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 05:24 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 XV

E. Breen Arntz, Esq.
Nevada Bar No. 3853
Breen@breen.com
Phone: 702-494-4800
Fax: 702-446-8164
Attorney for Appellant Darrell Moore and Charlene Moore

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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 XV** 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.

Robert McBride, Esq
McBride Hall
8329 W. Sunset Rd., Ste. 260
Las Vegas, NV 89113

Keith A. Weaver, Esq.
Lewis Brisbois Bisgaard & Smith, LLP
6385 S. Rainbow Blvd., Ste. 6000
Las Vegas, NV 89118

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

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

Thursday, February 6, 2020, 1:30 p.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. Samuel Wilson	6	77	151	159

Las Vegas, Nevada, Thursday, February 6, 2020

* * * * *

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

THE COURT: Is there anything outside the presence before we bring the jurors in?

MR. WEAVER: No, Your Honor.

MR. ARNTZ: No.

THE COURT: Okay.

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

THE COURT: Welcome back, ladies and gentlemen.

We are resuming the trial, and we already have in place.

Dr. Wilson, who of course we left off that testimony yesterday at a point to finish the other testimony, now he's returned.

We don't need to re-swear you, just acknowledge for the record you understand you're still under out.

THE WITNESS: I am, yes.

THE COURT: Thank you.

MR. WEAVER: Your Honor, just for housekeeping, the parties stipulated into evidence Exhibits 106 and 202.

THE COURT: Okay.

They will admitted.

Proceed.

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CONTINUING DIRECT EXAMINATION OF DR. SAMUEL WILSON

BY MR. WEAVER:

Q. Good afternoon, Dr. Wilson.

A. Good afternoon.

Q. Welcome back.

A. This is my third day.

Q. That certainly wasn't the expectation.

Dr. Wilson, we're going to start this afternoon with your credentials, since we weren't able to fully get to them yesterday.

Are you board-certified in general surgery and vascular surgery?

A. Yes.

Q. What does board certification mean?

A. It means, you have completed a required course of training to be a surgeon, and generally additional training for vascular surgery, and you sat a written and oral examination.

And in the case of vascular surgery re-certified every ten years.

Q. And do vascular surgeons perform amputations through advanced vascular disease?

A. Yes.

Q. Are vascular surgeons the primary surgeons

perform non-traumatic amputations?

A. It's done by multiple specialties, but I think the vascular surgeons has the majority.

Q. Why is that?

A. Well, they are the ones that are the prime care treatment of vascular disease, and to take many diabetic patients will have amputations, all the way to total amputations, to higher level amputations, and generally they continue to see the same physician that they've started out with, a vascular surgeon.

But orthopedic surgeons also do quite a number of amputations.

Q. What about general surgeons?

A. Traumatic amputations they would complete for example.

Q. And --

A. Not as many as vascular or orthopedic.

Q. And have you performed many, many amputations during the course of your career?

A. I have performed many amputations, yes.

Q. And roughly Dr. Wilson how long have you been board-certified in general surgery and vascular surgery?

A. General surgery since 1971.

I finished my residency in 1970.

And the vascular surgery boards came out, the first exam I think was '82.

And I took the exam in '83 to become board-certified.

Q. And do you presently have any academic appointments?

A. Yes.

I am a full professor, and if I could say recently titled distinguished, but no increase in salary, and I have been a professor in the University of California since approximately 1982.

Q. And when you say, with the University of California, has that been both UCLA and University of California Irvine?

A. Yes.

Q. Are they teaching institutions?

A. Yes.

Q. And when did you start at UCI, after having been at UCLA?

A. 1992.

Q. And what does a distinguished professor of surgery mean?

A. Oh, it means you have been around for a long time, and that you have contributed significantly to the advancement of your specialty

area in terms of publications, recommendations for treatment, research, so on.

Q. You also historically had an academic association with the VA Hospital system?

A. Yes.

Q. What did that consist of?

A. Well, for quite a number of years I was chief of surgery at our local VA Long Beach because we had an integrated residency program, our residents went there, and I retired from VA after approximately 50 years of service, so I retired from VA two years ago.

Q. And were you at one point in the military yourself, sir?

A. Yes.

Q. And what was your rank, and what was your branch of service?

A. I came in as a Major, United States Air Force, and as soon as you obtain board certification, which I did in 1971, then you're appointed a Major, and I left as a Major.

Q. And generally in a nutshell can you tell us about your teaching experience?

A. Well, I teach medical students, occasionally undergraduates, but not too often, and I

teach residents.

I teach both on the job and didactic lessons in the classroom.

Q. What does didactic mean?

A. Where you expound your knowledge to the students.

It's not where you are demonstrating surgery, or you are scrubbed in the operating room, it's in a classroom setting.

Q. Okay.

And in terms of I think you told us yesterday you teach existing physicians who are specialized doing residency in vascular surgery?

A. Yes.

Q. Who else if anyone do you teach?

A. Medical students and residents, and I do a fair amount of lecturing to medical staffs for their monthly educational conference.

And in years past I would speak at American College Of Surgeons annual meeting, Pacific Coast Surgical Society, and most of the surgical organizations.

Q. Do you treat patients still?

A. Currently, because I'm in the process of retiring from the University of California, I'm not

seeing patients currently, I'm doing consultative work, and -- but I have been seeing patients consistently throughout my career.

Q. And during the course of your career where you seen and treated patients, have you worked with nurse practitioners?

A. Yes, in my vascular clinic I relied on one or two nurse practitioners to help make it through it, yes.

Q. And what is a vascular clinic?

A. Where you see people with arterial and venous disease and amputations.

Q. Would it be fair to say that over the years you have seen thousands of patients with vascular disease?

A. I think so, yeah.

Q. Dr. Wilson, are you the author or co-author of medical text books or medical treatises regarding vascular surgery or vascular diseases?

A. Yes.

I would term it more as an editor, since you don't write the entire book, but you write contributions from people who may have for example more expertise in an area than you do.

Q. And roughly how many medical textbooks or

medical treatises are you the editor or co-editor of roughly?

A. At least a dozen.

Q. And have you contributed more than a hundred chapters to other people's medical textbooks or medical treatises regarding vascular surgery or vascular disease?

A. Yes.

Q. What would be the best estimate of the number of peer-reviewed articles in vascular surgery and vascular disease you have written?

A. It's close to 500, if not 500.

Q. And are those in peer-review journals?

A. Probably 90 percent.

Q. What does it mean to have an article that is peer-reviewed?

A. That means that the manuscript you send in for publication in that journal has been sent out, usually anonymously, so the reviewers, independent reviewers, usually three will read your manuscript and make a decision of whether or not it's of quality where it should be published in a journal.

Q. And in addition to contributing to hundreds of peer-reviewed journals, have you been a regular or occasional reviewer of a dozen or more medical

journals yourself?

A. Yeah.

I continue to review articles for publications.

Q. And I'm almost finished on the credentials part.

But have you also received recognition for having some of the most influential articles in vascular surgery and vascular disease?

A. I have.

Q. And what is that?

A. Very nice of you to bring that up.

Of most of the 50 most influential articles in vascular surgery I've been I'll say co-author on two of them, and I was very pleased to see that.

As you begin to end your career at least you can look back on see changes that you have made and been very important in people's lives.

Q. Thank you, Dr. Wilson.

Do you feel that you are qualified to offer opinions in this case about Mr. Moore's care and treatment in vascular surgery and vascular disease issues?

A. I really do.

Q. Dr. Wilson, do you have a recollection

based on your review of the materials in this case how Mr. Moore's foot was on December 28th, 2016 when he presented to the emergency department?

A. Yes.

Q. Would you tell us please what your recollection is of how his foot looked?

A. That it had all the indications of acute vascular ischemia.

Q. What were those conditions?

A. That his foot was cold, and that Mr. Moore recognized this was the same coldness that had occurred with previous occlusions of his graft.

That his skin was discolored.

I believe in one area it was called mottled.

That it was extremely painful.

I think those are the important things that I recall.

Q. Does that description, would that would be consistent with acute limb ischemia, based on your training and experience?

A. Yes.

Q. Do you have a recollection from Mr. Moore's deposition what he said his leg was like between December 25th and December 27th?

A. He said, and I don't want to misquote, so in terms he felt that his leg was not painful and was fine.

I can't give you the exact words.

I know he used the word, relieved, his leg was better, and it wasn't painful between the 25th and until the morning of the 28th.

Q. Dr. Wilson, do you have a recollection based on your review of Plaintiff Moore's deposition when he said his leg became cold?

A. Yes.

Q. What was that?

A. What was my recollection?

Q. Yes, as to when he said his leg became cold.

A. The morning of the 28th.

Q. Dr. Wilson, do you have an opinion about what may have happened to cause or be a substantial factor in Mr. Moore's occlusion of the profunda artery on December 28th, leading to his acute limb ischemia?

A. Well, certainly there would have been progression of vascular disease.

It is a progressive condition, and even the arteriogram was done on the 28th there's a statement

that the disease is much worse than it was on the last time the radiologist opened up the graft.

So there's advancement of disease.

The clotting of the profunda, I mean that could occur at any time when you have vascular disease without a good explanation, it just simply could happen.

There are other things that I could point to, but I might be speculating, and I was warned about that yesterday.

Q. Dr. Wilson, are you familiar with the term black box warning for purposes of pharmaceuticals?

A. Sure, yes.

Q. Would you tell jury what a black box warning is?

A. Okay.

A package insert goes with every drug that you get from a pharmacy, and you probably opened up hypertension medicine or whatever, and there's these big printouts that comes in the box, and a black box warning is actually literally got a heavy black line around it to draw the attention of patients and prescribers that this is an important complication, and I think what your leading to is the black box warning on Xarelto, and the warning, is if you stop

taking Xarelto, you can have a rebound clotting.

So for example a patient might be taking Xarelto chronically, and if it's stopped for more than 24 hours, which is the time you would stop it before surgery for example, then that can lead to thrombotic event is the term they use, could be in arteries, could be in veins, and could be in other sites of the body, don't have to be the leg.

Q. When you said thrombotic events, what does that mean?

A. Clotting.

Q. Hypothetically, Dr. Wilson, if for whatever reason Mr. Moore didn't every day list his Xarelto as prescribed within the week before December 28th, do you have an opinion whether based on a black box warning for Xarelto he may have been at an increased risk for arterial clotting in his leg?

A. If he didn't take the Xarelto, I think that clearly would place him at an increased risk.

Q. Dr. Wilson, I want you to assume that Dr. M has testified that had Mr. Moore's leg been properly diagnosed with acute limb ischemia on December 25th, and had he received appropriate medical treatment that day, which would have opened up the graft, Mr. Moore's leg would not have needed to be amputated.

I want you to hold that hypothetical for a moment.

A. Okay.

Q. And I want you to further assume that Dr. M has testified that part of the evidence for his opinion in that regard is that the graft could have been opened on the 25th of December because it had been opened up twice before in 2014 and 2015, do you recall it had been opened twice before in those two years?

A. Yes, I do.

Q. Do you agree with Dr. M's opinion that because the graft had been opened successfully two times before December 28th, that more likely than not it could have been opened a third time on December 25th?

A. No, I disagree with his statement because each time you open it up the chances of success diminish because the clotting is occurring for a reason, and by opening the graft you really don't correct the underlying reason, which is progression of vascular disease, and as each clotting event occurs it becomes more difficult to open the graft, whether you are doing it surgically or with thrombolytic therapy.

Q. Why does it get more difficult each time you need to open the graft?

A. Well, it's basically because the run off bed, that is the arteries leading off from where the graft is joined to the artery below the block, those smaller arteries leading off are still continuing to narrow, and in fact one of them was obstructed completely.

There's three vessels that come off just below the knee, and those begin to occlude with arthrosclerotic disease and diminishes blood flow in the graft, and you can take the clot and dissolve it or extract it surgically but the blood got less and less area to distribute, and so the flow in the graft decreases its velocity, and when blood flow becomes stagnant, it clots within a few minutes.

Q. If you were to assume that the graft could have been the clot, and the graft could have been dissolved on December of 2016, with that he indicated the graft had occluded in 2014, 2015 and 2016?

A. Could you say that again, please?

Q. Sure.

If the graft had been able to be unoccluded (sic), or the blockage was dissolved, in 2016, would that have been the third time the graft was occluded?

A. Yes.

Q. And given that trend, do you have an opinion to a reasonable degree of medical probability even if the graft had been able to be opened up whether it would have continued to occlude if not yearly, at least some period of time after there up to the present?

A. Well, unlike the stock market, past history does predict future performance, and he had clotting in '15, he had clotting in '14, and now he has clotting in '16.

It's going to clot again in '17, and I can say that with a high degree of probability.

Q. Is there a point at which even if historically the graft has been able to have the clot dissolved in it at some point more likely than not the end result will be amputation?

A. Yes.

Q. And why is that?

A. Well, because the disease is progressive, and you can take the clot out of the graft or dissolve a clot in the graft, but if you have got vascular disease that is occluding the arteries below where the graft is below the knee, it doesn't help even to remove the clot in the graft.

So it would be progression of disease inevitably.

The type of graft that is implanted, especially in the above knee position, isn't associated with clotting with a life expectancy of maybe 18 months.

I reviewed grafts placed below the knee, and the life expectancy was just an average of six months, so we don't place plastic grafts below the knee anymore, there's just not enough flow to keep it open.

So in this case, although certainly there would have been a clotting event that would have occurred within the next year.

Q. If the clot can't get dissolved by Heparin to keep the clot from promulgating, or to get the clot out, as Dr. M talked about, is the next treatment, if not the only treatment amputation?

A. Well, what you are hoping is that when the graft occludes, there will have been non-collateral flow established to maintain viability of the limb, which is what I had hoped would be the case for Mr. Moore, but there was certain unique circumstances that, particularly the occlusion of the internal iliac artery, so he was dependent on the one profunda

artery to maintain good satisfactory viability of the leg.

Circulation wasn't completely normal, but there was enough that you can get by, and when that profunda artery, the deep one, the one that is parallel to the femoral artery, when that occluded, he had no blood supply to the leg, and that's why on the 28th we have this emergency that Dr. M described.

Q. If there that is acute limb ischemia, as opposed to limb ischemia due to the occlusion of the graft, if the Heparin thrombolytics and lysis doesn't work, once it's acutely ischemic, is the next treatment amputation, such as what happened here?

A. Yes, if the ischemia is quite prominent, painful foot, you can't restore blood flow to it, the best solution then is an amputation.

An amputation has to be thought of in the sense of rehabilitation, not as necessarily failure on a physician.

Q. And what do you mean by the probability of rehabilitation?

A. That it would get the patient the prosthetic limb he could ambulate on.

With an acute ischemia, if that would persist in it, the leg would become gangrenous, and

you certainly couldn't ambulate on it.

Q. Mr. Moore's case on December 28th what were the factors ultimately required within a week or so an above the knee amputation, versus below the knee amputation, was there a way to keep the knee from being amputated below the knee?

A. Well, generally you want to do the amputation as low as possible because that gives the patient a lever arm when it comes to walking with a prosthesis.

Below knee is preferred over above knee because below knee you can fit a prosthesis, and no one in the room would know if the patient's wearing long trousers, that he has an amputation, he can really walk very well.

Above knee it's more difficult.

So we try to do below knee as much as possible.

Now, if you don't have enough circulation below knee, so that when you make the incision on the skin for example, and the bleeding is not good, then you end up with a stump that is not going to heal, and that is multiple hospitalizations, the bleeding of the stump, and really makes a patient bedbound.

So getting the above knee amputation means

that they were sure that it would heal at that level, and that he would be able to go ahead with rehabilitation.

Q. Dr. Wilson, is there in your opinion adequate medical literature that supports the opinions you just gave us over the course of the last ten minutes talking about if the graft continues to occlude, more likely than not it's going to end up in amputation?

A. Yeah.

I can't support that with a citation, but it's common sense to a vascular surgeon each time it clots, it's going to be worse.

Q. And you just used the term, stump.

Are you comfortable that in using the term stump instead of residual limb, it's not demonstrating a lack of insight into patients who have amputations?

A. No, patients and doctors use stump frequently.

When I worked at the Veteran's Hospital, we had a stump clinic, that's what we called it, where all the patients came who had amputations.

So I don't think it shows any disrespect.

Q. Dr. Wilson, you reviewed Dr. M's

deposition, is that correct?

A. Yes, I have.

Q. And when you reviewed Dr. M's deposition, did you see that there was about six inches of literature attached to his deposition as exhibits?

A. Yes, I saw that.

Q. And did I ask you to review the literature that Dr. M attached to -- or that Dr. M reviewed, considered, and relied upon for his opinion in the deposition?

A. I reviewed the literature, yes.

I was familiar with some of the articles, some I wasn't familiar with.

In general, it referred to acute ischemia, not chronic.

MR. ARNTZ: I'll make an objection.

We might need to come to the bench.

THE COURT: Why don't you come to the bench.

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

THE COURT: The objection is sustained.

Ask another question.

MR. WEAVER: Thank you, Your Honor.

BY MR. WEAVER:

Q. Dr. Wilson, diving back in a little bit more from where we left off yesterday, I think we were just leaving off with your opinion whether or not when it comes to the assessment of acute limb ischemia the five Ps are the gold standard.

Do you have an opinion in that regard?

A. Yes, I think that is the standard way of diagnosing an acute knee ischemia limb.

Q. Why is that?

A. Well, imaging will tell you where the block is generally, but it doesn't tell you the precise physical condition of the extremity. You only can tell that by examination.

So the five Ps refer to your history information, and your examination.

Q. And before we get into those five Ps, we've got a board that we'll put up the five Ps just to refer to briefly as we go to it, but would you tell the jury again generally what in the context of the five Ps, what an acute ischemia leg looks like in your opinion?

A. Okay.

The first one is pain, severe unrelenting pain in the foot, and more than that it's tender to

touch. If you touch it, the patient will feel it's very, very painful.

The second would be the color, these are forced a little, the color would be palor if the foot's elevated a little bit, and then if it's dropped down, it becomes a dusty purple color called rubular.

The third would be the paralysis, and generally that means you can't wiggle your toes, or you can't pull back your foot. You are getting foot drop.

Then there is paresthesia, and that is a sensation of an abnormal sensation in your leg, and in his case it would have been on the 28th would have been numbness in the foot, he couldn't have had any fine sense of touch. It would mean absence of palpable pulses, and likely absence of a flow signal if he used the Doppler.

And the last one, the last P I believe is poikilothermia, which is a big word to describe the foot would be cold, it's temperature would be at ambient temperature in the room because he's not getting blood flow to keep it at a normal 98.6.

Q. And poikilothermia, would that actually be a sixth one?

A. I lost count here.

MR. WEAVER: Your Honor, may I approach?

THE COURT: You may.

THE WITNESS: I think we got them all.

BY MR. WEAVER:

Q. So if you come to the board, you need to say, I'm going to the board, it's a housekeeping rule.

THE COURT: If you are going to, as witnesses, all we need to have in the record is, I'm going to the board, you are walking over there, you can say it on your way, say it when you get there, I just want to have in the written record you are not just sitting at the witness stand talking if you need to refer to something in the board.

BY MR. WEAVER:

Q. Before we get into the five Ps, you reviewed Dr. Jacobs' deposition, is that correct?

A. Yes.

Q. I want you to assume Dr. Jacobs has testified in his deposition he believes the charting by the emergency department nursing staff was accurate.

Do you agree with that?

A. I remember that, yes.

Q. And do you recall Dr. Jacob saying in his deposition that he believed that on December 25th Mr. Moore's leg looked, quote, unquote, essentially normal?

A. Yes.

Q. Do you agree with that as well?

A. From my reading of the record, it reflects essentially normal extremity.

Q. I want you to assume, Dr. Wilson, that Dr. M testified he agreed with the examination done of the triage nurse, Nurse Kuchinski. In fact, I'm going to read you his testimony.

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

Dr. M's answer was, actually I agree with it?

MR. ARNTZ: Your Honor, I don't think it's appropriate he's reading from Dr. Marmareano's deposition.

He testified he --

THE COURT: I respectfully disagree, want to know where the question is going because Dr.

Marmareano testified, we heard it we're, we're now trying to get information from this witness regarding those opinions, if I understand where we're going correctly, and clearly what was said I think is better than an attempted summary.

MR. ARNTZ: My objection was whether it's proper to read the deposition testimony in the record at all.

THE COURT: I thought -- Can I have everybody at the bench?

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

THE COURT: I think we cleared up some confusion.

Just to be clear, the reason why my understanding was to overrule, and what is being read from now is the earlier in this trial testimony of Dr. Marmareano, not deposition taken prior to trial, or other sworn testimony.

So again because we're going to be asking this, there's basically two ways, Mr. Weaver.

So say, you can assume certain facts, and ask an opinion, or actually read the testimony, so there's no confusion this was the actual testimony, and then ask.

I think for clarity sake for the jurors and the record, I think that is fair.

We'll see how that goes.

If there's other objections, of course we'll address them, but of course be sure you're reading accurately, which I'm sure you will endeavor to do, Mr. Weaver.

MR. WEAVER: I'll read it straight from the transcript, instead of my transcription of it, Your Honor.

BY MR. WEAVER:

Q. Dr. Wilson, I want you to assume with regard to the charting by the nursing staff, not Nurse Practitioner Bartmus or Dr. Lasry, but I want you to assume with regard to the emergency department nursing documentation, this was the question asked of Dr. M, and then it will be followed by his answer.

Question, so you have no criticisms of the exam that Nurse Kuchinski 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?

The answer, actually I agree with the examination.

I don't think there's anything unusual.

I think she's done the right thing, yeah.

Do you hold that opinion -- or do you disagree with Dr. Marmareano's conclusion with regard to the emergency department nurse's examination and charting of Mr. Moore?

A. No, I don't disagree with that.

Q. Dr. Wilson, before we get into the five Ps, do you have an opinion whether in order to do a proper assessment of Mr. Moore's left leg, his sock and his shoe he might have been wearing should have been taken off?

A. It should have been taken off, yes.

Q. That helps with the assessment?

A. It allows you to see the skin, assess the extremity, if it's warm or cold.

Yes, it should be done routinely.

Q. So, Dr. Wilson, let's start with the first of the P, the pain.

If Mr. Moore's leg was acutely ischemic on December 25th, what would you expect with regard to the pain?

MR. ARNTZ: Your Honor, I object.

This has been the subject of testimony at least three times with this witness, twice yesterday

and once today.

THE COURT: Mr. Arntz is correct.

Obviously if we covered the testimony, we can't duplicate the testimony, but does this help us understand a different line of questioning?

MR. WEAVER: It's just foundation.

I'll go into exactly what the pain was.

THE COURT: Okay.

MR. ARNTZ: Same objection, it's already been testified to.

THE COURT: I think we resolved the objection for now.

That objection was sustained.

I don't need to cover areas we covered already for foundation, but please make sure you are in a new area clarifying line of questioning.

BY MR. WEAVER:

Q. Dr. Wilson, do you have a recollection as to what the scale of Mr. Moore's pain was when he was in the emergency department per the documentation?

MR. ARNTZ: Objection.

Lacks foundation.

THE COURT: I -- Can I have counsel back up at the bench?

I want to clarify something.

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

THE COURT: All right.

The objection is overruled.

I think the objection, there was a little misunderstanding about what the specific intent of what the question was. I think we clarified that.

It's overruled.

I'm sure Mr. Weaver will want to re-ask the question just to be sure we're clear as we move forward.

MR. WEAVER: Thank you, Your Honor.

BY MR. WEAVER:

Q. Dr. Wilson, do you have a recollection based on your review of the emergency department chart on December 25th, 2016 what Mr. Moore identifies his pain would be on a pain scale, if you recall?

A. My collection is it was a plus 3, but I don't have it in front of me, so I can't cite it, but I do recollect seeing a 3.

Q. Okay.

MR. WEAVER: Could we put up Exhibit 100, Bates 1382, please?

BY MR. WEAVER:

Q. Dr. Wilson, I think this might refresh your recollection.

I think it might have been a 3 was acceptable to Mr. Moore, but if you look --

A. I see.

Q. Does that refresh your recollection what Mr. Moore's pain intensity was?

A. Intensity was 7.

Acceptable pain intensity, I presume that would be acceptable to Mr. Moore, was 3.

Q. And if we could go to Bates 1331, please, Dr. Wilson, do you recognize this as being part of the emergency department charting documentation by Nurse Practitioner Bartmus?

A. Yes.

Q. Do you see under chief complaint that it identifies Mr. Moore has left calf pain?

A. Yes, history of present illness, chief complaint, yes.

Q. And for purposes of your review of this case, what is the significance if any of Mr. Moore having the pain that he had in his calf, opposed to his foot or anywhere else?

A. Well, calf pain directs you to a venous

thrombosis in the calf, it would direct you to a gangrenous muscle tear or sprain, and ischemic pain is usually at the part most distant from the heart, so it would be the foot, and particularly for the foot, the toes and metatarsals.

Q. Why is it acute limb ischemia most commonly in the toes or the foot, the furthest place from the heart you said?

A. It's the part most distant for the blood to travel to.

Q. And is that what is most common that you would find consistent with acute limb ischemia, as opposed to in the calf?

A. Yes.

Q. Dr. Wilson, if we could move to the next P, which is palor.

What does palor mean?

A. Palor is pale.

Q. And if we could look at Bates 1389, please, Dr. Wilson, do you see on this nursing assessment by Nurse Pluchinski she identifies the skin to be a normal color?

A. Yes, I see that.

Q. And is that consistent in your experience with acute limb ischemia?

A. No.

Q. Is it consistent in your experience with chronic limb ischemia?

A. Yes.

Q. Dr. Wilson, let's move on now to the third category of pulses or pulselessness.

I think --

MR. WEAVER: May I approach, Your Honor, to move this?

THE COURT: You may.

BY MR. WEAVER:

Q. Dr. Wilson, I'm going to ask you some questions if I might about the pulselessness.

Can you tell us again what generally in the assessment of the five Ps pulselessness means?

A. The absence of a palpable pulse.

You need the dorsalis pedis posterior, popliteal or common femoral artery.

Q. And that is in assessing the five Ps?

A. Yes,

Q. Do you have an opinion, Dr. Wilson if there could be good blood flow in the leg, even in if there's absence of pulses?

A. Yes.

Q. Doctor, have you reviewed the pulse, and

why is that?

A. When you palpate a pulse, what you are feeling is the pressure in the artery that distends the artery to the extent you can feel it. So that requires a pressure certainly above a hundred millimeters, and remember your regular blood pressure ideally would be 120, could be higher, many people would be lower, so when you feel or palpate for a pulse and don't feel a pulse, you can certainly have flow in that artery, but the pressure inside the artery is not as high as it would be if there were no block there.

So there's a decrease in pressure, that's what the absence of a pulse means.

Q. All right.

And do you have a recollection one way or another based on your review of the depositions of Nurse Practitioner Bartmus and Dr. Lasry what they testified to with regard to whether they checked the pulses?

A. Yes.

In their depositions my recollection is they both said they felt pulses.

Q. And if their testimony here at trial is consistent with that, do you have an opinion on

whether or not that means they are lying?

A. I have no reason to believe they were lying, no.

Q. Why is that?

MR. ARNTZ: Objection.

Calls for speculation.

Lacks foundation.

THE COURT: He needs to clarify that.

I'll overrule.

But why is that?

MR. WEAVER: Fair enough.

I'll move on.

THE COURT: I want him to answer that question.

MR. WEAVER: Thank you.

I missed the overruled part.

BY MR. WEAVER:

Q. Why do you hold the opinion that you don't believe they were lying?

A. Well, there would be no point to lie.

You would enter into the medical record what you believe you observed and found on examination.

MR. ARNTZ: Sorry, Judge.

I object.

This is speculative.

I move to strike this testimony.

THE COURT: Overruled.

Please proceed, Mr. Weaver.

BY MR. WEAVER:

Q. Go ahead, doctor.

THE COURT: I thought he finished.

BY MR. WEAVER:

Q. Were you finished, Dr. Wilson?

A. Yes.

Q. Thank you.

A. I don't want to say anymore about that.

Q. Dr. Wilson, I want you to assume that here in trial Dr. M testified no fewer than five times that it is impossible for Mr. Moore to have pulses in his foot after the 2012 femoral popliteal artery by-pass procedure where the graft was placed, and I'm going to read you his testimony with regard to that.

This is my question to Dr. M.

What I'm talking about is, you do agree, don't the you, and I'm not talking about 12/25/16, which is where you keep going to, you told this jury over and over and over and over and over at least, my notes say five times, that after 2012 it was impossible for Mr. Moore to have pulses in his foot.

You said that to this jury, didn't you?

Answer, I did say that, yes.

Do you agree with Dr. M that it would be impossible to have pulses in Mr. Moore's foot, left foot, after the 2012 popliteal artery by-pass graft procedure?

A. I disagree with the statement on the basis that he had several follow-up examinations where my recollections that pulses were noted.

Q. And you have reviewed those materials.

Would there have been visits since 2012 where the pulses were detected?

A. I have reviewed the visits to Dr. Wiencek.

I don't have the material in front of me, it's in my bag outside.

Q. That's okay.

We will go through it.

A. I have reviewed it, yes.

Q. So if we might go to Joint Exhibit 109, Bates 55, please.

THE COURT: Was it received?

MR. WEAVER: Yes, it is.

All of these I'll be going through will be.

THE COURT: As a reminder.

MR. WEAVER: Thank you, Your Honor.

BY MR. WEAVER:

Q. Dr. Wilson, this is a document you seen before, correct?

A. Yes.

Q. And do you see where it says in this note dated August 10th, 2015, so roughly a year and four months before this incident on December 25th, 2016 from Dr. Wiencek's office, it says, quote, he has good pulses in both lower extremities dorsalis pedis on the left and posterior tibial on the right, he also has changes to both lower extremities, you have any reason to dispute the accuracy of Dr. Wiencek's offices note that said Mr. Moore had pulses in both lower extremities, both dorsalis pedis on the left and posterior tibial on the right?

A. I have no basis not to accept that.

It's written down, the examination, yes.

Q. If we may go to Bates 36, please.

Dr. Wilson, if you would look at the top right-hand corner, do you see this identified as a February 2016 office note from Dr. Wiencek, Mr. Moore's cardio-thoracic surgeon?

A. Yes, I see that.

Q. Do you accept that date as accurate?

Any reason to dispute the date?

A. I see the date, February 8th, 2016.

Q. Under history of present illness I want to draw your attention to where it says, quote, he had good pulses in both lower extremities, dorsalis pedis on the left, and posterior tibial on the right, he also has changes of chronic venous insufficiency in both lower extremities, patient is here for six month follow-up, do you see that?

A. Yes.

Q. Do you have any reason to doubt the accuracy of that February 8, 2016 note, so roughly ten months before this incident, that identifies Mr. Moore has good pulses in both lower extremities, dorsalis pedis on the left, and posterior tibial on the right?

A. I have no reason to doubt that observation.

Q. If we might go down to, please, Dr. Wilson, under the assessment and plan, do you see, Dr. Wilson, under the assessment and plan that it says that Mr. Moore was presenting for his six month follow-up for a pulse check, you see that?

A. Yes.

Q. Would it make sense to you that Mr. Moore would be presenting for a six month follow-up for a pulse check if he had no pulses?

A. It would he be presenting for a six month follow-up if he had no pulses?

Q. Correct.

A. Palpable pulses?

Q. Pulses, correct.

A. He could be, yes.

Q. My point is though, if he didn't have pulses since 2012 as Dr. M said, it would make sense he would not present for a check of those pulses, wouldn't it?

A. Well, it would be a routine appointment irrespective of what the pulse examination was showing.

Q. All right.

Do you see where it then says that the advanced nurse practitioner did a pulse check in the office I think it says, but I think it probably means did pulse check in the office, and the results were excellent?

A. Correct.

Q. Do you have any reason to dispute that Dr. Wilson when the pulses were checked that were identified above that Dr. Wiencek was wrong in saying that the pulses were excellent?

A. No, this is in correspondence with Dr.

Wiencek's observation.

Q. So if Dr. Wiencek says the pulses were excellent, is it fair for you to accept that?

A. Yes.

Q. And then if you would see where it continues on that it says he has some signs of venous insufficiency, and he continued to use compression stockings, do you see that?

A. Yes.

Q. And then would you read into the record if you would please, Dr. Wilson, the last sentence?

A. She has encouraged him to ambulate as much as possible, and I will see him again in another six months for another pulse check.

Q. So according to this note that is signed on the next page by Dr. Wiencek, Mr. Moore was asked to come back in six months for another, quote, unquote, pulse check, is that fair?

A. Yes.

Q. Do you accept that as accurate?

A. Yes.

Q. All right.

If we could go to Bates 56, please, it's Exhibit 113.

Dr. Wilson, I just want to orient you to

the date in the top right-hand corner.

Do you see it's May 9, 2016 in Mr. Wiencek's office?

A. I --

Q. Where it says date of service?

A. Yes.

Q. Then down at the bottom you see where it starts out, and I will plan to see him, and then it goes over to the next page, again in six months to a year for a pulse check?

A. Yes, I see that.

Q. And then it says, currently he has a strong anterior tibial pulse and good capillary refill by physical examination?

A. Yeah.

Q. Do you have any reason to dispute the accuracy of that?

A. No.

Q. Could you tell the jury what it means to have good capillary refill by physical examination?

A. It's a simple test where the patient is lying flat. You would squeeze the toe and let go and see if the blood comes very quickly within a few seconds, it is an indicator for you there is good flow of blood.

Q. We'll next go to Joint Exhibit 106 if we might please, and Bates 13.

Dr. Wilson, as this comes up, if you would orient yourself to the top left-hand corner, that is September 11th, 2014. That is 106, Bates 13.

Dr. Wilson, do you, even though it says ProCare Medical Group, do you recognize this to be Mr. Moore's primary care physician?

A. Yes.

Q. On this 9/11/2014 date down in the middle of the general examination do you see where it says, peripheral pulses brachial and DP pulses 2 plus and symmetrical bilaterally?

A. Yes, I see that.

Q. Do you have any reason to, Dr. Wilson, to dispute the accuracy of what appears to identify Mr. Moore's pulses bilaterally being taken?

A. I think that is what it states.

Q. And if it's 2 plus, does that mean it's normal?

A. Yes.

Q. All right.

If we could go next to the same exhibit, Bates 11, which is a 12/23/2014 visit with Mr. Moore with his PCP, Dr. Tran.

Dr. Wilson, under general examination about three quarters of the way down it will be highlighted it starts out, full range of motion, no clotting, no edema, and then it says, normal bilateral pulses, normal dorsalis pedis and posterior tibial pulses, you see that?

A. Yes.

Q. Do you have any reason to dispute Dr. Wilson that on that day Dr. Tran correctly felt normal bilateral pulses, normal dorsalis pedis, and normal posterior tibial pulses if that's what the doctor said?

A. I don't dispute that.

Q. We'll go to Bates 9 of Exhibit 106, please.

Dr. Wilson, as that comes up, can you orient yourself to the top left-hand corner, it will say April 16th, 2015, a visit with Dr. Tran again, do you see that?

A. Yes.

Q. And do you see three quarters of the way down under the general examination, it will come up highlighted where it says peripheral pulses intact and symmetrical?

MR. J. HYMANSON: Your Honor, a point of clarification.

He said, Bates 9.

I think he's referring to Bates 7.

MR. WEAVER: Thank you.

I appreciate that.

THE COURT: Thank you for the clarification.

BY MR. WEAVER:

Q. Dr. Wilson, do you see where it says peripheral pulses intact and symmetrical?

A. I do.

Q. If Dr. Tran documented that, do you have any reason to dispute that based on his physical examination that day that he concluded that Mr. Moore's peripheral pulses were intact and symmetrical?

A. I don't dispute that.

Q. And one more on this, then we'll move on.

And this is Bates 5.

Do you see where it's dated November 1st, 2016?

A. Yes.

Q. So that would be roughly the month before -- or month-and-a-half before this incident was December 25th, 2016, is that correct?

A. Yes.

Q. Do you see under -- this is by a physician assistant -- it appears a Matthew Sanders, do you see that in the top right-hand corner?

A. Yes.

Q. So this is a different examiner on this date.

Three quarters of the way down do you see where it says, full range of motion, no clubbing, no edema, normal bilateral pulses, normal dorsalis pedis and posterior tibial pulses, and then it says, peripheral pulses normal, do you see that?

A. I do.

Q. Do you have any reason to dispute Dr. Wilson that on November 1st, 2016, a month before this incident, this physician assistant Matthew Sanders based on his again examination of Mr. Moore determined that Mr. Moore had normal bilateral pulses, dorsalis pedis and posterior tibial pulses?

A. I don't dispute that.

Q. All right.

Just two more, Dr. Wilson.

If we might go to Joint Exhibit 202, please, it is Bates 154.

Dr. Wilson, what I'll have you take a look at is a May 23rd, 2016 exam date of Mr. Moore's pain

management physician.

This is Bates 151, please.

Do you see the exam date is 5/23/2016?

A. Yes.

Q. Now, first of all, if we could just go under pain, do you see the second paragraph that indicates the patient complains of low back pain radiates into the bilateral paralumbar area and intermittently into the bilateral feet, do you see that?

A. I see that.

Q. Do you see the start of the next paragraph says, patient complains of bilateral foot -- I think that means pain.

Do you see that?

A. I see that.

Q. Then do you see a couple sentences later where it says, the ankle pain increases with physical activity, you see that?

A. Yes.

Q. Would the increase in pain -- Do you have an opinion -- in the ankle that increases with physical activity to be musculoskeletal?

A. Yes.

Q. And then if you could just go a couple

pages over on that same visit, it's about five pages long, Bates 153, under the general exam.

Under the again exam do you see where it says CV?

A. Yes.

Q. Dr. Wilson, is CV a shorthand way to say cardio-vascular?

A. Yes.

Q. Is that typically your common way someplace that peripheral perfusion gets identified and documented?

A. Yes.

Q. Where, what does it say?

A. Normal pulses present.

Q. Do you have any reason to doubt the accuracy that on that date in May 23, 2016 is this different examiner is finding Mr. Moore's pulses are present and normal?

A. I don't dispute that.

Q. Just one more, Dr. Wilson, if we might, and that is Bates 111, still Exhibit 202, and it's dated 12/21/2016, and this is Mr. Moore's pain management physician whom he sees at Nevada Comprehensive Pain Center.

Do you understand that?

A. Yes.

Q. And do you see the exam date is December 21st, 2016, four days before Mr. Moore went to the emergency department and was seen by Nurse Practitioner Bartmus and Dr. Lasry on December 25th, 2016?

A. I understand that.

Q. And it identifies in that note Mr. Moore is on Xarelto, correct?

A. Right.

Q. And then if we could go a few pages in from that visit, Bates 113 under the general exam, do you see again I think it says CV is cardio-vascular?

A. Yeah.

Q. And cardio-vascular is somewhere typically pulses may get identified?

A. Yes.

Q. And what does it say there?

A. Normal pulses present.

Q. Do you have any basis to dispute the accuracy of the documentation in this document that four days before Mr. Moore came to St. Rose Hospital's emergency department, that his pulses were normal and present?

A. I don't.

Q. So Dr. Wilson based on your review of those materials, have you formed the opinion whether at least after 2012, up until December 21st, 2016 Mr. Moore had bilateral pulses that at times at least were documented as present and normal?

A. Yes, that's what the records you showed me show.

Q. All right.

So let's if we might just move into paresthesia, and tell the jury again what paresthesia is.

Did you say had something to do with sensitivity?

A. Yes, it's the sensation of unusual feelings, that can be numbness, can be pins and needles, it can be the sole of your foot feeling very hot, usually comes and goes, and in the case of a patient who has a neuralgia that would be not atypical, it would be what you would find.

Q. When you say, neuralga, you mean neuropathy Mr. Moore had?

A. Yes.

Q. And you understand he had it bilaterally, is that right?

A. Yes.

Q. If he has acute limb ischemia, how far would that affect his ability even with neuropathy to walk normally, if he got acute limb ischemia?

A. He couldn't walk normally.

Q. Why is that?

A. The foot would be too painful, it might be difficult for him to bring his foot up, dorsiflex.

There wouldn't be a good feeling of position sense for the foot.

So it would be very different than neuralgia, or as you termed it neuropathy.

Q. If we might pull up Joint Exhibit 100, please, Bates 1333, which is the emergency department records of December 25th, 2016.

Dr. Wilson, it will get highlighted in a moment, but I bring your attention to whether in the place where it says impaired gait, and then documented by Nurse Kuchinski it says, no.

A. Yes.

THE COURT: Can you direct him to where we're talking about?

MR. WEAVER: We can highlight it in just a moment.

THE COURT: That's what I meant.

Tell us where you are on the page.

MR. WEAVER: It should be under impaired gait.

THE COURT: Nobody is seeing that.

MR. WEAVER: I'll come back to that.

I have the wrong page number.

BY MR. WEAVER:

Q. Hypothetically, Dr. Wilson, if Nurse Kuchinski in her assessment --

THE COURT: Doctor, did you see something on here we didn't see yet?

THE WITNESS: No, I have page 3 of 84.

MR. WEAVER: Okay.

We'll come back to that, or just cut through this.

BY MR. WEAVER:

Q. Dr. Wilson, I want you to assume hypothetically that under the category of impaired gait Nurse Kuchinski documented, no, would you have any reason to dispute that based on your review of these materials?

A. No.

Q. All right.

And then would you tell the jury what paralysis means, please?

A. Inability to -- in this case to move the

toes, or to flex the ankle, bringing it up, bringing your foot up with the earliest motor signs in acute ischemia.

Q. If on December 25th, 2016 Mr. Moore had acute limb ischemia, would you expect that he would be able to ambulate normally and walk normally?

A. Not with acute limb ischemia.

Q. So is paralysis just a worse condition than paresthesia for purposes of analyzing for acute limb ischemia?

A. Well, paralysis is one assessment that you would make, yes.

Q. Is that primarily motor?

A. Motor.

Q. As opposed to just sensation?

A. Motor, yes.

Q. And if we could look at Bates 1350, please, Dr. Wilson, if you would direct your attention to a little bit down on this where it says, mode of discharge, and it says, ambulatory self assisted of gurney chair.

Would that indicate to you this documentation by the discharge nurse, Jeffrey Germane, that at least in his opinion Mr. Moore on December 25th, 2016 did not have paralysis?

A. Yes.

Q. Okay.

And then just one more category that I know is not typically on the list of five, but you called it popliteal thermea, is that right?

A. Yes.

Q. I'm guessing that is just to continue on the mnemonic device, but you said it means cold, is that correct?

A. Yes.

Q. And for purposes of acute limb ischemia, does it mean more than just cool?

A. Yes.

Q. Why is that, or what do you mean by that?

A. It means that the temperature of the foot is the same temperature as the environment, so it's cold.

Q. And if we could draw your attention to Bates 1382, and there will be a charting by Nurse Amy Kuchinski that indicates that Mr. Moore's skin was warm and dry.

Do -- Have you been able to highlight that yet?

Do you have any reason to dispute the accuracy that on December 25th, 2016 as charted by

Nurse Kuchinski that Dr. Jacobs and Dr. M agree with that Mr. Moore's skin was warm?

A. Yes.

Q. And then one more place if we might on Bates 1388.

Under 1388, under skin temperature, it should identify again by Amy Kuchinski that Mr. Moore's skin temperature was normal?

THE COURT: Mr. Weaver, can you please direct us, rather than us having to look over the whole document?

MR. WEAVER: I think I have the wrong page, so we'll move on.

THE COURT: You made a statement that such information is listed.

You need to produce that record, or I'll direct the jurors to disregard your statement.

Whether it's in this record or not isn't the point.

The point is, you made a record that shows something, you have to show it for the record.

MR. WEAVER: Fair enough.

Thank you, Your Honor.

If we could look at I think it's 1389 under CV, and then it says, skin color, and says, normal.

BY MR. WEAVER:

Q. Do you see that, Dr. Wilson?

A. I see that.

Q. Do you have any reason to dispute the accuracy of that?

A. I don't dispute that.

Q. Dr. Wilson, switching gears then, did you have an opinion whether or not based on this documentation, as well as additional documentation by Nurse Practitioner Bartmus and Dr. Lasry, the five Ps were assessed for Mr. Moore for purposes of acute limb ischemia?

A. Yes.

Q. And --

THE COURT: Do you have an opinion, or that was the opinion?

THE WITNESS: They were assessed, yes.

BY MR. WEAVER:

Q. Do you have an opinion whether or not the assessment of the five Ps point toward acute limb ischemia, or away from it?

A. It pointed away from it, towards a chronic process.

Q. And I think you told us yesterday that it's your opinion that on December 25th, 2016 you believe

Mr. Moore had chronic limb ischemia, but not acute limb ischemia, is that fair?

A. That's correct.

Q. Dr. Wilson, you told us that you agreed with -- or you identified with the venous ultrasound showed that there was occlusion of the graft, is that fair?

A. Yes.

Q. And you told us yesterday that it's your opinion that it wasn't clinically or medically-indicated for there to be an arterial ultrasound, correct?

A. Yes.

Q. Why do you hold that opinion?

A. Because he didn't have the signs that would demand a full arterial ultrasound investigation.

Q. And I believe you also told us yesterday when we were talking in the context of Dr. M's opinion there should have been a CTT angiogram, you told us that in your medical judgment on December 25th, 2016 there didn't need to be a CT angiogram either, is that correct?

A. Yes.

Q. Is that for the same reason?

A. Yes, they did not have a clinical

indication.

Q. Dr. Wilson, do you have an understanding -- or do you recall based on your review of the records what if any medical follow-up Nurse Practitioner and Dr. Lasry advised Mr. Moore to do when he was discharged?

A. That he should see his primary care physician and his vascular surgeon for follow-up.

Q. And do you recall that those two things were documented by Nurse Practitioner Bartmus and Dr. Lasry in terms of following up with Mr. Moore's vascular surgeon?

A. Yes.

Q. And do you have on opinion as a vascular surgeon the time frame within which Mr. Moore should be instructed to follow-up with his vascular surgeon?

A. Within 5 to 10 days.

Q. What do you base that on?

A. Well, he didn't have an emergency at that point, and it would be reasonable to allow the vascular surgeon to see his patient.

It was about a six-month period of time since he had seen Mr. Moore, as I recollect it was May of 2016 when he was last seen in Dr. Wiencek's office, so six months had passed, it would be a

routine appointment.

So I think it was appropriate to recommend he be followed up.

Q. And what was the information that Nurse Practitioner Bartmus had that you think was a good idea that caused her to tell Mr. Moore to follow-up with his vascular surgeon?

A. Well, his vascular surgeon would probably want to know that the graft that he had placed him on had been reopened, was now clotting again.

Q. And I think you identified that as a chronic condition, is that fair?

A. Yes, I believe it was.

Q. Do you have an opinion one way or another what the likely response would have been from a vascular surgeon or cardio-vascular surgeon like Dr. Wiencek if he had been called by Nurse Practitioner Bartmus on December 25th with the findings she was aware of at that time?

MR. ARNTZ: Objection.

You're asking for him to say what he thinks what Dr. Wiencek would have done?

THE COURT: That is speculation.

That seems to be accurate.

The objection is sustained.

MR. WEAVER: Okay.

THE COURT: Just the basis.

Sometimes the objection doesn't lend itself, but just the basis is fine.

MR. ARNTZ: I wanted to make sure I heard the question right.

THE COURT: I understand.

We had some confusion, so not a problem.

BY MR. WEAVER:

Q. Dr. Wilson, have all your opinions today been to a reasonable degree of medical probability?

A. Yes.

MR. WEAVER: Thank you.

I'll pass the questioning for now.

THE COURT: All right.

Thank you.

Mr. McBride, any questions?

MR. MC BRIDE: No questions, Your Honor.

THE COURT: We'll take a brief recess, but let's come back at 3:20. That gives you a little over 15 minutes, gives us an opportunity to do a few things in here and then resume then.

During this roughly 15 minute recess you're admonished.

(Jury admonished by the Court.)

THE COURT: See you back at 3:20.

Jury excused from the courtroom.

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

THE COURT: I need to make a record of multiple bench conferences.

Doctor, you may step down, return to the alcove room.

I noted three bench conferences that we should make a record of during this recent testimony of Dr. Wilson.

The first bench conference was an objection posed by Mr. Arntz related to a lot of inquiry by Mr. Weaver about literature that Dr. Marmareano may have reviewed, and did that literature support Dr. Marmareano's opinion.

The objection appeared to be based on a misunderstanding of the question that -- or I take that back.

This particular objection was based on the fact it had not been part of Dr. Marmareano's actual testimony in trial, and was not previously disclosed as an expert opinion.

I did sustain that objection, and Mr. Weaver moved on.

Mr. Arntz, anything to add?

MR. ARNTZ: No, Your Honor.

THE COURT: Mr. Weaver.

MR. WEAVER: No, Your Honor.

THE COURT: The second bench conference was with regard to Mr. Weaver beginning to ask questions of Dr. Wilson about testimony of Dr. Marmareano actually at the time of trial.

There was an objection to the appropriateness of reading testimony.

Part of the objection I believe was a misunderstanding that the question had entailed reading from the Dr. Marmareano's deposition, not his actual trial testimony, and then the objection evolved into an objection regarding foundation.

I ultimately allowed the questioning to proceed as designed, and I think I made that record in the record, but the discussion at the bench was a little bit of a better understanding what the line of questioning was, how it was going to proceed, and the best way to do it.

Mr. Weaver did offer potentially to pose it in hypothetical, as opposed to reading testimony.

I was inclined the take him up on that offer because I thought there's more clarity to be

the actual testimony and inquire about the opinion.

Mr. Arntz, anything to add to that?

MR. ARNTZ: No.

THE COURT: Mr. Weaver?

MR. WEAVER: No, Your Honor.

THE COURT: The last one was a bench conference that occurred after Mr. Arntz objected, and this was regarding asking Dr. Wilson about Mr. Moore's report of pain I believe on the December 25th visit, and had he identified that pain level.

I think again there was some misunderstanding of the question, and Mr. Arntz initially believed the question had been asking Dr. Wilson to scale the pain as relates to Mr. Moore's reports of the pain symptoms, but I understood and Mr. Weaver confirmed the question was just what had he seen in the records.

I did go ahead, overrule the objection, allow that line of inquiry to continue because there was some debate again about foundation and whether or not Dr. Wilson should be able to testify this way, but the Court's ultimate determination was based on the understanding there had been put into the record Dr. Wilson reviewed all these records and could speak to what his understanding of them was, or

recollection was, and then we went generally through each of the records and confirmed, and I think with the pain scale specifically we confirmed some specifics that Dr. Wilson may have not remembered correctly.

But I overruled that objection.

Mr. Arntz, anything further on that objection?

MR. ARNTZ: No, Your Honor.

THE COURT: Anything else, Mr. Weaver?

MR. WEAVER: No, Your Honor.

THE COURT: All right.

When we will come back a little bit before 3:25.

We really need to figure out where we are at in the trial, how late we're going into next week, so I could be ready when we break for the day to help these people understand where we are.

Also, this seems to be a moving target. I believe we identified courtroom 15-D as a courtroom where we can have Mr. Moore's testimony on the witness stand.

Is that acceptable?

We tried retrofit with some equipment we had making this one accessible, but that equipment

doesn't work, so we are needing one actually is built that way, but 15-D has that.

MR. P. HYMANSON: Your Honor, can we assist you when you come back to you know if we're half days, full days, or what, next week?

THE COURT: My schedule's always the same, Monday, Tuesday, and Wednesday half days.

The only issue is, if we go over to Thursday, I might throw myself off the building, then it doesn't matter.

MR. P. HYMANSON: I'm afraid you would have to get in line, Your Honor.

THE COURT: If I'm here on Valentine's Day, you all better be bringing some chocolates, flowers, and stuff I'm saying.

It's half days Monday, Tuesday, and Wednesday.

MR. P. HYMANSON: Very good.

Thank you, Your Honor.

(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 jurors back?

MR. ARNTZ: No.

MR. WEAVER: Did you want to talk about scheduling or anything?

THE COURT: Okay.

MR. MC BRIDE: Real quick.

THE COURT: Where are we at?

MR. MC BRIDE: I have the plan I think we talked about, probably the best-laid plan for tomorrow is going to be our experts, which is Dr. Shoji, Shoji in the morning, and Dr. Barcay in the afternoon.

And then depending on time, if there is any time available in the morning, I might try to squeeze maybe ten minutes of direct of Dr. Lasry on there just to clarify a couple of things, and that's going to be the extent of my direct, to the extent I don't know how much Mr. Arntz would have on cross for a ten-minute direct, but it just depends.

But then we can see how that goes.

But the other thing being is, that Dr. Lasry has to return to work next week, so he's not

going to be here Monday, or Tuesday, Wednesday.

THE COURT: We've already brought that up to the folks about that.

They should know Mr. Moore's not here today.

MR. MC BRIDE: Yeah.

THE COURT: So that takes care of today.

I don't know if we're getting to Mrs. Moore today, but we'll finish with Dr. Wilson.

Where does that put us with the next thing coming, what do we have and is anyone --

MR. ARNTZ: I have Charlene tomorrow, so I don't want do be put in the position where I don't have enough time to cross Dr. Lasry, knowing he's not coming next week, so we have to plan accordingly to at least give me 30 minutes for him.

MR. MC BRIDE: Like I said, it's going to be very limited examination, if I even choose to do it.

Frankly, he already got out --

THE COURT: Let me interrupt you.

You said in the morning, if you do it at all.

MR. MC BRIDE: The plan would be, after Dr. Shoji if we have time before the lunch break.

THE COURT: Otherwise, it might be in the afternoon?

MR. MC BRIDE: Or maybe not at all, just to clarify a couple things.

THE COURT: I understand.

Just your point is well-taken, if we put on Dr. Lasry, we're going to finish Dr. Lasry, so if we need time, we need time.

So it will be Friday night.

MR. MC BRIDE: Which is a good point.

Maybe I put him on first thing in the morning and Shoji right after.

THE COURT: It seems like that makes more sense, then take whatever time we need with Dr. Lasry and move onto the experts.

We still have to break when we have to break going a little into the noon hour, as long as were coming back at 1:30.

MR. MC BRIDE: Dr. Shoji's around tomorrow afternoon if we have to go a little bit farther.

THE COURT: I need to finish these people tomorrow, if we're not going to lose more time.

But back to my question, what are we doing next, what do we have left?

MR. ARNTZ: I don't think we're going to

get there certainly today, when I don't know are these their experts?

MR. MC BRIDE: One is mine, and one is his.

Barcay is his, and Shoji is mine in the morning.

And then we're --

MR. ARNTZ: Shoji's in the morning?

MR. MC BRIDE: We're going to put Lasry on for like I said ten minutes of direct, you will have 30 minutes at least of cross, I'll have ten minutes on direct, and then we'll go Shoji pretty quick I think, and then if we need to push him partly into the afternoon, we can do that.

And then Keith has Barcay.

MR. ARNTZ: Four hours?

MR. WEAVER: No.

I appreciate you have been accommodating to him.

I can check to see if he can come Monday if you prefer to finish your case tomorrow.

MR. ARNTZ: What I'd like to do --

THE COURT: You are making me insane.

I have to give some warning to the other department.

From my recollection we were talking about

various departments. I don't remember whether or not Department 22 down the hall came into the mix, but I think we can use some time if we need to, I just need to confirm.

MR. MC BRIDE: I thought we talked about yesterday about the best logistically would work out with the experts tomorrow.

THE COURT: We did.

MR. MC BRIDE: Logistically Monday would make sense.

THE COURT: That's why I have Monday lined up, but the suggestion came Mr. Arntz may want to finish his case, do Mr. Moore on Friday.

I have have to make sure I have a courtroom to use.

MR. ARNTZ: We're going to do it that way.

If we have the entire afternoon, we should be able to get Charlene and Darell done on Monday, and that's the last witnesses.

THE COURT: Yours too?

MR. MC BRIDE: Yep.

So then we can --

THE COURT: It does make sense to do it Monday.

MR. MC BRIDE: Knock it out then.

THE COURT: Then instruct and close on Tuesday?

MR. MC BRIDE: Yep.

THE COURT: I don't even want to think that because I thought we were into Wednesday.

MR. ARNTZ: In his opening he referenced to other people he is bringing.

You are not bringing --

MR. MC BRIDE: There's no reason to bring Volt (Phonetic), the economist if you're not bringing Claurete (Phonetic).

MR. ARNTZ: And not bringing the nurses?

MR. MC BRIDE: The nurses, I told them -- I released them from their subpoenas.

We thought about bringing Amy Kuchinski and Jeff Germane, had them under subpoena, but I don't think it's necessary.

I think the jury's losing interest at this point, and I think I would like to get the case done.

THE COURT: We'll see if they have any questions.

They've been pretty on top of it.

MR. ARNTZ: Did you say Wiencek?

MR. MC BRIDE: I never said that.

We introduced he may be a witness.

I don't know if you may call him or come up as a need.

THE COURT: We always have to say in front of the jurors any persons.

So I'm going to tell them Tuesday from what you're telling me.

MR. MC BRIDE: I think that is a fair estimate.

THE COURT: Monday in 15-D.

So that's where we are at right now, is that correct?

MR. P. HYMANSON: Dr. Wilson won't have to stay until Tuesday, will he?

(Thereupon, a discussion was had off the record.)

THE COURT: Let's get the jurors.

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

THE COURT: As we resume with Dr. Wilson.

Can I have you acknowledge for the record you understand you are still under oath?

THE WITNESS: Yes.

THE COURT: Okay.

Mr. Arntz.

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CROSS-EXAMINATION OF DR. SAMUEL WILSON

BY MR. ARNTZ:

Q. Dr. Wilson, my name is Breen Arntz, and I represent the Moores, and I'll be cross-examining you today.

You would agree, wouldn't you, you had relied heavily on the veracity or truthfulness of the records, in other words, you assumed they are accurate and true, and haven't really considered whether they aren't?

A. I have.

Q. Okay.

And in fact you have done that, you have reviewed my client's deposition, is that correct?

A. Yes, Mr. Moore and Mrs. Moore.

Q. Did you read their son's deposition?

A. Yes.

Q. So you saw in those two depositions Chris Moore and Darell Moore, they both disputed anybody at the emergency department having taken off Mr. Moore's sock.

Did you see that?

A. Yeah.

Q. Did you discount that testimony, or did you just decide to give more credibility or credence to the medical record?

A. Well, what I relied on was that in a routine examination of a patient socks and shoes would be removed by the nursing staff.

Q. Right.

That would be standard of care, wouldn't it?

A. I'm not an expert an emergency room standard of care, but just in terms of clinical examination of a patient, whether it's in your office or in an emergency room, it would be standard practice for nurses to either remove the shoes or socks, or more likely ask the patient to do that.

Q. Do you dispute in your report dated August 19, 2019 that you said you do have an expertise in the standard of care, and actually gave an opinion on

standard of care?

THE COURT: Can you be more specific with the question?

You just referred to the emergency room and others. BY MR. ARNTZ:

Q. Do you dispute in the report dated August 19th, 2019 that you said you do have the ability to testify as to standard of care for an emergency department?

A. I don't recall saying that.

Maybe you could read it out to me.

Q. Okay.

A. If I could continue, this is the first time I've been in court in Nevada, and in California you could only testify with regard to standard of care of emergency medicine doctors if you are an emergency medicine physician.

Q. Well, on the second page, the second full paragraph starts with, it's my opinion the patient was appropriately discharged with instructions to follow-up with his surgeon.

Isn't that a standard of care opinion?

A. That's very much a standard of practice, that is what you would do.

I don't dispute that at all.

Q. And you have given other opinions, you been here for the last couple days, where you said that Nurse Practitioner Bartmus and Dr. Lasry acted within the standard of care, didn't you?

A. You know, I don't recall saying that because I've tried to be very careful about not commenting on emergency room standard of care.

Q. Okay.

Let me ask you this:

In someone who comes in with a history of the problems Mr. Moore had, complaining of calf pain, is it your testimony you don't have an opinion whether or not the standard of care requires them to take off their sock?

A. I do have an opinion.

If you're asking me, should the patient being examined have his shoes and socks removed, yes, they should.

Q. Okay.

So when looking at the record Nurse Practitioner Bartmus and Dr. Lasry created in the hospital, you accepted what they said as being true and accurate, and you said you think it's true and accurate, but the testimony of Mr. Moore and his son would contradict that testimony, wouldn't it?

A. Potentially, yes, if that's what Mr. Moore said, that they didn't take off his shoes and socks.

Q. You said you read his deposition.

Did you see that in his deposition?

A. You will have to show that to me.

I can't recall the line and paragraph, but I'll accept that if you just read that.

Q. Are you saying it's not relevant to you whether or not they had him take off his shoes and socks?

A. I didn't say that.

Q. Well, the fact you don't recall it from the deposition would suggest it wasn't relevant to you.

A. Lots of things I don't recall exactly, but it is relevant.

Q. It actually is extremely relevant here, isn't it, if the standard of care requires them to take off the sock to actually feel for the pulses in his foot, correct?

A. Yes.

Q. Okay.

Now, I don't know if you had been aware of Nurse Practitioner Bartmus and Dr. Lasry's testimony from the trial.

I know counsel have been getting dailies,

so I don't know if they gave you the transcripts of that.

A. I have not seen those.

Q. Okay.

You also saw from the records, didn't you, that the ultrasound --

MR. ARNTZ: Court's indulgence for a second.

THE COURT: Yes.

BY MR. ARNTZ:

Q. Let me ask if you recall this modification Dr. Lasry made to the record.

You will recall the ultrasound finding was, there was no evidence of deep vein thrombosis, but there was what appeared to be the word appeared the arterial graft appeared occluded, you saw that?

A. Yes, I did.

Q. And you saw it in Dr. Lasry's note on the day after the Mr. Moore was in there he entered into his chart and signed a note that said that there was a possible occlusion, did you consider that a modification to the record?

A. It's pretty much the same thing to me, appears to be occluded, possible occlusion.

I think were splitting hair here.

Q. So you don't agree -- or you have testified that you have accepted there was an occlusion in the graft site on the left popliteal graft, correct?

A. Yes.

Q. And you don't see there's a distinction between saying there is an occlusion, and possibly an occlusion?

A. Yes, I would accept there is a distinction there, but the reports from x-rays, from x-ray physicians, radiologists often include terminology like that when they are reviewing a study, they will say, possible occlusion.

Yes, sometimes they say that.

I agree that is different from saying exactly, complete occlusion of the graft.

Q. Okay.

So if I understand what you're telling me, you're going to make some assumptions about whether or not the radiologist who is an MD, correct?

A. Radiologists would generally be and MD.

Q. And MD who read the ultrasound scan, that he may have been imprecise, you're going to make that assumption he might have been imprecise?

A. Yes, it could be based on -- When you read an ultrasound, the hard copy is selected images, so

the radiologist is not doing the ultrasound, has no control over what images he's looking at, so he can look at the images, and on the basis of the images the technician saved for him he can arrive at conclusions, this graft is probably occluded, yes.

Q. Well, then you changed the same words that Dr. Lasry changed.

He didn't say, it's possible, but probable occluded, did he?

A. I have forgotten what he said.

Q. It's right in front of you.

A. The --

MR. MC BRIDE: I'm going to object.

THE COURT: Objection?

MR. MC BRIDE: It's vague as to he and who, and we're not really clarifying who we're talking about now.

THE COURT: At this point because we do have a blown up portion, for the record, let's be clear who we're talking about.

BY MR. ARNTZ:

Q. Did you understand my conversation with you was in relation to the radiologist, who is an MD reading the film?

A. Yeah.

Q. So you can see from the report from that ultrasound he doesn't say possible.

He says, it appears occluded.

Correct?

A. Appears occluded is what he has in front of him.

Q. You seemed to make the same change Dr. Lasry did, and that leads me to a question about if you got a report from an ultrasound that said a possible occlusion, wouldn't that lead you to the need to do further investigation to see if it was possibly occluded, or absolutely occluded?

A. It could, depending on the patient's presentation.

Q. So the presentation is clearly in your analysis of this case, the presentation and exam that was done is critical because if that fails, and he didn't -- Nurse Practitioner Bartmus didn't get the pulses she says, Dr. Lasry didn't, then the rest of your opinion about that exam really is irrelevant, isn't it?

A. No, I disagree with that.

Q. So when you're looking at the five Ps, pulse is one of those Ps?

A. Yes.

Q. And if they had taken day his sock off, get a pulse in his foot the way they said they did, that's not a critical conclusion for your opinion?

A. That's a different question you're asking me.

Could you rephrase that, please?

Q. Well, originally what I said was, wouldn't you agree that the question of the exam and whether or not they got the pulses they said they did is critical to your overall opinion, and that without that your opinion doesn't carry much weight?

A. Well, thank you.

Actually, whether or not they felt the pulses is less relevant than you would think because you could certainly have a viable extremity without palpating pulses.

I think I've tried to explain that.

Q. Okay.

That is a distinction.

So what you are saying is, it doesn't matter to you whether they were being truthful about palpating the pulse, and it could have just easily been a Doppler?

A. Well, number one, I accepted the entries in the chart were truthful.

I have no reason to believe they would answer untruthful statements.

Number two, a Doppler does not detect pulses.

A Doppler defects flow in the artery.

Q. Okay.

I don't know how that changes my question because what I talked to you about was pulses and whether or not if the report isn't accurate about them taking the pulses, how it would affect your opinion.

And then you went into the discussion about whether or not they palpate the pulses isn't as important as we might think or what.

A. Rephrase it.

I am accepting the record as being truthful at entries.

I have no reason to believe they were less than truthful.

They entered what they observed, I believe.

Number two, in general, and not with regard to Mr. Moore, because I haven't examined Mr. Moore as you know, but in general you can have a viable extremity with all the rest of it intact and not feel pulses.

Q. So the question I want you to consider is, would it discount the veracity or truthfulness of that record if you heard from the testimony of Dr. Lasry and Nurse Practitioner Bartmus, and they said they palpated normal pulses, and then you found out that in fact they had not done that, would that undermine in any way the way you look at the accuracy of the medical record from the emergency department?

A. Well, I think you're can asking me if they falsified the finding of pulses, would that reflect negatively on my view of the rest of the record.

Is that your question?

Q. That's a better question, yeah.

A. Actually, it would.

If they falsified their entry, and in any way, it would make me be skeptical of perhaps the rest of the entries, sure.

Q. And we've heard you testify that you don't believe that the mere occurrence of the fem pop graft in 2012 would result in an absence of pulses, correct?

A. Yes.

The whole point is that you try to restore blood flow to the leg with the graft.

Q. Okay.

Do you have an opinion as to whether or not it is common for pulses to be palpable and normal following a fem pop graft?

A. It is common.

Q. It is common?

A. Yes.

Q. Okay.

So you do recall, don't you, that when Mr. Moore went in in 2012 to receive the fem pop graft, at the time he went in there to the emergency department he had no pulses, do you recall that?

A. Now, which date are we talking about?

Q. In November of 2012.

MR. WEAVER: Your Honor, that misstates the evidence that was in the emergency department.

MR. ARNTZ: Well --

THE COURT: It would be very helpful to look at Dr. Wiencek's records and other records and dates, it would be helpful.

MR. ARNTZ: Okay.

BY MR. ARNTZ:

Q. You see from the record up there --

MR. J. HYMANSON: This is page 82 of 101.

THE WITNESS: I'm familiar with this.

BY MR. ARNTZ:

Q. Give me a second.

You see the highlighted portion?

A. I do.

Q. And it indicates that excellent blood blow was obtained through the graft?

A. Yes.

Q. Below the knee.

And that then Doppler examination of the posterior tibial pulse not at the pre-operative --

A. Yes.

Q. So prior to receiving the fem pop graft he did not have pulses, but they were able to obtain them as a result of the graft, yes?

A. Yes.

Q. Okay.

So the need for the fem pop graft was because it was disease existed in his lower leg, correct?

A. Yes.

Q. And essentially resulted in a blockage of that artery in the lower leg, correct?

A. In the mid-thigh, yes.

Q. So before the operation to put in the graft there were no pulses, and then after they were able

to get a Doppler pulses.

Are you aware of any record says following the fem pop graft they were able to get palpable pulses that were normal?

A. Between 2012 and 2016?

Q. Yes.

A. Well, I believe Mr. Weaver at enormous pain went through to show that various individuals had felt pulses.

Q. I think what he said was, they indicated there were pulses present.

I didn't see they were palpable in any of those records.

A. In medical terminology it's common to use pulse if you feel it, and although sometimes they say, a Doppler pulse, what they mean is a flow.

A Doppler doesn't show the pulse.

After you finish a fem pop by-pass, there's often vascular constriction of the legs, you can have the artery clamped on the patient, some hours had gone by, and when you open up the graft, often you don't feel a pulse right away, a palpable pulse.

So you listen with Doppler, and if you hear a good Doppler signal, then you think you are okay, you have got it flowing.

The Doppler detects flow in your artery.

Q. And how long would you expect it before you return to palpable pulses?

A. You would like to see that within hours.

Q. Is that something you would expect to see in a record they made note of?

A. Not necessarily.

I would make note of it personally, but many people wouldn't, just depends on the detail of your post-operative visits.

Q. Do you recall seeing in the records from Dr. Simon --

A. Was he a radiologist that did an arteriogram?

Yes, I remember seeing this one.

Q. Do you remember seeing the letter of January 12th, 2015?

This was two months after the surgery?

A. Yes, I see that.

Q. You see he did suffer some ischemic neuropathic pain, and I believe this will resolve it by Doppler?

A. Yes.

Q. Are you saying the terminology being used by Dr. Simon where he said he found excellent pulses

by Doppler, that is actually a misuse of the terminology?

MR. MC BRIDE: Objection, Your Honor, that it's actually Dr. Wiencek later.

MR. ARNTZ: You're right, Dr. Wiencek.

THE WITNESS: It's not an exact use of the terminology.

With a Doppler you hear flow, and you don't -- it doesn't detect a pulse, it gives you flow.

So commonly people say a pulse was heard by Doppler, but what they mean is, they heard blood flow with the Doppler.

BY MR. ARNTZ:

Q. So this doesn't say, heard by Doppler, it says there are excellent pulses in the foot currently by Doppler examination?

A. Yes.

Q. And I don't know if you saw the other letters in Dr. Wiencek's file, but counsel brought them up yesterday, I believe where they talked -- or a similar note was made -- or they didn't use the word Doppler, just said, pulses?

A. Yes.

Q. So if Dr. Wiencek comes in here and explains the only way he was able to get a pulse was

by Doppler, would you have any reason to disagree with that?

A. No, if that's what his findings were, he could only hear a signal, wasn't able to palpate a pulse.

Q. You would agree with me, time is of the essence when dealing with an acute limb ischemia?

A. Yes.

Q. So the opinion 5 to 10 days is a reasonable enough time for him to get in to see his cardio-vascular surgeon, is that still your opinion, even in light of the fact three days later he lost his leg?

A. Yes, of course.

I know he lost his leg.

Q. So I may be wrong on this, and Dr. Marmareano may have said both, but my immediate recollection of what he said was, that if he has a blockage in the fem pop graft, then you would not be able to feel a pulse.

A. Yes, I think he said that.

Q. And you disagree with that?

A. It's possible, yes.

Q. It's possible you couldn't feel a pulse?

A. Sure.

Q. Okay.

Nurse Practitioner Bartmus made it very clear the pulse she felt, the palpable pulse she felt on the 25th, was a normal pulse.

Would you expect that in a person had a --

A. I think any pulse you would detect would be called a normal pulse, with the exception of a patient maybe hemorrhaging, but to grade a pulse plus 1, plus 2, plus 3, they are very artificial. I've never been able to do that in my practice.

I usually note, pulse present.

Q. So why in that letter that counsel showed you today where it says, plus 2 pulse, did you say that is a normal pulse?

A. I would say, that is normal, yes.

Q. Even though that is not something you have experience doing?

A. I don't grade it that way.

Maybe I'm not -- or don't have as fine a touch as Dr. Wiencek.

I think when he says, plus 2, he's saying that the Doppler exam shows good flow.

Q. I want to be really precise with this question because I think it's important for the jury to understand this.

What you are saying is that, first of all, when you hear the word normal from Nurse Practitioner Bartmus, and she doesn't qualify normal for him, normal for Mr. Moore, she just said, a normal pulse, that you're making an assumption that it probably wasn't a normal pulse, but was still a pulse, is that right?

A. No.

My assumption is, that she was able to palpate a pulse in Mr. Moore.

That's the assumption I made because that's what she said in her deposition.

Q. Okay.

So you don't put any relevance on the question of whether the pulse is a good normal pulse, or a diminished pulse?

A. No.

Look, if you could feel a pulse in a chronic path, that is fine.

Whether it's a grade plus 1 or plus 2, if you can feel it, that's good.

Q. So back to the question of whether you would expect us to find a normal pulse, or a palpable pulse, in someone who had already demonstrated his story of no pulses, when there was a blockage to the

artery.

Are you saying that you might feel something close to a normal pulse in someone who has a blockage in his artery?

A. You can, yes.

Q. Would that be common?

A. Not the most common, no.

Q. Normally you have to get it by Doppler, get the blood flow by Doppler?

A. Well, in the absence of a pulse, you are certainly able to hear blood flow by Doppler, if there's blood flow there, you can hear it by Doppler, yes.

Q. And could that blood flow by Doppler under those circumstances, would that have been from the collateral sources of blood?

A. Yes.

Q. If I understood your testimony yesterday, the collateral sources would have been created through the profunda?

A. The profunda primarily.

Q. How does it, the process of establishing collaterals, work?

A. Well, you will get a Nobel Price if you and I can figure that out, but I can give what the

current thinking is.

The current thinking is, that the demand for blood creates an anoxygenic environment, that is the absence of sufficient oxygen.

In the absence of sufficient oxygen, causes the blood vessels to dilate, and over time with exercise you will continue to dilate those blood vessels.

Now, as humans evolved we haven't done it as well as the lower mammals. For example, a rabbit will have severe ischemia and generate sufficient Dopplers, it will heal a gangrenous ulcer on its leg, humans can't do that, but we can develop with a continued exercised, absence of tobacco a usual measure, reducing blood pressure, cholesterol, you could have fairly good collateral flow, so symptoms will be not life-altering, and in fact in some instances a pulse will appear.

Q. So you gave factors that you know don't apply to Mr. Moore, right?

A. I used that in a general sense.

Q. But we're talking about Mr. Moore right now, and the question of whether his collaterals would have been sufficient to generate a pulse in the presence blockage to his artery?

A. Yes.

Q. And you just identified some factors that would make it more likely for that to be true and said, someone who doesn't have high cholesterol, exercised regularly, someone who doesn't smoke, correct?

A. Yes.

Q. Do you consider smoking an important factor?

A. Yes.

Q. Did you see anywhere in the record where either Nurse Practitioner Bartmus or Dr. Lasry considered that factor when they were examining Mr. Moore?

A. Well, they noted it in the history.

Q. It was noted in the history, but do you see anything suggests they considered it as a factor in evaluating his physical condition?

A. Well, that goes without saying.

If you are examining a patient, you ask about smoking because we know smoking has a deliquesce effect on the circulation.

Q. So he's give them the benefit of the doubt, says they did consider it, they would have considered then he had a history of occlusions, correct?

A. Yes.

Q. He had a history of smoking?

A. Yes.

Q. By all accounts, 30 to 40 years, correct?

A. Yes.

Q. He did he have a history of high cholesterol?

A. I don't know.

I don't recollect that.

Q. That is something they also should have considered?

A. It would be more the role of the primary care physician.

High cholesterol's not an emergency.

Q. What I'm trying to get at is, the question of whether Mr. Moore was a candidate for having sufficient collaterals, that it -- or he could withstand this occlusion in his leg, or whether they should have done more investigation to see exactly the extent of blood flow into his leg.

A. Well, I think their clinical examination of the leg showed that blood supply was adequate on the basis of what they recorded, and that that was appropriate to refer him back to a vascular surgeon to evaluate is there anything you need to do.

Q. Again, you're giving the full benefit of the doubt to them that the record they created is accurate, even in light of the fact that Mr. Moore is proven to have had an occlusion in his artery, had none of the factors would have supported good collateral blood flow, is that your testimony is, you give them that benefit of the doubt, even in light of those factors?

A. Yeah, I have no reason to believe that the record is inaccurate.

Q. Well, except for the fact Mr. Moore and his son both said they never took his sock off, and the fact that Dr. Lasry has modified a record from appears occluded, to possibly occluded.

A. Those to me what are unrelated, doesn't add up to a falsification of the record.

Q. Okay.

In November they just brought up the record showing in November 2016 November 1st, he had normal DP pulses.

What does that DP stand for?

A. Which date is that?

Q. November 1st, 2016.

A. And go ahead.

Q. It said he had normal DP pulses?

A. The dorsalis, feels the pulse on top of the foot.

Q. And then it says, at that time there was no evidence of calf pain, correct?

A. In 2015?

Q. No, November 1st, 2016.

MR. MC BRIDE: That's 2015 up there.

MR. ARNTZ: That is.

That's not to record I'm referring to.

I'm referring to the one brought up by counsel November 1st, 2016.

THE WITNESS: Okay.

I've got it.

BY MR. ARNTZ:

Q. You got it?

A. This is May 9, 2016.

Q. Do you recall the record I'm talking about they brought up to show there were pulses on November 1st, 2016?

A. Yeah.

Q. A little less than two months before he went in on the 5th of December, correct?

A. Right.

Q. And then he brought up a record that said it was 12/21/2016, four days before he went into the

emergency department?

A. Right.

Q. He didn't complain of calf pain, did he?

A. He was complaining of various pains, and I remember ankle pain I believe was one of the areas he complained of.

He had back pain, I believe.

Q. Right.

A. I can't recall the rest of it.

I don't know if he had calf pain at that time or not.

Q. I'll represent to you I read the record as was up there and saw no reference to calf pain.

A. All right.

Q. But it said he was on Xarelto?

A. Right.

Q. So within a week of going on the 25th he was on the medication.

We talked about the black box warning, correct?

A. Right.

MR. WEAVER: Well, Your Honor, lacks foundation.

Calls for speculation he was taking it.

BY MR. ARNTZ:

Q. It said in the record, on Xarelto.

Do you accept that record as true?

A. Yeah.

What that means is, that a prescription has been issued for Xarelto.

Q. So are you assuming that the accuracy of that record isn't the same as what you would expect from the emergency department on December 25th, 2016, that somehow that record is less accurate?

A. No.

What I'm saying is, that when you say a patient is on Xarelto, it means the physician has prescribed that medication.

It doesn't say anything about is he taking it, has he filled the prescription or not, you don't know about that, but the record says that it's been prescribed for him.

Q. Okay.

But you don't accept that means he's taking it?

A. Not necessarily.

I'm thinking about myself for example and I'm sure others who get prescriptions and don't necessarily follow the advice.

Q. So now what you're suggesting I guess is, that a person who went through an experience in November 8, 2012 where he had to have a femoral popliteal because he had no pulses in his foot, was put on Xarelto, has another event in December of 2014, they had to break an occlusion, and another one in 2015 they had to do the same thing, you're saying you don't thinkg that person took the prescription of Xarelto seriously?

A. I didn't say that.

Q. You're not assuming this record is true as other records you reviewed have to do with Dr. Lasry and Nurse Practitioner Bartmus?

A. Not true.

I didn't say that.

Q. So four days before he went in on the 5th there's no evidence of an occlusion, correct?

A. They don't have evidence of imaging of occlusion at that time.

Q. They don't have any pain symptoms in his leg suggest he might have an occlusion?

A. That's correct.

Q. He's on Xarelto.

He has normal pulses present, correct?

A. Palpable pulses, yes.

Q. It says, normal pulses.

I don't know it said palpable?

A. Okay.

I'll accept that.

Q. And then four days later he goes in the emergency department with pain in his calf, an ultrasound is showing he has an occlusion, but you assume that occlusion existed weeks or months before that, correct?

A. That's correct.

Q. To what extent are you familiar with the symptomology or symptoms associated with neuropathy?

A. Fairly familiar, yes.

Q. You're aware neuropathy can cause numbness, pain, and tingling in the person's feet?

A. Yes.

Q. And that numbness can be so pervasive around the sides of his feet, he might lose balance?

A. It would be a very advanced case.

I'm not sure that is typical at all.

Q. So you're not familiar with that symptom causing problems for people with neuropathy causing them to fall, or lose their balance?

A. It's a different type of neuropathy where you lose a position sense in diabetics, will have

difficulty walking because they have lost pressure sense in their feet.

Q. So to my knowledge there's several different types of neuropathy, the kind brought on by diabetes, correct?

A. Yes.

Q. The kind brought on by alcohol, correct?

A. Yeah.

Q. Alcoholic neuropathy.

Are you familiar with the neuropathy brought on by chemotherapy?

A. Yes.

Q. And there's idiopathic.

What that means is?

A. It simply means, we don't know what is causing it.

Q. So now within those different categories of neuropathy, are you telling the jury that those different types of neuropathy, diabetic neuropathy, is different symptoms than a chemotherapy neuropathy?

A. I don't know exactly what neuropathy of chemotherapy is like because I don't treat patients receiving chemotherapy as a rule.

Q. I guess my question is:

Do you have some source of knowledge or

experience with the concept that one type of neuropathy associated with one etiology will be different than another type of neuropathy?

A. I'm sorry, I can't answer that question. I'm not that skilled as a neurologist.

Q. Okay.

And are you aware the time he went into seeing to the emergency room on December 25th, 2016 he was using a cane?

A. I had read he used a cane, yes.

Q. Does that support the conclusion a person who uses a cane is somebody who has good balance, doesn't have any instability with his feet, and has a normal gait?

A. Well, you use a cane and have a normal gait, yes.

Q. Again, you accepted the reference in the record as being accurate, without paying attention to the other facts associated with Mr. Moore, namely that he used a cane?

A. I think it said he used a cane, or even a wheelchair, five percent of the time is my recollection.

Q. Okay.

A. I don't remember any of the notes in the

emergency room commenting on his use of a cane.

Q. Let me change gears a little bit.

You -- Are you currently retiring from academia?

A. Yes.

Q. And in association with that, are you also retiring from an active practice?

A. Yes.

Q. How long has that process been going on?

A. About a year.

Q. And does that apply equally to both of those, you have been retiring from the academia at the same rate you're retiring from your active practice?

A. I retired from active surgery over the last year.

I'm still very active in academic things, and editing, and writing in a textbook right now, and I have plenty of consultative work, so I gradually slowed down.

Q. You have been in academia since when?

A. I --

Q. By academia, I mean having an active teaching role as a college professor?

A. Yes.

Q. How long have you been doing that?

A. I was appointed to the faculty at UCLA in 1972.

Q. Since 1972, you have been writing articles and contributing to books and various other writings and presentations?

A. Yes.

Q. I'll say, your curriculum vitae is a doctor's word for resume?

A. It's just Latin.

Q. The curriculum vitae is about as long as I've ever seen one.

You must have over 2,000 articles in here?

A. No, 500.

Q. Really?

A. Not counting book chapters.

Q. Only one category, I see.

A. I published about ten to twelve articles a year when I was very active.

Q. One category I see 373.

You were invited to to do international lectures, 27 of those.

I mean, I was going through and doing a rough assessment of how many different entries there are, and there's got to be over a thousand entries.

A. Okay.

Q. I guess my question is:

Is this all the things you have done since 1972, or did you even go back beyond 1972?

A. There's about maybe ten that go back before '72 I did when I was in training.

Q. And what commitment of time do these different things you have contributed to, or writing, or go and speak, what commitment of time does that require?

A. Well, it would be probably a good ten percent of my time.

A lot of it would be done in the evening hours.

But all together it probably would be ten percent of my working hours.

Q. And then what percent of your working hours takes up -- would the academia take up, and by that I mean teaching position, whether it be in the hospital or --

A. I would be estimating at maybe 20 percent.

Q. So with all this stuff you have done, and all the things you have done since 1972, is your testimony that only takes up 30 percent of your time?

A. Yeah.

Q. The rest of the time is spending active practice?

A. Yes.

Q. How much to you charge to be here?

A. For this I charge $5,000.

However, this is my third day here, and we're going to have to work out some type of reconciliation.

I've have not paid for the hotel myself, I don't want you to think that.

But I'm not sure who has paid for it, Mr. Weaver's organization, but it's been three full days.

I left Los Angeles, I left my home on Tuesday morning at 5:30 a.m., and this is Thursday at 4:20, and I'm still here.

Q. And is your day -- are you saying your daily rate is $5,000?

A. I said, I've never been involved in anything like this before.

All I can tell you is, that usually when I testify in court, it's one day, or a half day, and it's $5,000.

Q. Okay.

So you charge the same for half day or full day is the same?

A. I never testified for a full day, so I don't know what the going rate is.

Q. But according to your fee schedule, if I understand you right, you would charge --

A. Ordinarily.

Q. -- $15,000 for the three days you have been here?

A. How much?

Q. $15,000?

A. Well, can you tell Mr. Weaver that that would happen?

I don't know what will happen.

I'm concerned.

Q. Okay.

A. Let me just say, that would be a very pleasant occasion if that did occur.

Q. You don't have any intention of charging that amount?

A. I have no idea yet what to do about this.

Q. Okay.

Would you say -- I'm jumping around a little bit, I'll get back into more of a flow here, but would you say the 28th he was properly assessed for amputation?

A. Not on the 28th.

I think it was -- the application I think was done by an orthopedic surgeon, and it was a couple of days later he was called in after the they decided that the thrombolysis wasn't going to work.

Q. The thrombolysis was done of the graft, wasn't it?

A. Yes.

And the attempt would be for any other arteries they could access.

Q. Was there any evidence they attempted to use TPA therapy on the profunda?

A. Yes.

Q. And were they successful with that?

A. They thought it was possibly successful that they reduced the amount of clot there.

Q. Isn't it true that in order for the TPA therapy to work, you have to have blood flowing through the area, in other words, there has to be a way for it to come in and go out?

A. For TPA?

Q. Yes.

A. No.

What TPA is, is usually given by a catheter into the clot itself to dissolve the clot.

So there's no blood flowing at that point.

Q. Okay.

The treatment that was rendered at the time of the amputation during that stay started on the 28th, would you say that was necessary as a result of the condition?

A. The amputation?

Q. Yes.

A. Yes, it was necessary.

Q. And you have done that type of treatment before, you customarily have your patient stay in ICU?

A. I missed that.

Q. Do you customarily have the patient stay in the ICU department?

A. Well, you do if the patient's receiving TPA because it can cause bleeding, as it did in Mr. Moore, from any other site where there's an opening of an artery.

Q. Because the thrombolytic in it?

A. Yes.

Q. And are you familiar with how long Mr. Moore stayed at the hospital for the amputation?

A. Before the amputation, or all together?

Q. The whole time.

A. Yeah -- I can't remember the exact number

of days, but it was in the order of a week.

Q. And that would have been reasonable and customary for that type of treatment he was receiving?

A. Yeah.

Q. And customarily would you have somebody who has received that type of treatment go from the hospital, the ICU, and go into a rehab facility?

A. Yes.

Q. How long would you normally expect to see someone in a rehab facility?

A. You know, it would just depend on what you wanted to accomplish in the rehab facility.

It would be some time later usually, let the patient go home for the amputation site to heal, and when that is healed, then you begin to do rehab to get him ready for prosthesis.

So probably actively it wouldn't occur for say two to three weeks, and then he would go into an out-patient rehab situation, parallel bar walking, possibly even an early fit prosthesis, crutches, all of that to get him going.

Q. Are you familiar with the classification of acute limb ischemia that is in stages?

A. That is in?

Q. Stages, stages 1, 2 and 3?

A. Yeah.

Q. So you see this is a chart broken down into three stages, and the second stage is 2-A and 2-B?

A. Yeah.

Q. And you are familiar with this classification system for acute limb ischemia?

A. I am.

Q. So the first stage says, limb is viable, not immediately threatened.

You see there's no sensory loss, no muscle weakness -- in both the arterial and venous?

A. Yes.

Q. Would you agree with the first stage of that acute limb ischemia?

A. Yes.

Q. And the second page -- there is two stages.

Stage A is marginally threatened, salvageable if promptly treated, and then it gives the different things you might see, says minimal dose or none.

What does that mean?

A. I guess it means that there's numbness of the toes.

Q. There may be numbness the toes minimal or

none, correct?

A. Yeah.

Q. And then in the muscle weakness it says, none.

And under Doppler it says, often inaudible in the arterial, and venous audible, correct?

A. Yes.

Q. So in the case of Mr. Moore --

A. Are you asking me if I agree with that?

Q. Do you not agree with this staging system?

A. I can certainly not agree with it if I don't.

Q. Is that your testimony, you don't agree with the staging system of acute limb ischemia?

A. Yeah, I think these are a little contrived, but an inaudible signal would put the patient into a 3-B in my estimation because an inaudible signal is really very advanced.

Q. 3-B or 2-B?

A. 2-B.

Sorry.

Q. Okay.

So a person who is a 2-A, marginally threatened, salvageable if not promptly treated, he may have an audible pulse by Doppler?

A. Possibly.

Q. So in the case of Mr. Moore there's been some discussion about the extent to his pain complaints in his calf, and that's been minimized by you I would say.

Do you agree with that, it has a minimal finding of calf pain?

A. No, that is what brought him to the emergency room on the 25th of December.

Q. But in relation to his acute limb ischemia, you didn't consider that being a significant finding?

A. That is not a finding of acute limb ischemia.

It's more the foot pain that signifies acute limb ischemia.

Q. Are you familiar with -- Do you know why Mr. Moore came to the emergency department on December 5th, Christmas day, of all days?

A. Yeah, it was my understanding he had calf pain, which had come on after a period of more walking than he generally did.

Q. Well, the calf pain had been present for a day, correct?

A. Yes.

Q. Okay.

And are you familiar with Mr. -- You're obviously familiar with Mr. Moore's history of occlusions in 2015 and 2014?

A. Yes.

Q. And initially the graft in 2012.

Are you aware that his doctor, Dr. Wiencek, had told him, if you feel anything like this, I need you to get to the emergency room as soon as possible?

A. I'm not aware of that discussion.

Q. Would you agree that that is sound advice?

A. Now, what exactly is the advice, if he has --

Q. If he has pain into his left lower limb, the place where he had the fem pop graft, if he feels pain in that area, he should get to the hospital as soon as possible, and have them call him --

A. Well, I think that is okay.

Q. Especially, given if fact he's already had two occlusions and a fem pop?

A. Yeah.

Q. So you know the reason he went to the emergency room on December 25th.

Do you find it significant he would go to the emergency room on Christmas of all days?

A. I suppose you could say, it bothered him

enough to skip Christmas dinner and go to the hospital, yes.

Q. Did you see --

A. On the other hand, it could be that he went because he felt there would be fewer people in the emergency room on Christmas.

It's an impossible question to answer.

Q. So is that another assumption you are making against my client, that he had some ulterior motive other than the fact he had these symptoms and been told to go?

MR. WEAVER: Objection, Your Honor.

He asked him to speculate in the first place.

THE COURT: You are asking him to speculate.

MR. ARNTZ: No, I'm questioning whether he has speculated.

I think he's speculating right now.

THE COURT: Clarify the question.

Sustained.

BY MR. ARNTZ:

Q. You just testified that he may have gone because he had this concern, but he may just have well have gone that day of all days because he might

have thought the number of patients was less, right?

A. No, I suggested both may have been operative.

One, he was concerned because of pain in his calf, he knew he had venous thrombosis in the past, perhaps he was concerned, and this is not speculating, I think he was concerned he might have deep vein thrombosis.

Q. So you went from an arterial problem he had been treated extensively for, and said the reason he went was because of a DVT, is that right?

Who said that?

Q. You just said that.

A. All right.

Q. The reason he went there was because of a concern of DVT, not because of an arterial occlusion?

A. I don't think Mr. Moore made a diagnosis.

I think he simply said, it happened.

Q. So when he got to the emergency room, the health care providers made a diagnosis?

A. Yes.

Q. Okay.

So are you aware of anything within the records that would help you discern whether it was he thought there might by fewer patients, or had this

concern of another occlusion in his artery?

A. No, I distinctly remember him saying in his deposition, it wasn't the same as when he had the prior occlusions.

Q. That's not my question.

My question was:

Do you know of anything within the records that would support or help you discern whether it was one or the other of the two motivations you gave for why he would go to the emergency room on Christmas day?

A. You know, I can't tell what was going on in his mind at that time.

Q. I'm asking if there's anything in the records could help you do that?

A. No.

Q. Okay --

THE COURT: Can I have counsel at the bench, please?

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

THE COURT: Folks, I'm sorry.

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

THE COURT: Thank you.

Mr. Arntz, whenever you ready.

Thank you.

BY MR. ARNTZ:

Q. I'll get back to that after we find the record.

This is the record from 12/25/2016.

This is where he goes in and says, it felt like spasm.

The report says, history of DVT on the leg and became concerned.

So nothing in that report says anything about how many patients that were going to be there, but it does talk about the fact he had motivation because of a concern because of his history, right?

A. Yes.

Q. Okay.

Do you treat individuals with chronic occlusions?

A. Yes.

Q. And how do you treat them?

A. Well, first of all, we would use what is called conservative non-interventional treatment.

We obtain if we can a normal blood pressure, normal cholesterol, anti-platelet agents

such as aspirin, more recently Xarelto's been approved for prevention of thrombolytic events, and commonly stated as a supervised exercise program, but we don't interpret that as going to the gym or walking a set distance or number of paces.

That's conservative management.

Q. And then what is more aggressive?

A. That would be obtaining an imaging test to see is there something that is safely correctable and that would significantly improve his life activities, but we won't make an intervention, unless the claudication has impacted -- I use the word claudication as chronic disease has impacted his ability to live a normal life.

Q. And claudication is another word for pain?

A. It's a cramping occurs in the calf with walking.

Q. Okay.

So he does indicate in his record -- or at least the record indicates that he felt spasms in his calf since the day before, he had a history of clotting and became concerned, right?

A. Right.

Q. Is it your testimony that -- First let me ask you, you probably don't anymore, but was there a

time when you were on call for emergency departments to go and work as a consult for people who were like Dr. Lasry's position might call you?

A. Up until just a few years ago --

Q. So --

A. -- when they started giving payments to be on call, my colleagues dropped me out of the call schedule.

Q. They didn't want you to get the payments?

A. They said, we don't want you older doctors working so hard.

Q. So I'm assuming your testimony is going to be, had you been called to see this patient, you would have sent him home, is that right?

A. If I would have been on call.

Q. Had you been on call, and been asked to come in see this patient, as a result you would have sent him home?

A. No, I would have probably listened to the report that either Nurse Bartmus or Dr. Lasry would give me and make a decision pasted on that report.

Q. Would you do a physical examination of him?

A. If I was called in?

Q. Yes, sir.

A. If I came in, yes.

Q. If you saw there was an occlusion in the ultrasound, and specifically in this ultrasound showed no evidence of DVP, but they did do a Doppler of the vein, correct?

A. Yes.

Q. But didn't do one of the artery?

A. Right.

Q. Would you have gone and ordered another test to doing a Doppler of the artery?

MR. MC BRIDE: Your Honor, can I object?

This is really beyond the scope, and also goes into our motion in limine on this subject.

THE COURT: Well, technically it is, but it does seem like we're going into some other areas.

I'll give you a little latitude, Mr. Arntz, but let's bring it back to the topic that was part of the direct.

MR. ARNTZ: Okay.

I'd like to make a record on that later, but --

THE COURT: That's fine.

BY MR. ARNTZ:

Q. So you would have done a Doppler of the artery?

A. I would have listened to the arteries in

the foot, yes.

Q. Is it important for you to know like that staging system talked about, it's important for you to know whether you can hear the blood flow in both the vein and the artery, correct?

A. What it does is backs up my clinical impression.

I would have come in, examined him, presumably arrived at the same conclusions Dr. Lasry had, and then you are the specialist, so I would have listened to the flow in the artery to back up my overall impression.

Q. And if you had done that Doppler of the artery and found there wasn't blood flow, what would you have done next?

A. Well, that would be a totally different picture if there wasn't blood flow because the foot would be very different, would be as it was on the 28th.

Q. So is staging the classification system we looked at earlier for a 2-A it says, marginally threatened, but salvageable if promptly treated, and then it talks about the sensation or loss, which could be none, muscle weaknesses could be none, but there is a difference, being what they said, this

Doppler signal, the vein being stronger possibly than the artery, is that your experience?

A. No.

They are two totally different signals.

With the vein you're listening for blood flow, and imaging to see if there's clots within the vein.

And then you're doing augmentation to see if you can make the blood flow accelerate, decelerate, it's a totally different examination, between the vein and artery.

Q. But it was brought up I think yesterday that it was significant to you that in the ultrasound done they did a Doppler of the vein, and they showed blood flow?

A. Yes.

Q. So my point is, you could have blood flow in the vein, but not have audible blood flow in the artery, is that correct?

A. I don't think so.

Q. So are you saying that this classification system is flawed when it talked about the Doppler signals?

A. Yeah, I'm not in agreement with it.

Q. Okay.

Let's talk about --

A. In fact, I don't even agree with the title, the classification of acute ischemia.

We're talking about, number one, it's not acute limb ischemia.

Q. Are you arguing with the standard for vascular surgery standards?

A. I don't know when these were published, or who published them.

Q. Do you generally adhere to those standards?

A. I would -- I would not classify my patients this way.

Q. You would classify them by the five Ps, which are all done manually by the examiner, in other words you get a pulse?

A. Yes.

Q. A visual, you do these other things that are not tests, they are examinations, correct?

A. Yes.

Q. But in this classification of acute limb ischemia you actually have a test, a Doppler test?

A. Right.

Q. That confirms blood flow in both the vein and the artery, but that I guess in your testimony is that that is less reliable than a physical exam where

you're looking at a patient?

A. No, in -- If I could just simply say that, I think that when you have an inaudible signal, that the condition is really a 2-B, not a 2-A, that is how it differs.

Inaudible signal really signifies advanced ischemia.

Q. Okay.

So let's just focus on 2-A, but let's do it the way you said, and if there's no difference in the audible signal from the Doppler, that would put it in a category where it's marginally threatened, salvageable if promptly treated.

You agree with that?

A. So if there's a signal, I would leave it at 2-A.

Q. Isn't that what your inference is?

A. If it's marginally threatened, salvageable if promptly treated, I don't know what promptly means in this. I expect they mean, maybe a week or so you bring the patient in for surgery, and he had an audible signal.

Yeah, I would leave that as a 2-A.

Q. All right.

I don't mean to be argumentative with you,

but the words marginally threatened and salvageable if promptly treated, those words to you suggest you could wait a week to treat him?

A. Well, what does marginally threatened mean, and what does threatened mean?

This is a very subjective description.

Q. These are classifications you said you accept.

Are you telling me you don't know what the words marginally threatened mean?

A. I don't know what they mean by marginally threatened.

I'd have to read the whole article to figure out what is going on here.

Q. What you don't see in this classification of acute limb ischemia is 1 and 2-A, you don't see actually in 3 or 2-B, you don't see any reference to extreme pain, do you?

A. Well, that's not a category.

It a very simple table.

It's not a category, it's in the table.

Q. It does talk about sensory issues though?

A. Sensory loss?

Q. Right.

A. I think by the way that is not as important

as a description of pain.

I would do it differently if I were writing the book.

Q. I got that.

A. I actually have.

Q. So if -- Let's say you have somebody in 2-B, what is immediately threatened, salvageable if immediately -- What does revascularized mean?

A. That is acute ischemia.

Q. And that is where you have toes associated with pain, and the rest they are talking about pain, correct?

A. Now we got pain, yep.

Q. And the muscle weakness is mild or moderate?

A. Yes.

Q. Certainly there was some evidence he had muscle weakness, he was using a cane and had spasming in his calf?

MR. WEAVER: Excuse me, Your Honor.

That lacks foundation.

There's been no evidence in the record he had pain.

THE COURT: Well --

MR. ARNTZ: There's evidence in the record,

maybe not in this medical record.

BY MR. ARNTZ:

Q. But he testified he used a cane and a wheelchair from time to time, correct?

A. Yes.

Q. So if we put him into that category, you would at least go and do another ultrasound of his arteries, wouldn't you?

A. If he was in -- or had the description of 2-B, yes, I would do an ultrasound.

Q. Would you admit him?

A. It depends on the amount of pain he had and the changes in his foot, the skin.

But if all of these are true, if he has an inaudible Doppler signal, I would get imaging and most likely admit the patient.

Q. Okay.

The differential diagnoses by practitioner are important, aren't they?

A. Yes.

Q. And explain for the jury what a differential diagnosis is.

A. That is a list of things that you think maybe the diagnosis -- and generally listed from what you think is the most likely diagnosis to the least

likely diagnosis.

Q. Did you happend to read Dr. Barcay's report?

A. His letter?

Q. Yes.

A. Yes.

Q. You saw in there he came in with pain to the emergency room department, he came in with pain at a fem pop graft appeared occluded, was given Percocet in the emergency department for the treatment of pain, do you remember that from the record?

A. I can't remember specifically, but I'll accept your recitation of it.

Q. And Percocet is a pretty strong narcotic for treatment of pain, isn't it?

A. Yes.

Q. So if he comes into the emergency room complaining of pain of intensity level of 7, but is given Percocet, you would expect that pain to diminish, wouldn't you?

A. Not really because he had been chronically taking even Oxycodone, which is pretty strong.

Q. Do you know whether he had taken any that day?

A. No.

Q. So they go, and they do a differential diagnosis, deep vein thrombosis,/S-RT right sprain or strain, right?

A. All right.

Q. I believe Mr. Dr. Barcay misinterpreted this record because he also included the arterial occlusion area, peripheral arterial disease.

Can you see they didn't include that in their differential diagnosis, did they?

A. The diagnosis 1 and 2 are I think from the past history.

Q. That's what I think too.

It says 6/27/2015?

A. Yeah.

Q. So those have been prior differential diagnoses?

A. Right.

Q. Of that?

A. Right.

Q. And yet in the differential diagnosis that Nurse Practitioner Bartmus and Dr. Lasry created they didn't include close in the differential diagnosis?

A. Okay.

Q. And you think that is okay, even though

there was an ultrasound showing an occlusion in the artery?

A. Yes, because he didn't have signs and symptoms that would lead you to believe that was the current problem.

He certainly had artery disease.

I don't believe the time they examined him that the arterial occlusion was acute, so --

Q. You didn't really know at that point, did you?

I mean, on December 21st, four days earlier, he had none of those symptoms, he didn't have any complaints that lead anybody to believe he should go to the emergency room, this is all things he's been through before, so are you saying that even in light of that fact there have been four days, and this developed in that time period, that is not acute?

MR. WEAVER: Objection, Your Honor.

It's quadruple compound.

THE COURT: It is multiple compound.

I'll sustain.

BY MR. ARNTZ:

Q. But you understand the foundation I laid for that regarding the examination on the 21st of December?

MR. WEAVER: It's still quadruple compound.

THE COURT: I don't think that is correct, Mr. Arntz.

If you want to break it down or something, but you're asking many compound questions.

MR. ARNTZ: I'm trying to get through this, Your Honor.

THE WITNESS: I appreciate that.

THE COURT: Change a few things.

BY MR. ARNTZ:

Q. Do you recall Mr. Moore was seen on December 21st, 2016, four days before he went into the emergency department?

A. At the pain management clinic, yes.

Q. And at that time he didn't say any signs or symptoms to that practioner he was having an acute ischemic event, did he?

A. No, he reported pain in his legs, but he didn't say, I have an acute arterial event.

Q. He reported pain in his ankle?

A. Yes.

Q. And they apparently took a pulse and found one?

A. I think so, yes.

Q. And within four days he had taken himself because of a concern he had over an arterial problem to the emergency department, right?

MR. WEAVER: Lack of foundation.

THE COURT: Sustained.

BY MR. ARNTZ:

Q. The note I read to you just a minute ago says, he had a concern for his leg, and that is the reason he was there, didn't it?

MR. WEAVER: Again, Your Honor, that lacks foundation it was an arterial problem.

That --

THE COURT: You want to put the note up and see what that description is, get that clarification?

MR. ARNTZ: These are things everybody heard.

I'm trying to get through it.

THE COURT: Mr. Arntz, put up the document and show the information.

BY MR. ARNTZ:

Q. Again, this is the report that comes in with, reports left calf pain since yesterday, felt like spasming, that's a sign, isn't it, a symptom that could lead to the conclusion he has a problem with an artery?

A. See, as I read that it says, but reports he has a history of DVT in the leg, and became concerned, and I read that as becoming concerned that he hasn't had a recurrent DVT in the leg.

Q. Fair enough.

And my own expert said, it was appropriate to do an ultrasound to rule out DVT, but in the process of doing that ultrasound they found evidence of an occlusion in the artery?

A. Yes.

Q. And so knowing that he had previous occlusions in the artery, and that was evident, wasn't it, by the note of 6/25 where we talk about the different diagnoses, and that treatment took place in June of 2015?

A. Yes.

Q. That showed he had a history of arterial occlusion, correct?

A. Yeah.

Q. So we have a person coming in with this concern and that finding from ultrasound, and without more would you have sent him home?

A. Well, if he had related to me the condition of his extremity as was noted in the chart, and if that had been related to me that he had no deep vein thrombosis, and he had a graft that looked like it was occluded again, but he didn't have symptoms or signs of acute ischemia.

I would review that as a chronic condition, and I think I would probably have said, given the preamble I've said, let me see him in the office and see what is going on.

If he had said that he's got signs of acute ischemia, his foot is cold, he's got pain in the toes, can't dorsiflex his foot, you know, I'd be in to take care of that, yeah.

Q. So if they called you and said, he presented with a concern about his leg, he has a history of acute arterial disease, he's had previous occlusions, and by the way we have an ultrasound shows an arterial occlusion, you wouldn't even come to the hospital?

A. It would depend on his condition.

If his extremity had the signs and symptoms

of normal circulation, what would be the point of rushing into the hospital?

You are not going to do anything.

Q. You named a couple of things, you would have done the -- already you said you would have done a Doppler of his artery?

A. I wouldn't have changed anything.

I would have heard audibles, given the signs and symptoms reported by Dr. Lasry and Nurse Practitioner.

Q. Again, your entire opinion is based on whether or not they actually did that pulse test, isn't it?

A. You're absolutely right.

Q. You would agree with me, wouldn't you, if Dr. Lasry failed to actually put his hands on Mr. Moore and examine him, that would be below the standard of care?

A. If Dr. Lasry had not examined him, that would.

I'm not going to comment on emergency medicine standards of care, but I would expect Dr. Lasry in the ordinary treatment of the patient would do that.

Q. You certainly would not have been able to

make the statement you made in the last question if you accept all those records as true, if in fact you had reason to suspect he had not put his hands on him and tested his pulse?

A. I don't have any reason to expect he didn't put his hands on him.

Q. Would you agree with me that the same would be true for Nurse Practitioner Bartmus, if she represents in the record she did a physical exam, and actually hadn't, that would be below the standard of care?

A. Yeah.

Q. In fact, that would be beyond the standard of below the standard of care, would be a violation of their oath as practitioners, wouldn't it?

A. Yeah.

Q. Creating a fraudulent record?

A. That's right.

Q. I'm skipping through a lot of stuff, so I I'm winding down.

What are the surgical options for someone who has an occluded artery?

And I'll ask you next if they differ based on whether it's chronic or acute, the surgical options for an occluded artery?

A. For with acute ischemia?

Q. Let's start with acute ischemia.

A. With acute ischemia.

Surgical options would be to extract the clot using a type of balloon catheter, and try to restore flow that way.

It's not particularly successful.

So today we generally go for lysis first with an attempt to dissolve the clot.

Q. Is a surgical thrombectomy an option?

A. Yes.

Q. Okay.

How about re-grafting it?

A. That's possibly an option, yes, you could put in a second graft, but if your first graft is not functioning, then the second graft is a very poor prognosis.

Q. When you say, a secondary graft, what do you mean?

A. If you put in a second by-pass.

Q. Okay.

I think you actually wrote an article many years ago on using a profunda to create a secondary graft?

A. Yes, made a movie of it.

Q. Is that something still an option?

A. Unfortunately, it hasn't been practiced widely, but it is an option, and it's sometimes appropriate.

What you would do is, take the graft off the profunda to avoid re-operating on a previously dissected area.

Q. You testified that your opinion is, he would have lost his leg regardless, and I'm assuming that opinion is based on -- or an assumption on my part, you wouldn't have admitted him on the 25th?

A. Given the record in the chart, no.

Q. If you had admitted him on the 25th, do you have an opinion whether he would have lost his leg anyway?

A. I think he was destine to loss that leg because of continual progression of disease.

I think he was developing end stage disease, wasn't going to be corrected other than temporarily.

Q. So previously you testified that that could have been a number of months, could have been a year or more, correct?

A. Yes.

Q. And importantly, it also may have involved

a different type of amputation, wouldn't it?

A. Possibly.

Q. Might have been below the knee?

A. It could have been.

Q. So him not getting admitted on the 25th possibly created a loss of chance on his part to have a successful treatment and have a longer period of time with his leg, correct?

A. What was done?

I mean, under what circumstances?

Q. If he's admitted, and they are treating him with TPA, or treating him with something to break up that clot, and if successful, that chance could keep his leg longer was lost by not being admitted?

A. If it were to be successful, and they opened up the graft, and there was flow through the graft, he would have retained his extremity for a longer period of time.

Q. At the very least had he not retained it forever, he would end up having amputation, he lost the chance to have on amputation below the knee?

A. I can't say that because of the unusual anatomy he had, not having an internal iliac artery, and then having a profunda that was compromised.

Q. So my question is, not whether he would have had a different outcome.

My question is:

Did he lose the chance to have a different outcome by not being admitted on the 25th?

A. I --

MR. WEAVER: Speculation, Your Honor.

THE COURT: Overruled.

THE WITNESS: I don't think so.

BY MR. ARNTZ:

Q. So even if he been admitted on that day in December of 2016, December 25th, even getting admitted that day, he's still going to lose his leg above the knee?

A. Well, I can't really answer that.

What I can say is, the disease was progressive, and he would eventually have had an amputation no matter what was done on the 25th.

Q. But it could have been years later, correct?

A. It would have been shorter than that.

Q. Well, you said -- earlier you said, a year.

Are you saying, it's only a year?

A. Probably a year because let's say he been admitted the 25th, they opened up his graft, and

marginally improved circulation, it would have clotted soon thereafter as it had done two previous occasion.

Each time it clots the situation is worse, inevitably will lead to an amputation.

Whether it's above the knee or below the knee, I can't tell you.

Q. But those were chances he lost by not getting admitted that day?

A. You're asking me -- Let's say he been admitted that day.

The admission doctors would have examined him, said, well, his leg's okay, let's not do anything.

Q. You're speculating that is what would have happened?

MR. WEAVER: Well, Your Honor, he's asking him to speculate.

THE COURT: Yes.

Sustained.

Agree.

He may finish his answer.

BY MR. ARNTZ:

Q. Are you done?

A. I finished, yeah.

Q. That is based on rank speculation, isn't it, that that is what health care providers that --

THE COURT: What is the objection?

MR. WEAVER: Speculation.

THE COURT: He was with the phrasing of the question.

Now, the fact it's already admitted, sustained.

BY MR. ARNTZ:

Q. That is based on speculation as to what they would have done, isn't it?

A. No, it's based on my knowledge of vascular surgery what would have been done.

Q. It's at least based on a present assumption they wouldn't have called a cardio-vascular surgeon, isn't it?

A. No -- Well, here's what I think:

I think he didn't have an indication to be admitted to the hospital on the 25th.

I think he didn't have an indication for a vascular consultation on an emergency basis.

He did have an indication to be followed up with his vascular surgeon and primary care doctor.

So whether or not he's been admitted to the hospital, that's encouraging me to speculate.

I can't tell what would have happened.

Q. And that conclusion is based on the fact he didn't do a full arterial ultrasound, right?

A. Right.

Q. And a full arterial ultrasound could have done other arteries besides just the grafts, right?

A. Right.

Q. So we don't know if there were clots in the profunda at that moment, but if there had been clots in the profunda at that moment, plus the clot in the graft, wouldn't you have admitted him?

A. If I had known all of that information, probably because if that had existed at that time, his signs and symptoms would have been much worse pointing towards an admission.

MR. ARNTZ: That's all I have.

THE COURT: Mr. Weaver, anything on redirect?

MR. WEAVER: Quickly.

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REDIRECT EXAMINATION OF DR. SAMUEL WILSON

BY MR. WEAVER:

Q. Dr. Wilson, none of the opinions you previously gave in response to the questions I posed have changed, have they?

A. It doesn't change any of my responses, no.

MR. WEAVER: Thank you.

No additional questions.

THE COURT: Any questions from any of the jurors?

We do have some jury questions.

So we will review them, and then to the extent there are any to ask, we'll ask them of you, and you respond to the jurors, and I will give counsel an opportunity to follow-up.

THE WITNESS: Okay.

I'm happy with that.

THE COURT: Can I have counsel at the bench, please?

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

THE COURT: Okay.

Doctor, these are juror questions.

If you could provide your answer to the

jury, unless we have an objection, the attorneys will follow-up.

I'm not at liberty to explain any of this information, simply read the questions exactly as they are written, and you --

THE WITNESS: Can I have a piece paper to write down?

THE COURT: I'm not going to ask them all at once, one at a time.

If you would like to see the papers, you can see them.

THE WITNESS: No, that's okay.

THE COURT: What is your definition of a, quote, palpable pulse, and is that definition different from a pulse described as, quote, normal?

If so, how is it different?

THE WITNESS: Okay.

A palpable pulse is the sensation of pulsation that you feel when you put your hand over an artery.

It requires a certain minimal blood pressure for you to feel that pulse.

And ordinarily it would be over a hundred, depending on whether if the artery's got a lot of calcification, as in a diabetic pressure would need

to be higher to feel the pulse.

The second part of the question was?

THE COURT: I have to read the question exactly as written.

What is your definition of a palpable pulse, and is that definition different from a pulse that is described as normal?

If so, how is it different?

THE WITNESS: A palpable pulse, if you can feel it, is generally considered normal.

Some physicians will grade it and say, well, it's not very strong.

Others will say, it's very, very strong.

To me, a normal pulse in most circumstances is if you feel it, and you can hold your finger up to your radial artery right now, and you can feel your pulse.

I think that covers it.

If the questioner wants to follow-up --

THE COURT: I just indicated, I'm not at liberty, nor they, to supplement the question.

After you answered the question, there's plenty more by the way, I will then give counsel the opportunity to follow-up.

THE WITNESS: Okay.

THE COURT: If you have more to give the jurors, that is fine.

THE WITNESS: No, I think we've covered what a pulse is.

THE COURT: Next question.

In your experience is there a medical decision between the term, appear, and, possible appear, and possible in quotes, with regard to a medical condition?

THE WITNESS: Yes, there's some difference.

Appears to me means that the technician or radiologist looking at it thinks it's occluded, but not completely sure.

Possible means that, you know, this could be occluded, but I'm not completely sure.

So I think they are very close in meaning.

I wouldn't parse it anymore than that.

THE COURT: Okay.

Would an ultrasound be performed with a knee-high sock on, would a knee-high sock be instructed to be left off until post ultrasound examination was complete?

THE WITNESS: The answer to that is:

You wouldn't do an ultrasound with the sock on, and you would leave the sock off until you finish

the ultrasound exam.

THE COURT: Dr. Wilson, in any occlusion in the major arteries, and grafts are collateral, the best system, the last resort, is to get adequate blood flow to lower extremities?

THE WITNESS: Yes.

THE COURT: Dr. Wilson, is it possible following a fem pop graft to have palpable pulses at one hospital visit, require a Doppler at the next visit to defect blood flow, and be able to have palpable pulses at any subsequent visit?

THE WITNESS: Of course.

If you go into a very cold examining room, your pulses, your arteries, will constrict, and it's very difficult to feel a pulse.

If you go into a warm room like this one, a hot room, then your arteries will dilate.

If you come out of the shower for example, you are flushed, blood is circulating, the heat has dilated all your arteries, and you are sure to feel a pulse.

It will vary between examiners.

Dr. Lasry could feel a pulse, and I would go there and maybe not, so sure, or vice versa, and you if see doctors clustered around a patient trying

to determine, do you feel it or not.

So yes, you could feel a pulse at certain times and be absent in other times, absolutely.

THE COURT: Can an artery be chronically occluded for decades, or how long can an artery be chronically occluded before it turns into an acute occlusion?

THE WITNESS: An artery can be chronically occluded for decades.

In fact, Mr. Moore's right femoral artery has been chronically occluded since 2012, that is eight years, not a decade, probably occluded before then, but it hasn't at this point progressed.

And if Mr. Moore takes an oath to avoid tobacco, to keep his cholesterol fine, his hypertension down, and treat it with Xarelto, it may never give him acute occlusion.

But that I don't have a crystal ball to look into it.

THE COURT: Would there be a difference in diagnostics, and/or treatment for occlusion in major arteries, or in native arteries, versus by-pass grafts?

THE WITNESS: Not really, there wouldn't be a difference in evaluation.

The difference here was that the graft had been included two previous times since it had been placed, that is the difference.

And with the chronic occlusion your big job is to determine is this limb viable right now or is it not, and if it's not, we got to do something.

And if it's viable, even though the graft is occluded, you decide is this something where collaterals are providing sufficient circulation to keep the leg alive, and if it is, that could be a stable situation, we call that stable claudication where the patient has symptoms of chronic occlusion, but is able to battle through life and get the things he needs to do done.

THE COURT: With an apparent occlusion on 12/25/16, could Mr. Moore have been instructed to take more milligrams of Xarelto for a greater effect, so to help free the occlusion?

THE WITNESS: No.

THE COURT: And --

THE WITNESS: The reason is, it would reduce bleeding to his brain or some other site.

THE COURT: Could Mr. Moore have been given a more potent blood thinner or other medication, either in the ER, or prescribed from the -- I'm

sorry, Juror Number 7, let me start again.

Could Mr. Moore have been given a more potent blood thinner or other medication, either in the ER, or prescribed from ER, to help free the parent occlusion?

THE WITNESS: Blood thinners such as Xarelto, or more commonly often Coumadin, you have heard of would not affect the clot at all. Those are given to prevent extension of a clot.

So if the patient has acute ischemia, we would generally give an intravenous Heparin that goes to work right away and prevents extension of an ongoing clotting process.

So I believe, if I can say this without getting in trouble, I believe that the clot had been there for some period of time because it couldn't -- or wasn't able to be dissolved on the 28th, which suggests to me it was an organized adherent clot.

Otherwise, you would have had the same result on the 28th as they had maybe prior years.

THE COURT: Okay.

THE WITNESS: So no, blood thinners would not have affected the outcome.

THE COURT: All right.

Mr. Weaver.

MR. WEAVER: No questions, Your Honor.

THE COURT: No follow-up?

Mr. Arntz.

MR. ARNTZ: I got a couple.

- - - -

RECROSS-EXAMINATION OF DR. SAMUEL WILSON

BY MR. ARNTZ:

Q. With respect to the folks, are you aware Dr. Lastry would have testified -- Dr. Lasry testified the pulses would have been diminished, and Nurse Practitioner Bartmus said the pulse was normal, do you make a distinction between those two?

A. I accept Dr. Lasry's comment, and if that's how he grades the pulses, that's fine.

In my purposes of, if there's a pulse present, that means that there's arterial pressure, arterial flow, and that is satisfactory.

Q. Are you aware Mr. Moore has testified, and will testify here, the only time he was instructed to take his sock off was during the ultrasound?

A. I believe that came out in one of the depositions that that was said in one of the depositions.

Q. And you just testified that the -- an occlusion can be chronic and be there for decades,

and specifically said, the one in his right thigh --

A. Yes.

Q. -- has been there for eight years, but you also said that -- well, then in the same question you said, it hasn't progress, but your overall perspective of this disease is, it's progressive, right?

A. It has hasn't progressed to acute ischemia yet, but no doubt it's progressing.

MR. ARNTZ: Okay.

THE COURT: Is that all?

MR. ARNTZ: Yes.

THE COURT: Doctor, that completes your testimony at that time.

Thank you.

THE WITNESS: Thank you.

THE COURT: All right.

Ladies and gentlemen of the jury, we're going to take our overnight recess.

Thank you for your patience by the way.

We went longer than expected today.

You will be returning tomorrow morning at 9:00 a.m. here in this courtroom, and we may have a different location at some point, but tomorrow morning we'll start here.

(Jury admonished by the Court.)

THE COURT: We'll see you tomorrow morning at 9:00.

Have a good night.

(Jurors excused from the courtroom.)

(Proceedings concluded.)

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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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

Thursday, February 6, 2020, 1:30 p.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. Samuel Wilson	6	77	151	159

Las Vegas, Nevada, Thursday, February 6, 2020

* * * * *

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

THE COURT: Is there anything outside the presence before we bring the jurors in?

MR. WEAVER: No, Your Honor.

MR. ARNTZ: No.

THE COURT: Okay.

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

THE COURT: Welcome back, ladies and gentlemen.

We are resuming the trial, and we already have in place.

Dr. Wilson, who of course we left off that testimony yesterday at a point to finish the other testimony, now he's returned.

We don't need to re-swear you, just acknowledge for the record you understand you're still under out.

THE WITNESS: I am, yes.

THE COURT: Thank you.

MR. WEAVER: Your Honor, just for housekeeping, the parties stipulated into evidence Exhibits 106 and 202.

THE COURT: Okay.

They will admitted.

Proceed.

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CONTINUING DIRECT EXAMINATION OF DR. SAMUEL WILSON

BY MR. WEAVER:

Q. Good afternoon, Dr. Wilson.

A. Good afternoon.

Q. Welcome back.

A. This is my third day.

Q. That certainly wasn't the expectation.

Dr. Wilson, we're going to start this afternoon with your credentials, since we weren't able to fully get to them yesterday.

Are you board-certified in general surgery and vascular surgery?

A. Yes.

Q. What does board certification mean?

A. It means, you have completed a required course of training to be a surgeon, and generally additional training for vascular surgery, and you sat a written and oral examination.

And in the case of vascular surgery re-certified every ten years.

Q. And do vascular surgeons perform amputations through advanced vascular disease?

A. Yes.

Q. Are vascular surgeons the primary surgeons

perform non-traumatic amputations?

A. It's done by multiple specialties, but I think the vascular surgeons has the majority.

Q. Why is that?

A. Well, they are the ones that are the prime care treatment of vascular disease, and to take many diabetic patients will have amputations, all the way to total amputations, to higher level amputations, and generally they continue to see the same physician that they've started out with, a vascular surgeon.

But orthopedic surgeons also do quite a number of amputations.

Q. What about general surgeons?

A. Traumatic amputations they would complete for example.

Q. And --

A. Not as many as vascular or orthopedic.

Q. And have you performed many, many amputations during the course of your career?

A. I have performed many amputations, yes.

Q. And roughly Dr. Wilson how long have you been board-certified in general surgery and vascular surgery?

A. General surgery since 1971.

I finished my residency in 1970.

And the vascular surgery boards came out, the first exam I think was '82.

And I took the exam in '83 to become board-certified.

Q. And do you presently have any academic appointments?

A. Yes.

I am a full professor, and if I could say recently titled distinguished, but no increase in salary, and I have been a professor in the University of California since approximately 1982.

Q. And when you say, with the University of California, has that been both UCLA and University of California Irvine?

A. Yes.

Q. Are they teaching institutions?

A. Yes.

Q. And when did you start at UCI, after having been at UCLA?

A. 1992.

Q. And what does a distinguished professor of surgery mean?

A. Oh, it means you have been around for a long time, and that you have contributed significantly to the advancement of your specialty

area in terms of publications, recommendations for treatment, research, so on.

Q. You also historically had an academic association with the VA Hospital system?

A. Yes.

Q. What did that consist of?

A. Well, for quite a number of years I was chief of surgery at our local VA Long Beach because we had an integrated residency program, our residents went there, and I retired from VA after approximately 50 years of service, so I retired from VA two years ago.

Q. And were you at one point in the military yourself, sir?

A. Yes.

Q. And what was your rank, and what was your branch of service?

A. I came in as a Major, United States Air Force, and as soon as you obtain board certification, which I did in 1971, then you're appointed a Major, and I left as a Major.

Q. And generally in a nutshell can you tell us about your teaching experience?

A. Well, I teach medical students, occasionally undergraduates, but not too often, and I

teach residents.

I teach both on the job and didactic lessons in the classroom.

Q. What does didactic mean?

A. Where you expound your knowledge to the students.

It's not where you are demonstrating surgery, or you are scrubbed in the operating room, it's in a classroom setting.

Q. Okay.

And in terms of I think you told us yesterday you teach existing physicians who are specialized doing residency in vascular surgery?

A. Yes.

Q. Who else if anyone do you teach?

A. Medical students and residents, and I do a fair amount of lecturing to medical staffs for their monthly educational conference.

And in years past I would speak at American College Of Surgeons annual meeting, Pacific Coast Surgical Society, and most of the surgical organizations.

Q. Do you treat patients still?

A. Currently, because I'm in the process of retiring from the University of California, I'm not

seeing patients currently, I'm doing consultative work, and -- but I have been seeing patients consistently throughout my career.

Q. And during the course of your career where you seen and treated patients, have you worked with nurse practitioners?

A. Yes, in my vascular clinic I relied on one or two nurse practitioners to help make it through it, yes.

Q. And what is a vascular clinic?

A. Where you see people with arterial and venous disease and amputations.

Q. Would it be fair to say that over the years you have seen thousands of patients with vascular disease?

A. I think so, yeah.

Q. Dr. Wilson, are you the author or co-author of medical text books or medical treatises regarding vascular surgery or vascular diseases?

A. Yes.

I would term it more as an editor, since you don't write the entire book, but you write contributions from people who may have for example more expertise in an area than you do.

Q. And roughly how many medical textbooks or

medical treatises are you the editor or co-editor of roughly?

A. At least a dozen.

Q. And have you contributed more than a hundred chapters to other people's medical textbooks or medical treatises regarding vascular surgery or vascular disease?

A. Yes.

Q. What would be the best estimate of the number of peer-reviewed articles in vascular surgery and vascular disease you have written?

A. It's close to 500, if not 500.

Q. And are those in peer-review journals?

A. Probably 90 percent.

Q. What does it mean to have an article that is peer-reviewed?

A. That means that the manuscript you send in for publication in that journal has been sent out, usually anonymously, so the reviewers, independent reviewers, usually three will read your manuscript and make a decision of whether or not it's of quality where it should be published in a journal.

Q. And in addition to contributing to hundreds of peer-reviewed journals, have you been a regular or occasional reviewer of a dozen or more medical

journals yourself?

A. Yeah.

I continue to review articles for publications.

Q. And I'm almost finished on the credentials part.

But have you also received recognition for having some of the most influential articles in vascular surgery and vascular disease?

A. I have.

Q. And what is that?

A. Very nice of you to bring that up.

Of most of the 50 most influential articles in vascular surgery I've been I'll say co-author on two of them, and I was very pleased to see that.

As you begin to end your career at least you can look back on see changes that you have made and been very important in people's lives.

Q. Thank you, Dr. Wilson.

Do you feel that you are qualified to offer opinions in this case about Mr. Moore's care and treatment in vascular surgery and vascular disease issues?

A. I really do.

Q. Dr. Wilson, do you have a recollection

based on your review of the materials in this case how Mr. Moore's foot was on December 28th, 2016 when he presented to the emergency department?

A. Yes.

Q. Would you tell us please what your recollection is of how his foot looked?

A. That it had all the indications of acute vascular ischemia.

Q. What were those conditions?

A. That his foot was cold, and that Mr. Moore recognized this was the same coldness that had occurred with previous occlusions of his graft.

That his skin was discolored.

I believe in one area it was called mottled.

That it was extremely painful.

I think those are the important things that I recall.

Q. Does that description, would that would be consistent with acute limb ischemia, based on your training and experience?

A. Yes.

Q. Do you have a recollection from Mr. Moore's deposition what he said his leg was like between December 25th and December 27th?

A. He said, and I don't want to misquote, so in terms he felt that his leg was not painful and was fine.

I can't give you the exact words.

I know he used the word, relieved, his leg was better, and it wasn't painful between the 25th and until the morning of the 28th.

Q. Dr. Wilson, do you have a recollection based on your review of Plaintiff Moore's deposition when he said his leg became cold?

A. Yes.

Q. What was that?

A. What was my recollection?

Q. Yes, as to when he said his leg became cold.

A. The morning of the 28th.

Q. Dr. Wilson, do you have an opinion about what may have happened to cause or be a substantial factor in Mr. Moore's occlusion of the profunda artery on December 28th, leading to his acute limb ischemia?

A. Well, certainly there would have been progression of vascular disease.

It is a progressive condition, and even the arteriogram was done on the 28th there's a statement

that the disease is much worse than it was on the last time the radiologist opened up the graft.

So there's advancement of disease.

The clotting of the profunda, I mean that could occur at any time when you have vascular disease without a good explanation, it just simply could happen.

There are other things that I could point to, but I might be speculating, and I was warned about that yesterday.

Q. Dr. Wilson, are you familiar with the term black box warning for purposes of pharmaceuticals?

A. Sure, yes.

Q. Would you tell jury what a black box warning is?

A. Okay.

A package insert goes with every drug that you get from a pharmacy, and you probably opened up hypertension medicine or whatever, and there's these big printouts that comes in the box, and a black box warning is actually literally got a heavy black line around it to draw the attention of patients and prescribers that this is an important complication, and I think what your leading to is the black box warning on Xarelto, and the warning, is if you stop

taking Xarelto, you can have a rebound clotting.

So for example a patient might be taking Xarelto chronically, and if it's stopped for more than 24 hours, which is the time you would stop it before surgery for example, then that can lead to thrombotic event is the term they use, could be in arteries, could be in veins, and could be in other sites of the body, don't have to be the leg.

Q. When you said thrombotic events, what does that mean?

A. Clotting.

Q. Hypothetically, Dr. Wilson, if for whatever reason Mr. Moore didn't every day list his Xarelto as prescribed within the week before December 28th, do you have an opinion whether based on a black box warning for Xarelto he may have been at an increased risk for arterial clotting in his leg?

A. If he didn't take the Xarelto, I think that clearly would place him at an increased risk.

Q. Dr. Wilson, I want you to assume that Dr. M has testified that had Mr. Moore's leg been properly diagnosed with acute limb ischemia on December 25th, and had he received appropriate medical treatment that day, which would have opened up the graft, Mr. Moore's leg would not have needed to be amputated.

I want you to hold that hypothetical for a moment.

A. Okay.

Q. And I want you to further assume that Dr. M has testified that part of the evidence for his opinion in that regard is that the graft could have been opened on the 25th of December because it had been opened up twice before in 2014 and 2015, do you recall it had been opened twice before in those two years?

A. Yes, I do.

Q. Do you agree with Dr. M's opinion that because the graft had been opened successfully two times before December 28th, that more likely than not it could have been opened a third time on December 25th?

A. No, I disagree with his statement because each time you open it up the chances of success diminish because the clotting is occurring for a reason, and by opening the graft you really don't correct the underlying reason, which is progression of vascular disease, and as each clotting event occurs it becomes more difficult to open the graft, whether you are doing it surgically or with thrombolytic therapy.

Q. Why does it get more difficult each time you need to open the graft?

A. Well, it's basically because the run off bed, that is the arteries leading off from where the graft is joined to the artery below the block, those smaller arteries leading off are still continuing to narrow, and in fact one of them was obstructed completely.

There's three vessels that come off just below the knee, and those begin to occlude with arthrosclerotic disease and diminishes blood flow in the graft, and you can take the clot and dissolve it or extract it surgically but the blood got less and less area to distribute, and so the flow in the graft decreases its velocity, and when blood flow becomes stagnant, it clots within a few minutes.

Q. If you were to assume that the graft could have been the clot, and the graft could have been dissolved on December of 2016, with that he indicated the graft had occluded in 2014, 2015 and 2016?

A. Could you say that again, please?

Q. Sure.

If the graft had been able to be unoccluded (sic), or the blockage was dissolved, in 2016, would that have been the third time the graft was occluded?

A. Yes.

Q. And given that trend, do you have an opinion to a reasonable degree of medical probability even if the graft had been able to be opened up whether it would have continued to occlude if not yearly, at least some period of time after there up to the present?

A. Well, unlike the stock market, past history does predict future performance, and he had clotting in '15, he had clotting in '14, and now he has clotting in '16.

It's going to clot again in '17, and I can say that with a high degree of probability.

Q. Is there a point at which even if historically the graft has been able to have the clot dissolved in it at some point more likely than not the end result will be amputation?

A. Yes.

Q. And why is that?

A. Well, because the disease is progressive, and you can take the clot out of the graft or dissolve a clot in the graft, but if you have got vascular disease that is occluding the arteries below where the graft is below the knee, it doesn't help even to remove the clot in the graft.

So it would be progression of disease inevitably.

The type of graft that is implanted, especially in the above knee position, isn't associated with clotting with a life expectancy of maybe 18 months.

I reviewed grafts placed below the knee, and the life expectancy was just an average of six months, so we don't place plastic grafts below the knee anymore, there's just not enough flow to keep it open.

So in this case, although certainly there would have been a clotting event that would have occurred within the next year.

Q. If the clot can't get dissolved by Heparin to keep the clot from promulgating, or to get the clot out, as Dr. M talked about, is the next treatment, if not the only treatment amputation?

A. Well, what you are hoping is that when the graft occludes, there will have been non-collateral flow established to maintain viability of the limb, which is what I had hoped would be the case for Mr. Moore, but there was certain unique circumstances that, particularly the occlusion of the internal iliac artery, so he was dependent on the one profunda

artery to maintain good satisfactory viability of the leg.

Circulation wasn't completely normal, but there was enough that you can get by, and when that profunda artery, the deep one, the one that is parallel to the femoral artery, when that occluded, he had no blood supply to the leg, and that's why on the 28th we have this emergency that Dr. M described.

Q. If there that is acute limb ischemia, as opposed to limb ischemia due to the occlusion of the graft, if the Heparin thrombolytics and lysis doesn't work, once it's acutely ischemic, is the next treatment amputation, such as what happened here?

A. Yes, if the ischemia is quite prominent, painful foot, you can't restore blood flow to it, the best solution then is an amputation.

An amputation has to be thought of in the sense of rehabilitation, not as necessarily failure on a physician.

Q. And what do you mean by the probability of rehabilitation?

A. That it would get the patient the prosthetic limb he could ambulate on.

With an acute ischemia, if that would persist in it, the leg would become gangrenous, and

you certainly couldn't ambulate on it.

Q. Mr. Moore's case on December 28th what were the factors ultimately required within a week or so an above the knee amputation, versus below the knee amputation, was there a way to keep the knee from being amputated below the knee?

A. Well, generally you want to do the amputation as low as possible because that gives the patient a lever arm when it comes to walking with a prosthesis.

Below knee is preferred over above knee because below knee you can fit a prosthesis, and no one in the room would know if the patient's wearing long trousers, that he has an amputation, he can really walk very well.

Above knee it's more difficult.

So we try to do below knee as much as possible.

Now, if you don't have enough circulation below knee, so that when you make the incision on the skin for example, and the bleeding is not good, then you end up with a stump that is not going to heal, and that is multiple hospitalizations, the bleeding of the stump, and really makes a patient bedbound.

So getting the above knee amputation means

that they were sure that it would heal at that level, and that he would be able to go ahead with rehabilitation.

Q. Dr. Wilson, is there in your opinion adequate medical literature that supports the opinions you just gave us over the course of the last ten minutes talking about if the graft continues to occlude, more likely than not it's going to end up in amputation?

A. Yeah.

I can't support that with a citation, but it's common sense to a vascular surgeon each time it clots, it's going to be worse.

Q. And you just used the term, stump.

Are you comfortable that in using the term stump instead of residual limb, it's not demonstrating a lack of insight into patients who have amputations?

A. No, patients and doctors use stump frequently.

When I worked at the Veteran's Hospital, we had a stump clinic, that's what we called it, where all the patients came who had amputations.

So I don't think it shows any disrespect.

Q. Dr. Wilson, you reviewed Dr. M's

deposition, is that correct?

A. Yes, I have.

Q. And when you reviewed Dr. M's deposition, did you see that there was about six inches of literature attached to his deposition as exhibits?

A. Yes, I saw that.

Q. And did I ask you to review the literature that Dr. M attached to -- or that Dr. M reviewed, considered, and relied upon for his opinion in the deposition?

A. I reviewed the literature, yes.

I was familiar with some of the articles, some I wasn't familiar with.

In general, it referred to acute ischemia, not chronic.

MR. ARNTZ: I'll make an objection.

We might need to come to the bench.

THE COURT: Why don't you come to the bench.

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

THE COURT: The objection is sustained.

Ask another question.

MR. WEAVER: Thank you, Your Honor.

BY MR. WEAVER:

Q. Dr. Wilson, diving back in a little bit more from where we left off yesterday, I think we were just leaving off with your opinion whether or not when it comes to the assessment of acute limb ischemia the five Ps are the gold standard.

Do you have an opinion in that regard?

A. Yes, I think that is the standard way of diagnosing an acute knee ischemia limb.

Q. Why is that?

A. Well, imaging will tell you where the block is generally, but it doesn't tell you the precise physical condition of the extremity. You only can tell that by examination.

So the five Ps refer to your history information, and your examination.

Q. And before we get into those five Ps, we've got a board that we'll put up the five Ps just to refer to briefly as we go to it, but would you tell the jury again generally what in the context of the five Ps, what an acute ischemia leg looks like in your opinion?

A. Okay.

The first one is pain, severe unrelenting pain in the foot, and more than that it's tender to

touch. If you touch it, the patient will feel it's very, very painful.

The second would be the color, these are forced a little, the color would be palor if the foot's elevated a little bit, and then if it's dropped down, it becomes a dusty purple color called rubular.

The third would be the paralysis, and generally that means you can't wiggle your toes, or you can't pull back your foot. You are getting foot drop.

Then there is paresthesia, and that is a sensation of an abnormal sensation in your leg, and in his case it would have been on the 28th would have been numbness in the foot, he couldn't have had any fine sense of touch. It would mean absence of palpable pulses, and likely absence of a flow signal if he used the Doppler.

And the last one, the last P I believe is poikilothermia, which is a big word to describe the foot would be cold, it's temperature would be at ambient temperature in the room because he's not getting blood flow to keep it at a normal 98.6.

Q. And poikilothermia, would that actually be a sixth one?

A. I lost count here.

MR. WEAVER: Your Honor, may I approach?

THE COURT: You may.

THE WITNESS: I think we got them all.

BY MR. WEAVER:

Q. So if you come to the board, you need to say, I'm going to the board, it's a housekeeping rule.

THE COURT: If you are going to, as witnesses, all we need to have in the record is, I'm going to the board, you are walking over there, you can say it on your way, say it when you get there, I just want to have in the written record you are not just sitting at the witness stand talking if you need to refer to something in the board.

BY MR. WEAVER:

Q. Before we get into the five Ps, you reviewed Dr. Jacobs' deposition, is that correct?

A. Yes.

Q. I want you to assume Dr. Jacobs has testified in his deposition he believes the charting by the emergency department nursing staff was accurate.

Do you agree with that?

A. I remember that, yes.

Q. And do you recall Dr. Jacob saying in his deposition that he believed that on December 25th Mr. Moore's leg looked, quote, unquote, essentially normal?

A. Yes.

Q. Do you agree with that as well?

A. From my reading of the record, it reflects essentially normal extremity.

Q. I want you to assume, Dr. Wilson, that Dr. M testified he agreed with the examination done of the triage nurse, Nurse Kuchinski. In fact, I'm going to read you his testimony.

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

Dr. M's answer was, actually I agree with it?

MR. ARNTZ: Your Honor, I don't think it's appropriate he's reading from Dr. Marmareano's deposition.

He testified he --

THE COURT: I respectfully disagree, want to know where the question is going because Dr.

Marmareano testified, we heard it we're, we're now trying to get information from this witness regarding those opinions, if I understand where we're going correctly, and clearly what was said I think is better than an attempted summary.

MR. ARNTZ: My objection was whether it's proper to read the deposition testimony in the record at all.

THE COURT: I thought -- Can I have everybody at the bench?

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

THE COURT: I think we cleared up some confusion.

Just to be clear, the reason why my understanding was to overrule, and what is being read from now is the earlier in this trial testimony of Dr. Marmareano, not deposition taken prior to trial, or other sworn testimony.

So again because we're going to be asking this, there's basically two ways, Mr. Weaver.

So say, you can assume certain facts, and ask an opinion, or actually read the testimony, so there's no confusion this was the actual testimony, and then ask.

I think for clarity sake for the jurors and the record, I think that is fair.

We'll see how that goes.

If there's other objections, of course we'll address them, but of course be sure you're reading accurately, which I'm sure you will endeavor to do, Mr. Weaver.

MR. WEAVER: I'll read it straight from the transcript, instead of my transcription of it, Your Honor.

BY MR. WEAVER:

Q. Dr. Wilson, I want you to assume with regard to the charting by the nursing staff, not Nurse Practitioner Bartmus or Dr. Lasry, but I want you to assume with regard to the emergency department nursing documentation, this was the question asked of Dr. M, and then it will be followed by his answer.

Question, so you have no criticisms of the exam that Nurse Kuchinski 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?

The answer, actually I agree with the examination.

I don't think there's anything unusual.

I think she's done the right thing, yeah.

Do you hold that opinion -- or do you disagree with Dr. Marmareano's conclusion with regard to the emergency department nurse's examination and charting of Mr. Moore?

A. No, I don't disagree with that.

Q. Dr. Wilson, before we get into the five Ps, do you have an opinion whether in order to do a proper assessment of Mr. Moore's left leg, his sock and his shoe he might have been wearing should have been taken off?

A. It should have been taken off, yes.

Q. That helps with the assessment?

A. It allows you to see the skin, assess the extremity, if it's warm or cold.

Yes, it should be done routinely.

Q. So, Dr. Wilson, let's start with the first of the P, the pain.

If Mr. Moore's leg was acutely ischemic on December 25th, what would you expect with regard to the pain?

MR. ARNTZ: Your Honor, I object.

This has been the subject of testimony at least three times with this witness, twice yesterday

and once today.

THE COURT: Mr. Arntz is correct.

Obviously if we covered the testimony, we can't duplicate the testimony, but does this help us understand a different line of questioning?

MR. WEAVER: It's just foundation.

I'll go into exactly what the pain was.

THE COURT: Okay.

MR. ARNTZ: Same objection, it's already been testified to.

THE COURT: I think we resolved the objection for now.

That objection was sustained.

I don't need to cover areas we covered already for foundation, but please make sure you are in a new area clarifying line of questioning.

BY MR. WEAVER:

Q. Dr. Wilson, do you have a recollection as to what the scale of Mr. Moore's pain was when he was in the emergency department per the documentation?

MR. ARNTZ: Objection.

Lacks foundation.

THE COURT: I -- Can I have counsel back up at the bench?

I want to clarify something.

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

THE COURT: All right.

The objection is overruled.

I think the objection, there was a little misunderstanding about what the specific intent of what the question was. I think we clarified that.

It's overruled.

I'm sure Mr. Weaver will want to re-ask the question just to be sure we're clear as we move forward.

MR. WEAVER: Thank you, Your Honor.

BY MR. WEAVER:

Q. Dr. Wilson, do you have a recollection based on your review of the emergency department chart on December 25th, 2016 what Mr. Moore identifies his pain would be on a pain scale, if you recall?

A. My collection is it was a plus 3, but I don't have it in front of me, so I can't cite it, but I do recollect seeing a 3.

Q. Okay.

MR. WEAVER: Could we put up Exhibit 100, Bates 1382, please?

BY MR. WEAVER:

Q. Dr. Wilson, I think this might refresh your recollection.

I think it might have been a 3 was acceptable to Mr. Moore, but if you look --

A. I see.

Q. Does that refresh your recollection what Mr. Moore's pain intensity was?

A. Intensity was 7.

Acceptable pain intensity, I presume that would be acceptable to Mr. Moore, was 3.

Q. And if we could go to Bates 1331, please, Dr. Wilson, do you recognize this as being part of the emergency department charting documentation by Nurse Practitioner Bartmus?

A. Yes.

Q. Do you see under chief complaint that it identifies Mr. Moore has left calf pain?

A. Yes, history of present illness, chief complaint, yes.

Q. And for purposes of your review of this case, what is the significance if any of Mr. Moore having the pain that he had in his calf, opposed to his foot or anywhere else?

A. Well, calf pain directs you to a venous

thrombosis in the calf, it would direct you to a gangrenous muscle tear or sprain, and ischemic pain is usually at the part most distant from the heart, so it would be the foot, and particularly for the foot, the toes and metatarsals.

Q. Why is it acute limb ischemia most commonly in the toes or the foot, the furthest place from the heart you said?

A. It's the part most distant for the blood to travel to.

Q. And is that what is most common that you would find consistent with acute limb ischemia, as opposed to in the calf?

A. Yes.

Q. Dr. Wilson, if we could move to the next P, which is palor.

What does palor mean?

A. Palor is pale.

Q. And if we could look at Bates 1389, please, Dr. Wilson, do you see on this nursing assessment by Nurse Pluchinski she identifies the skin to be a normal color?

A. Yes, I see that.

Q. And is that consistent in your experience with acute limb ischemia?

A. No.

Q. Is it consistent in your experience with chronic limb ischemia?

A. Yes.

Q. Dr. Wilson, let's move on now to the third category of pulses or pulselessness.

I think --

MR. WEAVER: May I approach, Your Honor, to move this?

THE COURT: You may.

BY MR. WEAVER:

Q. Dr. Wilson, I'm going to ask you some questions if I might about the pulselessness.

Can you tell us again what generally in the assessment of the five Ps pulselessness means?

A. The absence of a palpable pulse.

You need the dorsalis pedis posterior, popliteal or common femoral artery.

Q. And that is in assessing the five Ps?

A. Yes,

Q. Do you have an opinion, Dr. Wilson if there could be good blood flow in the leg, even in if there's absence of pulses?

A. Yes.

Q. Doctor, have you reviewed the pulse, and

why is that?

A. When you palpate a pulse, what you are feeling is the pressure in the artery that distends the artery to the extent you can feel it. So that requires a pressure certainly above a hundred millimeters, and remember your regular blood pressure ideally would be 120, could be higher, many people would be lower, so when you feel or palpate for a pulse and don't feel a pulse, you can certainly have flow in that artery, but the pressure inside the artery is not as high as it would be if there were no block there.

So there's a decrease in pressure, that's what the absence of a pulse means.

Q. All right.

And do you have a recollection one way or another based on your review of the depositions of Nurse Practitioner Bartmus and Dr. Lasry what they testified to with regard to whether they checked the pulses?

A. Yes.

In their depositions my recollection is they both said they felt pulses.

Q. And if their testimony here at trial is consistent with that, do you have an opinion on

whether or not that means they are lying?

A. I have no reason to believe they were lying, no.

Q. Why is that?

MR. ARNTZ: Objection.

Calls for speculation.

Lacks foundation.

THE COURT: He needs to clarify that.

I'll overrule.

But why is that?

MR. WEAVER: Fair enough.

I'll move on.

THE COURT: I want him to answer that question.

MR. WEAVER: Thank you.

I missed the overruled part.

BY MR. WEAVER:

Q. Why do you hold the opinion that you don't believe they were lying?

A. Well, there would be no point to lie.

You would enter into the medical record what you believe you observed and found on examination.

MR. ARNTZ: Sorry, Judge.

I object.

This is speculative.

I move to strike this testimony.

THE COURT: Overruled.

Please proceed, Mr. Weaver.

BY MR. WEAVER:

Q. Go ahead, doctor.

THE COURT: I thought he finished.

BY MR. WEAVER:

Q. Were you finished, Dr. Wilson?

A. Yes.

Q. Thank you.

A. I don't want to say anymore about that.

Q. Dr. Wilson, I want you to assume that here in trial Dr. M testified no fewer than five times that it is impossible for Mr. Moore to have pulses in his foot after the 2012 femoral popliteal artery by-pass procedure where the graft was placed, and I'm going to read you his testimony with regard to that.

This is my question to Dr. M.

What I'm talking about is, you do agree, don't the you, and I'm not talking about 12/25/16, which is where you keep going to, you told this jury over and over and over and over and over at least, my notes say five times, that after 2012 it was impossible for Mr. Moore to have pulses in his foot.

You said that to this jury, didn't you?

Answer, I did say that, yes.

Do you agree with Dr. M that it would be impossible to have pulses in Mr. Moore's foot, left foot, after the 2012 popliteal artery by-pass graft procedure?

A. I disagree with the statement on the basis that he had several follow-up examinations where my recollections that pulses were noted.

Q. And you have reviewed those materials.

Would there have been visits since 2012 where the pulses were detected?

A. I have reviewed the visits to Dr. Wiencek.

I don't have the material in front of me, it's in my bag outside.

Q. That's okay.

We will go through it.

A. I have reviewed it, yes.

Q. So if we might go to Joint Exhibit 109, Bates 55, please.

THE COURT: Was it received?

MR. WEAVER: Yes, it is.

All of these I'll be going through will be.

THE COURT: As a reminder.

MR. WEAVER: Thank you, Your Honor.

BY MR. WEAVER:

Q. Dr. Wilson, this is a document you seen before, correct?

A. Yes.

Q. And do you see where it says in this note dated August 10th, 2015, so roughly a year and four months before this incident on December 25th, 2016 from Dr. Wiencek's office, it says, quote, he has good pulses in both lower extremities dorsalis pedis on the left and posterior tibial on the right, he also has changes to both lower extremities, you have any reason to dispute the accuracy of Dr. Wiencek's offices note that said Mr. Moore had pulses in both lower extremities, both dorsalis pedis on the left and posterior tibial on the right?

A. I have no basis not to accept that.

It's written down, the examination, yes.

Q. If we may go to Bates 36, please.

Dr. Wilson, if you would look at the top right-hand corner, do you see this identified as a February 2016 office note from Dr. Wiencek, Mr. Moore's cardio-thoracic surgeon?

A. Yes, I see that.

Q. Do you accept that date as accurate?

Any reason to dispute the date?

A. I see the date, February 8th, 2016.

Q. Under history of present illness I want to draw your attention to where it says, quote, he had good pulses in both lower extremities, dorsalis pedis on the left, and posterior tibial on the right, he also has changes of chronic venous insufficiency in both lower extremities, patient is here for six month follow-up, do you see that?

A. Yes.

Q. Do you have any reason to doubt the accuracy of that February 8, 2016 note, so roughly ten months before this incident, that identifies Mr. Moore has good pulses in both lower extremities, dorsalis pedis on the left, and posterior tibial on the right?

A. I have no reason to doubt that observation.

Q. If we might go down to, please, Dr. Wilson, under the assessment and plan, do you see, Dr. Wilson, under the assessment and plan that it says that Mr. Moore was presenting for his six month follow-up for a pulse check, you see that?

A. Yes.

Q. Would it make sense to you that Mr. Moore would be presenting for a six month follow-up for a pulse check if he had no pulses?

A. It would he be presenting for a six month follow-up if he had no pulses?

Q. Correct.

A. Palpable pulses?

Q. Pulses, correct.

A. He could be, yes.

Q. My point is though, if he didn't have pulses since 2012 as Dr. M said, it would make sense he would not present for a check of those pulses, wouldn't it?

A. Well, it would be a routine appointment irrespective of what the pulse examination was showing.

Q. All right.

Do you see where it then says that the advanced nurse practitioner did a pulse check in the office I think it says, but I think it probably means did pulse check in the office, and the results were excellent?

A. Correct.

Q. Do you have any reason to dispute that Dr. Wilson when the pulses were checked that were identified above that Dr. Wiencek was wrong in saying that the pulses were excellent?

A. No, this is in correspondence with Dr.

Wiencek's observation.

Q. So if Dr. Wiencek says the pulses were excellent, is it fair for you to accept that?

A. Yes.

Q. And then if you would see where it continues on that it says he has some signs of venous insufficiency, and he continued to use compression stockings, do you see that?

A. Yes.

Q. And then would you read into the record if you would please, Dr. Wilson, the last sentence?

A. She has encouraged him to ambulate as much as possible, and I will see him again in another six months for another pulse check.

Q. So according to this note that is signed on the next page by Dr. Wiencek, Mr. Moore was asked to come back in six months for another, quote, unquote, pulse check, is that fair?

A. Yes.

Q. Do you accept that as accurate?

A. Yes.

Q. All right.

If we could go to Bates 56, please, it's Exhibit 113.

Dr. Wilson, I just want to orient you to

the date in the top right-hand corner.

Do you see it's May 9, 2016 in Mr. Wiencek's office?

A. I --

Q. Where it says date of service?

A. Yes.

Q. Then down at the bottom you see where it starts out, and I will plan to see him, and then it goes over to the next page, again in six months to a year for a pulse check?

A. Yes, I see that.

Q. And then it says, currently he has a strong anterior tibial pulse and good capillary refill by physical examination?

A. Yeah.

Q. Do you have any reason to dispute the accuracy of that?

A. No.

Q. Could you tell the jury what it means to have good capillary refill by physical examination?

A. It's a simple test where the patient is lying flat. You would squeeze the toe and let go and see if the blood comes very quickly within a few seconds, it is an indicator for you there is good flow of blood.

Q. We'll next go to Joint Exhibit 106 if we might please, and Bates 13.

Dr. Wilson, as this comes up, if you would orient yourself to the top left-hand corner, that is September 11th, 2014. That is 106, Bates 13.

Dr. Wilson, do you, even though it says ProCare Medical Group, do you recognize this to be Mr. Moore's primary care physician?

A. Yes.

Q. On this 9/11/2014 date down in the middle of the general examination do you see where it says, peripheral pulses brachial and DP pulses 2 plus and symmetrical bilaterally?

A. Yes, I see that.

Q. Do you have any reason to, Dr. Wilson, to dispute the accuracy of what appears to identify Mr. Moore's pulses bilaterally being taken?

A. I think that is what it states.

Q. And if it's 2 plus, does that mean it's normal?

A. Yes.

Q. All right.

If we could go next to the same exhibit, Bates 11, which is a 12/23/2014 visit with Mr. Moore with his PCP, Dr. Tran.

Dr. Wilson, under general examination about three quarters of the way down it will be highlighted it starts out, full range of motion, no clotting, no edema, and then it says, normal bilateral pulses, normal dorsalis pedis and posterior tibial pulses, you see that?

A. Yes.

Q. Do you have any reason to dispute Dr. Wilson that on that day Dr. Tran correctly felt normal bilateral pulses, normal dorsalis pedis, and normal posterior tibial pulses if that's what the doctor said?

A. I don't dispute that.

Q. We'll go to Bates 9 of Exhibit 106, please.

Dr. Wilson, as that comes up, can you orient yourself to the top left-hand corner, it will say April 16th, 2015, a visit with Dr. Tran again, do you see that?

A. Yes.

Q. And do you see three quarters of the way down under the general examination, it will come up highlighted where it says peripheral pulses intact and symmetrical?

MR. J. HYMANSON: Your Honor, a point of clarification.

He said, Bates 9.

I think he's referring to Bates 7.

MR. WEAVER: Thank you.

I appreciate that.

THE COURT: Thank you for the clarification.

BY MR. WEAVER:

Q. Dr. Wilson, do you see where it says peripheral pulses intact and symmetrical?

A. I do.

Q. If Dr. Tran documented that, do you have any reason to dispute that based on his physical examination that day that he concluded that Mr. Moore's peripheral pulses were intact and symmetrical?

A. I don't dispute that.

Q. And one more on this, then we'll move on.

And this is Bates 5.

Do you see where it's dated November 1st, 2016?

A. Yes.

Q. So that would be roughly the month before -- or month-and-a-half before this incident was December 25th, 2016, is that correct?

A. Yes.

Q. Do you see under -- this is by a physician assistant -- it appears a Matthew Sanders, do you see that in the top right-hand corner?

A. Yes.

Q. So this is a different examiner on this date.

Three quarters of the way down do you see where it says, full range of motion, no clubbing, no edema, normal bilateral pulses, normal dorsalis pedis and posterior tibial pulses, and then it says, peripheral pulses normal, do you see that?

A. I do.

Q. Do you have any reason to dispute Dr. Wilson that on November 1st, 2016, a month before this incident, this physician assistant Matthew Sanders based on his again examination of Mr. Moore determined that Mr. Moore had normal bilateral pulses, dorsalis pedis and posterior tibial pulses?

A. I don't dispute that.

Q. All right.

Just two more, Dr. Wilson.

If we might go to Joint Exhibit 202, please, it is Bates 154.

Dr. Wilson, what I'll have you take a look at is a May 23rd, 2016 exam date of Mr. Moore's pain

management physician.

This is Bates 151, please.

Do you see the exam date is 5/23/2016?

A. Yes.

Q. Now, first of all, if we could just go under pain, do you see the second paragraph that indicates the patient complains of low back pain radiates into the bilateral paralumbar area and intermittently into the bilateral feet, do you see that?

A. I see that.

Q. Do you see the start of the next paragraph says, patient complains of bilateral foot -- I think that means pain.

Do you see that?

A. I see that.

Q. Then do you see a couple sentences later where it says, the ankle pain increases with physical activity, you see that?

A. Yes.

Q. Would the increase in pain -- Do you have an opinion -- in the ankle that increases with physical activity to be musculoskeletal?

A. Yes.

Q. And then if you could just go a couple

pages over on that same visit, it's about five pages long, Bates 153, under the general exam.

Under the again exam do you see where it says CV?

A. Yes.

Q. Dr. Wilson, is CV a shorthand way to say cardio-vascular?

A. Yes.

Q. Is that typically your common way someplace that peripheral perfusion gets identified and documented?

A. Yes.

Q. Where, what does it say?

A. Normal pulses present.

Q. Do you have any reason to doubt the accuracy that on that date in May 23, 2016 is this different examiner is finding Mr. Moore's pulses are present and normal?

A. I don't dispute that.

Q. Just one more, Dr. Wilson, if we might, and that is Bates 111, still Exhibit 202, and it's dated 12/21/2016, and this is Mr. Moore's pain management physician whom he sees at Nevada Comprehensive Pain Center.

Do you understand that?

A. Yes.

Q. And do you see the exam date is December 21st, 2016, four days before Mr. Moore went to the emergency department and was seen by Nurse Practitioner Bartmus and Dr. Lasry on December 25th, 2016?

A. I understand that.

Q. And it identifies in that note Mr. Moore is on Xarelto, correct?

A. Right.

Q. And then if we could go a few pages in from that visit, Bates 113 under the general exam, do you see again I think it says CV is cardio-vascular?

A. Yeah.

Q. And cardio-vascular is somewhere typically pulses may get identified?

A. Yes.

Q. And what does it say there?

A. Normal pulses present.

Q. Do you have any basis to dispute the accuracy of the documentation in this document that four days before Mr. Moore came to St. Rose Hospital's emergency department, that his pulses were normal and present?

A. I don't.

Q. So Dr. Wilson based on your review of those materials, have you formed the opinion whether at least after 2012, up until December 21st, 2016 Mr. Moore had bilateral pulses that at times at least were documented as present and normal?

A. Yes, that's what the records you showed me show.

Q. All right.

So let's if we might just move into paresthesia, and tell the jury again what paresthesia is.

Did you say had something to do with sensitivity?

A. Yes, it's the sensation of unusual feelings, that can be numbness, can be pins and needles, it can be the sole of your foot feeling very hot, usually comes and goes, and in the case of a patient who has a neuralgia that would be not atypical, it would be what you would find.

Q. When you say, neuralga, you mean neuropathy Mr. Moore had?

A. Yes.

Q. And you understand he had it bilaterally, is that right?

A. Yes.

Q. If he has acute limb ischemia, how far would that affect his ability even with neuropathy to walk normally, if he got acute limb ischemia?

A. He couldn't walk normally.

Q. Why is that?

A. The foot would be too painful, it might be difficult for him to bring his foot up, dorsiflex.

There wouldn't be a good feeling of position sense for the foot.

So it would be very different than neuralgia, or as you termed it neuropathy.

Q. If we might pull up Joint Exhibit 100, please, Bates 1333, which is the emergency department records of December 25th, 2016.

Dr. Wilson, it will get highlighted in a moment, but I bring your attention to whether in the place where it says impaired gait, and then documented by Nurse Kuchinski it says, no.

A. Yes.

THE COURT: Can you direct him to where we're talking about?

MR. WEAVER: We can highlight it in just a moment.

THE COURT: That's what I meant.

Tell us where you are on the page.

MR. WEAVER: It should be under impaired gait.

THE COURT: Nobody is seeing that.

MR. WEAVER: I'll come back to that.

I have the wrong page number.

BY MR. WEAVER:

Q. Hypothetically, Dr. Wilson, if Nurse Kuchinski in her assessment --

THE COURT: Doctor, did you see something on here we didn't see yet?

THE WITNESS: No, I have page 3 of 84.

MR. WEAVER: Okay.

We'll come back to that, or just cut through this.

BY MR. WEAVER:

Q. Dr. Wilson, I want you to assume hypothetically that under the category of impaired gait Nurse Kuchinski documented, no, would you have any reason to dispute that based on your review of these materials?

A. No.

Q. All right.

And then would you tell the jury what paralysis means, please?

A. Inability to -- in this case to move the

toes, or to flex the ankle, bringing it up, bringing your foot up with the earliest motor signs in acute ischemia.

Q. If on December 25th, 2016 Mr. Moore had acute limb ischemia, would you expect that he would be able to ambulate normally and walk normally?

A. Not with acute limb ischemia.

Q. So is paralysis just a worse condition than paresthesia for purposes of analyzing for acute limb ischemia?

A. Well, paralysis is one assessment that you would make, yes.

Q. Is that primarily motor?

A. Motor.

Q. As opposed to just sensation?

A. Motor, yes.

Q. And if we could look at Bates 1350, please, Dr. Wilson, if you would direct your attention to a little bit down on this where it says, mode of discharge, and it says, ambulatory self assisted of gurney chair.

Would that indicate to you this documentation by the discharge nurse, Jeffrey Germane, that at least in his opinion Mr. Moore on December 25th, 2016 did not have paralysis?

A. Yes.

Q. Okay.

And then just one more category that I know is not typically on the list of five, but you called it popliteal thermea, is that right?

A. Yes.

Q. I'm guessing that is just to continue on the mnemonic device, but you said it means cold, is that correct?

A. Yes.

Q. And for purposes of acute limb ischemia, does it mean more than just cool?

A. Yes.

Q. Why is that, or what do you mean by that?

A. It means that the temperature of the foot is the same temperature as the environment, so it's cold.

Q. And if we could draw your attention to Bates 1382, and there will be a charting by Nurse Amy Kuchinski that indicates that Mr. Moore's skin was warm and dry.

Do -- Have you been able to highlight that yet?

Do you have any reason to dispute the accuracy that on December 25th, 2016 as charted by

Nurse Kuchinski that Dr. Jacobs and Dr. M agree with that Mr. Moore's skin was warm?

A. Yes.

Q. And then one more place if we might on Bates 1388.

Under 1388, under skin temperature, it should identify again by Amy Kuchinski that Mr. Moore's skin temperature was normal?

THE COURT: Mr. Weaver, can you please direct us, rather than us having to look over the whole document?

MR. WEAVER: I think I have the wrong page, so we'll move on.

THE COURT: You made a statement that such information is listed.

You need to produce that record, or I'll direct the jurors to disregard your statement.

Whether it's in this record or not isn't the point.

The point is, you made a record that shows something, you have to show it for the record.

MR. WEAVER: Fair enough.

Thank you, Your Honor.

If we could look at I think it's 1389 under CV, and then it says, skin color, and says, normal.

BY MR. WEAVER:

Q. Do you see that, Dr. Wilson?

A. I see that.

Q. Do you have any reason to dispute the accuracy of that?

A. I don't dispute that.

Q. Dr. Wilson, switching gears then, did you have an opinion whether or not based on this documentation, as well as additional documentation by Nurse Practitioner Bartmus and Dr. Lasry, the five Ps were assessed for Mr. Moore for purposes of acute limb ischemia?

A. Yes.

Q. And --

THE COURT: Do you have an opinion, or that was the opinion?

THE WITNESS: They were assessed, yes.

BY MR. WEAVER:

Q. Do you have an opinion whether or not the assessment of the five Ps point toward acute limb ischemia, or away from it?

A. It pointed away from it, towards a chronic process.

Q. And I think you told us yesterday that it's your opinion that on December 25th, 2016 you believe

Mr. Moore had chronic limb ischemia, but not acute limb ischemia, is that fair?

A. That's correct.

Q. Dr. Wilson, you told us that you agreed with -- or you identified with the venous ultrasound showed that there was occlusion of the graft, is that fair?

A. Yes.

Q. And you told us yesterday that it's your opinion that it wasn't clinically or medically-indicated for there to be an arterial ultrasound, correct?

A. Yes.

Q. Why do you hold that opinion?

A. Because he didn't have the signs that would demand a full arterial ultrasound investigation.

Q. And I believe you also told us yesterday when we were talking in the context of Dr. M's opinion there should have been a CTT angiogram, you told us that in your medical judgment on December 25th, 2016 there didn't need to be a CT angiogram either, is that correct?

A. Yes.

Q. Is that for the same reason?

A. Yes, they did not have a clinical

indication.

Q. Dr. Wilson, do you have an understanding -- or do you recall based on your review of the records what if any medical follow-up Nurse Practitioner and Dr. Lasry advised Mr. Moore to do when he was discharged?

A. That he should see his primary care physician and his vascular surgeon for follow-up.

Q. And do you recall that those two things were documented by Nurse Practitioner Bartmus and Dr. Lasry in terms of following up with Mr. Moore's vascular surgeon?

A. Yes.

Q. And do you have on opinion as a vascular surgeon the time frame within which Mr. Moore should be instructed to follow-up with his vascular surgeon?

A. Within 5 to 10 days.

Q. What do you base that on?

A. Well, he didn't have an emergency at that point, and it would be reasonable to allow the vascular surgeon to see his patient.

It was about a six-month period of time since he had seen Mr. Moore, as I recollect it was May of 2016 when he was last seen in Dr. Wiencek's office, so six months had passed, it would be a

routine appointment.

So I think it was appropriate to recommend he be followed up.

Q. And what was the information that Nurse Practitioner Bartmus had that you think was a good idea that caused her to tell Mr. Moore to follow-up with his vascular surgeon?

A. Well, his vascular surgeon would probably want to know that the graft that he had placed him on had been reopened, was now clotting again.

Q. And I think you identified that as a chronic condition, is that fair?

A. Yes, I believe it was.

Q. Do you have an opinion one way or another what the likely response would have been from a vascular surgeon or cardio-vascular surgeon like Dr. Wiencek if he had been called by Nurse Practitioner Bartmus on December 25th with the findings she was aware of at that time?

MR. ARNTZ: Objection.

You're asking for him to say what he thinks what Dr. Wiencek would have done?

THE COURT: That is speculation.

That seems to be accurate.

The objection is sustained.

MR. WEAVER: Okay.

THE COURT: Just the basis.

Sometimes the objection doesn't lend itself, but just the basis is fine.

MR. ARNTZ: I wanted to make sure I heard the question right.

THE COURT: I understand.

We had some confusion, so not a problem.

BY MR. WEAVER:

Q. Dr. Wilson, have all your opinions today been to a reasonable degree of medical probability?

A. Yes.

MR. WEAVER: Thank you.

I'll pass the questioning for now.

THE COURT: All right.

Thank you.

Mr. McBride, any questions?

MR. MC BRIDE: No questions, Your Honor.

THE COURT: We'll take a brief recess, but let's come back at 3:20. That gives you a little over 15 minutes, gives us an opportunity to do a few things in here and then resume then.

During this roughly 15 minute recess you're admonished.

(Jury admonished by the Court.)

THE COURT: See you back at 3:20.

Jury excused from the courtroom.

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

THE COURT: I need to make a record of multiple bench conferences.

Doctor, you may step down, return to the alcove room.

I noted three bench conferences that we should make a record of during this recent testimony of Dr. Wilson.

The first bench conference was an objection posed by Mr. Arntz related to a lot of inquiry by Mr. Weaver about literature that Dr. Marmareano may have reviewed, and did that literature support Dr. Marmareano's opinion.

The objection appeared to be based on a misunderstanding of the question that -- or I take that back.

This particular objection was based on the fact it had not been part of Dr. Marmareano's actual testimony in trial, and was not previously disclosed as an expert opinion.

I did sustain that objection, and Mr. Weaver moved on.

Mr. Arntz, anything to add?

MR. ARNTZ: No, Your Honor.

THE COURT: Mr. Weaver.

MR. WEAVER: No, Your Honor.

THE COURT: The second bench conference was with regard to Mr. Weaver beginning to ask questions of Dr. Wilson about testimony of Dr. Marmareano actually at the time of trial.

There was an objection to the appropriateness of reading testimony.

Part of the objection I believe was a misunderstanding that the question had entailed reading from the Dr. Marmareano's deposition, not his actual trial testimony, and then the objection evolved into an objection regarding foundation.

I ultimately allowed the questioning to proceed as designed, and I think I made that record in the record, but the discussion at the bench was a little bit of a better understanding what the line of questioning was, how it was going to proceed, and the best way to do it.

Mr. Weaver did offer potentially to pose it in hypothetical, as opposed to reading testimony.

I was inclined the take him up on that offer because I thought there's more clarity to be

the actual testimony and inquire about the opinion.

Mr. Arntz, anything to add to that?

MR. ARNTZ: No.

THE COURT: Mr. Weaver?

MR. WEAVER: No, Your Honor.

THE COURT: The last one was a bench conference that occurred after Mr. Arntz objected, and this was regarding asking Dr. Wilson about Mr. Moore's report of pain I believe on the December 25th visit, and had he identified that pain level.

I think again there was some misunderstanding of the question, and Mr. Arntz initially believed the question had been asking Dr. Wilson to scale the pain as relates to Mr. Moore's reports of the pain symptoms, but I understood and Mr. Weaver confirmed the question was just what had he seen in the records.

I did go ahead, overrule the objection, allow that line of inquiry to continue because there was some debate again about foundation and whether or not Dr. Wilson should be able to testify this way, but the Court's ultimate determination was based on the understanding there had been put into the record Dr. Wilson reviewed all these records and could speak to what his understanding of them was, or

recollection was, and then we went generally through each of the records and confirmed, and I think with the pain scale specifically we confirmed some specifics that Dr. Wilson may have not remembered correctly.

But I overruled that objection.

Mr. Arntz, anything further on that objection?

MR. ARNTZ: No, Your Honor.

THE COURT: Anything else, Mr. Weaver?

MR. WEAVER: No, Your Honor.

THE COURT: All right.

When we will come back a little bit before 3:25.

We really need to figure out where we are at in the trial, how late we're going into next week, so I could be ready when we break for the day to help these people understand where we are.

Also, this seems to be a moving target. I believe we identified courtroom 15-D as a courtroom where we can have Mr. Moore's testimony on the witness stand.

Is that acceptable?

We tried retrofit with some equipment we had making this one accessible, but that equipment

doesn't work, so we are needing one actually is built that way, but 15-D has that.

MR. P. HYMANSON: Your Honor, can we assist you when you come back to you know if we're half days, full days, or what, next week?

THE COURT: My schedule's always the same, Monday, Tuesday, and Wednesday half days.

The only issue is, if we go over to Thursday, I might throw myself off the building, then it doesn't matter.

MR. P. HYMANSON: I'm afraid you would have to get in line, Your Honor.

THE COURT: If I'm here on Valentine's Day, you all better be bringing some chocolates, flowers, and stuff I'm saying.

It's half days Monday, Tuesday, and Wednesday.

MR. P. HYMANSON: Very good.

Thank you, Your Honor.

(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 jurors back?

MR. ARNTZ: No.

MR. WEAVER: Did you want to talk about scheduling or anything?

THE COURT: Okay.

MR. MC BRIDE: Real quick.

THE COURT: Where are we at?

MR. MC BRIDE: I have the plan I think we talked about, probably the best-laid plan for tomorrow is going to be our experts, which is Dr. Shoji, Shoji in the morning, and Dr. Barcay in the afternoon.

And then depending on time, if there is any time available in the morning, I might try to squeeze maybe ten minutes of direct of Dr. Lasry on there just to clarify a couple of things, and that's going to be the extent of my direct, to the extent I don't know how much Mr. Arntz would have on cross for a ten-minute direct, but it just depends.

But then we can see how that goes.

But the other thing being is, that Dr. Lasry has to return to work next week, so he's not

going to be here Monday, or Tuesday, Wednesday.

THE COURT: We've already brought that up to the folks about that.

They should know Mr. Moore's not here today.

MR. MC BRIDE: Yeah.

THE COURT: So that takes care of today.

I don't know if we're getting to Mrs. Moore today, but we'll finish with Dr. Wilson.

Where does that put us with the next thing coming, what do we have and is anyone --

MR. ARNTZ: I have Charlene tomorrow, so I don't want do be put in the position where I don't have enough time to cross Dr. Lasry, knowing he's not coming next week, so we have to plan accordingly to at least give me 30 minutes for him.

MR. MC BRIDE: Like I said, it's going to be very limited examination, if I even choose to do it.

Frankly, he already got out --

THE COURT: Let me interrupt you.

You said in the morning, if you do it at all.

MR. MC BRIDE: The plan would be, after Dr. Shoji if we have time before the lunch break.

THE COURT: Otherwise, it might be in the afternoon?

MR. MC BRIDE: Or maybe not at all, just to clarify a couple things.

THE COURT: I understand.

Just your point is well-taken, if we put on Dr. Lasry, we're going to finish Dr. Lasry, so if we need time, we need time.

So it will be Friday night.

MR. MC BRIDE: Which is a good point.

Maybe I put him on first thing in the morning and Shoji right after.

THE COURT: It seems like that makes more sense, then take whatever time we need with Dr. Lasry and move onto the experts.

We still have to break when we have to break going a little into the noon hour, as long as were coming back at 1:30.

MR. MC BRIDE: Dr. Shoji's around tomorrow afternoon if we have to go a little bit farther.

THE COURT: I need to finish these people tomorrow, if we're not going to lose more time.

But back to my question, what are we doing next, what do we have left?

MR. ARNTZ: I don't think we're going to

get there certainly today, when I don't know are these their experts?

MR. MC BRIDE: One is mine, and one is his.

Barcay is his, and Shoji is mine in the morning.

And then we're --

MR. ARNTZ: Shoji's in the morning?

MR. MC BRIDE: We're going to put Lasry on for like I said ten minutes of direct, you will have 30 minutes at least of cross, I'll have ten minutes on direct, and then we'll go Shoji pretty quick I think, and then if we need to push him partly into the afternoon, we can do that.

And then Keith has Barcay.

MR. ARNTZ: Four hours?

MR. WEAVER: No.

I appreciate you have been accommodating to him.

I can check to see if he can come Monday if you prefer to finish your case tomorrow.

MR. ARNTZ: What I'd like to do --

THE COURT: You are making me insane.

I have to give some warning to the other department.

From my recollection we were talking about

various departments. I don't remember whether or not Department 22 down the hall came into the mix, but I think we can use some time if we need to, I just need to confirm.

MR. MC BRIDE: I thought we talked about yesterday about the best logistically would work out with the experts tomorrow.

THE COURT: We did.

MR. MC BRIDE: Logistically Monday would make sense.

THE COURT: That's why I have Monday lined up, but the suggestion came Mr. Arntz may want to finish his case, do Mr. Moore on Friday.

I have have to make sure I have a courtroom to use.

MR. ARNTZ: We're going to do it that way.

If we have the entire afternoon, we should be able to get Charlene and Darell done on Monday, and that's the last witnesses.

THE COURT: Yours too?

MR. MC BRIDE: Yep.

So then we can --

THE COURT: It does make sense to do it Monday.

MR. MC BRIDE: Knock it out then.

THE COURT: Then instruct and close on Tuesday?

MR. MC BRIDE: Yep.

THE COURT: I don't even want to think that because I thought we were into Wednesday.

MR. ARNTZ: In his opening he referenced to other people he is bringing.

You are not bringing --

MR. MC BRIDE: There's no reason to bring Volt (Phonetic), the economist if you're not bringing Claurete (Phonetic).

MR. ARNTZ: And not bringing the nurses?

MR. MC BRIDE: The nurses, I told them -- I released them from their subpoenas.

We thought about bringing Amy Kuchinski and Jeff Germane, had them under subpoena, but I don't think it's necessary.

I think the jury's losing interest at this point, and I think I would like to get the case done.

THE COURT: We'll see if they have any questions.

They've been pretty on top of it.

MR. ARNTZ: Did you say Wiencek?

MR. MC BRIDE: I never said that.

We introduced he may be a witness.

I don't know if you may call him or come up as a need.

THE COURT: We always have to say in front of the jurors any persons.

So I'm going to tell them Tuesday from what you're telling me.

MR. MC BRIDE: I think that is a fair estimate.

THE COURT: Monday in 15-D.

So that's where we are at right now, is that correct?

MR. P. HYMANSON: Dr. Wilson won't have to stay until Tuesday, will he?

(Thereupon, a discussion was had off the record.)

THE COURT: Let's get the jurors.

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

THE COURT: As we resume with Dr. Wilson.

Can I have you acknowledge for the record you understand you are still under oath?

THE WITNESS: Yes.

THE COURT: Okay.

Mr. Arntz.

- - - -

CROSS-EXAMINATION OF DR. SAMUEL WILSON

BY MR. ARNTZ:

Q. Dr. Wilson, my name is Breen Arntz, and I represent the Moores, and I'll be cross-examining you today.

You would agree, wouldn't you, you had relied heavily on the veracity or truthfulness of the records, in other words, you assumed they are accurate and true, and haven't really considered whether they aren't?

A. I have.

Q. Okay.

And in fact you have done that, you have reviewed my client's deposition, is that correct?

A. Yes, Mr. Moore and Mrs. Moore.

Q. Did you read their son's deposition?

A. Yes.

Q. So you saw in those two depositions Chris Moore and Darell Moore, they both disputed anybody at the emergency department having taken off Mr. Moore's sock.

Did you see that?

A. Yeah.

Q. Did you discount that testimony, or did you just decide to give more credibility or credence to the medical record?

A. Well, what I relied on was that in a routine examination of a patient socks and shoes would be removed by the nursing staff.

Q. Right.

That would be standard of care, wouldn't it?

A. I'm not an expert an emergency room standard of care, but just in terms of clinical examination of a patient, whether it's in your office or in an emergency room, it would be standard practice for nurses to either remove the shoes or socks, or more likely ask the patient to do that.

Q. Do you dispute in your report dated August 19, 2019 that you said you do have an expertise in the standard of care, and actually gave an opinion on

standard of care?

THE COURT: Can you be more specific with the question?

You just referred to the emergency room and others. BY MR. ARNTZ:

Q. Do you dispute in the report dated August 19th, 2019 that you said you do have the ability to testify as to standard of care for an emergency department?

A. I don't recall saying that.

Maybe you could read it out to me.

Q. Okay.

A. If I could continue, this is the first time I've been in court in Nevada, and in California you could only testify with regard to standard of care of emergency medicine doctors if you are an emergency medicine physician.

Q. Well, on the second page, the second full paragraph starts with, it's my opinion the patient was appropriately discharged with instructions to follow-up with his surgeon.

Isn't that a standard of care opinion?

A. That's very much a standard of practice, that is what you would do.

I don't dispute that at all.

Q. And you have given other opinions, you been here for the last couple days, where you said that Nurse Practitioner Bartmus and Dr. Lasry acted within the standard of care, didn't you?

A. You know, I don't recall saying that because I've tried to be very careful about not commenting on emergency room standard of care.

Q. Okay.

Let me ask you this:

In someone who comes in with a history of the problems Mr. Moore had, complaining of calf pain, is it your testimony you don't have an opinion whether or not the standard of care requires them to take off their sock?

A. I do have an opinion.

If you're asking me, should the patient being examined have his shoes and socks removed, yes, they should.

Q. Okay.

So when looking at the record Nurse Practitioner Bartmus and Dr. Lasry created in the hospital, you accepted what they said as being true and accurate, and you said you think it's true and accurate, but the testimony of Mr. Moore and his son would contradict that testimony, wouldn't it?

A. Potentially, yes, if that's what Mr. Moore said, that they didn't take off his shoes and socks.

Q. You said you read his deposition.

Did you see that in his deposition?

A. You will have to show that to me.

I can't recall the line and paragraph, but I'll accept that if you just read that.

Q. Are you saying it's not relevant to you whether or not they had him take off his shoes and socks?

A. I didn't say that.

Q. Well, the fact you don't recall it from the deposition would suggest it wasn't relevant to you.

A. Lots of things I don't recall exactly, but it is relevant.

Q. It actually is extremely relevant here, isn't it, if the standard of care requires them to take off the sock to actually feel for the pulses in his foot, correct?

A. Yes.

Q. Okay.

Now, I don't know if you had been aware of Nurse Practitioner Bartmus and Dr. Lasry's testimony from the trial.

I know counsel have been getting dailies,

so I don't know if they gave you the transcripts of that.

A. I have not seen those.

Q. Okay.

You also saw from the records, didn't you, that the ultrasound --

MR. ARNTZ: Court's indulgence for a second.

THE COURT: Yes.

BY MR. ARNTZ:

Q. Let me ask if you recall this modification Dr. Lasry made to the record.

You will recall the ultrasound finding was, there was no evidence of deep vein thrombosis, but there was what appeared to be the word appeared the arterial graft appeared occluded, you saw that?

A. Yes, I did.

Q. And you saw it in Dr. Lasry's note on the day after the Mr. Moore was in there he entered into his chart and signed a note that said that there was a possible occlusion, did you consider that a modification to the record?

A. It's pretty much the same thing to me, appears to be occluded, possible occlusion.

I think were splitting hair here.

Q. So you don't agree -- or you have testified that you have accepted there was an occlusion in the graft site on the left popliteal graft, correct?

A. Yes.

Q. And you don't see there's a distinction between saying there is an occlusion, and possibly an occlusion?

A. Yes, I would accept there is a distinction there, but the reports from x-rays, from x-ray physicians, radiologists often include terminology like that when they are reviewing a study, they will say, possible occlusion.

Yes, sometimes they say that.

I agree that is different from saying exactly, complete occlusion of the graft.

Q. Okay.

So if I understand what you're telling me, you're going to make some assumptions about whether or not the radiologist who is an MD, correct?

A. Radiologists would generally be and MD.

Q. And MD who read the ultrasound scan, that he may have been imprecise, you're going to make that assumption he might have been imprecise?

A. Yes, it could be based on -- When you read an ultrasound, the hard copy is selected images, so

the radiologist is not doing the ultrasound, has no control over what images he's looking at, so he can look at the images, and on the basis of the images the technician saved for him he can arrive at conclusions, this graft is probably occluded, yes.

Q. Well, then you changed the same words that Dr. Lasry changed.

He didn't say, it's possible, but probable occluded, did he?

A. I have forgotten what he said.

Q. It's right in front of you.

A. The --

MR. MC BRIDE: I'm going to object.

THE COURT: Objection?

MR. MC BRIDE: It's vague as to he and who, and we're not really clarifying who we're talking about now.

THE COURT: At this point because we do have a blown up portion, for the record, let's be clear who we're talking about.

BY MR. ARNTZ:

Q. Did you understand my conversation with you was in relation to the radiologist, who is an MD reading the film?

A. Yeah.

Q. So you can see from the report from that ultrasound he doesn't say possible.

He says, it appears occluded.

Correct?

A. Appears occluded is what he has in front of him.

Q. You seemed to make the same change Dr. Lasry did, and that leads me to a question about if you got a report from an ultrasound that said a possible occlusion, wouldn't that lead you to the need to do further investigation to see if it was possibly occluded, or absolutely occluded?

A. It could, depending on the patient's presentation.

Q. So the presentation is clearly in your analysis of this case, the presentation and exam that was done is critical because if that fails, and he didn't -- Nurse Practitioner Bartmus didn't get the pulses she says, Dr. Lasry didn't, then the rest of your opinion about that exam really is irrelevant, isn't it?

A. No, I disagree with that.

Q. So when you're looking at the five Ps, pulse is one of those Ps?

A. Yes.

Q. And if they had taken day his sock off, get a pulse in his foot the way they said they did, that's not a critical conclusion for your opinion?

A. That's a different question you're asking me.

Could you rephrase that, please?

Q. Well, originally what I said was, wouldn't you agree that the question of the exam and whether or not they got the pulses they said they did is critical to your overall opinion, and that without that your opinion doesn't carry much weight?

A. Well, thank you.

Actually, whether or not they felt the pulses is less relevant than you would think because you could certainly have a viable extremity without palpating pulses.

I think I've tried to explain that.

Q. Okay.

That is a distinction.

So what you are saying is, it doesn't matter to you whether they were being truthful about palpating the pulse, and it could have just easily been a Doppler?

A. Well, number one, I accepted the entries in the chart were truthful.

I have no reason to believe they would answer untruthful statements.

Number two, a Doppler does not detect pulses.

A Doppler defects flow in the artery.

Q. Okay.

I don't know how that changes my question because what I talked to you about was pulses and whether or not if the report isn't accurate about them taking the pulses, how it would affect your opinion.

And then you went into the discussion about whether or not they palpate the pulses isn't as important as we might think or what.

A. Rephrase it.

I am accepting the record as being truthful at entries.

I have no reason to believe they were less than truthful.

They entered what they observed, I believe.

Number two, in general, and not with regard to Mr. Moore, because I haven't examined Mr. Moore as you know, but in general you can have a viable extremity with all the rest of it intact and not feel pulses.

Q. So the question I want you to consider is, would it discount the veracity or truthfulness of that record if you heard from the testimony of Dr. Lasry and Nurse Practitioner Bartmus, and they said they palpated normal pulses, and then you found out that in fact they had not done that, would that undermine in any way the way you look at the accuracy of the medical record from the emergency department?

A. Well, I think you're can asking me if they falsified the finding of pulses, would that reflect negatively on my view of the rest of the record.

Is that your question?

Q. That's a better question, yeah.

A. Actually, it would.

If they falsified their entry, and in any way, it would make me be skeptical of perhaps the rest of the entries, sure.

Q. And we've heard you testify that you don't believe that the mere occurrence of the fem pop graft in 2012 would result in an absence of pulses, correct?

A. Yes.

The whole point is that you try to restore blood flow to the leg with the graft.

Q. Okay.

Do you have an opinion as to whether or not it is common for pulses to be palpable and normal following a fem pop graft?

A. It is common.

Q. It is common?

A. Yes.

Q. Okay.

So you do recall, don't you, that when Mr. Moore went in in 2012 to receive the fem pop graft, at the time he went in there to the emergency department he had no pulses, do you recall that?

A. Now, which date are we talking about?

Q. In November of 2012.

MR. WEAVER: Your Honor, that misstates the evidence that was in the emergency department.

MR. ARNTZ: Well --

THE COURT: It would be very helpful to look at Dr. Wiencek's records and other records and dates, it would be helpful.

MR. ARNTZ: Okay.

BY MR. ARNTZ:

Q. You see from the record up there --

MR. J. HYMANSON: This is page 82 of 101.

THE WITNESS: I'm familiar with this.

BY MR. ARNTZ:

Q. Give me a second.

You see the highlighted portion?

A. I do.

Q. And it indicates that excellent blood blow was obtained through the graft?

A. Yes.

Q. Below the knee.

And that then Doppler examination of the posterior tibial pulse not at the pre-operative --

A. Yes.

Q. So prior to receiving the fem pop graft he did not have pulses, but they were able to obtain them as a result of the graft, yes?

A. Yes.

Q. Okay.

So the need for the fem pop graft was because it was disease existed in his lower leg, correct?

A. Yes.

Q. And essentially resulted in a blockage of that artery in the lower leg, correct?

A. In the mid-thigh, yes.

Q. So before the operation to put in the graft there were no pulses, and then after they were able

to get a Doppler pulses.

Are you aware of any record says following the fem pop graft they were able to get palpable pulses that were normal?

A. Between 2012 and 2016?

Q. Yes.

A. Well, I believe Mr. Weaver at enormous pain went through to show that various individuals had felt pulses.

Q. I think what he said was, they indicated there were pulses present.

I didn't see they were palpable in any of those records.

A. In medical terminology it's common to use pulse if you feel it, and although sometimes they say, a Doppler pulse, what they mean is a flow.

A Doppler doesn't show the pulse.

After you finish a fem pop by-pass, there's often vascular constriction of the legs, you can have the artery clamped on the patient, some hours had gone by, and when you open up the graft, often you don't feel a pulse right away, a palpable pulse.

So you listen with Doppler, and if you hear a good Doppler signal, then you think you are okay, you have got it flowing.

The Doppler detects flow in your artery.

Q. And how long would you expect it before you return to palpable pulses?

A. You would like to see that within hours.

Q. Is that something you would expect to see in a record they made note of?

A. Not necessarily.

I would make note of it personally, but many people wouldn't, just depends on the detail of your post-operative visits.

Q. Do you recall seeing in the records from Dr. Simon --

A. Was he a radiologist that did an arteriogram?

Yes, I remember seeing this one.

Q. Do you remember seeing the letter of January 12th, 2015?

This was two months after the surgery?

A. Yes, I see that.

Q. You see he did suffer some ischemic neuropathic pain, and I believe this will resolve it by Doppler?

A. Yes.

Q. Are you saying the terminology being used by Dr. Simon where he said he found excellent pulses

by Doppler, that is actually a misuse of the terminology?

MR. MC BRIDE: Objection, Your Honor, that it's actually Dr. Wiencek later.

MR. ARNTZ: You're right, Dr. Wiencek.

THE WITNESS: It's not an exact use of the terminology.

With a Doppler you hear flow, and you don't -- it doesn't detect a pulse, it gives you flow.

So commonly people say a pulse was heard by Doppler, but what they mean is, they heard blood flow with the Doppler.

BY MR. ARNTZ:

Q. So this doesn't say, heard by Doppler, it says there are excellent pulses in the foot currently by Doppler examination?

A. Yes.

Q. And I don't know if you saw the other letters in Dr. Wiencek's file, but counsel brought them up yesterday, I believe where they talked -- or a similar note was made -- or they didn't use the word Doppler, just said, pulses?

A. Yes.

Q. So if Dr. Wiencek comes in here and explains the only way he was able to get a pulse was

by Doppler, would you have any reason to disagree with that?

A. No, if that's what his findings were, he could only hear a signal, wasn't able to palpate a pulse.

Q. You would agree with me, time is of the essence when dealing with an acute limb ischemia?

A. Yes.

Q. So the opinion 5 to 10 days is a reasonable enough time for him to get in to see his cardio-vascular surgeon, is that still your opinion, even in light of the fact three days later he lost his leg?

A. Yes, of course.

I know he lost his leg.

Q. So I may be wrong on this, and Dr. Marmareano may have said both, but my immediate recollection of what he said was, that if he has a blockage in the fem pop graft, then you would not be able to feel a pulse.

A. Yes, I think he said that.

Q. And you disagree with that?

A. It's possible, yes.

Q. It's possible you couldn't feel a pulse?

A. Sure.

Q. Okay.

Nurse Practitioner Bartmus made it very clear the pulse she felt, the palpable pulse she felt on the 25th, was a normal pulse.

Would you expect that in a person had a --

A. I think any pulse you would detect would be called a normal pulse, with the exception of a patient maybe hemorrhaging, but to grade a pulse plus 1, plus 2, plus 3, they are very artificial. I've never been able to do that in my practice.

I usually note, pulse present.

Q. So why in that letter that counsel showed you today where it says, plus 2 pulse, did you say that is a normal pulse?

A. I would say, that is normal, yes.

Q. Even though that is not something you have experience doing?

A. I don't grade it that way.

Maybe I'm not -- or don't have as fine a touch as Dr. Wiencek.

I think when he says, plus 2, he's saying that the Doppler exam shows good flow.

Q. I want to be really precise with this question because I think it's important for the jury to understand this.

What you are saying is that, first of all, when you hear the word normal from Nurse Practitioner Bartmus, and she doesn't qualify normal for him, normal for Mr. Moore, she just said, a normal pulse, that you're making an assumption that it probably wasn't a normal pulse, but was still a pulse, is that right?

A. No.

My assumption is, that she was able to palpate a pulse in Mr. Moore.

That's the assumption I made because that's what she said in her deposition.

Q. Okay.

So you don't put any relevance on the question of whether the pulse is a good normal pulse, or a diminished pulse?

A. No.

Look, if you could feel a pulse in a chronic path, that is fine.

Whether it's a grade plus 1 or plus 2, if you can feel it, that's good.

Q. So back to the question of whether you would expect us to find a normal pulse, or a palpable pulse, in someone who had already demonstrated his story of no pulses, when there was a blockage to the

artery.

Are you saying that you might feel something close to a normal pulse in someone who has a blockage in his artery?

A. You can, yes.

Q. Would that be common?

A. Not the most common, no.

Q. Normally you have to get it by Doppler, get the blood flow by Doppler?

A. Well, in the absence of a pulse, you are certainly able to hear blood flow by Doppler, if there's blood flow there, you can hear it by Doppler, yes.

Q. And could that blood flow by Doppler under those circumstances, would that have been from the collateral sources of blood?

A. Yes.

Q. If I understood your testimony yesterday, the collateral sources would have been created through the profunda?

A. The profunda primarily.

Q. How does it, the process of establishing collaterals, work?

A. Well, you will get a Nobel Price if you and I can figure that out, but I can give what the

current thinking is.

The current thinking is, that the demand for blood creates an anoxygenic environment, that is the absence of sufficient oxygen.

In the absence of sufficient oxygen, causes the blood vessels to dilate, and over time with exercise you will continue to dilate those blood vessels.

Now, as humans evolved we haven't done it as well as the lower mammals. For example, a rabbit will have severe ischemia and generate sufficient Dopplers, it will heal a gangrenous ulcer on its leg, humans can't do that, but we can develop with a continued exercised, absence of tobacco a usual measure, reducing blood pressure, cholesterol, you could have fairly good collateral flow, so symptoms will be not life-altering, and in fact in some instances a pulse will appear.

Q. So you gave factors that you know don't apply to Mr. Moore, right?

A. I used that in a general sense.

Q. But we're talking about Mr. Moore right now, and the question of whether his collaterals would have been sufficient to generate a pulse in the presence blockage to his artery?

A. Yes.

Q. And you just identified some factors that would make it more likely for that to be true and said, someone who doesn't have high cholesterol, exercised regularly, someone who doesn't smoke, correct?

A. Yes.

Q. Do you consider smoking an important factor?

A. Yes.

Q. Did you see anywhere in the record where either Nurse Practitioner Bartmus or Dr. Lasry considered that factor when they were examining Mr. Moore?

A. Well, they noted it in the history.

Q. It was noted in the history, but do you see anything suggests they considered it as a factor in evaluating his physical condition?

A. Well, that goes without saying.

If you are examining a patient, you ask about smoking because we know smoking has a deliquesce effect on the circulation.

Q. So he's give them the benefit of the doubt, says they did consider it, they would have considered then he had a history of occlusions, correct?

A. Yes.

Q. He had a history of smoking?

A. Yes.

Q. By all accounts, 30 to 40 years, correct?

A. Yes.

Q. He did he have a history of high cholesterol?

A. I don't know.

I don't recollect that.

Q. That is something they also should have considered?

A. It would be more the role of the primary care physician.

High cholesterol's not an emergency.

Q. What I'm trying to get at is, the question of whether Mr. Moore was a candidate for having sufficient collaterals, that it -- or he could withstand this occlusion in his leg, or whether they should have done more investigation to see exactly the extent of blood flow into his leg.

A. Well, I think their clinical examination of the leg showed that blood supply was adequate on the basis of what they recorded, and that that was appropriate to refer him back to a vascular surgeon to evaluate is there anything you need to do.

Q. Again, you're giving the full benefit of the doubt to them that the record they created is accurate, even in light of the fact that Mr. Moore is proven to have had an occlusion in his artery, had none of the factors would have supported good collateral blood flow, is that your testimony is, you give them that benefit of the doubt, even in light of those factors?

A. Yeah, I have no reason to believe that the record is inaccurate.

Q. Well, except for the fact Mr. Moore and his son both said they never took his sock off, and the fact that Dr. Lasry has modified a record from appears occluded, to possibly occluded.

A. Those to me what are unrelated, doesn't add up to a falsification of the record.

Q. Okay.

In November they just brought up the record showing in November 2016 November 1st, he had normal DP pulses.

What does that DP stand for?

A. Which date is that?

Q. November 1st, 2016.

A. And go ahead.

Q. It said he had normal DP pulses?

A. The dorsalis, feels the pulse on top of the foot.

Q. And then it says, at that time there was no evidence of calf pain, correct?

A. In 2015?

Q. No, November 1st, 2016.

MR. MC BRIDE: That's 2015 up there.

MR. ARNTZ: That is.

That's not to record I'm referring to.

I'm referring to the one brought up by counsel November 1st, 2016.

THE WITNESS: Okay.

I've got it.

BY MR. ARNTZ:

Q. You got it?

A. This is May 9, 2016.

Q. Do you recall the record I'm talking about they brought up to show there were pulses on November 1st, 2016?

A. Yeah.

Q. A little less than two months before he went in on the 5th of December, correct?

A. Right.

Q. And then he brought up a record that said it was 12/21/2016, four days before he went into the

emergency department?

A. Right.

Q. He didn't complain of calf pain, did he?

A. He was complaining of various pains, and I remember ankle pain I believe was one of the areas he complained of.

He had back pain, I believe.

Q. Right.

A. I can't recall the rest of it.

I don't know if he had calf pain at that time or not.

Q. I'll represent to you I read the record as was up there and saw no reference to calf pain.

A. All right.

Q. But it said he was on Xarelto?

A. Right.

Q. So within a week of going on the 25th he was on the medication.

We talked about the black box warning, correct?

A. Right.

MR. WEAVER: Well, Your Honor, lacks foundation.

Calls for speculation he was taking it.

BY MR. ARNTZ:

Q. It said in the record, on Xarelto.

Do you accept that record as true?

A. Yeah.

What that means is, that a prescription has been issued for Xarelto.

Q. So are you assuming that the accuracy of that record isn't the same as what you would expect from the emergency department on December 25th, 2016, that somehow that record is less accurate?

A. No.

What I'm saying is, that when you say a patient is on Xarelto, it means the physician has prescribed that medication.

It doesn't say anything about is he taking it, has he filled the prescription or not, you don't know about that, but the record says that it's been prescribed for him.

Q. Okay.

But you don't accept that means he's taking it?

A. Not necessarily.

I'm thinking about myself for example and I'm sure others who get prescriptions and don't necessarily follow the advice.

Q. So now what you're suggesting I guess is, that a person who went through an experience in November 8, 2012 where he had to have a femoral popliteal because he had no pulses in his foot, was put on Xarelto, has another event in December of 2014, they had to break an occlusion, and another one in 2015 they had to do the same thing, you're saying you don't thinkg that person took the prescription of Xarelto seriously?

A. I didn't say that.

Q. You're not assuming this record is true as other records you reviewed have to do with Dr. Lasry and Nurse Practitioner Bartmus?

A. Not true.

I didn't say that.

Q. So four days before he went in on the 5th there's no evidence of an occlusion, correct?

A. They don't have evidence of imaging of occlusion at that time.

Q. They don't have any pain symptoms in his leg suggest he might have an occlusion?

A. That's correct.

Q. He's on Xarelto.

He has normal pulses present, correct?

A. Palpable pulses, yes.

Q. It says, normal pulses.

I don't know it said palpable?

A. Okay.

I'll accept that.

Q. And then four days later he goes in the emergency department with pain in his calf, an ultrasound is showing he has an occlusion, but you assume that occlusion existed weeks or months before that, correct?

A. That's correct.

Q. To what extent are you familiar with the symptomology or symptoms associated with neuropathy?

A. Fairly familiar, yes.

Q. You're aware neuropathy can cause numbness, pain, and tingling in the person's feet?

A. Yes.

Q. And that numbness can be so pervasive around the sides of his feet, he might lose balance?

A. It would be a very advanced case.

I'm not sure that is typical at all.

Q. So you're not familiar with that symptom causing problems for people with neuropathy causing them to fall, or lose their balance?

A. It's a different type of neuropathy where you lose a position sense in diabetics, will have

difficulty walking because they have lost pressure sense in their feet.

Q. So to my knowledge there's several different types of neuropathy, the kind brought on by diabetes, correct?

A. Yes.

Q. The kind brought on by alcohol, correct?

A. Yeah.

Q. Alcoholic neuropathy.

Are you familiar with the neuropathy brought on by chemotherapy?

A. Yes.

Q. And there's idiopathic.

What that means is?

A. It simply means, we don't know what is causing it.

Q. So now within those different categories of neuropathy, are you telling the jury that those different types of neuropathy, diabetic neuropathy, is different symptoms than a chemotherapy neuropathy?

A. I don't know exactly what neuropathy of chemotherapy is like because I don't treat patients receiving chemotherapy as a rule.

Q. I guess my question is:

Do you have some source of knowledge or

experience with the concept that one type of neuropathy associated with one etiology will be different than another type of neuropathy?

A. I'm sorry, I can't answer that question. I'm not that skilled as a neurologist.

Q. Okay.

And are you aware the time he went into seeing to the emergency room on December 25th, 2016 he was using a cane?

A. I had read he used a cane, yes.

Q. Does that support the conclusion a person who uses a cane is somebody who has good balance, doesn't have any instability with his feet, and has a normal gait?

A. Well, you use a cane and have a normal gait, yes.

Q. Again, you accepted the reference in the record as being accurate, without paying attention to the other facts associated with Mr. Moore, namely that he used a cane?

A. I think it said he used a cane, or even a wheelchair, five percent of the time is my recollection.

Q. Okay.

A. I don't remember any of the notes in the

emergency room commenting on his use of a cane.

Q. Let me change gears a little bit.

You -- Are you currently retiring from academia?

A. Yes.

Q. And in association with that, are you also retiring from an active practice?

A. Yes.

Q. How long has that process been going on?

A. About a year.

Q. And does that apply equally to both of those, you have been retiring from the academia at the same rate you're retiring from your active practice?

A. I retired from active surgery over the last year.

I'm still very active in academic things, and editing, and writing in a textbook right now, and I have plenty of consultative work, so I gradually slowed down.

Q. You have been in academia since when?

A. I --

Q. By academia, I mean having an active teaching role as a college professor?

A. Yes.

Q. How long have you been doing that?

A. I was appointed to the faculty at UCLA in 1972.

Q. Since 1972, you have been writing articles and contributing to books and various other writings and presentations?

A. Yes.

Q. I'll say, your curriculum vitae is a doctor's word for resume?

A. It's just Latin.

Q. The curriculum vitae is about as long as I've ever seen one.

You must have over 2,000 articles in here?

A. No, 500.

Q. Really?

A. Not counting book chapters.

Q. Only one category, I see.

A. I published about ten to twelve articles a year when I was very active.

Q. One category I see 373.

You were invited to to do international lectures, 27 of those.

I mean, I was going through and doing a rough assessment of how many different entries there are, and there's got to be over a thousand entries.

A. Okay.

Q. I guess my question is:

Is this all the things you have done since 1972, or did you even go back beyond 1972?

A. There's about maybe ten that go back before '72 I did when I was in training.

Q. And what commitment of time do these different things you have contributed to, or writing, or go and speak, what commitment of time does that require?

A. Well, it would be probably a good ten percent of my time.

A lot of it would be done in the evening hours.

But all together it probably would be ten percent of my working hours.

Q. And then what percent of your working hours takes up -- would the academia take up, and by that I mean teaching position, whether it be in the hospital or --

A. I would be estimating at maybe 20 percent.

Q. So with all this stuff you have done, and all the things you have done since 1972, is your testimony that only takes up 30 percent of your time?

A. Yeah.

Q. The rest of the time is spending active practice?

A. Yes.

Q. How much to you charge to be here?

A. For this I charge $5,000.

However, this is my third day here, and we're going to have to work out some type of reconciliation.

I've have not paid for the hotel myself, I don't want you to think that.

But I'm not sure who has paid for it, Mr. Weaver's organization, but it's been three full days.

I left Los Angeles, I left my home on Tuesday morning at 5:30 a.m., and this is Thursday at 4:20, and I'm still here.

Q. And is your day -- are you saying your daily rate is $5,000?

A. I said, I've never been involved in anything like this before.

All I can tell you is, that usually when I testify in court, it's one day, or a half day, and it's $5,000.

Q. Okay.

So you charge the same for half day or full day is the same?

A. I never testified for a full day, so I don't know what the going rate is.

Q. But according to your fee schedule, if I understand you right, you would charge --

A. Ordinarily.

Q. -- $15,000 for the three days you have been here?

A. How much?

Q. $15,000?

A. Well, can you tell Mr. Weaver that that would happen?

I don't know what will happen.

I'm concerned.

Q. Okay.

A. Let me just say, that would be a very pleasant occasion if that did occur.

Q. You don't have any intention of charging that amount?

A. I have no idea yet what to do about this.

Q. Okay.

Would you say -- I'm jumping around a little bit, I'll get back into more of a flow here, but would you say the 28th he was properly assessed for amputation?

A. Not on the 28th.

I think it was -- the application I think was done by an orthopedic surgeon, and it was a couple of days later he was called in after the they decided that the thrombolysis wasn't going to work.

Q. The thrombolysis was done of the graft, wasn't it?

A. Yes.

And the attempt would be for any other arteries they could access.

Q. Was there any evidence they attempted to use TPA therapy on the profunda?

A. Yes.

Q. And were they successful with that?

A. They thought it was possibly successful that they reduced the amount of clot there.

Q. Isn't it true that in order for the TPA therapy to work, you have to have blood flowing through the area, in other words, there has to be a way for it to come in and go out?

A. For TPA?

Q. Yes.

A. No.

What TPA is, is usually given by a catheter into the clot itself to dissolve the clot.

So there's no blood flowing at that point.

Q. Okay.

The treatment that was rendered at the time of the amputation during that stay started on the 28th, would you say that was necessary as a result of the condition?

A. The amputation?

Q. Yes.

A. Yes, it was necessary.

Q. And you have done that type of treatment before, you customarily have your patient stay in ICU?

A. I missed that.

Q. Do you customarily have the patient stay in the ICU department?

A. Well, you do if the patient's receiving TPA because it can cause bleeding, as it did in Mr. Moore, from any other site where there's an opening of an artery.

Q. Because the thrombolytic in it?

A. Yes.

Q. And are you familiar with how long Mr. Moore stayed at the hospital for the amputation?

A. Before the amputation, or all together?

Q. The whole time.

A. Yeah -- I can't remember the exact number

of days, but it was in the order of a week.

Q. And that would have been reasonable and customary for that type of treatment he was receiving?

A. Yeah.

Q. And customarily would you have somebody who has received that type of treatment go from the hospital, the ICU, and go into a rehab facility?

A. Yes.

Q. How long would you normally expect to see someone in a rehab facility?

A. You know, it would just depend on what you wanted to accomplish in the rehab facility.

It would be some time later usually, let the patient go home for the amputation site to heal, and when that is healed, then you begin to do rehab to get him ready for prosthesis.

So probably actively it wouldn't occur for say two to three weeks, and then he would go into an out-patient rehab situation, parallel bar walking, possibly even an early fit prosthesis, crutches, all of that to get him going.

Q. Are you familiar with the classification of acute limb ischemia that is in stages?

A. That is in?

Q. Stages, stages 1, 2 and 3?

A. Yeah.

Q. So you see this is a chart broken down into three stages, and the second stage is 2-A and 2-B?

A. Yeah.

Q. And you are familiar with this classification system for acute limb ischemia?

A. I am.

Q. So the first stage says, limb is viable, not immediately threatened.

You see there's no sensory loss, no muscle weakness -- in both the arterial and venous?

A. Yes.

Q. Would you agree with the first stage of that acute limb ischemia?

A. Yes.

Q. And the second page -- there is two stages.

Stage A is marginally threatened, salvageable if promptly treated, and then it gives the different things you might see, says minimal dose or none.

What does that mean?

A. I guess it means that there's numbness of the toes.

Q. There may be numbness the toes minimal or

none, correct?

A. Yeah.

Q. And then in the muscle weakness it says, none.

And under Doppler it says, often inaudible in the arterial, and venous audible, correct?

A. Yes.

Q. So in the case of Mr. Moore --

A. Are you asking me if I agree with that?

Q. Do you not agree with this staging system?

A. I can certainly not agree with it if I don't.

Q. Is that your testimony, you don't agree with the staging system of acute limb ischemia?

A. Yeah, I think these are a little contrived, but an inaudible signal would put the patient into a 3-B in my estimation because an inaudible signal is really very advanced.

Q. 3-B or 2-B?

A. 2-B.

Sorry.

Q. Okay.

So a person who is a 2-A, marginally threatened, salvageable if not promptly treated, he may have an audible pulse by Doppler?

A. Possibly.

Q. So in the case of Mr. Moore there's been some discussion about the extent to his pain complaints in his calf, and that's been minimized by you I would say.

Do you agree with that, it has a minimal finding of calf pain?

A. No, that is what brought him to the emergency room on the 25th of December.

Q. But in relation to his acute limb ischemia, you didn't consider that being a significant finding?

A. That is not a finding of acute limb ischemia.

It's more the foot pain that signifies acute limb ischemia.

Q. Are you familiar with -- Do you know why Mr. Moore came to the emergency department on December 5th, Christmas day, of all days?

A. Yeah, it was my understanding he had calf pain, which had come on after a period of more walking than he generally did.

Q. Well, the calf pain had been present for a day, correct?

A. Yes.

Q. Okay.

And are you familiar with Mr. -- You're obviously familiar with Mr. Moore's history of occlusions in 2015 and 2014?

A. Yes.

Q. And initially the graft in 2012.

Are you aware that his doctor, Dr. Wiencek, had told him, if you feel anything like this, I need you to get to the emergency room as soon as possible?

A. I'm not aware of that discussion.

Q. Would you agree that that is sound advice?

A. Now, what exactly is the advice, if he has --

Q. If he has pain into his left lower limb, the place where he had the fem pop graft, if he feels pain in that area, he should get to the hospital as soon as possible, and have them call him --

A. Well, I think that is okay.

Q. Especially, given if fact he's already had two occlusions and a fem pop?

A. Yeah.

Q. So you know the reason he went to the emergency room on December 25th.

Do you find it significant he would go to the emergency room on Christmas of all days?

A. I suppose you could say, it bothered him

enough to skip Christmas dinner and go to the hospital, yes.

Q. Did you see --

A. On the other hand, it could be that he went because he felt there would be fewer people in the emergency room on Christmas.

It's an impossible question to answer.

Q. So is that another assumption you are making against my client, that he had some ulterior motive other than the fact he had these symptoms and been told to go?

MR. WEAVER: Objection, Your Honor.

He asked him to speculate in the first place.

THE COURT: You are asking him to speculate.

MR. ARNTZ: No, I'm questioning whether he has speculated.

I think he's speculating right now.

THE COURT: Clarify the question.

Sustained.

BY MR. ARNTZ:

Q. You just testified that he may have gone because he had this concern, but he may just have well have gone that day of all days because he might

have thought the number of patients was less, right?

A. No, I suggested both may have been operative.

One, he was concerned because of pain in his calf, he knew he had venous thrombosis in the past, perhaps he was concerned, and this is not speculating, I think he was concerned he might have deep vein thrombosis.

Q. So you went from an arterial problem he had been treated extensively for, and said the reason he went was because of a DVT, is that right?

Who said that?

Q. You just said that.

A. All right.

Q. The reason he went there was because of a concern of DVT, not because of an arterial occlusion?

A. I don't think Mr. Moore made a diagnosis.

I think he simply said, it happened.

Q. So when he got to the emergency room, the health care providers made a diagnosis?

A. Yes.

Q. Okay.

So are you aware of anything within the records that would help you discern whether it was he thought there might by fewer patients, or had this

concern of another occlusion in his artery?

A. No, I distinctly remember him saying in his deposition, it wasn't the same as when he had the prior occlusions.

Q. That's not my question.

My question was:

Do you know of anything within the records that would support or help you discern whether it was one or the other of the two motivations you gave for why he would go to the emergency room on Christmas day?

A. You know, I can't tell what was going on in his mind at that time.

Q. I'm asking if there's anything in the records could help you do that?

A. No.

Q. Okay --

THE COURT: Can I have counsel at the bench, please?

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

THE COURT: Folks, I'm sorry.

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

THE COURT: Thank you.

Mr. Arntz, whenever you ready.

Thank you.

BY MR. ARNTZ:

Q. I'll get back to that after we find the record.

This is the record from 12/25/2016.

This is where he goes in and says, it felt like spasm.

The report says, history of DVT on the leg and became concerned.

So nothing in that report says anything about how many patients that were going to be there, but it does talk about the fact he had motivation because of a concern because of his history, right?

A. Yes.

Q. Okay.

Do you treat individuals with chronic occlusions?

A. Yes.

Q. And how do you treat them?

A. Well, first of all, we would use what is called conservative non-interventional treatment.

We obtain if we can a normal blood pressure, normal cholesterol, anti-platelet agents

such as aspirin, more recently Xarelto's been approved for prevention of thrombolytic events, and commonly stated as a supervised exercise program, but we don't interpret that as going to the gym or walking a set distance or number of paces.

That's conservative management.

Q. And then what is more aggressive?

A. That would be obtaining an imaging test to see is there something that is safely correctable and that would significantly improve his life activities, but we won't make an intervention, unless the claudication has impacted -- I use the word claudication as chronic disease has impacted his ability to live a normal life.

Q. And claudication is another word for pain?

A. It's a cramping occurs in the calf with walking.

Q. Okay.

So he does indicate in his record -- or at least the record indicates that he felt spasms in his calf since the day before, he had a history of clotting and became concerned, right?

A. Right.

Q. Is it your testimony that -- First let me ask you, you probably don't anymore, but was there a

time when you were on call for emergency departments to go and work as a consult for people who were like Dr. Lasry's position might call you?

A. Up until just a few years ago --

Q. So --

A. -- when they started giving payments to be on call, my colleagues dropped me out of the call schedule.

Q. They didn't want you to get the payments?

A. They said, we don't want you older doctors working so hard.

Q. So I'm assuming your testimony is going to be, had you been called to see this patient, you would have sent him home, is that right?

A. If I would have been on call.

Q. Had you been on call, and been asked to come in see this patient, as a result you would have sent him home?

A. No, I would have probably listened to the report that either Nurse Bartmus or Dr. Lasry would give me and make a decision pasted on that report.

Q. Would you do a physical examination of him?

A. If I was called in?

Q. Yes, sir.

A. If I came in, yes.

Q. If you saw there was an occlusion in the ultrasound, and specifically in this ultrasound showed no evidence of DVP, but they did do a Doppler of the vein, correct?

A. Yes.

Q. But didn't do one of the artery?

A. Right.

Q. Would you have gone and ordered another test to doing a Doppler of the artery?

MR. MC BRIDE: Your Honor, can I object?

This is really beyond the scope, and also goes into our motion in limine on this subject.

THE COURT: Well, technically it is, but it does seem like we're going into some other areas.

I'll give you a little latitude, Mr. Arntz, but let's bring it back to the topic that was part of the direct.

MR. ARNTZ: Okay.

I'd like to make a record on that later, but --

THE COURT: That's fine.

BY MR. ARNTZ:

Q. So you would have done a Doppler of the artery?

A. I would have listened to the arteries in

the foot, yes.

Q. Is it important for you to know like that staging system talked about, it's important for you to know whether you can hear the blood flow in both the vein and the artery, correct?

A. What it does is backs up my clinical impression.

I would have come in, examined him, presumably arrived at the same conclusions Dr. Lasry had, and then you are the specialist, so I would have listened to the flow in the artery to back up my overall impression.

Q. And if you had done that Doppler of the artery and found there wasn't blood flow, what would you have done next?

A. Well, that would be a totally different picture if there wasn't blood flow because the foot would be very different, would be as it was on the 28th.

Q. So is staging the classification system we looked at earlier for a 2-A it says, marginally threatened, but salvageable if promptly treated, and then it talks about the sensation or loss, which could be none, muscle weaknesses could be none, but there is a difference, being what they said, this

Doppler signal, the vein being stronger possibly than the artery, is that your experience?

A. No.

They are two totally different signals.

With the vein you're listening for blood flow, and imaging to see if there's clots within the vein.

And then you're doing augmentation to see if you can make the blood flow accelerate, decelerate, it's a totally different examination, between the vein and artery.

Q. But it was brought up I think yesterday that it was significant to you that in the ultrasound done they did a Doppler of the vein, and they showed blood flow?

A. Yes.

Q. So my point is, you could have blood flow in the vein, but not have audible blood flow in the artery, is that correct?

A. I don't think so.

Q. So are you saying that this classification system is flawed when it talked about the Doppler signals?

A. Yeah, I'm not in agreement with it.

Q. Okay.

Let's talk about --

A. In fact, I don't even agree with the title, the classification of acute ischemia.

We're talking about, number one, it's not acute limb ischemia.

Q. Are you arguing with the standard for vascular surgery standards?

A. I don't know when these were published, or who published them.

Q. Do you generally adhere to those standards?

A. I would -- I would not classify my patients this way.

Q. You would classify them by the five Ps, which are all done manually by the examiner, in other words you get a pulse?

A. Yes.

Q. A visual, you do these other things that are not tests, they are examinations, correct?

A. Yes.

Q. But in this classification of acute limb ischemia you actually have a test, a Doppler test?

A. Right.

Q. That confirms blood flow in both the vein and the artery, but that I guess in your testimony is that that is less reliable than a physical exam where

you're looking at a patient?

A. No, in -- If I could just simply say that, I think that when you have an inaudible signal, that the condition is really a 2-B, not a 2-A, that is how it differs.

Inaudible signal really signifies advanced ischemia.

Q. Okay.

So let's just focus on 2-A, but let's do it the way you said, and if there's no difference in the audible signal from the Doppler, that would put it in a category where it's marginally threatened, salvageable if promptly treated.

You agree with that?

A. So if there's a signal, I would leave it at 2-A.

Q. Isn't that what your inference is?

A. If it's marginally threatened, salvageable if promptly treated, I don't know what promptly means in this. I expect they mean, maybe a week or so you bring the patient in for surgery, and he had an audible signal.

Yeah, I would leave that as a 2-A.

Q. All right.

I don't mean to be argumentative with you,

but the words marginally threatened and salvageable if promptly treated, those words to you suggest you could wait a week to treat him?

A. Well, what does marginally threatened mean, and what does threatened mean?

This is a very subjective description.

Q. These are classifications you said you accept.

Are you telling me you don't know what the words marginally threatened mean?

A. I don't know what they mean by marginally threatened.

I'd have to read the whole article to figure out what is going on here.

Q. What you don't see in this classification of acute limb ischemia is 1 and 2-A, you don't see actually in 3 or 2-B, you don't see any reference to extreme pain, do you?

A. Well, that's not a category.

It a very simple table.

It's not a category, it's in the table.

Q. It does talk about sensory issues though?

A. Sensory loss?

Q. Right.

A. I think by the way that is not as important

as a description of pain.

I would do it differently if I were writing the book.

Q. I got that.

A. I actually have.

Q. So if -- Let's say you have somebody in 2-B, what is immediately threatened, salvageable if immediately -- What does revascularized mean?

A. That is acute ischemia.

Q. And that is where you have toes associated with pain, and the rest they are talking about pain, correct?

A. Now we got pain, yep.

Q. And the muscle weakness is mild or moderate?

A. Yes.

Q. Certainly there was some evidence he had muscle weakness, he was using a cane and had spasming in his calf?

MR. WEAVER: Excuse me, Your Honor.

That lacks foundation.

There's been no evidence in the record he had pain.

THE COURT: Well --

MR. ARNTZ: There's evidence in the record,

maybe not in this medical record.

BY MR. ARNTZ:

Q. But he testified he used a cane and a wheelchair from time to time, correct?

A. Yes.

Q. So if we put him into that category, you would at least go and do another ultrasound of his arteries, wouldn't you?

A. If he was in -- or had the description of 2-B, yes, I would do an ultrasound.

Q. Would you admit him?

A. It depends on the amount of pain he had and the changes in his foot, the skin.

But if all of these are true, if he has an inaudible Doppler signal, I would get imaging and most likely admit the patient.

Q. Okay.

The differential diagnoses by practitioner are important, aren't they?

A. Yes.

Q. And explain for the jury what a differential diagnosis is.

A. That is a list of things that you think maybe the diagnosis -- and generally listed from what you think is the most likely diagnosis to the least

likely diagnosis.

Q. Did you happend to read Dr. Barcay's report?

A. His letter?

Q. Yes.

A. Yes.

Q. You saw in there he came in with pain to the emergency room department, he came in with pain at a fem pop graft appeared occluded, was given Percocet in the emergency department for the treatment of pain, do you remember that from the record?

A. I can't remember specifically, but I'll accept your recitation of it.

Q. And Percocet is a pretty strong narcotic for treatment of pain, isn't it?

A. Yes.

Q. So if he comes into the emergency room complaining of pain of intensity level of 7, but is given Percocet, you would expect that pain to diminish, wouldn't you?

A. Not really because he had been chronically taking even Oxycodone, which is pretty strong.

Q. Do you know whether he had taken any that day?

A. No.

Q. So they go, and they do a differential diagnosis, deep vein thrombosis,/S-RT right sprain or strain, right?

A. All right.

Q. I believe Mr. Dr. Barcay misinterpreted this record because he also included the arterial occlusion area, peripheral arterial disease.

Can you see they didn't include that in their differential diagnosis, did they?

A. The diagnosis 1 and 2 are I think from the past history.

Q. That's what I think too.

It says 6/27/2015?

A. Yeah.

Q. So those have been prior differential diagnoses?

A. Right.

Q. Of that?

A. Right.

Q. And yet in the differential diagnosis that Nurse Practitioner Bartmus and Dr. Lasry created they didn't include close in the differential diagnosis?

A. Okay.

Q. And you think that is okay, even though

there was an ultrasound showing an occlusion in the artery?

A. Yes, because he didn't have signs and symptoms that would lead you to believe that was the current problem.

He certainly had artery disease.

I don't believe the time they examined him that the arterial occlusion was acute, so --

Q. You didn't really know at that point, did you?

I mean, on December 21st, four days earlier, he had none of those symptoms, he didn't have any complaints that lead anybody to believe he should go to the emergency room, this is all things he's been through before, so are you saying that even in light of that fact there have been four days, and this developed in that time period, that is not acute?

MR. WEAVER: Objection, Your Honor.

It's quadruple compound.

THE COURT: It is multiple compound.

I'll sustain.

BY MR. ARNTZ:

Q. But you understand the foundation I laid for that regarding the examination on the 21st of December?

MR. WEAVER: It's still quadruple compound.

THE COURT: I don't think that is correct, Mr. Arntz.

If you want to break it down or something, but you're asking many compound questions.

MR. ARNTZ: I'm trying to get through this, Your Honor.

THE WITNESS: I appreciate that.

THE COURT: Change a few things.

BY MR. ARNTZ:

Q. Do you recall Mr. Moore was seen on December 21st, 2016, four days before he went into the emergency department?

A. At the pain management clinic, yes.

Q. And at that time he didn't say any signs or symptoms to that practioner he was having an acute ischemic event, did he?

A. No, he reported pain in his legs, but he didn't say, I have an acute arterial event.

Q. He reported pain in his ankle?

A. Yes.

Q. And they apparently took a pulse and found one?

A. I think so, yes.

Q. And within four days he had taken himself because of a concern he had over an arterial problem to the emergency department, right?

MR. WEAVER: Lack of foundation.

THE COURT: Sustained.

BY MR. ARNTZ:

Q. The note I read to you just a minute ago says, he had a concern for his leg, and that is the reason he was there, didn't it?

MR. WEAVER: Again, Your Honor, that lacks foundation it was an arterial problem.

That --

THE COURT: You want to put the note up and see what that description is, get that clarification?

MR. ARNTZ: These are things everybody heard.

I'm trying to get through it.

THE COURT: Mr. Arntz, put up the document and show the information.

BY MR. ARNTZ:

Q. Again, this is the report that comes in with, reports left calf pain since yesterday, felt like spasming, that's a sign, isn't it, a symptom that could lead to the conclusion he has a problem with an artery?

A. See, as I read that it says, but reports he has a history of DVT in the leg, and became concerned, and I read that as becoming concerned that he hasn't had a recurrent DVT in the leg.

Q. Fair enough.

And my own expert said, it was appropriate to do an ultrasound to rule out DVT, but in the process of doing that ultrasound they found evidence of an occlusion in the artery?

A. Yes.

Q. And so knowing that he had previous occlusions in the artery, and that was evident, wasn't it, by the note of 6/25 where we talk about the different diagnoses, and that treatment took place in June of 2015?

A. Yes.

Q. That showed he had a history of arterial occlusion, correct?

A. Yeah.

Q. So we have a person coming in with this concern and that finding from ultrasound, and without more would you have sent him home?

A. Well, if he had related to me the condition of his extremity as was noted in the chart, and if that had been related to me that he had no deep vein thrombosis, and he had a graft that looked like it was occluded again, but he didn't have symptoms or signs of acute ischemia.

I would review that as a chronic condition, and I think I would probably have said, given the preamble I've said, let me see him in the office and see what is going on.

If he had said that he's got signs of acute ischemia, his foot is cold, he's got pain in the toes, can't dorsiflex his foot, you know, I'd be in to take care of that, yeah.

Q. So if they called you and said, he presented with a concern about his leg, he has a history of acute arterial disease, he's had previous occlusions, and by the way we have an ultrasound shows an arterial occlusion, you wouldn't even come to the hospital?

A. It would depend on his condition.

If his extremity had the signs and symptoms

of normal circulation, what would be the point of rushing into the hospital?

You are not going to do anything.

Q. You named a couple of things, you would have done the -- already you said you would have done a Doppler of his artery?

A. I wouldn't have changed anything.

I would have heard audibles, given the signs and symptoms reported by Dr. Lasry and Nurse Practitioner.

Q. Again, your entire opinion is based on whether or not they actually did that pulse test, isn't it?

A. You're absolutely right.

Q. You would agree with me, wouldn't you, if Dr. Lasry failed to actually put his hands on Mr. Moore and examine him, that would be below the standard of care?

A. If Dr. Lasry had not examined him, that would.

I'm not going to comment on emergency medicine standards of care, but I would expect Dr. Lasry in the ordinary treatment of the patient would do that.

Q. You certainly would not have been able to

make the statement you made in the last question if you accept all those records as true, if in fact you had reason to suspect he had not put his hands on him and tested his pulse?

A. I don't have any reason to expect he didn't put his hands on him.

Q. Would you agree with me that the same would be true for Nurse Practitioner Bartmus, if she represents in the record she did a physical exam, and actually hadn't, that would be below the standard of care?

A. Yeah.

Q. In fact, that would be beyond the standard of below the standard of care, would be a violation of their oath as practitioners, wouldn't it?

A. Yeah.

Q. Creating a fraudulent record?

A. That's right.

Q. I'm skipping through a lot of stuff, so I I'm winding down.

What are the surgical options for someone who has an occluded artery?

And I'll ask you next if they differ based on whether it's chronic or acute, the surgical options for an occluded artery?

A. For with acute ischemia?

Q. Let's start with acute ischemia.

A. With acute ischemia.

Surgical options would be to extract the clot using a type of balloon catheter, and try to restore flow that way.

It's not particularly successful.

So today we generally go for lysis first with an attempt to dissolve the clot.

Q. Is a surgical thrombectomy an option?

A. Yes.

Q. Okay.

How about re-grafting it?

A. That's possibly an option, yes, you could put in a second graft, but if your first graft is not functioning, then the second graft is a very poor prognosis.

Q. When you say, a secondary graft, what do you mean?

A. If you put in a second by-pass.

Q. Okay.

I think you actually wrote an article many years ago on using a profunda to create a secondary graft?

A. Yes, made a movie of it.

Q. Is that something still an option?

A. Unfortunately, it hasn't been practiced widely, but it is an option, and it's sometimes appropriate.

What you would do is, take the graft off the profunda to avoid re-operating on a previously dissected area.

Q. You testified that your opinion is, he would have lost his leg regardless, and I'm assuming that opinion is based on -- or an assumption on my part, you wouldn't have admitted him on the 25th?

A. Given the record in the chart, no.

Q. If you had admitted him on the 25th, do you have an opinion whether he would have lost his leg anyway?

A. I think he was destine to loss that leg because of continual progression of disease.

I think he was developing end stage disease, wasn't going to be corrected other than temporarily.

Q. So previously you testified that that could have been a number of months, could have been a year or more, correct?

A. Yes.

Q. And importantly, it also may have involved

a different type of amputation, wouldn't it?

A. Possibly.

Q. Might have been below the knee?

A. It could have been.

Q. So him not getting admitted on the 25th possibly created a loss of chance on his part to have a successful treatment and have a longer period of time with his leg, correct?

A. What was done?

I mean, under what circumstances?

Q. If he's admitted, and they are treating him with TPA, or treating him with something to break up that clot, and if successful, that chance could keep his leg longer was lost by not being admitted?

A. If it were to be successful, and they opened up the graft, and there was flow through the graft, he would have retained his extremity for a longer period of time.

Q. At the very least had he not retained it forever, he would end up having amputation, he lost the chance to have on amputation below the knee?

A. I can't say that because of the unusual anatomy he had, not having an internal iliac artery, and then having a profunda that was compromised.

Q. So my question is, not whether he would have had a different outcome.

My question is:

Did he lose the chance to have a different outcome by not being admitted on the 25th?

A. I --

MR. WEAVER: Speculation, Your Honor.

THE COURT: Overruled.

THE WITNESS: I don't think so.

BY MR. ARNTZ:

Q. So even if he been admitted on that day in December of 2016, December 25th, even getting admitted that day, he's still going to lose his leg above the knee?

A. Well, I can't really answer that.

What I can say is, the disease was progressive, and he would eventually have had an amputation no matter what was done on the 25th.

Q. But it could have been years later, correct?

A. It would have been shorter than that.

Q. Well, you said -- earlier you said, a year.

Are you saying, it's only a year?

A. Probably a year because let's say he been admitted the 25th, they opened up his graft, and

marginally improved circulation, it would have clotted soon thereafter as it had done two previous occasion.

Each time it clots the situation is worse, inevitably will lead to an amputation.

Whether it's above the knee or below the knee, I can't tell you.

Q. But those were chances he lost by not getting admitted that day?

A. You're asking me -- Let's say he been admitted that day.

The admission doctors would have examined him, said, well, his leg's okay, let's not do anything.

Q. You're speculating that is what would have happened?

MR. WEAVER: Well, Your Honor, he's asking him to speculate.

THE COURT: Yes.

Sustained.

Agree.

He may finish his answer.

BY MR. ARNTZ:

Q. Are you done?

A. I finished, yeah.

Q. That is based on rank speculation, isn't it, that that is what health care providers that --

THE COURT: What is the objection?

MR. WEAVER: Speculation.

THE COURT: He was with the phrasing of the question.

Now, the fact it's already admitted, sustained.

BY MR. ARNTZ:

Q. That is based on speculation as to what they would have done, isn't it?

A. No, it's based on my knowledge of vascular surgery what would have been done.

Q. It's at least based on a present assumption they wouldn't have called a cardio-vascular surgeon, isn't it?

A. No -- Well, here's what I think:

I think he didn't have an indication to be admitted to the hospital on the 25th.

I think he didn't have an indication for a vascular consultation on an emergency basis.

He did have an indication to be followed up with his vascular surgeon and primary care doctor.

So whether or not he's been admitted to the hospital, that's encouraging me to speculate.

I can't tell what would have happened.

Q. And that conclusion is based on the fact he didn't do a full arterial ultrasound, right?

A. Right.

Q. And a full arterial ultrasound could have done other arteries besides just the grafts, right?

A. Right.

Q. So we don't know if there were clots in the profunda at that moment, but if there had been clots in the profunda at that moment, plus the clot in the graft, wouldn't you have admitted him?

A. If I had known all of that information, probably because if that had existed at that time, his signs and symptoms would have been much worse pointing towards an admission.

MR. ARNTZ: That's all I have.

THE COURT: Mr. Weaver, anything on redirect?

MR. WEAVER: Quickly.

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REDIRECT EXAMINATION OF DR. SAMUEL WILSON

BY MR. WEAVER:

Q. Dr. Wilson, none of the opinions you previously gave in response to the questions I posed have changed, have they?

A. It doesn't change any of my responses, no.

MR. WEAVER: Thank you.

No additional questions.

THE COURT: Any questions from any of the jurors?

We do have some jury questions.

So we will review them, and then to the extent there are any to ask, we'll ask them of you, and you respond to the jurors, and I will give counsel an opportunity to follow-up.

THE WITNESS: Okay.

I'm happy with that.

THE COURT: Can I have counsel at the bench, please?

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

THE COURT: Okay.

Doctor, these are juror questions.

If you could provide your answer to the

jury, unless we have an objection, the attorneys will follow-up.

I'm not at liberty to explain any of this information, simply read the questions exactly as they are written, and you --

THE WITNESS: Can I have a piece paper to write down?

THE COURT: I'm not going to ask them all at once, one at a time.

If you would like to see the papers, you can see them.

THE WITNESS: No, that's okay.

THE COURT: What is your definition of a, quote, palpable pulse, and is that definition different from a pulse described as, quote, normal?

If so, how is it different?

THE WITNESS: Okay.

A palpable pulse is the sensation of pulsation that you feel when you put your hand over an artery.

It requires a certain minimal blood pressure for you to feel that pulse.

And ordinarily it would be over a hundred, depending on whether if the artery's got a lot of calcification, as in a diabetic pressure would need

to be higher to feel the pulse.

The second part of the question was?

THE COURT: I have to read the question exactly as written.

What is your definition of a palpable pulse, and is that definition different from a pulse that is described as normal?

If so, how is it different?

THE WITNESS: A palpable pulse, if you can feel it, is generally considered normal.

Some physicians will grade it and say, well, it's not very strong.

Others will say, it's very, very strong.

To me, a normal pulse in most circumstances is if you feel it, and you can hold your finger up to your radial artery right now, and you can feel your pulse.

I think that covers it.

If the questioner wants to follow-up --

THE COURT: I just indicated, I'm not at liberty, nor they, to supplement the question.

After you answered the question, there's plenty more by the way, I will then give counsel the opportunity to follow-up.

THE WITNESS: Okay.

THE COURT: If you have more to give the jurors, that is fine.

THE WITNESS: No, I think we've covered what a pulse is.

THE COURT: Next question.

In your experience is there a medical decision between the term, appear, and, possible appear, and possible in quotes, with regard to a medical condition?

THE WITNESS: Yes, there's some difference.

Appears to me means that the technician or radiologist looking at it thinks it's occluded, but not completely sure.

Possible means that, you know, this could be occluded, but I'm not completely sure.

So I think they are very close in meaning.

I wouldn't parse it anymore than that.

THE COURT: Okay.

Would an ultrasound be performed with a knee-high sock on, would a knee-high sock be instructed to be left off until post ultrasound examination was complete?

THE WITNESS: The answer to that is:

You wouldn't do an ultrasound with the sock on, and you would leave the sock off until you finish

the ultrasound exam.

THE COURT: Dr. Wilson, in any occlusion in the major arteries, and grafts are collateral, the best system, the last resort, is to get adequate blood flow to lower extremities?

THE WITNESS: Yes.

THE COURT: Dr. Wilson, is it possible following a fem pop graft to have palpable pulses at one hospital visit, require a Doppler at the next visit to defect blood flow, and be able to have palpable pulses at any subsequent visit?

THE WITNESS: Of course.

If you go into a very cold examining room, your pulses, your arteries, will constrict, and it's very difficult to feel a pulse.

If you go into a warm room like this one, a hot room, then your arteries will dilate.

If you come out of the shower for example, you are flushed, blood is circulating, the heat has dilated all your arteries, and you are sure to feel a pulse.

It will vary between examiners.

Dr. Lasry could feel a pulse, and I would go there and maybe not, so sure, or vice versa, and you if see doctors clustered around a patient trying

to determine, do you feel it or not.

So yes, you could feel a pulse at certain times and be absent in other times, absolutely.

THE COURT: Can an artery be chronically occluded for decades, or how long can an artery be chronically occluded before it turns into an acute occlusion?

THE WITNESS: An artery can be chronically occluded for decades.

In fact, Mr. Moore's right femoral artery has been chronically occluded since 2012, that is eight years, not a decade, probably occluded before then, but it hasn't at this point progressed.

And if Mr. Moore takes an oath to avoid tobacco, to keep his cholesterol fine, his hypertension down, and treat it with Xarelto, it may never give him acute occlusion.

But that I don't have a crystal ball to look into it.

THE COURT: Would there be a difference in diagnostics, and/or treatment for occlusion in major arteries, or in native arteries, versus by-pass grafts?

THE WITNESS: Not really, there wouldn't be a difference in evaluation.

The difference here was that the graft had been included two previous times since it had been placed, that is the difference.

And with the chronic occlusion your big job is to determine is this limb viable right now or is it not, and if it's not, we got to do something.

And if it's viable, even though the graft is occluded, you decide is this something where collaterals are providing sufficient circulation to keep the leg alive, and if it is, that could be a stable situation, we call that stable claudication where the patient has symptoms of chronic occlusion, but is able to battle through life and get the things he needs to do done.

THE COURT: With an apparent occlusion on 12/25/16, could Mr. Moore have been instructed to take more milligrams of Xarelto for a greater effect, so to help free the occlusion?

THE WITNESS: No.

THE COURT: And --

THE WITNESS: The reason is, it would reduce bleeding to his brain or some other site.

THE COURT: Could Mr. Moore have been given a more potent blood thinner or other medication, either in the ER, or prescribed from the -- I'm

sorry, Juror Number 7, let me start again.

Could Mr. Moore have been given a more potent blood thinner or other medication, either in the ER, or prescribed from ER, to help free the parent occlusion?

THE WITNESS: Blood thinners such as Xarelto, or more commonly often Coumadin, you have heard of would not affect the clot at all. Those are given to prevent extension of a clot.

So if the patient has acute ischemia, we would generally give an intravenous Heparin that goes to work right away and prevents extension of an ongoing clotting process.

So I believe, if I can say this without getting in trouble, I believe that the clot had been there for some period of time because it couldn't -- or wasn't able to be dissolved on the 28th, which suggests to me it was an organized adherent clot.

Otherwise, you would have had the same result on the 28th as they had maybe prior years.

THE COURT: Okay.

THE WITNESS: So no, blood thinners would not have affected the outcome.

THE COURT: All right.

Mr. Weaver.

MR. WEAVER: No questions, Your Honor.

THE COURT: No follow-up?

Mr. Arntz.

MR. ARNTZ: I got a couple.

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RECROSS-EXAMINATION OF DR. SAMUEL WILSON

BY MR. ARNTZ:

Q. With respect to the folks, are you aware Dr. Lastry would have testified -- Dr. Lasry testified the pulses would have been diminished, and Nurse Practitioner Bartmus said the pulse was normal, do you make a distinction between those two?

A. I accept Dr. Lasry's comment, and if that's how he grades the pulses, that's fine.

In my purposes of, if there's a pulse present, that means that there's arterial pressure, arterial flow, and that is satisfactory.

Q. Are you aware Mr. Moore has testified, and will testify here, the only time he was instructed to take his sock off was during the ultrasound?

A. I believe that came out in one of the depositions that that was said in one of the depositions.

Q. And you just testified that the -- an occlusion can be chronic and be there for decades,

and specifically said, the one in his right thigh --

A. Yes.

Q. -- has been there for eight years, but you also said that -- well, then in the same question you said, it hasn't progress, but your overall perspective of this disease is, it's progressive, right?

A. It has hasn't progressed to acute ischemia yet, but no doubt it's progressing.

MR. ARNTZ: Okay.

THE COURT: Is that all?

MR. ARNTZ: Yes.

THE COURT: Doctor, that completes your testimony at that time.

Thank you.

THE WITNESS: Thank you.

THE COURT: All right.

Ladies and gentlemen of the jury, we're going to take our overnight recess.

Thank you for your patience by the way.

We went longer than expected today.

You will be returning tomorrow morning at 9:00 a.m. here in this courtroom, and we may have a different location at some point, but tomorrow morning we'll start here.

(Jury admonished by the Court.)

THE COURT: We'll see you tomorrow morning at 9:00.

Have a good night.

(Jurors excused from the courtroom.)

(Proceedings concluded.)

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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