

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.)

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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

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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.

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Las Vegas, NV 89118

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

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IN THE EIGHTH JUDICIAL DISTRICT COURT
CLARK COUNTY, NEVADA

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

JURY TRIAL
Before the Honorable Kathleen Delaney
Thursday, February 6, 2020, 1:30 p.m.
Reporter's Transcript of Proceedings

REPORTED BY:

BILL NELSON, RMR, CCR #191
CERTIFIED COURT REPORTER

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APPEARANCES:

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

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

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I N D E X

WITNESS	DR	CR	RDR	RCR
Dr. Samuel Wilson	6	77	151	159

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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.

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

3 THE COURT: Welcome back, ladies and
4 gentlemen.

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

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

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

13 THE WITNESS: I am, yes.

14 THE COURT: Thank you.

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

18 THE COURT: Okay.

19 They will admitted.

20 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

1 perform non-traumatic amputations?

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

4 Q. Why is that?

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

11 But orthopedic surgeons also do quite a
12 number of amputations.

13 Q. What about general surgeons?

14 A. Traumatic amputations they would complete
15 for example.

16 Q. And --

17 A. Not as many as vascular or orthopedic.

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

20 A. I have performed many amputations, yes.

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

24 A. General surgery since 1971.

25 I finished my residency in 1970.

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

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

5 Q. And do you presently have any academic
6 appointments?

7 A. Yes.

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

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

15 A. Yes.

16 Q. Are they teaching institutions?

17 A. Yes.

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

20 A. 1992.

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

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

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

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

5 A. Yes.

6 Q. What did that consist of?

7 A. Well, for quite a number of years I was
8 chief of surgery at our local VA Long Beach because
9 we had an integrated residency program, our residents
10 went there, and I retired from VA after approximately
11 50 years of service, so I retired from VA two years
12 ago.

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

15 A. Yes.

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

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

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

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

1 teach residents.

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

4 Q. What does didactic mean?

5 A. Where you expound your knowledge to the
6 students.

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

10 Q. Okay.

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

14 A. Yes.

15 Q. Who else if anyone do you teach?

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

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

23 Q. Do you treat patients still?

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

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

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

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

10 Q. And what is a vascular clinic?

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

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

16 A. I think so, yeah.

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

20 A. Yes.

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

25 Q. And roughly how many medical textbooks or

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

3 A. At least a dozen.

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

8 A. Yes.

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

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

13 Q. And are those in peer-review journals?

14 A. Probably 90 percent.

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

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

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

1 journals yourself?

2 A. Yeah.

3 I continue to review articles for
4 publications.

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

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

10 A. I have.

11 Q. And what is that?

12 A. Very nice of you to bring that up.

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

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

19 Q. Thank you, Dr. Wilson.

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

24 A. I really do.

25 Q. Dr. Wilson, do you have a recollection

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

4 A. Yes.

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

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

9 Q. What were those conditions?

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

13 That his skin was discolored.

14 I believe in one area it was called
15 mottled.

16 That it was extremely painful.

17 I think those are the important things that
18 I recall.

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

22 A. Yes.

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

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

4 I can't give you the exact words.

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

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

11 A. Yes.

12 Q. What was that?

13 A. What was my recollection?

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

16 A. The morning of the 28th.

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

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

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

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

3 So there's advancement of disease.

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

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

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

13 A. Sure, yes.

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

16 A. Okay.

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

1 taking Xarelto, you can have a rebound clotting.

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

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

11 A. Clotting.

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

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

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

1 I want you to hold that hypothetical for a
2 moment.

3 A. Okay.

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

11 A. Yes, I do.

12 Q. Do you agree with Dr. M's opinion that
13 because the graft had been opened successfully two
14 times before December 28th, that more likely than not
15 it could have been opened a third time on December
16 25th?

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

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

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

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

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

21 A. Could you say that again, please?

22 Q. Sure.

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

1 A. Yes.

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

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

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

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

18 A. Yes.

19 Q. And why is that?

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

1 So it would be progression of disease
2 inevitably.

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

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

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

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

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

1 artery to maintain good satisfactory viability of the
2 leg.

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

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

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

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

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

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

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

1 you certainly couldn't ambulate on it.

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

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

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

16 Above knee it's more difficult.

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

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

25 So getting the above knee amputation means

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

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

10 A. Yeah.

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

14 Q. And you just used the term, stump.

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

19 A. No, patients and doctors use stump
20 frequently.

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

24 So I don't think it shows any disrespect.

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

1 deposition, is that correct?

2 A. Yes, I have.

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

6 A. Yes, I saw that.

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

11 A. I reviewed the literature, yes.

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

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

16 MR. ARNTZ: I'll make an objection.

17 We might need to come to the bench.

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

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

22 THE COURT: The objection is sustained.

23 Ask another question.

24 MR. WEAVER: Thank you, Your Honor.

25

1 BY MR. WEAVER:

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

7 Do you have an opinion in that regard?

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

10 Q. Why is that?

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

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

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

23 A. Okay.

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

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

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

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

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

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

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

1 A. I lost count here.

2 MR. WEAVER: Your Honor, may I approach?

3 THE COURT: You may.

4 THE WITNESS: I think we got them all.

5 BY MR. WEAVER:

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

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

16 BY MR. WEAVER:

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

19 A. Yes.

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

24 Do you agree with that?

25 A. I remember that, yes.

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

5 A. Yes.

6 Q. Do you agree with that as well?

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

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

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

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

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

23 He testified he --

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

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

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

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

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

13 THE COURT: I think we cleared up some
14 confusion.

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

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

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

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

3 We'll see how that goes.

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

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

11 BY MR. WEAVER:

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

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

24 The answer, actually I agree with the
25 examination.

1 I don't think there's anything unusual.

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

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

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

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

13 A. It should have been taken off, yes.

14 Q. That helps with the assessment?

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

17 Yes, it should be done routinely.

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

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

23 MR. ARNTZ: Your Honor, I object.

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

1 and once today.

2 THE COURT: Mr. Arntz is correct.

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

6 MR. WEAVER: It's just foundation.

7 I'll go into exactly what the pain was.

8 THE COURT: Okay.

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

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

13 That objection was sustained.

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

17 BY MR. WEAVER:

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

21 MR. ARNTZ: Objection.

22 Lacks foundation.

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

25 I want to clarify something.

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

3 THE COURT: All right.

4 The objection is overruled.

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

8 It's overruled.

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

12 MR. WEAVER: Thank you, Your Honor.

13 BY MR. WEAVER:

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

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

22 Q. Okay.

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

25

1 BY MR. WEAVER:

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

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

6 A. I see.

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

9 A. Intensity was 7.

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

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

16 A. Yes.

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

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

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

25 A. Well, calf pain directs you to a venous

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

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

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

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

14 A. Yes.

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

17 What does palor mean?

18 A. Palor is pale.

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

23 A. Yes, I see that.

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

1 A. No.

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

4 A. Yes.

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

7 I think --

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

10 THE COURT: You may.

11 BY MR. WEAVER:

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

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

16 A. The absence of a palpable pulse.

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

19 Q. And that is in assessing the five Ps?

20 A. Yes,

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

24 A. Yes.

25 Q. Doctor, have you reviewed the pulse, and

1 why is that?

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

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

15 Q. All right.

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

21 A. Yes.

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

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

1 whether or not that means they are lying?

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

4 Q. Why is that?

5 MR. ARNTZ: Objection.

6 Calls for speculation.

7 Lacks foundation.

8 THE COURT: He needs to clarify that.

9 I'll overrule.

10 But why is that?

11 MR. WEAVER: Fair enough.

12 I'll move on.

13 THE COURT: I want him to answer that
14 question.

15 MR. WEAVER: Thank you.

16 I missed the overruled part.

17 BY MR. WEAVER:

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

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

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

24 MR. ARNTZ: Sorry, Judge.

25 I object.

1 This is speculative.

2 I move to strike this testimony.

3 THE COURT: Overruled.

4 Please proceed, Mr. Weaver.

5 BY MR. WEAVER:

6 Q. Go ahead, doctor.

7 THE COURT: I thought he finished.

8 BY MR. WEAVER:

9 Q. Were you finished, Dr. Wilson?

10 A. Yes.

11 Q. Thank you.

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

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

19 This is my question to Dr. M.

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

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

2 Answer, I did say that, yes.

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

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

10 Q. And you have reviewed those materials.
11 Would there have been visits since 2012
12 where the pulses were detected?

13 A. I have reviewed the visits to Dr. Wiencek.
14 I don't have the material in front of me,
15 it's in my bag outside.

16 Q. That's okay.
17 We will go through it.

18 A. I have reviewed it, yes.

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

21 THE COURT: Was it received?

22 MR. WEAVER: Yes, it is.

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

24 THE COURT: As a reminder.

25 MR. WEAVER: Thank you, Your Honor.

1 BY MR. WEAVER:

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

4 A. Yes.

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

16 A. I have no basis not to accept that.
17 It's written down, the examination, yes.

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

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

23 A. Yes, I see that.

24 Q. Do you accept that date as accurate?

25 Any reason to dispute the date?

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

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

9 A. Yes.

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

16 A. I have no reason to doubt that observation.

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

22 A. Yes.

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

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

3 Q. Correct.

4 A. Palpable pulses?

5 Q. Pulses, correct.

6 A. He could be, yes.

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

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

14 Q. All right.

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

20 A. Correct.

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

25 A. No, this is in correspondence with Dr.

1 Wiencek's observation.

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

4 A. Yes.

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

9 A. Yes.

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

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

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

19 A. Yes.

20 Q. Do you accept that as accurate?

21 A. Yes.

22 Q. All right.

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

25 Dr. Wilson, I just want to orient you to

1 the date in the top right-hand corner.

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

4 A. I --

5 Q. Where it says date of service?

6 A. Yes.

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

11 A. Yes, I see that.

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

15 A. Yeah.

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

18 A. No.

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

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

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

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

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

9 A. Yes.

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

14 A. Yes, I see that.

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

18 A. I think that is what it states.

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

21 A. Yes.

22 Q. All right.

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

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

7 A. Yes.

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

13 A. I don't dispute that.

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

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

19 A. Yes.

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

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

1 He said, Bates 9.

2 I think he's referring to Bates 7.

3 MR. WEAVER: Thank you.

4 I appreciate that.

5 THE COURT: Thank you for the
6 clarification.

7 BY MR. WEAVER:

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

10 A. I do.

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

16 A. I don't dispute that.

17 Q. And one more on this, then we'll move on.
18 And this is Bates 5.

19 Do you see where it's dated November 1st,
20 2016?

21 A. Yes.

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

25 A. Yes.

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

4 A. Yes.

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

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

12 A. I do.

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

19 A. I don't dispute that.

20 Q. All right.

21 Just two more, Dr. Wilson.

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

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

1 management physician.

2 This is Bates 151, please.

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

4 A. Yes.

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

11 A. I see that.

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

15 Do you see that?

16 A. I see that.

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

20 A. Yes.

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

24 A. Yes.

25 Q. And then if you could just go a couple

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

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

5 A. Yes.

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

8 A. Yes.

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

12 A. Yes.

13 Q. Where, what does it say?

14 A. Normal pulses present.

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

19 A. I don't dispute that.

20 Q. Just one more, Dr. Wilson, if we might, and
21 that is Bates 111, still Exhibit 202, and it's dated
22 12/21/2016, and this is Mr. Moore's pain management
23 physician whom he sees at Nevada Comprehensive Pain
24 Center.

25 Do you understand that?

1 A. Yes.

2 Q. And do you see the exam date is December
3 21st, 2016, four days before Mr. Moore went to the
4 emergency department and was seen by Nurse
5 Practitioner Bartmus and Dr. Lasry on December 25th,
6 2016?

7 A. I understand that.

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

10 A. Right.

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

14 A. Yeah.

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

17 A. Yes.

18 Q. And what does it say there?

19 A. Normal pulses present.

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

25 A. I don't.

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

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

8 Q. All right.

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

12 Did you say had something to do with
13 sensitivity?

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

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

22 A. Yes.

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

25 A. Yes.

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

4 A. He couldn't walk normally.

5 Q. Why is that?

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

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

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

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

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

19 A. Yes.

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

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

24 THE COURT: That's what I meant.

25 Tell us where you are on the page.

1 MR. WEAVER: It should be under impaired
2 gait.

3 THE COURT: Nobody is seeing that.

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

5 I have the wrong page number.

6 BY MR. WEAVER:

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

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

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

12 MR. WEAVER: Okay.

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

15 BY MR. WEAVER:

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

21 A. No.

22 Q. All right.

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

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

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

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

7 A. Not with acute limb ischemia.

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

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

13 Q. Is that primarily motor?

14 A. Motor.

15 Q. As opposed to just sensation?

16 A. Motor, yes.

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

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

1 A. Yes.

2 Q. Okay.

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

6 A. Yes.

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

10 A. Yes.

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

13 A. Yes.

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

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

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

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

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

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

3 A. Yes.

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

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

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

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

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

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

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

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

22 MR. WEAVER: Fair enough.

23 Thank you, Your Honor.

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

1 BY MR. WEAVER:

2 Q. Do you see that, Dr. Wilson?

3 A. I see that.

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

6 A. I don't dispute that.

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

13 A. Yes.

14 Q. And --

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

17 THE WITNESS: They were assessed, yes.

18 BY MR. WEAVER:

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

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

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

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

3 A. That's correct.

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

8 A. Yes.

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

13 A. Yes.

14 Q. Why do you hold that opinion?

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

17 Q. And I believe you also told us yesterday
18 when we were talking in the context of Dr. M's
19 opinion there should have been a CTT angiogram, you
20 told us that in your medical judgment on December
21 25th, 2016 there didn't need to be a CT angiogram
22 either, is that correct?

23 A. Yes.

24 Q. Is that for the same reason?

25 A. Yes, they did not have a clinical

1 indication.

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

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

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

13 A. Yes.

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

17 A. Within 5 to 10 days.

18 Q. What do you base that on?

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

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

1 routine appointment.

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

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

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

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

13 A. Yes, I believe it was.

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

20 MR. ARNTZ: Objection.

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

23 THE COURT: That is speculation.

24 That seems to be accurate.

25 The objection is sustained.

1 MR. WEAVER: Okay.

2 THE COURT: Just the basis.

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

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

7 THE COURT: I understand.

8 We had some confusion, so not a problem.

9 BY MR. WEAVER:

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

12 A. Yes.

13 MR. WEAVER: Thank you.

14 I'll pass the questioning for now.

15 THE COURT: All right.

16 Thank you.

17 Mr. McBride, any questions?

18 MR. MC BRIDE: No questions, Your Honor.

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

23 During this roughly 15 minute recess you're
24 admonished.

25 (Jury admonished by the Court.)

1 THE COURT: See you back at 3:20.

2 Jury excused from the courtroom.

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

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

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

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

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

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

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

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

1 Mr. Arntz, anything to add?

2 MR. ARNTZ: No, Your Honor.

3 THE COURT: Mr. Weaver.

4 MR. WEAVER: No, Your Honor.

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

9 There was an objection to the
10 appropriateness of reading testimony.

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

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

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

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

1 the actual testimony and inquire about the opinion.

2 Mr. Arntz, anything to add to that?

3 MR. ARNTZ: No.

4 THE COURT: Mr. Weaver?

5 MR. WEAVER: No, Your Honor.

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

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

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

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

6 But I overruled that objection.

7 Mr. Arntz, anything further on that
8 objection?

9 MR. ARNTZ: No, Your Honor.

10 THE COURT: Anything else, Mr. Weaver?

11 MR. WEAVER: No, Your Honor.

12 THE COURT: All right.

13 When we will come back a little bit before
14 3:25.

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

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

23 Is that acceptable?

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

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

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

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

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

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

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

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

18 MR. P. HYMANSON: Very good.

19 Thank you, Your Honor.

20

21 (Thereupon, a recess was had.)

22

23

24

25

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

3 THE COURT: Anything before we bring the
4 jurors back?

5 MR. ARNTZ: No.

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

8 THE COURT: Okay.

9 MR. MC BRIDE: Real quick.

10 THE COURT: Where are we at?

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

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

23 But then we can see how that goes.

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

1 going to be here Monday, or Tuesday, Wednesday.

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

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

6 MR. MC BRIDE: Yeah.

7 THE COURT: So that takes care of today.

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

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

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

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

20 Frankly, he already got out --

21 THE COURT: Let me interrupt you.

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

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

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

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

5 THE COURT: I understand.

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

9 So it will be Friday night.

10 MR. MC BRIDE: Which is a good point.

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

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

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

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

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

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

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

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

3 MR. MC BRIDE: One is mine, and one is his.
4 Barcay is his, and Shoji is mine in the
5 morning.

6 And then we're --

7 MR. ARNTZ: Shoji's in the morning?

8 MR. MC BRIDE: We're going to put Lasry on
9 for like I said ten minutes of direct, you will have
10 30 minutes at least of cross, I'll have ten minutes
11 on direct, and then we'll go Shoji pretty quick I
12 think, and then if we need to push him partly into
13 the afternoon, we can do that.

14 And then Keith has Barcay.

15 MR. ARNTZ: Four hours?

16 MR. WEAVER: No.

17 I appreciate you have been accommodating to
18 him.

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

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

22 THE COURT: You are making me insane.

23 I have to give some warning to the other
24 department.

25 From my recollection we were talking about

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

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

8 THE COURT: We did.

9 MR. MC BRIDE: Logistically Monday would
10 make sense.

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

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

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

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

20 THE COURT: Yours too?

21 MR. MC BRIDE: Yep.

22 So then we can --

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

25 MR. MC BRIDE: Knock it out then.

1 THE COURT: Then instruct and close on
2 Tuesday?

3 MR. MC BRIDE: Yep.

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

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

8 You are not bringing --

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

12 MR. ARNTZ: And not bringing the nurses?

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

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

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

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

22 They've been pretty on top of it.

23 MR. ARNTZ: Did you say Wiencek?

24 MR. MC BRIDE: I never said that.

25 We introduced he may be a witness.

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

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

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

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

9 THE COURT: Monday in 15-D.

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

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

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

16 THE COURT: Let's get the jurors.

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

3 THE COURT: As we resume with Dr. Wilson.

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

6 THE WITNESS: Yes.

7 THE COURT: Okay.

8 Mr. Arntz.

9 - - - -

10 **CROSS-EXAMINATION OF DR. SAMUEL WILSON**

11 BY MR. ARNTZ:

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

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

20 A. I have.

21 Q. Okay.

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

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

25 Q. Did you read their son's deposition?

1 A. Yes.

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

6 Did you see that?

7 A. Yeah.

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

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

14 Q. Right.

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

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

23 Q. Do you dispute in your report dated August
24 19, 2019 that you said you do have an expertise in
25 the standard of care, and actually gave an opinion on

1 standard of care?

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

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

6 Q. Do you dispute in the report dated August
7 19th, 2019 that you said you do have the ability to
8 testify as to standard of care for an emergency
9 department?

10 A. I don't recall saying that.

11 Maybe you could read it out to me.

12 Q. Okay.

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

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

22 Isn't that a standard of care opinion?

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

25 I don't dispute that at all.

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

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

8 Q. Okay.

9 Let me ask you this:

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

15 A. I do have an opinion.

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

19 Q. Okay.

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

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

3 Q. You said you read his deposition.
4 Did you see that in his deposition?

5 A. You will have to show that to me.
6 I can't recall the line and paragraph, but
7 I'll accept that if you just read that.

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

11 A. I didn't say that.

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

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

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

20 A. Yes.

21 Q. Okay.

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

25 I know counsel have been getting dailies,

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

3 A. I have not seen those.

4 Q. Okay.

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

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

9 THE COURT: Yes.

10 BY MR. ARNTZ:

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

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

17 A. Yes, I did.

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

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

25 I think were splitting hair here.

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

4 A. Yes.

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

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

13 Yes, sometimes they say that.

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

16 Q. Okay.

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

20 A. Radiologists would generally be and MD.

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

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

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

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

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

10 A. I have forgotten what he said.

11 Q. It's right in front of you.

12 A. The --

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

14 THE COURT: Objection?

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

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

21 BY MR. ARNTZ:

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

25 A. Yeah.

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

3 He says, it appears occluded.

4 Correct?

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

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

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

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

22 A. No, I disagree with that.

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

25 A. Yes.

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

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

6 Could you rephrase that, please?

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

12 A. Well, thank you.

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

17 I think I've tried to explain that.

18 Q. Okay.

19 That is a distinction.

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

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

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

3 Number two, a Doppler does not detect
4 pulses.

5 A Doppler defects flow in the artery.

6 Q. Okay.

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

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

15 A. Rephrase it.

16 I am accepting the record as being truthful
17 at entries.

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

20 They entered what they observed, I believe.

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

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

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

12 Is that your question?

13 Q. That's a better question, yeah.

14 A. Actually, it would.

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

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

22 A. Yes.

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

25 Q. Okay.

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

4 A. It is common.

5 Q. It is common?

6 A. Yes.

7 Q. Okay.

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

12 A. Now, which date are we talking about?

13 Q. In November of 2012.

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

16 MR. ARNTZ: Well --

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

20 MR. ARNTZ: Okay.

21 BY MR. ARNTZ:

22 Q. You see from the record up there --

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

24 THE WITNESS: I'm familiar with this.

25

1 BY MR. ARNTZ:

2 Q. Give me a second.

3 You see the highlighted portion?

4 A. I do.

5 Q. And it indicates that excellent blood flow
6 was obtained through the graft?

7 A. Yes.

8 Q. Below the knee.

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

11 A. Yes.

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

15 A. Yes.

16 Q. Okay.

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

20 A. Yes.

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

23 A. In the mid-thigh, yes.

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

1 to get a Doppler pulses.

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

5 A. Between 2012 and 2016?

6 Q. Yes.

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

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

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

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

17 A Doppler doesn't show the pulse.

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

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

1 The Doppler detects flow in your artery.

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

4 A. You would like to see that within hours.

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

7 A. Not necessarily.

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

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

13 A. Was he a radiologist that did an
14 arteriogram?

15 Yes, I remember seeing this one.

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

18 This was two months after the surgery?

19 A. Yes, I see that.

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

23 A. Yes.

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

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

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

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

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

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

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

13 BY MR. ARNTZ:

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

17 A. Yes.

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

23 A. Yes.

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

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

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

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

8 A. Yes.

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

14 A. Yes, of course.

15 I know he lost his leg.

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

21 A. Yes, I think he said that.

22 Q. And you disagree with that?

23 A. It's possible, yes.

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

25 A. Sure.

1 Q. Okay.

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

5 Would you expect that in a person had a --

6 A. I think any pulse you would detect would be
7 called a normal pulse, with the exception of a
8 patient maybe hemorrhaging, but to grade a pulse plus
9 1, plus 2, plus 3, they are very artificial. I've
10 never been able to do that in my practice.

11 I usually note, pulse present.

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

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

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

18 A. I don't grade it that way.

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

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

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

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

8 A. No.

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

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

13 Q. Okay.

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

17 A. No.

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

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

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

1 artery.

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

5 A. You can, yes.

6 Q. Would that be common?

7 A. Not the most common, no.

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

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

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

17 A. Yes.

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

21 A. The profunda primarily.

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

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

1 current thinking is.

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

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

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

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

21 A. I used that in a general sense.

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

1 A. Yes.

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

7 A. Yes.

8 Q. Do you consider smoking an important
9 factor?

10 A. Yes.

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

15 A. Well, they noted it in the history.

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

19 A. Well, that goes without saying.

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

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

1 A. Yes.

2 Q. He had a history of smoking?

3 A. Yes.

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

5 A. Yes.

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

8 A. I don't know.

9 I don't recollect that.

10 Q. That is something they also should have
11 considered?

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

14 High cholesterol's not an emergency.

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

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

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

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

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

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

17 Q. Okay.

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

21 What does that DP stand for?

22 A. Which date is that?

23 Q. November 1st, 2016.

24 A. And go ahead.

25 Q. It said he had normal DP pulses?

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

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

5 A. In 2015?

6 Q. No, November 1st, 2016.

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

8 MR. ARNTZ: That is.

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

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

12 THE WITNESS: Okay.

13 I've got it.

14 BY MR. ARNTZ:

15 Q. You got it?

16 A. This is May 9, 2016.

17 Q. Do you recall the record I'm talking about
18 they brought up to show there were pulses on November
19 1st, 2016?

20 A. Yeah.

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

23 A. Right.

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

1 emergency department?

2 A. Right.

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

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

7 He had back pain, I believe.

8 Q. Right.

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

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

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

14 A. All right.

15 Q. But it said he was on Xarelto?

16 A. Right.

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

19 We talked about the black box warning,
20 correct?

21 A. Right.

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

24 Calls for speculation he was taking it.

25

1 BY MR. ARNTZ:

2 Q. It said in the record, on Xarelto.

3 Do you accept that record as true?

4 A. Yeah.

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

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

11 A. No.

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

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

19 Q. Okay.

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

22 A. Not necessarily.

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

1 Q. So now what you're suggesting I guess is,
2 that a person who went through an experience in
3 November 8, 2012 where he had to have a femoral
4 popliteal because he had no pulses in his foot, was
5 put on Xarelto, has another event in December of
6 2014, they had to break an occlusion, and another one
7 in 2015 they had to do the same thing, you're saying
8 you don't thinkg that person took the prescription of
9 Xarelto seriously?

10 A. I didn't say that.

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

14 A. Not true.

15 I didn't say that.

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

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

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

22 A. That's correct.

23 Q. He's on Xarelto.

24 He has normal pulses present, correct?

25 A. Palpable pulses, yes.

1 Q. It says, normal pulses.

2 I don't know it said palpable?

3 A. Okay.

4 I'll accept that.

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

10 A. That's correct.

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

13 A. Fairly familiar, yes.

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

16 A. Yes.

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

19 A. It would be a very advanced case.

20 I'm not sure that is typical at all.

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

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

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

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

6 A. Yes.

7 Q. The kind brought on by alcohol, correct?

8 A. Yeah.

9 Q. Alcoholic neuropathy.

10 Are you familiar with the neuropathy
11 brought on by chemotherapy?

12 A. Yes.

13 Q. And there's idiopathic.

14 What that means is?

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

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

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

24 Q. I guess my question is:

25 Do you have some source of knowledge or

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

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

6 Q. Okay.

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

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

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

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

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

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

24 Q. Okay.

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

1 emergency room commenting on his use of a cane.

2 Q. Let me change gears a little bit.

3 You -- Are you currently retiring from
4 academia?

5 A. Yes.

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

8 A. Yes.

9 Q. How long has that process been going on?

10 A. About a year.

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

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

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

21 Q. You have been in academia since when?

22 A. I --

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

25 A. Yes.

1 Q. How long have you been doing that?

2 A. I was appointed to the faculty at UCLA in
3 1972.

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

7 A. Yes.

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

10 A. It's just Latin.

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

13 You must have over 2,000 articles in here?

14 A. No, 500.

15 Q. Really?

16 A. Not counting book chapters.

17 Q. Only one category, I see.

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

20 Q. One category I see 373.

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

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

1 A. Okay.

2 Q. I guess my question is:

3 Is this all the things you have done since
4 1972, or did you even go back beyond 1972?

5 A. There's about maybe ten that go back before
6 '72 I did when I was in training.

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

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

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

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

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

21 A. I would be estimating at maybe 20 percent.

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

25 A. Yeah.

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

3 A. Yes.

4 Q. How much to you charge to be here?

5 A. For this I charge \$5,000.

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

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

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

13 I left Los Angeles, I left my home on
14 Tuesday morning at 5:30 a.m., and this is Thursday at
15 4:20, and I'm still here.

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

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

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

23 Q. Okay.

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

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

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

5 A. Ordinarily.

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

8 A. How much?

9 Q. \$15,000?

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

12 I don't know what will happen.

13 I'm concerned.

14 Q. Okay.

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

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

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

20 Q. Okay.

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

25 A. Not on the 28th.

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

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

7 A. Yes.

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

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

12 A. Yes.

13 Q. And were they successful with that?

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

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

20 A. For TPA?

21 Q. Yes.

22 A. No.

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

25 So there's no blood flowing at that point.

1 Q. Okay.

2 The treatment that was rendered at the time
3 of the amputation during that stay started on the
4 28th, would you say that was necessary as a result of
5 the condition?

6 A. The amputation?

7 Q. Yes.

8 A. Yes, it was necessary.

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

12 A. I missed that.

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

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

19 Q. Because the thrombolytic in it?

20 A. Yes.

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

23 A. Before the amputation, or all together?

24 Q. The whole time.

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

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

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

5 A. Yeah.

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

9 A. Yes.

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

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

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

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

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

25 A. That is in?

1 Q. Stages, stages 1, 2 and 3?

2 A. Yeah.

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

5 A. Yeah.

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

8 A. I am.

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

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

13 A. Yes.

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

16 A. Yes.

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

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

22 What does that mean?

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

25 Q. There may be numbness the toes minimal or

1 none, correct?

2 A. Yeah.

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

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

7 A. Yes.

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

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

10 Q. Do you not agree with this staging system?

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

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

15 A. Yeah, I think these are a little contrived,
16 but an inaudible signal would put the patient into a
17 3-B in my estimation because an inaudible signal is
18 really very advanced.

19 Q. 3-B or 2-B?

20 A. 2-B.

21 Sorry.

22 Q. Okay.

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

1 A. Possibly.

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

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

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

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

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

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

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

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

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

24 A. Yes.

25 Q. Okay.

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

4 A. Yes.

5 Q. And initially the graft in 2012.

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

9 A. I'm not aware of that discussion.

10 Q. Would you agree that that is sound advice?

11 A. Now, what exactly is the advice, if he has
12 --

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

17 A. Well, I think that is okay.

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

20 A. Yeah.

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

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

25 A. I suppose you could say, it bothered him

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

3 Q. Did you see --

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

7 It's an impossible question to answer.

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

12 MR. WEAVER: Objection, Your Honor.

13 He asked him to speculate in the first
14 place.

15 THE COURT: You are asking him to
16 speculate.

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

19 I think he's speculating right now.

20 THE COURT: Clarify the question.

21 Sustained.

22 BY MR. ARNTZ:

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

1 have thought the number of patients was less, right?

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

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

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

12 Who said that?

13 Q. You just said that.

14 A. All right.

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

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

18 I think he simply said, it happened.

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

21 A. Yes.

22 Q. Okay.

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

1 concern of another occlusion in his artery?

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

5 Q. That's not my question.

6 My question was:

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

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

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

16 A. No.

17 Q. Okay --

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

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

22 THE COURT: Folks, I'm sorry.

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

25

1 THE COURT: Thank you.

2 Mr. Arntz, whenever you ready.

3 Thank you.

4 BY MR. ARNTZ:

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

7 This is the record from 12/25/2016.

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

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

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

16 A. Yes.

17 Q. Okay.

18 Do you treat individuals with chronic
19 occlusions?

20 A. Yes.

21 Q. And how do you treat them?

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

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

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

6 That's conservative management.

7 Q. And then what is more aggressive?

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

15 Q. And claudication is another word for pain?

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

18 Q. Okay.

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

23 A. Right.

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

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

4 A. Up until just a few years ago --

5 Q. So --

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

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

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

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

15 A. If I would have been on call.

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

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

22 Q. Would you do a physical examination of him?

23 A. If I was called in?

24 Q. Yes, sir.

25 A. If I came in, yes.

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

5 A. Yes.

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

7 A. Right.

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

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

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

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

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

18 MR. ARNTZ: Okay.

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

21 THE COURT: That's fine.

22 BY MR. ARNTZ:

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

25 A. I would have listened to the arteries in

1 the foot, yes.

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

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

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

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

16 A. Well, that would be a totally different
17 picture if there wasn't blood flow because the foot
18 would be very different, would be as it was on the
19 28th.

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

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

3 A. No.

4 They are two totally different signals.

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

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

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

16 A. Yes.

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

20 A. I don't think so.

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

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

25 Q. Okay.

1 Let's talk about --

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

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

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

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

10 Q. Do you generally adhere to those standards?

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

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

16 A. Yes.

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

19 A. Yes.

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

22 A. Right.

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

1 you're looking at a patient?

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

6 Inaudible signal really signifies advanced
7 ischemia.

8 Q. Okay.

9 So let's just focus on 2-A, but let's do it
10 the way you said, and if there's no difference in the
11 audible signal from the Doppler, that would put it in
12 a category where it's marginally threatened,
13 salvageable if promptly treated.

14 You agree with that?

15 A. So if there's a signal, I would leave it at
16 2-A.

17 Q. Isn't that what your inference is?

18 A. If it's marginally threatened, salvageable
19 if promptly treated, I don't know what promptly means
20 in this. I expect they mean, maybe a week or so you
21 bring the patient in for surgery, and he had an
22 audible signal.

23 Yeah, I would leave that as a 2-A.

24 Q. All right.

25 I don't mean to be argumentative with you,

1 but the words marginally threatened and salvageable
2 if promptly treated, those words to you suggest you
3 could wait a week to treat him?

4 A. Well, what does marginally threatened mean,
5 and what does threatened mean?

6 This is a very subjective description.

7 Q. These are classifications you said you
8 accept.

9 Are you telling me you don't know what the
10 words marginally threatened mean?

11 A. I don't know what they mean by marginally
12 threatened.

13 I'd have to read the whole article to
14 figure out what is going on here.

15 Q. What you don't see in this classification
16 of acute limb ischemia is 1 and 2-A, you don't see
17 actually in 3 or 2-B, you don't see any reference to
18 extreme pain, do you?

19 A. Well, that's not a category.

20 It a very simple table.

21 It's not a category, it's in the table.

22 Q. It does talk about sensory issues though?

23 A. Sensory loss?

24 Q. Right.

25 A. I think by the way that is not as important

1 as a description of pain.

2 I would do it differently if I were writing
3 the book.

4 Q. I got that.

5 A. I actually have.

6 Q. So if -- Let's say you have somebody in
7 2-B, what is immediately threatened, salvageable if
8 immediately -- What does revascularized mean?

9 A. That is acute ischemia.

10 Q. And that is where you have toes associated
11 with pain, and the rest they are talking about pain,
12 correct?

13 A. Now we got pain, yep.

14 Q. And the muscle weakness is mild or
15 moderate?

16 A. Yes.

17 Q. Certainly there was some evidence he had
18 muscle weakness, he was using a cane and had spasming
19 in his calf?

20 MR. WEAVER: Excuse me, Your Honor.

21 That lacks foundation.

22 There's been no evidence in the record he
23 had pain.

24 THE COURT: Well --

25 MR. ARNTZ: There's evidence in the record,

1 maybe not in this medical record.

2 BY MR. ARNTZ:

3 Q. But he testified he used a cane and a
4 wheelchair from time to time, correct?

5 A. Yes.

6 Q. So if we put him into that category, you
7 would at least go and do another ultrasound of his
8 arteries, wouldn't you?

9 A. If he was in -- or had the description of
10 2-B, yes, I would do an ultrasound.

11 Q. Would you admit him?

12 A. It depends on the amount of pain he had and
13 the changes in his foot, the skin.

14 But if all of these are true, if he has an
15 inaudible Doppler signal, I would get imaging and
16 most likely admit the patient.

17 Q. Okay.

18 The differential diagnoses by practitioner
19 are important, aren't they?

20 A. Yes.

21 Q. And explain for the jury what a
22 differential diagnosis is.

23 A. That is a list of things that you think
24 maybe the diagnosis -- and generally listed from what
25 you think is the most likely diagnosis to the least

1 likely diagnosis.

2 Q. Did you happen to read Dr. Barcay's
3 report?

4 A. His letter?

5 Q. Yes.

6 A. Yes.

7 Q. You saw in there he came in with pain to
8 the emergency room department, he came in with pain
9 at a fem pop graft appeared occluded, was given
10 Percocet in the emergency department for the
11 treatment of pain, do you remember that from the
12 record?

13 A. I can't remember specifically, but I'll
14 accept your recitation of it.

15 Q. And Percocet is a pretty strong narcotic
16 for treatment of pain, isn't it?

17 A. Yes.

18 Q. So if he comes into the emergency room
19 complaining of pain of intensity level of 7, but is
20 given Percocet, you would expect that pain to
21 diminish, wouldn't you?

22 A. Not really because he had been chronically
23 taking even Oxycodone, which is pretty strong.

24 Q. Do you know whether he had taken any that
25 day?

1 A. No.

2 Q. So they go, and they do a differential
3 diagnosis, deep vein thrombosis, /S-RT right sprain or
4 strain, right?

5 A. All right.

6 Q. I believe Mr. Dr. Barcay misinterpreted
7 this record because he also included the arterial
8 occlusion area, peripheral arterial disease.

9 Can you see they didn't include that in
10 their differential diagnosis, did they?

11 A. The diagnosis 1 and 2 are I think from the
12 past history.

13 Q. That's what I think too.

14 It says 6/27/2015?

15 A. Yeah.

16 Q. So those have been prior differential
17 diagnoses?

18 A. Right.

19 Q. Of that?

20 A. Right.

21 Q. And yet in the differential diagnosis that
22 Nurse Practitioner Bartmus and Dr. Lasry created they
23 didn't include close in the differential diagnosis?

24 A. Okay.

25 Q. And you think that is okay, even though

1 there was an ultrasound showing an occlusion in the
2 artery?

3 A. Yes, because he didn't have signs and
4 symptoms that would lead you to believe that was the
5 current problem.

6 He certainly had artery disease.

7 I don't believe the time they examined him
8 that the arterial occlusion was acute, so --

9 Q. You didn't really know at that point, did
10 you?

11 I mean, on December 21st, four days
12 earlier, he had none of those symptoms, he didn't
13 have any complaints that lead anybody to believe he
14 should go to the emergency room, this is all things
15 he's been through before, so are you saying that even
16 in light of that fact there have been four days, and
17 this developed in that time period, that is not
18 acute?

19 MR. WEAVER: Objection, Your Honor.

20 It's quadruple compound.

21 THE COURT: It is multiple compound.

22 I'll sustain.

23

24

25

1 BY MR. ARNTZ:

2 Q. But you understand the foundation I laid
3 for that regarding the examination on the 21st of
4 December?

5 MR. WEAVER: It's still quadruple compound.

6 THE COURT: I don't think that is correct,
7 Mr. Arntz.

8 If you want to break it down or something,
9 but you're asking many compound questions.

10 MR. ARNTZ: I'm trying to get through this,
11 Your Honor.

12 THE WITNESS: I appreciate that.

13 THE COURT: Change a few things.

14 BY MR. ARNTZ:

15 Q. Do you recall Mr. Moore was seen on
16 December 21st, 2016, four days before he went into
17 the emergency department?

18 A. At the pain management clinic, yes.

19 Q. And at that time he didn't say any signs or
20 symptoms to that practioner he was having an acute
21 ischemic event, did he?

22 A. No, he reported pain in his legs, but he
23 didn't say, I have an acute arterial event.

24 Q. He reported pain in his ankle?

25 A. Yes.

1 Q. And they apparently took a pulse and found
2 one?

3 A. I think so, yes.

4 Q. And within four days he had taken himself
5 because of a concern he had over an arterial problem
6 to the emergency department, right?

7 MR. WEAVER: Lack of foundation.

8 THE COURT: Sustained.

9 BY MR. ARNTZ:

10 Q. The note I read to you just a minute ago
11 says, he had a concern for his leg, and that is the
12 reason he was there, didn't it?

13 MR. WEAVER: Again, Your Honor, that lacks
14 foundation it was an arterial problem.

15 That --

16 THE COURT: You want to put the note up and
17 see what that description is, get that clarification?

18 MR. ARNTZ: These are things everybody
19 heard.

20 I'm trying to get through it.

21 THE COURT: Mr. Arntz, put up the document
22 and show the information.

23

24

25

1 BY MR. ARNTZ:

2 Q. Again, this is the report that comes in
3 with, reports left calf pain since yesterday, felt
4 like spasming, that's a sign, isn't it, a symptom
5 that could lead to the conclusion he has a problem
6 with an artery?

7 A. See, as I read that it says, but reports he
8 has a history of DVT in the leg, and became
9 concerned, and I read that as becoming concerned that
10 he hasn't had a recurrent DVT in the leg.

11 Q. Fair enough.

12 And my own expert said, it was appropriate
13 to do an ultrasound to rule out DVT, but in the
14 process of doing that ultrasound they found evidence
15 of an occlusion in the artery?

16 A. Yes.

17 Q. And so knowing that he had previous
18 occlusions in the artery, and that was evident,
19 wasn't it, by the note of 6/25 where we talk about
20 the different diagnoses, and that treatment took
21 place in June of 2015?

22 A. Yes.

23 Q. That showed he had a history of arterial
24 occlusion, correct?

25 A. Yeah.

1 Q. So we have a person coming in with this
2 concern and that finding from ultrasound, and without
3 more would you have sent him home?

4 A. Well, if he had related to me the condition
5 of his extremity as was noted in the chart, and if
6 that had been related to me that he had no deep vein
7 thrombosis, and he had a graft that looked like it
8 was occluded again, but he didn't have symptoms or
9 signs of acute ischemia.

10 I would review that as a chronic condition,
11 and I think I would probably have said, given the
12 preamble I've said, let me see him in the office and
13 see what is going on.

14 If he had said that he's got signs of acute
15 ischemia, his foot is cold, he's got pain in the
16 toes, can't dorsiflex his foot, you know, I'd be in
17 to take care of that, yeah.

18 Q. So if they called you and said, he
19 presented with a concern about his leg, he has a
20 history of acute arterial disease, he's had previous
21 occlusions, and by the way we have an ultrasound
22 shows an arterial occlusion, you wouldn't even come
23 to the hospital?

24 A. It would depend on his condition.

25 If his extremity had the signs and symptoms

1 of normal circulation, what would be the point of
2 rushing into the hospital?

3 You are not going to do anything.

4 Q. You named a couple of things, you would
5 have done the -- already you said you would have done
6 a Doppler of his artery?

7 A. I wouldn't have changed anything.

8 I would have heard audibles, given the
9 signs and symptoms reported by Dr. Lasry and Nurse
10 Practitioner.

11 Q. Again, your entire opinion is based on
12 whether or not they actually did that pulse test,
13 isn't it?

14 A. You're absolutely right.

15 Q. You would agree with me, wouldn't you, if
16 Dr. Lasry failed to actually put his hands on Mr.
17 Moore and examine him, that would be below the
18 standard of care?

19 A. If Dr. Lasry had not examined him, that
20 would.

21 I'm not going to comment on emergency
22 medicine standards of care, but I would expect Dr.
23 Lasry in the ordinary treatment of the patient would
24 do that.

25 Q. You certainly would not have been able to

1 make the statement you made in the last question if
2 you accept all those records as true, if in fact you
3 had reason to suspect he had not put his hands on him
4 and tested his pulse?

5 A. I don't have any reason to expect he didn't
6 put his hands on him.

7 Q. Would you agree with me that the same would
8 be true for Nurse Practitioner Bartmus, if she
9 represents in the record she did a physical exam, and
10 actually hadn't, that would be below the standard of
11 care?

12 A. Yeah.

13 Q. In fact, that would be beyond the standard
14 of below the standard of care, would be a violation
15 of their oath as practitioners, wouldn't it?

16 A. Yeah.

17 Q. Creating a fraudulent record?

18 A. That's right.

19 Q. I'm skipping through a lot of stuff, so I
20 I'm winding down.

21 What are the surgical options for someone
22 who has an occluded artery?

23 And I'll ask you next if they differ based
24 on whether it's chronic or acute, the surgical
25 options for an occluded artery?

1 A. For with acute ischemia?

2 Q. Let's start with acute ischemia.

3 A. With acute ischemia.

4 Surgical options would be to extract the
5 clot using a type of balloon catheter, and try to
6 restore flow that way.

7 It's not particularly successful.

8 So today we generally go for lysis first
9 with an attempt to dissolve the clot.

10 Q. Is a surgical thrombectomy an option?

11 A. Yes.

12 Q. Okay.

13 How about re-grafting it?

14 A. That's possibly an option, yes, you could
15 put in a second graft, but if your first graft is not
16 functioning, then the second graft is a very poor
17 prognosis.

18 Q. When you say, a secondary graft, what do
19 you mean?

20 A. If you put in a second by-pass.

21 Q. Okay.

22 I think you actually wrote an article many
23 years ago on using a profunda to create a secondary
24 graft?

25 A. Yes, made a movie of it.

1 Q. Is that something still an option?

2 A. Unfortunately, it hasn't been practiced
3 widely, but it is an option, and it's sometimes
4 appropriate.

5 What you would do is, take the graft off
6 the profunda to avoid re-operating on a previously
7 dissected area.

8 Q. You testified that your opinion is, he
9 would have lost his leg regardless, and I'm assuming
10 that opinion is based on -- or an assumption on my
11 part, you wouldn't have admitted him on the 25th?

12 A. Given the record in the chart, no.

13 Q. If you had admitted him on the 25th, do you
14 have an opinion whether he would have lost his leg
15 anyway?

16 A. I think he was destined to lose that leg
17 because of continual progression of disease.

18 I think he was developing end stage
19 disease, wasn't going to be corrected other than
20 temporarily.

21 Q. So previously you testified that that could
22 have been a number of months, could have been a year
23 or more, correct?

24 A. Yes.

25 Q. And importantly, it also may have involved

1 a different type of amputation, wouldn't it?

2 A. Possibly.

3 Q. Might have been below the knee?

4 A. It could have been.

5 Q. So him not getting admitted on the 25th
6 possibly created a loss of chance on his part to have
7 a successful treatment and have a longer period of
8 time with his leg, correct?

9 A. What was done?

10 I mean, under what circumstances?

11 Q. If he's admitted, and they are treating him
12 with TPA, or treating him with something to break up
13 that clot, and if successful, that chance could keep
14 his leg longer was lost by not being admitted?

15 A. If it were to be successful, and they
16 opened up the graft, and there was flow through the
17 graft, he would have retained his extremity for a
18 longer period of time.

19 Q. At the very least had he not retained it
20 forever, he would end up having amputation, he lost
21 the chance to have on amputation below the knee?

22 A. I can't say that because of the unusual
23 anatomy he had, not having an internal iliac artery,
24 and then having a profunda that was compromised.

25

1 Q. So my question is, not whether he would
2 have had a different outcome.

3 My question is:

4 Did he lose the chance to have a different
5 outcome by not being admitted on the 25th?

6 A. I --

7 MR. WEAVER: Speculation, Your Honor.

8 THE COURT: Overruled.

9 THE WITNESS: I don't think so.

10 BY MR. ARNTZ:

11 Q. So even if he been admitted on that day in
12 December of 2016, December 25th, even getting
13 admitted that day, he's still going to lose his leg
14 above the knee?

15 A. Well, I can't really answer that.

16 What I can say is, the disease was
17 progressive, and he would eventually have had an
18 amputation no matter what was done on the 25th.

19 Q. But it could have been years later,
20 correct?

21 A. It would have been shorter than that.

22 Q. Well, you said -- earlier you said, a year.
23 Are you saying, it's only a year?

24 A. Probably a year because let's say he been
25 admitted the 25th, they opened up his graft, and

1 marginally improved circulation, it would have
2 clotted soon thereafter as it had done two previous
3 occasion.

4 Each time it clots the situation is worse,
5 inevitably will lead to an amputation.

6 Whether it's above the knee or below the
7 knee, I can't tell you.

8 Q. But those were chances he lost by not
9 getting admitted that day?

10 A. You're asking me -- Let's say he been
11 admitted that day.

12 The admission doctors would have examined
13 him, said, well, his leg's okay, let's not do
14 anything.

15 Q. You're speculating that is what would have
16 happened?

17 MR. WEAVER: Well, Your Honor, he's asking
18 him to speculate.

19 THE COURT: Yes.

20 Sustained.

21 Agree.

22 He may finish his answer.

23 BY MR. ARNTZ:

24 Q. Are you done?

25 A. I finished, yeah.

1 Q. That is based on rank speculation, isn't
2 it, that that is what health care providers that --

3 THE COURT: What is the objection?

4 MR. WEAVER: Speculation.

5 THE COURT: He was with the phrasing of the
6 question.

7 Now, the fact it's already admitted,
8 sustained.

9 BY MR. ARNTZ:

10 Q. That is based on speculation as to what
11 they would have done, isn't it?

12 A. No, it's based on my knowledge of vascular
13 surgery what would have been done.

14 Q. It's at least based on a present assumption
15 they wouldn't have called a cardio-vascular surgeon,
16 isn't it?

17 A. No -- Well, here's what I think:

18 I think he didn't have an indication to be
19 admitted to the hospital on the 25th.

20 I think he didn't have an indication for a
21 vascular consultation on an emergency basis.

22 He did have an indication to be followed up
23 with his vascular surgeon and primary care doctor.

24 So whether or not he's been admitted to the
25 hospital, that's encouraging me to speculate.

1 I can't tell what would have happened.

2 Q. And that conclusion is based on the fact he
3 didn't do a full arterial ultrasound, right?

4 A. Right.

5 Q. And a full arterial ultrasound could have
6 done other arteries besides just the grafts, right?

7 A. Right.

8 Q. So we don't know if there were clots in the
9 profunda at that moment, but if there had been clots
10 in the profunda at that moment, plus the clot in the
11 graft, wouldn't you have admitted him?

12 A. If I had known all of that information,
13 probably because if that had existed at that time,
14 his signs and symptoms would have been much worse
15 pointing towards an admission.

16 MR. ARNTZ: That's all I have.

17 THE COURT: Mr. Weaver, anything on
18 redirect?

19 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

1 jury, unless we have an objection, the attorneys will
2 follow-up.

3 I'm not at liberty to explain any of this
4 information, simply read the questions exactly as
5 they are written, and you --

6 THE WITNESS: Can I have a piece paper to
7 write down?

8 THE COURT: I'm not going to ask them all
9 at once, one at a time.

10 If you would like to see the papers, you
11 can see them.

12 THE WITNESS: No, that's okay.

13 THE COURT: What is your definition of a,
14 quote, palpable pulse, and is that definition
15 different from a pulse described as, quote, normal?

16 If so, how is it different?

17 THE WITNESS: Okay.

18 A palpable pulse is the sensation of
19 pulsation that you feel when you put your hand over
20 an artery.

21 It requires a certain minimal blood
22 pressure for you to feel that pulse.

23 And ordinarily it would be over a hundred,
24 depending on whether if the artery's got a lot of
25 calcification, as in a diabetic pressure would need

1 to be higher to feel the pulse.

2 The second part of the question was?

3 THE COURT: I have to read the question
4 exactly as written.

5 What is your definition of a palpable
6 pulse, and is that definition different from a pulse
7 that is described as normal?

8 If so, how is it different?

9 THE WITNESS: A palpable pulse, if you can
10 feel it, is generally considered normal.

11 Some physicians will grade it and say,
12 well, it's not very strong.

13 Others will say, it's very, very strong.

14 To me, a normal pulse in most circumstances
15 is if you feel it, and you can hold your finger up to
16 your radial artery right now, and you can feel your
17 pulse.

18 I think that covers it.

19 If the questioner wants to follow-up --

20 THE COURT: I just indicated, I'm not at
21 liberty, nor they, to supplement the question.

22 After you answered the question, there's
23 plenty more by the way, I will then give counsel the
24 opportunity to follow-up.

25 THE WITNESS: Okay.

1 THE COURT: If you have more to give the
2 jurors, that is fine.

3 THE WITNESS: No, I think we've covered
4 what a pulse is.

5 THE COURT: Next question.

6 In your experience is there a medical
7 decision between the term, appear, and, possible
8 appear, and possible in quotes, with regard to a
9 medical condition?

10 THE WITNESS: Yes, there's some difference.

11 Appears to me means that the technician or
12 radiologist looking at it thinks it's occluded, but
13 not completely sure.

14 Possible means that, you know, this could
15 be occluded, but I'm not completely sure.

16 So I think they are very close in meaning.

17 I wouldn't parse it anymore than that.

18 THE COURT: Okay.

19 Would an ultrasound be performed with a
20 knee-high sock on, would a knee-high sock be
21 instructed to be left off until post ultrasound
22 examination was complete?

23 THE WITNESS: The answer to that is:

24 You wouldn't do an ultrasound with the sock
25 on, and you would leave the sock off until you finish

1 the ultrasound exam.

2 THE COURT: Dr. Wilson, in any occlusion in
3 the major arteries, and grafts are collateral, the
4 best system, the last resort, is to get adequate
5 blood flow to lower extremities?

6 THE WITNESS: Yes.

7 THE COURT: Dr. Wilson, is it possible
8 following a fem pop graft to have palpable pulses at
9 one hospital visit, require a Doppler at the next
10 visit to defect blood flow, and be able to have
11 palpable pulses at any subsequent visit?

12 THE WITNESS: Of course.

13 If you go into a very cold examining room,
14 your pulses, your arteries, will constrict, and it's
15 very difficult to feel a pulse.

16 If you go into a warm room like this one, a
17 hot room, then your arteries will dilate.

18 If you come out of the shower for example,
19 you are flushed, blood is circulating, the heat has
20 dilated all your arteries, and you are sure to feel a
21 pulse.

22 It will vary between examiners.

23 Dr. Lasry could feel a pulse, and I would
24 go there and maybe not, so sure, or vice versa, and
25 you if see doctors clustered around a patient trying

1 to determine, do you feel it or not.

2 So yes, you could feel a pulse at certain
3 times and be absent in other times, absolutely.

4 THE COURT: Can an artery be chronically
5 occluded for decades, or how long can an artery be
6 chronically occluded before it turns into an acute
7 occlusion?

8 THE WITNESS: An artery can be chronically
9 occluded for decades.

10 In fact, Mr. Moore's right femoral artery
11 has been chronically occluded since 2012, that is
12 eight years, not a decade, probably occluded before
13 then, but it hasn't at this point progressed.

14 And if Mr. Moore takes an oath to avoid
15 tobacco, to keep his cholesterol fine, his
16 hypertension down, and treat it with Xarelto, it may
17 never give him acute occlusion.

18 But that I don't have a crystal ball to
19 look into it.

20 THE COURT: Would there be a difference in
21 diagnostics, and/or treatment for occlusion in major
22 arteries, or in native arteries, versus by-pass
23 grafts?

24 THE WITNESS: Not really, there wouldn't be
25 a difference in evaluation.

1 The difference here was that the graft had
2 been included two previous times since it had been
3 placed, that is the difference.

4 And with the chronic occlusion your big job
5 is to determine is this limb viable right now or is
6 it not, and if it's not, we got to do something.

7 And if it's viable, even though the graft
8 is occluded, you decide is this something where
9 collaterals are providing sufficient circulation to
10 keep the leg alive, and if it is, that could be a
11 stable situation, we call that stable claudication
12 where the patient has symptoms of chronic occlusion,
13 but is able to battle through life and get the things
14 he needs to do done.

15 THE COURT: With an apparent occlusion on
16 12/25/16, could Mr. Moore have been instructed to
17 take more milligrams of Xarelto for a greater effect,
18 so to help free the occlusion?

19 THE WITNESS: No.

20 THE COURT: And --

21 THE WITNESS: The reason is, it would
22 reduce bleeding to his brain or some other site.

23 THE COURT: Could Mr. Moore have been given
24 a more potent blood thinner or other medication,
25 either in the ER, or prescribed from the -- I'm

1 sorry, Juror Number 7, let me start again.

2 Could Mr. Moore have been given a more
3 potent blood thinner or other medication, either in
4 the ER, or prescribed from ER, to help free the
5 parent occlusion?

6 THE WITNESS: Blood thinners such as
7 Xarelto, or more commonly often Coumadin, you have
8 heard of would not affect the clot at all. Those are
9 given to prevent extension of a clot.

10 So if the patient has acute ischemia, we
11 would generally give an intravenous Heparin that goes
12 to work right away and prevents extension of an
13 ongoing clotting process.

14 So I believe, if I can say this without
15 getting in trouble, I believe that the clot had been
16 there for some period of time because it couldn't --
17 or wasn't able to be dissolved on the 28th, which
18 suggests to me it was an organized adherent clot.

19 Otherwise, you would have had the same
20 result on the 28th as they had maybe prior years.

21 THE COURT: Okay.

22 THE WITNESS: So no, blood thinners would
23 not have affected the outcome.

24 THE COURT: All right.

25 Mr. Weaver.

1 MR. WEAVER: No questions, Your Honor.

2 THE COURT: No follow-up?

3 Mr. Arntz.

4 MR. ARNTZ: I got a couple.

5 - - - -

6 **RECROSS-EXAMINATION OF DR. SAMUEL WILSON**

7 BY MR. ARNTZ:

8 Q. With respect to the folks, are you aware
9 Dr. Lastry would have testified -- Dr. Lasry
10 testified the pulses would have been diminished, and
11 Nurse Practitioner Bartmus said the pulse was normal,
12 do you make a distinction between those two?

13 A. I accept Dr. Lasry's comment, and if that's
14 how he grades the pulses, that's fine.

15 In my purposes of, if there's a pulse
16 present, that means that there's arterial pressure,
17 arterial flow, and that is satisfactory.

18 Q. Are you aware Mr. Moore has testified, and
19 will testify here, the only time he was instructed to
20 take his sock off was during the ultrasound?

21 A. I believe that came out in one of the
22 depositions that that was said in one of the
23 depositions.

24 Q. And you just testified that the -- an
25 occlusion can be chronic and be there for decades,

1 and specifically said, the one in his right thigh --

2 A. Yes.

3 Q. -- has been there for eight years, but you
4 also said that -- well, then in the same question you
5 said, it hasn't progress, but your overall
6 perspective of this disease is, it's progressive,
7 right?

8 A. It has hasn't progressed to acute ischemia
9 yet, but no doubt it's progressing.

10 MR. ARNTZ: Okay.

11 THE COURT: Is that all?

12 MR. ARNTZ: Yes.

13 THE COURT: Doctor, that completes your
14 testimony at that time.

15 Thank you.

16 THE WITNESS: Thank you.

17 THE COURT: All right.

18 Ladies and gentlemen of the jury, we're
19 going to take our overnight recess.

20 Thank you for your patience by the way.

21 We went longer than expected today.

22 You will be returning tomorrow morning at
23 9:00 a.m. here in this courtroom, and we may have a
24 different location at some point, but tomorrow
25 morning we'll start here.

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(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.)

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REPORTER'S CERTIFICATE

I, Bill Nelson, a Certified Court Reporter
in and for the State of Nevada, hereby certify that
pursuant to NRS 2398.030 I have not included the
Social Security number of any person within this
document.

I further Certify that I am not a relative
or employee of any party involved in said action, not
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_____/s/ Bill Nelson_____

Bill Nelson, RMR, CCR 191

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) SS .

I, Bill Nelson, RMR, CCR 191, do hereby
certify that I reported the foregoing proceedings;
that the same is true and correct as reflected by my
original machine shorthand notes taken at said time
and place.

/s/ Bill Nelson

Bill Nelson, RMR, CCR 191
Certified Court Reporter
Las Vegas, Nevada

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TRAN

IN THE EIGHTH JUDICIAL DISTRICT COURT
CLARK COUNTY, NEVADA

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

JURY TRIAL
Before the Honorable Kathleen Delaney
Thursday, February 6, 2020, 1:30 p.m.
Reporter's Transcript of Proceedings

REPORTED BY:

BILL NELSON, RMR, CCR #191
CERTIFIED COURT REPORTER

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APPEARANCES:

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I N D E X

WITNESS	DR	CR	RDR	RCR
Dr. Samuel Wilson	6	77	151	159

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Las Vegas, Nevada, Thursday, February 6, 2020

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(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.

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

3 THE COURT: Welcome back, ladies and
4 gentlemen.

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

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

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

13 THE WITNESS: I am, yes.

14 THE COURT: Thank you.

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

18 THE COURT: Okay.

19 They will admitted.

20 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

1 perform non-traumatic amputations?

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

4 Q. Why is that?

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

11 But orthopedic surgeons also do quite a
12 number of amputations.

13 Q. What about general surgeons?

14 A. Traumatic amputations they would complete
15 for example.

16 Q. And --

17 A. Not as many as vascular or orthopedic.

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

20 A. I have performed many amputations, yes.

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

24 A. General surgery since 1971.

25 I finished my residency in 1970.

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

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

5 Q. And do you presently have any academic
6 appointments?

7 A. Yes.

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

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

15 A. Yes.

16 Q. Are they teaching institutions?

17 A. Yes.

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

20 A. 1992.

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

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

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

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

5 A. Yes.

6 Q. What did that consist of?

7 A. Well, for quite a number of years I was
8 chief of surgery at our local VA Long Beach because
9 we had an integrated residency program, our residents
10 went there, and I retired from VA after approximately
11 50 years of service, so I retired from VA two years
12 ago.

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

15 A. Yes.

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

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

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

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

1 teach residents.

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

4 Q. What does didactic mean?

5 A. Where you expound your knowledge to the
6 students.

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

10 Q. Okay.

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

14 A. Yes.

15 Q. Who else if anyone do you teach?

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

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

23 Q. Do you treat patients still?

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

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

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

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

10 Q. And what is a vascular clinic?

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

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

16 A. I think so, yeah.

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

20 A. Yes.

21 I would term it more as an editor, since
22 you don't write the entire book, but you write
23 contributions from people who may have for example
24 more expertise in an area than you do.

25 Q. And roughly how many medical textbooks or

1 medical treatises are you the editor or co-editor of
2 roughly?

3 A. At least a dozen.

4 Q. And have you contributed more than a
5 hundred chapters to other people's medical textbooks
6 or medical treatises regarding vascular surgery or
7 vascular disease?

8 A. Yes.

9 Q. What would be the best estimate of the
10 number of peer-reviewed articles in vascular surgery
11 and vascular disease you have written?

12 A. It's close to 500, if not 500.

13 Q. And are those in peer-review journals?

14 A. Probably 90 percent.

15 Q. What does it mean to have an article that
16 is peer-reviewed?

17 A. That means that the manuscript you send in
18 for publication in that journal has been sent out,
19 usually anonymously, so the reviewers, independent
20 reviewers, usually three will read your manuscript
21 and make a decision of whether or not it's of quality
22 where it should be published in a journal.

23 Q. And in addition to contributing to hundreds
24 of peer-reviewed journals, have you been a regular or
25 occasional reviewer of a dozen or more medical

1 journals yourself?

2 A. Yeah.

3 I continue to review articles for
4 publications.

5 Q. And I'm almost finished on the credentials
6 part.

7 But have you also received recognition for
8 having some of the most influential articles in
9 vascular surgery and vascular disease?

10 A. I have.

11 Q. And what is that?

12 A. Very nice of you to bring that up.

13 Of most of the 50 most influential articles
14 in vascular surgery I've been I'll say co-author on
15 two of them, and I was very pleased to see that.

16 As you begin to end your career at least
17 you can look back on see changes that you have made
18 and been very important in people's lives.

19 Q. Thank you, Dr. Wilson.

20 Do you feel that you are qualified to offer
21 opinions in this case about Mr. Moore's care and
22 treatment in vascular surgery and vascular disease
23 issues?

24 A. I really do.

25 Q. Dr. Wilson, do you have a recollection

1 based on your review of the materials in this case
2 how Mr. Moore's foot was on December 28th, 2016 when
3 he presented to the emergency department?

4 A. Yes.

5 Q. Would you tell us please what your
6 recollection is of how his foot looked?

7 A. That it had all the indications of acute
8 vascular ischemia.

9 Q. What were those conditions?

10 A. That his foot was cold, and that Mr. Moore
11 recognized this was the same coldness that had
12 occurred with previous occlusions of his graft.

13 That his skin was discolored.

14 I believe in one area it was called
15 mottled.

16 That it was extremely painful.

17 I think those are the important things that
18 I recall.

19 Q. Does that description, would that would be
20 consistent with acute limb ischemia, based on your
21 training and experience?

22 A. Yes.

23 Q. Do you have a recollection from Mr. Moore's
24 deposition what he said his leg was like between
25 December 25th and December 27th?

1 A. He said, and I don't want to misquote, so
2 in terms he felt that his leg was not painful and was
3 fine.

4 I can't give you the exact words.

5 I know he used the word, relieved, his leg
6 was better, and it wasn't painful between the 25th
7 and until the morning of the 28th.

8 Q. Dr. Wilson, do you have a recollection
9 based on your review of Plaintiff Moore's deposition
10 when he said his leg became cold?

11 A. Yes.

12 Q. What was that?

13 A. What was my recollection?

14 Q. Yes, as to when he said his leg became
15 cold.

16 A. The morning of the 28th.

17 Q. Dr. Wilson, do you have an opinion about
18 what may have happened to cause or be a substantial
19 factor in Mr. Moore's occlusion of the profunda
20 artery on December 28th, leading to his acute limb
21 ischemia?

22 A. Well, certainly there would have been
23 progression of vascular disease.

24 It is a progressive condition, and even the
25 arteriogram was done on the 28th there's a statement

1 that the disease is much worse than it was on the
2 last time the radiologist opened up the graft.

3 So there's advancement of disease.

4 The clotting of the profunda, I mean that
5 could occur at any time when you have vascular
6 disease without a good explanation, it just simply
7 could happen.

8 There are other things that I could point
9 to, but I might be speculating, and I was warned
10 about that yesterday.

11 Q. Dr. Wilson, are you familiar with the term
12 black box warning for purposes of pharmaceuticals?

13 A. Sure, yes.

14 Q. Would you tell jury what a black box
15 warning is?

16 A. Okay.

17 A package insert goes with every drug that
18 you get from a pharmacy, and you probably opened up
19 hypertension medicine or whatever, and there's these
20 big printouts that comes in the box, and a black box
21 warning is actually literally got a heavy black line
22 around it to draw the attention of patients and
23 prescribers that this is an important complication,
24 and I think what your leading to is the black box
25 warning on Xarelto, and the warning, is if you stop

1 taking Xarelto, you can have a rebound clotting.

2 So for example a patient might be taking
3 Xarelto chronically, and if it's stopped for more
4 than 24 hours, which is the time you would stop it
5 before surgery for example, then that can lead to
6 thrombotic event is the term they use, could be in
7 arteries, could be in veins, and could be in other
8 sites of the body, don't have to be the leg.

9 Q. When you said thrombotic events, what does
10 that mean?

11 A. Clotting.

12 Q. Hypothetically, Dr. Wilson, if for whatever
13 reason Mr. Moore didn't every day list his Xarelto as
14 prescribed within the week before December 28th, do
15 you have an opinion whether based on a black box
16 warning for Xarelto he may have been at an increased
17 risk for arterial clotting in his leg?

18 A. If he didn't take the Xarelto, I think that
19 clearly would place him at an increased risk.

20 Q. Dr. Wilson, I want you to assume that Dr. M
21 has testified that had Mr. Moore's leg been properly
22 diagnosed with acute limb ischemia on December 25th,
23 and had he received appropriate medical treatment
24 that day, which would have opened up the graft, Mr.
25 Moore's leg would not have needed to be amputated.

1 I want you to hold that hypothetical for a
2 moment.

3 A. Okay.

4 Q. And I want you to further assume that Dr. M
5 has testified that part of the evidence for his
6 opinion in that regard is that the graft could have
7 been opened on the 25th of December because it had
8 been opened up twice before in 2014 and 2015, do you
9 recall it had been opened twice before in those two
10 years?

11 A. Yes, I do.

12 Q. Do you agree with Dr. M's opinion that
13 because the graft had been opened successfully two
14 times before December 28th, that more likely than not
15 it could have been opened a third time on December
16 25th?

17 A. No, I disagree with his statement because
18 each time you open it up the chances of success
19 diminish because the clotting is occurring for a
20 reason, and by opening the graft you really don't
21 correct the underlying reason, which is progression
22 of vascular disease, and as each clotting event
23 occurs it becomes more difficult to open the graft,
24 whether you are doing it surgically or with
25 thrombolytic therapy.

1 Q. Why does it get more difficult each time
2 you need to open the graft?

3 A. Well, it's basically because the run off
4 bed, that is the arteries leading off from where the
5 graft is joined to the artery below the block, those
6 smaller arteries leading off are still continuing to
7 narrow, and in fact one of them was obstructed
8 completely.

9 There's three vessels that come off just
10 below the knee, and those begin to occlude with
11 atherosclerotic disease and diminishes blood flow in
12 the graft, and you can take the clot and dissolve it
13 or extract it surgically but the blood got less and
14 less area to distribute, and so the flow in the graft
15 decreases its velocity, and when blood flow becomes
16 stagnant, it clots within a few minutes.

17 Q. If you were to assume that the graft could
18 have been the clot, and the graft could have been
19 dissolved on December of 2016, with that he indicated
20 the graft had occluded in 2014, 2015 and 2016?

21 A. Could you say that again, please?

22 Q. Sure.

23 If the graft had been able to be unoccluded
24 (sic), or the blockage was dissolved, in 2016, would
25 that have been the third time the graft was occluded?

1 A. Yes.

2 Q. And given that trend, do you have an
3 opinion to a reasonable degree of medical probability
4 even if the graft had been able to be opened up
5 whether it would have continued to occlude if not
6 yearly, at least some period of time after there up
7 to the present?

8 A. Well, unlike the stock market, past history
9 does predict future performance, and he had clotting
10 in '15, he had clotting in '14, and now he has
11 clotting in '16.

12 It's going to clot again in '17, and I can
13 say that with a high degree of probability.

14 Q. Is there a point at which even if
15 historically the graft has been able to have the clot
16 dissolved in it at some point more likely than not
17 the end result will be amputation?

18 A. Yes.

19 Q. And why is that?

20 A. Well, because the disease is progressive,
21 and you can take the clot out of the graft or
22 dissolve a clot in the graft, but if you have got
23 vascular disease that is occluding the arteries below
24 where the graft is below the knee, it doesn't help
25 even to remove the clot in the graft.

1 So it would be progression of disease
2 inevitably.

3 The type of graft that is implanted,
4 especially in the above knee position, isn't
5 associated with clotting with a life expectancy of
6 maybe 18 months.

7 I reviewed grafts placed below the knee,
8 and the life expectancy was just an average of six
9 months, so we don't place plastic grafts below the
10 knee anymore, there's just not enough flow to keep it
11 open.

12 So in this case, although certainly there
13 would have been a clotting event that would have
14 occurred within the next year.

15 Q. If the clot can't get dissolved by Heparin
16 to keep the clot from promulgating, or to get the
17 clot out, as Dr. M talked about, is the next
18 treatment, if not the only treatment amputation?

19 A. Well, what you are hoping is that when the
20 graft occludes, there will have been non-collateral
21 flow established to maintain viability of the limb,
22 which is what I had hoped would be the case for Mr.
23 Moore, but there was certain unique circumstances
24 that, particularly the occlusion of the internal
25 iliac artery, so he was dependent on the one profunda

1 artery to maintain good satisfactory viability of the
2 leg.

3 Circulation wasn't completely normal, but
4 there was enough that you can get by, and when that
5 profunda artery, the deep one, the one that is
6 parallel to the femoral artery, when that occluded,
7 he had no blood supply to the leg, and that's why on
8 the 28th we have this emergency that Dr. M described.

9 Q. If there that is acute limb ischemia, as
10 opposed to limb ischemia due to the occlusion of the
11 graft, if the Heparin thrombolytics and lysis doesn't
12 work, once it's acutely ischemic, is the next
13 treatment amputation, such as what happened here?

14 A. Yes, if the ischemia is quite prominent,
15 painful foot, you can't restore blood flow to it, the
16 best solution then is an amputation.

17 An amputation has to be thought of in the
18 sense of rehabilitation, not as necessarily failure
19 on a physician.

20 Q. And what do you mean by the probability of
21 rehabilitation?

22 A. That it would get the patient the
23 prosthetic limb he could ambulate on.

24 With an acute ischemia, if that would
25 persist in it, the leg would become gangrenous, and

1 you certainly couldn't ambulate on it.

2 Q. Mr. Moore's case on December 28th what were
3 the factors ultimately required within a week or so
4 an above the knee amputation, versus below the knee
5 amputation, was there a way to keep the knee from
6 being amputated below the knee?

7 A. Well, generally you want to do the
8 amputation as low as possible because that gives the
9 patient a lever arm when it comes to walking with a
10 prosthesis.

11 Below knee is preferred over above knee
12 because below knee you can fit a prosthesis, and no
13 one in the room would know if the patient's wearing
14 long trousers, that he has an amputation, he can
15 really walk very well.

16 Above knee it's more difficult.

17 So we try to do below knee as much as
18 possible.

19 Now, if you don't have enough circulation
20 below knee, so that when you make the incision on the
21 skin for example, and the bleeding is not good, then
22 you end up with a stump that is not going to heal,
23 and that is multiple hospitalizations, the bleeding
24 of the stump, and really makes a patient bedbound.

25 So getting the above knee amputation means

1 that they were sure that it would heal at that level,
2 and that he would be able to go ahead with
3 rehabilitation.

4 Q. Dr. Wilson, is there in your opinion
5 adequate medical literature that supports the
6 opinions you just gave us over the course of the last
7 ten minutes talking about if the graft continues to
8 occlude, more likely than not it's going to end up in
9 amputation?

10 A. Yeah.

11 I can't support that with a citation, but
12 it's common sense to a vascular surgeon each time it
13 clots, it's going to be worse.

14 Q. And you just used the term, stump.

15 Are you comfortable that in using the term
16 stump instead of residual limb, it's not
17 demonstrating a lack of insight into patients who
18 have amputations?

19 A. No, patients and doctors use stump
20 frequently.

21 When I worked at the Veteran's Hospital, we
22 had a stump clinic, that's what we called it, where
23 all the patients came who had amputations.

24 So I don't think it shows any disrespect.

25 Q. Dr. Wilson, you reviewed Dr. M's

1 deposition, is that correct?

2 A. Yes, I have.

3 Q. And when you reviewed Dr. M's deposition,
4 did you see that there was about six inches of
5 literature attached to his deposition as exhibits?

6 A. Yes, I saw that.

7 Q. And did I ask you to review the literature
8 that Dr. M attached to -- or that Dr. M reviewed,
9 considered, and relied upon for his opinion in the
10 deposition?

11 A. I reviewed the literature, yes.

12 I was familiar with some of the articles,
13 some I wasn't familiar with.

14 In general, it referred to acute ischemia,
15 not chronic.

16 MR. ARNTZ: I'll make an objection.

17 We might need to come to the bench.

18 THE COURT: Why don't you come to the
19 bench.

20 (Thereupon, a discussion was had between
21 Court and counsel at sidebar.)

22 THE COURT: The objection is sustained.

23 Ask another question.

24 MR. WEAVER: Thank you, Your Honor.

25

1 BY MR. WEAVER:

2 Q. Dr. Wilson, diving back in a little bit
3 more from where we left off yesterday, I think we
4 were just leaving off with your opinion whether or
5 not when it comes to the assessment of acute limb
6 ischemia the five Ps are the gold standard.

7 Do you have an opinion in that regard?

8 A. Yes, I think that is the standard way of
9 diagnosing an acute knee ischemia limb.

10 Q. Why is that?

11 A. Well, imaging will tell you where the block
12 is generally, but it doesn't tell you the precise
13 physical condition of the extremity. You only can
14 tell that by examination.

15 So the five Ps refer to your history
16 information, and your examination.

17 Q. And before we get into those five Ps, we've
18 got a board that we'll put up the five Ps just to
19 refer to briefly as we go to it, but would you tell
20 the jury again generally what in the context of the
21 five Ps, what an acute ischemia leg looks like in
22 your opinion?

23 A. Okay.

24 The first one is pain, severe unrelenting
25 pain in the foot, and more than that it's tender to

1 touch. If you touch it, the patient will feel it's
2 very, very painful.

3 The second would be the color, these are
4 forced a little, the color would be palor if the
5 foot's elevated a little bit, and then if it's
6 dropped down, it becomes a dusty purple color called
7 rubular.

8 The third would be the paralysis, and
9 generally that means you can't wiggle your toes, or
10 you can't pull back your foot. You are getting foot
11 drop.

12 Then there is paresthesia, and that is a
13 sensation of an abnormal sensation in your leg, and
14 in his case it would have been on the 28th would have
15 been numbness in the foot, he couldn't have had any
16 fine sense of touch. It would mean absence of
17 palpable pulses, and likely absence of a flow signal
18 if he used the Doppler.

19 And the last one, the last P I believe is
20 poikilothermia, which is a big word to describe the
21 foot would be cold, it's temperature would be at
22 ambient temperature in the room because he's not
23 getting blood flow to keep it at a normal 98.6.

24 Q. And poikilothermia, would that actually be
25 a sixth one?

1 A. I lost count here.

2 MR. WEAVER: Your Honor, may I approach?

3 THE COURT: You may.

4 THE WITNESS: I think we got them all.

5 BY MR. WEAVER:

6 Q. So if you come to the board, you need to
7 say, I'm going to the board, it's a housekeeping
8 rule.

9 THE COURT: If you are going to, as
10 witnesses, all we need to have in the record is, I'm
11 going to the board, you are walking over there, you
12 can say it on your way, say it when you get there, I
13 just want to have in the written record you are not
14 just sitting at the witness stand talking if you need
15 to refer to something in the board.

16 BY MR. WEAVER:

17 Q. Before we get into the five Ps, you
18 reviewed Dr. Jacobs' deposition, is that correct?

19 A. Yes.

20 Q. I want you to assume Dr. Jacobs has
21 testified in his deposition he believes the charting
22 by the emergency department nursing staff was
23 accurate.

24 Do you agree with that?

25 A. I remember that, yes.

1 Q. And do you recall Dr. Jacob saying in his
2 deposition that he believed that on December 25th Mr.
3 Moore's leg looked, quote, unquote, essentially
4 normal?

5 A. Yes.

6 Q. Do you agree with that as well?

7 A. From my reading of the record, it reflects
8 essentially normal extremity.

9 Q. I want you to assume, Dr. Wilson, that Dr.
10 M testified he agreed with the examination done of
11 the triage nurse, Nurse Kuchinski. In fact, I'm
12 going to read you his testimony.

13 Question, so you have no criticism of the
14 exam that Nurse Kuchinski did initially, which
15 demonstrated the patient's leg was normal and warm,
16 and not cold or blue, you don't have any disagreement
17 or concerns with her examination?

18 Dr. M's answer was, actually I agree with
19 it?

20 MR. ARNTZ: Your Honor, I don't think it's
21 appropriate he's reading from Dr. Marmareano's
22 deposition.

23 He testified he --

24 THE COURT: I respectfully disagree, want
25 to know where the question is going because Dr.

1 Marmareano testified, we heard it we're, we're now
2 trying to get information from this witness regarding
3 those opinions, if I understand where we're going
4 correctly, and clearly what was said I think is
5 better than an attempted summary.

6 MR. ARNTZ: My objection was whether it's
7 proper to read the deposition testimony in the record
8 at all.

9 THE COURT: I thought -- Can I have
10 everybody at the bench?

11 (Thereupon, a discussion was had between
12 Court and counsel at sidebar.)

13 THE COURT: I think we cleared up some
14 confusion.

15 Just to be clear, the reason why my
16 understanding was to overrule, and what is being read
17 from now is the earlier in this trial testimony of
18 Dr. Marmareano, not deposition taken prior to trial,
19 or other sworn testimony.

20 So again because we're going to be asking
21 this, there's basically two ways, Mr. Weaver.

22 So say, you can assume certain facts, and
23 ask an opinion, or actually read the testimony, so
24 there's no confusion this was the actual testimony,
25 and then ask.

1 I think for clarity sake for the jurors and
2 the record, I think that is fair.

3 We'll see how that goes.

4 If there's other objections, of course
5 we'll address them, but of course be sure you're
6 reading accurately, which I'm sure you will endeavor
7 to do, Mr. Weaver.

8 MR. WEAVER: I'll read it straight from the
9 transcript, instead of my transcription of it, Your
10 Honor.

11 BY MR. WEAVER:

12 Q. Dr. Wilson, I want you to assume with
13 regard to the charting by the nursing staff, not
14 Nurse Practitioner Bartmus or Dr. Lasry, but I want
15 you to assume with regard to the emergency department
16 nursing documentation, this was the question asked of
17 Dr. M, and then it will be followed by his answer.

18 Question, so you have no criticisms of the
19 exam that Nurse Kuchinski did initially, which
20 demonstrated that the patient's leg was normal and
21 warm, and not cold or blue, you don't have any
22 disagreement or concerns with her examination that
23 night?

24 The answer, actually I agree with the
25 examination.

1 I don't think there's anything unusual.

2 I think she's done the right thing, yeah.

3 Do you hold that opinion -- or do you
4 disagree with Dr. Marmareano's conclusion with regard
5 to the emergency department nurse's examination and
6 charting of Mr. Moore?

7 A. No, I don't disagree with that.

8 Q. Dr. Wilson, before we get into the five Ps,
9 do you have an opinion whether in order to do a
10 proper assessment of Mr. Moore's left leg, his sock
11 and his shoe he might have been wearing should have
12 been taken off?

13 A. It should have been taken off, yes.

14 Q. That helps with the assessment?

15 A. It allows you to see the skin, assess the
16 extremity, if it's warm or cold.

17 Yes, it should be done routinely.

18 Q. So, Dr. Wilson, let's start with the first
19 of the P, the pain.

20 If Mr. Moore's leg was acutely ischemic on
21 December 25th, what would you expect with regard to
22 the pain?

23 MR. ARNTZ: Your Honor, I object.

24 This has been the subject of testimony at
25 least three times with this witness, twice yesterday

1 and once today.

2 THE COURT: Mr. Arntz is correct.

3 Obviously if we covered the testimony, we
4 can't duplicate the testimony, but does this help us
5 understand a different line of questioning?

6 MR. WEAVER: It's just foundation.

7 I'll go into exactly what the pain was.

8 THE COURT: Okay.

9 MR. ARNTZ: Same objection, it's already
10 been testified to.

11 THE COURT: I think we resolved the
12 objection for now.

13 That objection was sustained.

14 I don't need to cover areas we covered
15 already for foundation, but please make sure you are
16 in a new area clarifying line of questioning.

17 BY MR. WEAVER:

18 Q. Dr. Wilson, do you have a recollection as
19 to what the scale of Mr. Moore's pain was when he was
20 in the emergency department per the documentation?

21 MR. ARNTZ: Objection.

22 Lacks foundation.

23 THE COURT: I -- Can I have counsel back up
24 at the bench?

25 I want to clarify something.

1 (Thereupon, a discussion was had between
2 Court and counsel at sidebar.)

3 THE COURT: All right.

4 The objection is overruled.

5 I think the objection, there was a little
6 misunderstanding about what the specific intent of
7 what the question was. I think we clarified that.

8 It's overruled.

9 I'm sure Mr. Weaver will want to re-ask the
10 question just to be sure we're clear as we move
11 forward.

12 MR. WEAVER: Thank you, Your Honor.

13 BY MR. WEAVER:

14 Q. Dr. Wilson, do you have a recollection
15 based on your review of the emergency department
16 chart on December 25th, 2016 what Mr. Moore
17 identifies his pain would be on a pain scale, if you
18 recall?

19 A. My collection is it was a plus 3, but I
20 don't have it in front of me, so I can't cite it, but
21 I do recollect seeing a 3.

22 Q. Okay.

23 MR. WEAVER: Could we put up Exhibit 100,
24 Bates 1382, please?

25

1 BY MR. WEAVER:

2 Q. Dr. Wilson, I think this might refresh your
3 recollection.

4 I think it might have been a 3 was
5 acceptable to Mr. Moore, but if you look --

6 A. I see.

7 Q. Does that refresh your recollection what
8 Mr. Moore's pain intensity was?

9 A. Intensity was 7.

10 Acceptable pain intensity, I presume that
11 would be acceptable to Mr. Moore, was 3.

12 Q. And if we could go to Bates 1331, please,
13 Dr. Wilson, do you recognize this as being part of
14 the emergency department charting documentation by
15 Nurse Practitioner Bartmus?

16 A. Yes.

17 Q. Do you see under chief complaint that it
18 identifies Mr. Moore has left calf pain?

19 A. Yes, history of present illness, chief
20 complaint, yes.

21 Q. And for purposes of your review of this
22 case, what is the significance if any of Mr. Moore
23 having the pain that he had in his calf, opposed to
24 his foot or anywhere else?

25 A. Well, calf pain directs you to a venous

1 thrombosis in the calf, it would direct you to a
2 gangrenous muscle tear or sprain, and ischemic pain
3 is usually at the part most distant from the heart,
4 so it would be the foot, and particularly for the
5 foot, the toes and metatarsals.

6 Q. Why is it acute limb ischemia most commonly
7 in the toes or the foot, the furthest place from the
8 heart you said?

9 A. It's the part most distant for the blood to
10 travel to.

11 Q. And is that what is most common that you
12 would find consistent with acute limb ischemia, as
13 opposed to in the calf?

14 A. Yes.

15 Q. Dr. Wilson, if we could move to the next P,
16 which is palor.

17 What does palor mean?

18 A. Palor is pale.

19 Q. And if we could look at Bates 1389, please,
20 Dr. Wilson, do you see on this nursing assessment by
21 Nurse Pluchinski she identifies the skin to be a
22 normal color?

23 A. Yes, I see that.

24 Q. And is that consistent in your experience
25 with acute limb ischemia?

1 A. No.

2 Q. Is it consistent in your experience with
3 chronic limb ischemia?

4 A. Yes.

5 Q. Dr. Wilson, let's move on now to the third
6 category of pulses or pulselessness.

7 I think --

8 MR. WEAVER: May I approach, Your Honor, to
9 move this?

10 THE COURT: You may.

11 BY MR. WEAVER:

12 Q. Dr. Wilson, I'm going to ask you some
13 questions if I might about the pulselessness.

14 Can you tell us again what generally in the
15 assessment of the five Ps pulselessness means?

16 A. The absence of a palpable pulse.

17 You need the dorsalis pedis posterior,
18 popliteal or common femoral artery.

19 Q. And that is in assessing the five Ps?

20 A. Yes,

21 Q. Do you have an opinion, Dr. Wilson if there
22 could be good blood flow in the leg, even in if
23 there's absence of pulses?

24 A. Yes.

25 Q. Doctor, have you reviewed the pulse, and

1 why is that?

2 A. When you palpate a pulse, what you are
3 feeling is the pressure in the artery that distends
4 the artery to the extent you can feel it. So that
5 requires a pressure certainly above a hundred
6 millimeters, and remember your regular blood pressure
7 ideally would be 120, could be higher, many people
8 would be lower, so when you feel or palpate for a
9 pulse and don't feel a pulse, you can certainly have
10 flow in that artery, but the pressure inside the
11 artery is not as high as it would be if there were no
12 block there.

13 So there's a decrease in pressure, that's
14 what the absence of a pulse means.

15 Q. All right.

16 And do you have a recollection one way or
17 another based on your review of the depositions of
18 Nurse Practitioner Bartmus and Dr. Lasry what they
19 testified to with regard to whether they checked the
20 pulses?

21 A. Yes.

22 In their depositions my recollection is
23 they both said they felt pulses.

24 Q. And if their testimony here at trial is
25 consistent with that, do you have an opinion on

1 whether or not that means they are lying?

2 A. I have no reason to believe they were
3 lying, no.

4 Q. Why is that?

5 MR. ARNTZ: Objection.

6 Calls for speculation.

7 Lacks foundation.

8 THE COURT: He needs to clarify that.

9 I'll overrule.

10 But why is that?

11 MR. WEAVER: Fair enough.

12 I'll move on.

13 THE COURT: I want him to answer that
14 question.

15 MR. WEAVER: Thank you.

16 I missed the overruled part.

17 BY MR. WEAVER:

18 Q. Why do you hold the opinion that you don't
19 believe they were lying?

20 A. Well, there would be no point to lie.

21 You would enter into the medical record
22 what you believe you observed and found on
23 examination.

24 MR. ARNTZ: Sorry, Judge.

25 I object.

1 This is speculative.

2 I move to strike this testimony.

3 THE COURT: Overruled.

4 Please proceed, Mr. Weaver.

5 BY MR. WEAVER:

6 Q. Go ahead, doctor.

7 THE COURT: I thought he finished.

8 BY MR. WEAVER:

9 Q. Were you finished, Dr. Wilson?

10 A. Yes.

11 Q. Thank you.

12 A. I don't want to say anymore about that.

13 Q. Dr. Wilson, I want you to assume that here
14 in trial Dr. M testified no fewer than five times
15 that it is impossible for Mr. Moore to have pulses in
16 his foot after the 2012 femoral popliteal artery
17 by-pass procedure where the graft was placed, and I'm
18 going to read you his testimony with regard to that.

19 This is my question to Dr. M.

20 What I'm talking about is, you do agree,
21 don't the you, and I'm not talking about 12/25/16,
22 which is where you keep going to, you told this jury
23 over and over and over and over and over at least, my
24 notes say five times, that after 2012 it was
25 impossible for Mr. Moore to have pulses in his foot.

1 You said that to this jury, didn't you?

2 Answer, I did say that, yes.

3 Do you agree with Dr. M that it would be
4 impossible to have pulses in Mr. Moore's foot, left
5 foot, after the 2012 popliteal artery by-pass graft
6 procedure?

7 A. I disagree with the statement on the basis
8 that he had several follow-up examinations where my
9 recollections that pulses were noted.

10 Q. And you have reviewed those materials.
11 Would there have been visits since 2012
12 where the pulses were detected?

13 A. I have reviewed the visits to Dr. Wiencek.
14 I don't have the material in front of me,
15 it's in my bag outside.

16 Q. That's okay.
17 We will go through it.

18 A. I have reviewed it, yes.

19 Q. So if we might go to Joint Exhibit 109,
20 Bates 55, please.

21 THE COURT: Was it received?

22 MR. WEAVER: Yes, it is.

23 All of these I'll be going through will be.

24 THE COURT: As a reminder.

25 MR. WEAVER: Thank you, Your Honor.

1 BY MR. WEAVER:

2 Q. Dr. Wilson, this is a document you seen
3 before, correct?

4 A. Yes.

5 Q. And do you see where it says in this note
6 dated August 10th, 2015, so roughly a year and four
7 months before this incident on December 25th, 2016
8 from Dr. Wiencek's office, it says, quote, he has
9 good pulses in both lower extremities dorsalis pedis
10 on the left and posterior tibial on the right, he
11 also has changes to both lower extremities, you have
12 any reason to dispute the accuracy of Dr. Wiencek's
13 offices note that said Mr. Moore had pulses in both
14 lower extremities, both dorsalis pedis on the left
15 and posterior tibial on the right?

16 A. I have no basis not to accept that.
17 It's written down, the examination, yes.

18 Q. If we may go to Bates 36, please.

19 Dr. Wilson, if you would look at the top
20 right-hand corner, do you see this identified as a
21 February 2016 office note from Dr. Wiencek, Mr.
22 Moore's cardio-thoracic surgeon?

23 A. Yes, I see that.

24 Q. Do you accept that date as accurate?

25 Any reason to dispute the date?

1 A. I see the date, February 8th, 2016.

2 Q. Under history of present illness I want to
3 draw your attention to where it says, quote, he had
4 good pulses in both lower extremities, dorsalis pedis
5 on the left, and posterior tibial on the right, he
6 also has changes of chronic venous insufficiency in
7 both lower extremities, patient is here for six month
8 follow-up, do you see that?

9 A. Yes.

10 Q. Do you have any reason to doubt the
11 accuracy of that February 8, 2016 note, so roughly
12 ten months before this incident, that identifies Mr.
13 Moore has good pulses in both lower extremities,
14 dorsalis pedis on the left, and posterior tibial on
15 the right?

16 A. I have no reason to doubt that observation.

17 Q. If we might go down to, please, Dr. Wilson,
18 under the assessment and plan, do you see, Dr.
19 Wilson, under the assessment and plan that it says
20 that Mr. Moore was presenting for his six month
21 follow-up for a pulse check, you see that?

22 A. Yes.

23 Q. Would it make sense to you that Mr. Moore
24 would be presenting for a six month follow-up for a
25 pulse check if he had no pulses?

1 A. It would he be presenting for a six month
2 follow-up if he had no pulses?

3 Q. Correct.

4 A. Palpable pulses?

5 Q. Pulses, correct.

6 A. He could be, yes.

7 Q. My point is though, if he didn't have
8 pulses since 2012 as Dr. M said, it would make sense
9 he would not present for a check of those pulses,
10 wouldn't it?

11 A. Well, it would be a routine appointment
12 irrespective of what the pulse examination was
13 showing.

14 Q. All right.

15 Do you see where it then says that the
16 advanced nurse practitioner did a pulse check in the
17 office I think it says, but I think it probably means
18 did pulse check in the office, and the results were
19 excellent?

20 A. Correct.

21 Q. Do you have any reason to dispute that Dr.
22 Wilson when the pulses were checked that were
23 identified above that Dr. Wiencek was wrong in saying
24 that the pulses were excellent?

25 A. No, this is in correspondence with Dr.

1 Wiencek's observation.

2 Q. So if Dr. Wiencek says the pulses were
3 excellent, is it fair for you to accept that?

4 A. Yes.

5 Q. And then if you would see where it
6 continues on that it says he has some signs of venous
7 insufficiency, and he continued to use compression
8 stockings, do you see that?

9 A. Yes.

10 Q. And then would you read into the record if
11 you would please, Dr. Wilson, the last sentence?

12 A. She has encouraged him to ambulate as much
13 as possible, and I will see him again in another six
14 months for another pulse check.

15 Q. So according to this note that is signed on
16 the next page by Dr. Wiencek, Mr. Moore was asked to
17 come back in six months for another, quote, unquote,
18 pulse check, is that fair?

19 A. Yes.

20 Q. Do you accept that as accurate?

21 A. Yes.

22 Q. All right.

23 If we could go to Bates 56, please, it's
24 Exhibit 113.

25 Dr. Wilson, I just want to orient you to

1 the date in the top right-hand corner.

2 Do you see it's May 9, 2016 in Mr.
3 Wiencek's office?

4 A. I --

5 Q. Where it says date of service?

6 A. Yes.

7 Q. Then down at the bottom you see where it
8 starts out, and I will plan to see him, and then it
9 goes over to the next page, again in six months to a
10 year for a pulse check?

11 A. Yes, I see that.

12 Q. And then it says, currently he has a strong
13 anterior tibial pulse and good capillary refill by
14 physical examination?

15 A. Yeah.

16 Q. Do you have any reason to dispute the
17 accuracy of that?

18 A. No.

19 Q. Could you tell the jury what it means to
20 have good capillary refill by physical examination?

21 A. It's a simple test where the patient is
22 lying flat. You would squeeze the toe and let go and
23 see if the blood comes very quickly within a few
24 seconds, it is an indicator for you there is good
25 flow of blood.

1 Q. We'll next go to Joint Exhibit 106 if we
2 might please, and Bates 13.

3 Dr. Wilson, as this comes up, if you would
4 orient yourself to the top left-hand corner, that is
5 September 11th, 2014. That is 106, Bates 13.

6 Dr. Wilson, do you, even though it says
7 ProCare Medical Group, do you recognize this to be
8 Mr. Moore's primary care physician?

9 A. Yes.

10 Q. On this 9/11/2014 date down in the middle
11 of the general examination do you see where it says,
12 peripheral pulses brachial and DP pulses 2 plus and
13 symmetrical bilaterally?

14 A. Yes, I see that.

15 Q. Do you have any reason to, Dr. Wilson, to
16 dispute the accuracy of what appears to identify Mr.
17 Moore's pulses bilaterally being taken?

18 A. I think that is what it states.

19 Q. And if it's 2 plus, does that mean it's
20 normal?

21 A. Yes.

22 Q. All right.

23 If we could go next to the same exhibit,
24 Bates 11, which is a 12/23/2014 visit with Mr. Moore
25 with his PCP, Dr. Tran.

1 Dr. Wilson, under general examination about
2 three quarters of the way down it will be highlighted
3 it starts out, full range of motion, no clotting, no
4 edema, and then it says, normal bilateral pulses,
5 normal dorsalis pedis and posterior tibial pulses,
6 you see that?

7 A. Yes.

8 Q. Do you have any reason to dispute Dr.
9 Wilson that on that day Dr. Tran correctly felt
10 normal bilateral pulses, normal dorsalis pedis, and
11 normal posterior tibial pulses if that's what the
12 doctor said?

13 A. I don't dispute that.

14 Q. We'll go to Bates 9 of Exhibit 106, please.

15 Dr. Wilson, as that comes up, can you
16 orient yourself to the top left-hand corner, it will
17 say April 16th, 2015, a visit with Dr. Tran again, do
18 you see that?

19 A. Yes.

20 Q. And do you see three quarters of the way
21 down under the general examination, it will come up
22 highlighted where it says peripheral pulses intact
23 and symmetrical?

24 MR. J. HYMANSON: Your Honor, a point of
25 clarification.

1 He said, Bates 9.

2 I think he's referring to Bates 7.

3 MR. WEAVER: Thank you.

4 I appreciate that.

5 THE COURT: Thank you for the
6 clarification.

7 BY MR. WEAVER:

8 Q. Dr. Wilson, do you see where it says
9 peripheral pulses intact and symmetrical?

10 A. I do.

11 Q. If Dr. Tran documented that, do you have
12 any reason to dispute that based on his physical
13 examination that day that he concluded that Mr.
14 Moore's peripheral pulses were intact and
15 symmetrical?

16 A. I don't dispute that.

17 Q. And one more on this, then we'll move on.
18 And this is Bates 5.

19 Do you see where it's dated November 1st,
20 2016?

21 A. Yes.

22 Q. So that would be roughly the month before
23 -- or month-and-a-half before this incident was
24 December 25th, 2016, is that correct?

25 A. Yes.

1 Q. Do you see under -- this is by a physician
2 assistant -- it appears a Matthew Sanders, do you see
3 that in the top right-hand corner?

4 A. Yes.

5 Q. So this is a different examiner on this
6 date.

7 Three quarters of the way down do you see
8 where it says, full range of motion, no clubbing, no
9 edema, normal bilateral pulses, normal dorsalis pedis
10 and posterior tibial pulses, and then it says,
11 peripheral pulses normal, do you see that?

12 A. I do.

13 Q. Do you have any reason to dispute Dr.
14 Wilson that on November 1st, 2016, a month before
15 this incident, this physician assistant Matthew
16 Sanders based on his again examination of Mr. Moore
17 determined that Mr. Moore had normal bilateral
18 pulses, dorsalis pedis and posterior tibial pulses?

19 A. I don't dispute that.

20 Q. All right.

21 Just two more, Dr. Wilson.

22 If we might go to Joint Exhibit 202,
23 please, it is Bates 154.

24 Dr. Wilson, what I'll have you take a look
25 at is a May 23rd, 2016 exam date of Mr. Moore's pain

1 management physician.

2 This is Bates 151, please.

3 Do you see the exam date is 5/23/2016?

4 A. Yes.

5 Q. Now, first of all, if we could just go
6 under pain, do you see the second paragraph that
7 indicates the patient complains of low back pain
8 radiates into the bilateral paralumbar area and
9 intermittently into the bilateral feet, do you see
10 that?

11 A. I see that.

12 Q. Do you see the start of the next paragraph
13 says, patient complains of bilateral foot -- I think
14 that means pain.

15 Do you see that?

16 A. I see that.

17 Q. Then do you see a couple sentences later
18 where it says, the ankle pain increases with physical
19 activity, you see that?

20 A. Yes.

21 Q. Would the increase in pain -- Do you have
22 an opinion -- in the ankle that increases with
23 physical activity to be musculoskeletal?

24 A. Yes.

25 Q. And then if you could just go a couple

1 pages over on that same visit, it's about five pages
2 long, Bates 153, under the general exam.

3 Under the again exam do you see where it
4 says CV?

5 A. Yes.

6 Q. Dr. Wilson, is CV a shorthand way to say
7 cardio-vascular?

8 A. Yes.

9 Q. Is that typically your common way someplace
10 that peripheral perfusion gets identified and
11 documented?

12 A. Yes.

13 Q. Where, what does it say?

14 A. Normal pulses present.

15 Q. Do you have any reason to doubt the
16 accuracy that on that date in May 23, 2016 is this
17 different examiner is finding Mr. Moore's pulses are
18 present and normal?

19 A. I don't dispute that.

20 Q. Just one more, Dr. Wilson, if we might, and
21 that is Bates 111, still Exhibit 202, and it's dated
22 12/21/2016, and this is Mr. Moore's pain management
23 physician whom he sees at Nevada Comprehensive Pain
24 Center.

25 Do you understand that?

1 A. Yes.

2 Q. And do you see the exam date is December
3 21st, 2016, four days before Mr. Moore went to the
4 emergency department and was seen by Nurse
5 Practitioner Bartmus and Dr. Lasry on December 25th,
6 2016?

7 A. I understand that.

8 Q. And it identifies in that note Mr. Moore is
9 on Xarelto, correct?

10 A. Right.

11 Q. And then if we could go a few pages in from
12 that visit, Bates 113 under the general exam, do you
13 see again I think it says CV is cardio-vascular?

14 A. Yeah.

15 Q. And cardio-vascular is somewhere typically
16 pulses may get identified?

17 A. Yes.

18 Q. And what does it say there?

19 A. Normal pulses present.

20 Q. Do you have any basis to dispute the
21 accuracy of the documentation in this document that
22 four days before Mr. Moore came to St. Rose
23 Hospital's emergency department, that his pulses were
24 normal and present?

25 A. I don't.

1 Q. So Dr. Wilson based on your review of those
2 materials, have you formed the opinion whether at
3 least after 2012, up until December 21st, 2016 Mr.
4 Moore had bilateral pulses that at times at least
5 were documented as present and normal?

6 A. Yes, that's what the records you showed me
7 show.

8 Q. All right.

9 So let's if we might just move into
10 paresthesia, and tell the jury again what paresthesia
11 is.

12 Did you say had something to do with
13 sensitivity?

14 A. Yes, it's the sensation of unusual
15 feelings, that can be numbness, can be pins and
16 needles, it can be the sole of your foot feeling very
17 hot, usually comes and goes, and in the case of a
18 patient who has a neuralgia that would be not
19 atypical, it would be what you would find.

20 Q. When you say, neuralga, you mean neuropathy
21 Mr. Moore had?

22 A. Yes.

23 Q. And you understand he had it bilaterally,
24 is that right?

25 A. Yes.

1 Q. If he has acute limb ischemia, how far
2 would that affect his ability even with neuropathy to
3 walk normally, if he got acute limb ischemia?

4 A. He couldn't walk normally.

5 Q. Why is that?

6 A. The foot would be too painful, it might be
7 difficult for him to bring his foot up, dorsiflex.

8 There wouldn't be a good feeling of
9 position sense for the foot.

10 So it would be very different than
11 neuralgia, or as you termed it neuropathy.

12 Q. If we might pull up Joint Exhibit 100,
13 please, Bates 1333, which is the emergency department
14 records of December 25th, 2016.

15 Dr. Wilson, it will get highlighted in a
16 moment, but I bring your attention to whether in the
17 place where it says impaired gait, and then
18 documented by Nurse Kuchinski it says, no.

19 A. Yes.

20 THE COURT: Can you direct him to where
21 we're talking about?

22 MR. WEAVER: We can highlight it in just a
23 moment.

24 THE COURT: That's what I meant.

25 Tell us where you are on the page.

1 MR. WEAVER: It should be under impaired
2 gait.

3 THE COURT: Nobody is seeing that.

4 MR. WEAVER: I'll come back to that.

5 I have the wrong page number.

6 BY MR. WEAVER:

7 Q. Hypothetically, Dr. Wilson, if Nurse
8 Kuchinski in her assessment --

9 THE COURT: Doctor, did you see something
10 on here we didn't see yet?

11 THE WITNESS: No, I have page 3 of 84.

12 MR. WEAVER: Okay.

13 We'll come back to that, or just cut
14 through this.

15 BY MR. WEAVER:

16 Q. Dr. Wilson, I want you to assume
17 hypothetically that under the category of impaired
18 gait Nurse Kuchinski documented, no, would you have
19 any reason to dispute that based on your review of
20 these materials?

21 A. No.

22 Q. All right.

23 And then would you tell the jury what
24 paralysis means, please?

25 A. Inability to -- in this case to move the

1 toes, or to flex the ankle, bringing it up, bringing
2 your foot up with the earliest motor signs in acute
3 ischemia.

4 Q. If on December 25th, 2016 Mr. Moore had
5 acute limb ischemia, would you expect that he would
6 be able to ambulate normally and walk normally?

7 A. Not with acute limb ischemia.

8 Q. So is paralysis just a worse condition than
9 paresthesia for purposes of analyzing for acute limb
10 ischemia?

11 A. Well, paralysis is one assessment that you
12 would make, yes.

13 Q. Is that primarily motor?

14 A. Motor.

15 Q. As opposed to just sensation?

16 A. Motor, yes.

17 Q. And if we could look at Bates 1350, please,
18 Dr. Wilson, if you would direct your attention to a
19 little bit down on this where it says, mode of
20 discharge, and it says, ambulatory self assisted of
21 gurney chair.

22 Would that indicate to you this
23 documentation by the discharge nurse, Jeffrey
24 Germane, that at least in his opinion Mr. Moore on
25 December 25th, 2016 did not have paralysis?

1 A. Yes.

2 Q. Okay.

3 And then just one more category that I know
4 is not typically on the list of five, but you called
5 it popliteal thermea, is that right?

6 A. Yes.

7 Q. I'm guessing that is just to continue on
8 the mnemonic device, but you said it means cold, is
9 that correct?

10 A. Yes.

11 Q. And for purposes of acute limb ischemia,
12 does it mean more than just cool?

13 A. Yes.

14 Q. Why is that, or what do you mean by that?

15 A. It means that the temperature of the foot
16 is the same temperature as the environment, so it's
17 cold.

18 Q. And if we could draw your attention to
19 Bates 1382, and there will be a charting by Nurse Amy
20 Kuchinski that indicates that Mr. Moore's skin was
21 warm and dry.

22 Do -- Have you been able to highlight that
23 yet?

24 Do you have any reason to dispute the
25 accuracy that on December 25th, 2016 as charted by

1 Nurse Kuchinski that Dr. Jacobs and Dr. M agree with
2 that Mr. Moore's skin was warm?

3 A. Yes.

4 Q. And then one more place if we might on
5 Bates 1388.

6 Under 1388, under skin temperature, it
7 should identify again by Amy Kuchinski that Mr.
8 Moore's skin temperature was normal?

9 THE COURT: Mr. Weaver, can you please
10 direct us, rather than us having to look over the
11 whole document?

12 MR. WEAVER: I think I have the wrong page,
13 so we'll move on.

14 THE COURT: You made a statement that such
15 information is listed.

16 You need to produce that record, or I'll
17 direct the jurors to disregard your statement.

18 Whether it's in this record or not isn't
19 the point.

20 The point is, you made a record that shows
21 something, you have to show it for the record.

22 MR. WEAVER: Fair enough.

23 Thank you, Your Honor.

24 If we could look at I think it's 1389 under
25 CV, and then it says, skin color, and says, normal.

1 BY MR. WEAVER:

2 Q. Do you see that, Dr. Wilson?

3 A. I see that.

4 Q. Do you have any reason to dispute the
5 accuracy of that?

6 A. I don't dispute that.

7 Q. Dr. Wilson, switching gears then, did you
8 have an opinion whether or not based on this
9 documentation, as well as additional documentation by
10 Nurse Practitioner Bartmus and Dr. Lasry, the five Ps
11 were assessed for Mr. Moore for purposes of acute
12 limb ischemia?

13 A. Yes.

14 Q. And --

15 THE COURT: Do you have an opinion, or that
16 was the opinion?

17 THE WITNESS: They were assessed, yes.

18 BY MR. WEAVER:

19 Q. Do you have an opinion whether or not the
20 assessment of the five Ps point toward acute limb
21 ischemia, or away from it?

22 A. It pointed away from it, towards a chronic
23 process.

24 Q. And I think you told us yesterday that it's
25 your opinion that on December 25th, 2016 you believe

1 Mr. Moore had chronic limb ischemia, but not acute
2 limb ischemia, is that fair?

3 A. That's correct.

4 Q. Dr. Wilson, you told us that you agreed
5 with -- or you identified with the venous ultrasound
6 showed that there was occlusion of the graft, is that
7 fair?

8 A. Yes.

9 Q. And you told us yesterday that it's your
10 opinion that it wasn't clinically or
11 medically-indicated for there to be an arterial
12 ultrasound, correct?

13 A. Yes.

14 Q. Why do you hold that opinion?

15 A. Because he didn't have the signs that would
16 demand a full arterial ultrasound investigation.

17 Q. And I believe you also told us yesterday
18 when we were talking in the context of Dr. M's
19 opinion there should have been a CTT angiogram, you
20 told us that in your medical judgment on December
21 25th, 2016 there didn't need to be a CT angiogram
22 either, is that correct?

23 A. Yes.

24 Q. Is that for the same reason?

25 A. Yes, they did not have a clinical

1 indication.

2 Q. Dr. Wilson, do you have an understanding --
3 or do you recall based on your review of the records
4 what if any medical follow-up Nurse Practitioner and
5 Dr. Lasry advised Mr. Moore to do when he was
6 discharged?

7 A. That he should see his primary care
8 physician and his vascular surgeon for follow-up.

9 Q. And do you recall that those two things
10 were documented by Nurse Practitioner Bartmus and Dr.
11 Lasry in terms of following up with Mr. Moore's
12 vascular surgeon?

13 A. Yes.

14 Q. And do you have an opinion as a vascular
15 surgeon the time frame within which Mr. Moore should
16 be instructed to follow-up with his vascular surgeon?

17 A. Within 5 to 10 days.

18 Q. What do you base that on?

19 A. Well, he didn't have an emergency at that
20 point, and it would be reasonable to allow the
21 vascular surgeon to see his patient.

22 It was about a six-month period of time
23 since he had seen Mr. Moore, as I recollect it was
24 May of 2016 when he was last seen in Dr. Wiencek's
25 office, so six months had passed, it would be a

1 routine appointment.

2 So I think it was appropriate to recommend
3 he be followed up.

4 Q. And what was the information that Nurse
5 Practitioner Bartmus had that you think was a good
6 idea that caused her to tell Mr. Moore to follow-up
7 with his vascular surgeon?

8 A. Well, his vascular surgeon would probably
9 want to know that the graft that he had placed him on
10 had been reopened, was now clotting again.

11 Q. And I think you identified that as a
12 chronic condition, is that fair?

13 A. Yes, I believe it was.

14 Q. Do you have an opinion one way or another
15 what the likely response would have been from a
16 vascular surgeon or cardio-vascular surgeon like Dr.
17 Wiencek if he had been called by Nurse Practitioner
18 Bartmus on December 25th with the findings she was
19 aware of at that time?

20 MR. ARNTZ: Objection.

21 You're asking for him to say what he thinks
22 what Dr. Wiencek would have done?

23 THE COURT: That is speculation.

24 That seems to be accurate.

25 The objection is sustained.

1 MR. WEAVER: Okay.

2 THE COURT: Just the basis.

3 Sometimes the objection doesn't lend
4 itself, but just the basis is fine.

5 MR. ARNTZ: I wanted to make sure I heard
6 the question right.

7 THE COURT: I understand.

8 We had some confusion, so not a problem.

9 BY MR. WEAVER:

10 Q. Dr. Wilson, have all your opinions today
11 been to a reasonable degree of medical probability?

12 A. Yes.

13 MR. WEAVER: Thank you.

14 I'll pass the questioning for now.

15 THE COURT: All right.

16 Thank you.

17 Mr. McBride, any questions?

18 MR. MC BRIDE: No questions, Your Honor.

19 THE COURT: We'll take a brief recess, but
20 let's come back at 3:20. That gives you a little
21 over 15 minutes, gives us an opportunity to do a few
22 things in here and then resume then.

23 During this roughly 15 minute recess you're
24 admonished.

25 (Jury admonished by the Court.)

1 THE COURT: See you back at 3:20.

2 Jury excused from the courtroom.

3 (Thereupon, the following proceedings were
4 had out of the presence of the jury.):

5 THE COURT: I need to make a record of
6 multiple bench conferences.

7 Doctor, you may step down, return to the
8 alcove room.

9 I noted three bench conferences that we
10 should make a record of during this recent testimony
11 of Dr. Wilson.

12 The first bench conference was an objection
13 posed by Mr. Arntz related to a lot of inquiry by Mr.
14 Weaver about literature that Dr. Marmareano may have
15 reviewed, and did that literature support Dr.
16 Marmareano's opinion.

17 The objection appeared to be based on a
18 misunderstanding of the question that -- or I take
19 that back.

20 This particular objection was based on the
21 fact it had not been part of Dr. Marmareano's actual
22 testimony in trial, and was not previously disclosed
23 as an expert opinion.

24 I did sustain that objection, and Mr.
25 Weaver moved on.

1 Mr. Arntz, anything to add?

2 MR. ARNTZ: No, Your Honor.

3 THE COURT: Mr. Weaver.

4 MR. WEAVER: No, Your Honor.

5 THE COURT: The second bench conference was
6 with regard to Mr. Weaver beginning to ask questions
7 of Dr. Wilson about testimony of Dr. Marmareano
8 actually at the time of trial.

9 There was an objection to the
10 appropriateness of reading testimony.

11 Part of the objection I believe was a
12 misunderstanding that the question had entailed
13 reading from the Dr. Marmareano's deposition, not his
14 actual trial testimony, and then the objection
15 evolved into an objection regarding foundation.

16 I ultimately allowed the questioning to
17 proceed as designed, and I think I made that record
18 in the record, but the discussion at the bench was a
19 little bit of a better understanding what the line of
20 questioning was, how it was going to proceed, and the
21 best way to do it.

22 Mr. Weaver did offer potentially to pose it
23 in hypothetical, as opposed to reading testimony.

24 I was inclined to take him up on that
25 offer because I thought there's more clarity to be

1 the actual testimony and inquire about the opinion.

2 Mr. Arntz, anything to add to that?

3 MR. ARNTZ: No.

4 THE COURT: Mr. Weaver?

5 MR. WEAVER: No, Your Honor.

6 THE COURT: The last one was a bench
7 conference that occurred after Mr. Arntz objected,
8 and this was regarding asking Dr. Wilson about Mr.
9 Moore's report of pain I believe on the December 25th
10 visit, and had he identified that pain level.

11 I think again there was some
12 misunderstanding of the question, and Mr. Arntz
13 initially believed the question had been asking Dr.
14 Wilson to scale the pain as relates to Mr. Moore's
15 reports of the pain symptoms, but I understood and
16 Mr. Weaver confirmed the question was just what had
17 he seen in the records.

18 I did go ahead, overrule the objection,
19 allow that line of inquiry to continue because there
20 was some debate again about foundation and whether or
21 not Dr. Wilson should be able to testify this way,
22 but the Court's ultimate determination was based on
23 the understanding there had been put into the record
24 Dr. Wilson reviewed all these records and could speak
25 to what his understanding of them was, or

1 recollection was, and then we went generally through
2 each of the records and confirmed, and I think with
3 the pain scale specifically we confirmed some
4 specifics that Dr. Wilson may have not remembered
5 correctly.

6 But I overruled that objection.

7 Mr. Arntz, anything further on that
8 objection?

9 MR. ARNTZ: No, Your Honor.

10 THE COURT: Anything else, Mr. Weaver?

11 MR. WEAVER: No, Your Honor.

12 THE COURT: All right.

13 When we will come back a little bit before
14 3:25.

15 We really need to figure out where we are
16 at in the trial, how late we're going into next week,
17 so I could be ready when we break for the day to help
18 these people understand where we are.

19 Also, this seems to be a moving target. I
20 believe we identified courtroom 15-D as a courtroom
21 where we can have Mr. Moore's testimony on the
22 witness stand.

23 Is that acceptable?

24 We tried retrofit with some equipment we
25 had making this one accessible, but that equipment

1 doesn't work, so we are needing one actually is built
2 that way, but 15-D has that.

3 MR. P. HYMANSON: Your Honor, can we assist
4 you when you come back to you know if we're half
5 days, full days, or what, next week?

6 THE COURT: My schedule's always the same,
7 Monday, Tuesday, and Wednesday half days.

8 The only issue is, if we go over to
9 Thursday, I might throw myself off the building, then
10 it doesn't matter.

11 MR. P. HYMANSON: I'm afraid you would have
12 to get in line, Your Honor.

13 THE COURT: If I'm here on Valentine's Day,
14 you all better be bringing some chocolates, flowers,
15 and stuff I'm saying.

16 It's half days Monday, Tuesday, and
17 Wednesday.

18 MR. P. HYMANSON: Very good.

19 Thank you, Your Honor.

20

21 (Thereupon, a recess was had.)

22

23

24

25

1 (Thereupon, the following proceedings were
2 had out of the presence of the jury.):

3 THE COURT: Anything before we bring the
4 jurors back?

5 MR. ARNTZ: No.

6 MR. WEAVER: Did you want to talk about
7 scheduling or anything?

8 THE COURT: Okay.

9 MR. MC BRIDE: Real quick.

10 THE COURT: Where are we at?

11 MR. MC BRIDE: I have the plan I think we
12 talked about, probably the best-laid plan for
13 tomorrow is going to be our experts, which is Dr.
14 Shoji, Shoji in the morning, and Dr. Barcay in the
15 afternoon.

16 And then depending on time, if there is any
17 time available in the morning, I might try to squeeze
18 maybe ten minutes of direct of Dr. Lasry on there
19 just to clarify a couple of things, and that's going
20 to be the extent of my direct, to the extent I don't
21 know how much Mr. Arntz would have on cross for a
22 ten-minute direct, but it just depends.

23 But then we can see how that goes.

24 But the other thing being is, that Dr.
25 Lasry has to return to work next week, so he's not

1 going to be here Monday, or Tuesday, Wednesday.

2 THE COURT: We've already brought that up
3 to the folks about that.

4 They should know Mr. Moore's not here
5 today.

6 MR. MC BRIDE: Yeah.

7 THE COURT: So that takes care of today.

8 I don't know if we're getting to Mrs. Moore
9 today, but we'll finish with Dr. Wilson.

10 Where does that put us with the next thing
11 coming, what do we have and is anyone --

12 MR. ARNTZ: I have Charlene tomorrow, so I
13 don't want to be put in the position where I don't
14 have enough time to cross Dr. Lasry, knowing he's not
15 coming next week, so we have to plan accordingly to
16 at least give me 30 minutes for him.

17 MR. MC BRIDE: Like I said, it's going to
18 be very limited examination, if I even choose to do
19 it.

20 Frankly, he already got out --

21 THE COURT: Let me interrupt you.

22 You said in the morning, if you do it at
23 all.

24 MR. MC BRIDE: The plan would be, after Dr.
25 Shoji if we have time before the lunch break.

1 THE COURT: Otherwise, it might be in the
2 afternoon?

3 MR. MC BRIDE: Or maybe not at all, just to
4 clarify a couple things.

5 THE COURT: I understand.

6 Just your point is well-taken, if we put on
7 Dr. Lasry, we're going to finish Dr. Lasry, so if we
8 need time, we need time.

9 So it will be Friday night.

10 MR. MC BRIDE: Which is a good point.

11 Maybe I put him on first thing in the
12 morning and Shoji right after.

13 THE COURT: It seems like that makes more
14 sense, then take whatever time we need with Dr. Lasry
15 and move onto the experts.

16 We still have to break when we have to
17 break going a little into the noon hour, as long as
18 were coming back at 1:30.

19 MR. MC BRIDE: Dr. Shoji's around tomorrow
20 afternoon if we have to go a little bit farther.

21 THE COURT: I need to finish these people
22 tomorrow, if we're not going to lose more time.

23 But back to my question, what are we doing
24 next, what do we have left?

25 MR. ARNTZ: I don't think we're going to

1 get there certainly today, when I don't know are
2 these their experts?

3 MR. MC BRIDE: One is mine, and one is his.
4 Barcay is his, and Shoji is mine in the
5 morning.

6 And then we're --

7 MR. ARNTZ: Shoji's in the morning?

8 MR. MC BRIDE: We're going to put Lasry on
9 for like I said ten minutes of direct, you will have
10 30 minutes at least of cross, I'll have ten minutes
11 on direct, and then we'll go Shoji pretty quick I
12 think, and then if we need to push him partly into
13 the afternoon, we can do that.

14 And then Keith has Barcay.

15 MR. ARNTZ: Four hours?

16 MR. WEAVER: No.

17 I appreciate you have been accommodating to
18 him.

19 I can check to see if he can come Monday if
20 you prefer to finish your case tomorrow.

21 MR. ARNTZ: What I'd like to do --

22 THE COURT: You are making me insane.

23 I have to give some warning to the other
24 department.

25 From my recollection we were talking about

1 various departments. I don't remember whether or not
2 Department 22 down the hall came into the mix, but I
3 think we can use some time if we need to, I just need
4 to confirm.

5 MR. MC BRIDE: I thought we talked about
6 yesterday about the best logistically would work out
7 with the experts tomorrow.

8 THE COURT: We did.

9 MR. MC BRIDE: Logistically Monday would
10 make sense.

11 THE COURT: That's why I have Monday lined
12 up, but the suggestion came Mr. Arntz may want to
13 finish his case, do Mr. Moore on Friday.

14 I have have to make sure I have a courtroom
15 to use.

16 MR. ARNTZ: We're going to do it that way.

17 If we have the entire afternoon, we should
18 be able to get Charlene and Darell done on Monday,
19 and that's the last witnesses.

20 THE COURT: Yours too?

21 MR. MC BRIDE: Yep.

22 So then we can --

23 THE COURT: It does make sense to do it
24 Monday.

25 MR. MC BRIDE: Knock it out then.

1 THE COURT: Then instruct and close on
2 Tuesday?

3 MR. MC BRIDE: Yep.

4 THE COURT: I don't even want to think that
5 because I thought we were into Wednesday.

6 MR. ARNTZ: In his opening he referenced to
7 other people he is bringing.

8 You are not bringing --

9 MR. MC BRIDE: There's no reason to bring
10 Volt (Phonetic), the economist if you're not bringing
11 Claurete (Phonetic).

12 MR. ARNTZ: And not bringing the nurses?

13 MR. MC BRIDE: The nurses, I told them -- I
14 released them from their subpoenas.

15 We thought about bringing Amy Kuchinski and
16 Jeff Germane, had them under subpoena, but I don't
17 think it's necessary.

18 I think the jury's losing interest at this
19 point, and I think I would like to get the case done.

20 THE COURT: We'll see if they have any
21 questions.

22 They've been pretty on top of it.

23 MR. ARNTZ: Did you say Wiencek?

24 MR. MC BRIDE: I never said that.

25 We introduced he may be a witness.

1 I don't know if you may call him or come up
2 as a need.

3 THE COURT: We always have to say in front
4 of the jurors any persons.

5 So I'm going to tell them Tuesday from what
6 you're telling me.

7 MR. MC BRIDE: I think that is a fair
8 estimate.

9 THE COURT: Monday in 15-D.

10 So that's where we are at right now, is
11 that correct?

12 MR. P. HYMANSON: Dr. Wilson won't have to
13 stay until Tuesday, will he?

14 (Thereupon, a discussion was had off the
15 record.)

16 THE COURT: Let's get the jurors.

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1 (Thereupon, the following proceedings were
2 had in open court and in the presence of the jury.):

3 THE COURT: As we resume with Dr. Wilson.

4 Can I have you acknowledge for the record
5 you understand you are still under oath?

6 THE WITNESS: Yes.

7 THE COURT: Okay.

8 Mr. Arntz.

9 - - - -

10 **CROSS-EXAMINATION OF DR. SAMUEL WILSON**

11 BY MR. ARNTZ:

12 Q. Dr. Wilson, my name is Breen Arntz, and I
13 represent the Moores, and I'll be cross-examining you
14 today.

15 You would agree, wouldn't you, you had
16 relied heavily on the veracity or truthfulness of the
17 records, in other words, you assumed they are
18 accurate and true, and haven't really considered
19 whether they aren't?

20 A. I have.

21 Q. Okay.

22 And in fact you have done that, you have
23 reviewed my client's deposition, is that correct?

24 A. Yes, Mr. Moore and Mrs. Moore.

25 Q. Did you read their son's deposition?

1 A. Yes.

2 Q. So you saw in those two depositions Chris
3 Moore and Darell Moore, they both disputed anybody at
4 the emergency department having taken off Mr. Moore's
5 sock.

6 Did you see that?

7 A. Yeah.

8 Q. Did you discount that testimony, or did you
9 just decide to give more credibility or credence to
10 the medical record?

11 A. Well, what I relied on was that in a
12 routine examination of a patient socks and shoes
13 would be removed by the nursing staff.

14 Q. Right.

15 That would be standard of care, wouldn't
16 it?

17 A. I'm not an expert an emergency room
18 standard of care, but just in terms of clinical
19 examination of a patient, whether it's in your office
20 or in an emergency room, it would be standard
21 practice for nurses to either remove the shoes or
22 socks, or more likely ask the patient to do that.

23 Q. Do you dispute in your report dated August
24 19, 2019 that you said you do have an expertise in
25 the standard of care, and actually gave an opinion on

1 standard of care?

2 THE COURT: Can you be more specific with
3 the question?

4 You just referred to the emergency room and
5 others. BY MR. ARNTZ:

6 Q. Do you dispute in the report dated August
7 19th, 2019 that you said you do have the ability to
8 testify as to standard of care for an emergency
9 department?

10 A. I don't recall saying that.

11 Maybe you could read it out to me.

12 Q. Okay.

13 A. If I could continue, this is the first time
14 I've been in court in Nevada, and in California you
15 could only testify with regard to standard of care of
16 emergency medicine doctors if you are an emergency
17 medicine physician.

18 Q. Well, on the second page, the second full
19 paragraph starts with, it's my opinion the patient
20 was appropriately discharged with instructions to
21 follow-up with his surgeon.

22 Isn't that a standard of care opinion?

23 A. That's very much a standard of practice,
24 that is what you would do.

25 I don't dispute that at all.

1 Q. And you have given other opinions, you been
2 here for the last couple days, where you said that
3 Nurse Practitioner Bartmus and Dr. Lasry acted within
4 the standard of care, didn't you?

5 A. You know, I don't recall saying that
6 because I've tried to be very careful about not
7 commenting on emergency room standard of care.

8 Q. Okay.

9 Let me ask you this:

10 In someone who comes in with a history of
11 the problems Mr. Moore had, complaining of calf pain,
12 is it your testimony you don't have an opinion
13 whether or not the standard of care requires them to
14 take off their sock?

15 A. I do have an opinion.

16 If you're asking me, should the patient
17 being examined have his shoes and socks removed, yes,
18 they should.

19 Q. Okay.

20 So when looking at the record Nurse
21 Practitioner Bartmus and Dr. Lasry created in the
22 hospital, you accepted what they said as being true
23 and accurate, and you said you think it's true and
24 accurate, but the testimony of Mr. Moore and his son
25 would contradict that testimony, wouldn't it?

1 A. Potentially, yes, if that's what Mr. Moore
2 said, that they didn't take off his shoes and socks.

3 Q. You said you read his deposition.
4 Did you see that in his deposition?

5 A. You will have to show that to me.
6 I can't recall the line and paragraph, but
7 I'll accept that if you just read that.

8 Q. Are you saying it's not relevant to you
9 whether or not they had him take off his shoes and
10 socks?

11 A. I didn't say that.

12 Q. Well, the fact you don't recall it from the
13 deposition would suggest it wasn't relevant to you.

14 A. Lots of things I don't recall exactly, but
15 it is relevant.

16 Q. It actually is extremely relevant here,
17 isn't it, if the standard of care requires them to
18 take off the sock to actually feel for the pulses in
19 his foot, correct?

20 A. Yes.

21 Q. Okay.

22 Now, I don't know if you had been aware of
23 Nurse Practitioner Bartmus and Dr. Lasry's testimony
24 from the trial.

25 I know counsel have been getting dailies,

1 so I don't know if they gave you the transcripts of
2 that.

3 A. I have not seen those.

4 Q. Okay.

5 You also saw from the records, didn't you,
6 that the ultrasound --

7 MR. ARNTZ: Court's indulgence for a
8 second.

9 THE COURT: Yes.

10 BY MR. ARNTZ:

11 Q. Let me ask if you recall this modification
12 Dr. Lasry made to the record.

13 You will recall the ultrasound finding was,
14 there was no evidence of deep vein thrombosis, but
15 there was what appeared to be the word appeared the
16 arterial graft appeared occluded, you saw that?

17 A. Yes, I did.

18 Q. And you saw it in Dr. Lasry's note on the
19 day after the Mr. Moore was in there he entered into
20 his chart and signed a note that said that there was
21 a possible occlusion, did you consider that a
22 modification to the record?

23 A. It's pretty much the same thing to me,
24 appears to be occluded, possible occlusion.

25 I think were splitting hair here.

1 Q. So you don't agree -- or you have testified
2 that you have accepted there was an occlusion in the
3 graft site on the left popliteal graft, correct?

4 A. Yes.

5 Q. And you don't see there's a distinction
6 between saying there is an occlusion, and possibly an
7 occlusion?

8 A. Yes, I would accept there is a distinction
9 there, but the reports from x-rays, from x-ray
10 physicians, radiologists often include terminology
11 like that when they are reviewing a study, they will
12 say, possible occlusion.

13 Yes, sometimes they say that.

14 I agree that is different from saying
15 exactly, complete occlusion of the graft.

16 Q. Okay.

17 So if I understand what you're telling me,
18 you're going to make some assumptions about whether
19 or not the radiologist who is an MD, correct?

20 A. Radiologists would generally be and MD.

21 Q. And MD who read the ultrasound scan, that
22 he may have been imprecise, you're going to make that
23 assumption he might have been imprecise?

24 A. Yes, it could be based on -- When you read
25 an ultrasound, the hard copy is selected images, so

1 the radiologist is not doing the ultrasound, has no
2 control over what images he's looking at, so he can
3 look at the images, and on the basis of the images
4 the technician saved for him he can arrive at
5 conclusions, this graft is probably occluded, yes.

6 Q. Well, then you changed the same words that
7 Dr. Lasry changed.

8 He didn't say, it's possible, but probable
9 occluded, did he?

10 A. I have forgotten what he said.

11 Q. It's right in front of you.

12 A. The --

13 MR. MC BRIDE: I'm going to object.

14 THE COURT: Objection?

15 MR. MC BRIDE: It's vague as to he and who,
16 and we're not really clarifying who we're talking
17 about now.

18 THE COURT: At this point because we do
19 have a blown up portion, for the record, let's be
20 clear who we're talking about.

21 BY MR. ARNTZ:

22 Q. Did you understand my conversation with you
23 was in relation to the radiologist, who is an MD
24 reading the film?

25 A. Yeah.

1 Q. So you can see from the report from that
2 ultrasound he doesn't say possible.

3 He says, it appears occluded.

4 Correct?

5 A. Appears occluded is what he has in front of
6 him.

7 Q. You seemed to make the same change Dr.
8 Lasry did, and that leads me to a question about if
9 you got a report from an ultrasound that said a
10 possible occlusion, wouldn't that lead you to the
11 need to do further investigation to see if it was
12 possibly occluded, or absolutely occluded?

13 A. It could, depending on the patient's
14 presentation.

15 Q. So the presentation is clearly in your
16 analysis of this case, the presentation and exam that
17 was done is critical because if that fails, and he
18 didn't -- Nurse Practitioner Bartmus didn't get the
19 pulses she says, Dr. Lasry didn't, then the rest of
20 your opinion about that exam really is irrelevant,
21 isn't it?

22 A. No, I disagree with that.

23 Q. So when you're looking at the five Ps,
24 pulse is one of those Ps?

25 A. Yes.

1 Q. And if they had taken day his sock off, get
2 a pulse in his foot the way they said they did,
3 that's not a critical conclusion for your opinion?

4 A. That's a different question you're asking
5 me.

6 Could you rephrase that, please?

7 Q. Well, originally what I said was, wouldn't
8 you agree that the question of the exam and whether
9 or not they got the pulses they said they did is
10 critical to your overall opinion, and that without
11 that your opinion doesn't carry much weight?

12 A. Well, thank you.

13 Actually, whether or not they felt the
14 pulses is less relevant than you would think because
15 you could certainly have a viable extremity without
16 palpating pulses.

17 I think I've tried to explain that.

18 Q. Okay.

19 That is a distinction.

20 So what you are saying is, it doesn't
21 matter to you whether they were being truthful about
22 palpating the pulse, and it could have just easily
23 been a Doppler?

24 A. Well, number one, I accepted the entries in
25 the chart were truthful.

1 I have no reason to believe they would
2 answer untruthful statements.

3 Number two, a Doppler does not detect
4 pulses.

5 A Doppler defects flow in the artery.

6 Q. Okay.

7 I don't know how that changes my question
8 because what I talked to you about was pulses and
9 whether or not if the report isn't accurate about
10 them taking the pulses, how it would affect your
11 opinion.

12 And then you went into the discussion about
13 whether or not they palpate the pulses isn't as
14 important as we might think or what.

15 A. Rephrase it.

16 I am accepting the record as being truthful
17 at entries.

18 I have no reason to believe they were less
19 than truthful.

20 They entered what they observed, I believe.

21 Number two, in general, and not with regard
22 to Mr. Moore, because I haven't examined Mr. Moore as
23 you know, but in general you can have a viable
24 extremity with all the rest of it intact and not feel
25 pulses.

1 Q. So the question I want you to consider is,
2 would it discount the veracity or truthfulness of
3 that record if you heard from the testimony of Dr.
4 Lasry and Nurse Practitioner Bartmus, and they said
5 they palpated normal pulses, and then you found out
6 that in fact they had not done that, would that
7 undermine in any way the way you look at the accuracy
8 of the medical record from the emergency department?

9 A. Well, I think you're can asking me if they
10 falsified the finding of pulses, would that reflect
11 negatively on my view of the rest of the record.

12 Is that your question?

13 Q. That's a better question, yeah.

14 A. Actually, it would.

15 If they falsified their entry, and in any
16 way, it would make me be skeptical of perhaps the
17 rest of the entries, sure.

18 Q. And we've heard you testify that you don't
19 believe that the mere occurrence of the fem pop graft
20 in 2012 would result in an absence of pulses,
21 correct?

22 A. Yes.

23 The whole point is that you try to restore
24 blood flow to the leg with the graft.

25 Q. Okay.

1 Do you have an opinion as to whether or not
2 it is common for pulses to be palpable and normal
3 following a fem pop graft?

4 A. It is common.

5 Q. It is common?

6 A. Yes.

7 Q. Okay.

8 So you do recall, don't you, that when Mr.
9 Moore went in in 2012 to receive the fem pop graft,
10 at the time he went in there to the emergency
11 department he had no pulses, do you recall that?

12 A. Now, which date are we talking about?

13 Q. In November of 2012.

14 MR. WEAVER: Your Honor, that misstates the
15 evidence that was in the emergency department.

16 MR. ARNTZ: Well --

17 THE COURT: It would be very helpful to
18 look at Dr. Wiencek's records and other records and
19 dates, it would be helpful.

20 MR. ARNTZ: Okay.

21 BY MR. ARNTZ:

22 Q. You see from the record up there --

23 MR. J. HYMANSON: This is page 82 of 101.

24 THE WITNESS: I'm familiar with this.

25

1 BY MR. ARNTZ:

2 Q. Give me a second.

3 You see the highlighted portion?

4 A. I do.

5 Q. And it indicates that excellent blood flow
6 was obtained through the graft?

7 A. Yes.

8 Q. Below the knee.

9 And that then Doppler examination of the
10 posterior tibial pulse not at the pre-operative --

11 A. Yes.

12 Q. So prior to receiving the fem pop graft he
13 did not have pulses, but they were able to obtain
14 them as a result of the graft, yes?

15 A. Yes.

16 Q. Okay.

17 So the need for the fem pop graft was
18 because it was disease existed in his lower leg,
19 correct?

20 A. Yes.

21 Q. And essentially resulted in a blockage of
22 that artery in the lower leg, correct?

23 A. In the mid-thigh, yes.

24 Q. So before the operation to put in the graft
25 there were no pulses, and then after they were able

1 to get a Doppler pulses.

2 Are you aware of any record says following
3 the fem pop graft they were able to get palpable
4 pulses that were normal?

5 A. Between 2012 and 2016?

6 Q. Yes.

7 A. Well, I believe Mr. Weaver at enormous pain
8 went through to show that various individuals had
9 felt pulses.

10 Q. I think what he said was, they indicated
11 there were pulses present.

12 I didn't see they were palpable in any of
13 those records.

14 A. In medical terminology it's common to use
15 pulse if you feel it, and although sometimes they
16 say, a Doppler pulse, what they mean is a flow.

17 A Doppler doesn't show the pulse.

18 After you finish a fem pop by-pass, there's
19 often vascular constriction of the legs, you can have
20 the artery clamped on the patient, some hours had
21 gone by, and when you open up the graft, often you
22 don't feel a pulse right away, a palpable pulse.

23 So you listen with Doppler, and if you hear
24 a good Doppler signal, then you think you are okay,
25 you have got it flowing.

1 The Doppler detects flow in your artery.

2 Q. And how long would you expect it before you
3 return to palpable pulses?

4 A. You would like to see that within hours.

5 Q. Is that something you would expect to see
6 in a record they made note of?

7 A. Not necessarily.

8 I would make note of it personally, but
9 many people wouldn't, just depends on the detail of
10 your post-operative visits.

11 Q. Do you recall seeing in the records from
12 Dr. Simon --

13 A. Was he a radiologist that did an
14 arteriogram?

15 Yes, I remember seeing this one.

16 Q. Do you remember seeing the letter of
17 January 12th, 2015?

18 This was two months after the surgery?

19 A. Yes, I see that.

20 Q. You see he did suffer some ischemic
21 neuropathic pain, and I believe this will resolve it
22 by Doppler?

23 A. Yes.

24 Q. Are you saying the terminology being used
25 by Dr. Simon where he said he found excellent pulses

1 by Doppler, that is actually a misuse of the
2 terminology?

3 MR. MC BRIDE: Objection, Your Honor, that
4 it's actually Dr. Wiencek later.

5 MR. ARNTZ: You're right, Dr. Wiencek.

6 THE WITNESS: It's not an exact use of the
7 terminology.

8 With a Doppler you hear flow, and you don't
9 -- it doesn't detect a pulse, it gives you flow.

10 So commonly people say a pulse was heard by
11 Doppler, but what they mean is, they heard blood flow
12 with the Doppler.

13 BY MR. ARNTZ:

14 Q. So this doesn't say, heard by Doppler, it
15 says there are excellent pulses in the foot currently
16 by Doppler examination?

17 A. Yes.

18 Q. And I don't know if you saw the other
19 letters in Dr. Wiencek's file, but counsel brought
20 them up yesterday, I believe where they talked -- or
21 a similar note was made -- or they didn't use the
22 word Doppler, just said, pulses?

23 A. Yes.

24 Q. So if Dr. Wiencek comes in here and
25 explains the only way he was able to get a pulse was

1 by Doppler, would you have any reason to disagree
2 with that?

3 A. No, if that's what his findings were, he
4 could only hear a signal, wasn't able to palpate a
5 pulse.

6 Q. You would agree with me, time is of the
7 essence when dealing with an acute limb ischemia?

8 A. Yes.

9 Q. So the opinion 5 to 10 days is a reasonable
10 enough time for him to get in to see his
11 cardio-vascular surgeon, is that still your opinion,
12 even in light of the fact three days later he lost
13 his leg?

14 A. Yes, of course.

15 I know he lost his leg.

16 Q. So I may be wrong on this, and Dr.
17 Marmareano may have said both, but my immediate
18 recollection of what he said was, that if he has a
19 blockage in the fem pop graft, then you would not be
20 able to feel a pulse.

21 A. Yes, I think he said that.

22 Q. And you disagree with that?

23 A. It's possible, yes.

24 Q. It's possible you couldn't feel a pulse?

25 A. Sure.

1 Q. Okay.

2 Nurse Practitioner Bartmus made it very
3 clear the pulse she felt, the palpable pulse she felt
4 on the 25th, was a normal pulse.

5 Would you expect that in a person had a --

6 A. I think any pulse you would detect would be
7 called a normal pulse, with the exception of a
8 patient maybe hemorrhaging, but to grade a pulse plus
9 1, plus 2, plus 3, they are very artificial. I've
10 never been able to do that in my practice.

11 I usually note, pulse present.

12 Q. So why in that letter that counsel showed
13 you today where it says, plus 2 pulse, did you say
14 that is a normal pulse?

15 A. I would say, that is normal, yes.

16 Q. Even though that is not something you have
17 experience doing?

18 A. I don't grade it that way.

19 Maybe I'm not -- or don't have as fine a
20 touch as Dr. Wiencek.

21 I think when he says, plus 2, he's saying
22 that the Doppler exam shows good flow.

23 Q. I want to be really precise with this
24 question because I think it's important for the jury
25 to understand this.

1 What you are saying is that, first of all,
2 when you hear the word normal from Nurse Practitioner
3 Bartmus, and she doesn't qualify normal for him,
4 normal for Mr. Moore, she just said, a normal pulse,
5 that you're making an assumption that it probably
6 wasn't a normal pulse, but was still a pulse, is that
7 right?

8 A. No.

9 My assumption is, that she was able to
10 palpate a pulse in Mr. Moore.

11 That's the assumption I made because that's
12 what she said in her deposition.

13 Q. Okay.

14 So you don't put any relevance on the
15 question of whether the pulse is a good normal pulse,
16 or a diminished pulse?

17 A. No.

18 Look, if you could feel a pulse in a
19 chronic path, that is fine.

20 Whether it's a grade plus 1 or plus 2, if
21 you can feel it, that's good.

22 Q. So back to the question of whether you
23 would expect us to find a normal pulse, or a palpable
24 pulse, in someone who had already demonstrated his
25 story of no pulses, when there was a blockage to the

1 artery.

2 Are you saying that you might feel
3 something close to a normal pulse in someone who has
4 a blockage in his artery?

5 A. You can, yes.

6 Q. Would that be common?

7 A. Not the most common, no.

8 Q. Normally you have to get it by Doppler, get
9 the blood flow by Doppler?

10 A. Well, in the absence of a pulse, you are
11 certainly able to hear blood flow by Doppler, if
12 there's blood flow there, you can hear it by Doppler,
13 yes.

14 Q. And could that blood flow by Doppler under
15 those circumstances, would that have been from the
16 collateral sources of blood?

17 A. Yes.

18 Q. If I understood your testimony yesterday,
19 the collateral sources would have been created
20 through the profunda?

21 A. The profunda primarily.

22 Q. How does it, the process of establishing
23 collaterals, work?

24 A. Well, you will get a Nobel Price if you and
25 I can figure that out, but I can give what the

1 current thinking is.

2 The current thinking is, that the demand
3 for blood creates an anoxygenic environment, that is
4 the absence of sufficient oxygen.

5 In the absence of sufficient oxygen, causes
6 the blood vessels to dilate, and over time with
7 exercise you will continue to dilate those blood
8 vessels.

9 Now, as humans evolved we haven't done it
10 as well as the lower mammals. For example, a rabbit
11 will have severe ischemia and generate sufficient
12 Dopplers, it will heal a gangrenous ulcer on its leg,
13 humans can't do that, but we can develop with a
14 continued exercised, absence of tobacco a usual
15 measure, reducing blood pressure, cholesterol, you
16 could have fairly good collateral flow, so symptoms
17 will be not life-altering, and in fact in some
18 instances a pulse will appear.

19 Q. So you gave factors that you know don't
20 apply to Mr. Moore, right?

21 A. I used that in a general sense.

22 Q. But we're talking about Mr. Moore right
23 now, and the question of whether his collaterals
24 would have been sufficient to generate a pulse in the
25 presence blockage to his artery?

1 A. Yes.

2 Q. And you just identified some factors that
3 would make it more likely for that to be true and
4 said, someone who doesn't have high cholesterol,
5 exercised regularly, someone who doesn't smoke,
6 correct?

7 A. Yes.

8 Q. Do you consider smoking an important
9 factor?

10 A. Yes.

11 Q. Did you see anywhere in the record where
12 either Nurse Practitioner Bartmus or Dr. Lasry
13 considered that factor when they were examining Mr.
14 Moore?

15 A. Well, they noted it in the history.

16 Q. It was noted in the history, but do you see
17 anything suggests they considered it as a factor in
18 evaluating his physical condition?

19 A. Well, that goes without saying.

20 If you are examining a patient, you ask
21 about smoking because we know smoking has a
22 deliquesce effect on the circulation.

23 Q. So he's give them the benefit of the doubt,
24 says they did consider it, they would have considered
25 then he had a history of occlusions, correct?

1 A. Yes.

2 Q. He had a history of smoking?

3 A. Yes.

4 Q. By all accounts, 30 to 40 years, correct?

5 A. Yes.

6 Q. He did he have a history of high
7 cholesterol?

8 A. I don't know.

9 I don't recollect that.

10 Q. That is something they also should have
11 considered?

12 A. It would be more the role of the primary
13 care physician.

14 High cholesterol's not an emergency.

15 Q. What I'm trying to get at is, the question
16 of whether Mr. Moore was a candidate for having
17 sufficient collaterals, that it -- or he could
18 withstand this occlusion in his leg, or whether they
19 should have done more investigation to see exactly
20 the extent of blood flow into his leg.

21 A. Well, I think their clinical examination of
22 the leg showed that blood supply was adequate on the
23 basis of what they recorded, and that that was
24 appropriate to refer him back to a vascular surgeon
25 to evaluate is there anything you need to do.

1 Q. Again, you're giving the full benefit of
2 the doubt to them that the record they created is
3 accurate, even in light of the fact that Mr. Moore is
4 proven to have had an occlusion in his artery, had
5 none of the factors would have supported good
6 collateral blood flow, is that your testimony is, you
7 give them that benefit of the doubt, even in light of
8 those factors?

9 A. Yeah, I have no reason to believe that the
10 record is inaccurate.

11 Q. Well, except for the fact Mr. Moore and his
12 son both said they never took his sock off, and the
13 fact that Dr. Lasry has modified a record from
14 appears occluded, to possibly occluded.

15 A. Those to me what are unrelated, doesn't add
16 up to a falsification of the record.

17 Q. Okay.

18 In November they just brought up the record
19 showing in November 2016 November 1st, he had normal
20 DP pulses.

21 What does that DP stand for?

22 A. Which date is that?

23 Q. November 1st, 2016.

24 A. And go ahead.

25 Q. It said he had normal DP pulses?

1 A. The dorsalis, feels the pulse on top of the
2 foot.

3 Q. And then it says, at that time there was no
4 evidence of calf pain, correct?

5 A. In 2015?

6 Q. No, November 1st, 2016.

7 MR. MC BRIDE: That's 2015 up there.

8 MR. ARNTZ: That is.

9 That's not to record I'm referring to.

10 I'm referring to the one brought up by
11 counsel November 1st, 2016.

12 THE WITNESS: Okay.

13 I've got it.

14 BY MR. ARNTZ:

15 Q. You got it?

16 A. This is May 9, 2016.

17 Q. Do you recall the record I'm talking about
18 they brought up to show there were pulses on November
19 1st, 2016?

20 A. Yeah.

21 Q. A little less than two months before he
22 went in on the 5th of December, correct?

23 A. Right.

24 Q. And then he brought up a record that said
25 it was 12/21/2016, four days before he went into the

1 emergency department?

2 A. Right.

3 Q. He didn't complain of calf pain, did he?

4 A. He was complaining of various pains, and I
5 remember ankle pain I believe was one of the areas he
6 complained of.

7 He had back pain, I believe.

8 Q. Right.

9 A. I can't recall the rest of it.

10 I don't know if he had calf pain at that
11 time or not.

12 Q. I'll represent to you I read the record as
13 was up there and saw no reference to calf pain.

14 A. All right.

15 Q. But it said he was on Xarelto?

16 A. Right.

17 Q. So within a week of going on the 25th he
18 was on the medication.

19 We talked about the black box warning,
20 correct?

21 A. Right.

22 MR. WEAVER: Well, Your Honor, lacks
23 foundation.

24 Calls for speculation he was taking it.

25

1 BY MR. ARNTZ:

2 Q. It said in the record, on Xarelto.

3 Do you accept that record as true?

4 A. Yeah.

5 What that means is, that a prescription has
6 been issued for Xarelto.

7 Q. So are you assuming that the accuracy of
8 that record isn't the same as what you would expect
9 from the emergency department on December 25th, 2016,
10 that somehow that record is less accurate?

11 A. No.

12 What I'm saying is, that when you say a
13 patient is on Xarelto, it means the physician has
14 prescribed that medication.

15 It doesn't say anything about is he taking
16 it, has he filled the prescription or not, you don't
17 know about that, but the record says that it's been
18 prescribed for him.

19 Q. Okay.

20 But you don't accept that means he's taking
21 it?

22 A. Not necessarily.

23 I'm thinking about myself for example and
24 I'm sure others who get prescriptions and don't
25 necessarily follow the advice.

1 Q. So now what you're suggesting I guess is,
2 that a person who went through an experience in
3 November 8, 2012 where he had to have a femoral
4 popliteal because he had no pulses in his foot, was
5 put on Xarelto, has another event in December of
6 2014, they had to break an occlusion, and another one
7 in 2015 they had to do the same thing, you're saying
8 you don't thinkg that person took the prescription of
9 Xarelto seriously?

10 A. I didn't say that.

11 Q. You're not assuming this record is true as
12 other records you reviewed have to do with Dr. Lasry
13 and Nurse Practitioner Bartmus?

14 A. Not true.

15 I didn't say that.

16 Q. So four days before he went in on the 5th
17 there's no evidence of an occlusion, correct?

18 A. They don't have evidence of imaging of
19 occlusion at that time.

20 Q. They don't have any pain symptoms in his
21 leg suggest he might have an occlusion?

22 A. That's correct.

23 Q. He's on Xarelto.

24 He has normal pulses present, correct?

25 A. Palpable pulses, yes.

1 Q. It says, normal pulses.

2 I don't know it said palpable?

3 A. Okay.

4 I'll accept that.

5 Q. And then four days later he goes in the
6 emergency department with pain in his calf, an
7 ultrasound is showing he has an occlusion, but you
8 assume that occlusion existed weeks or months before
9 that, correct?

10 A. That's correct.

11 Q. To what extent are you familiar with the
12 symptomology or symptoms associated with neuropathy?

13 A. Fairly familiar, yes.

14 Q. You're aware neuropathy can cause numbness,
15 pain, and tingling in the person's feet?

16 A. Yes.

17 Q. And that numbness can be so pervasive
18 around the sides of his feet, he might lose balance?

19 A. It would be a very advanced case.

20 I'm not sure that is typical at all.

21 Q. So you're not familiar with that symptom
22 causing problems for people with neuropathy causing
23 them to fall, or lose their balance?

24 A. It's a different type of neuropathy where
25 you lose a position sense in diabetics, will have

1 difficulty walking because they have lost pressure
2 sense in their feet.

3 Q. So to my knowledge there's several
4 different types of neuropathy, the kind brought on by
5 diabetes, correct?

6 A. Yes.

7 Q. The kind brought on by alcohol, correct?

8 A. Yeah.

9 Q. Alcoholic neuropathy.

10 Are you familiar with the neuropathy
11 brought on by chemotherapy?

12 A. Yes.

13 Q. And there's idiopathic.

14 What that means is?

15 A. It simply means, we don't know what is
16 causing it.

17 Q. So now within those different categories of
18 neuropathy, are you telling the jury that those
19 different types of neuropathy, diabetic neuropathy,
20 is different symptoms than a chemotherapy neuropathy?

21 A. I don't know exactly what neuropathy of
22 chemotherapy is like because I don't treat patients
23 receiving chemotherapy as a rule.

24 Q. I guess my question is:

25 Do you have some source of knowledge or

1 experience with the concept that one type of
2 neuropathy associated with one etiology will be
3 different than another type of neuropathy?

4 A. I'm sorry, I can't answer that question.
5 I'm not that skilled as a neurologist.

6 Q. Okay.

7 And are you aware the time he went into
8 seeing to the emergency room on December 25th, 2016
9 he was using a cane?

10 A. I had read he used a cane, yes.

11 Q. Does that support the conclusion a person
12 who uses a cane is somebody who has good balance,
13 doesn't have any instability with his feet, and has a
14 normal gait?

15 A. Well, you use a cane and have a normal
16 gait, yes.

17 Q. Again, you accepted the reference in the
18 record as being accurate, without paying attention to
19 the other facts associated with Mr. Moore, namely
20 that he used a cane?

21 A. I think it said he used a cane, or even a
22 wheelchair, five percent of the time is my
23 recollection.

24 Q. Okay.

25 A. I don't remember any of the notes in the

1 emergency room commenting on his use of a cane.

2 Q. Let me change gears a little bit.

3 You -- Are you currently retiring from
4 academia?

5 A. Yes.

6 Q. And in association with that, are you also
7 retiring from an active practice?

8 A. Yes.

9 Q. How long has that process been going on?

10 A. About a year.

11 Q. And does that apply equally to both of
12 those, you have been retiring from the academia at
13 the same rate you're retiring from your active
14 practice?

15 A. I retired from active surgery over the last
16 year.

17 I'm still very active in academic things,
18 and editing, and writing in a textbook right now, and
19 I have plenty of consultative work, so I gradually
20 slowed down.

21 Q. You have been in academia since when?

22 A. I --

23 Q. By academia, I mean having an active
24 teaching role as a college professor?

25 A. Yes.

1 Q. How long have you been doing that?

2 A. I was appointed to the faculty at UCLA in
3 1972.

4 Q. Since 1972, you have been writing articles
5 and contributing to books and various other writings
6 and presentations?

7 A. Yes.

8 Q. I'll say, your curriculum vitae is a
9 doctor's word for resume?

10 A. It's just Latin.

11 Q. The curriculum vitae is about as long as
12 I've ever seen one.

13 You must have over 2,000 articles in here?

14 A. No, 500.

15 Q. Really?

16 A. Not counting book chapters.

17 Q. Only one category, I see.

18 A. I published about ten to twelve articles a
19 year when I was very active.

20 Q. One category I see 373.

21 You were invited to to do international
22 lectures, 27 of those.

23 I mean, I was going through and doing a
24 rough assessment of how many different entries there
25 are, and there's got to be over a thousand entries.

1 A. Okay.

2 Q. I guess my question is:

3 Is this all the things you have done since
4 1972, or did you even go back beyond 1972?

5 A. There's about maybe ten that go back before
6 '72 I did when I was in training.

7 Q. And what commitment of time do these
8 different things you have contributed to, or writing,
9 or go and speak, what commitment of time does that
10 require?

11 A. Well, it would be probably a good ten
12 percent of my time.

13 A lot of it would be done in the evening
14 hours.

15 But all together it probably would be ten
16 percent of my working hours.

17 Q. And then what percent of your working hours
18 takes up -- would the academia take up, and by that I
19 mean teaching position, whether it be in the hospital
20 or --

21 A. I would be estimating at maybe 20 percent.

22 Q. So with all this stuff you have done, and
23 all the things you have done since 1972, is your
24 testimony that only takes up 30 percent of your time?

25 A. Yeah.

1 Q. The rest of the time is spending active
2 practice?

3 A. Yes.

4 Q. How much to you charge to be here?

5 A. For this I charge \$5,000.

6 However, this is my third day here, and
7 we're going to have to work out some type of
8 reconciliation.

9 I've have not paid for the hotel myself, I
10 don't want you to think that.

11 But I'm not sure who has paid for it, Mr.
12 Weaver's organization, but it's been three full days.

13 I left Los Angeles, I left my home on
14 Tuesday morning at 5:30 a.m., and this is Thursday at
15 4:20, and I'm still here.

16 Q. And is your day -- are you saying your
17 daily rate is \$5,000?

18 A. I said, I've never been involved in
19 anything like this before.

20 All I can tell you is, that usually when I
21 testify in court, it's one day, or a half day, and
22 it's \$5,000.

23 Q. Okay.

24 So you charge the same for half day or full
25 day is the same?

1 A. I never testified for a full day, so I
2 don't know what the going rate is.

3 Q. But according to your fee schedule, if I
4 understand you right, you would charge --

5 A. Ordinarily.

6 Q. -- \$15,000 for the three days you have been
7 here?

8 A. How much?

9 Q. \$15,000?

10 A. Well, can you tell Mr. Weaver that that
11 would happen?

12 I don't know what will happen.

13 I'm concerned.

14 Q. Okay.

15 A. Let me just say, that would be a very
16 pleasant occasion if that did occur.

17 Q. You don't have any intention of charging
18 that amount?

19 A. I have no idea yet what to do about this.

20 Q. Okay.

21 Would you say -- I'm jumping around a
22 little bit, I'll get back into more of a flow here,
23 but would you say the 28th he was properly assessed
24 for amputation?

25 A. Not on the 28th.

1 I think it was -- the application I think
2 was done by an orthopedic surgeon, and it was a
3 couple of days later he was called in after the they
4 decided that the thrombolysis wasn't going to work.

5 Q. The thrombolysis was done of the graft,
6 wasn't it?

7 A. Yes.

8 And the attempt would be for any other
9 arteries they could access.

10 Q. Was there any evidence they attempted to
11 use TPA therapy on the profunda?

12 A. Yes.

13 Q. And were they successful with that?

14 A. They thought it was possibly successful
15 that they reduced the amount of clot there.

16 Q. Isn't it true that in order for the TPA
17 therapy to work, you have to have blood flowing
18 through the area, in other words, there has to be a
19 way for it to come in and go out?

20 A. For TPA?

21 Q. Yes.

22 A. No.

23 What TPA is, is usually given by a catheter
24 into the clot itself to dissolve the clot.

25 So there's no blood flowing at that point.

1 Q. Okay.

2 The treatment that was rendered at the time
3 of the amputation during that stay started on the
4 28th, would you say that was necessary as a result of
5 the condition?

6 A. The amputation?

7 Q. Yes.

8 A. Yes, it was necessary.

9 Q. And you have done that type of treatment
10 before, you customarily have your patient stay in
11 ICU?

12 A. I missed that.

13 Q. Do you customarily have the patient stay in
14 the ICU department?

15 A. Well, you do if the patient's receiving TPA
16 because it can cause bleeding, as it did in Mr.
17 Moore, from any other site where there's an opening
18 of an artery.

19 Q. Because the thrombolytic in it?

20 A. Yes.

21 Q. And are you familiar with how long Mr.
22 Moore stayed at the hospital for the amputation?

23 A. Before the amputation, or all together?

24 Q. The whole time.

25 A. Yeah -- I can't remember the exact number

1 of days, but it was in the order of a week.

2 Q. And that would have been reasonable and
3 customary for that type of treatment he was
4 receiving?

5 A. Yeah.

6 Q. And customarily would you have somebody who
7 has received that type of treatment go from the
8 hospital, the ICU, and go into a rehab facility?

9 A. Yes.

10 Q. How long would you normally expect to see
11 someone in a rehab facility?

12 A. You know, it would just depend on what you
13 wanted to accomplish in the rehab facility.

14 It would be some time later usually, let
15 the patient go home for the amputation site to heal,
16 and when that is healed, then you begin to do rehab
17 to get him ready for prosthesis.

18 So probably actively it wouldn't occur for
19 say two to three weeks, and then he would go into an
20 out-patient rehab situation, parallel bar walking,
21 possibly even an early fit prosthesis, crutches, all
22 of that to get him going.

23 Q. Are you familiar with the classification of
24 acute limb ischemia that is in stages?

25 A. That is in?

1 Q. Stages, stages 1, 2 and 3?

2 A. Yeah.

3 Q. So you see this is a chart broken down into
4 three stages, and the second stage is 2-A and 2-B?

5 A. Yeah.

6 Q. And you are familiar with this
7 classification system for acute limb ischemia?

8 A. I am.

9 Q. So the first stage says, limb is viable,
10 not immediately threatened.

11 You see there's no sensory loss, no muscle
12 weakness -- in both the arterial and venous?

13 A. Yes.

14 Q. Would you agree with the first stage of
15 that acute limb ischemia?

16 A. Yes.

17 Q. And the second page -- there is two stages.

18 Stage A is marginally threatened,
19 salvageable if promptly treated, and then it gives
20 the different things you might see, says minimal dose
21 or none.

22 What does that mean?

23 A. I guess it means that there's numbness of
24 the toes.

25 Q. There may be numbness the toes minimal or

1 none, correct?

2 A. Yeah.

3 Q. And then in the muscle weakness it says,
4 none.

5 And under Doppler it says, often inaudible
6 in the arterial, and venous audible, correct?

7 A. Yes.

8 Q. So in the case of Mr. Moore --

9 A. Are you asking me if I agree with that?

10 Q. Do you not agree with this staging system?

11 A. I can certainly not agree with it if I
12 don't.

13 Q. Is that your testimony, you don't agree
14 with the staging system of acute limb ischemia?

15 A. Yeah, I think these are a little contrived,
16 but an inaudible signal would put the patient into a
17 3-B in my estimation because an inaudible signal is
18 really very advanced.

19 Q. 3-B or 2-B?

20 A. 2-B.

21 Sorry.

22 Q. Okay.

23 So a person who is a 2-A, marginally
24 threatened, salvageable if not promptly treated, he
25 may have an audible pulse by Doppler?

1 A. Possibly.

2 Q. So in the case of Mr. Moore there's been
3 some discussion about the extent to his pain
4 complaints in his calf, and that's been minimized by
5 you I would say.

6 Do you agree with that, it has a minimal
7 finding of calf pain?

8 A. No, that is what brought him to the
9 emergency room on the 25th of December.

10 Q. But in relation to his acute limb ischemia,
11 you didn't consider that being a significant finding?

12 A. That is not a finding of acute limb
13 ischemia.

14 It's more the foot pain that signifies
15 acute limb ischemia.

16 Q. Are you familiar with -- Do you know why
17 Mr. Moore came to the emergency department on
18 December 5th, Christmas day, of all days?

19 A. Yeah, it was my understanding he had calf
20 pain, which had come on after a period of more
21 walking than he generally did.

22 Q. Well, the calf pain had been present for a
23 day, correct?

24 A. Yes.

25 Q. Okay.

1 And are you familiar with Mr. -- You're
2 obviously familiar with Mr. Moore's history of
3 occlusions in 2015 and 2014?

4 A. Yes.

5 Q. And initially the graft in 2012.

6 Are you aware that his doctor, Dr. Wiencek,
7 had told him, if you feel anything like this, I need
8 you to get to the emergency room as soon as possible?

9 A. I'm not aware of that discussion.

10 Q. Would you agree that that is sound advice?

11 A. Now, what exactly is the advice, if he has
12 --

13 Q. If he has pain into his left lower limb,
14 the place where he had the fem pop graft, if he feels
15 pain in that area, he should get to the hospital as
16 soon as possible, and have them call him --

17 A. Well, I think that is okay.

18 Q. Especially, given if fact he's already had
19 two occlusions and a fem pop?

20 A. Yeah.

21 Q. So you know the reason he went to the
22 emergency room on December 25th.

23 Do you find it significant he would go to
24 the emergency room on Christmas of all days?

25 A. I suppose you could say, it bothered him

1 enough to skip Christmas dinner and go to the
2 hospital, yes.

3 Q. Did you see --

4 A. On the other hand, it could be that he went
5 because he felt there would be fewer people in the
6 emergency room on Christmas.

7 It's an impossible question to answer.

8 Q. So is that another assumption you are
9 making against my client, that he had some ulterior
10 motive other than the fact he had these symptoms and
11 been told to go?

12 MR. WEAVER: Objection, Your Honor.

13 He asked him to speculate in the first
14 place.

15 THE COURT: You are asking him to
16 speculate.

17 MR. ARNTZ: No, I'm questioning whether he
18 has speculated.

19 I think he's speculating right now.

20 THE COURT: Clarify the question.

21 Sustained.

22 BY MR. ARNTZ:

23 Q. You just testified that he may have gone
24 because he had this concern, but he may just have
25 well have gone that day of all days because he might

1 have thought the number of patients was less, right?

2 A. No, I suggested both may have been
3 operative.

4 One, he was concerned because of pain in
5 his calf, he knew he had venous thrombosis in the
6 past, perhaps he was concerned, and this is not
7 speculating, I think he was concerned he might have
8 deep vein thrombosis.

9 Q. So you went from an arterial problem he had
10 been treated extensively for, and said the reason he
11 went was because of a DVT, is that right?

12 Who said that?

13 Q. You just said that.

14 A. All right.

15 Q. The reason he went there was because of a
16 concern of DVT, not because of an arterial occlusion?

17 A. I don't think Mr. Moore made a diagnosis.

18 I think he simply said, it happened.

19 Q. So when he got to the emergency room, the
20 health care providers made a diagnosis?

21 A. Yes.

22 Q. Okay.

23 So are you aware of anything within the
24 records that would help you discern whether it was he
25 thought there might be fewer patients, or had this

1 concern of another occlusion in his artery?

2 A. No, I distinctly remember him saying in his
3 deposition, it wasn't the same as when he had the
4 prior occlusions.

5 Q. That's not my question.

6 My question was:

7 Do you know of anything within the records
8 that would support or help you discern whether it was
9 one or the other of the two motivations you gave for
10 why he would go to the emergency room on Christmas
11 day?

12 A. You know, I can't tell what was going on in
13 his mind at that time.

14 Q. I'm asking if there's anything in the
15 records could help you do that?

16 A. No.

17 Q. Okay --

18 THE COURT: Can I have counsel at the
19 bench, please?

20 (Thereupon, a discussion was had between
21 Court and counsel at sidebar.)

22 THE COURT: Folks, I'm sorry.

23 (Thereupon, a discussion was had between
24 Court and counsel at sidebar.)

25

1 THE COURT: Thank you.

2 Mr. Arntz, whenever you ready.

3 Thank you.

4 BY MR. ARNTZ:

5 Q. I'll get back to that after we find the
6 record.

7 This is the record from 12/25/2016.

8 This is where he goes in and says, it felt
9 like spasm.

10 The report says, history of DVT on the leg
11 and became concerned.

12 So nothing in that report says anything
13 about how many patients that were going to be there,
14 but it does talk about the fact he had motivation
15 because of a concern because of his history, right?

16 A. Yes.

17 Q. Okay.

18 Do you treat individuals with chronic
19 occlusions?

20 A. Yes.

21 Q. And how do you treat them?

22 A. Well, first of all, we would use what is
23 called conservative non-interventional treatment.

24 We obtain if we can a normal blood
25 pressure, normal cholesterol, anti-platelet agents

1 such as aspirin, more recently Xarelto's been
2 approved for prevention of thrombolytic events, and
3 commonly stated as a supervised exercise program, but
4 we don't interpret that as going to the gym or
5 walking a set distance or number of paces.

6 That's conservative management.

7 Q. And then what is more aggressive?

8 A. That would be obtaining an imaging test to
9 see is there something that is safely correctable and
10 that would significantly improve his life activities,
11 but we won't make an intervention, unless the
12 claudication has impacted -- I use the word
13 claudication as chronic disease has impacted his
14 ability to live a normal life.

15 Q. And claudication is another word for pain?

16 A. It's a cramping occurs in the calf with
17 walking.

18 Q. Okay.

19 So he does indicate in his record -- or at
20 least the record indicates that he felt spasms in his
21 calf since the day before, he had a history of
22 clotting and became concerned, right?

23 A. Right.

24 Q. Is it your testimony that -- First let me
25 ask you, you probably don't anymore, but was there a

1 time when you were on call for emergency departments
2 to go and work as a consult for people who were like
3 Dr. Lasry's position might call you?

4 A. Up until just a few years ago --

5 Q. So --

6 A. -- when they started giving payments to be
7 on call, my colleagues dropped me out of the call
8 schedule.

9 Q. They didn't want you to get the payments?

10 A. They said, we don't want you older doctors
11 working so hard.

12 Q. So I'm assuming your testimony is going to
13 be, had you been called to see this patient, you
14 would have sent him home, is that right?

15 A. If I would have been on call.

16 Q. Had you been on call, and been asked to
17 come in see this patient, as a result you would have
18 sent him home?

19 A. No, I would have probably listened to the
20 report that either Nurse Bartmus or Dr. Lasry would
21 give me and make a decision based on that report.

22 Q. Would you do a physical examination of him?

23 A. If I was called in?

24 Q. Yes, sir.

25 A. If I came in, yes.

1 Q. If you saw there was an occlusion in the
2 ultrasound, and specifically in this ultrasound
3 showed no evidence of DVP, but they did do a Doppler
4 of the vein, correct?

5 A. Yes.

6 Q. But didn't do one of the artery?

7 A. Right.

8 Q. Would you have gone and ordered another
9 test to doing a Doppler of the artery?

10 MR. MC BRIDE: Your Honor, can I object?

11 This is really beyond the scope, and also
12 goes into our motion in limine on this subject.

13 THE COURT: Well, technically it is, but it
14 does seem like we're going into some other areas.

15 I'll give you a little latitude, Mr. Arntz,
16 but let's bring it back to the topic that was part of
17 the direct.

18 MR. ARNTZ: Okay.

19 I'd like to make a record on that later,
20 but --

21 THE COURT: That's fine.

22 BY MR. ARNTZ:

23 Q. So you would have done a Doppler of the
24 artery?

25 A. I would have listened to the arteries in

1 the foot, yes.

2 Q. Is it important for you to know like that
3 staging system talked about, it's important for you
4 to know whether you can hear the blood flow in both
5 the vein and the artery, correct?

6 A. What it does is backs up my clinical
7 impression.

8 I would have come in, examined him,
9 presumably arrived at the same conclusions Dr. Lasry
10 had, and then you are the specialist, so I would have
11 listened to the flow in the artery to back up my
12 overall impression.

13 Q. And if you had done that Doppler of the
14 artery and found there wasn't blood flow, what would
15 you have done next?

16 A. Well, that would be a totally different
17 picture if there wasn't blood flow because the foot
18 would be very different, would be as it was on the
19 28th.

20 Q. So is staging the classification system we
21 looked at earlier for a 2-A it says, marginally
22 threatened, but salvageable if promptly treated, and
23 then it talks about the sensation or loss, which
24 could be none, muscle weaknesses could be none, but
25 there is a difference, being what they said, this

1 Doppler signal, the vein being stronger possibly than
2 the artery, is that your experience?

3 A. No.

4 They are two totally different signals.

5 With the vein you're listening for blood
6 flow, and imaging to see if there's clots within the
7 vein.

8 And then you're doing augmentation to see
9 if you can make the blood flow accelerate,
10 decelerate, it's a totally different examination,
11 between the vein and artery.

12 Q. But it was brought up I think yesterday
13 that it was significant to you that in the ultrasound
14 done they did a Doppler of the vein, and they showed
15 blood flow?

16 A. Yes.

17 Q. So my point is, you could have blood flow
18 in the vein, but not have audible blood flow in the
19 artery, is that correct?

20 A. I don't think so.

21 Q. So are you saying that this classification
22 system is flawed when it talked about the Doppler
23 signals?

24 A. Yeah, I'm not in agreement with it.

25 Q. Okay.

1 Let's talk about --

2 A. In fact, I don't even agree with the title,
3 the classification of acute ischemia.

4 We're talking about, number one, it's not
5 acute limb ischemia.

6 Q. Are you arguing with the standard for
7 vascular surgery standards?

8 A. I don't know when these were published, or
9 who published them.

10 Q. Do you generally adhere to those standards?

11 A. I would -- I would not classify my patients
12 this way.

13 Q. You would classify them by the five Ps,
14 which are all done manually by the examiner, in other
15 words you get a pulse?

16 A. Yes.

17 Q. A visual, you do these other things that
18 are not tests, they are examinations, correct?

19 A. Yes.

20 Q. But in this classification of acute limb
21 ischemia you actually have a test, a Doppler test?

22 A. Right.

23 Q. That confirms blood flow in both the vein
24 and the artery, but that I guess in your testimony is
25 that that is less reliable than a physical exam where

1 you're looking at a patient?

2 A. No, in -- If I could just simply say that,
3 I think that when you have an inaudible signal, that
4 the condition is really a 2-B, not a 2-A, that is how
5 it differs.

6 Inaudible signal really signifies advanced
7 ischemia.

8 Q. Okay.

9 So let's just focus on 2-A, but let's do it
10 the way you said, and if there's no difference in the
11 audible signal from the Doppler, that would put it in
12 a category where it's marginally threatened,
13 salvageable if promptly treated.

14 You agree with that?

15 A. So if there's a signal, I would leave it at
16 2-A.

17 Q. Isn't that what your inference is?

18 A. If it's marginally threatened, salvageable
19 if promptly treated, I don't know what promptly means
20 in this. I expect they mean, maybe a week or so you
21 bring the patient in for surgery, and he had an
22 audible signal.

23 Yeah, I would leave that as a 2-A.

24 Q. All right.

25 I don't mean to be argumentative with you,

1 but the words marginally threatened and salvageable
2 if promptly treated, those words to you suggest you
3 could wait a week to treat him?

4 A. Well, what does marginally threatened mean,
5 and what does threatened mean?

6 This is a very subjective description.

7 Q. These are classifications you said you
8 accept.

9 Are you telling me you don't know what the
10 words marginally threatened mean?

11 A. I don't know what they mean by marginally
12 threatened.

13 I'd have to read the whole article to
14 figure out what is going on here.

15 Q. What you don't see in this classification
16 of acute limb ischemia is 1 and 2-A, you don't see
17 actually in 3 or 2-B, you don't see any reference to
18 extreme pain, do you?

19 A. Well, that's not a category.

20 It a very simple table.

21 It's not a category, it's in the table.

22 Q. It does talk about sensory issues though?

23 A. Sensory loss?

24 Q. Right.

25 A. I think by the way that is not as important

1 as a description of pain.

2 I would do it differently if I were writing
3 the book.

4 Q. I got that.

5 A. I actually have.

6 Q. So if -- Let's say you have somebody in
7 2-B, what is immediately threatened, salvageable if
8 immediately -- What does revascularized mean?

9 A. That is acute ischemia.

10 Q. And that is where you have toes associated
11 with pain, and the rest they are talking about pain,
12 correct?

13 A. Now we got pain, yep.

14 Q. And the muscle weakness is mild or
15 moderate?

16 A. Yes.

17 Q. Certainly there was some evidence he had
18 muscle weakness, he was using a cane and had spasming
19 in his calf?

20 MR. WEAVER: Excuse me, Your Honor.

21 That lacks foundation.

22 There's been no evidence in the record he
23 had pain.

24 THE COURT: Well --

25 MR. ARNTZ: There's evidence in the record,

1 maybe not in this medical record.

2 BY MR. ARNTZ:

3 Q. But he testified he used a cane and a
4 wheelchair from time to time, correct?

5 A. Yes.

6 Q. So if we put him into that category, you
7 would at least go and do another ultrasound of his
8 arteries, wouldn't you?

9 A. If he was in -- or had the description of
10 2-B, yes, I would do an ultrasound.

11 Q. Would you admit him?

12 A. It depends on the amount of pain he had and
13 the changes in his foot, the skin.

14 But if all of these are true, if he has an
15 inaudible Doppler signal, I would get imaging and
16 most likely admit the patient.

17 Q. Okay.

18 The differential diagnoses by practitioner
19 are important, aren't they?

20 A. Yes.

21 Q. And explain for the jury what a
22 differential diagnosis is.

23 A. That is a list of things that you think
24 maybe the diagnosis -- and generally listed from what
25 you think is the most likely diagnosis to the least

1 likely diagnosis.

2 Q. Did you happen to read Dr. Barcay's
3 report?

4 A. His letter?

5 Q. Yes.

6 A. Yes.

7 Q. You saw in there he came in with pain to
8 the emergency room department, he came in with pain
9 at a fem pop graft appeared occluded, was given
10 Percocet in the emergency department for the
11 treatment of pain, do you remember that from the
12 record?

13 A. I can't remember specifically, but I'll
14 accept your recitation of it.

15 Q. And Percocet is a pretty strong narcotic
16 for treatment of pain, isn't it?

17 A. Yes.

18 Q. So if he comes into the emergency room
19 complaining of pain of intensity level of 7, but is
20 given Percocet, you would expect that pain to
21 diminish, wouldn't you?

22 A. Not really because he had been chronically
23 taking even Oxycodone, which is pretty strong.

24 Q. Do you know whether he had taken any that
25 day?

1 A. No.

2 Q. So they go, and they do a differential
3 diagnosis, deep vein thrombosis, /S-RT right sprain or
4 strain, right?

5 A. All right.

6 Q. I believe Mr. Dr. Barcay misinterpreted
7 this record because he also included the arterial
8 occlusion area, peripheral arterial disease.

9 Can you see they didn't include that in
10 their differential diagnosis, did they?

11 A. The diagnosis 1 and 2 are I think from the
12 past history.

13 Q. That's what I think too.

14 It says 6/27/2015?

15 A. Yeah.

16 Q. So those have been prior differential
17 diagnoses?

18 A. Right.

19 Q. Of that?

20 A. Right.

21 Q. And yet in the differential diagnosis that
22 Nurse Practitioner Bartmus and Dr. Lasry created they
23 didn't include close in the differential diagnosis?

24 A. Okay.

25 Q. And you think that is okay, even though

1 there was an ultrasound showing an occlusion in the
2 artery?

3 A. Yes, because he didn't have signs and
4 symptoms that would lead you to believe that was the
5 current problem.

6 He certainly had artery disease.

7 I don't believe the time they examined him
8 that the arterial occlusion was acute, so --

9 Q. You didn't really know at that point, did
10 you?

11 I mean, on December 21st, four days
12 earlier, he had none of those symptoms, he didn't
13 have any complaints that lead anybody to believe he
14 should go to the emergency room, this is all things
15 he's been through before, so are you saying that even
16 in light of that fact there have been four days, and
17 this developed in that time period, that is not
18 acute?

19 MR. WEAVER: Objection, Your Honor.

20 It's quadruple compound.

21 THE COURT: It is multiple compound.

22 I'll sustain.

23

24

25

1 BY MR. ARNTZ:

2 Q. But you understand the foundation I laid
3 for that regarding the examination on the 21st of
4 December?

5 MR. WEAVER: It's still quadruple compound.

6 THE COURT: I don't think that is correct,
7 Mr. Arntz.

8 If you want to break it down or something,
9 but you're asking many compound questions.

10 MR. ARNTZ: I'm trying to get through this,
11 Your Honor.

12 THE WITNESS: I appreciate that.

13 THE COURT: Change a few things.

14 BY MR. ARNTZ:

15 Q. Do you recall Mr. Moore was seen on
16 December 21st, 2016, four days before he went into
17 the emergency department?

18 A. At the pain management clinic, yes.

19 Q. And at that time he didn't say any signs or
20 symptoms to that practioner he was having an acute
21 ischemic event, did he?

22 A. No, he reported pain in his legs, but he
23 didn't say, I have an acute arterial event.

24 Q. He reported pain in his ankle?

25 A. Yes.

1 Q. And they apparently took a pulse and found
2 one?

3 A. I think so, yes.

4 Q. And within four days he had taken himself
5 because of a concern he had over an arterial problem
6 to the emergency department, right?

7 MR. WEAVER: Lack of foundation.

8 THE COURT: Sustained.

9 BY MR. ARNTZ:

10 Q. The note I read to you just a minute ago
11 says, he had a concern for his leg, and that is the
12 reason he was there, didn't it?

13 MR. WEAVER: Again, Your Honor, that lacks
14 foundation it was an arterial problem.

15 That --

16 THE COURT: You want to put the note up and
17 see what that description is, get that clarification?

18 MR. ARNTZ: These are things everybody
19 heard.

20 I'm trying to get through it.

21 THE COURT: Mr. Arntz, put up the document
22 and show the information.

23

24

25

1 BY MR. ARNTZ:

2 Q. Again, this is the report that comes in
3 with, reports left calf pain since yesterday, felt
4 like spasming, that's a sign, isn't it, a symptom
5 that could lead to the conclusion he has a problem
6 with an artery?

7 A. See, as I read that it says, but reports he
8 has a history of DVT in the leg, and became
9 concerned, and I read that as becoming concerned that
10 he hasn't had a recurrent DVT in the leg.

11 Q. Fair enough.

12 And my own expert said, it was appropriate
13 to do an ultrasound to rule out DVT, but in the
14 process of doing that ultrasound they found evidence
15 of an occlusion in the artery?

16 A. Yes.

17 Q. And so knowing that he had previous
18 occlusions in the artery, and that was evident,
19 wasn't it, by the note of 6/25 where we talk about
20 the different diagnoses, and that treatment took
21 place in June of 2015?

22 A. Yes.

23 Q. That showed he had a history of arterial
24 occlusion, correct?

25 A. Yeah.

1 Q. So we have a person coming in with this
2 concern and that finding from ultrasound, and without
3 more would you have sent him home?

4 A. Well, if he had related to me the condition
5 of his extremity as was noted in the chart, and if
6 that had been related to me that he had no deep vein
7 thrombosis, and he had a graft that looked like it
8 was occluded again, but he didn't have symptoms or
9 signs of acute ischemia.

10 I would review that as a chronic condition,
11 and I think I would probably have said, given the
12 preamble I've said, let me see him in the office and
13 see what is going on.

14 If he had said that he's got signs of acute
15 ischemia, his foot is cold, he's got pain in the
16 toes, can't dorsiflex his foot, you know, I'd be in
17 to take care of that, yeah.

18 Q. So if they called you and said, he
19 presented with a concern about his leg, he has a
20 history of acute arterial disease, he's had previous
21 occlusions, and by the way we have an ultrasound
22 shows an arterial occlusion, you wouldn't even come
23 to the hospital?

24 A. It would depend on his condition.

25 If his extremity had the signs and symptoms

1 of normal circulation, what would be the point of
2 rushing into the hospital?

3 You are not going to do anything.

4 Q. You named a couple of things, you would
5 have done the -- already you said you would have done
6 a Doppler of his artery?

7 A. I wouldn't have changed anything.

8 I would have heard audibles, given the
9 signs and symptoms reported by Dr. Lasry and Nurse
10 Practitioner.

11 Q. Again, your entire opinion is based on
12 whether or not they actually did that pulse test,
13 isn't it?

14 A. You're absolutely right.

15 Q. You would agree with me, wouldn't you, if
16 Dr. Lasry failed to actually put his hands on Mr.
17 Moore and examine him, that would be below the
18 standard of care?

19 A. If Dr. Lasry had not examined him, that
20 would.

21 I'm not going to comment on emergency
22 medicine standards of care, but I would expect Dr.
23 Lasry in the ordinary treatment of the patient would
24 do that.

25 Q. You certainly would not have been able to

1 make the statement you made in the last question if
2 you accept all those records as true, if in fact you
3 had reason to suspect he had not put his hands on him
4 and tested his pulse?

5 A. I don't have any reason to expect he didn't
6 put his hands on him.

7 Q. Would you agree with me that the same would
8 be true for Nurse Practitioner Bartmus, if she
9 represents in the record she did a physical exam, and
10 actually hadn't, that would be below the standard of
11 care?

12 A. Yeah.

13 Q. In fact, that would be beyond the standard
14 of below the standard of care, would be a violation
15 of their oath as practitioners, wouldn't it?

16 A. Yeah.

17 Q. Creating a fraudulent record?

18 A. That's right.

19 Q. I'm skipping through a lot of stuff, so I
20 I'm winding down.

21 What are the surgical options for someone
22 who has an occluded artery?

23 And I'll ask you next if they differ based
24 on whether it's chronic or acute, the surgical
25 options for an occluded artery?

1 A. For with acute ischemia?

2 Q. Let's start with acute ischemia.

3 A. With acute ischemia.

4 Surgical options would be to extract the
5 clot using a type of balloon catheter, and try to
6 restore flow that way.

7 It's not particularly successful.

8 So today we generally go for lysis first
9 with an attempt to dissolve the clot.

10 Q. Is a surgical thrombectomy an option?

11 A. Yes.

12 Q. Okay.

13 How about re-grafting it?

14 A. That's possibly an option, yes, you could
15 put in a second graft, but if your first graft is not
16 functioning, then the second graft is a very poor
17 prognosis.

18 Q. When you say, a secondary graft, what do
19 you mean?

20 A. If you put in a second by-pass.

21 Q. Okay.

22 I think you actually wrote an article many
23 years ago on using a profunda to create a secondary
24 graft?

25 A. Yes, made a movie of it.

1 Q. Is that something still an option?

2 A. Unfortunately, it hasn't been practiced
3 widely, but it is an option, and it's sometimes
4 appropriate.

5 What you would do is, take the graft off
6 the profunda to avoid re-operating on a previously
7 dissected area.

8 Q. You testified that your opinion is, he
9 would have lost his leg regardless, and I'm assuming
10 that opinion is based on -- or an assumption on my
11 part, you wouldn't have admitted him on the 25th?

12 A. Given the record in the chart, no.

13 Q. If you had admitted him on the 25th, do you
14 have an opinion whether he would have lost his leg
15 anyway?

16 A. I think he was destined to lose that leg
17 because of continual progression of disease.

18 I think he was developing end stage
19 disease, wasn't going to be corrected other than
20 temporarily.

21 Q. So previously you testified that that could
22 have been a number of months, could have been a year
23 or more, correct?

24 A. Yes.

25 Q. And importantly, it also may have involved

1 a different type of amputation, wouldn't it?

2 A. Possibly.

3 Q. Might have been below the knee?

4 A. It could have been.

5 Q. So him not getting admitted on the 25th
6 possibly created a loss of chance on his part to have
7 a successful treatment and have a longer period of
8 time with his leg, correct?

9 A. What was done?

10 I mean, under what circumstances?

11 Q. If he's admitted, and they are treating him
12 with TPA, or treating him with something to break up
13 that clot, and if successful, that chance could keep
14 his leg longer was lost by not being admitted?

15 A. If it were to be successful, and they
16 opened up the graft, and there was flow through the
17 graft, he would have retained his extremity for a
18 longer period of time.

19 Q. At the very least had he not retained it
20 forever, he would end up having amputation, he lost
21 the chance to have on amputation below the knee?

22 A. I can't say that because of the unusual
23 anatomy he had, not having an internal iliac artery,
24 and then having a profunda that was compromised.

25

1 Q. So my question is, not whether he would
2 have had a different outcome.

3 My question is:

4 Did he lose the chance to have a different
5 outcome by not being admitted on the 25th?

6 A. I --

7 MR. WEAVER: Speculation, Your Honor.

8 THE COURT: Overruled.

9 THE WITNESS: I don't think so.

10 BY MR. ARNTZ:

11 Q. So even if he been admitted on that day in
12 December of 2016, December 25th, even getting
13 admitted that day, he's still going to lose his leg
14 above the knee?

15 A. Well, I can't really answer that.

16 What I can say is, the disease was
17 progressive, and he would eventually have had an
18 amputation no matter what was done on the 25th.

19 Q. But it could have been years later,
20 correct?

21 A. It would have been shorter than that.

22 Q. Well, you said -- earlier you said, a year.
23 Are you saying, it's only a year?

24 A. Probably a year because let's say he been
25 admitted the 25th, they opened up his graft, and

1 marginally improved circulation, it would have
2 clotted soon thereafter as it had done two previous
3 occasion.

4 Each time it clots the situation is worse,
5 inevitably will lead to an amputation.

6 Whether it's above the knee or below the
7 knee, I can't tell you.

8 Q. But those were chances he lost by not
9 getting admitted that day?

10 A. You're asking me -- Let's say he been
11 admitted that day.

12 The admission doctors would have examined
13 him, said, well, his leg's okay, let's not do
14 anything.

15 Q. You're speculating that is what would have
16 happened?

17 MR. WEAVER: Well, Your Honor, he's asking
18 him to speculate.

19 THE COURT: Yes.

20 Sustained.

21 Agree.

22 He may finish his answer.

23 BY MR. ARNTZ:

24 Q. Are you done?

25 A. I finished, yeah.

1 Q. That is based on rank speculation, isn't
2 it, that that is what health care providers that --

3 THE COURT: What is the objection?

4 MR. WEAVER: Speculation.

5 THE COURT: He was with the phrasing of the
6 question.

7 Now, the fact it's already admitted,
8 sustained.

9 BY MR. ARNTZ:

10 Q. That is based on speculation as to what
11 they would have done, isn't it?

12 A. No, it's based on my knowledge of vascular
13 surgery what would have been done.

14 Q. It's at least based on a present assumption
15 they wouldn't have called a cardio-vascular surgeon,
16 isn't it?

17 A. No -- Well, here's what I think:

18 I think he didn't have an indication to be
19 admitted to the hospital on the 25th.

20 I think he didn't have an indication for a
21 vascular consultation on an emergency basis.

22 He did have an indication to be followed up
23 with his vascular surgeon and primary care doctor.

24 So whether or not he's been admitted to the
25 hospital, that's encouraging me to speculate.

1 I can't tell what would have happened.

2 Q. And that conclusion is based on the fact he
3 didn't do a full arterial ultrasound, right?

4 A. Right.

5 Q. And a full arterial ultrasound could have
6 done other arteries besides just the grafts, right?

7 A. Right.

8 Q. So we don't know if there were clots in the
9 profunda at that moment, but if there had been clots
10 in the profunda at that moment, plus the clot in the
11 graft, wouldn't you have admitted him?

12 A. If I had known all of that information,
13 probably because if that had existed at that time,
14 his signs and symptoms would have been much worse
15 pointing towards an admission.

16 MR. ARNTZ: That's all I have.

17 THE COURT: Mr. Weaver, anything on
18 redirect?

19 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

1 jury, unless we have an objection, the attorneys will
2 follow-up.

3 I'm not at liberty to explain any of this
4 information, simply read the questions exactly as
5 they are written, and you --

6 THE WITNESS: Can I have a piece paper to
7 write down?

8 THE COURT: I'm not going to ask them all
9 at once, one at a time.

10 If you would like to see the papers, you
11 can see them.

12 THE WITNESS: No, that's okay.

13 THE COURT: What is your definition of a,
14 quote, palpable pulse, and is that definition
15 different from a pulse described as, quote, normal?

16 If so, how is it different?

17 THE WITNESS: Okay.

18 A palpable pulse is the sensation of
19 pulsation that you feel when you put your hand over
20 an artery.

21 It requires a certain minimal blood
22 pressure for you to feel that pulse.

23 And ordinarily it would be over a hundred,
24 depending on whether if the artery's got a lot of
25 calcification, as in a diabetic pressure would need

1 to be higher to feel the pulse.

2 The second part of the question was?

3 THE COURT: I have to read the question
4 exactly as written.

5 What is your definition of a palpable
6 pulse, and is that definition different from a pulse
7 that is described as normal?

8 If so, how is it different?

9 THE WITNESS: A palpable pulse, if you can
10 feel it, is generally considered normal.

11 Some physicians will grade it and say,
12 well, it's not very strong.

13 Others will say, it's very, very strong.

14 To me, a normal pulse in most circumstances
15 is if you feel it, and you can hold your finger up to
16 your radial artery right now, and you can feel your
17 pulse.

18 I think that covers it.

19 If the questioner wants to follow-up --

20 THE COURT: I just indicated, I'm not at
21 liberty, nor they, to supplement the question.

22 After you answered the question, there's
23 plenty more by the way, I will then give counsel the
24 opportunity to follow-up.

25 THE WITNESS: Okay.

1 THE COURT: If you have more to give the
2 jurors, that is fine.

3 THE WITNESS: No, I think we've covered
4 what a pulse is.

5 THE COURT: Next question.

6 In your experience is there a medical
7 decision between the term, appear, and, possible
8 appear, and possible in quotes, with regard to a
9 medical condition?

10 THE WITNESS: Yes, there's some difference.

11 Appears to me means that the technician or
12 radiologist looking at it thinks it's occluded, but
13 not completely sure.

14 Possible means that, you know, this could
15 be occluded, but I'm not completely sure.

16 So I think they are very close in meaning.

17 I wouldn't parse it anymore than that.

18 THE COURT: Okay.

19 Would an ultrasound be performed with a
20 knee-high sock on, would a knee-high sock be
21 instructed to be left off until post ultrasound
22 examination was complete?

23 THE WITNESS: The answer to that is:

24 You wouldn't do an ultrasound with the sock
25 on, and you would leave the sock off until you finish

1 the ultrasound exam.

2 THE COURT: Dr. Wilson, in any occlusion in
3 the major arteries, and grafts are collateral, the
4 best system, the last resort, is to get adequate
5 blood flow to lower extremities?

6 THE WITNESS: Yes.

7 THE COURT: Dr. Wilson, is it possible
8 following a fem pop graft to have palpable pulses at
9 one hospital visit, require a Doppler at the next
10 visit to defect blood flow, and be able to have
11 palpable pulses at any subsequent visit?

12 THE WITNESS: Of course.

13 If you go into a very cold examining room,
14 your pulses, your arteries, will constrict, and it's
15 very difficult to feel a pulse.

16 If you go into a warm room like this one, a
17 hot room, then your arteries will dilate.

18 If you come out of the shower for example,
19 you are flushed, blood is circulating, the heat has
20 dilated all your arteries, and you are sure to feel a
21 pulse.

22 It will vary between examiners.

23 Dr. Lasry could feel a pulse, and I would
24 go there and maybe not, so sure, or vice versa, and
25 you if see doctors clustered around a patient trying

1 to determine, do you feel it or not.

2 So yes, you could feel a pulse at certain
3 times and be absent in other times, absolutely.

4 THE COURT: Can an artery be chronically
5 occluded for decades, or how long can an artery be
6 chronically occluded before it turns into an acute
7 occlusion?

8 THE WITNESS: An artery can be chronically
9 occluded for decades.

10 In fact, Mr. Moore's right femoral artery
11 has been chronically occluded since 2012, that is
12 eight years, not a decade, probably occluded before
13 then, but it hasn't at this point progressed.

14 And if Mr. Moore takes an oath to avoid
15 tobacco, to keep his cholesterol fine, his
16 hypertension down, and treat it with Xarelto, it may
17 never give him acute occlusion.

18 But that I don't have a crystal ball to
19 look into it.

20 THE COURT: Would there be a difference in
21 diagnostics, and/or treatment for occlusion in major
22 arteries, or in native arteries, versus by-pass
23 grafts?

24 THE WITNESS: Not really, there wouldn't be
25 a difference in evaluation.

1 The difference here was that the graft had
2 been included two previous times since it had been
3 placed, that is the difference.

4 And with the chronic occlusion your big job
5 is to determine is this limb viable right now or is
6 it not, and if it's not, we got to do something.

7 And if it's viable, even though the graft
8 is occluded, you decide is this something where
9 collaterals are providing sufficient circulation to
10 keep the leg alive, and if it is, that could be a
11 stable situation, we call that stable claudication
12 where the patient has symptoms of chronic occlusion,
13 but is able to battle through life and get the things
14 he needs to do done.

15 THE COURT: With an apparent occlusion on
16 12/25/16, could Mr. Moore have been instructed to
17 take more milligrams of Xarelto for a greater effect,
18 so to help free the occlusion?

19 THE WITNESS: No.

20 THE COURT: And --

21 THE WITNESS: The reason is, it would
22 reduce bleeding to his brain or some other site.

23 THE COURT: Could Mr. Moore have been given
24 a more potent blood thinner or other medication,
25 either in the ER, or prescribed from the -- I'm

1 sorry, Juror Number 7, let me start again.

2 Could Mr. Moore have been given a more
3 potent blood thinner or other medication, either in
4 the ER, or prescribed from ER, to help free the
5 parent occlusion?

6 THE WITNESS: Blood thinners such as
7 Xarelto, or more commonly often Coumadin, you have
8 heard of would not affect the clot at all. Those are
9 given to prevent extension of a clot.

10 So if the patient has acute ischemia, we
11 would generally give an intravenous Heparin that goes
12 to work right away and prevents extension of an
13 ongoing clotting process.

14 So I believe, if I can say this without
15 getting in trouble, I believe that the clot had been
16 there for some period of time because it couldn't --
17 or wasn't able to be dissolved on the 28th, which
18 suggests to me it was an organized adherent clot.

19 Otherwise, you would have had the same
20 result on the 28th as they had maybe prior years.

21 THE COURT: Okay.

22 THE WITNESS: So no, blood thinners would
23 not have affected the outcome.

24 THE COURT: All right.

25 Mr. Weaver.

1 MR. WEAVER: No questions, Your Honor.

2 THE COURT: No follow-up?

3 Mr. Arntz.

4 MR. ARNTZ: I got a couple.

5 - - - -

6 **RECROSS-EXAMINATION OF DR. SAMUEL WILSON**

7 BY MR. ARNTZ:

8 Q. With respect to the folks, are you aware
9 Dr. Lastry would have testified -- Dr. Lasry
10 testified the pulses would have been diminished, and
11 Nurse Practitioner Bartmus said the pulse was normal,
12 do you make a distinction between those two?

13 A. I accept Dr. Lasry's comment, and if that's
14 how he grades the pulses, that's fine.

15 In my purposes of, if there's a pulse
16 present, that means that there's arterial pressure,
17 arterial flow, and that is satisfactory.

18 Q. Are you aware Mr. Moore has testified, and
19 will testify here, the only time he was instructed to
20 take his sock off was during the ultrasound?

21 A. I believe that came out in one of the
22 depositions that that was said in one of the
23 depositions.

24 Q. And you just testified that the -- an
25 occlusion can be chronic and be there for decades,

1 and specifically said, the one in his right thigh --

2 A. Yes.

3 Q. -- has been there for eight years, but you
4 also said that -- well, then in the same question you
5 said, it hasn't progress, but your overall
6 perspective of this disease is, it's progressive,
7 right?

8 A. It has hasn't progressed to acute ischemia
9 yet, but no doubt it's progressing.

10 MR. ARNTZ: Okay.

11 THE COURT: Is that all?

12 MR. ARNTZ: Yes.

13 THE COURT: Doctor, that completes your
14 testimony at that time.

15 Thank you.

16 THE WITNESS: Thank you.

17 THE COURT: All right.

18 Ladies and gentlemen of the jury, we're
19 going to take our overnight recess.

20 Thank you for your patience by the way.

21 We went longer than expected today.

22 You will be returning tomorrow morning at
23 9:00 a.m. here in this courtroom, and we may have a
24 different location at some point, but tomorrow
25 morning we'll start here.

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(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.)

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REPORTER'S CERTIFICATE

I, Bill Nelson, a Certified Court Reporter
in and for the State of Nevada, hereby certify that
pursuant to NRS 2398.030 I have not included the
Social Security number of any person within this
document.

I further Certify that I am not a relative
or employee of any party involved in said action, not
a person financially interested in said action.

_____/s/ Bill Nelson_____

Bill Nelson, RMR, CCR 191

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) SS .

I, Bill Nelson, RMR, CCR 191, do hereby
certify that I reported the foregoing proceedings;
that the same is true and correct as reflected by my
original machine shorthand notes taken at said time
and place.

/s/ Bill Nelson

Bill Nelson, RMR, CCR 191
Certified Court Reporter
Las Vegas, Nevada

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