SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF RICHMOND : CIVIL TERM : PART DCM3

JOANNE KILLIAN,

Plaintiff,

- against -

FRANK FAZIO,

Defendant.

INDEX NO. 101692-2014

TRIAL

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

October 12, 2017

B E F O R E:

HON. DESMOND A. GREEN,
Supreme Court Justice.

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

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DEBORAH MAIRA,
ROSEMARY PFISTER,
SENIOR COURT REPORTERS,

THE COURT: Okay, same appearances.

MR. SIKOSCOW: Thank you, Your Honor.

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

THE COURT: Yes, we could raise that now.

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

Okay, well first let me hear from you.

MR. SIMONSON: Yes, Your Honor.

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

THE COURT: No, Alternate Number 3.

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

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

THE COURT: Was it Juror Number 3?

COURT OFFICER: It's Alternate Number 3.

MR. SIMONSON: I have no objection.

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

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

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

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

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

THE COURT: Yes.

MR. SIMONSON: No, I'm sorry.

THE COURT: Theresa Manilla.

MR. SIMONSON: Theresa Manilla.

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

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

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

THE COURT: Yes, sir.

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

THE COURT: Okay.

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

MR. SIMONSON: Sure, Your Honor.

THE COURT: Could we bring her in?

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

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

THE COURT: Yes, please.

COURT OFFICER: Juror entering.

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

THE COURT: How are you?

ALTERNATE JUROR NO. 3: I'm fine.

THE COURT: Good to see you again.

I got the report about the donuts.

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

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

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

THE COURT: Okay.

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

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

THE COURT: Great.

ALTERNATE JUROR NO. 3: Thank you.

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

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

THE COURT: Yes.

(Whereupon, the jury enters the courtroom.)

THE CLERK: The jury is present and properly seated.

Do both sides stipulate?

MR. SIMONSON: Yes.

MR. SIKOSCOW: Yes.

THE COURT: Mr. Simonson, your next witness.

MR. SIMONSON: Good morning, everyone.

The plaintiff calls to the stand Dr. Alan Schechter.

THE CLERK: Please raise your right hand.

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

THE CLERK: Please give your name and professional address.

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

THE CLERK: Please spell your name for the reporter.

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

THE COURT: Okay, Mr. Simonson.

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

DIRECT EXAMINATION

BY MR. SIMONSON:

Q Good morning, Dr. Schechter.

A Good morning.

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

A I certainly will.

Q Thank you.

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

A Certainly.

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

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

THE COURT: Could you spell that for me?

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

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

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

never called.

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

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

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

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

A Certainly.

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

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

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

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

A Absolutely.

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

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

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

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

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

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

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

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

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

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

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

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

A Yes, most of it was done for plaintiffs.

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

MR. SIKOSCOW: Objection.

THE COURT: Overruled.

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

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

MR. SIMONSON: Thank you, Your Honor.

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

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

A Yes.

Q And just talk about that, how that works.

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

Q Over the years have you found that -- well withdrawn.

When it comes to you getting cases to review and look at the standard of care from a group, is that almost always plaintiffs' case?

A Yes.

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

A That's correct.

Q Do you feel you've lost your objectivity?

A Not at all.

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

time?

A I am compensated for my time.

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

A Yes.

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

A Yes, I am.

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

A I do.

Q And what do you charge?

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

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

A That's correct.

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

A Probably between 60 and 80 times since 1984.

Q And you testified in other cases in New York?

A Yes.

Q And you testified in New Jersey?

A Yes, I have.

Q And I believe Massachusetts?

A Yes, I have.

Q Connecticut?
A Yes, in Connecticut, also.
Q And anyplace else?
A In Pennsylvania.
Q You know, I'm going to ask you this question. I think it's almost rude in a way, but I'm going to ask you anyway.
If you look back over the years -- withdrawn.
By the way, do you operate on patients?
A Well, it depends on --
Q Like big surgeries, like heart surgery and all --
A No, mine are emergency procedures. We do, of course.
Q And are you compensated for big operations and big procedures?
A I don't do big procedures, so I'm not compensated for those.
Q Would you say over the years what percentage of your income comes from doing your medical paperwork?
A Between 10 and 20 percent.
Q Now, Doctor, have you worked with my firm before?
A I believe we had one prior case.
Q Have you and I ever worked in court together?
A No.
Q Did I ask you some time ago to take a look at the care rendered by Dr. Fazio, in all its aspects and circumstances, and come to a decision as to whether Dr. Fazio met the standard

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

A Yes.

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

A Yes, I did.

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

A Yes, I did.

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

A Yes, I did.

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

A Yes, I did.

Q Did you review X-rays?

A I did.

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

A Yes, examinations before trial.

Q That's another way of saying it.

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

A Yes.

Q Did you read it?

A I did read it.

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

A Yes.

Q Did you read that?

A I did.

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

A Yes.

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

A Yes.

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

A Yes.

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

Do you understand?

A I do understand.

Q Okay.

And did you read all that material?

A Yes, I did.

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

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

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

THE COURT: What the hospital itself requires.

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

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

THE WITNESS: Correct.

THE COURT: Okay.

Were you given the protocol for Richmond University Medical Center?

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

THE COURT: Okay.

Okay, Mr. Simonson, you can continue.

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

THE COURT: No, continue questioning.

BY MR. SIMONSON:

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

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

Will you assume that?

A I will assume that.

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

A Yes.

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

A Yes.

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

A I will.

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

A That's correct.

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

A Sure.

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

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

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

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

I became Board Certified in internal medicine in 1982,

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

Q And to recertify means what?

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

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

A That's correct.

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

A Absolutely.

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

Q And for several years, in addition to your clinical

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

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

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

Q And who do you teach?

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

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

medicine.

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

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

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

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

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

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

Q And so I guess one of the questions I would ask is:

What is an emergency physician? What is emergency medicine?

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

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

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

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

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

THE WITNESS: Oh, I'm sorry.

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

A Absolutely, it's part of trauma.

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

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

A Yes.

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

A It's common.

THE COURT: Well which one is common?

THE WITNESS: Fractures.

THE COURT: There are two parts, okay? Mr. Simonson mentioned two parts; he mentioned displaced and non-displaced.

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

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

THE COURT: Speak to the jury.

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

A Certainly.

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

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

Q "Oblique" means what?

A That it's at an angle.

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

A That's correct.

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

A I was originally trained with films, yes.

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

MR. SIKOSCOW: Objection to form, Your Honor.

THE COURT: Overruled.

You can answer that.

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

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

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

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

A Yes, it is.

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

A Absolutely.

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

A I do.

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

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

THE COURT: Overruled.

Doctor, if you understand the question you can answer.

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

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

A Certainly.

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

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

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

up to the operating room.

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

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

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

MR. SIKOSCOW: Objection, Your Honor.

THE COURT: Overruled.

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

A Yes.

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

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

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

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

A Yes.

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

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

Q What are ADL or activities of daily living?

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

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

A Absolutely.

Q Why is that?

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

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

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

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

A It is relevant.

Q Why?

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

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

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

A Absolutely.

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

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

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

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

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

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

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

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

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

A That's correct.

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

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

A Yes.

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

Was that decision within the standard of care?

A Yes, it was.

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

A That's correct.

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

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

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

But given the particular complaints that Ms. Killian had, both on mechanism of injury and the fall, and the physical complaints that are documented in the emergency department chart and on physical exam, and the abnormalities on the plain film, the standard of care required that you go to the next level. And the next level -- because you know that those plain films are gonna miss a certain percentage, anywhere between 10 and 20 percent of impacted fractures, that you need to go to the next level. And that's going to either be a CT scan of the hip or an MRI, and those are gotten from the emergency department.

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

A Okay.

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

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

A Yes.

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

A Yes.

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

A Yes.

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

A Yes.

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

A Yes, it is.

Q Would you please tell the jury.

A Certainly.

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

walk on that fracture, obviously. But, if you're unsure about whether the patient has a fracture or not, one of the key aspects of the physical exam that you do as an emergency physician is to have the patient get up and walk. And you watch the patient walk and you ask the patient if they're having pain. Because, for example, I weigh about 190 pounds. If I stand up, that's much more force on my hips than if I just push on them. So that force will elicit pain on impacted occult fractures. It's a very basic and routine part on an examination of someone you are concerned about a hip fracture. Because, fundamentally, what you want the patient to be able to do is to walk and not be having a hip fracture. So you have to test the walking. It's a basic responsibility as a standard of care for the emergency physician to do that gate testing.

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

A Yes.

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

So far so good?

A I'm assuming.

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

A Yes.

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

Would you assume that?

A Yes.

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

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

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

Would you do that?

A Yes.

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

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

A Yes.

MR. SIKOSCOW: Objection.

THE COURT: Sustained. Sustained. Sustained.

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

A Much more likely than not.

Q Why is that?

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

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

MR. SIKOSCOW: Objection.

THE COURT: Sustained.

Could you rephrase that in a way that I could at

least understand it?

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

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

A Yes.

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

A That's correct.

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

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

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

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

So the standard of care -- because this is

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

THE COURT: Okay, speak to the jury.

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

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

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

A That's correct.

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

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

MR. SIKOSCOW: Objection.

THE COURT: Sustained.

Assuming there was a fracture.

MR. SIMONSON: Yes.

THE COURT: I think you should use that term.

MR. SIMONSON: Thank you, Your Honor.

THE COURT: Assuming there was a fracture.

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

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

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

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

A I'm listening to you, yes.

Q Thank you.

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

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

MR. SIKOSCOW: Objection to form, Your Honor.

THE COURT: Overruled.

You can answer that, Doctor.

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

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

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

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

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

THE COURT: Okay.

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

THE WITNESS: Okay.

(Whereupon, jury exits the courtroom.)

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

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

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

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

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

MR. SIMONSON: Yes on behalf of plaintiff.

MR. SIKOSCOW: Yes.

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

THE COURT: Continued direct.

MR. SIMONSON: Thank you.

CONTINUED DIRECT EXAMINATION

BY MR. SIMONSON:

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

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

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

A Yes.

MR. SIKOSCOW: Objection.

THE COURT: Overruled.

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

THE COURT: Assuming it's there.

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

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

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

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

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

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

MR. SIKOSCOW: Objection.

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

non displaced fracture there.

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

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

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

MR. SIKOSCOW: Objection to form.

THE COURT: Overruled.

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

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

A Yes.

Q What's the basis of your answer?

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

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

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

MR. SIKOSCOW: Objection.

THE COURT: Overruled.

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

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

A Yes, it was.

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

A Yes, exactly, that is this presentation is an

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

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

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

A Yes.

Q What is the basis of your opinion?

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

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

A Yes.
Q Have you reviewed the March 3rd hip x-rays from Richmond?
A Yes.
Q And, Doctor, in your opinion what is the emergency medicine standard of care and reasonable and prudent interpretation of the March 3rd hip x-rays?
MR. SIKOSCOW: Objection cumulative.
THE COURT: Overruled.
A The March 3rd hip x-rays were not normal. There was an abnormality in the femoral neck of that right hip and that required further imaging to see if that abnormality was, in fact, an impacted hip fracture.
Q Doctor, if I show you -- I know I've shown you this before, but if I show you Plaintiff's Exhibit 8 which is the blowup and ask -- may I approach, your Honor?
THE COURT: Yes.
Q -- and ask you whether the line between the two Xs' is the abnormality and/or anomaly you just testified to?
A Correct, that's an abnormality --
MR. SIKOSCOW: Objection.
THE COURT: Overruled.
A -- in the femoral neck, the right hip. And, given the mechanism of injury and given the complaints that Miss Killian had and given the findings of pain when she

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

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

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

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

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

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

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

A Yes.

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

A Yes, he did.

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

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

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

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

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

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

A Yes, it was.

Q Please tell us the basis.

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

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

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

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

A Yes.

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

A No.

Q Why not.

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

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

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

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

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

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

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

MR. SIKOSCOW: Objection cumulative.

THE COURT: Overruled, you can answer that.

A Yes, I do have an opinion.

Q What is your opinion?

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

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

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

A I'm sorry the 16th.

Q Doctor, last topic.

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

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

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

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

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

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

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

A Yes, there was.

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

A Absolutely.

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

A That's correct.

Q What does that mean?

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

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

A Absolutely.

Q Why is that?

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

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

MR. SIMONSON: Thank you, very much.

THE WITNESS: You're welcome.

THE COURT: Cross-examination.

MR. SIKOSCOW: Thank you, your Honor.

CROSS-EXAMINATION

BY MR. SIKOSCOW:

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

A Very well. Good afternoon.

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

A Very nice to meet you.

Q You and I have never met, true?

A That's true.

Q Just some background questions first.

When were you first contacted regarding this matter?

A I believe in 2016.
Q The file in front of you, what is that?
A That's the file of the medical records and a copy of my C.V. and a list of the items that I reviewed.
MR. SIKOSCOW: Can we marked as an exhibit for identification, your Honor?
MR. SIMONSON: No objection, your Honor.
THE COURT: Okay. What are we up to?
Members of the jury, the C.V. is just a fancy Latin term, curriculum vitae, all it means is your resume.
This will be Defendant's A for identification only. It's being marked for I.D. only, Defendant's D.
(Whereupon, the above-referenced item was so marked Defendant's D for identification at this time.)
MR. SIKOSCOW: May I, your Honor?
THE COURT: Yes, sir, thank you.
Q Who initially contacted you, Doctor?
A Somebody from Mr. Simonson's office, I don't know if it was Mr. Simonson himself or someone else from his office.
Q Your practice, is it not, to get a summary of the case over the phone before you agree to review it?
A Yes, I'll ask what the case is about.
Q In this case you would of learned the basic

allegations?

A Yes.

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

A Correct.

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

A In general, yes.

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

A Yes.

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

A Correct.

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

A Correct.

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

A Correct.

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

A Correct.

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

A True.

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

A True.

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

A True.

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

A True.

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

A True.

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

A True.

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

judgment how to best treat the patient, true?

A True.

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

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

Q Every cases --

THE COURT: Let him finish his answer, okay.

Finish your answer.

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

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

THE DEFENDANT: No.

THE COURT: Please explain.

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

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

required to do.

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

MR. SIKOSCOW: May I, your Honor?

THE COURT: Yes, sir.

Q Every patient is different right, Doctor?

A Correct.

Q Let's talk about pain.

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

A True.

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

A That's true.

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

A That's true.

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

A Correct.

Q And the physician may perform a physical

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

A That is true.

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

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

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

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

A I will.

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

A Absolutely.

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

A True.

Q Discharge the patient, true?

A True.

Q And those decisions are made based upon many bits

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

A True.

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

A That's true.

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

A True.

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

A Yes.

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

A That's correct.

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

A That's correct.

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

A True.

THE COURT: I need the doctor to explain to all

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

THE WITNESS: Certainly.

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

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

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

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

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

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

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

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

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

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

THE WITNESS: Okay.

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

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

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

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

THE COURT: Thank you, Doctor.

Q Let's talk about registered nurses, okay.

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

A That is correct.

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

A Absolutely.

Q And they routinely assess vital signs, true?

A True.

Q They take patient histories, true?

A True.

Q They perform physical examinations on patients, true?

A That's true.
Q They can listen to a patient's heart, lungs or touch their abdomen to see how distended or not, things that?
A True.
Q They administer medications, right?
A That's true.
Q And doctors rely on nurses to do those types of things on a daily basis, true?
A That's true.
Q Now one of the other things nurses do on a routine basis, they do what is called fall risk assessments, true?
A True.
Q Meaning every patients that's either admitted to a hospital or seen in an emergency department evaluated by a nurse very soon after they're arrival to assess whether or not that patient is at risk for falling, true?
A That is true.
Q And what those nurses are trained to do, by the way -- withdrawn.
Performing a fall risk assessment is something that nurses, registered nurses, almost exclusively do?
A That's correct.
Q They're trained to do that?
A That's correct.
Q And they're trained to ask the patient questions

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

A That's correct.

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

A True.

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

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

A That's true.

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

A True.

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

A That's true.

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

bathroom in their respective hospital rooms, true?

A True.

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

A True.

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

A True.

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

A True.

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

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

A What do you mean by aptitude.

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

A Yes.

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

A Yes.

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

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

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

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

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

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

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

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

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THE CLERK: Case on trial continued.

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

THE COURT: Yes.

COURT OFFICER: Jury entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: Welcome back, everyone.

Everyone can be seated.

THE CLERK: The jury is present and properly seated.

Do both sides stipulate?

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

MR. SIKOSCOW: Yes.

THE COURT: Doctor?

(Whereupon, the witness resumes the witness stand.)

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

THE WITNESS: Yes.

MR. SIKOSCOW: May I, Your Honor?

THE COURT: Yes.

MR. SIKOSCOW: Thank you.

CROSS-EXAMINATION (Continued)

BY MR. SIKOSCOW:

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

A Yes.

Q Deposition transcripts you were provided to review.

A Yes.

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

A Yes.

Q You read it?

A I did.

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

A That is correct.

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

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

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

A No.

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

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

A Correct.

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

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

THE COURT: Overruled.

MR. SIMONSON: Thank you.

Q You can answer that question.

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

Q Yeah.

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

A That's true.

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

A That is true.

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

A That is correct.

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

A Yes.

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

A I have not.

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

Can you assume that?

A I am assuming that.

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

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

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

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

A True.

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

nurse was the one observing the gate, true?
A True.
Q Now, emergency medical technicians or first responders, they're also individuals that have a certain type of training, correct?
A Correct.
Q And we've seen this already during this trial, but the first responders, the Emergency Medical Technicians that responded to the scene of Ms. Killian's fall on March 3rd created a record, true?
A That's true.
Q You reviewed that, right?
A I did.
Q And they documented -- you would agree that they documented their observations as accurately as possible, true?
A True.
Q You have no reason to believe otherwise, right?
A That's correct.
Q And they documented, as we know, 10 out of 10 pain, true?
A That's true.
Q And we agree, do we not, that that's a subjective pain score, correct?
A That's true.
Q It's just a piece of information that goes into the

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

A True.

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

A That's correct.

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

A That's true.

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

A True.

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

A That's correct.

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

A That's correct.

Q They also documented PMS times 4, true?

A That's correct.

Q And that means what, Doctor?

A It means pulse, motor and sensory for the four

extremities.

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

A I believe it's sensory.

Q Motor being...?

A Motor is the strength, that's the movement part. Sensory is, "Do you feel me touching you?"

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

A That's correct.

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

A True.

Q To her right leg, true?

A True.

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

A True.

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

A That's correct.

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

A Correct.

Q And we know that Nurse Triollo documented in her triage

note that the patient was brought in by ambulance, true?
A That's correct.
Q Status, post slip and fall, true?
A That's correct.
Q No loss of consciousness, right?
A That's correct.
Q Complaint of pain to the right hip and leg, right?
A Correct.
Q And ambulatory at the scene, true?
A Correct.
Q And those are pieces of information that the EMT provided to Nurse Triollo, correct?
A That's correct.
Q And she documented them because they're important pieces of clinical information, correct?
A Correct.
Q Important for the triage nurse, as well as, eventually, the emergency medicine physician who evaluates the patient, true?
A True.
Q They speak to the mechanism of injury, true?
A True.
Q "No loss of consciousness" means there's relatively a lesser likelihood of a head injury, true?
A True.

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

A Correct.

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

A True.

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

A True.

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

A Yes.

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

A Correct.

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

A Correct.

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

A Yes.

Q And we know when Ms. Killian arrived at triage she endorsed a pain scale of 5 out of 10, correct?
A That's correct.
Q With no pain medication between the 10 out of 10 and the 5 out of 10, true?
A Correct.
Q We can agree she never got pain medication at any point in time before being discharged from the emergency department, correct?
A That's correct.
Q Her vital signs at triage were within normal limit, true?
A True.
Q A person with significant pain may be expected to have an increased respiratory rate?
A They may.
Q They may have an increased pulse?
A They may.
Q Before I get to Dr. Fazio's involvement, Doctor, just generally, because I don't think we really had too much anatomy above the bones and the joint capsule of the hip.
A Okay.
Q Okay?
But we obviously have what we all know now to be the femur, the femoral neck, the femoral head, which is the ball

that sits in the socket which is called the acetabulum.
A Acetabulum.
Q Correct?
A Yes.
Q And there is a joint capsule around the femoral neck and femoral head, correct?
A Correct.
Q It's made up of ligaments?
A Correct.
Q And those are soft tissue?
A Those are soft tissue.
Q And around that same area there are tendons --
A Yes.
Q -- which attach bone to muscle, correct?
A Correct.
Q And, obviously, there's muscle, many muscles that involve the hip in some way, shape or form, true?
A That's correct.
Q Dr. Fazio saw the patient at approximately 4:19 p.m., correct?
A That's correct.
Q Thereabouts, right?
A That's correct.
Q And that was timely, correct?
A Yes, it was.

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

A That is correct.

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

A Yes.

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

A Correct.

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

A That's correct.

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

A That's correct.

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

A True.

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

A That's correct.

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

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

the note from the prehospital providers and from triage.

Q He chose the word "discomfort," true?

A True.

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

A That's correct.

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

What's the basis for that?

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

Q My question wasn't clear perhaps.

He took a history from Ms. Killian, true?

A Yes.

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

A True.

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

A True.

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

A True.

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

A Patients will complain of pain.

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

Q Sure.

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

A In general, yes, that's correct.

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

A True.

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

A True.

Q They performed a physical examination of her, right?

A That's correct.

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

A That's true, yes.

Q Now, he found no pelvic tenderness, true?

A Correct.

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

A Doesn't have a fracture of the pelvis.

Q Of the pelvis?

A Correct.

Q Or the hip?
A You can have hip -- you can have a hip fracture without pelvic discomfort on palpation.
Q My question is, negative pelvic tenderness is consistent with someone who doesn't have a hip fracture, true?
A True.
Q He then, as we've touched on already, assessed range of motion, true?
A True.
Q And he documented "Some discomfort on range of motion," accurate?
A That's accurate.
Q And, again, that would be a descriptor of whatever Ms. Killian is telling Dr. Fazio she's feeling during the act of the range of motion, true?
A True.
Q Again, he didn't use the word "pain," true?
A True.
Q He used the word "discomfort," true?
A True.
Q And he qualified it further with some discomfort, right?
MR. SIMONSON: I think some pain, Your Honor, was his testimony.
THE COURT: Okay, use the term "pain," whatever is

in the record that's admitted into evidence.

MR. SIMONSON: The chart, Your Honor.

THE COURT: The chart.

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

A Correct.

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

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

A That is correct.

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

A True.

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

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

Q Just to maybe digress for a second...

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

A That's correct.

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

A That's correct.

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

A I don't believe that's true.

Q No?

A No.

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

A I would have to see what was specifically said.

Q In terms of what?

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

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

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

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

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

Q Doctor, strength, sensation BCR, WNL?

A Yes.

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

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

A True.

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

A True.

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

A That's correct.

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

A That's correct.

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

A No, I have no reason to believe that.

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

A True.

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

A Correct.

Q Did I get that accurate?

A Yes.

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

A True.

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

A Of all fractures.

Q Of all fractures.

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

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

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

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

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

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

THE COURT: Thank you.

Q Do you subscribe to any journals, Doctor?

A Yes, I do.

Q Which journals do you subscribe to?

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

Q You receive the Journal of Emergency Medicine?

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

Q Do you consider it authoritative?

A No, I don't.

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

MR. SIMONSON: Objection.

THE COURT: Overruled.

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

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

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

have to retract the paper that they wrote.

Q Do you agree with the statement that --

MR. SIMONSON: Whose statement, Your Honor?

THE COURT: Where is it coming from?

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

MR. SIMONSON: Thank you, Your Honor.

Q Doctor, can we -- withdrawn.

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

A That's true.

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

A That's correct.

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

A Correct.

Q You went to -- withdrawn.

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

A That's correct.

Q They were available in 1981, 1982, true?

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

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

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

A I believe there were.

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

A True.

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

A True.

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

A True.

Q Four-year program?

A Four- or five-year program.

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

A True.

Q And they are to report, in the official radiology

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

A True.

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

A True.

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

A Correct.

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

A Correct.

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

A True.

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

A That's correct.

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

A I believe I do.

Q Do you have the discharge instructions?

A I believe I do. I'm looking for it right now.

I have the page which I think you're gonna be referencing.

Q Thank you.

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

A That's correct.

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

A That is correct.

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

Do you agree with that?

A That she said that?

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

A She should have sought medical attention.

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

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

A True.

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

A True.

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

A True.

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

A Those are the two records.

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

THE COURT: You could approach.

MR. SIKOSCOW: -- five minutes review?

THE COURT: You want us to take a break?

We could take a recess.

MR. SIKOSCOW: Okay.

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

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

(Whereupon, the jury exits the courtroom.)

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

THE WITNESS: Thank you.

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

(Whereupon, a brief recess is taken.)

COURT OFFICER: Your Honor, all set?

THE COURT: Yes.

COURT OFFICER: Jury entering.

(Whereupon, the jury enters the courtroom.)

THE CLERK: The jury is present and properly seated.

Do both sides stipulate?

MR. SIKOSCOW: Yes.

MR. SIMONSON: On behalf of plaintiff, yes.

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

THE WITNESS: Yes.

THE COURT: Continued cross.

MR. SIKOSCOW: Thank you, Your Honor.

CROSS-EXAMINATION (Continued)

BY MR. SIKOSCOW:

Q Dr. Schechter, one last question:

Did you receive the CVS record to review?

A The...?

Q Did you review the CVS Pharmacy record?
A No, this is what I have, the whole list of everything I've seen.
Q Do you have any records that you requested that you weren't provided?
A No.
MR. SIKOSCOW: Thank you.
THE COURT: That's it?
MR. SIKOSCOW: That's it for now, Your Honor.
MR. SIMONSON: Well I don't know -- that's the way it works, Your Honor? Is that it or I'll get up, otherwise I'll sit down.
THE COURT: Well he has no more.
Do you have a redirect?
MR. SIMONSON: Yes, Your Honor.
THE COURT: Okay, this is now redirect.

REDIRECT EXAMINATION

BY MR. SIMONSON:

Q Dr. Schechter, you were asked a lot of questions about whether something is consistent with and if a patient has something that's consistent with, does that mean that she has it?
A No.
Q What does it mean?
A It means that she may have it or she may not have it.

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

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

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

A Correct.

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

A In general, no.

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

A Yes.

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

fell below the standard of care, why is that?

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

And, given those findings, what you need to do is to do the appropriate diagnostic radiologic evaluation, and that includes a CT scan or an MRI. And then if the CT scan and MRI is negative and there is to fracture, then, by diagnosis of exclusion, you're left with soft tissue injury.

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

A That's correct.

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

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

Q And you work closely with nurses.

A I do.

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

department.

A Absolutely.

Q And with respect to --

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

MR. SIMONSON: Absolutely, Your Honor.

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

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

A No.

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

A Yes.

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

A Correct.

Q I think you said -- I'll ask and follow-up.

Is gait assessment by the emergency physician a critical aspect of the physical exam when a patient has a differential like Miss Killian of hip fracture?

A Yes, it is.

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

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

Q Is it ever within the standard of care for the

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

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

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

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

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

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

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

A That's correct.

MR. SIMONSON: Thank you.

THE COURT: Okay, any more questions.

RECROSS EXAMINATION

BY MR. SIKOSCOW:

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

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

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

A I don't remember the specifics of it.

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

A That's correct.

MR. SIKOSCOW: Thank you.

MR. SIMONSON: No questions.

THE COURT: Okay, thank you.

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

When there is a fracture of a bone, when does

it start to heal?

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

THE COURT: Any questions?

MR. SIMONSON: No, your Honor.

MR. SIKOSCOW: No, your Honor.

THE COURT: Thank you, very much.

THE COURT: Counsel, come up.

(Bench conference.)

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

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

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

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

So you have to go to your second job tomorrow.

So please be back in the jury room 9:55 a.m. The attorneys will be here earlier and we will start promptly at 10:00 a.m. We expect to begin with the defense case at that time.

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

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

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

(Certification valid only when signed in blue ink)

DEBORAH MAIRA, OCR
OFFICIAL COURT REPORTER
SUPREME COURT-RICHMOND COUNTY

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