COURT OFFICER: All rise. Jury entering.

(Jury enters courtroom; the following occurred:)

COURT OFFICER: You may be seated please.

THE COURT: Mr. Argintar, do you have another witness?

MR. ARGINTAR: Yes, Your Honor. Doctor Mark Schiffer.

COURT OFFICER: Witness entering.

(Witness approaches witness stand.)

COURT OFFICER: Remain standing right here. Raise your right hand please.

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

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

THE WITNESS: My name is Mark Schiffer, S-C-H-I-F-F-E-R. My office address is 158 East 84th Street, New York, New York 10028.

THE COURT: Good afternoon, Doctor Schiffer.

THE WITNESS: Good afternoon, Your Honor.

THE COURT: You may inquire.

MR. ARGINTAR: Thank you.

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DIRECT EXAMINATION

BY MR. ARGINTAR:

Q. Good afternoon, Doctor Schiffer.

A. Good afternoon.

Q. Are you licensed to practice medicine in the State of New York?

A. Yes, I am.

Q. At some point, did my office ask you to review materials regarding the care and treatment of Wilbur Rodriguez?

A. Yes, sir.

Q. How long ago was that?

A. Approximately in the summer of 2009.

Q. And have we spoken over the phone in between 2009 and today?

A. Yes, we have.

Q. And have we met in person between 2009 and today?

A. Yes, we have.

Q. Okay. As far as reviewing cases for litigation that are sent to you, do you review cases for both defendants and plaintiffs?

A. Yes, I do.

Q. Where did you go to medical school?

A. I went Northwestern University in Chicago, Illinois.

Q. Okay. And after you graduated medical school, what did you do next?

A. I did a residency in internal medicine at Lenox Hill Hospital in New York City from 1977 until 1980 and then I was a chief resident in internal medicine 1980 to '81 and then I did a fellowship in cardiology from 1981 to 1983.

Q. Okay. Are you board certified in any areas of medicine?

A. Yes, in internal medicine and in cardiovascular disease.

Q. Let's talk about your first board certification. What is internal medicine?

A. Internal medicine involves the care of the adult with general medical problems.

Q. And you mentioned you're also board certified in cardiovascular disease. Can you describe that?

A. Cardiovascular disease deals with disorders of the cardiovascular system, the heart, the blood vessels and so for forth.

Q. Where do you currently work?

A. I have a private practice in Manhattan. It's a group practice. I'm one of five doctors and I also hold a position at Lenox Hill Hospital where I'm the director of the cardiac intensive care unit.

Q. What does it mean to be the director of the cardiac intensive care unit at Lenox Hospital?

A. The cardiac intensive care unit is the area of the

hospital where the care for critically ill patients with cardiac disease, patients who have had heart attacks, heart failure, heart arrhythmia problems. It's a 12-bedded unit and then there are 16 beds considered intermediate area. I have responsibility for all aspects of the unit including administration, policies, the overall care of the patients and also the education of the doctor trainees that rotate through of fellows of cardiology and the residents in internal medicine and medical students.

Q. Do you care for critically ill patients?

A. Yes, I do.

Q. Is my office paying you for your time away from your practice from the hospital today?

A. Yes.

Q. and what is my office paying you?

A. $850 an hour.

Q. Okay. Are we also paying you for your time in court as well?

A. Yes.

Q. What have you reviewed in preparation for your testimony today?

A. I reviewed the medical record of Wilbur Rodriguez at Montefiore Medical Center. I reviewed the autopsy report. I reviewed a deposition testimony and I also reviewed one trial transcript of testimony given by the emergency room doctor.

Q. Okay. Do you have any teaching responsibilities

currently?

A. Yes, I do.

Q. What are those?

A. As part of my responsibility in the cardiac intensive care unit, I make rounds on a daily basis with house staff, with interns, residents and fellows and I have responsibility for teaching them on a daily basis and I also have responsibility for organizing various educational conferences in the hospital on a regular basis.

Q. Okay. Are you familiar with the standard of care for medical doctors in New York?

A. Yes, I am.

Q. Are you familiar with the standard of care for medical residents in New York?

A. Yes, I am.

Q. And how are you familiar with the standard of care for both medical doctors and medical residents? What is your basis, sir?

A. In addition to the fact that I was a resident at one time, over my career, I've spent many many years teaching residents. I have contact with residents on a daily basis and I have responsibility for overseeing that the residents in my institution carry out their responsibilities properly.

Q. As chief of the cardiac intensive care unit at Lenox Hill Hospital, do you have experience in witnessing patients die

from respiratory disease?

A. Yes, I do.

Q. How many patients over your career have you seen die from respirator disease?

A. Well, having been doing this for nearly 30 years, it's run into certainly many hundreds or more. It's something that we see unfortunately on a daily basis in a busy hospital and a busy critical care unit.

Q. Okay. In your experience as the head of the cardiac intensive care unit, do patients who die of respiratory disease typically experience pain as they die?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained.

Q. in your experience of witnessing patients die from respiratory disease, are pain medications administered to them more often than not?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained.

Q. Doctor, have you ever treated patients who were diagnosed with pneumonia?

A. Yes, I have.

Q. Okay. Now, I ask you have you ever witnessed patients die of respiratory disease? Have you ever in your experience a patient die from pneumonia?

A. Yes, I have many times.

Q. Okay. In your experience of witnessing patients die from pneumonia, is it your experience that that is a painful death?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained.

Q. Is there any level of pain in your experience of witnessing patients die from pneumonia?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained. Why don't you come up?

(Discussion off the record.)

THE COURT: Continue.

Q. Doctor, what typically happens in your experience when a patiently dies from a respiratory disease?

MR. SHAUB: Objection, your Honor.

THE COURT: What typically happens?

Q. And, Doctor, what have been the circumstances of you witnessing a patient die from respiratory disease?

MR. SHAUB: Objection.

THE COURT: What is the circumstances?

Sustained.

Q. Doctor, what does a patient go through when in your experience you have witnessed them die from respiratory disease?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained.

Q. Doctor, can you tell me the sequence of events

medically that a patient goes through from a medical perspective in your experience when you've witnessed them die from respiratory disease?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained.

Q. Doctor, medically, what does a patient go through in your experience based on your experience when they die from respiratory disease?

MR. SHAUB: Objection.

THE COURT: Come up.

(Discussion off the record.)

Q. Doctor Schiffer, what does the body go through from a medical perspective when somebody dies from respiratory distress?

A. Um, usually, it's a sequence of events and, obviously, it depends on where the person is and what type of care they are having but when a person dies from respiratory disease, typically, over a period of time, they're not able to maintain oxygen levels in the blood either because they tire out from trying to breathe enough to maintain oxygenation or because the lungs are so impaired either from infection, the lungs are filled with fluid and with inflammatory substances that there can no longer be the exchange of gas between the lungs and the blood stream so oxygen levels begin to drop. Carbon dioxide levels in the blood begin to rise. The body becomes acid and

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MR. SHAUB: Objection, your Honor.

THE COURT: Sustained.

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eventually bodily functions begin to shutdown. Patients become more and more lethargic. Eventually, they lose consciousness. They may have a sense of struggling to breathe to maintain oxygenation and then eventually as the body becomes more acid and there's more carbon dioxide, typically, the heart beat begins to slow down and the breathing begins to slow down independently. Eventually, all cardiac and lung functions cease, brain functions cease because of lack of oxygen and the body dies.

Q. Okay. Doctor Schiffer, do you have an opinion within a reasonable degree of medical certainty what the cause of death was for Wilbur Rodriguez?

A. I do.

Q. And what is your opinion as to what the cause of death of Wilbur Rodriguez was?

A. In my opinion, he died of respiratory failure due to overwhelming and severe bronchopneumonia in all of his lung fields.

Q. And what is your basis for saying that Wilbur Rodriguez died of overwhelming bronchopneumonia?

A. I base it on the entire medical record that is a description of the history, the physical examination, the chest x-ray reports, the CAT scan of the lung report and the autopsy report that I reviewed.

Q. And, by the way, Doctor Schiffer, the medical process

that you've just described from a respiratory death from respiratory distress, would that be the same if somebody were to die from overwhelming pneumonia?

A. Yes. Overwhelming pneumonia is one type of a disorder that results in severe respiratory distress.

Q. Now, Doctor Schiffer, you mention that one of the basis -- correct me if I'm wrong -- one of the basis that Wilbur Rodriguez died from the respiratory death was the autopsy report; is that correct?

A. Yes, it is.

MR. SHAUB: Can I just see?

Q. Doctor Schiffer, do you agree with what the medical examiner states here cause of death bronchopneumonia, complicated diabetes mellitus?

A. I do.

Q. Okay. Now, Doctor Schiffer, looking now on one of the pages of the medical examiner's report, is there anything in here that supports your opinion that Wilbur Rodriguez died from a respiratory death?

A. Yes, there is. The third item from the top under the heading Respiratory System is a description of what we call the gross examination of the autopsy material meaning not microscopic but the medical examiner visually inspected the body parts during the autopsy and in part of that inspection they also weighed the body parts.

Q. What did Wilbur Rodriguez's lungs weigh on the medical examiner's inspection?

A. The right lung as it reads here weighed 1606O grams and the left lung weighed 780 grams. Typically, the right lung weighs a little bit more than the left but the normal weight for lungs that are not deceased are about 4 to 500 grams for the right lung and maybe 400 or so grams for the left. So these lungs are very very heavy which is consistent with pneumonia.

Q. Okay. And other than being consistent with pneumonia, what does the lungs, as you've described being very heavy, signify to you as to his cause of death?

A. Well, this autopsy report is consistent with the clinical findings that were made while the patient was alive and that is that there was severe and diffused pneumonia in both lungs and in all lobes of the both lungs.

Q. Okay. Now, I want you to assume that Doctor Mukherji testified yesterday that he had the opinion that Wilbur Rodriguez likely died from a sudden cardiac event. Was that opinion supported by the medical evidence in this case?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained.

MR. ARGINTAR: May we approach, Your Honor?

THE COURT: Sure.

(Discussion off the record.)

MR. ARGINTAR: May I proceed, Your Honor?

THE COURT: Yes, please.

Q. Doctor Schiffer, I want you to assume that Doctor Mukherji testified that he thought that Wilbur Rodriguez's death was likely from a sudden cardiac event. Do you agree with Doctor Mukherji's opinion?

A. No. I don't agree with that.

Q. Why do you not agree with it?

A. From having reviewed the medical record again and the autopsy findings, it's my opinion that Mr. Rodriguez died of respiratory failure. On the autopsy, he did not have any coronary heart disease meaning he didn't have blockages in his arteries. He was on -- when he was in the emergency department, he was on a cardiac monitor continuously or almost continuously from the time he arrived until the time that he was transported up to his bed and during that time there was no finding of any cardiac arrhythmia. So that looking at the case of somebody who has the severe and overwhelming pneumonia who had an arterial blood gas determination that showed that he was very sick and having difficulty being oxygenated. It certainly based on my experience is much more plausible that he died of respiratory cause than he died of some sudden cardiac event.

Q. Now, is there anything that supports you in the medical examiner's examination that would lead you to believe that this is not a cardiac death?

A. Again, he has evidence, I think, of some mild, what is

called hypertensive heart disease, is the heart muscle was a little bit thickened but he did not have any evidence of a heart attack. That's something that would be seen clearly on an autopsy. There was no evidence of any heart muscle damage, any heart attack. He had no blockages in any arteries. He had no evidence of any rhythm disturbance in the nearly 12 hours that he was on a cardiac monitor and his electrocardiogram even had some minor abnormalities would not be the type to produce a sudden cardiac event. There is a lot of evidence that he had severe and life threatening respiratory illness and not any evidence that he had any life threatening cardiac event.

Q. Now, Doctor Schiffer, we'll come back later to talking about Wilbur Rodriguez's death but now I want you to go to around 11:00 p.m. after Doctor Mukherji admits Wilbur Rodriguez to Northwest 8, okay?

A. Yes.

Q. Okay. Who was the first doctor to see him on Northwest 8?

A. It was the first year resident, Doctor Bellows.

Q. And, Doctor Schiffer, what is a first-year resident?

A. a first-year resident is what's used to be called an intern. It is a -- that is a doctor someone who's graduated from medical school and is in their first year of training typically in a hospital setting after the first year of medical school.

Q. How would you classify the experience level of a first-year resident?

A. Well, of course, it's partially dependent on the time of year. residents typically begin on July 1st. This occurred in January so this doctor had been out of medical school for about six, six months or six and a half months so I would consider this doctor to be relatively inexperienced and certainly to be considered a doctor in training.

Q. Okay. Who was the second doctor who saw Wilbur Rodriguez once he was on Northwest 8?

A. I don't want to mispronounce the name. I think it was a Doctor Bhullar I believe.

Q. That's as I understand it. Doctor Bhullar, do you know what level of experience he had?

A. By definition, this is what's called a PGY-2, a postgraduate year two. This doctor had one more year of experience than the first doctor Doctor Bellows.

Q. Is PGY-2 is that a doctor still in training?

A. Yeah. These doctors are all considered to be trainees. This doctor is a year and a half out of medical school. This doctor would not have privileges to practice medicine at the hospital where he was except under the supervision of a more senior doctor.

Q. Did either the first or second-year resident who saw Wilbur Rodriguez on Northwest 8 at any time did they alert the

attending doctor?

A. No, not as it was indicated in the record.

Q. What is an attending doctor?

A. An attending doctor is a doctor who has completed all of his or her training and is considered to be fully trained and credentialed to assume responsibility for the care of a patient and sometimes is known as the admitting doctor but this is a doctor who has the final responsibility for the patient's care.

Q. Okay. Now, let's first go over Doctor Bellows, the first-year resident's note. Does he indicate in his note that blood gases were drawn?

A. Yes. There is an area where he writes down the results of the blood gas that was done in the emergency department.

Q. Okay. Now, the blood gases that were drawn is there anything that you find significant about those?

A. Yes. A blood gas is a measurement of certain findings in arterial blood. So the blood as opposed to blood which is typically drawn from the vein this is blood specifically drawn from an artery and in a blood gas the laboratory measures what's known as the PH which is a measurement of the acid or base or the acidity of the blood, measures the concentration of carbon dioxide in the blood and also measures the concentration of oxygen in the blood and something known as bicarbonate which is also in the blood stream.

In this blood gas, which was taken with the patient breathing room air, meaning without any supplemental oxygen, the PH was approximately 7.4 which is normal but the PCO2 which is a concentration of carbon dioxide which is 28 which is low. The reason this is significant is that when patients are stimulated to breathe more vigorously they begin to hyperventilate and when they do that they begin to, as we say, blow off their carbon dioxide. The carbon dioxide levels in the blood decrease. A normal PC2 level is about 40 and 28 is significantly low indicating that the patient is breathing some combination of fast and/or deep in trying to maintain oxygenation and at the same time the PO2 which is the concentration of oxygen in the blood is about 48. This is dramatically low. The normal is typically is somewhere between 90 and 100. So we have a situation where a patient is breathing more vigorously than normal but at the same time the blood oxygenation levels are dangerously low. So this is the assessment of that blood gas of a patient that is critically ill.

THE COURT: Counsel, this is a good time to stop.

MR. ARGINTAR: One more question, Your Honor.

THE COURT: Go ahead.

Q. Doctor, I want you to assume that Doctor Mukherji testified that his blood gases that were drawn indicated that his health was improving. Do you agree or disagree with that assessment?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained. This is good time to stop, counsel.

MR. ARGINTAR: Okay. Yes, your Honor.

THE COURT: Ladies and gentlemen, we're going to break for lunch. please do not discuss the case amongst yourself or with anyone else. Keep an open mind. I'll see you at 2:15. Thank you.

COURT OFFICER: All rise.

(Jury exits courtroom.)

THE COURT: Doctor, you are to return to at 2:15. We'll continue the examination.

THE WITNESS: Yes, ma'am.

THE COURT: Have a pleasant lunch.

MR. SHAUB: We ask if the doctor has any notes or anything he brought with him about this case can I look at it that over lunch?

THE COURT: Yes, Doctor, did you bring anything?

THE WITNESS: I have nothing.

MR. SHAUB: You brought nothing with you?

THE WITNESS: You can look at my briefcase.

MR. SHAUB: If you tell me it's nothing, it's nothing.

THE WITNESS: No, it's nothing.

THE COURT: Okay.

MR. SHAUB: Before we close for the day, I want to make sure the memoranda of law is marked as a court exhibit.

THE COURT: Okay. She'll mark it later.

(A luncheon recess was taken.)

A F T E R N O O N S E S S I O N,

COURT OFFICER: All rise. Come to order.

THE CLERK: Index No. 30701/2009. Evelyn Rivera, as Administratrix of the Estate of Wilbur Rodriguez, Deceased, versus Montefiore Medical Center.

The jury is not present.

THE COURT: Counsel, one of you had an application before I bring the jury down?

MR. ARGINTAR: Yeah. Not an application. I just wanted to put a statement on the record that I forgot to do earlier before today started, in regards to conversations with my client.

THE COURT: Okay.

MR. ARGINTAR: Counsel, has spoken with Ms. Rivera, the plaintiff in this action.

MR. SHAUB: Not me. You said counsel.

MR. ARGINTAR: Plaintiff's counsel has spoken with Ms. Rivera. The plaintiff in this action about any discussion regarding settlement.

THE COURT: Why don't we have the doctor step outside, please.

(Whereupon, the doctor exits courtroom.)

MR. ARGINTAR: Ms. Rivera has indicated to plaintiff's counsel that she has no interest, no matter what the settlement offer is by defense counsel in settling

this case. I even proposed the possibility that the defendant in this case, the hospital, would admit liability in the terms of the settlement. She indicated to me that she wants a verdict in this case. That is all she wants. And because of that, myself and defense counsel are unable to engage in any meaningful settlement negotiations.

I'm making this statement in the presence of Ms. Rivera. And we've spoken about this several times. And at this point, I just wanted to put on the record that is her intentions and that's the way she feels.

THE COURT: Did you convey to her, I believe there's an initial offer of $300,000?

MR. SHAUB: Yes.

MR. ARGINTAR: Yes. Plaintiff's counsel, although I conveyed to Ms. Rivera that $300,000 was offered by the defendant, she said that number doesn't matter. There's no number that I would settle this case for. She wants a verdict. It didn't even get to the point where I can say I recommend you take this or don't recommend. In fact, just for the record, I would not recommend at this point that she take a settlement offer of $300,000.

THE COURT: You're saying this in open court in her presence. However, she's the same witness that testified with an interpreter. I don't know how much Ms. Rivera understands what you just said and what has been

going on in the courtroom.

MR. ARGINTAR: Well, Your Honor, Ms. Rivera does understand English very well. The reason I had the interpreter for her is because she has much more difficulty speaking English and expressing herself in the English language. When it comes to comprehension, my understanding is she understands everything that's said.

I asked her, do you understand what's going on in court, and she tells me she understands everything.

THE COURT: Do you mind if I ask if she understands what you said and if she agrees.

MR. ARGINTAR: I do not mind.

THE COURT: Ms. Rivera, can you come up to where the attorney is?

(Whereupon, Ms. Rivera enters court well.)

THE COURT: Ms. Evelyn Rivera, as the administratrix and the plaintiff in this case on behalf of your son Wilbur Rodriguez, did you understand everything that the attorney just stated to the Court?

MS. RIVERA: Yes.

THE COURT: And part of what he stated was that the defendant had offered $300,000 for you to settle this case. And he said that you indicated that you were not interested in that offer. And basically, no amount of money would resolve this. That you do not want a

settlement; is that correct?

MS. RIVERA: I want to continue with the case.

THE COURT: You want to continue with the case. So the money that defendant has offered -- on this side, is the defendant. They offered $300,000. You don't want that? You're not interested in that?

MS. RIVERA: No.

THE COURT: Are you interested in trying to obtain, to try to obtain more money from the defendant to try to settle this?

MS. RIVERA: I want the case continued.

THE COURT: To continue until the end?

MS. RIVERA: Yes.

THE COURT: You want the decision to be by the jury?

MS. RIVERA: Yes.

THE COURT: You want them to make the decision?

MS. RIVERA: Yes.

THE COURT: You don't want your attorney to settle this, this attorney, and not have the jury have a voice in what happens?

MS. RIVERA: No. I want continue with the jury.

THE COURT: Okay. Thank you very much.

And you understood everything that's been going on

in the courtroom?

MS. RIVERA: Yes.

THE COURT: Okay. That takes care of that. Anything else?

MR. ARGINTAR: No, Your Honor.

THE COURT: Can we bring the jury down now?

MR. ARGINTAR: Yes.

THE COURT: Can you get the doctor back on the stand?

How long are you going to be with the doctor?

MR. ARGINTAR: 30 minutes.

THE COURT: I need to give him as much time as he needs for his cross. He hasn't really had enough time. We're going to have to bring the doctor back. You keep it short. You're almost there.

MR. ARGINTAR: I'm getting there.

THE COURT: So he has enough time.

MR. ARGINTAR: I'll give him enough time, Your Honor.

(Whereupon, the witness resumes the witness stand.)

COURT OFFICER: All rise. Jurors entering.

(Whereupon, the jury enters the courtroom.)

(Whereupon, the following takes place on the record, in open court in the presence of the jury, among the Court, Mr. Argintar and Mr. Shaub.)

THE COURT: You may be seated.

Counsel, you may continue with your examination --

MR. ARGINTAR: Thank you.

THE COURT: -- of the doctor.

CONTINUED DIRECT EXAMINATION BY

MR. ARGINTAR:

Q. Good afternoon, Doctor.

A. Good afternoon.

Q. We left off before lunch talking about Wilbur Rodriguez' blood gases. Do you remember that?

A. Yes, I do.

Q. Just briefly, what is the significance that you found in his blood gases and what did that indicate, if anything, about Wilbur Rodriguez' health?

A. The blood gas in my opinion, indicated somebody who had a very, very severe respiratory problem. As I pointed out before, because one of the measurements, the PCO-2 indicated that he was attempting to breathe as vigorously as he could to support his oxygen levels. But at the same time, his oxygen levels were dangerously low. So this is the pattern or picture of somebody with a severe respiratory compromise.

Q. Now, going -- I'm reading now from the first page of Dr. Bellows' note in the hospital chart. Plaintiff's Exhibit 1. Dr. Bellows wrote baseline exercise tolerance unlimited, but now unable to walk upstairs.

What, if any, significance does that have to you medically?

A. It's just another indication of severe respiratory ailment. And what the doctor is describing when he says exercise tolerance unlimited, he means that he's able to do anything within reason. Physical activity, climb stairs, walk briskly on the street, without any limitation but within the last couple of days, he's short of breath walking up a flight of stairs.

Q. Dr. Bellows also wrote patient was in his usual state of health until two days, PTA, when he began to experience shortness of breath at rest.

What does that sentence, if anything, signify to you?

A. The abbreviation PTA means prior to admission. What the doctor is saying that he was in his usual health meaning that he was living his life and doing his job and feeling okay, and then two days before admission, before he came to the hospital, he became short of breath. But being short of breath at rest is even more significant because what that means is that you have a hard time breathing just sitting in a chair or resting in bed as opposed to walking around or walking up a flight of stairs.

Q. Now, going to page four of Dr. Bellows' note under general appearance, he writes the word lethargic. What, if anything, does that signify to you?

A. Lethargic is a description of his appearance lethargy. It means that a patient is not responding quickly. They look sleepy or tired or sluggish. And that is frequently seen when there's poor oxygenation and also when people are very sick and the blood -- excuse me. The brain is not getting enough oxygen. And it produces a general sluggishness in the patient.

Q. Now, on page seven of eight of Dr. Bellows' note, next to number one, he writes shortness of breath likely two out of two, diffuse pneumonia and in presence multilobular. Do you agree with that statement?

A. I do agree with it. The symbol two/two means secondary to. What the doctor is saying is that the shortness of breath is secondary to multilobular pneumonia. That is pneumonia that is affecting multiple lobes of both lungs. He's in essence confirming what my read of the record is. That this is a severe respiratory illness.

Q. Number two says ARF, unclear etiology. What is ARF?

A. ARF in this context means acute renal failure. That's kidney failure.

Q. What is the significance to you of a patient as written here of acute renal failure?

A. Acute renal failure just by itself, can be life-threatening problem. What it means is that the kidneys have stopped functioning or functioning at a very low level so that they're not able to remove toxins from the bloodstream.

And patients can develop acidosis. The blood can become acid. Other abnormalities of electrolytes, potassium, can occur. And in the setting of someone who's critically ill for another reason in this case, a respiratory illness, to have kidney failure at the same time, makes it even more of a dangerous situation because the body is not able to compensate in any way or I should say the kidneys are not able to compensate in any way for some of the problems that occur with the respiratory illness.

Q. Now, we previously mentioned that in addition to the first year resident Dr. Bellows, Wilbur Rodriguez was also seen on the floor northwest eight by Dr. Bhullar; is that correct?

A. Yes.

Q. Dr. Schiffer, I'm going to show you a note from Dr. Bhullar's hospital note and it says PNA severity index is class four. And then it appears there's an equal sign there. Mortality risk greater than nine percent.

My first question is, what is the PNA severity index?

A. PNA is an initial that stands for pneumonia. And the PNA severity index is a scoring system that can be used in which a variety of factors about a patient including their gender, their age, their vital signs, their oxygen levels, their kidney functions, their blood count, all of these things are entered into a scoring system. And then you can calculate what's called severity index. And it's a way that doctors can use to sort of

quantify the risk of, in this case, mortality. So what that means is that according to the PNA severity index, Wilbur Rodriguez had a greater than nine percent chance of dying from this pneumonia.

Q. Now, Doctor, how significant to you would that be if in your examination of a patient, you found that he had a greater than nine percent chance of dying from pneumonia?

MR. SHAUB: Objection, Your Honor.

THE COURT: Repeat that question for me, please.

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

THE COURT: How significant would that be?

MR. ARGINTAR: I'll withdraw it and re-ask.

Q. Doctor, would it be significant to you if you found that a patient had a greater than nine percent chance of dying from pneumonia?

MR. SHAUB: Objection.

THE COURT: Sustained.

Q. Doctor, would a PNA severity index of four with a corresponding mortality rate as noted in the hospital chart have any significance to you as a physician?

MR. SHAUB: Objection.

THE COURT: Sustained.

MR. ARGINTAR: Basis for the objection?

THE COURT: Come up.

(Whereupon, there is a discussion held off the record, at the bench, among the Court, Mr. Argintar and Mr. Shaub.)

Q. Dr. Schiffer, what would be the standard of care for a second year resident if they were to find that a patient had a PNA severity index of four with a corresponding mortality rate of greater than nine percent?

A. The standard of care would require that the doctor take all appropriate steps to ensure that the patient is properly observed. That the vital signs, the oxygen level are properly observed on a continuous basis. In my estimation, having a mortality risk of greater than nine percent which is one out of ten, means that this is a very sick person. And having a risk of dying of one out of ten is something that would be of great concern. And this is the type of patient that would require the highest level of observation, really minute to minute until it's felt he's out of danger.

Q. Dr. Schiffer, was it a deviation from good and accepted standards of medicine for Dr. Bhullar given his finding of PNA severity index of four, to not contact the fellow -- the attending Dr. Green?

A. Yes. Most definitely.

Q. And why is that your opinion?

A. For the simple reason that as I testified earlier, the

doctors who were in the hospital, Dr. Bellows and Bhullar, they're trainees. They're students. Even though they have M.D., they are considered to be trainees. Whereas Dr. Green is the attending physician who's assigned to the care of the patient. The reason that there is an attending who's assigned, is that every patient needs to have a senior doctor who is responsible for their care. And, of course, the senior doctor can't be of any help if he's not aware of the existence of the patient. And so that the standard of care requires, especially in a patient who's this sick, that the attending been contacted. And that the case be discussed with the attending. And so that there's a clear understanding of the proper way to care for the patient.

Q. Doctor, I'm going to ask you the same question now for Dr. Bellows. Was it a deviation from good and accepted standards of medicine for Dr. Bellows, the first year resident, given the findings in his note, to not contact the attending Dr. Green?

A. Right. I would give the same answer. I would say that in this situation, Dr. Bhullar and Dr. Bellows, they're acting together as a team. They're both caring for the same patient. So it would have been sufficient for either one of them to have contacted the attending. I'm not saying that they both had to make separate phone calls to the attending. But as a team, the standard of care required the two doctors to make sure that at

least one of them had presented the case to the attending doctor and had a conversation about it.

Q. Now, Doctor, I asked you that question specifically with regard to attending. Would your answer be the same or different if I asked the same question as far as both of those doctors with respect to calling any doctor who wasn't still in training?

A. I'm sorry?

MR. ARGINTAR: Withdrawn.

Q. Now, Dr. Schiffer, what I want to go over with you next is the nursing notes from 11 p.m. up until 4:40 when Wilbur Rodriguez is found unresponsive. Okay?

A. Yes.

Q. First, I want to go over the 11 p.m. note. It says -- at this point, the patient receiving supplemental oxygen?

A. Yes, he is.

Q. It says here pulse oximetry, 90 percent. What significance does that have to you?

A. A patient who's receiving supplemental oxygen who's only able to maintain an oxygen saturation of 90 percent or slightly higher, is still a very, very sick patient. Ordinarily, a patient receiving supplemental oxygen would have a saturation of close to 100 percent, if not 100 percent. And so that is one indication of a patient with a very, very severe respiratory problem.

Q. Now, how about up here where it says complains of shortness of breath on oxygen, what, if anything, does that signify to you?

A. That's saying to me that despite the fact that the patient is receiving oxygen, that he is still feeling as though he's short of breath. He's not getting enough air. Shortness of breath is what we call a symptom. That's something that a person feels. Something that they can describe or report to a nurse or doctor.

Q. Now, the 12:30 a.m. note says patient is complaining of shortness of breath. O-2 continuing in a venting mask. What significance is that to you?

A. Well, it's saying that the patient continues to be short of breath. Which is -- would not be surprising. And that the patient is on a venting mask. There are two ways basically that we administer oxygen to patients who are breathing on their own meaning who are not on a ventilation. One is to administer oxygen through the nose. A nasal cannula. And the other is to do it by a face mask which is called a venting mask. A venting mask is typically used in sicker patients because it's possible to deliver higher concentration of oxygen and also the doctors can know much more precisely what the concentration of oxygen is that the patient is receiving.

Q. At 1:45 a.m., a Foley catheter is inserted. Is there any indication on the 1:45 a.m. note whether or not the patient

complains of shortness of breath?

A. There's no mention of that. I'm having -- if I could look at a copy or approach that board, Your Honor.

THE COURT: Counsel, the witness cannot see.

A. My eyes are not what they used to be.

There's no mention of any breathing issue in this particular note at 1:45.

Q. Is there any indication in the 1:45 note, whether the patient complained of or denied experiencing shortness of breath?

A. There's no mention one way or the other about any breathing complaints in that note.

Q. Now, the 2:30 a.m. note says, patient pulse oximetry, 92 percent. No shortness of breath noted. Now, is there any indication in this note, that there was any discussion with the patient about whether or not he had complaints of shortness of breath?

MR. SHAUB: Objection, Your Honor.

THE COURT: Overruled.

A. The note, it just says what it says. And what it says is that there's no shortness of breath noted. The way that I interpret the note --

MR. SHAUB: Objection, Your Honor.

THE COURT: Overruled.

A. The way I interpret is it -- is that the nurse is

saying she's not noting shortness of breath. Rather that the patient is either saying that he's short of breath or saying that he's not short of breath.

Q. Dr. Schiffer, you're familiar with how nursing notes are typically generated in hospitals, would that be fair to say?

A. Yes, I am.

Q. When it comes to a complaint, and I'm not specifically talking about with this patient Wilbur Rodriguez but patients in general, when a subject of complaint such as shortness of breath, would it be the standard practice in a nursing note to write that a patient either complains of something or denies of something?

MR. SHAUB: Objection, Your Honor.

THE COURT: Sustained.

Q. Dr. Schiffer, given your knowledge of how nursing notes are generated in hospitals, if a patient did not complain of shortness of breath, what would you expect to see in the note?

MR. SHAUB: Objection.

THE COURT: Sustained.

Q. Dr. Schiffer, the 4 a.m. note that says patient was resting in bed, no signs of shortness of breath noted. Same question for this note. Is there any indication in this note that there was any conversation with the patient about whether or not he had shortness of breath?

A. There isn't. When I read the note or what the note

specifically says, is that there are no signs of shortness of breath. In medical terms, there's a difference between a sign and a symptom, as I said before. A symptom is something that the patient reports or something that they feel. A sign is something that is noted by observer. And a sign can be something that is detected on a physical examination or a sign is something that can be observed by looking at a patient. So that there is a difference between a sign and a symptom.

This note specifically says there is no sign of shortness of breath, meaning that there was nothing that the nurse was observing herself that indicated shortness of breath.

Q. Is it possible for a patient to have shortness of breath, even though a nurse does not see a sign?

A. It is. The typical sign of shortness of breath would be either rapid breathing or breathing very deeply or breathing in a way that indicates that the patient may be struggling to breathe. And depending on how the patient is observed. For example, whether they're under the covers or whether they're able to be fully observed could potentially influence the nurses assessment of whether shortness of breath is present.

Q. Dr. Schiffer, do you have an opinion within a reasonable degree of medical certainty whether more likely than not Wilbur Rodriguez was experiencing shortness of breath at 2:30 a.m.?

MR. SHAUB: Objection, Your Honor.

A. I believe that --

MR. SHAUB: Objection.

THE COURT: No, no.

THE WITNESS: I apologize.

THE COURT: Sustained.

Q. Dr. Schiffer, do you have an opinion within a reasonable degree of medical certainty whether Wilbur Rodriguez was suffering from shortness of breath at 2:30 a.m.?

A. May I answer?

THE COURT: There's no objection.

MR. SHAUB: Objection.

THE COURT: Overruled.

A. Based on everything that I've seen in the record and the description of the patient and the nature of this illness, I am quite certain that he was experiencing shortness of breath at 2:30 a.m.

Q. Now, Doctor, I'm going to ask you the same question about 4:00 a.m. Do you have an opinion within a reasonable degree of medical certainty whether Wilbur Rodriguez was experiencing shortness of breath at 4 a.m.?

A. I have the same answer at 4 a.m.

Q. What is your basis for your opinion that he was experiencing shortness of breath at 4 a.m.?

A. I'm basing my opinion on the fact that he had a severe overwhelming bilateral pneumonia. And even though he was being

treated with antibiotics, it was far too early in his course for him to be getting any relief from his symptoms at that time.

Q. Now, Dr. Schiffer, the next note 4:40 a.m., patient is unresponsive. Do you see where it says that?

A. Yes.

Q. Doctor, do you have an opinion as to whether or not Wilbur Rodriguez died at some point between 4 a.m. and 4:40?

A. I do believe that he died at some point between 4 and 4:40 a.m.

Q. Is it possible to know when exactly he died between 4 and 4:40?

A. I don't believe it's possible to know precisely when this happened.

Q. Now, Dr. Schiffer, assuming that Wilbur Rodriguez died from pneumonia, is it medically possible that he experienced no pain prior to his death?

MR. SHAUB: Objection, Your Honor.

THE COURT: Sustained.

MR. ARGINTAR: May we approach?

THE COURT: No.

Q. Dr. Schiffer, I want you to assume that Dr. Sixsmith yesterday testified that because Wilbur Rodriguez had severe pneumonia in both lungs, was noted to be very hypoxic, was noted to be in acute renal failure, was noted to have high respirations, high white blood cell count, that it was a

deviation from good and accepted standards of medicine for Dr. Mukherji to admit Wilbur Rodriguez to northwest eight, a general medicine floor that does not have continuous vital sign monitoring, cardiac monitoring or respiration monitoring, do you have an opinion, Dr. Schiffer, with a reasonable degree of medical certainty whether Dr. Mukherji's decision to admit Wilbur Rodriguez to northwest eight was a substantial factor in causing his death?

A. I do.

Q. And what is your opinion?

A. My opinion is that it was a substantial contributing factor.

Q. Why is that your opinion?

A. Because I believe that as sick as he was, that Mr. Rodriguez had a treatable illness. Had he been properly observed and monitored, that when his respirations began to tire and he was on the verge of suffering cardiopulmonary arrest, that appropriate steps could have been taken to save his life and allow him to be sufficiently treated until he could have recovered from this illness.

Q. Dr. Schiffer, what steps in your medical opinion, would have been taken once his respirations dropped below a certain point?

MR. SHAUB: Objection, Your Honor.

THE COURT: Sustained.

Q. Dr. Schiffer, you just indicated that Dr. Mukherji's failure to admit Wilbur Rodriguez to northwest eight was a substantial factor in causing his death; is that correct?

A. Yes, it is.

Q. You also mentioned that you feel his death was preventable; is that correct?

A. Yes.

Q. Are there any steps that could have been taken to prevent Wilbur Rodriguez' death?

MR. SHAUB: Objection, Your Honor.

THE COURT: Sustained.

Q. If -- assuming Wilbur Rodriguez had been hooked up to continuous respiration monitoring, what would have occurred medically once his respirations dropped below a certain point?

A. If he had been observed appropriately, both his respirations, his oxygen saturation, blood gases, heart rate, blood pressure and so forth, at a certain point in time when it became apparent that he was becoming increasingly unstable and not able to breathe for himself, then the doctors and nurses would have inserted a breathing tube which is called endotracheal tube in his trachea. He would have been put on a mechanical ventilation, and the machine would have been breathing for him. And other steps would have been taken to ensure that the vital organs in the brain received appropriate amount of oxygen until such time that he could recover from his

illness.

Q. Do you have an opinion within a reasonable degree of medical certainty if Wilbur Rodriguez had been admitted to a floor with continuous monitoring, more likely than not, would he be alive today?

MR. SHAUB: Objection, Your Honor.

THE COURT: Sustained.

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

DIRECT EXAMINATION

BY MR. ARGINTAR:

Q. Doctor Schiffer, do you have an opinion within a reasonable degree of medical certainty if the hospital through its doctors and staff deviated from good and accepted standards of medicine when they failed to administer continuous respiratory cardiac and vital signs monitoring to Wilbur Rodriguez at 11:00 p.m. when he was noted to have shortness of breath on oxygen?

MR. SHAUB: Objection, your Honor. We went over this.

MR. ARGINTAR: We didn't.

THE COURT: Approach.

(Discussion off the record.)

THE COURT: Counsel, continue please.

MR. ARGINTAR: Can I have the last question read back please?

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

THE COURT: Yes. That objection is overruled. You may answer.

A. I do have an opinion.

Q. And what is that opinion?

A. My opinion is that they did deviate from the standard of care at that time when the patient was admitted to the

hospital in the absence of appropriate monitoring.

Q. And what is your basis for that being a deviation?

A. My basis is my assessment of the entire medical record, his complaints, the findings of the doctors with regard to his blood gas, his x-ray, his CAT scan, the autopsy findings and my own experience in having cared for such patients. I believe that many there is a deviation from the standard of care and had he been admitted to the appropriate area in the hospital and monitored properly that he would be alive today.

Q. You sort of jumped the gun a little bit, Doctor Schiffer. My next question was that deviation a substantial factor in causing Wilbur Rodriguez's death?

A. Yes, it was a substantial contributing cause or factor in his death.

Q. And why was it a substantial factor in causing his death?

MR. SHAUB: We just heard this. Objection.

THE COURT: Overruled.

A. Because despite the fact that he was very ill when he was admitted to the hospital, there was ample opportunity for him to be supported and treated and if that had been done I believe that more likely than not that he would have recovered from his respiratory ailment and that he would be alive.

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

THE COURT: The last portion that he would have

recovered and would be alive?

MR. SHAUB: More likely than not.

THE COURT: That part, yes, the more than likely part is stricken.

Q. Okay. Doctor Schiffer, same question for the 12:30 a.m. note. Was it a deviation for the hospital through its doctors and staff from good and accepted standards of medicine to not administer continuous vital sign, cardiac and respiratory monitoring given the fact that Wilbur Rodriguez is noted to complain of shortness of breath on a venti mask?

A. Yes. I believe that it was a deviation.

Q. And what is the basis for that?

A. The basis is the same as I have said is that that's further indication of a patient with a severe respiratory ailment who had not yet an opportunity to respond to treatment.

Q. And was that failure to administer continuous monitoring at that point a substantial factor in causing his death?

A. Yes, it was.

Q. And is the basis for that opinion the same as to what you had mentioned for the previous nursing note?

A. Yes, it is.

Q. Okay. Doctor Schiffer, is it fair to say that it is your opinion that Wilbur Rodriguez died at some point between 4:00 and 4:40 a.m.?

A. Yes.
Q. Is it also fair to say that it is your opinion based on everything --
MR. SHAUB: I object. It's leading. He's the expert. The first thing was something I always said. It doesn't make a difference. Now, I'm going to object.
MR. ARGINTAR: I'm about to say something that already was said as well.
THE COURT: Sustained.
Q. Doctor Schiffer, what is your opinion as to how Wilbur Rodriguez died?
MR. SHAUB: Objection.
Q. The cause of death?
MR. SHAUB: Objection.
THE COURT: Sustained.
Q. Doctor, do you have an opinion within a reasonable degree of medical certainty as to the cause of death of Wilbur Rodriguez?
MR. SHAUB: We went over this, Judge. I object.
THE COURT: Overruled.
A. I do have an opinion.
Q. And what is your opinion?
A. My opinion is he died of respiratory failure secondary to bronchopneumonia.
Q. Okay. Now, Doctor Schiffer, if a patient dies of

bronchopneumonia, such as Wilbur Rodriguez, do they experience pain?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained.

Q. Doctor Schiffer, do you have an opinion within a reasonable degree of medical certainty whether or not Wilbur Rodriguez experienced pain prior to his death?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained. Come up.

(Discussion off the record.)

Q. Doctor Schiffer, what are the symptoms of a patient who dies from pneumonia?

MR. SHAUB: Objection, your Honor.

THE COURT: What are the symptoms?

MR. ARGINTAR: Withdrawn.

Q. Doctor Schiffer, what happens in a patient physiologically when they died from pneumonia?

MR. SHAUB: We just started the examination again.

THE COURT: Overruled. Go ahead.

A. In the course of dying from pneumonia, the patient's blood oxygen levels begin to drop, carbon dioxide levels begin to rise, the brain and the vital signs are deprived of oxygen, the heart is deprived of oxygen and eventually if the patient tires out and stops breathing, the heart slows down, eventually

the heart stops and the patient is dead?

Q. Does the patient suffocate?

MR. SHAUB: Objection, your Honor.

MR. ARGINTAR: It's not leading.

THE COURT: Sustained.

Q. Is there another way to describe a respiratory death?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained.

Q. What sensation, if any, does a patient feel if they suffocate to death?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained.

Q. Doctor Schiffer, in a patient who dies from pneumonia, physiologically what happens to the lungs?

A. In a patient with pneumonia severe enough to cause death, the lungs gradually are filled with fluid as evidenced in this case in the autopsy findings the lungs that are much much heavier than normal because they were filled with fluid. And as the patient begins to deteriorate there is a sense of air hunger struggling to breathe.

MR. SHAUB: Objection, your Honor. I move to strike.

THE COURT: As nonresponsive to that last part?

MR. SHAUB: Yes, Your Honor.

THE COURT: That last part was not responsive to

your question, Mr. Argintar.

Q. Doctor Schiffer, you just mentioned that there's a struggle for air. Is that correct?

MR. SHAUB: Objection, your Honor.

MR. ARGINTAR: I'm recapping what he said.

THE COURT: You can't to do that. Sustained.

MR. ARGINTAR: You didn't strike that part.

THE COURT: Yes, I did.

Q. Doctor Schiffer, assuming as your opinion is that Wilbur Rodriguez died from pneumonia, do you have an opinion as to whether or not he was aware that he was dying?

MR. SHAUB: Objection, your Honor.

THE COURT: Overruled.

A. I have an opinion that in the course of his deterioration that he was aware of the fact that he was struggling to breathe and ultimately that he was dying and I base this on my experience with many patients just like --

MR. SHAUB: Objection, your Honor, I move to strike.

Q. What is your basis for the fact that Wilbur Rodriguez --

MR. SHAUB: I move to strike the entire answer first, Judge.

THE COURT: The only thing that's going to be stricken is what he based it on. You asked him a question.

That last portion what he based it on is stricken.

Q. Doctor Schiffer --

May I proceed?

THE COURT: Yes.

Q. Doctor Schiffer, what is your basis for your opinion that Wilbur Rodriguez was aware that he was dying?

MR. SHAUB: Objection, your Honor.

THE COURT: Overruled.

A. I have -- I've had the opportunity actually to treat many patients over the years, some of whom had what you would term near death experiences from pneumonia respiratory failure and I've had an opportunity to hear from them what the sensation --

MR. SHAUB: Objection, your Honor. I move to strike.

THE COURT: That's stricken.

Q. Doctor Schiffer, I'll ask you again. What is your basis for the opinion that Wilbur Rodriguez was consciously aware that he was dying?

MR. SHAUB: Objection, your Honor.

THE COURT: Overruled.

A. I have personally observed patients who have died from pneumonia and I have observed their appearance and I've observed them struggling to breathe while maintaining some level of consciousness. So based on my direct observations, that forms a

basis for me to understand what Wilbur Rodriguez was experiencing prior to his death.

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

THE COURT: Overruled.

Q. Doctor Schiffer, do you have an opinion as to how long this process takes of dying from pneumonia?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained.

Q. Doctor Schiffer, do you have an opinion as to how long Wilbur Rodriguez was aware that he was dying?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained.

Q. Doctor Schiffer, before somebody dies of pneumonia, such as your opinions of Wilbur Rodriguez, what happens in the five minutes before they die?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained.

Q. In the five minutes before a patient dies from pneumonia physiologically, what occurs?

MR. SHAUB: Objection. We heard this now to be the third time.

THE COURT: Is your answer the same physiologically what would occur as you indicated when you're having respiratory failure?

THE WITNESS: Substantially, yes.

THE COURT: Sustained.

Q. Doctor Schiffer, are patients able -- are patients who have this type of pneumonia in the five minutes before their death are they able to speak?

MR. SHAUB: Objection, your Honor.

THE COURT: Let's talk about this patient.

Q. Doctor Schiffer, during the period that Wilbur Rodriguez was consciously aware that he was dying --

MR. SHAUB: Objection. Finish your question.

Q. Do you have an opinion as to whether or not during that period he would have been able to speak?

MR. SHAUB: Objection, your Honor.

THE COURT: To mostly the first part?

MR. SHAUB: Yes.

THE COURT: Sustained.

Q. Doctor Schiffer, you testified that Wilbur Rodriguez would have been consciously aware that he was dying. Is that correct?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained. Come up.

(Discussion off the record.)

MR. ARGINTAR: May I proceed?

THE COURT: Yes, please.

Q. Doctor Schiffer, is dying from pneumonia a painful process?

MR. SHAUB: Objection, your Honor.

THE COURT: Overruled.

A. Yes, it is.

Q. And why do you say yes?

MR. SHAUB: Objection, your Honor.

THE COURT: Overruled.

A. It's painful because dying from pneumonia means not getting enough air, not getting enough oxygen and struggling to breathe and so that by its very definition struggling to breathe is a painful experience for any patient.

Q. How long does the process take of dying of pneumonia?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained.

Q. How long does it take for the lungs to be incompatible with life?

MR. SHAUB: Objection, your Honor.

THE COURT: For the lungs to be what?

MR. ARGINTAR: Incompatible.

THE COURT: For the lungs?

MR. ARGINTAR: For a patient with pneumonia -- withdrawn.

Q. How long are patients aware that they're dying?

MR. SHAUB: Objection, your Honor.

THE COURT: I'm going to have to sustain this based on our discussion.

Q. Do you have an opinion as to how long Wilbur Rodriguez was aware that he was dying?

MR. SHAUB: Objection, your Honor.

THE COURT: Overruled. I believe the answer is yes. Do you have an opinion?

THE WITNESS: I do have an opinion.

Q. And what is your opinion?

MR. SHAUB: Objection, your Honor.

THE COURT: Sustained. What's the basis of your opinion?

THE WITNESS: My basis.

THE COURT: Based on what?

A. It's based on my reading of the record, my understanding of this individual case and my own experience in treating patients with similar types of pneumonia.

THE COURT: Next question.

Q. What is your basis for your opinion as to how long Wilbur Rodriguez was aware that he was dying?

MR. SHAUB: Objection, your Honor.

THE COURT: Overruled.

A. My basis is my review of the record and my own experience in treating patients with pneumonia in patients similar to Mr. Rodriguez.

Q. What is your opinion about that?

MR. SHAUB: Objection, your Honor.

MR. ARGINTAR: He hadn't said his opinion. He said he has an opinion. Now, I'm asking what is it.

MR. SHAUB: Same objection.

THE COURT: Sustained.

Q. Doctor, what is your opinion as to how long Wilbur Rodriguez was aware that he was dying?

MR. SHAUB: Objection, your Honor.

THE COURT: What specifically in the records indicate to you that there was a limit of awareness.

A. Because he was not unconscious at the time at 4:00 a.m. when he was last observed by the nurse. Therefore, I can place the time of his becoming unresponsive and unconscious some time between 4 and 4:40 and so that I can make some judgment as to and also the observation was made at certain times during the night that he had an oxygen saturation that was over 90 percent and so I can begin to pinpoint what it was that he began to deteriorate sufficiently that he ultimately went on to die. I can't be more precise than that, Your Honor.

THE COURT: Next question.

Q. Doctor Schiffer, what is your opinion as to the amount of time that Wilbur Rodriguez was aware that he was dying?

MR. SHAUB: Objection, your Honor.

THE COURT: Overruled.

A. I believe it was at least five to ten minutes before he died and, again, I can't say exactly when it was that he died

only that it was some time between 4 and 4:40 a.m. but there was in my opinion there was a period of time as he began to deteriorate that he was aware of the fact that he was struggling to breathe and that he was dying.

Q. And why did you say approximately five minutes?

A. Five to ten minutes. It takes time especially in a younger person for blood oxygen levels to drop sufficiently and for carbon dioxide to rise sufficiently and until finally the patient loses consciousness.

MR. ARGINTAR: Thank you very much, Doctor Schiffer.

MR. SHAUB: May I inquire, Your Honor?

THE COURT: Yes.

CROSS EXAMINATION

BY MR. SHAUB:

Q. Good afternoon, Doctor Schiffer.

A. Good afternoon.

Q. My name is Henry Shaub. I represent the people at Montefiore Medical Center who you say completely departed from the standard of care and caused the death of Mr. Rodriguez. You and I have never met before, have we?

A. No.

Q. We've never spoken before, have we?

A. No.

Q. You spoke to Mr. Argintar before you took the witness

stand?

A. Yes.

Q. How much are you being paid?

A. $850 a hour.

Q. Did that start from the time you left your house this morning until you go back to your home tonight?

THE COURT: And your answer is no?

A. It starts from the time I arrive at the courthouse until the time I leave the courthouse.

Q. So what time did you leave the courthouse this morning?

A. 9:45.

Q. Well, if I were to tell you Mr. Argintar told me that you charged $8,000 for your day in court would that be right?

A. That would be right.

Q. So that's more than the time from coming at 9:45 to leaving at 4:30, isn't it?

A. I also met with Mr. Argintar several times in the last week and, you know, for which I'm not charging. I rolled it into today's fee.

Q. You said that you were charging 800 or 850.

A. 850.

Q. 850 an hour. That wasn't correct for what you were charging?

A. It is accurate.

Q. Doctor, fair enough. Let me ask you this. Can we agree that not every patient that has community acquired pneumonia gets better?

A. Yes, we can.

Q. We can agree, Doctor, can we not, that community acquired pneumonia even when treated properly can lead to a patient's death?

A. Yes.

Q. We can agree, Doctor, that actually community acquired pneumonia is the 7th leading cause of death in the United States of America, true?

A. I don't know the statistic but I'll accept it for the purposes of this.

Q. Doctor, we can agree for those patients who have community acquired pneumonia that are admitted to the hospital even when they are treated in the proper way 15, 15 percent of those patients don't make it, they pass on, true?

A. Again, I don't know the statistic and that assumes that all patients are the same which they're not of course.

Q. Of course. I understand that. It's just a statistic but we understand, Doctor, do we not, that -- withdrawn.

Do you agree that 15 percent of all patients that are admitted to hospital with community acquired pneumonia do not survive the hospitalization?

A. Again, as I --

Q. Just a yes or no, Doctor. You've done this before?

MR. ARGINTAR: He answered it.

Q. Withdrawn. Doctor, how many times have you testified in court?

A. Between 30 and 40 times.

Q. And isn't it true you've never testified on behalf of a defendant, true?

A. Not yet.

Q. You've always testified on behalf of plaintiffs or the parties bringing the lawsuit, correct?

A. I testified in depositions.

Q. At the trial, Doctor, just like you answered the first question at the time of trial you've never testified on behalf of a plaintiff -- on behalf of a defendant, correct?

A. Correct.

Q. Okay. So you know how the questions go and how this cross examination usually is conducted because you've done it before, correct?

A. I'm doing the best I can, Mr. Shaub.

Q. I'm sure you are.

MR. ARGINTAR: Object. Strike that.

Q. Let me go back to my question. Do you agree that there's a morality rate or death rate of 15 percent of all patients that have community acquired pneumonia that come into the hospital and are treated in accordance with good medical

practice?

MR. ARGINTAR: Asked and answered.

THE COURT: Overruled.

MR. ARGINTAR: He never answered.

THE COURT: Overruled.

A. As I said, I don't know the statistic but I'll accept it for the purpose of your discussion.

Q. I want you to assume, Doctor, that Diane Sixsmith testified under oath that 15 percent was the recognized percentage of morality of patients that are admitted to a hospital with community acquired pneumonia that even if they're treated properly don't make it. So you would agree with it, right?

A. are you asking me if I were to accept that? I said I do accept that. I don't know the statistic.

Q. Now, Doctor, just and this is obvious you were never in the hospital in January of 2009, correct?

A. Not Montefiore.

Q. Right. You never treated Mr. Rodriguez, correct?

A. Correct.

Q. You never saw him?

A. Never.

Q. Never spoke to him?

A. Never met him.

Q. Never touched him?

A. No.
Q. Had no contact with him?
A. Never met him.
Q. So you're testifying from looking at certain notes and making certain assumptions, correct?
A. Testifying from reviewing the record and the deposition and the autopsy.
Q. Well, Doctor, let's take a look at some of the records. You said that in your opinion Mr. Rodriguez suffered from respiratory failure, correct?
A. Correct.
Q. Before he suffered from respiratory failure, he suffered from respiratory distress, correct, or are you saying --
A. No. Respiratory failure is more severe.
Q. Okay. So as I understand your opinion then he had respiratory failure from the time he came into Montefiore Hospital until the time that he passed?
A. Yes.
Q. Okay. Now, Doctor, can the court officer --
COURT OFFICER: Sure.
MR. SHAUB: -- please provide the witness with Plaintiff's Exhibit 1 which is the Montefiore medical.
(Handing)
Q. Now, Doctor, in a patient that has respiratory

failure, you would expect as you already told us to have difficulty in breathing, correct?

A. Correct.

Q. They will have increased rate of respiration because they are having difficulty in breathing, correct?

A. I'm sorry. I didn't hear the last question.

Q. I said that patients who have respiratory failure have a higher respiration rate because they are having difficulty in breathing, correct?

A. Typically, yes.

Q. You also told us that patients that have respiratory failure, there's a buildup of carbon dioxide in their blood and it affects their brain so they tend to be confused and unclear, true?

A. That can occur much later in the course.

(Continued on the next page ...)

Q. Well, Doctor, let's take a look at the nurses record. Have you seen this record before?

A. Yes.

Q. Take a look at it. It's entitled Medical Surgical and Critical Care Patient Admission Database and Flow Sheet, timed 11 p.m. Do you see that?

A. Yes.

Q. The first page. Turn to the second page. Do you see where it's under the heading neurological?

A. Yes.

Q. It says the patient is awake and alert. It's checked?

A. Correct.

Q. A patient in severe respiratory distress, you already told us becomes confused. They would not be awake and alert as he was?

A. I did not testify to that Mr. Shaub.

Q. A patient is having respiratory failure, having difficulty breathing so severe and they have lack of oxygen and buildup of carbon dioxide, would have difficulty being able to be responsive; true?

A. That's a progressive problem.

Q. Then we can agree as of the time at 11 p.m. according to the nurse, he was awake and alert; correct?

A. Yes.

Q. He was responsive to verbal contact; correct?

A. Correct.
Q. He was oriented to person, place and time; correct?
A. Correct.
Q. He was checked not to be confused; correct? He was not confused?
A. Correct.
Q. On the next section, it indicates his speech was clear; correct?
A. Correct.
Q. It indicates under response, AO times three, that means alert and oriented times three?
A. Yes.
Q. That means that he is being able to clearly know where he is, who he's speaking to and who -- and where he is?
A. Yes.
Q. Patients that are having respiratory failure, Doctor, we heard from Dr. Sixsmith who have a rise in their heart rate oftentimes; correct?
A. Typically, yes.
Q. Typically. Here, according to the nurse, his pulse rhythm was regular; correct?
A. Correct.
Q. We also know that under the bottom respiratory, there's initial SOB. It says shortness of breath. They saw that?
A. Yes.

Q. And then it says cyanosis, and then it's checked no; correct?

A. Correct.

Q. Patients who -- patients who are in respiratory distress or trouble breathing and not getting a lot of oxygen, will begin to turn an abnormal color and that could be described as cyanotic?

A. As I teach my house staff, it's very unreliable signs.

Q. It's one of the signs, Doctor, isn't it?

A. Yes, it is.

Q. In this one, he was not cyanotic?

A. Correct.

Q. If we go down, turning the page, going to page five of this form -- page numbers in the lower right-hand corner -- are you on that page, Doctor?

A. Yes.

Q. We can see on that page, page five of this form, they're asking him about pain and comfort; correct? Do you see that?

A. Yes.

Q. And it says, do you currently have pain? And the "no" is checked; correct?

A. Correct.

Q. Go to the next page. Under psychosocial on the top, behavior, he's cooperative; true?

A. True.

Q. It also says his mood, he's calm; true?

A. True.

Q. And, in fact, going back to the second page in the upper right-hand corner, it says call Bellows in reach; correct?

A. Yes.

Q. Now, Doctor, can we agree that based on the nurses assessment at 11 p.m., given that he was described as being awake, alert, oriented, clear speech, no cyanosis, no pain, mood was calm and cooperative, and all those things we discussed, that would not be consistent with a patient that's in severe respiratory distress, is it? Just yes or no.

A. Well, I was going to say it depends how you define severe.

Q. So in terms of what you said earlier, that he was so sick and his respiratory function was so impaired and his pneumonia was so bad, he had to be in a unit, intensive care unit. Didn't you tell us that?

A. Absolutely.

Q. And you told us that was the condition that he was in after 11:00 in the evening when he came to the floor; correct?

A. That's correct.

Q. So, Doctor, we can agree that these things that we're seen by the nurse and recorded by the nurse at the time that she evaluated Mr. Rodriguez, is not consistent with patient that was

in severe respiratory distress that required admission; isn't that true?

A. Yes.

Q. Now, in addition, Doctor, if you take a look -- withdrawn.

As you told us, the patient that's in severe respiratory distress, when -- withdrawn.

When Mr. Rodriguez came to the floor, his vital signs were checked, were they not?

A. Yes, they were.

Q. Do you know what they are? Do you have them in front of you?

A. I could get to them. If you have the page, I'll get there quicker.

Q. It's the nurse's note. It's this one.

MR. SHAUB: Can I approach the witness? It might be hard for him to see.

Q. Is this close enough?

A. Yes.

Q. I have bad eyes. I understand what it's like.

In 11 p.m., VS is vital signs?

A. Yes.

Q. BP, 120 over 66?

A. Yes.

Q. That's normal?

A. I think it's low for him.
Q. It's within the normal range?
A. I think it's low for him.
Q. What was his normal?
A. I think that he had untreated hypertension. What his normal was, I think it was much higher.
Q. But, Doctor, based on the information they had in the record, his blood pressure -- withdrawn.
I want you to assume Dr. Sixsmith said the blood pressure was within normal limits. Do you disagree with Dr. Sixsmith?
A. I think it is a normal blood pressure, but I think it's low for him.
Q. Now, in relation to that, Doctor, P?
A. That's the pulse.
Q. That stands for pulse, P, 72?
A. Yes.
Q. That's within normal limits; correct?
A. Correct.
Q. And R, respiration, that's the rate in which someone breathes; correct?
A. Yes.
Q. 20. That's what's recorded in the chart?
A. Yes.
Q. That's within normal limits?

A. It's a little elevated.

Q. I want you to assume Dr. Sixsmith said yes, that the normal rate of respiration is between 12 and 20. Would you disagree with that?

A. The whole --

Q. Excuse me. Would you disagree with that or not?

A. That's the upper limit of normal. Make it easy.

THE COURT: I didn't hear your answer.

A. It's the upper limit of normal.

Q. Within the range of normal. It's normal, but upper limit of normal?

A. Correct.

Q. And the temperature, 97.1; correct?

A. Correct.

Q. So, Doctor, can we agree if a patient was in severe respiratory distress as you described earlier, a patient wouldn't have vital signs that were normal like his, would they?

A. That's not necessarily true.

Q. Not necessarily true. Okay.

Now, we can agree, Doctor, that if a patient is in severe respiratory distress, when they are observed by medical examiner, they would appear sickly looking; correct?

A. The medical -- you mean, the person doing the autopsy?

Q. No. I meant the medical healthcare provider. I'll do the question this way. I'm trying to go fast, Doctor.

A. I'm sorry. I'm not trying to be sneaky. You said medical examiner.

THE COURT: Don't try to go fast. No one is forcing you to go fast. Just ask your question.

Q. There is an assessment that physicians do when they see a patient, which is described as general appearance of the patient; correct?

A. Correct.

Q. And that would describe somebody as being in no distress, mild distress, moderate distress or severe distress?

A. Correct.

Q. That's something that you doctors use when you see a patient and make assessment of a patient; right?

A. Correct.

Q. Now, Doctor, you were asked questions before about a note of Dr. Bellows?

A. Yes.

Q. That is the PGY-1 that we described. He filled out a note as an H and P form; correct?

A. Yes.

Q. That's called a History and Physical form?

A. Yes, it is.

Q. You're familiar whenever a patient is admitted to a hospital, one of the doctors fill out one of the lengthy forms to get information about a patient; correct?

A. Correct.

MR. SHAUB: Can I approach the witness and point him --

A. I have Dr. Bellows' note.

Q. Can you please turn, Doctor, to page four of Dr. Bellows' note, that form. There's a heading called general appearance; correct?

A. Yes.

Q. Now, you were asked by Mr. Argintar only certain parts of that note, weren't you?

A. Yes.

Q. You left out the part -- withdrawn.

You were asked questions about the word lethargic that appears under general impression or appearance, but you weren't asked -- withdrawn.

Why don't we read the words next to general appearance. First, NAD. What does that mean?

A. That stands for no acute distress.

Q. If a patient is in severe respiratory distress, they would not appear to anybody to be in no acute distress, would they?

A. To anybody? I think only I can speak to this examiner.

Q. My point is, what you said, it's so obvious a person is in severe respiratory distress, even a medical student would be able to observe that that patient looks to be in some form of

distress.

MR. ARGINTAR: Objection to form.

Q. True?

THE COURT: Sustained.

Q. Can we agree according to Dr. Bellows and his impression of the patient, it showed that there was no acute distress?

A. Yes.

Q. Then you were read today by Dr. Mukherji the word lethargic that appeared in the sentence?

A. Yes.

Q. You didn't read the next two or three words after that. Lethargic but oriented times three; correct?

A. Correct.

Q. If a patient is lethargic because there's too much carbon dioxide in the blood and not enough oxygen, not only would they become lethargic but they lose their orientation. They become confused. They have difficulty in speaking; correct?

A. That can come in a later stage, yes.

Q. Doctor, lethargy and confusion, these are all things that you told us earlier come about because of a lack of oxygen?

A. Right; but they don't occur simultaneously.

Q. For Mr. Rodriguez, according to Dr. Bellows, he appeared in no acute distress. He was lethargic but oriented

times three; correct?

A. Correct.

Q. Now, by the way, Doctor, do you know what time Dr. Bellows saw Mr. Rodriguez?

A. Well, the notes are not timed. But my impression was he was seen sometime between 11 and midnight.

Q. Okay. And do you know what time Mr. Rodriguez got to the hospital?

A. I'm sorry?

Q. Do you know what time Mr. Rodriguez got to the hospital?

A. 11:45 a.m., I believe.

Q. So he'd been in the hospital for 12 hours and it's nighttime.

Would you expect a patient that was sitting around all day and nighttime they might be a little tired?

A. I certainly would.

Q. Now, Doctor, under -- as you told us by history, Dr. Bellows was told by Mr. Rodriguez that he had been complaining of shortness of breath and that's what brought him to the hospital; correct?

A. Yes.

Q. And can we agree, sir, that there was no indication that on examination, that he was complaining of shortness of breath at the time of the examination?

A. Not at the time of the exam.

Q. And Doctor, we can agree -- by the way, Dr. Bellows also found that there was no JVD. Did you see that?

A. Yes.

Q. That means no jugular venous distention?

A. Correct.

Q. And Doctor, that is a condition that occurs when there's backup of fluid between the lungs and the heart; correct?

A. No. That's usually a sign of right sided heart failure.

Q. Is the right side of the heart, the part of the heart that pumps the blood to the lungs?

A. Yes. Jugular venous distention, you wouldn't expect to see in someone like this, especially if they're a little dehydrated.

Q. If a patient is suffering from severe pneumonia and the lungs are filling with fluid as you said, wouldn't you expect to see that affecting the pumping ability of the right side of the heart?

A. Not necessarily.

Q. Not necessarily. Which means that it could?

A. No. Jugular venous distention has nothing to do with this case.

Q. Doctor, we know what's -- withdrawn.

Were you aware that prior to Dr. Bellows and Dr. Bhullar seeing Mr. Rodriguez, Mr. Rodriguez had been seen by a medical admitting resident?

A. He was seen by a critical care fellow.

Q. And are you aware that he was also seen by a medical admitting resident?

A. I didn't see a note from the doctor.

Q. Did you read the depositions?

A. I did.

Q. Did you read the depositions of --

A. There were a lot of pages. If it says they were seen by admitting resident, I'll accept that, but I don't remember verbatim the entire deposition.

Q. Doctor, that's often in teaching hospitals, how patients is admitted to the hospital; correct?

A. Yes.

Q. So if the emergency-room physician makes a decision to admit the patient to a particular area of the hospital, it's routine for this patient to be seen by a medical admitting resident; true?

A. True.

Q. And that medical admitting resident, accepts the patient into that medical service; true?

A. True.

Q. And then that medical admitting resident will have a

team of other more junior residents to do the initial evaluation and workup; correct?

A. Correct.

Q. And the medical admitting resident is usually or almost always -- withdrawn.

The medical admitting resident, is a senior resident; true?

A. I don't know the protocols in this medical center.

Q. In the medical centers that you work, the medical admitting resident is a senior resident?

A. Typically, a third year resident.

Q. That resident has to do an evaluation to make a determination whether that patient can be accepted to the medical service or not; correct?

A. Correct.

Q. And it's routine, is it not, that in addition to the medical -- withdrawn.

If a patient is admitted to the medical floor, and has been evaluated by medical admitting resident, a PGY-2 and PGY-1 and patient is admitted in the middle of the night, that attending physician will not be called in unless in the judgment of those doctors, there's a reason for an attending to come in; true?

MR. ARGINTAR: Object to the form.

A. Yeah. I think that --

Q. Okay.

MR. SHAUB: Your Honor?

THE COURT: Sustained.

Q. Let me ask you this: You would agree that not every medical patient that's admitted to the medical floor in the middle of the night in a teaching hospital has the medical attending come in to see the patient and evaluate the patient?

A. I would agree with that, yes.

Q. So in a teaching institution like the one you work in and Montefiore, there are residents of all different levels that evaluate the patient and they have to make a judgment in their minds whether additional help is needed from a medical attending? Just yes or no?

A. I --

Q. If you can't answer yes or no, that's fine.

A. I can't answer yes or no.

Q. Okay. In your hospital, isn't it true that a medical attending has up to 24 hours to come into the hospital to see a patient that's been admitted under their service?

A. True.

Q. So during those 24 hours -- withdrawn.

And you've done that in your own practice; correct?

A. Yes.

Q. So when you're not in the hospital and a patient of yours is admitted to the hospital, the resident staff of all

different levels are evaluating the patient and making decisions; correct?

A. We always get called. We don't always come in. Depending on the situation.

Q. In this case, the decision to admit Mr. Rodriguez to be involved with the consultation of emergency room attending physician, a critical care fellow, and medical admitting resident, a PGY-1 and PGY-2, five doctors; correct?

A. Correct.

Q. And in their judgment, at that point in time, they were under the impression it was safe and proper for Mr. Rodriguez to be admitted to the medical floor; true?

A. True.

Q. And you disagree with all their judgments; true?

A. True.

Q. Now, in addition to Dr. Bellows, we know Dr. Bhullar saw Mr. Rodriguez and evaluated him, also; correct?

A. Yes.

Q. Now, Dr. Bellows wrote a seven page evaluation form of Mr. Rodriguez; correct?

A. Correct.

Q. Dr. Bhullar wrote a three-page and two lines on the next page evaluation of Mr. Rodriguez as well; correct?

A. Correct.

Q. And you reviewed that; correct?

A. Yes.

Q. You're aware, are you not, that on -- withdrawn.

Do you know how much time Dr. Bhullar spent with Mr. Rodriguez in his evaluation?

A. No.

Q. Did you read his E.B.T.?

A. I did, but again, that detail escapes my memory.

Q. I want you to assume that Dr. Bhullar testified under oath that he spent between 45 minutes to an hour in his evaluation of Mr. Rodriguez that evening; okay?

A. Okay.

Q. If he didn't spend that -- if did he spend that amount of time, that's a pretty --

A. That's a generous amount of time.

Q. Thank you very much. That's a generous amount of time?

A. Yes.

Q. That's not a quick one, two, three evaluation. That's spending a lot of time with the patient on admission?

A. Yes.

Q. And we know in his note, Doctor, do we not, that his findings demonstrated that again just like Dr. Bellows, he found under general appearance, NAD, no acute distress; correct? You want to take a look at it?

A. I'm sure it's correct. I'll take a look while you

proceed. Okay. Yes. I have it.

Q. You got it?

A. Yes.

Q. In addition, he notes on his record there's a zero with a line through it. That means no; correct?

A. Yes.

Q. That's what you doctors use shorthand for. Zero with a line through it, accessory muscles; correct?

A. Yes.

Q. If a patient is having severe respiratory difficulties, difficulty in breathing and as you said they have air hunger, they begin to use other muscles that -- to help them breathe; correct?

MR. ARGINTAR: Objection to form. He's talking about two different times.

MR. SHAUB: No, I'm not.

THE COURT: Sustained.

Q. The patient has severe respiratory distress and having difficulty breathing, they need something known as accessory muscles; correct?

A. Yes.

Q. What are accessory muscles?

A. The muscles around the neck, the chest as opposed to using the diaphragm for breathing.

Q. A doctor can look at the patient, and see if they're

using the accessory muscles to help them determine if a patient is having severe respiratory distress or having severe difficulty in breathing; correct?

A. Correct.

Q. Dr. Bhullar did that and there was no evidence that he had severe difficulty breathing at that time according to Dr. Bhullar; correct?

A. Correct.

Q. In addition to that, it notes in the same entry, that the patient speaks full sentences; correct?

A. Correct.

Q. A patient that's in severe respiratory distress, who's having trouble getting their breath, they are unable to speak in full sentences; correct?

A. Correct.

Q. So the finding that the patient was in no acute distress, there was no use of accessory muscles and the patient was able to speak in full sentences, would suggest at that time according to Dr. Bhullar, the patient did not appear to be in severe respiratory distress; right?

A. At that time, correct.

Q. Now, Doctor, can we agree that as of the evaluation by both Dr. Bellows and Dr. Bhullar, there was an indication that Mr. Rodriguez was having problems with his kidneys; correct?

A. Yes.

Q. But we know, Doctor, do we not, that his kidney problem was something that started to occur before his pneumonia; correct?

A. I would say it's likely that he had some kidney disease prior to the onset of the pneumonia.

Q. I want you to assume, also Dr. Sixsmith agreed, he had a chronic problem with kidneys and the pneumonia kind of made it worse; correct? That make sense to you?

A. Yes.

Q. Now, Doctor, we can agree that at the time of the evening of June -- January 24th into the early-morning hours of January 25th, Mr. Rodriguez did not require emergency hemodialysis; true?

A. True.

Q. That condition with respect to his kidneys is something that could be evaluating the beginning of the next day when he was admitted to the hospital; correct?

A. He was in the hospital in the daytime, but yes. I disagree. If I may, I can't answer yes or no. If you allow me a sentence.

Q. Okay. You can't say yes or no. Let's go on to what happened after he was admitted to the hospital and had the evaluations by Dr. -- by the doctors we just discussed, and he underwent certain treatment by the nursing staff; correct?

A. Yes.

Q. Now, we know, Doctor, do we not that as of 11 p.m. in addition to the form that you and I went over that was filled out by the nurse, there's also a nursing progress record; correct?

A. Yes.

Q. Can you find that for me, please. I'm sorry.

MR. SHAUB: Judge, can I approach?

THE COURT: Yes.

(Whereupon, counsel approaches the witness.)

Q. Now, in addition to the form that the nurse filled out, the progress note indicates that he was alert and oriented times three; correct?

A. Correct.

Q. And we already spoke of the fact that there's a note complained of shortness of breath and he was on oxygen, supplemental oxygen?

A. Yeah. I think it says three liters per minute.

Q. Now, Doctor, a patient that's suffering from pneumonia, an important treatment for that patient is to receive antibiotics; correct?

A. Correct.

Q. And he received proper antibiotics when he was first admitted into the emergency room; correct?

A. I think there was a bit of a delay, but he eventually got it.

Q. I want you to assume that Dr. Sixsmith testified yesterday the E.R. physician that the antibiotic treatment was in accordance with good practice for Mr. Rodriguez?

A. Okay.

Q. You would agree with that; right?

A. Yes.

Q. Now, in addition to antibiotic treatment for a patient with pneumonia, the other important thing to do would be to supplement the patient's oxygen; correct?

A. Yes.

Q. And you would agree that in a patient that is suffering from pneumonia, it's the goal or the objective of the doctors to avoid intubation or putting a tube down his throat if it's possible; true?

A. I would say if it's safe and possible, yes.

Q. It's because by putting a tube down the throat of a patient who has pneumonia, you can cause further injury to the lungs by forcing air and the pressure in; true?

A. True.

Q. You can also introduce additional ventilator infection which are hard to treat; true?

A. True.

Q. As a doctor, what you try to do is not use a ventilation but use other means of supplemental oxygen to treat the patient?

A. True.

Q. And we know that even though you're giving supplemental oxygen and you're giving antibiotics, the patient's lung function is still not normal because they have an infection; correct?

A. Correct.

Q. So you would expect over a period of time, that the lung function will remain to be abnormal, while you're trying to treat it with the antibiotics and provide supplemental oxygen; true?

A. True.

Q. So we can agree, Doctor, can we not, that if a patient is having worsening oxygenation, then their respiratory effort would become more distressed? It would be more of a problem for them, correct, does that make sense?

A. I understand what you're trying to say. Typically, if their oxygenation deteriorates, they're going to struggle more to breathe.

Q. As their oxygen level deteriorates, they struggle. If the CO-2 level goes up, that also will cause very clear signs; true?

A. It's not always so clear in the beginning.

Q. But you told us about signs and symptoms. Signs are things that doctors and nurses can see; correct?

A. Correct.

Q. Symptoms are the things that a patient reports?
A. Correct.
Q. If a patient is having difficulty in breathing, doctors or nurses can see that; correct?
A. Yes.
Q. And the way they can see it is by the things we talked about before such as using accessory muscles; correct?
A. Correct.
Q. You can see it by their respiration rate continuing to go up because they're breathing faster, trying to compensate for not enough oxygen; true?
A. True.
Q. And patients that are -- that have respiratory distress, it's getting worse, they start to almost feel like they're gasping for air; correct?
A. Yes. Late in the course, it's true.
Q. Excuse me?
A. Later in the course.
Q. And that's something that can be observed by the doctors and nurses; correct?
A. Correct.
Q. And even if a patient is -- withdrawn.
Now, we know, Doctor, do we not, that not only was the patient evaluated, Mr. Rodriguez evaluated at 11. 12:30, there's note by the nurse that she's evaluating the patient as

well; correct?

A. Yes.

Q. And then we know at 1:45 in the morning, they were doing a procedure on him; correct?

A. Correct.

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

Q. They were inserting a folly catheter, correct?
A. Correct.
Q. And that takes a little bit of time to do that, right?
A. Yes.
Q. And that was something that was done by the nurses actually physically touching the patient?
A. Yes.
Q. They had to look at the patient to do this?
A. Yes.
Q. And we know, Doctor, they also were collecting bloods for other types of testing that were to be run also?
A. Yes.
Q. There was a series of blood tests that were ordered that were being carried out at that time?
A. Yes.
Q. Doctor, we can agree as of that time if Mr. Rodriguez was gasping for air, was using accessory muscles, was breathing at a very fast rate, these are all things that could have been observed by the nurse, true?
A. Had they been present, yes. I don't believe they were based on this.
Q. You believe they were present?
A. I said I don't believe.
Q. Well, 1:45, how do you insert a folly and do a blood test without being present?

A. Mr. Shaub, I'm agreeing with you.

Q. Okay, fine. After 1:45, the nurse notes that she's back at 2:30, correct?

A. Yes.

Q. Now, when she notes no SOB, shortness of breath in this case noted, would you agree that's shorthand for a nurse saying I'm looking at the patient and they don't look like they were having any difficulty in breathing?

A. Yes.

Q. It's 2:30 in the morning. You would agree, Doctor, you don't wake up the patient to say, hey, how are you doing? You feeling okay? That's not what doctors and nurses do. You want the patient to get rest to help them to get better?

A. In this case, true.

Q. The nurse in fulfilling her obligation and trying to do the best thing for the patient can go in and check on the patient. If he's having gasping for air or using his accessory muscles or he's got a rapid rate or a very slow rate that's something that the trained nurse can see, right?

A. True.

Q. So we know by 2:30 in the morning he's not in any respiratory difficulties, true, according to the note.

A. It depends how you define respiratory difficulties.

Q. The things we just talked about, the gasping, the accessory muscles, the elevated respiratory rate?

A. He had a lot of respiratory difficulties, a lot.

Q. But, Doctor, as of that point in time 2:30 in the morning, he's not demonstrating the respiratory difficulties that are so severe that he requires being admitted into the intensive care unit, true or not true?

A. I disagree --

Q. Fair enough.

A. -- with the second part of your statement.

Q. Okay. At 4:00 a.m., there is a nurse note -- withdrawn.

By the way, did you ever speak to any of the nurses that were involved in the care?

A. No.

Q. Did you see any depositions by them?

A. No.

Q. It would be important to know what they saw and what they didn't?

A. I'm reading what they wrote.

Q. Would it be important for you to know what they said they did for Mr. Rodriguez?

A. Yes.

Q. Because if they told you that they were observing the patient looking for respiratory distress and they didn't see any then your opinions might be different in this case, true?

MR. ARGINTAR: Objection to form.

THE COURT: Overruled.

A. I, um --

Q. Yes or no?

A. I think they wrote what they saw.

Q. That's not responsive to my question.

A. I'm sorry. Can you read it back?

MR. SHAUB: Can I read it back? That was a good one.

MR. ARGINTAR: Objection, your Honor.

THE COURT: Your assessment of the question is stricken.

Read back the last question please.

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

A. I don't think it would affect my opinion.

Q. Okay. Fair enough. Now, we know, Doctor, that again at 4:00 a.m. there's no signs of shortness of breath. We talked about that, correct?

A. Yes.

Q. And that's by observation of the nurse. And as you told us between 4 and 4:40 in the morning, we don't have any notes about what happened to him, right?

A. Correct.

Q. Now, if as -- withdrawn.

You described that a patient that's suffering from

severe respiratory distress will begin to have a sense of struggling for oxygen, correct?

A. Correct.

Q. Gasping for oxygen, correct?

A. Correct.

Q. And at that point when they have that, they're aware from what you're saying, right?

A. Yes.

Q. And, Doctor, if a patient was experiencing that, wouldn't you expect the patient to push the call bell that was right by the bedside, just yes or no?

A. If they can.

Q. If they can. But patients that -- withdrawn.

When a patient has -- withdrawn.

You're a cardiologist, right?

A. Yes.

Q. You've seen circumstances where patients experience heart failure, correct?

A. Yes.

Q. And when they have heart failure, all of a sudden, the heart stops, the fluid backs up to the lung and it happens very quickly in a matter of minutes, correct?

A. Yeah. It's not always when the heart stops but the general threshold of what you're saying is true.

Q. It's a very general sudden event.

A. Yes.

Q. A patient with pneumonia that's experiencing his respiratory difficulties that's something that's a progressive problem that takes more time for it to occur, correct, generally?

A. I think it's been occurring over time with this patient.

Q. But as the patient begins to be more anxious before they go from nothing, there's a period that they could be more anxious, short of breath, a little more quickly start getting -- coughing, start being aware that something is going on. Most patients if that's happening will push a button to get help, no?

A. I don't know what most patients do.

Q. Do you expect that patients would push a button to call for help if that's what happened to them?

A. It's dark at night, a strange place, panicking, may not be able to find the bell.

Q. You don't know. You weren't there?

A. Nor were you.

Q. That's correct, Doctor, you know as do I. A patient that you would expect that's having what you observed would have had an opportunity if that truly is what was happening to reach out for help, true?

A. If he could.

Q. Okay.

THE COURT: Approach.

(Discussion off the record.)

Q. Doctor, can we agree that it's possible that Mr. Rodriguez suffered from a sudden cardiac event, true?

A. Anything is possible.

Q. Okay. Patients can die from a -- when they experience a sudden lethal abnormal heart rhythm, correct?

A. As I said, anything can happen.

Q. That's one of the ways patients die, correct?

A. Yes.

Q. In fact, there are patients in the hospital that have these kinds of sudden unexpected lethal arrhythmias even when doctors see it they can't help the patient and the patient passes?

A. True.

Q. Now, Doctor, you told us, did you not, that you were aware according to the autopsy there was some abnormality with regard to Mr. Rodriguez's heart?

A. Correct.

Q. There was left ventricular hypertrophy?

A. Yes.

Q. That means the left side of the heart, the big pumping chamber, was thickened, was enlarged, correct?

A. Yes.

Q. That was because he had -- that was consistent with

hypertension, correct?

A. Yes.

Q. That goes back to what you said before?

A. Yes.

Q. Okay. Doctor, we can agree that patients with left ventricular hypertrophy are more prone or more at risk to develop a sudden lethal arrhythmia, true?

A. Yes.

Q. And patients with diabetes and left ventricle hypertrophy increase risk for a sudden deadly rhythm, true?

A. The diabetes relates to coronary disease which he did not have. I don't think that was a factor.

Q. The stresses from infection such as pneumonia can exacerbate or make worse the risk to a patient like Mr. Rodriguez with ventricular hypertrophy, the left side of the heart, to develop a sudden lethal cardiac arrest, true?

A. It's possible.

Q. Okay. And when that happens to a patient it's like lightning. It just happens. They go out and never know what happened?

A. If it happens that way.

Q. Okay. You've testified 30, 40 times?

A. I believe so.

Q. You told us you only testified for plaintiffs in the context of a courtroom, true?

A. Up until now, yes.
Q. Okay. You give depositions all the time?
A. Not too often.
Q. You review cases a lot?
A. Yes.
Q. How many cases do you review a year?
A. Maybe 30.
Q. Okay. You've done work for Mr. Argintar's office, Sullivan, Papain and all the other people?
A. Yes.
Q. How many times have you done that?
A. Over the years?
Q. Yeah.
A. Probably 50 times over 15 years.
Q. Fifty times you testified for Vito Cannaro back in 1994 which has been a long time ago. You've been doing that for more than 15 years?
A. Whatever that is.
Q. Were you paid yet in advance for your deposition for your trial testimony here?
A. Yes, I was.
Q. And how much did you get in advance?
A. It wasn't in advance. It was today.
Q. Before you took the witness stand, you got a check?
A. Yes.

Q. And that was for how much?
A. $8,000.
Q. Okay. Upon all the work you did before this, you say you got the case in 2009?
A. Yes.
Q. How much time did you spend doing that?
A. Probably three hours.
Q. Since that time how much time did you spend up until today?
A. Another two hours.
Q. Okay. Five hours of how much an hour, 800, 850?
A. 850.
Q. It would be fair to say a total you charged something around 12, $13,000 for your work in this case?
A. Yes.
Q. You reviewed all these materials that you got from Mr. Argintar's office a couple of years ago?
A. Yes.
Q. And you didn't bring any of them with you?
A. No.
Q. Where are they?
A. In my home.
Q. Did you make any notes?
A. Initially, I made notes.
Q. So, but?

A. And after I was preparing for, you know, the case I discarded my notes.

Q. Wait, wait a second. You made notes about your thoughts in reviewing this case?

A. Right.

Q. And before you came to court to testify, you threw them out?

A. Well, as I'm leaving, I prepared for the last several days.

Q. You threw out the notes?

A. Yes.

Q. Doctor, in the 40 or so times you've given testimony when you've been questioned by the defense lawyer like myself, isn't it a fact that almost all the time you're asked do you have any notes, bring the notes, where are the notes. You heard that question before?

A. Yeah.

Q. Right? And knowing that you took the notes before you came you threw them away?

A. Well --

Q. Just yes or no?

A. Yes, I did.

Q. By the way, Doctor, did you calculate the PSI score in this case?

A. I did actually.

Q. Okay. And it should have been a three instead of a four, right?

A. I came up with a four.

Q. Isn't it true, Doctor, that his hemoglobin, his hematocrit was over 30 when that study was done?

A. I think it was 27.

Q. there was a study that his hematocrit was 31, right?

A. It depends on which lab you look at it.

Q. And it was 31 and then after he got fluids then his number went down to just short of 30, true?

A. True.

Q. And, Doctor, the difference between the PSI4 and the PSI3 is the PSI3 is only a .9 percent risk of death, correct?

A. I'll have to take it on faith.

Q. Okay.

MR. SHAUB: Okay. Judge, I appreciate everyone's patience and I have no further questions. Thank you, Judge.

MR. ARGINTAR: Nothing, Your Honor.

THE COURT: Okay. Thank you, Doctor.

Approach please.

(Discussion off the record.)

THE COURT: Ladies and gentlemen of the jury, as I indicated to you earlier this week and last, we are not going to be in session tomorrow and Friday. If you recall