

1 SUPREME COURT OF THE STATE OF NEW YORK

2 COUNTY OF RICHMOND : CIVIL TERM : PART DCM3

-----X

3 JOANNE KILLIAN, :

4 Plaintiff, :

5 - against - : INDEX NO.
101692-2014

6 :

7 FRANK FAZIO, :

8 Defendant. :

-----X TRIAL

9 Richmond County Courthouse
26 Central Avenue
Staten Island, New York 10301

10 October 12, 2017

11 B E F O R E:

12 HON. DESMOND A. GREEN,
Supreme Court Justice.

13

14 A P P E A R A N C E S:

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21

22

23 DEBORAH MAIRA,
ROSEMARY PFISTER,
24 SENIOR COURT REPORTERS,

25

1 THE COURT: Okay, same appearances.

2 MR. SIKOSCOW: Thank you, Your Honor.

3 I just wanted to ask the Court whether or not we
4 were going to address the issue that was raised just before
5 we broke yesterday regarding one of the jurors not being
6 available, I believe it was on Monday.

7 THE COURT: Yes, we could raise that now.

8 And it's my understanding it was Alternate
9 Number 3. We are running out of time. This case is taking
10 a long time. Since this is Alternate Number 3 --

11 Okay, well first let me hear from you.

12 MR. SIMONSON: Yes, Your Honor.

13 Counsel for plaintiff would strenuously object to
14 unseating Juror Number 3.

15 THE COURT: No, Alternate Number 3.

16 MR. SIMONSON: Oh, I apologize, Your Honor.

17 MR. SIKOSCOW: Yesterday it was said as Juror
18 Number 3.

19 THE COURT: Was it Juror Number 3?

20 COURT OFFICER: It's Alternate Number 3.

21 MR. SIMONSON: I have no objection.

22 THE COURT: That's what threw me off. It's
23 Alternate Number 3.

24 MR. SIMONSON: I get it, I'm sorry.

25 THE COURT: So we're going to be working on

1 Monday. So, rather than having this juror remain with us,
2 we can excuse --

3 MR. SIMONSON: Ms. Hall, Kelly Hall, Your Honor.

4 THE COURT: Yes.

5 MR. SIMONSON: No, I'm sorry.

6 THE COURT: Theresa Manilla.

7 MR. SIMONSON: Theresa Manilla.

8 THE COURT: Because today is a full day. One of
9 the jurors had a prior commitment for tomorrow so we will
10 not be working tomorrow. And we just need to keep going,
11 because we also have expert witnesses who are scheduled, and
12 to rework the schedule will be problematic.

13 So, counselors, with your permission, I'd like to
14 have our officer simply excuse this juror today rather
15 than -- because it would be today anyway, because we would
16 not be working tomorrow.

17 MR. SIMONSON: With the understanding that we're
18 excusing Alternate Number 3, Theresa Manilla.

19 THE COURT: Yes, sir.

20 MR. SIMONSON: Plaintiff consents to that, Your
21 Honor.

22 THE COURT: Okay.

23 Would you like me to bring alternate Number 3 in
24 so that you could both thank her? This way you could see
25 for yourself who is being excused.

1 MR. SIMONSON: Sure, Your Honor.

2 THE COURT: Could we bring her in?

3 (Whereupon, there is a pause in the proceedings.)

4 COURT OFFICER: Are you ready for the juror, Your
5 Honor.

6 THE COURT: Yes, please.

7 COURT OFFICER: Juror entering.

8 (Whereupon, Alternate Juror Number 3 enters the
9 courtroom.)

10 THE COURT: How are you?

11 ALTERNATE JUROR NO. 3: I'm fine.

12 THE COURT: Good to see you again.

13 I got the report about the donuts.

14 ALTERNATE JUROR NO. 3: There's some really
15 interesting ones I brought, so...

16 THE COURT: Because of the nature of the case, and
17 we already have a lot of experts scheduled to testify, we
18 understand your situation for Monday. If you cannot come on
19 Monday, we've agreed to excuse you, but it's entirely up to
20 you.

21 ALTERNATE JUROR NO. 3: Well I can come -- my
22 doctor's appointment is 8:00. They just need a doctor to be
23 on call to read the results. I don't think it should take
24 long. So I just didn't know what time court would start,
25 that's why I wanted to let you know in case.

1 THE COURT: Okay.

2 Then why don't you hang out with us a bit and
3 we'll see what happens. You have our phone number; in the
4 event there's a problem Monday morning, you give us a call.
5 We'd love for you to stay with us.

6 ALTERNATE JUROR NO. 3: I'd love to stay. I'm
7 upset that I'm an alternate.

8 THE COURT: Great.

9 ALTERNATE JUROR NO. 3: Thank you.

10 (Whereupon, Alternate Juror Number 3 exits the
11 courtroom.)

12 COURT OFFICER: Are you ready for the jury, Your
13 Honor.

14 THE COURT: Yes.

15 (Whereupon, the jury enters the courtroom.)

16 THE CLERK: The jury is present and properly
17 seated.

18 Do both sides stipulate?

19 MR. SIMONSON: Yes.

20 MR. SIKOSKOW: Yes.

21 THE COURT: Mr. Simonson, your next witness.

22 MR. SIMONSON: Good morning, everyone.

23 The plaintiff calls to the stand Dr. Alan
24 Schechter.

25 THE CLERK: Please raise your right hand.

1 D R. A L A N S C H E C H T E R, called as a
2 witness on behalf of the plaintiff, having first been duly
3 sworn by the clerk of the court, was examined and testified
4 as follows:

5 THE CLERK: Please give your name and professional
6 address.

7 THE WITNESS: My name is Dr. Alan Schechter, and
8 my professional address is Emergency Department Montefiore
9 Medical Center, 111 East 210th Street, Bronx, New York
10 10467.

11 THE CLERK: Please spell your name for the
12 reporter.

13 THE WITNESS: S-C-H-E-C-H-T-E-R, my first name is
14 Alan, A-L-A-N.

15 THE COURT: Okay, Mr. Simonson.

16 MR. SIMONSON: Thank you so much, Your Honor.

17 DIRECT EXAMINATION

18 BY MR. SIMONSON:

19 Q Good morning, Dr. Schechter.

20 A Good morning.

21 Q I'm going to ask you to do your very best to keep your
22 voice up so that all of the jurors can hear all of your
23 answers. If I drop my voice at all or if you don't hear a
24 question, and certainly if you don't understand a question,
25 will you let me know before you answer?

1 A I certainly will.

2 Q Thank you.

3 I'd like, before we go and talk about all your
4 extensive medical credentials, talk about your role over the
5 years as an expert witness, okay?

6 A Certainly.

7 Q So when was it that you first began to act as an expert
8 in medical malpractice cases?

9 A In 1984. It was actually -- I basically was wandering
10 down the hallway in the emergency department at Montefiore
11 Medical Center, and one of the other physicians came out and
12 asked me if I knew a particular diagnosis called IHSS,
13 Idiopathic Hypertrophic Subaortic Stenosis.

14 THE COURT: Could you spell that for me?

15 THE WITNESS: Idiopathic, I-D-I-O-P-A-T-H-I-C,
16 hypertrophic, H-Y-P-E-R-T-R-O-P-H-I-C, stenosis,
17 S-T-E-N-O-S-I-S.

18 A In any event, I was asked if I knew about this
19 diagnosis and I did.

20 And it turned out that there was someone else who was
21 supposed to be an expert in a case and had written a report, and
22 that particular physician actually passed away. And the case
23 was coming up, and they needed someone just to explain his
24 report, and I said, Sure, I'd be happy to do it," and I read his
25 report, it was correct. In fact, the case settled and I was

1 never called.

2 About six months later someone called me and asked
3 would I be willing to review a case, and I said, "Sure, of
4 course."

5 And that's how I started doing reviews. And it was
6 consistent with what I was doing anyway in the emergency
7 department, because we do have our own morbidity and mortality
8 conferences, and we do have what is called "quality improvement
9 committees," where we look at all kinds of adverse outcomes, so
10 it's merely a continuation of that.

11 Q So I'm not going to ask you about morbidity and
12 mortality conferences, because it's not really relevant to
13 what's going on here.

14 But I would like to ask you, and kind of move into
15 that, when you talk about quality assurance and peer review,
16 would you explain what you do at Montefiore about that and what
17 that means?

18 A Certainly.

19 So I'm chairman of the emergency department's Quality
20 Improvement Committee. So we look at all adverse outcomes, we
21 look at all mortalities in the emergency department, we also
22 look at unexpected outcomes. That is, we start to do a
23 therapeutic intervention and the patient doesn't do well. And
24 then we want to find out why that happened. That is, was the
25 standard of care met or not? And is there anything we can do,

1 whether the standard of care was met or not, to prevent this
2 from ever happening again? And I've been chairman of the
3 emergency department Quality Improvement Committee since 1988.

4 So it's a very basic part of medicine. That is, we
5 review what we do, and if there are adverse outcomes, we see
6 what the standard of care is and we see whether we can, in fact,
7 ensure that the standard of care is, again, applied in all
8 future cases. And if a physician didn't meet the standard of
9 care, we educate the physician about what the standard of care
10 is and then we hope that he won't do it again. And if -- in
11 certain cases we would monitor a physician.

12 Q And as part of looking at standard of care in the
13 emergency department, would that include misdiagnosis and
14 failure to diagnose?

15 A Absolutely.

16 So we would look at people who missed X-ray readings,
17 people who discharged patients who needed to be admitted,
18 patients who did diagnostic studies that were inappropriate.

19 So we look at all of those things. We're constantly
20 trying to improve the quality of care, to essentially decrease
21 variation and move to what the standard of care is for all of
22 our patients.

23 Q When you talk about an adverse event, and I understand
24 that's a medical way of talking about things, that means
25 something unexpected happened bad to the patient?

1 A That's correct. That's correct. We didn't expect or
2 we did not want this outcome to occur. And then we determine
3 whether, in fact, the standard of care was applied or not.
4 Because even when the standard of care is applied,
5 occasionally, you will have a bad outcome. But if it turns out
6 that either the standard of care wasn't applied by the
7 physician or there was a system's issue that we have to
8 correct, then we will correct that in order that the next
9 patient not suffer this adverse event.

10 Q And in your quality assurance role, when you look at
11 the question of whether a doctor did or did not meet the
12 standard of care, do you bring objective analysis to that?

13 A Yes, we do. We use -- basically, we use peer review.
14 We would look at what other physicians in a similar situation
15 would do, and we look to see, are there set standards. There
16 might be national standards, hospital-wide standards, and see
17 whether those are applied appropriately.

18 Q And when you were asked by me to review Ms. Killian's
19 case and the care rendered to her by Dr. Fazio under the
20 circumstances on March 3, 2014, did you bring the same
21 objectivity to that analysis that you bring when you sit in
22 quality assurance?

23 A Absolutely. I looked at the case as if it occurred in
24 my hospital.

25 Q By the way, in terms of compensating, do you receive

1 additional compensation from the hospital for acting in the
2 role of quality assurance?

3 A Yes, part of my salary and part of my job is to do
4 those reviews, and I'm paid for those reviews.

5 Q Now, over the years, if you look at the great number of
6 cases -- was most of that work done for plaintiffs?

7 A Yes, most of it was done for plaintiffs.

8 Q When you look at a case on behalf of a patient, what
9 percentage of cases do you say, "No, I can't help you. I don't
10 think the case has merit."

11 MR. SIKOSCOW: Objection.

12 THE COURT: Overruled.

13 A In about two thirds of the cases I say that the
14 standard of care was met.

15 THE COURT: Ladies and gentlemen, when it comes to
16 witnesses, a lay person cannot give his or her opinion the
17 way Dr. Schechter is permitted to give it. But he's an
18 expert, and so he's able to give you a lot more information
19 based upon his experience and expertise. That's why he's
20 permitted to answer questions that others would not be
21 permitted to answer.

22 MR. SIMONSON: Thank you, Your Honor.

23 Q Dr. Schechter, over the years did you find that you
24 were listed or associated with groups that try to put
25 plaintiffs' lawyers together with an expert in a particular

1 field, emergency medicine, to evaluate cases and determine
2 whether the standard of care was met or not met?

3 A Yes.

4 Q And just talk about that, how that works.

5 A Well, basically, there are several organizations that
6 ask me to review cases. So I review cases for Medical Review
7 Associates; I review cases for a group called Mednick
8 Associates; I review cases for a group called Second Opinion;
9 I've reviewed cases in the past for MedQuest. And I also get
10 cases directly from attorneys who will call me and ask me to
11 review cases. And I've gotten cases from defense firms, also,
12 to review.

13 Q Over the years have you found that -- well withdrawn.
14 When it comes to you getting cases to review and look
15 at the standard of care from a group, is that almost always
16 plaintiffs' case?

17 A Yes.

18 Q Have you found over the years that you have been
19 reviewing and testifying in plaintiffs' cases in the
20 overwhelming majority of cases?

21 A That's correct.

22 Q Do you feel you've lost your objectivity?

23 A Not at all.

24 Q Is it customary, as you understand it, as someone who
25 has testified and worked on cases, to be compensated for your

1 time?

2 A I am compensated for my time.

3 Q And are you compensated for your time in reviewing the
4 matters?

5 A Yes.

6 Q And then are you compensated for your time for coming
7 to court and testifying?

8 A Yes, I am.

9 Q Can you tell me, do you charge an hourly rate for your
10 reviews?

11 A I do.

12 Q And what do you charge?

13 A I charge \$500 per hour for review and I charge \$5,000 a
14 day to come to court.

15 Q And you said you've been involved in this since 1984?

16 A That's correct.

17 Q Can you tell us approximately how many times you've
18 actually come to court to testify?

19 A Probably between 60 and 80 times since 1984.

20 Q And you testified in other cases in New York?

21 A Yes.

22 Q And you testified in New Jersey?

23 A Yes, I have.

24 Q And I believe Massachusetts?

25 A Yes, I have.

1 Q Connecticut?

2 A Yes, in Connecticut, also.

3 Q And anyplace else?

4 A In Pennsylvania.

5 Q You know, I'm going to ask you this question. I think
6 it's almost rude in a way, but I'm going to ask you anyway.

7 If you look back over the years -- withdrawn.

8 By the way, do you operate on patients?

9 A Well, it depends on --

10 Q Like big surgeries, like heart surgery and all --

11 A No, mine are emergency procedures. We do, of course.

12 Q And are you compensated for big operations and big
13 procedures?

14 A I don't do big procedures, so I'm not compensated for
15 those.

16 Q Would you say over the years what percentage of your
17 income comes from doing your medical paperwork?

18 A Between 10 and 20 percent.

19 Q Now, Doctor, have you worked with my firm before?

20 A I believe we had one prior case.

21 Q Have you and I ever worked in court together?

22 A No.

23 Q Did I ask you some time ago to take a look at the care
24 rendered by Dr. Fazio, in all its aspects and circumstances,
25 and come to a decision as to whether Dr. Fazio met the standard

1 of care as he treated Ms. Killian and acted reasonably and
2 prudently?

3 A Yes.

4 Q And we're going to go into it in great detail, but I
5 just want to ask you, sort of in an umbrella way, did you,
6 after doing your analysis, reach the conclusion and the opinion
7 that there were aspects of Dr. Fazio's care that were not
8 reasonable and prudent and that fell below the standard of
9 care?

10 A Yes, I did.

11 Q And, in making your evaluation, did you review records
12 and X-rays?

13 A Yes, I did.

14 Q And, of course, did you review the hospital record from
15 Richmond.

16 A Yes, I did.

17 Q And did you review the hospital records from Staten
18 Island beginning on March 16th?

19 A Yes, I did.

20 Q Did you review X-rays?

21 A I did.

22 Q And, also, as part of the case, did I provide you with
23 what is called deposition testimony?

24 A Yes, examinations before trial.

25 Q That's another way of saying it.

1 Did I provide you with Dr. Fazio's deposition?

2 A Yes.

3 Q Did you read it?

4 A I did read it.

5 Q Did I provide you with Ms. Killian's deposition?

6 A Yes.

7 Q Did you read that?

8 A I did.

9 Q And did I provide you with depositions of a couple of
10 nurses and a couple of lay people?

11 A Yes.

12 Q Were you provided with the trial testimony of
13 Dr. Fazio?

14 A Yes.

15 Q And were you provided with the trial testimony of
16 Dr. Sicherman?

17 A Yes.

18 Q I didn't provide with you Ms. Killian's testimony
19 because it would be just available this morning.

20 Do you understand?

21 A I do understand.

22 Q Okay.

23 And did you read all that material?

24 A Yes, I did.

25 THE COURT: Well there's just one other thing.

1 Were you provided with the protocol from Richmond
2 University Medical Center as to their emergency room on
3 October 3, 2014?

4 THE WITNESS: I'm not sure -- I don't understand
5 what you mean by "protocol."

6 THE COURT: What the hospital itself requires.

7 For example, you just mentioned -- you can face
8 the jury.

9 You just mentioned that there could be an issue
10 with the doctor or an issue with the institution. The
11 institution would be a protocol, right?

12 THE WITNESS: Correct.

13 THE COURT: Okay.

14 Were you given the protocol for Richmond
15 University Medical Center?

16 THE WITNESS: No, I was not given any policies and
17 procedures.

18 THE COURT: Okay.

19 Okay, Mr. Simonson, you can continue.

20 MR. SIMONSON: Your Honor, I just spoke to
21 Mr. Sikoscow and we -- we can approach.

22 THE COURT: No, continue questioning.

23 BY MR. SIMONSON:

24 Q Doctor, I want you to assume that as far, as this case
25 goes, and as far as anybody knows, that there were no specific

1 written guidelines, procedures or protocols relevant to
2 Dr. Fazio's care of Ms. Killian.

3 Will you assume that?

4 A I will assume that.

5 Q Now, Doctor, I think you're used to being asked your
6 opinion in these matters.

7 A Yes.

8 Q When I ask for your opinion, will you assume each and
9 every time that I am asking for your opinion to a reasonable
10 degree of medical certainty or medical probability?

11 A Yes.

12 Q And even if I don't use those words each time I ask for
13 your opinion or each time you express an opinion, will you only
14 express those opinions that you hold to a reasonable degree of
15 medical certainty or probability?

16 A I will.

17 Q And you're a physician licensed to practice medicine in
18 the State of New York?

19 A That's correct.

20 Q We seem to have gotten, in this case, to being asking
21 everybody, where did you go to high school, where did you grow
22 up, so why don't you tell the Court that.

23 A Sure.

24 I grew up in Brooklyn, so I went to James Madison High
25 School, and I graduated from James Madison High School in 1970.

1 And then I went down Bedford Avenue and I went to Brooklyn
2 College, and I graduated from Brooklyn College in 1974. Then I
3 went up to Boston, and I went to Boston University School of
4 Medicine and I graduated in 1978. And then I came back to
5 New York, and I did my residency at Montefiore Medical Center,
6 which is the university teaching hospital of Albert Einstein
7 Hospital of Medicine. I did my residency in Internal Medicine.
8 I actually went back to Boston for one year to do ophthalmology,
9 and decided that I like medicine much, much more, where you see
10 the whole patient rather than just the eyes itself. I went back
11 to Montefiore, completed my residency at Montefiore, and then
12 started to work, and I've worked continuously at Montefiore
13 Medical Center in the Emergency Department.

14 When I finished my residency in 1982, Emergency
15 Medicine was not a free-standing separate specialty. So, in
16 fact, Montefiore had what was called "Emergency Services," so I
17 worked for the Department of Medicine Emergency Services and
18 also ran a primary care clinic for Montefiore Medical Center and
19 ran a primary care clinic for them.

20 I continued on as the emergency department continued to
21 expand and became a full-time department in 1997, and I've had
22 basically -- I have a dual appointment in the Department of
23 Medicine and the Department of Emergency Medicine, but all of my
24 practice now is in the Department of Emergency Medicine.

25 I became Board Certified in internal medicine in 1982,

1 and then in 1988 I became Board Certified in emergency medicine.
2 And I recertified in 1998 and 2008, and I will recertify again
3 in 2018.

4 Q And to recertify means what?

5 A Well, in your first certification there is an oral and
6 written part. And then for each of the recertifications, it's
7 a national test, and you take the national test every ten
8 years. Additionally, every year you take what are called
9 lifelong educational tests, where you take a test every year on
10 the computer.

11 Q And so, if I understand, you're double Board Certified.
12 You're Board Certified in internal medicine and in emergency
13 medicine.

14 A That's correct.

15 Q And I think you alluded to this, but will it be
16 accurate to say that a distinct separate specialty of emergency
17 medicine is rather new compared to, say, internal medicine,
18 general surgery or ophthalmology, eye doctors?

19 A Absolutely.

20 So what happened in emergency medicine is originally it
21 was a co-joint board, and then it became a full and independent
22 board, and that's been relatively recently. And it now is a
23 full, free-standing specialty, nationally recognized and equal
24 to internal medicine, pediatric surgery.

25 Q And for several years, in addition to your clinical

1 practice, that is actually being in the emergency department
2 and giving care and treatment and evaluation to patients, did
3 you act both as the assistant director and associate director
4 of the Montefiore emergency department?

5 A Right. At various times I've been the assistant
6 director of the emergency department at Montefiore Medical
7 Center and I've been the associate director.

8 And then when we had the -- we had a combining of the
9 Jacobi residency in emergency medicine and now the Montefiore
10 residency in emergency medicine. It became -- it's actually one
11 of the largest emergency medicine training programs in the
12 United States. I believe we have 64 residents now. And at that
13 time, from an administrative point of view, I moved all of my
14 administrative time to teaching direct patient care and to the
15 quality improvement activities that I was doing.

16 Q And who do you teach?

17 A Oh, so we teach a way wide array of people. Of course
18 we teach our emergency medicine residents; we teach our
19 internal medicine residents; we teach orthopedic residents who
20 rotate through; we teach anesthesia residents who rotate
21 through; we teach family practice residents who rotate through.

22 There's also a specialty in pediatric emergency
23 medicine. These are pediatricians who then do a fellowship in
24 emergency medicine. They rotate to the adult side, and we teach
25 those pediatric emergency medicine fellows adult emergency

1 medicine.

2 We teach medical students. We are the teaching
3 hospital for Albert Einstein College of Medicine. So medical
4 students rotate through our emergency department and get their
5 experience in taking care of patients in emergency situations.

6 And we also have what are called "electives," where
7 medical students from other institutions come and spend two
8 weeks at Jacobi and two weeks at Montefiore, and they do it to
9 get emergency medicine experience. And, also, these are people
10 who are going to be applying for an emergency medicine
11 residency, so they want to see different emergency training
12 programs, and we have an opportunity to see them, to see if they
13 would be a good fit for our residency.

14 Q At present, how many hours a week do you spend in the
15 emergency department actually taking care of patients?

16 A Probably about 36 hours per week. It's scheduled for
17 about 32. But it varies from week to week, because there are
18 twelve-hour shifts, ten-hour shifts and eight-hour shifts, so
19 it varies. And based on the requirements for documentation,
20 almost always, you stay almost an hour afterwards doing the
21 documentation necessary to, number one, make sure your patients
22 are getting the appropriate care, and, also, to hand off
23 patients, that is to sign patients off to the next shift.

24 One of the things that emergency medicine has is it,
25 quite frankly, is shift work. And what that does is it means we

1 have standards and we have a way of doing things so that the
2 next physician is going to know what was already done and what
3 we can expect the next physician will do for our patients.
4 Because a patient's time of care, timeline of care, may not
5 necessarily totally overlap with our clinical time that we are
6 in the emergency department. There's actually State regulations
7 that you can't work more than 12 hours, you have to top stop.

8 Q And so I guess one of the questions I would ask is:
9 What is an emergency physician? What is emergency
10 medicine?

11 A Emergency medicine is great. What emergency medicine
12 is is we take care of patients who come in with
13 undifferentiated problems. That is, in general, we have never
14 seen these patients before. Of course there are patients who
15 have chronic conditions who will come back to Montefiore and
16 I'll say, "Oh, I've seen you two weeks ago."

17 But, in any event, we see patients who come in with a
18 variety of complaints. They can be surgical complaints, they
19 can be medical complaints, they can be psychiatric complaints,
20 they can be trauma, they can be infection, they can be cardiac,
21 they can be pulmonary.

22 So what we do is we evaluate the patient, we look at
23 the chief complaint that they have, we look at their past
24 medical history, we look at the mechanism of injury, if it's an
25 injury that brought the patient to the emergency department, we

1 look to see what was done before. And we evaluate those
2 patients, we treat those patients, we stabilize those patients.
3 If we can complete the treatment for the patients, we'll
4 complete the treat for the patients. We make a determination
5 whether ongoing care has to be provided. Does the patient need
6 to be admitted? We make a determination as to what kind of
7 studies, either blood tests or X-rays need to be done. We make
8 a determination as to whether special consults are necessary.
9 And then we provide a completion for the patient of our care,
10 and make sure that then further care is going to continue,
11 either in an inpatient basis or as an outpatient basis. Or it
12 may be that our care for, like, a strep throat, we've given the
13 antibiotics. And the expectation is that they will get better,
14 and we give them instructions to come back if they don't get
15 better, and we tell them to have routine followup with their
16 primary care physician otherwise.

17 THE COURT: Doctor, I understand it's a Brooklyn
18 trait, but we're trying to get everything on the record. If
19 you could just slow down.

20 THE WITNESS: Oh, I'm sorry.

21 Q Would it be correct to say or incorrect to say that
22 orthopedic trauma, including fractures of bones, breaking of
23 bones, is a significant part of the work of the emergency
24 department?

25 A Absolutely, it's part of trauma.

1 Trauma is one of the basic elements in emergency
2 medicine. And trauma includes broken bones, internal bleeding,
3 soft tissue injuries, brain injuries, contusions. So all of
4 those things come into trauma. And we're the first people,
5 aside from the prehospital providers, that see those patients,
6 stabilize those patients, begin the workup for those patients.
7 And those patients who require further inpatient care, surgical
8 care, specialty care, we get that for them.

9 Q In your decades-long experience, have you dealt with
10 patients who fell and fractured their hips, whether it be a
11 non-displaced fracture or displaced fracture?

12 A Yes.

13 Q Is that something common or uncommon in the emergency
14 department?

15 A It's common.

16 THE COURT: Well which one is common?

17 THE WITNESS: Fractures.

18 THE COURT: There are two parts, okay?

19 Mr. Simonson mentioned two parts; he mentioned displaced and
20 non-displaced.

21 Is one more common than the other? Let's
22 differentiate.

23 THE WITNESS: Displaced fractures are more common
24 than non-displaced fractures.

25 THE COURT: Speak to the jury.

1 Q I guess we've had this before, but at the risk of being
2 a little repetitive, could you tell the jury what a plain film
3 X-ray radiograph is?

4 A Certainly.

5 A plain film is where an X-ray is taken, there is an
6 X-ray film -- or now it's done by computer, where it basically
7 is an electronic type of film. And an X-ray beam is -- X-ray
8 cathode tube discharges X-rays. Those X-rays travel, go through
9 the tissue and then create an image. Bone is dense, so bone
10 stops the X-rays; so the film, where there's bone, will look
11 white. Where there is no bone more X-rays get through, and, as
12 a result, the film looks dark. And that's how you get an X-ray.

13 So plain films, being that it's just one plane, one
14 view, it's either front to back or back to front, or sideways or
15 oblique.

16 Q "Oblique" means what?

17 A That it's at an angle.

18 Q And is it your understanding that in this particular
19 case, in Ms. Killian's presentation to the emergency department
20 on March 3, 2014, that Dr. Fazio looked at actual films and not
21 computer-generated images?

22 A That's correct.

23 Q And is that how you were originally trained, with
24 films?

25 A I was originally trained with films, yes.

1 Q So, please tell the jury your knowledge and experience
2 as it relates to reading plain films of the bones, including
3 the hips, that are taken in the emergency department, and how
4 it is that custom and practice seems to be that, when a patient
5 comes to the emergency department and needs X-rays, plain
6 films, that it's the emergency department doctor who's reading
7 them and not a specialist in radiology?

8 MR. SIKOSCOW: Objection to form, Your Honor.

9 THE COURT: Overruled.

10 You can answer that.

11 A So, basically, emergency physicians are going to look
12 at the films first. It actually does depend on the institution
13 in which you work. So I do have the benefit -- at Montefiore I
14 have radiology available 24/7. So my films are read by a
15 radiologist, in almost all circumstances, before the patient
16 goes home.

17 For trauma films, plain films, they are rapidly
18 available and we look at them. Prior to the advent of our
19 computerized system, we would just walk right down the hall and
20 we can look at the X-rays ourselves. So we would put them on
21 what's called a "view box" and we would look at them. There was
22 also -- there was something that was basically a bright light,
23 which is basically just a light bulb, which would help with more
24 subtle findings. Currently, for years and years, we use a
25 system that's called PACS, but there are other systems. But,

1 basically, as soon as the film is shot now, I actually have the
2 image of it and I can look at it on my computer.

3 Q And, Doctor, if an emergency department, such as
4 Richmond University Medical Center, makes a determination that
5 the way they're going to do it is that the emergency department
6 physician orders plain films and reviews plain films, and,
7 unless that physician decides they need someone else to look at
8 them, they're the only one to look at them, is that within
9 standard of care?

10 A Yes, it is.

11 Q And, in addition to plain films, are there occasions
12 when patients in the emergency department have CAT scans or
13 MRIs?

14 A Absolutely.

15 Q And, as an emergency room physician, do you look at
16 those as well or no?

17 A I do.

18 Q Now, could you talk about your understanding of custom
19 and practice in the emergency department with respect to the
20 role of consultants in specialties other than emergency
21 medicine?

22 MR. SIKOSCOW: Objection to the form, Your Honor.

23 THE COURT: Overruled.

24 Doctor, if you understand the question you can
25 answer.

1 A My understanding -- you're asking me how we would use
2 consults?

3 Q Yes. In other words, the whole idea of having consults
4 and the like.

5 A Certainly.

6 So emergency medicine physicians take care of the
7 overwhelming number of patients themselves; they treat the
8 patients, they make decision a about admitting or discharging
9 the patient. But there are a subset of patients who have
10 particular illnesses or injuries that require specialists to
11 come in. So if I have somebody with a fracture, it's going to
12 require operative intervention, that is going to be somebody
13 that an orthopedist is gonna be called in to see. If I have
14 somebody who has acute myocardial infarction, an acute heart
15 attack, an acute ST segment elevation MI, those patients are
16 gonna be whisked upstairs by our interventional cardiologists to
17 cardiac care.

18 In other hospitals, the protocol would be, potentially,
19 to use TPA or a thrombolytic agent. So different hospitals have
20 different capabilities, and they practice within the standards
21 of the capabilities of their hospitals.

22 So if I have somebody that has a very severe infection
23 that's going to require surgical debridement, what we call
24 "necrotizing fasciitis," the surgeons -- we would call a
25 surgical consult to come in, and those patients will be rushed

1 up to the operating room.

2 So, as emergency physicians, we do the initial
3 evaluation, we make the determination of what the patient has,
4 and then we make a determination whether, in fact, a specialist,
5 who has skills beyond what an emergency medicine physician has,
6 should be coming in to help us.

7 So, even for things like airway -- I may have a patient
8 with a very difficult airway. And I call anesthesia in
9 anticipation that this is going to be a very difficult airway,
10 and they have an added set of skills than I have, where I may be
11 forced to do something called a --

12 Q Doctor, I'm going to interrupt you now, because you
13 know more than anybody can imagine, but we're not talking about
14 that now.

15 MR. SIKOSCOW: Objection, Your Honor.

16 THE COURT: Overruled.

17 Q So, Doctor, are you familiar with the numeric rating
18 scale for patient self-reporting her pain?

19 A Yes.

20 Q And could you explain to the jury what that is, what
21 that means and why it's used?

22 A It's a pain scale. The pain scale that's mostly used
23 is a 0 through 10 scale. So 0 is no pain, 10 is the worst
24 possible pain the patient could possibly imagine. And we use
25 that in order to determine whether the treatments for the pain

1 are having a particular effect. Are the pain medicines we're
2 giving relieving some of the pain? And we will tell patients
3 that we're not going to be able to get rid of all of your pain.
4 Our goal is to make the pain tolerable, and that is what we do
5 when we start. That is, we set the expectations for our
6 patients about what we can reasonably expect to do. And so in
7 a pain scale, if someone says it's 10 out of 10 pain, you're
8 asking them, "This is the worst pain you ever have had in your
9 whole life?" And often, after you word it that way, they may
10 revise the pain downward.

11 Q Is it correct to say that the scale, putting aside 0
12 for no pain, goes 1 through 4 to 6 and 7 to 10?

13 A Yes.

14 Q And 4 to 6 which would include 4, 5 or 6, what is that?

15 A That's basically moderate to severe pain. It's
16 moderate pain in the 4 to 5 range. As you get up to 6, you're
17 beginning to bump into severe pain.

18 Q What are ADL or activities of daily living?

19 A Activities of daily living is what we do every day. We
20 brush our teeth, we put our clothes on. It's what a normal
21 person does in order to get through the day.

22 Q And in emergency medicine, is it or is it not part of a
23 reasonable and prudent evaluation to take into account what the
24 patient's pain scale was at the scene if it's trauma?

25 A Absolutely.

1 Q Why is that?

2 A Because it's telling you, number one, that if it's
3 severe pain, that the trauma may very well be what's called a
4 "high-impact trauma," a trauma which has caused significant
5 injury to the patient, either broken bones or soft tissue
6 bleeding. So that pain scale is important.

7 Q And if a patient, a person is walking, slips and falls
8 to the ground and lands on their hip, is that necessarily a
9 high-impact trauma or something else?

10 A It can be high impact. It depends on how high they
11 fell from and what the -- and, again, it's high impact for the
12 particular patient. What's the patient status? That is, is
13 the patient osteoporotic? Are they a 90-year-old person or are
14 they, you know, a 15-year-old child or young adult? So the
15 results to the body of the force will depend on the patient's
16 baseline condition.

17 Q But in evaluating a patient for the potential, the
18 possibility that a fracture may exist, is it relevant or not
19 relevant, for instance, if the person would be a 56-year-old
20 female?

21 A It is relevant.

22 Q Why?

23 A Well, because a 56-year-old female is going to have
24 thinner bones, in general, than an 18-year-old football player,
25 athlete. So that the force of the fall in a 56-year-old woman

1 is more likely to lead to a fracture than the same fall in a
2 very healthy and athletic 18-year-old man.

3 Q When evaluating the patient, do you take the clinical
4 picture as a whole, that is the circumstances as a whole for
5 that particular patient into account as you review the X-ray?

6 A Absolutely.

7 What you're looking for is the mechanism of injury and
8 what the baseline condition is of the patient, because what that
9 does is directs you to look for an injury that may be exhibited
10 on the X-ray.

11 Q Jumping ahead, if a patient happens to have a
12 non-displaced fracture of the femoral neck, which is
13 undiagnosed in the emergency department, and the patient is
14 sent home with instructions to weight bare as tolerated, all
15 right, does that or does that not present any risk to the
16 patient?

17 A It certainly presents risk to the patient. Because
18 when you have a non-displaced fracture, that means a fracture
19 where the bones are still aligned, but the structure, because
20 of the fracture, makes them unstable, and if you ambulate, if
21 you walk, what you're doing is you're putting -- if I stand up,
22 I'm putting weight on my hips, I'm putting a force on this
23 non-displaced fracture. And what that will do -- so it will
24 cause the fracture to displace, and that makes it a more
25 complicated treating problem.

1 Q Doctor, in your opinion, based upon your long knowledge
2 and experience as a emergency doctor dealing with orthopedic
3 trauma, is there any question in your mind, or is there a
4 question in your mind that weight bearing on and putting weight
5 on a non-displaced fracture of the femoral neck can cause it to
6 displace?

7 A I have no doubt, it can cause it to be displaced.

8 Q I think you sort of touched on it, but I'm going to ask
9 you specifically:

10 In an emergency department, what is the role and
11 significance, if any, of the patient's presenting complaint and
12 what is called the "mechanism of injury"?

13 A The presenting complaint and the mechanism of injury
14 are the things that direct the emergency physician to focus in
15 a particular area. So if a patient comes in and falls and has
16 hip pain, I'm not gonna concentrate on trying to find out
17 whether the patient has a strep throat. I'm going to
18 concentrate on the fact that this was a patient who fell, this
19 is a patient who had blunt force trauma to a bony area, and
20 this patient is at risk for a fracture, so I'm going to look
21 for the fracture. I'm going to take a history, I'm going to do
22 a physical exam, and I'm going to do appropriate radiology
23 studies until I can effectively rule out a fracture.

24 Q And when you say "rule out a fracture," does that mean
25 prove it doesn't exist?

1 A That's correct.

2 Q And I want you to assume that in evaluating
3 Ms. Killian, Dr. Fazio testified that he had a short list of
4 differentials. In fact, it was so short that it only included
5 two. It included soft tissue injury and hip fracture.

6 In your opinion, in the circumstances regarding
7 Ms. Killian, were those two differentials within the standard of
8 care?

9 A Yes.

10 Q And I want you to assume that Dr. Fazio, under all of
11 the circumstances presenting to him with regard to Ms. Killian,
12 decided that it would be reasonable and prudent to do several
13 X-rays, I think ten in number, including X-rays of the right
14 hip.

15 Was that decision within the standard of care?

16 A Yes, it was.

17 Q So we know that you ordered plain films, true?

18 A That's correct.

19 Q In your opinion, what is the role of plain films, and
20 specifically plain films of the hip, in the situation that
21 Ms. Killian found herself as of the time that she arrived in
22 the emergency department on March 3rd?

23 A It's a good initial screening test. It's the initial
24 test you do cause it will show most of the fractures. However,
25 it won't show all of the fractures, especially impacted

1 fractures, which can be subtle but which are clinically
2 present. So it's a good screening test. Because if, in fact,
3 it was a displaced fracture, that is separated, the emergency
4 physician is essentially done in the sense that his path is set
5 for him, it's to call the orthopedic surgeon to adequately
6 treat Ms. Killian's pain and to make sure that she doesn't eat
7 because there's a distinct possibility she's going to be going
8 to the OR soon. If the test doesn't show a fracture, it's
9 nondiagnostic.

10 But given the particular complaints that Ms. Killian
11 had, both on mechanism of injury and the fall, and the physical
12 complaints that are documented in the emergency department chart
13 and on physical exam, and the abnormalities on the plain film,
14 the standard of care required that you go to the next level.

15 And the next level -- because you know that those plain films
16 are gonna miss a certain percentage, anywhere between 10 and
17 20 percent of impacted fractures, that you need to go to the
18 next level. And that's going to either be a CT scan of the hip
19 or an MRI, and those are gotten from the emergency department.

20 Q And, Doctor, as we move on I'm going to ask you about
21 getting a CAT scan and MRI, standard of care and deviations
22 from standard of care, I'd like to cover something else before
23 we get there.

24 A Okay.

25 Q I want you to assume that Dr. Fazio, and Dr. Fazio

1 alone, was responsible for Ms. Killian's care while she was in
2 the emergency department, he was the only one making decisions
3 about her, and that he was the only doctor who examined her,
4 okay?

5 A Yes.

6 Q And I want you to assume that part of his examination
7 was to asses, to examine Ms. Killian for active range of motion
8 and passive range of motion, okay?

9 A Yes.

10 Q Was it within the standard of care for Dr. Fazio to do
11 these parts of the physical exam?

12 A Yes.

13 Q Now, are you familiar with that aspect of a physical
14 exam known as "gate assessment"?

15 A Yes.

16 Q And do you have an opinion whether a patient such as
17 Ms. Killian, that is Ms. Killian who presents with a fall from
18 standing and lands on her hip, in your opinion, is gate
19 assessment a critical part of a complete physical exam?

20 A Yes, it is.

21 Q Would you please tell the jury.

22 A Certainly.

23 Now, gate means walk, the ability to walk. Is the
24 walking normal? Now, you have -- if the patient had a fracture,
25 you know the patient had a fracture, then you don't want them to

1 walk on that fracture, obviously. But, if you're unsure about
2 whether the patient has a fracture or not, one of the key
3 aspects of the physical exam that you do as an emergency
4 physician is to have the patient get up and walk. And you watch
5 the patient walk and you ask the patient if they're having pain.
6 Because, for example, I weigh about 190 pounds. If I stand up,
7 that's much more force on my hips than if I just push on them.

8 **So that force will elicit pain on impacted occult fractures.**

9 It's a very basic and routine part on an examination of someone
10 you are concerned about a hip fracture. Because, fundamentally,
11 what you want the patient to be able to do is to walk and not be
12 having a hip fracture. So you have to test the walking. It's a
13 basic responsibility as a standard of care for the emergency
14 physician to do that gate testing.

15 Q So for Ms. Killian, specifically, in your opinion,
16 would gate assessment be required under the standard of care?

17 A Yes.

18 Q Now, I want you to assume that, prior to discharge,
19 Dr. Fazio never saw Ms. Killian walk and that he did not
20 personally do a gate assessment.

21 So far so good?

22 A I'm assuming.

23 Q I want you to further assume that Dr. Fazio delegated
24 to an emergency department nurse the task of performing a
25 predischarge gate assessment on Ms. Killian, right?

1 A Yes.

2 Q And I want you to assume that the nurse reported to
3 Dr. Fazio that the gate was steady or even, in all respects,
4 normal.

5 Would you assume that?

6 A Yes.

7 Q In your opinion, did Dr. Fazio deviate from accepted
8 standards of care? Did he fail to act as a reasonably prudent
9 emergency physician in delegating Ms. Killian's gate assessment
10 to an emergency department nurse?

11 A Yes, he failed. The responsibility is a physician
12 responsibility, because the physician has carefully examined
13 the patient, the physician knows the mechanism of injury, and
14 the physician knows particularly what they're looking for and
15 what to ask the patient. This is a physician diagnostic
16 evaluation; you cannot delegate that responsibility to someone
17 else.

18 Q For this next question, Doctor, I want you to assume
19 that when Ms. Killian was in the emergency department, that
20 she, in fact, had a non-displaced fracture of her right femoral
21 neck.

22 Would you do that?

23 A Yes.

24 Q With that assumption, do you have an opinion one way or
25 the another, whether more likely than not, gate assessment by

1 Dr. Fazio would have been positive that it showed a problem?

2 A Yes.

3 MR. SIKOSCOW: Objection.

4 THE COURT: Sustained. Sustained. Sustained.

5 Q Doctor, to your knowledge and experience in decades of
6 emergency medicine, would you say it's more likely than not or
7 not more likely than not that a patient with a non-displaced
8 femoral neck fracture will evidence some problem on gait
9 assessment by an emergency doctor?

10 A Much more likely than not.

11 Q Why is that?

12 A Because of the mechanism of injury. This is, in fact,
13 a fracture. It's a bone that's broken that just has not
14 clearly separated yet that is displaced. And if you're now
15 putting pressure on that, it's gonna cause some motion of that
16 bone and it's gonna cause pain. So the standing and walking
17 will elicit pain, overwhelmingly, in those patients.

18 Q Assuming that Ms. Killian had a non-displaced fracture
19 of the femoral neck, the right femoral neck, in your opinion,
20 was Dr. Fazio's failure to personally assess her gait a
21 substantial factor in discharging her with a diagnosis of no
22 fracture?

23 MR. SIKOSCOW: Objection.

24 THE COURT: Sustained.

25 Could you rephrase that in a way that I could at

1 least understand it?

2 MR. SIMONSON: Of course, Your Honor. It's
3 obviously a poor question.

4 Q First, I want you to assume that Ms. Killian, in fact,
5 had a non-displaced fracture of the femoral neck on March 3,
6 2014 while she was in the emergency department.

7 A Yes.

8 Q And you told us that, in your opinion, it was a
9 deviation from accepted standards of care for Dr. Fazio to
10 discharge Ms. Killian without personally assessing her gait,
11 correct?

12 A That's correct.

13 THE COURT: Okay, Doctor, let me just jump in
14 here.

15 You're talking about standard of care. Would it
16 be -- is there a distinction between the standard of care
17 from Montefiore and from the Richmond University Medical
18 Center? Is there a difference?

19 You use the term "standard of care," so could you
20 explain to all of us what you mean when you say "standard of
21 care." Standard of care in comparison to what?

22 THE WITNESS: What a similarly trained physician
23 given this kind of presentation with Ms. Killian's
24 presentation would do.

25 So the standard of care -- because this is

1 physical exam and that is the same at Montefiore and at
2 Richmond University Hospital, and it's the same in pretty
3 much -- it's the same in every hospital that is doing this
4 part of the exam, testing whether a patient can walk. That
5 is available to all physicians. There are other standards
6 of care --

7 THE COURT: Okay, speak to the jury.

8 THE WITNESS: There are other standards of care.
9 Obviously, if I'm in a small community hospital that doesn't
10 have cardiac care, the standard of care for that small
11 community hospital to provide cardiac care is not available,
12 they don't have the resources.

13 This is a basic physical exam assessment that can
14 be done and should be done as the standard of care in any
15 hospital in the United States.

16 Q And, Doctor, you told us that failing to do a personal
17 gate assessment was a deviation from the standard of care on
18 the part of Dr. Fazio, and you told us that the overwhelming
19 likelihood was that, had he done so, and if a non-displaced
20 fracture was present, it would have shown some issue or
21 problem.

22 A That's correct.

23 Q And so, therefore, Doctor, I'm asking you, under those
24 assumptions, in your opinion, was Dr. Fazio's failure to
25 personally assess Ms. Killian's gate a substantial factor in

1 having her leave the emergency department with an undiagnosed
2 femoral neck fracture?

3 MR. SIKOSCOW: Objection.

4 THE COURT: Sustained.

5 Assuming there was a fracture.

6 MR. SIMONSON: Yes.

7 THE COURT: I think you should use that term.

8 MR. SIMONSON: Thank you, Your Honor.

9 THE COURT: Assuming there was a fracture.

10 A Assuming there was a fracture, it was a substantial
11 contributor to inappropriately discharging Ms. Killian.
12 Because, had Dr. Fazio done the gate testing, overwhelmingly,
13 Ms. Killian would have complained about pain or had some
14 abnormality in her gate that would have been picked up by an
15 emergency physician, a physician, and that would have been
16 another prompt to force the standard of care to be done, which
17 is a CT scan of the hip or an MRI. And that, overwhelmingly,
18 would have diagnosed the impacted fracture, and that would have
19 caused the patient, Ms. Killian, to get an orthopedic consult
20 and be admitted, and it would have prevented the subsequent
21 damage that occurred when Ms. Killian's non-displaced fracture,
22 after discharge, became a displaced fracture.

23 Q So, Doctor, I want you to assume that Dr. Fazio
24 personally read all the X-rays, including the views of the hip,
25 and that when he read the X-rays of the hip, he determined that

1 they were nondiagnostic for fracture and that he told
2 Ms. Killian that she did not have a fracture.

3 I want to you further assume that at the time of
4 discharge a fracture was no longer in his differential, okay?

5 A I'm listening to you, yes.

6 Q Thank you.

7 And I want you to further assume that Dr. Fazio no
8 longer had a concern for fracture, and decided to discharge
9 Ms. Killian without ordering a CAT scan or MRI.

10 In your opinion, under Ms. Killian's particular
11 circumstances, with the understanding that Dr. Fazio looked at
12 the X-ray and said it was nondiagnostic, did Dr. Fazio deviate
13 from accepted standards of care in discharging Ms. Killian
14 without first ordering a CAT scan or MRI?

15 MR. SIKOSCOW: Objection to form, Your Honor.

16 THE COURT: Overruled.

17 You can answer that, Doctor.

18 A Yes, he did deviate from the accepted standards of
19 medical care, because we would know that plain films are an
20 initial screening test, but they are not adequate in a
21 presentation such as Ms. Killian to rule out, to prove that she
22 does not have a fracture. The standard of care requires that
23 you move to a more sophisticated imaging, and that imaging is
24 either a CT scan of the hip or MRI of the hip, and that's the
25 standard of care.

1 The key is that this was a nondiagnostic X-ray, that is
2 it could not rule out a fracture. It could show you if this is
3 a fracture, but it cannot tell you that there is no fracture
4 based on the presentation that Ms. Killian had.

5 Q And, Doctor, what is it, specifically, about
6 Ms. Killian's presentation, from the fall through her
7 examination by Dr. Fazio, that leads you to the opinion that no
8 matter what's on the X-ray in, you know, a negative fashion,
9 that the standard of care in Ms. Killian's case required a CAT
10 scan or an MRI?

11 A You have to look at how Ms. Killian presented. She
12 presented with a significant fall, she presented with,
13 initially, 10 out of 10 hip pain. In the emergency department,
14 the lowest level of pain that I see documented is 5 out of 10.
15 She had pain on range of motion of her hip.

16 This constellation, in a 56-year-old woman with this
17 mechanism of injury and the physical findings that were there,
18 is a hip fracture until proven otherwise. And if the initial
19 screening test doesn't show a fracture, it's a nondiagnostic
20 test, the next step is to get, as a standard of care, a CT scan
21 of the hip or an MRI of the hip based on the clinical condition,
22 the mechanism of injury, the chief complaint and the pain that
23 Ms. Killian was complaining about and the physical findings that
24 were done.

25 THE COURT: Okay.

1 Doctor, you've been at this now for one hour.
2 These jurors have been paying close attention to what you've
3 been saying. It's the perfect time for us to take a break.

4 THE WITNESS: Okay.

5 (Whereupon, jury exits the courtroom.)

6 (Whereupon, the witness is excused from the
7 witness stand.)

8 THE COURT: Let's take a ten-minute recess.

9 (Whereupon, Deborah Maira is relieved by Rosemary
10 Pfister as official court reporter.)

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1 (Whereupon, the jury entered the courtroom at
2 this time.)

3 THE CLERK: Counsel stipulate that all jurors
4 are present and properly seated.

5 MR. SIMONSON: Yes on behalf of plaintiff.

6 MR. SIKOSCOW: Yes.

7 THE CLERK: Doctor, please be reminded you're
8 still under oath.

9 THE COURT: Continued direct.

10 MR. SIMONSON: Thank you.

11 CONTINUED DIRECT EXAMINATION

12 BY MR. SIMONSON:

13 Q Dr. Schechter, assuming that Miss Killian did
14 indeed have a non displaced fracture of her right femoral
15 neck when she was in the emergency department on March 3rd,
16 in your opinion what is the likelihood that a CAT scan or an
17 MRI would have revealed the fracture?

18 A It would of overwhelmingly revealed the fracture,
19 that these are the studies you use to look for the fracture;
20 they're very, very sensitive.

21 Q And in your opinion if a CAT scan or an MRI had
22 been positive for the presence of a fracture of the femoral
23 neck, in your opinion would that have revealed a non
24 displaced fracture?

25 A Yes.

1 MR. SIKOSCOW: Objection.

2 THE COURT: Overruled.

3 A Yes, it would of revealed a non displaced fracture
4 of the femoral neck.

5 THE COURT: Assuming it's there.

6 MR. SIKOSCOW: Your Honor, I also object to
7 cumulative testimony.

8 THE COURT: Okay, overruled. You can answer
9 that.

10 The question is if there was a non displaced
11 fracture there, would the MRI or CAT scan reveal it?

12 THE WITNESS: Yes, and the reason it would
13 reveal it is because of what we call the sensitivity of
14 the study.

15 An MRI or CAT scan are very, very sensitive,
16 that is, they are very, very effective in finding those
17 non displaced fractures that are missed by plain films.

18 Q And assuming that Miss Killian had a non displaced
19 fracture of the right femoral neck while she was in emergency
20 room on March 3rd, in your opinion was Dr. Fazio's failure
21 to order a CAT scan or MRI a substantial factor in
22 discharging her from the emergency department with an
23 undiagnosed non displaced fracture?

24 MR. SIKOSCOW: Objection.

25 THE COURT: Again, it's assuming there was a

1 non displaced fracture there.

2 A Yes. Assuming there was a non displaced fracture,
3 it was a deviation by Dr. Fazio to not order the CT or MRI
4 because the CT or MRI overwhelmingly would have found the
5 fracture.

6 And, once the fracture was found, Miss Killian
7 should never had been discharged from the emergency
8 department. An orthopedic consult should have been obtained
9 at that time.

10 Q Doctor, is the answer you just gave a basis for
11 saying that the deviation on the part of Dr. Fazio was, in
12 fact, a substantial factor in discharging Miss Killian with
13 an undiagnosed femoral neck fracture assuming she had one?

14 MR. SIKOSCOW: Objection to form.

15 THE COURT: Overruled.

16 A Yes, it was. And the reason is because the CT or
17 MRI would have found the fracture and that would have
18 prevented Dr. Fazio as a standard of care from discharging
19 Miss Killian.

20 Q I want you to assume that Dr. Fazio choose not to
21 order an MRI or CAT scan, in these particular circumstances
22 in your opinion did the standard of care then require that
23 Dr. Fazio obtain an orthopedic consult before discharging
24 Miss Killian?

25 A Yes.

1 Q What's the basis of your answer?

2 A The basis of my answer is how Miss Killian
3 presented. She presented with a mechanism of injury of a
4 fall.

5 She had pain in her hip. Both complaining about
6 pain in her hip ten out of ten initially and five out of ten
7 in the emergency department and she had pain when she was
8 ranging her hip.

9 If Dr. Fazio decided not to order the standard of
10 care MRI or CT Scan, then an orthopedic consult was mandatory
11 to determine whether, in fact, Miss Killian had an occult
12 fracture. And, it has been my experience in years of
13 practice what the orthopedic surgeon will do --

14 MR. SIKOSCOW: Objection.

15 THE COURT: Overruled.

16 A -- he will order a CT Scan or MRI based on the
17 presentation that Miss Killian had.

18 Q In these circumstances, Doctor, in your opinion was
19 Dr. Fazio's failure to obtain an orthopedic consult before
20 discharge a deviation from accepted standard of care was it
21 unreasonable and imprudent?

22 A Yes, it was.

23 Q Is the basis of your answer what you just said a
24 moment ago?

25 A Yes, exactly, that is this presentation is an

1 impacted fracture until proven otherwise. The imaging that
2 was done the plain films, were not adequate to rule it out
3 based on the complaints clearly documented in the chart.

4 Miss Killian had, until proven otherwise, a non
5 displaced fracture of the right femoral neck and that needed
6 to be diagnosed prior to her having a decision to be
7 discharged. Because, once it was diagnosed, she would never
8 have been discharged.

9 Q And, Doctor, assuming there was a non displaced
10 fracture of the femoral neck while Miss Killian was in the
11 emergency department on March 3rd, in your opinion was Dr.
12 Fazio's failure to obtain an orthopedic consult before
13 discharge a substantial factor in discharging Miss Killian
14 with an undiagnosed non displaced femoral neck fracture?

15 A Yes.

16 Q What is the basis of your opinion?

17 A The basis of the opinion is, again, as we talked
18 about Miss Killian had a mechanism of injury, symptoms and
19 signs of a non displaced hip fracture. And, had an
20 orthopedic surgeon been called, he would have or she would
21 have ordered an MRI and/or CT Scan of the hip and
22 overwhelmingly that would have diagnosed the impacted femoral
23 neck fracture.

24 Q And, Doctor, have you reviewed the March 3rd
25 x-rays in total?

1 A Yes.

2 Q Have you reviewed the March 3rd hip x-rays from
3 Richmond?

4 A Yes.

5 Q And, Doctor, in your opinion what is the emergency
6 medicine standard of care and reasonable and prudent
7 interpretation of the March 3rd hip x-rays?

8 MR. SIKOSCOW: Objection cumulative.

9 THE COURT: Overruled.

10 A The March 3rd hip x-rays were not normal. There
11 was an abnormality in the femoral neck of that right hip and
12 that required further imaging to see if that abnormality was,
13 in fact, an impacted hip fracture.

14 Q Doctor, if I show you -- I know I've shown you this
15 before, but if I show you Plaintiff's Exhibit 8 which is the
16 blowup and ask -- may I approach, your Honor?

17 THE COURT: Yes.

18 Q -- and ask you whether the line between the two Xs'
19 is the abnormality and/or anomaly you just testified to?

20 A Correct, that's an abnormality --

21 MR. SIKOSCOW: Objection.

22 THE COURT: Overruled.

23 A -- in the femoral neck, the right hip. And, given
24 the mechanism of injury and given the complaints that
25 Miss Killian had and given the findings of pain when she

1 ranged her hip, it is suggestive of an impacted hip fracture.

2 And, the standard of care requires you move to the
3 next imaging level to prove that she had the hip fracture or
4 to effectively rule it out. An that imaging is either a CT
5 Scan of the hip or an MRI.

6 Q Doctor, when you looked at hip x-rays to evaluate
7 them, did you look at the x-rays in isolation or did you look
8 at the x-rays taking into account the entire clinical
9 presentation and information that was available to Dr. Fazio
10 from the time Miss Killian fell and landed on her right hip
11 on March 3rd until her discharge?

12 A The standard of care is that you take into account
13 when you're interpreting x-rays the clinical condition of the
14 patient. That is the mechanism of injury that occurred, that
15 is the forces that occurred, where those forces occurred
16 which is to the right hip, you take into account the age of
17 the patient and you take into account the complaints that the
18 patient is having and you take into account the physical
19 findings that you've elicited in your physical exam.

20 And, then you look at the x-rays because clinically
21 when she came in she had a hip fracture until proven
22 otherwise. And then when you look at that x-ray that is not
23 a normal x-ray and you need to proceed to the next study.
24 And the next study is a CT Scan or MRI as a standard of care.

25 Q And, Doctor, is your interpretation of an x-ray an

1 interpretation made within the specialty of emergency
2 medicine looking at the films and looking at the picture as a
3 whole as the patient was in the emergency department under
4 Dr. Fazio's care?

5 A Yes.

6 Q In your opinion, did Dr. Fazio deviate from
7 accepted standards of care in his reading of the x-ray and,
8 in particular, failing to recognize the abnormally or anomaly
9 that you described?

10 A Yes, he did.

11 Q In your opinion had the correct finding been made,
12 the standard of care finding been made as you testified
13 should have been done, what would the standard of care then
14 require if anything?

15 A The standard of care would have required that you
16 proceed to the next imaging study which is either a CT Scan
17 or MRI which would better delineate what that abnormality is.

18 And, given the clinical presentation, it's an
19 impacted femoral neck fracture until proven otherwise. And
20 the CT or the MRI would have proven that it was impacted
21 fracture of the right femoral neck.

22 Q And if Dr. Fazio had made the finding as testified
23 to by you and decided not do a CAT scan or MRI, would the
24 standard of care then require that before discharging
25 Miss Killian he get an orthopedic consult?

1 A That's correct. If he made the decision not to
2 image the case, not to image Miss Killian's hip with CT or
3 MRI and the standard of care required that he get an
4 orthopedist because the orthopedist would of looked at this
5 film and would have said an MRI or CT Scan was required.

6 Q Assuming that Miss Killian had a non displaced
7 fracture of the femoral neck on the right side on
8 March 3rd, was Dr. Fazio's failure to recognize the
9 abnormality you testified to a substantial factor in
10 Miss Killian leaving the emergency department with an
11 undiagnosed non displaced fracture of the femoral neck?

12 A Yes, it was.

13 Q Please tell us the basis.

14 A The basis of this is given her history, given the
15 fact that this is not a normal x-ray, that there is an
16 abnormality, there's that line there which is abnormal, the
17 standard of care given the mechanism of injury, the pain that
18 she had and the physical findings was that this is an
19 impacted femoral neck fracture until proven otherwise.

20 And given that abnormality, the standard of care
21 required as you go to the next step which is a CT Scan of the
22 hip or an MRI and that's the standard of care.

23 And, overwhelmingly, that would have diagnosed the
24 impacted femoral neck fracture and would have prompted of the
25 admission of an orthopedic consultation and surgical repair.

1 Q Doctor, let's assume that the x-rays of the hip
2 done on 3rd are completely totally absolutely normal, can you
3 make that assumption?

4 A Yes.

5 Q Under that assumption, did the standard of care
6 allow Dr. Fazio to discharge Miss Killian without a CAT scan,
7 an MRI or an orthopedic consult?

8 A No.

9 Q Why not.

10 A The reason is plain films are simply not sensitive
11 enough, it will miss too many of these impacted fractures,
12 between 10 and 20 percent.

13 So that if you have this set of physical findings,
14 this mechanism of injury, that is, that Miss Killian falls,
15 she has ten out of ten hip pain, she comes to the emergency
16 department, she continues to have pain, she has pain when she
17 ranges motion of her hip, given that set of circumstances
18 this is an impacted femoral neck fracture until proven
19 otherwise.

20 Even a totally, totally normal x-ray is simply
21 insensitive enough that you are required to then move to the
22 next study.

23 If you have a fracture on plain films you're done,
24 you have a fracture, you call orthopedics.

25 But, if you don't have a fracture a normal film in

1 this setting is simply a non diagnostic film. It does not
2 allow you to say she does not have a fracture and that's why
3 we do CT scans and MRIs or call orthopedics and the
4 orthopedist will tell us to do those.

5 Q Doctor, in looking at the totality of the
6 circumstances in this case from Miss Killian's fall on
7 March 3rd and landing directly on her right hip up through
8 the emergency department care at Richmond and then the
9 presentation and diagnosis on March 16 of a displaced
10 fracture of the femoral neck, in your opinion to a reasonable
11 degree of medical certainty do you have an opinion one way or
12 the other whether Miss Killian left the emergency department
13 on March 3rd with a non displaced fracture which then
14 displaced?

15 MR. SIKOSCOW: Objection cumulative.

16 THE COURT: Overruled, you can answer that.

17 A Yes, I do have an opinion.

18 Q What is your opinion?

19 A My opinion is that she had the non displaced
20 fracture when she was treated on March 3rd as a result of
21 the fall on ice. And, the physical findings that were there
22 and the x-ray findings and that that non displaced fracture
23 when she was discharged, was discharged in an unstable
24 condition and as a result of the forces that occurred from
25 the 3rd to the 13th, that impacted fracture became a complete

1 fracture where there was no longer alignment and it was a
2 complete disrupted fracture of her right femoral neck.

3 Q You said the 13th, did you mean to say the 16th?

4 A I'm sorry the 16th.

5 Q Doctor, last topic.

6 Would you please talk about custom and practice and
7 standard of care as it relates to instructions to patients to
8 follow-up with doctors once they leave the emergency
9 department?

10 A Certainly. In emergency medicine we discharge our
11 patients with the expectation is, in general, we wouldn't see
12 them again, someone else will see them. So, we tell them to
13 have follow-up with their primary care doctor.

14 Many of the patients that we have, often don't have
15 a primary care doctor so we provide them with an opportunity
16 to follow-up in one of our clinics.

17 In those patients who are being discharged with a
18 specialty problem, we give them a referral to the specialist;
19 so it may be to a cardiologist or an orthopedist or to a
20 general surgeon. But, in fact, we need to provide some
21 further care after the episodic care that we provided in the
22 emergency department.

23 And it is our hope that those patients will follow
24 our recommendations. And we are available to them to explain
25 to them why we want this to happen. And we tell the patients

1 if you worsen, you can always come back to the emergency
2 department, we're open 24/7.

3 Q And in the documentation that you saw with regard
4 specifically to Miss Killian, was there instructions in those
5 documents about following up?

6 A Yes, there was.

7 Q Would you prefer as the emergency department
8 physician that patient follow-up?

9 A Absolutely.

10 Q Is it known in emergency medicine that sometimes
11 patients don't follow-up? I think the expression, correct me
12 if I'm wrong, is lost to follow-up?

13 A That's correct.

14 Q What does that mean?

15 A That means that our plan was for the patient to be
16 seen at a certain time, either they had a clinic appointment
17 or was supposed to call for a clinic appointment and for
18 whatever the reason is, the patient decided not to follow our
19 advice and so the patient becomes lost to follow-up.

20 Q And, Doctor, if it can be done under the standard
21 of care, if it can be done, with reason and prudence with the
22 everyday tools available, would the goal be, would it be to
23 always make the diagnosis of a fracture in the emergency
24 department rather than leave it to an outside doctor?

25 A Absolutely.

1 Q Why is that?

2 A Because you want to be able to align the fracture
3 and stabilize the fracture.

4 If you have a fracture, a fracture means that
5 there's a break in the bone. And, if the fracture is in an
6 area which is unstable such as an impacted femoral neck
7 fracture, what can happen if you don't effectively diagnosis
8 it in a timely manner, that impacted and aligned fracture can
9 now become a dis-aligned fracture and the treatment becomes
10 much more difficulty.

11 MR. SIMONSON: Thank you, very much.

12 THE WITNESS: You're welcome.

13 THE COURT: Cross-examination.

14 MR. SIKOSCOW: Thank you, your Honor.

15 CROSS-EXAMINATION

16 BY MR. SIKOSCOW:

17 Q Good afternoon, Dr. Schechter, how are you?

18 A Very well. Good afternoon.

19 Q My name is Alex Sikoscow. I represent Dr. Fazio.

20 A Very nice to meet you.

21 Q You and I have never met, true?

22 A That's true.

23 Q Just some background questions first.

24 When were you first contacted regarding this
25 matter?

1 A I believe in 2016.

2 Q The file in front of you, what is that?

3 A That's the file of the medical records and a copy
4 of my C.V. and a list of the items that I reviewed.

5 MR. SIKOSCOW: Can we marked as an exhibit for
6 identification, your Honor?

7 MR. SIMONSON: No objection, your Honor.

8 THE COURT: Okay. What are we up to?

9 Members of the jury, the C.V. is just a fancy
10 Latin term, curriculum vitae, all it means is your
11 resume.

12 This will be Defendant's A for identification
13 only. It's being marked for I.D. only, Defendant's D.

14 (Whereupon, the above-referenced item was so
15 marked Defendant's D for identification at this time.)

16 MR. SIKOSCOW: May I, your Honor?

17 THE COURT: Yes, sir, thank you.

18 Q Who initially contacted you, Doctor?

19 A Somebody from Mr. Simonson's office, I don't know
20 if it was Mr. Simonson himself or someone else from his
21 office.

22 Q Your practice, is it not, to get a summary of the
23 case over the phone before you agree to review it?

24 A Yes, I'll ask what the case is about.

25 Q In this case you would of learned the basic

1 allegations?

2 A Yes.

3 Q Including failure -- alleged failure to diagnose a
4 femoral neck fracture?

5 A Correct.

6 Q You learn that during your first contact between
7 Mr. Simonson's office and yourself over the phone, true?

8 A In general, yes.

9 Q So we can agree before you review the file or
10 x-rays in this case, you understood what the claims were
11 true?

12 A Yes.

13 Q You understood March 16, 2014, Miss Killian was
14 diagnosed with a displaced femoral neck fracture?

15 A Correct.

16 Q We can agree that Dr. Fazio didn't have that
17 information when he reviewed the films on March 3rd, true?

18 A Correct.

19 Q Now generally speaking, Doctor Schechter,
20 Miss Killian's presentation was what doctors call status post
21 fall, correct?

22 A Correct.

23 Q And she came in complaining of right hip and leg
24 pain, correct?

25 A Correct.

1 Q And that's not uncommon -- or you can say in the
2 affirmative, it's a common presentation to the emergency
3 department, true?

4 A True.

5 Q And almost all patients who present in that way
6 status post fall at least have some degree of discomfort or
7 pain or else they wouldn't go to the emergency department,
8 true?

9 A True.

10 Q And not every patient who presents status post fall
11 complaining of right hip and leg pain has a fracture, true?

12 A True.

13 Q And not every patient who presents status post fall
14 with right hip and leg pain gets necessarily an orthopedic
15 consult, true?

16 A True.

17 Q They don't necessarily get a CT or MRI, true?

18 A True.

19 Q And it's the emergency physician's job, at least in
20 part, to evaluate the patient that comes to the emergency
21 department status post fall with right leg and hip pain,
22 true?

23 A True.

24 Q And use everything that doctor learns during the
25 evaluation and decides using the physician's best medical

1 judgment how to best treat the patient, true?

2 A True.

3 Q Using medical judgment whether the patient requires
4 emergent care, true?

5 A It depends on the circumstances when you use
6 medical judgment. There are certain things that are
7 standards and there are other things which fall into medical
8 judgments.

9 Q Every cases --

10 THE COURT: Let him finish his answer, okay.

11 Finish your answer.

12 A There are certain things in which medical judgment
13 examines comes in and there are other things in which the
14 standard is clearly there and that you have to proceed with
15 the standard.

16 THE COURT: What's the difference, Doctor, you
17 know, medical judgment and standard, aren't they one and
18 the same?

19 THE DEFENDANT: No.

20 THE COURT: Please explain.

21 THE DEFENDANT: In medical judgment it means
22 that there may be multiple different choices that all of
23 which would be acceptable.

24 The standard of care is the standard that a
25 similarly trained physician given a similar patient is

1 required to do.

2 So, in this case, it can be judgment about
3 whether you're going to do an MRI or a CT Scan, but the
4 standard of care requires you do one of those advanced
5 images.

6 MR. SIKOSCOW: May I, your Honor?

7 THE COURT: Yes, sir.

8 Q Every patient is different right, Doctor?

9 A Correct.

10 Q Let's talk about pain.

11 Patients come in with varying degrees of pain to
12 the emergency department, true?

13 A True.

14 Q Physician talks to the patient, asks the patient
15 how he or she feels, true?

16 A That's true.

17 Q Performs the physical examination in an effort to
18 get more information about the pain, true?

19 A That's true.

20 Q And, in fact, from the first moment the physician
21 lays eyes on the patient just by observing the patient, just
22 getting information about the patient, what pain that patient
23 may or may not be in, true?

24 A Correct.

25 Q And the physician may perform a physical

1 examination on the patient and then ask how the patient is
2 feeling during that particular aspect of the examination,
3 true?

4 A That is true.

5 Q And the physician takes all this information with
6 respect to pain and makes a judgment does he or she not about
7 the level of the patient's comfort, discomfort or pain, true
8 not true or you can't answer?

9 A It can't be answered as a simple yes or no; he
10 makes a determination.

11 Q I'm going to do my best just so we move along to
12 ask my questions in a way that can be answered yes or no.

13 I ask that you do that unless you feel you can't
14 answer it in that way, you just let me know, okay?

15 A I will.

16 Q You've been given that instruction before, true?

17 A Absolutely.

18 Q Now you mentioned on question from Mr. Simonson
19 emergency medicine physician has to use everything he or she
20 learns about a patient during the evaluation and make a
21 decision whether or not to admit the patient, true?

22 A True.

23 Q Discharge the patient, true?

24 A True.

25 Q And those decisions are made based upon many bits

1 of data that the physician elicits, obtains, during the
2 emergency department stay, true?

3 A True.

4 Q And these are doctors that are trained to analyze
5 all those pieces of data in order to make those ultimate
6 decisions about discharge or admission, true?

7 A That's true.

8 Q And doctors are trained to utilize judgment in
9 analyzing those pieces of data, true?

10 A True.

11 Q Now, in the emergency department, there's what you
12 would call a team of health care providers, true?

13 A Yes.

14 Q Every patient gets at least one nurse assigned
15 along with an emergency attending when they register into the
16 emergency department, true?

17 A That's correct.

18 Q And some emergency departments may have other
19 specialists like P.A.s or nurse practitioners from time to
20 time, correct?

21 A That's correct.

22 Q And all of those health care providers have certain
23 roles they fulfill, true?

24 A True.

25 THE COURT: I need the doctor to explain to all

1 of us the distinction between a P.A, physician assistant,
2 and a nurse; if you could tell us the distinction as well
3 as the educational distinction?

4 THE WITNESS: Certainly.

5 So nurses work along with physicians and in
6 caring for patients and we work as a team.

7 Physician assistants sometimes fall into a
8 category called physician extenders. That is, they have
9 medical training from college and then they get training
10 in one of their sites in the hospital and they treat
11 patients.

12 In New York State they are not independent
13 practitioners, that is, they're always supervised by a
14 physician so they present cases to the emergency
15 department attending.

16 Depending on the rules of the hospital and the
17 location of the treatment area, some hospitals will have
18 physician assistants see the ambulatory patients, what we
19 call our fast track patients. And then they're
20 supervised afterwards, they're expected to ask if they
21 have a question with respect to go to the supervising
22 attending whose seeing his own more acute patients.

23 And then those treatments provided by the
24 physician's assistants are reviewed and they may be
25 reviewed after the patient is discharged and the

1 attending physician reviews the note and makes a
2 determination whether the standard of care was met and
3 signs off on the case.

4 If there's a concern, which occasionally
5 happens, then they will call -- the attending will have
6 the attending called back for further evaluation.

7 We now have what's called nurse practitioners.
8 Nurse practitioners have in many hospitals very similar
9 roles to physician's assistants although they were
10 trained as nurses first, then get additional clinical
11 training.

12 And, in New York State, it is my understanding
13 that they have the ability to be what's call independent
14 practitioners. They can have an affiliation with
15 physicians but they can, in fact, run a primary care
16 site. And, so all of those different people are members
17 of the health care team.

18 THE COURT: Can they give scripts, which one
19 can write out a prescription?

20 THE WITNESS: Okay.

21 So in nurse practitioners can write scripts;
22 physician's assistants can write scripts but I do not
23 believe they are able to write opioid scripts any more, I
24 don't know if they ever were.

25 In any event, if it ever comes to where that's

1 happens, an attending will write that script because they
2 want to go over the patient before we would ever
3 discharge a patient on narcotics. But, routine scripts,
4 they can write.

5 Additionally, in the hospital they are now an
6 integral part of the in-patient teams; so they're going
7 to be cardiothoracic P.A.s; vascular P.A.s, there are
8 going to be E.N.T. P.A.s and they function quite
9 independently though supervised by an attending and they
10 have a role analogous to a very senior resident on the
11 team.

12 THE COURT: Thank you, Doctor.

13 Q Let's talk about registered nurses, okay.

14 Registered nurses are individuals who are licensed
15 by the State of New York, correct?

16 A That is correct.

17 Q And they serve an important part in the emergency
18 department you would agree, right?

19 A Absolutely.

20 Q And they routinely assess vital signs, true?

21 A True.

22 Q They take patient histories, true?

23 A True.

24 Q They perform physical examinations on patients,
25 true?

1 A That's true.

2 Q They can listen to a patient's heart, lungs or
3 touch their abdomen to see how distended or not, things that?

4 A True.

5 Q They administer medications, right?

6 A That's true.

7 Q And doctors rely on nurses to do those types of
8 things on a daily basis, true?

9 A That's true.

10 Q Now one of the other things nurses do on a routine
11 basis, they do what is called fall risk assessments, true?

12 A True.

13 Q Meaning every patients that's either admitted to a
14 hospital or seen in an emergency department evaluated by a
15 nurse very soon after they're arrival to assess whether or
16 not that patient is at risk for falling, true?

17 A That is true.

18 Q And what those nurses are trained to do, by the
19 way -- withdrawn.

20 Performing a fall risk assessment is something that
21 nurses, registered nurses, almost exclusively do?

22 A That's correct.

23 Q They're trained to do that?

24 A That's correct.

25 Q And they're trained to ask the patient questions

1 about their medical history which may impact whether or not
2 they're at risk, the patient at is risks for falling, true?

3 A That's correct.

4 Q They're trained to physically examine the patient,
5 to determine whether or not they're at risk for falling,
6 true?

7 A True.

8 Q They're during their fall risk assessment --
9 withdrawn.

10 During a registered nurse's fall risk assessment,
11 they will assess the patient physically to determine whether
12 or not they're steady on their feet or not, true?

13 A That's true.

14 Q And based upon the registered nurse's fall risk
15 assessment, the registered nurse will then recommend or
16 implement appropriate fall precautions for that particular
17 patient, given that patient's particular fall risk, true?

18 A True.

19 Q Everyday in hospitals all over this State nurses
20 assess patients that are in a hospital to determine whether
21 or not they can safely go from their bed to the bathroom in
22 their rooms, correct?

23 A That's true.

24 Q They watch a patient walk to see whether or not
25 it's safe for that patient to transfer from the bed to the

1 bathroom in their respective hospital rooms, true?

2 A True.

3 Q They're trained to determine whether or not a
4 patient is unsteady on their feet, true?

5 A True.

6 Q They're trained to ask questions to a patient to
7 elicit whether or not that patient has any discomfort, pain
8 or difficulty while they're walking, true?

9 A True.

10 Q A nurse as well as a doctor can ask a patient while
11 they're walking how does it feel, true?

12 A True.

13 Q And they can equally with equal efficacy --
14 withdrawn.

15 They can with equal aptitude document whether or
16 not a patient reports any complaint or concern while they're
17 walking, true?

18 A What do you mean by aptitude.

19 Q A nurse and a doctor can equally ask a patient how
20 does it feel, how do you feel walking, right?

21 A Yes.

22 Q And they can with equal ability take whatever the
23 patient says to them and write it down on a piece of paper,
24 true?

25 A Yes.

1 Q I'm going to go back just before we break for
2 lunch, you mentioned the materials that were provided to you
3 by Mr. Simonson's office?

4 THE COURT: Okay, this is a perfect break.
5 We're going back now. We're going back.

6 So when we come back, we will go back, okay.

7 Everyone we'll take our lunch recess. Please
8 continue to keep an open mind. Do not talk about the
9 case. Stay off of those Smart Phones. Kind of scary you
10 can Google everything now. And, please be back in your
11 jury room at 2:10, we will begin promptly at 2:15.

12 (Whereupon, the jury left the courtroom at this
13 time.)

14 THE COURT: Counselors, if you need the
15 conference, I will make sure it's open for you.

16 (Whereupon, the luncheon recess was taken at
17 this time.)

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1 * * * * *

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

3 * * * * *

4 THE CLERK: Case on trial continued.

5 COURT OFFICER: Your Honor, are you ready for the
6 jury?

7 THE COURT: Yes.

8 COURT OFFICER: Jury entering.

9 (Whereupon, the jury enters the courtroom.)

10 THE COURT: Welcome back, everyone.

11 Everyone can be seated.

12 THE CLERK: The jury is present and properly
13 seated.

14 Do both sides stipulate?

15 MR. SIMONSON: Yes, on behalf of the plaintiff.

16 MR. SIKOSCOW: Yes.

17 THE COURT: Doctor?

18 (Whereupon, the witness resumes the witness
19 stand.)

20 THE CLERK: Doctor, please be reminded you are
21 still under oath.

22 THE WITNESS: Yes.

23 MR. SIKOSCOW: May I, Your Honor?

24 THE COURT: Yes.

25 MR. SIKOSCOW: Thank you.

1 CROSS-EXAMINATION (Continued)

2 BY MR. SIKOSCOW:

3 Q Dr. Schechter, we left off talking about the EBT
4 transcripts.

5 A Yes.

6 Q Deposition transcripts you were provided to review.

7 A Yes.

8 Q Was one of those transcripts the deposition of a Nurse
9 Kruglyak, K-R-U-G-L-Y-A-K?

10 A Yes.

11 Q You read it?

12 A I did.

13 Q You learned that Ms. Kruglyak is a Registered Nurse,
14 true?

15 A That is correct.

16 Q She's working in the emergency department at RUMC as
17 well as the emergency department at Lincoln Hospital in the
18 Bronx, true?

19 A I'm -- I don't remember it word for word, but I'm gonna
20 accept what you say. It sounds right.

21 Q Is there any reason to doubt that she wasn't an
22 appropriately trained Registered Nurse?

23 A No.

24 Q And you learned, did you not, from your review of the
25 materials, that she had Ms. Killian walk approximately 100

1 feet, 50 feet away from her and 50 feet back towards her before
2 discharge, true?

3 A Correct.

4 Q And you learned that to Ms. Kruglyak's observation
5 she -- Ms. Killian had a steady gate, true?

6 MR. SIMONSON: Your Honor, we don't have the
7 witness here and we haven't read the deposition, so I think
8 it's going to have to be asked in the form of a hypothetical
9 assuming.

10 THE COURT: Overruled.

11 MR. SIMONSON: Thank you.

12 Q You can answer that question.

13 A I'm sorry, just repeat it one more time. I'm sorry.

14 Q Yeah.

15 You learned from your review of the materials that
16 Nurse Kruglyak observed Ms. Killian having a steady gate, true?

17 A That's true.

18 Q And there's documentation in the Richmond University
19 Medical Center record corresponding to Nurse Kruglyak's
20 observation of Ms. Killian walking prior to her departure from
21 the hospital, true?

22 A That is true.

23 Q And Nurse Kruglyak documented, "No questions or
24 concerns," comma, "steady gate," true?

25 A That is correct.

1 Q Now, steady gate is something very different than
2 someone not being able to walk without holding onto something;
3 would you agree?

4 A Yes.

5 Q You have not received Ms. Killian's testimony from
6 yesterday.

7 A I have not.

8 Q I want you to assume she testified that she couldn't
9 remember one way or the other whether or not she walked at all
10 in the emergency department, but as soon as she got home in the
11 car, she had to hold onto something in order to ambulate, to
12 walk, okay?

13 Can you assume that?

14 A I am assuming that.

15 Q And can you assume that to be true? That's
16 Ms. Killian's recollection.

17 Would you agree that if a nurse observed her holding
18 onto something while walking, that a nurse would be able to
19 determine that that's not a steady gate?

20 A She should determine that that's not a steady gate.

21 Q That would be within reason to expect a nurse to
22 perceive that, true?

23 A True.

24 Q In fact, if a person couldn't walk without holding onto
25 something, it wouldn't make a difference whether a doctor or a

1 nurse was the one observing the gate, true?

2 A True.

3 Q Now, emergency medical technicians or first responders,
4 they're also individuals that have a certain type of training,
5 correct?

6 A Correct.

7 Q And we've seen this already during this trial, but the
8 first responders, the Emergency Medical Technicians that
9 responded to the scene of Ms. Killian's fall on March 3rd
10 created a record, true?

11 A That's true.

12 Q You reviewed that, right?

13 A I did.

14 Q And they documented -- you would agree that they
15 documented their observations as accurately as possible, true?

16 A True.

17 Q You have no reason to believe otherwise, right?

18 A That's correct.

19 Q And they documented, as we know, 10 out of 10 pain,
20 true?

21 A That's true.

22 Q And we agree, do we not, that that's a subjective pain
23 score, correct?

24 A That's true.

25 Q It's just a piece of information that goes into the

1 mixer, so to speak, for a physician to make, ultimately, a
2 judgment about the patient's pain, true?

3 A True.

4 Q One of the other things a physician will do to asses
5 pain is to look at the patient's demeanor, whether there's any
6 outward signs of pain, true?

7 A That's correct.

8 Q If a patient is able to speak, able to speak
9 coherently, that would go into the equation as well in judging
10 a person's pain, true?

11 A That's true.

12 Q Whether a patient is able to stand or whether they're
13 able to walk is also something that would factor into the
14 equation of what of the patient's pain level, true?

15 A True.

16 Q Now, the EMTs documented, as we've seen, that the
17 patient was ambulatory, true?

18 A That's correct.

19 Q Meaning, to their observation, Ms. Killian was able to
20 walk at the scene, true?

21 A That's correct.

22 Q They also documented PMS times 4, true?

23 A That's correct.

24 Q And that means what, Doctor?

25 A It means pulse, motor and sensory for the four

1 extremities.

2 Q Pulse, motor and sensory or pulse, motor and strength?

3 A I believe it's sensory.

4 Q Motor being...?

5 A Motor is the strength, that's the movement part.

6 Sensory is, "Do you feel me touching you?"

7 Q And times 4 means all four extremities, meaning both
8 arms and both legs, true?

9 A That's correct.

10 Q So, to the EMTs observation, Ms. Killian had intact
11 motor ability, true?

12 A True.

13 Q To her right leg, true?

14 A True.

15 Q And the EMTs report pertinent findings that they make
16 to the triage nurse when they arrive at the hospital, true?

17 A True.

18 Q And the triage nurse then documents in the medical
19 record at the hospital what the EMTs impart to him or her,
20 correct?

21 A That's correct.

22 Q And we know the triage nurse in this case was a nurse
23 by the name of Nurse Triollo, T-R-I-O-L-L-O.

24 A Correct.

25 Q And we know that Nurse Triollo documented in her triage

1 note that the patient was brought in by ambulance, true?

2 A That's correct.

3 Q Status, post slip and fall, true?

4 A That's correct.

5 Q No loss of consciousness, right?

6 A That's correct.

7 Q Complaint of pain to the right hip and leg, right?

8 A Correct.

9 Q And ambulatory at the scene, true?

10 A Correct.

11 Q And those are pieces of information that the EMT
12 provided to Nurse Triollo, correct?

13 A That's correct.

14 Q And she documented them because they're important
15 pieces of clinical information, correct?

16 A Correct.

17 Q Important for the triage nurse, as well as, eventually,
18 the emergency medicine physician who evaluates the patient,
19 true?

20 A True.

21 Q They speak to the mechanism of injury, true?

22 A True.

23 Q "No loss of consciousness" means there's relatively a
24 lesser likelihood of a head injury, true?

25 A True.

1 Q And "Ambulatory at scene" speaks to the patient's lower
2 extremity status, true?

3 A Correct.

4 Q It speaks to other things as well, but it speaks to her
5 ability to move her legs, true?

6 A True.

7 Q It speaks to her ability to coordinate her upper area
8 and lower portions of her body, true?

9 A True.

10 Q And you would agree, Doctor, or would you not, that
11 being able to walk is an important piece of information in
12 assessing for a potential fracture?

13 A Yes.

14 Q And the first of information that was made known to
15 Nurse Triollo and subsequently Dr. Fazio was that Ms. Killian
16 was able to walk, true?

17 A Correct.

18 Q And one of the reasons the ability to walk is a
19 significant piece of information is because of the stress it
20 places on the hip joint itself, correct?

21 A Correct.

22 Q Not only the person's body weight, but all of the
23 muscles that are pushing and pulling on the hip multiply the
24 force on the hip.

25 A Yes.

1 Q And we know when Ms. Killian arrived at triage she
2 endorsed a pain scale of 5 out of 10, correct?

3 A That's correct.

4 Q With no pain medication between the 10 out of 10 and
5 the 5 out of 10, true?

6 A Correct.

7 Q We can agree she never got pain medication at any point
8 in time before being discharged from the emergency department,
9 correct?

10 A That's correct.

11 Q Her vital signs at triage were within normal limit,
12 true?

13 A True.

14 Q A person with significant pain may be expected to have
15 an increased respiratory rate?

16 A They may.

17 Q They may have an increased pulse?

18 A They may.

19 Q Before I get to Dr. Fazio's involvement, Doctor, just
20 generally, because I don't think we really had too much anatomy
21 above the bones and the joint capsule of the hip.

22 A Okay.

23 Q Okay?

24 But we obviously have what we all know now to be the
25 femur, the femoral neck, the femoral head, which is the ball

1 that sits in the socket which is called the acetabulum.

2 A Acetabulum.

3 Q Correct?

4 A Yes.

5 Q And there is a joint capsule around the femoral neck
6 and femoral head, correct?

7 A Correct.

8 Q It's made up of ligaments?

9 A Correct.

10 Q And those are soft tissue?

11 A Those are soft tissue.

12 Q And around that same area there are tendons --

13 A Yes.

14 Q -- which attach bone to muscle, correct?

15 A Correct.

16 Q And, obviously, there's muscle, many muscles that
17 involve the hip in some way, shape or form, true?

18 A That's correct.

19 Q Dr. Fazio saw the patient at approximately 4:19 p.m.,
20 correct?

21 A That's correct.

22 Q Thereabouts, right?

23 A That's correct.

24 Q And that was timely, correct?

25 A Yes, it was.

1 Q And his note contains information from the triage note,
2 correct?

3 A That is correct.

4 Q And it was appropriate for him to consider that
5 information from triage, true?

6 A Yes.

7 Q And he then takes a history from Ms. Killian, correct?

8 A Correct.

9 Q And he finds out some more information through
10 questioning her, including the fact that she landed on her
11 elbow and right hip, true?

12 A That's correct.

13 Q That hadn't been documented previously anywhere,
14 correct?

15 A That's correct.

16 Q And then he asks her questions about her pain level,
17 true?

18 A True.

19 Q He documents that she complains of discomfort to her
20 right lower extremity, true?

21 A That's correct.

22 Q And that would have been information he discerned or
23 distilled from whatever Ms. Killian told him about her pain,
24 right?

25 A And the history that was obtained from -- that is --

1 the note from the prehospital providers and from triage.

2 Q He chose the word "discomfort," true?

3 A True.

4 Q He didn't say "pain," correct?

5 A That's correct.

6 Q You're saying that his use of "discomfort" incorporated
7 the prehospital care information.

8 What's the basis for that?

9 A I'm saying his note -- you said it. His note
10 incorporated prehospital care information.

11 Q My question wasn't clear perhaps.

12 He took a history from Ms. Killian, true?

13 A Yes.

14 Q He asked her how she was feeling, in sum and substance,
15 true?

16 A True.

17 Q And whatever she said to him, he recorded it as
18 "discomfort," right?

19 A True.

20 Q He didn't use the word "pain," true?

21 A True.

22 Q Pain, especially significant pain, from your
23 experience, Doctor, is not something patients, especially
24 patients like Ms. Killian with no difficulty communicating,
25 don't have any difficulty conveying to a doctor, right?

1 A Patients will complain of pain.

2 I'm actually not totally sure what you're asking.

3 Q Sure.

4 The patient's in significant pain. It's usually not
5 difficult for them to convey that to a doctor, right?

6 A In general, yes, that's correct.

7 Q And Dr. Fazio's discussion with Ms. Killian about the
8 level of her pain was all appropriate, true.

9 A True.

10 Q And it's more information to -- it's more information
11 for him to ultimately asses the level of her pain, true?

12 A True.

13 Q They performed a physical examination of her, right?

14 A That's correct.

15 Q It wasn't just focused entirely on the hip; it involved
16 the head, the neck, the chest and other areas appropriately so,
17 true?

18 A That's true, yes.

19 Q Now, he found no pelvic tenderness, true?

20 A Correct.

21 Q And that's consistent with someone who doesn't have a
22 fracture, true?

23 A Doesn't have a fracture of the pelvis.

24 Q Of the pelvis?

25 A Correct.

1 Q Or the hip?

2 A You can have hip -- you can have a hip fracture without
3 pelvic discomfort on palpation.

4 Q My question is, negative pelvic tenderness is
5 consistent with someone who doesn't have a hip fracture, true?

6 A True.

7 Q He then, as we've touched on already, assessed range of
8 motion, true?

9 A True.

10 Q And he documented "Some discomfort on range of motion,"
11 accurate?

12 A That's accurate.

13 Q And, again, that would be a descriptor of whatever
14 Ms. Killian is telling Dr. Fazio she's feeling during the act
15 of the range of motion, true?

16 A True.

17 Q Again, he didn't use the word "pain," true?

18 A True.

19 Q He used the word "discomfort," true?

20 A True.

21 Q And he qualified it further with some discomfort,
22 right?

23 MR. SIMONSON: I think some pain, Your Honor, was
24 his testimony.

25 THE COURT: Okay, use the term "pain," whatever is

1 in the record that's admitted into evidence.

2 MR. SIMONSON: The chart, Your Honor.

3 THE COURT: The chart.

4 Q Doctor, I'm going to show you Dr. Fazio's note with
5 respect to range of motion.

6 A Correct.

7 (Whereupon, the item referred to is published to
8 the jury.)

9 Q It says there, "Patient can range with some
10 discomfort," true?

11 A That is correct.

12 Q Now, some discomfort on range of motion is consistent
13 with a soft tissue injury, true?

14 A True.

15 Q Would you agree, Doctor, that, typically, if a patient
16 has a fracture, whether it's displaced or non-displaced,
17 they're going to have very significant pain on range of motion.

18 A In general, in general, most patients will have
19 significant pain with a fracture and range of motion.

20 Q Just to maybe digress for a second...

21 Soft tissue injuries, there's been some testimony.
22 Would you agree, if a patient has a soft tissue injury,
23 sometimes due to swelling, may feel a little worse the next day
24 than they do in the minutes and hours after the acute injury?

25 A That's correct.

1 Q Now, part of the range of motion was a straight leg
2 raise.

3 A That's correct.

4 Q And a straight -- an active straight leg raise, does it
5 not create more force on the hip joint than even walking?

6 A I don't believe that's true.

7 Q No?

8 A No.

9 Q Would you defer to an orthopedic surgeon op that point?

10 A I would have to see what was specifically said.

11 Q In terms of what?

12 A In terms of straight leg raise and how it was done and
13 how it was tested.

14 Q Would you agree that a straight leg raise with
15 resistance against the top of the shin would create more force
16 and stress on a hip joint than walking?

17 A I can't say one way or the other.

18 Q Dr. Fazio documented that ms. Killian's strength was
19 within normal limits, true?

20 A I'm just looking for the -- I'm going to accept it for
21 you. I can't see it on the chart right now, you'd have to show
22 it to me, but I'm gonna accept it if that's what you're saying.

23 Q Doctor, strength, sensation BCR, WNL?

24 A Yes.

25 Q So that would be the second really -- the second

1 assessment of her motor strength if you include the EMT's
2 assessment, true?

3 A True.

4 Q Normal strength is consistent with someone who doesn't
5 have a fracture of the hip, true?

6 A True.

7 Q Now, after his initial examination of Ms. Killian, you
8 know Dr. Fazio ordered X-rays, right?

9 A That's correct.

10 Q He didn't order any pain medication, true?

11 A That's correct.

12 Q Do you have any reason to believe that if Dr. Fazio
13 thought pain medication was needed, any reason to believe he
14 wouldn't have given it for some reason?

15 A No, I have no reason to believe that.

16 Q So, we can agree that after Dr. Fazio's examination,
17 including history and physical examination of Ms. Killian, it
18 was his conclusion that Ms. Killian's condition didn't warrant
19 pain medication, true?

20 A True.

21 Q Doctor, you testified on direct that 10 to 20 percent
22 of impacted fractures may not show up on X-ray.

23 A Correct.

24 Q Did I get that accurate?

25 A Yes.

1 Q Well, impacted fractures are a subset of fractures,
2 true?

3 A True.

4 Q And would you agree with the statement that over
5 96 percent of fractures are seen on X-ray?

6 A Of all fractures.

7 Q Of all fractures.

8 A I don't know the specific number for that. Because all
9 fractures include displaced fractures, which are the majority
10 of fractures that you're going to see on plain films, because
11 they are the majority of fractures.

12 Q Are you aware of any studies that have investigated the
13 incidents of occult fractures in the emergency department on
14 plain X-ray?

15 A There are studies. I have -- I can't site you the
16 studies, but there are studies that were done, which is the
17 reason that we move on to CT or MRI.

18 Q Are you aware of the Chiang study that was published in
19 the Journal of Orthopedics in 2012 which analyzed occult
20 femoral neck fractures in initial injury radiographs?

21 THE COURT: Could you spell that name for us,
22 counsel?

23 MR. SIKOSCOW: C-H-I-A-N-G.

24 THE COURT: Thank you.

25 Q Do you subscribe to any journals, Doctor?

1 A Yes, I do.

2 Q Which journals do you subscribe to?

3 A New England Journal of Medicine; JAMA, J-A-M-A, which
4 is the Journal of the American Medical Association, the journal
5 that comes with the American Academy of Family Practice;
6 another emergency medicine journal, I don't remember the
7 specific -- it's like Journal of Emergency Medicine. And then
8 I get a number of what are called unsolicited journals.

9 Q You receive the Journal of Emergency Medicine?

10 A Yes, I do receive the Journal of Emergency Medicine.

11 Q Do you consider it authoritative?

12 A No, I don't.

13 Q You know from testifying that if you say "No" to that I
14 can't read from the article, right?

15 MR. SIMONSON: Objection.

16 THE COURT: Overruled.

17 He can answer if he knows the answer. If he
18 doesn't know...

19 Q You've been asked that question before, right?

20 A I have. And the answer is that authoritative means
21 that every word is correct. And, in fact, there's nothing in a
22 journal published where every single word is going to be
23 correct. There are journals which have good articles; there
24 are journals which have articles which turn out to be incorrect
25 later, even peer-reviewed journals which, occasionally, they

1 have to retract the paper that they wrote.

2 Q Do you agree with the statement that --

3 MR. SIMONSON: Whose statement, Your Honor?

4 THE COURT: Where is it coming from?

5 MR. SIKOSCOW: I'll move on, Your Honor.

6 MR. SIMONSON: Thank you, Your Honor.

7 Q Doctor, can we -- withdrawn.

8 Dr. Fazio performed an initial interpretation in the
9 emergency department of the X-rays, true?

10 A That's true.

11 Q And it was reasonable for him to expect that the
12 hospital's radiologist will subsequently review those same
13 images and then dictate or type an official report, correct?

14 A That's correct.

15 Q And radiologists are specially trained in interpreting
16 radiological images, correct?

17 A Correct.

18 Q You went to -- withdrawn.

19 You didn't complete or attend any emergency medicine
20 residency programs, true?

21 A That's correct.

22 Q They were available in 1981, 1982, true?

23 A Actually, there was no -- in fact, in New York there
24 was -- one is Jacobi. I don't know if anything else was
25 available at that time, certainly nothing academic.

1 It wasn't an independent specialty at the time. There
2 were essentially no full departments of emergency medicine. So
3 that in the period of time when I started, which is 1978, in
4 fact, people went into internal medicine, surgery or pediatrics,
5 and emergency services were what the standard was for emergency
6 medicine.

7 Q Were there any residency programs in emergency medicine
8 in 1981, to your knowledge?

9 A I believe there were.

10 Q You had not completed your training yet by that time,
11 true?

12 A True.

13 Q Anyway, radiologists attend and complete a radiology
14 residency program, true?

15 A True.

16 Q They're trained on how to interpret all types of
17 radiological imaging, including X-rays, true?

18 A True.

19 Q Four-year program?

20 A Four- or five-year program.

21 Q And when radiologists review images, in this case an
22 X-ray, it's their responsibility to look at that X-ray for any
23 and all abnormalities, true?

24 A True.

25 Q And they are to report, in the official radiology

1 report that they create when they're done with their review of
2 the X-ray, any and all abnormalities that they have found,
3 true?

4 A True.

5 Q And we know in this case, Dr. Giaimo, the hospital's
6 radiologist, reviewed Ms. Killian's hip X-rays and found no
7 fracture or acute injury, true?

8 A True.

9 Q Radiologists are given what's called a clinical
10 history.

11 A Correct.

12 Q So that they have a context for their review of the
13 images, true?

14 A Correct.

15 Q In this case, Dr. Giaimo was told the clinical history
16 included "Pain," comma, "status post fall," true?

17 A True.

18 Q On direct you indicated that if the patients don't have
19 a primary care, what doctors like you and doctors like
20 Dr. Fazio do in the emergency department is you give the
21 patient the number for the hospital's clinic, right?

22 A That's correct.

23 Q Do you have a copy of the hospital chart there?

24 A I believe I do.

25 Q Do you have the discharge instructions?

1 A I believe I do. I'm looking for it right now.
2 I have the page which I think you're gonna be
3 referencing.

4 Q Thank you.

5 The discharge instructions provide information for the
6 Richmond University Medical Center Clinic, correct?

7 A That's correct.

8 Q And above that, I believe there's the number for the
9 emergency department should Ms. Killian not be able to get an
10 appointment at the clinic, true?

11 A That is correct.

12 Q Again, Doctor, you couldn't have had Ms. Killian's
13 testimony to review before today. But I want you to assume
14 that she testified yesterday that several days before
15 March 16th her condition worsened to the point where she
16 couldn't get out of bed and that she probably should have
17 called 9-1-1.

18 Do you agree with that?

19 A That she said that?

20 Q Do you agree that she should have called 9-1-1 at that
21 time?

22 A She should have sought medical attention.

23 Q And you agree, do you not, Doctor, that she should have
24 followed up with either the Richmond University Medical Center
25 Clinic or called the emergency department within two or three

1 days after her discharge for follow-up care, true?

2 A True.

3 Q If she was unable to walk on Day 2, Day 3, Day 4,
4 Day 5, Day 6, or whenever it was up until just before she fell,
5 and she presented to an emergency department anywhere, she
6 would have gotten an orthopedic consult, true?

7 A True.

8 Q And the diagnosis would have been made before she fell,
9 true?

10 A True.

11 Q What other records were you given besides the SIUH
12 record and Richmond University Medical Center record?

13 A Those are the two records.

14 MR. SIKOSCOW: May I, Your Honor, just for --

15 THE COURT: You could approach.

16 MR. SIKOSCOW: -- five minutes review?

17 THE COURT: You want us to take a break?

18 We could take a recess.

19 MR. SIKOSCOW: Okay.

20 THE COURT: We'll take a brief recess, ten-minute
21 recess.

22 Please continue to keep an open mind and please do
23 not talk about this case amongst yourselves or with anyone
24 else.

25 (Whereupon, the jury exits the courtroom.)

1 THE COURT: Okay, Doctor, you can stretch your
2 legs.

3 THE WITNESS: Thank you.

4 (Whereupon, the witness is excused from the
5 witness stand.)

6 (Whereupon, a brief recess is taken.)

7 COURT OFFICER: Your Honor, all set?

8 THE COURT: Yes.

9 COURT OFFICER: Jury entering.

10 (Whereupon, the jury enters the courtroom.)

11 THE CLERK: The jury is present and properly
12 seated.

13 Do both sides stipulate?

14 MR. SIKOSCOW: Yes.

15 MR. SIMONSON: On behalf of plaintiff, yes.

16 THE CLERK: Doctor, you are reminded you are still
17 under oath.

18 THE WITNESS: Yes.

19 THE COURT: Continued cross.

20 MR. SIKOSCOW: Thank you, Your Honor.

21 CROSS-EXAMINATION (Continued)

22 BY MR. SIKOSCOW:

23 Q Dr. Schechter, one last question:

24 Did you receive the CVS record to review?

25 A The...?

1 Q Did you review the CVS Pharmacy record?

2 A No, this is what I have, the whole list of everything
3 I've seen.

4 Q Do you have any records that you requested that you
5 weren't provided?

6 A No.

7 MR. SIKOSCOW: Thank you.

8 THE COURT: That's it?

9 MR. SIKOSCOW: That's it for now, Your Honor.

10 MR. SIMONSON: Well I don't know -- that's the way
11 it works, Your Honor? Is that it or I'll get up, otherwise
12 I'll sit down.

13 THE COURT: Well he has no more.

14 Do you have a redirect?

15 MR. SIMONSON: Yes, Your Honor.

16 THE COURT: Okay, this is now redirect.

17 REDIRECT EXAMINATION

18 BY MR. SIMONSON:

19 Q Dr. Schechter, you were asked a lot of questions about
20 whether something is consistent with and if a patient has
21 something that's consistent with, does that mean that she has
22 it?

23 A No.

24 Q What does it mean?

25 A It means that she may have it or she may not have it.

1 That is something that -- something that's consistent, maybe
2 consistent with a particular disease state or normality, but,
3 in fact, there may be a disease state that you would have this
4 part of the exam normal, because this part of the exam would
5 not pick up that abnormality.

6 So, for example, if you have a femoral neck fracture,
7 which is in this area, and I push on the pelvis, it is very
8 possible I will not elicit any pain by pushing on the pelvic
9 ring, even though you have a non-displaced femoral neck fracture
10 (indicating).

11 Q And we know that the differential, as you said,
12 consistent with the standard of care in this case was soft
13 tissue injury and fracture.

14 A Correct.

15 Q So, if a patient has a soft tissue injury and that's
16 not diagnosed, but they're sent home, is there any real risk to
17 a patient being sent home with a non-diagnosed soft tissue
18 injury?

19 A In general, no.

20 Q And can a patient have lots of stuff consistent with a
21 soft tissue injury yet have a fracture?

22 A Yes.

23 Q So, assuming Ms. Killian had lots of stuff that could
24 be consistent with a soft tissue injury, yet you're still
25 critical of the care that Dr. Fazio gave and said it went and

1 fell below the standard of care, why is that?

2 A Because, in fact, you can have both a soft tissue
3 injury and a femoral neck fracture, you can have a femoral neck
4 fracture without a soft tissue injury, or you can have a soft
5 tissue injury without a femoral neck fracture.

6 And, given those findings, what you need to do is to do
7 the appropriate diagnostic radiologic evaluation, and that
8 includes a CT scan or an MRI. And then if the CT scan and MRI
9 is negative and there is no fracture, then, by diagnosis of
10 exclusion, you're left with soft tissue injury.

11 Q And you can send the patient home and give them some
12 pain meds and tell them that the pain might get worse before it
13 gets better.

14 A That's correct.

15 Q Now, was there any information gathered at the scene or
16 at triage that would lead a reasonable emergency room doctor to
17 say that proves there's no fracture of the right hip?

18 A No, there was nothing there. In fact, there was
19 everything to say this is a hip fracture until proven
20 otherwise, and that's the initial 10 out of 10 pain, and then 5
21 out of 10 pain in the emergency department.

22 Q And you work closely with nurses.

23 A I do.

24 Q And I think it's been said that the Registered Nurses
25 are very much a part of the backbone of the emergency

1 department.

2 A Absolutely.

3 Q And with respect to --

4 THE COURT: Could you just hold that thought for
5 one second?

6 MR. SIMONSON: Absolutely, Your Honor.

7 (Whereupon, Deborah Maira is relieved by Rosemary
8 Pfister as Official Court Reporter.)

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1 Q Was any radiologist involved in anyway, shape or
2 form with Ms. Killian's care or films on March 3rd?

3 A No.

4 Q Now in a patient like Miss Killian where the
5 standard of care requires that the differential diagnosis
6 include hip fracture, with respect to the physical exam are
7 there certain things that you would say are critical aspects
8 of the physical exam?

9 A Yes.

10 Q When we say physical exam, we're talking about
11 physical exam by an emergency medicine physician, right?

12 A Correct.

13 Q I think you said -- I'll ask and follow-up.
14 Is gait assessment by the emergency physician a
15 critical aspect of the physical exam when a patient has a
16 differential like Miss Killian of hip fracture?

17 A Yes, it is.

18 Q And whether a nurse is trained in doing risk
19 assessment for falls and all of the things that are involved
20 in that, is it ever, ever within the standard of care to
21 never watch the patient walk, the physician never watch the
22 patient walk?

23 A That's not within the standard of care for a
24 physician.

25 Q Is it ever within the standard of care for the

1 emergency room physician to delegate to the nurse the sole
2 responsibility to assess the patient's gait?

3 A No, it's the standard of care is that the physician
4 must do that part of the exam in someone that they're
5 evaluating for hip fracture.

6 It's a physician's responsibility, he cannot
7 delegate that to anyone else.

8 Q But if the nurse is experienced in fall assessments
9 and anything like that why can't the doctor safely reasonably
10 and prudently delegate that to the nurse?

11 A Because this is not about fall assessment. This is
12 about the findings both pain and the quality of the gait for
13 an impacted femoral neck fracture; and, those things can be
14 subtle, and that's why a physician needs to do that exam
15 himself. And, he needs to observe the patient, Miss Killian.
16 And, needs to then ask Miss Killian specific questions about
17 the gait and about how that effects her symptoms; whether she
18 has any pain with this gait.

19 And, that would have elicited pain, and it would
20 have forced the movement to do a CT Scan or an MRI which
21 would have diagnosed the impacted femoral neck fracture prior
22 to discharge.

23 Q You use the term impacted, are you talking about a
24 non displaced fracture?

25 A That's correct.

1 MR. SIMONSON: Thank you.

2 THE COURT: Okay, any more questions.

3 RECROSS EXAMINATION

4 BY MR. SIKOSCOW:

5 Q Doctor Schechter, did you read Dr. Fazio's
6 testimony during Court of how he performed the pelvic
7 tenderness portion of his examination?

8 A I did read it, I don't remember it word for word
9 now.

10 Q Did he just say he just touched the pelvic rim or
11 did he describe how he would try and palpate the femoral
12 neck?

13 A I don't remember the specifics of it.

14 Q Just so I'm clear, if Ms. Killian's condition was
15 such that she couldn't walk without holding onto something, a
16 doctor and a nurse could equally identify that something is
17 wrong if that was to be, true?

18 A That's correct.

19 MR. SIKOSCOW: Thank you.

20 MR. SIMONSON: No questions.

21 THE COURT: Okay, thank you.

22 Doctor, with regards -- I'll ask you the
23 questions, I'll use the mike so everyone can hear but
24 please face the jury and speak into the them.

25 When there is a fracture of a bone, when does

1 it start to heal?

2 THE WITNESS: I'm sorry, it's several weeks
3 before you'll see radio graphic evidence of healing. I
4 would leave it to an orthopedic surgeon to talk about the
5 way that osteoblast and osteoclast which are the cells in
6 the bone actually respond to trauma. But
7 radiographically it's several weeks.

8 THE COURT: Any questions?

9 MR. SIMONSON: No, your Honor.

10 MR. SIKOSCOW: No, your Honor.

11 THE COURT: Thank you, very much.

12 THE COURT: Counsel, come up.

13 (Bench conference.)

14 THE COURT: Okay, jurors, that will be it for
15 the week. Remember we're off tomorrow.

16 So please continue to keep an open mind. Do
17 not talk about this case among yourselves or with anyone
18 else.

19 Again please know it's kind of hard do, you
20 hear a lot of things, you may want to start looking it
21 up, you may want to Google it, you may want to Google us;
22 that's scary. Please do not do so.

23 If there was a way I could bring you back
24 tomorrow but I can't since there will be no testimony,
25 okay.

1 So you have to go to your second job tomorrow.

2 So please be back in the jury room 9:55 a.m.

3 The attorneys will be here earlier and we will start
4 promptly at 10:00 a.m. We expect to begin with the
5 defense case at that time.

6 All right, so safe home, have a wonderful
7 weekend, see you soon.

8 (Whereupon, the jury left the courtroom at this
9 time and the case stood in recess until Monday morning
10 October 16, 2017.)

11

12

13 DEBORAH MAIRA, and ROSEMARY M. PFISTER, RPR, CSR,
14 Senior Court Reporters, in and for the State of New York, do
15 hereby certify that the foregoing transcript is true and
16 accurate to the best of their knowledge, skill and ability.

15

16 (Certification valid only when signed in blue ink)

17

18

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21 OFFICIAL COURT REPORTER OFFICIAL COURT REPORTER
22 SUPREME COURT-RICHMOND COUNTY SUPREME COURT-RICHMOND COUNTY

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