THE WITNESS: Robert Goldstein.

THE CLERK: Spell your last name.

THE WITNESS: G-O-L-D-S-T-E-I-N.

THE CLERK: Business address.

THE WITNESS: 2425 Eastchester Road, Bronx, New York and also 1123 Park Avenue, New York.

THE CLERK: Thank you.

MR. MALLAS: Your Honor?

THE COURT: Yes.

DIRECT-EXAMINATION

BY MR. MALLAS:

Q. Good morning, Dr. Goldstein.

A. Good morning.

Q. You were retained by my office to examine Christopher Peat; correct?

A. That's correct.

Q. Before we get to that, can you tell the jury are you licensed to practice medicine in the State of New York?

A. I am.

Q. And do you practice in any specific area of medicine?

A. I practice plastic and reconstructive surgery. That's what my board specialty is and that's what I practice.

Q. How long have you been practicing?

A. I graduated from medical school in 1977. So I did a residency then went into practice after completing my residency

which would be in 1984.

Q. And can you tell the jury a little bit about your educational background?

A. I went to medical school at Pennsylvania State University, graduated in 1977. From 1977 to 1982 I did a residency in general surgery at Montefiore Hospital. From 1982 to 1984 I did a residency in plastic and reconstructive surgery also as Montefiore Hospital and Albert Einstein College of Medicine. Then I did a fellowship in hand micro surgery in 1984. After completing that portion of my training, I was on the staff of Montefiore Hospital.

Q. And can you tell the jury a little bit about your professional background?

A. I was a full-time employee at Montefiore Hospital from 1984 to about 1998. In 1998 I went into private practice pretty much in the same location. I've been on the staff at Montefiore Hospital Medical Center all of that time. In addition, I have privileges at Lawrence Hospital in Bronxville and Westchester Square Hospital in the Bronx. I have an academic appointment to Albert Einstein College of Medicine as an associate professor of surgery, division of plastic surgery. I maintain a both an active practice in treating patients and also have responsibilities and duties, you know, dealing with medical students and residents as part of my career.

Q. Now, earlier you said you're board certified. Can you

tell the jury what that means to be board certified?

A. I'm board certified in plastic and reconstructive surgery. Basically what that means is it's a process where after you've completed a residency program, you have to take two examinations. The first examination is a written examination which is administered. After you complete the written examination and successfully pass that, you have to submit to the board a case list of what your practice profile activity is for about a year, 18 months. The board reviews that practice profile. If they accept the practice profile, then you take an oral examination in that specialty. Once you pass the oral examination, you are deemed board certified in that speciality and mine is plastic surgery.

Q. So you are board certified; correct?

A. That's correct.

Q. And now, you told us what hospitals you just touched upon, you also teach?

A. Yes. The main hospital I work at is Montefiore Hospital which is part of Albert Einstein College of Medicine. So as part of that we have a residency training program. We usually have four residents a year, about a total of eight residents. So I have teaching responsibilities to those residents either in the form of rounds or lectures, they work on cases with me in the operating room.

In addition, we periodically have medical students

from the medical school that rotate through the service sometimes stay in my office and do things like that.

Q. Now, you said the area that your specialty is in plastic surgery and reconstructive surgery, can you briefly describe for the jury what those specialities are?

A. Well, plastic surgery is kind of a broad based specialty. It covers a lot of different sort of niches within that. There's the obvious thing such as, you know, liposuction and tummy tucks and breast enhancement, noses and faces. That's one aspect of it. The other aspect of that -- and I do those things.

The other aspects of it I deal with people who have been in various types of accidents, scar types of problems, burns is also a part of that reconstructive aspect. So I've dealt with in the past. Acute burns do more later reconstruction of burn injuries then the present time. There's also the reconstructive aspect of it such as breast reconstruction after a mastectomy. Skin cancer reconstruction after skin cancer surgery.

And the other aspect, which is kind of a particular interest of mine that's also within the practice of plastic surgery, is hand surgery dealing with injuries to tendons, nerves, bones, specifically in the hand. That's kind of an overlap with orthopedic surgery but it's something that I've been trained to do in this part of my practice.

Q. Now, as part of your practice have you ever treated patients who have had severe burn injuries?

A. Yes.

Q. And have you ever treated patients as part of your practice who had severe burns with grafting?

A. Yes.

Q. Have you ever treated patients as part of your practice who had severe burn injuries, have grafting and scarring?

A. Yes.

Q. And have you been called to New York State court to testify on behalf of burn victims?

A. Yes.

Q. And have you testified on behalf of burn victims from the fire department?

A. Yes.

MR. MALLAS: Your Honor, I offer Dr. Goldstein as an expert.

THE COURT: So deemed.

Q. Now, moving on. You and I met before this case; correct?

A. Correct.

Q. And have you ever testified on my behalf before?

A. No.

Q. Now, are you being compensated for your time away from

your practice?

A. I am.

Q. Now, let's get to your examination of Christopher Peat.

Did you examine Mr. Peat on behalf of my office?

A. I did. That was in February of 2009.

MR. MALLAS: Your Honor, I ask, with permission, that Dr. Goldstein be allowed to look at his report if necessary during the course of this examination.

THE COURT: If it refreshes his recollection, of course.

Q. And can you tell us when you examined Christopher Peat?

A. That examination took place on February 27, 2009.

Q. And in connection with that examination did you review any medical records?

A. I did.

Q. What medical records did you review?

A. There were a variety of medical records including the medical records from Jacobi Hospital where he was an inpatient. There were medical records from Burke Rehabilitation Hospital where he was a patient after his discharge from Jacobi. There was, I believe, an ambulance call report. There was quite a large stack of records. There may have been other things thrown in there. The bulk of it was taken from those things.

Q. Now, can you tell the jury generally what your examination revealed?

A. Well, the purpose of my examination was to assess the injury that Mr. Peat had and look at the subsequent treatment that he had in terms of medical treatment and surgical treatment and rehabilitation treatment and piece together what his function -- what his complaints were and determine whether these complaints were consistent with the injuries that he had and whether there was any -- and to an extent what the prognosis or what the future would dictate in terms of dealing with the burn injuries and the grafting and the scarring that he has.

Q. And did you come to a determination whether or not Chris Peat did sustain burns and scars?

A. I came to a conclusion that he did.

Q. Can you tell the jury what BSA means or body surface area as it relates to burn victims?

A. Well, BSA does stand for body surface area. And when you're assessing someone who has burns to their body, the treatment that the patient is given is somewhat dictated by what percentage of their body is burned. So there are charts and guidelines that talk about what part of the body is and they ascribe a percentage to that and it's different for adults and in children because a child does not have the same proportion of their torso, their chest and their abdomen as opposed to their extremities as they grow up. So when you see someone who is

burned in terms of how you resuscitate them with fluids, it's -- there are formulas based upon what percentage of the body that is burned.

So, for example, in an adult an arm is 9 percent. So each arm will be 9 percent. That's 18 percent. Torso is the front is 18 percent, the back is 18 percent. Each leg is about 18 percent. And if you have spattering of burns like all over the place where it doesn't involve one extremity, there is a guideline that says basically the palm of your hand is one percent of your body. So if someone, you know, has burns all over the place, you can kind of, you know, piece together what percentage of their body is burned.

Q. And did you come to a conclusion as to what portion of Chris' body was burned; what the BSA --

A. Well --

Q. -- was?

A. I didn't examine him when he was burned, that was from the medical records. But the medical records indicate that it was in the neighborhood of 50 and I saw some estimates that were a little bit higher but I would say that the majority of the medical records that he had a 50 percent total body surface area of burn.

Q. And there's different degrees of burns; correct?

A. Correct.

Q. And based on your examination, your review of the

records, did you determine what the degree of burns Christopher Peat suffered?

A. The medical records said they were second and third degree burns.

Q. Now, I want you to explain the difference between first degree, second degree, third degree burns to the jury. I know we discussed it. We have a diagram here that you said will assist you in explaining to the jury.

A. It would be helpful I think.

MR. MALLAS: Your Honor, may I have this marked?

THE COURT: Sure.

MR. DOODY: No objection.

MR. WRIGHT: No objection.

MR. VAN ETTEN: No objection.

MR. JONES: No objection.

MR. MALLAS: Plaintiff's 37 in evidence.

THE COURT: 37 into evidence. It's for demonstrative purposes.

(Whereupon, a diagram was marked as Plaintiff's Exhibit 37 in evidence.)

THE COURT: It's demonstrative evidence.

MR. MALLAS: Yeah, Judge.

THE COURT: It doesn't go into the jury room.

MR. DOODY: Okay.

THE COURT: Is he going to be explaining?

MR. MALLAS: Yes.

THE COURT: Is he going to be standing up?

MR. MALLAS: Well, can he do it from the stand but then I will be blocking your view.

THE COURT: Well, if that's the case you can put the easel here and the doctor can come up here because it's easier for her.

MR. MALLAS: Okay. Perfect.

THE COURT: And anyone who wishes to go over there can. And, Doctor, you may step down.

Can everyone see?

THE JURORS: Yes.

Q. Can you explain to the jury the difference between the different degrees of burns, Doctor?

A. The degree of burns first, second and third degree relates to how deep the burn went. So it relates to the deepness, the depth of the skin. So this is a cross section of the skin. And the outer layer of skin is the epidermis. That's the part you see outside. Then there's a layer of skin called dermis and underneath the dermis is the subcutaneous fat and underneath the fat are muscle and bones and all the way down.

The epidermis and the dermis are different thicknesses in different parts of the body. It's thicker on the back and on the sole of the foot then it is on your face and your eyelids. So it's not consistent across the entire body. There's

different thicknesses of these layers.

Essentially a first degree burn is the most superficial, it's a burn to the epidermis. It doesn't really go into the dermis. The best example of that is a sunburn. Skin turns a little red, hurts for a little bit, goes away in a couple of days. That's a first degree burn.

A second degree burn by definition is any burn that blisters. So you could get a second degree sunburn if you develop blisters but what that means is that the burn has gone through the epidermis and into some level of the dermis. It could be a miniscule amount, it could be a deeper amount but it's gone into the dermis and the reason it blisters is because fluids come out of the body and separate that burned skin from the healthy skin.

A third degree burn is a burn that goes through the entire thickness of the epidermis and the dermis down to the subcutaneous fat. And there are even fourth degree burns which is not in this case but it can go down involving the muscle in the bone in much deeper burns.

This diagram of the skin is also somewhat important in understanding how the burns are treated with skin grafts because how the skin grafts are taken relates to the epidermis and the dermis. But that's the categorization of burns.

Most burns are not pure. They're usually a mixture because a burn is related to the thickness of the skin, the

temperature of the burning agent, and the length of time that the burning agent is in contact with the skin. And that's, you know, unless you put someone in an oven, that's not usually an even keel all across the body. So there's gradation in mixed first, second and third degrees burns.

Q. Now, you could have a seat, Doctor.

Now, Doctor, Christopher Peat suffered second degree and third degree burns; correct?

A. That's what the medical records show, yes.

Q. And when you examined Christopher Peat, did your examination reveal scarring because of these burns?

A. The examination showed scarring as a result of the burns and the skin grafting and the surgery that he had for taking care of these burns. There were no burns when I saw him. It was the result of the surgeries he had.

Q. And can you tell the jury what parts of his body he had burns on -- I'm sorry, that he had scarring on?

A. They pretty much involved, well, 50 percent of his body. So there were burns that involved his face, neck, chest, shoulders, arms, back, and he had scars from the donor sites of skin grafts on his legs and buttocks.

Q. I'm going to show you -- I'm going to hand to you some exhibits.

MR. MALLAS: And I'm handing to the doctor 13H, 13G, 13F, 13E, D, C, B and A. So 13A through H, Your

Honor.

Q. And I'm going to ask you, you can take either all of them, one of them or however you'd like and just explain to the jury what those pictures show and what areas they show scarring and just indicate.

A. This is 13H. It's a picture of his right and left thigh and portions of his right hand and forearm. There's areas of discoloration of the skin, what I refer to as hypopigmented skin, lighter skin and hyperpigmented skin, that's throughout here. On the thigh area in the leg these are actually not the burns these are the donor areas from where the skin grafts were taken. This is healed -- on his hand that's healed skin graft on his hand.

This is 13G and this is an area of hypo and hyperpigmented, you know, mild areas of the darken -- large dark and light skin. This is also, I believe, a donor area where the skin graft was taken on his thigh.

Q. What exhibit is that?

A. This is 13F. This is a photograph of his back, shoulders and neck area and this shows the healed skin grafts on his back. And in addition to the areas of color and pigmentary changes, the skin grafts are put through a process called meshing to expanded the skin grafts. And that's what all of these little square and triangles are that you see in the back over here. The skin grafts are meshed and I guess we'll talk

about that later when we talk about the surgical procedure but that's why you see this sort of pattern there.

These whitish lines here are basically like seams where the sheets of skin grafts are abutted to each other as they are placed on the body.

This is 12E.

Q. 13E you mean?

A. Oh, 13E. 13E. This is the right side. Again, it shows meshed hypo and hyperpigmented skin graft. And it also shows in the area of the right armpit a band which we call contractual band that developed during the course of the treatment. This is like that area of tight skin that eventually had surgery on to have it released.

13D this is a photo of his face. It shows, again, hypo and hyperpigmented scarring involving his forehead, his eyelids, nose and lip areas.

13C is a frontal photograph showing from the forehead down to around just below the bellybutton. Similar type of thing with areas of hyper and hypopigmented skin graft and secondary, you know, burns also going down his arm.

13B is the right shoulder deltoid region, again, with the skin graft.

And this is 13A, this is the left side and armpit area. Again, with these modeled areas of hypo and hyperpigmented skin grafts.

Q. And I want to ask you, these types of burns that we discussed, the second and third degree burns, and even these procedures that we will get to in a moment, is that painful?

A. Well, the burns themselves are certainly painful. You know, even a sunburn, you know, is painful because you're --

Q. This is a lot worse than a sunburn; correct?

A. Well, both in its extent and its depth. The burns are painful because you're -- you know, there's nerve endings in the skin. The surgeries to remove the burned skin and the skin grafts also are painful.

Q. Now, this scarring that you showed and pointed out to the jury in the photographs, is it consistent with the scarring that was revealed during your examination?

A. Yes.

Q. Now, let's talk about your examination. Other than what you've already told us and I ask that we go through it, we'll start with the head and work our way down.

Can you tell us what your physical examination showed?

A. Well, the -- when I examined him after he told me what his complaints and problems seemed to be, I looked at basically started at his head and worked my way down in somewhat of a sequential fashion. So there were, as you saw in the photographs, on the facial area areas of pigmentary changes. Some hypo some hyperpigmentation around his nose and his ears that were the result of the healed burns. He didn't really have

any skin graft to those areas.

There was an area in particular around the ear where there was some loss of contour and shape of the ear. And also around the lip area there were burns that he sustained around the lip area that kind of obliterated or effaced the junction between the normal pink part of the lip and the surrounding skin. That's actually called the wet mucosus. He had like this blending of pigmentary changes that went from his lips onto his face.

There was some scarring around the nose area.

Then extending down to his chest and his back, there were wide areas of, you know, lighter skin, darker skin in a model pattern that had this meshed or little boxes in it from the areas that had the skin graft and these were on his neck, his chest, his back, his shoulder, his arms extending all the way down to his hands.

When I examined his hand, there was some issue in terms of not cosmetic but functional changes in the area of the hand. In particular what I noticed was in the fourth finger of the left hand -- I'm sorry, the fifth finger the left hand, he had what we call it a mallet finger which was a contracture or a bending of the distal joint of the little finger that was a sequella of the burns. He also had some obliteration of the web spaces between the digits. They were not normal because the burns extended onto the top of the hand and onto the -- between

the digits. There was also some tightness of the skin in a contracture between the thumb and the index finger that I noted.

Let me just see. The right elbow he was -- had a -- from the burns here this right arm, the right elbow, he was not able to bring the arm completely straight. Straight would be 180 degrees and I noted that he had lost about 30 degrees from the 180 degrees getting it straight.

Q. And why is that, Doctor? What were you basing that loss of range of motion?

A. Well, I didn't have -- the loss of range of motion is either related to a problem with the joint and the ligaments of the elbow itself which I did not assess. I didn't do an x-ray or an MRI. Or it was somewhat related to just the scarring in the skin itself that was preventing the full extension of the elbow.

Q. That's something that certainly needs to be addressed; correct?

A. It will need to be addressed at some point in time.

Q. I'm sorry, Doctor, I cut you off.

A. I think that pretty much covers the -- you know, the findings that I had at the time of my examination.

Q. Now, with the hands, were there any functional issues with the hands?

A. Well, as I mentioned he had what we call a flexion deformity of the little finger, we call that a mallet finger.

There was -- I use the term it's called an induction contracture between the thumb and the index finger. Normally you can get the thumb at about 90 -- right angle will be 90 degrees with the index finger, his was brought in. That is a hinderance in terms of trying to, you know, grab things whether it's a -- anything from a glass, to tools, work instruments, things like that.

The contracture of the little finger in terms of what that might inhibit you from doing it often helps -- it will prevent you from grabbing things intensively because you cannot a get around larger objects. It could interfere even with simple things like just putting your hands in your pocket because the finger bent in gets in the way.

Q. Now, Doctor, what are arthralgias?

A. That's just a medical term for pain or discomfort, you know, you can have joint arthralgias, you can have muscle aches and pains. Just a general term for aches and pains.

(Continued on next page....)

Q. And you saw that term in the medical records?
A. Yes.
Q. And when you examined Chris, did he present with pain?
A. Yes.
Q. And what is hyperhidrosis?
A. That is a term that means problems with sweating, not being able to sweat completely, and this is not an uncommon complaint in patients that either have burns or have had skin grafts.

Do you want me to explain it?

Q. Yes. Please explain what its effects are, too, what it is and what its effects are.
A. Amongst a lot of things, the skin has a function of regulating body temperature. It does this by allowing -- by changing the blood vessels in the skin so that allowing heat to be released or constricting, allowing heat to be preserved.

The other thing is the skin secretes oils that are important for lubrication of the skin and just making the skin flexible and pliable, and so when you have a patient who has burns or a patient who has had burns and skin grafts, when you start moving around the skin you don't transport all of these oil-secreting and lubricating glands that are in the skin, and the ability of the skin to temperature regulate is not normal, so often patients who have skin grafts and burns will have issues with skin that is dry, that cracks, that constantly needs

to be moisturized or lubricated with some type of moisturizing or lubrication, because they don't have these oil glands in their skin, which is part of normal skin.

The other thing is that it's a common complaint that they don't sweat, so they are sensitive to cold and sensitive to heat. They don't have the ability to thermal regulate their body to the same degree as someone who has normal skin, so they become sensitive to extremes of temperature.

Q. And based on your examination, your review and your analysis in this case, did Chris suffer from hyperhidrosis?

A. He had told me that these are issues that he has and it's consistent with the injury that he had and the skin grafts that he had.

Q. Now, Doctor, can you tell the jury what decreased sensory appreciation is?

A. That has what -- that relates to the body's ability to touch things and know that -- what you're touching. You know, you pick up a pen, you know it's a pen. You go into your pocket to pick up some coins or keys, you know what they are because your mind knows what you're touching on your fingers.

Skin grafts and burnt skin often injure the nerves that allow that to happen. It's not that these nerves are completely wiped out and that the patient has no sensation at all. It's just that they're kind of messed up.

Q. Does Chris suffer from decreased sensory appreciation?

A. Yes.

Q. And there is a term we discussed as part of this trial. I want you to explain to the jury what that is.

You've heard of a Jobst dressing, of course?

A. Yes.

Q. Can you tell the jury what Jobst dressing is?

A. Basically, Jobst is the manufacturer. It's an elastic dressing and, you know, they can be fitted for the face, they can be fitted for the chest, they can be fitted for the legs. They can be fitted for the arms, and what -- why we put people in Jobst dressings, especially after skin grafts, is that you want to maintain as tight a fit of the skin graft to keep it in contact with the body so that it doesn't form keloids and hypertrophic scars.

So, it's basically like a very form fitted body suit that usually is -- sometimes you don't have to -- you get them off the shelf, but often they're measured and custom manufactured for the person to keep compression on the area of the skin grafts.

Q. Is it uncomfortable?

A. Well, they're not pleasant. I mean, it's like wearing a girdle that goes from your -- if you wear them on your face down to your toes. It depends on the body.

They're hard to get on because they're form fitting. You have to -- if it's hot out, it's worse. They're less of a

problem in winter weather, and they're just tight fitting. It's like wearing a tight-fitting garment all the time.

Q. Before I go on and go over some surgeries with you, these injuries that Chris Peat suffered on July 1, 2003, were they life threatening?

A. Yes.

Q. Can you tell the jury why they were life threatening?

A. Well, people die from burns, and especially when you have a fifty percent total body surface area burn, there is certainly a mortality associated with that. And the reason that they're life threatening is a number of fold.

In the beginning, over the first, you know, couple of days after the burn, there are huge losses of fluid that the body just pours out because one of the effects of skin is to maintain fluid balance in the body. So when you have fifty percent of your skin burned and injured you have huge loss of fluid. It's very akin, you know, if you fell and banged your knee, your knee swells up. Well, imagine that happening to fifty percent of your body all at one time.

So, the initial treatment for burns is what we call fluid resuscitation, and that is giving large volumes of fluid to maintain pulse and blood pressure and stabilize the patient.

In addition, in this particular case, he also had a burn in a close space, so there is what we call products of combustion that he inhaled, not only carbon monoxide, but all

the things that were burning, the polyurethane. Whatever was burning in the apartment he was inhaling, so there was inhalation injury.

Because of this he required ventilatory support with, you know, first putting a breathing tube down him and then changing that to a tracheostomy, but without that that would have been, you know, potentially life threatening.

In the long term, going further on, one of the effects, one of the major jobs of the skin is to prevent infection. There are all kinds of organisms that are normally on the skin. However, they don't get inside the body because the epidermis is a barrier to that. If you take away the epidermis, you have lost that barrier.

In addition to losing that barrier, in the -- in treating him he had what we call lines. He had a lot of lines. He had lines for giving him intravenous fluids. He had lines for monitoring urine output. He had lines for monitoring blood pressure. These are all foreign bodies that are portals to get infected, and he did have episodes where he had what we call sepsis, where there was bacteria and yeasts and fungi that were in his system, and that is like the third way that patients can succumb to their burn injuries.

Q. Okay. Now, I want to talk now about some of the medical records, and let's talk about the ambulance first, and I want you to assume that there has been testimony that there is

evidence that Christopher Peat was on fire for approximately six minutes or so. Okay? And that he was ultimately extinguished by the fire department. Then he talked -- he testified here that when he was in the ambulance, he felt like he was on top of charcoal.

Can you explain to the jury why that is?

A. Well, the simplest explanation, he's -- in the course of this injury his clothes caught fire, so his clothes were burning on his body while the underlying skin was getting burned.

You know, you have to put out fire. And even after you put out the -- you know, put out the actual fire itself, unless you remove the clothing that that still can be hot, or unless you then wrap the patient in cold, cold water, which can be a double-edged sword, because you don't want to lower the patient's body temperature, you can't just throw them in an ice bath. You have to do it in a way that doesn't lower their body temperature.

The skin doesn't just go to normal temperature in a snap. It would be akin to, you know, you take something off, you know, off a stove or off an oven, a piece of, you know, something. You heat a piece of meat, you put it on the counter, it doesn't go to room temperature immediately. It takes time to get to that temperature.

So that is why it would not be unusual for someone to

have the sensation that their skin is still hot and still burning.

Q. Okay. Now, I want to talk about the admission to Jacobi Hospital. Okay? And we discussed the testimony.

I want to go over some of the surgeries for the jury, and is it fair from your review of the records that Chris had over a dozen procedures in Jacobi Hospital?

A. Yeah. I think it was either thirteen or fourteen.

MR. MALLAS: And, Your Honor, I'd like to give Dr. Goldstein Plaintiff's Exhibits 4A, 11A, 10A, 8A and 7A, so he can use them to explain along with the surgeries.

THE COURT: Yes, certainly.

(Whereupon, the exhibits are handed to the witness.)

Q. Now, if we can start with July 1, 2003, he underwent a procedure on that date; correct?

A. Yes.

Q. Okay. And I am not going to even attempt to pronounce the name of that procedure. Can you tell the jury what he underwent on that date?

A. It says July 1st he underwent what is called escharotomies of both of his upper extremities. That was when he was immediately admitted to the hospital.

Q. Can you explain to the jury what an escharotomy is, what its function is, what it does?

A. When skin is burned it forms what is called an eschar, and that is just a term for burnt skin that has lost -- it's the term for a full thickness burn, a third-degree burn that has formed a leathery type of nonyielding burn.

So normal skin, like on the hand is, you can pinch it (indicating). It moves. When you have a third-degree burn it becomes like shoe leather. It's very nonflexible, noncompliant, and it shrinks as it burns, just like anything else that is cooked shrinks, because, you know, you're moving, you're taking, first of all, the fluid out of the tissue and you're denaturing the protein, so it shrinks.

When you have a burn to an extremity, an arm or leg, and even to some degree the chest, and it's 360 degrees around, this contracture, or the shrinking of this tissue, will eventually strangulate the circulation. It will be enough to close off the veins, then close off the arteries, and can lead to gangrene of the extremity.

So, the simplist thing to do to prevent that, and this is something that usually has to be done within the first four to six hours after this, is you cut the eschar. You just make a slit in it. It pops open, and it takes away this unyielding shoe leather type of scenario to allow circulation to be established.

Q. Do any of the exhibits demonstrate that? And, of course, tell us which exhibit you're referring to, Doctor.

A. This is 11A, and this is a picture I believe of his left arm. This is the hand. This is sort of around the elbow. This is going up towards the shoulder.

And this is kind of -- this doesn't look like normal skin. This is a whitish, grayish third-degree burn of skin, and this cut here, going from here to here, and also into the fingers, is the escharotomy, and what you can see is that nothing has been removed here. It's just a cut, and then the skin pops open. And the whole purpose of that is to allow the arteries and the veins to supply blood to the extremity.

Q. Now, on July 4, 2003, he underwent a procedure; correct?

A. Yes.

Q. Can you explain to the jury what procedure he underwent on July 4th?

A. Well, what he had on July 4th was one of many procedures that are called either debridements or burn scar excisions. What you call them is really, you know, not all that important.

But what -- the next goal in treating a burn patient is to get rid of the burned skin that is there and start to replace it with either your own skin or artificial skin, you know, in some type of sequential manner.

So on July 4th, he underwent what is called a debridement, and basically a debridement is a surgical procedure

for removing the dead tissue.

Q. Can you tell us the different ways that that tissue can be debrided?

A. It could be done with a scalpel, where it's cut away. It could be done with an electric cautery, where you use an electrical device to remove it.

Q. How is that electrical device used to remove it?

A. Basically it's an electrical current that has a cutting tool on it that allows -- that cuts through the tissue to remove it. It works very similar. It's like an electrical knife in a sense.

The other way is what we call tangential incision. Tangential incision, I will try to explain, basically is using a special type of surgical knife. It's not an electrical knife. It's a stainless steel knife that cuts through the skin at a tangent. So, if this is the skin, you're cutting through it at a tangent. Instead of going straight down, you're cutting through it this way (indicating).

And the goal is that you take little layers of the dead skin off, almost like if you were cutting cheese with a cheese, you know, slicer.

You look for signs that you have come to viable or alive tissue. And you know that by seeing little dots of bleeding. So, you might work on an arm or a chest and start cutting away, you know, dead skin, and when you start to see

little dots of bleeding you know that you have come to an area where that skin is alive, and that is a potential bed to then put a skin graft on it.

So, the debridements, the tangential incision, the burn incision, these are all kinds of different ways of accomplishing the same thing, and that is getting rid of the burn tissue and preparing it for a skin graft.

Q. Okay. And now we will go over them, not each one individually, but he had numerous -- over the course of a couple of months, he had numerous debridements; right?

A. Well, yes. You can't remove -- you can't remove all the burned tissue at one time. First of all, you don't have enough skin graft to cover it. If he is burned fifty percent of the body, you can't take the other half of the body and use it to cover that. You have accomplished very little.

The other thing is each one of these procedures takes time. They're done under general anesthesia and also, importantly, there is -- can be a fair amount of blood loss during each one of these procedures, so you have to be guided by how the patient is doing with the surgery, what their blood loss is, what their fluid requirements are, and you kind of tackle them in geographical areas.

You might work on the chest one day, then an arm another day, the back another day, the leg another day. You know, you have to set up a plan, and you try to execute that

plan to get the burn removed and the skin graft there.

Q. And then on July 6, okay, he underwent another debridement; correct?

A. Yes.

Q. This time it was of the right arm and the neck; correct?

A. Yes. It says the right arm, neck, and he had skin grafting to the right arm and neck, and they took it from the -- skin grafting from the right thigh.

Q. Can you explain to the jury, I know we have touched upon it, what skin grafting is?

A. It's basically taking a piece of skin from one part of the body and putting it on another part of the body where you need the skin. And, well, you might say to yourself how does that help, you're just trading one wound for another.

But if you remember when I talked about the epidermis and the dermis, if you're taking just the epidermis and a slight thickness of the dermis, that dermis from where you took the skin graft will heal itself in a matter of, you know, seven to fourteen days, so you actually have the ability of going back at some later time and taking more skin from that same area if you need it. So, you know, if someone has an eighty percent burn, you can go back to these areas. And then you have artificial skin that you can use periodically.

The other thing that is done with the skin grafts, it

goes through a process called meshing, where you -- skin graft comes off as a sheet. You know, it's sort of a rectangular piece of tissue. And by placing that tissue through a device called a mesher, you can increase the surface area of it.

Usually, it's one and a half to one, so you can then take that skin that's gone through a mesher. It makes it like an accordion, and you can stretch it. So, if you take a piece of skin that is three inches by two inches, you can cover an area that is greater than three inches by two inches. You just get more bang for the buck.

Q. Now, that is called a homograft; correct?

A. No, that is called autograft.

Q. That means it comes from your own body?

A. Own body.

Q. Then there is allografts; correct?

A. Correct.

Q. That means the skin comes from someplace else?

A. We actually use the term homograft. Homograft is skin from a tissue bank. It's human skin that's tested and preserved, and you get it from a tissue bank.

Q. And then Chris Peat also had artificial skin; correct?

A. Yes.

Q. Okay. Can you tell us what type of artificial skin was used and what the purpose of using artificial skin is for?

A. They used two products on him. One is something

called Integra. The other is something called Alloderm.

Integra technically is not skin. It's a manufactured product. It's kind of a neat product in the sense that it's bilaminal, meaning it has two layers. It has an outer later of a very fine silicone sheeting, and then it has an inner layer which is a manufactured matrix. It's not tissue. It's a matrix that allows the body to ingrow into it.

The purpose of it is you can put that on an area of burn and the silicon sheeting acts like an artificial epidermis. It has an effect of preventing bacteria from getting in, and it keeps fluids in the body. And what usually -- the way it's done is that after the matrix gets attached to the body, you can peel off the silicon sheeting and then take a very, very thin graft, usually an epidermal graft, not even dermis, and put it on this matrix.

So, it's a product that allows you to go to the shelf, take it off and supply artificial epidermis and dermis for a period of time.

Alloderm is a different product. Alloderm is actually obtained from human tissue, and it's the dermis of human tissue that has been denatured and treated in a way to not be rejected from humans so that it can be used as an artificial skin.

And sometimes Alloderm will actually take as normal skin, and you do not have to put a skin graft on it. Sometimes you have to also add an epidermal graft to it.

But those are the two products that were used.

Q. I'm not going to go over each surgery, but, you know Chris had, like we said, more than a dozen procedures from July 1st until August 22nd; correct?

A. Yes.

Q. And this included debridement to various parts of his body; correct?

A. Yes.

Q. Chest, back, neck, shoulders, arms?

A. Yes.

Q. Legs?

Even the face had debridements; correct?

A. He had another procedure that really had nothing to do with debridements and skin graft. He had placement of a vena cava filter.

Q. I was going to get to that. But why don't you tell the jury what that is?

A. He had a problem with developing blood clots, which are not totally uncommon in anyone who has been immobilized, and he had blood clots in his leg.

Now, blood clots in your leg are a problem, but the real danger is if the blood clots come from the leg, go into the artery in the abdomen called the vena cava and then travel to the lung. That is what is called a pulmonary embolism.

A pulmonary embolism can be fatal, because if this

blood clot travels to the lung, then the heart can't pump blood into the lungs because it has a blockage.

Normally, these are treated with anticoagulants. However, in someone who you're taking down to the operating room to do these debridements, you can't put them on anticoagulants because they'll just keep on bleeding, so they put in the vena cava filter that essentially is like a strainer that sits in the blood vessel to prevent any blood clots, if they were to break off from the legs, traveling into the lungs.

Q. And if you don't put this in and this blood clot -- deep vein thrombosis, is that another name for it?

A. Yes.

Q. And you have the pulmonary embolism that you just explained, --

A. Yes.

Q. -- Chris could have died; correct?

A. Well, pulmonary emboli, depending upon their size, could be -- they can -- at the very least will cause chronic lung disease, because you have broken off a piece of the lung.

If they're large they can lead to death. So, there's a range, you know, but anywhere from some shortness of breath to you can't breathe at all.

Q. And just getting back to the surgeries now, Chris also had skin grafting on multiple sites of his body, correct, including basically his whole upper torso; correct?

A. Yes.
Q. Parts of his legs; correct?
A. Yes.
Q. And he also had areas of the legs that there was harvesting?
A. Yes.
Q. Okay. Now, these procedures are done under anesthesia; correct?
A. They are.
Q. So at the time the procedure is done, it's not painful; right?
A. No. He's asleep. He's under general anesthesia for the procedure.
Q. Afterwards, are these conditions painful?
A. Most definitely.
Q. Now, these -- during his stay at the hospital, we already said that he required multiple blood transfusions; correct?
A. Yes.
Q. Then you also said that he developed some infections. You mentioned sepsis and candida?
A. Yes.
Q. Can you explain to the jury what these infections are?
A. Well, he had bacterial infections that were documented and he had candida, I believe possibly other fungal infections

that he developed, and this happens because when you have burns your skin barrier is destroyed and your immune system is knocked out.

He was on a lot of different antibiotics. Now, the antibiotics are useful for fighting the bacterial infections, but they allow for what we call opportunistic infections, meaning normally someone isn't going to get a yeast infection in their blood and a fungal infection in their blood unless their immune system has been wiped out or unless they're on a lot of antibiotics that allow these other things, these yeast and fungi to grow. Hence, we call them opportunistic.

And it's very akin to, you know, for -- possibly the women in the jury can relate to you're put on an antibiotic for a urinary tract infection and the next thing you know you have a vaginal yeast infection. It's that type of thing.

The antibiotics allow for the fungi and yeast to grow, so you need the antibiotics and, you know, you just have to deal with what their -- what the complications are.

Q. Now, we have the medical records from Jacobi in evidence, and I want you to assume he was on ventilatory support from July 1, 2003 to August 21, 2003.

Can you tell the jury what ventilatory support is?

A. Basically, it's being put on a respirator. A breathing tube is put into the trachea, and it allows for oxygen to be delivered to the lungs, and it's necessary (a) because he

had an inhalation injury because of the inhalation of the, quote, products of combustion that were there. In addition, he was on -- because of his constant trips back and forth to the operating room, and in a method to manage his pain, usually he was placed on a number of fairly strong doses of narcotics, all of which suppress the breathing.

So to keep his oxygenation and his breathing supported he was placed on a respirator, and at some point in time instead of putting a tube through his mouth into the breathing tube, they did a tracheostomy, where they put a tube above the breastbone directly into the trachea. It's easier and usually more comfortable for the patient than having some tube coming out of their mouth.

Q. That is one of the lines that you were talking about, where the incision had to be made; right?

A. Correct.

Q. I want you to assume the records show at some point he was discharged and went to Burke.

Before I talk about Burke, I want to talk about when he went back to Jacobi Hospital in November. Okay?

And can you tell the jury what a scar contracture -- I've been practicing to say that right -- release surgery of the right axilla is?

A. I believe I showed you in one of the photographs that he had this band of tissue around the armpit area. The armpit

and axilla are the same thing. The axilla is the armpit.

So, because of the burns or because of the skin graft or because of the combination of both, he developed a scar contracture that prevented him from elevating or releasing his shoulder. So, he came back to the hospital, I believe it was in November or December of that year, to have surgery to release that contracture.

THE COURT: Okay, we are taking a break.

THE COURT OFFICER: All rise. The jury is now exiting.

(Whereupon, the jury exits the courtroom.)

(Whereupon, there is a recess taken.)

(Continued on the next page...)

THE COURT CLERK: Remain seated.

THE COURT OFFICER: Jury entering.

(Whereupon, the jury enters the courtroom.)

(TIME NOTED: 12:10 p.m.)

THE COURT: Have a seat.

THE COURT CLERK: Dr. Goldstein, I remind you that you remain under oath, sir.

MR. MALLAS: Before we on to Burke, and I neglected, as we're going over the procedures, if you could use the photographs to explain some of the procedures that we spoke to the jury?

Not that one. We've already gone over those procedures?

A Um, this is Exhibit 10-A. And this is a photograph of what looks to me like his back. This is being up here, his head, the back of his arm, and this is the area of the back after removal of the burn after the surgery in preparation -- I don't know the exact timing of this photograph, this would seem to me either in preparation for a skin graft.

This is kind of what it looks like after the burn has been removed.

Q And those are the areas which you talked about, about the spotting and the blood?

A Yes. Yeah, like you're looking for these like little spots of blood.

This is 8-A. And, again, I don't know the timing of

this. This is also his back, his head is up over here, his buttocks is down here. This actually looks to me either to do one of two things; this could have been the integra in place, after the integra was in place. Because to me this has sort of a shiny sort of appearance to it, in preparation for the removal of that silken outer sheathing in placement of the skin graft.

It's hard for me to tell exactly where in the course of the events this was taken. Clearly, there is his back after the burn tissue has been removed.

And this is 7-A. 7-A. And here he's lying on his back, head to the right, feet to the left. And, again, the area of excise burn on the lateral aspect of his chest/arm/shoulder area.

Q Now, I wanted to talk about burn rehabilitation, we're discussing.

He had -- you looked at those record, correct?

A Yes.

Q He had occupational therapy, correct?

A Yes.

Q Tell the jury what occupational therapy is?

A It's a type of therapy that kind of deals with, to a large extent, of activities of daily living; letting a patient do things like eating, getting in and out of bed, getting in and out of a car, working with utensils. Using, you know, toiletries, using a commode. The kind of -- it's not really

like going back and working at a job, it's a type of therapy usually geared to getting you back into your home environment and how are you going to deal with stairs and getting in and out of a car and, you know, walking and things like that.

Q And also physical therapy?

A Yes.

Q Can you tell the jury what that is?

A In general, physical therapy really concentrates on developing increased strength, increased range of motion. You know, dealing with areas that you know have contractures. And some strengthening exercises. And it's geared more towards particular areas of the body.

So, you might work, you know, concentrate on a shoulder or a hip or a leg or a knee, back. That sort of thing. The kind of -- they're not, you know, one doesn't preclude the other. They kind of do overlap. It's just that they're designed to address a little bit different aspects of how you function on a day-to-day basis.

Q So, as such, they were teaching them how to do things and how to build him up physically to do them?

A Correct.

Q Also, you're not going to touch upon it really at all. He also received counseling at Burke, correct?

A Yes.

Q Now, I'm not going to go over all the Burke records,

we'll be here until next Thursday. But, I want to touch on just some various things and which is part of 3-A, B and C talk about heterotopic ossification of both elbows. Can you tell the jury what that is?

A Well, ossification in the simplest form is calcium deposits. The elbow is the elbow. So, for reasons that I don't think are totally understood, burn patients will sometimes get heterotopic ossification.

Heterotopic means calcification in a place they shouldn't be. You know, you should have calcifications in your bone, but you shouldn't have calcifications in the soft tissue of your elbow.

So, you know, we see this often where -- and it might be related to hemorrhaging in the muscle or around the joint or ligaments. I don't really know the exact answers to why it occurs. But, it's not unheard of and not unusual for burn patients to get this heterotopic ossification and particularly around the elbow. And that could create a problem in terms of mobility and flexibility and range of motion of the elbow. And sometimes they do require surgery for incision. Sometimes they can be handled with therapy. It really depends on what the patient's needs are and how they progress.

Q Now, also, again, I'm going to go through some various entries and actually explain some of them.

I'm reading from inpatient note of September 10th,

2003. And one of the things they said talks about transfers:

Patient performed ambulatory transfer from wheelchair to rolling walker with contact guard.

A Contact what?

Q Guard.

Can you explain to the jury what that?

A I'm not sure what you mean by contact guard. But, basically, as part of his therapy they are trying to get him to be able to be self sufficient in a home environment.

So, in the normal course of living you have to get from your bed, out of bed. You have to get from a bed to a chair. You have to get from a chair to the bathtub. You have to get from the bathtub to the toilet. You have to get into a car periodically. You have to walk up stairs.

So, transferring is just teaching him how to do these things in a way that's both comfortable, efficient and safe.

Q So, that's something like just teaching someone to do this?

A Well, right. He's not going to be able to do it the way he did before the injury. So, it's kind of giving him the tools and the tricks to do it, you know, the way he is right now.

Q Because of his injuries, he couldn't do it normally anymore?

A Correct.

Q Then on the bed mobility, it says -- and I'll read it to you:

Patient went from sitting at the edge of the mat to supine with supervision.

Tell the jury what that means.

A Basically, he sat on his bed and he laid on his back.

Q And that's something that he had to be taught to do, correct?

A Well, yeah, because, you know, first of all, in the beginning he was in a hospital setting for many months, he was on a respirator, he had all these operations. You lose muscle tone, you lose muscle strength, and whatever you are able -- even something as simple as sitting on a bed and then laying on your back to go to sleep, you're going to do it differently after an injury like this, as before the injury. Just a method of figuring out how he's going to do.

Q Next, I want to jump all the way up to November 19th, 2003. And this is after he has this other surgery in Jacobi. And it states he reported that he is depressed because he feels that his surgery has caused a decline in his level of independence.

The patient was informed that decline is temporary and surgery should allow him to gain more range of motion, which in turn increase his long term level of independence.

Is that uncommon in burn victims that they have these

setbacks?

A Well, I think it's not uncommon in any type of victim, whether the injury is a burn or whether an automobile accident or whether it's, you know, even surgery for some type of cancer or tumor. You know, you, after these types of injuries, no matter what the mechanism of injury is, you're going to have to do things differently than you've done them all your life.

So, you might say to yourself, gee, now I'm in my 30's, now I have to learn how to go to bed; I have to learn how to sit on a toilet. You know, that's a depressing thought; I'm not going to be doing how I did the first 30 years or 35 years of my life. I have to learn a whole new way of doing it.

People cope with that in different methods and different manners. So, yeah, it's depressing and he needs a lot of supportive care.

Q Okay. Now, I want to jump to December 4th, 2003. And the talks about wound care, removal of all dressings with moistening, including wet compresses and water pressure from spray. Wounds cleansed. Patient with increased oozing to compression garment, and increase time to remove garments without damaging in the process.

Is that a problem you have with burn victims in just changing the dressing, that becomes an issue?

A Well, in the initial stages 'til all of these skin grafts and everything healed, you have small areas of open

wounds. You know, not everything takes 100 percent. So, it's all -- you have little sores and openings here and there.

So, you know, you know, if you're changing the dressings, the dressings get stuck. It's like you had a scrape and you have to take the dressing off, it gets stuck, so you soak it in water. You generally pull it. It takes a little bit of time. These, eventually -- these eventually get better, but in the beginning it's a process.

Q Now, I want to move away from Burke. Before we do that, Doctor, do you have an opinion within a reasonable degree of medical certainty whether the injuries and the residual effects, as well as the treatments that we discussed, were causally related to the fire of June 1st, 2003?

A I do.

Q What is that?

A And they are causally related to the fire in 2003.

Q Doctor, as part of your examination and review of this file, did you come to a prognosis from Mr. Peat based on your examination of him?

A I did.

Q Okay, what is it?

A It's my opinion that the scarring that he has and the deformities that he has are permanent.

Q And the functional disabilities that you discussed, are they --

A Yes.

Q Now, do you have an opinion with a reasonable degree of medical certainty if Christopher Peat is disabled from doing any manual labor?

MR. DOODY: Objection. Relevance.

THE COURT: Overruled.

A I do.

Q What is that.

A He's not going to be able to do the type of manual labor that he had been doing prior to this accident.

The effects of the burns on his ability to do floor finishing and things like this, in my opinion, will preclude him from doing this type of work in the future.

Q Now, Doctor, can you tell the jury what palliative care is?

A Well, going into the future, in terms of types of supportive care and needs that he may require in the future, um, you know, he will need, you know, mental support in terms of, you know, mental things that are going on with him. He will need future --

MR. DOODY: Objection, your Honor. Beyond the scope of the witness' expertise. There's another witness coming in to testify about that.

MR. MALLAS: He's right. We'll have Dr. Annapolis talk about the mental stuff.

Just one thing, just palliative care, if you can explain to the jury what the difference of palliative care and acute care is?

A Well, as in terms of palliative care, for example, dealing with the burns that he has. He's going to require things like constant lubrication and constant moisturizing of the skin. He's going need to be followed by physicians and be sure that he doesn't develop things like cracks and irritations and infections in the skin where the skin grafts have occurred.

The problems he has with his hand, in terms of the inability to extend the elbow, and the problems he has with his fingers, these have to be watched so that to make sure that they don't progress.

There may be -- you know, in the future, there may be other procedures that aren't even available now that might become available to correct these things. I don't know, they're not --

MR. DOODY: Objection. Speculation.

THE COURT: That latter portion sustained.

Q Well, let me ask you specific things.

Do you believe that Mr. Peat will need to be treated by rehabilitation specialists?

A I believe he should be followed by a rehabilitation specialist, sure.

Q Dermatologist?

A Yes.
Q Physiatrist?
A Yes.
Q Orthopedist?
A For his elbow, yes.
Q Will he need medical equipment into the future?
A Possibly.
MR. DOODY: Objection.
THE COURT: Overruled.
Q Will he need, you know, you talked about lubrication. Will he need these medicines, lubricant prescriptions, whatever?
A Clearly moisturizers and lubricants are something that he's going to be needing all the rest of his life because of just the nature of skin grafts and how they behave.
Q And will he continually need physical therapy and occupational therapy?
A That's very likely that he will, because it's unpredictable as to how he is right now will change as he ages and as his physical needs change.
Q Now, Doctor, I'm going to ask you to assume certain things:
I want you to assume that there's been testimony that on July 1st, 2003, while Christopher Peat was working at the Fordham Hill refinishing floors and building for Apartment 17-D,, a fire erupted in the apartment causing him to catch on

fire.

I want you to assume that there's been testimony that he exited the apartment, ran down 17 flights of stairs on fire, and was extinguished by the fire department in front of the building.

I want you to assume that there is evidence in the record that Mr. Peat was on fire for approximately six minutes.

After the flames were extinguished from his body, he was taken by ambulance to Jacobi, en route to the hospital there was testimony that saline was poured on his skin and he testified that he was in excruciating pain.

I want you to assume the medical records in evidence indicate upon his admission to Jacobi he was intubated and sedated.

During his stay at the hospital he underwent over a dozen surgeries, including escharotomies of both upper extremities and hands, debridement of burn tissue on his back, arms, hands and ankle, shoulders, chest, bilateral flank and right leg.

I want you to assume that he remained on ventilator support from July 1st, 2003, to August 21st, 2003.

I want you to assume from his medical records in evidence, he required numerous blood transfusions, and he developed sepses.

And I want you to assume that the medical records in

evidence indicate there was a tracheostomy and he was treated by a variety of medical professions in this hospital: Ophthalmology, physical therapy, occupational therapy, infection disease, anesthesiology and physiatry.

I want you to an assume there's evidence on September 8th, 2003, he was released from Jacobi Hospital and transferred to Burke Rehabilitation in White Plains.

I want you to assume there is medical records in evidence too that indicate at Burke he underwent both physical therapy and occupational therapy, four debridements in the infected areas.

I want you to assume that Peat testified while he was in Burke he had pain and restriction.

He testified he was unable to walk and had to re-learn how to walk. He was unable to perform activities, including feeding and bathing himself, all of which had to be taught to him.

I want you to assume there's evidence on November 27, 2003, the medical records indicate that Mr. Peat was transferred back to Jacobi Medical Center where he underwent a scar contracture of the right axial. After the surgery, Mr. Peat was placed on full chest and right arm cast.

I want you to assume that he returned to Burke for rehabilitation and on November 20th, 2003, he was transferred back to Jacobi Hospital and remained until November 25th, 2003.

During that time he had a cast and staples from his surgery removed. He thereafter returned to Burke Rehabilitation, where he continued his occupational and physical occupational therapy, as well as counsel. He remained until September 19th, 2003, and released to his home.

I want you to assume that he continued to treat as an outpatient in Burke until the end of 2004.

I want you to assume there's been testimony from Mr. Peat that he continues to do his home exercises as he's instructed.

He testified that he continues to have problems, including inability to walk, the feeling that his skin is tight. He has losses in his range of motion in his upper extremities.

I want you to assume that he has a loss of sensitivity in the affected areas. He has cracking in the affected areas and must lubricated every day, multiple times.

I want you to assume that there's evidence that Mr. Peat still has scarring from his injuries.

Doctor, do you have an opinion within a reasonable degree of medical certainty whether the fire of July 1st, 2003 was the competent producing cause of the injuries and complaints and treatments I've outlined for you?

A I do.

Q What is that?

A It's my opinion that they are the cause of these

things that you outlined.

Q Doctor, do you have an opinion with a reasonable degree of medical certainty whether or not the injuries, complaints and residual effects I have outlined you are permanent in nature?

A I do.

Q What is that opinion?

A It is my opinion they are permanent.

Q Doctor, do you have an opinion that the injuries and residual affects will continue into the future?

A I do.

Q What is that opinion?

A I think they will progress and have problems into the future.

Q How long?

A Probably the rest of his life.

MR. MALLAS: No further questions, your Honor.

MR. DOODY: May I, your Honor?

THE COURT: Yes.

CROSS EXAMINATION

BY MR. DOODY:

Q Doctor, I'd like you to assume I'm easily confused, so give me a simple answer.

You would agree with me that you are not Mr. Peat's treating physician, correct?

A That's correct.

Q You were retained in this to spend some time with him and review the medical records solely for the purposes of testifying in court today, correct?

A That's correct.

Q And when were you first contacted to appear as an expert witness in this case, Doctor?

A I was first contacted about this case prior to my examination and report. I don't know when I was contacted that the case was actually going to trial. I don't know exactly if that's what you're looking for?

Q No. I'm looking for when you were first contacted before?

A Some time prior to February 27th, 2009.

Q And you were provided with all the medical records that counsel spoke to you about today, correct?

A I was provided with multiple medical records. I'm not sure I had everything.

Q Jacobi, Burke. Did you have Dr. Winston's report, his records?

A That name does not strike me in particular. I know I had the Jacobi records, which were the ones that were most important to me. And the Burke records, which were the most important to me. I'm not sure about --

Q Do you know the name of the doctor who performed the surgery, the bulk of the operations on Mr. Peat?

A Well, the burn services run by Dr. Leib, Dr. Greenstein. I believe Dr. Gary is involved. These are all people that I know; Winston and Richards I believe may have been the burn fellow for a period of time during his --

Q Now you said something that I don't understand.

Can you tell me what a burn fellow is?

A I don't know what Dr. Winston Richard's, is it? I don't know what his specific training was, but Jacobi Hospital has a fellowship in burn care, which usually is someone who is interested in learning more about treating burns and stays there anywhere from six months to two years some of them have stayed there.

Q Okay. Now, you indicated that you're obviously being compensated for your time here today, correct?

A Yes.

Q And what's the amount of your compensation, sir?

A The amount I was paid for being away from my practice and preparation is $8,000.

Q Sorry?

A $8,000.

Q Okay. And when you talk preparation, that doesn't include the examination or the time you spent with Mr. Peat as well as your review of the medical records, true?

A Well, yes and no. I mean, the original examination in and review of the medical records was done in February of 2009.

I received a fee of $500 for that.

Q I'm sorry?

A 500.

Q 500? .

A Now, when I was notified that this was coming to trial, I clearly did not remember the details of what I saw in February of 2009, so I had to re-review the medical records and my report and that sort of thing.

Q Total package, 85 hundred bucks?

A That's about right.

Q Thank you, Doctor.

Have you previously performed the surgeries, the debridement surgeries that are outlined in the records?

A Many times.

Q And what institutions do you have admitting privileges presently?

A Montefiore Hospital Medical Center, Westchester Square Hospital, Lawrence Hospital, and I also work at a surgery center.

Q And are any of those institutions burn centers?

A No.

Q Jacobi is, correct?

A Jacobi is a regional burn center, correct. I used to work at Jacobi, I do not anymore.

Q One time you saw Mr. Peat on one occasion?

A Yes.
Q Have you seen him since February '09, is it?
A Just this morning.
Q Did you talk to him this morning?
A Just to say hello.
Q Nothing beyond that?
A No.
Q Do you have your report in front of you?
A I do.
Q If you can, your understanding or Mr. Peat advised you that he was in the process of refinishing the floor with polyurethane when he was injured, is that correct?
A That was my understanding, correct.
Q And just so I'm clear. At the end of your report -- plaintiff, from a plastic surgery standpoint, you indicate that no further surgical correction to his scarring and -- scars and problems are permanent -- his scars and functional problems are permanent and are not amenable to surgical correction, true?
A At the time I issued my report, correct.
Q In 2009 that was your opinion?
A Correct.
Q Has your opinion changed?
A No, not substantially.
Q I mean, you haven't talked to him, you haven't reviewed any further medical record, correct?

A No, I haven't. That's correct.

Q And do you have any understanding as to what his present medical treatment is, how often he sees any doctors, if at all?

A No, I do not.

Q Do you know if he presently undergoes any occupational therapy?

A No, I don't.

Q Do you know if he presently undergoes any physical therapy?

A No.

Q Do you have any idea if he undergoes any medical treatment at present?

A I don't have access to his present medical records. I said I only had the medical records relating to the accident through the Burke, you know, admission, and then the subsequent surgery. I have nothing from his medical records over 2010, 2011.

Q So, that would be a no, I don't know what he's doing presently, correct?

A Yes.

Q You would agree with me, wouldn't you, Doctor, that the bulk, the overwhelming bulk of his treatments, the surgeries, the inpatient treatment, the therapies, the outpatient treatment, the overwhelming bulk of the treatment necessary for

the injuries he sustained has occurred in the past, correct?

A Correct.

MR. DOODY: Nothing further, Doctor.

Thank you.

MR. WRIGHT: No questions.

MR. VAN ETTEN: No questions, your Honor.

MR. JONES: No questions, your Honor.

MR. MALLAS: Nothing further, your Honor.

THE COURT: Thank you, Dr. Goldstein. You may step down.

Well, that concludes the taking of the testimony today, Thursday.

Please come back tomorrow, Friday, at 10 a.m.

Thank you very much. Enjoy your afternoon.

THE COURT OFFICER: All rise. Jury is now exiting.

(Whereupon, the jury exits the courtroom.)

(TIME NOTED: 12:40 p.m.)

(Whereupon, Court is adjourned to 6/10/11.)