IN THE SUPREME COURT OF THE STATE OF NEVADA

DIGNITY HEALTH D/B/A ST. ROSE DOMINICAN HOSPITAL – SIENA CAMPUS,

Petitioner,

v.

THE EIGHT JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA *er rel.* **THE COUNTY OF CLARK**, and **THE HONORABLE JUDGE MARIA GALL**,

Respondents,

And,

LIVIU RADU CHISIU, as special administrator for the Estate of **ALINA BADOI**, and as parent of **SOPHIA RELINA CHISIU**, a minor and heir of the Estate,

Real Parties in Interest.

Supreme Court Case No.:

Dist. Ct. Case No.: A-18-775572-C

PETITIONER'S APPENDIX TO THE PETITION WRIT OF MANDAMUS
Vol. 4 of 5

TYSON J. DOBBS, ESQ.
Nevada Bar No. 11953
HALL PRANGLE & SCHOONVELD, LLC
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Attorneys for Petitioner Dignity Health d/b/a St. Rose Dominican Hospital – Siena Campus

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of HALL PRANGLE & SCHOONVELD, LLC; that on the 5th day of January 2023, I served a true and correct copy of the foregoing **PETITIONER'S APPENDIX (VOL. 1-5) TO THE PETITION FOR WRIT OF MANDAMUS** via USPS mail and/or E-Service Master List for the above referenced matter in the Nevada Supreme Court e-filing System in accordance with the electronic service requirements of Administrative Order 14-2 and the Nevada Electronic Filing and Conversion Rules, to the following:

Peter S. Christiansen, Esq.
R. Todd Terry, Esq.
Kendelee L. Works, Esq.
Whitney J. Barrett, Esq.
Keely A. Perdue, Esq.
CHRISTIANSEN LAW OFFICES
810 S. Casino Center Blvd., Suite 104
Las Vegas, Nevada 89101
Attorneys for Real Parties in Interest

Judge Maria Gall
Department IX
Eighth Judicial District Court
200 Lewis Avenue
Las Vegas, NV 8915

/s/ Nicole Etienne
An employee of HALL PRANGLE & SCHOONVELD, LLC

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CURRICULUM VITAE
YAAKOV BEILIN, M.D.

Professor of Anesthesiology and OB/GYN
Icahn School of Medicine at Mount Sinai
Vice-Chair for Quality- Dept. of Anesthesiology
Director, Obstetric Anesthesia
New York, New York

ACADEMIC APPOINTMENTS:

July 1991-June 1992	Instructor Department of Anesthesiology Mount Sinai School of Medicine New York, New York 10029-6574
July 1992-Dec 1994	Clinical Assistant Professor Department of Anesthesiology Mount Sinai School of Medicine New York, New York 10029-6574
January 1995-May 2001	Assistant Professor Department of Anesthesiology Mount Sinai School of Medicine New York, New York 10029-6574
January 1998-May 2001	Assistant Professor Dept. of Obstetrics, Gynecology & Reproductive Science Mount Sinai School of Medicine New York, New York 10029-6574
June 2001-December 2007	Associate Professor Department of Anesthesiology, and Dept. of Obstetrics, Gynecology & Reproductive Science Mount Sinai School of Medicine New York, New York 10029-6574
January 2008-December 2012	Professor Department of Anesthesiology, and Dept. of Obstetrics, Gynecology & Reproductive Science Mount Sinai School of Medicine New York, New York 10029-6574

Academic appointments (continued):

January 2013- Present	Professor with Tenure Department of Anesthesiology, and Dept. of Obstetrics, Gynecology & Reproductive Science Mount Sinai School of Medicine New York, New York 10029-6574

HOSPITAL APPOINTMENTS:

July 1991-Present	Assistant Attending Anesthesiologist Department of Anesthesiology The Mount Sinai Hospital New York, New York 10029-6574
Jan 1991-1999	Assistant Attending Anesthesiologist Department of Anesthesiology City Hospital Center at Elmhurst Elmhurst, NY 11373
GAPS IN EMPLOYMENT	None

EDUCATION:

Sept 1979-June 1983	Yeshiva University New York, New York Degree: B.A., June 1983 Majors: Chemistry and Mathematics
Sept 1983-June 1987	Mount Sinai School of Medicine of The City University of New York New York, New York Degree: M.D., June 1987

POST-DOCTORAL TRAINING:

July 1987-June 1988	Medicine Internship, Department of Medicine Maimonides Medical Center Brooklyn, New York 11219
July 1988-June 1990	Resident, Department of Anesthesiology Mount Sinai School of Medicine New York, New York 10029-6574
July 1990-June 1991	Specialty year, Obstetric Anesthesia Department of Anesthesiology Mount Sinai School of Medicine New York, New York 10029-6574

CERTIFICATION:

July 1988	Diplomate The National Board of Medical Examiners, #349331
April 1992	Diplomate The American Board of Anesthesiology, Inc., #20508
April 2010	TeamSTEPPS Master Trainer, Duke Medical Center

LICENSURE:

July 1988-Present	New York, #176850
January 2004 – Dec 2007	New Jersey # 25MA07678900

HONORS/AWARDS/PATENTS:

1979-1983	Dean's List – 4 years Yeshiva University New York, New York
1981-1983	Alpha Epsilon Delta, Pre-medical honor society Yeshiva University New York, New York
June 1983	Graduated magna cum laude Yeshiva University New York, New York
June 1987	Doctor Joseph R. Jagust Anesthesiology Award Mount Sinai School of Medicine
June 1998	Outstanding Research in Anesthesiology Award Department of Anesthesiology, Mount Sinai School of Medicine
May 1999	Selected as one of Top 10 Scientific Abstracts International Anesthesia Research Society, 73rd congress Abstract: "The obstetrician group, not epidural analgesia, influences the cesarean section rate for the nulliparous woman in labor."

HONORS/AWARDS/PATENTS (Continued):

Jan 2001-Dec 2002	Clinical Scholar Research Award International Anesthesia Research Society Cleveland, Ohio 44131-2571 (See grant section)
June 2003	Outstanding Teaching Award Department of Anesthesiology, Mount Sinai School of Medicine
June 2006	Elected to membership in: The Association of University Anesthesiologists

OTHER PROFESSIONAL APPOINTMENTS:

Departmental Committees:

1992-Present	Performance Improvement Committee
1993-Present	Vice Chair, Research Committee
1993-Present	Resident Evaluation Committee
2000-2004	Finance Committee
January 2005 – Present	Departmental coordinator for JCAHO preparations and education
March 2006 – Present	Member, Promotions Committee
Jan 2008 –Present	Member, Steering Committee for the Anesthesiology morbidity and mortality Conference CME Program

Hospital Committees:

October 1995-Nov 1996	Member Reengineering Committee for L&D
July 2001 – Present	Labor floor committee
Sept 2004 – Present	Committee for the provision of care, treatment and services, Manhattan workgroup

Hospital Committees (continued):

July 2004 – Present	Perioperative Care Committee
January 2005 – Present	JCAHO National Safety Goals Committee
January 2005 – Present	JCAHO Medication Management Committee
October 2006- Present	Member Hospital Quality Review Board
January 2007- Present	Member, Surgical Care Improvement Project (SCIP)
July 2007 – Present	Member, Multidisciplinary pain committee
July 2005-Present	Member, Clinical review Committee
Jan 2008 – present	Member, Quality and Patient Safety Council
Jan 2008- Present	Member Quality Care Council
Jan 2008 –Present	Member FOJP Surgical Quality Improvement Group
Jan 2008 –Present	Member, institutional pain committee
January 2008 – June 1015	Member Data Safety and monitoring Board for GCO project # 08-1422, ketamine in treatment-resistant bipolar depression

National Committees:

July 1, 1994-Present	Member of Research Committee Society for Obstetric Anesthesia and Perinatology
July, 1997 – Dec 1997	Member of Pulmonary Artery Catheter Consensus Conference for The Society of Critical Care Medicine
Feb, 2000 - Present	Abstract Review Committee Society for Obstetric Anesthesia and Perinatology
July 2000-2002	Contributor to the Self-Education and Evaluation (SEE) Program of the American Society of Anesthesiologists
Jan 2002 – 2010	Member of the Subcommittee on Obstetric Anesthesia and Perinatology of the American Society of Anesthesiologists (ASA)

National Committees (continued):

Jan 2001 – Present	Abstract Review Committee on Obstetric Anesthesia and Perinatology of the American Society of Anesthesiologists (ASA)
May 2004 – Present	Member of the regional perinatal center maternal mortality review team, New York
January 2005 – 2010	Member of the Committee on Obstetrical Anesthesia of the American Society of Anesthesiologists (ASA)
February 2006 – 2008	Consultant to the American Society of Anesthesiologists Task Force on Guidelines for Obstetric Anesthesia
January 2007 – 2009	Consultant to the American Society of Anesthesiologists Task Force on the Prevention, Detection and Management of Respiratory Depression Associated with Neuraxial Opioid Administration
January 2009-Present	Member, Patient Safety Committee Society for Obstetric Anesthesia and Perinatology
June 2010- Present	Member of the ASA Educational Track Subcommittee on Obstetric Anesthesia
December 2012-Present	Member of the New York State Society of Anesthesiologists' Committee on Continuous Quality Improvement and Peer Review.
May 2013- Present	Member organizing Committee for the 48th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology

ADMINISTRATIVE LEADERSHIP APPOINTMENTS
Internal
Anesthesiology Department:

January 2014 – Present	Director Obstetric Anesthesiology
Nov 2000 – December 2013	Co-Director Obstetric Anesthesiology • Oversees busy clinical service • 7,000 deliveries per annum • Sets clinical standards • Directs resident and fellow teaching
July 1997-July 2017	Director Obstetric Anesthesia research and fellowship • Initiated ACGME Fellowship • Initiated more than 30 research projects • Leads journal club
July 2017 – Present	Director Obstetric Anesthesia Fellowship • Oversees the Fellowship including clinical, research and educational initiatives
Jan 2007- 2017	Vice-Chair for Quality, Department of Anesthesiology • Sets policies and protocols for Department • Chairs performance improvement committee • Representative from anesthesiology to many hospital safety committees
Jan 2013 – Dec 2013	Member, Anesthesiology Executive Committee • Oversaw day to day activity of the Department during period of chairs absence
July 2017- Present	Vice-Chair for Quality for Anesthesiology, Mount Sinai Health System • Oversees quality for the Department of Anesthesiology at the system level

Mount Sinai Hospital

Jan 2008 – Present	Chair, Clinical Review Committee • Provide oversight to the timely evaluation and identification of quality issues and incidents that involve actual or potential risk to patients. • Evaluates root cause analyses and other high profile complications

External

July 1994 - 2004	Editor of the Research column for the newsletter of Society for Obstetric Anesthesia and Perinatology
December 2007- Present	Member Editorial Board, International Journal of Obstetric Anesthesia
January 2009 – Present	Member Editorial Board, Obstetric Anesthesia Digest

TRAINING RECORD:

Name	Level of Trainee	Role in training	Dates	Training venue	Trainees Current status
Merceditas Lagmay, MD	*Senior resident*	*Preceptor*	*1991-'92*	*Labor and delivery floor*	*Atlantic City Medical Center, NJ*
Ellen Brand, MD	*Senior resident*	*Preceptor*	*1991-'92*	*Labor and delivery floor*	*Director Obstetric Anesthesia, Stanford Hospital, CT*
Neil Nahmias, MD	*Senior resident*	*Preceptor*	*1993-'94*	*Labor and delivery floor*	*Holy Name Hospital, NJ*
Jung Kim, MD	*Senior resident*	*Preceptor*	*1994-'95*	*Labor and delivery floor*	*Assistant Professor, New York University*
Jeffrey Zahn, MD	*Senior resident*	*Preceptor*	*1995-'96*	*Labor and delivery floor*	*Assistant Professor, Mount Sinai School of Medicine*
Mihai Galea, MD	*Fellow*	*Supervisor*	*1997-'98*	*Labor and delivery floor*	*Assistant Professor, Maimonides Medical Center*
Sharon Abramovitz, MD	*Fellow*	*Supervisor*	*1998-'99*	*Labor and delivery floor*	*Assistant Professor*, Weill Medical College, NY
Ashalatha Nair, MD	*Fellow*	*Supervisor*	*2000-'01*	*Labor and delivery floor*	Director Obstetric Anesthesia, Elmhurst City Hosp. Queens, NY
Jonathan Rosenstreich, MD	*Senior resident*	*Supervisor*	*2003-'04*	*Labor and delivery floor*	UCLA Medical Center, California
Jonathan Epstein, MD	*Fellow*	*Supervisor*	*2008-2009*	*Labor and delivery floor*	Assistant Prof, Roosevelt Hospital of Mount Sinai,NY, NY
Yelena Spitzer, MD	*Fellow*	*Supervisor*	*2013-2014*	*Labor and delivery floor*	Assistant Professor, Albert Einstein College of Medicine, Bronx, NY
Alison Schmeck, MD	*Fellow*	*Supervisor*	*2013-2014*	*Labor and delivery floor*	Staff Anesthesiologist, Holy Name Hospital, Teaneck, NJ
Nakiyah Knibbs, MD	*Fellow*	*Supervisor*	*2014-2015*	*Labor and delivery floor*	Assistant Professor, Icahn School of Medicine

					at Mount Sinai, NY, NY
Michael Marotta, MD	*Fellow*	*Supervisor*	*2014-2015*	*Labor and delivery floor*	Assistant Professor, Elmhurst Hospital, Queens, NY
Joshua Hamburger, MD	*Fellow*	*Supervisor*	*2015-2016*	*Labor and delivery floor*	Assistant Professor, Icahn School of Medicine at Mount Sinai
David Gutman, MD	*Fellow*	*Supervisor*	*2015-2016*	*Labor and delivery floor*	Assistant Professor, South Carolina
Dorian Batt, MD	*Fellow*	*Supervisor*	*2016-2017*	*Labor and delivery floor*	Assistant Professor, , Weill Medical College, NY
Amita Kulkarny, MD	*Fellow*	*Supervisor*	*20176-2018*	*Labor and delivery floor*	Current Fellow
Eli Zarkhin, MD	*Fellow*	*Supervisor*	*20176-2018*	*Labor and delivery floor*	Current Fellow

TEACHING ACTIVITIES:

Teaching Activity/Topic	Level	Role	Number of Learners	Number of hours week/month/year	Years Taught
3rd year Community Medicine Clerkship	*Medical School Course*	*Preceptor for research project*	*2*	*10 hours per year*	*1992*
1st year Research Integrative Core	*Medical School Course*	*Preceptor for research project*	*1*	*12 hours per year*	*2001*
3rd year medical school intersession clerkship	*Medical School Course*	*Moderator*	*12*	*One week course*	*2003-2008*
Research elective	*Medical School elective*	*Preceptor*	*8*	*3 months per year*	*1994-Present*
Didactic lectures in Obstetric Anesthesia	*Department Level*	*Co-Director*	*20 per year*	*6 hours per month*	*1994-Present*
Journal club for obstetric anesthesia	*Department Level*	*Director*	*4-6*	*12 months per year*	*1997-2011*
Moderator Anesthesiology morbidity and mortality conference	*Department Level*	*Moderator*	*100-150*	*3-4 sessions per year*	*1995-Present*
Coordinator Anesthesiology PI Conference	*Department Level*	*Director*	*100-150*	*12 sessions per year*	*2008-Present*

GRANT SUPPORT:

Past Grants:

1. Medical School (PI: Constantine A. Bona) 6/85-9/85 10%
National Institute of Health's summer research fellowship for medical students. $1000
The ability of monoclonal antibodies to function as vaccines.
(Role: research assistant)

2. GCO # 00-435 (PI: Yaakov Beilin) 6/14/ 2000 – 6/13/ 2001 5%
Becton Dickinson & Co. $4,000
Clinical evaluation of the Durasafe Plus™ Epidural Kit.

3. GCO # 97-008 AN (PI: Yaakov Beilin) 1/2/97-4/30/98 5%
Astra Zeneca Co. $2,000
A prospective and randomized, and double-blind study evaluating a new local anesthetic, ropivacaine.

4. GCO # 00-128 (PI: Yaakov Beilin) 3/15/2000- 4/30/2003 5%
Dade-Behring $40,000
The evaluation of a new point-of-care platelet function monitor, the PFA-100, in the parturient.

5. GCO # 98-190 (PI: Yaakov Beilin) 1/1/2001-12/31/2002 10%
International Anesthesia Research Society, Research Award $75,000
The effect of epidural fentanyl on infant breast feeding: A prospective randomized study

6. GCO # 01-0597 (PI: Yaakov Beilin) 8/01-12/2001 5%
Astra Zeneca Inc. $5000
A prospective, randomized and double-blind study evaluating three local anesthetics for labor analgesia: bupivacaine vs. ropivacaine vs. levobupivacaine.

CURRENT UNFUNDED PROJECTS

1. GCO # 08-00127 (PI: Yaakov Beilin) 1/2008-Present 10%
Analysis of Adverse Outcomes in Anesthesiology

2. GCO # 14-0730 (PI: Jaimie Hyman) 2/2014-present
Characterizing "maternal near misses": Identifying contributing factors and assessing healthcare provider stress. 20%

Completed Unfunded Research Projects:

1. GCO # 90-145 ME (PI: Yaakov Beilin) 2/1/90-6/30/91 10%
An *in vitro* study to determine if tumor necrosis factor, interleukin-1 or interleukin-6 are mediators of preeclampsia.

2. GCO # 91-311 AN (PI: Yaakov Beilin) 7/31/91-6/30/93 10%
A questionnaire study of 1000 post-partum women to assess patients' attitudes towards obstetrical anesthesia.

3. GCO # 93-467 AN (PI: Yaakov Beilin) 11/29/93-5/31/95 10%
A prospective and randomized and double-blind study to determine the optimum distance that the epidural catheter should be threaded into the epidural space.

4. GCO # 93-705 AN (PI: Yaakov Beilin) 12/1/93-35/31/96 5%
A prospective and randomized study to assess the value of the anesthesiologist's preoperative interview for the parturient.

5. GCO # 94-217 AN (PI: Yaakov Beilin) 4/29/94-6/30/96 5%
A survey of the management of controversial situations in obstetrical anesthesia.

6. GCO # 94-510 AN (PI: Yaakov Beilin) 10/3/94-7/1/96 5%
A prospective and randomized and double-blind study to assess the use of subhypnotic doses of propofol to treat pruritus caused by intrathecal opioids after cesarean section.

7. GCO # 96-319 AN (PI: Yaakov Beilin) 6/3/96-7/1/96 5%
A retrospective study evaluating the effects of epidural fentanyl administered during labor on breast-feeding.

8. GCO # 95-086 AN (PI: Yaakov Beilin) 3/1/95-7/31/97 5%
A prospective and randomized and double-blind study to determine the best treatment of incomplete analgesia after placement of an epidural anesthetic for the woman in labor.

9. GCO # 95-375 AN (PI: Ivan Dimich) 10/1/95-1/31/97 5%
A prospective and randomized study of the cardiovascular effects of concomitant administration of nifedipine and magnesium in pigs. (Role: Research consultant)

10. GCO # 96-265 AN (PI: Yaakov Beilin) 5/20/96-7/1/97 5%
A multi-center trial evaluating the effect of propofol on the pregnancy rate in women undergoing gamete intrafallopian transfer (GIFT).

Completed Unfunded Research Projects (continued):

11. GCO # 95-806 AN (PI: Yaakov Beilin) 12/1/95-7/1/97 5%
A retrospective study evaluating the safety of regional anesthesia and delivery in the parturient with a platelet count less than 100,000 mm^{-3}.

12. GCO # 95-805 AN (PI: Yaakov Beilin) 12/1/95-12/1/97 5%
A prospective study of the effect of magnesium sulfate on platelet function in the parturient.

13. GCO # 95-435 AN (PI: Yaakov Beilin) 7/28/95-7/31/98 5%
A prospective and randomized study evaluating the accuracy of the visual analogue scale in assessing changes in pain intensity in the surgical patient.

14. GCO # 97-401 AN (PI: Yaakov Beilin) 7/1/97-11/1/99 5%
A prospective and randomized study evaluating the effect of patient position during epidural labor analgesia on the incidence of incomplete analgesia.

15. GCO # 97-850AN (PI: Yaakov Beilin) 12/30/97-12/10/99 5%
A prospective and randomized study evaluating the quality of analgesia when air versus saline is used for identification of the epidural space with the loss-of-resistance technique.

16. GCO # 96-690 AN (PI: Jeffrey Zahn) 10/17/96-10/10/99 5%
A prospective and randomized study comparing blood pressure in the upper versus the lower extremity in the parturient. (Role: Mentor)

17. GCO # 97-861AN (PI: Jeffrey Zahn) 12/3/97-1/5/2000 5%
A prospective and randomized, and double-blind study evaluating spinal bupivacaine for cervical cerclage. (Role: Mentor)

18. GCO # 97-155 AN (PI: Yaakov Beilin) 3/3/97-3/2000 5%
A prospective study evaluating factors that may influence the cesarean section rate.

19. GCO # 00-1013AN (PI: Yaakov Beilin) 3/01-4/02 5%
A prospective, randomized and double-blind study evaluating the efficacy of epidural morphine to treat episiotomy pain.

20. GCO # 99-720AN (PI: Yaakov Beilin) 10/99-11/01 5%
A prospective, randomized and double-blind study evaluating the optimal epidural infusion that should be utilized following the combined spinal-epidural technique for labor analgesia.

21. GCO 06-0188 (PI: David Wax) 1/2006-6/2007 10%
Effect of Automatic AIMS reminder on Compliance with Antibiotic Administration.

Completed Unfunded Research Projects (continued):

22. GCO # 07-1011 (PI: Yaakov Beilin) 9/2007 – 1/2009 10%
The effect of degree of labor pain at time of epidural placement on mode of delivery

23. GCO # 07-1244 AN (PI: David Wax) 11/1/2007 1/2009 10%
Frequency and Predictors of Editing of Physiologic Data in AIMS Records

24. GCO # 05-0655 (PI: David Reich) 12/2005- 1/2008 10%
Intraoperative predictors of surgical site infection

25. GCO # 06-1249 (PI: Yaakov Beilin) 11/2006-Present 10%
User acceptance of CompuRecord on labor and delivery

26. GCO 07-0266 (PI: David Wax) 1/2007- 12/2009 10%
Survey of Perioperative Glycemic Control

27 GCO # 05-0295 (PI: David Wax) 6/2005-9/2008 10%
Intraoperative Glucose Control

28. GCO # 05-0812 (PI: Yaakov Beilin) 6/2005-12/2009 10%
SOAP SCORE project

29. GCO # 07-1217 AN (PI: David Wax) 11/1/2007 10%
Predictors of Patient Pain Mgt Modality care

30. GCO # 05-1155 (PI: Yaakov Beilin) 12/2005- 2008 20%
Epidural vs. combined spinal-epidural for labor analgesia: Impact on obstetric outcome.

31. GCO # 08-00449 (PI: Yaakov Beilin) 10/2008-2012
Are Serial Platelet Counts needed in women with Preeclampsia

32. GCO#:11-04406 (PI:Jason Epstein) 10/2011-2013
Fluid and Acid-base Management Strategies and Postoperative Outcome in Renal Allotransplant Patients

ORIGINAL PEER-REVIEWED PUBLICATIONS:

1. Sigal NH, Chan M, Reale MA, Moran TM, **Beilin Y,** Schulman JL, Bona CA. The human and murine influenza-specific B Cell repertoires share a common idiotype. J Immunol 1987;139:1985-90.

2. Schulman JL, Moran TM, Reale MA, **Beilin Y,** Sigal NH, Bona CA. Effects of immunization with syngeneic monoclonal anti-idiotype antibody on antibody responses to influenza viruses. Monogr Allergy 1987;22:143-49.

3. **Beilin Y,** Leibowitz AB. (case report) Anesthesia for an achondroplastic dwarf presenting for urgent cesarean section. Int J Obstet Anesth 1992;2:96-7.

4. **Beilin Y,** Bernstein HH. (case report) Successful epidural anaesthesia for a patient with Takayasu's arteritis presenting for caesarean section. Can J Anaesth 1993;40:64-6.

5. **Beilin Y,** Bernstein HH, Zucker-Pinchoff B: The optimal distance that a multi-orifice epidural catheter should be threaded into the epidural space. Anesth Analg 1995; 81:301-4.

6. **Beilin Y,** Rosenblatt MA, Bodian CA, Lagmay-Aroesty MM, Bernstein HH. Information and concerns about obstetric anesthesia: a survey of 320 obstetric patients. Int J Obstet Anesth 1996;5:145-51.

7. **Beilin Y,** Bodian CA, Haddad EM, Leibowitz AB. Practice patterns of anesthesiologists regarding situations in obstetric anesthesia where clinical management is controversial. Anesth Analg 1996;83:735-41.

8. Ammar T, **Beilin Y,** Bernstein HH. (Case report) Successful regional anesthesia for a woman with a single ventricle presenting for labor and delivery. J Cardiothorac Vasc Anesth 1996;10:640-2.

9. **Beilin Y,** Zahn J, Comerford M. Safe epidural analgesia in thirty parturients with platelet counts between 69,000 and 98,000 mm^{-3}. Anesth Analg 1997;85:385-8.

10. **Beilin Y.** and consensus participants. Pulmonary artery catheter consensus conference: consensus statement. Crit Care Med 1997; 25:910-25.

11. Leibowitz AB, **Beilin Y.** Pulmonary artery catheters and outcome in the perioperative period. New Horizons 1997;5:214-27.

Original Peer-Reviewed Publications (continued):

12. **Beilin Y,** Bernstein HH, Zucker-Pinchoff B, Zahn J, Zenzen WJ. Subhypnotic doses of propofol do not relieve pruritus induced by intrathecal morphine following cesarean section. Anesth Analg, 1998;86:310-3.

13. **Beilin Y,** Bronheim D, Mandelbaum C. (case report) Hemothorax during "j" wire change of a right internal jugular vein catheter. Anesthesiology, 1998; 88:1399-400.

14. **Beilin Y,** Zahn J, Bernstein HH, Zucker-Pinchoff B, Zenzen WJ, Andres LA. Treatment of incomplete analgesia after placement of an epidural anesthetic for the woman in labor. Anesthesiology, 1998;88:1502-6.

15. **Beilin Y.** Anesthesia for nonobstetric surgery during pregnancy. Mt Sinai J Med 1998;65:265-70.

16. Dimich I, Neustein S, Bernstein HH, Shiang H, **Beilin Y**. Cardiovascular consequences of the concomitant administration of nifedipine and magnesium sulfate in pigs. Int J Obstet Anesth 1998;7:247-50.

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23. **Beilin Y.** Obstetric anesthesia - Key words. Syllabus for The 38th annual New York Anesthesiology Review, 2001.

Proceedings of Symposia (continued):

24. **Beilin Y.** Stat cesarean section - regional versus general anesthesia. Problem-Based Learning Discussions for the American Society of Anesthesiologists, 2001:L-101.

25. **Beilin Y.** Anesthesia for cesarean section – regional or general anesthesia? Syllabus for The 55th Annual Post graduate Assembly in Anesthesiology, of the New York State Society of Anesthesiologists, 2001:A61-63.

26. **Beilin Y.** Thrombocytopenia and neuraxial analgesia. Syllabus for The 55th Annual Post graduate Assembly in Anesthesiology, of the New York State Society of Anesthesiologists, 2001;115-6.

27. **Beilin Y,** Abramovitz S. Patient with severe pre-eclampsia. Syllabus for The 55th Annual Post graduate Assembly in Anesthesiology, of the New York State Society of Anesthesiologists, 2001;136-9.

28. **Beilin Y.** Advances in labor analgesia. Syllabus for The Texas Anesthesia Conference for Obstetrics (TACO). 2002:15-23.

29. **Beilin Y.** The real world: Spinal versus epidural anesthesia for cesarean section – maternal satisfaction, non-reassuring fetal heart rate, and postoperative analgesia. Syllabus for The Texas Anesthesia Conference for Obstetrics (TACO). 2002:85-89.

30. **Beilin Y.** Evaluation of platelet function in parturients: The platelet function analyzer (PFA-100) is more reliable. Syllabus for The Texas Anesthesia Conference for Obstetrics (TACO). 2002:97-102.

31. **Beilin Y.** Stat cesarean section - regional versus general anesthesia. Syllabus for The 39th annual New York Anesthesiology Review, 2002.

32. **Beilin Y.** Obstetric anesthesia - Key words. Syllabus for The 39th annual New York Anesthesiology Review, 2002.

33. **Beilin Y.** Stat cesarean section - regional versus general anesthesia. Problem-Based Learning Discussions for the American Society of Anesthesiologists, 2001:L-68.

34. **Beilin Y.** The Patient for Cesarean Delivery Is Hemorrhaging!! Problem-Based Learning Discussions for the American Society of Anesthesiologists, 2002:L-83101.

35. **Beilin Y,** Abramovitz S. The parturient with severe pre-eclampsia. Syllabus for The 56th Annual Post graduate Assembly in Anesthesiology, of the New York State Society of Anesthesiologists, 2002;139-42.

Proceedings of Symposia (continued):

36. **Beilin Y.** Thrombocytopenia, Low Molecular Weight Heparin and Epidural Labor Analgesia: What is an Anesthesiologist To Do? Syllabus for The 57th Annual Post graduate Assembly in Anesthesiology, of the New York State Society of Anesthesiologists, 2003.

37. **Beilin Y,** Abramovitz S. Elevated blood pressure in the parturient. Syllabus for The 57th Annual Post graduate Assembly in Anesthesiology, of the New York State Society of Anesthesiologists, 2003.

38. **Beilin Y.** The Patient for Cesarean Delivery Is Hemorrhaging!! Problem-Based Learning Discussions for the American Society of Anesthesiologists, 2004:L-165.

39. **Beilin Y,** Abramovitz S. Elevated blood pressure in the parturient. Syllabus for The 58th Annual Post graduate Assembly in Anesthesiology, of the New York State Society of Anesthesiologists, 2004.

40. **Beilin Y.** Stat Cesarean Section: Regional Vs. General Anesthesia. Syllabus for the 31st Annual Virginia Apgar Seminar, 2005;1-7.

41. **Beilin Y.** Thrombocytopenia and Low Molecular Weight Heparin: Implications for Regional Anesthesia. Syllabus for the 31st Annual Virginia Apgar Seminar, 2005;61-9.

42. **Beilin Y.** Non-Obstetric Surgery During Pregnancy. Syllabus for the 31st Annual Virginia Apgar Seminar, 2005;31-39.

43. **Beilin Y.** "Non-Obstetric Surgery During Pregnancy." Syllabus for the 42nd Annual New York Anesthesiology Review, 2005.

44. **Beilin Y.** "Anesthetic Management of Preeclampsia." Syllabus for the 42nd Annual New York Anesthesiology Review, 2005.

45. **Beilin Y.** "Anesthetic Management of Peri-Partum Hemorrhage." Syllabus for the 42nd Annual New York Anesthesiology Review, 2005.

46. **Beilin Y,** Bernstein HH. "Stat Cesarean Section: Regional Vs. General Anesthesia." Syllabus for the 42nd Annual New York Anesthesiology Review, 2005.

47. **Beilin Y.** Does Neuraxial Labor Analgesia Affect Newborn Behavior and Breastfeeding? Syllabus for The 59th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, 2005.

Proceedings of Symposia (continued):

48. **Beilin Y.** Anesthetic Management of Preeclampsia. Syllabus for The 59th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, 2005.

49. **Beilin Y.** Elevated Blood Pressure in the Parturient. Syllabus for The 59th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, 2005.

50. **Beilin Y.** "Non-Obstetric Surgery During Pregnancy." Syllabus for the 43rd Annual New York Anesthesiology Review, 2006.

51. **Beilin Y.** "Anesthetic Management of Preeclampsia." Syllabus for the 43rd Annual New York Anesthesiology Review, 2006.

52. **Beilin Y.** "Anesthetic Management of Peri-Partum Hemorrhage." Syllabus for the 43rd Annual New York Anesthesiology Review, 2006.

53. **Beilin Y,** Bernstein HH. "Stat Cesarean Section: Regional Vs. General Anesthesia." Syllabus for the 43rd Annual New York Anesthesiology Review, 2006.

54. **Beilin Y.** Elevated Blood Pressure in the Parturient. Syllabus for The 60th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, 2006.

55. **Beilin Y.** "Anesthesia for the parturient for Non-Obstetric Surgery." Syllabus for the 44th Annual New York Anesthesiology Review, 2007.

56. **Beilin Y.** "Labor neuraxial analgesia: An evidence Based Approach." Syllabus for the 44th Annual New York Anesthesiology Review, 2007.

57. **Beilin Y.** "Anesthetic Management of Peri-Partum Hemorrhage." Syllabus for the 44th Annual New York Anesthesiology Review, 2007.

58. **Beilin Y,** Bernstein HH. "Preterm pregnancy complicated by hypertension." Syllabus for the 44th Annual New York Anesthesiology Review, 2007.

59. **Beilin Y.** "Anesthetic techniques for labor: an evidence based approach." Syllabus for the 33rd Annual Virginia Apgar Seminar, 2007.

60. **Beilin Y.** Thrombocytopenia and Low Molecular Weight Heparin: Implications for Regional Anesthesia. Syllabus for the 33rd Annual Virginia Apgar Seminar, 2007.

61. **Beilin Y.** Non-Obstetric Surgery During Pregnancy. Syllabus for the 33rd Annual Virginia Apgar Seminar, 2007.

Proceedings of Symposia (continued):

62. **Beilin Y.** "Anesthetic Management of the woman at risk for postpartum hemorrhage." Syllabus for Challenges in Obstetrics, Gynecology, and Women's Health Meeting 2007.

63. **Beilin Y.** Labor neuraxial analgesia: An evidence-based approach. Syllabus for The Hawaii Anesthesiology Update 2007.

64. **Beilin Y.** Thrombocytopenia and Low molecular weight heparin. Syllabus for The Hawaii Anesthesiology Update 2007.

65 **Beilin Y.** Non-obstetric surgery during pregnancy. Syllabus for The Hawaii Anesthesiology Update 2007.

66. **Beilin Y.** Management and treatment of obstetric hemorrhage. Syllabus for The Hawaii Anesthesiology Update 2007.

67. **Beilin Y.** Anesthesia for urgent cesarean delivery. Syllabus for The Hawaii Anesthesiology Update 2007.

68. **Beilin Y.** "Anesthesia for the parturient for Non-Obstetric Surgery." Syllabus for the 45th Annual New York Anesthesiology Review, 2008.

69. **Beilin Y.** ""Labor neuraxial analgesia: An evidence Based Approach." Syllabus for the 45th Annual New York Anesthesiology Review, 2008.

70. **Beilin Y.** ""Anesthetic Management of Peri-Partum Hemorrhage "Syllabus for the 45th Annual New York Anesthesiology Review, 2008.

71. **Beilin Y,** Bernstein HH. "Preterm pregnancy complicated by hypertension."Syllabus for the 45th Annual New York Anesthesiology Review, 2008.

72. **Beilin Y**. "Post partum headache: Differential diagnosis and treatment." Syllabus for Challenges in Obstetrics, Gynecology, and Women's Health Meeting 2008.

73. **Beilin Y.** Thrombocytopenia and Regional Analgesia for Labor – How Low Can You Go?" Syllabus for the 21st International Congress of the Israel Society of Anesthesiologists, Tel Aviv, Israel, 2008.

74. **Beilin Y.** "Anesthesia for the parturient for Non-Obstetric Surgery." Syllabus for the 45th Annual New York Anesthesiology Review, 2009.

75. **Beilin Y.** ""Labor neuraxial analgesia: An evidence Based Approach." Syllabus for the 45th Annual New York Anesthesiology Review, 2009.

Proceedings of Symposia (continued):

76. **Beilin Y.** ""Anesthetic Management of Peri-Partum Hemorrhage "Syllabus for the 45th Annual New York Anesthesiology Review, 2009.

77. **Beilin Y,** Bernstein HH. "Preterm pregnancy complicated by hypertension."Syllabus for the 45th Annual New York Anesthesiology Review, 2009.

78. **Beilin Y.** Thrombocytopenia and Regional Analgesia for Labor – How Low Can You Go?" Syllabus for Challenges in Obstetrics, Gynecology, and Women's Health Meeting 2009.

79. **Beilin Y.** "Anesthesia for the parturient for Non-Obstetric Surgery." Syllabus for the 45th Annual New York Anesthesiology Review, 2010.

80. **Beilin Y.** ""Labor neuraxial analgesia: An evidence Based Approach." Syllabus for the 45th Annual New York Anesthesiology Review, 2010.

81. **Beilin Y.** ""Anesthetic Management of Peri-Partum Hemorrhage "Syllabus for the 45th Annual New York Anesthesiology Review, 2010.

82. **Beilin Y,** Bernstein HH. "Preterm pregnancy complicated by hypertension."Syllabus for the 45th Annual New York Anesthesiology Review, 2010.

83. **Beilin Y.** Practical Suggestions for Improving Safety In Your Unit: Safety Rounds Beyond Board Sign Out. Syllabus for the 47th Annual meeting of the Society for Obstetric Anesthesia and perinatology, Toronto, Canada, May 18, 2015.

INVITED LECTURES/PRESENTATIONS AND VISITING PROFESSORSHIPS

1. "Anesthesia for labor and delivery." Grand rounds lecture for the Division of Maternal Fetal Medicine, Department of Obstetrics and Gynecology, Mount Sinai School of Medicine, New York, NY, November 9, 1994.

2. "The bleeding patient." Lecture at The 32nd annual New York Anesthesiology Review, New York, NY, June 14, 1995.

3. "Neurologic complications in the obstetric patient." Grand rounds lecture for The Department of Anesthesiology, Englewood Hospital and Medical Center, Englewood, NJ, September 6, 1995.

4. "Update on obstetric anesthesia." Grand rounds lecture for The Department of Obstetrics and Gynecology, Mount Sinai School of Medicine, New York, NY, October 11, 1995.

5. "Nonobstetric surgery for the pregnant patient." Grand rounds lecture for The Department of Anesthesiology, Saint Barnabas Medical Center, Livingstone, NJ, November 15, 1995.

6. "Anesthesia for non-obstetrical surgery." Lecture at the 49th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 10, 1995.

7. "Update on obstetric anesthesia." Grand rounds lecture for the Department of Obstetrics and Gynecology, New York Medical *College, New York, NY, April 23, 1996.

8. "Update on obstetric anesthesia." Grand rounds lecture for the Department of Obstetrics and Gynecology, Saint Vincent's Medical Center, Staten Island, NY, May 31, 1996.

9. "A pregnant patient with an acute abdomen." Lecture at The 33rd annual New York Anesthesiology Review, New York, NY, June 14, 1996.

10. "A pregnant patient with an acute abdomen." Lecture at The 34th annual New York Anesthesiology Review, New York, NY, March 24, 1997.

11. "Nonobstetric surgery for the pregnant patient." Grand rounds lecture for The Department of Anesthesiology, Baystate Medical Center, Springfield, MA, April 17, 1997.

12. "Update on obstetric anesthesia." Grand rounds lecture for The Department of Anesthesiology, White Plains Hospital, White Plains, NY, May 6, 1997.

Invited Lectures/Presentations and Visiting Professorships (continued):

13. "Update on obstetric anesthesia." Grand rounds lecture for The Department of Anesthesiology, Maimonides Medical Center, Brooklyn, NY, August 13, 1997.

14. "Stat cesarean section - regional versus general anesthesia." Lecture at annual meeting of the American Society of Anesthesiologists, San Diego, CA, October, 21, 1997.

15. "Stat cesarean section - regional versus general anesthesia." Lecture at The 35th annual New York Anesthesiology Review, New York, NY, March 16, 1998.

16. "An update of obstetric anesthesia." Grand rounds lecture for The Department of Anesthesiology, Brookdale Hospital, Brooklyn, NY, March 24, 1998.

17. "Update on obstetrical anesthesia." Grand rounds lecture for the Department of Obstetrics and Gynecology, Lincoln Medical and Mental Health Center, New York Medical College, Bronx, NY, August 4, 1998.

18. "Stat cesarean section - regional versus general anesthesia." Lecture at the annual meeting of the American Society of Anesthesiologists, San Diego, CA, October 20, 1998.

19. "Stat cesarean section - regional versus general anesthesia." Lecture at the annual meeting of the American Society of Anesthesiologists, San Diego, CA, October 21, 1998.

20. "Stat cesarean section - regional versus general anesthesia." Lecture at The 52nd Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 15, 1998.

21. "Management of the parturient with heart disease." Lecture at the 17th annual symposium: Clinical update in anesthesia and advanced in techniques of cardiopulmonary bypass, St. Thomas. US, Virgin Islands, January 29, 1999.

22. "An update of obstetrical anesthesia." Visiting Professor and Grand rounds lecture for the Department of Anesthesiology, St. Joseph's Hospital and Medical Center, Paterson, NJ, February 18, 1999.

23. "Stat cesarean section - regional versus general anesthesia." Lecture at The 36th annual New York Anesthesiology Review, Orlando, FL, March 22, 1999.

24. "Obstetric anesthesia - Key words." Presentation at The 36th annual New York Anesthesiology Review, Orlando, FL, March 23, 1999.

Invited Lectures/Presentations and Visiting Professorships (continued):

25. "Walking epidurals and other obstetric advances." Lecture at the 24th annual meeting of the American Society of Regional Anesthesia, Philadelphia, PA, May 7,1999.

26. "Post dural puncture headaches: Diagnosis and management." Lecture at the 24th annual meeting of the American Society of Regional Anesthesia, Philadelphia, PA, May 9, 1999.

27. "Update in obstetric anesthesia." Grand rounds lecture at the Island-wide anesthesiology forum of the Sisters of Charity Medical Center. Staten Island, NY, July 13, 1999.

28. "Stat cesarean section - regional versus general anesthesia." Lecture at the annual meeting of the American Society of Anesthesiologists, Dallas, TX, October 11, 1999.

29. "Stat cesarean section - regional versus general anesthesia." Lecture at the annual meeting of the American Society of Anesthesiologists, Dallas, TX, October 12, 1999.

30. "Thrombocytopenia and regional anesthesia for the parturient – How low can you go?" Lecture at The 12th International Symposium on Anesthesia and Intensive Care, Tel Aviv, Israel, December 8, 1999.

31. "New techniques in obstetric anesthesia." Lecture at The 12th International Symposium on Anesthesia and Intensive Care, Tel Aviv, Israel, December 9, 1999.

32. "Regional anesthesia and thrombocytopenia: How low can you go?" Panel lecture at the 53rd Postgraduate Assembly, meeting of the New York State Society of Anesthesiologists, New York, NY, December 12, 1999.

33."Stat cesarean section - regional versus general anesthesia." Lecture at The 53rd Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 13, 1999.

34. "Post dural puncture headaches: Diagnosis and management." Visiting Professor and Grand rounds lecture for the Department of Anesthesiology, New York University School of Medicine, January 13, 2000.

35. "Regional anesthesia and thrombocytopenia: How low can you go?" Grand rounds lecture for the Department of Anesthesiology, New York Medical College, February 3, 2000.

36. "Update in obstetric anesthesia." Grand rounds lecture for the Department of Anesthesiology, Vassar Brothers Hospital, Poughkeepsie, NY, March 16, 2000.

Invited Lectures/Presentations and Visiting Professorships (continued):

37. "Thrombocytopenia and regional anesthesia for the parturient – How low can you go?" Visiting Professor and Grand rounds lecture for the Willem Luykx, MD Memorial Lecture Series of the Department of Anesthesiology at the University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School, New Brunswick, NJ, April 5, 2000.

38. Moderator for Case Discussions at the 32nd annual meeting of the Society for Obstetric Anesthesia and Perinatology, Montreal, Canada, June 4, 2000,

39. "Stat cesarean section - regional versus general anesthesia. "Lecture at the annual meeting of the American Society of Anesthesiologists, San Francisco, CA, October 17, 2000.

40. "Advances in obstetric anesthesia." Lecture at the Fall Meeting of the 4th District of The New York State Society of Anesthesiologists, Albany, NY, November 8, 2000.

41. "Postdural puncture headache." Grand rounds lecture for the Department of Anesthesiology, Albany Medical College, Albany, NY, November 9, 2000.

42. "Labor analgesia Challenges." Lecture at The 54th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 10, 2000.

43. "Labor analgesia Challenges." Lecture at The 54th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 11, 2000.

44. "Elevated blood pressure in the parturient." Lecture at The 54th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 12, 2000.

45. "Post dural puncture headaches: Diagnosis and management." Visiting Professor and Grand rounds lecture for the Department of Anesthesiology, New York University School of Medicine, January 24, 2001.

46. "Advances in labor analgesia." Grand rounds lecture for the Department of Anesthesiology, Maimonides Medical Center, Brooklyn, NY, February 9, 2001.

47. "Advances in labor analgesia." Grand rounds lecture for the Department of Anesthesiology, New York Medical College, Valhalla, NY, February 11, 2001.

48. "Stat cesarean section - regional versus general anesthesia". Lecture at The 38th annual New York Anesthesiology Review, Orlando, FL, March 12, 2001.

Invited Lectures/Presentations and Visiting Professorships (continued):

49. "Obstetric anesthesia - Key words." Presentation at The 38th annual New York Anesthesiology Review, Orlando, FL, March 12, 2001.

50. "Update in obstetric anesthesia." Grand rounds presentation for the Department of Obstetrics and Gynecology, Lehigh Valley Hospital, Allentown, PA, April 20,2001.

51. "New Amide Local Anesthetics." Grand rounds presentation for the Departments of Anesthesiology and Surgery, St. Elizabeth's Hospital of Tufts Medical School, Brighton, MA, September 20,2001.

52. "Safe Neuraxial Anesthesia." Panel Moderator at the annual meeting of the American Society of Anesthesiologists, New Orleans, LA, October 15, 2001.

53. "Thrombocytopenia and regional anesthesia for the parturient – How low can you go?" Lecture at the annual meeting of the American Society of Anesthesiologists, New Orleans, LA, October 15, 2001.

54. "Stat cesarean section - regional versus general anesthesia." Lecture at the annual meeting of the American Society of Anesthesiologists, New Orleans, LA, October 16, 2001.

55. "Overview of Regional Anesthesia." Lecture for District Managers at Purdue Pharmaceuticals, Stanford, CT, October 29, 2001.

56. "New Amide Local Anesthetics." Lecture for District Managers at Purdue Pharmaceuticals, Stanford, CT, October 29, 2001.

57. "Cesarean delivery: regional vs. General Anesthesia." Panel lecture at the 55th Postgraduate Assembly, meeting of the New York State Society of Anesthesiologists, New York, NY, December 9, 2001.

58. "Regional anesthesia and thrombocytopenia in the OB patient: How low can you go?" Panel lecture at the 55th Postgraduate Assembly, meeting of the New York State Society of Anesthesiologists, New York, NY, December 9, 2001.

59. "Regional anesthesia and thrombocytopenia in the OB patient: How low can you go?" Focus session lecture at the 55th Postgraduate Assembly, meeting of the New York State Society of Anesthesiologists, New York, NY, December 9, 2001.

60. "Elevated blood pressure in the parturient." Lecture at The 55th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 10, 2001.

Invited Lectures/Presentations and Visiting Professorships (continued):

61. "Thrombocytopenia and regional anesthesia for the parturient – How low can you go?" Visiting Professor and Grand rounds lecture for the Department of Anesthesia and Critical Care, Beth Israel Deaconess Medical Center of Harvard Medical School, Boston, MA, January 15, 2002.

62. "Non-obstetric surgery during pregnancy." Grand rounds lecture for the Department of Anesthesiology, New York Medical College, Valhalla, NY, February 4, 2002.

63. "Non-obstetric surgery during pregnancy." Grand rounds lecture for the Departments of Anesthesiology of New York Hospital and Memorial Sloan Kettering Cancer Center of The Joan and Sanford I. Weill Medical College of Cornell University, New York, NY, February 11, 2002.

64. "Advances in labor analgesia." Lecture at the Texas Anesthesia Conference for Obstetrics (TACO 2002). Houston, TX, March 1, 2002.

65. "The real world: Spinal versus epidural anesthesia for cesarean section – maternal satisfaction, non-reassuring fetal heart rate, and postoperative analgesia." Lecture at the Texas Anesthesia Conference for Obstetrics (TACO 2002). Houston, TX, March 1, 2002.

66. "Evaluation of platelet function in parturients: The platelet function analyzer (PFA-100) is more reliable." Lecture at the Texas Anesthesia Conference for Obstetrics (TACO 2002). Houston, TX, March 1, 2002.

67. "Stat cesarean section - regional versus general anesthesia". Lecture at The 39th annual New York Anesthesiology Review, Orlando, FL, March 11, 2002.

68. "Obstetric anesthesia - Key words." Presentation at The 39th annual New York Anesthesiology Review, Orlando, FL, March 11, 2002.

69. Lecture for poster review at the 34th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Hilton Head Island, South Carolina, May 2, 2002.

70. "Advances in Obstetric Anesthesia." Grand rounds presentation for the Department of Anesthesiology, Hackensack University Medical Center, Hackensack, NJ, August 20, 2002.

71. "Stat cesarean section - regional versus general anesthesia." Lecture at the annual meeting of the American Society of Anesthesiologists, Orlando, FL, October 14, 2002.

72. "The patient for cesarean delivery is hemorrhaging." Lecture at the annual meeting of the American Society of Anesthesiologists, Orlando, FL, October 14, 2002.

Invited Lectures/Presentations and Visiting Professorships (continued):

73. "Thrombocytopenia, aspirin, and low molecular weight heparin: Maintaining the safety of neuraxial anesthesia. Lecture at the annual meeting of the American Society of Anesthesiologists, Orlando, FL, October 16, 2002.

74. "Optimizing OB Anesthesia: An Anesthesiologist's Perspective." Grand rounds presentation for the Department of Obstetrics and Gynecology and Reproductive Sciences, Mount Sinai School of Medicine of New York University, October 30, 2002.

75. "The parturient with severe preeclampsia." Lecture at The 56th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 9, 2002.

76. "Cesarean delivery: Regional vs. general anesthesia." Grand rounds lecture for the Department of Anesthesiology, New York Medical College, Valhalla, NY, February 2, 2003.

77. Judge for the Gertie Marx Symposium at the 34th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Phoenix, Arizona , May 15, 2003.

78. "The complicated parturient, breakfast with the experts." Presentation at 34th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Phoenix, Arizona , May 17, 2003.

79. "Cesarean Delivery: Regional Vs. General Anesthesia." Visiting Professor and grand rounds presentation at Stony Brook University Hospital, Stony Brook, NY, June 19, 2003.

80. "Thrombocytopenia and Low Molecular Weight Heparin: Implications for Regional Anesthesia." Visiting Professor and grand rounds presentation at Stony Brook University Hospital, Stony Brook, NY, June 20, 2003.

81. "Thrombocytopenia, Low Molecular Weight Heparin and Epidural Labor Analgesia: What is an Anesthesiologist To Do?" Lecture at The 57th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 14, 2003.

82. "Elevated blood pressure in the parturient." Lecture at The 57th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 15, 2003.

83. "Post dural puncture headaches: Diagnosis and management." Lecture at the 29 Annual Spring Meeting of the American Society of Regional Anesthesia and Pain Medicine, March 12, 2004, Orlando, Florida.

Invited Lectures/Presentations and Visiting Professorships (continued):

84. Judge for Gertie Marx Symposium at the 36th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Fort Meyers, Florida, May 12, 2004.

85. Moderator for poster session at the 36th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Fort Meyers, Florida, May 12, 2004.

86. "The patient for cesarean delivery is hemorrhaging." Lecture at the annual meeting of the American Society of Anesthesiologists, Las Vegas, NV, October 25, 2004.

87. "The patient for cesarean delivery is hemorrhaging." Lecture at the annual meeting of the American Society of Anesthesiologists, Las Vegas, NV, October 26, 2004.

88. Poster Discussion Moderator, "Obstetric Anesthesia." Presented at the annual meeting of the American Society of Anesthesiologists, Las Vegas, NV, October 26, 2004.

89. "Fetal Monitoring, has it changed outcome? Lecture at The 58th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 10, 2004.

90. "Preeclampsia." Grand rounds lecture for the Department of Anesthesiology, New York Medical College, Valhalla, NY, February 7, 2005.

91. "Anesthetic Management of Peri-Partum Hemorrhage." Lecture at the 31st Annual Virginia Apgar Seminar, Orlando, Florida, March 11, 2005.

92. "Stat Cesarean Section: Regional Vs. General Anesthesia. Lecture at the 31st Annual Virginia Apgar Seminar, Orlando, Florida, March 11, 2005.

93. "Thrombocytopenia and Low Molecular Weight Heparin: Implications for Regional Anesthesia." Lecture at the 31st Annual Virginia Apgar Seminar, Orlando, Florida, March 11, 2005.

94. "Non-Obstetric Surgery During Pregnancy." Lecture at the 31st Annual Virginia Apgar Seminar, Orlando, Florida, March 11, 2005.

95. "Non-Obstetric Surgery During Pregnancy." Lecture at the 42nd Annual New York Anesthesiology Review, Orlando, Florida, March 22, 2005.

96. "Anesthetic Management of Preeclampsia." Lecture at the 42nd Annual New York Anesthesiology Review, Orlando, Florida, March 22, 2005.

Invited Lectures/Presentations and Visiting Professorships (continued):

97. "Anesthetic Management of Peri-Partum Hemorrhage." Lecture at the 42nd Annual New York Anesthesiology Review, Orlando, Florida, March 22, 2005.

98. "Stat Cesarean Section: Regional Vs. General Anesthesia." Lecture at the 42nd Annual New York Anesthesiology Review, Orlando, Florida, March 22, 2005.

99. Judge for Gertie Marx Symposium at the 37th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Palm Desert, CA, May 5, 2005.

100. "Update on Obstetric Anesthesia: Myth vs. reality." Grand rounds presentation for the Department of Obstetrics and Gynecology and Reproductive Sciences, Mount Sinai School of Medicine of New York University, June 8, 2005.

101. "Does Neuraxial Anesthesia Impact on Obstetric Outcome." Grand rounds lecture for the Department of Anesthesiology, Saint Vincent Catholic Medical Centers, New York, NY, November 9, 2005.

102. "Does Neuraxial Labor Analgesia Affect Newborn Behavior and Breastfeeding?" Lecture at The 59th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 11, 2005.

103. "Anesthetic Management of Preeclampsia." Lecture at The 59th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 12, 2005.

104. "Elevated Blood Pressure in the Parturient." Lecture at The 59th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 13, 2005.

105. "Does Neuraxial Anesthesia Impact on Obstetric Outcome." Grand rounds lecture for the Department of Anesthesiology, Saint Josephs' Regional Medical Center, Paterson, NJ, January 5, 2006.

106. "Does Neuraxial Anesthesia Impact on Obstetric Outcome?" Grand rounds lecture for the Department of Anesthesiology, New York Medical College, Valhalla, NY, February 6, 2006.

107. "Non-Obstetric Surgery During Pregnancy." Lecture at the 43rd Annual New York Anesthesiology Review, Orlando, Florida, March 15, 2006.

Invited Lectures/Presentations and Visiting Professorships (continued):

108. "Anesthetic Management of Preeclampsia." Lecture at the 43rd Annual New York Anesthesiology Review, Orlando, Florida, March 15, 2006.

109. "Anesthetic Management of Peri-Partum Hemorrhage." Lecture at the 43rd Annual New York Anesthesiology Review, Orlando, Florida, March 15, 2006.

110. "Management of Hypertensive crises in pregnancy." Lecture at the Critical Care Obstetric Anesthesia Workshop at the 38th annual meeting of the Society for Obstetric Anesthesia and Perinatology, Hollywood, Fl, April 26, 2006.

111. "A non-particulate antacid should be used routinely in all patients undergoing cesarean section." Lecture at the 38th annual meeting of the Society for Obstetric Anesthesia and Perinatology, Hollywood, Fl, April 27, 2006.

112. "Labor neuraxial analgesia: An evidence based approach." Grand rounds lecture at St. Clare's Hospital Complex, Denville, NJ, May 17, 2006.

113. Poster Discussion Moderator, "Obstetric Anesthesia: Labor analgesia." Presented at the annual meeting of the American Society of Anesthesiologists, Chicago, IL, October 16, 2006.

114. "Elevated blood pressure in the parturient." Lecture at the annual meeting of the American Society of Anesthesiologists, Chicago, IL, October 16, 2006.

115. "Elevated blood pressure in the parturient." Lecture at the annual meeting of the American Society of Anesthesiologists, Chicago, IL, October 17, 2006.

116. Poster Discussion Moderator, "Obstetric Anesthesia: Cesarean Section and Complicated Obstetrics." Presented at the annual meeting of the American Society of Anesthesiologists, Chicago, IL, October 18, 2006

117. Moderator of Gertie F. Marx Memorial Lecture on Obstetrical Anesthesia: Current Debates in Obstetrical Anesthesia. Presented at The 60th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 10, 2006.

118. "Use of Non-Particulate Antacid for Elective Cesarean Delivery." Lecture at The 60th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 10, 2006.

119. "HELLP Syndrome." Lecture at The 60th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 11, 2006.

Invited Lectures/Presentations and Visiting Professorships (continued):

120. "Elevated Blood Pressure in the Parturient." Lecture at The 60th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 11, 2006.

121. "Thrombocytopenia and Low Molecular Weight Heparin." Grand rounds lecture for the Department of Anesthesiology, New York Medical College, Valhalla, NY, February 12, 2007.

122. "Anesthetic techniques for labor: an evidence based approach." Presented at the 33rd Annual Virginia Apgar Seminar, Orlando, FL, March 11, 2007.

123. "Thrombocytopenia and Low Molecular Weight Heparin: Implications for Regional Anesthesia." Presented at the 33rd Annual Virginia Apgar Seminar, Orlando, FL, March 11, 2007.

124. "Non-Obstetric Surgery During Pregnancy." Presented at the 33rd Annual Virginia Apgar Seminar, Orlando, FL, March 11, 2007.

125. "Anesthesia for the parturient for Non-Obstetric Surgery." Presented at the 44th Annual New York Anesthesiology Review, Orlando, FL March 12, 2007.

126. "Labor neuraxial analgesia: An evidence Based Approach." Presented at the 44th Annual New York Anesthesiology Review, Orlando, FL, March 12, 2007.

127. "Anesthetic Management of Peri-Partum Hemorrhage." Presented at the 44th Annual New York Anesthesiology Review, Orlando, FL, March 12, 2007.

128. "Preterm pregnancy complicated by hypertension." Presented at the 44th Annual New York Anesthesiology Review, Orlando, FL, March 12, 2007.

129. "Anesthetic Management of the woman at risk for postpartum hemorrhage." Lecture at Challenges in Obstetrics, Gynecology, and Women's Health Meeting sponsored by the Department of Obstetrics and Gynecology of Mount Sinai School of Medicine, New York, NY, April 25, 2007.

130. Lecture for poster review at the 39th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Banff, Canada, May 18, 2007.

131. "Labor neuraxial analgesia: An evidence-based approach." Lecture at The Hawaii Anesthesiology Update 2007, Maui, Hawaii, August 6, 2007.

132. "Thrombocytopenia and Low molecular weight heparin". Lecture at The Hawaii Anesthesiology Update 2007, Maui, Hawaii, August 6, 2007.

Invited Lectures/Presentations and Visiting Professorships (continued):

133. "Non-obstetric surgery during pregnancy". Lecture at The Hawaii Anesthesiology Update 2007, Maui, Hawaii, August 7, 2007.

134. "Management and treatment of obstetric hemorrhage." Lecture at The Hawaii Anesthesiology Update 2007, Maui, Hawaii, August 9, 2007.

135. "Anesthesia for urgent cesarean delivery." Lecture at The Hawaii Anesthesiology Update 2007, Maui, Hawaii, August 10, 2007.

136. Poster Discussion Moderator, "Obstetric Anesthesia: Labor analgesia." Presented at the annual meeting of the American Society of Anesthesiologists, San Francisco, CA, Chicago, IL, October 14, 2007.

136. "Obstetric Hemorrhage." Lecture at The 61st Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 10, 2007.

137. Stat cesarean delivery: Spinal vs. general Anesthesia. Lecture at The 61st Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 10, 2007.

138. Management of Obstetric Hemorrhage. Grand rounds lecture for the Department of Anesthesiology, New York Medical College, Valhalla, NY, February 4, 2008.

139. "Anesthesia for the parturient for Non-Obstetric Surgery." Presented at the 45th Annual New York Anesthesiology Review, Orlando, FL March 18, 2008.

140. "Labor neuraxial analgesia: An evidence Based Approach." Presented at the 45th Annual New York Anesthesiology Review, Orlando, FL, March 18, 2008.

141. "Anesthetic Management of Peri-Partum Hemorrhage." Presented at the 45th Annual New York Anesthesiology Review, Orlando, FL, March 18, 2008.

142. "Preterm pregnancy complicated by hypertension."Presented at the 45th Annual New York Anesthesiology Review, Orlando, FL, March 18, 2008.

143. "Post partum headache: Differential diagnosis and treatment." Lecture at Challenges in Obstetrics, Gynecology, and Women's Health Meeting sponsored by the Department of Obstetrics and Gynecology of Mount Sinai School of Medicine, New York, NY, April 16, 2008.

144. Moderator for Multidisciplinary Case Forum entitled, "Obesity". Presented at the 40th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Chicago, IL April 30, 2008.

Invited Lectures/Presentations and Visiting Professorships (continued):

145. Visiting Professor at Ochsner medical center. "Thrombocytopenia and LMWH: Implications for Regional Anesthesia" and Moderator for Journal Club. New Orleans, LA, May 19-20, 2008

146. "Thrombocytopenia and Neuraxial Anesthesia". "Presented at the 1st International Symposium on Anesthesia and Critical Care, Myney Hyeshua Medical Center (MHMC), Bnei Brak, Israel, September 15, 2008.

147. "Thrombocytopenia and Regional Analgesia for Labor – How Low Can You Go?" Presented at the 21st International Congress of the Israel Society of Anesthesiologists, Tel Aviv, Israel, September 17, 2008.

148. "The time has come to Abandon the Routine Epidural test Dose for Labor." Presented at the 21st International Congress of the Israel Society of Anesthesiologists, Tel Aviv, Israel, September 17, 2008.

149. Poster Discussion Moderator, "Obstetric Anesthesia: Labor analgesia." Presented at the annual meeting of the American Society of Anesthesiologists, Orlando, Fl, October 19, 2008.

150. "Obstetric Hemorrhage." Lecture at The 62nd Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 17, 2008.

151. Stat cesarean delivery: Spinal vs. general Anesthesia. Lecture at The 62nd Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 17, 2008.

152. Labor Neuraxial Analgesia: An evidence Based approach. Grand Rounds Lectures at the Tel Aviv Sourasky Medical Center, Ichalov Hospital, Tel-Aviv, Israel, Jan 20, 2009.

153. Postpartum headache: Diagnosis and Management. Grand rounds lecture for the Department of Anesthesiology, New York Medical College, Valhalla, NY, February 10, 2009.

154. "Anesthesia for the parturient for Non-Obstetric Surgery." Presented at the 46th Annual New York Anesthesiology Review, Orlando, FL March 24, 2009.

155. "Labor neuraxial analgesia: An evidence Based Approach." Presented at the 46th Annual New York Anesthesiology Review, Orlando, FL, March 24, 2009.

156. "Anesthetic Management of Peri-Partum Hemorrhage." Presented at the 46th Annual New York Anesthesiology Review, Orlando, FL, March 22, 2009.

Invited Lectures/Presentations and Visiting Professorships (continued):

157. "Preterm pregnancy complicated by hypertension."Presented at the 46th Annual New York Anesthesiology Review, Orlando, FL, March 22, 2009.

158. "Thrombocytopenia and regional Anesthesia: How Low can you go?" Lecture at Challenges in Obstetrics, Gynecology, and Women's Health Meeting sponsored by the Department of Obstetrics and Gynecology of Mount Sinai School of Medicine, New York, NY, April 22, 2009.

159. Judge for the Gertie Marx Symposium at the 41st Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Washington, DC, April 30, 2009.

160. Moderator for poster discussion section at the 41st Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Washington, DC, April 31, 2009.

161. "Labor neuraxial analgesia: An evidence Based Approach." Grand Rounds Lecture for Department of Anesthesiology, St. Josephs' Medical center, Paterson, NJ, June 11, 2009

162. Placenta Accreta and Maternal Hemorrhage. Lecture and panelist at the annual meeting of the American Society of Anesthesiologists, New Orleans, LA, October 19, 2009.

163. "Postdural Puncture Headache." Lecture at The 63nd Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 14, 2009.

164. Stat cesarean delivery: Spinal vs. general Anesthesia. Lecture at The 63nd Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 14, 2009.

165. A Special Lecture" "An update on Obstetric Anesthesia". Lecture at the 28th Annual Symposium: Clinical update in anesthesiology, surgery and perioperative medicine, Paradise Island, Bahamas, January 22, 2010.

166. "Anesthesia for the parturient for Non-Obstetric Surgery." Grand rounds lecture for the Department of Anesthesiology, New York Medical College, Valhalla, NY, February 1, 2010.

167. "Anesthesia for the parturient for Non-Obstetric Surgery." Presented at the 47th Annual New York Anesthesiology Review, Orlando, FL March 15, 2010.

168. "Labor neuraxial analgesia: An evidence Based Approach." Presented at the 47th Annual New York Anesthesiology Review, Orlando, FL, March 15, 2010.

Invited Lectures/Presentations and Visiting Professorships (continued):

169. "Anesthetic Management of Peri-Partum Hemorrhage." Presented at the 47th Annual New York Anesthesiology Review, Orlando, FL, March 15, 2010.

170. "Preterm pregnancy complicated by hypertension."Presented at the 47th Annual New York Anesthesiology Review, Orlando, FL, March 15, 2010.

171. Judge for Gertie Marx Research competition at the 42nd Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, San Antonio, TX, May 13, 2010.

172. Moderator for "Breakfast with the Experts" session at the 42nd Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, San Antonio, TX, May 16, 2010.

173. "Thrombocytopenia and Regional anesthesia: How low can you go?" Grand Rounds Lecture for Department of Anesthesiology, St. Josephs' Medical center, Paterson, NJ, September 2, 2010.

174. "Thrombocytopenia and Low Molecular Weight heparin: Implications for Neuraxial Anesthesia. Refresher Course Lecture at the annual meeting of the American Society of Anesthesiologists, San Diego, CA, October 17, 2010.

175. "Severe Preeclampsia." Lecture at the annual meeting of the American Society of Anesthesiologists, San Diego, CA, October 18, 2010.

176. Focus session moderator: Challenges in obstetric anesthesia: Preventing maternal death and The Joint Commission Sentinel alert. Moderator at The 64th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 13, 2010.

177. Stat cesarean delivery: Spinal vs. general Anesthesia. Lecture at The 64th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 13, 2010.

178. Maternal hemorrhage. Lecture at The 64th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 13, 2010.

179. Thrombocytopenia and Neuraxial Anesthesia: Implications for the anesthesiologist. Grand Rounds Lecture for Department of Anesthesiology at the Tel Aviv Sourasky Medical Center, Ichalov Hospital, Tel-Aviv, Israel, Jan 24, 2011.

180. Labor Neuraxial Analgesia: An evidence Based approach. Grand Rounds Lecture for Department of Anesthesiology at Shaare Zedek Medical center, Israel, Jan 27, 2011.

Invited Lectures/Presentations and Visiting Professorships (continued):

181. A practical Approach to Obstetric Anesthesia: What every obstetrician should know. Grand rounds lecture for The Department of Obstetrics and Gynecology, Mount Sinai School of Medicine, New York, NY, March 2, 2011.

182. "Anesthesia for the parturient for Non-Obstetric Surgery." Presented at the 48th Annual New York Anesthesiology Review, Orlando, FL March 29, 2011.

183. "Thrombocytopenia in the Parturient: Implications for neuraxial anesthesia." Presented at the 47th Annual New York Anesthesiology Review, Orlando, FL, March 29, 2011.

184. "Anesthetic Management of Peri-Partum Hemorrhage." Presented at the 48th Annual New York Anesthesiology Review, Orlando, FL, March 29, 2011.

185. "Preterm pregnancy complicated by hypertension." Presented at the 48th Annual New York Anesthesiology Review, Orlando, FL, March 29, 2011.

186. Moderator for Workshop: "Thromboelastogram in Obstetric and Non-Obstetric Anesthesia" at the 22nd International Congress of the Israel Society of Anesthesiologists, Tel Aviv, Israel, September 13, 2011.

187. "Platelet Function in High Risk Obstetrics." Presented at the 22nd International Congress of the Israel Society of Anesthesiologists, Tel Aviv, Israel, September 13, 2011.

188. "Management of Postdural Puncture Headache: What is the Evidence?" Presented at the 22nd International Congress of the Israel Society of Anesthesiologists, Tel Aviv, Israel, September 14, 2011.

189. "Thrombocytopenia and Neuraxial Anesthesia: Implications for the Obstetric Anesthesiologist." Presented at the 22nd International Congress of the Israel Society of Anesthesiologists, Tel Aviv, Israel, September 15, 2011.

190. "Thrombocytopenia and Low Molecular Weight heparin: Implications for Neuraxial Anesthesia. Refresher Course Lecture at the annual meeting of the American Society of Anesthesiologists, Chicago, IL, October 19, 2011.

191. "WHO Alert on Postpartum Hemorrhage: Protocols-Preparation-Novel Therapies." Lecture at the annual meeting of the American Society of Anesthesiologists, San Diego, CA, October 17, 2011.

192. Focus session moderator: Challenges in obstetric anesthesia: Moderator at The 65th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 12, 2011.

Invited Lectures/Presentations and Visiting Professorships (continued):

193. "Postdural Puncture Headache." Lecture at The 65nd Postgraduate Assembly in Anesthesiology, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 13, 2011.

194. Stat cesarean delivery: Spinal vs. general Anesthesia. Lecture at The 65th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 13, 2011.

195. "Anesthesia for the parturient for Non-Obstetric Surgery." Presented at the 49th Annual New York Anesthesiology Review, Orlando, FL March 19, 2012.

196. "Thrombocytopenia in the Parturient: Implications for neuraxial anesthesia." Presented at the 47th Annual New York Anesthesiology Review, Orlando, FL, March 19, 2012.

197. "Anesthetic Management of Peri-Partum Hemorrhage." Presented at the 48th Annual New York Anesthesiology Review, Orlando, FL, March 19, 2012.

198. "Preterm pregnancy complicated by hypertension." Presented at the 48th Annual New York Anesthesiology Review, Orlando, FL, March 19, 2012.

199. "Inadequate Labor Analgesia: Fixing a Bad Epidural." Presented at the 2012 Sol Shnider, M.D. Obstetric Anesthesia Meeting, San Francisco, CA, March 23, 2012.

200. "Previous Cesarean Delivery: Implications of Accreta and Uterine Rupture. Presented at the 2012 Sol Shnider, M.D. Obstetric Anesthesia Meeting, San Francisco, CA, March 25, 2012.

201. "Platelets and Epidurals: Latest Recommendations." Presented at the 2012 Sol Shnider, M.D. Obstetric Anesthesia Meeting, San Francisco, CA, March 25, 2012.

202. "Alert on Postpartum Hemorrhage: Protocols-Preparation-Novel Therapies." Presented at the Annual meeting of the International Anesthesia Research Society (IARS). Boston, MA, May 18, 2012.

203. "Thrombocytopenia and Low Molecular Weight heparin: Implications for Neuraxial Anesthesia. Refresher Course Lecture at the annual meeting of the American Society of Anesthesiologists, Washington, DC, October 14, 2012.

204. "Major Obstetric Hemorrhage." Moderator of clinical forum at the annual meeting of the American Society of Anesthesiologists, Washington, DC, October 16, 2012.

Invited Lectures/Presentations and Visiting Professorships (continued):

205. Stat cesarean delivery: Spinal vs. general Anesthesia. Lecture at The 66th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 17, 2012.

206. Focus session moderator: Challenges in obstetric anesthesia: Moderator at The 66th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 17, 2012.

207. "Thrombocytopenia and Low Molecular Weight heparin: Implications for Neuraxial Anesthesia. Lecture at The 66th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 17, 2012.

208. "Thrombocytopenia and Low Molecular Weight heparin: Implications for Neuraxial Anesthesia. Grand rounds lecture for the Department of Anesthesiology, New York University School of Medicine, NYU Langone Medical Center School of Medicine, January 30, 2013.

209. "Thrombocytopenia in the Parturient: Implications for neuraxial anesthesia." Presented at the Current Anesthesia Practice Meeting, New York, NY, March 18, 2013.

210. "Anesthetic Management of Peri-Partum Hemorrhage." Presented at the Current Anesthesia Practice Meeting, New York, NY, March 18, 2013.

211. "Post partum headache." Presented at the Current Anesthesia Practice Meeting, New York, NY, March 18, 2013.

212. "Anesthesia for the parturient for Non-Obstetric Surgery." Presented at the 49th Annual New York Anesthesiology Review, Orlando, FL March 19, 2013.

213. "Thrombocytopenia in the Parturient: Implications for neuraxial anesthesia." Presented at the 47th Annual New York Anesthesiology Review, Orlando, FL, March 19, 2013.

214. "Anesthetic Management of Peri-Partum Hemorrhage." Presented at the 48th Annual New York Anesthesiology Review, Orlando, FL, March 19, 2013.

215. "Preterm pregnancy complicated by hypertension." Presented at the 48th Annual New York Anesthesiology Review, Orlando, FL, March 19, 2013.

216. "Musings of an Obstetric Anesthesia: A 25 year perspective. Presented as a Grand Rounds Presentation for the Department of Obstetrics, Gynecology and Reproductive Sciences, Icahn School of Medicine, New York, NY, April 10, 2013.

Invited Lectures/Presentations and Visiting Professorships (continued):

217. Soap Pro-Con Debate. "General anesthesia is the technique of choice for suspected placenta accreta". Presented at the 45th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, San Juan, Puerto Rico, April 28, 2013.

218. "Postpartum headache: Whose Headache Is It?" Resident Seminar for the Department of Anesthesiology, McGill University School of Medicine, Montreal, Quebec, Canada, October 2, 2013.

219. "Obstetric Hemorrhage." Wesley Bourne Memorial Lecture, Department of Anesthesiology, McGill University School of Medicine, Montreal, Quebec, Canada, October 2, 2013.

220. "Thrombocytopenia and Low Molecular Weight heparin: Implications for Neuraxial Anesthesia." Grand Rounds presentation for Department of Anesthesiology and Obstetrics, McGill University School of Medicine, Montreal, Quebec, Canada, October 3, 2013.

221. "Just Another Day on Labor and Delivery." Moderator of clinical forum at the annual meeting of the American Society of Anesthesiologists, San Francisco, CA, October 14, 2013.

222. "External Cephalic Version." Lecture at the annual meeting of the American Society of Anesthesiologists, San Francisco, CA, October 14, 2013

223. "Thrombocytopenia and Low Molecular Weight heparin: Implications for Neuraxial Anesthesia. Refresher Course Lecture at the annual meeting of the American Society of Anesthesiologists, San Francisco, CA, October 16, 2013.

224. "Stat cesarean delivery: Spinal vs. general Anesthesia." Lecture at The 67th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 16, 2013.

225. Focus session moderator: Challenges in obstetric anesthesia: Moderator at The 67th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 16, 2013.

226. "External Cephalic Version." Lecture at The 67th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 16, 2013.

227. "Nonobstetric surgery During Pregnancy." Lecture at 32nd Annual Symposium: Clinical Update in Anesthesiology, Surgery and Perioperative Medicine, Nassau, Bahamas, January 22, 2014.

Invited Lectures/Presentations and Visiting Professorships (continued):

228. "Obstetric Hemorrhage." Grand rounds lecture at Metropolitan Hospital, New York, NY, March 6, 2014.

229. "Safety Rounds Beyond Board Sign Out." Lecture at the 47th Annual meeting of the Society for Obstetric Anesthesia and perinatology, Toronto, Canada, May 18, 2014.

230. Moderator for safety session, "Practical Suggestions for Improving Safety In Your Unit." Session at the 47th Annual meeting of the Society for Obstetric Anesthesia and perinatology, Toronto, Canada, May 18, 2014.

231. "Postpartum headache". Grand Rounds Lecture for Department of Anesthesiology at Shaare Zedek Medical center, Israel, September 15, 2014.

232. "Thrombocytopenia and neuraxial anesthesia". Refresher course lecture at the 23rd International Congress of the Israel Society of Anesthesiologists & Critical Care, Tel-Aviv, Israel, September 17, 2014.

233. "My mom is still in pain". Lecture at the 23rd International Congress of the Israel Society of Anesthesiologists & Critical Care, Tel-Aviv, Israel, September 17, 2014.

234. "Anesthesia for Nonobstetric Surgery and Procedures." Refresher course lecture at the Annual meeting of the American Society of Anesthesiologists, New Orleans, LA, October 12, 2014.

235. "Failed Labor Epidural: Where, Oh Where Did My Pesky Catheter Go?" Lecture at the Annual meeting of the American Society of Anesthesiologists, New Orleans, LA, October 13, 2014.

236. "Basic Considerations for the Occasional Obstetric Anesthesiologist." Session moderator at the Annual meeting of the American Society of Anesthesiologists, New Orleans, LA, October 13, 2014.

237. "Stat cesarean delivery: Spinal vs. general Anesthesia." Lecture at The 68th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 15, 2014.

238. Focus session moderator: Advise for the Occasional Labor Floor Anesthesiologist: Moderator at The 68th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 15, 2014.

239. "Labor Analgesia: Keeping your Customers Satisfied." Lecture at The 68th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 15, 2014.

Invited Lectures/Presentations and Visiting Professorships (continued):

240. Moderator for Journal club, "Obstetric hemorrhage." Mount Sinai Roosevelt Hospital, New York ,NY, March 17, 2015.

241. "Obstetric Hemorrhage." Grand rounds lecture for Department of Anesthesiology. Mount Sinai Roosevelt Hospital, New York, NY, March 17, 2015.

242. "Non-Obstetric Surgery During Pregnancy." Lecture at the 41st Annual Virginia Apgar Seminar, Obstetric Anesthesia and Care of the Newborn. Orlando, Florida, March 20, 2015.

243. "Maternal Hemorrhage." Lecture at the 41st Annual Virginia Apgar Seminar, Obstetric Anesthesia and Care of the Newborn. Orlando, Florida, March 20, 2015.

244. "External Cephalic Version." Lecture at the 41st Annual Virginia Apgar Seminar, Obstetric Anesthesia and Care of the Newborn. Orlando, Florida, March 20, 2015.

245. "Maternal safety bundles." Moderator for session at the 47th annual meeting for the meeting of the Society for Obstetric Anesthesia and Perinatology, Colorado Springs, CO, May 14, 2015.

246. "Labor Analgesia Techniques and Thrombocytopenia." Lecture at the 2015 Armed forces district Annual Meeting for the American College of Obstetricians and Gynecologists. Norfolk, Virginia, October 21, 2015.

247. "General Anesthesia for Placenta Accreta: Always or Never." Lecture at the Annual meeting of the American Society of Anesthesiologists, San Diego, CA, New Orleans, LA, October 25, 2015.

248. "Leading the way to success on labor and delivery: What every obstetric anesthesiologist must know." Moderator at the Annual meeting of the American Society of Anesthesiologists, San Diego, CA, New Orleans, LA, October 25, 2015.

249. "Anesthesia for Nonobstetric Surgery and Procedures." Refresher course lecture at the Annual meeting of the American Society of Anesthesiologists, San Diego, CA, October 26, 2015.

250. "Safety rounds: beyond board sign out." Lecture at the Annual meeting of the American Society of Anesthesiologists, San Diego, CA, New Orleans, LA, October 26, 2015.

251. "postpartum headache." Grand Rounds Lecture for Department of Anesthesiology, St. Josephs' Medical center, Paterson, NJ, November 19, 2015.

Invited Lectures/Presentations and Visiting Professorships (continued):

252. "Stat cesarean delivery: Spinal vs. general Anesthesia." Lecture at The 69th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 14, 2015.

253. Focus session moderator: Problems in Obstetric Anesthesia Moderator at The 69th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 15, 2015.

254. "Obstetric Hemorrhage." Lecture at The 69th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 15, 2015.

255. "Postpartum Headache." Grand rounds lecture for the Department of Anesthesiology, New York Medical College, Valhalla, NY, February 22, 2016.

256. "What every obstetrician should know about obstetric anesthesia." Grand rounds lecture for the Department of Obstetrics and Gynecology Mount Sinai-Beth Israel Hospital, New York, NY. April 20. 2016.

257. "Moderator for Poster Discussion" at the 48th annual meeting for the meeting of the Society for Obstetric Anesthesia and Perinatology, Boston, MA, May 19, 2016.

258. "Postpartum Headache." Grand rounds lecture for the Department of Anesthesiology, Maimonides Medical Center, Brooklyn, NY, September 21, 2016.

259. "Anesthesia for Nonobstetric Surgery and Procedures." Refresher course lecture at the Annual meeting of the American Society of Anesthesiologists, Chicago, IL, October 26, 2016.

260. "What's new in Obstetric Hemorrhage?" The Gertie F. Marx Memorial Lecture at the 70th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 9, 2016.

261. Focus session moderator: Current issues in Obstetric Anesthesia moderator at The 70th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 12, 2016.

262. "Obstetric Hemorrhage Safety Bundles." Lecture at The 70th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 12, 2016.

Invited Lectures/Presentations and Visiting Professorships (continued):

263. "Stat cesarean delivery: Spinal vs. general Anesthesia." Lecture at The 70th Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 12, 2016.

264. "Obstetric Hemorrhage" Grand Rounds Lecture for Department of Anesthesiology, St. Josephs' Medical center, Paterson, NJ, January 5, 2017.

265. "What's new in Obstetric Hemorrhage" Grand Rounds Lecture for Department of Anesthesiology, Beilinson Hospital, Rabin Medical Center, Petah Tikva, Israel, January 9, 2017.

266. "Anesthesia for Nonobstetric Surgery." SOAP Virtual grand Rounds. February 8, 2017.

267. "Moderator for Poster Discussion" at the 49th annual meeting for the meeting of the Society for Obstetric Anesthesia and Perinatology, Bellevue, Seattle, May 12, 2017.

268. "Anesthesia for Non-obstetric Surgery and Procedures." Refresher course lecture at the Annual meeting of the American Society of Anesthesiologists, Boston, MA, October 23, 2017.

269. "Low Platelet Count and Labor Analgesia" Lecture at the 24th International Conference of the Israeli Society of Anesthesiologists, Tel Aviv, Israel, Nov 7, 2017.

270. "Pain and Analgesics in Special Circumstances." Lecture at the 24th International Conference of the Israeli Society of Anesthesiologists, Tel Aviv, Israel, Nov 7, 2017.

271. "What's New in Obstetric Anesthesia: 2016 in Review and Focused Discussion." Lecture at the 24th International Conference of the Israeli Society of Anesthesiologists, Tel Aviv, Israel, Nov 8, 2017

272. Focus session moderator: Current issues in Obstetric Anesthesia moderator at The 71st Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 11, 2017.

273. "Stat cesarean delivery: Spinal vs. general Anesthesia." Lecture at The 71st Postgraduate Assembly, Meeting of the NY State Society of Anesthesiologists, New York, NY, December 11, 2017.

274. "Labor Analgesia, What to expect." Lecture for the Refuah Health Center, New Square, New York, February 7, 2018.

Invited Lectures/Presentations and Visiting Professorships (continued):

275. "Anesthesia for Non-obstetric Surgery During Pregnancy." Grand rounds lecture for Department of Anesthesia, Critical Care and Pain Medicine, Massachusetts General Hospital, Harvard medical School, February 15, 2018.

276. "Department of Anesthesiology, perioperative and pain medicine: Quality Improvement Program. Lecture for Quality Leadership Council of The Mount Sinai Health System. Mount Sinai West, New York, NY, March 23, 2018.

MEDIA RESOURCE EDUCATIONAL MATERIALS:

1. Organized the internet site for the Obstetric Anesthesia Fellowship at Mount Sinai Hospital. http://www.mssm.edu/anesthesiology/obs_fellowship.shtml.

2. **Beilin Y.** Effects on newborn behavior and the impact on breastfeeding. Audio-Digest Recording. 2006 volume 48.

3. **Beilin Y.** Expert opinion Lowest platelet count for labor epidural placement. SOAP website, 2011.

4. Beilin, Y. Patient Safety Committee: "How We Do It" Expert Opinion Management of Obstructive Sleep Apnea and Morbid Obesity on Labor and Delivery. SOAP Newsletter, Winter 2018.

WEB BASED PUBLICATIONS:

1. Mount Sinai Departmental website for the Division of Obstetric Anesthesia
http://www.mssm.edu/anesthesiology/obstetric_anesthesia/departm

2. Wax DB, Schaner D, Hossain S, Bodian CA, Reich DL, **Beilin Y**. Intraoperative Factors Associated with Development of Surgical Site Infection after Colorectal Surgery. The Internet Journal of Anesthesiology 2009;20.

3. **Beilin Y,** Mahoney B. The iatrogenically anti-coagulated parturient. In: Fleisher L, Hawkins J., eds. Decision Support in Medicine, 2014.
Access at : https://www.decisionsupportinmedicine.com/

CLINICAL TEACHING PORTFOLIO

PAPERS PRESENTED AT NATIONAL MEETINGS INCLUDING ABSTRACTS:

1. **Beilin Y,** Bernstein HH, Mayer L. Serum Levels of Tumor necrosis factor, Interleukin-1, Interleukin-2 and Interleukin-6 in the parturient with preeclampsia. Presented at The Northeast Anesthesia Resident Conference, Sarasota Springs, NY, , April 19, 1991.

2. **Beilin Y,** Rosenblatt MA, Lagmay-Aroesty MM, Bernstein HH, Bodian CA. The need for a pre-labor anesthesia interview in the parturient. Presented at the International Anesthesia Research Society 68th Congress, Orlando, Florida, March 1994.
Abstract: Anesth Analg 1994;78:S27.

3. Ammar T, **Beilin Y.** Anesthesia for the parturient with a single ventricle. Presented at The 12th Annual Symposium and Clinical Update in Anesthesiology and Advances in Techniques in Cardiopulmonary Bypass, St. Thomas, USVI, January 1994.

4. **Beilin Y,** Bernstein HH, Nahmias N. How far should a multi-orifice epidural catheter be threaded into the epidural space. Presented at the 24th annual meeting of The Society for Obstetrical Anesthesia and Perinatology meeting, Philadelphia, PA, May 1994.

5. **Beilin Y,** Bernstein HH. How far should a multi-orifice epidural catheter be threaded into the epidural space. Presented at The International Anesthesia Research Society 69th Congress, Honolulu, Hawaii, March 1995.
Abstract: Anesth Analg 1995;80:S32.

6. **Beilin Y,** Leibowitz, AB, Haddad EM, Bodian CA. Clinical use of the bleeding time test in obstetric anesthesia. Presented at The American Society of Anesthesiologists annual meeting, Atlanta, GA, October 1995.
Abstract: Anesthesiology 1995;83:A1057.

7. **Beilin Y,** Kim J, Bernstein HH, Zenzen WJ, B. Zucker-Pinchoff B, Kahn PJ. Failure of subhypnotic doses of propofol to treat pruritus induced by intrathecal morphine following cesarean section. Presented at The International Anesthesia Research Society 70th Congress, Washington, DC, March 1996.
Abstract: Anesth Analg 1996;82:S22.

Papers presented at national meetings including abstracts (continued):

8. **Beilin Y,** Bernstein HH, Zucker-Pinchoff B, Zahn J, Zenzen WJ. Treatment of incomplete analgesia after placement of an epidural anesthetic for the woman in labor. Presented at the 26th annual meeting of The Society for Obstetrical Anesthesia and Perinatology meeting, Tucson, AZ, May 1996.

9. **Beilin Y,** Leibowitz AB, Haddad EM, Bodian, CA. Practice patterns of anesthesiologists regarding situations in obstetric anesthesia where clinical management is controversial. Presented at the 26th annual meeting of The Society for Obstetrical Anesthesia and Perinatology meeting, Tucson, AZ, May 1996.

10. Dimich I, Neustein S, Bernstein HH, **Beilin Y,** Shiang H. Cardiovascular consequences of the concomitant administration of nifedipine and magnesium in pigs. Presented at The American Society of Anesthesiologists annual meeting, New Orleans, LA, October 1996.
Abstract: Anesthesiology 1996;85:A880.

11. **Beilin Y,** Leibowitz AB, Haddad EM, Bodian, CA. Practice patterns of anesthesiologists regarding situations in obstetric anesthesia where clinical management is controversial. Presented at The American Society of Anesthesiologists annual meeting, New Orleans, LA, October 1996.
Abstract: Anesthesiology 1996;85:A872.

12. **Beilin Y,** Bernstein HH, Zucker-Pinchoff B, Zahn J, Zenzen WJ. Treatment of incomplete analgesia after placement of an epidural anesthetic for the woman in labor. Presented at The International Anesthesia Research Society 71st Congress,
San Francisco, CA, March 1997.
Abstract: Anesth Analg 1997;84:S381.

13. Zahn J, Zuccarelli M, **Beilin Y.** Regional anesthesia in parturients with platelet counts < 100,000 mm^{-3}. Presented at The International Anesthesia Research Society 71st Congress, San Francisco, CA, March 1997.
Abstract: Anesth Analg 1997;84:S414.

14. Zahn J, Zuccarelli M, **Beilin Y.** Regional anesthesia in parturients with platelet counts < 100,000 mm^{-3}. Presented at The 4th annual America-Japan Anesthesia Congress, San Francisco, CA, March 1997.

15. Freedman G, Bautista-Davis EC, **Beilin Y,** Holtzberg N. The optimal method to administer the visual analogue scale (VAS). Presented at The annual meeting for the American Society of Regional Anesthesia, Atlanta GA, April 12, 1997.
Abstract: Reg Anesth 1997;22:S33.

Papers presented at national meetings including abstracts (continued):

16. **Beilin Y,** Mukherjee T, Andres LA, Vincent RD, Hock DL, Sparks AET, Munson AK, Minnich ME, Steinkampf MP. Use of propofol probably does not effect pregnancy outcome following gamete intrafallopian transfer (gift). Presented at the 29th annual meeting of The Society for Obstetrical Anesthesia and Perinatology, Bermuda, April, 1997.

17. **Beilin Y,** Mukherjee T, Andres LA, Vincent RD, Hock DL, Sparks AET, Munson AK, Minnich ME, Steinkampf MP. Use of propofol probably does not effect pregnancy outcome following gamete intrafallopian transfer (gift). Presented at The American Society of Anesthesiologists annual meeting, San Diego, CA, October, 1997.
Abstract: Anesthesiology 1997;87:A884.

18. **Beilin Y,** Andres LA, Comerford BA. Epidural analgesia with and without fentanyl during labor does not impact on infant breast feeding. Presented at the 4th International Congress of the European Society of Obstetric Anesthesiology, Herzlyia, Israel, November, 1997.

19. **Beilin Y,** Andres LA, Comerford BA, Salerno JL. Epidural analgesia with and without fentanyl during labor does not impact on infant breast feeding. Presented at The International Anesthesia Research Society 72nd Congress, Orlando, FL, March 1998.
Abstract: Anesth Analg 1998;86:S363

20. Zahn J, **Beilin Y,** Bernstein HH, Andres LA, Salerno J, Bodian CA, Telfeyan C. Comparison of non-invasive blood pressure measurements during cesarean section. Presented at The International Anesthesia Research Society 72nd Congress, Orlando, FL, March 1998.
Abstract: Anesth Analg 1998;86:S391.

21. Galea MA, **Beilin Y,** Zahn J, Bernstein HH. The optimal dose of epidural ropivacaine for use during labor and delivery. Presented at the 30th annual meeting of The Society for Obstetrical Anesthesia and Perinatology, Vancouver, BC, Canada, May 1. 1998.

22. Galea MA, **Beilin Y,** Zahn J, Bernstein HH. The optimal dose of epidural ropivacaine for use during labor and delivery. Presented at The American Society of Anesthesiologists annual meeting, Orlando, Fl, October 19, 1998.
Abstract: Anesthesiology 1998;89:A81021.

23. **Beilin Y,** Friedman F, Bernstein HH, Andres LA, Bodian CA. The obstetrician group, not epidural analgesia, influences the cesarean section rate for the nulliparous woman in labor. Presented an The International Anesthesia Research Society 73rd Congress, Los Angeles, CA, March 13, 1999.
Abstract: Anesth Analg 1999;88:S249.

Papers presented at national meetings including abstracts (continued):

24. Zahn J, Abramovitz SE, Bernstein HH, **Beilin Y.** Subarachnoid fentanyl with low dose bupivacaine vs. lidocaine for cervical cerclage. Presented at the 31st annual meeting of The Society for Obstetrical Anesthesia and Perinatology, Denver, CO, May 22, 1999. Abstract: Anesthesiology 1999;90:A24.

25. **Beilin Y,** Abramovitz S, Zahn J, Bernstein HH. The effect of patient position, lateral vs. supine, on the quality of labor epidural analgesia. Presented at the 18th International Congress of the of the Israel Society of Anesthesiologists, Haifa, Israel, June 22, 1999.

26. Abramovitz SE, Zahn J, Enis S, Bernstein HH, **Beilin Y.** The effect of patient position, lateral vs. supine, on the quality of labor epidural analgesia. Presented at The American Society of Anesthesiologists annual meeting, Dallas, TX, October 11, 1999. Abstract: Anesthesiology 1999;91:A1078.

27. Ekwa-Ekoko C, Abramovitz A, **Beilin Y,** Holzman I, Weiser J, Kavanagh N. Labor epidural fentanyl and newborn breast-feeding. Presented at The Annual Meeting of the Society for Pediatric Research, Boston, MA, May 12, 2000
Abstract: Pediatr Res 2000;47:A187.

28. Zahn J, Arnold I, Hossain S, Bernstein HH, **Beilin Y.** The Quality of Analgesia When Air Vs. Saline Is Used for Identification of the Epidural Space. Presented at The American Society of Anesthesiologists annual meeting, San Francisco, CA, October 17, 2000.
Abstract: Anesthesiology 2000;93:A1100.

29. Zahn J, Bernstein HH, Telfeyan C, Arnold I, **Beilin Y.** Subarachnoid low dose bupivacaine vs. lidocaine, with fentanyl, for cervical cerclage. Presented an The International Anesthesia Research Society 75th Congress, Ft. Lauderdale, Florida, March 19,2001.
Abstract: Anesth Analg 2001;92:S224.

30. Nair A, Arnold I, Bernstein HH, Telfeyan C, **Beilin Y.** The optimal epidural infusion following the combined spinal epidural technique for labor. Presented at the 33rd Annual Meeting of The Society for Obstetrical Anesthesia and Perinatology, San Diego, California, April 26, 2001.
Abstract: Anesthesiology 2001;94:A10.

31. Nair A, Arnold I, Goolie-Scindain J, Bodian CA, Hossain S, **Beilin Y.** Evaluation of platelet function in the parturient using the platelet function analyzer (PFA-100®). Presented at the 33rd Annual meeting of The Society for Obstetrical Anesthesia and Perinatology, San Diego, California, April 28, 2001.
Abstract: Anesthesiology 2001;94:A78.

Papers presented at national meetings including abstracts (continued):

32. Nair A, Arnold I, Bernstein HH, Zahn J, **Beilin Y.** The optimal epidural infusion following the combined spinal epidural technique for labor. Presented at The American Society of Anesthesiologists annual meeting, New Orleans, LA, October 15, 2001. Abstract: Anesthesiology 2001; 95:A1058

33. Martin G, **Beilin Y,** Holzman I, Ekwa-Ekoko C, Arnold I, Weiser J. Does maternal epidural fentanyl affect breastfeeding? Presented at the Greater New York Conference on Perinatal Research, November 7, 2002.

34. **Beilin Y,** Weiser J, Martin G, Bernstein HH, Arnold I, Zahn J, Holzman I. The Effect Of Epidural Anesthesia With And Without Fentanyl On Infant Breast Feeding: A Prospective, Randomized, Double-Blind Study. Presented at the 37th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Palm Desert, CA, May 6, 2005. Abstract: Anesthesiology 2005;102:A52.

35. **Beilin Y,** Guinn NR, Arnold I, Zahn J, Bernstein HH. Local anesthetics and obstetric outcome: ropivacaine vs. levobupivacaine vs. bupivacaine: A prospective randomized double-blind study. Presented at the 37th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Palm Desert, CA, May 6, 2005.
Abstract: Anesthesiology 2005;102:A75.

36. **Beilin Y,** Arnold I, Hossain S. Evaluation of The Platelet Function Analyzer (PFA-100®) vs. the thromboelastogram (TEG) in the Parturient. Presented at the 37th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Palm Desert, CA, May 7, 2005.
Abstract: Anesthesiology 2005;102:A48.

37. Wax D, **Beilin Y,** Krol M, Reich DL. Infrequent Use of Insulin Therapy for Intraoperative Hyperglycemia in an Academic Medical Center. Presented at The American Society of Anesthesiologists annual meeting, New Orleans, LA, October 25, 2005.
Abstract: Anesthesiology 2005;102:A48.

38. Torrillo T, Bronster DJ, **Beilin Y.** Posterior reversible encephalopathy syndrome (PRES): A complicated case of post-partum headache. Presented at the 38th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Hollywood, FL, April 28, 2006. Abstract: Anesthesiology 2006;104:A96.

Papers presented at national meetings including abstracts (continued):

39. Tumuluri S, **Beilin Y.** Vaginal Delivery Complicated By Severe Hemorrhage Requiring Recombinant Factor VIIa And Pulmonary Hypertension Necessitating A Right Ventricular Assist Device. Presented at the 39th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Banff, Canada, May 19, 2007
Abstract: Anesthesiology 2007;106:A242.

40. Varnado-Rhodes Y, Liao M, Tumuluri SS, Scher C, **Beilin Y.** Vaginal Delivery Complicated By Severe Hemorrhage Requiring Recombinant Factor VIIa And Pulmonary Hypertension Necessitating A Right Ventricular Assist Device. Presented at The American Society of Anesthesiologists Annual Meeting, Orlando, Fl, October 16, 2007.

41. Mungall D, **Beilin Y.** A survey of anesthesiologists and nurses attitudes toward the implementation of an Anesthesia Information Management System on a labor and delivery floor. Presented at the 40th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Chicago, IL April 30, 2008.

42. Mungall D, **Beilin Y.** The Effect of Degree of Labor Pain at Time of Labor Neuraxial Analgesia on Mode of Delivery in women admitted for induction of labor. Presented at the 40th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Chicago, IL April 30, 2008.

43. Epstein, J, **Beilin Y.** Are serial platelet counts warranted in preeclamptic women? Presented at the 41th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Washington, DC, April 30, 2009.

44. Mungall D, **Beilin Y**. The Association of the Degree of Labor Pain at the Time of Epidural Analgesia Placement and Mode of Delivery in Nulliparous Women Presenting for an Induction of Labor: A Retrospective Study. Presented at the 41th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Washington, DC, May 1, 2009.

45. Mahoney B, **Beilin Y.** Successful Management of Acetaminophen Overdose and Sickle Cell Crisis during Cesarean Section. Presented at the 42nd Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, San Antonio, Texas, May 16, 2010.

46. Mahoney B, Epstein, J, **Beilin Y.** Are serial platelet counts warranted in preeclamptic women? Presented at the annual meeting of the American Society of Anesthesiologists. San Diego, CA, October 17, 2010.

47. Mahoney B, **Beilin Y.** Successful Management of Acetaminophen Overdose and Sickle Cell Crisis during Cesarean Section. Presented at the annual meeting of the American Society of Anesthesiologists. San Diego, CA, October 17, 2010.

Papers presented at national meetings including abstracts (continued):

48. Birenberg B, **Beilin Y.** Rare Etiology of Postpartum Headache: Sinus Thrombosis. Presented at the annual meeting of the American Society of Anesthesiologists. San Diego, Ca, October 17, 2010.

49. Mathney ER, **Beilin Y**. Successful cesarean delivery in a woman status post fontan procedure. Presented at the clinical update in anesthesiology, surgery and perioperative medicine: 29th annual symposium, St. Martin, French West Indies, January 20, 2011.

50. Hofer IS, Mahoney B, Koenigsberg J, Chietero M, **Beilin Y**. An EXIT procedure in a patient with malignant hyperthermia. Presented at the 43rd Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Las Vegas, NV, April 17, 2011.

51. Hofer IS, Mahoney B, Koenigsberg J, Chietero M, **Beilin Y**. An EXIT procedure in a patient with malignant hyperthermia. Presented at the annual meeting of the American Society of Anesthesiologists, San Diego, CA, October 16, 2011.

52. Afonso A, **Beilin Y.** Respiratory arrest in patients undergoing arteriovenous graft placement with interscalene and supraclavicular block. Presented at the 37th annual regional anesthesia and pain meeting and workshops, San Diego, Ca, March 16, 2012.

53. Hamby C, Frost E, **Beilin Y.** Acute grief in the operating room: treating the awake OB patient. Presented at the 66th annual postgraduate assembly in Anesthesiology of the New York State Society of Anesthesiologists, New York, NY, December 16, 2012.

54. Gopwani SR, **Beilin Y.** Group B Streptococcal Meningitis following Epidural Blood Patch. Presented at the 45th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, San Juan, Puerto Rico, April 27, 2013.

55. Spitzer Y, Zahn J, **Beilin Y.** Protamine use in a parturient with massive hemorrhage from placental abruption while receiving intravenous heparin. Poster presentation at the 46th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, San Juan, Puerto Rico, April 27, 2014.

56. Spitzer Y, Weiner M, **Beilin Y.** Left Ventricular Non-Compaction Syndrome in a Parturient. Poster presentation at the 47th Annual meeting of the Society for Obstetric Anesthesia and perinatology, Toronto, Canada, May 18, 2014.

57. Tseng KS, **Beilin Y**. Initiation of an institutional practice guideline affecting fluid management and intraoperative acid-base outcomes in renal transplant patients. Presented at The 89th Congress of the International Anesthesia Research Society, Honolulu, Hawaii, March 21,2015.

58. Knibbs N, Ben Hamo O, Hyman J, Sela H, **Beilin Y,** Einav S. Characterization of Maternal Near Miss in Two Tertiary Referral Hospitals in Developed Nations. Poster presentation at the 47th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Colorado Springs, CO, May 14, 2015.

59. Marotta M, Friedman F, Naidich T, **Beilin Y.** CVT: Curious Vein Thrombosis. Poster presentation at the 47th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Colorado Springs, CO, May 15, 2015.

60. Katz D, **Beilin Y.** The Effect of Adding Intrathecal Epinephrine to Hyperbaric Bupivacaine and Preservative Free Morphine for Repeat Cesarean Delivery: A Double Blind Prospective Randomized Control Trial. Poster presentation at the 49th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Bellevue, Seattle, May 12, 2017.

61. Katz D, **Beilin Y.** Functional Fibrinogen in Pregnancy. Poster presentation at the 49th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Bellevue, Seattle, May 12, 2017.

62. **Katz D,** Beilin Y. Implementation of Triton, an FDA-Approved Technology for Quantification of Blood Loss (QBL): A Performance Improvement Study. Poster presentation at the 28th Health Care Risk Management Conference: Using Data to Reduce Malpractice Risk. February 28, 2018, New York NY.

63. Romano D, Hyman J, Katz D, Knibbs N, Einav S, **Beilin Y.** Etiology of ICU Admission in Obstetric Patients Differs by Mode of Conception. Poster presentation at the 50th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Miami, FL, May 11, 2018.

64. Riley K, Kim E, **Katz D,** Beilin Y. Terbutaline Versus Nitroglycerin for External cephalic Version. Poster presentation at the 50th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Miami, FL, May 11, 2018.

65. Kulkarni A, Knibbs, N, **Beilin Y.** CSF Cutaneous Fistula in the Parturient with Coagulopathy. Poster presentation at the 50th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology, Miami, FL, May 11, 2018.

EDITORIAL ACTIVITIES (GUEST REVIEWER):

1. Anesthesiology
2. Anesthesia & Analgesia
3. The International Journal of Obstetric Anesthesia
4. Journal of Clinical Anesthesia
5. The American Journal of Anesthesiology
6. Progress in Anesthesiology
7. Regional anesthesia and pain medicine
8. Drugs
9. Pediatric International,
10. Methods and Findings in Experimental and Clinical Pharmacology
11. Physicians' Services Incorporated Foundation, Toronto, Ontario
12. Archives of Gynecology and Obstetrics
13. Basic and Clinical Pharmacology
14. Pain Management
15. Anesthesiology research and practice
16. Pharmacology
17. Minerva Anesthesia
18. Pediatric
19. European Journal of Anaesthesiology

EXHIBIT 2

EXHIBIT 2

General
Vascular
Specialists

Earl D. Cottrell, M.D., F.A.C.S.
Bruce J. Hirschfeld, M.D., F.A.C.S.
Frank T. Jordan, M.D., F.A.C.S.

June 02, 2018

R. Todd Carey, Esquire
Christiansen Law Firm
810 South Casino Center Boulevard
Suite 104
Las Vegas, NV 89101

COMPREHENSIVE RECORD REVIEW

Regarding : Alina Badoi

Dear Todd:

I am in receipt of a Dropbox with records and documents regarding the peripartum events that occurred, as they relate to the death of your client, Alina Badoi. The following records/documents were reviewed by me in this matter: Quest Lab; Comprehensive Cancer Centers; WHASN Records [Women's Health Association of Southern Nevada]; op and consultation reports; pregnancy records; Affidavit; Affidavit of Identification; Autopsy Report; certification of records; record of examination; records reviewed by Coroner; report of investigation; Clark County Coroner; Affidavit of Death; x-rays and scene photographs; exam photos; St. Rose Dominican Hospital Sienna Campus Records; x-rays and autopsy photos. You have asked me to evaluate the medical records and to opine as to what medical facts and/or factors resulted in her death. None of the conclusions reached in this report reflect any opinions I may have, with respect to any standards of care in this matter. All conclusions in this report are to a reasonable degree of medical probability and reflect my opinions as they relate to medical causation in this matter.

10/07/2016- May 10, 2017 WHASN RECORDS (Pages 32-70 of 70 Pages)
Pregnancy records, ultrasound and lab reports
Copies of St. Rose records [op reports and consultations] (Pages 1-30 of 70 pages)

10/07/016 QUEST LABORATORY (Page 3 of 3)
Hemoglobin 10.6 g/dL
Hematocrit 35.2%
MCV 71.0 fL
MCH 21.4 pg
MCHC 30.1 g/dL

Red Cell Distribution 20.1%

01/23/2017 QUEST LABORATORY (Page 2 of 3)
Hemoglobin 8.3 g/dL
Hematocrit 27.5%
MCV 69.7 fL
MCH 21.0 pg
MCHC 30.1 g/dL
Red Cell Distribution 20.8%

03/23/2017 QUEST LABORATORY (Page 1 of 3)
Hemoglobin 7.8 g/dL
Hematocrit 26.5%
MCV 67.8 fL
MCH 20.0 pg
MCHC 29.5 g/dL
Red Cell Distribution 22.6%

03/29/2017 COMPREHENSIVE CANCER CENTERS OF NEVADA CONSULT (Page 1 of 10)
Referral from: Amit Garg, M.D.

Attending Physician: Ghulam Kashef, M.D.

Reason for Consult: Iron Deficiency Anemia

History of Present Illness:
The patient is a very pleasant female who has been seen and evaluated by her primary care physician. The patient is pregnant. She has complained of fatigue. A CBC obtained has shown a hemoglobin of 7.8. MCV was 67.8. White blood cell count was 9.5 and platelet count normal. She has been placed on oral iron supplementation with poor toleration. She has been referred to this clinic for further evaluation and recommendations.

On my evaluation, she reported fatigue. She did not report any fevers, chills, or night sweats. No chest pain or cough. No melena or hematochezia. No hematuria. No musculoskeletal or neurological symptoms.

Past Medical History:
1. History of hypothyroidism
2. History of anemia

Assessment:

1. Iron deficiency anemia
2. Poor toleration of oral iron
3. Fatigue secondary to anemia

Plan:

1. We will schedule for IV iron infusion with iron sucrose 200 mg weekly for three weeks.
2. Return to clinic in six weeks, with repeat labs. She was instructed to call in the interim if she needs to be seen earlier.

05/09/2017 ST. ROSE DOM-SIENA RECORDS ASSESSMENT DOCUMENTATION Page 3815 of 4.422 Pages

Triage/Observation Status and Plan PCM Entered on 05/09/2017 20:18 PDT
Assessment Triage OB: Scheduled induction that would like to reschedule her induction for another time if everything looks ok with baby and it is ok with her MD
Name of Clinician Contracted: Herpolsheimer, Arthur MD
Reason for Call: Notified patient here for her induction but is requesting to be induced at a later time as long as everything is ok with baby. Patient being induced for polyhydramnios and AMA. SVE done 0/20/-3. Orders given to call back once NST done.

05/09/2017 ST. ROSE DOM-SIENA RECORDS GENERAL INFORMATION Page 3836 - 3838 of 4.422 Pages

05/09/2017 20:37 PDT
Patient discharged at this time. Verbalized understanding of all instructions

05/09/2017 20:21 PDT Call to MD
Notified of category 1 strip. Patient contracting every 4-8 minutes. Patient verbalizes she does not feel contractions. MD verbalized patient can be discharged to follow up in office and with HRPC tomorrow.

05/15/2017 ST ROSE DOM-SIENA RECORDS ORDERS (Page 1466 of 4.422 Pages)

Order Date/Time 05/15/2017 16:29 PDT
Ordering Physician: Herpolsheimer, Arthur
Order Details: "If patient desires epidural, please contact anesthesia"

05/16/2017 ST. ROSE DOM-SIENA RECORDS GENERAL INFORMATION (Page 2605 of 4.422 Pages

05/16/2017 Charted Time: 00:58 PDT

Charted by Krista Molinaro, RN
"Kim MD in room to discuss POC with patient about epidural placement, Kim, J. **is concerned with patient's platelet count being low and patient having a nose bleed at this moment. MD ordered for another platelet count to be manually done before epidural"**

Corrected Results
@28 Events: Corrected from Kim MD in room to discuss POC with patient about epidural placement on 5/16/2017 01:10 PDT by Molinaro, Krista RN

05/16/2017 ST. ROSE DOM-SIENA RECORDS GENERAL INFORMATION (Page 2604 of 4,422 Pages)
05/16/2017 Charted Time: 02:15 PDT
"Kim J MD spoke with Abuan, Ronaldo in lab about manual platelet count. After speaking with him Kim, J verbalized he **would not place epidural due to the dramatic variance in the number between the automated test and the manual test."**

05/16/2017 Charted Time 03:00 PDT
"Herpolsheimer MD in room to discuss pain management options with patient since Kim, J. **will not place epidural."**

05/16/2017 ST. ROSE DOM-SIENA RECORDS GENERAL INFORMATION (Page 2598 of 4,422 pages)
05/16/2017 14:45 PDT (Events)
Charted by Delaney McCoy, RN
Dr. Herpolsheimer at bedside for delivery

05/15/2017 17:45 PDT (Events)
Peri-care done, pads changed, pt. tolerated well, **epidural cath removed, tip intact**

05/16/2017 WHASN RECORDS OP REPORT DR. HERPOLSHEIMER (Page 30 of 70 Pages)
Procedure Performed: Spontaneous vaginal delivery and midline episiotomy with repair

Postoperative Diagnosis: Intrauterine pregnancy, delivered

Anesthesia: Epidural

Findings: A 6 pound 7 ounce female infant with Apgar scores of 9 and 9, delivered at 1451 Pacific Time on 05/16/2017

05/16/2017 ST. ROSE DOM-SIENA RECORDS PROGRESS NOTES Page 669 of 4,422 Pages
Delivery Note
05/16/2017 15:28 PDT
Physician Arthur Herpolsheimer, MD
Preoperative Diagnosis: Intrauterine pregnancy

Procedure Performed: Spontaneous vaginal delivery and midline episiotomy with repair

Postoperative Diagnosis: Intrauterine pregnancy, delivered

Anesthesia: Epidural

05/16/2017 ST. ROSE DOM-SIENA RECORDS GENERAL INFORMATION (Page 2596 of 4,422 Pages)
Charted by Krista Molinaro RN
Chart Time: 20:58 PDT
Name of Clinician Contacted: Amit Garg, MD

05/16/2017 20:45 PDT
Patient up to chair at side of bed. RN placed overlay on bed and changed all linens. Patient verbalized she is feeling a lot of tingling in her legs and very dizzy. Verbalized I would call MD to discuss these symptoms with him.

05/16/2017 20:58 PDT
Notified MD of patient having a lot of tingling in lower extremities and feeling very dizzy. MD verbalized to stop magnesium infusion for now and restart it at 1.5 gms in 1 hour

05/17/2017 ST. ROSE DOM-SIENA RECORDS GENERAL INFORMATION (Page 2587 of 4,422 Pages)
05/17/2017 10:45 PDT
Charted by Mary Brown RN
Name of Clinician contacted: Herpolsheimer, Arthur H. M.D.
Time Provider Contacted 10:45:00
Reason for Call/Info Given to MD:
"Other: Dr. in to visit pt. he assess pt. concerns with leg heaviness and tingling. He reviews with RN concern for an epidural hematoma and requests on call neurologist and neuro surgeon phone #'s to consult, will follow for new orders.

05/17/2017 ST. ROSE DOM-SIENA RECORDS GENERAL INFORMATION (Page 2595 of 4,422 Pages)
05/17/2017
Charted by Stacy Taylor, RN
Charted Time: 01:20 PDT
"Patient complaining of tingling in her legs, unable to sleep or stand it."

05/17/2017 ST. ROSE DOM-SIENA RECORDS GENERAL INFORMATION (Page 2594 of 4,422 Pages)
05/17/2017 Charted Time: 01:25 PDT
Charted by Stacy Taylor, RN
Name of Clinician Contacted: Amit Garg, MD
"Other notified MD of patient's mg level and that she cannot stand the tingling in her legs. MD stated to turn magnesium off."

05/17/2017 04:35
Other: Notified MD of patient's blood pressures and numbness in right leg. MD ordered p.o. labetalol. Pt. unable to tolerate magnesium
Clarified with MD that he did not want IV hydralazine, MD stated not at this time

05/17/2017 ST. ROSE DOM-SIENA RECORDS GENERAL INFORMATION (Page 2593 of 4,422 Pages)
05/17/2017 Charted Time: 05:33 PDT
Charted by Stacy Taylor, RN
Name of Clinician Contacted: Amit Garg, MD

05/17/2017 05:30 Events: patient denies headache, blurring vision or epigastric pain

05/17/2017 05:33 PDT Other: call given to MD regarding BP's still elevated

05/17/2017 06:27 PDT Other: Notified MD of blood pressures, received orders on 5/17/2017 06:30 PDT

05/17/2017 ST. ROSE DOM-SIENA RECORDS GENERAL INFORMATION (Page 2592 of 4,422 Pages)
05/17/2017 Charted Time: 05:33 PDT
Charted by Stacy Taylor, RN
Name of Clinician Contacted: Amit Garg, MD

05/17/2017 05:50

Other: no call back, called MD, MD in OR, informed of pt. BP's, received order for hydralazine

05/17/2017 ST. ROSE DOM-SIENA RECORDS GENERAL INFORMATION (Page 2591 of 4,422 Pages)
05/17/2017 Charted Time: 06:35 PDT
Charted by Stacy Taylor, RN
"Updated patient on plan of care. Patient very anxious, reports numbness in legs. Tried to get patient out of bed, patient unable to put weight on legs."

05/17/2017 ST. ROSE DOM-SIENA RECORDS GENERAL INFORMATION (Page 2591 of 4,422 Pages)
05/17/2017 Charted Time: 07:15 PDT
Charted by Stacy Taylor, RN
Name of Clinician Contacted: Leejon Moore, MD

05/17/2017 07:05 PDT (Events)
Anesthesiologist states **he does not think itching, pain numbness is related to epidural.**

05/17/2017 07:30 PDT (Events)
B/P is noted, pt. has been medicated with labetalol, she is showing signs of escalating anxiety which she states is not pain related but that she is itching like crazy and her legs are tingling, it appears from report this started around 0500

05/17/2017 07:30 PDT (Events)
Calming techniques reviewed and practiced, POC to request Benadryl from Dr. Moore who was just in to see pt. and keep pt. turned off her back side and positioned to her sides reviewed and started to the left and propped for comfort, will follow.

05/17/2017 07:30 PDT (Reason for Call/Info given to MD)
Dr. Called concerning patient's itching which is escalating her anxiety. He gives verbal order for Benadryl and requests RN call OB to review labs

05/17/2017 ST. ROSE DOM-SIENA RECORDS GENERAL INFORMATION (Page 2588 of 4,422 Pages)
05/17/2017 Charted Time: 09:45 PDT
Charted by Mary Brown, RN
Name of Clinician Contacted: Arthur Herpolsheimer, MD

"Dr. on unit and updated on pt. status, concerns with itching and lower legs being heavy and tingling, we review labs together and that she has been seen by Dr. Moore this am about these concerns, will follow

05/17/2017 Charted Time: 10:45 am
Dr. in to visit pt. he assess pt. concerns with leg heaviness and tingling, he reviews with RN concern for an epidural hematoma and requests on call neurologist and neuro surgeon phone #'s to consult, will follow for new orders.

05/17/2017 ST. ROSE DOM-SIENA RECORDS GENERAL INFORMATION (Page 2587 of 4.422 Pages)
05/17/2017 Charted Time: 11:20 PDT
Charted by Mary Brown, RN
Name of Clinician Contacted: Arthur Herpolsheimer, MD
Provider/MD present, Other: Dr. alerts RN and requests pt. be n.p.o. and to start NS at 125 mL/hr and a bolus of 500 ml's discussed and he ok's, will follow

05/17/2017 13:00 PDT
HOB up. Other: Pt. returned back to her backside, boosted up in bed, peri-care done, preparing for MRI

05/17/2017 13:15 PDT
Pt. leaves unit with stable assessment no changes. RN has reviewed MRI process with her will follow

05/17/2017 ST. ROSE DOM-SIENA RECORDS GENERAL INFORMATION (Page 2586 of 4. 422 Pages)
05/17/2017 15:15 PDT
Charted by Mary Brown RN
Name of Clinician contacted: Herpolsheimer, Arthur H. M.D.
Time Provider Contacted 15:05:00
Reason for Call/Info Given to MD:
Other: Dr. call unit to update on MRI results, RN is at BS checking pt. into room, he leaves word with Pam T, RN that POC is to do laminectomy and remove hematoma, pt. to be n.p.o.

05/17/2017 ST ROSE DEM-SIENA RECORDS MRI Page 3695 of 4.422 Pages
05/17/2017 14:50 PDT
Reason for Exam: MR T Spine wo+w Con B LE Paresis s/p epidural anesthesia

Impression:

1. Significantly limited study secondary to patient motion artifact
2. There is prominent nodular enhancing epidural soft tissue within the anterior and lateral epidural space extending from approximately T2 through T6-T7. This results in moderate to several central canal stenosis at approximately T3. This appearance is nonspecific, and can be seen with lymphoma, metastatic disease (in the case of breast cancer) and infection (infection is unlikely to cause this appearance within 24 hours following the epidural injection). Confirmation with CT may be of benefit
3. Ill-defined patchy and enhancement is also seen within the posterior aspect of the central canal at the mid and lower thoracic levels related to #2.
4. There is a suggestion of an epidural fluid collection extending from approximately T5-6 extending into the lumbar levels. A primary differential consideration is an epidural hematoma. Epidural abscess is less likely. Further evaluation with contrast-enhanced Ct may be of benefit. There is a small nonspecific enhancing lesion within the T11 vertebral body. The main differential considerations include atypical hemangioma versus metastatic disease.

Findings were discussed with Dr. Seiff at approximately 2:50 PM on 5/17/2017.

05/17/2017 ST ROSE DEM-SIENA RECORDS MRI Page 3693 of 4,422 Pages
05/17/2017 18:53 PDT
Reason for Exam: MR L Spine wo Con bilateral lower extremity weakness s/p epidural

Impression:
Extensive abnormal epidural process causes extensive mass effect on the thecal sac in the lumbar spine. This is probably partly related to the epidural process described in the thoracic spine but is also probably partly due to the fluid from recent epidural anesthesia administration.

05/17/2017 ST. ROSE DEM-SIENA RECORDS MRI Page 3692 of 4,422 Pages
05/17/2017 19:32 PDT
Reason for Exam: MR T Spine wo Con bilateral lower extremity weakness s/p epidural

Impression:
Extensive heterogeneous epidural process is re-demonstrated. There are some areas where it contacts the cord but does not cause mass effect on the cord.

05/17/2017 ST. ROSE DEM-SIENA RECORDS PROGRESS NOTES - NURSING (Page 1964 of 4,422 Pages)
5/17/2017 19:35 PDT

"rec'd patient came from MRI arrived to room 2227 placed on cardiac monitor and oriented to room and equipment, patient is AAO x 3 still c/o numbness and tingling sensation to bilateral lower extremities. VS see on computer data and Dr. McPherson will be here.

05/17/2017 ST ROSE DEM-SIENA RECORDS ICU HISTORY AND PHYSICAL (Pages 21-23 of 4,422 Pages)
05/17/2017 20:48 PDT
Reason for ICU Admission: Paraparesis, possible epidural hematoma

History of Present Illness:
Ms. Badoi is a 41-year-old female, who is generally well most of her life. She has a history of Hashimoto's thyroiditis and had a partial thyroidectomy and is on thyroid replacement therapy. She is gravida 1, para 1, status post normal vaginal delivery on 05/16/2017 after an epidural anesthesia. Subsequent to delivery, the patient started noticing some tingling and abnormal sensations in her legs. Became clear that the legs were quite weak and quite spastic. MRI of the lumbar spine was done on 05/17 at 1420 for further evaluation and this was normal. Thoracic spine was done at 1450 and this showed abnormality. Had enhancing epidural soft tissue within the anterior and lateral epidural space T2 through T6 to T7 with moderate to severe central canal stenosis at approximately T3. Ill-defined patchy enhancement is also seen in the posterior aspect of the central canal at the mid and lower thoracic levels. Suggestion of epidural fluid collection extending from approximately T5 to T6 into lumbar areas. Possible epidural hematoma abscess less likely. Also enhancing lesion in T11 vertebral body, which may be due to an atypical hemangioma versus metastatic disease per radiologist, Dr. Seiff was notified. Repeat MRI of the L-spine was done at 1853 and this showed extensive abnormal epidural process now causing extensive mass effect along the thecal sac in the lumbar spine. **This is probably related to the epidural process in the thoracic spine and is also partly due to fluid from the recent epidural anesthesia administration as the radiologist's report.** Repeat CT-spine was also done and showed extensive heterogeneous epidural process re-demonstrated some areas where it contacts the cord but does not seem to cause mass effect on the cord.

Laboratory Data: On admission to the hospital on 05/15, she was mildly anemic with hemoglobin of 10. Normal white count. MCV was reduced at 77. Platelets reduced at 94,000. Subsequent CBC showed an estimated platelet count of 140,000 to 160,000 on 05/17 at 6:26 a.m. It is estimated to be 80,000 to 100,000. Repeat done on 1644 today showed a platelet count of 74,000. Coags have not yet been done. Sodium was slightly reduced at 130. LFTs were elevated. ALT 142, AST 146, and alkaline phosphatase 149. Urinalysis unremarkable on admission. No chest x-ray performed.

Impression:

1. Acute spastic paraparesis on 05/17/2016 with abnormal MRI in thoracic and L-spine, possible epidural hematoma
2. Thrombocytopenia
3. Unknown coagulation status
4. Gravida 1, para 1, normal vaginal delivery with epidural anesthesia on 05/16
5. Hypertension
6. History of Hashimoto's thyroiditis, status post previous partial thyroidectomy
7. Abnormal liver function tests and preeclampsia

Plan:

1. We will monitor in the ICU
2. Continue neuro checks
3. Neurosurgical consult with Dr. Seiff
4. Check DIC panel
5. Platelet transfusion
6. Blood pressure control

05/17/2017 WHASN RECORDS CONSULTATION DR. SEIFF (Pages 25-26 of 70 Pages)

History of Present Illness:

This is a 41-year-old female, who is post delivery day #1. I got a call earlier in the day by Dr. Herpolsheimer with concern for possible spinal epidural hematoma, since the patient had developed significant bilateral lower extremity motor deficit, had received an epidural catheter for labor, and there was a question of possible thrombocytopenia during her course. The initial MRI had too much motion artifact for interpretation with respect to surgical decision making. Therefore, she was sent back to the MRI scanner for additional images, also transferred to the ICU so she could receive mannitol, she also received high-dose Decadron. The follow up imaging was suggestive of an epidural hematoma from the mid thoracic spine to the mid lumbar spine, and she was taken to surgery emergently for evacuation.

Past Medical History: Hashimoto thyroiditis
Surgical History: Partial thyroidectomy

Laboratory Data: Labs are significant for hyponatremia to 130 and platelets 274 and then 86K. D-dimer is also elevated. Through, there was no complaints suggestive of venous thromboembolism.

The MRI's revealed a mixed density collection that was both ventral, dorsal and lateral to the cord from the mid lumbar spine up to the mid thoracic spine. Interestingly, there was

also a sizeable nodular lesion up at the T3-T4 level, ventral to the cord which enhanced. I reviewed the case with 3 radiologists, 2 of them neuro-radiologist, and the consensus was that this represented an epidural hematoma, with the rostral thoracic lesion being somewhat enigmatic and possibly consistent with metastasis of lymphoma.

Impression:
A 41-year-old female, post delivery day #1, who had what looks like a thoracolumbar epidural hematoma with significant mass effect on the spinal cord, and she was taken to surgery emergently, however, intraoperatively an intradural hematoma was found. She underwent complete evacuation. For now she is intubated and to be extubated when deemed stable and she is awake.

05/17/2017 WHASN RECORDS OP REPORT T8 THROUGH L3 LAMINECTOMIES FOR EVACUATION MICHAEL SEIFF, M.D. (Page 27-29 of 70 Pages)

Preoperative Diagnosis: Thoracolumbar Epidural Hematoma

Procedure:
1. T8 through L3 laminectomies for evacuation of intradural hematoma
2. Operative microscope for microsurgical technique
3. Intraoperative fluoroscopy for localization

Indication: The patient is a 41-year-old female, who is postpartum and developed bilateral lower extremity paresthesias followed by spastic paraplegia, workup ultimately revealed what was thought to be an epidural hematoma and she was taken to surgery emergently for evacuation. Intraoperatively an intradural hematoma was found.

She was taken to ICU in hemodynamically stable condition.

05/18/2017 ST. ROSE DOM-SIENA RECORDS ONCOLOGY/HEMATOLOGY CONSULT DR. GHANI (Page 24-26 of 4,422 Pages
Medical Oncology/Hematology Consult

Impression:
1. Thrombocytopenia with some clumping, question immune mediated with some effect of pseudothrombocytopenia i.e. platelet clumping
2. Postpartum day #3
3. T8-L3 laminectomy for evacuation of intradural hematoma
4. Leukocytosis, question reactive
5. History of iron deficiency

6. Elevated LFTs

Plan:

1. I discussed with the patient further workup. WE will check peripheral smear B12 folate and iron studies
2. Platelet count should be drawn on citrate tube
3. Watch platelet count closely. Currently, platelet count is going towards normal. Today's platelet count is 149. We will follow along with you
4. Above discussed with patient and her husband

05/18/2017 ST. ROSE DOM-SIENA RECORDS CONSULT DR. SELCO (Page 26-32 of 4,422 Pages)

Chief Complaint:
Epidural Hematoma B/L LE Weakness

History of Present Illness:
She developed B/L LE progressive paraparesis and numbness on post-partum day #1 after epidural anesthesia. She delivered via NSVD following the onset of gestational hypertension. Dr. Herpolsheimer contacted me. I advised STAT MRI T+L spine. She had a thoracolumbar intradural hematoma. She was taken to the OR last night by Dr. Seiff and had a T8-L3 lami for intradural hematoma evacuation.

Her husband is present. She is awake and alert on the vent. She has some movement in the proximal thighs, she can flex her knees somewhat and she can plantar flex and dorsiflex her bilateral feet somewhat. She has normal sensation post-operatively.

She did not receive enoxaparin or heparin SQ this admission.

Nothing specific other than the mentioned above is reportedly making the symptoms commence, improve or worsen.

05/18/2017 WHASN RECORDS QUEST LAB BLOOD CLOTS FROM EPIDURAL (Page 22 of 70 Pages)

Diagnosis:
Blood clots from epidural

Gross:
Received in formalin labeled "Badoi, Alina DOB 05/24/1975" and "blood clots" is an aggregate of dark maroon clot 4.0 x 3.0 x 0.6 cm. The tissue is soft and friable.

05/19/2017 ST. ROSE DOM-SIENA RECORDS SOCIAL SERVICES DOCUMENTATION (Page 2281 of 4,422 Pages)
"MSW met with Radu (patient's boyfriend) who voiced his concern that surgery was from T8-L3 lami due to hematoma that there was a delay in care as it was brought to medical team's attention at 10 a.m. and *nothing was done about it for 12+ hours."*

05/20/2017 WHASN RECORDS OP REPORT CHARLES MCPHERSON, M.D. (Page 21 of 70 Pages)
Pre and Postoperative Diagnosis: Altered mental status, intubation needed for airway protection

Procedure: Endotracheal intubation

Procedure in Detail: The patient recently had a spontaneous vaginal delivery and then developed lower extremity paraparesis due to epidural hematoma, for which she underwent extensive laminectomy yesterday. She was extubated. Post-procedure was doing well, however, late in the evening of 05/19 according to the nurses, the patient began getting confused and then more somnolent. The patient was sent for stat CT scan of the brain which showed intraventricular and some subdural blood with enlargement of the ventricles consistent with hydrocephalus. The patient had been transferred to the ICU prior to the CAT scan. I was called with the results when the patient arrived after she came back from the CAT scan and neurosurgeons have been called. When I arrived, the patient was somnolent with some response to stimulation and voice, therefore endotracheal intubation was recommended. Sister was at the bedside. The patient was administered 20 mg of etomidate using a MAC 4 blade. When the blade was first placed into the mouth, the patient then began biting down very hard and chipped her left front tooth. The patient was given 50 mg of Rocuronium for paralysis, then with a MAC 4 blade the airway was well visualized with a grade 1 view. There is a small amount of yellow dried mucus in the hypopharynx which was suctioned. A #7.5 endotracheal tube was placed on first attempt under direct visualization without difficulty. There was good color change to C02 sensor. Good breath sounds bilaterally and good oxygenation.

Complications: Left front upper tooth chipped when patient bit on laryngoscope. No other complications.

05/20/2017 WHASN RECORDS OP REPORT JAMES FORAGE, M.D. (Pages 20 of 70 Pages)
Pre and Postoperative Diagnosis: Hydrocephalus

Procedure Performed:
Right frontal ventriculostomy

Indication for Procedure:
This is a 41-year-old female, who developed altered mental status, and was found to have an intraventricular hemorrhage and was found to have hydrocephalus, which requires diversion of CSF.

05/22/2017 ST. ROSE DOM-SIENA RECORDS MRI (Page 3684-3685 of 4,422 Pages)
05/22/2017 17:00 PDT
Reason for Exam: (MR L spine wo+w Con) Thoracolumbar intradural hemorrhage after epidural anesthesia; epidural enhancement present on pre-op images??

Addendum:
After review of the medical record the patient is noted to have **HELLP**. Given this is a diagnosis of spinal complications of HELLP is more favored

Impression:
Postoperative changes with intradural blood products noted as described above. The largest collection of blood products is noted anteriorly at L4-L5. No definite enhancement is identified

06/01/2017 ST. ROSE DOM-SIENA RECORDS PROGRESS NOTE – NURSING Page 1929 of 4,422 Pages
07:00 PDT
"Gave report to Neelam, RN at pt. bedside. Updated her on new orders. Pt. has been placed in Trendelenburg for 15 minutes hourly. Headache resulted, and Tylenol given. Vitals table, however blood pressure has remained in the 140s to 150s. Pt. received 1 dose IV Labetalol prn. Pt. is alert and oriented x 4, and is still weak on the right lower extremity. See assessment for further details.

06/01/2017 ST. ROSE DOM-SIENA RECORDS PROGRESS NOTE – NURSING Page 1926 of 4,422 Pages
15:00 PDT
"Physical therapist started working with the patient brought head end of the bed up and pt. started c/o pain, unable to tolerate pain. Pt. requested pain medication. Methocarbamol given as ordered. St. pt. couldn't tolerate pain and started crying. Head end of bed put down and pt. repositioned to make comfortable. Continue to follow."

06/02/2017 WHASN RECORDS OP REPORT MICHAEL SEIFF, M.D. (Pages 15-16 of 70 Pages)
Pre and Post-operative Diagnosis: Thoracic epidural hematoma

Procedure Performed: Evacuation of thoracic epidural hematoma. Intraoperative neurophysiologic monitoring of somatosensory and motor evoked potentials and EMGs.

Indications:
The patient is a 42 year-old female, several weeks out from T8 through L3 laminectomy for evacuation of intradural hematoma, who has been improving slowly with regard to lower extremity function, she has spastic paraplegia preoperatively, but postoperative imaging has revealed an epidural hematoma with persistent mass effect on the thoracic spine, especially opposite T9 through 11. It was therefore elected to take her to surgery to evacuate this collection.

06/03/2017 ST. ROSE DOM-SIENA RECORDS PROGRESS NOTE – NURSING Page 1965 of 4,422 Pages
11:25 PDT
"Patient sitting up in bed working with physical therapy. C/o dizziness. Assisted by PT Karl to laying position. Became unresponsive and witness seizure activity. Hypotensive following seizure. Dr. Hutchison to room immediately. Patient began to awaken calling out for the MD to remove the oxygen mask from her face. Again became unresponsive, hypotensive, Code Blue called.

06/03/2017 WHASN RECORDS CODE BLUE NOTE WILLIAM HUTCHISON, M.D. (Pages 6-7 of 70 Pages)
Code Blue Note

"I was on the unit and was called into the room because the patient had a seizure. When I got there, she had already completed a clonic-tonic seizure and was slightly postictal. She had a very lower blood pressure of 60/40. We supported her in her breathing. Respiratory was in the room and we assisted her oxygenation. She awoke from that and started moving around groaning and moaning, answering questions appropriately. She denied any pain. Her pressure, however, remained very low. We were in the process of starting Levophed drip when the patient's eyes deviated to the right and it appeared that she had another seizure. At this juncture, the decision to continue bagging her, intubate her was made. I made two attempts to intubate her orally. We did not have a good color change on the C02 monitor, although I did have good breath sounds bilaterally and the 02 sats were greater than 85%. We elected to discontinue the endotracheal tube and bag her. However, we had the same experience. Finally, I was able to intubate her using a GlideScope. However, by

this time, she had lost a pulse and CPR was underway. We ran CPR, ACLS for pulseless electrical activity for over 75 minutes using multiple amps of epinephrine, multiple amps of sodium bicarbonate. We obtained blood gases during the code blue. Her initial blood gas showed pH less than 6.92, pC02 of 102, but this is a venous blood gas with a p02 of 31 (throughout CPR, her oxygen saturation was greater than 90% for most of the CPR activity). We gave her a total of 6 amps of sodium bicarbonate. Her next blood gas showed a pH of 6.99, pC02 of 123, but the p02 was 31. This may be a venous blood gas. Her oxygen saturation again peripherally was 100%. We placed the end-tidal C02 monitor which initially was 9, but after giving multiple amps of sodium bicarbonate, improved to greater than 33. However, it drifted back down again. Family was at bedside obviously distraught. I explained the situation to the daughter as well as a friend of the daughters who is an RN and personal friend of Dr. Dijana Jefic. I spoke with Dr. Dijana Jefic over the telephone explaining the situation to her and she did explain the situation to the friend, as did I, who is an RN. The friend agreed that we had run ACLS for PEA over 75 minutes and the change for a meaningful recovery as almost 0. At this time, the code was called. The family was distraught at the bedside and I did my best to comfort them. Nursing supervisors present as well as charge nurse, Liz, who assisted throughout the code. Dr. Seiff's coverage was present and we explained the situation to him. To the best of our ability to determine what happened, the patient appears to have had some sort of catastrophic CNS event, possibly extension of her hemorrhage, possibly a clot, it is difficult to say. The puzzling thing was the profound hypotension initially, which we cannot explain."

06/03/2017 ST. ROSE DOM-SIENA RECORDS DISCHARGE SUMMARY (Pages 9-14 of 4,422 Pages)
Date of Admission: 05/15/2017

Date of Discharge: 06/03/2017

Reason for Admission: Intrauterine pregnancy with spontaneous vaginal delivery

Final Diagnoses:

1. Cardiac arrest. Presumably due to catastrophic event, differential diagnosis including pulmonary embolus, catastrophic CNS event, or myocardial infarction.
2. Seizure
3. Acute spastic paraparesis on 05/17 with an abnormal MRI of the thoracic and lumbar spine, status post T8-L3 laminectomy for epidural hematoma evacuation on 05/18.
4. Status post spinal hematoma evacuation on June 2nd per Dr. Seiff
5. Status post placement of lumbar drain, 05/23

6. Acute confusion and somnolence on 05/19 with demonstrated subdural hemorrhage and dilated ventricles compatible with hydrocephalus. 05/20, status post right frontal ventriculostomy
7. Large respiratory failure on 05/18, extubated 05/19, transferred to ICU and re-intubated on 05/20 for altered mental status. Extubated on 05/22.
8. Status post normal vaginal delivery with epidural 05/16 G1, P1
9. Hypertension
10. History of Hashimoto's thyroiditis, status post partial thyroidectomy and thyroid replacement
11. Abnormal liver function studies with preeclampsia
12. Leukocytosis
13. Thrombocytopenia
14. Elevated D-dimer with normal Pro Time

Hospital Course:
This 42 year-old white female delivered a 6 pound 7 ounce female infant with Apgars of 9 and 9 on 05/16 via spontaneous vaginal delivery. She did have an epidural placed. On 05/17, she had acute spastic paraparesis with abnormalities seen on MRI of the thoracic and lumbar spine possibly consistent with epidural hematoma. She did have thrombocytopenia. She was taken to a laminectomy for intradural hematoma evacuation on 05/18 per Dr. Michael Seiff. Apparently, there was an epidural hematoma present. There was question of possible thrombocytopenia during her course. However, per Dr. Selco's note, she did not receive any enoxaparin or heparin. Dr. Ghani was consulted from Hematology-Oncology and noted that she had thrombocytopenia with platelet clumping. He ordered further testing. Her plated count was 94,000 with a CBC platelet count showing between 140 and 160,000 on 05/17 and a repeat was done which was 74,000. On 05/18 in the morning platelet count was 104 and platelets on 05/17 dropped to 86,000. On 05/17 at 1644 it was 74,000. D-dimer was 5817. Fibrinogen 308. PT 10.3. INR 0.9 with PTT of 24. Dr. Ghani noted the MRI of the thoracic spine showed extensive heterogeneous epidural process. MRI of the lumbar spine showed extensive abnormal epidural process causing extensive mass on the thecal sac. Bilateral lower extremity Dopplers did not reveal deep vein thrombosis. The patient was given mannitol and Decadron on a taper. By 05/18 she was successfully extubated but had some nausea. She was downgraded to maternal and child floor. However, she had altered mental status and needed to be reintubated on 05/20, transferred back to ICU. Apparently, she was getting more confused, more somnolent. She was sent for stat CT scan of her brain which showed intraventricular and some subdural blood with enlargement of the ventricles consistent with hydrocephalus. On 05/20 at 4:30 in the morning, a right frontal ventriculostomy drain was placed because of need for diversion of CSF. Echocardiogram done on 05/20 showed ejection fraction of 65-70%. Her encephalopathy did improve after the interventricular drain was placed. She

was following commands. After placement of the right ventricular shunt catheter, the degree of ventricular dilation decreased and mild intraventricular hemorrhage was noted in the occipital horns in 3rd and 4th ventricle with mild infiltrative extra-axial blood products and subdural and subarachnoid hemorrhage at the region of the foramen magnum and extra medullary to the ventral upper cervical spinal cord and the visualized portions. There may have been a tiny lacunar infarct noted at the left aspect of the splenium of the corpus collosum at 4 mm.

Dr. Anthony Nguyen noted that she had transient thrombocytopenia with some clumping question and immune-mediated effect. He recommended keeping the platelets greater than 100 and recommended 1 unit of platelets. On 05/21, the EVD was draining clear CSF. The hemoglobin dropped to 7.4 without obvious bleeding. On 05/22, the patient was extubated. She was comfortable with mild stridor. Decadron and racemic epi were given to treat the mild stridor but she remained awake, alert and communicative. A von Willebrand's panel was drawn and the results were pending on 05/22. On 05/23 her thrombocytopenia was better with platelet count of 224,000. MRI of the spine on 05/22 showed intradural blood products mixed intensity. A Lumbar drain was recommended as well as bed positioning maneuvers to facilitate more rapid removal of CSF. Dr. Kashef saw the patient on 05/23 from Hem/Onc. On 05/23 Dr. Konchada from IR placed a lumbar drain. About 15 mL of straw-colored CSF was aspirated from the colostomy collection cylinder using sterile technique. On 05/24 the patient was more awake, her voice improved. The lumbar drain stopped draining on 04/24 and Dr. Selco was following. The output was darkly colored bloody CSF, but the EVD showed the ICP was at 10 mm and it was draining well. On 05/24 the lumbar drain was flushed. She was started on Mestinon 30 mg p.o. t.i.d. per Dr. Selco. On 05/25, a lumbar drain was flushed with Isovue contrast and repositioned. Then it was functioning better. On 05/26 she was drowsy but arousable. She felt tingling and numbness to bilateral lower extremities. On 05/26 the EVD was clamped. The ICP was 1. The lumbar drain was draining freely, with 20 mL every 4 hours. The EVD was draining 20 mL every 4 hours alternating with the lumbar drain every 4 hours per Dr. Selco's order. The patient had bilateral lower extremity pain especially with being turned and sitting. Additional history was obtained where she had a thyroidectomy and blood internally at age 15, developing hematoma that cause neck compression and compromised talking and swallowing for several months. This raised the question of von Willebrand's disease. She has heavy menses also raising the question of von Willebrand's disease. Dr. Litchfield increased her levothyroxine from 50 mcg p.o. every day to 112 mcg every day during her pregnancy. TSH during this admission was 3.27, within normal limits. The transferrin was 314 from 05/19, vitamin B12 level was 252, folate 113.1, ferritin 125, CA-19.9 was okay. The CA 27.29 was 21.7, the CEA was 0.74, CA-125 was 104.6 which is high, normal being between 0-35. The rheumatoid factor was less than 14, the ANA was negative. Mitochondrial M2 was 6.1, artifact and antibody was 10. It was felt that she had

platelet clumping possibly due to the blood draw tube EDTA sensitivity. There was the question of von Willebrand's disease based on the clinical results. She was started on trazodone for a poor sleep on 05/27. It was noted that the drainage slowed between 05/26 and 05/27 on her lumbar drain. Order was given to clamp the EVD, continue Ancef 1 g every 8 hours, and open the lumbar drain every 2 hours to drain 20 mL in reverse Trendelenburg. CT scan or CT myelogram of the spine to rule out AVM once blood removed from the intradural space was recommended. On 05/28 it was noted her CSF was dark auburn. On 05/29, family refused to have medication noted at 6:50. On 05/29 Dr. Kashef noted that the patient had possible von Willebrand's disease. Need to repeat labs for a definitive diagnosis once her clinical condition is stabilized. On 05/29 Dr. Selco noted that her pain was better on tapentadol and that she slept well. Her sister refused the trazodone. She was eating a little more and had a small bowel movement. Her abdomen was less distended and she was passing gas. On 05/29 Dr. Selco aspirated about 20 mL of darkly colored CSF from the lumbar drain using sterile technique. On 05/30, she was more awake and in better mood, complained of minor headache but just took some Tylenol and had good sleep. Her EVD was continued to be clamped with ICP 10-16 and LD in the lumbar drain rather draining 20 mL every 4 hours, dark brown colored. Her bilateral lower extremities were still weak and she was unable to move her legs. She had a decent lunch on 05/29 and with bladder training and felt a pressure. Her Foley was clamped and her bladder was full and when unclamped, emptied 1060 mL from the Foley. On 05/31 the EVD and LD were both clamped as she was scheduled for an MRI. She did not complain of any headache. She did have some breast discomfort and lactation nurse was sent in, recommended ibuprofen and pseudoephedrine to stop the lactation, but ibuprofen and other non steroidals were not an option at that time because of bleeding. On 05/31 it was noted that she slept well passing some gas and having some bowel movement smears. She had asymmetric bilateral lower extremity weakness, left stronger than right, and both were improving. On 06/01, it was noted that her extraventricular drain was open but not draining and the lumbar drain was clamped. She did not sleep well because Trendelenburg was ordered for drainage. She was feeling the pressure on bladder training. Dr. Selco noted that her EVD was draining at 20 mL every 4 hours and her intracranial pressure was normal with a CSF fairly clear. Lumbar drain was to be left in for the CT myelogram before removing it. On 06/02 she was awake and alert and felt much better than yesterday. She was anxious and hoping to undergo surgery. The EVD and LD were clamped. She underwent evacuation of a thoracic epidural hematoma per Dr. Seiff on 06/02. She was in the prone position for surgery. The wound was opened and the hematoma was evacuated throughout the entire length of the lamina though the entire length of the laminectomy deficit was visualized. A 1/8 inch Hemovac drain was left in place and tunneled out from the incision beneath the muscle. The muscle was reapproximated. Fascia was approximated. Subdural layer was reapproximated and the epidermis was reapproximated as well. Dressings were applied and exudating drain was anchored and there were no

complications. On 06/03 the patient was awake, working with Speech Therapy. Family was in the room. She was moving all 4 extremities well. The EVD was still in place but not draining.

I was suddenly called into the room because the patient had a seizure. When I got there she had completed a tonic-clonic seizure, was slightly postictal. She had a very low blood pressure of 60/40 with supported breathing and oxygenation. She awoke from the post-ictal phase in a couple of minutes and starting moving around groaning and moaning and answering questions appropriately. She denied any pain. Her pressure increased a bit and dropped again. We gave her a fluid bolus. We were in the process of starting a Levophed drip when her eyes deviated to the right and it appeared she was having another seizure. At this point, the decision to keep bagging her was made and the decision was made to intubate her. I made 2 attempts to intubate her orally but we did not have a good color change on her C02 monitor, although I did have good breath sounds bilaterally and the oxygen saturations were greater than 85%. Because of color change being more than slightly yellow, we discontinued the endotracheal tube to bag her once again. Oxygen saturation improved to 100%. I tried intubating her with a bougie. I felt the endotracheal rings were well with the bougie and the endotracheal tube went in without a problem. However, we had the same experience with the carbon-dioxide indicator, so once again we disconnected the ET tube and bagged her. Finally, I intubated her with a glide scope. We did have a good C02 indicator at this time. However, by this time she lost her pulse and CPR was underway. Then extensive CPR with ACLS for over 75 minutes ensued using multiple amps of epinephrine, multiple amps of sodium bicarbonate. WE obtained blood gases during the Code Blue. Initial blood gas showed a pH less than 6.92, pC02 of 102, but this was felt to be a venous blood gas with a P02 was 31. Throughout most of this CPR, her oxygen saturation was 100%. We gave her a total of 6 amps of sodium bicarbonate and the next blood gas showed a pH of 6.99, pC02 of 123, but the patient remained in PEA> Throughout the extension ACLs we never recovered pulses although we had excellent femoral pulses on cardiac compression.

The family was at the bedside and I comforted them at bedside and spoke with the family as well as a friend of the daughters who was an RN and a personal friend of Dijana Jefic, M.D. I did speak with Dr. Jefic by phone to explain the situation to her and she did explain the situation to her daughter which was as follows:

Basically, the patient was in PEA for about 75-80 minutes. We did not recover the heart and at that point the Code Blue was called.

Dr. Seiff's coverage was present and reviewed the above with him. Dr. Selco had been contacted by phone during the code and wondered about the possibility of pulmonary

embolus. The differential diagnosis of her terminal event includes pulmonary embolus, catastrophic CNS event, as well as myocardial infarction.

06/04/2017 AFFIDAVIT RECORDS AUTOPSY REPORT OF ALANE M. OLSON MD PATHOLOGIST Page 2 of 9 Pages

Cause of Death:

"It is my opinion that this 42-year-old Caucasian female, Alina Badoi, died as a result of bilateral pulmonary thromboemboli due to deep venous thrombosis due to acute spastic paraparesis following intradural hemorrhage associated with epidural anesthesia. Other significant conditions include recent pregnancy, pre-eclampsia, probable von Willebrand disease.

Manner of Death: ACCIDENT (Therapeutic complication)

SUMMARY

At the time of events reviewed above, Ms. Badoi was 41 years of age, and her obstetrical history was uncomplicated. She presented to St. Rose Dominican hospital Siena Campus on May 09, 2017, in the late third term of her first pregnancy, and she was supposed to be induced, at that time, but requested that the induction be put off one week, if it was medically feasible. This was deemed acceptable to her obstetrician, Dr. Herpolsheimer, and Ms. Badoi was discharged and readmitted to St. Rose on May 16, 2017, for a vaginal delivery, with epidural anesthetic. It is noted and of clinical significance that Dr. Kim, of anesthesia, appears to have been initially consulted for the purposes of placing an epidural anesthetic in Ms. Badoi, but he had concerns, because of her presentation with thrombocytopenia and epistaxis. He ordered that a manual platelet count be done before he would make a decision regarding epidural anesthesia for Ms. Badoi. Dr. Kim, apparently, spoke with Ronaldo Abuan in the lab at St. Rose regarding this manual platelet count, and after this, he advised that he would not place the epidural anesthetic in Ms. Badoi, because of a dramatic variance in the platelet count, as determined by the automated test versus the manual test.

Records reflect that around 3 p.m. on May 16, 2017, Ms. Badoi delivered a 6 pound, 7 ounce female infant via a spontaneous vaginal delivery, with midline episiotomy and repair. Intrauterine pregnancy was felt to be uncomplicated, and anesthesia was documented to be epidural. Within 6 hours of delivery, there was chart documentation of clinical complications postpartum. Charting at 8:45 p.m. indicated that Ms. Badoi had developed symptoms of tingling and numbness (paresthesias) involving her lower extremities and associated with dizziness. Her physician was first notified of this fact at approximately 9 p.m., on the day of delivery, and by 10:45 p.m., on May 16th, Dr. Herpolsheimer personally

evaluated Ms. Badoi, and raised initial concern about a possible epidural hematoma. Ms. Badoi's lower extremity symptoms became progressive to include not only paresthesias of her lower extremities, but also weakness, for which she could really not effectively put weight on her legs, and she became progressively anxious and developed lower extremity pruritus, making it impossible for her to rest or sleep. Beginning at about 1:20 a.m. on May 17th, there is documentation of multiple calls to the covering physician for Ms. Badoi's ongoing lower extremity complaints, as well as for hypertension. On the morning of May 17, 2017, Dr. Moore, of anesthesia, was notified of Ms. Badoi's lower extremity pruritus, pain, and numbness, and it was his clinical opinion that this was unrelated to her epidural anesthetic. He did evaluate Ms. Badoi that morning, and prescribed Benadryl for the pruritus and anxiety, as well as instituted "calming techniques."

By 10:45 a.m., on the 17th, Dr. Herpolsheimer was still concerned that Ms. Badoi's lower extremity symptoms were related to an epidural hematoma, and he was given the phone numbers of the on-call neurologist and neurosurgeon, in order to request appropriate consultations. By 11:20 a.m., Ms. Badoi was made n.p.o., and was given a 500-cc bolus of fluids, and IV fluids were started, at 125 cc/hour. Stat thoracic and lumbar spine MRIs were ordered at about 1:15 p.m., and were difficult studies, because of motion artifact. By 3:15 p.m., the MRIs had been completed, with results indicating a significant thoracolumbar epidural process, for which Ms. Badoi was to be scheduled for laminectomy and evacuation of hematoma of the spinal canal.

Ms. Badoi was kept n.p.o., and was transferred to the ICU by Dr. Charles McPherson, of pulmonary medicine, and was stabilized there between around 7:35 p.m. and 8:48 p.m., with lower extremity spastic paraparesis felt to be due to an epidural hematoma, confirmed by thoracic and lumbar spine MRIs. Dr. McPherson noted her medical history to be significant for Hashimoto's thyroiditis status post thyroidectomy and on thyroid replacement therapy. She was noted to be gravida 1, para 1, with complications of her epidural anesthetic. Thrombocytopenia was noted, with a platelet count of 94,000 and a hemoglobin of 10. Dr. McPherson noted that other platelet counts ranged from 80,000 to 100,000, all the way as high as 140,000 to 160,000. He additionally noted the development of postpartum hyponatremia, with a sodium of 130 and elevation of liver function tests of a mild degree, with an ALT, AST, and alkaline phosphatase in the 140 to 150 range. He also documented ongoing postpartum hypertension, and set up a protocol of neuromonitoring in the ICU, and was to check a DIC panel, control blood pressure, and ordered platelet transfusions.

Dr. Michael Seiff, of neurosurgery, evaluated Ms. Badoi, and brought her to the operating room on May 17, 2017, with a diagnosis of thoracolumbar epidural hematoma. He noted her to be a 41-year-old female one day postpartum, who, unfortunately developed bilateral

lower extremity paresthesias, followed by spastic paraplegia, with evaluation subsequently determining the likelihood of an epidural hematoma, for which she was emergently brought to the operating room. Intraoperatively, Dr. Seiff documented that an intradural hematoma was found, requiring T8 through L3 laminectomies for evacuation of the intradural hematoma.

Ms. Badoi remained intubated on postoperative day #1, and ongoing supportive care and management was given. She was seen by Dr. Ghani, of hematology, on May 18th, with thrombocytopenia associated with platelet clumping, reactive leukocytosis, iron deficiency anemia, and elevated liver function tests. She was noted to have gestational hypertension and a platelet count, at that time, of 149,000. A full hematology evaluation was ordered, along with supportive hematology care, including checking for Von Willebrand disease.

Additionally, on May 18, 2017, Ms. Badoi underwent neurology evaluation by Dr. Selco for an epidural hematoma, with bilateral lower extremity weakness. He documented that he had been notified by Dr. Herpolsheimer the day before, and he had advised a stat MRI of the thoracic and lumbar spines, which resulted in the defined clinical diagnosis of a thoracolumbar intradural hematoma, which was evacuated by Dr. Seiff.

Ms. Badoi was noted to be awake and alert on a ventilator at the time of Dr. Selco's neurologic evaluation, and had some movement in the proximal thighs and some ability to flex her knees and plantar flex and dorsiflex her feet. Sensation was felt to be normal postoperatively. Note was made that she received no regular or low-molecular weight heparins during the current admission.

On May 19, 2017, a social service note indicates that there was a discussion with Radu (the patient's boyfriend), and he voiced his concern that there was a delay in getting Ms. Badoi to the O.R. for laminectomy and evacuation of intradural hematoma, with the clinical problem first observed at 10 a.m., and surgery for definitive clinical intervention not being performed for more than 12 hours. The following day, Ms. Badoi developed altered mental status requiring emergency orotracheal intubation for airway protection, which was performed by Dr. McPherson, and complicated by a chip to the left front upper tooth. An MRI of the brain, at that time, for altered mental status revealed intraventricular hemorrhage and hydrocephalus, for which she was seen by Dr. Jim Forage, of neurosurgery, and brought to the operating room for placement of a right ventricular catheter. Note is made that the patient had an echocardiogram, which showed a good and well-preserved ejection fraction, and that a von Willebrand's panel was drawn, but not definitively conclusive for the presence of that disease. By May 22nd, a repeat MRI of the lumbar spine showed intradural blood products of mixed intensity, for which a lumbar drain was subsequently placed by interventional radiologist, Dr. Konchada, on May 23rd. It

was around this time that there was first mention of the clinical problem of HELLP syndrome (hemolysis, elevated liver enzymes, and low platelet count).

Supportive care continued for Ms. Badoi, with adjustment of her medications, and for which primary cancers and/or immunologic/rheumatologic diseases were considered, but ruled out. Ms. Badoi clinically progressed to become more awake and responsive, but continued to complain of a headache intermittently. By May 31st, she was felt to have a better sleep pattern, but persistent, asymmetric bilateral lower extremity weakness, with the left lower extremity being stronger than the right, but both lower extremities were felt to be clinically improving. Bladder training was begun, and intracranial pressures were normal, and the lumbar drain was left in place for possibly proceeding with CT-myelography before removing it. Eventually, her EVD and LD were clamped. An MRI of the thoracic spine revealed an epidural hematoma, for which Dr. Seiff confirmed a diagnosis of a thoracic epidural hematoma. Dr. Seiff returned Ms. Badoi to the operating room on June 02, 2017, for evacuation of thoracic epidural hematoma, including intraoperative neurophysiologic neuromonitoring. Dr. Seiff noted that Ms. Badoi had been progressing approximately two weeks status post T8-L3 laminectomies for evacuation of intradural hematoma, but with ongoing spastic paraplegia, for which postoperative imaging revealed an epidural hematoma, with persistent mass effect on the thoracic spine, especially at the T9-T11 levels, for which elective surgical evacuation was performed.

By the next morning, on June 03, 2017, at 11:25 a.m., Ms. Badoi was sitting up in bed and working with physical therapy, when she reported becoming dizzy, and was laid down, after which she became unresponsive, had seizure-like activity, and was hypotensive. A Code Blue was called, and Ms. Badoi lost her electrical rhythm and pulse, and extensive resuscitation occurred over more than 75 minutes, before she was eventually pronounced dead, after aggressive resuscitative efforts failed. The moribund event was felt to be: pulmonary embolism versus catastrophic CSN event versus MI.

An autopsy was performed by Dr. Alane Olson on June 04, 2017. The cause of death was felt to be as a result of bilateral pulmonary thromboemboli due to deep venous thrombosis secondary to acute spastic paraparesis, following intradural hemorrhage associated with epidural anesthesia. Other comorbid conditions included recent pregnancy, pre-eclampsia, and possible von Willebrand disease. Ms. Badoi's manner of death was ruled accidental (therapeutic complication).

After review of the medical records, I am in agreement with the pathologist, Dr. Olson, as it relates to the causation in this matter. Unfortunately, Ms. Badoi suffered severe complications of an epidural anesthetic at the time of her vaginal delivery, with the development of paresthesias, weakness, and subsequently spastic paraplegia of her lower

extremities. A thoracolumbar pathologic process was clearly identified on postpartum MRIs, requiring Dr. Seiff to emergently bring Ms. Badoi to the operating room for extensive T8-L3 laminectomies and evacuation of a compressive intradural spinal cord hematoma. Ms. Badoi's clinical course remained complicated, with the development of altered mental status and an intracranial subarachnoid hemorrhage requiring CSF diversion in the form of a right ventriculostomy catheter. She also subsequently required ongoing lumbar drainage by placement of a lumbar drain. Ms. Badoi's course was complicated by the presentation with and ongoing problems of thrombocytopenia, for which hematologic evaluation was never clearly definitive for the presence of von Willebrand disease, which, however, was suspected. Despite aggressive surgical treatment, she developed another thoracic epidural process requiring another surgery by Dr. Seiff on June 2nd. On the following day, she had an acute cardiopulmonary event resulting in pulseless asystole and for which resuscitation was unsuccessful, and for which she was pronounced dead.

Clinically, during her hospitalization, Ms. Badoi was felt to possibly have HELLP syndrome, which is a known complication of pregnancy, and at least, by some, felt to be a severe form of preeclampsia, otherwise known as gestational hypertension accompanied by proteinuria in the third trimester of pregnancy. The exact etiology of HELLP syndrome is not definitively known, but Ms. Badoi had a known risk factor of her age greater than 40. I am unaware of any known preventative management that could have been employed to avoid gestational hypertension and its complications in Ms. Badoi. HELLP syndrome has three definitive features, which include hemolysis, elevated liver enzymes, and platelet counts below normal. Ms. Badoi had at least two of these elements, though the records do not definitively reflect the presence of hemolysis after a very thorough hematologic workup. HELLP syndrome is known to be rare and occurs in less than 1% of all pregnancies, but possibly in 5% to 10% of patients with preeclampsia. Older maternal age, with pregnancy, is a known risk factor in the development of this syndrome, where preeclampsia is felt to occur in younger patients. While the possibility of HELLP syndrome as a clinical diagnosis was raised within the medical records of Ms. Badoi, no clinical classification was noted, and I will leave this to an obstetrical expert to discuss whether or not Ms. Badoi, in fact, had HELLP syndrome, and whether she had the presentation consistent with Class I disease, which is when statistically mortality can occur. The prognosis for HELLP syndrome is good, with most patients stabilizing within 24 to 48 hours, and noted protracted postpartum recovery times occurring in patients with Class I disease. Class I disease or that of complete HELLP syndrome is associated with the highest incidence of perinatal maternal morbidity and mortality, with death occurring in 1% to 3% of patients that develop HELLP, and with perinatal mortality rates of up to one-third. Morbid outcomes include DIC (disseminated intravascular coagulation), placental abruption, pulmonary edema, and renal failure.

Whether or not Ms. Badoi clinically developed a form of HELLP syndrome does not appear to be relevant to her cause of death. She clinically did present with elevated liver function tests and thrombocytopenia, and along with a clinical presentation of epistaxis, prompted Dr. Kim, of anesthesia, to appropriately refuse epidural anesthetic. Records document, however, that an epidural anesthetic was administered to Ms. Badoi for her vaginal delivery, which included episiotomy and subsequent repair. Unfortunately, the epidural anesthetic resulted in the development of an extensive intradural thoracolumbar hematoma. As a consequence of this intradural spinal cord bleed, symptomatic compression of Ms. Badoi's spinal cord developed and resulted in lower extremity paresthesias, numbness, and spastic weakness/paralysis. This resulted in the need for an emergency evacuation of the intradural hematoma, which occurred on the day after her vaginal delivery. Her clinical course was one of continued and ongoing lower extremity paraparesis and immobilization in the ICU, further complicated by altered mental status and intracranial subarachnoid hemorrhage, with hydrocephalus, requiring CSF diversion, with a right ventriculostomy. Despite aggressive management, her spinal cord hematoma redeveloped, requiring a return to the operating room more than two weeks after her initial spinal surgery. The following day, Ms. Badoi suffered a massive bilateral pulmonary embolism, which resulted in her death.

At autopsy, the pathologist correctly laid out the course of events that were causative in Ms. Badoi's death. To summarize, Ms. Badoi developed a rare and terrible complication of an epidural anesthetic at the time of her vaginal delivery. The epidural anesthetic caused the development of an intrathecal spinal bleed, which caused a compressive effect on the thoracolumbar spinal cord, and required emergency decompression on May 17, 2017. Ms. Badoi remained paraparetic and/or paraplegic for some time, and was immobilized in the ICU. Other bleeding events were noted, and she was given blood products to inhibit further bleeding complications. All of these events led to a cascade of clinical consequence, which resulted in the activation of the body's coagulation system, which physiologically is turned on in order to prevent ongoing bleeding and subsequently death. Unfortunately, the cascade of events leading to activation of the clotting mechanisms resulted in the development of a likely pelvic vein thrombosis due to activation of the clotting cascade, as well as the pressure of intrauterine pregnancy and lower extremity immobilization in the ICU, and with lower extremity paraparesis/paraplegia. The thromboembolic event that culminated in this unfortunate cascade was that of a massive pulmonary embolism, and causally was the event, which led to the death of Ms. Badoi. If not but for the complications of the epidural anesthetic, Ms. Badoi would not have developed the noxious cascade of events that culminated in the pulmonary embolism and her death. I reserve the right to amend or addend these findings as further records or documents become available.

I declare under penalty of perjury that the foregoing is true and correct pursuant to NRS 53.045.

Sincerely,

Bruce J. Hirschfeld, M.D., F.A.C.S.
BJH:kk

CURRICULUM VITAE
BRUCE J. HIRSCHFELD, M.D.

ADDRESS

	OFFICE:	General Vascular Specialists 7200 W Cathedral Rock, Suite 130 Las Vegas, Nevada 89128 702-228-8600 Fax 702-228-8689
PERSONAL	**Date of Birth:**	July 30, 1958 New York City, New York
	Marital Status:	Divorced
	Children:	Two (Hailey & Hillary Hirschfeld)
EDUCATION	**Premedical:**	Duke University Durham, North Carolina Bachelor of Sciences (Magna Cum Laude) September 1976 - May 1980
	Medical School:	Baylor College of Medicine Houston, Texas Doctorate of Medicine, 1984
	Internship:	Baylor College of Medicine Houston, Texas General Surgery Intern July 1984 - June 1985
	Residency:	Baylor College of Medicine Houston, Texas General Surgery Residency July 1985 - June 1987
		Baylor University Medical Center Houston, Texas General Surgery Residency July 1987 - June 1989
	Fellowship:	Baylor College of Medicine Houston, Texas Vascular Surgery Fellowship July 1989 - June 1990

LICENSURE

Texas	G-8178	Effective 8/23/85
Texas Controlled Substance Certificate	M8859776	
Nevada	6059	Effective 7/1/90
Nevada Controlled Substance Certificate	CS5654	
Federal DEA Certificate	AH3221986	
Alaska	4544	Effective 11/2/00
Hawaii	11232	Effective 10/13/00

BOARD CERTIFICATION

American Board of Surgery	#34955	2/5/90 - 7/1/2020
General Vascular Surgery	#46079	5/22/91 - 7/1/2023
Surgical Critical Care	#774	10/18/91 - 7/1/2013

PRIVATE PRACTICE

May 15, 2002 - Present	General Vascular Specialists 7200 W Cathedral Rock, Suite 130 Las Vegas, Nevada 89128 702-228-8600 Fax 702-228-8689
February 2, 2002 - May 14, 2002	Leave of Absence
May 1, 1993 - February 1, 2002	The Nevada Surgical Group 7200 W Cathedral Rock, Suite 130 Las Vegas, Nevada 89128 702-258-7788 3100 W Charleston Blvd., Suite 204 Las Vegas, NV 89102 3201 S Maryland Parkway, Suite 218 Las Vegas, NV 89109
August 1, 1990 - April 30, 1993	Vascular Surgical Specialists 3100 W Charleston Blvd., Suite 204 Las Vegas, NV 89102

PROFESSIONAL SOCIETIES

American College of Surgeons (Associate Fellow)
Michael E. DeBakey International Surgical Society
Peripheral Vascular Surgery Society
Society for Critical Care Medicine
National Oncology Society

PROFESSIONAL SOCIETIES (cont.)

Nevada State Medical Association
Clark County Medical Association
The Society of Laparoscopic Surgeons
International Society of Endovascular Specialists
Association for the Advancement of Wound Care
SAGES (Society of American Gastrointestinal Endoscopic Surgeons)

APPOINTMENTS

	Clinical Assistant Professor of Surgery Department of Surgery University of Nevada
2009	Medical Director Medical Services of America Home Health
March, 2005- 2009	Medical Director Oasis Home Health, Inc.
2005 – 2007	Medical Director Valley Hospital Medical Center Wound Care Center
April 2, 2000 - 2004	Medical Director Summerlin Medical Center Wound Care Center
June 1999 - Present	State of Nevada Medical/Dental Screening Panel Participant
August 16, 2001	Chief Investigator Western Institutional Review Board Performance evaluation of changes to Ancure Endograft System and instructions for use
January 17-31, 2012	Shadowing by Henry Chen

PUBLICATIONS

Hirschfeld, B.J., McAlister, D.S., Pizzo S., and Thompson, W.M.,: Evaluation of the Anode and Cathode for Transcatheter Electrocoagulation. Acta Radiologica Diagnosis 22:133, 1981.

Philpott, C.C., Hirschfeld, B.J., Clark, H.C., and Thompson, W.M.,: The Mechanism of Transcatheter Electrocoagulation (TCEC). Investigative Radiology 18:100, 1983.

LECTURES

May 9, 2000	Summerlin Medical Center, Medical Director Wound Care Clinic Grand Opening Topic: Ischemic Wounds
May 25, 2000	DVT Prevention and Treatment Pharmacia & UpJohn
September 29, 2000	UMC Grand Rounds Peripheral Arterial Disease Intermittent Claudication and Pletal
November 15, 2000	Pharmacia & UpJohn Low Molecular Weight Heparin Prevention and Treatment of Venous Thromboembolism
March 21, 2001	Intermittent Claudication Periferal Arterial Disease The Latest Pharmaceutical Therapy, Pletal
June29 - July 1, 2002	Scleroderma Foundation National Conference 2002 "Living Well with Scleroderma" Wound Care Management in Scleroderma
July 20, 2002	Summerlin Hospital Medical Center Multidisciplinary Education Lecture Lymphedema: Etiology, Diagnosis & Management

HOSPITAL AFFILLIATIONS

September 30, 1990 Associate / Surgery	University Medical Center of Southern Nevada 1800 W Charleston Blvd. Las Vegas, Nevada 89102
September 1, 1990 Active / Surgery	Sunrise Hospital 3186 S Maryland Parkway Las Vegas, Nevada 89109
January 21, 2003 Courtesy	Desert Springs Hospital 2075 E Flamingo Road Las Vegas, Nevada 89119

HOSPITAL APPOINTMENTS (cont.)

January 17, 1991 Associate / Surgery	Saint Rose Dominican Hospital 102 E Lake Mead Drive Henderson, Nevada 89015
Sienna Campus	3001 Saint Rose Parkway Henderson, Nevada 89052
August 17, 2000 Active / Surgery	Mountain View Hospital 3100 N Tenaya Way Las Vegas, Nevada 89128
May 31, 2011 Courtesy	North Vista Hospital 1409 E Lake Mead Blvd. N. Las Vegas, Nevada 89030
February 17, 2010 Provisional Status	Southern Hills Hospital 9300 W Sunset Road Las Vegas, NV 89148
November, 2011 Active/Surgery	Spring Valley Hospital 5400 Rainbow Blvd Las Vegas, Nevada 89118
November 30, 2011 Active/Surgery	Valley Hospital 620 Shadow Lane Las Vegas, Nevada 89106

CME COURSES AND ANNUAL MEETINGS

6/25/88	Tulane Medical Center New Orleans, Louisiana **Surgical Forum**	4 Credit Hrs
11/17 - 11/19/89	Albert Einstein College of Medicine Montefiore Medical Center **16th Annual Current Critical Problems in Vascular Surgery**	22 Credit Hrs
9/24 - 9/28/90	U.C.L.A. Medical Center Los Angeles, California **8th Annual UCLA Symposium: A Comprehensive Review & Update of What's New In Vascular Surgery**	32 Credit Hrs
8/1 - 8/4/91	Huntington Memorial Hospital San Francisco, California **Computed Sonography Imaging and Doppler Course**	15 Credit Hrs

CME COURSES AND ANNUAL MEETINGS (cont.)

9/27 - 9/29/91	University of Utah School of Medicine Salt Lake City, Utah **Laparoscopic Cholestectomy**	24 Credit Hrs
10/10 - 10/13/91	University of Health Sciences / The Chicago Medical School Chicago, Illinois **10th Annual Chicago Critical Care Symposium & Board Review**	26 Credit Hrs
3/21 - 3/26/93	Medical Education Collaborative Aspen, Colorado **The Rocky Mountain Vascular Disease Symposium**	20 Credit Hrs
12/1 - 12/2/95	Education Design Marietta, Georgia **Advanced Operative Laparoscopy for General Surgeons**	14 Credit Hrs
1/28 - 2/2/96	The American Institute of Ultrasound in Medicine Kauai, Hawaii **5th Annual Symposium: Diagnostic and Therapeutic Approach to Vascular Diseases**	32 Credit Hrs
3/19/96	Johnson & Johnson Interventional Systems Company **Palmaz Balloon - Expandable Stent For Use In Iliac Arteries**	
3/3/97	Endo-Surgery Institute Cincinnati, Ohio **Advanced Laparoscopic Hernia Procedures**	3 Credit Hrs Hands on Exp.
3/3 - 3/4/97	Endo-Surgery Institute Cincinnati, Ohio **Advanced Laparoscopic Gastric Procedures**	3 Credit Hrs Hands on Exp.
6/12 - 6/14/97	The Institute for Medical Education **8th Annual Symposium on Interventional Therapy for Vascular Disease**	19 Credit Hrs
10/12 - 10/15/97	Medical Education Collaborative **Frontiers in Vascular Disease 97**	18 Credit Hrs

CME COURSES AND ANNUAL MEETINGS (cont.)

11/13 - 11/14/97	University of Cincinnati College of Medicine **Laparoscopic Abdominal Solid Organ Surgery** Snowmass, Colorado **Rocky Mountain Vascular Disease Symposium**	14 Credit Hrs
3/23 - 3/25/99	Arizona Heart Institute **Intermediate Endovascular Interventions** **Hands on Training course**	17 Credit Hrs
5/21/99	Medical Ethic and Professional Responsibility **1998 - 1999 Update for the Nevada Physician**	3 Credit Hrs
11/11 - 11/12/99	Arizona Heart Institute **The AnueRx Stent Graft Physician Training Program**	
1/25/00	Vanderbilt University Hospital **AAA training program for the application of the Ancure Endograft System for Abdominal Aortic Aneurysm Repair**	
2/13 - 2/17/00	International Society of Endovascular Specialists **International Congress 2000 on Endovascular Interventions**	11.5 Credit Hrs
3/24/00	Valley Hospital Medical Center **Endovascular Repair for Aneurysm privileges granted**	
9/12/00	Ethicon, Inc. Somerville, New Jersey **Integra Artificial Skin Physician Training Program**	
2/9 - 2/10/01	Society of Critical Care Medicine San Francisco, California **Fifth Critical Care Refresher Course**	14.5 Credit Hrs
2/13/01	International Society of Endovascular Specialists Arizona Heart Institute **International Congress XIV on Endovascular Interventions**	2.5 Credit Hrs
2/14/01	Arizona Heart Institute **ELCA Laboratory Training**	8 Credit Hrs

CME COURSES AND ANNUAL MEETINGS (cont.)

2/11 - 2/15/01	International Congress XIV Arizona Heart Institute **Endovascular Interventions**	12.5 Credit Hrs
5/3/01	**14th Annual Symposium on Advanced Wound Care & Medical Research Forum on Wound Repair**	4 Credit Hrs
5/31/01	InforMed **Medical Ethics and Professional Responsibility**	2 Credit Hrs
8/5 - 8/12/01	American Seminar Institute **Cardiology Review**	20 Credit Hrs
8/24/01	Audio Digest Foundation **Family Practice** **Pediatrics** **Emergency Medicine** **Internal Medicine**	 10 Credit Hrs 2 Credit Hrs 4 Credit Hrs 4 Credit Hrs
8/16 - 8/20/02	Society of Critical Care Medicine Chicago, Illinois **SCCM/ACCP 4th Combined Critical Care Course**	
4/26/03	Nevada Oncology Society Joint Sponsored by University of Kentucky Las Vegas, NV **AMA Physicians Recognition Award**	3.5 Credit Hrs
8/25 - 8/28/03	Summerlin Hospital Hyperbaric Medicine Center **Hyperbaric Medicine**	40 Credit Hrs
6/17 - 6/29/04	Audio Digest Foundation **Imaging in Vascular Surgery** **Medicolegal Misadventures** **Spotlight on Endocrine Surgery** **When Cells Go Wild** **Issues in Gastrointestinal Disorders** **Gastrointestinal Complications** **Topics in Endocrine Surgery** **Advances in Breast Cancer Surgery** **Medical Errors** **What's New in Colorectal Surgery**	 2 Credit Hrs 2 Credit Hrs 2 Credit Hrs 2 Credit Hrs 2 Credit Hrs 2 Credit Hrs 2 Credit Hrs 2 Credit Hrs 2 Credit Hrs 2 Credit Hrs 2 Credit Hrs

CME COURSES AND ANNUAL MEETINGS (cont.)

5/18/05	Thomson American Health Consultants	
	Professionalism and Ethics in the ED	2 Credit Hrs
	The Medical Malpractice Crisis: Why Are Physicians Losing?	1 Credit Hr
	Missed MI: Costly, Deadly, and Sometimes Unpreventable	1 Credit Hr
	Appropriate Documentation: Your First (and Best) Defense	1 Credit Hr
5/26/05	Thomson American Health Consultants	
	Raising the Ghost of 1918: Could Flu be the Ultimate Bioweapon?	1 Credit Hr
5/27/05	Thomson American Health Consultants	
	Plague in the Big Apple: Rare Cases Trigger Bioterrorism Response	1 Credit Hr
	Be Alert for Ricin Poison Cases after Deadly Toxin Used in Threat	1 Credit Hr
	Wise or Ill-Advised? Smallpox Vaccine Program Hits Hiatus	1 Credit Hr
6/27/05	Audio-Digest Foundation	
	Critical Care Update	2 Credit Hrs
	Spotlight on Trauma	2 Credit Hrs
	Traumatic Injuries	2 Credit Hrs
	Tips on Trauma	2 Credit Hrs
	Orthopaedic Trauma	2 Credit Hrs
	Trauma Wounds	2 Credit Hrs
	ATLS: Fact or Fiction?	2 Credit Hrs
	Head Trauma	2 Credit Hrs
	Trauma of the Torso	2 Credit Hrs
	More on Trauma	2 Credit Hrs
1/16 – 1/21/06	The North American Center for Continuing Medical Education American College of Hyperbaric Medicine Columbus, Ohio **Principles of Wound Healing and Hyperbaric Medicine**	47.5 Credit Hrs
4/27/07	The University of Nevada School of Medicine	
	Risk Management for the Physician Office	3.5 Credit Hrs
1/14 – 1/15/08	Gore Advanced AAA Symposium Las Vegas, Nevada	

CME COURSES AND ANNUAL MEETINGS (cont.)

5/26/09	The University of Oklahoma College of Medicine Oklahoma City, Oklahoma	
	Medical Ethics Today: A CME Update	2 Credit Hrs
3/31/09	Oakstone Medical Publishing	
	The New York General Surgery Board Review	41.5 Credit Hrs
10/1/09	American College of Surgeons	
	Surgical Education and Self-Assessment Program No.13	60 Credit Hrs
12/28/09-01/01/10	American Seminar Institute Playa Del Carmen, Mexico	
	General Surgery Review	18 Credit Hrs
2/28/10	Audio-Digest Foundation	
	Resistent Bugs	2 Credit Hrs
	Laparoscopy Update	2 Credit Hrs
	A New Look at Surgery	2 Credit Hrs
	Renal Failure/Hyperbaric Medicine	2 Credit Hrs
	Issues in the Pelvic Region	2 Credit Hrs
	Anticoagulants and Blood	2 Credit Hrs
	Weighty Surgical Issues	2 Credit Hrs
	GI Surgery	2 Credit Hrs
	Thyroid Surgery	2 Credit Hrs
5/16/11	Johns Hopkins University School Of Medicine	
	Practical Reviews in General Surgery	3 Credit Hrs
5/28/11	Medical Risk Management	
	Risk Management Consult: Avoiding Medical Systems Failures	4 Credit Hrs
8/9/11	Society for Vascular Surgery	
	Vascular Educatioon and Self-Assessment Program VESAP 1	45 Credit Hrs
8/12-8/14/2011	American Physician Institute for Advanced Professional Studies Schaumburg, Illinois	
	Vascular Surgery Comprehensive Review Course	29 Credit Hours
3/18/12	Medical Risk Management	
	Risk Management Consult: Documentation	5 Credit Hrs

CME COURSES AND ANNUAL MEETINGS (cont.)

10/2012	American Physician Institute for Advanced Professional Studies Oak Brook, Illinois **Vascular Surgery Comprehensive review**	27 Credit Hrs
9/10/2012	David Geffen School of Medicine at UCLA Hollywood, California **What's New in Vascular and Endovascular Surgery**	34.5 Credit Hrs
4/27/2013	Medical Risk Management **Risk Management: Managing Disruptive Physician Behavior**	5 Credit Hrs
4/15/15	Medical Risk Management Risk management: Avoiding Medical System Failures,	5 Credit Hrs
5/2/16	Medical Risk Management Risk management: Essentials for physicans second edition	10 credit Hrs
4/5/17	Medical Risk Management Risk management: The Complete Series second edition	6 Credit Hrs
3/3/18	Medical Risk Management Risk management: Avoiding Medical System Failures	6 Credit Hrs
3/28/18	Med-IG Can a known complication be Malpractice	1 Credit Hr
4/1/18	David Geffen School of Medicine at UCLA Comprehensive Review and Update of Whats new in Vascular and Endovascular Surgery	25 Credit Hrs

EXHIBIT 3

EXHIBIT 3

Jonathan Lanzkowsky, M.D., F.A.C.O.G
1107 5th Avenue, Suite 1e
New York, N.Y. 10128

Mr. Terry;

As you are aware I am a board-certified obstetrician-gynecologist who has been in continuous practice since 1996. I admit my obstetrical patients to the Mount Sinai Hospital in NYC and am a Clinical Instructor in Obstetrics and Gynecology at The Mount Sinai School of Medicine. With my partners, I manage and deliver 1000 obstetrical patients per year and have personally delivered more than 6500 women. At your request I reviewed the records concerning Alina Badoi and the care she received during her May 2017 admission to St. Rose-Siena Hospital in Henderson, Nevada.

Briefly, this was the first pregnancy for this 41-year-old women. She had a past medial history that was significant only for Hashimoto's thyroiditis and persistent hypothyroidism following a thyroidectomy that was complicated by the development of a hematoma. She took Tirosint for thyroid supplementation. She also had a history of ovarian cysts and menorrhagia (heavy menses).

Ms. Badoi initiated prenatal care on 10/07/2016 at 9 weeks 2 days. She would have been considered to have a High-Risk Pregnancy based on her advanced maternal age and history of hypothyroidism. Advanced maternal age is a significant risk factor for fetal growth restriction, fetal demise, gestational diabetes, hypertensive disorders of pregnancy including pre-eclampsia and eclampsia, poor maternal outcomes to name a few. She was compliant with her visits. Her prenatal care was initially uncomplicated, she did develop thrombocytopenia at 24 weeks as demonstrated by a CBC that showed a platelet count of 124,000 additionally, she was noted to have a severe anemia with a hemoglobin of 8.3 at that time. This low platelet count was likely due to gestational thrombocytopenia at that time in her pregnancy as this is a common finding in the mid to late trimesters. Of note, despite her apparent compliance with oral iron therapy her anemia worsened implying that; either she did not have iron deficiency, or she was not properly absorbing iron from the gut. She was therefor scheduled for intravenous iron therapy.

Ms. Badoi also developed polyhydramnios (excessive amniotic fluid) which has many known causes but is often idiopathic. She was correctly scheduled for induction of labor for polyhydramnios at 39 weeks on 05/09/20216 and although not mentioned, she should have been induced at that time for advanced maternal age in any event due to the risk of sudden fetal death and the increasing risks for the development of hypertensive disorder in this age group. Her induction was ultimately delayed due to an unfavorable cervix (with the reasoning that a poor cervical exam may increase the chances of failed inductions and increase the risk of cesarean section) it was rescheduled for 05/15/2016 at 40 weeks and 5 days.

In any event the patient was admitted for induction on the 15th of May. On admission the patient was noted to have elevated blood pressure, proteinuria, and low platelets. These findings meet the criteria for pre-eclampsia. She evidenced systolic blood pressures of greater than 165 and therefore met criteria for pre-eclampsia with severe

features. This diagnosis would not be made by the medical staff until nine hours after her first severe elevation in blood pressure.

On May 16th at 0058 hours the patient was evaluated for epidural placement which was delayed secondary to the patient's history of presumed gestational thrombocytopenia and having an active nosebleed. The anesthesiologist requested a repeat platelet count based on these findings and when the platelet count returned in the normal range, he placed the epidural was indeed placed at 0836 hrs.

At 0641 the patient had severe range blood pressures and nursing notified Dr. Herplosheimer who treated the elevation with i.v. hydralazine to control the BP. Despite the patient having multiple elevations in blood pressure in the severe range Magnesium Sulfate (MgSO4) was not ordered until 0945. Missing the significance of Ms. Badoi's elevated BP's by medical and nursing staff is a breach of the standard of care and led to delayed treatment with Magnesium Sulfate and/or other medications to lower her BP. Mg So4 is given to reduce the risks of seizure due to worsening pre-eclampsia and has the additional side effect of lowering maternal BP though it is not given for that purpose per-se.

On May 16, 2017, Ms. Badoi delivered a female infant 6lbs. 7oz. with Apgars of 9/9 at 1451 hrs. Although delivery is the ultimate treatment for pre-eclampsia the disease-process does not cease immediately at delivery and can often take days and sometimes weeks to resolve. The patient remains at risk for complications of pre-eclampsia with the greatest elevations in BP occurring in the immediate postpartum period. It is for this reason that MgSO4 is continued for 24 hours following delivery as the risk of seizure development remains high following delivery as was done here. Ms. Badoi had her epidural catheter removed at 1745 hrs.

On the postpartum floor at 2045 hrs., Ms. Badoi complained of tingling in her legs and when notified Dr. Garg was notified, he ordered the MgSo4 held for one hour concerned that this was a possible reaction to MgSO4. Although her symptoms did not improve and in fact worsened during this time, the MgSo4 was restarted, and no effort was made to ascertain the cause of Badoi's symptoms having ruled out MgSO4 toxicity as a cause. Failing to re-evaluate Ms. Badoi after MgSo4 was discontinued to see if symptoms improved was a breach of the standard of care.

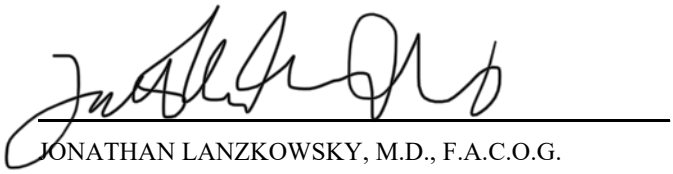
Of significant concern the patient continued to have severe range BP that should have been treated with fast acting anti-hypertensives (like hydralazine). On 05/17/2017 at 0402, Nurse Taylor informed the attending OB Dr. Garg that Ms. Badoi's BP was 182/99. This elevated BP required immediate medical treatment and failure to render such care was a breach of the standard of care Ms. Badoi's repeat BP 15 minutes was later was 183/97 which also went untreated. The patient continued to have a BP in severe ranges with worsening neurologic symptoms in her lower extremities., At 0435, Nurse Taylor again called Dr. Garg who ordered oral labetalol. Nurse Taylor correctly queried Dr. Garg to be certain he did not want to give IV hydralazine, he declined and ordered labetalol and, of note, did not evaluate the patient. The management of these pressures with oral antihypertensives was a breach of the standard of care. Finally, at 0547 when contacted again regarding Ms. Badoi's BP of 183/98, Dr. Garg ordered a small dose (5mg) of IV hydralazine. This was an unusually small dose that had a predictable minimal effect on Ms. Badoi's pressures which remained in the severe range (167/97 at 0602 hrs.). By 0626 hrs. Ms. Badoi's labs returned confirming HELLP syndrome (High BP, Elevated Liver enzymes, Low Platelets) a form of severe pre-eclampsia. As the patient's neurologic injuries progressed, she continued to have significantly elevated and untreated severe BP, treated only with

oral Labetalol until 1824 hrs. when she was given an additional 20mg of Hydralazine as a standing order about one hour later she is transferred to the ICU. The management of these pressures with oral antihypertensives represents a breach of the standard of care.

It is my opinion to a reasonable degree of medical certainty that the nursing and medical staff at St. Rose-Siena breached the standard of care by improperly treating Ms. Badoi's hypertension, especially during the postpartum period. Improperly treated hypertension is a known risk factor for vascular injury and hemorrhagic stroke and may have contributed to the worsening of this patient's intradural bleeding. I reserve the right to modify and/or add to these opinions based upon additional information.

I declare under penalty of perjury under the law of the State of Nevada that the foregoing is true and correct.

Executed this 24 day of May, 2022



JONATHAN LANZKOWSKY, M.D., F.A.C.O.G.

Jonathan Lanzkowsky, MD, FACOG
71 Homestead Rd. Tenafly, NJ 07670
201 569-4343

Date of Birth: June 03, 1966

Birth Place: New York, NY

Certification: 1994 Diplomate National Board of Medical Examiners

1999 Board Certified American College of Obstetrics and Gynecology

2000 Fellow of the American College of Obstetrics and Gynecology

Licensure: New York State License 201530
New Jersey State License 25MA07181400 (on hold)
DEA BL5231067

Medical Education: 1993-1997 Internship and Residency in Obstetrics and Gynecology Albert Einstein College of Medicine/Montefiore Medical Center, Bronx, NY
Administrative Chief Resident 1997
Award for Special Excellence in Edoscopic Surgery
American College of Gynecologic Laparoscopists
Lewis Award for Operative Obstetrics

1989-1993 Finch University of Health Sciences/the Chicago Medical School, North Chicago, IL
Doctor of Medicine

Undergraduate Education: 1985-1988 New York University
Bachelor of Arts

1984-1985 Adelphi University
Transferred to NYU

Employment:

July 1997-November 2000
Partner in private practice
Alan Adler MD, PC
New York, NY

December 2000- June 2008
Partner in private practice
Kerenyi, Scher, Grazi, MD, PC
New York, NY

July 2008- Present
Founding partner in private practice
Victor M. Grazi, MD, Andrew R. Kramer, MD &
Jonathan Lanzkowsky, MD, PC
New York, NY

2010-2015
Medical Director for "PregPrep" corporation

2013-2015
Division Head, Division of Women's Health / The
Refuah Health Center, Spring Valley, NY

Professional Organizations:

The American College of Obstetrics and Gynecology
Fellow/Diplomate

Physician for Reproductive Choice and Health
William K. Rashbaum and George Tiller Award Board
Member

Mount Sinai Hospital Department of Obstetrics Policy
Improvement Committee member 2007-2014

,

Mount Sinai Hospital Gynecology Department Performance
Improvement and Quality Assurance Committee member
2014- present

Hospital Affiliations:

Mount Sinai Medical Center
New York, NY
Department of Ob/Gyn
Attending Physician

Teaching Positions:

Mount Sinai School of Medicine
New York, NY
Department of Ob/Gyn and Woman's Health
Clinical Instructor

Expert Testimony:

06/03/2009, 06/08/2009- Murray- Davison v. Ennin
(Brooklyn County Court, Brooklyn, NY)- defense verdict

02/13/2008- Caroll v. Betancourt
(Manhattan County, NY, NY)- defense verdict

4/20/2012- Cheeks v. Allen and Bronx Lebanon
(Bronx County, NY)- defense verdict

2/2014- Akalski v. Lipton, (White Plains, NY)- defense verdict

10/2019- Breve v. Lutheran Medical Center, et al.- settled
Pre-verdict

9/2021- Elkind v. Cleary and NYPH et al. - defense verdict
(Kings County, NY)

Reviewed 10/3/2021

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Dignity Health, a Foreign Non-Profit Corporation
d/b/a St. Rose Dominican Hospital – Siena Campus

DISTRICT COURT

CLARK COUNTY, NEVADA

LIVIU RADU CHISIU, as Special Administrator for the ESTATE OF ALINA BADOI, Deceased; LIVIU RADU CHISIU, as Parent and Natural Guardian of SOPHIA RELINA CHISIU, a minor, as Heir of the ESTATE OF ALINA BADOI, Deceased Plaintiffs, vs. DIGNITY HEALTH, a Foreign Non-Profit Corporation d/b/a ST. ROSE DOMINICAN HOSPITAL – SIENA CAMPUS; JOON YOUNG KIM, M.D., an Individual; U.S. ANESTHESIA PARTNERS, INC., a Foreign Corporation; DOES I through X, inclusive; and ROE BUSINESS ENTITIES XI through XX, inclusive, Defendants.	CASE NO.: A-18-775572-C DEPT NO.: 9 **ORDER GRANTING DEFENDANT DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL'S MOTION FOR SUMMARY JUDGMENT**

Defendant Dignity Health d/b/a St. Rose Dominican Hospital – Siena Campus' Motion for Summary Judgment came before the Court on June 22, 2022. Plaintiffs appeared by and through their counsel, Kendelee Leascher Works, Esq. of Christiansen Trial Lawyers; Defendants Joon Young Kim, M.D. and U.S. Anesthesia Partners, Inc., appeared by and through

their attorney, Adam Schneider, Esq. of the law firm of John Cotton & Associates; and Defendant Dignity Health d/b/a St. Rose Dominican Hospital – Siena Campus appeared by and through its attorney, Tyson J. Dobbs, Esq. of the law firm HALL PRANGLE & SCHOONVELD, LLC.

The Court having reviewed the pleadings and papers on file by the parties and hearing the oral arguments relating thereto, and good cause appearing, hereby enters the Following Findings of Fact, Conclusions of Law, and Order:

FINDINGS OF FACT

1. Alina Badoi was admitted to St. Rose Hospital on May 15, 2017, for induction of labor. During her labor an epidural was administered by an anesthesiologist, Defendant Joon Young Kim.

2. Ms. Badoi remained hospitalized at St. Rose from May 15, 2017, until she passed away on June 3, 2017.

3. Plaintiff alleges negligence by Dr. Kim associated with the placement of the epidural. Plaintiff further alleges Dignity Health is vicariously liable for Dr. Kim's negligence via agency and/or ostensible agency.

4. Defendant Dr. Kim is not an employee of St. Rose Hospital and never has been. At the time Dr. Kim provided medical care to Ms. Badoi, he was an employee of a physician group practice with which St. Rose contracted to provide professional consultation and treatment of patients in need of emergency Specialty medical care who present to St. Rose's emergency department or who are inpatients.

5. At the time he provided medical treatment to Alina Badoi, Dr. Kim had privileges to practice anesthesiology at eight hospitals in Las Vegas, including St. Rose Hospital, in addition to several surgical centers.

6. Dr. Kim's practice group decided the hospital at which Dr. Kim would work on a given day, including May 15, 2017, when he administered an epidural to Ms. Badoi at St. Rose Hospital. Dr. Kim's practice group made all his scheduling assignments. For obstetrics labor

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and delivery assignments, hospital assignments were typically made a month or two in advance. St. Rose Hospital was not responsible for setting Dr. Kim's schedule.

7. Dr. Kim had never seen Ms. Badoi in person prior to her admission to St. Rose.

8. During Alina Badoi's treatment, physicians treating patients at St. Rose Hospital, including anesthesiologists, were not employees of the Hospital.

9. As of May 15, 2017, Alina Badoi had been employed at St. Rose Hospital as a social worker for more than three years, working closely with nurses and physicians for approximately 40 hours per week during that time.

10. Liviu Chisiu, Ms. Badoi's partner of five years, and the Special Administrator for the Estate of Alina Badoi and parent and natural guardian of Sophia Relina Chisiu, a minor, as heir of the Estate of Alina Badoi, testified he assumed that as an employee of St. Rose Hospital for three years prior to her death, Ms. Badoi probably had some knowledge as to the relationship between the hospital and physicians. At his deposition Mr. Chisiu testified he believed Dr. Kim worked for U.S. Anesthesia Partners.

11. Dr. Kim testified he did not talk to Ms. Badoi or Mr. Chisiu about whether he was independent from St. Rose Hospital.

12. On January 31, 2017, during a preadmission visit to St. Rose Hospital prior to the date of her admission on May 15, 2017, Ms. Badoi signed paperwork in anticipation of her admission to deliver her baby.

13. In this preadmission paperwork, entitled the Conditions of Admission, Ms. Badoi expressly acknowledged that the physicians that would be treating her at St. Rose Hospital were not employees or agents of St. Rose Hospital.

14. Ms. Badoi separately initialed a paragraph entitled "Legal Relationship between Hospital and Doctors", that expressly states in part:

> Doctors and Surgeons providing services to the Patient, including the radiologist, pathologist, emergency doctors, hospitalists, anesthesiologist, intensive care doctors and others, are not employees or agents of the Hospital. They have been granted the privilege of using the hospital for the care and treatment of their

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> patients, but they are not employees. ***You will receive a separate bill from the doctors for their services***.

(emphasis in original).

15. Ms. Badoi also expressly certified that her signature on the Conditions of Admission meant that she had read and understood the form and was given the opportunity to ask questions.

16. When Ms. Badoi presented to the hospital on May 15, 2017, for the scheduled induction of labor for the delivery of her child, she executed another consent form entitled "Consent for Procedure".

17. That form identifies the procedure to be performed as "Vaginal Delivery with or without Episiotomy with Repair." The physician performing the procedure is identified as Dr. Herpolsheimer. As to the relationship between Dr. Herpolsheimer and the hospital, the form expressly states:

> Dr. Herpolsheimer is the physician who will perform your procedure. The procedure physician is an independent contractor and is not an employee, representative, or agent of the Hospital.

18. The Consent for Procedure form also has a section that identifies the anesthesia contemplated for the procedure. That section further states that "[a]nesthesiologists and CRNA's are independent practitioners and are not employees or agents of the Hospital."

19. Ms. Badoi executed the consent form on May 15, 2017, at 1545, acknowledging that she had read and understood the information contained therein.

20. Thereafter, Ms. Badoi underwent several additional procedures over the next few weeks at St. Rose Hospital, including a laminectomy, lumbar drain placement, peripheral catheter placement, ventriculostomy, and CT of the head. For each of these procedures Ms Badoi or her representative executed a consent that states that the physician performing the procedure is "not an employee, representative, or agent of the Hospital." Each of these consents also states that "[a]nesthesiologists and CRNA's are independent practitioners and are not employees or agents of the Hospital."

21. Ms. Badoi passed away while still hospitalized at St. Rose Hospital on June 3, 2017.

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22. There is no evidence of any affirmative statement from Ms. Badoi in the form of a Declaration, Affidavit, or Answers to Interrogatories concerning Ms. Badoi's belief regarding Dr. Kim's relationship to St. Rose Hospital because Ms. Badoi is deceased.

CONCLUSIONS OF LAW

23. NRCP 56 allows for summary judgment when there is no genuine issue of material fact and the moving party is entitled to a judgment as a matter of law. *Busch v. Flangas* 108 Nev. 821, 837 P.2d 438 (1992). Summary judgment does not involve resolution of factual issues but seeks to discover if any real issue of fact exists. *Daugherty v. Wabash Life Insurance Co.*, 87 Nev. 32, 482 P.2d 814 (1971).

24. Where an essential element of a claim for relief is absent, summary judgment is proper. *Bulbman. Inc. v. Nevada Bell* 108 Nev. 105, 111, 825 P.2d 588, 592 (1992). The party opposing summary judgment must set forth specific, admissible evidence which supports her claim. *Posadas v. City of Reno* 109 Nev. 448, 452, 851 P.2d 438, 442 (1993). A party opposing summary judgment may not rely on the allegations of her pleadings to raise a material issue of fact where the moving party supports his motion with competent evidence. *Barmettler v. Reno Air, Inc.* 956 P.2d 1382 (Nev. 1998).

25. The nonmoving party bears the burden of showing there is more than "some metaphysical doubt" as to the operative facts in order to avoid summary judgment being entered in the moving party's favor. *Wood v. Safeway* 121 Nev. 724, 121 P.3d 1026 (2005).

26. "The existence of an agency relationship is generally a question of fact for the jury if the facts showing the existence of agency are disputed, or if conflicting inferences can be drawn from the facts." *Schlotfeldt v. Charter Hosp. of Las Vegas*, 112 Nev. 42, 47, 910 P.2d 271, 274 (1996) (citing *Latin American Shipping Co. Inc., v. Pan American Trading Corp.*, 363 So.2d 578, 579–80 (Fla.Dist.Ct.App.1978)). However, "[a] question of law exists as to whether sufficient competent evidence is present to require that the agency question be forwarded to a jury." *Id*. (citing *In re Cliquot's Champagne*, 70 U.S. 114, 140, 18 L.Ed. 116 (1865)).

27. The determination of "whether an issue of fact exists for a jury to decide is similar to determining whether a genuine issue of fact is present to preclude summary

judgment." *Id*. (citing *Oehler v. Humana, Inc.*, 105 Nev. 348, 351-352, 775 P.2d 1271, 1273 (1989)).

28. "The general rule of vicarious liability is that an employer is liable for the negligence of its employee but not the negligence of an independent contractor." *McCroskey v. Carson Tahoe Regional Medical Center*, 408 P.3d 149 (Nev. 2017) (citing *Oehler v. Humana Inc.*, 105 Nev. 348, 351, 775 P.2d 1271 (Nev. 1989)).

29. An exception to this rule exists when a hospital (1) selects the doctor to treat the patient and (2) the patient reasonably believes that the doctor is employed by the hospital. *Id*. (emphasis added) (citing *Renown Health, Inc. v. Vanderford*, 126 Nev. 221, 228, 235 P.3d 614, 618 (2010); *see also Schlotfeldt v. Charter Hosp. of Las Vegas*, 112 Nev. 42, 48, 910 P.2d 271, 275 (1996). If such is the case, the hospital may be "vicariously liable for the doctor's actions under the doctrine of ostensible agency." *Id*. (citing *Schlotfeldt v. Charter Hosp. of Las Vegas*, 112 Nev. 42, 48, 910 P.2d 271, 275 (1996)). On the contrary, a conclusion that "agency does not exist requires only the negation of one element of the agency relationship." *Schlotfeldt*, at n. 3.

30. "[A] doctor's mere affiliation with a hospital is not sufficient to hold a hospital vicariously liable for the doctor's negligent conduct." *Id*. at 48. And "a hospital does not generally expose itself to vicarious liability for a doctor's actions by merely extending staff privileges to that doctor." *Id.*

31. With respect to ostensible agency, the Nevada Supreme Court has stated that "typical questions of fact for the jury include, 1) whether a patient entrusted herself to the hospital; 2) whether the hospital selected the doctor to serve the patient; 3) whether a patient reasonably believed the doctor was an employee or agent of the hospital; and 4) whether the patient was on notice that a doctor was an independent contractor." *Id*. at 49.

32. Here, it is undisputed that Dr. Kim was not an employee of St. Rose Hospital but an independent contractor. Accordingly, there can be no vicarious liability premised on an actual agency relationship between Dr. Kim and St. Rose Hospital.

33. With respect to ostensible agency, there is no evidence of any affirmative statement from Ms. Badoi in the form of a Declaration, Affidavit, or Answers to Interrogatories

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to support a conclusion that Ms. Badoi held a reasonable belief that Dr. Kim was an agent or employee of St. Rose Hospital because Ms. Badoi is deceased.

34. On the contrary, the only evidence of Ms. Badoi's subjective belief regarding the relationship between Dr. Kim and the hospital is set forth in the various hospital forms she signed. Ms. Badoi acknowledged reading and understanding the forms, which notified her of the independent contractor status of anesthesiologists such as Dr. Kim. *See e.g. McCroskey v. Carson Tahoe Regional Medical Center*, 408 P.3d 149 (Nev. 2017) (explaining that "whether the patient was put on notice that a doctor was an independent contractor" is a factor considered to determine the reasonableness of a patient's believe about the agency status of a physician) (citing *Schlotfeldt v. Charter Hosp. of Las Vegas,* 112 Nev. 42, 48, 910 P.2d 271, 274 (1996)).

35. There was no evidence presented to suggest that Ms. Badoi did not have an opportunity to review the forms signed. Indeed, Ms. Badoi was not emergently admitted to the hospital nor admitted in labor. She presented to the hospital for a scheduled induction of labor after previously presenting to the same hospital to sign preadmission paperwork. Furthermore, as a Dignity Health social worker working in a hospital setting with physicians for three years Ms. Badoi was not a typical patient.

36. Lastly, unlike situations in which a plaintiff offers a declaration or testifies regarding her subjective belief, Ms. Badoi is deceased. There will be no forthcoming declaration or testimony from her to contradict the representations in the existing evidence regarding her acknowledgement of Dr. Kim's relationship to the hospital. Accordingly, relief under NRCP 56(d) to conduct additional discovery is unwarranted. *See Aviation Ventures, Inc. v. Joan Morris, Inc.*, 121 Nev. 113, 118, 110 P.3d 59, 62 (2005) (holding motions for NRCP 56(d) relief are "appropriate only when the movant expresses how further discovery will lead to the creation of a genuine issue of material fact"); *see also See Feliciano v. American West Homes, Inc.*, 2012 Nev. Unpub. LEXIS 1087, 2012 WL 3079106, July 27, 2012, unpublished disposition at n. 5 (finding it within the Court's discretion to deny a motion for a continuance as futile where the requested depositions of defendant's principals were unlikely to produce relevant evidence).

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37. Summary judgment is therefore appropriate as there has to be a material issue of fact, not just an issue of fact. And there is no genuine issue of material fact for trial as to Plaintiff's claim for vicarious liability against St. Rose Hospital for the alleged negligence of Dr. Kim. The evidence is insufficient to establish the elements necessary to prove an ostensible agency relationship between St. Rose Hospital and Dr. Kim, or to "require the agency question be forwarded to a jury". *See, e.g. Schlotfeldt v. Charter Hosp. of Las Vegas*, 112 Nev. 42, at n.4, 910 P.2d 271 (1996) (citing *In re Cliquot's Champagne,* 70 U.S. 114, 140, 18 L.Ed. 116 (1865)).

ORDER

IT IS THEREFORE ORDERED, AJUDGED, AND DECREED that Defendant Dignity Health d/b/a St. Rose Dominican Hospital – Siena Campus' Motion for Summary Judgement is GRANTED as to Plaintiffs' claim for Vicarious Liability/Agency/Ostensible Agency for the alleged professional negligence of Defendant Joon Young Kim.

IT IS SO ORDERED.

Dated this 15th day of August, 2022

Maria Gall

4F8 226 1153 DF77
Maria Gall
District Court Judge

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Respectfully Submitted by: **HALL PRANGLE & SCHOONVELD, LLC** _____/s/ Tyson Dobbs_____ MICHAEL E. PRANGLE, ESQ. Nevada Bar No. 8619 TYSON J. DOBBS, ESQ. Nevada Bar No. 11953 1140 North Town Center Drive, Ste. 350 Las Vegas, Nevada 89144	Approved as to Form and Content: **CHRISTIANSEN LAW OFFICES** ____/s/ Keely Chippoletti _____ PETER S. CHRISTIANSEN, ESQ. Nevada Bar No. 5254 R. TODD TERRY, ESQ. Nevada Bar No. 6519 KEELY P. CHIPPOLETTI, ESQ. Nevada Bar No. 13931 810 S. Casino Center Blvd., Ste. 104 Las Vegas, Nevada 89101 *Attorneys for Plaintiffs*
Approve as to form and content: JOHN COTTON & ASSOCIATES /s/ Adam Schneider Adam Schneider, Esq. 7900 W. Sahara Ave. Suite 200 Las Vegas Nevada 89117 *Attorneys for U.S. Anesthesia Partners, Inc. and Joon Young Kim, M.D.*	

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Nicole M. Etienne

From: Keely Perdue <keely@christiansenlaw.com>
Sent: Monday, August 15, 2022 9:04 AM
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Cc: Adam Schneider; Tyson Dobbs; Todd Terry; Arielle Atkinson; Aileen Bencomo; Jonathan Crain; Kendelee Works
Subject: Re: Order Granting Agency MSJ (Badoi)

[External Email] CAUTION!.

You can use my e-signature. Thank you.

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On Aug 12, 2022, at 8:42 AM, Adam Schneider <aschneider@jhcottonlaw.com> wrote:

Nicole- permission granted. Thank you kindly.

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Subject: Order Granting Agency MSJ (Badoi)

Attached please find the Order Granting Motion for Summary Judgment. Please let me know if I have your permission to electronically sign.

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CSERV

DISTRICT COURT
CLARK COUNTY, NEVADA

Estate of Alina Badoi, Plaintiff(s)	CASE NO: A-18-775572-C
vs.	DEPT. NO. Department 9
Dignity Health, Defendant(s)	

AUTOMATED CERTIFICATE OF SERVICE

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Order Granting Summary Judgment was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:

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DISTRICT COURT

CLARK COUNTY, NEVADA

LIVIU RADU CHISIU, as Special Administrator for the ESTATE OF ALINA BADOI, Deceased; LIVIU RADU CHISIU, as Parent and Natural Guardian of SOPHIA RELINA CHISIU, a minor, as Heir of the ESTATE OF ALINA BADOI, Deceased Plaintiffs, vs. DIGNITY HEALTH, a Foreign Non-Profit Corporation d/b/a ST. ROSE DOMINICAN HOSPITAL – SIENA CAMPUS; JOON YOUNG KIM, M.D., an Individual; U.S. ANESTHESIA PARTNERS, INC., a Foreign Corporation; DOES I through X, inclusive; and ROE BUSINESS ENTITIES XI through XX, inclusive, Defendants.	CASE NO.: A-18-775572-C DEPT NO.: 9 **DEFENDANT DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL'S MOTION FOR RECONSIDERATION OF THE ORDER GRANTING PLAINTIFFS' MOTION FOR LEAVE TO FILE AMENDED COMPLAINT** **HEARING REQUESTED**

COMES NOW, Defendant, ST. ROSE DOMINICAN HOSPITAL – SIENA CAMPUS, by and through its attorneys of record, HALL PRANGLE & SCHOONVELD, LLC, hereby files

this Motion for Reconsideration of the Order Granting Plaintiffs' Motion for Leave to File Amended Complaint. This Motion is supported by the attached Points and Authorities.

DATED this 19th day of August, 2022.

HALL PRANGLE & SCHOONVELD, LLC

By: */s/:Tyson J. Dobbs*

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MEMORANDUM OF POINTS AND AUTHORITIES

I.

INTRODUCTION

St. Rose Hospital respectfully requests reconsideration of this Court's order granting Plaintiff leave to amend the complaint. Since the motion was granted, there has been new facts disclosed, which confirm Plaintiff's Motion to Amend was not evaluated under the appropriate standard of review and should have been denied.

Specifically, and as set forth in detail below, Plaintiff's Motion to Amend was filed on the last day to file motions to amend pleadings or add parties, May 2, 2022, after the case had been litigated for four years. The Motion attached a proposed amended complaint that detailed additional allegations of negligence by unidentified nurses and physicians at St. Rose Hospital. The proposed amended complaint stated that a "Declaration" of Jonathan Lanzkowsky, M.D. ("Declaration") was "attached" thereto, and "supported" the allegations in the proposed amended complaint. However, the referenced affidavit of merit was strangely missing from the proposed amended complaint, notwithstanding the express requirement in EDCR 2.30 that any such exhibit be attached to a proposed amended complaint. *See* EDCR 2.30 (requiring that "all" exhibits "must" be attached to amended pleadings, and that a proposed amended pleading "must" be attached to a motion for leave to amend)

The reason the Declaration was not attached to the proposed amended complaint only recently became clear upon the filing of Plaintiffs' amended complaint – *the Declaration simply did not exist.* Indeed, the Declaration was created on May 24, 2022, *three weeks after the Motion to Amend was filed and three weeks after the deadline to file a motion to amend had expired.* Accordingly, the representation that the Declaration was attached and supported the proposed amended complaint was knowingly false.

Moreover, Plaintiffs' Motion to Amend was proffered to the Court as a motion "to conform to the evidence unearthed in discovery." *See* Motion at 1:28-2:1. The revelations in the Declaration confirm this was also a demonstrably false premise for the Motion to Amend. The Declaration makes it clear that Dr. Lanzkowsky did not review any of the discovery conducted

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over the course of the four years in which this litigation was pending. Rather, he reviewed the very same medical records Plaintiffs have had within their possession for five years – the same medical records that provided the basis for the two expert affidavits attached to the original complaint.

Both these misrepresentations are critical to the Court's ruling on the Motion to Amend as it led the Court to evaluate the merits of the motion under *only* NRCP 15(a), although it should have first been evaluated under NRCP 16(b). *See Nutton v. Sunset Station, Inc*., 131 Nev. 279 (2015) (holding that "when a motion seeking leave to amend a pleading is filed after the expiration of the deadline for Filing such motions, the district court must first determine whether 'good cause' exists for missing the deadline under NRCP 16(b) before the court can consider the merits of the motion under the standards of NRCP 15(a)"); *see also* EDCR 2.30 (stating that "[a]ll *amended pleadings* must contain copies of all exhibits referred to in such amended pleadings[,]" and that "[a] copy of a proposed *amended pleading* *must be attached* to any motion to amend the pleading" (emphasis added)).

Here, an NRCP 16(b) "good cause" analysis was not undertaken because Plaintiffs misrepresented the timeliness of their motion. Pursuant to EDCR 2.30 the Motion could not, and should not have been filed until May 24, 2022, when the Declaration was created. Knowing this, Plaintiffs misrepresented the existence of the Declaration in both the motion and the proposed amended complaint. Again, had Plaintiffs properly obtained the Declaration before filing the Motion to Amend, it would have been *objectively* untimely, and Plaintiff would have to have shown good cause for the delay. This would have been impossible, however, since the Declaration itself is based exclusively on the medical records Plaintiffs' have had within their possession since day one. Thus, Plaintiffs' pronouncement that the motion was brought to "conform to the evidence unearthed in discovery" is, again, a blatant misrepresentation made to circumvent Nevada law and gain an advantage in this litigation.

In summary, Plaintiffs' misrepresentations about the existence of the Affidavit and the basis thereof, misled this Court's analysis. Plaintiffs' Motion was not properly before the Court under EDCR 2.30 and should have been analyzed under the standards set forth in *Nutton*. Under

such an analysis, it is clear there was no good cause for the delay. Moreover, Plaintiffs' misrepresentations are further evidence that the Motion itself was dilatory and brought in bad faith under NRCP 15. The Court should therefore reconsider its order and deny Plaintiff's Motion for Leave to Amend.

II.

RELEVANT FACTS AND PROCEDURAL HISTORY

A. Plaintiffs' Complaint and the information available at the time the original Complaint was filed four years ago.

Four years ago, on June 5, 2018, Plaintiff filed the Complaint alleging professional negligence by an anesthesiologist, Defendant Dr. Joon Young Kim, M.D. *See* Plaintiff's original Complaint. The Complaint alleges Dr. Kim failed to "fully assess Alina Badoi's bleeding risk prior to placing the epidural catheter for labor analgesia;" and then erred by placing "the epidural in a patient at significant risk for bleeding." *See* Exhibit A at ¶ 22.

The Complaint included two Declarations from physicians. The first was from Yaakov Beilin, M.D., who reviewed the St. Rose Hospital records and concluded that "[t]he records show that Alina had *preeclampsia, [and] a dramatic variation in platelet counts . . .*" He thus concludes that Dr. Kim was negligent by (1) failing to full assess Alina's bleeding risk; and (2) by placing the epidural catheter. He opines that these failures caused the hematoma in Alina Badoi's spine. *See* Dr. Beilin's Declaration attached to the original Complaint.

The second Declaration is that of Bruce Hirschfeld. Dr. Hirschfeld reviewed Alina Badoi's prenatal records, hospital records, death certificate, coroner's report, and several other records. In fact, he specifically states that he was in possession of 4,422 pages of St. Rose Hospital records for Alina Badoi. From those records Dr. Hirschfield provides a comprehensive timeline of the treatment, that includes a discussion of all the facts pertinent to Plaintiff's new allegations in the proposed amended Complaint, including Ms. Badoi's platelet levels, elevated blood pressure, epidural catheter removal, subsequent complaints of numbness, tingling and inability to stand, the orders and treatment regarding magnesium sulfate, the timing of the MRIs, and a discussion of HELLP syndrome. Nevertheless, Dr. Hirschfield's opinion is limited to

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causation – that the epidural placed by Dr. Kim ultimately caused the bleed that caused the pulmonary embolism that caused Ms. Badoi's death. *See* Dr. Hirschfeld's Declaration attached to the original Complaint.

Accordingly, there were no independent criticisms of St. Rose Hospital in the expert affidavit. Thus, the sole theory of liability against St. Rose Hospital was derivative of the alleged professional negligence of Dr. Kim.[1] *Cf.* NRS 41A.071 (requiring an affidavit of merit that identifies each provider of health care a plaintiff contends was negligent, and that sets forth "a specific act or acts of alleged negligence separately as to each defendant . . .").

B. <u>In 2019 Plaintiff confirmed knowledge of all the allegations and criticisms set forth in the proposed amended Complaint.</u>

Nearly three years ago, on December 4, 2019, Defendants took the deposition of the administrator of Alina Badoi's estate, Plaintiff Liviu Chisiu. Mr. Chisiu was Ms. Badoi's partner and the father of her child. He testified that even before Alina's death he requested and received her medical records because he realized that something was "not quite right" with her treatment. *See* Excerpts of Deposition Transcript of Liviu Chisiu, at 143:14-144:10, attached hereto as **Exhibit A**. Plaintiff testified that within a month of Alina's Badoi's death in June 2017, he consulted an attorney for a potential lawsuit. *Id*. at 149:23-150:12.

In December of 2019, Plaintiff also testified about his firsthand observations of the treatment provided to Alina regarding her high blood pressure – which is a new criticism levied in the amended complaint. He even raised these concerns with the nurses and physicians at the time. *Id*. at 170:1-175:15.

Notwithstanding Plaintiff's testimony years ago, there was no discovery conducted by Plaintiff for over a year and there were no motions to amend the complaint filed until the Motion to Amend filed on May 2, 2022.

---

[1] Based on the factual allegations, the Complaint included six separate causes of action: (1) Professional Negligence (2) Negligent Credentialing; (3) Fraudulent Concealment and/or Omissions; (4) Negligent Hiring, Training, Retention and Supervision; (5) Ostensible Agency/Vicarious Liability; and (6) Wrongful Death Pursuant to NRS 41.085.

On January 29, 2021, Judgment on the Pleadings was granted under NRS 41A.071 as to Plaintiff's claims for Negligent Credentialing and Negligent Hiring, Training, and Supervision.

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C. Plaintiffs waited three years to take depositions and no discovery was conducted after November 2021.

Plaintiff finally began taking depositions of in February of 2021 – just under three years from the filing of the Original Complaint. Between February 18, 2021, and November 22, 2021, Plaintiff took ten depositions of various nurses and physicians involved in Alina Badoi's treatment. The hospital nursing staff deposed included Mary Brown, RN (June 16, 2021), Krista Molinaro Fulks, RN (October 4, 2021), Delaney McCoy, RN (October 6, 2021), and Tracy Jones, RN (October 6, 2021). Plaintiff also deposed Alina's treating physicians, Dr. Herpolsheimer and Dr. Garg, with whom she treated both before and at the hospital. Dr. Herpolsheimer's deposition was taken in two installments on January 15, 2021 and May 15, 2021. Dr. Garg's deposition was taken on November 22, 2021.

D. St. Rose Hospital's Motion for Judgment on the Pleadings and Plaintiff's stipulation that the sole claim for relief was Vicarious Liability for Dr. Kim.

At the conclusion of the depositions taken of its staff, St. Rose Hospital filed a Motion for Summary Judgment and, alternatively, Motion for Partial Judgment on the Pleadings on October 18, 2021. At that time, Plaintiffs had been in possession of the 4,000+ pages of St. Rose Hospital records for four years, Plaintiff's deposition had been taken two years earlier, and nine of the ten depositions taken by Plaintiff had been completed.

The basis for the motion for summary judgment was the expiration of the statute of limitations given the Complaint was filed more than one year after the patient's death. The Motion for Partial Judgment on the Pleadings sought alternative relief by way of dismissal of the redundant multiple claims asserted in the Complaint, including wrongful death and professional negligence, since the factual allegations contemplated only a single claim for vicarious liability against St. Rose Hospital for the alleged malpractice of the anesthesiologist, co-defendant Dr. Kim. *See* Motion for Summary Judgment, filed on October 18, 2021.

On November 8, 2021, Plaintiff filed an opposition to the summary judgment motion. As it relates to the alternative relief, the Opposition amounted to a non-opposition as it conceded that the single theory of liability was Vicarious Liability against St. Rose Hospital for the alleged professional negligence of Dr. Kim. The Opposition did not request leave to amend despite the

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fact that Plaintiff had been in possession of the 4,000 pages of hospital records for four years, had those records reviewed by two medical experts, had the benefit of Plaintiff's deposition completed two years earlier, and Plaintiffs' counsel had completed nine additional depositions. *See* Plaintiff's Opposition to St. Rose Hospital's Motion for Summary Judgment, filed on November 8, 2021.

In fact, after the last deposition in this case was taken on November 22, 2021, the first hearing on the Motion for Summary Judgment was held on December 8, 2021. There was no suggestion at the hearing that Plaintiff would be seeking leave to amend the complaint.

Additionally, Plaintiff submitted supplemental briefing on January 10, 2021, and a second round of oral argument was entertained on February 2, 2022. Again, there was no suggestion that Plaintiffs intended to seek leave to amend the complaint.

The Court's minute order denying the Motion for Summary Judgment was issued on February 24, 2024, which set an additional hearing on the alternative relief for March 16, 2022.

On March 16, 2022, the Motion for Partial Judgment on the Pleadings came before the Court. At the hearing Plaintiffs' counsel reiterated the non-opposition to the motion, stating that the Complaint was indeed limited to a Vicarious Liability claim against St. Rose premised on Dr. Kim's conduct. Moreover, Plaintiffs' counsel was once again silent regarding any intention to amend the complaint. On the contrary, rather than await the Court's ruling on the Motion for Partial Judgment on the Pleadings, *Plaintiffs' counsel stipulated on the record that the Complaint against St. Rose Hospital is limited to a claim for vicarious liability based on the alleged professional negligence of the codefendant physician, Dr. Kim*. *See* Transcript of Hearing from March 16, 2022, attached hereto as **Exhibit B**.

The formal order regarding the Motion for Summary Judgment and Motion for Partial Judgment on the Pleadings was thereafter entered on Friday April 29, 2022. The Order expressly states:

> Per the stipulation of the parties at the hearing on Dignity Health's Motion for Partial Judgment on the Pleadings, IT IS HEREBY ORDERED AND DECREED THAT Plaintiffs' Complaint against Dignity Health d/b/a St. Rose Hospital – Siena Campus is limited to a cause of action for professional negligence based on a theory

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> of vicarious liability (i.e. actual agency/ostensible agency) for the alleged professional negligence of Defendant Joon Young Kim, M.D.

See Order Regarding Motion for Summary Judgment and Moton for Partial Judgment on the Pleadings, filed on April 29, 2022.

E. <u>Plaintiffs' Motion to Amend and representations regarding a Declaration that did not exist</u>.

On May 2, 2022, three days after this Order was entered confirming the limitation on Plaintiffs' claims, Plaintiff filed the Motion to Amend, which essentially sought to add multiple unidentified health care providers as defendants in this case, without technically adding them as parties.[2] This was notwithstanding the fact that nothing changed between the stipulation and order in March. In fact, there had been no additional discovery undertaken since November 2021.

The Motion to Amend was filed four years after the complaint was filed on the last day to amend pleadings and add parties set pursuant to the *tenth* extension of the deadlines. The Motion cites the language of the proposed amended complaint which asserts "additional allegations" of negligence as follows:

> 35. St. Rose's delay in treatment of Alina's significantly elevated and untreated severe blood pressure led to vascular injuries, including an epidural bleed and a brain bleed, and contributed to the pulmonary embolism which ultimately caused Alina's death.
>
> . . .
>
> 40. Defendants' treatment and care of Decedent fell below the applicable standard of care, including but not limited to:
>
> . . .
>
> c. Repeatedly failing to properly monitor or treat Decedent's elevated blood pressure.
>
> d. Awaiting necessary treatment which resulted in delays in diagnosing Decedent's condition.
>
> . . .
>
> 62. Decedent entrusted her care and treatment to Defendants; Defendant St. Rose selected Defendant Kim, an anesthesiologist, *and other nurses and physicians to monitor and*

[2] The proposed amended complaint includes no direct claims against St. Rose Hospital. The new claims are all premised on negligence of unidentified physicians or nurses for which Plaintiffs seek to subject the hospital to vicarious liability.

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> *treat Decedent and Decedent reasonably believed Defendant Kim and other nurses and physicians were employees or agents of Defendant St. Rose. . .*

The Motion then represents to the Court that these "additional allegations concerning St. Rose's breaches of the standard of care are supported by Plaintiffs' expert, Jonathan Lanzkowsky, M.D." *See* Motion at 6:9-10. The proposed amended complaint states that a Declaration from Dr. Lanzkowsky is "attached". However, there was no Declaration from Dr. Lanzkowsky attached to the proposed amended complaint.

Additionally, the Motion states multiple times that it was brought "to conform to the evidence unearthed in discovery." *See, e.g.* Motion at 1:28-2:1 and 6:20-21.

The Court did not entertain argument on the Motion. Rather the Court granted the Motion stating: "I have to give leave freely to amend and then you can file a Rule 12 Motion or whatever afterwards." *See* Transcript of Hearing, dated June 22, 2022, attached hereto as **Exhibit C**. The Court did not conduct an NRCP 16(b) analysis of "good cause" for the delay in bringing the motion, but was not aware that the affidavit of merit referenced in the Motion and proposed amended complaint did not exist.

F. <u>Plaintiff's Amended Complaint confirms Dr. Lanzkowsky's Declaration did not exist at the time of the Motion to Amend and that the Motion was based on information Plaintiff's had within their possession for five years.</u>

The Order Granting Plaintiffs' Motion to Amend was entered on August 5, 2022. On August 9, 2022, Plaintiffs filed the Amended Complaint.

Attached as Exhibit 3 to Plaintiff's Amended Complaint is a Declaration from Jonathan Lanzkowsky, M.D. The Declaration was executed on May 24, 2022 – 22 days after the Motion to Amend was filed. Dr. Lanzkowsky confirms in the Declaration that he reviewed only Ms. Badoi's medical records. He makes no reference to any of the evidence "unearthed in discovery" over the four years this case has been pending. There are no citations to depositions, written discovery, or other evidence.

Additionally, contrary to the representations in the Motion to Amend and Amended Complaint, Dr. Lanzkowsky's Declaration makes no mention of any breach of the standard of care related to "awaiting necessary treatment which resulted in delays in diagnosing Decedent's

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condition." Dr. Lanzkowsky's Declaration likewise does not conclude that "St. Rose's delay in treatment of Alina's significantly elevated and untreated severe blood pressure led to vascular injuries . . . ." Rather, he merely states that "improperly treating Ms. Badoi's hypertension . . . may have contributed to the worsening of this patient's intradural bleeding." *See* Exhibit 3 to Plaintiff's Amended Complaint.

G. Summary Judgment was granted at to the sole claim for relief pending against St. Rose Hospital for four years.

After Plaintiffs stipulated that the sole claim for relief against St. Rose Hospital was vicarious liability for Dr. Kim's conduct, St. Rose Hospital filed a Motion for Summary Judgment. That Moton was granted at a hearing on June 22, 2022. This Motion for Summary Judgment would have been dispositive as to St. Rose Hospital had leave not been granted to assert additional vicarious liability claims against St. Rose for the conduct of non-parties known to Plaintiff for years.

As set forth below, the Motion to Amend was untimely and there was no good cause for the delay with its filing. This Court should therefore reconsider the order granting leave to amend.

III.

STANDARD OF REVIEW

A. Motions for Reconsideration.

Nevada Eighth Judicial District Court Rule 2.24 provides:

> (a) No motions once heard and disposed of may be renewed in the same cause, nor may the same matters therein embraced be reheard, unless by leave of the court granted upon motion therefor, after notice of such motion to the adverse parties.
>
> (b) A party seeking reconsideration of a ruling of the court, other than any order that may be addressed by motion pursuant to NRCP 50(b), 52(b), 59 or 60, must file a motion for such relief within 14 days after service of written notice of the order or judgment unless the time is shortened or enlarged by order. A motion for rehearing or reconsideration must be served, noticed, filed and heard as is any other motion. A motion for reconsideration does not toll the period for filing a notice of appeal from a final order or judgment.

> (c) If a motion for rehearing is granted, the court may make a final disposition of the cause without reargument or may reset it for reargument or resubmission or may make such other orders as are deemed appropriate under the circumstances of the particular case.

The Nevada Supreme Court has further explained that a court has the inherent authority to reconsider its prior orders. *Trail v. Faretto*, 91 Nev. 401, 536 P.2d 1026 (1975); s*ee also* EDCR 2.24. A district court may reconsider a previously decided issue if substantially different evidence is subsequently introduced or the decision is clearly erroneous. *Masonry & Tile Contractors Ass'n of S. Nev. V. Jolley Urga and Wirth, Ltd*., 113 Nev. 737, 941 P.2d 486 (1997). Reconsideration is appropriate "when new issues of fact or law are raised supporting a ruling contrary to the ruling already reached . . . ." *Moore v. City of Las Vegas*, 92 Nev. 402, 405, 551 P.2d 244, 246 (1976).

IV.

ARGUMENT

This Court should reconsider the Order Granting Plaintiffs' Leave to File Amended Complaint because Plaintiffs' Amended Complaint raises "new issues of fact" that support a contrary ruling to that reached previously. *Moore v. City of Las Vegas*, 92 Nev. 402, 405, 551 P.2d 244, 246 (1976). Specifically, Plaintiffs' Amended Complaint confirms that Plaintiffs misrepresented both the existence of a Declaration supporting the proposed amended complaint, and the very reason the motion was brought when it was. Plaintiffs' capitalized on these misrepresentations to avoid a "good cause" analysis under NRCP 16(b), and to conceal Plaintiffs dilatory conduct associated with asserting claims that should have been asserted four years ago.

A. Plaintiffs misrepresented the existence of the Declaration to avoid a good cause analysis under NRCP 16(b).

EDCR 2.30 plainly requires that amended pleadings "must contain copies of all exhibits referred to in such amended pleadings," and that "[a] copy of a proposed amended pleading must be attached to any motion to amend the pleading." This rule appears particularly relevant to professional negligence cases, which are "void ab initio" if an affidavit of merit is not attached to the filing. *See* NRS 41A.071; *see also Washoe Med. Ctr. v. Second Judicial Dist. Court of State*

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of Nev. ex rel. Cnty. of Washoe, 122 Nev. 1298, 1300, 148 P.3d 790, 792 (2006). Accordingly, both under NRS 41A.071 and EDCR 2.30 attaching Dr. Lanzkowsky's Declaration to the proposed amended complaint was a prerequisite to consideration of Plaintiff's Motion to Amend.

Indisputably, here, there was no affidavit of merit attached to the proposed amended complaint to support the new allegations of negligence. However, Plaintiffs misrepresented the existence of the affidavit, leading both counsel and the Court to believe that this supporting affidavit existed. Such a misrepresentation was material in that it means Plaintiffs' Motion was filed prematurely and was not ripe for consideration. Indeed, had Plaintiff waited three weeks for Dr. Lanzkowsky to draft his Declaration, the Motion would have not only been dilatory, but objectively untimely since the deadline for filing Motions to Amend was May 2, 2022 – the same date the improper Motion to Amend was filed.

The misrepresentation regarding the existence of the affidavit was clearly made to avoid a good cause analysis under *Nutton v. Sunset Station, Inc.*, 131 Nev. 279, 285, 357 P.3d 966, 971 (Nev. App. 2015). The Court in *Nutton* reasoned that "[w]here a scheduling order has been entered, the lenient standard under Rule 15(a), which provides leave to amend 'shall be freely given,' must be balanced against the requirement under Rule 16(b) that the Court's scheduling order 'shall not be modified except upon a showing of good cause." *Id.* at 285, 357 P.3d at 971 (quoting *Grochowski v. Phoenix Constr.*, 318 F.3d 80, 86 (2d Cir.2003)). The Court added that

> Disregard of the [scheduling] order would undermine the court's ability to control its docket, disrupt the agreed-upon course of the litigation, and reward the indolent and the cavalier." *Johnson v. Mammoth Recreations, Inc.*, 975 F.2d 604, 610 (9th Cir.1992). NRCP 16 was drafted precisely to prevent this from occurring, and "Its standards may not be short-circuited by an appeal to those of Rule 15."

Id. at 285–86, 357 P.3d at 971. Accordingly, the Court held:

> "when a party seeks leave to amend a pleading after the expiration of the deadline for doing so, it must first demonstrate 'good cause' under NRCP 16(b) for extending the deadline to allow the merits of the motion to be considered by the district court before the merits of the motion may then be considered under NRCP 15(a)."

Id. at 287, 357 P.3d at 972.

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Here, Plaintiffs' Motion should have been evaluated under NRCP 16(b) since the Motion was not ripe and should not have been filed before May 24, 2022 – the date the Declaration was drafted. However, Plaintiffs prevented any such analysis by misrepresenting the existence of the Declaration, while at the same time arguing their Motion to Amend was timely. This lack of candor with the Court led to the very result the *Nutton* Court was trying to prevent. It "disrupt[ed] the agreed-upon course of the litigation, and reward[ed] the indolent and the cavalier." *See id.* at 285–86, 357 P.3d at 971. Indeed, Plaintiff was indolent in waiting four years to bring the Motion to Amend when the information providing the basis for the Motion was contained within the medical records Plaintiffs have had since day one. Plaintiff was certainly cavalier in bringing the Motion to Amend after seven months of no discovery and after entering a stipulation and order limiting Plaintiffs' claims to Vicarious Liability. Then, through misrepresentations about the existence of a necessary NRS 41A.071 affidavit, and about the reason for the timing of the motion, Plaintiff was rewarded with new claims against St. Rose Hospital based on information Plaintiffs' own experts had reviewed four years earlier, thus necessitating the continuance of the discovery deadlines and trial. In fact, Plaintiffs' deception regarding the existence of Dr. Lanzkowsky's Declaration ensured the Motion for Summary Judgment granted in St. Rose Hospital's favor on June 22, 2022, was not dispositive of the entire case against St. Rose Hospital. Therefore, these new factual and legal issues warrant reconsideration by this Court.

B. Plaintiffs' Motion to Amend fails the "good cause" analysis set forth in *Nutton v. Sunset Station, Inc.*, 131 Nev. 279, 357 P.3d 966 (Nev. App. 2015).

Had an NRCP 16(b) analysis been conducted as required by *Nutton*, Plaintiffs' Motion to Amend would have been denied as there was no good cause for Plaintiffs delay in bringing the Motion to Amend.

To determine "whether "good cause" exists under Rule 16(b), the basic inquiry for the trial court is whether the filing deadline cannot reasonably be met despite the diligence of the party seeking the amendment." *Id.* at 287, 357 P.3d at 971 (quoting *See* 6A Charles Alan Wright, Arthur R. Miller & Mary Kay Kane, *Federal Practice and Procedure* § 1522.2 (2010)).

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The Court identified four factors that may be considered in evaluating a party's diligence, including: "(1) the explanation for the untimely conduct, (2) the importance of the requested untimely action, (3) the potential prejudice in allowing the untimely conduct, and (4) the availability of a continuance to cure such prejudice." *Id* at 287, 357 P.3d at 972.

Nevertheless, the four factors are not exclusive. In fact, "if the moving party was not diligent in at least attempting to comply with the deadline, 'the inquiry should end.'" *Id*. (quoting *Johnson v. Mammoth Recreations, Inc.*, 975 F.2d 604, 609 (9th Cir.1992)). The Court added that the first factor – the explanation for the untimely motion – "is by far the most important and may in many cases be decisive by itself." *Id*. The Court even offered the example of a lack of diligence being "when a party was aware of the information behind its amendment before the deadline, yet failed to seek amendment before it expired." *Id*.

In *Nutton*, the plaintiff sued Sunset Station in relation to a fall at the bowling alley, which plaintiff's complaint alleged was caused by excessive lane wax. Three weeks after the expiration of the deadline to amend pleadings, plaintiff sought leave to amend the complaint to change the theory of the case, claiming the fall was caused by Sunset Station's failure to provide plaintiff with bowling shoes. The Court affirmed the district court's denial of the motion for leave, concluding the plaintiff did not act diligently in requesting leave three weeks after the deadline had expired. The Court agreed with the defendant that the proposed amendment set forth a "different theory of the case than had been originally pleaded . . ." and noted the original complaint made no mention of the new theory of liability. The court cited the fact that the plaintiff could have filed the motion before the deadline as the "parties had already conducted discovery relating to his proposed new claim." Moreover, the Court referenced the fact that plaintiff "proffered no explanation as to why he could not have filed his motion before the deadline . . . ." *See Nutton* at 288-289.

Here, it is undisputed that Plaintiffs were aware of, and conducted discovery related to the information supporting the proposed amendment years before the deadline. Moreover, as was the case in *Nutton*, the proposed amendment completely changed the theory of liability against St. Rose Hospital and proffered no legitimate explanation for the four-year delay in

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moving to amend the Complaint. Again, Dr. Lanzkowsky's Declaration completely undercuts Plaintiffs' representation in the Motion to Amend that the Motion was brought to "conform to the evidence unearthed in discovery" since Dr. Lanzkowsky *did not review any of the evidence* "unearthed in discovery." Rather, he reviewed the very same documents Plaintiffs' other experts reviewed four years ago. That it took Plaintiffs' four years to obtain Declaration from Dr. Lanzkowsky is inexcusable, particularly given the Plaintiffs' deposition testimony nearly three years ago regarding the issues raised in the Motion to Amend, and Plaintiffs' silence on the issue during the pendency of St. Rose Hospital's Motion for Judgment on the Pleadings, which Plaintiffs ultimately stipulated to. Accordingly, the Motion to Amend should have been denied under the first factor alone.

Notwithstanding, the other factors do not support any finding of good cause either. First, the importance of bringing vicarious liability claims against non-party healthcare providers four years into litigation cannot be understated. If St. Rose is to seek indemnity or contribution from such providers, it would be at exceptional expense in a subsequent litigation given the timeframe for bringing those providers into this case has expired. Moreover, as stated in the Opposition to the Motion to Amend, the arguments of which are incorporated herein, the prejudice to St. Rose is substantial. St. Rose has spent years and significant resources exploring and developing a defense theory premised on a defense of Dr. Kim's treatment. That defense, including theories regarding causation, are entirely different than those applicable to other physicians and nurses involved in the treatment in different roles and at different stages. St. Rose is thus left to conduct additional discovery, hire additional experts, and re-evaluate the entire defense theory and strategy. Even now, however, the identities of these new non-party "defendants" that St. Rose Hospital must now defend, are unclear. This is because Plaintiffs' expert, Dr. Lanzkowsky, offers purposely vague and conclusory allegations of wrongdoing by unidentified physicians and nurses. Indeed, Dr. Lanzkowsky was suspiciously careful not to identify who he believed to be negligent, an obvious tactic by Plaintiffs to cast a wide net against the hospital, contrary to the specific requirements of NRS 41A.071.

/ / /

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The reality is that Plaintiffs are on a desperate fishing expedition to find claims against St. Rose Hospital to keep it in this case, even asserting additional ostensible agency claims against physicians that had a preexisting relationship with Plaintiff. These dilatory tactics should not be condoned, and Plaintiffs should be precluded from using St. Rose Hospital as a scapegoat for their own failure to identify the proper defendants to this lawsuit four years ago.

C. Plaintiff's misrepresentations are further evidence that Plaintiffs' Motion to Amend was dilatory and brought in bad faith.

Not only are Plaintiffs' misrepresentations about the existence of Dr. Lanzkowsky's Declaration relevant to an NRCP 16(b) analysis they are further evidence that Plaintiffs' Motion to Amend was dilatory and in bad faith. Again, it is worth noting that summary judgment was granted as to the sole claim for relief pending against St. Rose at the time the Motion to Amend was filed. Plaintiffs were very aware that summary judgment was inevitable and therefore rushed out an improper and premature Motion to Amend, which was advanced on a knowingly false premise about its timing and foundation. Accordingly, for the reasons set forth herein, together with those set forth in the Opposition to the Motion to Amend, this Court should reconsider is prior order granting Plaintiffs leave to amend.

V.

CONCLUSION

For the reasons set forth above, St. Rose Hospital respectfully requests this Court reconsider its prior order granting Plaintiffs leave to amend.

DATED this 19th day of August, 2022.

HALL PRANGLE & SCHOONVELD, LLC

By: */s/:Tyson J. Dobbs*
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of HALL PRANGLE & SCHOONVELD, LLC; that on the 19th day of August, 2022, I served a true and correct copy of the foregoing **DEFENDANT DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL'S MOTION FOR RECONSIDERATION OF THE ORDER GRANTING PLAINTIFFS' MOTION FOR LEAVE TO FILE AMENDED COMPLAINT** via the Court e-filing System in accordance with the electronic service requirements of Administrative Order 14-2 and the Nevada Electronic Filing and Conversion Rules, to the following:

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/s/ Reina Claus
An employee of HALL PRANGLE & SCHOONVELD, LLC

Exhibit A

Exhibit A

DISTRICT COURT
CLARK COUNTY, NEVADA

LIVIU RADU CHISIU, as Special Administrator of the ESTATE OF ALINA BADOI, deceased; LIVIU RADU CHISIU, as Parent and Natural Guardian of SOPHIA RELINA CHISIU, a minor, as Heir of the ESTATE OF ALINA BADOI, deceased,

Plaintiffs,

vs.

CASE NO. A-18-775572-C
DEPT. NO. XXXII

DIGNITY HEALTH, a Foreign Non-Profit Corporation d/b/a ST. ROSE DOMINICAN HOSPITAL-SIENA CAMPUS; JOON YOUNG KIM, M.D., an individual; U.S. ANESTHESIA PARTNERS, INC., a Foreign Corporation; DOES I through X and ROE BUSINESS ENTITIES XI through XX,

Defendants.

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

DEPOSITION OF
LIVIU RADU CHISIU

December 4, 2019

1:05 p.m.

7900 West Sahara Avenue
Suite 200
Las Vegas, Nevada

Gary F. Decoster, CCR No. 790

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WITNESS: LIVIU RADU CHISIU

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Deposition of Liviu Radu Chisiu
December 4, 2019

(Prior to the commencement of the deposition, all of the parties present agreed to waive statements by the court reporter, pursuant to Rule 30(b)(4) of NRCP.)

LIVIU RADU CHISIU, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. SCHNEIDER:

Q. Please state your name for the record.
A. Liviu Chisiu.
Q. Can you spell it for the court reporter, please?
A. L-I-V-I-U, last name C-H-I-S, as in Sam, I-U.
Q. And we introduced ourselves off the record, but for the record, you go by Leo?
A. Leo. Leo.
Q. Leo?
A. Leo, L-E-O, um-hum.
Q. And we would spell that L --
A. L-E-O.
Q. Leo, have you ever been deposed before?
A. To what, I'm sorry?
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

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or than getting more involved.
Q. Got it.
MR. SCHNEIDER: Okay. Pass the witness. I appreciate the time.
THE DEPONENT: Thank you.
EXAMINATION
BY MR. DOBBS:
Q. All right, Mr. Chisiu, I introduced myself -- do you guys want to take a break?
MR. TERRY: I do not.
MR. SCHNEIDER: You mispronounced it, by the way.
MR. DOBBS: Is it Chisiu, did I say it right?
MR. TERRY: Chisiu.
THE DEPONENT: Chisiu.
MR. DOBBS: Chisui, I'm sorry.
THE DEPONENT: It's okay, don't worry.
MR. DOBBS: I'm pronouncing phonetically.
MR. TERRY: I did that on the other case; you were there.
BY MR. DOBBS:
Q. I apologize for mispronouncing your name.
A. That's okay.
Q. I represent Dignity Health in this litigation. I'm probably going to jump around quite a

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bit.
A. Oh, that's wonderful.
Q. And I apologize in advance. I've been taking notes and so I'm just going to go through the way I took the notes and not try to keep it all together.
MR. TERRY: Sorry to interrupt, but do you -- just he's got child care issues.
MR. DOBBS: What time, I mean --
THE DEPONENT: If I can be out of here by 5:30, if not, we can, or whatever.
MR. DOBBS: Okay. Well, let's keep going.
THE DEPONENT: Yeah.
MR. DOBBS: I mean --
MR. TERRY: Do you need to make a call?
THE DEPONENT: If I need to stay more, I'm going to probably just need to let somebody know.
MR. DOBBS: What time do you need to make a call to make an arrangement in the event that we run that long?
THE DEPONENT: 4:30.
MR. DOBBS: 4:30. Okay, let's get started and see where we're at by 4:30 --
THE DEPONENT: Perfect.
MR. DOBBS: -- and then we can decide, all right?

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THE DEPONENT: Yes, please.
BY MR. DOBBS:
Q. When did you -- well, let me try to back up a little bit.
You stated that at some point prior to the deposition here today, you reviewed Alina's medical records?
A. Yes.
Q. And you assumed that that was thousands of pages of medical records; is that correct?
A. Yeah, I looked through, yeah.
Q. There was quite a few medical records?
A. Yes.
Q. When did you first request those medical records from St. Rose Hospital?
A. I requested some records even before her passing. I don't recall exactly the date.
Q. And so that was while she was still admitted to the hospital?
A. Yes, I think end of June.
Q. Well, she passed away the beginning of --
A. End of May, I'm sorry.
Q. Okay.
A. End of May.
Q. So the end of May of 2007, you requested the

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records from the hospital while she was still at the hospital?
A. Yes.
Q. And what was the purpose of requesting those records?
A. Well, because I realized that something is not done right. When you go happy, when you leave healthy from the house to give birth to a baby and things like this happen, I realize that something maybe is not quite right.
Q. And had you already had that conversation with the surgeon by that point who told you that the epidural was in the intradural space?
A. I guess after that, yeah. I don't -- I don't recall being that . . .
Q. And so what you knew was you came in with Alina for her to give birth --
A. Yes.
Q. -- and after the birth, she is now having paralysis, correct?
A. Yes.
Q. She has to have a laminectomy?
A. Yes.
Q. And then you had a conversation with a surgeon who said that basically, what I understood

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Q. And then did you make any additional requests for the records after that or was that the last time that you personally requested the records?
A. Me personally, I requested with the attorney after the -- all the legal thing was done.
Q. Okay. So after the lawsuit was filed, you had an attorney, there was another request made for the records?
A. That's correct.
Q. Okay.
A. And that was made, yeah.
Q. And do you recall how long that took for you to get those records that time?
A. I have no idea. I don't know.
Q. After the -- strike that.
When was the first time -- or let me ask it a different way.
When was it that you decided to seek an attorney to represent you in this case? Was it while Alina was still in the hospital or was it after she had passed?
A. After she had passed.
Q. Do you remember approximately how long had passed before you sought an attorney?
A. Not that long. After that the days went

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pretty by -- I cannot recall, but it was pretty -- it should be in there when.
Q. Was it a month or less?
A. Till we consulted or what -- could you please repeat the question?
Q. When you decided to seek an attorney.
A. When we decided to seek, probably like, yeah, right after it happened, after, in the first month, we decided that we're going to seek it.
Q. When you say we, is that you and Alina's sister?
A. Yes.
Q. Could you provide me your educational background?
A. I have a degree in physical therapy.
Q. Where did you get that degree?
A. In Romania.
Q. Romania?
A. Yes.
Q. In what year?
A. Graduated in 2000.
Q. And when did you move to the United States?
A. Oh, no, I'm sorry, 2000 -- I moved to the United States -- I graduated in -- gosh, I'm old. I think -- I think I graduated '98.

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Q. And then you said you moved to the States in 2000?
A. 2000, yes.
Q. And do you practice physical therapy for a living?
A. No.
Q. And what do you do for a living?
A. Real estate.
Q. And how long have you been doing real estate?
A. From 2005, '6.
Q. Other than having a physical therapy degree, do you have any other medical training?
A. No.
Q. When was the last time that you practiced physical therapy, if you did practice after you got your degree?
A. I didn't really practice.
Q. You got the degree in physical therapy but didn't really work as a physical therapist ever?
A. No.
Q. And you and Alina were not married, true?
A. Correct.
Q. Did you guys have any plans to get married?
A. Yes.
Q. And what were the plans as far as getting

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married? Was it that you had a date set or --
A. No, we didn't have the date set. In the future.
Q. Was there a plan in place between you and Sophia -- not Sophia, sorry, strike that.
As far as you and Alina, had you discussed how it was that you and Alina would be caring for Sophia once she was born?
A. Together like a family.
Q. Was there any discussion of you or Alina quitting your job for one of you to stay at home with Sophia?
A. Well, I would be to spend a little bit more time since my time, my schedule, was flexible, and her to spend time on the afternoon and the evening time when she --
Q. So you, as a real estate agent, you're able to kind of pick and choose your hours?
A. Kind of, exactly, so she had the weekends, I'm more busy on the weekends, and . . .
Q. So neither of you were going to quit your job to stay at home?
A. No.
Q. Am I correct?
A. That's correct, yes.

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complication with the actual procedure on the thyroid or was it just the thyroid condition that she had?
A. No, they had a surgery, she had a surgery done to the thyroid.
Q. Okay.
A. Surgery when she was, I think, 13, 14.
Q. And my question is, when you said that she discussed the problem with the thyroid, was it just the fact that she had had a surgery on her thyroid and had a condition or issue with her thyroid?
A. Yeah, that she had the surgery and that she's taking treatment for that.
Q. It wasn't -- there was no suggestion that there was like a problem or complication in that procedure or surgery?
A. No.
Q. Correct?
A. Yes.
Q. Okay. And if I'm understanding your testimony, you never saw Alina have a nosebleed during her admission to St. Rose Hospital?
A. During the admission, I don't recall.
Q. And I think I got most of this, but it was -- what day was Sophia born?
A. On May 16.

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Q. May 16. And then you stated that Alina had elevated blood pressure, was it on the night of the 16th?
A. She had elevated blood pressure a little bit starting before, and then after the birth it was really high.
Q. And when you say it was really high, I think you stated that you believed it was somewhere around 190 over 90?
A. Much higher. It was -- at some point it was 200 with a hundred something.
Q. Do you recall what time of day that was?
A. During the evening time. And like I said, after that, during that night, it wasn't me that stayed there all the time. I returned in the morning.
Q. What time did you leave that evening?
A. I don't recall exactly, but sometime around 10:00-ish, I would say, probably.
Q. So you felt comfortable enough that evening to go home?
A. Yes.
Q. Even though she had the high blood pressure?
A. It was not that high yet.
Q. Okay. When did it get really high, in your opinion?

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A. I cannot give you my opinion. It should be in the records.
Q. Okay.
A. But what I've been told from the person that stayed there with her, from Ileana that night, that during the night it got really high.
Q. Okay. So when you left around 10:00 p.m., you weren't very concerned about the blood pressure?
A. No.
Q. Is that true?
A. Yes.
Q. And then, but you've since heard from Alina's sister -- was it Alina's sister that stayed overnight?
A. No.
Q. This was the friend?
A. The friend, yes.
Q. Okay. And what was her name one more time?
A. Ileana.
Q. Okay. So you've since heard from Ileana that her blood pressure went up that evening?
A. Yes.
Q. And what time did you come in the next morning?
A. Around 8 o'clock.
Q. And it's my understanding you had some sort

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of discussion with a nurse about the elevated blood pressure, true?
A. Yes.
Q. Did that discussion occur on the night of the 16th or the morning of the 17th?
A. Well, with me the discussion occurred in the morning of the 17th, but Ileana mentioned during that night to the nurses also about the blood pressure.
Q. Okay. But the first conversation you had was on the morning of the 17th, with a nurse?
A. If I recall correctly, yes.
Q. Okay. And you told the nurse that -- I mean, tell me again, how did that conversation go? You just asked what they're going to do about the high blood pressure?
A. Well, I was asking what they're going to do about the numbness and if they're going to do something to lower the blood pressure.
Q. And when did -- when was the first complaint of numbness? Was it on the night of the 16th or the morning of the 17th?
A. My first complaint to -- like it was in the morning of the 17th.
Q. And that's the first time that you learned that Alina was having numbness?

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A. By the time I got back, yes.
Q. Okay.
A. But during the night, they were telling them the same thing, they were telling the nurses the same thing, the same thing.
Q. And when you had the discussion with the nurse about the elevated blood pressure and the numbness and tingling, what was the nurse's response to you?
A. They're going to talk to the doctor probably.
Q. And do you remember the name of this nurse that you spoke with?
A. Oh, no, no, but they were -- by the morning time, there was a different nurse, I'm sorry, yeah, so --
Q. But that's the nurse we're talking about, the morning of the 17th.
A. Yeah, no, I don't know her name.
Q. Okay. And she told you she was going to talk to the doctor?
A. Yes.
Q. And did she talk to the doctor, as far as you know?
A. I don't know. I don't know. As far as I know, I'm not sure, and I don't think that they did

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because I don't know that they gave her any medication to lower it. But my biggest concern, it was why was -- why they left it so high during the nighttime, a whole night.
Q. Did you ask them about that?
A. Why did they left it, no.
Q. But did you see a doctor that day, the 17th?
A. Yes.
Q. Okay. And so you come in in the morning at 8 o'clock. You talk to the nurse around that time. She tells you she's going talk to the doctor and then at some point later in the day the doctor comes in and you see the doctor?
A. That's correct, but in that moment, I was more worried about the numbness in the leg than the blood pressure.
Q. And do you recall who the first doctor was that you saw that day on the 17th?
A. H.
Q. And did you talk with him about the numbness and the blood pressure?
A. Yes.
Q. Do you recall exactly or precisely, approximately what time you spoke with Dr. H? Was it early afternoon, late afternoon?

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A. In the morning, but probably around 10:00-ish. I'm not sure, I don't, yeah.
Q. So closer to the morning, before noon?
A. Closer to -- somewhere there, yes.
Q. Okay. So you spoke with the nurse about your concerns around 8 o'clock or so and then you saw Dr. H around 10 o'clock or closer to noon?
A. Yeah, but the concerns to the nurse, they were addressed in the nighttime, too, about the blood pressure.
Q. And Dr. H's -- what was the plan of care at that time as far as he verbalized to you?
A. He forgot probably about the blood pressure and he went to bring the specialist to see why she's numb. I don't know, they didn't . . .
Q. And was it that after Dr. H comes in and has a specialist come, orders the specialist to come see Alina, there's the MRI -- is the MRI ordered at that time, after or do you recall specifically?
A. Well, the first MRI was sometime after noon and the second MRI was later after noon, like 7, 8 o'clock, the first one around 2 o'clock.
Q. Okay.
A. Something around, something like that.
Q. And do you know how long it took to get that

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first MRI done?
A. Not sure.
Q. Has any health care provider been critical of the timing of that MRI?
A. I'm sorry, could you please repeat?
Q. Has any health care provider voiced a criticism to you that that MRI should have been done sooner?
A. If any health care provider said that, no. Meaning like if another doctor came and they said, Well, did you --
Q. Yeah, did another doctor come in and say, or at any point in time, any health care provider, doctor, physician, nurse, that you've spoken with said, yeah, it took them too long to get that MRI done?
A. I don't recall.
Q. And I ask just because it seemed to me that you had suggested earlier that you were frustrated that it seemed to take long to get the MRI done.
A. Definitely.
Q. Okay. And when you say it took long, as far as an estimate, it took a couple hours to get it done, it -- how long from the time that you knew that an MRI was supposed to be done till the time it was

Exhibit B

Exhibit B

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Steven D. Grierson
CLERK OF THE COURT

RTRAN

DISTRICT COURT

CLARK COUNTY, NEVADA

ESTATE OF ALINA BADOI, Plaintiff, vs. DIGNITY HEALTH, Defendant,	CASE#: A-18-775572-C DEPT. II

BEFORE THE HONORABLE CARLI L. KIERNY, DISTRICT COURT JUDGE

WEDNESDAY, MARCH 16, 2022

RECORDER'S TRANSCRIPT OF HEARING:
ARGUMENT

APPEARANCES: [All appearances via videoconference]

For the Plaintiff: KENDELEE LEASCHER WORKS, ESQ.

For Defendant: ADAM A. SCHNEIDER, ESQ.
TYSON J. DOBBS, ESQ.

RECORDED BY: JESSICA KIRKPATRICK, COURT RECORDER

Las Vegas, Nevada, Wednesday, March 16, 2022

[Case called at 9:28 a.m.]

THE COURT: Calling page 2, Badoi versus Dignity Health, A775572.

[Colloquy between the Court and staff]

MR. SCHNEIDER: Good morning, Your Honor, Adam Schneider, 10216, for codefendants Dr. Kim and US Anesthesia Partners.

THE COURT: Okay.

MR. DOBBS: Your Honor, Tyson Dobbs for Dignity Health.

THE COURT: Got it.

MS. WORKS: Your Honor, Kendelee Works for the Badoi plaintiffs in the Dignity Health matter.

THE COURT: Okay, looks like we've got everyone then. Thank you for making your appearances. We're here for a motion of the --

THE RECORDER: Is somebody's computer on in here that is not --

THE COURT: Hang on. We're going to try to figure it out.

THE CLERK: I think it's mean. That's strange. Okay, testing.

THE COURT: Are we good, Jessica?

THE RECORDER: I think so.

THE COURT: Okay. All right. In this matter we're on for -- we'd already decided the first part of this motion. Now we're on for the second part of the motion, the partial judgment on the pleadings.

Mr. Dobbs, this was your motion. Did you want to be heard further on the pleadings?

MR. DOBBS: Yes, Your Honor, if that's okay.

THE COURT: Of course.

MR. DOBBS: Basically we filed this motion at -- to kind of clarify what was alleged in the complaint. The way I understood the allegations with this is this a special negligence action against the hospital based on vicarious liability for Dr. Kim. That's what the factual allegations are. That's what the expert affidavit is in the complaint.

But then discovery there was several depositions where people were being deposed and it seems as if they were being deposed as defendants, some of the nursing staff, as opposed to fact witnesses. And so that's -- we brought the motion to basically seek dismissal under 41A.071 of the extraneous claims, which appear to be duplicative to me in the sense that we have a vicarious liability claim and there's a professional negligence claim and there's lastly a wrongful death claim.

So we brought the motion and I was expecting with the opposition if they were going to -- if they had some sort of additional

claim against the hospital that in the opposition they would set forth, hey, no you're reading the complaint wrong. There's also a claim against the hospital for nurse so-and-so who was negligent or whatever. The opposition didn't contain any information to that effect. I believe the opposition -- it's essentially a non-opposition in my opinion in that it seems to agree that the negligence in this case against the hospital is premised exclusively on vicarious liability for Dr. Kim.

What they do say is hey, you shouldn't dismiss the wrongful death claim because it's not a claim. Which to me I think supports my motion in that if it's not a claim and it's pled as a claim it should be dismissed. And then it says well you can't dismiss the vicarious liability claim because it's not a claim it's a theory. Well whether you dismiss the vicarious liability claim or whether you dismiss the professional negligence claim, to the extent it tries to cast a wide net I don't think it makes a difference.

I think what we need or what I am requesting as far as relief is just the confirmation in the ruling that yes, the professional negligence claim, the way it's worded, is too broad given what the support is in the affidavit of merit which is exclusively negligence against Dr. Kim and that the hospital is on the hook for ostensible agency. So again, I'm not seeking a dismissal outright of the hospital from this case. I'm just trying to make sure that I am defending the right allegations and that I don't need 10, 11, 12 experts in this case.

So, from my point of view, Your Honor, it appears that this motion is unopposed. I didn't see anything in there that said anything other than the claims we've asserted are not claims. So unless the Court has additional question that's all I have to say.

THE COURT: Understood, Mr. Dobbs.

Mr. Schneider, I know you're on. Was this something that you had joined?

MR. SCHNEIDER: No, Your Honor. I did file a joinder, but it was in regards to the motion for summary judgment component, not the motion for judgment on the pleadings component.

THE COURT: Okay. That was my understanding as well. I just wanted to clarify that.

MR. SCHNEIDER: Absolutely, Judge.

THE COURT: Perfect. And then, Ms. Works, did you want to respond to what Mr. Dobbs brought up?

MS. WORKS: I do, Your Honor. And with all due respect to opposing counsel, frankly this is exhausting. In 2018 I ended up -- hailed to the Nevada Supreme Court on a writ petition in a medical malpractice case because Dignity Health said that I should have included the theory of ostensible agency in my medical malpractice complaint. So eight writ petitions later, Mr. Schneider will recall the case, Baxter versus Dignity Health, the Supreme Court denied the writ petition and ostensible agency pursuant to Judge David Jones' order was going to go to the jury. Fortunately

we were able to resolve the matter short of a jury verdict.

In any case ostensible agency is in this complaint, because in 2018 Dignity Health, albeit different counsel than Mr. Dobbs, said hey you can't claim ostensible agency now despite the fact that we've litigated it and done discovery for years on the issue, because you didn't put it in the complaint. Now back then I'm pretty certain I argued something similar to what Mr. Dobbs said today, which is ostensible agency is a theory of liability. It's a theory of liability under which the hospital can be held negligent and held to answer for the conduct of Dr. Kim.

I think the complaint is clear that our theory o liability against St. Rose is based on ostensible agency and/or vicarious liability. It would be ostensible agency to the extent that the hospital can confirm that Dr. Kim was not an employee or technically an agent. It would -- or that would be vicarious liability. I'm not sure if I -- oh, it would be ostensible agency if under *Schlotfeldt* and its progeny we can demonstrate that although Dr. Kim was not technically employed by the hospital, he was an ostensible agent and thus St. Rose has to be held to answer for his conduct, his professional negligence.

Certainly the Court should not dismiss the professional negligence claim, because that's supported by an affidavit. That is the crux and if the Court gets rid of professional negligence then St. Rose will be back again saying well no you -- now you can't hold St. Rose responsible for anything because it's medical malpractice

action and without professional negligence you can't have a claim against a hospital.

So I'm happy if the Court wants or defense counsel wants us to move the ostensible agency allegations under the professional negligence claim. It seems to be a fool's errand that's totally unnecessary because there -- it's not duplicative relief. Everybody agrees we're not going to get a different category of damages for ostensible agency versus professional negligence. It's the mechanism by which St. Rose can be held liable for Dr. Kim's negligence,

Same thing with wrongful death, Your Honor, it is codified under the Nevada Revised Statutes, wrongful death, it is a cause of action. It's certainly based on professional negligence. But again it's included in the complaint so that there's no guessing about what our theories of liability are and what the recoverable damages under the Nevada Revised Statutes under the wrongful death statue would be.

The wrongful death statute lays out different categories of damages to be recovered by different plaintiffs, different heirs, the heirs versus the estate. And so that's laid out in the complaint so that there's no question when we get on the eve of trial that I'm going to be at the Supreme Court answering to a writ petition saying that I can't ask for certain categories of damages on behalf of my differently situated clients and so that there's no question that I can argue the theory of ostensible agency and the Court can determine

whether or not that's a jury question.

And so the extent they're seeking dismissal it's simply not required. They're not -- I agree they're not -- ostensible agency isn't a separate cause of action. But I think that given Dignity Health's motion practice in prior cases and the risk that there could be these arguments going forward, the wise thing for everybody to do to the extent that there's even a question at this point would be for us to amend the complaint and just cut and paste those ostensible agency allegations into the professional negligence claim.

And I'm happy to move the wrongful death allegations with respect to what damages are recoverable into the prayer for relief. I don't believe it's necessary. I don't believe that there's really any question before the Court. I don't believe that defense counsel honestly is unaware or not on notice of what the issues are here. But if that's going to clear up the matter, I'm happy to do that. But dismissal or judgment on the pleadings at this point is simply not the remedy.

THE COURT: Understood, Ms. Works.

So turning to Mr. Dobbs it sounds like it -- you are largely in agreement on this issue.

MR. DOBBS: Yes.

THE COURT: Was -- would Ms. Works' proposed --

MR. DOBBS: Well, Your Honor, I think --

THE COURT: -- cutting and pasting into the professional negligence prayer, would that alleviate your concerns about what

you're defending against, or does that not change your issue?

MR. DOBBS: Your Honor, as long as we have a stipulation here that that's the theory of professional negligence, vicarious liability for Dr. Kim, I think that in order from the Court to that affect would work and then we could proceed under the allegations as pled.

THE COURT: Okay.

MR. DOBBS: Moving it, I don't know if that makes any real difference to me. The problem is the professional negligence allegation is Dignity Health, it's nurses, everybody in the world breached the standard of care so it's quite broad. And so that's why I was seeking dismissal in the professional negligence claim, just to the extent it asserts -- it attempts to assert a direct claim against Dignity for its own conduct or for the conduct of some unnamed nurse or something like that. That's what we're seeking dismissal of.

And so I mean, to me it would be I don't think it's a problem if you have professional negligence cause of action against Dr. Kim, vicarious liability cause of action or theory of liability, whether it's a cause of action or a theory I think it still needs to be pled in the complaint or otherwise it would be just weird to sue multiple people and just say well everybody is on the hook for vicarious liability.

But I think it's been pled, vicarious liability. There's no -- I mean, we're on notice that this is a cause of action against the

hospital for the alleged negligence of Dr. Kim. I don't disagree with that. And so to me it would make more sense instead of the pro -- instead of looping everything into the professional negligence, leave the professional negligence claim against Dr. Kim, vicarious liability for professional negligence of Dr. Kim would be against the hospital. That's how I would -- that seems to be -- make more sense to me.

THE COURT: So really you just want it to be those two causes -- those two --

MR. DOBBS: Yes.

THE COURT: -- actions to be amended to specify it's just Dr. Kim.

MR. DOBBS: Yeah, just specify that it's just Dr. Kim. I mean, and the reason I brought the motion is well I can see how their -- this cause of action is quite broad --

THE COURT: Sure.

MR. DOBBS: -- the way it's alleged. The affidavit is not broad. But the cause of action is broad. And then discovery was quite broad. So you're like am I -- am I not seeing something here? Do I need 20 experts instead of 2? And so that's kind of where I'm at. But I think we're on the same page, Ms. Works and I, as far as what this case is actually about. So whether that's via just a court order saying this is a -- the cause of action against Dignity Health is professional -- it is professional negligence based on vicarious liability of Dr. Kim. That would work for me too.

THE COURT: Any objection --

MS. WORKS: Your Honor, --

THE COURT: -- to just putting that out there? Was Mr. Schneider speaking up or was that Ms. Works?

MS. WORKS: This is Ms. Works, Your Honor.

THE COURT: Okay.

MS. WORKS: May I go ahead or was the Court finished?

THE COURT: Yes, go ahead.

MS. WORKS: Your Honor, I'm fine with the latter part of what Mr. Dobbs suggested that it can be in a court order. But it has to be that it's a theory of -- or that it's a professional negligence cause of action against St. Rose based on either vicarious liability or ostensible agency. Those are two different theories depending on Dr. Kim's actual employment status. And so it would have to be both vicarious liability or ostensible agency.

And the professional negligence cause of action has to stand. It's never going to stand up on an appeal for my client if the professional negligence action is dismissed. I'm certain I would get arguments that I can't have anything but a professional negligence claim against a hospital when it derives from medical malpractice. And so it has to be professional negligence based on ostensible agency or by vicarious liability.

MR. DOBBS: And that's perfectly fine with me, Your Honor.

THE COURT: All right. So it would be fair to say that

both of you would agree that the cause of action against Dignity Health is simply professional negligence against Dr. Kim based on vicarious negligence and ostensible agency?

MR. DOBBS: Yeah, professional negligence against the hospital based on --

THE COURT: Against the hospital, right.

MR. DOBBS: -- the vicarious liability or ostensible agency of Dr. Kim.

MS. WORKS: Correct, Your Honor.

THE COURT: All right. The cause of action against Dignity Health is professional negligence against the hospital based on vicarious negligence and ostensible agency of Dr. Kim.

MR. DOBBS: Yes.

THE COURT: So ordered.

MR. DOBBS: Okay.

THE COURT: All right.

MS. WORKS: Thank you.

THE COURT: By stipulation of the parties, that is what's ordered.

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MR. DOBBS: Thank you, Your Honor.

THE COURT: All right. Thank you.

[Hearing concluded at 9:42 a.m.]

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio/video proceedings in the above-entitled case to the best of my ability.

Jessica Kirkpatrick

Jessica Kirkpatrick
Court Recorder/Transcriber

Exhibit C

Exhibit C

TRAN

DISTRICT COURT

CLARK COUNTY, NEVADA

* * * * *

ESTATE OF ALINA BADOI, LIVIU CHISIU, Plaintiffs, vs. DIGNITY HEALTH, ET AL., Defendants.	)	CASE NO. A-18-775572-C DEPT. NO. IX **Transcript of Proceedings**

BEFORE THE HONORABLE MARK GIBBONS, SENIOR JUDGE

DEFENDANTS' MOTION FOR SUMMARY JUDGMENT; PLAINTIFFS' MOTION FOR LEAVE TO FILE AMENDED COMPLAINT

WEDNESDAY, JUNE 22, 2022

APPEARANCES:

For the Plaintiffs: KENDELEE WORKS, ESQ.

For the Defendants: ADAM SCHNEIDER, ESQ.
TYSON DOBBS, ESQ.

RECORDED BY: GINA VILLANI, DISTRICT COURT
TRANSCRIBED BY: KRISTEN LUNKWITZ

Proceedings recorded by audio-visual recording; transcript produced by transcription service.

WEDNESDAY, JUNE 22, 2022, AT 9:02 A.M.

THE COURT: This is case number A-18-775572, *Estate of Alina Badoi versus Dignity Health*. This is on for Dignity's Motion for Summary Judgment and the Plaintiffs' Motion for Leave to Amend. Good morning --

MS. WORKS: Good morning.

MR. DOBBS: Good morning.

THE COURT: -- to both of you.

Okay. Let me start with the Dignity's Motion for Summary Judgment. I guess my question would be -- is -- the Doctor, if I understand correctly, he's -- he has privileges at the hospital -- with the St. Rose and all like that, but he's not an employee of St. Rose. Is that correct?

MR. DOBBS: That is correct, Your Honor.

THE COURT: So, he's an anesthesiologist --

THE COURT RECORDER: Your Honor, can we state their appearances for the record?

THE COURT: I'm sorry. Go ahead.

MR. DOBBS: Tyson Dobbs for Dignity Health.

MR. SCHNEIDER: Adam Schneider for Dr. Kim and USAP, Inc.

MS. WORKS: Good morning, Your Honor. Kendelee Works on behalf of plaintiffs.

THE COURT: Okay. Thank you.

So, I'll address this to counsel for the plaintiff then like that. So, my -- it's your case. So, I just make sure I have the facts correct.

So, the Dr. Kim has privileges at the St. Rose Hospitals, that he's not an employee of the Hospital, and, basically, he, I assume, is an anesthesiologist. He was brought in my the physician to do the operation. So, it wasn't -- he wasn't brought in by the Hospital. Correct? It was by the -- whoever the doctor was in charge usually retains the anesthesiologist for the procedures. Correct?

MS. WORKS: Your Honor, it -- the mostly correct.

THE COURT: Okay.

MS. WORKS: With a couple of clarifications.

In this instance, the Doctor is actually employed by another defendant, who is US Anesthesia Partners. So, USAP, just to abbreviate, does the assignment, assigns the doctors to what hospitals they're going to go to, but St. Rose contracts with USAP. So, con -- so, St. Rose is still effectively selecting this doctor because it has to approve what physicians are --

THE COURT: Okay. Got it.

MS. WORKS: -- coming to its facilities --

THE COURT: Well, let me -- it's their Motion, so I'll let them argue it and then I think I understand the

facts.

So, go ahead, counsel.

MR. DOBBS: Yes, Your Honor. You're correct. There's no dispute here that Dr. Kim is not an employee or agent of the Hospital. So, the theory of liability that's currently in the case is that the Hospital is on the hook via ostensible agency for Dr. Kim. And so that's the only claim against the Hospital that's currently in the case.

To establish ostensible agency against the Hospital for Dr. Kim's liability, they have to, one, show that the Hospital selected Dr. Kim. And, two, they have to show that the patient had a reasonable belief that the Doctor was an employee of the Hospital.

And the first one you've just touched on. The selection, the only evidence that they've brought forth of a selection by the Hospital of Dr. Kim is the contract between the Hospital and USAP. And it's not -- and it's actually not even USAP. It's a contract between the Hospital and a physician practice group. And, basically, the contract says: Hey, this is an independent contractor agreement. You guys pick your physicians. They have to be credentialed at the Hospital. But you're the ones that are responsible for figuring out who is going to be at the Hospital when, or whatever.

So, it was this physician practice group that is

then staffing. They're the ones that set Dr. Kim's schedule. They're the ones that assigned him to St. Rose Hospital that day, as opposed to Mountain View, or some other Hospital which he had privileges.

The -- there's no evidence that St. Rose had any role in selecting Dr. Kim to be this patient's physician. The only thing we have is a contract between the Hospital and a practice group. But we know from *Schlotfeldt,* which is one of the primary cases on ostensible agency, mere privileges at a hospital -- a physician having privileges at a hospital is not enough to warrant ostensible agency. It's not enough to create an issue of fact regarding ostensible agency. There has to be more.

THE COURT: Can I ask you one question?

MR. DOBBS: Yes.

THE COURT: In the -- when the lawsuit was filed, and some time ago, it's an older case, the Affidavit was filed -- or Declaration by the expert. What did they allege in there against the Hospital to -- in order to file the case in the first place?

MR. DOBBS: The only thing that's alleged to create the ostensible agency claim is that the physician was an agent or ostensible agent of the Hospital.

THE COURT: Okay.

MR. DOBBS: So the claims are all directed at Dr.

Kim and it's directed at Dr. Kim for the placement of the epidural, for not assessing the bleeding risk prior to placing the epidural. That's the claim against him. And then the Complaint says ostensible agency. They've actually got a claim in there that says vicarious liability, ostensible agency, for Dr. Kim.

THE COURT: Okay.

MR. DOBBS: For -- against the Hospital for Dr. Kim.

THE COURT: Got it. Okay.

MR. DOBBS: So, the first element is selection and the second element is a reasonable belief. You have to establish both of these to get ostensible agency.

Here, the only evidence we have in this case regarding this patient's belief about Dr. Kim's status, relationship to the Hospital, is her signature on approximately -- I think it's 10 or 11 consents signed at the Hospital that say: Anesthesiologists are not employees or agents of the Hospital. She specifically signs that provision of the Agreement and then she signs the bottom of the Agreement that says: I have -- I fully understand what I'm signing. I've had the opportunity to read and ask questions. And then she acknowledges it.

That's the only evidence in this case regarding the patient's belief about whether Dr. Kim was an agent or

employee of the Hospital. There's nothing else. What the plaintiffs have tried to do in their Opposition is say: Well, this agreement is ambiguous. You've got these separate provisions that one says -- something about the Hospital is going to provide services, including the anesthesia services. It's a different paragraph than the legal relationship paragraph.

They're trying to draw up some confusion about those paragraphs in those conditions of admission that the patient signed, but there is no confusion. And the patient herself acknowledged that she understood the forms and she signed them, having fully had the opportunity to ask questions and her questions were answered. So, they haven't provided any evidence that shows that the patient believed anything, other than what she represented in those documents.

And this isn't a typical patient. I'll add this. She was an actual employee of Dignity Health for three years prior to the incident as a social worker. So, she was working closely with doctors and with nurses, 40 hours a week, five days a week, for three years prior to her delivery in this case. So, this isn't somebody that was unfamiliar with the Hospital, unfamiliar with its practices. She had the experience and knowledge coming in. And, then, when she comes in, she signs all these documents

and the only evidence that we have, and that we will ever have in this case, is that this patient signed all these records acknowledging that Dr. Kim was not an employee or agent of the Hospital.

So, to argue now that there's somehow a question of fact regarding this patient's belief, and to suggest that it somehow could be reasonable that she did not believe Dr. Kim to be an agent of the Hospital, there's just no foundation for it. There's no evidence and there simply -- there can't be.

The -- they cite *McCroskey* as an example of a case that would warrant finding an issue of fact. *McCroskey* is different than this case, because, in *McCroskey*, the patient signs several consents at a different facility and then comes into the Hospital. And, on the date of her procedure, she's in labor, she doesn't sign the consent. And so the Supreme Court says: Hey, the consent is not determinative, you've got to look at all the other facts to determine whether there's an issue of fact.

Well, in our case, these consents that the patient signed, she signed them once before she comes to the Hospital and it's at the very Hospital that she's going to have the procedure. She comes in the day of the procedure, she signs again another conditions of admission that says the same thing, anesthesiologists are not employees or

agents. And, then, she signs the third consent for the specific procedure which was the labor and delivery of her child that, again, identifies her OB and says he's not an agent or employee of the Hospital. And then it says the anesthesiologists are not agents or employees of the Hospital.

So, she signed three consents right there. And there's no other evidence that she assumed, believed anything other than she documented, and she wouldn't have because she was an employee of the Hospital anyway so she knew.

THE COURT: Okay. I got it.

MR. DOBBS: So, with that, you know, unless --

THE COURT: Okay.

MR. DOBBS: -- you have any questions, Your Honor.

THE COURT: Okay, counsel.

MS. WORKS: Respectfully, those are all fantastic arguments for the jury, Your Honor, but they deserve to go to a jury because we're here on summary judgment and those are all contested, genuine issues of fact.

The fact that Ms. Badoi was an employee actually cuts against counsel's argument because she was an employee as a social worker. So, given her status as an employee, it was reasonable -- it would have been reasonable and it would be up to a jury to decide: Well, did she believe

because she was an employee as a social worker that the doctors and nurses around her were also employees of the Hospital? The answer is she's dead, unfortunately. So we don't know. We're never going to hear it straight from her mouth, but based on all of the other circumstances surrounding the signature on the admissions forms, when she signed them.

Those admission forms are just like what was at issue in *McCroskey* --

THE COURT: How would you prove it at the trial if she's deceased and -- what type of testimony would be at trial to avoid let's say a directed verdict on this issue?

MS. WORKS: For example, Dr. Kim's testimony himself is that he did not recall or he did not tell Ms. Badoi or her partner either way whether he was an employee of the Hospital or an independent contractor. So, you're going to hear that he didn't say that. You're going to hear her partner say that he didn't know -- and perhaps I should quote for the Court.

So, this is Dr. Kim's testimony: When you met Alina and Liviu that first time, did --

And he actually goes by Leo.

Did you tell them that you were an employee of USAP or ACI or say anything about that?

His answer: I did not.

Did you talk to them about whether you're independent from St. Rose in any manner whatsoever?

I did not.

And, so, you'll have his -- you'll have Dr. Kim's testimony. You will have the contractual agreements at issue, which are just like those in *McCroskey*, but perhaps even more of a genuine issue of fact in this case because Ms. Badoi herself was an employee of the Hospital.

In *McCroskey*, it's actually strikingly similar because the plaintiff, the patient at issue, was a volunteer at the Hospital. So they would have had those same arguments: Hey, you're familiar with the Hospital. But, here, we have the argument that as an employee, it would have been reasonable for her to assume that other nurses, physicians, and so forth were also employees of the Hospital, just like her. So, that's not an unreasonable inference on her part and that's the standard, Your Honor: Reasonable. Did she have a reasonable belief that Dr. Kim was an employee of the Hospital?

And let's not forget the four-part test that's at issue and that's from *Schlotfeldt*, as counsel alluded to. First is whether a patient entrusted himself to the Hospital. And we also have a genuine -- or there's no genuine issue of fact on that and that falls strikingly in favor of the plaintiff. She obviously entrusted herself to

the Hospital.

Two, whether the Hospital's selected the doctor or medical provider to serve the patient. And there is a genuine issue of fact here, Your Honor, because Dr. Kim testified that he was assigned that entire day to St. Rose Hospital. He got the assignment a couple of months in advance.

THE COURT: And who assigned him then?

MS. WORKS: His employer.

THE COURT: It wasn't the --

MS. WORKS: United -- US Anesthesia Partners.

THE COURT: -- Hospital that --

MS. WORKS: Correct. It certainly wasn't Ms. Badoi that selected him.

THE COURT: Right.

MS. WORKS: But -- so, his employer selects him to be on call, but here's the critical fact, Your Honor. He's in the on call room, where he'd been for about seven hours, and a nurse of St. Rose -- because who's going to tell him where to go? It's not his employer at that point. It's somebody from St. Rose who -- a nurse calls and says: Hey, Ms. Badoi wants an epidural. And, so, that's when he goes to the room.

So, it's an agent of St. Rose calling Dr. Kim, selecting Dr. Kim, to go attend to this patient, to Ms.

Badoi. That's certainly not Ms. Badoi's choice. She didn't say: Hey, send me an anesthesiologist from United Anesthesia Partners. Or: Hey, send me Dr. Kim. Or: Send me -- I want somebody else. She didn't have that option. And, so, that's critical under all of the caselaw is that she is entrusting herself to St. Rose. St. Rose is ultimately choosing who goes and gives her that epidural that day. And the choice -- the decision is not hers.

So, the first two factors under the four-part test falls sq1uarely in favor of plaintiff and, at a minimum, are genuine issues of fact that go to the jury.

The third -- third, whether patient reasonably believed the doctor or medical provider was an employee or agent of the Hospital. And that was what we started with today, Your Honor. Was it a reasonable belief? Well, whether it was a reasonable belief is a question of fact for the jury. The jury may ultimately decide that it wasn't, but Ms. Badoi signed these forms and she was an employee of the Hospital, and she should have known what was going on. But the fact that she was an employee, again, cuts both ways because she was not an independent contractor. So, you have a genuine issue of fact there.

You're going to hear from her partner as to what their beliefs were. You're going to hear from Dr. Kim that he himself never says to Ms. Badoi that: Hey, I'm an

independent contractor. And all of the forms that were signed, based on *McCroskey*, are insufficient and we went through that at length, you know, what's in bold, what's highlighted here in the pleadings and I can go through that with Your Honor now, but I don't want to belabor the point, unless the Court has questions on that issue.

But the forms are much like those at issue in *McCroskey*. And, then, you have the issue of *McCroskey*, it being a volunteer. Ms. Badoi being an employee. And, so, again, *McCroskey* also falls squarely in favor of there being a genuine issue of fact as to Ms. Badoi's reasonable belief.

And, then, the final part of the four-part test, whether the patient was on notice that a doctor or medical provider was an independent contractor. Again, another genuine issue of fact as to that point, given that Dr. Kim himself never informed Ms. Badoi and the forms that she signed, which, by the way, the first form that she signed -- the first time she signed is four months in advance. That's much like *McCroskey* who had signed, I think, maybe 22 days in advance. So, these forms were signed well in advance.

The Court in *McCroskey* found that -- also that to be an issue, the timing of when the forms was signed in relation to the actual admission. And, so, based on the

four-part test, *Schlotfeldt* and *McCroskey*, there is, at a minimum, genuine issues of fact as to all of these issues for which a jury should decide ostensible agency.

And I would note for the Court that I've had this battle with St. Rose many times. Five years ago we were in a case called *William Baxter*. Judge David Jones found that ostensible agency was at issue. He'd signed much of the same admissions forms. He actually was a living plaintiff, but the Court -- Judge Jones said: Hey, it's a genuine issue of fact for the jury to decide. St. Rose took -- Dignity Health took it up on a writ. Supreme Court declined to hear that particular issue.

So, there's square evidence based on the caselaw that this is a genuine issue of fact for a jury to decide and we ask that the Motion be denied.

THE COURT: Okay. All right.

Briefly?

MR. DOBBS: Yes.

Your Honor, I think you -- the question you asked was the right one, which is: What type of testimony at trial would there be regarding the patient's reasonable belief? There would be none. The patient, different from those other cases --

THE COURT: There was a deposition taken of her or anything --

MR. DOBBS: No deposition of her. There was a deposition of her partner. It was taken, but none of her, Ms. Badoi, because she had died during the medical treatment. And, so, the only thing we have are these consents.

So, this is different than *McCroskey* who had a living plaintiff that could testify what her assumption was about the employees of the Hospital. This is different than the *Baxter* case where the plaintiff is alive and able to testify.

This patient -- if there's -- you know, you're going to put all this evidence to try to contradict her own statements that she understood that the doctors were employees -- were not employees of the Hospital. And so that's the only evidence that we have.

The suggestion that it's a reasonable inference that she believed him to be -- to not be an employee, I just think it's ridiculous given the fact that she worked there. And, so, these -- unless she knew that the St. Rose was lying to all of its patients on their forms by saying that their anesthesiologists were actual employees, it's not a reasonable inference. And it's certainly not a reasonable inference given that we have 10 consents that she signed that said: I acknowledge that he's not an employee of the Hospital.

Regarding Dr. Kim's testimony, he was asked at his deposition -- this is the -- the plaintiff, I'm sorry. Leo, who is the partner of the -- Ms. Badoi, question:

> My understanding of your conversation was you never had any conversation with Dr. Kim about his relationship with Dignity Health, true?
>
> Yes.
>
> And you believed that he worked for US Anesthesia Partners, true?
>
> Yes.

That was his testimony. And, then, when he was asked -- you know, and I think this kind of goes to the reasonable belief or reasonable assumptions here when we're trying to say what's a reasonable inference, the question to him at deposition:

> Question: And she actually had worked at the Hospital, too, so I would assume she had some knowledge, too, as to the relationship between the Hospital and physicians. You'd agree with that?
>
> Answer: Probably she did. Yes.

So the only evidence we have in this case is what she signed, acknowledging the nonemployees. Her own partner or plaintiff in this case has said: Yeah, she probably knew they were -- that the relationship between the doctors and the employees.

And, so, we really -- we have no evidence to deal with, Your Honor.

THE COURT: Okay. Got it. Thank you.

Okay. Well, again, the standard here under Rule 56, it has to be a material issue of fact, not an issue of fact. There's a difference between the two. In this case, here, we have no Declaration, no Affidavit of the plaintiff, because she's deceased. You know, like that. So, we don't have any affirmative statement.

As counsel made a great argument for the plaintiff, if there were an Affidavit or Declaration stating that under oath, that would create a genuine issue of material fact. There isn't. You know, it isn't here, unfortunately, because she passed away. As such, the Motion for Summary Judgment is granted.

Counsel, again, I thank you -- for plaintiff, you did a great argument. Absent the Affidavit, I can't do it. You need that. Under Rule 56, if there was Answers to Interrogatories, a deposition, an Affidavit, we can consider all that. None of that exists. So, there's no issue of fact, material fact. It's actually of fact, but not material fact.

Prepare the Order, please.

MR. DOBBS: Thank you, Your Honor.

THE COURT: Thank you.

MR. SCHNEIDER: Your Honor, we have --

THE COURT: Oh, I'm sorry. Motion to Amend. I'm going to grant the Motion to Amend. I'll tell you right now, it's -- I knew you were going to come back. Probably statute of limitations issue or others, but I have to give leave freely to amend and then you can file a Rule 12 Motion or whatever afterwards.

MR. DOBBS: Okay.

THE COURT: Okay?

MR. DOBBS: It's over. So, the Motion for Summary Judgment was granted?

THE COURT: Yes.

MR. DOBBS: And the Motion -- and you're granting the Motion for Leave To Amend?

THE COURT: Yes.

MR. DOBBS: All right.

THE COURT: Okay. And then subject -- and you can come in and file a Rule 12 or Rule 56 Motion on that -- on the Amended Complaint, you know, like that. Because, again, I don't know what the statute of limitations issues and all that are on that, but the law is -- from the Supreme Court is you have to give free leave to amend and the proper way to challenge it is by Motions after the Amended Complaint is filed. Okay?

MR. DOBBS: Yes, Your Honor.

THE COURT: So, Motion is granted.

MS. WORKS: Thank you.

MR. SCHNEIDER: And, Judge, we have a piece of housekeeping in light of this Court's ruling.

THE COURT: Yeah.

MR. SCHNEIDER: Which is expert disclosures are due in 10 days, give or take. So, I think it's probably appropriate now -- or at least you'll be seeing very soon, and I want to make sure that it's kind of not coming out of left field, it will be some version of a Motion to -- either a stipulation to move dates and as a byproduct of that --

THE COURT: Well, I -- if you want to stip to move the dates, it's okay with me. My concern is the case is four years old. So, we have -- I know the Supreme Court suspended the Rule 41(e) for a period of time. I don't know the date from when to when. I don't recall -- I signed the original Order as a member of the Court to suspend it, but that -- so that will extend the five years, but you'll have to tackle that issue when you get to it.

So, see if you can get a stipulation on that. And, if not, we'll deal with it on a Motion.

MR. SCHNEIDER: Okay. Thank you, Judge.

THE COURT: Okay. Thank you, all. Thank you both for excellent --

MS. WORKS: Thank you, Your Honor.

THE COURT: -- arguments on both sides.

MR. DOBBS: Okay. Thank you, Your Honor.

MS. WORKS: Thanks.

PROCEEDING CONCLUDED AT 9:23 A.M.

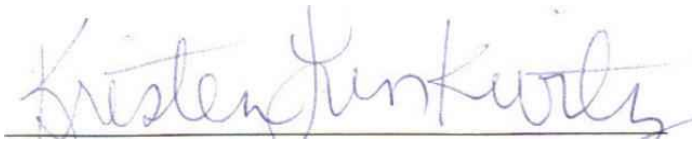
* * * * *

CERTIFICATION

I certify that the foregoing is a correct transcript from the audio-visual recording of the proceedings in the above-entitled matter.

AFFIRMATION

I affirm that this transcript does not contain the social security or tax identification number of any person or entity.



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DISTRICT COURT

CLARK COUNTY, NEVADA

LIVIU RADU CHISIU, as Special Administrator for the ESTATE OF ALINA BADOI, Deceased; LIVIU RADU CHISIU, as Parent and Natural Guardian of SOPHIA RELINA CHISIU, a minor, as Heir of the ESTATE OF ALINA BADOI, Deceased Plaintiffs, vs. DIGNITY HEALTH, a Foreign Non-Profit Corporation d/b/a ST. ROSE DOMINICAN HOSPITAL – SIENA CAMPUS; JOON YOUNG KIM, M.D., an Individual; U.S. ANESTHESIA PARTNERS, INC., a Foreign Corporation; DOES I through X, inclusive; and ROE BUSINESS ENTITIES XI through XX, inclusive, Defendants.	CASE NO.: A-18-775572-C DEPT NO.: 9 **DEFENDANT DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL'S MOTION TO DISMISS, OR ALTERNATIVELY, MOTION TO STRIKE** **HEARING REQUESTED**

COMES NOW, Defendant, ST. ROSE DOMINICAN HOSPITAL – SIENA CAMPUS, by and through its attorneys of record, HALL PRANGLE & SCHOONVELD, LLC, and hereby files this Motion to Dismiss, or, alternatively, Motion to Strike.

This Motion is made and based on the papers and pleadings on file herein, the following points and authorities submitted in support hereof, the Exhibits attached hereto and any oral arguments that be heard regarding this matter.

DATED this 23rd day of August 2022.

HALL PRANGLE & SCHOONVELD, LLC

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MEMORANDUM OF POINTS & AUTHORITIES

I.

INTRODUCTION

Plaintiffs recently filed an amended complaint (the "Amended Complaint") adding vicarious liability claims against St. Rose Hospital for alleged negligence by a nurse and physicians that treated Alina Badoi during hospitalization at St. Rose Hospital on May 16-17, 2017. As these allegations are brought for the first time more than five years after Alina Badoi's death, and more than four years after the original complaint was filed, these newly asserted claims are barred by the statute of limitations. Alternatively, Defendant requests the new declaration added to support Plaintiffs' new theory of liability be stricken under NRCP 12(f), since it is not the declaration that was referenced in the proposed amended complaint approved by the Court for filing. In addition, Defendant requests dismissal of the newly asserted vicarious liability claims based on the conduct of unnamed "nursing staff" due to noncompliance with NRS 41A.071 as to such claims.

II.

RELEVANT PROCEDURAL BACKGROUND

Plaintiffs' Complaint was filed on June 5, 2018. Based on the factual allegations, the Complaint initially included six separate causes of action: (1) Professional Negligence (2) Negligent Credentialing; (3) Fraudulent Concealment and/or Omissions; (4) Negligent Hiring,

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Training, Retention and Supervision; (5) Ostensible Agency/Vicarious Liability; and (6) Wrongful Death Pursuant to NRS 41.085.

On January 29, 2021, Judgment on the Pleadings was granted under NRS 41A.071 as to Plaintiff's claims for Negligent Credentialing and Negligent Hiring, Training, and Supervision. *See* Order Granting Judgment on the Pleadings, filed on February 10, 2021.

Thereafter, at a March 16, 2022, hearing on a Motion for Partial Judgment on the Pleadings filed by St. Rose Hospital, Plaintiffs' counsel stipulated – and the Court ordered – that:

> Plaintiffs' Complaint against Dignity Health d/b/a St. Rose Hospital – Siena Campus is limited to a cause of action for professional negligence based on a theory of vicarious liability (i.e. actual agency/ostensible agency) for the alleged professional negligence of Defendant Joon Young Kim, M.D.

See Order Regarding Motion for Summary Judgment and Moton for Partial Judgment on the Pleadings, filed on April 29, 2022.

On June 22, 2022, summary judgment was granted for St. Rose Hospital regarding the sole theory of liability remaining against it. *See* Order Granting Summary Judgment, filed on August 15, 2022. However, at the same hearing, Plaintiff was granted leave to amend the complaint to assert vicarious liability claims against St. Rose Hospital for the conduct of non-party nurses and physicians. *See* Order Granting Motion to Amend, filed on August 5, 2022.

III.

STATEMENT OF RELEVANT FACTS

A. Facts Relevant to the Motion to Dismiss based on the expiration of the statute of limitations.

According to the Complaint and expert affidavits, Alina Badoi was admitted to St. Rose Hospital on May 15, 2017, for induction of labor. *See generally* Amended Complaint. Prior to giving birth, the anesthesiologist, Dr. Joon Young Kim, placed an epidural catheter for pain. *Id.* Ms. Badoi developed spastic paraparesis and an intradural hematoma for which she underwent a laminectomy from T8 to L3. *Id.* She passed away on June 3, 2017, due to pulmonary thromboemboli. *Id.*

On June 5, 2018, Plaintiff filed the original Complaint. *See* Original Complaint, filed June 5, 2018. The anesthesiologist, Dr. Kim, and St. Rose Hospital were the only defendants.

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The professional negligence claim against Dr. Kim for misplacing an epidural and causing a hemorrhage in Plaintiff's spine was supported by the affidavit of an anesthesiologist. *See* Declaration of Yaakov Beilin, attached to the Original Complaint as Exhibit 1. The claims against St. Rose Hospital were entirely derivative of Dr. Kim's alleged professional negligence. *See generally,* Original Complaint.

On August 9, 2022, Plaintiff filed an Amended Complaint that assets additional claims against St. Rose Hospital for alleged professional negligence of a non-party nurse and two non-party obstetricians alleged to have occurred on May 16-17, 2017. *See* Plaintiff's Amended Complaint, filed August 9, 2022. The new claims are premised on the declaration of an obstetrician, Jonathan Lanzkowsky, M.D., which is attached to the Amended Complaint.

B. Facts Relevant to the Motion to Strike Plaintiffs' expert's declaration due to it being a different declaration than that referenced in the proposed amended complaint.

Plaintiffs' Amended Complaint was filed pursuant to a motion to amend filed on May 2, 2022. The proposed amended complaint attached to the motion to amend stated that a declaration of Dr. Lanzkowsky was attached thereto. *See* Plaintiff's proposed amended complaint, attached to Plaintiff's Motion to Amend, filed May 2, 2022. The Court granted Plaintiffs leave to filed the proposed amended complaint. *See* Notice of Entry of Order Granting Leave to Amend, filed August 5, 2022.

However, the declaration that was attached to the proposed amended complaint was not that referenced in the proposed amended complaint. It could not have been. This is because Dr. Lanzkowsky's declaration was created three weeks after the motion to amend and proposed amended complaint were filed. *See* Declaration of Jonathan Lanzkowsky, M.D., dated May 24, 2022, attached as Exhibit 3 to Plaintiffs' Amended Complaint. Accordingly, the proposed amended complaint for which Plaintiff was granted leave to amend, was not the proposed amended complaint that was ultimately filed with the Court. *Cf.* EDCR 2.30 (defining an amended pleading as including any exhibits referenced therein).

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C. <u>Facts Relevant to the Motion to Dismiss the newly added professional negligence claims under NRS 41A.071.</u>

The claims added per Plaintiffs' Amended Complaint are described as a breach of the applicable standard of care arising from:

> [1] Repeatedly failing to properly monitor or treat Decedent's elevated blood pressure.
>
> [2] Awaiting necessary treatment which resulted in delays in diagnosing Decedent's condition.

See Plaintiffs' Amended Complaint, at ¶ 40.

Dr. Lanzkowsky's declaration is the purported support for these allegations. Dr. Lanzkowsky's report consists of the following four/five opinions, only the first of which is arguably directed at a nurse:

> At 0641 the patient had severe range blood pressures and nursing notified Dr. Herplosheimer who treated the elevation with i.v. hydralazine to control the BP. Despite the patient having multiple elevations in blood pressure in the severe range Magnesium Sulfate (MgSO4) was not ordered until 0945. *Missing the significance of Ms. Badoi's elevated BP's by medical and nursing staff is a breach of the standard of care* and led to delayed treatment with Magnesium Sulfate and/or other medications to lower her BP. Mg So4 is given to reduce the risks of seizure due to worsening pre-eclampsia and has the additional side effect of lowering maternal BP though it is not given for that purpose per-se.
>
> . . .
>
> On the postpartum floor at 2045 hrs., Ms. Badoi complained of tingling in her legs and when notified *Dr. Garg* was notified, he ordered the MgSo4 held for one hour concerned that this was a possible reaction to MgSO4. Although her symptoms did not improve and in fact worsened during this time, the MgSo4 was restarted, and no effort was made to ascertain the cause of Badoi's symptoms having ruled out MgSO4 toxicity as a cause. *Failing to reevaluate Ms. Badoi after MgSo4 was discontinued to see if symptoms improved was a breach of the standard of care.*
>
> Of significant concern the patient continued to have severe range BP that should have been treated with fast acting anti-hypertensives (like hydralazine). On 05/17/2017 at 0402, Nurse

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> Taylor informed the attending OB Dr. Garg that Ms. Badoi's BP was 182/99. This elevated BP required immediate medical treatment and failure to render such care was a breach of the standard of care Ms. Badoi's repeat BP 15 minutes was later was 183/97 which also went untreated. The patient continued to have a BP in severe ranges with worsening neurologic symptoms in her lower extremities., At 0435, Nurse Taylor again called Dr. Garg who ordered oral labetalol. Nurse Taylor correctly queried Dr. Garg to be certain he did not want to give IV hydralazine, he declined and ordered labetalol and, of note, did not evaluate the patient. *The management of these pressures with oral antihypertensives was a breach of the standard of care.*
>
> Finally, at 0547 when contacted again regarding Ms. Badoi's BP of 183/98, Dr. Garg ordered a small dose (5mg) of IV hydralazine. This was an unusually small dose that had a predictable minimal effect on Ms. Badoi's pressures which remained in the severe range (167/97 at 0602 hrs.). By 0626 hrs. Ms. Badoi's labs returned confirming HELLP syndrome (High BP, Elevated Liver enzymes, Low Platelets) a form of severe pre-eclampsia. As the patient's neurologic injuries progressed, she continued to have significantly elevated and untreated severe BP, treated only with oral Labetalol until 1824 hrs. when she was given an additional 20mg of Hydralazine as a standing order about one hour later she is transferred to the ICU. *The management of these pressures with oral antihypertensives represents a breach of the standard of care.*

See Declaration of Dr. Lanzkowsky, attached to Plaintiff's Amended Complaint.

Dr. Lankowsky then summarizes his opinions as follows:

> It is my opinion to a reasonable degree of medical certainty that the nursing and medical staff at St. Rose-Siena breached the standard of care by improperly treating Ms. Badoi's hypertension, especially during the postpartum period. . . .

Id.

IV.

STANDARD OF REVIEW

A. Motion to Dismiss.

Nevada Rule of Civil Procedure 12(b)(5) provides for dismissal of a cause of action for the "failure to state a claim upon which relief can be granted." A motion to dismiss tests the legal sufficiency of the claim set out against the moving party. *See Zalk-Josephs Co. v. Wells-Cargo, Inc.*, 81 Nev. 163, 400 P.2d 621 (1965). Dismissal is appropriate where a plaintiff's

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allegations "are insufficient to establish the elements of a claim for relief." *Hampe v. Foote*, 118 Nev. 405, 408, 47 P.3d 438, 439 (2002), *overruled in part on other grounds by Buzz Stew, LLC v. City of N. Las Vegas*, 124 Nev. 224, 228, 181 P.3d 670, 672 (2008). To survive dismissal under NRCP 12(b)(5), a complaint must contain "facts, which if true, would entitle the plaintiff to relief." *Buzz Stew, LLC v. City of N. Las Vegas*, 124 Nev. 224, 228, 181 P.3d 670, 672 (2008). Hence, in analyzing the validity of a claim the court is to accept plaintiff's factual allegations "as true and draw all inferences in the Plaintiff's favor." *Id.*

Nevertheless, the court is not bound to accept as true a plaintiff's legal conclusions, and "[t]hreadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice." *Ashcroft v. Iqbal*, 556 U.S. 662, 678, 129 S.Ct. 1937 (2009) (analyzing the federal counterpart to NRCP 12(b)(5)). Moreover, the court may not take into consideration mattes outside of the pleading being attacked. *Breliant v. Preferred Equities Corp.*, 109 Nev. 842, 847, 858 P.2d 1258, 1261 (1993).

B. Motion to Strike.

Nevada Rule of Civil Procedure 12(f) allows the Court to "strike from a pleading […] any redundant, immaterial, impertinent, or scandalous matter." NRCP 12(f).

V.

ARGUMENT

A. Plaintiffs' claims against St. Rose Hospital via the Amended Complaint are barred by the Statute of Limitations and must be dismissed.

Plaintiffs' belated claims against St. Rose Hospital for the actions of unnamed physicians and a nurse are a mere attempt by Plaintiffs to circumvent the procedural limitations set forth in both NRS 41A.071 and NRS 41A.097. Specifically, Plaintiffs are seeking an end-run around the one-year statute of limitations set forth in NRS 41A.097, by bringing these new claims against the principal only – knowing very well that any claim asserted directly against these non-party alleged agents would be time-barred. Moreover, Plaintiffs actions undercut the very purpose and intent of NRS 41A.071, as any claims against these non-party healthcare providers were "void ab initio" since they were not set forth in the expert declarations attached to the original complaint.

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1. Plaintiffs cannot circumvent NRS 41A.097 by asserting claims against a principal that would otherwise be time-barred against the alleged agent.

The Nevada Supreme Court has denounced Plaintiffs' creative pleading tactics, precluding plaintiffs from circumventing NRS 41A by asserting claims only against a principal in actions involving professional negligence. *See, e.g., Estate of Curtis v. S. Las Vegas Med. Inv'rs, LLC,* 136 Nev. 350, 353, 466 P.3d 1263, 1267 (2020). In *Estate of Curtis* the plaintiffs in that case brought claims against a nursing home for the alleged negligence of a nurse during the treatment of a patient. To avoid the statutory restrictions that would otherwise apply to claims brought directly against the nurse, the complaint purposely did not name the nurse as a defendant in the action, naming only the principal. The Court, however, clarified that a party could not circumvent the NRS 41A requirements by asserting administrative claims "inextricably linked" to professional against a principal only. *Id*. at 354, 466 P.3d at 1267.

Likewise, here, Plaintiffs must not be allowed to circumvent the time limitations set forth in NRS 41A.097 by bringing their claims against the hospital only, more than five years after the allegedly negligent medical treatment occurred.

Indeed, although there is no Nevada case that directly addresses the factual situation present in the instant case, Courts in other jurisdictions have appropriately concluded that a plaintiff cannot pursue vicarious liability claims against a principal "after its right to assert a claim against the agent has become procedurally barred." *See Abshure v. Methodist Healthcare-Memphis Hosps.*, 325 S.W.3d 98, 106 (Tenn. 2010). In *Abshure*, the Tennessee Supreme Court reasoned that "plaintiffs should not be permitted to engage in an 'encircling movement' against the principal when they cannot pursue a 'frontal attack' on the agent." *See id.*

In fact, in announcing this logical premise, the Tennessee Supreme Court relied on an appellate court decision, which presents a nearly identical situation to that at issue in this case. *See, e.g. Huber v. Marlow*, 2008 WL 2199827 (Tenn. Ct. App. May 28, 2008). In *Huber*, the plaintiffs brought a timely suit against multiple defendants for alleged medical malpractice causing a fall and intracranial hemorrhage. Two of the initial defendants were a physician practice group called Internists of Knoxville, PLLC ("Internists"), and its employee, Dr. Marlow. The plaintiffs later amended their complaint to bring an additional vicarious liability claim against Internists for the alleged negligence of a non-party employed physician also involved in

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the treatment, one Dr. Rankin. Because the timeframe for bringing suit directly against Dr. Rankin had expired under Tennessee law, Internists filed a motion for summary judgment, arguing that it could not be liable for its agent's negligence given the plaintiff's claims against the agent would be time-barred. The district court, agreed, and granted summary judgment for Internists.

In affirming the district court's decision, the Court of Appeals refuted the plaintiff's reliance on the relation back doctrine. The Court explained that although the relation back doctrine

> would allow Plaintiffs to amend their complaint to include further allegations against Dr. Marlow (who was timely sued) and/or Internists of Knoxville *in its capacity as Dr. Marlow's employer*, they cannot be used to support an "end run" around the statute of repose as against Dr. Rankin or Internists of Knoxville in its capacity as Dr. Rankin's employer.

Id. (emphasis in original).

Additionally, the Court equated the amendment asserting a new vicarious liability claim against a non-party with adding a new party to the litigation, stating:

> In the present case, although Plaintiffs did not add Dr. Rankin as a defendant, they have, for all practical purposes and effect, tried to add a new party defendant more than three years after the alleged negligence and injury-Internists of Knoxville, *in its capacity as Dr. Rankin's employer*-based solely upon the actions of Dr. Rankin, a nonparty employee against whom the Plaintiffs' cause of action has been extinguished by the statute of repose. The relation back doctrine of Tenn. R. Civ. P. 15.03 does not contemplate nor permit such a result.

Id.

As was the case in *Huber*, Plaintiffs' end-run around NRS 41A.097 should not be condoned. They are bringing new vicarious liability claims that are time-barred under NRS 41A.097, as to the alleged agents. Indeed, pursuant to NRS 41A.097(2) "an action for injury or wrongful death against a provider of health care may not be commenced *more than 3 years after the date* of injury *or 1 year after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury*, whichever occurs first...." (emphasis added). The Nevada Supreme Court has clarified that a Plaintiff must "satisfy *both* the one-year discovery

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rule and the three-year limitations period." *Wynn v. Sunrise Hosp. & Med. Ct.*, 128 Nev., 277 P.3d 458, 461 (2012) (emphasis added).

Here, the alleged negligence of the non-party physicians and nurse occurred on May 16 and 17, 2017. Ms. Badoi died three weeks later on June 3, 2017. Plaintiffs thereafter filed suit on June 5, 2018. Consequently, even if the date the original complaint was filed is considered the accrual date for purposes of the statute of limitations, the statute of limitations expired on any claims against the nurses and physicians involved in Plaintiffs' treatment on June 5, 2019 – more than three years ago. Consequently, as was the case in *Huber*, the statute of limitations against the purported agents has expired. Thus, Plaintiffs must necessarily argue that the new vicarious liability claims relate back to the filing of the original complaint under NRCP 15. However, as was the case in *Huber*, relation back has no application in this instance.

2. Allowing relation back under NRCP 15 is inconsistent with the purpose of NRS 41A.071 and Nevada Supreme Court precedent.

First, Plaintiffs' amended complaint alleging vicarious liability claims against non-parties in relation to treatment provided five years ago is really Plaintiffs' attempt to cure a defect in their original pleading and bring the Complaint into compliance with NRS 41A.071.

Indeed, a NRS 41A.071 mandates that any complaint against a provider of health care be filed with an affidavit/declaration that: (1) supports the allegations of the complaint; (2) was prepared by a medical expert in a field "substantially similar" to that of the healthcare provider alleged to be negligent; (3) identifies by name or conduct the healthcare provider alleged to have been negligent; and (4) identifies the "specific act or acts of alleged negligence *separately* as to each defendant . . . ." (emphasis added).

Here, although the declarations attached to Plaintiffs' original complaint met this requirement as to a claim for professional negligence against the anesthesiologist, Dr. Kim, the original complaint did not meet any of these requirements as to any claims against any other providers.

Where the affidavit merit fails to comply with NRS 41A.071 as to any defendant, the Nevada Supreme Court has held that complaint "is void and must be dismissed; no amendment is permitted." *See Washoe Med. Ctr. v. Second Judicial Dist. Court*, 122 Nev. 1298, 1304, 148

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P.3d 794 (2006). The Nevada Supreme Court further explained that a defective affidavit of merit means the complaint "*does not legally exist and cannot be amended*." *Id*. (emphasis added). The Court further explained the interplay between the NRCP 15, which governs amended pleadings, and NRS 41A.071 stating:

> NRCP 15(a)'s amendment provisions, whether allowing amendment as a matter of course or leave to amend, are inapplicable. A complaint that does not comply with NRS 41A.071 is void and must be dismissed; no amendment is permitted.

Id. at 1304, 148 P.3d at 794.

As a matter of fact, in disallowing amendments aimed at bringing a complaint into compliance with NRS 41A.071, the majority opinion necessarily considered and rejected the the dissenting opinion, which argued the plaintiff "under NRCP 15(a), was permitted to filed the amended complaint . . . which, under NRCP 15(c), related back to supersede the original filing . . . for statute of limitations purposes." Id. at 1308 (Maupin dissenting opinion).

Here, as was announced in *Washoe*, as between NRCP 15 and NRS 41A.071, the latter controls. There is no relation back of Plaintiffs' Amended Complaint since the original complaint failed to set forth any viable claims against the non-party nurse or physicians. In fact, the original complaint itself was arguably untimely[1] as it was filed more than one year after Ms. Badoi's death. Plaintiffs should therefore be precluded from an end-run around both NRS 41A.071 and NRS 41A.097 by asserting claims that should have been raised in the original complaint four years later. This is particularly true given the only claim ever properly before the Court against St. Rose (vicarious liability for Dr. Kim) has since been dismissed. The entire theory against St. Rose is brand new and independent of the claims asserted in the original complaint. In other words, there is nothing to relate back to.

[1] *See* Defendant's Motion for Summary Judgment filed October 18, 2021.

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3. Plaintiffs' new claims are akin to an amendment adding parties that does not warrant relation back under NRCP 15(c)(2) since Plaintiffs consciously elected not to bring the new claims in the original complaint.

Nevertheless, as addressed by the Court in *Huber*, Plaintiffs here "have, for all practical purposes and effect, [added] a new party defendant more than three years after the alleged negligence . . . ." *See Huber, supra*.

Pursuant to the plain language of NRCP 15(c)(2), amendments adding parties are limited to situations in which the party to be added "knew or should have known," during the timeframe for serving the original complaint, "that the action would have been brought against it but for a mistake concerning the proper party's identity." In other words, the party to be added needs to have knowledge of a mistake in identifying the proper parties to the original complaint, not just knowledge of the action itself.

Consistent therewith, amendments concerning parties do not relate back where a plaintiff consciously elected not to name a particular party in the original complaint. *See e.g. Garvey v. Clark County*, 91 Nev. 127, 129, 532 P.2d 269, 271 (1975) (holding that amendments adding parties the plaintiff "consciously elected" not to name when the action was commenced, do not relate back to the original pleading); *see also Krupski v. Costa Crociere S. p. A.*, 130 S. Ct. 2485, 2494 (2010) (stating "that making a deliberate choice to sue one party instead of another while fully understanding the factual and legal differences between the two parties is the antithesis of making a mistake concerning the proper party's identity"). Rather, relation back for new parties applies when the failure to name a defendant in an original pleading "was . . . a mistake in nomenclature . . . ." *Jimenez v. State*, 98 Nev. 204, 644 P.2d 1023 (1982); *see also Costello v. Casler*, 127 Nev. 436, 254 P.3d 631 (2011) (applying relation back to a claim mistakenly filed against a deceased party as opposed to the decedent's estate)*; Echols v. Summa Corp*., 95 Nev. 720, 722, 601 P.2d 716, 717 (1979) (finding relation back where a plaintiff sued the wrong corporate entity because the right corporate entity was aware that it was only not named in the original pleading due to a "misnomer").

Here, there was never any "mistake concerning the proper party's identity" in the original Complaint. On the contrary, Plaintiffs made a conscious election to sue who they sued, and bring the claims they brought, in the original complaint. This is made very clear from the

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declaration of Dr. Lanzkowsky, attached to the Amended Complaint, which confirms that he came to his opinions after reviewing the very same medical records Plaintiffs' initial experts reviewed four years ago. Hence, Plaintiff's change of heart four years later about who should have been sued, or what claims should have been brought, does not warrant relation back under NRCP (c)(2).

4. Relation back is also unwarranted under NRCP (c)(1) since Plaintiffs new claims are based on claims and theories not set forth in the Amended Complaint, as evidenced by the need for an additional expert declaration to support the claims.

Still, even if analyzed under NRCP 15(c)(1), Plaintiffs' newly asserted vicarious liability claims still fail since the new claims premised on conduct of a non-party nurse and physicians do not arise "out of the conduct, transaction, or occurrence set out – or attempted to be set out – in the original pleading." The conduct or occurrence set out in the original complaint was alleged negligence by the anesthesiologist, Dr. Kim, in placing an epidural catheter during Ms. Badoi's labor that is alleged to have caused an epidural hematoma. Plaintiffs' new claims – supported by a new expert declaration – are premised on alleged negligence by two obstetricians in treating Ms. Badoi's hypertension "especially during the postpartum period."[2]

Accordingly, similar to the Court's reasoning in *Huber, supra*, relation back under NRCP 15(c)(1) may contemplate additional claims or allegations against Dr. Kim – since he is the only party against whom claims from the original complaint are currently asserted – but it does not contemplate the addition of new claims against non-parties, premised on an entirely separate fact pattern and causation theory.

In fact, the Nevada Supreme Court has "refused to allow a new claim based upon a new theory of liability asserted in an amended pleading to relate back under NRCP 15(c) after the statute of limitations had run." *Badger v. Eighth Jud. Dist. Ct.*, 132 Nev. 396, 404, 373 P.3d 89, 95 (2016) (citing *Nelson v. City of Las Vegas,* 99 Nev. 548, 556-557, 665 P.2d 1141, 1146 (1983)). If an amendment "states a new cause of action that describes a new and entirely different source of damages, the amendment does not relate back, as the opposing party has not been put on notice concerning the facts in issue." *Nelson v. City of Las Vegas,* 99 Nev. 548, 556-

[2] As set forth below, the declaration fails to support any vicarious liability claim against St. Rose Hospital based on negligence of the nursing staff.

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557, 665 P.2d 1141, 1146 (1983) (citation omitted). The Supreme Court has also clarified that NRCP 15(c) "does not permit us to so liberalize limitation statutes when new facts, conduct and injuries are pleaded, that the limitation statutes lose their meaning. [Citations omitted.]" *Id.*

In *Nelson*, the Nevada Supreme Court found a complaint for battery time-barred where "the original complaint and first amended complaint gave absolutely no indication that a claim for battery existed." *Id.* The Court cited the fact that the complaints did not allege the factual predicate for the battery, i.e., the "physical contact" between the parties.

Similarly, here, the original complaint "gave absolutely no indication" that a claim for negligence against non-party obstetricians and nurses existed. In fact, the lack of notice is even more pronounced in this case since such claims were, as matter of law, an impossibility given they require expert support pursuant to NRS 41A.071. Thus, until Plaintiffs produced and attached a declaration specifically detailing the alleged negligence of the nurse and physicians believed to be negligent, the Complaint could *only* be premised on the alleged negligence of Dr. Kim in misplacing the epidural, which allegedly caused the bleeding in Ms. Badoi's spine. As a matter of fact, just months before the Amended Complaint was filed Plaintiffs' counsel stipulated that the only theory set forth in the original complaint was alleged negligence by Dr. Kim, for which St. Rose Hospital was alleged to be vicarious liability.

Finally, and maybe most importantly, that the alleged negligence of the non-party nurse and physicians contemplate a "a new cause of action that describes a new and entirely different source of damages," is very evident from the fact that there are no other claims pending against St. Rose Hospital, given summary judgment was previously granted as to the vicarious liability claim for Dr. Kim. Consequently, Plaintiffs cannot save their dilatory Amended Complaint through resort to NRCP 15(c)(1). The Amended Complaint is time-barred and must be dismissed.

B. <u>Plaintiffs cannot rely on frivolous arguments regarding fraudulent concealment to save the Complaint from dismissal.</u>

Although there are unfounded allegations of "fraudulent concealment" set forth in the Complaint, they do not provide any basis to toll the statute of limitations.

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First, as of April 29, 2022, this Court ordered per the parties' stipulation that Plaintiffs' "Complaint against Dignity Health d/b/a St. Rose Hospital – Siena Campus is limited to a cause of action for professional negligence based on a theory of vicarious liability (i.e. actual agency/ostensible agency) for the alleged professional negligence of Defendant Joon Young Kim, M.D." Plaintiffs have thus appropriately forfeited the unfounded Fraudulent Concealment claim.

Next, as this issue was addressed in detail in the previous Motion for Summary Judgment regarding the statute of limitations filed October 18, 2021, the arguments of which are incorporated herein by reference, Plaintiffs cannot meet their burden to toll the statute of limitations under NRS 41A.097(3). In short, to warrant tolling for concealment, Plaintiffs carry the burden to prove (1) the defendant "intentionally withheld information" and (2) "that this withholding would have hindered a reasonably diligent plaintiff from procuring an expert affidavit." *Winn v. Sunrise Hosp. and Med. Ctr.*, 128 Nev. Adv. Op. 23, 277 P.3d 458, 464 (2012). "In other words, the concealment must have interfered with a reasonable plaintiff's ability to satisfy the statutory requirement that the complaint be accompanied by an expert affidavit." *See Kushnir v. Eighth Judicial District Court*, 137 Nev. Adv. Op. 41, 2021 WL 3464145 at *4 (Aug 5. 2021).

This clearly did not occur in this case given Plaintiffs were able to secure two expert affidavits four years prior to filing the Amended Complaint. Moreover, Dr. Lanzkowsky's declaration was not even based on any discovery conducted since the original complaint was filed years ago. It was based exclusively on the same medical records Plaintiffs' two other experts used as the basis for their opinions in 2018.

Nevertheless, and even if Plaintiffs contend the fraudulent concealment is still at play in this case, it fails under each of NRS 41A.071, NRCP 12(b)(5), or NRCP 9.

1. Plaintiff's Fraudulent Concealment claim fails under NRS 41A.071.

First, the Nevada Supreme Court has made it very clear that claims that are "inextricably linked" to professional negligence are subject to NRS 41A.071 and must be supported by an affidavit of merit. *See*, e.g. *Estate of Curtis v. S. Las Vegas Med. Inv'rs, LLC*, 136 Nev. Adv. Op. 39, 466 P.3d 1263, 1267 (2020); *Szymborski v. Spring Mountain Treatment Ctr.*, 133 Nev. 638,

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647, 403 P.3d 1280, 1288 (2017); *Montanez v. Sparks Family Hospital, Inc*., 137 Nev, Adv, Op., 77, 499 P.3d 1189, 2021 WL 5856811 at *1 (2021).

In fact, in *Schwarts v. University Medical Center of So. Nevada, et al*., No. 77554, decided March 28, 2020, the plaintiffs brought a similar claim for "civil conspiracy" contending it was not be subject to the requirements of NRS 41A. The Nevada Supreme Court stated that in order to support their allegation, the Schwartses "…would necessarily have to prove the underlying medical malpractice…" *Id.* at *3. Therefore, the Court found that plaintiffs' civil conspiracy claim – although not entitled professional negligence or medical malpractice – nevertheless had to comply with the requirements of NRS 41A. *Id.* at *4.

Likewise, here, Plaintiffs' "fraudulent concealment" claim is necessarily based on Plaintiffs' establishing the underlying professional negligence. The claim is in realty, therefore, a claim subject to NRS 41A.071. However, there is no suggestion in any of the three affidavits of merit submitted by Plaintiffs that there was any information the experts needed to render an opinion. On the contrary, based on the 4400 pages of medical records the Plaintiffs had within their possession in 2018, Plaintiffs filed the Complaint. The claim is void under NRS 41A.071.

2. Plaintiffs' Fraudulent Concealment claim fails under NRCP 12(b)(5) and NRCP 9(b).

Plaintiffs' vague allegations are also insufficient to even state a claim for fraud. The elements of a fraudulent concealment claim are: (1) Defendant concealed or suppressed a material fact; (2) Defendant was under a duty to disclose the concealed fact; (3) Defendant intentionally concealed or suppressed the fact with the intention of defrauding plaintiff(s); (3) Plaintiff(s) did not know about the fact and would have acted differently had they known; and (4) Plaintiff sustained causation and damages as a result of the concealment or suppression of the fact. *Nevada Power Co. v. Monsanto Co*., 891 F.Supp. 1406, 1415 (D. Nev. 1995); Riviera v. Morris, Inc., 395 F.3d 142 (9th Cir. 2005) (citing *Dow Chem. Co. v. Mahlum*, 14 Nev. 1468 (1998) overruled in part on other grounds).

In pleading their fraudulent concealment claim, here, Plaintiffs do not identify any facts that were concealed or suppressed as a part of the purported conspiracy, much less any other elements of fraudulent concealment. *Id*. at ¶ 47-60.

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Additionally, nothing in Plaintiffs' Complaint satisfies the particularity requirement of NRCP 9(b). *See Larson v. Homecomings Financial, LLC*, 680 F.Supp. 2d 1230, 1234 (D. Nev. 2009) (stating that a fraudulent concealment claim must satisfy the heightened pleading requirements of NRCP 9(b)). The Nevada Rules of Civil Procedure require that "averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity." NRCP 9(b). "The circumstances that must be detailed include averments to the time, the place, the identity of the parties involved, and the nature of the fraud or mistake." *Brown v. Kellar*, 97 Nev. 582, 583-584, 636 P.2d 874, 874 (Nev., 1981) (citing 5 Wright and Miller, Federal Practice and Procedure s 1297 at p. 403 (1969)). The fraudulent concealment claims must also be stated with particularity. *See Hale v. Burkhardt*, 104 Nev. 632, 637-38, 764 P.2d 866, 869 (1988).

Here, Plaintiffs have failed to plead even the bare elements of fraudulent concealment. The purported fraudulent concealment claim is grounded on vague and conclusory allegations that Defendants (plural) have "altered, destroyed and/or concealed" medical records. *See* Amended Complaint at ¶ 47-60. However, Plaintiffs have been in possession of 4000+ pages of medical records for five years, which have been reviewed by three separate experts, and Plaintiffs is unable to articulate a single fact, record, or otherwise that was concealed.

Additionally, the reference to *Rocker v. KPMG, LLP*122 Nev. 1185, 148 P.3d 703 (2006) in the Amended Complaint to convince the court to apply a relaxed pleading standard is unavailing, particularly since we are four years into this case and the deadline to amend the pleading has now long since passed. As the deadline for amending the pleadings has passed and Plaintiffs never sought leave to plead the claim with more particularity, Plaintiffs have no excuse for the bare, unfounded averments of fraud.

Notwithstanding, the relaxed pleading standard articulated in *Rocker* is only applied when the court is "convinced that the facts necessary for pleading with particularity are peculiarly within the defendant's knowledge or are readily obtainable by him." *Labasan v. Countrywide Mortgage Ventures, LLC*, No. 2:09-CV-02315-KJD, 2010 WL 3810008, at *2 (D. Nev. Sept. 20, 2010) (citing *Rocker*, 148 P.3d at 703). Moreover, the plaintiff must (1) plead sufficient facts in the complaint to support a strong inference of fraud; (2) aver that a relaxed

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pleading standard is appropriate; and (3) show in the complaint that fraud could not be pled with more particularity because the required information is in the defendant's possession. *Rocker*, 122 Nev. At 1195, 148 P.3d at 709.

In this case, the Plaintiffs' conclusory allegations of the elements for fraudulent concealment simply do not satisfy the heightened pleading requirements under NRCP 9(b) or *Rocker*. Therefore, to the extent Plaintiff attempts to revive this cause of action to thwart dismissal under the statute of limitations, the argument and/or claim should be summarily dismissed.

C. Dr. Lanzkowsky's Declaration should be stricken from the Complaint under NRCP 12(f) since it was not included with the proposed amended complaint.

Alternatively, St. Rose Hospital requests this Court strike Dr. Lanzkowsky's declaration from the Amended Complaint as it was not attached to the proposed amended complaint for which leave was granted. Striking the declaration is warranted because the Amended Complaint currently on file is not the same pleading that was submitted to the Court with the proposed amended complaint. See EDCR 2.30 (defining "amended pleading" as including any referenced exhibits). Indeed, it is indisputable that Dr. Lanzkowsky's declaration was not included with the Motion to Amend or attached to the proposed amended complaint. In fact, Dr. Lanzkowsky's declaration, which is attached to the Amended Complaint, was not in existence at that time the proposed amended complaint was filed. Rather, it was created three weeks later. Consequently, it cannot possibly be the declaration referred to in the proposed amended complaint. Accordingly, the proposed amended complaint and the Amended Complaint, are indisputably different documents supported by different declarations. Dr. Lanzkowsky's declaration should therefore be stricken pursuant to NRCP 12(f) as Plaintiff did not obtain leave of Court to attach a declaration *that* declaration to the Amended Complaint.

D. Plaintiffs' newly asserted allegations must be dismissed pursuant to NRS 41A.071.

Given Dr. Lanzkowsky's declaration is a rogue document that should be stricken from the Amended Complaint, the newly added claims against St. Rose Hospital should be dismissed for lack of expert support. Alternatively, the newly added claims against the unnamed nurses

and the allegations associated with a "delay" in treatment must be dismissed pursuant to NRS 41A.071 because they are not properly supported with an expert affidavit/declaration.

NRS § 41A.071 states:

> If an action for professional negligence is filed in the district court, the district court ***shall dismiss the action***, without prejudice, if the action is filed without an affidavit that:
>
> 1. Supports the allegations contained in the action;
> 2. Is submitted by a medical expert who practices or has practiced in an area that is substantially similar to the type of practice engaged in at the time of the alleged professional negligence;
> 3. Identifies by name, or describes by conduct, each provider of health care who is alleged to be negligent; ***and***
> 4. Sets forth factually a specific act or acts of alleged negligence separately as to each defendant in simple, concise and direct terms.

Nev. Rev. Stat § 41A.071 (emphasis added).

Again, District courts "have no discretion with respect to dismissal" where a complaint fails to comply with NRS 41A.071. *Washoe Med. Ctr. v. Second Judicial Dist. Court*, 122 Nev. 1298, 1304, 148 P.3d 794 (2006). Moreover, NRS 41A.071 "applies even when only some of the claims violate the NRS 41A.071 affidavit requirement." *Fierle v. Perez*, 125 Nev. 728, 738, 219 P.3d 906, 912 (2009) (affirming dismissal of a negligent training and supervision claim for the failure to comply with the affidavit requirement although a claim for Res Ipsa Loquitur survived) *overruled on other grounds by Egan v. Chambers*, 129 Nev. Adv. Op. 25, 299 P.3d 364, 367 (2013). Thus "the claims can be severed, dismissing some while allowing others to proceed." *Id.* As stated by the Nevada Court of Appeals:

> NRS 41A.071 requires dismissal of any medical malpractice *claim* that is unaccompanied by an affidavit of merit supporting the allegations contained in the complaint and signed by a medical expert who practices or has practiced in an area that is substantially similar to the type of practice engaged in at the time of the alleged malpractice.

See Dauksavage v. Hulka, 67034, 2015 WL 9485180, at *2 (Nev. App. Dec. 17, 2015) (unpublished) (citing to *Fierle v. Perez*, 125 Nev. at 736, 219 P.2d at 911) (Emphasis added).

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Here, if Dr. Lanzkowsy's declaration is stricken as it should be, all claims against St. Rose Hospital are *void ab initio* under NRS 41A.071.

Nevertheless, even if the Amended Complaint is not void in its entirety, it is subject to partial dismissal given Dr. Lanzkowsy's declaration does not satisfy NRS 41A.071 as to several new allegations set forth in the Amended Complaint. Specifically, the Amended Complaint summarizes the new claims and allegations of professional negligence as follows: (1) a breach of the standard of care by "[a]waiting necessary treatment which resulted in delays in diagnosing Decedent's condition;" and (2) a breach of the standard of care by "[r]epeatedly failing to properly monitor or treat Decedent's elevated blood pressure."

As set forth below, the allegation of a breach associated with "[a]waiting necessary treatment which resulted in delays in diagnosing Decedent's condition" must be dismissed. Similarly, the allegations in the Complaint that a nurse, or nurses, failed to properly monitor or treat Decedent's elevated blood pressure, likewise fails.

1. **Plaintiffs' new allegations that St. Rose breached the standard of care by "awaiting necessary treatment which resulted in delays in diagnosing Decedent's condition is nowhere to be found in Dr. Lanzkowsky's declaration.**

Although Dr. Lanzkowsky's declaration offers criticisms of the treatment of Ms. Badoi's hypertension/blood pressure, he offers no criticisms that may be interpreted as a breach of the standard of care relating to "[a]waiting necessary treatment which resulted in delays in diagnosing Decedent's condition."[3] Thus, any claim based upon a delay in treatment is not supported by the expert's declaration and must therefore be dismissed as unsupported under NRS 41A.071(1).

2. **Plaintiffs' allegation(s) that a nurse(s) did not "properly monitor or treat Decedent's elevated blood pressure" are not specifically set out or supported by an expert in substantially similar type of practice.**

Another mandatory element of a declaration submitted pursuant to NRS 41A.071 is that the declaration be "submitted by a medical expert who practices or has practiced in an area that is substantially similar to the type of practice engaged in at the time of the alleged professional

[3] This is really not surprising given Plaintiffs' counsel did not have the benefit of Dr. Lanzkowsky's declaration at the time the Amended Complaint was drafted given the declaration was created weeks later.

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negligence." NRS 41A.071(2). In addition, under NRS 41A.071(3) and (4), the negligent actors are to be identified, as are the "specific act or acts of alleged negligence separately as to each defendant in simple, concise and direct terms."

Here, Dr. Lanzkowsky is the only expert proffered to support the allegations that the nursing staff breached a duty of care regarding the monitoring or treatment of Ms. Badoi's hypertension. However, Dr. Lanzkowsky is an obstetrician, he is not a nurse. Accordingly, while he certainly a physician in substantially the same practice area as the obstetricians he criticizes, he does not maintain a practice similar to that of a nurse.

Additionally, each of Dr. Lanzkowsky's criticisms that could be interpreted as criticisms of the nursing staff are addressed in turn below:

> At 0641 the patient had severe range blood pressures and *nursing notified Dr. Herplosheimer* who treated the elevation with i.v. hydralazine to control the BP. Despite the patient having multiple elevations in blood pressure in the severe range Magnesium Sulfate (MgSO4) *was not ordered* until 0945. *Missing the significance of Ms. Badoi's elevated BP's by medical and nursing staff* is a breach of the standard of care and led to delayed treatment with Magnesium Sulfate and/or other medications to lower her BP. Mg So4 is given to reduce the risks of seizure due to worsening pre-eclampsia and has the additional side effect of lowering maternal BP though it is not given for that purpose per-se.

See Declaration of Dr. Lanzkowsky, attached to Amended Complaint (emphasis added).

In this first allegation it is alleged that the nursing staff in fact notified Dr. Herpolsheimer of the severe range pressures. Dr. Lanzkowsky merely criticizes the failure to order Magnesium Sulfate, which is a task reserved exclusively to physicians. Nonetheless, Dr. Lanzkowsky then strangely concludes that "missing the significance of Ms. Badoi's elevated BP's" was a breach of the standard of care not only by the "medical staff," but a breach by the "nursing staff".

Accordingly, it is entirely unclear what the breach was on the part of the nursing staff, or which nurse was allegedly negligent. Certainly the nurse at 0641 notified Dr. Herpolsheimer of the severe range pressures, so she is presumably not the "nursing staff" that "missed the significance of Ms. Badoi's elevated BP's . . . ." In fact, this purposely vague conclusion by Dr. Lanzkowsky also goes to the very purpose as to why a "substantially similar" expert is required. Dr. Lanzkowsky's declaration utterly fails to explain what obligations the nursing staff had

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regarding the patient's blood pressures, other than informing the doctor, which was admittedly done in this situation. Therefore, this allegation fails to meet both NRS 41A.071(3) and (4) as it does not identify the negligent nurses nor describe the "specific act(s)" of alleged negligence in "simple, concise, and direct terms[4]."

> On the postpartum floor at 2045 hrs., Ms. Badoi complained of tingling in her legs and when notified Dr. Garg was notified, he ordered the MgSo4 held for one hour concerned that this was a possible reaction to MgSO4. Although her symptoms did not improve and in fact worsened during this time, the MgSo4 was restarted, and no effort was made to ascertain the cause of Badoi's symptoms having ruled out MgSO4 toxicity as a cause. Failing to reevaluate Ms. Badoi after MgSo4 was discontinued to see if symptoms improved was a breach of the standard of care.

Id.

This next allegation makes no mention whatsoever of any nursing issues, but vaguely concludes that the patient should have been reevaluated after Mag Sulfate was discontinued. This can only be an allegation of negligence by Dr. Garg, as it there is no mention of any nursing conduct anywhere within the paragraph.

> Of significant concern the patient continued to have severe range BP that should have been treated with fast acting anti-hypertensives (like hydralazine). On 05/17/2017 at 0402, *Nurse Taylor informed the attending OB Dr. Garg* that Ms. Badoi's BP was 182/99. This elevated BP required immediate medical treatment and failure to render such care was a breach of the standard of care Ms. Badoi's repeat BP 15 minutes was later was 183/97 which also went untreated. The patient continued to have a BP in severe ranges with worsening neurologic symptoms in her lower extremities., At 0435, *Nurse Taylor again called Dr. Garg who ordered oral labetalol. Nurse Taylor correctly queried Dr. Garg* to be certain he did not want to give IV hydralazine, he declined and ordered labetalol and, of note, did not evaluate the patient. The management of these pressures with oral antihypertensives was a breach of the standard of care.

Id.

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[4] Alternatively, Defendant requests a more definite statement as to the basis for this allegation that the nurse was negligent.

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This third allegation again provides a purposely vague allegation regarding who breached the standard of care. Yet, again, however, it is clearly a breach attributed to Dr. Garg since Nurse Taylor's actions are actually commended by Dr. Lanzkowsky.

> Finally, at 0547 when contacted again regarding Ms. Badoi's BP of 183/98, Dr. Garg ordered a small dose (5mg) of IV hydralazine. This was an unusually small dose that had a predictable minimal effect on Ms. Badoi's pressures which remained in the severe range (167/97 at 0602 hrs.). By 0626 hrs. Ms. Badoi's labs returned confirming HELLP syndrome (High BP, Elevated Liver enzymes, Low Platelets) a form of severe pre-eclampsia. As the patient's neurologic injuries progressed, she continued to have significantly elevated and untreated severe BP, treated only with oral Labetalol until 1824 hrs. when she was given an additional 20mg of Hydralazine as a standing order about one hour later she is transferred to the ICU. The management of these pressures with oral antihypertensives represents a breach of the standard of care.

Id.

This fourth and final criticism by Dr. Lanzkowsky in the Amended Complaint again offers no criticisms of any nurse. Rather, Dr. Lanzkowsky's ire once again is directed at Dr. Garg.

> It is my opinion to a reasonable degree of medical certainty that the nursing and medical staff at St. Rose-Siena breached the standard of care by improperly treating Ms. Badoi's hypertension, especially during the postpartum period. . . .

Lastly, Dr. Lanzkowsky suggests, without naming names, that the "nursing" and "medical" staff breached the standard of care regarding the treatment of Ms. Badoi's hypertension. Dr. Lanzkowsky's silence as to the purportedly negligent actors is gamesmanship, plain and simple.

Nevertheless, from the detailed analysis above, it is clear that the only allegations of negligence set forth in the Dr. Lanzkowsky's declaration are:

- one unintelligible allegation of negligence against a nurse regarding Dr. Herpolsheimer's failure to order Magnesium Sulfate;
- one allegation of negligence by Dr. Herpolsheimer regarding his failure to order Magnesium Sulfate pre-delivery; and

- three allegations of negligence by Dr. Garg regarding his management of the Magnesium Sulfate.

The one allegation of negligence against a single nurse must be dismissed as it does not set out the specific acts of negligence attributable to her. Again, that this "criticism" – if you can even call it that – comes from an obstetrician, as opposed to a nurse, is telling and representative as to why the legislature made it a point to require these affidavits be from an expert in the "same or substantially similar" area of practice. Therefore, the single, vague suggestion of negligence by a nurse for informing Dr. Herpolsheimer of the patient's blood pressure values should be dismissed under NRS 41A.071. Plaintiffs Amended Complaint against St. Rose Hospital must therefore be limited to the ostensible agency claims for each of Drs. Herpolsheimer and Garg.

VI.

CONCLUSION

Based upon the foregoing, Defendant respectfully request that this Court dismiss Plaintiffs' remaining claims against St. Rose Hospital.

DATED this 23rd day of August, 2022.

HALL PRANGLE & SCHOONVELD, LLC

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of HALL PRANGLE & SCHOONVELD, LLC; that on the 23rd day of August 2022, I served a true and correct copy of the foregoing **DEFENDANT DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL'S MOTION TO DISMISS, OR ALTERNATIVELY, MOTION TO STRIKE** via the Court e-filing System in accordance with the electronic service requirements of Administrative Order 14-2 and the Nevada Electronic Filing and Conversion Rules, to the following:

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DISTRICT COURT

CLARK COUNTY, NEVADA

LIVIU RADU CHISIU, as Special Administrator of the ESTATE OF ALINA BADOI, Deceased; LIVIU RADU CHISIU, as Parent and Natural Guardian of SOPHIA RELINA CHISIU, a minor, as Heir of the ESTATE OF ALINA BADOI, Deceased; Plaintiff, vs. DIGNITY HEALTH, a Foreign Non-Profit Corporation d/b/a ST. ROSE DOMINICAN HOSPITAL – SIENA CAMPUS; JOON YOUNG KIM, M.D., an Individual; FIELDEN, HANSON, ISAACS, MIYADA, ROBISON, YEH, LTD., a Nevada Professional Corporation d/b/a USAP-Nevada; DOES I through X; and ROE BUSINESS ENTITIES XI through XX, inclusive, Defendants.	CASE NO.: A-18-775572-C DEPT NO.: 9 **PLAINTIFFS' OPPOSITION TO DEFENDANT DIGNITY HEALTH D/B/A ST. ROSE DOMINICAN HOSPITAL'S MOTION FOR RECONSIDERATION OF THE ORDER GRANTING PLAINTIFFS' MOTION FOR LEAVE TO FILE AMENDED COMPLAINT** DATE OF HEARING: SEPTEMBER 23, 2022 TIME OF HEARING: CHAMBERS

Plaintiffs Liviu Radu Chisiu, as Special Administrator of the Estate of Alina Badoi, Deceased, and Liviu Radu Chisiu, as Parent and Natural Guardian of Sophia Relina Chisiu, a minor, as Heir of the Estate of Alina Badoi, Deceased, by and through their undersigned counsel,

hereby oppose Defendant Dignity Health d/b/a St. Rose Dominican Hospital's ("St. Rose") Motion for Reconsideration of the Order Granting Plaintiffs' Motion for Leave to File Amended Complaint.

In an effort to manufacture "new issues of fact" to justify reconsideration, St. Rose falsely accuses Plaintiffs of misrepresenting the existence of Dr. Lanzkowsky's declaration at the time Plaintiffs moved for leave to amend their complaint. St. Rose is wrong. At the time Plaintiffs filed their motion, Dr. Lanzkowsky had offered opinions that gave rise to additional breaches of the standard of care by St. Rose based on the conduct of its own nurses and physicians. Plaintiffs promptly moved for leave to amend to conform to the evidence unearthed in discovery, including the newly asserted opinions of Dr. Lanzkowsky. Plaintiffs' motion clearly and accurately stated: "The additional allegations concerning St. Rose's breaches of the standard of care are supported by Plaintiffs' expert, Jonathan Lanzkowsky, M.D." Motion dated May 2, 2022, at 6:9-11. Contrary to St. Rose's assertions otherwise, an expert affidavit is NOT required for the proposed amended complaint. After the Court granted Plaintiffs' motion for leave to amend, Plaintiffs properly filed their Amended Complaint with the requisite declarations/affidavits of merit of Drs. Lanzkowsky, Beilin, and Hirschfeld attached thereto. St. Rose's instant motion is nothing more than an attempt to rehash its failed arguments that were previously presented to, and rejected by, the Court. St. Rose's unhappiness with the Court's Order does not justify reconsideration. As such, this Court should deny the motion.

This Opposition is based upon the pleadings and papers on file in this action, the Points and Authorities set forth herein, and argument to be made by counsel at the time of the hearing.

MEMORANDUM OF POINTS AND AUTHORITIES

I.

INTRODUCTION AND RELEVANT BACKGROUND

This is a professional negligence case arising out of care rendered to Decedent Alina Badoi ("Alina" or "Decedent") during her hospitalization at St. Rose Dominican Hospital's Siena Campus from May 15 through June 3, 2017. On May 15, 2017, Alina was admitted to St. Rose

to give birth to her child, Sophia. Amended Complaint at ¶ 15, on file herein. Sophia was delivered vaginally on May 16, 2017. *Id*. On May 16, 2017, at 0058, prior to the delivery of her child, Defendant Joon Young Kim, M.D. ("Dr. Kim"), an anesthesiologist, was consulted for the purpose of placing an epidural. Exhibit 2 at pg. 4 and 22, attached to Amended Complaint. However, Dr. Kim noted concerns about Alina's presentation with thrombocytopenia (low platelet count) and epistaxis (nose bleed). *Id*. Dr. Kim ordered a manual platelet count be done before he would make a decision regarding placement of epidural anesthesia. *Id*.

At 0215, Dr. Kim alleges he spoke with Ronaldo Abuan in the lab at St. Rose regarding his manual platelet count and subsequently advised that he would not place the epidural anesthetic in Alina due to a dramatic variance in the platelet count between the automated test and the manual test. *Id*. At 0300, Alina's OBGYN, Arthur Herpolsheimer, M.D. (hereinafter "Dr. Herpolsheimer"), purportedly discussed pain management options with Alina since Dr. Kim would not place an epidural. *Id*. at pg. 4.

At 1445, Alina delivered her baby Sophia vaginally with epidural anesthesia. *Id*. at pg. 22. Within six (6) hours of delivery, Alina began to experience clinical complications postpartum. *Id*. At 2045, Alina developed symptoms of tingling and numbness (parathesias) involving her lower extremities and associated with dizziness. *Id*. Dr. Herpolsheimer was notified of Alina's symptoms at 2058. *Id*. at pgs. 5 and 22.

On May 17, 2017, at 0705, the records state, "anesthesiologist does not think itching, pain numbness is related to epidural." *Id*. at pg. 7. Around 1045, Dr. Herpolsheimer personally evaluated Alina and raised initial concern about a possible epidural hematoma. *Id*. at pg. 8. Alina's lower extremity symptoms became progressively worse and she subsequently developed acute spastic paraparesis and underwent a laminectomy from T8 to L3 for an intradural hematoma, *inter alia*, more than twelve (12) hours after her clinical problem was first observed. Amended Complaint at ¶ 16; Exhibit 2 at pg. 24, attached to Amended Complaint.

Alina subsequently developed epidural and subdural hematomas. Exhibit 1 at pg. 1, attached to Amended Complaint. Lumbar spinal and interventricular drains were placed during Alina's clinical course. *Id*.; Amended Complaint at ¶ 16. While attempting physical therapy at St. Rose, Alina coded and passed away on June 3, 2017. *Id*.

An autopsy was performed by Forensic Pathologist Dr. Alane M. Olson of the Clark County Coroner on June 4, 2017. Exhibit 2 at pg. 22, attached to Complaint. Dr. Olson issued her findings on August 7, 2017, at which time she concluded Alina's death was caused by bilateral pulmonary thromboemboli due to or as a consequence of deep venous thrombosis due to or as a consequence of acute spastic paraparesis following intradural hemorrhage associated with epidural anesthesia. Amended Complaint at ¶ 17, 21.

On June 5, 2018, Plaintiffs filed their Complaint against St. Rose, Dr. Kim, and U.S. Anesthesia Partners ("USAP"), alleging the following claims for relief: Professional Negligence; Negligent Credentialing (against St. Rose only); Fraudulent Concealment and/or Omissions; Negligent Hiring, Training, Retention and Supervision (against St. Rose and USAP); Ostensible Agency/Vicarious Liability (against St. Rose and USAP); and Wrongful Death Pursuant to NRS 41.085. The original Complaint was supported by Yaakov Beilin, M.D. and Bruce J. Hirschfeld, M.D. Since that time, the parties engaged in extensive discovery, including twelve depositions and multiple sets of written discovery.

On April 27, 2022 during preparation for the then-existing initial expert disclosure deadline of May 2, 2022, Plaintiffs' expert, Jonathan Lanzkowsky, M.D. offered opinions that gave rise to additional breaches of the standard of care by St. Rose based on the conduct of its nurses and medical staff. *See* Decl. of R. Todd Terry, attached as **Exhibit 1**. After learning of Dr. Lanzkowsky's opinions, and in accordance with the deadline to add parties or amend pleadings, on May 2, 2022, Plaintiffs promptly moved for leave to amend their Complaint to include additional allegations concerning St. Rose's breaches of the standard of care consistent with the opinions of Dr. Lanzkowsky. **Exhibit 1**; *see also* Motion dated May 2, 2022 and Reply brief dated

May 30, 2022, on file herein. On June 22, 2022, the Court granted Plaintiffs' Motion for Leave to File Amended Complaint. *See* Order dated August 2, 2022, on file herein. On August 9, 2022, Plaintiffs filed the Amended Complaint with the requisite affidavits/declarations of merit of Drs. Beilin, Hirschfeld, and Lanzkowsky attached thereto.

II.

LEGAL ARGUMENT

A. THE COURT MAY GRANT LEAVE TO RECONSIDER A PRIOR RULING ONLY IN VERY RARE INSTANCES, NONE OF WHICH EXIST HERE.

Pursuant to EDCR 2.24(a), "[n]o motions once heard and disposed of may be renewed in the same cause, nor may the same matters therein embraced be reheard, ***unless by leave of the court granted upon motion therefor***, after notice of such motion to the adverse parties." (emphasis added). Leave of court is necessary because "[l]itigants are not entitled to a rehearing as a matter of right." *Bates v. Nevada Sav. & Loan Ass'n*, 85 Nev. 441, 443, 456 P.2d 450, 452 (1969) (citation omitted); *see also Geller v. McCown*, 64 Nev. 102, 108, 178 P.2d 380, 381 (1947) ("Rehearings are not granted as a matter of right, and are not allowed for the purpose of reargument, unless there is a reasonable probability that the court may have arrived at an erroneous conclusion.") (internal citations omitted).

In fact, a court's inherent power to reconsider a previously decided issue is not unfettered. It is an abuse of discretion for a court to rehear a motion when the motion for rehearing contains no new issues of law and makes reference to no new or additional facts. *See Moore v. City of Las Vegas*, 92 Nev. 402, 405, 551 P.2d 244, 246 (1976) (holding that it was an abuse of discretion for the district court to entertain a motion for rehearing when the only feature that distinguished the motion for rehearing from the prior motion was "the citation of additional authorities for the proposition of law already set forth and adequately supported by reference to relevant authorities in the earlier motions.").

A district court may reconsider a previously decided issue "if substantially different evidence is subsequently introduced or the decision is clearly erroneous." *Masonry & Tile Contractors Ass'n of S. Nevada v. Jolley, Urga & Wirth, Ltd.*, 113 Nev. 737, 741, 941 P.2d 486,

489 (1997); *see also Leslie Salt Co. v. United States*, 55 F.3d 1388, 1393 (9th Cir. 1995) (stating that a "court may reconsider previously decided questions in cases in which there has been an intervening change of controlling authority, new evidence has surfaced, or the previous deposition was clearly erroneous and would work a manifest injustice."). "Only in ***very rare instances*** in which new issues of fact or law are raised supporting a ruling contrary to the ruling already reached should a motion for rehearing be granted." *Moore*, 92 Nev. at 405, 551 P.2d at 246 (emphasis added); *see also Koninklijke Philips Elecs. N.V. v. KXD Tech., Inc.*, 245 F.R.D. 470, 472 (D. Nev. 2007) ("A motion for reconsideration 'should not be granted absent highly unusual circumstances, unless the district court is presented with newly discovered evidence, committed clear error, or if there is an intervening change in the controlling law.'") (citation omitted).

Here, St. Rose is unhappy with the Court's Order. St. Rose's unhappiness, however, is not enough to warrant reconsideration. Aside from manufacturing "new issues of fact" by effectively accusing Plaintiffs of lying to the Court about the existence of Dr. Lanzkowsky's declaration—which, as discussed below, is patently false—St. Rose has not offered anything the Court has not already heard. St. Rose has failed to meet its onerous burden of demonstrating the Court should agree to rehear or reconsider the Court's Order.

B. ST. ROSE'S MOTION FOR RECONSIDERATION IS IMPROPER BECAUSE IT MERELY REGURGITATES THE SAME ARGUMENTS THAT WERE CONSDIERED AND REJECTED BY THE COURT DURING THE ORIGINAL PROCEEDING.

In support of its Motion, St. Rose attempts to manufacture "new issues of fact" by accusing Plaintiffs of misrepresenting the existence of Dr. Lanzkowsky's declaration. However, as set forth in the Decl. of R. Todd Terry, attached as **Exhibit 1**, prior to the filing of Plaintiffs' motion for leave to amend, on April 27, 2022, Plaintiffs' counsel received a report from Dr. Lanzkowsky that offered opinions giving rise to additional breaches of the standard of care by St. Rose based on the conduct of its nurses and medical staff. *Id*. After learning of Dr. Lanzkowsky's opinion, on May 2, 2022, Plaintiffs promptly moved for leave to amend their Complaint to include additional allegations concerning St. Rose's breaches of the standard of care consistent with the newly asserted opinion of Dr. Lanzkowsky; meanwhile, Dr. Lanzkowsky reduced his report to a

sworn declaration as required by NRS 41A.071. *Id*. There is no dispute Plaintiffs' motion was filed within the deadline to amend pleadings or add parties.

That Plaintiffs were in possession of a report, rather than a sworn declaration, at the time Plaintiffs moved for leave to amend their complaint is a distinction without a difference because the substance of Dr. Lanzkowsky's opinions contained in his report are identical to those contained in his sworn declaration. *Id*. The fact remains that at the time Plaintiffs filed their motion, Dr. Lanzkowsky had offered opinions giving rise to additional breaches of the standard of care by St. Rose based on the conduct of its own nurses and physicians. Plaintiffs *promptly and timely*[1] moved for leave to amend to conform to the evidence unearthed in discovery, including the newly asserted opinions of Dr. Lanzkowsky. Plaintiffs' motion clearly and accurately stated: "The additional allegations concerning St. Rose's breaches of the standard of care are supported by Plaintiffs' expert, Jonathan Lanzkowsky, M.D." Motion dated May 2, 2022, at 6:9-11. After the Court granted Plaintiffs' request for leave to amend, Plaintiffs filed their Amended Complaint with the requisite declaration of Dr. Lanzkowsky attached thereto. *See* Amended Complaint dated August 9, 2022, on file herein.

Even if Dr. Lanzkowsky's declaration was attached to Plaintiff's motion for leave to amend, the outcome would be the same because St. Rose offers the same failed arguments that were previously presented to, and rejected by, the Court—specifically, that Dr. Lanzkowsky's declaration was not attached to the proposed amended complaint; that no additional discovery had taken place since November 2021; and that Plaintiffs have been in possession of the medical records and information to support the amendment for four years. St. Rose previously made each of these unavailing arguments in its Opposition to Plaintiffs' Motion for Leave to File Amended Complaint, which the Court squarely rejected. *See* Opposition dated May 18, 2022, on file herein. St. Rose's re-assertion of the same failed arguments is insufficient to justify reconsideration of the Court's factually and legally sound Order.

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[1] If Plaintiffs had waited until May 24, 2022, to file their motion, as St. Rose suggests, St. Rose would surely argue Plaintiffs were dilatory in seeking amendment because Plaintiffs would have been in possession of Dr. Lanzkowsky's opinions for nearly a month.

C. EVEN IF THE COURT IS INCLINED TO RECONSIDER THE ORDER, THE RULING SHOULD STAND BECAUSE PLAINTIFFS ESTABLISHED GOOD CAUSE FOR THE AMENDMENT.

Despite St. Rose's assertions to the contrary, Plaintiffs' Amended Complaint did not change the theory of liability against St. Rose nor add any new causes of action or additional parties. Rather, the Amended Complaint alleges two additional breaches of the standard of care against St. Rose based on vicarious liability (i.e., actual agency/ostensible agency) for the professional negligence its own nurses and physicians, which contributed to the pulmonary embolism that ultimately caused Alina's death. Since the inception of this case, the Complaint against St. Rose has been based on vicarious liability/ostensible agency. Nothing about that has changed save and except for two additional breaches of the standard of care by St. Rose for: 1) the repeated failures of its physicians and nurses to properly monitor or treat Alina's elevated blood pressure, and 2) awaiting necessary treatment which resulted in delays in diagnosing Alina's condition. Justice requires that such claims be brought into this lawsuit so Plaintiffs may pursue all avenues of recourse against St. Rose and recover all damages arising out of St. Rose's breaches of the standard of care which contributed to Alina's death.

1. Plaintiffs' Motion was Timely Filed in Good Faith.

Not only was Plaintiffs' Motion brought in accordance with the Court-ordered deadline to bring motions to amend pleadings, to which all parties stipulated and agreed, it was brought five months prior to the then-discovery cutoff date of October 3, 2022. That Plaintiffs sought leave of Court to amend their Complaint within the timeframe to do so negates any notion of undue delay, bad faith, or dilatory motive. To find otherwise renders the deadline to amend pleadings completely meaningless.

The Amended Complaint is not a complete change of theory in the opposite direction, as St. Rose suggests. The Amended Complaint is consistent with the original Complaint in that Plaintiffs still allege St. Rose was negligent in its care and treatment of Alina vis-à-vis vicarious liability and/or ostensible agency. The Amended Complaint only seeks to hold St. Rose liable for additional breaches of the standard of care in its negligent care and treatment of Alina. As Plaintiffs accurately stated in their underlying motion, the amendment was brought in order to

conform to the evidence uncovered in discovery, including the opinions of Dr. Lanzkowsky wherein he opines as to additional breaches of the standard of care by St. Rose. Plaintiffs' counsel is well aware of the requirements of Rule 11 and would not have brought the Amended Complaint if it was not in good faith.

St. Rose complains that Plaintiffs' Motion comes after the hearing on St. Rose's Motion for Judgment on the Pleadings, at which time Plaintiffs stipulated the Complaint against St. Rose was limited to a cause of action for professional negligence based on a theory of vicarious liability (i.e., actual agency/ostensible agency) for the alleged professional negligence of Defendant Joon Young Kim, M.D. However, that stipulation was made during the hearing on March 16, 2022, based on the operative Complaint on file at that time. Plaintiffs ***never*** waived their right to file a motion for leave to amend consistent with the stipulated deadline to do so. Indeed, it was not until after the March 16 hearing, on April 27, 2022, that Plaintiffs learned Dr. Lanzkowsky has offered opinions that give rise to additional breaches of the standard of care by St. Rose based on the conduct of its own nurses and physicians. *See* **Exhibit 1**.

St. Rose mischaracterizes Liviu Chisiu's deposition testimony in asserting that Mr. Chisiu confirmed knowledge of the allegations and criticisms set forth in the proposed amendment in 2019. As a lay person, Mr. Chisiu does not have the necessary knowledge or qualifications to determine what ultimately caused and/or contributed to the pulmonary embolism that caused Alina's death. Although Mr. Chisiu testified he had some concern about Alina having elevated blood pressure one night, Mr. Chisiu testified in that moment, he was more worried about the numbness in Alina's leg than her blood pressure. Liviu Chisiu Dep. at 170:01-174:16, relevant portions attached as **Exhibit 2**.

Counsel for St. Rose went on to confirm he was not asking Mr. Chisiu for his personal opinion because Mr. Chisiu is not a doctor and not qualified to give such opinions. Mr. Chisiu conceded he was not a doctor, never worked in a hospital, and has no knowledge about how long it typically takes to get an MRI done:

Q. And I'm not asking your opinion because you're not –

A. I'm not a, yeah.

Q. You're not a doctor, right?
A. Correct.
Q. And you're – I mean, you had some training to be a physical therapist?
A. Yeah.
Q. But you've never worked in a hospital?
A. Correct.

Id. at 178:08-21. Thus, despite St. Rose's assertions to the contrary, Mr. Chisiu does not have the medical knowledge or qualifications necessary to know whether the allegations set forth in the Amended Complaint caused or contributed to the pulmonary embolism that caused Alina's death.

St. Rose notes that Plaintiffs have been in possession of all St. Rose records since June 2017 and no discovery has taken place since November 2021. Conveniently, St. Rose fails to mention that since November 2021, its counsel has objected to Plaintiffs' request to take additional fact witness depositions, asserting that Plaintiffs have reached the 10-deposition limit allowed under NRCP 30(a)(2)(A)(i). Counsel for St. Rose refused to stipulate to allow Plaintiffs to exceed the 10-deposition limit for additional fact witness depositions. *See* Email String, attached as **Exhibit 3**. St. Rose also fails to call attention to the fact that Plaintiffs moved for leave to amend as the parties were preparing to disclose initial experts by the then-existing deadline of May 2, 2022, but which was continued to October 3, 2022, to allow St. Rose to adequately defend against the allegations in the Amended Complaint. *See* Amended Scheduling Order dated August 9, 2022, on file herein. St. Rose also fails to mention that on February 25, 2022, Counsel for St. Rose agreed to continue the deadline to amend pleadings and add parties from March 2, 2022, to May 2, 2022. *See* Stipulation and Order to Extend Discovery Deadlines (Tenth Request) dated February 25, 2022, on file herein.

The parties are still in the midst of discovery. St. Rose's NRCP 30(b)(6) designee has yet to be deposed. Moreover, initial expert disclosures are not due until October 3, 2022. Discovery does not close until January 3, 2023. As mentioned above, the parties stipulated and agreed to continue the deadline to amend pleadings to May 2, 2022. *See* Stipulation and Order to Extend Discovery Deadlines (Tenth Request) dated February 25, 2022, on file herein. If the time remaining in discovery was truly insufficient for St. Rose to defend against Plaintiffs' Amended

Complaint such that St. Rose would be unduly prejudiced, then why did St. Rose agree to continue the deadline for leave to amend to May 2, 2022? St. Rose cannot reasonably argue the Amended Complaint will cause any undue delay or prejudice, as the amendment was sought within the deadline to do so and there is ample time remaining in discovery.

2. Good Cause Exists for the Requested Amendment, and Plaintiffs Have Not Exhibited Undue Delay, Bad Faith or Dilatory Motive in Moving for Amendment.

Contrary to St. Rose's position that there has been undue delay, Plaintiffs only learned of Dr. Lanzkowsky's opinions supporting amendment on April 27, 2022, after receiving his report. St. Rose relies upon *Nutton v. Sunset Station*, 131 Nev. 279, 357 P.3d 966 (Nev. App. 2015), in which the Nevada Appellate Court stated "lack of diligence has been found when a party was aware of the information behind its amendment before the deadline [to amend], yet failed to seek amendment before it expired." In this regard, St. Rose asserts that Plaintiffs have been in possession of the information regarding the Amended Complaint well before the deadline to amend pleadings. However, St. Rose's reliance on *Nutton* is misplaced because Plaintiffs did in fact seek amendment before the deadline to do so expired, so as to not cause any undue delay. Additionally, Plaintiffs have been diligent in uncovering information pertinent to their claims and were never in possession of information necessary to successfully plead and prove causation for the two additional breaches of the standard of care by St. Rose set forth in the Amended Complaint until Dr. Lanzkowsky rendered those opinions in April 2022. Under these circumstances, the interests of justice plainly mandate granting Plaintiff's Motion for Leave to File Amended Complaint.

The Amended Complaint was filed on August 9, 2022. St. Rose has not explained why the 5 months remaining in discovery is insufficient to explore Plaintiffs' claims around the amendment. Notably, St. Rose fails to identify what different or additional discovery would be required. Experts have not yet been disclosed or deposed. The deadline to disclose rebuttal experts is not until November 3, 2022. Therefore, St. Rose still has the ability to fully question Plaintiffs' experts about their opinions related to the amendment and defend against those opinions. There is ample time to conduct the limited, if any, additional discovery that may be needed.

St. Rose next asserts that the amendment is prejudicial. Specifically, St. Rose falsely claims the deadline for seeking equitable or contractual remedies via a third-party contribution or indemnity action has expired and cries foul about unidentified nurses and physicians who were negligent in the care and treatment of Alina. Certainly, St. Rose is aware of the identities of the nurses and physicians it employed, or otherwise granted privileges, in its care of treatment of Alina while she was admitted at St. Rose. To claim otherwise would be feigning ignorance.

Further, St. Rose is not prejudiced because any contribution or indemnity claims it may have are not yet ripe. The statute of limitations period for St. Rose's contribution claim does not expire until one year after a judgment is entered against St. Rose in this matter. NRS 17.285. Similarly, the statute of limitations period for St. Rose's indemnity claim does not expire until four years after judgment. *Saylor v. Arcotta*, 126 Nev. 92, 225 P.3d 1276 (2010). In other words, St. Rose retains the ability to seek both claims in a separate action after an adverse judgment. Therefore, it is not only unnecessary for St. Rose to bring contribution or indemnity claims at this time, but also premature. These claims are purely derivative of a potential judgment against St. Rose, and no liability or damages have yet been assessed.

Plaintiffs have surely shown good cause to amend based on the newly asserted opinions of Dr. Lanzkowsky. There is no prejudice to St. Rose by the amendment because the primary legal theory of the case remains consistent—that is, St. Rose is vicariously and/or ostensibly liable for the negligent care and treatment of Alina. The proposed amendment simply seeks to allege two additional breaches of the standard of care by St. Rose.

3. An Expert Affidavit is NOT Required for the Proposed Amended Complaint.

Contrary to St. Rose's assertions otherwise, an expert affidavit is NOT required for the proposed amended complaint. St. Rose previously made this same unavailing argument in its Opposition to Plaintiff's motion for leave to amend, which the Court rejected. Again, St. Rose fails to cite any legal authority for the proposition that an affidavit of merit must be attached to a motion for leave to amend. Plaintiffs recognize that the *filing* of the Amended Complaint must be supported by an affidavit of merit pursuant to NRS 41A.071. Plaintiffs complied with that

requirement by filing the Amended Complaint on August 9, 2022, with the requisite affidavits/declarations of merit attached.

4. Plaintiffs' Claims Relate Back to their Initial Complaint.

In its Opposition to Plaintiffs' motion for leave to amend (which St. Rose incorporates by reference), St. Rose unsuccessfully argued Plaintiffs' Amended Complaint fails because the statute of limitations has expired and the amended claims do not "relate back" to the original Complaint. St. Rose's assertion that the timeliness of Plaintiffs' claims should be analyzed under NRCP 15(c)(2) for amendments that change parties is nonsensical. The Amended Complaint does not change any parties, but rather asserts claims that arose out of the conduct, transaction or occurrence set out in the original pleading. Pursuant to NRCP 15(c), an amendment of a pleading "relates back" to the date of the original pleading when the claim or defense asserted in the amended pleading arose out of the "conduct, transaction, or occurrence" set forth in the original pleading. Here, there is no doubt the two additional breaches of the standard of care by St. Rose set forth in the Amended Complaint "relate back" to the filing of the original Complaint, as both arise out of the negligent care and treatment of Alina while she was in the care of St. Rose.

In support of its position that the amendment is barred by the statute of limitations, St. Rose relies upon *Nelson v. City of Las Vegas*, 99 Nev. 548, 556, 665 P.2d 1141, 1146 (1983). There, the plaintiff previously alleged intentional infliction of emotion distress and sought to add a battery cause of action, which was a new cause of action that described a new and entirely different source of damages.

Here, contrary to the plaintiff in *Nelson*, the Amended Complaint did not add any new causes of action. Nor did it change any parties or their theory of liability in its entirety. Rather, Plaintiffs' source of damages remains the same. Consistent with the original Complaint, the Amended Complaint alleges St. Rose was negligent in its care and treatment of Alina vis-à-vis vicarious liability and/or ostensible agency. The Amended Complaint only seeks to hold St. Rose liable for additional breaches of the standard of care in its negligent care and treatment of Alina. Thus, the defense of this case will remain virtually the same, as St. Rose is still defending against Plaintiffs' malpractice claim.

Importantly, while sitting on the District Court bench, current Nevada Supreme Court Justice Silver allowed an amendment *during the course of trial*. *See* Trial Transcript in the matter of *Cantrell v. Summerlin Hospital Medical Center*, attached hereto as **Exhibit 4**. There, Judge Silver permitted the plaintiff to amend her complaint to add a claim for intentional concealment and put forth a prayer for relief for punitive damages to the jury. *Id*.

III.

CONCLUSION

Based on the foregoing facts, law, and analysis, Plaintiffs respectfully request that this Court enter an Order denying Defendant Dignity Health d/b/a St. Rose Dominican Hospital's ("St. Rose") Motion for Reconsideration of the Order Granting Plaintiffs' Motion for Leave to File Amended Complaint.

Dated this 2nd day of September, 2022.

CHRISTIANSEN TRIAL LAWYERS

By_____
PETER S. CHRISTIANSEN, ESQ.
R. TODD TERRY, ESQ.
KEELY P. CHIPPOLETTI, ESQ.
Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that I am an employee of CHRISTIANSEN TRIAL LAWYERS, and that on this 2nd day of September, 2022 I caused the foregoing document entitled **PLAINTIFFS' OPPOSITION TO DEFENDANT DIGNITY HEALTH D/B/A ST. ROSE DOMINICAN HOSPITAL'S MOTION FOR RECONSIDERATION OF THE ORDER GRANTING PLAINTIFFS' MOTION FOR LEAVE TO FILE AMENDED COMPLAINT** to be served upon those persons designated by the parties in the E-Service Master List for the above-referenced matter in the Eighth Judicial District Court eFiling System in accordance with the mandatory electronic service requirements of Administrative Order 14-2 and the Nevada Electronic Filing and Conversion Rules.

An employee of Christiansen Trial Lawyers

EXHIBIT 1

EXHIBIT 1

DECLARATION OF R. TODD TERRY, ESQ.

I, R. TODD TERRY, ESQ., hereby declare as follows:

1. I am an attorney licensed to practice law in the State of Nevada and am an attorney at the law firm of Christiansen Trial Lawyers in Las Vegas, Nevada.

2. I represent the Plaintiffs in the matter entitled *Estate of Alina Badoi, et al. v. Dignity Health, et al.*, Case No. A-18-775571-C.

3. I make this declaration based on my own personal knowledge of the case. I have personal knowledge of the contents of this declaration and could competently testify thereto.

4. I make this declaration in support of Plaintiffs' Opposition to Defendant Dignity Health d/b/a St. Rose Dominican Hospital's ("St. Rose") Motion for Reconsideration of the Order Granting Plaintiffs' Motion for Leave to File Amended Complaint.

5. On and around April 27, 2022, during preparation for the then-existing initial expert disclosure deadline of May 2, 2022, I had several conversations with and I received a report from Plaintiffs' retained expert, Jonathan Lanzkowsky, M.D., that offered opinions giving rise to additional breaches of the standard of care by St. Rose based on the conduct of its nurses and medical staff.

6. After learning of Dr. Lanzkowsky's opinions, on May 2, 2022, Plaintiff's promptly moved for leave to amend their Complaint to include additional allegations concerning St. Rose's breaches of the standard of care consistent with the newly asserted opinions of Dr. Lanzkowsky; meanwhile, Dr. Lanzkowsky reduced his report to a sworn declaration as required by NRS 41A.071.

7. That Plaintiffs were in possession of a report, rather than a sworn declaration, at the time Plaintiffs moved for leave to amend their complaint is a distinction without a difference because the substance of Dr. Lanzkowsky's opinions contained in his report are identical to the opinions contained in his sworn declaration.

/ / /

/ / /

/ / /

I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct.

Dated this 2nd day of September, 2022.

R. TODD TERRY, ESQ.

EXHIBIT 2

EXHIBIT 2

Page 1

DISTRICT COURT
CLARK COUNTY, NEVADA

LIVIU RADU CHISIU, as Special Administrator of the ESTATE OF ALINA BADOI, deceased; LIVIU RADU CHISIU, as Parent and Natural Guardian of SOPHIA RELINA CHISIU, a minor, as Heir of the ESTATE OF ALINA BADOI, deceased,

Plaintiffs,

vs. CASE NO. A-18-775572-C
DEPT. NO. XXXII

DIGNITY HEALTH, a Foreign Non-Profit Corporation d/b/a ST. ROSE DOMINICAN HOSPITAL-SIENA CAMPUS; JOON YOUNG KIM, M.D., an individual; U.S. ANESTHESIA PARTNERS, INC., a Foreign Corporation; DOES I through X and ROE BUSINESS ENTITIES XI through XX,

Defendants.

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

DEPOSITION OF
LIVIU RADU CHISIU

December 4, 2019

1:05 p.m.

7900 West Sahara Avenue
Suite 200
Las Vegas, Nevada

Gary F. Decoster, CCR No. 790

Page 2

APPEARANCES OF COUNSEL

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INDEX OF EXAMINATION

WITNESS: LIVIU RADU CHISIU

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Deposition of Liviu Radu Chisiu
December 4, 2019

(Prior to the commencement of the deposition, all of the parties present agreed to waive statements by the court reporter, pursuant to Rule 30(b)(4) of NRCP.)

LIVIU RADU CHISIU, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. SCHNEIDER:

Q. Please state your name for the record.
A. Liviu Chisiu.
Q. Can you spell it for the court reporter, please?
A. L-I-V-I-U, last name C-H-I-S, as in Sam, I-U.
Q. And we introduced ourselves off the record, but for the record, you go by Leo?
A. Leo. Leo.
Q. Leo?
A. Leo, L-E-O, um-hum.
Q. And we would spell that L --
A. L-E-O.
Q. Leo, have you ever been deposed before?
A. To what, I'm sorry?
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

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complication with the actual procedure on the thyroid or was it just the thyroid condition that she had?
A. No, they had a surgery, she had a surgery done to the thyroid.
Q. Okay.
A. Surgery when she was, I think, 13, 14.
Q. And my question is, when you said that she discussed the problem with the thyroid, was it just the fact that she had had a surgery on her thyroid and had a condition or issue with her thyroid?
A. Yeah, that she had the surgery and that she's taking treatment for that.
Q. It wasn't -- there was no suggestion that there was like a problem or complication in that procedure or surgery?
A. No.
Q. Correct?
A. Yes.
Q. Okay. And if I'm understanding your testimony, you never saw Alina have a nosebleed during her admission to St. Rose Hospital?
A. During the admission, I don't recall.
Q. And I think I got most of this, but it was -- what day was Sophia born?
A. On May 16.

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Q. May 16. And then you stated that Alina had elevated blood pressure, was it on the night of the 16th?
A. She had elevated blood pressure a little bit starting before, and then after the birth it was really high.
Q. And when you say it was really high, I think you stated that you believed it was somewhere around 190 over 90?
A. Much higher. It was -- at some point it was 200 with a hundred something.
Q. Do you recall what time of day that was?
A. During the evening time. And like I said, after that, during that night, it wasn't me that stayed there all the time. I returned in the morning.
Q. What time did you leave that evening?
A. I don't recall exactly, but sometime around 10:00-ish, I would say, probably.
Q. So you felt comfortable enough that evening to go home?
A. Yes.
Q. Even though she had the high blood pressure?
A. It was not that high yet.
Q. Okay. When did it get really high, in your opinion?

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A. I cannot give you my opinion. It should be in the records.
Q. Okay.
A. But what I've been told from the person that stayed there with her, from Ileana that night, that during the night it got really high.
Q. Okay. So when you left around 10:00 p.m., you weren't very concerned about the blood pressure?
A. No.
Q. Is that true?
A. Yes.
Q. And then, but you've since heard from Alina's sister -- was it Alina's sister that stayed overnight?
A. No.
Q. This was the friend?
A. The friend, yes.
Q. Okay. And what was her name one more time?
A. Ileana.
Q. Okay. So you've since heard from Ileana that her blood pressure went up that evening?
A. Yes.
Q. And what time did you come in the next morning?
A. Around 8 o'clock.
Q. And it's my understanding you had some sort

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of discussion with a nurse about the elevated blood pressure, true?
A. Yes.
Q. Did that discussion occur on the night of the 16th or the morning of the 17th?
A. Well, with me the discussion occurred in the morning of the 17th, but Ileana mentioned during that night to the nurses also about the blood pressure.
Q. Okay. But the first conversation you had was on the morning of the 17th, with a nurse?
A. If I recall correctly, yes.
Q. Okay. And you told the nurse that -- I mean, tell me again, how did that conversation go? You just asked what they're going to do about the high blood pressure?
A. Well, I was asking what they're going to do about the numbness and if they're going to do something to lower the blood pressure.
Q. And when did -- when was the first complaint of numbness? Was it on the night of the 16th or the morning of the 17th?
A. My first complaint to -- like it was in the morning of the 17th.
Q. And that's the first time that you learned that Alina was having numbness?

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A. By the time I got back, yes.
Q. Okay.
A. But during the night, they were telling them the same thing, they were telling the nurses the same thing, the same thing.
Q. And when you had the discussion with the nurse about the elevated blood pressure and the numbness and tingling, what was the nurse's response to you?
A. They're going to talk to the doctor probably.
Q. And do you remember the name of this nurse that you spoke with?
A. Oh, no, no, but they were -- by the morning time, there was a different nurse, I'm sorry, yeah, so --
Q. But that's the nurse we're talking about, the morning of the 17th.
A. Yeah, no, I don't know her name.
Q. Okay. And she told you she was going to talk to the doctor?
A. Yes.
Q. And did she talk to the doctor, as far as you know?
A. I don't know. I don't know. As far as I know, I'm not sure, and I don't think that they did

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because I don't know that they gave her any medication to lower it. But my biggest concern, it was why was -- why they left it so high during the nighttime, a whole night.
Q. Did you ask them about that?
A. Why did they left it, no.
Q. But did you see a doctor that day, the 17th?
A. Yes.
Q. Okay. And so you come in in the morning at 8 o'clock. You talk to the nurse around that time. She tells you she's going talk to the doctor and then at some point later in the day the doctor comes in and you see the doctor?
A. That's correct, but in that moment, I was more worried about the numbness in the leg than the blood pressure.
Q. And do you recall who the first doctor was that you saw that day on the 17th?
A. H.
Q. And did you talk with him about the numbness and the blood pressure?
A. Yes.
Q. Do you recall exactly or precisely, approximately what time you spoke with Dr. H? Was it early afternoon, late afternoon?

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A. In the morning, but probably around 10:00-ish. I'm not sure, I don't, yeah.
Q. So closer to the morning, before noon?
A. Closer to -- somewhere there, yes.
Q. Okay. So you spoke with the nurse about your concerns around 8 o'clock or so and then you saw Dr. H around 10 o'clock or closer to noon?
A. Yeah, but the concerns to the nurse, they were addressed in the nighttime, too, about the blood pressure.
Q. And Dr. H's -- what was the plan of care at that time as far as he verbalized to you?
A. He forgot probably about the blood pressure and he went to bring the specialist to see why she's numb. I don't know, they didn't . . .
Q. And was it that after Dr. H comes in and has a specialist come, orders the specialist to come see Alina, there's the MRI -- is the MRI ordered at that time, after or do you recall specifically?
A. Well, the first MRI was sometime after noon and the second MRI was later after noon, like 7, 8 o'clock, the first one around 2 o'clock.
Q. Okay.
A. Something around, something like that.
Q. And do you know how long it took to get that

Page 176

first MRI done?
A. Not sure.
Q. Has any health care provider been critical of the timing of that MRI?
A. I'm sorry, could you please repeat?
Q. Has any health care provider voiced a criticism to you that that MRI should have been done sooner?
A. If any health care provider said that, no. Meaning like if another doctor came and they said, Well, did you --
Q. Yeah, did another doctor come in and say, or at any point in time, any health care provider, doctor, physician, nurse, that you've spoken with said, yeah, it took them too long to get that MRI done?
A. I don't recall.
Q. And I ask just because it seemed to me that you had suggested earlier that you were frustrated that it seemed to take long to get the MRI done.
A. Definitely.
Q. Okay. And when you say it took long, as far as an estimate, it took a couple hours to get it done, it -- how long from the time that you knew that an MRI was supposed to be done till the time it was

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completed?
A. Well, I'm not sure about the MRI, but when I look at the whole time from how long it took from the time that the problem started for her to get to the surgery, that seems like a long time because from -- yeah, so that seemed like a long time, being in -- considering the fact that you are in a hospital, you're not scheduling somewhere to go to.
Q. Has any health care provider, and that's a physician, nurse, expert, anybody that you've spoken with, told you that Alina should have been taken to surgery sooner than she was?
A. I don't recall.
Q. You don't recall if anybody's ever said that to you?
A. No. I was, we were talking, many people were giving opinions, I don't know, and it depending when, yeah, so I don't recall.
Q. It depends on when, like what do you mean?
A. Like right in that moment somebody to say, well, why are we waiting till 7 o'clock, which physician was -- no, I don't recall that.
Q. And I'm talking about at any point in time from during the hospitalization till today, that you've spoken with some sort of provider, expert or

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someone that has told you personally, yeah, it took too long for that surgery to get done?
A. If a physician from the hospital told me that or if it's my opinion or if it's my --
Q. And I'm not asking your opinion because you're not --
A. I'm not a, yeah.
Q. You're not a doctor, right?
A. Correct.
Q. And you're -- I mean, you had some training to be a physical therapist?
A. Yeah.
Q. But you've never worked in a hospital?
A. Correct.
Q. And you don't know how long it typically takes to get an MRI done, true?
A. Yes.
Q. And you don't know how long it takes to get a neurosurgeon or a spine surgeon in to do a back procedure?
A. Correct.
Q. So what I'm asking is, is not your opinion. I'm asking has anybody told you, be it a physician or a nurse or other person with medical expertise, that this procedure that was done on Alina took too long,

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that it should have been a lot sooner?
A. Well, I've been told that, but I'm not sure if they were experts or, yeah, I don't, I don't know of an expert to tell me that as of now.
Q. Okay. So as far as -- you said you've been told that. Who has told you that?
A. Well, I don't recall, but if it takes that many hours being in the hospital, to me it seems that it could have happened faster, and going back to what Dr. Seiff said after the surgery, that his opinion was that it's going to be just on couple vertebraes and it just got extended on eight of them.
So now if we're talking about if that surgery would have done faster, if that laminectomy should have been done on eight vertebrae or not, then I can say that a specialist told me that, yeah, if it would have been done faster, then it would not be that -- on that many levels, on that many vertebraes.
Q. Okay.
A. That bleeding was happening as we -- if those people were waiting for MRIs to work or not work, that bleeding was making her more paralyzed, so --
Q. Did Dr. Seiff tell you anything about that how much Alina had bled in her spine between the time that the MRI was done and the time that he did the

Page 180

surgery?
A. No, but I guess that can be seen in the records. He said when he went into surgery -- when he went out of the surgery that he expect it to go much faster and he expect it to be just on couple vertebrae, and instead of that, it was on eight.
Q. But did he say to you, had I gotten in there earlier, I could have done a lot better or we could have had a much better result?
A. Not that I recall.
Q. And it's my understanding that eventually, after the surgery, Alina was transferred to the ICU, correct?
A. Correct.
Q. And then it was a couple days later she was transferred back to the lower -- to another floor?
A. No, she was transferred to Mommy and the Baby, yes.
Q. Okay. So the Mommy and Baby floor --
A. Is where the, yes, the third floor, where the delivery is. She was not transferred to intermediate care or other type of thing, so right from the ICU one day after the surgery, sent her up to, yeah.
Q. Okay. And how long was she on that floor before she started -- the confusion started?

EXHIBIT 3

EXHIBIT 3

From: **Tyson Dobbs** tdobbs@HPSLAW.COM
Subject: RE: Badoi v Dignity Health - Deposition Availability re Witnesses
Date: March 10, 2022 at 6:23 PM
To: Keely Perdue keely@christiansenlaw.com, Nicole M. Etienne netienne@HPSLAW.COM
Cc: Todd Terry tterry@christiansenlaw.com, Esther Barrios Sandoval esther@christiansenlaw.com

TD

Keely,

I can stipulate to exceed the 10 deposition limit for expert depositions but I do not believe it necessary for additional fact witness depositions. I am available for a 2.34 next Wednesday afternoon or Thursday if that works for you?

HALL PRANGLE+ SCHOONVELD LLC
WHERE TRIAL LAWYERS ARE THE NORM

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Legal Assistant: Nicole Etienne
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From: Keely Perdue <keely@christiansenlaw.com>
Sent: Thursday, March 10, 2022 11:53 AM
To: Tyson Dobbs <tdobbs@HPSLAW.COM>; Nicole M. Etienne <netienne@HPSLAW.COM>
Cc: Todd Terry <tterry@christiansenlaw.com>; Esther Barrios Sandoval <esther@christiansenlaw.com>
Subject: Re: Badoi v Dignity Health - Deposition Availability re Witnesses

[External Email] CAUTION!.

Tyson,

Are you willing to stipulate to allow us to exceed the 10-deposition limit? We believe the complexity of this case justifies exceeding the presumptive limit given the length of and number of people involved in Alina's treatment. Alternatively, please let us know your availability for a 2.34 conference.

Keely Perdue Chippoletti, Esq.
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keely@christiansenlaw.com

From: Tyson Dobbs <tdobbs@HPSLAW.COM>
Date: Wednesday, March 9, 2022 at 1:35 PM
To: Esther Barrios Sandoval <esther@christiansenlaw.com>, "Nicole M. Etienne" <netienne@HPSLAW.COM>
Subject: RE: Badoi v Dignity Health - Deposition Availability re Witnesses

Esther,

Geraldine Bent was not a hospital employee at the time of the treatment. However, by my count Plaintiff has reached the 10 deposition limit for the case so leave of court is required under NRCP 30 before these depositions may proceed. If the Court allows the depositions, we will reach for availability for Geoconda and Erica.

Thanks.

<image001.jpg>

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From: Esther Barrios Sandoval <esther@christiansenlaw.com>
Sent: Tuesday, March 8, 2022 4:41 PM
To: Tyson Dobbs <tdobbs@HPSLAW.COM>; Nicole M. Etienne <netienne@HPSLAW.COM>
Subject: Re: Badoi v Dignity Health - Deposition Availability re Witnesses

[External Email] CAUTION!.

Good afternoon Counsel,

I'm just following on the last known information of Geraldine Bent, Geoconda Hughges, RN, and Erica Joy Carino. Please advise. Thank you.

Esther Barrios
Christiansen Trial Lawyers
710 South 7th Street
Las Vegas, NV 89101
Phone: (702) 240-7979
Fax (866) 412-6992

From: "Nicole M. Etienne" <netienne@HPSLAW.COM>
Date: Monday, September 13, 2021 at 3:50 PM
To: Esther Barrios Sandoval <esther@christiansenlaw.com>
Subject: RE: Badoi v Dignity Health - Deposition Availability re Witnesses

Hi Esther,

Maybe I'm missing something but I gave you dates for Krista and you sent a notice out.

I'll have to follow up with Tyson on the other 3 as they are not current employees and I'm trying to track down their last knowns

<image002.jpg>

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Legal Assistant to:
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Michael Shannon
Tyson Dobbs

From: Esther Barrios Sandoval <esther@christiansenlaw.com>
Sent: Monday, September 13, 2021 3:41 PM
To: Nicole M. Etienne <netienne@HPSLAW.COM>
Subject: Re: Badoi v Dignity Health - Deposition Availability re Witnesses

[External Email] CAUTION!.

Hi Nicole,

I am following back on the remaining witnesses. Thank you!

1. Krista Molinaro, RN
2. Geraldine Bent
3. Geoconda Hughges RN
4. Erica Joy Carino

Esther Barrios
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From: Esther Barrios Sandoval <esther@christiansenlaw.com>
Date: Friday, August 27, 2021 at 2:40 PM
To: "Nicole M. Etienne" <netienne@HPSLAW.COM>
Subject: Re: Badoi v Dignity Health - Deposition Availability re Witnesses

Yes, thank you!

Esther Barrios
Legal Assistant
Christiansen Trial Lawyers
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From: "Nicole M. Etienne" <netienne@HPSLAW.COM>
Date: Friday, August 27, 2021 at 2:37 PM
To: Esther Barrios Sandoval <esther@christiansenlaw.com>
Subject: RE: Badoi v Dignity Health - Deposition Availability re Witnesses

Great thanks as long as everyone wears a mask and the room in large enough I will let her know.

<image003.jpg>

Nicole Etienne
Legal Assistant
O: 702.212.1446
Email: netienne@HPSLAW.COM

1140 North Town Center Dr.
Suite 350
Las Vegas, NV 89144
F: 702.384.6025

Legal Assistant to:
Casey Tyler
Michael Shannon
Tyson Dobbs

From: Esther Barrios Sandoval <esther@christiansenlaw.com>
Sent: Friday, August 27, 2021 2:31 PM
To: Nicole M. Etienne <netienne@HPSLAW.COM>
Subject: Re: Badoi v Dignity Health - Deposition Availability re Witnesses

[External Email] CAUTION!.

Hi Nicole,

Todd wants to move forward with Delaney's in-person deposition. Our office will follow Covid-19 safety guidelines. You can also let Delaney know that the both the reporter and the attorney have been vaccinated. Thank you!

Esther Barrios
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From: Esther Barrios Sandoval <esther@christiansenlaw.com>
Date: Friday, August 27, 2021 at 12:30 PM
To: "Nicole M. Etienne" <netienne@HPSLAW.COM>
Subject: Re: Badoi v Dignity Health - Deposition Availability re Witnesses

Hi Nicole,

I'll schedule Krista Molinaro for Oct 5th at 10 a.m. via Zoom. I'll double check with Todd re Delaney since we count with big conference rooms and follow Covid guidelines. Thank you!

Esther Barrios
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From: "Nicole M. Etienne" <netienne@HPSLAW.COM>
Date: Thursday, August 26, 2021 at 11:43 AM
To: Esther Barrios Sandoval <esther@christiansenlaw.com>
Subject: RE: Badoi v Dignity Health - Deposition Availability re Witnesses