Page 725

(Jury enters courtroom; the following occurred:)

COURT OFFICER: You may be seated please.

THE COURT: Good morning, ladies and gentlemen.

JURORS: Good morning.

THE COURT: Mr. Shaub, call your next witness.

MR. SHAUB: Defense calls Doctor Mark Silberman to the stand, Your Honor.

(Witness approaches witness stand.)

COURT OFFICER: Raise your right hand, left hand on the Bible.

D O C T O R M A R K S I L B E R M A N, a witness called on behalf of the Defense, having first been duly sworn/affirm, took the stand and testified as follows:

THE CLERK: Please be seated. In a loud and clear voice, please state and spell your name for the record and give your office address.

THE WITNESS: Mark Silberman. That's Mark, M-A-R-K; S-I-L-B, like boy, E-R-M-A-N and my office address is Columbia University Medical Center 622 West 168th Street, New York, New York 10032.

THE COURT: Good morning, Doctor.

THE WITNESS: Good morning.

THE COURT: I would ask you to keep your voice up. The acoustics in the room is not very good.

THE WITNESS: Okay.

THE COURT: You may inquire, counsel.

MR. SHAUB: Thank you, your Honor.

DIRECT EXAMINATION

BY MR. SHAUB:

Q. Doctor Silberman, good morning.

A. Good morning.

Q. Are you a physician duly licensed to practice medicine in the State of New York, sir?

A. Yes, I am.

Q. And can you please tell the jury, the ladies and gentlemen of the jury, a little bit about your background, training beginning with your undergraduate degree?

A. I'm from Illinois originally. I went to my undergraduate at Washington University in Saint Louis where I got a bachelor's degree in biological sciences. After that, I went back to Chicago, my hometown, and I went to Northwestern University for my MD degree and spent four years there. After graduating with my medical degree, I came east to Columbia University where I did an additional six years of postgraduate training. The first three years were a residency in internal medicine which is all the different adult diseases heart, lungs, kidneys, gastrointestinal, neurological and then I did an additional three years fellowship in pulmonary diseases of the lungs and critical care which is taking care of the sickest

patient.

Q. What is a fellowship? What does it mean to do a fellowship in pulmonary and critical care medicine?

A. Well, after internal medicine, the first three years after medical school I did, I finished my MD then I did the three years of internal medicine. At that point, I could have been an attending physician taking care of patients but I went on to further specialize in diseases of the lung and taking care of critical care patients. The fellowship as well basically on-going training higher level of responsibility and a specialized focus on those areas of medicine.

Q. After having completed your residency in internal medicine and having completed your fellowship in pulmonary critical care medicine, what did you next do professionally after that?

A. Well, I continued to work at Columbia University Medical Center as an attending physician and my specialized focus has been to work in the emergency department and in the ICU primarily as well as on the floor in the hospital but my primary focus is taking care of the critically ill patients who presented to the emergency department with serious illnesses and also teaching and seeing patients and caring for patients in the intensive care unit at Columbia. And in addition, helping with the transition of patients from the emergency department into the hospital to make sure that they get the care they need when

they're going from the care of the ER doctors to the care after the inpatient doctors.

Q. Now, for how long a period of time have you been practicing -- withdrawn.

You're still at Columbia?

A. I'm still at Columbia.

Q. And still doing the kind of things you just described?

A. Yes.

Q. For how long a period of time have you been doing that kind of work at Columbia?

A. Well, I graduated medical school in 1984 from the six years of training from '84 to 1990. So from 1990 until today, which is 22 years, I've been practicing as an attending physician focusing on taking care of patients myself as well taking care of patients, supervising, training medical students, residents fellows who are training to become doctors or who are already doctors but are training further in those specialized areas.

THE COURT: Doctor, if you could, just slow down a little bit because the reporter is taking down everything you are saying.

THE WITNESS: I tend to speak fast. I'm sorry.

THE COURT: I know they have to keep up with you.

THE WITNESS: My apologies.

Q. That must come from the years in the ER that people

speak fast?

A. Right.

Q. Doctor, are you board certified?

A. Yes, I have.

Q. What does it mean to be board certified?

A. Board certification means you've taken specialized training in an area of medicine and then you have to meet the criteria of the Board that supervises which involves taking examinations, some of them are oral, some of them are written examinations as well as maintaining continuing education within those fields.

Q. Are these national examinations?

A. Yes, these are the national examinations.

Q. Okay. Now, are you board certified in any fields?

A. Yes, I am.

Q. Could you tell us what fields you are board certified in?

A. I have four board certifications. The first is internal medicine, then I also have the board certification in critical care, I have a board certification in emergency medicine, and I have board certification in pulmonary disease.

Q. Okay. Now, Doctor, you said that you have teaching responsibilities. Where do you teach?

A. I teach at the Columbia University Medical Center, some teaching in a lecture setting in a classroom talking about

shock or pneumonia or different things like that but also most of my teaching as well is really at the bedside, as we say. So in the intensive care unit, I have just finished my ICU rotation in the medical intensive care unit. I will round with a team of doctors and we'll go from bedside to bedside discussing, you know, this patient is on the ventilator, this patient's oxygen level, this patient's blood pressure, discussing all the different treatments and medications in how the patient is doing and we'll go all the way around at ICU and I'll discuss with the fellows in critical care medicine what their discussions had been, discussions with the residents, help them to learn how to best manage the patient, to try to diagnose their illnesses and help them recover.

Q. Do you hold any formal academic positions any place?

A. Yes. I'm assistant professor of clinical medicine at Columbia University.

Q. Now, Doctor, do you belong to any professional societies?

A. Yes, I do.

Q. Just tell us about a few?

A. Well, there's the American College of Chest Physicians which is for diseases of the lung and for critically ill patients, an association of doctors. There's the society for Academic Emergency Medicine which is really for teaching and progressive care in the emergency department and for research

related to that. There are many organizations.

Q. Are you also a member of the American College of Emergency Physicians?

A. Yes.

Q. Now, Doctor, last point. Have you done any volunteer work in the medical field?

A. Yes, I do a lot of volunteer work both on an international level and on a local level here in New York. Internationally, I've had the opportunity to work at the charity hospital in Mongolia out in Asia. We have projects in India. We set up the trainer's program, a group of my colleagues at Columbia, in India where we help them begin an EMT training program for ambulance personnel. We also train the people who teach the EMT course and we help them set up this 1288 which is the equivalent of a 911 system, the first organized ambulance system in the country of India several years ago and that's spreading and growing and building right now.

There's also a project -- I just got back from -- the Dominican Republic. We have a project where we do teaching in Santiago in the medical school, teach trauma and critical care and cardiac life support as well as do some injury prevention projects in the Dominican Republic. If you've been, it's a beautiful warm country with beaches and sun and you'll see a motorcycle with three, four or even five people with mon and dad and the child in between holding a baby. It's beautiful weather

but what they have it's really terrible. We are trying to promote the use of helmets there which is an uphill battle. We had some success with our injury prevention program. That's internationally then locally I'm a volunteer medical director for -- I live just here in Westchester County -- I'm the volunteer medical director for four local community ambulance corps where the community members work as EMT's and provide ambulance service to the local community. And in addition to that, I do some work with AIDS patients. Every January here in New York City I volunteer my time.

Q. Doctor, as of the present time, can you explain to us what is your experience in treating patients with pneumonia?

A. Well, pneumonia is one of the most common infections we face. The people come with a cough and fever. It's an everyday occurrence in the emergency department. Sometimes they have bronchitis, sometimes they have mild pneumonia, sometimes they have severe pneumonia, something we see pretty common in the emergency department.

Q. Is this something you actually treated during the course of your career?

A. Yes, all the time.

Q. Well, is it something that you taught other physicians how to treat?

A. Yes.

Q. all right. Doctor, before we get to the details of

the case, have you testified in court before?

A. Yes, I have.

Q. Roughly, when was the first time you testified in court?

A. Maybe about 10 or 12 years.

Q. And over those last 10 or 12 years, how often have you come to court to testify approximately?

A. There was a rape case in New York that a woman was my patient just about two years ago.

MR. ARGINTAR: Objection.

THE COURT: Sustained.

Q. Okay.

A. I was --

THE COURT: Sustained, sustained.

THE WITNESS: I'm sorry.

THE COURT: When I say sustained, don't speak.

THE WITNESS: Okay.

Q. How many times over the course of the last 10 or 12 years have you testified?

A. An average of maybe twice a year.

Q. Okay. And have you testified at the request of my office when we're representing a doctor or a hospital in the past?

A. Yes, I have.

Q. Okay. Have you testified in a case where in another

cases where I asked you actually to come to court in testify?

A. Yes. I testified once before with you.

Q. Have you testified on behalf of my partners in the course of your professional career?

A. Yes, I have.

Q. Now, when you've testified in court, have you also testified -- I don't want any details of it -- but testified on behalf of your patients from time to time?

A. Yes, I have.

Q. Okay. Now, in addition to testifying, have you been asked to review cases involving claims of medical malpractice?

A. Yes.

Q. Over what period of time?

A. Again, about more than ten years.

Q. Okay. Over the course of those ten years with what frequency -- how often were you actually called upon to take a look at cases?

A. It varies tremendously. Sometimes I'm not reviewing any cases and then other times I'll get several requests to review cases.

Q. You say several. That's on a monthly basis or something like that?

A. Yes.

Q. And in the course of reviewing cases, have you reviewed cases not only on behalf of doctors or hospitals that

are being sued but on behalf of patients from time to time?

A. Yes.

Q. Okay. And, Doctor, when you're doing this kind of legal/medical work, I assume you're compensated for your services, your professional time?

A. Right.

Q. Now, Doctor, did there come a time when my office asked you to review certain materials in this case?

A. Yes, sir.

Q. Do you remember -- withdrawn.

Do you recall approximately when you were first contacted?

A. I first received the chart in May 2010.

Q. When you first reviewed the materials, you got the chart and the autopsy report and some legal papers, right?

A. Correct.

Q. After that, did there come a time that you received additional materials?

A. Yes. In 2011, I received the pretrial testimony of Mrs. Rivera and also the doctors who are involved in the case.

Q. And did there come a time after -- withdrawn.

At the time that you received those depositions, would it be fair to say you had not yet gotten the deposition of Doctor Mukherji at that point because it hadn't been done yet?

A. Correct.

Q. Now, approximately how much did you spend in the review in May and the review in 2010 and the review in 2011?

A. I checked my records and in 2010 I spent three and a half hours reviewing the chart and meet with the attorneys and talk about the medical aspects of the case.

Q. That wasn't with me, was it?

A. No. That was one of your associates.

Q. Okay.

A. And then in 2011 I spent four hours reviewing the pretrial transcripts and also meeting with another associate of yours.

Q. Okay. And for that time, you were compensated for your time?

A. Yes.

Q. And what was the rate of compensation?

A. $440 per hour.

Q. Since that time, did you and I meet?

A. Yes.

Q. When was the first time we met to discuss this case approximately?

A. About a month ago. I don't remember the exact date.

Q. Okay. And since that time, have you received and reviewed additional materials?

A. Yes, I have.

Q. And what else have you reviewed up to the present

time?

A. Well, I got electronic transcripts of the trial testimony so I've been reviewing that on a regular basis over the last week or so.

Q. And did there come a time when you and I met?

A. Yes.

Q. Before today?

A. Yes.

Q. And when was that?

A. Yesterday.

Q. Okay. And, Doctor, approximately how many hours did you devote to reviewing the trial testimony over the last -- that we generated over the last couple of weeks?

A. Approximately five hours.

Q. All right. And are you being compensated for your time here in court setting aside your regular schedule to be available?

A. Yes. I had to clear my schedule to be here today. I'm charging for the day.

Q. What is your rate of compensation?

A. Same rate but I charge for ten hours to clear the entire day to be here, available as long as you need me.

Q. Doctor, I want to ask you the following. I want you to assume the following information before you answer the next question, okay?

A. Yes.

Q. All right. I want you to assume that Mr. Rodriguez back in January of 24, 2009 was 44 years of age and he presented to the emergency room at Montefiore Medical Center at approximately 11:45 in the morning and he was complaining of shortness of breath at that time and at the time he was seen by the triage nurse, the first nurse in the hospital. His vital signs revealed a pulse or a heart rate of 83, a blood pressure of 108 over 73, a respiration rate of 22, a temperature of 97, and his pulse oximetry on room air was 79 percent.

I want you to assume further within 15 minutes he was back in the treatment area of the emergency room and on room air, his pulse oximetry was 86 percent and I want you to assume further that he was given supplemental oxygen through nasal cannula, little tubes in his nose and that improved his pulse oximetry to 96 percent.

I want you to assume further that in the emergency room he was evaluated by Doctor Mukherji, a board certified emergency room physician, along with a resident and on his examination he found there were rales or abnormal breath sounds on both sides of his lungs, that the x-ray showed diffused pacification and his impression was that Mr. Rodriguez was likely suffering from pneumonia. I want you to assume all of that. Okay, Doctor?

A. Yes.

Q. I want you to further assume that Doctor Mukherji ordered and had the patient started on antibiotics of ceftriaxone. Did I say that right?

A. Yes, you did.

Q. Okay. And he also was receiving supplemental oxygen and IV hydration.

I want you to assume further that Doctor Mukherji, as part of his plan, wanted Mr. Rodriguez or directed that Mr. Rodriguez be admitted to the hospital and I want you to assume further that Doctor Mukherji testified in his judgment he did not order the patient admitted to the ICU or a monitored unit. That was the trial testimony. That's what the records reflect.

Now, Doctor, you saw all of this between the records and the testimony, correct?

A. Yes.

(Continued on the next page ...)

Q. Doctor, do you have an opinion within a reasonable degree of medical certainty, whether the judgment of Dr. Mukherji with regard to his decision as to where Mr. Rodriguez should be admitted to the hospital, was a reasonable exercise of judgment in accordance with accepted medical practices as they existed in January of 2009?

A. I do.

Q. What's your opinion?

A. That was a reasonable appropriate medical decision.

Q. Why?

A. Well, basically, what we know is that Mr. Rodriguez had pneumonia. He had crackles in his lungs. And his oxygen level was low. It was a serious pneumonia.

The doctors prescribed antibiotics to begin treatment for the pneumonia. And then they had to see what was happening with his oxygen level.

The first oxygen level in triage was very concerning because it was quite low. Dangerously low. They gave him the nasal prongs to put in his nasal. Then they rechecked the oxygen level.

Basically, patients with pneumonia who have low oxygen level, may need three different types of support. They may need low flow oxygen, but that might not help. If that doesn't help, they need high flow oxygen. If that doesn't help, then they need a ventilator.

In this case, Mr. Rodriguez was given the low flow nasal oxygen. And his oxygen level improved. Anything above 90 percent oxygenation means that the red blood cells in the body are picking up enough oxygen to deliver good oxygen to the brain, good oxygen to the heart, good oxygen to all the vital organs.

Q. I thought, Doctor, we heard testimony that normal O-2 saturation is 95, 98, 100 percent?

A. That's correct. Normal saturation for probably everyone sitting here, if we don't have lung disease, our oxygen saturation, if we went around and put a pulse oximetry on everyone in the room, would be 95 to 100. 98 is average for someone sitting here. 98, 99 normal. And normal people is anywhere from 95 to 100.

The way the red blood cells are designed, the body has a margin of safety. Whenever anyone is sick, if the oxygen saturation is between 90 and 100, we as doctors are happy. We know anything above 90 percent saturation means there's plenty of oxygen on every one of the red blood cell to deliver good oxygen to the body. 95 to 100 is normal. But 90 to 100 is safe for a patient who has a lung problem.

So given the low flow oxygen, the saturation greater than 90 percent, we're in the safety zone. He did not need 100 percent non-rebreather mask. He did not need to have a tube put in. Low flow oxygen with his pneumonia corrected his oxygen

level.

Based upon that fact, he is a patient who will need to be in the hospital. That saturation of 79 percent was very concerning in triage. But good news was low flow oxygen, he's better. At one point, the nasal oxygen actually has varying percentages of oxygen. If you're breathing more through your mouth than your nose. If you're breathing faster or slower, the percentage of oxygen is going to vary. Sometimes we do low flow oxygen by mask, which is the other thing they did for him a little later on. 40 percent venting mask. But then that's not 100 percent oxygen. That's not a high flow oxygen saturation. That's low flow oxygen, and the saturation was in the safety zone between 90 to 100 percent.

So therefore, given that he responded to low flow oxygen, that's a patient that does not require intubation. Does not require admission to the ICU.

The second that we watch for, making sure the patients blood pressure is not indicating shock. If the blood pressure is dangerously low, then we have to give special medications in the ICU to bring the pressure up.

In the absence of hypoxia, not responsive to low flow oxygen, in the absence of any signs of shock, Mr. Rodriguez did need to be in the hospital. Did need to get oxygen. Did need to get antibiotics. And did need to be followed by the doctors and the nurses. He did not meet criteria for admission to a

monitored unit.

Q. I want you to assume that Dr. Sixsmith testified that Dr. Mukherji departed from good and accepted practice in not admitting Mr. Rodriguez to a monitored unit or more specifically she said into an intensive care unit.

Do you have an opinion, within a reasonable degree of medical certainty, whether you agree or disagree with Dr. Sixsmith?

A. I disagree.

Q. Why?

A. Well, you know, basically, I just explained why he was appropriate for admission to the hospital. And for admission to the floor.

Medicine is something we practice looking forward. We can never look backwards. Based on the oxygen level, based on almost 12 hours of monitoring in the emergency department, Mr. Rodriguez was doing well. His blood pressure, his pulse, his oxygen level, his degree of comfort, his ability to breathe without being labored or leaning forward or huffing and puffing, he was doing well over that period of monitoring in the emergency department.

Looking forward, yes, he has a bad pneumonia. Yes, he needs to be in the hospital. But there's no indication that he should be in a high level critical care type setting.

So if you can come in like Dr. Sixsmith did and say,

well, he died during the night. Obviously, you did something wrong.

MR. ARGINTAR: Objection.

THE COURT: Sustained.

Q. Let me ask you this, Doctor: Do patients with pneumonia like the kind of problem that Mr. Rodriguez suffered, with a clinical presentation with vital signs with response to O-2 -- with response to oxygen supplementation, are those the patients that are routinely treated in the medical floor in the greater Metropolitan area?

MR. ARGINTAR: Objection to form.

THE COURT: Sustained.

Q. Is there a particular area in the hospital where patients with pneumonia should be treated?

A. The vast majority of the patients with pneumonia are admitted to the medical floor. Only patients with pneumonia who require mechanical ventilator with the tube put in or show instability of their vital signs, signs of shock, those are the patients that clearly need to be in the intensive care unit for pneumonia.

Q. Doctor, I want you to assume that Dr. Mukherji called in a critical care consultant for evaluation of Mr. Rodriguez.

I want you to assume that the person who responded was Dr. Leung, who was a critical care fellow in her first year of her fellowship, having completed her residency in internal

medicine.

I want you to assume that in her evaluation of Mr. Rodriguez, she obtained a history that he had shortness of breath. She obtained a history that the pulse oximetry on room air, he had an oxygen saturation of 86 percent, but on administration of oxygen, the pulse ox was 96 percent.

I want you to assume further on evaluation, Dr. Leung noted that Mr. Rodriguez' pulse was 80. His respiratory rate was 22. His oxygenation was 96 percent.

I want you to assume further that Dr. Leung, as noted in the chart, recorded that Mr. Rodriguez was able to lie flat. Was able to speak in full sentences. Was not using any accessory muscles to breathe. And based on her evaluation, she reached an impression he was suffering from pneumonia. She added additional antibiotics, moxifloxacin?

A. Moxifloxacin.

Q. And she indicated that he did not require admission to the ICU or monitored unit. And, in fact, discussed her plan with the ICU or critical care attending, Dr. Foronjy. And that the plan was for Mr. Rodriguez to be cared for on the medical floor, which was Northwest 8 at Montefiore Medical Center. I want you to assume all that.

First of all, you saw all the information in the testimony and in the records?

A. Yes. I saw Dr. Leung's consult, and I read her

testimony.

Q. Doctor, do you have an opinion with a reasonable degree of medical certainty, whether or not Dr. Leung's treatment was in accordance with treatment and judgment and plan, I should say, that was in accordance with good and accepted medical practices?

A. Yes.

Q. What's your opinion?

A. Yes. Her note reflected a very careful assessment of the history. A careful examination of the patient. She looked for signs of respiratory distress or respiratory difficulty. She noted the oxygenation was low, but responded to the low flow three liter nasal oxygen. And she appropriately made recommendations for treatment with antibiotics and for follow-up of the patient's kidney function.

Q. Doctor, what was the significance, if any -- withdrawn.

What is the significance, if anything, about her findings that the patient was able to lie flat, speak full sentences and not use accessory muscles to breathe?

A. That's very significant.

Q. Why?

A. Whenever a patient has pneumonia, the doctors are looking and the nurses are looking for signs of respiratory difficulty. This is what we call work of breathing. How hard is the patient working to breathe. As I look at all of you

sitting in the jury box, you're relaxed. You're not using any muscles to breathe. Breathing is easy.

If we were to go outside and run up four flights of stairs, when you get to the top, you'd see your chest muscles. Your muscles being used. The same kind of thing can happen with bad pneumonia. The patient may be sitting on the stretcher or lying on the stretcher and despite being at rest, they could be labored to breathe, working hard, using the muscles, the chest muscles, the abdominal muscles, the shoulder muscles. They might be leaning forward and working hard to breathe.

But as a doctor or nurse looks at a patient, they are looking for those signs of labored breathing. Difficulty breathing. Respiratory distress. Work of breathing.

And these signs of him being able to lie flat, relaxed, being able to express a full sentence without having to stop and take a breath, those are all signs that his breathing is compensated. He's doing fine. He's not working hard. He's not going to tire out. Those are predictive signs that this pneumonia is under control with the oxygen, the fluids and the antibiotics that he's receiving.

Q. Doctor, we know that Dr. Leung indicated under impression, he's very hypoxic. Is the impression of being very hypoxic consistent with what you just described?

A. Well, the term very hypoxic is appropriate. That goes back to the triage number. On room air in triage, his

oxygenation was 79 percent. That's a red flag. That's concerning. But at the same time, he got nasal oxygen, and we're in the above 90 percent safety zone. And he's breathing comfortable.

Now, Dr. Leung did additional testing to confirm those finding. She took the oxygen off. She waited a period of minutes and then she drew blood from the radial artery in the wrist to measure all those things. The blood pH, the blood carbon dioxide level and the blood oxygen level, which are all tests to see how well the lung is working.

Q. Now, Doctor, Dr. Leung in her note indicated the arterial blood gas as ABG and in parenthesis says RA. What does that mean?

A. Room air. The patient is breathing 21 percent oxygen from the atmosphere. No extra oxygen.

Q. And the value of the first -- the first number she described was pH, 7.387. What was the significance of that?

A. That's the acid base balance of the blood. And the body needs a narrow range of acid base blood for the physiological process to take place. That's a normal pH. 7.35 and 7.45 is normal pH. The acid base balance is normal.

Q. And this is the time when he's not receiving oxygen; correct?

A. Correct.

Q. In fact, Doctor, if you take a look, there's a couple

other numbers there. Can you tell us what the number is?

A. Four numbers listed here. The first one was the pH which we just discussed.

The second number, PCO-2 which is a fancy medical term for the carbon dioxide level. This is the carbon dioxide level. It's 27. That's lower than normal, but that's actually a good sign. That means he's breathing a little extra to get carbon dioxide off and try to keep his oxygen up. This means, he has some degree of reserve in his lungs. He can breathe more than normal to blow off extra carbon dioxide.

The third number is where we are concerned, which is what was identified at triage. 48.9 is the oxygen level in the blood. There's two ways of measuring oxygen. Direct pressure and saturation.

See, the fourth number is the saturation. So here, we have an oxygen level of 48.9. On room air. We know his lungs are not working normally. That's low oxygen level leading to a saturation of 86 percent. Below the safety zone of 90 percent.

Q. That's with him getting oxygen?

A. With no oxygen being delivered, which is why he's being admitted to the hospital, to be given oxygen and to have his oxygen level checked periodically.

So we know from over here, 86 percent oxygenation on room air, RA. Then 94 percent on three liters, nasal oxygen. He's on the low flow nasal prongs when Dr. Leung is assessing

him.

Off the oxygen, low oxygen level. Needs to be admitted to be given oxygen and antibiotics.

On the oxygen, we see that over here -- where is it? Room air, 86 percent. Danger. Three liters nasal oxygen, 94 percent, safety zone.

Q. Doctor, you mentioned that Dr. Leung made a reference or recommendation for renal consult. Do you see that?

A. Yes, I did.

Q. Now, do you have an opinion with a reasonable degree of medical certainty, whether that was good practice to do that?

A. Yes, I do.

Q. Why? What is your opinion?

A. That was definitely a good practice.

Q. Why?

A. The blood tests that were done on Mr. Rodriguez showed that the BUN and the creatinine, which are the main tests for kidney function, were very elevated. And he was in a degree of renal failure.

Now, basically with renal failure, there's emergency medicine and critical care prospective. Is the potassium dangerous? Is the fluid balance dangerous? Is the pH dangerous?

There are certain danger signs that we look for with kidney function. There are five things. He did not have any of

the immediate danger signs of kidney failure that would require emergency dialysis to cleanse his blood. He does have a risk in the future for developing any of those problems. Given the level of his kidney dysfunction, at some point in the future, he is very likely to require dialysis. So he doesn't need a kidney consult now, because he doesn't have any of the danger signs that require emergency dialysis.

It would be wise to have a kidney specialist follow him in the hospital, see him the next day or within 24 to 48 hours to follow along for a couple reasons. To figure out why he's in kidney failure and to plan going forward, is he going to need dialysis at some point in the future? Is he going to need the special vein graft in his arm so he can go on and off the dialysis machine? What is he going to need to maintain his health going forward?

Q. I want you to assume Mr. Rodriguez was admitted to medical floor Northwest 8 about 11 p.m. When he was admitted, he was seen by a Dr. Bellows and Dr. Bhullar. Dr. Bhullar being more senior to Dr. Bellows.

I want you to assume further that Dr. Bhullar during the evaluation of Mr. Rodriguez, had spoken to another senior resident to him, Dr. Banner concerning the care and management of Mr. Rodriguez.

I want you to assume further that on examination by Dr. Bellows and Dr. Bhullar, their chart reflects that he was

described as being in no acute distress. NAD appears in the chart.

I want you to assume further, it's recorded that he's alerted and oriented times three.

I want you to assume further that the chart of the two doctors reflects that Mr. Rodriguez was not using accessory muscles to breathe.

I want you to assume further, it's noted that he's speaking in full sentences.

And I want you to further assume that he is -- the note reflects that he's suffering from hypoxia without getting oxygen.

I want you to assume further that both Dr. Bhullar and Dr. Bellows reached an impression he was suffering from pneumonia. And the plan was for him to continue on antibiotics, I.V. fluids and supplemental oxygen.

I want you to assume further that Dr. Bhullar testified in this court that in his judgment, Mr. Rodriguez did not require admission to a monitored unit or ICU as of the time of his evaluation between 11 and 12 or 12:30 in the morning.

Doctor, do you have an opinion within a reasonable degree of medical certainty, whether or not the care and treatment rendered by Dr. Bhullar and Dr. Bellows and more specifically, their plan to manage Mr. Rodriguez on Northwest 8, was in accordance with good and accepted medical practice as a

reasonable exercise of medical judgment?

A. I do.

Q. What's your opinion?

A. My opinion is that there are notes in the chart that reflect again a very careful, thorough evaluation taking the history of what led to this problem. The two days of shortness of breath. The cough. The nausea. The diarrhea. A thorough evaluation of what had transpired so far. The vital signs in the emergency. The low oxygen level. The good response to oxygen. They did their own physical examination at that time, looking for any signs of respiratory difficulty.

Based upon that, they also reviewed the blood tests and the x-rays and CAT scan of the lungs. That was done.

Based upon all that, clearly the diagnosis of pneumonia was appropriate. And the vital signs were stable. And the oxygen level was well compensated with the nasal oxygen. Actually, at that point, it was 40 percent venting mask that he was on.

And based upon all those findings, the patient being comfortable with the treatment that was being provided, it was appropriate for him to be on the floor, the regular floor in the hospital receiving antibiotics, I.V. fluids and periodically checks by the nurses and doctors in Montefiore Hospital.

Q. I want you to assume that Dr. Schiffer?

MR. ARGINTAR: Dr. Schiffer.

Q. I want you to assume that Dr. Schiffer testified as of 11 p.m. when Mr. Rodriguez was evaluated by Dr. Bellows and Dr. Bhullar, Mr. Rodriguez was in respiratory distress. Had complaints of shortness of breath. And because of that, he should have been admitted to a monitored unit.

Do you have an opinion within a reasonable degree of medical certainly whether you agree or disagree with Dr. Mark Schiffer, medical doctor?

A. I disagree.

Q. Why?

A. Well, basically again, you don't look at one little piece of data in isolation. Yes. The patient complained of shortness of breath. He's here. He was in the hospital with pneumonia. That's expected. You look at the entire picture. Doctors look at a collage of the picture. You look at the oxygenation. You look at the work on breathing. You look at the overall vital signs. You listen to the lungs.

Putting all those things together, not one little piece of data saying he complained of shortness of breath, which was expected, looking at the global picture, overall piece of information that you have, he is stable. His vital signs are good. His oxygen level is good and he's breathing fine. He's getting antibiotics and I.V. fluids.

There was no indication to move him from the medical floor for a different level of care at that time.

Q. I want you to assume on admission to the floor, Mr. Rodriguez was evaluated by Nurse Shajimon when she evaluated him, recorded that he was alert and oriented times three. He was not confused. His speech was clear. He was described as calm. He was cooperative. He was not complaining of pain. He was not cyanotic. And that she reached an impression he was not suffering from respiratory distress as of the time of her evaluation. And as of the time she was treating him in the course of that night.

Doctor, do you have an opinion within a reasonable degree of medical certainty whether or not Nurse Shajimon's evaluation of Mr. Rodriguez was in accordance with accepted standards of care?

A. Yes.

Q. Why?

A. Again, her notes in the chart reflect extensive initial evaluation when the patient arrived on the floor. Then ongoing notes over time over the subsequent hours that he was there. She spent time evaluating the patient, looking at him. Observing him. And there were no danger signs that would alert a nurse that the patient is in trouble. That he needs to be moved or something different needs to be done.

Q. I want you to assume Nurse Shajimon testified that the practice at Montefiore Hospital Northwest 8, was that every hour, either the nurse or nurse's assistant would check the

patient, in addition to the additional interventions that the nurses might be performing, such as in this case, starting I.V.s, changing I.V.s and inserting a Foley catheter.

Doctor, do you have an opinion with a reasonable degree of medical certainty, if that's good practice?

A. Yes. That's standard practice. I've been familiar with the nurses making periodic rounds, and the nurse's assistants making rounds. And if there's a change in the patient's condition, they note it.

Q. When checking a patient when he's asleep like Mr. Rodriguez, is it standard of care to wake him up and say how are you feeling?

A. Your patients would be pretty unhappy if you did that. You want to let them get rest so they can recover from the illness. During that period of time, you can observe a patient sleeping. What is their respiratory pattern? Is it labored? Relaxed? Is their color pink? Is there any sign of distress? Sweating? Uncomfortable?

Observing a patient while sleeping is part of good medical practice for the nurse, also.

Q. I want you to assume, Mark Schiffer testified at 12:30 in the morning, it was his opinion that Mr. Rodriguez was suffering from shortness of breath and respiratory distress. And at that time, he should have been moved to a monitored unit.

Do you have an opinion with a reasonable degree of

medical certainty whether you agree or disagree with that opinion?

A. What time are you asking?

Q. 12:30 p.m.

A. 12:30 p.m., I disagree.

Q. Why?

A. Again, the resident as well as the intern, did another assessment. And the patient on his assessment showed the same signs of being in no labored breathing. No signs of respiratory working high. No signs of distress. He was stable and appropriate for the floor.

Q. Doctor, I want you to assume that the autopsy report was prepared and indicated that the cause of death was bronchopneumonia complicated with diabetes mellitus.

I want you to assume further that Mark Schiffer testified that Dr. Rodriguez suffered from respiratory distress that led to respiratory arrest that caused him to struggle to breathe and to suffer cardiac arrest.

Do you have an opinion within a reasonable degree of medical certainty, whether you agree or disagree with Dr. Schiffer?

A. I disagree.

Q. Can you tell us why?

A. Well, clearly, what we do know, there was cardiac arrest. Because the patient was found unresponsive and his

heart had stopped. That's a known fact from the records and from what was observed.

But what is unusual about this case is when patients die from progressive overwhelming pneumonia as the primary issue, they develop this progressive worsening, shortness of breath, labored breathing. It goes through stages. It's a process that generally occurs over a period of hours to days where the pneumonia will be getting worse and worse.

And there was no evidence here when he was observed in the emergency department, when he went to the floor of this progressive labored breathing, getting heavier, heavier, using accessory muscles, fighting for air. There was no evidence of that.

We do know that he had a bad diffused pneumonia. We do know that he had untreated diabetes mellitus from the autopsy results. He said he was on no medication. And we know he had a diabetic injury to the kidney from the --

Q. That's reported on the autopsy report?

A. I don't want to get into technicalities. The autopsy report has Kimmelstiel-Wilson lesions. To make it simple, they saw the scar tissue on the kidneys, classic for diabetes that hasn't been well treated.

Q. Is that not treated for a couple hours or couple days?

A. No. That's not treated for years.

We know about the pneumonia. We know about the kidney

problems. We know about the diabetes from the autopsy. And finally, he has what's called left ventricular hypertrophy. An enlargement and thickening of the heart that increases your risk for cardiac problems.

Q. Is that something that's documented in the autopsy report as a finding by the medical examiner of a left ventricular hypertrophy or enlarged left side of the heart?

A. Yes. That's in the report from the medical examiner in her examination of the heart.

So with all this constellation of findings in the autopsy, both the known bilateral pneumonia that was not causing the labored breathing or major distress, the most likely thing that occurred -- and this is based on all my experience in treating thousands and thousands of patients who are very sick -- that he had a cardiac arrhythmia suddenly in the setting of all the medical problems. And his heart stopped and he died.

Q. When that happens, does it happen quickly, like lightening?

A. An arrhythmia happens in seconds.

Q. A patient doesn't even know it happened?

A. No. You just kind of pass out and that's the end.

MR. SHAUB: Thank you very much. I have nothing further.

(Whereupon, the transcript is continued on the next page.)

THE COURT: Counsel.

MR. ARGINTAR: Thank you.

CROSS EXAMINATION

BY MR. ARGINTAR:

Q. Good afternoon, Doctor.

A. Good afternoon.

Q. We've never met before?

A. No.

Q. We have never spoken before?

A. Not that I know of, no.

Q. You've been under cross examination before, correct?

A. Yes.

Q. Okay. If I ask you a yes-or-no question, I ask that you answer it yes or no. If you can't, make that clear and I'll try and rephrase the question. Is that okay?

A. Fine, sure.

Q. Okay. The autopsy report that was done where it says cause of death bronchopneumonia complicating diabetes myelitis it doesn't saying about a cardiac arrhythmia, does it?

A. No.

Q. So, true or false, you disagree with the medical examiner in this case as to the cause of death. Do you disagree or agree?

A. I'd be happy to explain but I can't answer yes or no.

Q. You can't answer yes or no. Okay.

Do you agree that the most likely cause of death as stated by the medical examiner in his report is bronchopneumonia complicating diabetes myelitis. Do you agree with that?

A. I agree that was the acute illness, yes.

Q. Do you agree that that's what the medical examiner said the cause of death was in his report?

A. We can all see it there.

Q. We can all see it? Okay.

A. Yes.

Q. Do you disagree that pneumonia was the primary cause of death for Wilbur Rodriguez? Do you agree or disagree with that?

A. It depends on your perspective on that the final event was the cardiac arrest but the pneumonia was part of what led to it.

Q. Well, Doctor, every patient who dies has a cardiac arrest eventually, correct?

A. Yes.

Q. Okay. So when you say that Wilbur Rodriguez had a cardiac arrest, you can say that for every single person in the world who dies?

A. Not dying from pneumonia but from having arrhythmia.

Q. But every single person in this world eventually has a cardiac arrest?

A. Their heart will stop, yes.

Q. You agree that there's absolutely nothing in the autopsy report that would indicate that Wilbur Rodriguez had a heart attack? Do you agree with that?

A. I didn't say he had a heart attack. I said he had arrhythmia.

Q. Do you agree with me that there's no evidence that he had a heart attack? Do you agree?

A. There's no evidence of a blocked blood vessel.

Q. Of a heart attack?

A. You would have to define what you're saying.

Q. Well, I'll ask you this. There's no evidence of any blockages in his heart, correct?

A. Agreed.

Q. Okay. Would you agree that that would be the most likely evidence of a heart attack in an autopsy?

A. Not in this case because in arrhythmia it does not leave a blockage in the heart. Arrhythmia is just a sudden electrical erratic heart beat that stops the heart and that's a most likely explanation in this case.

Q. Doctor Silberman, you are not a medical examiner, correct?

A. Correct.

Q. Do you agree with me that you are not as qualified as a medical examiner to do an autopsy?

A. That's correct.

Q. Okay. And the medical examiner in this case said that the most likely cause of death, as indicated in his report, was pneumonia. You agree with that?

A. Agreed, yes.

Q. You just agreed he's more qualified than you to do the autopsy, correct?

A. Correct.

Q. You also agree that the medical examiner in this case has absolutely no interest whatsoever in the outcome of the case we have here today?

A. None that I know of.

Q. He's not a witness on behalf of the plaintiff or the defendant, correct?

A. Correct.

Q. You are here to testify on behalf of the defendant, the hospital, correct?

A. Based on the medicine, yes.

Q. I know you reviewed the medicine but you're being compensated today to testify on behalf of the defendant?

A. I'm just here to give my medical opinion.

Q. But when you receive records from Mr. Shaub's office, you're aware because you worked with his firm before that Mr. Shaub and his firm they represent hospitals and doctors in these medical malpractice case. You're aware of that?

A. If there's a problem, I have no hesitation telling him

the doctor made had a mistake.

Q. Doctor, that's not what I asked. You're aware when you get records from him it's going to be from his office, that his office represents doctors and hospitals. You're aware of that, correct?

MR. SHAUB: We do other stuff too.

MR. ARGINTAR: Okay. Your Honor --

THE COURT: Do you want to testify?

MR. SHAUB: Not right now.

THE COURT: Continue.

Q. Doctor, off the bat when you get records from Mr. Shaub's office, you're aware that if he eventually is going to use you to testify you're aware that it's going to be on behalf of a doctor or hospital if you choose to accept the case?

A. Well, I would never testify if I don't agree with the care that was given.

Q. I know but if you do agree you're aware that it's going to be on behalf of a doctor or a hospital, correct?

A. If the care is appropriate, I will agree to give testimony but not otherwise.

Q. Okay. Now, so your theory is that despite that the autopsy says nothing about a sudden cardiac arrhythmia your theory is that that's the most likely way that Wilbur Rodriguez died; is that correct?

A. Cardiac arrhythmia does not show up on autopsy. It's

a sudden electrical event like an abnormality of lighting and then it's gone. There's no evidence that the medical examiner could find anything about arrhythmia. I'm basing my opinion on the clinical picture of what happened over time and based on years of experience and --

Q. You didn't do the autopsy, did you?

A. I know. I did not.

Q. The medical examine did?

A. Yes.

Q. Do you agree that he could have written here under cause of death cardiac arrhythmia? Do you agree that he could have written that?

MR. SHAUB: Objection.

THE COURT: Sustained.

Q. Doctor, if the medical examiner thought that the cause of death was cardiac arrhythmia, do you agree that that would have been written under cause of death?

MR. SHAUB: Objection, your Honor.

THE COURT: Overruled.

A. They're doing an autopsy so they're looking at the gross pathology. They look at all the different organs and they do a microscopic analysis. Cardiac arrhythmia is based on the clinical scenario of what was going on with the patient, what the prognosis over time was and what happened with the nursing him at 4:00, comfortably sleeping without respiratory distress

and then being found unresponsive, without a pulse.

Q. Doctor Silberman, you agree that there was a diagnosis of severe pneumonia before Wilbur Rodriguez died? Do you agree with that?

A. Yes.

Q. And there's a diagnosis of pneumonia as the cause of death as indicated by the medical examiner after Wilbur Rodriguez died? Do you agree with that?

A. I agree with it.

Q. It is your testimony that Wilbur Rodriguez did not die from pneumonia despite the fact we have a diagnosis before and after his death of pneumonia but that rather he died from a sudden cardiac arrhythmia? Is that your testimony?

A. He died with pneumonia from a sudden cardiac arrhythmia, yes.

Q. Even if I assume -- assuming that we take your testimony that he died of a sudden cardiac arrhythmia, would you agree with me, regardless of whether you agree with me or not, if I say he died from pneumonia, you say he died from a sudden cardiac arrhythmia. Regardless of that, if Wilbur Rodriguez had been on a floor with continuous monitoring, do you agree that his chances of survival regardless of our disagreement would have greatly increased had he been on the floor with continuous monitoring?

A. It's impossible to speculate. There's a chance.

Q. A better chance of his survival if he had been on a floor with continuous monitoring, would you at least agree with that? Even assuming your theory of a sudden cardiac arrhythmia, if he was on a floor with continuous monitoring, he would have a greater chance of survival?

A. Based on --

Q. Any floor with continuous cardiac monitoring that would have alerted hospital staff immediately upon the arrhythmia that you say caused his death. Will you agree that his chances of survival would have increased?

A. If he was in the ICU and the arrhythmia was immediately, you know, recognized and shock could be given that there was a chance that he could have survived.

Q. Right. Because even with your theory of a sudden cardiac arrhythmia, if you're in a floor with continuous monitoring such as an ICU and you agree that they are step down floors, first of all, that have continuous monitoring in a hospital? Do you agree with that?

A. Montefiore has a telemetry floor with heart monitoring.

Q. So if Wilbur Rodriguez was on a continuous monitor where they could have rushed to him immediately upon the sudden cardiac arrhythmia, they could come to him and shocked him immediately, correct?

A. In the ICU, the response time is much quicker than on

the telemetry unit. As I said, in the ICU, that could be something that could make a difference.

Q. Is the response time greater than 40 minutes in the ICU?

A. Obviously not.

Q. Sometimes better, right, in the ICU?

A. Response time is better. You can respond.

Q. How about the step down unit where they have continuous cardiac monitoring, is that response quicker than 40 minutes?

A. You would have to look at the response time. You have to look at the results of multiple hospital studies across the country in telemetry units and the recovery from cardiac arrests and they really didn't reach statistical significance in improvement in outcomes.

Q. You mean to tell me he's on a step down unit with continuous cardiac monitoring that you believe it would have taken more than 40 minutes to come to Wilbur Rodriguez' aid upon his sudden cardiac arrhythmia?

MR. SHAUB: I object to the form of the question.

THE COURT: Overruled.

A. That wasn't what I said.

Q. You agree with me that if he was on a step down unit with continuous cardiac monitoring they would have gotten to Wilbur Rodriguez much quicker than 40 minutes. You agree with

that?

A. Generally, when the heart stops on a telemetry unit, the response time is within a few minutes, yes.

Q. Within a few minutes?

A. Correct.

Q. You're aware that Wilbur Rodriguez went 40 minutes where nobody responded to him, correct?

MR. SHAUB: Objection, Your Honor. Objection.

MR. ARGINTAR: I'll withdraw the question.

Q. You're aware that 40 minutes go by from when Wilbur Rodriguez is last checked on until he's found unresponsive? You're aware there's a forty-minute gap? Do you agree with that?

A. I know he was seen by the nurse and comfortably breathing fine at 4:00 a.m. and I know that some time between 4:00 a.m. and 4:40 or 4:55 a.m., some time during that period, he became unresponsive. Whether that was a minute before, ten minutes, I don't know exactly how long it was.

Q. But just to wrap up this area, Doctor, you'll agree with me that his chances of survival increased whether we agree or not if he's on a floor with continuous monitoring? You agree with that?

MR. SHAUB: I object. This is --

THE COURT: That's okay. It's the fourth time he can ask.

A. You have to have an indication for cardiac monitoring

before you can --

Q. That wasn't my question. If he was on continuous cardiac monitoring, his survival prognosis would have been better? You agree with me?

A. He would have needed to have an indication beforehand.

Q. That's not my question, Doctor. If he was there -- I know you don't agree with me that he should have been there -- if he was there, his prognosis for survival would have been better than if he was --

A. If he had cardiac arrhythmia, he would be better off on a heart monitor.

MR. ARGINTAR: Your Honor, I move to strike.

THE COURT: Doctor, the question calls for a yes or no if you can answer yes or no. If you cannot, you have to indicate that.

THE WITNESS: Okay. I'm sorry.

Q. Doctor, my question is this. If Wilbur Rodriguez had been on a continuous cardiac monitor, assuming your theory of a sudden cardiac arrhythmia, his chances of survival would have been better than had he been where he was on Northwest 8, yes or no?

A. Mm-hmm. I can't answer that yes or no but I would be happy to explain.

Q. Okay. Doctor, do you remember testifying for Mr. Shaub's firm in the case LaPierre, December 1st, 2001?

A. Yes.

Q. And that was in the County of Queens. You were asked the question:

"QUESTION: And what does that say with respect to the level of monitoring that was being done on this particular patient in that particular unit?

"ANSWER: It shows that the monitoring was very close and that he was rapidly -- his rhythm abnormality was rapidly recognized and his successful resuscitation with a shock was shown it was rapidly recognized. We know when ventricular fibrillation is shock very early on it's successfully resuscitated to a normal heart rhythm which is what occurred in this case. If there is a delay in the recognition of that abnormal rhythm, the electrical shock becomes less effective."

Do you remember saying that?

A. I agree with that.

Q. Do you agree with me that if there's a delay in the electrical shock that the shock becomes less effective in patients who have a sudden cardiac arrhythmia?

A. That's correct.

Q. You mention that it was very significant to you -- correct me if I'm wrong -- that Wilbur Rodriguez could speak full sentences when he was examined by Doctor Leung. Is that significant to you?

A. Yes, it was.

Q. Okay. Are you aware that there's also a note in the chart where it says that Wilbur Rodriguez cannot speak full sentences?

A. Yes. I saw that nurse's note. I'm fully aware of it.

Q. Would that concern you as a physician the fact that there was a note that he cannot speak full sentences?

A. Again, you're looking at all the pieces of data. That would be one piece of important data to consider, yes.

Q. Well, you don't take one of them to be accurate and one of them not to be accurate, do you?

A. No.

Q. Okay.

A. Different observers, different times.

Q. Okay. For somebody not to be able to speak full sentences, would you agree with me that's an indication that the respiratory health is pretty poor?

A. It is an indication that they have, you know, decreased oxygen level so they can eventualy speak a certain number of words and then take a breath and then continue, yes.

Q. You agree with me in triage when he came in with O2 saturation of 79 percent that is alarming to a physician? Do you agree with that?

A. Yes.

Q. You agree with me that 79 percent is barely

sustainable with life? Do you agree with that?

A. It depends on the circumstances. With some people with congenital heart disease and chronic hypoxic can walk around for years with O2 sats in the 70s.

Q. Doctor Shaub, I would ask you to assume --

THE COURT: Doctor Shaub?

Q. I mean Mr. Shaub.

MR. SHAUB: I have a JD degree.

MR. ARGINTAR: Juris Doctorate Shaub.

Q. Mr. Shaub asked you to assume that a Doctor Ken Banner was consulted by Doctor Bhullar. Do you remember when he asked you to assume?

A. He's the ER. I'm familiar with that.

Q. Are you aware that Doctor Bhullar testified that Doctor Banner actually did his own independent examination of Wilbur Rodriguez? Are you aware of that?

A. Well, I don't know if I would classify it that way because the MAR, the medical admitting resident's role is very specific in terms of processing the patient from the ER to the inpatient service.

Q. I want you to assume that Doctor Bhullar, in fact, did testify that Doctor Ken Banner did an examination of Wilbur Rodriguez. Okay. I want you to assume --

A. For, in addition, specifically for that purpose.

Q. He said he did an examination of Wilbur Rodriguez. Do

you agree with me that it is poor practice for a doctor in a hospital to do an examination of a patient and not have a single note in the chart? Do you agree that is poor?

A. I disagree.

Q. Okay, Doctor. Same LaPierre case we were talking about, County of Queens. You were testifying for Mr. Shaub's firm December 1st, 2003:

"QUESTION: Doctor, it's good and accepted practice, isn't it, to write notes in a patient's chart?

"ANSWER: Yes."

Do you remember testifying to that?

A. Of course.

Q. Now, Doctor, if this Doctor Banner did his own independent examination of Wilbur Rodriguez, do you agree with me that he should have put a note in the chart?

A. Five other doctors wrote extensive notes.

Q. Doctor --

MR. ARGINTAR: I move to strike, Your Honor.

THE COURT: That is stricken.

Q. Yes or no, would it had been good and accepted practice for Doctor Banner, assuming he did an independent examination of Wilbur Rodriguez, would it had been good and accepted practice for him to put a note in the chart?

A. It would be very hard to explain my answer but I can't answer yes or no.

Q. Okay. Now, we've gone over the fact that the critical care fellow was Doctor Leung, correct?

A. Correct.

Q. She was a first-year fellow.

A. She was a PGY4, her first year in fellowship training.

Q. Four years out of medical school?

A. Yes.

Q. Still in training, correct?

A. Correct.

Q. She testified and, as in her note, that she wanted a renal ultrasound and a renal consult, correct?

A. That's correct.

Q. Okay. I also want you to assume that Doctor Leung testified that when I asked her when did you want this renal consult to occur, her answer was before being discharged. Do you agree with that? That he needed the renal consult just before he was discharged?

A. I agree that it was not a stat consult. It didn't need to be done immediately. The ultrasound did not need to be done immediately. The patient should be seen within 24 or 48 hours for a renal consult.

Q. He never got the renal consult before he died, did he?

A. Like if --

Q. Yes or no? Yes or no? Did he ever get the renal consult before he died?

A. No.
Q. Did he ever get the renal ultrasound before he died?
A. No.
Q. Did he ever see a pulmonologist before he died?
A. No.
Q. Now, the two doctors -- withdrawn.
Would you agree that communication is important in a hospital between doctors?
A. Very important.
Q. Very important?
A. Yes.
Q. Now, are you aware that Doctor Mukherji's note where he writes admit was done between 12:30 and 1:30 p.m. Are you aware of that?
A. Yes.
Q. Are you aware that the ICU consult by Doctor Leung was approximately around 5:30 p.m.?
A. Yes.
Q. All right. So, Doctor, would you agree with me that when Doctor Mukherji wrote his note to admit -- withdrawn.
You're aware of the fact that it was Doctor Mukherji's decision where to admit Wilbur Rodriguez, correct?
A. Yes.
Q. So would you agree with me that when Doctor Mukherji wrote his note to admit he had, in fact, not spoken with the

critical care doctor yet?

A. Clearly that's correct.

Q. Clearly that's, correct?

A. That decision -- well --

Q. That's correct. Now, the two residents that see Doctor -- that see Wilbur Rodriguez on Northwest 8, Doctor Bellows and Doctor Bhullar, correct?

A. Yes.

Q. Well, Doctor Bellows was a first-year resident?

A. Yes.

Q. One year out of medical school?

A. Yes.

Q. Doctor Bhullar two years out of medical school?

A. Yes.

Q. Would you agree with me those two doctors are very inexperienced?

A. It speaks for itself. They have a year and two years of experience.

Q. They are still in training?

A. Still in training.

Q. Still learning the practice of medicine?

A. Correct.

Q. They have no hospital privileges of their own, correct?

A. They have privileges to write orders and manage

patients.

Q. But they can't admit patients on their own in the hospital, correct?

A. It's part of a team.

Q. They couldn't just go out and open their own medical practice?

A. They could under New York State law after one year of training.

Q. A first-year resident can go out and start their own practice?

A. To get a license in New York State, you have to have one year of postgraduate training and you can open a general practice.

Q. Nobody does that?

A. Nobody does that any more. That's from the previous generation.

Q. So, Doctor, practically speaking, neither of these two doctors would open their own practice, correct?

A. They are both in the three-year training program.

Q. Three-year training?

A. Correct.

Q. And those are the only two doctors who see Wilbur Rodriguez after 11:00 p.m. and before he's found unresponsive at 4:40. Would you agree with that?

A. Correct.

Q. Okay. So the only two doctors for the five -- in the five hours before Wilbur Rodriguez dies are first-year resident in training and a second-year resident in training, true?

A. That's correct, yes.

Q. Now, Doctor, there's some mild cases of pneumonia and some severe cases of pneumonia, correct?

A. Yes.

Q. Some you can send them home; some are life threatening?

A. Correct.

Q. Doctor, have you seen this page in the chart?

A. Of course, yes.

Q. You see 2:30 p.m. he's at 95 percent O2 saturation, correct?

A. Correct.

Q. And then over time it goes down 94, then 94, then 92 at 7:00 p.m. Do you see that?

A. They are all in the safety zone, as I said above, 90 percent.

Q. It's going down though, correct?

A. One to two points is --

Q. Is it going down?

A. Ninety-two is less than 94.

Q. Okay. That's what I was getting at. He's also receiving some more oxygen. Is that correct?

Page 780

A. That's not true.
Q. Well, he goes from 3 liter, 3 liter, 3 liter, 4 liter?
A. Four is more than three.
Q. Four is more than three. We can agree on that?
A. It's still local oxygen, low level.
Q. But it's more than three. So he's getting more oxygen. Four is greater than three, and he's 92 -- which 92 is lower than 94. We can agree on that, correct?
A. The next sheet has the stats back up to 96 which you don't have that.
Q. Doctor, are you aware that Wilbur Rodriguez at 11:00 p.m. is noted to be complaining of shortness of breath while on supplemental oxygen?
A. The COSOB could mean he's complaining of shortness of breath but he is complaining of shortness of breath. It depends on how you interpret it. He was in the hospital for pneumonia and shortness of breath.
Q. Are you also testifying at 11:00 p.m. complaining of shortness of breath doesn't mean it's happening at 11:00 p.m. Don't you think that's a reasonable interpretation, Doctor?
A. Well, 11:00 p.m. it says COSOB.
Q. On oxygen?
A. On oxygen.
Q. Three liters?
A. Three liters. So his complaint is shortness of

breath. That's correct. Whether that's coming in or out at this moment it's impossible to say.

Q. It says 11:00 p.m. right here, right?

A. It does.

Q. And that corresponds with the rest of the note?

A. Right.

Q. Would you agree with me that it's a reasonable interpretation of this note this is all happening at 11:00 p.m. Is that a reasonable interpretation?

A. Yes. That note should be written on or about events occurring at 11:00 p.m.

Q. Thank you. Okay. Now, 12:30 a.m. now on the 25th, we have patient is complaining of shortness of breath O2 -- I'll bring it closer -- O2 --

A. I can see it.

Q. -- complaining of shortness of breath, O2 continued venti mask. Do you see that?

A. Correct.

Q. Now, Wilbur Rodriguez actually has a mask on and giving him oxygen, correct?

A. Correct.

Q. Okay. So do you agree at 12:30 Wilbur Rodriguez is also complaining of shortness of breath, correct?

A. Yes.

Q. Okay. Because this -- you would agree with me this

has to be referring to something else because the venti mask is not even referenced in the 11:00 p.m. note?

A. 11:00 p.m. it says three liters then at 12:30 it says venti mask.

Q. When the nurse came in here the other day and said that her 12:30 note of complaining of shortness of breath actually referred to 11:00 p.m. that can't be possible, is it?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained.

Q. I want you to assume that the nurse came in here and told the ladies and gentlemen of the jury that her 12:30 note that says patient complains of shortness of breath referred to 11:00 p.m. I want you to assume she testified --

MR. SHAUB: Objection, your Honor. I object.

THE COURT: Come up.

(Discussion off the record.)

MR. ARGINTAR: May I proceed?

THE COURT: Yes. Can you just repeat that question please

MR. ARGINTAR: Sure.

Q. I want you to assume, Doctor, that the nurse who came in the other day said that when she wrote patient complains of shortness of breath on a venti mask at 12:30 a.m. she was actually referring to when Wilbur Rodriguez came in at 11:00 p.m.

Doctor, that is not a reasonable interpretation of this note, is it?

MR. SHAUB: I object to the form of that question, Judge.

THE COURT: Can you just approach one more time?

(Discussion off the record.)

MR. ARGINTAR: May I proceed?

THE COURT: Yes.

Q. Doctor, would you agree that a reasonable interpretation from a medical perspective such as yours is that patient complains of shortness of breath on a venti mask because of what is occurring at 12:30 a.m. Do you agree with that?

A. I would be happy to explain.

Q. Yes or no? Okay. If you can't answer it yes or no --

A. I can't answer it.

Q. You can't answer that?

A. Can't say.

Q. You can't. Well, he wasn't on venti mask at 11:00 p.m., was he?

A. I don't know what time he switched from nasal cannula to venti mask.

Q. Well, it says on oxygen three liters, right, at 11, correct?

A. Correct.

Q. It doesn't say anything about a venti mask, does it?

A. Correct.
Q. It says venti mask at 12:30 a.m., correct?
A. It does, yes.
Q. So I'm going to ask you again. Would you agree with me these complaints are happening concurrently with the note at 12:30 a.m., yes or no?
A. I would be happy to explain but I can't say yes or no.
Q. If you can't, you can't.
The 4:00 a.m. note here, Doctor, would you agree with me that we don't know what his O2 saturation is at 4:00 a.m.?
A. Correct, it's not --
Q. It's not noted?
A. Not noted in that note.
Q. We don't know what his respirations were at 4:00 a.m.?
A. It's not noted.
Q. Doctor, we don't know what his pulse are at 4:00 a.m., do we?
A. Correct.
Q. And then 40 minutes later is when he's found unresponsive?
A. Correct.
Q. Now, would you agree with me that nurses should check on a patient more frequently the more concern they are with his health. Do you agree with that general proposition?
A. She should -- it's their clinical judgment to decide

how frequently to check a patient.

Q. If a nurse is more concerned with a patient, you would agree with me, they check on him more often?

A. Yes.

Q. Less concerned check on him less amount of time?

A. Yes.

Q. So between 11 and 12:30, the nurse writes a note after an hour and a half, correct?

A. Correct.

Q. Okay. Then between 12:30 and 1:45 we have an hour and 15 minutes, correct?

A. Correct.

Q. From 1:45 to 2:30 the nurse writes another note another hour and 15 minutes, correct?

MR. SHAUB: Objection, your Honor.

A. What's -- from 1:45 to 2:30 should be 45 minutes.

Q. I'm sorry. My bad math.

THE COURT: You're what?

MR. ARGINTAR: That was my bad math.

THE COURT: Bad math. I thought you said bad mat.

MR. ARGINTAR: My bad math.

Q. Forty-five minutes, okay?

A. Yes.

Q. We have a shorter time interval now, correct?

A. Correct.

Q. Okay. Then we go back between 2:30 and 4:00 a.m we're at the hour and a half?

A. Yes.

Q. Okay. Thank you. Then there's a 40-minute interval, correct?

A. Correct.

Q. That is the shortest interval of any of the nurse's notes on this entire page, correct?

A. Correct.

Q. So would it be fair to say, Doctor, yes or no, that the nurse was becoming more concerned with Wilbur Rodriguez' health based on the time intervals for which she was checking on him? Yes or no?

A. I can't say that these times correlate exactly with what she was checking, that she was documenting. I couldn't say one way or the other.

(Continued on the next page ...)

Q. So is it your testimony, she was checking on him but not documenting it?

A. Oftentimes, nurses will make frequent rounds, and they document when there's a change or they want to write something down. The interactions with the patient often are far more frequent than what's written in the chart, based on my experience.

Q. Dr. Silberman, a patient is complaining of shortness of breath while having a venting mask supplying oxygen to them. That is a bad sign for a patient; do you agree with that?

A. Well, it's a concern, but you have to put it into the context of the entire picture, as I said before.

Q. That would be a concern?

A. Yes.

Q. Not all pneumonia patients come into the hospital with complaints of shortness of breath while on a venting mask. Do you agree with that?

A. Not all of them.

Q. Would you agree the more severe pneumonia patients -- and I think you testified that Wilbur Rodriguez had severe pneumonia. Would you agree that the more severe pneumonia patients, would complain of shortness of breath while on a venting mask? Do you agree with that?

A. They may. I certainly experienced that, yes.

Q. Now, do you agree with me that the last documented --

withdrawn.

Would you agree with me, that the last thing stated by Wilbur Rodriguez as documented in the chart before he was found unresponsive, is that he complained of shortness of breath? Do you agree with that?

MR. SHAUB: Objection, Your Honor.

THE COURT: Can you repeat that for me, please.

(Whereupon, the requested testimony was read back by the reporter.)

THE COURT: Last thing stated by Mr. Rodriguez?

MR. ARGINTAR: As documented in the chart, Your Honor.

THE COURT: Overruled.

A. That's the last thing written there, yes.

Q. And so we know that the last thing Wilbur Rodriguez said before he was found unresponsive as documented by the chart is a complaint of shortness of breath?

MR. SHAUB: Objection, Your Honor.

MR. ARGINTAR: I'm not done with my question.

MR. SHAUB: I think it's an objection.

Q. Doctor, you just agreed with me -- I'll start over.

That the last thing as recorded in the chart that was stated by Wilbur Rodriguez before he was found unresponsive, was a complaint of shortness of breath. Do you agree with me that nothing was done at that time to move him to a setting with

continuous respiratory and cardiac monitoring? Do you agree with that?

A. That's correct, clearly.

Q. Doctor, yes or no, don't you think a patient who has a venting mask on him and is still complaining of shortness of breath, given the fact that he's got a diagnosis of diffuse pneumonia previously, a diagnosis of acute renal failure previously, should be moved to a setting with continuous monitoring? Yes or no?

A. That's not one of the criteria for continuing monitoring. We have very clear criteria.

MR. ARGINTAR: No further questions, Your Honor.

REDIRECT EXAMINATION BY

MR. SHAUB:

Q. Doctor, you just said that having complaints of shortness of breath on a venting mask, having renal problems and diffuse pneumonia is not the criteria for admission to an ICU or monitored unit. What do you mean by that?

A. That's correct. So patients with pneumonia -- the most frequent complaints among pneumonia patients is, I feel short of breath. I have cough. I have shortness of breath. These are the common things you hear.

The vast majority of the patients with pneumonia, well over 90 percent, never need to be in an ICU. And the reason for that is shortness of breath is a normal part of pneumonia. Some

patients come to the emergency room and say, I have cough and feel shortness of breath. We'll examine them. Give them a prescription to go home and take antibiotics.

Shortness of breath is not a criteria for admission to the ICU or a monitored bed. There are specific criteria which is hypoxia requiring intubation. You can't get it up with low flow oxygen. In fact, you can't get it up with high flow oxygen. 100 percent mask. The patient needs to go on a ventilator in the ICU. That's not the situation in this case.

Again, shock where the blood pressure is abnormally low and the circulation is not working to get blood and oxygen to the tissue. That's an indication for the ICU.

What happened to Mr. Rodriguez is very unfortunate, but he did not meet any of the criteria.

MR. ARGINTAR: Objection.

THE COURT: Sustained.

Q. Let's stay with the question.

A. He did not meet any of the criteria for transfer to the ICU.

Q. If a patient was complaining of shortness of breath on a venting mask and that condition was significant enough to cause him hypoxia, is there something or things that the nurse or doctor could observe about the patient without asking him any questions?

A. Yes.

Q. What?

A. There are many things that would be observed if the pneumonia is getting worse and the patient is in danger. His respiratory rate would be going up. We know that a respiratory rate greater than 30 is a concerning sign. He never had that.

We know that his heart rate could go up if he's in distress. A heart rate greater than 125 in a patient with pneumonia is very concerning. He didn't have that.

We know that a patient who's working hard to breathe at rest where they're using their extra muscles and laboring away like they've been running up a flight of stairs, that's a sign of danger. It wasn't there.

So all of these danger signs that are being looked for were not present. Complaint of shortness of breath does not equal these other objective danger signs.

Q. Doctor, you were asked whether or not Dr. Bellows who was the doctor in training, first-year resident, Dr. Bhullar who was a second-year resident, doctor in training, doctor, and you were asked whether these people were inexperienced.

Doctor, physicians, even medical students, let alone physicians that are first or second year, are they trained to recognize respiratory distress?

MR. ARGINTAR: Objection. Leading.

THE COURT: Sustained.

Q. What training do you give when you teach medical

students first-year residents, second-year residents when it comes to recognizing respiratory distress?

MR. ARGINTAR: Objection. Leading.

THE COURT: I'm going to sustain it.

Q. Do you teach residents?

A. Yes. Clearly.

Q. Is part of the training to learn to recognize respiratory distress?

A. Yes. I teach at the bedside. When we have patients who are laboring or who have hypoxia, I'll bring the residents over and explain the findings so they're aware of it and know what to look for. This is something we see commonly in the emergency department, on the floor in the hospital and in the ICU.

Q. Now, Doctor, medical students, do they actually work in a hospital at some point in their career?

A. Yes. Medical school is a four-year training program. When I trained, we used to --

Q. No. No. Now?

A. Now, we move the clinical training to the -- after one and a half years of medical school, you go into the hospital. So you have two and a half years.

Q. What do the medical students do when they go to the hospital?

A. They see patients. They examine patients. They write

orders under supervision of doctors. They're taking care of patients.

Q. When a doctor is a resident, do they see and treat patients when they're first and second-year residents?

A. Yes, they do.

Q. A national major medical teaching center like Montefiore, for a resident that's a PGY-1 or PGY-2, what would be your expectation as to how many times they've done physical examinations on patients?

MR. ARGINTAR: Objection.

THE COURT: Sustained.

Q. By the way, Doctor, you were asked questions by Mr. Argintar about whether the patient, Mr. Rodriguez, was on a venting mask or not. I want to read to you the trial testimony of Nurse Shajimon. Page 559, line two.

"QUESTION: Now, you said he came up from the emergency room on a stretcher, and I think you said he was attached to oxygen?

"ANSWER: Yes."

Page 559, line 18.

"QUESTION: Let me ask you before we go any further, so he came to the floor with oxygen. Was that by mask?

"ANSWER: Yes."

So when you're asked questions before whether he

came on the floor with a nasal cannula then changed to a mask, Doctor, Nurse Shajimon who was the one that was there, told us he came in by mask.

Does that make any differences to you in terms of whether or not he had an increasing requirement for oxygen while on the floor from --

A. It doesn't change my opinion.

Q. Now, Doctor, you were asked about the progression of the O-2 saturation and how the numbers went from 86 on room air, then oxygen went from 96, 95, 94, 94, 92 percent. Do you see that?

A. Yes, I do.

Q. 92 percent was 7 p.m.?

A. That's correct.

Q. There's another page that counsel didn't blow up. You saw the other page, did you not?

A. Yes, I did.

Q. In the other page -- I'll withdraw the question.

MR. SHAUB: Can we pass up to the doctor, Plaintiff's Exhibit 1 in evidence.

THE COURT: Officer.

(Whereupon, the exhibit is handed to the witness.)

THE COURT: Thank you.

COURT OFFICER: You're welcome.

Q. Doctor, I want to call your attention to the second

page of the chart that counsel blew up and just showed you. All right?

A. Yes.

Q. Now, this is a chart reflecting vital signs for the remaining period of time that he was in the emergency room?

A. Yes. 7 p.m. to 10 p.m., this sheet has.

Q. Can you tell us, Doctor, what was the oxygen saturation while -- after the 7:00 study that Mr. Argintar asked you about?

A. It's documented four times as 96 percent.

Q. And as --

A. At 7:30, 8:00, 9:00 and 10:00.

Q. By the time he left the emergency room, his oxygenation was 96 percent?

A. Correct.

Q. Is that a good thing or bad thing?

A. That's good. Again, consistent with his hemoglobin molecules carrying oxygen. Anything over 90 percent is good.

Q. You told us normal is 95 to 100; correct?

A. Yes. Again, in the setting of pneumonia, there's a margin of safety. Anything above 90 percent is good tissue oxygen delivery to the brain, to the heart and to the other vital organs.

Q. Is that progression of 96 percent from 7:30 or so, to 10:30, 10:00 at night, is that consistent or inconsistent with a

patient having respiratory distress, labored breathing and difficulty oxygenation?

A. It's well within the safety zone of 90 percent.

Q. Now, Doctor, you were asked questions about the note by Nurse Shajimon about notes, "complains of shortness of breath on oxygen."

Could we agree the person who could best tell us what was meant by that, is the person that wrote it?

MR. ARGINTAR: Objection.

THE COURT: Sustained.

Q. In reading that note in the context of everything else that was written about the patient, what did you interpret that entry to mean when she suggested shortness of breath on oxygen?

A. Again, the patient coming in with pneumonia, shortness of breath is expected. And he's on oxygen with a saturation of 92 percent. He's not in dire straits or not in deep trouble when he needs to be in the ICU.

Q. Now, you were asked questions, was Mr. Rodriguez ever seen by a pulmonologist. You said no.

Was there any reason for Mr. Rodriguez to be referred to a pulmonologist at any point during this admission?

A. There was no indication for a pulmonary consult.

Q. Why not?

A. Basically, pneumonia is one of the most common adult medical problems. The most common infection, along with urinary

tract infection. General internal medicine doctors treat pneumonia all the time without specialty consultations being needed. It's routine.

He was getting appropriate antibiotics. As a pulmonologist, I see that they were doing all the right things. Oxygen, antibiotics to treat all the potential bacterial causes, I.V. fluids and admission to a hospital.

Q. If a pulmonologist was called, a pulmonologist such as yourself, was there anything else they could have done or should have done under those circumstances?

A. Continue the antibiotics. Continue to observe the patient and his progression.

Q. Now, you were asked questions before about making notes in the chart. It's good practice to make notes in the chart. And whether the fact that Dr. Banner did not make a note in the chart, whether that was a departure or problem.

Do you remember that testimony?

A. Yes.

Q. And you said you couldn't answer the question yes or no?

A. Right.

Q. What was the significance, if any, of the fact that Dr. Banner was the medical admitting resident in terms of his responsibility with regard to making notes?

A. We know there were seven doctors involved.

MR. ARGINTAR: Objection. It's not responsive.

THE COURT: Sustained.

Q. Doctor, I want you to assume that Dr. Bhullar testified that it's not the standard of practice at Montefiore Hospital for the medical admitting resident, the senior resident to make a note when accepting a patient to be admitted to the medical floor. I want you to assume that. You saw that, did you not?

A. Yes.

Q. Doctor, is that standard of care, is that good practice?

A. That's good practice.

Q. Why?

A. Well, basically, each doctor that's taking care of the patient has a specific role. The medical admitting resident, his role or her role is to basically talk to the emergency department. Talk to the inpatient doctors. And help transition the care from the E.R. where doctors have seen the patient and written extensive notes to the doctors in the hospital where they're going to see the patient and write extensive notes.

The role of the medical admitting resident is more of a logistics. Helping move the patient from the E.R. to the inpatient service. And they don't need to write a note when all the other doctors have written extensive notes.

Q. Now, Doctor, you were asked questions about the importance of Mr. Rodriguez being able to speak in full

sentences. Do you remember that?

A. Yes.

Q. And we know, Doctor, that Dr. Leung indicated he could speak in full sentences; correct?

A. Correct.

Q. And counsel referred you to a nurse's note that indicated that he had difficulty in speaking full sentences. Do you remember that?

A. Yes, I remember that note.

Q. Do you remember what time that was?

A. That was in the emergency department. The nurse that writes with the big letters. I think it was later on in his --

Q. Around 7, 7:30?

A. That's approximately right.

Q. I want you to assume Dr. Bhullar said he did not see the patient until after the patient was on the floor after 11:00.

A. That's correct.

Q. I want you to assume he testified that he spent 45 minutes to an hour with the patient. You saw that; right?

A. Yes, I did.

Q. Does Dr. Bhullar's note make reference to the patient able to speak in full sentences?

MR. ARGINTAR: Objection to leading.

Q. What, if anything, does Dr. Bhullar's note say with

regard to speaking in full sentences?

A. Right here on the note, it says in general, NAD, no acute distress. Then a no sign. No accessory muscle used. Speaking full sentences.

Q. So Dr. Bhullar, in his assessment, four hours after that note of the nurse, indicated that he was able to speak in full sentences; correct?

A. Correct.

Q. What's the significance?

A. The significance is again, looking at the overall picture, the patient is not labored with his breathing. His oxygenation is in a good range, and he's doing fine. He's in the hospital for treatment of pneumonia. There's no sign that he's getting into trouble.

Q. Doctor, last question.

You were asked whether or not you agree or disagree with the cause of death listed by the medical examiner in the autopsy report. Do you remember that?

A. Yes, I do.

Q. You said you can't answer it yes or no?

A. Right.

Q. Can you explain why not or what you meant by that?

A. Well, the medical examiner can look at the organs. When he looks at the lungs, he sees there's pneumonia. When the medical examiner looks at the kidneys, he sees there's damage to

the kidneys from diabetes. When he looks at the heart, he sees that the muscle is thickened. He can only look at what the organs show, both on looking at them with his eyes and on looking at them by taking pieces of tissue and looking under the microscope. The medical examiner is looking at the patient after he passed.

The clinical doctors, such as myself, can put that information together as a full picture of what was the oxygen level, what were vital signs, what was the examination. And putting all that information together, the patient was not drowning from pneumonia. Not labored breathing. It wouldn't have changed so suddenly.

He had kidney failure. He had pneumonia. And he likely had a sudden cardiac arrest. That's the most clinical, appropriate, likely explanation, given everything that we know, both from the autopsy and from his course in the hospital.

Yes, he did have pneumonia, but that was a component that lead to the cardiac arrest.

Q. Now, Doctor, when asked whether or not there was any evidence of a heart attack on the autopsy report, and you said no.

Is there a difference between what lay people use in terms of heart attack and what you as medical doctors call a heart attack and lethal arrhythmia?

A. Yes.

Q. What's the difference?

A. So the classic heart attack is when you have hardening of the arteries that feed oxygen to the heart muscles. When one of the arteries get blocked, part of the muscle of the heart dies. The muscle can't pump because it doesn't get oxygen. That's the classic heart attack.

That's different than what we're talking about here. Here, we're talking about abnormality of the electrical impulse that goes from the top of the heart down to the bottom to make the muscle react.

Q. As a natural pacemaker?

A. Right. The electrical signal is the pacemaker that makes the heart beat. It's not a heart attack of a block. It's erratic electrical signal in the setting of pneumonia, renal failure, diabetes; all these other conditions.

Q. Now, Doctor, would the autopsy show any evidence of a stopping of the heart from an electrical abnormal lethal rhythm?

A. No. That's not something that the medical examiner can see any evidence of. It's like there's a lightening bolt. It's an electrical phenomenon, then it's gone. There's no evidence left of that afterwards.

Q. Doctor, as a general proposition, is every patient that has an acute event, even witnessed in the hospital, survivable?

MR. ARGINTAR: Objection.

THE COURT: Sustained.

Q. Well, Doctor, is there a certain percentage of patients who suffer from pneumonia that even if they get all the treatment in accordance with good practice, that they don't survive?

MR. ARGINTAR: Objection.

THE COURT: Sustained.

MR. SHAUB: I have nothing further, Judge. Thank you.

MR. ARGINTAR: May I?

THE COURT: Yes, please.

RECROSS EXAMINATION BY

MR. ARGINTAR:

Q. Doctor, I think you just mentioned that it's your opinion that Wilbur Rodriguez had an erratic electrical signal; is that correct?

A. You can say it that way, yes.

Q. Did any of the EKGs that Wilbur Rodriguez had while he was in the hospital show that he had arrhythmia?

A. He did have what's called a right bundle branch block.

THE COURT: A what?

THE WITNESS: He did have a right bundle branch block, which is an abnormality of the electrical signal passing from the top of the heart down to the chambers on the bottom. So there was a blockage of that electrical signal to part of the main pumping chambers of the heart.

Q. Would you agree he was never noted to have an arrhythmia after review of the EKGs in the hospital chart?

A. No. He had no ventricular fibrillation. No tachycardia.

Q. Would you agree, no arrhythmia was noted in the EKGs?

A. Okay.

THE COURT: That's correct? Okay?

THE WITNESS: Yes. There was no other arrhythmia beyond the bundle branch block.

Q. Despite the fact that there was no arrhythmia in the EKGs that were performed on Wilbur Rodriguez while he was in the hospital, it's still your opinion that it was an arrhythmia that caused his death; correct?

A. Correct.

Q. Now, you also mentioned that Wilbur Rodriguez did not have drowning in the lungs. Do you remember saying that?

A. Yes.

Q. What hasn't been mentioned yet, Doctor, is are you aware that on the autopsy report that his right lung weighs 660 -- 1660 grams? Are you aware of that?

A. Yes.

Q. Are you aware that is much larger, much heavier than a normal lung? Do you agree with that?

A. Yes. Average right lung would be 600 grams. He definitely has pneumonia in there.

Q. Would you agree that it weighs so much more than a normal lung because it's filled with fluid? Do you agree with that?

A. He has pneumonia, yes. That's expected.

Q. Yes or no, his lung is filled with fluid; yes? Correct?

A. To some degree, yes.

Q. Would you agree with me that he likely has -- he was dying because he experienced a sensation of fluid buildup in his lungs?

MR. SHAUB: Objection, Your Honor. Beyond the scope of the redirect, Your Honor.

THE COURT: Sustained.

Q. Doctor, do you agree that the fact that his lung is more than twice the size of a normal lung, indicates yes or no, that he died from pneumonia?

A. You said size. I don't think that's what you meant to say.

Q. Weight?

A. Normally, the lung is air, so it weighs nothing, and this weighed much more than that.

Q. It's indicative of the time that he died from pneumonia?

A. It's consistent with pneumonia.

Q. Doctor, you mentioned that you do teaching of

residents; correct?

A. Correct.

Q. Because they're residents in training, as a more experienced doctor, you like to consult with them about their findings? Would that be fair to say?

A. Yes.

Q. Are you aware that the first and second year resident who saw Wilbur Rodriguez on Northwest 8, never called the attending Dr. Green? Are you aware of that?

MR. SHAUB: Objection, Your Honor. Beyond the scope of direct, cross and redirect.

MR. ARGINTAR: It's not.

THE COURT: Sustained.

Q. On the 11 p.m. nursing note by Nurse Shajimon, does it say anywhere in the note that the Wilbur Rodriguez is on a venting mask?

A. No.

Q. Does it say he's on a venting mask at 12:30 a.m.?

A. Yes.

MR. ARGINTAR: No further questions.

MR. SHAUB: Just one.

THE COURT: You said one question.

REDIRECT EXAMINATION BY

MR. SHAUB:

Q. Doctor, looking at Nurse Shajimon's note, do you know

what she wrote after oxygen? All the little words after that?

A. Yes. Looks like three liters per minute.

MR. ARGINTAR: That's one question.

MR. SHAUB: All right. That's one question. You're right. I'm a man of my word. I have no further questions.

MR. ARGINTAR: I have nothing else, Your Honor.

MR. SHAUB: Defense rests, Your Honor.

THE COURT: Wait, wait. Slow down.

Thank you, Doctor. You may step down.

THE WITNESS: Thank you.

(Whereupon, the witness was excused.)

THE COURT: We have procedures.

MR. SHAUB: Sorry, Judge.

THE COURT: Do you have any other evidence or witnesses you'd like to present?

MR. SHAUB: No, I don't, Your Honor.

THE COURT: Therefore?

MR. SHAUB: Defense rests, Your Honor.

THE COURT: Ladies and gentlemen of the jury -- oh, you reserve applications until after I excuse the jury?

MR. SHAUB: Yes.

THE COURT: Ladies and gentlemen of the jury, that's all the evidence you're going to hear in the case.

As we discussed yesterday as far as scheduling, we