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

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 21st 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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TRAN

IN THE EIGHTH JUDICIAL DISTRICT COURT
CLARK COUNTY, NEVADA

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

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

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.

I N D E X

WITNESS	DR	CR	RDR	RCR
Dr. Alexander Marmureanu	9	48		

Las Vegas, Nevada, Friday, January 31, 2020

* * * * *

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

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

MR. WEAVER: Good morning, Your Honor.

I brought this to Mr. Arntz's attention this morning, but I was waiting for the transcript, just to be sure, and I'm sure we'll get it soon, but the issue is the Defense believes yesterday Mr. Arntz's opening he he said to the jury there were one or more items on the lifecare plan, I think the example was wheelchairs, but I think there was other things that Mr. Moore, quote, unquote, could not afford, that Dr. Fish, who is testifying this afternoon testified in his deposition the medical -- necessary medically indicated items on the lifecare plan would be covered by Medicare, and especially with regard to one wheelchair, not that there was payment issued, not there wasn't Medicare issued.

The only reason Mr. Moore doesn't have the electric wheelchair is because as of a few months ago he hasn't been fitted for it.

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

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

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

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

THE COURT: Okay.

So let's wait until we get the transcript.

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

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

MR. WEAVER: This morning.

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

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

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

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

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

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

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

MR. WEAVER: Thank you, Your Honor.

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

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

Do you anticipate any other witnesses today?

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

We can go with their son.

THE COURT: All right.

We'll see where we are at.

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

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

THE COURT: Thank you.

The jury's now present in the courtroom.

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

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

MR. ARNTZ: I call Dr. Alexander Marmureanu.

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

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

DR. ALEXANDER MARMUREANU,

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

THE CLERK: Please be seated.

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

THE WITNESS: Sure.

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

THE COURT: Thank you.

- - - -

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

surgery, vascular surgery.

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

A. Yes, sir.

Q. Let's go through your qualifications.

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

Do you know Dr. Wilson?

A. No, sir.

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

Q. Okay.

Currently what are your positions you hold?

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

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

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

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

Q. What types of past positions have you held?

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

Q. I can --

A. Let me answer the best way I can.

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

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

Q. Are you board-certified?

A. Yes.

Q. What are you board-certified in?

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

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

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

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

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

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

You are fellowship-trained?

A. Yes, sir.

Q. That is different than being board-certified?

A. That's correct.

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

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

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

Q. Okay.

What faculty positions have you held over the years?

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

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

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

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

Q. You have been on a number of different

medical school committees.

What does that involve?

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

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

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

Q. Okay.

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

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

So all those companies coming out, they

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

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

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

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

A. The answer is, yes.

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

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

So medicine is not separate.

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

in to my area.

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

A. Yes, sir.

There's only one standard of care.

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

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

A. Every day, sir.

Q. Okay.

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

A. Yes.

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

A. Yes, sir.

The standard of care was breached by both of them.

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

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

Q. Right.

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

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

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

Now, there are certain key words.

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

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

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

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

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

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

MR. ARNTZ: Can I use this?

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

THE COURT: I understand.

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

So we have an easel here.

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

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

THE WITNESS: I fully agree with you.

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

MR. ARNTZ: Yes.

There's some markers there.

BY MR. ARNTZ:

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

A. May I show --

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

Counsel can relocate to see what you are doing.

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

can see it?

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

I want them to see it.

MR. ARNTZ: You bet.

THE COURT: Okay.

THE WITNESS: So he comes to the ER basically with this pain.

We know he's not a normal patient.

In 2012 -- Let me draw this quick.

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

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

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

BY MR. ARNTZ:

Q. Splits?

A. Splits.

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

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

and that's where it is.

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

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

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

The most important thing is that the jurors hear.

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

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

THE COURT: I know.

Slow down, and speak up.

THE WITNESS: So this is the knee here.

This is the groin.

This is the femoral artery.

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

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

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

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

Take your time, and speak up.

BY MR. ARNTZ:

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

A. A lot of information.

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

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

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

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

After the fem pop he had signals in one of

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

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

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

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

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

This is going to be extremely important for this trial.

So he had this by-pass done in 2012.

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

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

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

understand what the issue is.

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

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

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

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

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

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

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

First of all, the gentleman never had, for

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

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

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

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

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

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

Q. Doctor, just a second --

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

THE COURT: Any objection?

MR. MC BRIDE: No, Your Honor.

THE COURT: We understand that to be

multiple binders as well.

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

THE COURT: I could stand corrected.

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

MR. ARNTZ: Okay.

You're right.

I apologize.

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

MR. ARNTZ: Okay.

THE COURT: Any objection to the admission?

MR. MC BRIDE: No, Your Honor.

THE COURT: All right.

101 is admitted.

BY MR. ARNTZ:

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

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

A. SRDSMR-00081.

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

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

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

I got one that works.

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

THE COURT: Yes.

THE WITNESS: 2012ish clinically no blood flow.

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

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

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

So this is the diagnosis for surgery.

What did they do?

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

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

That is how bad this initial area was down here.

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

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

Can I have page two?

Q. Yes.

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

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

All this hope is in this graft.

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

So let's see what he did.

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

Then Doppler.

Why Doppler?

Because he wanted to feel it.

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

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

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

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

So let me say this one more time.

We have the by-pass.

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

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

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

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

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

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

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

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

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

How can you have normal blood flowing here? Impossible.

Q. Didn't he lose his leg sometime sooner?

Did you -- Let me ask this question.

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

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

We know he had a fem pop graft.

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

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

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

Now, you close the graft.

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

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

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

He never had pulses there with the graft open.

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

However, here's what happens:

The clot creates clots.

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

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

is called TPA, which is a clot buster.

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

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

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

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

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

What brings him here?

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

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

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

They sent him home with no answer.

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

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

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

Q. Go ahead and have a seat.

A. Thank you.

Q. Okay.

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

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

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

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

calf, but it should be ruled out.

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

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

They should have been done together.

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

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

Where is that blood coming from?

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

There was flow in the vein.

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

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

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

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

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

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

That is exactly what happened.

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

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

A. I'm not sure it was documented.

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

graft is there. This study is the one.

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

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

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

A. Well, a few things.

Q. Let me ask you one thing.

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

A. Absolutely not.

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

The angiogram is done with contrast, and

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

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

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

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

So there are many options that can be used

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

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

So that's where we're at.

Q. Is redoing the graft an option?

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

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

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

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

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

Where is the blood coming from?

Impossible.

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

A. Absolutely not true.

I never said this.

I challenge them to show me that.

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

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

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

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

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

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

A. No.

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

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

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

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

A. Yes.

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

A. Let me interrupt you for a second.

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

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

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

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

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

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

The second time they didn't.

The third time they did the right thing.

The leg was dead, called outflow.

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

just not true.

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

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

A. Yes, sir.

Q. What does that mean?

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

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

The gentleman ended up with an amputation.

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

A. Yes, sir.

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

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

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

A. Yes, sir.

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

A. Yes, sir.

Q. Okay.

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

You treat patients for that?

A. I do amputations.

Obviously above the knee amputation is worse.

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

You know, somebody ran in the Olympics.

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

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

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.)

(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.)

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

THE COURT: Anything before we bring the jury in?

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

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

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

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

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

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

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

THE COURT: Okay.

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

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

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

THE WITNESS: Yes, I do.

- - - -

CROSS-EXAMINATION OF DR. ALEXANDER MARMUREANU

BY MR. MC BRIDE:

Q. Good morning, Dr. Marmureanu.

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

A. Apologies accepted.

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

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

A. Okay.

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

A. Yes, I do, sir.

I have it right here, sir.

Q. Do you have it in front of you?

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

A. I think I did.

I don't remember, I probably did.

I usually do.

I don't remember about this one.

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

A. That's correct.

Q. And --

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

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

A. Yes, sir.

Q. Well over 30 times?

A. Yes, sir.

Q. Approximately over a hundred times over your career?

A. Approximately less than 50.

Q. Less than 50, but more than 30?

A. Yes, sir.

Q. All right.

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

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

A. Correct, sir.

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

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

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

A. No, sir, it covers everything.

Let me explain.

Every cardiac case has vascular in it.

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

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

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

A. Yes.

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

A. Well, somewhat.

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

Q. Certainly.

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

A. True.

Q. All right.

You are not an emergency room physician, a

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

A. True.

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

A. True.

Q. All right.

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

A. Pretty much.

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

Q. Right.

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

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

A. Correct.

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

A. Yes, sir.

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

A. Correct, sir.

Q. All right.

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

A. Let me repeat this.

You are a hundred percent correct.

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

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

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

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

A. Or cardiac or thoracic, yes.

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

A. True, sir.

Q. All right.

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

A. True, sir.

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

A. Correct.

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

A. True.

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

A. And vascular, sir.

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

A. Yes.

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

sure exactly how they call me.

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

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

Q. All right.

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

A. Correct, sir.

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

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

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

myocardial infarction.

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

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

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

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

A. Correct.

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

A. Well --

Q. Is that correct?

A. Can you repeat the question?

Q. Sure.

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

A. Somewhat.

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

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

A. Yes, sir.

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

room, true?

A. True.

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

Do you have your deposition?

A. Which page?

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

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

You just want that version for now?

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

THE WITNESS: I have a copy.

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

THE COURT: Yes, you may.

THE COURT: Okay.

BY MR. MC BRIDE:

Q. All right.

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

those questions of you at your deposition?

A. I remember very well.

Q. Okay.

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

A. That's correct.

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

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

I have the page.

I understand standard of care is individual.

Q. Let's talk about that.

I'll direct you actually to your testimony.

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

A. Which page?

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

A. 48?

Q. Yeah, for -- Actually go back.

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

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

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

THE WITNESS: I can't wait.

BY MR. MC BRIDE:

Q. Go to page 47, if you will.

A. I'm here.

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

A. Line 7?

Q. Line 7.

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

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

A. No, sir.

Where are you reading?

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

A. I disagree with that.

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

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

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

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

A. I already did, sir.

Q. So you read it to yourself.

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

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

literature says?

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

Was that your answer, sir?

A. Yes, that's I said.

I disagree with it.

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

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

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

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

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

Q. Right.

Doctor, I understand.

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

with me.

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

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

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

THE COURT: Sure.

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

MR. P. HYMANSON: Thank you.

THE COURT: All right.

Thank you.

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

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

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

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

will be a line of inquiry.

All right?

THE WITNESS: Yes.

BY MR. MC BRIDE:

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

Read those to yourself if you could.

A. Page 48, sir?

Q. Page 48.

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

A. I did, sir.

Q. Perfect.

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

MR. ARNTZ: Excuse me.

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

Mr. Arntz.

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

record.

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

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

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

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

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

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

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

to keep it to the formality here.

BY MR. MC BRIDE:

Q. Okay.

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

A. I disagree to that, sir.

Q. Okay.

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

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

You're reading it wrong, sir.

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

Q. Sure.

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

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

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.)

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

THE COURT: Go ahead, everybody have a seat.

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

THE WITNESS: I'm sorry.

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

We have a process.

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

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

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

answers, and I ask you to answer them.

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

Mr. Arntz.

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

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

So there's more to his answer.

THE COURT: That is not the problem.

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

That's not the problem, Mr. Arntz.

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

You let him ask the questions.

If you think there's something else you can

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

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

What is your question?

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

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

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

I'm saying, let me repeat the question.

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

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

THE DEFENDANT: Between five to ten times.

THE COURT: Then you know how this works.

THE DEFENDANT: I don't know about this.

THE COURT: You know how this works.

He's cross-examining you.

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

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

THE WITNESS: I'm sorry.

Thank you.

THE COURT: Can we get this back on track?

MR. MC BRIDE: Yes.

Thank you.

THE COURT: All right.

Thank you.

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

THE COURT: Please have your seats.

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

THE WITNESS: Yes, I do.

THE COURT: Thank you.

BY MR. MC BRIDE:

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

I want to ask you a couple of other

questions first of all.

A. Okay.

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

A. Yes, sir.

Q. And what did you talk about?

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

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

A. That's what I remember.

I went to the bathroom.

I asked him where was the bathroom.

And I asked if I could get more water.

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

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

I don't --

Q. I don't mean to interrupt.

Were you done?

A. Actually, I don't remember.

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

Q. All right.

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

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

Can you be more precise?

Q. Sure.

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

A. I remember that.

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

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

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

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

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

A. Yeah.

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

A. I don't understand your question.

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

Q. Sure.

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

A. Not necessarily.

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

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

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

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

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

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

A. Incorrect, and I can explain that.

Q. You know what, your counsel --

A. I can explain that to the jury.

Let me clarify.

Heparin is not a thrombolytic. You said IV thrombolytic.

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

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

A. It's not eventually.

You are started promptly.

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

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

A. Yes.

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

clot was unable to be resolved, correct?

A. Incorrect.

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

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

A. I --

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

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

A. Correct.

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

A. Correct.

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

A. Incorrect.

Q. Okay.

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

A. Correct.

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

A. Wrong.

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

A. No, sir.

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

Q. Okay.

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

A. Correct.

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

A. Correct, sir.

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

A. Yes, sir.

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

A. Correct.

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

A. Correct.

Q. All right.

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

A. Ultimately, yes.

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

A. I'm not sure how to answer.

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

Q. Right.

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

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

those records.

Q. All right.

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

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

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

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

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

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

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

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

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

correct.

I wasn't aware, no.

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

A. No, sir.

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

A. 10 years, sir.

Q. All right.

And you have given 50 depositions, right?

A. Less than 50.

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

A. Yes.

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

A. That is wrong.

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

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

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

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

A. Yes, sir.

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

A. Yes.

Q. His wife, right?

A. Yes, sir.

Q. His son, Christopher?

A. Yes.

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

A. I don't remember, sir.

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

A. I don't remember.

Q. Do you know who Dr. Wiencek was?

A. I don't remember.

Q. Okay.

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

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

A. Wiencek.

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

A. I do not remember, sir.

Q. Right.

I didn't see it.

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

Take a look at the list.

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

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

A. Wrong, sir.

Q. Okay.

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

insufficiency?

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

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

A. I'm aware of that.

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

A. Correct, sir.

Q. All right.

Now, if I can refer you to --

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

MR. ARNTZ: No objection.

MR. WEAVER: No objection.

THE COURT: 190 is admitted.

You may inquire.

MR. MC BRIDE: Thank you.

BY MR. MC BRIDE:

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

I think we're switched over.

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

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

A. Thank you.

Q. Actually, there we go.

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

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

Q. Okay.

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

A. I --

Q. Do you see that in the history of present

illness section?

A. I see that sir, yes.

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

A. I agree, sir.

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

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

Q. Okay.

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

A. Correct.

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

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

A. That sounds fair, yeah.

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

A. Sure.

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

A. Somewhat correct, somewhat incorrect.

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

Q. Right.

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

A. Yes, sir.

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

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

Q. Sure.

I'll show you that page in a second.

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

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

I'm not disagreeing, it's correct.

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

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

You have seen that?

A. Yes, sir.

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

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

A. And also the graft.

Q. Also the graft.

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

A. Yes and no.

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

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

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

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

A. We're saying the same thing.

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

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

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

A. May I explain?

Q. Sure.

A. You are somewhat correct, but mainly

incorrect.

Q. Okay.

That seems to be happening quite a bit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So you are correct, sir.

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

A. Yes, everything is inside.

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

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

A. That would have been easy to declot then.

Q. Right.

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

Mr. Moore returned on May 9, 2016 to Dr. Wiencek.

Have you seen that record before?

A. I don't remember.

Q. Okay.

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

A. Yes, sir.

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

A. Yes, sir.

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

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

A. Yes, sir.

Q. Not just the left leg?

A. Yes, sir.

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

A. Yes, sir.

Q. No reason to disagree with that?

A. No.

Q. Right?

A. No.

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

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

Q. Sure is.

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

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

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

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

You see that?

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

Q. You have no reason to disagree with that?

A. No.

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

A. I'm sorry.

Is that a question?

Q. Yeah.

Have you seen any of those records?

A. I don't remember.

A few years went by perhaps.

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

A. I think he did.

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

A. Could be.

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

A. I don't remember.

I'm not sure.

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

Q. Okay.

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

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

I don't remember.

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

A. It's possible.

He was discharged on Xarelto.

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

A. I'm not aware, number one.

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

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

about it so --

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

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

Q. Right.

Because you have not seen those records?

A. I don't remember.

So perhaps we can put them on the screen.

Q. Sure.

Let's look at page 18.

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

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

You ever seen this record before?

A. Perhaps.

I don't remember.

Q. Okay.

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

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

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

Q. Sure.

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

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

Q. It's different.

May I explain?

Q. Your counsel can explain that.

But this --

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

I don't think I agree.

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

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

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

Q. Sure.

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

A. Yes, sir.

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

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

Q. Okay.

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

A. Although, we know what is written here.

You are correct.

Q. Okay.

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

situation based on the visit on December 25.

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

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

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

I think it's correct.

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

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

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

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

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

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

A. Yes, sir.

Q. You have seen these records before, right?

A. Yes.

THE COURT: Previously admitted.

MR. MC BRIDE: Thank you, Your Honor.

BY MR. MC BRIDE:

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

A. Correct, sir.

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

A. Correct, sir.

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

A. Correct, sir.

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

A. Yes, sir.

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

A. Yes, sir, you're correct.

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

A. Yes, correct.

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

A. Most of them, yes.

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

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

I can explain that.

In other words, smoking is not good for the

blood vessels.

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

Q. Gotcha.

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

A. Yes, sir.

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

A. Actually, I said the opposite.

I said, two things.

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

enough blood flow to the arteries to the foot.

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

Q. Okay.

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

A. It's not the gold standard.

A gold standard is an angiogram.

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

So no, I disagree.

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

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

A. I'm not saying they are irrelevant.

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

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

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

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

Q. Okay.

Really.

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

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

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

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

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

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

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

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

A. Correct.

Q. Color?

A. Pain, yeah.

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

A. Pulselessness, pulse, or pulselessness, yeah.

Q. And paraesthesia, which is numbness, right?

A. Yeah.

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

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

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

I'm not sure.

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

A. It could.

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

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

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

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

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

prior occlusion, right, you looked at those records?

A. When he got the graft initially?

Q. Yes.

A. Correct, yes.

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

A. Yes, sir.

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

A. Yeah, well, was documented.

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

Q. In June you're talking about?

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

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

A. Correct.

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

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

A. Yeah, correct.

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

A. Not necessarily.

I mean --

Q. Well --

A. -- it's never the same.

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

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

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

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

That was never taken into consideration on the 25th.

Q. Okay.

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

A. No.

Q. We could go back.

A. We can -- should go back.

I think it's fairly similar.

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

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

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

A. The 25th.

The 28th there was discoloration.

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

A. Correct, yes.

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

A. Yes.

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

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

A. Yeah.

I one hundred percent agree with you.

Unfortunately, he's not a doctor.

Q. So let me ask my next question.

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

A. Mottled, that is dead.

Q. Right.

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

A. He didn't, correct.

Q. Right.

His leg --

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

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

A. By the ER team?

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

A. Well, somewhat incorrect.

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

You are also correct he complained of pain

and numbness.

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

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

So that is not a normal patient.

Q. Okay.

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

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

Q. Right, by the tech.

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

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

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

you remember him saying that in his report?

A. Appeared an occlusion, correct.

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

Here it is, it's 1411.

It's St. Rose Exhibit 100?

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

A. Well, not exactly, but similar.

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

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

When a patient walks in, a patient who has

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

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

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

A. Not directly, no.

That is my interpretation of those words.

Q. Right.

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

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

A. I've seen that, yes.

Q. And it happens quite often, right?

A. It's up to the radiologist.

Q. Sure.

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

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

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

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

A. A hundred percent.

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

A. I don't need quote, unquote.

It's definitely abnormal.

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

A. Not all the time.

It's used at times.

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

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

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

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

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

that right?

A. You are correct.

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

A. Actually, I agree with the examination.

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

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

A. Correct.

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

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

based on the small collaterals he had for years.

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

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

A. I don't remember.

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

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

I know what he testified in his deposition.

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

A. I don't remember.

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

A. I don't remember.

It's possible.

He can have those symptoms, yeah.

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

A. I provided 11 articles.

I don't remember.

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

A. Would you mind showing it to us?

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

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

MR. WEAVER: I'm sorry.

I didn't hear what he said?

THE WITNESS: 11 articles, 10 or 11.

BY MR. MC BRIDE:

Q. Okay.

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

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

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

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

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

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

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

A. Yes.

Q. And --

A. 12 and --

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

A. Correct.

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

A. Correct.

1 is -- we all have a 1.

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

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

Q. A 2-A.

That particular article also talks about the five Ps?

A. You could talk --

Q. I'm asking you this question:

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

MR. P. HYMANSON: Excuse me.

May we approach, Your Honor?

THE COURT: Yes.

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

THE COURT: Thank you.

All right. You may proceed with further questioning.

BY MR. MC BRIDE:

Q. All right.

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

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

A. Correct.

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

A. I Googled him.

Q. Okay.

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

A. I don't know, sir.

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

A. I'm not aware.

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

A. I do.

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

A. I agree.

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

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

A. Yes.

Q. And --

THE COURT: Not in this particular case.

MR. MC BRIDE: Right.

BY MR. MC BRIDE:

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

Do you recall reviewing that particular publication?

A. I --

Q. You listed all the trials you testified in?

A. My own list.

Q. Yes.

A. Yeah, I made the list.

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

Does that sound about, right?

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

Q. Okay.

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

A. That's correct.

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

A. I believe so.

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

A. It should be more than that.

I think he needs to write me a check then.

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

A. That's correct, sir.

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

A. Yes, that's correct.

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

A. That's correct.

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

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

A. No, I do not, sir.

Q. Is it more than 20 hours?

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

Q. Yes?

A. I hope so, yeah.

Q. More than 30 hours?

A. I just don't know.

This was two years I think, yeah.

Q. Do you keep track of the amount of time you spend, in order to bill to the Plaintiff's attorney?

A. I do, and you have my bills, you have my invoices, so I think you know better than I do.

Q. You don't have those with you?

A. No, I provided them to you at the deposition.

Q. In terms of whatever those invoices reflect in terms of the amount of time that you have spent up to the time of your deposition, that would be accurate, right?

A. That's correct.

Q. And then how about since your deposition October of 2019, to today, how much time, additional

time, have you spent reviewing and preparing for your trial testimony?

A. I'm not sure.

I spent a fair amount of time just looking through records and so on, so I'm not sure.

Q. So those bills we don't have.

So that's why I am trying to get your best estimate.

Can you estimate, was it more than 20 hours?

A. I would have to check.

More than 10 for sure.

Q. Is it fair to stay 10 to -- 10 to 20 hours?

A. Perhaps.

Q. Then you also charge 10,000 a day for trial testimony?

A. That's correct.

Q. Not including travel expenses, right?

A. That's correct.

Q. Did you come up last night or today?

A. Last night.

Q. Did you have a meeting with counsel to go over your testimony here today?

A. No, I had a meeting for dinner.

Q. For dinner.

Did you talk about your testimony?

A. A little bit, yeah.

Q. You also advertise your services as an expert in several publications, right?

A. Well, depends how you perhaps -- I don't call it advertising, but I'm listed, could be for advertising, I'm listed in a certain directories, my office is, that's correct.

Q. And so you recall testifying in your deposition that there's several advertising -- or services that you have in your name listed as a potential expert, do you have your name listed as a potential expert in emergency medicine in any of those advertisements?

A. No, sir.

Q. You said you paid a couple of thousand dollars a year for advertising, is that right?

A. Mr. Weaver said that, and I actually agreed with him.

I wasn't sure, I think it's possible, yes.

Q. Do you know what the amount you spent for advertising was?

A. No, sir, but it sounds right.

Q. Let me check my notes.

A. I think your firm is probably one of the

advertised in, I've been one of your experts a few years ago.

Q. One of my experts?

A. Yeah, your law firm you work for.

Q. Well, I've met you before today, right?

A. No, I'm saying the law firm, I've been an expert for you guys as a Defense expert, and they said they found me --

Q. I don't know how it turned out because I never met you before today, and so at any rate I'm glad you were happy.

Are you aware, you have read Dr. Jacobs, the expert emergency room physician for the Plaintiff, you read his report and deposition?

A. I did, two reports actually, and a deposition, yes.

Q. Are you aware of Dr. Jacobs' testimony where he stated that it was irrelevant if Dr. Lasry even seen the patient, since he reviewed the case with Nurse Practitioner Bartmus.

Q. Can you repeat the question?

A. Sure.

Were you aware of Dr. Jacobs' testimony where he said it was irrelevant whether or not Dr. Lasry even saw the patient on December 25, as long as

he discussed the case with Nurse Practitioner Bartmus?

A. You asked me if I seen, or agree with his statement.

Q. I'm asking, have you seen that?

A. I don't remember that.

I think it's relevant.

If he said he did, and didn't do it, it's very relevant.

Q. And I think you testified too that you're not making any specific judgment on Dr. Lasry and whether he personally evaluated the patient, and you would leave that to the jury to decide, right?

A. I did say that.

MR. MC BRIDE: Thank you, doctor.

That's all I have.

THE WITNESS: Thank you, sir.

THE COURT: So we're going to go ahead and take our lunch recess now, then resume with Mr. Weaver's questioning and any redirect from counsel, but rather than be to far into the lunch hour, I think it's a good time to take a lunch break now.

We'll return at 1:30.

It's a little after 12 now, so that gives you enough time to find a place to eat.

(Jury admonished by the Court.)

THE COURT: Have a good lunch.

See you at 1:30.

(Jury excused from the courtroom.)

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

THE COURT: Just to make a record -- Doctor, you may step down.

Actually, probably just leave them there. We're coming back after lunch with your testimony.

There was a brief bench conference seeking to discuss -- or raising an objection --

THE MARSHAL: One of the jurors said they have a question.

MR. MC BRIDE: Let's wait.

THE COURT: Find out what it is, and they can write a note.

Assuming it's related to the trial or witness?

THE MARSHAL: To the witness.

THE COURT: Remind them it's at the end of the questioning of the witness, but they can certainly write their question down to have it read.

Back to the bench conference.

So Mr. Hymanson had posed an objection

because Mr. McBride was discussing an article with the doctor, and some specific article component, and of course the doctor had indicated he reviewed up to 10 or 11 articles, and so Mr. Hymanson was concerned that way of questioning would continue, it would be imperative to have the specific article referenced shown to refresh the recollection of the doctor.

Mr. McBride indicated he thought he had given sufficient specifics to that article, specifically he did not intend to have further inquiry about other articles, so I think the questioning went on to another path after that.

Mr. Hymanson or Mr. Arntz, anything you want to add to the bench conference?

MR. P. HYMANSON: No, Judge.

MR. ARNTZ: No.

THE COURT: Mr. McBride?

MR. MC BRIDE: No, Your Honor.

THE COURT: I did instruct counsel if he was going to continue to inquire about particular articles, he should either have that article itself, or as much as possible, so to attempt to refresh the recollection of the witness, but it wasn't necessary.

We'll see you all back, get started at 1:30.

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

C E R T I F I C A T E

STATE OF NEVADA)
) ss.
CLARK COUNTY)

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. JASON LASRY, M.D., ET AL, Defendants.	)	Case No. A-17-766426-C Dept. No. 25

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

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.

I N D E X

WITNESS	DR	CR	RDR	RCR
Dr. Alexander Marmureanu	9	48		

Las Vegas, Nevada, Friday, January 31, 2020

* * * * *

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

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

MR. WEAVER: Good morning, Your Honor.

I brought this to Mr. Arntz's attention this morning, but I was waiting for the transcript, just to be sure, and I'm sure we'll get it soon, but the issue is the Defense believes yesterday Mr. Arntz's opening he he said to the jury there were one or more items on the lifecare plan, I think the example was wheelchairs, but I think there was other things that Mr. Moore, quote, unquote, could not afford, that Dr. Fish, who is testifying this afternoon testified in his deposition the medical -- necessary medically indicated items on the lifecare plan would be covered by Medicare, and especially with regard to one wheelchair, not that there was payment issued, not there wasn't Medicare issued.

The only reason Mr. Moore doesn't have the electric wheelchair is because as of a few months ago he hasn't been fitted for it.

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

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

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

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

THE COURT: Okay.

So let's wait until we get the transcript.

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

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

MR. WEAVER: This morning.

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

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

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

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

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

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

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

MR. WEAVER: Thank you, Your Honor.

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

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

Do you anticipate any other witnesses today?

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

We can go with their son.

THE COURT: All right.

We'll see where we are at.

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

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

THE COURT: Thank you.

The jury's now present in the courtroom.

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

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

MR. ARNTZ: I call Dr. Alexander Marmureanu.

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

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

DR. ALEXANDER MARMUREANU,

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

THE CLERK: Please be seated.

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

THE WITNESS: Sure.

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

THE COURT: Thank you.

- - - -

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

surgery, vascular surgery.

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

A. Yes, sir.

Q. Let's go through your qualifications.

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

Do you know Dr. Wilson?

A. No, sir.

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

Q. Okay.

Currently what are your positions you hold?

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

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

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

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

Q. What types of past positions have you held?

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

Q. I can --

A. Let me answer the best way I can.

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

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

Q. Are you board-certified?

A. Yes.

Q. What are you board-certified in?

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

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

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

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

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

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

You are fellowship-trained?

A. Yes, sir.

Q. That is different than being board-certified?

A. That's correct.

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

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

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

Q. Okay.

What faculty positions have you held over the years?

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

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

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

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

Q. You have been on a number of different

medical school committees.

What does that involve?

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

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

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

Q. Okay.

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

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

So all those companies coming out, they

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

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

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

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

A. The answer is, yes.

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

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

So medicine is not separate.

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

in to my area.

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

A. Yes, sir.

There's only one standard of care.

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

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

A. Every day, sir.

Q. Okay.

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

A. Yes.

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

A. Yes, sir.

The standard of care was breached by both of them.

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

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

Q. Right.

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

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

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

Now, there are certain key words.

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

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

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

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

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

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

MR. ARNTZ: Can I use this?

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

THE COURT: I understand.

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

So we have an easel here.

MR. MC BRIDE: I'm sorry to interrupt, but can we also have a question and answer, as opposed to a straight narrative?

THE COURT: I think we're getting there, and obviously have whatever illustration it's going to be, but yes, doctor, we appreciate very much you have a lot of information to provide, but this is direct examination, so just not a narrative dialogue.

THE WITNESS: I fully agree with you.

THE COURT: Is it time to do the illustration now?

MR. ARNTZ: Yes.

There's some markers there.

BY MR. ARNTZ:

Q. What is it you want to show the jury?

A. May I show --

THE COURT: You will have to turn it that way, so the jurors can see it.

Counsel can relocate to see what you are doing.

Mr. Arntz, can you help him, so the jurors

can see it?

I'm not worried, I can see it afterwards.

I want them to see it.

MR. ARNTZ: You bet.

THE COURT: Okay.

THE WITNESS: So he comes to the ER basically with this pain.

We know he's not a normal patient.

In 2012 -- Let me draw this quick.

This is the aorta, the biggest blood vessel in the body.

At this point it comes down, that's the chest here, that's the belly, those are the legs.

His blood comes down, bifurcates, the big blood vessel bifurcates.

BY MR. ARNTZ:

Q. Splits?

A. Splits.

It comes in, and I'm not going to focus more on definition, so this is the left side, this is the right side.

We know from the previous notes that we had a lot of this here, in 2012 he had a graft, this wasn't able to extend, if you have surgery in here, not to focus on the left leg, but the left leg here,

and that's where it is.

This area was below the femoral, there was no blood flow going toward the knee, barely blood flow below the knee, sort of by-passing like a car driving down the highway, the highway stops here and it goes away, here the surgeon created --

THE COURT: Doctor, it's not really where you're speaking -- you're speaking very quickly.

If you could slow down, and pick up the volume, I'm sure my reporter will be fine.

The most important thing is that the jurors hear.

So you can relocate where you were, just slow down and speak up.

THE WITNESS: There's a lot of information I want to get.

THE COURT: I know.

Slow down, and speak up.

THE WITNESS: So this is the knee here.

This is the groin.

This is the femoral artery.

Mr. Moore did not have -- Here in 2012 he had what is called a by-pass.

Why it's important is because this is the history when he showed up to the emergency room, he

had a by-pass, and they've seen there was -- before the by-pass there was no flow, its very, very important here --

THE COURT: Doctor, the jurors can't see the board the way it's facing now.

Take your time, and speak up.

BY MR. ARNTZ:

Q. Let's go step-by-step, and then can you turn it more for them to see it.

A. A lot of information.

So the blood comes down from the by-pass, this is the circulation at that time was his left leg, there was blockages there, so due to the fact the blood cannot come down through the circulation, there was a need for an eight millimeter hose by-pass graft brings the blood down below the knee.

This is called the femoral artery, and you will hear the term fem pop (Phonetic). Fem pop is the by-pass.

While the fem pop is done, it's not as good as God made it, but it really brings some blood into the foot.

Before the fem pop in 2012 there was no blood here, it was extremely poor.

After the fem pop he had signals in one of

the arteries, two arteries, one comes on top of your foot, one comes down here.

The artery here has a flow, but not palpable. When you check for pulses the way we all check for pulses here, you feel it.

Here it could be tricky, but you should feel it plus one, plus two, those are pulses.

When we can can't feel it, we use what is called a Doppler probe, just like this, a transducer, put it on the vessel, and you're going to hear that is flowing systole and diastole, so we know there's a flow.

So after those kind of operations I put an X, and I tell the nurse every hour, you go in, and you check that pulse in there.

This is going to be extremely important for this trial.

So he had this by-pass done in 2012.

In 2014 he didn't have any blood coming down here.

He went to the ER, he complained, and they opened it, they dripped medication, just like in your pipe at home or sink gets clogged, you put some stuff in there, clog buster, it opens, he went home.

So now we're going back -- I want you to

understand what the issue is.

He goes back to the ER in 2016 complains of pain here when he walks, and we know all his history.

So somebody would think that he have another problem here. Once they start clotting, chances are they would continue to clot.

So once he gets to the ER, it's been documented he has a history of fem pop grafts, and the first thing that is being done is a test to look if there's a clot in his veins, which is actually a good idea.

Q. Before you go to the ultrasound, Nurse Practitioner Bartmus was here yesterday, testified she did two physical exams of Mr. Moore where she was able to detect a normal pulse in the top of the foot and the ankle, and she was able to determine from getting a normal pulse that she -- or he had no peripheral perfusion.

Explain to the jury whether or not that is even possible in Mr. Moore.

A. First of all, what you heard yesterday is absolutely impossible.

That is not true and impossible, and I'll show you why, and you will understand immediately.

First of all, the gentleman never had, for

the last many years at least, we know for a fact that since 2012 or before he did not have a normal exam.

People with normal exams there's probable pulses, like us here, they don't get fem pop grafts, nobody that is normal gets a graft, so if he had a graft, he was abnormal.

The surgeon said in 2012 that before his operation he had no pulse.

He also said in his op note once he finishes the operation in 2012, there was only one of the arteries has a pulse, and it was done only by Doppler.

In other words, what the surgeon in 2012, when the graft was new, checked here, and he was happy with that only one of the arteries in the foot, which is the PT, was very faint, couldn't feel it, couldn't feel it.

That graft was open, and he couldn't feel the pulse after he did it in 2012.

Q. Doctor, just a second --

I'd like to move the admission of Joint Exhibit 101.

THE COURT: Any objection?

MR. MC BRIDE: No, Your Honor.

THE COURT: We understand that to be

multiple binders as well.

MR. ARNTZ: Actually, I think it's just the last section of one binder, I think number 6.

THE COURT: I could stand corrected.

I just remember being informed by my clerk when we first started the trial that the Exhibit 100 was six binders, and 102 took up a couple additional binders.

MR. ARNTZ: Okay.

You're right.

I apologize.

THE COURT: So binder 6 and 7 are the Exhibit 101.

MR. ARNTZ: Okay.

THE COURT: Any objection to the admission?

MR. MC BRIDE: No, Your Honor.

THE COURT: All right.

101 is admitted.

BY MR. ARNTZ:

Q. Doctor, I understand I actually gave you the sheets from the op report.

Could you read for us what the numbers on the bottom, the Bate's number is?

A. SRDSMR-00081.

Q. We're going to bring that up on the screen.

Explain to the jury what is it you're reading in this op report that gives you this information?

A. Do you have a laser pointer, or a stick, or something?

I got one that works.

MR. J. HYMANSON: Your Honor, may I approach?

THE COURT: Yes.

THE WITNESS: 2012ish clinically no blood flow.

We have arteries going down, veins bring the blood up, ischemic left leg with left iliac artery.

So in 2012 he had that procedure. Normal people don't get a by-pass, and somebody has normal pulses.

People with normal pulses also don't lose their leg. Nobody here is going to lose their leg by Monday.

So this is the diagnosis for surgery.

What did they do?

Well the artery up here, you remember before the femoral has a big aneurysm, and they put a stent in there, and for lack of a better term,

there's a lot of junk in there, which means the blood is not going down, there's so much plaque, so they open the artery and scoop the plaque out, clean everything out, and put a patch.

That is how bad this initial area was down here.

Femoral by-pass below the knee, 8 millimeter Gore-Tex reported.

So you understand, that is where the surgeon is starting with -- he finishes the diagnosis with and what he did.

Can I have page two?

Q. Yes.

A. We're all happy when we finish the surgery.

We have to be sure that that foot, which is here, you need circulation down here.

All this hope is in this graft.

So if you need to document for the patient to do well, and for us to claim success, feel better as a surgeon that there's blood flow going down, how you do this, you can fill the pocket if you are there, you feel them, may not be there, then you have to redo your work or use a Doppler, which is a Doppler.

So let's see what he did.

He checked the flow, finished the operation, don't worry about that, that tells you how he did the graft from the top femoral artery to here, and excellent blood flow was obtained, you have the graft, close.

Then Doppler.

Why Doppler?

Because he wanted to feel it.

Then an examination of the posterior tibial pulse, you remember we talked about that right here, one of the arteries, not both.

He had the Doppler pulse, which is a weak pulse, in one of the arteries, only he's telling you here in 2012.

He's also telling you why it's so important that this pulse that he felt by Doppler was not present pre-op, but now it's present.

So he's saying, which makes a lot of sense, that is the way it is, there was not blood flow moving through this circulation, blood flow was coming here, and now there's blood going down.

So let me say this one more time.

We have the by-pass.

Before he did the by-pass there was no pulse.

After the by-pass he has fusion here, saying good flows were measured through this portion of the graft, and before this he has flow in one artery by Doppler only.

So the best this gentleman can have, four years after after this graft has been closed, once in 2014 or 2015 reopened, so it's not as good as new.

So in the best scenario he can have, why his graft is open, it's here is a Doppler PT pulse present.

But now in 2016 the graft is closed, which we have a study that shows that graft is closed.

So not only he doesn't have this, because this the posterior tibial pulse is gone, because that comes from the graft, and the graft is done, he got no pulse, so if anybody tells you they felt normal pulses, pounding pulses by hand, it's just not true, it's impossible.

It's also impossible that even if the graft would be open, he wouldn't have palpable pulses. He never had palpable pulses in the last five, six, or seven years, that's why he got a by-pass.

Once they have a by-pass -- or before they have a by-pass, you have to be sure they don't have palpable pulses, so once the by-pass is done there

are no pulses, they can't be normal, this thing is done, blood is not coming off of here.

How can you have normal blood flowing here? Impossible.

Q. Didn't he lose his leg sometime sooner?

Did you -- Let me ask this question.

Did you make a determination whether or not the occlusion was seen on the ultrasound on 2016, whether that was a chronic occlusion?

A. Acute, the definition of acute is less than -- We don't know that much about this gentleman's history, but we know enough to say, more likely than not.

We know he had a fem pop graft.

We know that the leg, the graft was open after it was open.

We know that he developed symptoms, pain while walking into the casino the day before, then thereafter going to the emergency room on Christmas day, and they do a study which showed the graft is closed.

So this goes together with the fact the graft just closed because that's when he started having pain, there's no more blood going there.

Now, you close the graft.

The reality that there's some itty bitty small things included here -- so even if it's closed, the leg doesn't die within six hours.

If you take a normal guy on a motorcycle, has an accident, the artery gets torn apart, that guy has a vascular ischemia in six hours.

The problem is that the collaterals, there is still absolutely no pulse, not enough to give you a pulse.

He never had pulses there with the graft open.

With the graft closed four years after it's impossible to have palpable pulses.

However, here's what happens:

The clot creates clots.

So the first thing you do as a doctor, you start giving Heparin, and a lot of it. It will not prevent -- it will not bust the clot, but will prevent further clot from coming back in.

Here is the problem, you create some clots, now the clots are going up, and now up and up, so this gentleman did not have that kind of Heparin given to him, which is an IV dripper, and the next best thing is to do exactly what they've done here before, to go into this tube here, and then give what

is called TPA, which is a clot buster.

So he had this done in 2015 and also had this done in 2018 -- or I'm sorry, in 2015 when he clotted was in June I think, and then in 2016 three days after.

In other words, this happened before he showed up to the ER approximately a year, and they opened the graft, and it happened again three days after.

He went home, everything became ischemic, and at that point they did what they are supposed to do.

The PA was here, and he did Heparin, but none of those things happened.

So to summarize, I'm sure there will be more questions, but he comes to the ER, differential diagnosis is why, so this patient's in the ER.

What brings him here?

He will tell you he's got pain and got his history.

The ER team wants to rule out a clot in his veins, which is actually a good idea, but then they stopped.

Differential diagnosis means -- which are the top five problems, what could give him the pain.

They sent him home with no answer.

The number one is arterial insufficiency because it happened before he has a history that is the cure, it tells you claudication as the name, you know the graft is closed, so the work-up was done for the vein, which should be there.

Nowhere in the documentation from the hospital it says that anybody with suspicion of this issue, which is the ischemic leg due to closure of the graft, even now the radiologist clearly said, hey, the graft is closed, do more work-up one it, do surgery if you want to get more blood.

None of those things were done, and the patient went home, and that's it.

Q. Go ahead and have a seat.

A. Thank you.

Q. Okay.

So you're not critical of Nurse Practitioner Bartmus or Dr. Lasry for the ultrasound that should have been done?

A. Not only not critical, I'm in agreement it should be done.

Q. When there are signs or symptoms to support a differential diagnosis of DVT?

A. DVT, deep vein thrombosis, could be in the

calf, but it should be ruled out.

Not only did I agree with that study, but a duplex, a vascular duplex arterial or venous, it's that transducer, the same Doppler, is a fancier one that goes around the leg artery and veins and checks the flows.

They checked the veins, but they never checked the arteries.

They should have been done together.

There's no downside in using that, they travel together.

Q. How could you have blood flow in the vein, but not have it in the artery?

Where is that blood coming from?

A. Well, they didn't look for blood flow in the veins, they looked for clots.

There was flow in the vein.

He didn't find deep vein thrombosis that could give you pain in the calf and should be evaluated.

The problem is, during -- or not a problem, it's just a good problem during the study, the technician who apparently throughout the history decided to move the transducer up a little bit and saw the graft being closed, so at that point the

radiologist who read the study, he said, hey, your graft is closed, follow-up with different studies.

And what we usually do as a vascular surgeon, we get what is called an angiogram, even a CAT scan, CT, Charlie Thomas, angiogram on, or just plain and simple you put a catheter and insert contrast and see is -- if there's no flow.

This is an emergency, somebody will lose their leg if you don't establish flow.

If there's no flow coming down, the leg will not die in six hours, but the leg more likely than not will die in a few days.

That is exactly what happened.

Q. So in addition to the ultrasound -- Let me ask you something.

I've been telling this jury, because I'm not aware of this, are you aware of an issue where he had a prior DVT?

A. I'm not sure it was documented.

Now, the truth is, even if he didn't have a prior DVT, it should be ruled out, I don't think it's a problem, and the fact they were ordering this kind of study was actually good, but it wasn't enough because not only they rule out the DVT, but now it showed you -- the arterial pathology shows you the

graft is there. This study is the one.

Unfortunately, the study was read as being normal. Absolutely, it's not normal, shows the graft is closed.

You don't walk, you don't run, you jump on those patients because again if you don't open that graft, the leg will go away, and let me re-emphasize one more time, in 2012, '14, '15, '16 there's absolutely no way, impossible to have palpable pulses in this patient just because there's no blood going down there.

Q. What is the first thing Nurse Practitioner Bartmus and Dr. Lasry should have done once they recognized the presence of the clot?

A. Well, a few things.

Q. Let me ask you one thing.

Are you able to tell by looking at the ultrasound whether the clot is a chronic clot, or acute clot?

A. Absolutely not.

Even looking at the angiogram, you put contrast in there, and at that point -- so the ultrasound will give you some sort of vague view of what's inside.

The angiogram is done with contrast, and

you see, and then you don't see, but can see this blank because there's a blockage.

So the first thing when he sees this number one odd arterial duplex, versus vascular duplex, the same thing should have been ordered from the beginning, have the transducer, the doctor go in the arteries, in the veins, you will see that close.

Next, call a vascular surgeon, call an interventional radiologist, so they can look, do an angiogram and start squirting TPA clot busters, start medical management, start the Heparin, to prevent further clotting because once you have this classic up, up, up, and even as patients will eventually -- there is no way to say impossible, say he would have needed the amputation, all is possible, but they would have a lower level amputation if this area is viable.

If the clot keeps on going up, the only thing remaining is called AK, above the knee amputation, versus BK, a below the knee amputation, so Heparin to stop the clot from moving, AKA surgery, we put the balloons in there, inflate the balloon, and pull the balloon towards you, fish all the clot out, and return the flow.

So there are many options that can be used

many times, Rotor Rooter, to clean the gentleman's graft.

We have devices, we put them in and suck the clot out.

So that's where we're at.

Q. Is redoing the graft an option?

A. Absolutely, called a graft revision. I probably wouldn't start there, we would first start a Heparin IV drip, a lot of it, to prevent further clotting, shoot the clot buster, pull the device to suck the clot out, or even going surgically, do an incision in the groin, the same area here, cut, you have the graft, and start fishing it all out, and then we re-establish the pulses down here to a Doppler level, never to a palpable level.

Q. What do you make of the finding that Nurse Practitioner Bartmus testified to yesterday when she said she found normal peripheral perfusion, normal pulse, and normal cap refill?

A. Not true, it's absolutely impossible in any patient that has a vascular path, that has a graft that is closed.

In this patient, Mr. Moore, he never had this kind of exam, even in 2012 before and after the surgery is what his surgeon said, he couldn't feel

pulses when the graft was new, so to me I have to say it's absolutely impossible four years after to have a normal exam when the graft is closed.

Where is the blood coming from?

Impossible.

Q. Doctor, one of that things brought up yesterday in counsel's opening was that you have testified that after three occlusions, two or three clots, then you're going to lose your leg?

A. Absolutely not true.

I never said this.

I challenge them to show me that.

I actually brought my depo expert report, checked them. It's nowhere there I don't believe in that, and even if it would be true, which it's not true, this is his second one.

What is true is, the fact that once he starts clotting, it will continue to clot, that graft.

That is why you have to be very cognizant, that is why you have to be very diligent and timing his leg, so you have to be sure you establish flow as fast as you can, so I actually said in my deposition, which I have it here, that you can go in -- it don't even mean if he clots four times he's going to lose

his leg, I said the opposite, I have the page numbers, you can go as many times as you can and fix it.

It might not be possible at some point, but there's no way to know if you will ever clot again or not while on anti-coagulation.

Q. Was sending him home with Xarelto, was that a good thing to do?

A. No.

First of all, he shouldn't have gone home.

Second, the only recognized way to treat this issue is Heparin IV drip.

You usually have 5,000 units, you run, and you check labs on him every four to six hours to be sure that the blood is extremely thin, and that is the standard of care in this kind of problem.

Q. So in addition to the ultrasound of the vein, also of the artery?

A. Yes.

Q. They should have done a Doppler of the artery?

A. Let me interrupt you for a second.

They done had an ultrasound of the artery because the transducer moved, and the radiologist says, hey, your graft is closed, so they have enough

information even to go to the next step, to get an angiogram.

They didn't have a perfect duplex of the arteries, which they weren't open, but they knew they had enough to move to the next step, calling a vascular surgeon, calling an interventional radiologist, asking for a CT, computerized angiogram, a regular angiogram, nothing fancy, just squirt contrast in through the graft, it's closed, then do something to fix that.

The way it's been done before, one year before, the way it's been done three days after when actually the leg was dead.

So three days after they have done the right thing in the ER, done what they were supposed to do, so he's been in the ER three times.

The first time they had done the right thing, opened the graft.

The second time they didn't.

The third time they did the right thing.

The leg was dead, called outflow.

If everything gets clotted here, you can try to open this graft as much as you can. It's not because the graft or clot is old, there's nowhere nobody can prove this graft was closed chronically,

just not true.

However, if everything here gets clotted, and all those small vessels, it doesn't matter, there's no blood going -- it has nowhere to go, and that is what happened on the 28th when he came back three days after, the leg was cold, numb, blue, this vein is gone, and unfortunately because the clotting went up, he couldn't have the BKA, he had to have the AKA.

Q. Do you have an opinion as to whether ultimately the amputation was due to the breach in the standard of care?

A. Yes, sir.

Q. What does that mean?

A. It means, that due to the fact the emergency team, Dr. Lasry and Miss Bartmus, fell below the standard of care.

In other words, they didn't do their job.

The gentleman ended up with an amputation.

Q. Was the amputation a direct result of their failure to focus on the standard of care?

A. Yes, sir.

Q. Do you have an opinion whether or not that leg could have been saved on the 25th?

A. Yes, sir, it could have been saved.

Q. Is that opinion to a reasonable degree of medical probability?

A. Yes, sir.

Q. In other words, you believe more likely than not that had that treatment taken place on the 25th, he would have kept his leg?

A. Yes, sir.

Q. Okay.

What is the customary treatment for someone had to have an amputation above the knee after?

You treat patients for that?

A. I do amputations.

Obviously above the knee amputation is worse.

First of all, any amputation is worse than not having an amputation, but above the knee, it's more intrusive toward his lifestyle than below the knee, which is a shorter prosthesis, and people tend to walk around and function.

You know, somebody ran in the Olympics.

But below the knee is an easier prosthesis to fit, and patients do better than above the knee.

In regards to follow-up, there's a lot of physical therapy, occupational therapy, and what have you.

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.)

(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.)

(Thereupon, the following proceedings were had out of the presence of the jury.):

THE COURT: Anything before we bring the jury in?

MR. MC BRIDE: I was just going to say, we're going to go until 12:30, is that still the plan?

THE COURT: It depends how long you think you're going to take.

I can break whenever in the morning, I just can't start again until 1:30.

So if we go a little later in the afternoon -- but the later we take the morning it creates the imbalance again.

So the goal is to aim for 12 and 12:30, but ultimately be sure they have more time in the morning to get their stuff together, than afternoon people.

I wouldn't want to go much later than 12:30.

MR. MC BRIDE: I don't think it's going to be that.

THE COURT: Okay.

(Thereupon, the following proceedings were had in open court, and in the presence of the jury.):

THE COURT: Go ahead and have your seats. Everyone else can have a seat as well.

I just want to ask you for the record, you understand you're still under oath?

THE WITNESS: Yes, I do.

- - - -

CROSS-EXAMINATION OF DR. ALEXANDER MARMUREANU

BY MR. MC BRIDE:

Q. Good morning, Dr. Marmureanu.

I have to apologize because yesterday I think I absolutely butchered your name in my opening statement. I want to apologize for it in advance.

A. Apologies accepted.

And let me assure you, it's not the first time it happened.

Q. May I call you Dr. M, just to make it easier for the jury to remember, if that's okay?

A. Okay.

Q. Now, doctor, you remember your deposition in this case was taken a few months ago back in October of 2019, do you recall that?

A. Yes, I do, sir.

I have it right here, sir.

Q. Do you have it in front of you?

You reviewed that deposition before today to check for any completion or inaccuracies, is that correct?

A. I think I did.

I don't remember, I probably did.

I usually do.

I don't remember about this one.

Q. In fact, you did not make any changes to any part of your deposition transcript, is that true?

A. That's correct.

Q. And --

A. Let me say, I don't remember reviewing it, but obviously, because I did review it, I didn't make any changes, so you are correct.

Q. And you have been deposed numerous times over the years as an expert witness and as a treating physician, right?

A. Yes, sir.

Q. Well over 30 times?

A. Yes, sir.

Q. Approximately over a hundred times over your career?

A. Approximately less than 50.

Q. Less than 50, but more than 30?

A. Yes, sir.

Q. All right.

And now, doctor, I want to go through some of your qualifications that you mentioned you went over with Mr. Arntz before in his questioning.

You stated that your specialty is thoracic and cardio-vascular surgery, correct?

A. Correct, sir.

Q. Is it fair to say that you would be considered a heart surgeon?

A. Well, I hope so, but not only heart surgeon, heart surgeon, lung surgeon, vascular surgeon.

Q. But your primary area of expertise, specialty included on the CV that you provided to us is in the area of cardiac surgery and cardio-thoracic surgery, correct?

A. No, sir, it covers everything.

Let me explain.

Every cardiac case has vascular in it.

When I do cardiac surgery by-pass surgery for blockages, instead of having a fem pop, you have a by-pass on the heart, take a vein from the leg, from here, and you see it on top of the heart, which leads from the aorta, the big blood vessel, all the

way to the coronary arteries, so every cardiac --be cause I do it -- it's vascular in terms of we work on vascular structures every single time.

Q. I don't mean to downplay any significance of the vascular system because that is all part of your practice, correct?

A. Yes.

Q. But you were not an emergency medicine physician, correct?

A. Well, somewhat.

I mean, I don't know how you define emergency room physician, but I'm not the doctor like Mr. Lasry, but I'm on call for vascular surgery for the ER just to see patients like Mr. Moore when the ER doctor asks me to see those kind of patients, so I see them in the ER, which some people would say, well, you have seen him in the ER, you provided care in the emergency room.

Q. Certainly.

But you are a cardio-thoracic and cardio-vascular surgeon on call, or gets consulted on occasion by the emergency department, correct?

A. True.

Q. All right.

You are not an emergency room physician, a

board-certified emergency room physician, like Dr. Lasry, correct?

A. True.

Q. You don't spend your full day practicing emergency medicine, who would treat all sorts of different types of complaints from a heart attack, to a common cold, to a trauma case in the emergency department, true?

A. True.

Q. All right.

In fact, you did not perform an internship or residency specifically in emergency medicine, correct?

A. Pretty much.

When we do our general surgery residency, we will go through all the services, including emergency room, so I spent months in the emergency room during my training, but that is the extent of me spending months in the ER.

Q. Right.

A. That's not what I'm looking for.

Q. So as a surgery resident, you're going to spend time in the emergency department as part of your rotation, right?

A. Correct.

Q. And you do that as well as part of your internship, correct?

A. Yes, sir.

Q. And that internship was actually back in New York, and back in 1994 to 1995, correct?

A. Correct, sir.

Q. All right.

So that is the last time you would have actually spent a significant amount of time rotating through the emergency department as part of your internship or residency, correct?

A. Let me repeat this.

You are a hundred percent correct.

This is the last time I've been in training in the emergency room spending time.

Part of my -- Actually, I would say, every day I go to the emergency room to see patients.

Just because some of my old patients come back in, new consults come back in, and I go to nine hospitals, so I spend a fair amount, but that is the extent, as a surgeon.

Q. You're specifically treating your prior patients who might return to the emergency department because of a vascular issue, right?

A. Or cardiac or thoracic, yes.

Q. You're not treating other patients in an emergency department on a regular basis for every other type of ailment, or potential complaint, a broken arm, any of those things, true?

A. True, sir.

Q. All right.

In fact, you're not board-certified in emergency medicine, right?

A. True, sir.

Q. You're not a member of any nationally-recognized emergency medicine organizations, true?

A. Correct.

Q. You're also not a member of the American College Of Emergency Physicians, correct?

A. True.

Q. You are a member of separate cardio-thoracic surgery associations, right?

A. And vascular, sir.

Q. As well as American College Of Surgeons, right?

A. Yes.

Well, I have my application in there, and I understand it's been approved, so I have a different title, about American College Of Surgeons, so I'm not

sure exactly how they call me.

I just applied a year ago, so to be precise, yes, I'm some sort of a member, but didn't get my membership, I'm ongoing, my application is there for the American College Of Surgeons, which deals with general surgery.

I am a member of the Society Of Thoracic Surgeons, International Society For Cardiac Surgery, so a member of a lot of societies, international vascular surgeons deal with what I currently practice, and because I practice some general surgery, I recently applied to the American College Of Surgeons.

Q. All right.

In looking at your CV that you provided to us before your deposition, I noted too that you have not conducted any research specifically in the area of emergency medicine, correct?

A. Correct, sir.

Q. And you're not on any specific committees that specifically deal with diagnosis and treatment in the emergency room, true?

A. It's untrue, but let me explain why.

I'm a member -- We spoke earlier called systemic, is on the EKG waives, that's the elevation,

myocardial infarction.

So there's a patient comes up as an emergency comes up with a heart attack, he needs to go do the cardiac catheterization, a blockage around the heart needs an angiogram, then they need to go upstairs, and then need to be treated by the balloon -- or by surgery it's called systemic, so it's very important to do this within 30 minutes to 90 minutes, it's called door to balloon, walks through the door to the balloon, so I'm part of that committee and covers the emergency room in regards to being sure that things are being done in a timely fashion.

Q. That specifically would relate to an area of -- your area cardio-vascular -- and cardio-vascular surgery, correct?

A. It covers the ER people say, come to the ER, and then we get called, so we have to be available.

Q. Going back to your CV, doctor, you have not offered any manuscripts for that?

A. Correct.

Q. For that matter, specifically in the area of the diagnosis or treatment of acute limb ischemia, correct?

A. Well --

Q. Is that correct?

A. Can you repeat the question?

Q. Sure.

Isn't it true -- I looked through your CV, looked through all your manuscripts you provided us all, the other the publications you listed, and I think even in your deposition you told us you have not specifically authored any publications that deal with the diagnosis of and treatment of acute limb ischemia, true?

A. Somewhat.

We spoke in the depo and here, but I think over all you are correct, but for the record there is one paper I presented to the International Association Of Vascular Surgeons in 1998 we went over in the depo in regards to I think it was venous ulcers, and he had a venous ulcer, and in the paper it addresses actually certain issues in regards to chronic, acute ischemia, as well as venous disease, so that is one paper.

Q. That was 18 years before this presentation by Mr. Moore to the emergency room, correct?

A. Yes, sir.

Q. It wasn't specifically on the diagnosis or treatment of acute limb ischemia in the emergency

room, true?

A. True.

Q. Now, let's get to your deposition because I want to clear that up, so we can be on the same page here.

Do you have your deposition?

A. Which page?

MR. MC BRIDE: Your Honor, I'd like to move to publish the deposition of Dr. M.

THE COURT: Go ahead, make the formality and publish it, then we'll get back to the questioning.

You just want that version for now?

MR. MC BRIDE: He -- actually if he has a copy.

THE WITNESS: I have a copy.

MR. MC BRIDE: Can I approach to make sure we're on the same page?

THE COURT: Yes, you may.

THE COURT: Okay.

BY MR. MC BRIDE:

Q. All right.

Doctor, in terms of your deposition, there was a lot of questions, you remember Mr. Weaver was present and actually took the lead on asking a lot of

those questions of you at your deposition?

A. I remember very well.

Q. Okay.

And, in fact, do you remember there was some questions that related to the medical literature that you provided to us, or at least included as part of your file you had done research on prior to your deposition, you remember that?

A. That's correct.

And I explained to him, it's again not about him, but we did have a fair discussion about literature, which is different than the patient's case.

I made it very clear that the literature or the guidelines don't represent the standard of care.

I have the page.

I understand standard of care is individual.

Q. Let's talk about that.

I'll direct you actually to your testimony.

You would agree with me in your deposition you testified --

A. Which page?

Q. -- under oath, on page 48 where you already had it.

A. 48?

Q. Yeah, for -- Actually go back.

I think there was some question that you were going back and forth, and I think there was some stepping on the toes where you were talking over each other, Mr. Weaver and you, so there was this little interaction that you had, so it actually starts at page --

A. Sorry to interrupt you, but they went on for three hours, so you have to be more precise than that.

THE COURT: I assure you, counsel will be very professional.

THE WITNESS: I can't wait.

BY MR. MC BRIDE:

Q. Go to page 47, if you will.

A. I'm here.

Q. It's line 7, this is 7 through 14, and then we'll go through the next page too.

A. Line 7?

Q. Line 7.

And, doctor, you would agree with me at the time of your deposition you specified that given Mr. Moore's chronic peripheral vascular disease, and chronic occlusion to his fem pop by-pass graft, he

would ultimately require an amputation of his left leg, would you agree what that?

A. No, sir.

Where are you reading?

Q. I'm not reading from the deposition now.

A. I disagree with that.

Q. So let's get to your you disagree with that.

Let's go to page 47, and you read line 7 through 14, all right?

A. Well, you might want to read for the jury, that's the question for Mr. Weaver.

Q. I'm asking if you could read it to yourself?

A. I already did, sir.

Q. So you read it to yourself.

Now, let me read it, so the jury understands what the question was.

But the literature that you have in front of you, unless I read it wrong, which I may have very easily, the question from Mr. Weaver is, that after more than two failed -- after the by-passes failed more than two times, even after re-vascularization, more likely than not the end result is going to be amputation, do you disagree that is what the

literature says?

And your answer was, yeah, well the literature or the guidelines don't represent the standard of care.

Was that your answer, sir?

A. Yes, that's I said.

I disagree with it.

And then the literature or the guidelines don't represent the standard of care, I said that, yes.

Q. So you disagree that's what the literature said?

A. Well, I think we're talking about Mr. Moore at the time.

This, you're taking this out of context. We have two lawyers, I just agreed in regards to Mr. Moore, and I have it all over, clotting two or three times with amputation.

Actually on line 4 I'm saying that, if it continues to clot, it doesn't not mean he is going to need an amputation, this is line 4.

Q. Right.

Doctor, I understand.

Let me get to the questions, and you can feel free to answer however you want, or disagree

with me.

I'm trying to get to your deposition testimony and what was testified there.

Now, so continuing on, page 48, line 2 --

MR. P. HYMANSON: Your Honor, may we approach, please?

THE COURT: Sure.

(Thereupon, a discussion was had between Court and counsel at sidebar.)

MR. P. HYMANSON: Thank you.

THE COURT: All right.

Thank you.

With that clarification, maybe I can assist as we get started.

So, doctor, there's a particular format about how we inquire of someone whose previously given a deposition.

I would ask that you please pause and let counsel give you the directions, rather than trying to also direct the process. It will be easier in the long run.

What he's doing now when he asks you to look at portions of your deposition is simply to read those portions to yourself to potentially refresh your recollection of your testimony, and then there

will be a line of inquiry.

All right?

THE WITNESS: Yes.

BY MR. MC BRIDE:

Q. Now, doctor, let me refer you actually to the question and answer at lines 5 through 11.

Read those to yourself if you could.

A. Page 48, sir?

Q. Page 48.

Actually, start at line 2, and go down to line 11.

A. I did, sir.

Q. Perfect.

So, doctor, isn't it true that you testified at your deposition that if the graft failed two times, three times, it's a possibility, or more likely than not, it will continue to fail in this patient, or a patient will require an amputation, and we agree on that, that was your testimony, correct, sir?

MR. ARNTZ: Excuse me.

THE COURT: Hold on, there's an objection.

Mr. Arntz.

MR. ARNTZ: The same objection, that is not the proper use of the deposition, reading it into the

record.

THE COURT: At this point in time I think we are trying to sort of get to the heart of what's here.

I'm going to give a little bit of leeway. Let's see if we can make this work. I'm not quite sure how else to get at it, unless we highlight some things.

Maybe Mr. McBride, ask the question, get his answer. If it doesn't match, come back to the deposition.

MR. MC BRIDE: That's what I did earlier, so I was trying to short-circuit it.

THE COURT: But what I think we want the clarity is, just because you ask the doctor to read a portion to refresh his recollection, you still have to ask the question and then get his answer, and if it doesn't match, then you can go back to the depo and look at it.

If we have to go through that type of formality, that is fine, it is typically how it's done.

Sometimes more familiarity with each other makes it short-cut some of those things, but I'm going to sustain Mr. Arntz's objection, and let's try

to keep it to the formality here.

BY MR. MC BRIDE:

Q. Okay.

Doctor, do you recall that testimony when I asked you, given Mr. Moore's chronic peripheral vascular disease, and prior occlusions, you would agree he would ultimately require an amputation of his left leg, correct?

A. I disagree to that, sir.

Q. Okay.

And, again, does paragraph 2 through -- lines 2 through 11, does that refresh your recollection as to what you testified in your deposition in that regard?

A. Yes, it reflects I'm right, and you are wrong, and if possible we can put it here, let the jury be the jury.

You're reading it wrong, sir.

Allow me to finish my answer for the Judge and the jury.

Q. Sure.

A. You want me to be silent, but can I read aloud?

Q. I don't want you to be silent, you can answer your questions.

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.)

(Thereupon, the following proceedings were had out of the presence of the jury.):

THE COURT: Go ahead, everybody have a seat.

Doctor, I didn't want to admonish you for the first time in front of jury, but that type of editorializing and trying to direct the process is exactly what I just told you not to do.

THE WITNESS: I'm sorry.

THE COURT: I will ask you to please not do that again.

We have a process.

Back to counsel, Mr. McBride, we were already in that area, so I really didn't have a problem with you going back to the depo and saying that, but you read this, and I said this, we have to get off that because the two of you are going to sit here and keep going at it, and I'm not going to have it.

So I don't know how to resolve this one, but doctor, I will in the future admonish you in front of the jury if you continue to try to direct the testimony.

Counsel's going to ask the questions, he's going to ask you what to read, going to ask your

answers, and I ask you to answer them.

Don't forget, your counsel's going to have the opportunity to redirect and examine you as well, but we cannot be here all day with that kind of gamesmanship.

Mr. Arntz.

MR. ARNTZ: I think the problem in this particular instance was, he wasn't allowed his right to look and reference the entire answer.

In fact, he says at line 13, I'm not done, please.

So there's more to his answer.

THE COURT: That is not the problem.

Listen to this, doctor, listen to me before you think you know what to tell me.

That's not the problem, Mr. Arntz.

Counsel's allowed to say, look at whatever, if you think there's something else, you deal with that on direct, but if he has a different answer, he's welcome to give it, but we are not going to sit here and tell the jury, oh well, you need to let the jury read this, that's not how it works, doctor. This deposition doesn't go in front of the jury.

You let him ask the questions.

If you think there's something else you can

respectfully say, I believe there's more to my answer.

I'm not trying to direct your testimony either, but I'm not having this.

What is your question?

THE WITNESS: Thank you for allowing me to speak, and I really apologize.

I'm not saying I know. Actually, I don't know what to do.

With all due respect, what he's reading here is my testimony, it's clearly he's not saying what it is supposed to say.

I'm saying, let me repeat the question.

I'm repeating Mr. Weaver's question, and he's saying that was my testimony, when clearly at line 6 -- so what are you saying, let me repeat the question, and I repeat the question, and he's saying that that is what I said.

THE COURT: Doctor, how many times have you given testimony in court?

THE DEFENDANT: Between five to ten times.

THE COURT: Then you know how this works.

THE DEFENDANT: I don't know about this.

THE COURT: You know how this works.

He's cross-examining you.

If you don't believe what he's indicating is complete or accurate testimony, you will have the opportunity to correct it.

It's not a fight over what is in the depo, it's a dialogue about what the testimony is or is not.

THE WITNESS: I'm sorry.

Thank you.

THE COURT: Can we get this back on track?

MR. MC BRIDE: Yes.

Thank you.

THE COURT: All right.

Thank you.

(Thereupon, the following proceedings were had in open court and in the presence of the jury.):

THE COURT: Please have your seats.

Even though it was just a short recess, Dr. Marmureanu, please acknowledge for the record you understand you are still under oath.

THE WITNESS: Yes, I do.

THE COURT: Thank you.

BY MR. MC BRIDE:

Q. I'm actually going to veer off of the deposition transcript for a minute, doctor.

I want to ask you a couple of other

questions first of all.

A. Okay.

Q. On the break, not this last one, the short one, but on the prior break you had an opportunity to step outside and speak to Mr. Arntz and other counsel, correct?

A. Yes, sir.

Q. And what did you talk about?

A. I told them that I found it -- I was pleasantly surprised you were here, I think it's going to go very well, and somewhat surprised when I was shaking Mr. Weaver's hand, he was unhappy and didn't look at me, and I was disappointed.

Q. That's the only thing you talked about during that break with Mr. Arntz?

A. That's what I remember.

I went to the bathroom.

I asked him where was the bathroom.

And I asked if I could get more water.

Q. You also talked about your testimony you gave previously, right, when Mr. Arntz was questioning you?

A. I don't remember, perhaps we did.

I don't --

Q. I don't mean to interrupt.

Were you done?

A. Actually, I don't remember.

I said that -- I don't remember if we did talk, perhaps we did.

Q. All right.

Now, getting back to the facts of this case, in terms of your deposition at the time of your deposition you made some conclusions based on the timing of the last time that any sort of thrombolytic -- TPA therapy, or Drano therapy, would have worked in Mr. Moore's case, do you remember that testimony you gave then?

A. I'm not sure I understand your question.

Can you be more precise?

Q. Sure.

Were you able to determine the period of time is, the absolute last time that the thrombolytic therapy he received previously in your opinion that would have been able to have been used in his case on the 25th or 26th, when was the last time it would have been able to have been used in order to save his leg?

A. I remember that.

We talked in the depo about it, and the best of my recollection I wasn't able to come -- I

said it in my expert report, obviously I said, should have dealt promptly, and with this patient, and I believe Mr. Weaver said, how many hours, and I said, well, it's never by the hour because you will have to call the surgeon, you will have to call the interventional radiologist, chances are he would have gone into the 26th, and this is not a one-shot deal.

This is an infusion first of Heparin that will preclude further clotting form, and then a TPA you keep dripping into the legs and hope the clot will dissolve, so this is not an hour or two.

I again said, that should have been promptly started once the issue was recognized, and then would have more likely than not continued into the 26th.

Q. In your opinion would you agree with me that thrombolytic therapy is not indicated for a patient with chronic or limited ischemia?

A. Yeah.

Q. You would agree in terms of the timing of when the thrombolytic therapy would have been helpful, or prevented the ultimate outcome in Mr. Moore's case, you really don't know when that time line is, you're speculating to that, right?

A. I don't understand your question.

I can try to answer, but if you can reformulate it.

Q. Sure.

You would agree there's a number of factors would have to take place in order for the thrombolytic therapy to be successful, true?

A. Not necessarily.

You have to -- I mean, first of all, that was discussed in the depo, and let me -- I'm trying not to confuse the depo.

On one hand there was normal pulses, but on the other hand I think your expert said that he would have needed amputation anyhow, even with normal pulses, so there was -- we had a little battle there because you can't have it both ways, but regards to the acute versus chronic, when you have a patient that has limb ischemia, no blood in his foot, and you believe that it one hour, one day, or one week, you do it because you most likely will save that leg.

Nobody is going to look at the clock, say well, we believe we're not going to do this thing, we're going to cut his leg, so I disagree with that.

In other words, if a patient shows up, he will get TPA.

Q. Let me try to simplify it for you, doctor.

You would agree with me, doctor, when Mr. Moore returned to the hospital on December 28th, thrombolytic therapy was initiated with the IV Heparin, correct?

A. Incorrect, and I can explain that.

Q. You know what, your counsel --

A. I can explain that to the jury.

Let me clarify.

Heparin is not a thrombolytic. You said IV thrombolytic.

Q. Let me clarify the question, so we can be on the same page then, doctor.

You agree with me though that when Mr. Moore returned on the 28th, he was eventually put on thrombolytic therapy, correct?

A. It's not eventually.

You are started promptly.

He was started on thrombolytic and Heparin, two different things here.

Q. That's what I'm getting at, he was started as soon as he was diagnosed in the emergency room on December 28th, correct?

A. Yes.

Q. And you would agree with me that even after 24 hours of thrombolytic therapy and Heparin, the

clot was unable to be resolved, correct?

A. Incorrect.

Q. Well, your counsel can follow-up with those answers.

I'm trying to get like a yes or no from you.

A. I --

Q. So if I can follow up with my next question, doctor.

The thrombolytic therapy initiated on the 28th ultimately proved to be unsuccessful, correct?

A. Correct.

Q. Ultimately, Mr. Moore required to have his leg amputated, right?

A. Correct.

Q. Hypothetically, if Mr. Moore had been started on thrombolytic therapy on December 25, and it was unsuccessful, can you listen to me, you would agree with me that he would have ultimately required an amputation, correct?

A. Incorrect.

Q. Okay.

Now, in this particular case you were first contacted to review this case by counsel, Plaintiff's counsel, a few years back, right?

A. Correct.

Q. And at the time you knew the end result of what happened to Mr. Moore, right?

A. Wrong.

Q. You weren't provided with information about what the case was about, and the fact that Mr. Moore had had to have his leg amputated as a result of an arterial occlusion?

A. No, sir.

When he first contacted me, I didn't know anything about the case.

Q. Okay.

But after reviewing the case, you came to the -- you were provided with additional medical records, right?

A. Correct.

Q. Including the records from December 28th, correct?

A. Correct, sir.

Q. And records following December 28th for other hospitalizations, right?

A. Yes, sir.

Q. When you went and started your review, you didn't just stop at December 25th, correct, in your review?

A. Correct.

Q. You had those other records that you followed up and found out what happened to him, right?

A. Correct.

Q. All right.

So you knew there was an amputation ultimately occurred, correct?

A. Ultimately, yes.

Q. Now, in regards to the records that you were provided, you would agree with me you have a list at the time of your deposition, you would agree with me you did not review all of Mr. Moore's prior treating physician records, correct?

A. I'm not sure how to answer.

The review I was given to me, I have a list.

Q. Right.

According to the list, I don't know if you have your actual file materials with you, based on one of the invoices attached as an exhibit in this case you were provided with records from St. Rose Hospital that were approximately 995 pages, do you recall that?

A. I don't, but if I billed for it, I reviewed

those records.

Q. All right.

Are you aware that -- again, we can verify because he have numerous volumes of medical records behind you -- that in fact there 2,865 pages just from St. Rose lose alone, are you aware of that?

A. I'm not sure I understand the question, sir.

I have a list, if I can help with everything here.

Q. I know you have listed St. Rose Hospital, right, you have it listed there how many pages were part of the St. Rose records?

A. I don't know, whatever you gave me, that's what I reviewed.

Q. I'll represent to you -- Do you have any reason to disagree if it was in your invoice, there was a total of 985 pages that you indicated that you had read and billed for, do you recall that?

A. I don't recall, but if it's on the invoice, that is what I've done, yes.

Q. And again, my question now is, are you aware there are actually 2,865 pages of records just from St. Rose Hospital alone?

A. Well, if you tell me, you're probably

correct.

I wasn't aware, no.

Q. Did you ever ask Mr. Arntz or prior counsel as to whether or not you had been provided with everything that you needed to review in this case before coming and giving your deposition and coming to court?

A. No, sir.

Q. And you would agree with me, you have done expert work for some time, right, over the past 10, 15 years?

A. 10 years, sir.

Q. All right.

And you have given 50 depositions, right?

A. Less than 50.

Q. And you testified in trial or mediation 5 to 10 times, right?

A. Yes.

Q. And you agree with me, it's your role as an expert witness, it's important that any expert witness who is going to come in and criticize the care and treatment provided by any physician, that it is important that you have all of the available records in order the make sure you didn't miss anything, right?

A. That is wrong.

Q. That's wrong, you don't think you need all the records?

A. No, you need enough to make your opinion, if I may explain.

Q. Well, Mr. Arntz can follow-up with that.

Well, in this particular case you also were provided with deposition transcripts, right?

A. Yes, sir.

Q. And you read Mr. Moore's transcript, right?

A. Yes.

Q. His wife, right?

A. Yes, sir.

Q. His son, Christopher?

A. Yes.

Q. Do -- You weren't provided with the records, I didn't see it listed -- tell me if I'm wrong -- you weren't provided with the medical records from St. Rose Stanford Clinic, true?

A. I don't remember, sir.

Q. Those are Dr. Wiencek's records. Do you recall seeing his office records?

A. I don't remember.

Q. Do you know who Dr. Wiencek was?

A. I don't remember.

Q. Okay.

I'll represent -- or Wiencek, the vascular surgeon?

Q. Maybe it's a Romanian pronunciation, I'm mispronouncing.

A. Wiencek.

Q. You have read those office notes he has from St. Rose Stanford Clinic?

A. I do not remember, sir.

Q. Right.

I didn't see it.

I'll represent to you -- Do you want to take a look at the list?

Take a look at the list.

A. If it's not here, I didn't see it, sir.

Q. As the treating cardiovascular surgeon, Dr. Wiencek, those records would be important to you in order to see if they provide any additional information, or if they contradict any other information that you were provided in the records, right?

A. Wrong, sir.

Q. Okay.

Are you aware Dr. Wiencek diagnosed the Plaintiff as suffering from chronic venous

insufficiency?

A. I remember reading that, and actually I did say he had a venous ulcer, yes.

Q. So you are aware that Mr. Moore had been diagnosed and had suffered from chronic venous insufficiency for many years, right?

A. I'm aware of that.

Q. And, in fact, you said you weren't aware specifically of records reflecting a DVT diagnosis, but you're aware it was mentioned in the records somewhere, right?

A. Correct, sir.

Q. All right.

Now, if I can refer you to --

MR. MC BRIDE: At this time I'd like to move for the introduction of Joint Exhibit 109, which is Dr. Wiencek's records.

MR. ARNTZ: No objection.

MR. WEAVER: No objection.

THE COURT: 190 is admitted.

You may inquire.

MR. MC BRIDE: Thank you.

BY MR. MC BRIDE:

Q. Doctor, I just wanted to kind of refer you to a couple of notes from there. We're going to show it up on the screen.

I think we're switched over.

If we could look at -- Are you aware Dr. Wiencek saw Mr. Moore in his office on February -- in February of 2016, February 8, 2016, it's SRSC-36, Exhibit 109, which has been admitted, and they will show it.

In fact, doctor, it should show up on your screen now.

A. Thank you.

Q. Actually, there we go.

Do you see that record, have you seen that before?

A. I might, just don't remember, sir.

Q. Okay.

Well, you are aware that Dr. Wiencek reported that he had been -- Mr. Moore had been doing well, was ambulating with the aid of a cane, and approximately five percent of the time he uses the wheelchair, are you aware of that?

A. I --

Q. Do you see that in the history of present

illness section?

A. I see that sir, yes.

Q. And then you note here, Dr. Wiencek notes he has good pulses above and lower extremities on the femoral on the left and tibial on the right, you see that?

A. I agree, sir.

Q. As of February 8th of 2016, good pulses were noted in both lower extremities?

A. That is what is documented, and I believe the graft was open at that time.

Q. Okay.

This is ten months before, ten months before he presented to St. Rose emergency room?

A. Correct.

So I believe the graft was open, so that is right, he had pulses.

Q. And, in fact, are you aware he was supposed to return to Dr. Wiencek's office on a regular basis every six months to have regular checks on his pulses and see how he was doing?

A. That sounds fair, yeah.

Q. He was also using compression stockings, and that was appropriate, right?

A. Sure.

Q. Compression stockings, do they assist with maintaining blood flow as best as possible, as well as to prevent DVT?

A. Somewhat correct, somewhat incorrect.

Basically, the venous part of the disease it assists with, doesn't promote the blood glow, just takes care of the venous insufficiency part.

Q. Right.

That was something that was appropriate, given Mr. Moore's prior venous insufficiency, right?

A. Yes, sir.

Q. And I'll represent to you -- Have you seen the records from Dr. Irwin Simon?

A. I seen pages, don't remember all of them, but can you refresh my memory.

Q. Sure.

I'll show you that page in a second.

But are you aware that in that particular letter being written by Dr. Wiencek to Dr. Simon, acknowledging he had been diagnosed with a prior DVT, have you seen that document before?

A. I've seen it and agree with it.

I'm not disagreeing, it's correct.

Q. The only reason I'm going over this is because there was a lot of times yesterday by Mr.

Arntz with Terry Bartmus, who was on the stand, about where that came from, so I just wanted to make sure we're on the same page.

You have seen that?

A. Yes, sir.

And I truly believe I actually said earlier there was an indication to look for DVT.

Q. In fact, the reason why you recall Dr. Wiencek actually prescribed the patient with the Xarelto is in an effort to help deal with the potential -- as a prophylactic to deal with potential DVTs, right?

A. And also the graft.

Q. Also the graft.

I think you said in the deposition the Xarelto in your opinion does not really work for arterial insufficiency, is that your testimony?

A. Yes and no.

In a steady-staged patient it's better than nothing.

In a patient comes to the ER with the graft being closed, and again I don't believe he had any pulses because the pulses were coming from the graft that shows my point, but you have to move to what you read the way they've done it on the 28th to

thrombolytics and Heparin, so Xarelto is not good anymore, it's good for a patient that does it at home, but once it's in trouble, Xarelto is not enough anymore.

Q. You're aware Xarelto has been actually recommended and previously was used as an off-label use to assist in blood flow, arterial blood flow as well?

A. We're saying the same thing.

I agree, if the patient's home, he benefits better than nothing.

What I'm saying is, that on the 25th when he showed up with the graft being closed, and again at that time all this was gone because these no blood flow was coming from anywhere, Xarelto doesn't do it, it's all thrombolytics and Heparin, like you just said.

Q. And one of the blood tests that is done in a particular patient to determine if a blood thinning medication such as Xarelto is working properly, they order a PT, a prothrombotic, as well as an INR, correct?

A. May I explain?

Q. Sure.

A. You are somewhat correct, but mainly

incorrect.

Q. Okay.

That seems to be happening quite a bit.

A. You are correct in terms of the order, those are called coagulation studies.

Heparin, we talked earlier, once you give it, Heparin, the drip, that you provoke -- preclude the clot from being formed, you can measure PT/PTT or RNR, so that is when you give Heparin, the only way to flow, if it works, you measure that.

So to answer your question, the studies are being ordered, the Xarelto does not, it's not measured by PT/PTT, so you are incorrect by nobody measured Xarelto, that is done for Heparin.

I'm sorry, Xarelto, you give it, it's a certain dose, and patients live with it.

So you are correct to give Xarelto, but the PT/PTT is not for Xarelto, it's for the Heparin.

Q. Are there medications in your experience, doctor, as a cardio-vascular surgeon such as Dr. Wiencek, could prescribe in advance, or could have given to Mr. Moore in an effort to attempt to -- a stronger blood thinner, such as Coumadin or Warfarin, to be able to help deal with the potential issue of an arterial occlusion in the future?

A. Well, you bring up a very good point.

Coumadin is what he's talking about, it's the same thing, this is a pill, and for coagulation.

Xarelto, I'm actually not saying that Dr. Wiencek did anything wrong, his decision was to start Xarelto, I don't think it's bad, rules out the DVT, makes the blood thinner to flow better through this graft, hopefully it doesn't clot.

You can make an argument why don't we make the medicine stronger.

Coumadin, which is actually rat poison, that is what Coumadin is, so you measure what is called RNR, different ways to measure, that you get what you pay for.

That Coumadin will make the blood really thin, and people can bleed through their hands, or if they fall, they get hit by a car, die from a subdural, so you don't want to go on that side.

So yes, he could have done Aspirin or Plavix, could have done Coumadin.

He said it, with Xarelto I don't think it's a problem until he gets in trouble and shows up at the ER.

Q. And I guess what I'm getting at is, the fact Dr. Wiencek now that I understand you're not

critical of him, and neither are we, but Dr. Wiencek had an understanding of Mr. Moore's prior fem pop occlusions, correct?

A. First of all, let me re-emphasize even more, even if you will not have had an occlusion, it's beneficial for him to be on some sort of blood thinner because this fem pop is unnatural, it's plastic tubing, so you want to give them something anyhow because we know God didn't make them perfect, so at some point they will clot.

So you are correct, sir.

Q. In fact, the fem pop, if I can approach real quick the photo or the drawing, just so the jury understands, your drawing here of this tube, obviously you're giving it a reference point, but it's ultimately inside the patient's leg?

A. Yes, everything is inside.

Q. I just wanted to make sure that was clear.

It's not something that is attached to the exterior of the leg he's wearing around?

A. That would have been easy to declot then.

Q. Right.

So again going back -- or you aware then of the visit -- this is the same, it's 14, the page number.

Mr. Moore returned on May 9, 2016 to Dr. Wiencek.

Have you seen that record before?

A. I don't remember.

Q. Okay.

Again, this is for a three-month follow-up for a pulse check, right?

A. Yes, sir.

Q. That specifically is for a pulse check, that's what it says, yes?

A. Yes, sir.

Q. It says, he's been doing well, still able to walk for a few blocks, and then gets tired of the bilateral legs.

He's talking about both of his legs causing the problems, right?

A. Yes, sir.

Q. Not just the left leg?

A. Yes, sir.

Q. Again, he reported the use of a cane and a wheelchair when in a casino, and again noted he has good pulses in both lower extremities, and on the right, you see that?

A. Yes, sir.

Q. No reason to disagree with that?

A. No.

Q. Right?

A. No.

Q. Again, the graft was open at that time and reflects into the pulse?

A. That is the reason he's checking pulses, he wants to see if the graft is open?

Q. Sure is.

Then he reports that he was doing -- if you look at the assessment and plan portion at the very end, and it says, assessment of plan.

And it says, he will continue on Xarelto and will continue that.

He will continue to do his walking elevation and compression stockings, and I will plan, next page, to see him again in six months to a year for a pulse check.

Currently he has a strong anterior tibial pulse and good capillary refill by physical examination.

You see that?

A. Actually, it's different than what he's saying earlier, but in essence kind of saying the same thing, he has pulses.

Q. You have no reason to disagree with that?

A. No.

Q. And are you aware, have you seen any records from on Mr. Moore that in fact Mr. Moore on December 21, 2016, four days before he arrived in the emergency room department, he was seen at the Nevada Spine -- or excuse me, the Nevada Pain Clinic?

A. I'm sorry.

Is that a question?

Q. Yeah.

Have you seen any of those records?

A. I don't remember.

A few years went by perhaps.

Q. And do you know if based on your review of the records from whatever source, do you know if Mr. Moore had actually been treated on a regular basis for chronic back pain?

A. I think he did.

Q. And do you know if any of those times he was also reporting leg pain as well, and calf pain?

A. Could be.

Q. And do you know what was done on any of those occasions by the physicians there to determine whether or not there was any sort of vascular insufficiency, or arterial insufficiency?

A. I don't remember.

I'm not sure.

It's a spinal, probably not a vascular point of view.

Q. Okay.

Were you aware -- Have you seen any of the medical records from Walgreen's, the pharmacy that Mr. Moore received his prescriptions from?

A. Perhaps. I mean, a few years back.

I don't remember.

Q. I know you don't remember reviewing Dr. Wiencek's chart, ever going through it, but do you recall from either the Walgreen's records or Dr. Wiencek's records the fact that on December 27, 2016 a phone call was placed to refill his prescription for Xarelto?

A. It's possible.

He was discharged on Xarelto.

Q. And a call was made to Dr. Wiencek's office, and Dr. Wiencek called in the prescription for Xarelto, were you aware of that?

A. I'm not aware, number one.

Number two, I'm not sure if Dr. Wiencek did it on the 27th.

This is an automatic refill. My office does them all the time. Sometimes I don't even know

about it so --

Q. And you have not seen any records to indicate that that was an automatic refill, did you?

A. I don't remember, but also I don't see any records that Dr. Wiencek personally called the pharmacy and said, we need to do it.

Q. Right.

Because you have not seen those records?

A. I don't remember.

So perhaps we can put them on the screen.

Q. Sure.

Let's look at page 18.

This is Dr. Wiencek's records still, Exhibit 109.

It's is RC-18, and right up at the top, go right there, and zero in. You see that is December 27, 2016, right?

You ever seen this record before?

A. Perhaps.

I don't remember.

Q. Okay.

You see where it says fax refill to Walgreen's with refill per Dr. Wiencek?

It doesn't say that was an automatic refile, right?

A. The patients call says, if run out of medication, call my office, and as per Dr. Wiencek the office or nurse says, hey, John Doe ran out, should we just refill that, and I say, sure, go ahead and give him two months or three months, and then they faxed for Xarelto as per Dr. Wiencek, which is right.

Q. Sure.

What I'm getting at isn't one of your criticisms, doctor.

You mentioned in your deposition there was an inadequate follow-up by Dr. Lasry, as well as Nurse Practitioner Bartmus, they didn't give proper instructions for him to follow-up with his vascular surgeon, isn't that what you stated in your report and testified at your deposition?

Q. It's different.

May I explain?

Q. Your counsel can explain that.

But this --

A. You're correct, I had an issue with that, and I continue to have an issue.

I don't think I agree.

Q. You would agree with me that this documentation suggests Mr. Moore would have called in

a prescription on December 27th before he returned, the day before he returned to the hospital with the complaints of the severe pain and discoloration to his leg, correct?

A. I'm not sure I understand the question.

Q. Sure.

December 27 was the day before he went into the emergency department again, right?

A. Yes, sir.

Q. This would reflect a phone call was placed to Dr. Wiencek to refill his Xarelto, correct?

A. A hundred percent correct, that's all it shows.

Q. Okay.

And we don't know what was explained to Dr. Wiencek about whether the patient informed him what had happened in the hospital, or whether he needed to make an appointment, we don't know any of that information, right?

A. Although, we know what is written here.

You are correct.

Q. Okay.

Now, I think we talked about, you don't have an issue with the fact he had been diagnosed with a DVT previously, and we cleared that whole

situation based on the visit on December 25.

I want to go back now to the December 25th visit, okay?

You don't have a problem with the fact that Nurse Practitioner Bartmus had indicated in her records that a prior history of DVT had been reported?

A. I don't have a problem with that, sir.

I think it's correct.

Q. Do you recall from reading Christopher Moore's deposition, that Christopher Moore testified that that is what was conveyed to the hospital personnel, he had a prior history of DVT, you're aware of that testimony?

A. Yes, but there -- First of all, let me simplify this.

I'm not in any way, shape, or form critical of her ordering an ultrasound for the DVT, but it was communicated to the emergency room team he had a prior history of clot in the leg, which is my understanding they totally thought there was only a DVT, versus a clot in the the leg, being the clot in the leg after the graft.

Q. We'll get to that, and now we'll pull the actual records.

These are the records from St. Rose on December 25, Exhibit 100, and it's starting at 1331.

Now, doctor, you have those in front of you?

A. Yes, sir.

Q. You have seen these records before, right?

A. Yes.

THE COURT: Previously admitted.

MR. MC BRIDE: Thank you, Your Honor.

BY MR. MC BRIDE:

Q. And, in fact, this would indicate that one of the things -- First of all, in terms of Mr. Moore's past medical history, which was significant, I think you agreed in your deposition with the fact Mr. Moore was a long-time smoker?

A. Correct, sir.

Q. And I think you stated pretty clearly that smoking is not good for your arterial perfusion, right?

A. Correct, sir.

Q. In fact, it's something that you would advise every one of your patients, they should do their best to try to quit smoking, especially if they have a condition and surgery that Mr. Moore had in 2012, right?

A. Correct, sir.

Q. And that would be something you would repeat to a patient every time you saw that patient in follow-up for a pulse check or other visits in the hospital, that they -- you would advise them to stop smoking, right?

A. Yes, sir.

Q. And is part of the reason because that can -- smoking has been proven to actually affect the arterial and vascular system in human beings?

A. Yes, sir, you're correct.

Q. And it would have some effect on his arterial occlusive disease,, correct?

A. Yes, correct.

Q. You're aware that despite -- and again, I'm sure you had patients who despite your best effort to try to advise them to stop smoking, it's a difficult habit to break, and they continue to smoke, right?

A. Most of them, yes.

Q. And a lot of those patients still continue to have problems with arterial occlusion, as long as they keep smoking, right?

A. Well, some do, some don't.

I can explain that.

In other words, smoking is not good for the

blood vessels.

People, they don't smoke, end up with bad occlusive disease, and people that smoke, they don't have it that bad, but over all it's not -- it's good for them not to smoke, but it's not a great limited step, we advise them not to smoke.

Q. Gotcha.

You're aware in this case Mr. Moore continued to smoke, and even at the time of his deposition I believe, unless he's been able to stop that at the time of his deposition, I took that he continued to smoke one or two packs a day, do you remember that?

A. Yes, sir.

Q. Now, with regard to this note, and in particular the information that was provided, did you say that there was no indication that Dr. Lasry and Nurse Practitioner Bartmus were aware of any history of prior occlusions?

A. Actually, I said the opposite.

I said, two things.

I said, in their differential diagnosis, which I don't have to look at your screen because I know it by heart, there's nowhere mentioned the possibility of arterial insufficiency, like not

enough blood flow to the arteries to the foot.

There's a note from Miss Bartmus there was an old graft, and some history of clot could be computer-generated, but it's there, and again in the differential diagnosis this part is missing, but somewhere in the history it shows to be present.

Q. Okay.

And I want to get to, you would agree with me that in terms of the gold standard to diagnose acute limb ischemia, would be to use the five Ps, you heard of that?

A. It's not the gold standard.

A gold standard is an angiogram.

Five Ps is part of the physical exam. It's very objective. We have a screen there, subjective is perhaps not, so five Ps, this is going a hundred years back when our old doctors didn't really have all the tools we have.

So no, I disagree.

The five Ps are a basically -- actually not being used anymore.

Q. So you're saying five Ps are irrelevant to a clinical examination of the patient in the emergency department?

A. I'm not saying they are irrelevant.

I'm saying, they do not represent the standard of care.

The standard of care is done, actually not even the arterial duplex, the standard of care is an angiogram where the radiologist and vascular surgeon shoot contrast to make the circulation of the graft and see if the graft is open or closed.

This is 2020, we look at the screen, and we see it's not.

Five Ps refers to touching the leg and feeling if it's warm, if it's cold, if the patient can move it, those are usually not being done anymore.

Q. Okay.

Really.

Do you know why in terms of why the medical records we have from Dr. Wiencek after December 2016 and other records from the hospitals that Mr. Moore treated as after the December of 2016, why they would then continue to use the five Ps?

A. Well, they are not using the five Ps.

They are using -- not really going to five Ps.

A physical exam you look at the leg, you touch the leg, you check the pulse, see if you feel

it, you ask them to move their leg, see if they are able to because a lot of ischemia, they don't move it very well.

There's a lot of issues. Scratch it, take a car key, scratch the toes, do you feel this, do you feel anything, and they tell you, the foot feels cold, the foot feels numb, they cannot move.

You tell them to press your foot like you press the gas pedal in, so indirectly it's physical exam, not really the five Ps, and you decide from there which way you're going to go.

Q. So in this particular case if you could just encourage me for a second on the five Ps, the five Ps would indicate pain, right?

A. Correct.

Q. Color?

A. Pain, yeah.

Q. And then that would be color, if it's colored, and pulselessness, right?

A. Pulselessness, pulse, or pulselessness, yeah.

Q. And paraesthesia, which is numbness, right?

A. Yeah.

Q. Are you aware from the medical records in fact Mr. Moore had reported at least to Dr. Wiencek

when he diagnoses some elements of neuropathy he developed in his lower left legs?

A. He did not have diabetes, but he might have had neuropathy.

I'm not sure.

Q. Neuropathy in short, that can cause numbness, right?

A. It could.

Q. And then paralysis, right, if you are not able to move or ambulate, then you're paralyzed, right?

A. Well, we go back to the five Ps, which is part of the physical exam.

It's not totally paralyzed -- Well, if it's paralyzed, that is what happened the 28th. Usually it's the lack of movement, hey, press the gas petal, or press the clutch, and they can't do it, so it's lack of movement.

Nobody puts the five Ps, and then makes notes on them, but indirectly that is part of the physical exam, you look for things, yeah, and document that.

Q. So based on you comparing the physical examination performed on Mr. Moore in the emergency department when he was admitted back in 2014 for one

prior occlusion, right, you looked at those records?

A. When he got the graft initially?

Q. Yes.

A. Correct, yes.

Q. And then you also looked at the records from June 2015 where he had another occlusion, correct?

A. Yes, sir.

Q. You seen the medical records and what was documented under the five Ps by the physicians on both of those visits, right?

A. Yeah, well, was documented.

I mean, there's a discrepancy regards to him being or not being evaluated.

Q. In June you're talking about?

A. I'm talking when he came in, he -- no, December.

Q. I'm talking about you have seen those other visits where it was documented about what his presentation was under those five Ps from 2014 and 2015, right?

A. Correct.

Q. And now you have seen additional documentation too from Dr. Wiencek, at least today, in terms of the adequate perfusion, at least no

reports of pain, those sorts of things would indicate Dr. Wiencek was doing a physical examination using that method, right?

A. Yeah, correct.

Q. So, in fact, you agree with me that on those other visits to the emergency department where an occlusion required the thrombolytic therapy, he was admitted for that purpose, you would agree with me his presentation on each of those two occasions was actually significantly different than what it was on December 25, 2016?

A. Not necessarily.

I mean --

Q. Well --

A. -- it's never the same.

It's like looking at two cars, two people, they are never the same, but it's sometimes -- I can only talk about what I think is important at the presentation on the 25th was generated, the amputation, or lack of treatment generated amputation.

As far as his depo, he complained that leg being a bit more cool and numb, and he shows up to the ER complaining of what is called claudication, which is clearly to represent vascular arterial

ischemia, so if somebody comes to the ER on the 25th, and that is what is important, it's not important what happened a year or two or six months before, it's important what happened the 25th, was that kind of issue, a different diagnosis should be generated including the DVT, but mainly including the arterial insufficiency, knowingly somewhere in those notes they document there was a fem pop graft that failed the year before, but you don't see it anywhere.

This was a working diagnosis, and in other words, is this graft op or not, can we do anything if it's closed to open?

That was never taken into consideration on the 25th.

Q. Okay.

Doctor, you would agree with me the presentation was different on those prior two visits where he required admission and thrombolytic therapy, you agree with that?

A. No.

Q. We could go back.

A. We can -- should go back.

I think it's fairly similar.

Q. You would agree that there was discoloration noted in 2015, right?

A. I think there was, if I recall correct, yeah.

Q. You would agree with me, there's no note of any discoloration at the visit in December of 2016, correct?

A. The 25th.

The 28th there was discoloration.

Q. The 25th I'm talking about. You would agree no discoloration, right?

A. Correct, yes.

Q. In fact, you remember reading Mr. Moore's deposition testimony where he said in fact that his leg looked normal, you remember that?

A. Yes.

Q. And do you remember what he said about his leg on the 26th and the 27th, you remember what he said?

He said his leg looked normal, didn't it?

A. Yeah.

I one hundred percent agree with you.

Unfortunately, he's not a doctor.

Q. So let me ask my next question.

It wasn't until December 28th when he noted severe cold, causing excruciating pain, and his foot and leg was black and blue or mottled, right?

A. Mottled, that is dead.

Q. Right.

And that didn't have mottled presentation on the 25th, right?

A. He didn't, correct.

Q. Right.

His leg --

A. It was still salvageable at that time, the leg.

Q. The leg was described within normal limits, right?

A. By the ER team?

Q. I'm talking about every source that you looked at from his own deposition testimony, his son's testimony, as well as the depositions also of Dr. Lasry and Nurse Practitioner Bartmus, as well as the medical records from St. Rose Hospital on December 25, they all indicated that his skin and appearance and the condition of his leg was otherwise normal, with the exception of a report of pain and numbness, correct?

A. Well, somewhat incorrect.

You are correct that the ER team, Dr. Lasry and Miss Bartmus, documented as normal.

You are also correct he complained of pain

and numbness.

You forgot to bring up again the claudication, which is a clear sign of vascular ischemia.

And like I previously said, we're going to get there, it's the result of the ultrasound that is not normal, the ultrasound clearly shows the graft was closed, and that is highly abnormal.

So that is not a normal patient.

Q. Okay.

Actually, now we're on that subject, that is a good segway, you talked about the ultrasound report, the venous Doppler ultrasound done by the radiologist at St. Rose, do you recall that?

A. Yeah, it was done by the tech, not the radiologist.

Q. Right, by the tech.

In that particular case, in fact, that is interpreted by a radiologist subsequently, right?

A. Correct, by the tech initialing it, then by the radiology.

Q. So you have two people looking at it, and in this case we were fortunate, as you indicated the tech actually went farther up to actually check out the arterial system and found a possible occlusion,

you remember him saying that in his report?

A. Appeared an occlusion, correct.

Q. Now, I think you -- Let me get to that page.

Here it is, it's 1411.

It's St. Rose Exhibit 100?

Doctor, I think you testified from questions from Mr. Arntz the radiologist who interpreted this and looked at the arterial and saw the evidence of the possible occlusion, that that radiologist stated, do something now, instructed the ER physicians to take action immediately, call a vascular surgeon, do more studies, clinical correlation if necessary, isn't that sort of what you -- to paraphrase what you said in response to Mr. Arntz?

A. Well, not exactly, but similar.

So the impression is, no evidence of DVT, so no clot in the foot, in the left lower extremity, left femoral graft appears occluded.

If you would be in a submarine, you would see a red light and a sound, this cannot be more of an emergency, those words here, those six words there represent flags, alarms, red lights, all over.

When a patient walks in, a patient who has

a history of clot, the fem pop -- has been clotted before, comes in with pain, comes in with basically being numb, and foot pain, the first thing you do, you rule out that the graft has to be open, and there was not part of the working diagnosis for them, so then the physician says, hey, that is what I think, at that point automatically if a computer would be available to have done it, an arterial duplex gets in right away, your arterial part, and generate an angiogram to follow, you would hope, so -- but that wasn't done, that's my point.

Q. My point was really more to what you testified earlier where you said that the -- I'll let the jury decide what you actually testified to, but I had in my note that you said the radiologist reported that something needs to be done, a vascular surgeon needs to be consulted, or an arteriogram needed to be performed.

That is not what it says in that report, correct?

A. Not directly, no.

That is my interpretation of those words.

Q. Right.

In fact, you have seen reports that have come back from a radiologist when they happened upon

a finding that wasn't maybe something that they expect to find or not the main purpose of the exam, where they've actually used the term further clinical correlation is recommended or suggested, correct?

A. I've seen that, yes.

Q. And it happens quite often, right?

A. It's up to the radiologist.

Q. Sure.

A. It's not up to the radiologist who reads the film to tell the ER physician or vascular surgeon what needs to be done.

All they need to say is, whatever they said, this seems to be occluded, and I figure out, or the ER physician or Nurse Practitioner, what needs to be done.

Unfortunately, because they were never looking at this issue, they have done nothing about it.

Q. But this is something you would agree with me the purpose of this study was to rule out a DVT, right?

A. A hundred percent.

Q. So in the context of that you'd say the radiologist actually found is this additional, quote, unquote, abnormal finding, right?

A. I don't need quote, unquote.

It's definitely abnormal.

Q. In that particular case you would agree with me that since this wasn't the specific test for it, that the language that the radiologist, if he was concerned about it, would be to recommend further clinical correlation with other studies, that's the language that is used all the time by radiologists, right?

A. Not all the time.

It's used at times.

But it's not the radiologist's job to be concerned, it's the ER job to be concerned.

So all what he said, he reads films, he's objective, looks there, sees what it says, and he reports it.

It's up to the doctor who cares for the patient what to do.

He could call the ER, he could be -- he as a vascular surgeon -- he could start the Heparin, he could do a lot of things, or do anything. It's their responsibility, not the radiologist's responsibility.

Q. I understand you don't have any criticisms of any of the hospital personnel or the nurses who actually cared for Mr. Moore on December 25th, isn't

that right?

A. You are correct.

Q. So you have no criticism of the exam that Nurse Kuchinsky did initially, which demonstrated that the patient's leg was normal and warm, and not cold or blue, you don't have any disagreement or concerns with her examination that night?

A. Actually, I agree with the examination.

I don't think there's anything unusual. I think she done the right thing, yeah.

Q. Now, in this particular case on the ultrasound it demonstrated the venous flow was shown to be normal, right?

A. Correct.

Q. So in order -- You agree with me, in order for there to be normal flow in the veins against gravity towards the heart, back up to the heart, there has to be sufficient blood flow down the arteries, true?

A. There has to be some flow, which I earlier spoke about the collaterals, so this leg didn't die in six hours, that is where the leg was warm, the leg never had a pulse, but there were collateral enough to keep it going for three days until everything clotted, and they had to amputate it, and that's all

based on the small collaterals he had for years.

Q. Did you see anything -- I wanted to talk about that.

Do you see any reference in the 12/25 visit that any examination demonstrated -- or a complaint by Mr. Moore of coldness into the toes specifically?

A. I don't remember.

He did complain of a cool leg, cold leg, colder leg, but that is exactly what happened.

Q. And I'm just trying to limit it.

I know what he testified in his deposition.

I'm talking about specifically, did you see a reference to cold toes?

A. I don't remember.

Q. Are you aware that one of the visits that he had in the emergency department, I believe it was either in the 2014 or 2015 visit, that one of his reports of complaints was cold toes and calf, do you remember reading that?

A. I don't remember.

It's possible.

He can have those symptoms, yeah.

Q. So one of the articles you provided to us at the time your deposition is the Hanky article, you remember that?

A. I provided 11 articles.

I don't remember.

Q. The Hanky article that talks about acute limb ischemia, do you remember that?

A. Would you mind showing it to us?

Q. We can't unfortunately, that is part of the rules of evidence, but do you recall reviewing an article on acute limb ischemia from Hanky?

A. 11 articles I brought, that's correct.

MR. WEAVER: I'm sorry.

I didn't hear what he said?

THE WITNESS: 11 articles, 10 or 11.

BY MR. MC BRIDE:

Q. Okay.

And in that article, are you aware of that, that article, you agree with me it does not discuss the diagnosis and treatment of chronic limb ischemia, true?

A. Actually, I don't remember right now as I sit here.

The articles were just looked at are again data likely previously said, the articles don't represent the standard of care, either the guidelines don't necessarily represent the standard of care for a patient.

I truly believe if I can help you, that this was not -- Well, there was chronic -- in terms of he had vascular disease for many years, and there was an acute presentation, which is a definition less than two weeks that got him on the Christmas day in the emergency room.

So I'm more concerned about the acute part of the presentation.

Q. In particular I just wanted to talk very quickly about the article that mentions the classification system.

Are you aware of that classification system to determine a viable limb?

A. Yes.

Q. And --

A. 12 and --

Q. Type one is a viable limb, not immediately threatened, no sensory or muscle weakness?

A. Correct.

Q. And then you have it progressively gets worst, up to the point of amputation is the only way, right?

A. Correct.

1 is -- we all have a 1.

3 is dead on the 28th, and there's 2-A,

2-B, 2-A marginally threatened, 2-B seriously threatened, so when he showed up, he was a 2-A, 2-B, that's why the leg didn't die within six hours because you're giving out, the collaterals were good enough to support a leg for that long.

Q. A 2-A.

That particular article also talks about the five Ps?

A. You could talk --

Q. I'm asking you this question:

Do you agree with me that article discusses the five Ps as a way to diagnose acute limb ischemia, using that classification --

MR. P. HYMANSON: Excuse me.

May we approach, Your Honor?

THE COURT: Yes.

(Thereupon, a discussion was had between Court and counsel at sidebar.)

THE COURT: Thank you.

All right. You may proceed with further questioning.

BY MR. MC BRIDE:

Q. All right.

Now, Dr. Wilson, you asked a question, if you know the expert on behalf of the Defense in this

case, Dr. Samuel Wilson, and you said that you did not know him, right?

A. Correct.

Q. Do you know -- Have you done any investigation into his background, or training, or experience based on reviewing his expert reports, or anything like that?

A. I Googled him.

Q. Okay.

Are you aware of what sort of reputation he owns as a physician in the California community as a vascular surgeon?

A. I don't know, sir.

Q. Are you aware of the textbook that Dr. Wilson has authored, and other textbooks he's authored over his career, in the field of vascular surgery?

A. I'm not aware.

Q. Doctor, would you agree that physicians can disagree on recommendations of treatment for any given patient?

A. I do.

Q. And just because they disagree, that does not mean there was negligence on the part of a particular physician, correct?

A. I agree.

Q. Now, just very quickly -- Actually, I may be quicker than I thought.

You have had your deposition taken, like we talked about, over 50 times, or close to 50, lower than 50?

A. Yes.

Q. And --

THE COURT: Not in this particular case.

MR. MC BRIDE: Right.

BY MR. MC BRIDE:

Q. And, doctor, you provided us with a list of your testimony at trial and depositions before today, and I think it went back to 2015.

Do you recall reviewing that particular publication?

A. I --

Q. You listed all the trials you testified in?

A. My own list.

Q. Yes.

A. Yeah, I made the list.

Q. So at least since 2015 by my count there were at least 18 depositions, and I think three trials, one mediation.

Does that sound about, right?

A. Probably more than that I think, but it's probably right.

Q. Okay.

You charge a flat rate $1,000 for deposition, with a two-hour minimum, right?

A. That's correct.

Q. And in this particular case your deposition took three hours, so you were given a check for $1500, right?

A. I believe so.

Q. And then you charged $650 an hour, it's $650 an hour?

A. It should be more than that.

I think he needs to write me a check then.

Q. $650 an hour for review of records, is that right?

A. That's correct, sir.

Q. $650 an hour for review of the literature, correct?

A. Yes, that's correct.

Q. Let me ask you, do you have any idea -- and that is $650 an hour for report preparation, right?

A. That's correct.

Q. As you sit here, do you have an estimate of the total amount of time that you have spent

reviewing the records in this case, preparing your report, and preparing for trial here today?

A. No, I do not, sir.

Q. Is it more than 20 hours?

A. Yes, definitely overall for the last few years.

Q. Yes?

A. I hope so, yeah.

Q. More than 30 hours?

A. I just don't know.

This was two years I think, yeah.

Q. Do you keep track of the amount of time you spend, in order to bill to the Plaintiff's attorney?

A. I do, and you have my bills, you have my invoices, so I think you know better than I do.

Q. You don't have those with you?

A. No, I provided them to you at the deposition.

Q. In terms of whatever those invoices reflect in terms of the amount of time that you have spent up to the time of your deposition, that would be accurate, right?

A. That's correct.

Q. And then how about since your deposition October of 2019, to today, how much time, additional

time, have you spent reviewing and preparing for your trial testimony?

A. I'm not sure.

I spent a fair amount of time just looking through records and so on, so I'm not sure.

Q. So those bills we don't have.

So that's why I am trying to get your best estimate.

Can you estimate, was it more than 20 hours?

A. I would have to check.

More than 10 for sure.

Q. Is it fair to stay 10 to -- 10 to 20 hours?

A. Perhaps.

Q. Then you also charge 10,000 a day for trial testimony?

A. That's correct.

Q. Not including travel expenses, right?

A. That's correct.

Q. Did you come up last night or today?

A. Last night.

Q. Did you have a meeting with counsel to go over your testimony here today?

A. No, I had a meeting for dinner.

Q. For dinner.

Did you talk about your testimony?

A. A little bit, yeah.

Q. You also advertise your services as an expert in several publications, right?

A. Well, depends how you perhaps -- I don't call it advertising, but I'm listed, could be for advertising, I'm listed in a certain directories, my office is, that's correct.

Q. And so you recall testifying in your deposition that there's several advertising -- or services that you have in your name listed as a potential expert, do you have your name listed as a potential expert in emergency medicine in any of those advertisements?

A. No, sir.

Q. You said you paid a couple of thousand dollars a year for advertising, is that right?

A. Mr. Weaver said that, and I actually agreed with him.

I wasn't sure, I think it's possible, yes.

Q. Do you know what the amount you spent for advertising was?

A. No, sir, but it sounds right.

Q. Let me check my notes.

A. I think your firm is probably one of the

advertised in, I've been one of your experts a few years ago.

Q. One of my experts?

A. Yeah, your law firm you work for.

Q. Well, I've met you before today, right?

A. No, I'm saying the law firm, I've been an expert for you guys as a Defense expert, and they said they found me --

Q. I don't know how it turned out because I never met you before today, and so at any rate I'm glad you were happy.

Are you aware, you have read Dr. Jacobs, the expert emergency room physician for the Plaintiff, you read his report and deposition?

A. I did, two reports actually, and a deposition, yes.

Q. Are you aware of Dr. Jacobs' testimony where he stated that it was irrelevant if Dr. Lasry even seen the patient, since he reviewed the case with Nurse Practitioner Bartmus.

Q. Can you repeat the question?

A. Sure.

Were you aware of Dr. Jacobs' testimony where he said it was irrelevant whether or not Dr. Lasry even saw the patient on December 25, as long as

he discussed the case with Nurse Practitioner Bartmus?

A. You asked me if I seen, or agree with his statement.

Q. I'm asking, have you seen that?

A. I don't remember that.

I think it's relevant.

If he said he did, and didn't do it, it's very relevant.

Q. And I think you testified too that you're not making any specific judgment on Dr. Lasry and whether he personally evaluated the patient, and you would leave that to the jury to decide, right?

A. I did say that.

MR. MC BRIDE: Thank you, doctor.

That's all I have.

THE WITNESS: Thank you, sir.

THE COURT: So we're going to go ahead and take our lunch recess now, then resume with Mr. Weaver's questioning and any redirect from counsel, but rather than be to far into the lunch hour, I think it's a good time to take a lunch break now.

We'll return at 1:30.

It's a little after 12 now, so that gives you enough time to find a place to eat.

(Jury admonished by the Court.)

THE COURT: Have a good lunch.

See you at 1:30.

(Jury excused from the courtroom.)

(Thereupon, the following proceedings were had out of the presence of the jury.):

THE COURT: Just to make a record -- Doctor, you may step down.

Actually, probably just leave them there. We're coming back after lunch with your testimony.

There was a brief bench conference seeking to discuss -- or raising an objection --

THE MARSHAL: One of the jurors said they have a question.

MR. MC BRIDE: Let's wait.

THE COURT: Find out what it is, and they can write a note.

Assuming it's related to the trial or witness?

THE MARSHAL: To the witness.

THE COURT: Remind them it's at the end of the questioning of the witness, but they can certainly write their question down to have it read.

Back to the bench conference.

So Mr. Hymanson had posed an objection

because Mr. McBride was discussing an article with the doctor, and some specific article component, and of course the doctor had indicated he reviewed up to 10 or 11 articles, and so Mr. Hymanson was concerned that way of questioning would continue, it would be imperative to have the specific article referenced shown to refresh the recollection of the doctor.

Mr. McBride indicated he thought he had given sufficient specifics to that article, specifically he did not intend to have further inquiry about other articles, so I think the questioning went on to another path after that.

Mr. Hymanson or Mr. Arntz, anything you want to add to the bench conference?

MR. P. HYMANSON: No, Judge.

MR. ARNTZ: No.

THE COURT: Mr. McBride?

MR. MC BRIDE: No, Your Honor.

THE COURT: I did instruct counsel if he was going to continue to inquire about particular articles, he should either have that article itself, or as much as possible, so to attempt to refresh the recollection of the witness, but it wasn't necessary.

We'll see you all back, get started at 1:30.

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

C E R T I F I C A T E

STATE OF NEVADA)
) ss.
CLARK COUNTY)

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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