 aloud?

24 Q. I don't want you to be silent, you can  
25 answer your questions.

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A. You're wrong, sir.

THE COURT: We're going to take a little  
break, about five minutes, let the jurors step out  
for about five minutes.

(Jury admonished by the Court.)

THE COURT: See you back when we see you  
back.

(Jury excused from the courtroom.)

(Thereupon, a recess was had.)

1           (Thereupon, the following proceedings were  
2 had out of the presence of the jury.):

3           THE COURT: Go ahead, everybody have a  
4 seat.

5           Doctor, I didn't want to admonish you for  
6 the first time in front of jury, but that type of  
7 editorializing and trying to direct the process is  
8 exactly what I just told you not to do.

9           THE WITNESS: I'm sorry.

10          THE COURT: I will ask you to please not do  
11 that again.

12          We have a process.

13          Back to counsel, Mr. McBride, we were  
14 already in that area, so I really didn't have a  
15 problem with you going back to the depo and saying  
16 that, but you read this, and I said this, we have to  
17 get off that because the two of you are going to sit  
18 here and keep going at it, and I'm not going to have  
19 it.

20          So I don't know how to resolve this one,  
21 but doctor, I will in the future admonish you in  
22 front of the jury if you continue to try to direct  
23 the testimony.

24          Counsel's going to ask the questions, he's  
25 going to ask you what to read, going to ask your

1       answers, and I ask you to answer them.

2               Don't forget, your counsel's going to have  
3       the opportunity to redirect and examine you as well,  
4       but we cannot be here all day with that kind of  
5       gamesmanship.

6               Mr. Arntz.

7               MR. ARNTZ: I think the problem in this  
8       particular instance was, he wasn't allowed his right  
9       to look and reference the entire answer.

10              In fact, he says at line 13, I'm not done,  
11       please.

12              So there's more to his answer.

13              THE COURT: That is not the problem.

14              Listen to this, doctor, listen to me before  
15       you think you know what to tell me.

16              That's not the problem, Mr. Arntz.

17              Counsel's allowed to say, look at whatever,  
18       if you think there's something else, you deal with  
19       that on direct, but if he has a different answer,  
20       he's welcome to give it, but we are not going to sit  
21       here and tell the jury, oh well, you need to let the  
22       jury read this, that's not how it works, doctor.  
23       This deposition doesn't go in front of the jury.

24              You let him ask the questions.

25              If you think there's something else you can

1 respectfully say, I believe there's more to my  
2 answer.

3 I'm not trying to direct your testimony  
4 either, but I'm not having this.

5 What is your question?

6 THE WITNESS: Thank you for allowing me to  
7 speak, and I really apologize.

8 I'm not saying I know. Actually, I don't  
9 know what to do.

10 With all due respect, what he's reading  
11 here is my testimony, it's clearly he's not saying  
12 what it is supposed to say.

13 I'm saying, let me repeat the question.

14 I'm repeating Mr. Weaver's question, and  
15 he's saying that was my testimony, when clearly at  
16 line 6 -- so what are you saying, let me repeat the  
17 question, and I repeat the question, and he's saying  
18 that that is what I said.

19 THE COURT: Doctor, how many times have you  
20 given testimony in court?

21 THE DEFENDANT: Between five to ten times.

22 THE COURT: Then you know how this works.

23 THE DEFENDANT: I don't know about this.

24 THE COURT: You know how this works.

25 He's cross-examining you.

1           If you don't believe what he's indicating  
2       is complete or accurate testimony, you will have the  
3       opportunity to correct it.

4           It's not a fight over what is in the depo,  
5       it's a dialogue about what the testimony is or is  
6       not.

7           THE WITNESS: I'm sorry.

8           Thank you.

9           THE COURT: Can we get this back on track?

10          MR. MC BRIDE: Yes.

11          Thank you.

12          THE COURT: All right.

13          Thank you.

14          (Thereupon, the following proceedings were  
15       had in open court and in the presence of the jury.):

16          THE COURT: Please have your seats.

17          Even though it was just a short recess, Dr.  
18       Marmureanu, please acknowledge for the record you  
19       understand you are still under oath.

20          THE WITNESS: Yes, I do.

21          THE COURT: Thank you.

22       BY MR. MC BRIDE:

23           Q. I'm actually going to veer off of the  
24       deposition transcript for a minute, doctor.

25           I want to ask you a couple of other

1 questions first of all.

2 A. Okay.

3 Q. On the break, not this last one, the short  
4 one, but on the prior break you had an opportunity to  
5 step outside and speak to Mr. Arntz and other  
6 counsel, correct?

7 A. Yes, sir.

8 Q. And what did you talk about?

9 A. I told them that I found it -- I was  
10 pleasantly surprised you were here, I think it's  
11 going to go very well, and somewhat surprised when I  
12 was shaking Mr. Weaver's hand, he was unhappy and  
13 didn't look at me, and I was disappointed.

14 Q. That's the only thing you talked about  
15 during that break with Mr. Arntz?

16 A. That's what I remember.

17 I went to the bathroom.

18 I asked him where was the bathroom.

19 And I asked if I could get more water.

20 Q. You also talked about your testimony you  
21 gave previously, right, when Mr. Arntz was  
22 questioning you?

23 A. I don't remember, perhaps we did.

24 I don't --

25 Q. I don't mean to interrupt.

1                   Were you done?

2           A.     Actually, I don't remember.

3                   I said that -- I don't remember if we did  
4 talk, perhaps we did.

5           Q.     All right.

6                   Now, getting back to the facts of this  
7 case, in terms of your deposition at the time of your  
8 deposition you made some conclusions based on the  
9 timing of the last time that any sort of thrombolytic  
10 -- TPA therapy, or Drano therapy, would have worked  
11 in Mr. Moore's case, do you remember that testimony  
12 you gave then?

13          A.     I'm not sure I understand your question.

14                   Can you be more precise?

15          Q.     Sure.

16                   Were you able to determine the period of  
17 time is, the absolute last time that the thrombolytic  
18 therapy he received previously in your opinion that  
19 would have been able to have been used in his case on  
20 the 25th or 26th, when was the last time it would  
21 have been able to have been used in order to save his  
22 leg?

23          A.     I remember that.

24                   We talked in the depo about it, and the  
25 best of my recollection I wasn't able to come -- I

1 said it in my expert report, obviously I said, should  
2 have dealt promptly, and with this patient, and I  
3 believe Mr. Weaver said, how many hours, and I said,  
4 well, it's never by the hour because you will have to  
5 call the surgeon, you will have to call the  
6 interventional radiologist, chances are he would have  
7 gone into the 26th, and this is not a one-shot deal.

8 This is an infusion first of Heparin that  
9 will preclude further clotting form, and then a TPA  
10 you keep dripping into the legs and hope the clot  
11 will dissolve, so this is not an hour or two.

12 I again said, that should have been  
13 promptly started once the issue was recognized, and  
14 then would have more likely than not continued into  
15 the 26th.

16 Q. In your opinion would you agree with me  
17 that thrombolytic therapy is not indicated for a  
18 patient with chronic or limited ischemia?

19 A. Yeah.

20 Q. You would agree in terms of the timing of  
21 when the thrombolytic therapy would have been  
22 helpful, or prevented the ultimate outcome in Mr.  
23 Moore's case, you really don't know when that time  
24 line is, you're speculating to that, right?

25 A. I don't understand your question.

1           I can try to answer, but if you can  
2 reformulate it.

3           Q.     Sure.

4           You would agree there's a number of factors  
5 would have to take place in order for the  
6 thrombolytic therapy to be successful, true?

7           A.     Not necessarily.

8           You have to -- I mean, first of all, that  
9 was discussed in the depo, and let me -- I'm trying  
10 not to confuse the depo.

11           On one hand there was normal pulses, but on  
12 the other hand I think your expert said that he would  
13 have needed amputation anyhow, even with normal  
14 pulses, so there was -- we had a little battle there  
15 because you can't have it both ways, but regards to  
16 the acute versus chronic, when you have a patient  
17 that has limb ischemia, no blood in his foot, and you  
18 believe that it one hour, one day, or one week, you  
19 do it because you most likely will save that leg.

20           Nobody is going to look at the clock, say  
21 well, we believe we're not going to do this thing,  
22 we're going to cut his leg, so I disagree with that.

23           In other words, if a patient shows up, he  
24 will get TPA.

25           Q.     Let me try to simplify it for you, doctor.

1           You would agree with me, doctor, when Mr.  
2 Moore returned to the hospital on December 28th,  
3 thrombolytic therapy was initiated with the IV  
4 Heparin, correct?

5           A.     Incorrect, and I can explain that.

6           Q.     You know what, your counsel --

7           A.     I can explain that to the jury.

8                     Let me clarify.

9                     Heparin is not a thrombolytic. You said IV  
10 thrombolytic.

11           Q.     Let me clarify the question, so we can be  
12 on the same page then, doctor.

13                     You agree with me though that when Mr.  
14 Moore returned on the 28th, he was eventually put on  
15 thrombolytic therapy, correct?

16           A.     It's not eventually.

17                     You are started promptly.

18                     He was started on thrombolytic and Heparin,  
19 two different things here.

20           Q.     That's what I'm getting at, he was started  
21 as soon as he was diagnosed in the emergency room on  
22 December 28th, correct?

23           A.     Yes.

24           Q.     And you would agree with me that even after  
25 24 hours of thrombolytic therapy and Heparin, the

1 clot was unable to be resolved, correct?

2 A. Incorrect.

3 Q. Well, your counsel can follow-up with those  
4 answers.

5 I'm trying to get like a yes or no from  
6 you.

7 A. I --

8 Q. So if I can follow up with my next  
9 question, doctor.

10 The thrombolytic therapy initiated on the  
11 28th ultimately proved to be unsuccessful, correct?

12 A. Correct.

13 Q. Ultimately, Mr. Moore required to have his  
14 leg amputated, right?

15 A. Correct.

16 Q. Hypothetically, if Mr. Moore had been  
17 started on thrombolytic therapy on December 25, and  
18 it was unsuccessful, can you listen to me, you would  
19 agree with me that he would have ultimately required  
20 an amputation, correct?

21 A. Incorrect.

22 Q. Okay.

23 Now, in this particular case you were first  
24 contacted to review this case by counsel, Plaintiff's  
25 counsel, a few years back, right?

1           A.     Correct.

2           Q.     And at the time you knew the end result of  
3 what happened to Mr. Moore, right?

4           A.     Wrong.

5           Q.     You weren't provided with information about  
6 what the case was about, and the fact that Mr. Moore  
7 had had to have his leg amputated as a result of an  
8 arterial occlusion?

9           A.     No, sir.

10                  When he first contacted me, I didn't know  
11 anything about the case.

12           Q.     Okay.

13                  But after reviewing the case, you came to  
14 the -- you were provided with additional medical  
15 records, right?

16           A.     Correct.

17           Q.     Including the records from December 28th,  
18 correct?

19           A.     Correct, sir.

20           Q.     And records following December 28th for  
21 other hospitalizations, right?

22           A.     Yes, sir.

23           Q.     When you went and started your review, you  
24 didn't just stop at December 25th, correct, in your  
25 review?

1           A.     Correct.

2           Q.     You had those other records that you  
3 followed up and found out what happened to him,  
4 right?

5           A.     Correct.

6           Q.     All right.

7                 So you knew there was an amputation  
8 ultimately occurred, correct?

9           A.     Ultimately, yes.

10          Q.     Now, in regards to the records that you  
11 were provided, you would agree with me you have a  
12 list at the time of your deposition, you would agree  
13 with me you did not review all of Mr. Moore's prior  
14 treating physician records, correct?

15          A.     I'm not sure how to answer.

16                 The review I was given to me, I have a  
17 list.

18          Q.     Right.

19                 According to the list, I don't know if you  
20 have your actual file materials with you, based on  
21 one of the invoices attached as an exhibit in this  
22 case you were provided with records from St. Rose  
23 Hospital that were approximately 995 pages, do you  
24 recall that?

25          A.     I don't, but if I billed for it, I reviewed

1 those records.

2 Q. All right.

3 Are you aware that -- again, we can verify  
4 because he have numerous volumes of medical records  
5 behind you -- that in fact there 2,865 pages just  
6 from St. Rose lose alone, are you aware of that?

7 A. I'm not sure I understand the question,  
8 sir.

9 I have a list, if I can help with  
10 everything here.

11 Q. I know you have listed St. Rose Hospital,  
12 right, you have it listed there how many pages were  
13 part of the St. Rose records?

14 A. I don't know, whatever you gave me, that's  
15 what I reviewed.

16 Q. I'll represent to you -- Do you have any  
17 reason to disagree if it was in your invoice, there  
18 was a total of 985 pages that you indicated that you  
19 had read and billed for, do you recall that?

20 A. I don't recall, but if it's on the invoice,  
21 that is what I've done, yes.

22 Q. And again, my question now is, are you  
23 aware there are actually 2,865 pages of records just  
24 from St. Rose Hospital alone?

25 A. Well, if you tell me, you're probably

1 correct.

2 I wasn't aware, no.

3 Q. Did you ever ask Mr. Arntz or prior counsel  
4 as to whether or not you had been provided with  
5 everything that you needed to review in this case  
6 before coming and giving your deposition and coming  
7 to court?

8 A. No, sir.

9 Q. And you would agree with me, you have done  
10 expert work for some time, right, over the past 10,  
11 15 years?

12 A. 10 years, sir.

13 Q. All right.

14 And you have given 50 depositions, right?

15 A. Less than 50.

16 Q. And you testified in trial or mediation 5  
17 to 10 times, right?

18 A. Yes.

19 Q. And you agree with me, it's your role as an  
20 expert witness, it's important that any expert  
21 witness who is going to come in and criticize the  
22 care and treatment provided by any physician, that it  
23 is important that you have all of the available  
24 records in order the make sure you didn't miss  
25 anything, right?

1           A.     That is wrong.

2           Q.     That's wrong, you don't think you need all  
3 the records?

4           A.     No, you need enough to make your opinion,  
5 if I may explain.

6           Q.     Well, Mr. Arntz can follow-up with that.

7                   Well, in this particular case you also were  
8 provided with deposition transcripts, right?

9           A.     Yes, sir.

10          Q.     And you read Mr. Moore's transcript, right?

11          A.     Yes.

12          Q.     His wife, right?

13          A.     Yes, sir.

14          Q.     His son, Christopher?

15          A.     Yes.

16          Q.     Do -- You weren't provided with the  
17 records, I didn't see it listed -- tell me if I'm  
18 wrong -- you weren't provided with the medical  
19 records from St. Rose Stanford Clinic, true?

20          A.     I don't remember, sir.

21          Q.     Those are Dr. Wiencek's records. Do you  
22 recall seeing his office records?

23          A.     I don't remember.

24          Q.     Do you know who Dr. Wiencek was?

25          A.     I don't remember.

1 Q. Okay.

2 I'll represent -- or Wiencek, the vascular  
3 surgeon?

4 Q. Maybe it's a Romanian pronunciation, I'm  
5 mispronouncing.

6 A. Wiencek.

7 Q. You have read those office notes he has  
8 from St. Rose Stanford Clinic?

9 A. I do not remember, sir.

10 Q. Right.

11 I didn't see it.

12 I'll represent to you -- Do you want to  
13 take a look at the list?

14 Take a look at the list.

15 A. If it's not here, I didn't see it, sir.

16 Q. As the treating cardiovascular surgeon, Dr.  
17 Wiencek, those records would be important to you in  
18 order to see if they provide any additional  
19 information, or if they contradict any other  
20 information that you were provided in the records,  
21 right?

22 A. Wrong, sir.

23 Q. Okay.

24 Are you aware Dr. Wiencek diagnosed the  
25 Plaintiff as suffering from chronic venous

1 insufficiency?

2 A. I remember reading that, and actually I did  
3 say he had a venous ulcer, yes.

4 Q. So you are aware that Mr. Moore had been  
5 diagnosed and had suffered from chronic venous  
6 insufficiency for many years, right?

7 A. I'm aware of that.

8 Q. And, in fact, you said you weren't aware  
9 specifically of records reflecting a DVT diagnosis,  
10 but you're aware it was mentioned in the records  
11 somewhere, right?

12 A. Correct, sir.

13 Q. All right.

14 Now, if I can refer you to --

15 MR. MC BRIDE: At this time I'd like to  
16 move for the introduction of Joint Exhibit 109, which  
17 is Dr. Wiencek's records.

18 MR. ARNTZ: No objection.

19 MR. WEAVER: No objection.

20 THE COURT: 190 is admitted.

21 You may inquire.

22 MR. MC BRIDE: Thank you.

23

24

25

1 BY MR. MC BRIDE:

2 Q. Doctor, I just wanted to kind of refer you  
3 to a couple of notes from there. We're going to show  
4 it up on the screen.

5 I think we're switched over.

6 If we could look at -- Are you aware Dr.  
7 Wiencek saw Mr. Moore in his office on February -- in  
8 February of 2016, February 8, 2016, it's SRSC-36,  
9 Exhibit 109, which has been admitted, and they will  
10 show it.

11 In fact, doctor, it should show up on your  
12 screen now.

13 A. Thank you.

14 Q. Actually, there we go.

15 Do you see that record, have you seen that  
16 before?

17 A. I might, just don't remember, sir.

18 Q. Okay.

19 Well, you are aware that Dr. Wiencek  
20 reported that he had been -- Mr. Moore had been doing  
21 well, was ambulating with the aid of a cane, and  
22 approximately five percent of the time he uses the  
23 wheelchair, are you aware of that?

24 A. I --

25 Q. Do you see that in the history of present

1 illness section?

2 A. I see that sir, yes.

3 Q. And then you note here, Dr. Wiencek notes  
4 he has good pulses above and lower extremities on the  
5 femoral on the left and tibial on the right, you see  
6 that?

7 A. I agree, sir.

8 Q. As of February 8th of 2016, good pulses  
9 were noted in both lower extremities?

10 A. That is what is documented, and I believe  
11 the graft was open at that time.

12 Q. Okay.

13 This is ten months before, ten months  
14 before he presented to St. Rose emergency room?

15 A. Correct.

16 So I believe the graft was open, so that is  
17 right, he had pulses.

18 Q. And, in fact, are you aware he was supposed  
19 to return to Dr. Wiencek's office on a regular basis  
20 every six months to have regular checks on his pulses  
21 and see how he was doing?

22 A. That sounds fair, yeah.

23 Q. He was also using compression stockings,  
24 and that was appropriate, right?

25 A. Sure.

1           Q.     Compression stockings, do they assist with  
2 maintaining blood flow as best as possible, as well  
3 as to prevent DVT?

4           A.     Somewhat correct, somewhat incorrect.

5                     Basically, the venous part of the disease  
6 it assists with, doesn't promote the blood glow, just  
7 takes care of the venous insufficiency part.

8           Q.     Right.

9                     That was something that was appropriate,  
10 given Mr. Moore's prior venous insufficiency, right?

11          A.     Yes, sir.

12          Q.     And I'll represent to you -- Have you seen  
13 the records from Dr. Irwin Simon?

14          A.     I seen pages, don't remember all of them,  
15 but can you refresh my memory.

16          Q.     Sure.

17                     I'll show you that page in a second.

18                     But are you aware that in that particular  
19 letter being written by Dr. Wiencek to Dr. Simon,  
20 acknowledging he had been diagnosed with a prior DVT,  
21 have you seen that document before?

22          A.     I've seen it and agree with it.

23                     I'm not disagreeing, it's correct.

24          Q.     The only reason I'm going over this is  
25 because there was a lot of times yesterday by Mr.

1 Arntz with Terry Bartmus, who was on the stand, about  
2 where that came from, so I just wanted to make sure  
3 we're on the same page.

4 You have seen that?

5 A. Yes, sir.

6 And I truly believe I actually said earlier  
7 there was an indication to look for DVT.

8 Q. In fact, the reason why you recall Dr.  
9 Wiencek actually prescribed the patient with the  
10 Xarelto is in an effort to help deal with the  
11 potential -- as a prophylactic to deal with potential  
12 DVTs, right?

13 A. And also the graft.

14 Q. Also the graft.

15 I think you said in the deposition the  
16 Xarelto in your opinion does not really work for  
17 arterial insufficiency, is that your testimony?

18 A. Yes and no.

19 In a steady-staged patient it's better than  
20 nothing.

21 In a patient comes to the ER with the graft  
22 being closed, and again I don't believe he had any  
23 pulses because the pulses were coming from the graft  
24 that shows my point, but you have to move to what you  
25 read the way they've done it on the 28th to

1 thrombolytics and Heparin, so Xarelto is not good  
2 anymore, it's good for a patient that does it at  
3 home, but once it's in trouble, Xarelto is not enough  
4 anymore.

5 Q. You're aware Xarelto has been actually  
6 recommended and previously was used as an off-label  
7 use to assist in blood flow, arterial blood flow as  
8 well?

9 A. We're saying the same thing.

10 I agree, if the patient's home, he benefits  
11 better than nothing.

12 What I'm saying is, that on the 25th when  
13 he showed up with the graft being closed, and again  
14 at that time all this was gone because there no blood  
15 flow was coming from anywhere, Xarelto doesn't do it,  
16 it's all thrombolytics and Heparin, like you just  
17 said.

18 Q. And one of the blood tests that is done in  
19 a particular patient to determine if a blood thinning  
20 medication such as Xarelto is working properly, they  
21 order a PT, a prothrombotic, as well as an INR,  
22 correct?

23 A. May I explain?

24 Q. Sure.

25 A. You are somewhat correct, but mainly

1 incorrect.

2 Q. Okay.

3 That seems to be happening quite a bit.

4 A. You are correct in terms of the order,  
5 those are called coagulation studies.

6 Heparin, we talked earlier, once you give  
7 it, Heparin, the drip, that you provoke -- preclude  
8 the clot from being formed, you can measure PT/PTT or  
9 RNR, so that is when you give Heparin, the only way  
10 to flow, if it works, you measure that.

11 So to answer your question, the studies are  
12 being ordered, the Xarelto does not, it's not  
13 measured by PT/PTT, so you are incorrect by nobody  
14 measured Xarelto, that is done for Heparin.

15 I'm sorry, Xarelto, you give it, it's a  
16 certain dose, and patients live with it.

17 So you are correct to give Xarelto, but the  
18 PT/PTT is not for Xarelto, it's for the Heparin.

19 Q. Are there medications in your experience,  
20 doctor, as a cardio-vascular surgeon such as Dr.  
21 Wiencek, could prescribe in advance, or could have  
22 given to Mr. Moore in an effort to attempt to -- a  
23 stronger blood thinner, such as Coumadin or Warfarin,  
24 to be able to help deal with the potential issue of  
25 an arterial occlusion in the future?

1           A.     Well, you bring up a very good point.

2                   Coumadin is what he's talking about, it's  
3 the same thing, this is a pill, and for coagulation.

4                   Xarelto, I'm actually not saying that Dr.  
5 Wiencek did anything wrong, his decision was to start  
6 Xarelto, I don't think it's bad, rules out the DVT,  
7 makes the blood thinner to flow better through this  
8 graft, hopefully it doesn't clot.

9                   You can make an argument why don't we make  
10 the medicine stronger.

11                   Coumadin, which is actually rat poison,  
12 that is what Coumadin is, so you measure what is  
13 called RNR, different ways to measure, that you get  
14 what you pay for.

15                   That Coumadin will make the blood really  
16 thin, and people can bleed through their hands, or if  
17 they fall, they get hit by a car, die from a  
18 subdural, so you don't want to go on that side.

19                   So yes, he could have done Aspirin or  
20 Plavix, could have done Coumadin.

21                   He said it, with Xarelto I don't think it's  
22 a problem until he gets in trouble and shows up at  
23 the ER.

24           Q.     And I guess what I'm getting at is, the  
25 fact Dr. Wiencek now that I understand you're not

1 critical of him, and neither are we, but Dr. Wiencek  
2 had an understanding of Mr. Moore's prior fem pop  
3 occlusions, correct?

4 A. First of all, let me re-emphasize even  
5 more, even if you will not have had an occlusion,  
6 it's beneficial for him to be on some sort of blood  
7 thinner because this fem pop is unnatural, it's  
8 plastic tubing, so you want to give them something  
9 anyhow because we know God didn't make them perfect,  
10 so at some point they will clot.

11 So you are correct, sir.

12 Q. In fact, the fem pop, if I can approach  
13 real quick the photo or the drawing, just so the jury  
14 understands, your drawing here of this tube,  
15 obviously you're giving it a reference point, but  
16 it's ultimately inside the patient's leg?

17 A. Yes, everything is inside.

18 Q. I just wanted to make sure that was clear.

19 It's not something that is attached to the  
20 exterior of the leg he's wearing around?

21 A. That would have been easy to declot then.

22 Q. Right.

23 So again going back -- or you aware then of  
24 the visit -- this is the same, it's 14, the page  
25 number.

1                   Mr. Moore returned on May 9, 2016 to Dr.  
2                   Wienczek.

3                   Have you seen that record before?

4           A.     I don't remember.

5           Q.     Okay.

6                   Again, this is for a three-month follow-up  
7                   for a pulse check, right?

8           A.     Yes, sir.

9           Q.     That specifically is for a pulse check,  
10           that's what it says, yes?

11          A.     Yes, sir.

12          Q.     It says, he's been doing well, still able  
13           to walk for a few blocks, and then gets tired of the  
14           bilateral legs.

15                   He's talking about both of his legs causing  
16           the problems, right?

17          A.     Yes, sir.

18          Q.     Not just the left leg?

19          A.     Yes, sir.

20          Q.     Again, he reported the use of a cane and a  
21           wheelchair when in a casino, and again noted he has  
22           good pulses in both lower extremities, and on the  
23           right, you see that?

24          A.     Yes, sir.

25          Q.     No reason to disagree with that?

1           A.     No.

2           Q.     Right?

3           A.     No.

4           Q.     Again, the graft was open at that time and  
5 reflects into the pulse?

6           A.     That is the reason he's checking pulses, he  
7 wants to see if the graft is open?

8           Q.     Sure is.

9                   Then he reports that he was doing -- if you  
10 look at the assessment and plan portion at the very  
11 end, and it says, assessment of plan.

12                   And it says, he will continue on Xarelto  
13 and will continue that.

14                   He will continue to do his walking  
15 elevation and compression stockings, and I will plan,  
16 next page, to see him again in six months to a year  
17 for a pulse check.

18                   Currently he has a strong anterior tibial  
19 pulse and good capillary refill by physical  
20 examination.

21                   You see that?

22           A.     Actually, it's different than what he's  
23 saying earlier, but in essence kind of saying the  
24 same thing, he has pulses.

25           Q.     You have no reason to disagree with that?

1           A.     No.

2           Q.     And are you aware, have you seen any  
3 records from on Mr. Moore that in fact Mr. Moore on  
4 December 21, 2016, four days before he arrived in the  
5 emergency room department, he was seen at the Nevada  
6 Spine -- or excuse me, the Nevada Pain Clinic?

7           A.     I'm sorry.

8                   Is that a question?

9           Q.     Yeah.

10                   Have you seen any of those records?

11          A.     I don't remember.

12                   A few years went by perhaps.

13          Q.     And do you know if based on your review of  
14 the records from whatever source, do you know if Mr.  
15 Moore had actually been treated on a regular basis  
16 for chronic back pain?

17          A.     I think he did.

18          Q.     And do you know if any of those times he  
19 was also reporting leg pain as well, and calf pain?

20          A.     Could be.

21          Q.     And do you know what was done on any of  
22 those occasions by the physicians there to determine  
23 whether or not there was any sort of vascular  
24 insufficiency, or arterial insufficiency?

25          A.     I don't remember.

1 I'm not sure.

2 It's a spinal, probably not a vascular  
3 point of view.

4 Q. Okay.

5 Were you aware -- Have you seen any of the  
6 medical records from Walgreen's, the pharmacy that  
7 Mr. Moore received his prescriptions from?

8 A. Perhaps. I mean, a few years back.

9 I don't remember.

10 Q. I know you don't remember reviewing Dr.  
11 Wiencek's chart, ever going through it, but do you  
12 recall from either the Walgreen's records or Dr.  
13 Wiencek's records the fact that on December 27, 2016  
14 a phone call was placed to refill his prescription  
15 for Xarelto?

16 A. It's possible.

17 He was discharged on Xarelto.

18 Q. And a call was made to Dr. Wiencek's  
19 office, and Dr. Wiencek called in the prescription  
20 for Xarelto, were you aware of that?

21 A. I'm not aware, number one.

22 Number two, I'm not sure if Dr. Wiencek did  
23 it on the 27th.

24 This is an automatic refill. My office  
25 does them all the time. Sometimes I don't even know

1 about it so --

2 Q. And you have not seen any records to  
3 indicate that that was an automatic refill, did you?

4 A. I don't remember, but also I don't see any  
5 records that Dr. Wiencek personally called the  
6 pharmacy and said, we need to do it.

7 Q. Right.

8 Because you have not seen those records?

9 A. I don't remember.

10 So perhaps we can put them on the screen.

11 Q. Sure.

12 Let's look at page 18.

13 This is Dr. Wiencek's records still,  
14 Exhibit 109.

15 It's is RC-18, and right up at the top, go  
16 right there, and zero in. You see that is December  
17 27, 2016, right?

18 You ever seen this record before?

19 A. Perhaps.

20 I don't remember.

21 Q. Okay.

22 You see where it says fax refill to  
23 Walgreen's with refill per Dr. Wiencek?

24 It doesn't say that was an automatic  
25 refile, right?

1           A.     The patients call says, if run out of  
2 medication, call my office, and as per Dr. Wiencek  
3 the office or nurse says, hey, John Doe ran out,  
4 should we just refill that, and I say, sure, go ahead  
5 and give him two months or three months, and then  
6 they faxed for Xarelto as per Dr. Wiencek, which is  
7 right.

8           Q.     Sure.

9                   What I'm getting at isn't one of your  
10 criticisms, doctor.

11                  You mentioned in your deposition there was  
12 an inadequate follow-up by Dr. Lasry, as well as  
13 Nurse Practitioner Bartmus, they didn't give proper  
14 instructions for him to follow-up with his vascular  
15 surgeon, isn't that what you stated in your report  
16 and testified at your deposition?

17          Q.     It's different.

18                  May I explain?

19          Q.     Your counsel can explain that.

20                  But this --

21          A.     You're correct, I had an issue with that,  
22 and I continue to have an issue.

23                  I don't think I agree.

24          Q.     You would agree with me that this  
25 documentation suggests Mr. Moore would have called in

1 a prescription on December 27th before he returned,  
2 the day before he returned to the hospital with the  
3 complaints of the severe pain and discoloration to  
4 his leg, correct?

5 A. I'm not sure I understand the question.

6 Q. Sure.

7 December 27 was the day before he went into  
8 the emergency department again, right?

9 A. Yes, sir.

10 Q. This would reflect a phone call was placed  
11 to Dr. Wiencek to refill his Xarelto, correct?

12 A. A hundred percent correct, that's all it  
13 shows.

14 Q. Okay.

15 And we don't know what was explained to Dr.  
16 Wiencek about whether the patient informed him what  
17 had happened in the hospital, or whether he needed to  
18 make an appointment, we don't know any of that  
19 information, right?

20 A. Although, we know what is written here.

21 You are correct.

22 Q. Okay.

23 Now, I think we talked about, you don't  
24 have an issue with the fact he had been diagnosed  
25 with a DVT previously, and we cleared that whole

1 situation based on the visit on December 25.

2 I want to go back now to the December 25th  
3 visit, okay?

4 You don't have a problem with the fact that  
5 Nurse Practitioner Bartmus had indicated in her  
6 records that a prior history of DVT had been  
7 reported?

8 A. I don't have a problem with that, sir.  
9 I think it's correct.

10 Q. Do you recall from reading Christopher  
11 Moore's deposition, that Christopher Moore testified  
12 that that is what was conveyed to the hospital  
13 personnel, he had a prior history of DVT, you're  
14 aware of that testimony?

15 A. Yes, but there -- First of all, let me  
16 simplify this.

17 I'm not in any way, shape, or form critical  
18 of her ordering an ultrasound for the DVT, but it was  
19 communicated to the emergency room team he had a  
20 prior history of clot in the leg, which is my  
21 understanding they totally thought there was only a  
22 DVT, versus a clot in the the leg, being the clot in  
23 the leg after the graft.

24 Q. We'll get to that, and now we'll pull the  
25 actual records.

1                   These are the records from St. Rose on  
2                   December 25, Exhibit 100, and it's starting at 1331.

3                   Now, doctor, you have those in front of  
4                   you?

5                   A.     Yes, sir.

6                   Q.     You have seen these records before, right?

7                   A.     Yes.

8                   THE COURT:   Previously admitted.

9                   MR. MC BRIDE:   Thank you, Your Honor.

10                  BY MR. MC BRIDE:

11                  Q.     And, in fact, this would indicate that one  
12                  of the things -- First of all, in terms of Mr.  
13                  Moore's past medical history, which was significant,  
14                  I think you agreed in your deposition with the fact  
15                  Mr. Moore was a long-time smoker?

16                  A.     Correct, sir.

17                  Q.     And I think you stated pretty clearly that  
18                  smoking is not good for your arterial perfusion,  
19                  right?

20                  A.     Correct, sir.

21                  Q.     In fact, it's something that you would  
22                  advise every one of your patients, they should do  
23                  their best to try to quit smoking, especially if they  
24                  have a condition and surgery that Mr. Moore had in  
25                  2012, right?

1           A.     Correct, sir.

2           Q.     And that would be something you would  
3 repeat to a patient every time you saw that patient  
4 in follow-up for a pulse check or other visits in the  
5 hospital, that they -- you would advise them to stop  
6 smoking, right?

7           A.     Yes, sir.

8           Q.     And is part of the reason because that can  
9 -- smoking has been proven to actually affect the  
10 arterial and vascular system in human beings?

11          A.     Yes, sir, you're correct.

12          Q.     And it would have some effect on his  
13 arterial occlusive disease,, correct?

14          A.     Yes, correct.

15          Q.     You're aware that despite -- and again, I'm  
16 sure you had patients who despite your best effort to  
17 try to advise them to stop smoking, it's a difficult  
18 habit to break, and they continue to smoke, right?

19          A.     Most of them, yes.

20          Q.     And a lot of those patients still continue  
21 to have problems with arterial occlusion, as long as  
22 they keep smoking, right?

23          A.     Well, some do, some don't.

24                   I can explain that.

25                   In other words, smoking is not good for the

1 blood vessels.

2 People, they don't smoke, end up with bad  
3 occlusive disease, and people that smoke, they don't  
4 have it that bad, but over all it's not -- it's good  
5 for them not to smoke, but it's not a great limited  
6 step, we advise them not to smoke.

7 Q. Gotcha.

8 You're aware in this case Mr. Moore  
9 continued to smoke, and even at the time of his  
10 deposition I believe, unless he's been able to stop  
11 that at the time of his deposition, I took that he  
12 continued to smoke one or two packs a day, do you  
13 remember that?

14 A. Yes, sir.

15 Q. Now, with regard to this note, and in  
16 particular the information that was provided, did you  
17 say that there was no indication that Dr. Lasry and  
18 Nurse Practitioner Bartmus were aware of any history  
19 of prior occlusions?

20 A. Actually, I said the opposite.

21 I said, two things.

22 I said, in their differential diagnosis,  
23 which I don't have to look at your screen because I  
24 know it by heart, there's nowhere mentioned the  
25 possibility of arterial insufficiency, like not

1 enough blood flow to the arteries to the foot.

2           There's a note from Miss Bartmus there was  
3 an old graft, and some history of clot could be  
4 computer-generated, but it's there, and again in the  
5 differential diagnosis this part is missing, but  
6 somewhere in the history it shows to be present.

7           Q.     Okay.

8           And I want to get to, you would agree with  
9 me that in terms of the gold standard to diagnose  
10 acute limb ischemia, would be to use the five Ps, you  
11 heard of that?

12          A.     It's not the gold standard.

13                     A gold standard is an angiogram.

14                     Five Ps is part of the physical exam. It's  
15 very objective. We have a screen there, subjective  
16 is perhaps not, so five Ps, this is going a hundred  
17 years back when our old doctors didn't really have  
18 all the tools we have.

19                     So no, I disagree.

20                     The five Ps are a basically -- actually not  
21 being used anymore.

22          Q.     So you're saying five Ps are irrelevant to  
23 a clinical examination of the patient in the  
24 emergency department?

25          A.     I'm not saying they are irrelevant.

1 I'm saying, they do not represent the  
2 standard of care.

3 The standard of care is done, actually not  
4 even the arterial duplex, the standard of care is an  
5 angiogram where the radiologist and vascular surgeon  
6 shoot contrast to make the circulation of the graft  
7 and see if the graft is open or closed.

8 This is 2020, we look at the screen, and we  
9 see it's not.

10 Five Ps refers to touching the leg and  
11 feeling if it's warm, if it's cold, if the patient  
12 can move it, those are usually not being done  
13 anymore.

14 Q. Okay.

15 Really.

16 Do you know why in terms of why the medical  
17 records we have from Dr. Wiencek after December 2016  
18 and other records from the hospitals that Mr. Moore  
19 treated as after the December of 2016, why they would  
20 then continue to use the five Ps?

21 A. Well, they are not using the five Ps.

22 They are using -- not really going to five  
23 Ps.

24 A physical exam you look at the leg, you  
25 touch the leg, you check the pulse, see if you feel

1 it, you ask them to move their leg, see if they are  
2 able to because a lot of ischemia, they don't move it  
3 very well.

4 There's a lot of issues. Scratch it, take  
5 a car key, scratch the toes, do you feel this, do you  
6 feel anything, and they tell you, the foot feels  
7 cold, the foot feels numb, they cannot move.

8 You tell them to press your foot like you  
9 press the gas pedal in, so indirectly it's physical  
10 exam, not really the five Ps, and you decide from  
11 there which way you're going to go.

12 Q. So in this particular case if you could  
13 just encourage me for a second on the five Ps, the  
14 five Ps would indicate pain, right?

15 A. Correct.

16 Q. Color?

17 A. Pain, yeah.

18 Q. And then that would be color, if it's  
19 colored, and pulselessness, right?

20 A. Pulselessness, pulse, or pulselessness,  
21 yeah.

22 Q. And paraesthesia, which is numbness, right?

23 A. Yeah.

24 Q. Are you aware from the medical records in  
25 fact Mr. Moore had reported at least to Dr. Wiencek

1 when he diagnoses some elements of neuropathy he  
2 developed in his lower left legs?

3 A. He did not have diabetes, but he might have  
4 had neuropathy.

5 I'm not sure.

6 Q. Neuropathy in short, that can cause  
7 numbness, right?

8 A. It could.

9 Q. And then paralysis, right, if you are not  
10 able to move or ambulate, then you're paralyzed,  
11 right?

12 A. Well, we go back to the five Ps, which is  
13 part of the physical exam.

14 It's not totally paralyzed -- Well, if it's  
15 paralyzed, that is what happened the 28th. Usually  
16 it's the lack of movement, hey, press the gas pedal,  
17 or press the clutch, and they can't do it, so it's  
18 lack of movement.

19 Nobody puts the five Ps, and then makes  
20 notes on them, but indirectly that is part of the  
21 physical exam, you look for things, yeah, and  
22 document that.

23 Q. So based on you comparing the physical  
24 examination performed on Mr. Moore in the emergency  
25 department when he was admitted back in 2014 for one

1 prior occlusion, right, you looked at those records?

2 A. When he got the graft initially?

3 Q. Yes.

4 A. Correct, yes.

5 Q. And then you also looked at the records  
6 from June 2015 where he had another occlusion,  
7 correct?

8 A. Yes, sir.

9 Q. You seen the medical records and what was  
10 documented under the five Ps by the physicians on  
11 both of those visits, right?

12 A. Yeah, well, was documented.

13 I mean, there's a discrepancy regards to  
14 him being or not being evaluated.

15 Q. In June you're talking about?

16 A. I'm talking when he came in, he -- no,  
17 December.

18 Q. I'm talking about you have seen those other  
19 visits where it was documented about what his  
20 presentation was under those five Ps from 2014 and  
21 2015, right?

22 A. Correct.

23 Q. And now you have seen additional  
24 documentation too from Dr. Wiencek, at least today,  
25 in terms of the adequate perfusion, at least no

1 reports of pain, those sorts of things would indicate  
2 Dr. Wiencek was doing a physical examination using  
3 that method, right?

4 A. Yeah, correct.

5 Q. So, in fact, you agree with me that on  
6 those other visits to the emergency department where  
7 an occlusion required the thrombolytic therapy, he  
8 was admitted for that purpose, you would agree with  
9 me his presentation on each of those two occasions  
10 was actually significantly different than what it was  
11 on December 25, 2016?

12 A. Not necessarily.

13 I mean --

14 Q. Well --

15 A. -- it's never the same.

16 It's like looking at two cars, two people,  
17 they are never the same, but it's sometimes -- I can  
18 only talk about what I think is important at the  
19 presentation on the 25th was generated, the  
20 amputation, or lack of treatment generated  
21 amputation.

22 As far as his depo, he complained that leg  
23 being a bit more cool and numb, and he shows up to  
24 the ER complaining of what is called claudication,  
25 which is clearly to represent vascular arterial

1 ischemia, so if somebody comes to the ER on the 25th,  
2 and that is what is important, it's not important  
3 what happened a year or two or six months before,  
4 it's important what happened the 25th, was that kind  
5 of issue, a different diagnosis should be generated  
6 including the DVT, but mainly including the arterial  
7 insufficiency, knowingly somewhere in those notes  
8 they document there was a fem pop graft that failed  
9 the year before, but you don't see it anywhere.

10 This was a working diagnosis, and in other  
11 words, is this graft op or not, can we do anything if  
12 it's closed to open?

13 That was never taken into consideration on  
14 the 25th.

15 Q. Okay.

16 Doctor, you would agree with me the  
17 presentation was different on those prior two visits  
18 where he required admission and thrombolytic therapy,  
19 you agree with that?

20 A. No.

21 Q. We could go back.

22 A. We can -- should go back.

23 I think it's fairly similar.

24 Q. You would agree that there was  
25 discoloration noted in 2015, right?

1           A.     I think there was, if I recall correct,  
2     yeah.

3           Q.     You would agree with me, there's no note of  
4     any discoloration at the visit in December of 2016,  
5     correct?

6           A.     The 25th.  
7                   The 28th there was discoloration.

8           Q.     The 25th I'm talking about. You would  
9     agree no discoloration, right?

10          A.     Correct, yes.

11          Q.     In fact, you remember reading Mr. Moore's  
12     deposition testimony where he said in fact that his  
13     leg looked normal, you remember that?

14          A.     Yes.

15          Q.     And do you remember what he said about his  
16     leg on the 26th and the 27th, you remember what he  
17     said?

18                   He said his leg looked normal, didn't it?

19          A.     Yeah.

20                   I one hundred percent agree with you.

21                   Unfortunately, he's not a doctor.

22          Q.     So let me ask my next question.

23                   It wasn't until December 28th when he noted  
24     severe cold, causing excruciating pain, and his foot  
25     and leg was black and blue or mottled, right?

1           A.     Mottled, that is dead.

2           Q.     Right.

3                     And that didn't have mottled presentation  
4 on the 25th, right?

5           A.     He didn't, correct.

6           Q.     Right.

7                     His leg --

8           A.     It was still salvageable at that time, the  
9 leg.

10          Q.     The leg was described within normal limits,  
11 right?

12          A.     By the ER team?

13          Q.     I'm talking about every source that you  
14 looked at from his own deposition testimony, his  
15 son's testimony, as well as the depositions also of  
16 Dr. Lasry and Nurse Practitioner Bartmus, as well as  
17 the medical records from St. Rose Hospital on  
18 December 25, they all indicated that his skin and  
19 appearance and the condition of his leg was otherwise  
20 normal, with the exception of a report of pain and  
21 numbness, correct?

22          A.     Well, somewhat incorrect.

23                     You are correct that the ER team, Dr. Lasry  
24 and Miss Bartmus, documented as normal.

25                     You are also correct he complained of pain

1 and numbness.

2           You forgot to bring up again the  
3 claudication, which is a clear sign of vascular  
4 ischemia.

5           And like I previously said, we're going to  
6 get there, it's the result of the ultrasound that is  
7 not normal, the ultrasound clearly shows the graft  
8 was closed, and that is highly abnormal.

9           So that is not a normal patient.

10          Q.    Okay.

11               Actually, now we're on that subject, that  
12 is a good segway, you talked about the ultrasound  
13 report, the venous Doppler ultrasound done by the  
14 radiologist at St. Rose, do you recall that?

15          A.    Yeah, it was done by the tech, not the  
16 radiologist.

17          Q.    Right, by the tech.

18               In that particular case, in fact, that is  
19 interpreted by a radiologist subsequently, right?

20          A.    Correct, by the tech initialing it, then by  
21 the radiology.

22          Q.    So you have two people looking at it, and  
23 in this case we were fortunate, as you indicated the  
24 tech actually went farther up to actually check out  
25 the arterial system and found a possible occlusion,

1 you remember him saying that in his report?

2 A. Appeared an occlusion, correct.

3 Q. Now, I think you -- Let me get to that  
4 page.

5 Here it is, it's 1411.

6 It's St. Rose Exhibit 100?

7 Doctor, I think you testified from  
8 questions from Mr. Arntz the radiologist who  
9 interpreted this and looked at the arterial and saw  
10 the evidence of the possible occlusion, that that  
11 radiologist stated, do something now, instructed the  
12 ER physicians to take action immediately, call a  
13 vascular surgeon, do more studies, clinical  
14 correlation if necessary, isn't that sort of what you  
15 -- to paraphrase what you said in response to Mr.  
16 Arntz?

17 A. Well, not exactly, but similar.

18 So the impression is, no evidence of DVT,  
19 so no clot in the foot, in the left lower extremity,  
20 left femoral graft appears occluded.

21 If you would be in a submarine, you would  
22 see a red light and a sound, this cannot be more of  
23 an emergency, those words here, those six words there  
24 represent flags, alarms, red lights, all over.

25 When a patient walks in, a patient who has

1 a history of clot, the fem pop -- has been clotted  
2 before, comes in with pain, comes in with basically  
3 being numb, and foot pain, the first thing you do,  
4 you rule out that the graft has to be open, and there  
5 was not part of the working diagnosis for them, so  
6 then the physician says, hey, that is what I think,  
7 at that point automatically if a computer would be  
8 available to have done it, an arterial duplex gets in  
9 right away, your arterial part, and generate an  
10 angiogram to follow, you would hope, so -- but that  
11 wasn't done, that's my point.

12 Q. My point was really more to what you  
13 testified earlier where you said that the -- I'll let  
14 the jury decide what you actually testified to, but I  
15 had in my note that you said the radiologist reported  
16 that something needs to be done, a vascular surgeon  
17 needs to be consulted, or an arteriogram needed to be  
18 performed.

19 That is not what it says in that report,  
20 correct?

21 A. Not directly, no.

22 That is my interpretation of those words.

23 Q. Right.

24 In fact, you have seen reports that have  
25 come back from a radiologist when they happened upon

1 a finding that wasn't maybe something that they  
2 expect to find or not the main purpose of the exam,  
3 where they've actually used the term further clinical  
4 correlation is recommended or suggested, correct?

5 A. I've seen that, yes.

6 Q. And it happens quite often, right?

7 A. It's up to the radiologist.

8 Q. Sure.

9 A. It's not up to the radiologist who reads  
10 the film to tell the ER physician or vascular surgeon  
11 what needs to be done.

12 All they need to say is, whatever they  
13 said, this seems to be occluded, and I figure out, or  
14 the ER physician or Nurse Practitioner, what needs to  
15 be done.

16 Unfortunately, because they were never  
17 looking at this issue, they have done nothing about  
18 it.

19 Q. But this is something you would agree with  
20 me the purpose of this study was to rule out a DVT,  
21 right?

22 A. A hundred percent.

23 Q. So in the context of that you'd say the  
24 radiologist actually found is this additional, quote,  
25 unquote, abnormal finding, right?

1           A.    I don't need quote, unquote.

2                    It's definitely abnormal.

3           Q.    In that particular case you would agree  
4 with me that since this wasn't the specific test for  
5 it, that the language that the radiologist, if he was  
6 concerned about it, would be to recommend further  
7 clinical correlation with other studies, that's the  
8 language that is used all the time by radiologists,  
9 right?

10          A.    Not all the time.

11                    It's used at times.

12                    But it's not the radiologist's job to be  
13 concerned, it's the ER job to be concerned.

14                    So all what he said, he reads films, he's  
15 objective, looks there, sees what it says, and he  
16 reports it.

17                    It's up to the doctor who cares for the  
18 patient what to do.

19                    He could call the ER, he could be -- he as  
20 a vascular surgeon -- he could start the Heparin, he  
21 could do a lot of things, or do anything. It's their  
22 responsibility, not the radiologist's responsibility.

23          Q.    I understand you don't have any criticisms  
24 of any of the hospital personnel or the nurses who  
25 actually cared for Mr. Moore on December 25th, isn't

1     that right?

2           A.     You are correct.

3           Q.     So you have no criticism of the exam that  
4     Nurse Kuchinsky did initially, which demonstrated  
5     that the patient's leg was normal and warm, and not  
6     cold or blue, you don't have any disagreement or  
7     concerns with her examination that night?

8           A.     Actually, I agree with the examination.

9                   I don't think there's anything unusual.  I  
10    think she done the right thing, yeah.

11          Q.     Now, in this particular case on the  
12    ultrasound it demonstrated the venous flow was shown  
13    to be normal, right?

14          A.     Correct.

15          Q.     So in order -- You agree with me, in order  
16    for there to be normal flow in the veins against  
17    gravity towards the heart, back up to the heart,  
18    there has to be sufficient blood flow down the  
19    arteries, true?

20          A.     There has to be some flow, which I earlier  
21    spoke about the collaterals, so this leg didn't die  
22    in six hours, that is where the leg was warm, the leg  
23    never had a pulse, but there were collateral enough  
24    to keep it going for three days until everything  
25    clotted, and they had to amputate it, and that's all

1 based on the small collaterals he had for years.

2 Q. Did you see anything -- I wanted to talk  
3 about that.

4 Do you see any reference in the 12/25 visit  
5 that any examination demonstrated -- or a complaint  
6 by Mr. Moore of coldness into the toes specifically?

7 A. I don't remember.

8 He did complain of a cool leg, cold leg,  
9 colder leg, but that is exactly what happened.

10 Q. And I'm just trying to limit it.

11 I know what he testified in his deposition.

12 I'm talking about specifically, did you see  
13 a reference to cold toes?

14 A. I don't remember.

15 Q. Are you aware that one of the visits that  
16 he had in the emergency department, I believe it was  
17 either in the 2014 or 2015 visit, that one of his  
18 reports of complaints was cold toes and calf, do you  
19 remember reading that?

20 A. I don't remember.

21 It's possible.

22 He can have those symptoms, yeah.

23 Q. So one of the articles you provided to us  
24 at the time your deposition is the Hanky article, you  
25 remember that?

1           A.     I provided 11 articles.

2                     I don't remember.

3           Q.     The Hanky article that talks about acute  
4 limb ischemia, do you remember that?

5           A.     Would you mind showing it to us?

6           Q.     We can't unfortunately, that is part of the  
7 rules of evidence, but do you recall reviewing an  
8 article on acute limb ischemia from Hanky?

9           A.     11 articles I brought, that's correct.

10                   MR. WEAVER: I'm sorry.

11                   I didn't hear what he said?

12                   THE WITNESS: 11 articles, 10 or 11.

13 BY MR. MC BRIDE:

14           Q.     Okay.

15                   And in that article, are you aware of that,  
16 that article, you agree with me it does not discuss  
17 the diagnosis and treatment of chronic limb ischemia,  
18 true?

19           A.     Actually, I don't remember right now as I  
20 sit here.

21                   The articles were just looked at are again  
22 data likely previously said, the articles don't  
23 represent the standard of care, either the guidelines  
24 don't necessarily represent the standard of care for  
25 a patient.

1           I truly believe if I can help you, that  
2   this was not -- Well, there was chronic -- in terms  
3   of he had vascular disease for many years, and there  
4   was an acute presentation, which is a definition less  
5   than two weeks that got him on the Christmas day in  
6   the emergency room.

7           So I'm more concerned about the acute part  
8   of the presentation.

9           Q.    In particular I just wanted to talk very  
10   quickly about the article that mentions the  
11   classification system.

12           Are you aware of that classification system  
13   to determine a viable limb?

14          A.    Yes.

15          Q.    And --

16          A.    12 and --

17          Q.    Type one is a viable limb, not immediately  
18   threatened, no sensory or muscle weakness?

19          A.    Correct.

20          Q.    And then you have it progressively gets  
21   worst, up to the point of amputation is the only way,  
22   right?

23          A.    Correct.

24                1 is -- we all have a 1.

25                3 is dead on the 28th, and there's 2-A,

1 2-B, 2-A marginally threatened, 2-B seriously  
2 threatened, so when he showed up, he was a 2-A, 2-B,  
3 that's why the leg didn't die within six hours  
4 because you're giving out, the collaterals were good  
5 enough to support a leg for that long.

6 Q. A 2-A.

7 That particular article also talks about  
8 the five Ps?

9 A. You could talk --

10 Q. I'm asking you this question:

11 Do you agree with me that article discusses  
12 the five Ps as a way to diagnose acute limb ischemia,  
13 using that classification --

14 MR. P. HYMANSON: Excuse me.

15 May we approach, Your Honor?

16 THE COURT: Yes.

17 (Thereupon, a discussion was had between  
18 Court and counsel at sidebar.)

19 THE COURT: Thank you.

20 All right. You may proceed with further  
21 questioning.

22 BY MR. MC BRIDE:

23 Q. All right.

24 Now, Dr. Wilson, you asked a question, if  
25 you know the expert on behalf of the Defense in this

1 case, Dr. Samuel Wilson, and you said that you did  
2 not know him, right?

3 A. Correct.

4 Q. Do you know -- Have you done any  
5 investigation into his background, or training, or  
6 experience based on reviewing his expert reports, or  
7 anything like that?

8 A. I Googled him.

9 Q. Okay.

10 Are you aware of what sort of reputation he  
11 owns as a physician in the California community as a  
12 vascular surgeon?

13 A. I don't know, sir.

14 Q. Are you aware of the textbook that Dr.  
15 Wilson has authored, and other textbooks he's  
16 authored over his career, in the field of vascular  
17 surgery?

18 A. I'm not aware.

19 Q. Doctor, would you agree that physicians can  
20 disagree on recommendations of treatment for any  
21 given patient?

22 A. I do.

23 Q. And just because they disagree, that does  
24 not mean there was negligence on the part of a  
25 particular physician, correct?

1           A.    I agree.

2           Q.    Now, just very quickly -- Actually, I may  
3 be quicker than I thought.

4                    You have had your deposition taken, like we  
5 talked about, over 50 times, or close to 50, lower  
6 than 50?

7           A.    Yes.

8           Q.    And --

9                    THE COURT:  Not in this particular case.

10                   MR. MC BRIDE:  Right.

11 BY MR. MC BRIDE:

12           Q.    And, doctor, you provided us with a list of  
13 your testimony at trial and depositions before today,  
14 and I think it went back to 2015.

15                    Do you recall reviewing that particular  
16 publication?

17           A.    I --

18           Q.    You listed all the trials you testified in?

19           A.    My own list.

20           Q.    Yes.

21           A.    Yeah, I made the list.

22           Q.    So at least since 2015 by my count there  
23 were at least 18 depositions, and I think three  
24 trials, one mediation.

25                    Does that sound about, right?

1           A.     Probably more than that I think, but it's  
2     probably right.

3           Q.     Okay.

4                     You charge a flat rate \$1,000 for  
5     deposition, with a two-hour minimum, right?

6           A.     That's correct.

7           Q.     And in this particular case your deposition  
8     took three hours, so you were given a check for  
9     \$1500, right?

10          A.     I believe so.

11          Q.     And then you charged \$650 an hour, it's  
12     \$650 an hour?

13          A.     It should be more than that.

14                     I think he needs to write me a check then.

15          Q.     \$650 an hour for review of records, is that  
16     right?

17          A.     That's correct, sir.

18          Q.     \$650 an hour for review of the literature,  
19     correct?

20          A.     Yes, that's correct.

21          Q.     Let me ask you, do you have any idea -- and  
22     that is \$650 an hour for report preparation, right?

23          A.     That's correct.

24          Q.     As you sit here, do you have an estimate of  
25     the total amount of time that you have spent

1 reviewing the records in this case, preparing your  
2 report, and preparing for trial here today?

3 A. No, I do not, sir.

4 Q. Is it more than 20 hours?

5 A. Yes, definitely overall for the last few  
6 years.

7 Q. Yes?

8 A. I hope so, yeah.

9 Q. More than 30 hours?

10 A. I just don't know.

11 This was two years I think, yeah.

12 Q. Do you keep track of the amount of time you  
13 spend, in order to bill to the Plaintiff's attorney?

14 A. I do, and you have my bills, you have my  
15 invoices, so I think you know better than I do.

16 Q. You don't have those with you?

17 A. No, I provided them to you at the  
18 deposition.

19 Q. In terms of whatever those invoices reflect  
20 in terms of the amount of time that you have spent up  
21 to the time of your deposition, that would be  
22 accurate, right?

23 A. That's correct.

24 Q. And then how about since your deposition  
25 October of 2019, to today, how much time, additional

1 time, have you spent reviewing and preparing for your  
2 trial testimony?

3 A. I'm not sure.

4 I spent a fair amount of time just looking  
5 through records and so on, so I'm not sure.

6 Q. So those bills we don't have.

7 So that's why I am trying to get your best  
8 estimate.

9 Can you estimate, was it more than 20  
10 hours?

11 A. I would have to check.

12 More than 10 for sure.

13 Q. Is it fair to stay 10 to -- 10 to 20 hours?

14 A. Perhaps.

15 Q. Then you also charge 10,000 a day for trial  
16 testimony?

17 A. That's correct.

18 Q. Not including travel expenses, right?

19 A. That's correct.

20 Q. Did you come up last night or today?

21 A. Last night.

22 Q. Did you have a meeting with counsel to go  
23 over your testimony here today?

24 A. No, I had a meeting for dinner.

25 Q. For dinner.

1 Did you talk about your testimony?

2 A. A little bit, yeah.

3 Q. You also advertise your services as an  
4 expert in several publications, right?

5 A. Well, depends how you perhaps -- I don't  
6 call it advertising, but I'm listed, could be for  
7 advertising, I'm listed in a certain directories, my  
8 office is, that's correct.

9 Q. And so you recall testifying in your  
10 deposition that there's several advertising -- or  
11 services that you have in your name listed as a  
12 potential expert, do you have your name listed as a  
13 potential expert in emergency medicine in any of  
14 those advertisements?

15 A. No, sir.

16 Q. You said you paid a couple of thousand  
17 dollars a year for advertising, is that right?

18 A. Mr. Weaver said that, and I actually agreed  
19 with him.

20 I wasn't sure, I think it's possible, yes.

21 Q. Do you know what the amount you spent for  
22 advertising was?

23 A. No, sir, but it sounds right.

24 Q. Let me check my notes.

25 A. I think your firm is probably one of the

1 advertised in, I've been one of your experts a few  
2 years ago.

3 Q. One of my experts?

4 A. Yeah, your law firm you work for.

5 Q. Well, I've met you before today, right?

6 A. No, I'm saying the law firm, I've been an  
7 expert for you guys as a Defense expert, and they  
8 said they found me --

9 Q. I don't know how it turned out because I  
10 never met you before today, and so at any rate I'm  
11 glad you were happy.

12 Are you aware, you have read Dr. Jacobs,  
13 the expert emergency room physician for the  
14 Plaintiff, you read his report and deposition?

15 A. I did, two reports actually, and a  
16 deposition, yes.

17 Q. Are you aware of Dr. Jacobs' testimony  
18 where he stated that it was irrelevant if Dr. Lasry  
19 even seen the patient, since he reviewed the case  
20 with Nurse Practitioner Bartmus.

21 Q. Can you repeat the question?

22 A. Sure.

23 Were you aware of Dr. Jacobs' testimony  
24 where he said it was irrelevant whether or not Dr.  
25 Lasry even saw the patient on December 25, as long as

1 he discussed the case with Nurse Practitioner  
2 Bartmus?

3 A. You asked me if I seen, or agree with his  
4 statement.

5 Q. I'm asking, have you seen that?

6 A. I don't remember that.

7 I think it's relevant.

8 If he said he did, and didn't do it, it's  
9 very relevant.

10 Q. And I think you testified too that you're  
11 not making any specific judgment on Dr. Lasry and  
12 whether he personally evaluated the patient, and you  
13 would leave that to the jury to decide, right?

14 A. I did say that.

15 MR. MC BRIDE: Thank you, doctor.

16 That's all I have.

17 THE WITNESS: Thank you, sir.

18 THE COURT: So we're going to go ahead and  
19 take our lunch recess now, then resume with Mr.  
20 Weaver's questioning and any redirect from counsel,  
21 but rather than be too far into the lunch hour, I  
22 think it's a good time to take a lunch break now.

23 We'll return at 1:30.

24 It's a little after 12 now, so that gives  
25 you enough time to find a place to eat.

1 (Jury admonished by the Court.)  
2 THE COURT: Have a good lunch.  
3 See you at 1:30.  
4 (Jury excused from the courtroom.)  
5 (Thereupon, the following proceedings were  
6 had out of the presence of the jury.):  
7 THE COURT: Just to make a record --  
8 Doctor, you may step down.  
9 Actually, probably just leave them there.  
10 We're coming back after lunch with your testimony.  
11 There was a brief bench conference seeking  
12 to discuss -- or raising an objection --  
13 THE MARSHAL: One of the jurors said they  
14 have a question.  
15 MR. MC BRIDE: Let's wait.  
16 THE COURT: Find out what it is, and they  
17 can write a note.  
18 Assuming it's related to the trial or  
19 witness?  
20 THE MARSHAL: To the witness.  
21 THE COURT: Remind them it's at the end of  
22 the questioning of the witness, but they can  
23 certainly write their question down to have it read.  
24 Back to the bench conference.  
25 So Mr. Hymanson had posed an objection

1 because Mr. McBride was discussing an article with  
2 the doctor, and some specific article component, and  
3 of course the doctor had indicated he reviewed up to  
4 10 or 11 articles, and so Mr. Hymanson was concerned  
5 that way of questioning would continue, it would be  
6 imperative to have the specific article referenced  
7 shown to refresh the recollection of the doctor.

8 Mr. McBride indicated he thought he had  
9 given sufficient specifics to that article,  
10 specifically he did not intend to have further  
11 inquiry about other articles, so I think the  
12 questioning went on to another path after that.

13 Mr. Hymanson or Mr. Arntz, anything you  
14 want to add to the bench conference?

15 MR. P. HYMANSON: No, Judge.

16 MR. ARNTZ: No.

17 THE COURT: Mr. McBride?

18 MR. MC BRIDE: No, Your Honor.

19 THE COURT: I did instruct counsel if he  
20 was going to continue to inquire about particular  
21 articles, he should either have that article itself,  
22 or as much as possible, so to attempt to refresh the  
23 recollection of the witness, but it wasn't necessary.

24 We'll see you all back, get started at  
25 1:30.

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MR. WEAVER: Thank you, Your Honor.  
(Thereupon, a luncheon recess was had.)

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REPORTER'S CERTIFICATE

I, Bill Nelson, a Certified Court Reporter  
in and for the State of Nevada, hereby certify that  
pursuant to NRS 2398.030 I have not included the  
Social Security number of any person within this  
document.

I further Certify that I am not a relative  
or employee of any party involved in said action, not  
a person financially interested in said action.

          /s/ Bill Nelson          

Bill Nelson, RMR, CCR 191

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) SS .

I, Bill Nelson, RMR, CCR 191, 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.

/s/ Bill Nelson

Bill Nelson, RMR, CCR 191  
Certified Court Reporter  
Las Vegas, Nevada

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