SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF NASSAU: TRIAL TERM PART

- -X

ELYSE LONG, AS ADMINISTRATRIX OF THE ESTATE OF JERRY LONG, DECEASED, Index No. 01491/13

Plaintiff,

-against-

NEW YORK-PRESBYTERIAN HOSPITAL/WEILL CORNELL MEDICAL CENTER, BRENNA M. FARMER, M.D.,

Defendants.

- -X

Nassau Supreme Court
Mineola, New York 11501
October 26, 2017

B E F O R E: HONORABLE JULIANNE T. CAPETOLA, J.S.C.
(Justice of the Supreme Court)

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OFFICIAL COURT REPORTER

THE CLERK: Case on trial continued in the matter of Elyse Long as administratrix of the estate of Jerry Long deceased against New York Presbyterian Hospital/Weill Cornell Medical Center and Brenna M. Farmer M.D.

Appearances remain the same as previously noted.

COURT OFFICER: Jury entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: Good morning everyone.

My allergies are horrendous today, so I'm not crying. I apologize but I sound like I have a cloth-pin on my nose.

We are ready for the next witness.

MR. CRAFA: Thank you, your Honor. The plaintiff calls Dr. Alan Schechter, please.

(Whereupon, the witness takes the stand.)

THE CLERK: Please stand. Raise your right hand.

Do you solemnly swear the testimony you are about to give to the Court is the truth, the whole truth and nothing but the truth so help you God?

THE WITNESS: I do.

THE CLERK: Be seated.

THE WITNESS: Thank you.

THE CLERK: Doctor, for the record, state your first and last name, spell your first and last name.

THE WITNESS: Alan, A-L-A-N, Schechter, S-C-H-E-C-H-T-E-R.

THE CLERK: Your business address.

THE WITNESS: Montefiore Medical Center, 111 East 210th Street, Bronx, New York 10467 Emergency Department.

DIRECT-EXAMINATION

BY MR. CRAFA:

Q Good morning, Dr. Schechter?

A Good morning.

Q Doctor, let's begin a little bit with your educational background, start with college and take us from there, if you would.

A Certainly. After I graduated high school, I went to Brooklyn College. I was in Brooklyn College from 1970 through 1974. I graduated with a degree in chemistry.

After my graduation from Brooklyn College, I went to Boston University, School of Medicine. I went to Boston University School of Medicine from 1974 through 1978, and then I came back to New York. I started my residency at Montefiore Medical Center.

In 1978 emergency medicine was not a full and

independent specialty at that time. So it was usually handled by internal medicine or surgery or pediatrics. So I entered an internal medicine program, and I was an internal medicine intern and then resident.

I spent one year going back to Boston. I thought I might want to be an ophthalmologist. After doing it for a few months, I realized taking care of the whole patient was more my personality, what I would like to do.

I came back to Montefiore, finished up my residency in internal medicine and continued on at Montefiore as an attending. So I became an attending in the department of medicine in the division of emergency services. So the department of medicine was running the emergency department, and then had input from surgery and input from pediatrics.

Over time, the department specialty of emergency medicine grew and it became a full and independent specialty. So I became board certified through practice in emergency medicine, I became board certified in internal medicine in 1982. I became board certified in emergency medicine in 1988.

In emergency medicine you have to recertify every ten years. It's a national test. So I recertified in 1998, in 2008 and I will recertify again in 2018.

In about 1997 the department of emergency medicine

became an independent department at Albert Einstein College of Medicine and Montefiore which was the teaching hospital at Albert Einstein College of Medicine. Subsequent to that we actually totally merged. We now run the medical school.

I became a duly appointed assistant professor, assistant professor of internal medicine and an assistant professor of emergency medicine.

Over time, because emergency medicine became much more busy as a specialty, I dropped my assistant professorship in internal medicine and I continued my assistant professorship in emergency medicine, although I remained with a duly appointment in the department of emergency medicine and the department of internal medicine.

Q Doctor, describe for us, if you could, your teaching responsibilities.

A Certainly. So we are a major teaching hospital. We are called Touche Medical Center. So we are the major teaching hospital for Albert Einstein College of Medicine. So we teach medical students who rotate through the emergency department. We have one of the largest residencies in emergency medicine. I believe we now have over a four-year spread period 64 residents. We teach emergency medicine residents at Montefiore Medical Center. Part of their experience is at Montefiore Medical Center and part of their experience is at Jacobi Medical Center, so

they get a varied experience.

In addition to the emergency medicine residents, I teach internal medicine residents who get experience in taking care of patients who come in with what we call undifferentiated. They come with a complaint and a little bit of history and you have to figure out what's going on with them and initiate appropriate workups and treatments.

Additionally, I teach orthopedic residents who rotate through. I teach family medicine residents who rotate through. I teach physician assistant -- students who rotate through and additionally, nurse practitioner students who rotate through.

Basically, in all of these fields in which there needs to be some exposure to taking care of a fresh new patient that you have never seen before that has a problem. So not only emergency medicine, but all of these specialties I am the person who teaches them how to go about evaluating those patients.

Q And doctor, describe your practice of medicine.

A Basically, I am a clinician. I see emergency patients every week. Usually I work three -- varies, three to four shifts, either 12 hours, ten hours or eight hours, they're rotating shifts. I see patients on my own. I see all the patients with the residents or the students are seeing.

So every patient that presents to Montefiore Emergency Department gets evaluated by an attending physician, such as me. We take the full history. We do the full physical and then we discuss with the people we are teaching what should be done with the patient. Obviously, it varies. So a student will have this rudimentary-level of what needs to be done.

As you look at a resident, especially as they progress over time, they become closer and closer to what an attending should be doing, and the speed at which an attending should be doing it, and the ordering of the priority of activities that are necessary to treat the patient in an optimal way, and that should come over time through the training that we give them.

Q Doctor, are you on any committees at the hospital?

A Yes. I'm chairman of the quality improvement committee for the emergency department at Montefiore, and I've been doing that since 1988. It's one of the most enjoyable things that I do, aside from taking care of patients. What we do is we look at both system issues, that is how can we make the emergency department flow better so that the patients get a better experience, that they get their treatments in an optimal manner, and so that we get them appropriately treated, admitted or discharged or referred for follow-up.

Additionally, one of the most important things we do is we look at adverse outcomes, that is, if you're going to be in an emergency department, there are going to be outcomes which occur which you don't want to occur. They can occur because it's the natural history of the disease or they can occur because there was a medical error, whether the medical error was due to a clinician's lack of knowledge or whether the medical error was due to the clinician's negligence or whether the medical error occurred because there was a system involved that pushed the decision tree to an area which we didn't want it to go. We look at all of those cases.

Every mortality that occurs in the emergency department, those are reported monthly. I share a meeting on a monthly basis.

In addition, if any adverse outcome occurs, we look at those adverse outcomes, and we may internally refer them or they may be referred from outside departments.

A department may come to us and say, You really didn't do the job that you should have done on this particular case, and then they're assigned to other, attendants called peer review, and then they're presented at committee meetings. A decision is made as to whether the standard of care was met or not. Then if the standard of care was met and was an unavoidable outcome, we'll state

that. If the standard of care wasn't met, then we'll look to find out a way that this should never happen again.

Q And doctor, I don't think you mentioned, I know you're licensed to practice medicine in New York, when were you so licensed?

A I was licensed to practice medicine in New York in 1979.

Q And have you testified as an expert witness in various courts over the years?

A I have.

Q In emergency medicine?

A Yes.

Q And doctor, I know as an expert witness you're entitled to be compensated for your time here today. Can you tell the jury, please, at what rate?

A So for reviews I charge $500 an hour and to appear in court I charge $5,000 for a day.

Q And doctor, have you reviewed certain records and materials relating to the care and treatment of Jerry Long back on December 23, 2011?

A Yes, I have.

Q And doctor, have you come to certain opinions and conclusions with respect to your review of those materials?

A Yes, I have.

Q And are your opinions to a reasonable degree of

medical certainty?

A Yes, they are.

Q And doctor, I want you to assume, if you would, that on December 23, 2011 Jerry Long was a 45-year-old man in his usual state of health. He commuted from his home in Oceanside to his job at a Duane Reade in Manhattan. He was a store manager.

While at work that day, December 23, 2011, some time before 9:25 in the morning, Jerry felt a sudden onset of severe pain in his lower right abdominal area. An ambulance was called, and we know from our ambulance records, which you have in the record and it's here in evidence, that ambulance was called at 9:25 in the morning. They came over to Duane Reade. Jerry was awake, alert, speaking in full sentences. He told the ambulance personnel about the pain he had. He was alert and oriented times three. They noted a blood pressure of 40 systolic?

A Systolic.

Q Systolic is the right word.

They put him on the floor, raised his legs. They called for another ambulance. They called for an advanced life support ambulance which came over, and they arrived at the store the Duane Reade about 9:37.

They noted normal sinus rhythm.

What is that, doctor?

A So a sinus rhythm just means that when the electrical activity of the heart occurs, that the transmission of the electrical activities start in the atrium, then goes to the ventricle. So it starts in the sinus node. So that's why they call it a sinus rhythm.

Q And doctor, the ALS ambulance crew took his blood pressure at 9:41 in the morning, and they note BP of 109/82.

Doctor, is that significant when you compare it to the BLS note of a 40 systolic blood pressure?

A Well, correct. Certainly a 40 systolic blood pressure is very, very low blood pressure. When you look at the blood pressure of 109 over 82, that's a normal blood pressure.

Q And doctor, they found that Mr. Long denied chest pain, denied shortness of breath. They note he reported a sudden onset of severe pain to the right lower abdomen, the right inguinal area and radiating over to his flank. He became -- he lapsed into unconsciousness and became unresponsive.

They did note in their record that there was a sustained tachycardia, they call it, for less than a minute that self-corrected to sinus tachycardia.

What is that?

A Certainly. What happens when a heart is under stress is it may change its rhythm. So one of the rhythms

that can occur, the heart cells become transiently ischemic, which means, they don't get enough blood. They can begin to fire erratically.

The impulse starting at the sinus node, it actually starts in the ventricles, it goes very, very fast. So you have what's called ventricular tachycardia. That's a very fast heart rate. It's going to be over 150. It can approach 200.

Normally, if the rhythm doesn't stop, we give medications if the patient is awake. If the patient is in shock, we simply defibrillate them, that is, we hook them up to cardiac monitors which I'm sure you have seen. Basically, give them an electrical discharge. That resets the heart, then goes back to sinus node.

In Mr. Long's particular case, it was described as for under a minute and it reverted all by itself. So he had a run of a very rapid heart rate from a ventricle focus which can be assigned that the heart isn't getting enough oxygen or some other metabolic stress from what we call catastrophic insult. When you have an insult, the body sends out a lot of adrenaline. These things can cause the heart to have an arrhythmia.

He had a period of under a minute ventricular tachycardia, and then his body was able to reset itself back to sinus rhythm.

Q And doctor, the records of the ambulance crew also note that Mr. Long had marked rigidity and increased pain on general palpation. Would that be a significant history to the practitioner?

MR. CREAN: Objection, your Honor. Objection to the term. I don't think that's what it says. I don't think that's an inaccurate reading of the EMT note.

MR. CRAFA: Well, we have the note in evidence.

MR. CREAN: Let's --

THE COURT: Would you like to rephrase your question, if it's incorrect?

MR. CRAFA: I don't think it is.

THE WITNESS: I --

THE COURT: No, you cannot say anything. Sorry, doctor, no disrespect.

MR. CRAFA: It notes, marked rigidity and increase pain on gentle palpation. Is that not what you have?

MR. CREAN: No, I don't think that word is "marked."

MR. CRAFA: That word right there?

MR. CREAN: Yep.

MR. CRAFA: You don't think that says

"marked"?

MR. CREAN: No.

MR. CRAFA: Okay.

MR. CREAN: I think it says noted.

MR. CRAFA: All right. Leave out the word marked. It says rigidity.

MR. CREAN: What do you think, doctor? That's very inappropriate. I am sorry. I withdraw that. Sorry.

THE COURT: Can you read that chart?

THE WITNESS: I believe I can.

THE COURT: What do you think it says?

THE WITNESS: I think it says "noted."

THE COURT: Okay.

Q Okay. Noted rigidity and increased pain on gentle palpation.

THE COURT: Thank you. He can't read his own handwriting.

Q Does he have that?

A Yes.

Q Is that significant information?

A Yes.

Q Why that?

A Because it suggests there's an acute abdominal process that's occurring in Mr. Long, that is, if you read

the note that's in the ambulance call report, what happened to Mr. Long is succinctly here, he develop acute onset of abdominal main in the right lower quadrant, radiates to the flank, passes out, has a period of hypotensive, then has a period where he has a run of Vtach which stops. He has no chest pain. No shortness of breath. When the pre-hospital providers, the ambulance crew, pushes on his belly, they noticed that he has some rigidity which means that he's tensing up, and that he has pain on gentle palpation. That means they're pushing lightly, but he still has pain.

That scenario is an intra-abdominal catastrophe until proven otherwise. That is the thing that you think about as a pre-hospital provider and as an emergency physician, that there was some major bleed which occurred.

Cause in another part of the note he says, they describe him particularly as pale and gray and low blood pressure, acute onset. This is some sort of acute blood loss in the belly. As a result, intravenous is put on. He is given oxygen. He is transported emergency to Weill Medical Center.

Q And doctor, I would also note that there's no evidence of any trauma?

A That is correct.

Q And doctor, arrived at the hospital at about 9:48 a.m. He was unconscious and he remained that way. At 10:09

we have some of these vital signs here, Doc.

THE COURT: Could I just ask the jury, do you prefer when the lights are out, when that's on or doesn't matter to you guys?

A JUROR: Doesn't matter.

THE COURT: Okay then, we'll leave it on. Thanks. I appreciate it. From my angle, I can't see anything.

You can't see it?

THE WITNESS: No.

MR. CRAFA: It will come on sharper.

THE WITNESS: Yeah, no. It's just the contrast.

THE COURT: There you go.

THE WITNESS: That's much better. Thank you, Judge.

THE COURT: You're exercising your arm everyday.

Q And doctor, at about 10:09 in the morning, Mr. Long's been in the hospital now for about 20 minutes. They note additional heart rate of 130 and a blood pressure of 153 over 111.

Now, doctor, I would ask you as an emergency room physician, is the history of the patient important?

A Oh, absolutely it's important.

Q Why is that?

A Because the history is the amount of information, the data points that we get in order to make a determination of what this patient could have. So the history becomes key in directing us in the appropriate workup that we need to do and to generate an appropriate, what we call, differential diagnosis, that is, what are the things that can cause this. Then when we make up that list, which ones do we have to workup right away and which ones can be pushed back a little bit.

Q And doctor, given the history that we've now talked about, given the vital signs that were noted by the ambulance crew, the initial vital signs in the hospital, do you have an opinion with a reasonable degree of medical certainty as to a differential diagnosis for this unconscious, unresponsive patient?

A Yes, I do.

Q What would that be?

A The differential diagnosis, the leading diagnosis in someone who presents with acute onset of abdominal pain, period of hypotensive with syncope, who then has a blood pressure which is fluctuating, who has a tender abdomen, who has some flank pain is an intra-abdominal bleed until proven otherwise. The most common one is an abdominal aortic aneurysm, but there are other bleeds that can occur that

will not be picked up by things such as a fast exam.

So that when Mr. Long comes in, this is an intra-abdominal bleed of a catastrophic nature that needs an aggressive workup, aggressive therapy and an aggressive diagnosis and surgical intervention at the time he comes in, and that is the leading diagnosis that he has.

Q And doctor, I want you to assume that Dr. Farmer, the attending physician in the ER at New York Presbyterian that day, tells us that her initial differential diagnosis at about ten a.m. was evaluate for aortic dissection intra-abdominal or intra mass bleeding, and there was a search for a proximal cardiac lesion.

Are you familiar with that?

A I am.

Q And do you agree with that, doctor?

A That's a reasonable differential diagnosis. It includes those things that are catastrophic, that needs to be handled immediately which is an acute intra-abdominal bleed which is causing shock. It also deals with some other things that can happen. So aortic dissection is a reasonable diagnosis to think about.

Now, he didn't have chest pain. He didn't have shortness of breath up until and we don't know after he passed out what he had, but you can have an aortic dissection. An aortic dissection, there are two kinds, type

A and type B. Type A is a very proximal lesion, comes out of the aorta as it comes off the heart.

THE COURT: A little slower. These are not medical students. They're a jury. They have to understand you and I have to understand you and my court reporter needs to make a record.

THE WITNESS: Absolutely I will.

THE COURT: Thank you.

A So the type A dissection is a tear in the aorta which comes off, very close to where the heart is.

A type B dissection is a dissection which occurs as the aorta is going down toward the chest and into the abdomen, that tear can leak. It can leak its free fluid in the abdomen or it can leak into what we call the retroperitoneal space.

The abdomen has a lot of its organs and its blood vessels behind, basically, a sheet of fibrous tissue. So that, the blood dissection is along the fibrous tissue and the muscles, but doesn't go freely into the abdomen.

What you can have in a situation like that is some intermittent bleeding. You have bleeding. You drop your blood pressure so the bleeding slows down cause you don't have the pressure which forces the blood out of the tear of the hole in the blood vessel. Your blood pressure comes up, you bleed again some more. So it's slow, then fast, then

slow, then fast, a bleed.

If it's retroperitoneal, you won't see it. You may not see it on a fast exam, but it's clearly there. It's clearly causing shock and it's clearly causing pain. There are methods to make that diagnosis, and those methods include stat, CT scan and at the same time getting a surgeon -- this is going to be a surgical emergency. We, as emergency physicians, can make the diagnosis, but in reality, we can't effectively treat a major tear in a major arterial blood vessel that's in the abdomen. That's going to require a surgical intervention.

An expert in endovascular intervenes to actually open the patient up, putting pressure on that and sealing off that tear. Because it is a time is of the essence diagnosis, you start that work up immediately when the patient comes in. When it's in your differential and that is a reasonable part of your differential because the delay can be catastrophic.

Q Why is that, doctor?

A The delay is catastrophic because you continue to bleed, and the longer you continue to bleed, the more you're going to go into shock. The more you go into shock, the more difficult it's going to be for the surgeon to effectively reverse the injury and the bleeding that occurred. If you continue to bleed over a prolonged period

of time, you can go into something called disseminate intravascular coagulopathy which can be more difficult for you to control your bleeding.

In these situations what you want to do is get the patient, such as Mr. Long, to the definitive person who can treat the patient and that's a surgeon. As an emergency physician, your obligation, the standard of care that you must follow is to make the diagnosis rapidly and to call the surgeon in rapidly.

It may be that you're not going to be able to clearly define where the bleeding is, but if you know there's bleeding, if you have reason to believe that the bleeding, more likely than not, is in the belly cause if it's not, you're not vomiting it up, you're not -- it's not coming out your bottom and you're hypotensive and abdominal pain, you call the surgeon. The surgeon will help you make the workup appropriate for the degree of illness of the patient.

There are times when the patient will be scooped to the operating room because in the --

MR. CREAN: Objection, your Honor. Objection to "there are times."

THE COURT: I'm going to sustain.

MR. CREAN: Certainly, there are lots of times when people are taken to the operating room. I

don't know that that relates to these facts.

THE COURT: I'm going to stop the narrative and ask for a question, please. Thank you.

Q Doctor, you jumped ahead of me a bit. I asked about the differential, then you went into what you do about the differential. We'll get into that in a bit.

I want to address this: Dr. Farmer told us here that one of the first things they did is they drew blood from the patient, and they have a machine right there in the ER that they can check the blood for -- to be very colloquial if I can -- and those blood values report came back at 10:11 in the morning. It showed a very low hematocrit, hematocrit of less than ten, but Dr. Farmer tells us that report was absolutely no good. The other values associated with the report indicates that there was either a malfunction in the machine or something was wrong. Could not use those values at all.

Does that happen from time to time in the emergency department?

A It certainly does.

Q What do you do about that?

A Repeat the test. We try another sample and repeat the test.

Q Dr. Farmer didn't do that, doctor. Dr. Farmer waited for the complete blood count, for blood she had drawn

or was drawn on the patient to come back, which we know from her record came back about 11:05. So she didn't have reliable blood values back for about an hour. The hematocrit, when those blood values did come back, was 18.9. Is that low?

A Yes, that's definitely low. So a normal -- for a normal male, your hematocrit is going to be probably about between 42 and 48, varies from lab to lab, but into the 40s. So if you have hematocrit of 20, basically you've lost half of your red blood controls and you lost half of your oxygen carrying capacity as a result of that.

Q And doctor, would that lack of blood explain the patient's symptoms? Would that lack of blood, that hematocrit value from blood taken shortly after the patient gets to the hospital, would that explain the patient's symptoms?

A Absolutely.

Q Would it explain the changes in the heart?

MR. CREAN: Your Honor, I'm okay if Mr. Crafa is going to do all the testifying, but it's highly suggestive and inappropriate.

MR. CRAFA: I feel like I said very little. Let me ask --

THE COURT: Rephrase, please.

Q Doctor, in your opinion, to a reasonable degree of

medical certainty, does the hematocrit value reported at 11:05 in the morning at 18.9, how does that relate to the patient's symptomatology?

A Well, it's consistent with what we expected based on the presentation which is this is going to an intra-abdominal catastrophic bleed. That is, Mr. Long had no history of anemia. He is a person who came to work -- he was going to work and suddenly develops severe abdominal pain, flank pain, collapsed and then had a period of time when he was able to say, I don't have chest pain. I don't have shortness of breath. I do have abdominal pain. He is described as pale. All of those things are consistent clinically with severe intra-abdominal bleed.

Now, we get back hematocrit which is 18, which is half of the normal value that you would expect for someone such as Mr. Long. And so that says and supports that this is a catastrophic intra-abdominal bleed. Now you have blood work which confirms what your clinical suspicion is, that this is an intra-abdominal bleed that's causing tremendous anemia to Mr. Long.

Q Now, doctor, I would ask you, when we look at these vital signs from the period of about 10:09 in the morning until 10:30 in the morning, we see initially the BP at 10:09 at 153 over 111. What do you make of that blood pressure?

A Well, that's actually a little on the high side, so that's hypertension. That is actually not so surprising. When someone has an acute event, you may know it as a fight or flight response, where you have an adrenaline surge. What happens is the body's vasculature will clamp down. So you have a transient rise in blood pressure due to the stress of the pain that's occurring and the shock that the patient has experienced, so that the body is compensating. So the heart is beating very, very hard, and the blood vessels are constricting, so the blood pressure will go up.

Q Now, we see that again at 10:12 in the morning the blood pressure is at 157 over 101, and then at 10:25 a.m. we see a blood pressure of 129 over 82.

Doctor, I want you to assume that there are two fast studies that we mentioned earlier. Both of them were completed by about 11:17, but Dr. Farmer's indicates that in her view, the first one at least, was finished by about 10:30 or so in the morning.

Doctor, these blood pressures that are hypertensive and not hypotensive and the fast study done at that time was negative. Does that rule out an intra-abdominal bleed?

A Not at all. We know that the fast study, at best, the fast study was actually designed for blood trauma. It wasn't designed for this. It was a focused assessment by

sonography trauma. We use it for other things, but it is not good for a retroperitoneal bleed. Its goal is to look to see if there is free fluid in front of the peritoneum or a huge amount of fluid. If there is not, it doesn't mean that there's not a bleed. It means you need to go on and do other evaluations.

So, it is totally consistent that the first fast and even the second fast may be non-diagnostic. Doesn't mean it's negative. It means it just hasn't seen the bleed that's there.

Q Now, doctor, at 10:25 in the morning we see --

MR. CREAN: Your Honor, I object to the retrospective elements that he's putting into it. I move to strike.

The fact that doing the test won't get the bleed that, you know, is there. I mean, that's completely with after acquiring information. I move to strike that because it is his postulate that -- well, I move to strike.

MR. CRAFA: Well, let me rephrase.

Q Doctor, you told us that an intra-abdominal bleed would be on the differential when the patient arrives. Dr. Farmer told us an intra-abdominal bleed was on her differential when the patient arrived.

My question for you is: This information that we

have up til about 10:25 in the morning, a negative fast, hypertensive BPs, does that rule that off your differential?

A No, it does not.

Q The question then is: Why not?

A It doesn't because, in fact, the fast exam can miss blood that's in certain parts of the abdomen.

Q Now, doctor, at about 10:25 in the morning they started Dopamine with this patient. What's that for?

A Dopamine is what's called the catecholamine. So what Dopamine does is it makes the blood vessel contract, and it makes the heart pump stronger. It's used to raise the blood pressure.

Q And they installed a catheter into Mr. Long's bladder. They noted clear yellow urine was out. What do you make of that for this patient?

A Well, it shows that, in fact, the blood is not coming from his urinary tract. It's showing he is making urine. That he's perfusing. It's one of the things you would follow over time to see if he's continuing to well perfuse his kidneys.

Q Doctor, at 10:35 in the morning suddenly the blood pressure drops to 58 over 42, and at 10:45 it's at 54 over 14. At 10:35 Dopamine drip was increased. At 10:45 RIJ cordis was placed and the Dopamine drip was increased again.

Doctor, do you have an opinion to a reasonable

degree of medical certainty as to what's going on with the patient, and why his blood pressure is suddenly dropping like this?

A Well, Jerry Long is bleeding to death. What's happening is he's continuing, based on a much more likely than not basis, based on the clinical presentation he has, that he's bleeding into his belly, and he's no longer able on his own to keep his blood pressure up.

So what was done was that they put what's called a central line cordis, a large line into the internal jugular on the right, and they're giving him pressors. They're giving him things to make his heartbeat stronger and to give his blood vessels constricting quality to them. At this point other things needed to be done.

THE COURT: Stop. There's no question before you.

Q Let's jump just a little bit further, doctor.

THE COURT: Thanks, please.

Q We see at 11:07 in the morning a unit of O negative packed red blood cells was beginning to be infused into Jerry Long. That's the first unit of blood that Mr. Long got that morning.

We see, doctor, at 11:19 in the morning his blood pressure is 84 over 62. What is the significance of the blood and this blood pressure?

A When the blood is being given, what you're doing is you're actually treating, to some degree, his hematogenic shock, that he's bleeding to death. He needs more blood in his blood vessels. That is blood that's in the retroperitoneal or blood that's in the belly itself isn't going to perfuse it, just pools there. But by putting more blood, transfusing him, you're giving blood cells into the intravascular space. It allows him to, in fact, bring his blood pressure back up again to adequately perfuse -- to better perfuse I should say.

Q Doctor, do you have an opinion to a reasonable degree of medical certainty given the differential diagnosis with this patient as to whether or not it was a departure from good and accepted medical practice not to transfuse the patient prior to 11:07 in the morning?

A It was a departure from good and accepted medical practice.

Q Even without a reliable blood value study?

A Correct. We transfuse clinically very, very often. In fact, very, very early on in a bleed. The hematocrit may not be very low cause it takes a while for the blood, the free fluid that's in the body, to reentered the vasculature. So, initially, the blood that's remaining will have the same hematocrit that the original blood that was lost will have. Only later the hematocrit drops.

So, clinically, we have Mr. Long who had an acute onset of right lower quadrant pain and then had a syncope episode, was pale, the pre-hospital, prior notes documented he had flank pain too. This is an intra-abdominal bleed and clinically transfusing him is what the standard of care is.

Q Well, doctor, the intraoperative bleed, along with other potential bleeds, was part of a differential, right?

A That's correct.

Q And that's a medical suspicion that might be what's causing the patient's problem; is that right?

A That's much more likely what's causing the patient problem based on the clinical presentation that Mr. Long presented with.

Q And would there be any danger to the patient in transfusing blood before you know that the patient needs it?

A There's always a danger in transfusions. You could have a transfusion reaction. So it's done only when the benefits outweigh the risks. Here you have somebody who has clinically a catastrophic intra-abdominal bleed. In fact, giving that unit of blood can be life saving cause it can buy you more time until the surgeon can come down, until the patient can go to the OR.

MR. CREAN: Objection, move to strike.

THE COURT: Grounds?

MR. CREAN: Speculative.

THE COURT: Say it again.

MR. CREAN: Speculative. He is speculating about if you do certain things, other things might be --

THE COURT: Specifically, what was speculative?

MR. CREAN: If you give blood at a certain time, other things may or may not happen.

THE COURT: Well, I'm going to overrule your objection cause the witness was explaining why sometimes the benefits would outweigh the risk. That was part of his explanation.

Q And Dr. Schechter, I want you to assume that Dr. Farmer has testified here that she had her resident Dr. Ferrer call for a surgical consult after seeing the results of an abdominal sonogram conducted by a radiology technician in the emergency department some time between 11:30 and 12:20.

The ultrasound report notes that the radiologist Dr. Watson called Dr. Farmer with the results at 12:20. Dr. Farmer tells us that she saw the results as the technician was actually performing the study. The emergency department, the record does not indicate that Dr. Ferrer placed a call to the surgical resident at any particular time. We do have a note from the surgical resident saying

he was called at 1:05 in the afternoon, but let's go with Dr. Farmer's testimony that surgery was called at around 12:20 or so in the afternoon.

Do you have an opinion to a reasonable degree of medical certainty as to the timing in this case of Jerry Long, the timing as to call for a surgical consult?

A I do.

Q What is your opinion?

A My opinion is that the surgeon should have been called basically when Mr. Long arrived. Because when Mr. Long arrived, he had a history of abdominal pain, a history of syncope, a history of transient Vtach, a history of now being unresponsive described as pale. This is an intra-abdominal bleed of catastrophic nature until proven otherwise, and the treatment for that is going to be surgical.

What you do is you bring the surgeon in early cause the surgeon can help expedite the workup, and can make a decision to do what's called a scoop and run and to bring the patient up to the operating room. In the operating room you can do many things that are necessary radiography to make the diagnosis. If you can't make the diagnosis, you can do either laparoscopy or laparotomy and take a look inside.

In some cases like this in which the patient is

bleeding to death, in which you have effect treatments for this, bringing the patient to the definitive site which is the operating room is the obligation of the team which is the emergency physician and the immediately called surgical consult.

Q Doctor, do you have an opinion to a reasonable degree of medical certainty as to whether the failure to call for a surgical consult until 12:20 p.m. at the earliest was a departure from good and accepted medical practice?

A Yes, I do.

Q And I think you just explained why.

A Yes.

Q And doctor, do you have an opinion to a reasonable degree of medical certainty as to whether or not this departure was a substantial factor in causing the death of Jerry Long?

A Yes, I do.

Q What is that opinion?

A It was a substantial factor in causing Mr. Jerry Long's death from bleeding to death. Mr. Long came to the emergency department at about ten o'clock in the morning, and he did not go to the OR until almost two o'clock. There were four hours in which he was bleeding to death. Had the surgeon come in earlier, the standard of care that would have been required would have been to bring him to the OR

earlier and --

MR. CREAN: Object, Judge. I have not heard -- may I have a voir dire?

THE COURT: Okay.

VOIR DIRE-EXAMINATION

BY MR. CREAN:

Q Doctor, did you undergo a surgical residency?

A No, I did not.

Q Are you a surgeon?

A No, I am not.

Q Are you board certified in surgery?

A No, I am not.

Q Have you performed surgery in the last 30 years?

A Minor procedures but not the procedures you're asking for.

THE COURT: Please let the witness answer and can you slow down. You're talking over each other.

Q Have you performed laparoscopy on a patient in extremis in 30 years?

A No.

Q Ever?

A No.

Q Have you performed laparotomy where you open the patient up in a patient that's in extremis?

A As an attending, no.

Q You didn't take boards in surgery?

A Correct.

Q No residency in surgery?

A Correct.

Q You would not call yourself a surgeon?

A That's correct.

Q But yet, you'll come here and give a surgical opinion about what procedures can be done under what circumstances to save this person's life; is that what you're saying?

A As an emergency physician, yes, because we deal -- we work with surgeons all of the time.

Q That's not what I asked you. I asked you that -- you're offering your statement as if you have expertise in that area. I just want to see if you agree with me that you have no expertise in the area of making surgical decisions; isn't that correct?

THE COURT: Don't answer that. Have a seat. The voir dire is over. You have gone beyond the scope of the voir dire. I'm going to permit the witness to continue his answer as an expert in emergency department protocol, and that's how he was answering the question, not as a surgeon. So I'm going to permit the answer. You can cross. Thank you.

CONTINUED DIRECT-EXAMINATION

BY MR. CRAFA:

Q To state my question a little bit differently, doctor. Do you have an opinion to a reasonable degree of medical certainty as to whether the departure in not calling for a surgical consult until 12:20 in the afternoon at the earliest deprived Jerry Long of a substantial opportunity to survive?

A Yes, I do have an opinion.

Q What is that opinion?

MR. CREAN: Note my objection, please.

THE COURT: Of course.

A The opinion is that it deprive Mr. Long of the opportunity to survive.

Q And doctor, we talked a little bit about the importance of timing in a situation like this. Why is timing so important?

A Well, timing is important because there are certain situations, such as continued bleeding, where the longer the patient is bleeding, the more metabolic insults he will develop. So that by intervening early, you have a better opportunity of not only saving the patient, but ensuring there are no irreversible injuries that are occurring to the patient.

Q And doctor, I want you to assume that Dr. Farmer has told us that she could not call surgery before she had

the results of the intra-abdominal sonogram because she could not give surgery a surgical cause, a reason to come down. Do you agree with that?

A Do I agree with that reasoning? No.

Q Why not?

A The reasoning is incorrect.

Q Why is that?

A In fact, we call surgical consults often because we're not sure of the specific diagnosis. Importantly, we call surgical consults in cases like this in which there's catastrophic bleeding in order that they make a decision with us about what the most optimal care is. Often the optimal care for patients who are coming in with catastrophic intra-abdominal bleeding is to bring the patient up to the operating room where they can do the necessary angiograms --

MR. CREAN: Your Honor, this is where I object. Here we go. He's going again into the specialty of surgical decision-making.

THE COURT: So I'm going to stop you right there. In other words, the optimal care -- just read me back the last part.

In other words, doctor, what you're saying is to go right in the OR so that they can further diagnose, without discussing what they can do, is that

what you're saying?

THE WITNESS: Correct. That is, we work as a team and the surgeon needs to be called in early so that he can optimally provide the services that he does. We do know what those services are.

Q Okay. Doctor, you spent some time in the case talking about CAT scan; that the patient was transported to the radiology department at about 12:20.

According to what Dr. Farmer tells us, there's notes in the record at about 1:00 p.m. The radiologist from the CAT scan called Dr. Ferrer and told Dr. Ferrer the results of the CAT scan.

Doctor, what is the purpose of a CAT scan in a patient with an intra-abdominal bleed on the differential diagnosis?

A The purpose of the CAT scan is to see if we can find the exact site of the bleed, and for patients who are stable, then that's a very reasonable thing to do for patients who are unstable. Then a decision must be made with the surgeon about whether the surgeon wants to take an unstable patient to the CAT scan or whether he wants to continue to transfuse the patient and bring the patient up to the OR where he can do -- I as an emergency physician knows what they can do -- an angiogram which is, in fact, what happened in this case or do a laparoscopy or a

laparotomy. Those are the things that we bring the surgeon in early for so that he has an opportunity to do it as opposed to someone who has bled for hours and hours and hours and only got two units of blood.

Q Doctor, the CAT scan reported at 1:00 p.m. in the presentation of a suspected bleed in the right lower abdominal quadrant. Dr. Farmer tells us that that is consistent with the patient's complaint at Duane Reade of right lower quadrant abdominal pain.

Dr. Farmer testified here that she could not take the patient to the CAT scan before 12:20 in the afternoon because he was too unstable. Do you agree with that?

A I agree that he was very unstable. What you need to do is -- that's why you bring the surgeon in early. The surgeon will make a decision about whether he wants to take the patient up to the operating room, just the showing that there's a likelihood of a catastrophic intra-abdominal bleed, and he will find out where that site of bleeding is in the operating room where he has a controlled situation or he may make the decision we're going to do a really quick -- we'll run over to the CAT scan, we'll look at the images on the screen, and if we see definitive bleeding in a site, we'll rush him from the CAT scan room to the OR. That was denied to Mr. Long because they didn't call surgery until such a late period of time.

Q Doctor, is a CT scan in your opinion to a reasonable degree of medical certainty required to perform a diagnosis on Jerry Long?

A No, it's not.

Q And why is that?

A Because he had signs and symptoms of intra-abdominal bleed and that can be diagnosed in the OR. It can be diagnosed in the OR by doing an angiogram. It can be diagnosed in the OR by doing a laparoscopy. It can diagnosed in the OR by doing a laparotomy. In fact, the official sonogram showed there was pre-fluid in the abdomen. After so many hours of bleeding and so they now saw free fluid and that free fluid is blood. Again, it supports the diagnosis that he had coming in which is a catastrophic intra-abdominal bleed.

Q Doctor, I want you to assume that Dr. Farmer tells us she decided to send the patient to the CT scan in the presence of two residents after packaging him up, as she described it, meaning, disconnected the intubation machine, making sure the radiology intubation machine was ready, disconnecting some of his IVs but hanging them on portable stands, I guess, and the two residents took Mr. Long over to the CAT scan. She decided to do that at about 12:20 after having the results of the abdominal ultrasound that showed the free fluid to attempt to ascertain the source of the

bleeding.

Do you agree, doctor, that Jerry Long should have gone to CAT scan at that time?

A No. I believe that the surgeon, the attending surgeon should have been notified, and the attending surgeon should have come down and seen the patient. The attending surgeon should have made a decision about whether they were going to send the patient to CAT scan or bring the patient up to the operating room.

Q And doctor, I want you to assume that after radiology, Mr. Long came back to the emergency department, the surgeons came down and they took over his care. He was taken to the operating room at about 2:00 p.m., and he was pronounced dead at 3:11 p.m. The official cause of death in the medical examiner's note says exsanguination due to a ruptured femoral artery. Are you familiar with that?

A Yes, I am.

Q Doctor, do you have an opinion to a reasonable degree of medical certainty as to whether or not getting Jerry Long to the operating room earlier in the day would have provided Mr. Long with a substantial opportunity for a cure or to survive this ordeal?

A Yes, I do.

MR. CREAN: Objection.

THE COURT: Grounds.

MR. CREAN: Form of the question.

THE COURT: Specifically.

MR. CREAN: I don't want to improve the question.

THE COURT: Okay.

MR. CREAN: I object to it.

THE COURT: Can you rephrase, counsel.

MR. CRAFA: Sure.

Q Doctor, do you have an opinion to a reasonable degree of medical certainty if Jerry Long had gotten to the OR an hour earlier, two hours earlier, two and a half hours earlier, even three hours earlier, do you have an opinion as to whether or not that would have provided Mr. Long with a substantial opportunity for a cure or stated another way, to survive this medical condition?

A Yes, I do.

MR. CREAN: Objection.

Q What is that opinion?

THE COURT: I'm going to allow it.

A My opinion is it would have allowed him a substantial opportunity to have survived. If you look at the course, he basically survived for four hours with a catastrophic bleed, with hematocrit down to 18 and with all of that he was surviving. The earlier that you intervened, the better the outcome because he would not have had such a

long period of time of bleeding, not such an extensive period of bleeding. He had three liters of blood in his abdomen. The total blood volume for somebody is five liters. He had three liters in his belly. When he came in, the original ultrasound didn't show anywhere near that. So he was allowed to bleed to death for something that could have been effectively treated. It's a tear in one blood vessel. By moving that timeline earlier, that would have markedly improved his chances for survival.

Q And doctor, you had mentioned the phrase earlier hemorrhagic shock, what is that?

A Hemorrhagic is when you bleed to death. That is your blood volume is lost to such a great degree that it puts hypotensive, inadequate perfusion to your body. It can affect other organs. It can make your heart look ischemic, that has ischemic changes on it. It can cause acidosis and all of those things, once the hemorrhagic shock is reversed and once you give the blood back and once you stop the bleeding, all of those things should reverse.

Q Dr. Farmer tells us, in her view, Mr. Long was in cardiogenic shock. Do you agree with that?

A Well, there was some component when I looked through the records. There is some -- there is some statements done by the critical care residents who are down there, CCU, and an ICU resident down there. They did an

ultrasound of the heart. They said that the pumping wasn't that great. That is not at all surprising given the degree of metabolic derangement.

THE COURT: What does that mean?

THE WITNESS: That he was very acidosis. That his PH failed to below seven, it was 68; that he had marked anemia; that he had shock. So all of those things can make the heart not work as efficiently as it should work, but those things are reversible when you take care of the anemia and the acidosis.

Q Doctor, we've discussed a few minutes ago --

THE COURT: Could I just ask a question? Acidosis.

THE WITNESS: So our normal PH, which is the concentration of hidden irons in our body, is 74. As you get to be -- as more acid goes into your body, your PH drops. It's like a negative log rhythm. Anyway, just think about it as the more acidotic you are, the more your number is going to go down below 74. So a PH of below seven is very acidotic, and it affects the way the enzymes work in your body.

Additionally, because he had lost half of his oxygen carrying capacity, because his hematocrit which should have been over 40 was now 18, below 20, the amount of oxygen that was being delivered to his

organs, including his heart, was half of what it should be. So all of those things will make the heart what's called relatively ischemic, that is, those cells aren't going to work as well because they're not going to work as well. They will not pump as well.

When you take care of the hemorrhagic shock, the acidosis goes away and the oxygen carrying capacity comes back. The heart comes back to its normal function.

Q We talked earlier, doctor, about the Vtach noted by the ambulance crew less than one minute that self-corrected. We also have a brief EKG strip in the record.

I would ask you, doctor, in your opinion to a reasonable degree of medical certainty did Mr. Long have a heart attack?

A No. Mr. Long did not have a heart attack. He had a transient arrhythmia, and then he had some evidence of probable ischemia. The ischemia is not a heart attack. Ischemia merely means that for a period of time the heart muscle cells were not getting the amount of oxygen that they required because the perfusion was inadequate for the demand, the muscle demand. But we know that he didn't have a heart attack cause we have the results of the autopsy and the autopsy is unequivocal. He did not have a heart attack.

Q And doctor, let's talk about the autopsy.

Dr. Farmer told us yesterday that at her deposition in 2015 when Mr. Long was wheeled into the operating room, she thought he had a chance to survive. She's changed that opinion and now she tells us that at no time had they gotten Mr. Long to surgery did he have any chance to survive.

MR. CREAN: Objection, just to the editorial statement, Judge. Objection to that. Sorry to interrupt you.

THE COURT: He's characterizing the defendant's testimony.

MR. CREAN: I understand that. I object.

THE COURT: I'll allow it.

Q Okay. She's changed her opinion on that now, doctor, and she tells us now -- yesterday and perhaps even the day before -- that in her view at no time had they gotten Mr. Long to the operating room, including ten a.m. in the morning, did he have any chance to survive. She bases -- that's based upon what she believed to be his multi-organ failure and the autopsy report with respect to his coronary artery disease.

Do you agree with that, doctor?

A No, I don't. Not at all.

Q Why not?

A Let's start with the heart first. If you take a look at the heart, there's no question that Jerry Long had atherosclerosis heart disease. Atherosclerosis is one of the most common diseases in American society. If you look at the actual description and I'm going to read it off --

Q Before you do --

MR. CRAFA: I am going to have to offer the autopsy report in evidence cause we have been talking about it for the last couple of days, but it's actually not in evidence yet.

THE COURT: Sure. Any objection, sir?

MR. CREAN: None, Judge. May need to be redacted.

MR. CRAFA: Yes, I agree with that, Judge.

THE COURT: So we redact it and put it in evidence later or you need it now?

MR. CRAFA: We may have to redact it later.

THE COURT: We'll put it in later, unless you need to refer? Are you putting it up on the screen?

MR. CRAFA: No, no. Let's just put it in and not show it to the jury until we redact it.

THE COURT: Okay.

(Plaintiff's 1 so marked in evidence.)

THE COURT: To be redacted.

MR. CRAFA: Thank you.

Q Now, doctor, the autopsy report is in evidence, but I'm going to ask you before you read any portion out loud, what portion are you planning on reading.

A I'm going to read starting on page four, the cardiovascular system.

THE COURT: Wait, wait. Let counsel look.

Q Okay. I'm with you. You're at the bottom of page four. Start.

A Correct. Cardiovascular system. The heart weighs 360 grams and has normal distribution of right predominant coronary arteries with focal 90 percent atherosclerotic stenosis of the distal left anterior descending coronary artery up to 75 percent stenosis of the proximal left anterior descending coronary artery and left circumflex coronary artery and 50 percent stenosis of the mid right coronary artery.

Most importantly, there is no recent thrombus. So what happens in a heart attack is that you have a thrombus, you have an --

THE COURT: Can you say that in lay terms because none of us know what you're saying.

A So he has coronary disease. He has a build up of plaque in his coronary arteries, but a heart attack is different. A heart attack is a complete occlusion of an epicardial coronary artery and that's not there.

He has narrowing. He has disease. He does not -- he does not have a heart attack. He has narrowing of disease but there is no recent thrombus.

The myocardium is homogeneous, dark red and firm without pallor, hemorrhage, softening of fibrosis.

There's no physical sign of a heart attack. There's no permanent muscle damage that was noted on this autopsy done by this pathologist.

And then the rest of it is, the left ventricle wall is 1.0 centimeters and the right is 0.3. The endocardial surfaces are unremarkable. The mitral value has moderate ballooning degeneration of the leaflets (Comment: Mitral valve prolapse.)

It's one of the ennobles that people can have in their heart. It's unrelated. This condition will not cause him death or anything.

The venae cavae and pulmonary arteries are patent.

Q Doctor, during the time Mr. Long was in the hospital, did he have multi-organ failure?

A Well, he did have multi-organ failure, in that, he had myocardium ischemia, but that was because he had transient inadequate blood flow to the heart. He has periods where he wasn't waking up, so he had dysfunction of his brain and he was hypotensive. So his cardiovascular system as a whole was not working correctly.

Q And doctor, do you have an opinion to a reasonable degree of medical certainty as to whether Mr. Long was deprived of a substantial opportunity to survive this condition despite his coronary artery disease and despite multi-organ failure?

MR. CREAN: Objection, Judge, wasn't that asked already?

THE COURT: No.

A Yes, I do have an opinion.

Q What is that opinion?

A That he was deprived of the opportunity for survival; that none of these lesions in the heart were lesions that would have killed him. These are lesions that are treatable. These are lesions that are common in American society. He could have been treated. If he became symptomatic with stents or a bypass, there was nothing in that autopsy in the heart that indicated that he had a heart attack or that the heart injury caused his death.

Q Now, doctor, can you tell us why was he unconscious and unresponsive?

A He was unconscious basically for multiple factors, that is, he was someone who was profoundly metabolically challenged because of the profound acidosis. In addition, he was someone who had marked hypotensive and inadequate perfusion.

THE COURT: You have to say this all again in English.

A He wasn't getting as much blood flow as was necessary to keep him awake and alert, but that doesn't mean that he has permanent brain damage. What that means is he simply was not, during the time that he was bleeding to death, receiving enough blood flow or enough blood; that adequate oxygenation or enough blood that was of an appropriate PH so that he could be awake and cognitive in his thinking, but it doesn't mean that he was brain dead. No, it means that he needed to have all of those things corrected so that his brain could basically return to normal function.

Q And doctor, was the multi-organ failure, was that reversible?

A Yes.

Q And why do you say that?

A Because all this multi-organ failure was due to hemorrhagic shock. He was bleeding to death and that is totally treatable. You stop the bleeding. You give blood transfusions. You bring back his blood pressure and he should come back to a normal status.

Q Meaning wake up?

A Yes.

Q And doctor, we see in the record, in the ambulance

crew report and in some of the notes in the emergency department, that he had palpable carotid or carotid pulses. What does that tell us?

A That's actually doing what the body is supposed to do. So the body based with hemorrhagic shock will clamp down peripherally in order to maintain blood flow to the heart and to the brain. So it will decrease blood flow to the extremities. It will decrease blood flow to the gut. Decrease blood flow to the kidneys. It will do everything it can with the limited amount of blood that it has left to direct blood flow to the brain and to the heart because those are the key organs that the patient has.

MR. CRAFA: Thank you, doctor.

THE WITNESS: You're welcome.

THE COURT: We're going to take a recess. Please watch your step getting down.

(Whereupon, the jury steps out of the courtroom.)

THE COURT: Don't talk to your counsel about your testimony.

(Whereupon, the witness steps down.)

(Whereupon, a brief recess is held.)

(After the recess the following occurred:)

COURT OFFICER: Jury entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: Doctor, I am going to ask you to take the stand please.

(Whereupon, the witness resumes the stand.)

MR. CREAN: May I, your Honor?

THE COURT: Of course, sir.

MR. CREAN: Thank you.

CROSS-EXAMINATION

BY MR. CREAN:

Q Good morning, doctor.

A Good morning.

Q My name is Peter Crean. I represent Dr. Farmer but you met me before in a courtroom.

A I believe so. I know your face.

Q And that's usually not a --

A It's a compliment.

Q -- good thing when they say that. Thanks.

You get to court and testify quite a bit?

A About two times a year, sometimes more, sometimes less.

Q And you review cases frequently for plaintiffs bringing you lawsuits against doctors, correct?

A Correct.

Q Now, when it comes to Mr. Long's coronary artery disease, you said something interesting. You said that coronary artery disease is common in society.

A Yes.

Q But do you mean to say that it's sort of a benign condition?

A No, no, it's not benign.

Q Just answer my question. Is it a benign condition?

A No.

Q Is coronary artery disease a dangerous condition?

A Yes.

Q Is it a deadly condition? Can it be a deadly condition?

A It can be.

Q And to say that there was not a heart attack in Mr. Long, quite correctly on autopsy, doesn't mean that he wasn't at high risk for a heart attack, right?

A That's correct.

Q And one of his lesions -- he had two substantial blockages described in the autopsy. One was 90 percent of the size of the lumen which is the blood carrying tunnel, right?

A That's correct.

Q And this is the left anterior descending artery? This is the artery that feeds the left ventricle, correct?

A That's correct.

Q Left ventricle, for all intense and purposes, the

business end of the heart?

A I would agree with you.

Q It's the pump. If there's a decrease flow to the pump and the pump starts to not function as well as it is, it's a serious condition?

A Yes.

Q And there's a second lesion in the left anterior descending. It was noted to be 75 percent. They noted something about where its location was in the autopsy, and that, you would tell us, is particularly important about its character. And would you tell the Court and jury what it is about the 75 percent lesion in the left anterior descending, its location, and why that would be particularly important to the survivability of a patient.

A Certainly. So it's 75 percent stenosis of the proximal left anterior descending coronary artery. So that it's coming right off the left main proximal. So if you have a heart attack at that point, which means, a total occlusion of that coronary artery, it's going to cause significant injury to all of the muscle tissue, muscle tissue beyond that occlusion.

Q So, to say it a little differently, it's at the beginning of the vessel, right out of the heart, right off the aorta, that feeds the pump or the left ventricle and off of that are several smaller cells which also feed the

ventricle?

A That's a correct statement.

Q The importance about proximal when it comes to a lesion as critical as 75 percent is that if it blocks -- if it has a sudden rupture of plaque, if it has a clot, it shuts down all the blood flow to the rest of the left ventricle. And what happens then typically is the patient dies, right?

A Actually, can't be answered as a yes or no cause you have other feeder cells that are --

Q Understood?

A Right.

Q There was --

THE COURT: We are not having a conversation. We have to have questions and answers so we can all hear, please.

Q There's no evidence of collateral support to support him if there with a blockage of the main vessel?

A That's correct.

Q And this vessel -- and we'll get to what else a blockage of this size can accomplish -- just while we're talking about this vessel and its importance to a patient and frankly to a family, is that this has a nickname or something that you in the medical profession refer to the left anterior descending artery as, what is that name?

A Some people call that name the widow maker.

Q And they call it the widow maker because if that blocks, the show is very often over, correct?

A I can't give you a percentage but often.

Q Now, in addition to the idea of a blockage causing a heart attack and killing Mr. Long, you know relatively on the spot or soon thereafter, there's other effects that these blockages can have, that is, they decrease the flow of blood to the heart muscle, correct?

A That's correct.

Q Decrease flow of blood to the heart muscle leads to decreased performance of the left ventricle, correct?

A Correct.

Q And when there's decreased flow of the blood to the left ventricle, the left ventricle doesn't pump as well, correct?

A That's correct.

Q And we know that because we know that Dr. Farmer had the -- withdrawn.

Now, when the function of the heart and particularly the left ventricle, as we're talking about it, has decreased flow and is, therefore, not pumping well, then there's decreased flow of blood back additionally, not just because of the blockages but because it's not pumping well and perfusing back to the heart muscle, correct?

A I'm not -- are you asking --

Q I'm asking, when the heart wall, when the left ventricle wall doesn't pump well, it has the effect of decreasing the flow of blood out and then back to the muscle so that the muscle then --

A Yes.

Q -- does increasing poorly?

A Yes, it decreases perfusion. Yes, you're right.

Q And one of the things that happens during this process -- well, this process can be called ischemia, correct?

A It is, yes.

Q And that's a decrease of oxygen, glucose and blood to the heart muscle in which the cells then start to be injured and in some cases die, right?

A Correct.

Q If they die, it's infarct?

A If they -- well, if they die you can have myocardia infarction. Myocardia infraction, really occlusion of the infraction is an occlusion of the epicardial cells. What you can have is it's a spectrum --

Q I understand that. So let me ask some more questions.

When this process is occurring, decreased blood flow to the left ventricle, decreased pumping of the left

ventricle, therefore, decreasing blood flow back, it can manifest itself. We already said that process is ischemia which is a decrease in nutrients to the cells of the heart, right?

A That's correct.

Q Which can proceed to become death of cells which can then be catastrophic?

A Correct.

Q We know that one of the effects that this can have is to cause something related to the other part of how the heart works apart from the plumbing, if you will, the electrical system of the heart?

A Yes, you're correct.

Q So now what can happen in this context is that because of the decrease flow of oxygen and blood to the heart muscle and the decreasing function, it can have cardiac dysrhythmia, right?

A That's correct.

Q The electrical conjunction that causes the different chambers to be synchronously and to make an orderly pumping of the blood, that can get deranged, correct?

A That is correct.

Q You told this jury, this morning in fact, that Mr. Long had that, that process actually occurred in

Mr. Long?

A Yes, you're absolutely correct.

Q And you told them that the original electrical impulse stopped coming from the sinus node on the right side of the heart and started originating on the ventricular side; is that correct?

A That is correct.

Q That was called a ventricular tachycardia?

A Correct, ventricular tachycardia.

Q What are the two most deadly ventricular rhythms known in cardiology?

A Well, the two most deadly ones are ventricular tachycardia, fibrillation and acidosis.

Q Well, acidosis, of course, that's when it's over --

A Right. Those are the two deadly ones. If you're asking if ventricular tachycardia is a dangerous rhythm, of course it is.

Q Ventricular tachycardia is a dangerous rhythm?

A Yes.

Q It's a deadly rhythm?

A It can be.

Q If it is not interrupted, one would therefore proceed usually to ventricular fibrillation and death?

A No, that's actually not true. Many people --

Q Wait for my question, please.

MR. CRAFA: Your Honor.

THE COURT: We have to let him answer the question.

MR. CRAFA: No, no, it was asked and answered.

THE COURT: Okay. He said no.

Q So in this case we know that Mr. Long had runs of sustained ventricular tachycardia which then self-terminated. We know that, right?

A I believe he had one run that was documented. One note, I believe, may have said two runs. Both of them terminated by themselves.

Q That's what I just said. Why are you looking at counsel? I just said --

A I'm looking at the chart.

Q Doctor, if you could listen to me. I said, did he have two or multiple occasions of ventricular tachycardia which was sustained but self-terminated?

MR. CRAFA: Objection.

THE COURT: The answer was one, maybe two.

MR. CREAN: Okay, that's his answer. That's fine.

THE COURT: That's why he was looking at the notes cause he only --

MR. CREAN: Feel free to look at the notes any time.

THE COURT: That's what the witness said to you. He said, I'm looking at the notes.

MR. CREAN: No, no.

THE COURT: There's one possible notation of a second, correct?

THE WITNESS: Correct.

Q Okay. I would like you to assume there were two and it was associated with him losing consciousness, right?

A Yes.

Q And that's commonly what happens because the heart really isn't functioning at all from the standpoint of pumping blood out of the ventricle because it's beating so fast it can't fill?

A That's not correct for ventricular tachycardia. You can have ventricular tachycardia in which you're awake and alert. It can be for prolonged periods of time. You can treat it with medication. If you become unconscious or go into shock then you defibrillate electrically, but there are many, many occasions that we use for ventricular tachycardia. That's a stable ventricular tachycardia.

Q I understand that. You're not suggesting to this jury this ventricular tachycardia was part of his medical history, are you? That he had, as part of his medical

history, he would have stable ventricular tachycardia. You're not suggesting that?

A No, I'm not suggesting that.

Q You would consider the fact that someone in the field had runs of ventricular tachycardia sustained, but then self-terminating, lost consciousness, and then lost his blood pressure, you would consider that a very serious situation?

A Absolutely.

Q And when it affected the wall motion of the left ventricle, such that, the ventricle is not pumping and the electrical conduction is deranged, you would consider that -- you would have to consider that a cardiac potential catastrophic, correct?

A Are you saying that the left ventricle is not functioning at all? I'm missing --

Q No.

THE COURT: Are you talking about Mr. Long or are you talking in general?

MR. CREAN: I was talking in general.

THE WITNESS: Okay.

Q What I wanted to say is, a patient that has had runs of ventricular tachycardia, that is losing function of his left ventricle wall, has abnormal -- has EKG changes with at least ST elevations and ST depressions, would be in

a position where one looking at that factor would consider them in a serious cardiac potential catastrophic?

A That's correct.

Q And one which required all directed attention, correct?

A I don't understand the question of "all directed attention."

Q You're probably more right than me on that, so I'll rephrase the question.

Because in emergency departments, you people do many things at the same time?

A Correct. That's right.

Q But your priority of attention in such a patient would be this person can be having a cardiac catastrophic and could shortly lose his electrical function of his heart?

MR. CRAFA: Are we talking about Mr. Long or somebody else?

THE COURT: Counsel?

MR. CREAN: I said generally. Talking general.

A Right. In general, if that's the only problem that the patient --

Q That's not what I said, doctor.

MR. CREAN: I move to strike. I'm talking about these factors.

THE COURT: What factors? The ones you just said about the heart?

MR. CREAN: Yes.

Q And that you said is a potential cardiac catastrophic, that is something that requires substantial attention in the emergency department?

A Substantial attention, yes.

Q It requires that out and in the field, EMTs to give it top priority, correct?

A Substantial priority.

Q You would think that loss of consciousness is an important finding or historical feature?

A Yes.

Q Because you understand that syncope can be related to cardiac disease and certainly ventricular tachycardia?

A Yes.

Q And we already said that ventricular tachycardia can be a deadly rhythm, correct?

A Correct.

Q And so repeated. When one has a syncope episode and wakes up and then has another syncope episode which is documented as ventricular tachycardia, it sort of doubles the concern in a way of the reality of the situation?

A Increases the concern.

Q Okay. But then when the patient -- things are done

and the patient's blood pressure is restored and his heart rate, for whatever reason, is effectively beating and the patient doesn't wake up, that would be considered a significant finding?

A Yes.

Q When time passes, from the time that patient loses consciousness and 20 minutes, half an hour, the patient doesn't wake up, that would be considered even more concerning?

A Yes.

Q Because what you'd be -- what you would be appreciating is the fact that there had been substantial underperfusion of the brain cells which have been insulted, correct?

A Correct.

Q And when the patient is then assessed by medical professionals who then find him unresponsive, that's yet a further step, correct, a further stage, if you will?

A Correct.

Q And "unresponsive" means -- and forgive me, I don't mean to make light of it, but you guys know how to poke and pinch and try and do things to elicit neurologic response such as pain or other things. When that's all unavailing, it tells you about the state of the patient's brain function?

A Correct.

Q And there's a certain scale that's used by people in emergency medicine and certainly by paramedics to measure so you guys can speak with one in your language and is that known as a glascow coma score?

A Yes, it is.

Q A glascow coma score is used for the purpose of being able to assess people's neurologic function out in the field, and then they can tell you when they bring them in and you know exactly what they mean?

A Correct.

Q So the perfect score is 15?

A Correct.

Q And it has to do with assessing eye movements?

A Motor and verbal.

Q Motor and verbal. And you get three or so or four points for each?

A Right, correct.

Q And then you total them up and then you get the score. When Mr. Long was assessed out in the field, their initial assessment was to give him a 14, correct?

A I don't remember a 14 or 15, but I'll accept it was 14. I have to look at the number.

Q We'll check it just to make sure I'm right. And that indicated one's state for his neurologic situation?

A Correct.

Q By the time they left the field in the ambulance, he then had a glascow coma score of three?

A That is correct.

Q Three is the lowest score one can get?

A Correct. You can't get below a three.

Q Three is essentially coma, right?

A It is coma.

Q And so when we talk about multi-organ failure, we're talking about -- and in this case, by the way, you know Mr. Long never woke up, correct?

A That's correct.

Q And despite many interventions being done, he didn't receive pain medication and didn't need it, correct?

A Correct.

Q After he got to the hospital -- and the jury already knows this -- after 10:25 a.m., he had a very substantial cardiovascular collapse, correct?

A Meaning that he was in shock?

Q Meaning that his blood pressures all dropped?

A Yes.

Q When he was being transported, leaving the scene and being transported, his blood pressures were -- I think all hypotensive, 157 over 111 and numbers like that above normal?

A Correct.

Q So lots of perfusion was going to the brain, correct?

A Correct.

Q And he never woke up?

A Correct.

Q After he was at the hospital and his blood pressure had a dramatic drop, he dropped to blood pressures in the 50's over 30 and at times 40's, in the systolic of the 40's, and actually for periods of that extended time, 45 minutes or more, he had blood pressures in the 30's?

A Correct, but that has to be clarified.

Q Okay. I'll keep going and try and clarify it.

During the time of those low blood pressures, which was approximately 10:25 through after 11:00, Mr. Long's brain, as well as his organs, were underperfused?

A That is correct.

Q Because the heart was not functioning adequately, and the perfusion of resources, blood fluid was insufficient for the organs to be properly perfused to continue to function?

A Correct.

Q And as a result what happened was his brain continued to be underperfused for an extended period of time so that insult that made him unconscious and put him in a

coma, by virtue of the fact that he lost his cardiovascular function, continued for a lengthy period of time and would have increased the insult to his brain, correct?

A That is correct.

Q And those are all manifestations of brain damage, right?

A Of brain dysfunction.

Q Of brain damage. When one doesn't wake up with proper perfusion over an extended period of time? I accept brain dysfunction.

A Because brain dysfunction can be reversible.

Q Brain dysfunction can be reversible. Brain damage, which occurs when there's an extended period of insufficient oxygenation and blood flow then can cause something called hypoxia similar to ischemia?

A Yes.

Q I mean, it is ischemia?

A Yes.

Q Called brain cell ischemia?

A Yes.

Q And then you have dysfunction?

A Yes.

Q Then when that continues for an extended period of time, you then have what becomes anoxic dysfunction?

A Correct.

Q And so, for instance, if you would take somebody, just for purposes of giving my adversary pleasure, you were to stick my head in the pool under water for a while, for a period of time I could sustain that?

A Correct.

Q And then after an extended period of time, I might wake up and I might be in dysfunction and it might be reversible. But when you go far enough, you go five minutes, seven minutes, eight minutes without the proper oxygen perfusion to the brain cells, you then have brain damage of various degrees.

A You can have a low flow state that affects brain cell dysfunction -- brain cell function but does not cause irreversible brain cell death and we actually know this very well.

Q And we know cause that's what my analogy is, being held without any oxygen. If you measured this person for a period of time, three minutes, five minutes, seven minutes, what we do know is after an extended period of time that period -- that dysfunction then becomes actual death of cells by the very, very science we were talking about before when we were talking about ischemia.

A You're talking about a hypothetical patient who has no blood flow to a particular area of the brain or who has been deprived of oxygen or ten minutes no oxygen at all.

Q Okay.

A That hypothetical case, yes, you will have brain dysfunction that will become permanent brain damage and anoxic damage, yes.

Q And then the brain starts to swell?

A It may swell, yes.

Q So anoxic brain damage, doctor, isn't just confined to people who have a total exsanguination of oxygen and blood, right?

A That's correct.

Q We know that relative low flow status, meaning, you're getting very low blood pressure after a period of time, they also suffer anoxic injury?

A They can.

Q And those people don't wake up, right?

A Some of them don't wake up, that's true.

Q And they go into a coma?

A Some of them do.

Q And they become unresponsive?

A Some of them do.

Q So that when people push and poke to try and elicit pain, they can't elicit pain?

A Some of them do.

Q You would say, would you not, that systolic blood pressure of 50 is profound shock?

A Yes.

Q You would say that it was near death?

A It was profound shock. I'm not sure that -- I don't know that you can answer near death. I can't answer that question.

Q Did you ever testify under oath that, His blood pressure was 50 over 30, that's profound shock, that's near death. He is described as cyanotic is purple and profoundly hypotensive, lethargic. He's not even having enough nutrients. He's not adequately perfusing his brain because of the low blood pressure. So, in fact, he is near death? did you ever testify to that?

A I'm sure I did.

Q Now, when Mr. Long was at the scene, he was initially breathing, you have it there?

A Yes.

Q And I'll show it to the jury, but my IT skills are not working today.

When they first went and took his vital signs at the scene, did they find that his breathing rate was 18?

A I just want to take a look because there were two.

Q I think the ALS.

A Yes, the ALS you're talking about. Yes, yes, it was 18.

Q And that's abnormally high but only slightly so?

A You're talking 12 to 20, 16 normal. It's not --
Q Isn't the usual 12 to 16? But I know what you're saying. I heard --
A Sometimes when --
Q -- some of the things you were saying. My breathing respirations went up?
A Right.
THE COURT: You're speaking over each other.
Q So 18, it would be considered high or high normal?
A Correct.
Q And that continued for --
A I'm just.
Q -- many minutes?
A Yes.
Q They then, and people who are somewhat short of breath, that's what you do, right, you breath faster to get more oxygen in?
A That's correct.
Q And so then Mr. Long's breathing went down to six?
A That's correct.
Q And you would consider that severely abnormally low?
A Correct.
Q You're not going to oxygenate yourself being six times a minute?

A For the most part, yes, it's not a normal respiratory rate.

Q And so while we talk about things like shortness of breath, breathing at a rate like six is certainly shortness of breath or he's not oxygenated properly?

A Shortness of breath is what the patient tells. It's a subjective symptom. This is a vital sign.

Q And so the reliable thing would be what the paramedics record, right?

A The history is reliable as to what the patient says. The vital signs are reliable as to what the vital signs are.

Q Yes. Now I am asking, six would be a suboptimal breathing pattern for a patient in the field?

A Yes.

Q And scary?

A Yes.

Q Scary because it means that when he's having an MI or something else, he's maybe on his way to respiratory failure?

A That's correct.

Q So what happens next --

A They --

Q -- is he then loses his respirations. So they now see he's not breathing and they have to assist his

breathing, correct? Now, they are breathing essentially for him?

A That's correct.

Q And forcing oxygen in?

A That's correct.

Q So the subject of shortness of breath really becomes just a historical statement by a patient, but what's important to you as the ED physician when he comes in is the fact that he's not breathing for himself at all?

A They're both important. They describe two different things.

Q Okay. But what's really important is that he's not breathing?

A They're both important.

Q Well, doctor --

A The breathing is really important.

Q Doctor --

THE COURT: Wait, wait. Stop. Stop.

Q What's more important, the fact that the patient is not breathing or that the patient before was breathing at a faster rate, says he didn't have shortness of breath? Which is more important to you as a clinician? When the patient comes in?

A Making sure the patient is breathing is more important. That doesn't diminish the history.

Q Thank you. Thank you. Now, he's not breathing for himself, correct?

A That's correct.

Q And it was clear in short order that even the bagging, the breathing, forcing oxygen in was suboptimal, correct?

A That's correct.

Q Even that wasn't getting him what he needed from an oxygenate standpoint?

A Correct, cause the O2 stat was 85.

Q Would you tell Court and jury, that's very suboptimal?

A It's suboptimum.

Q So not breathing on his own, having somebody assisting or trying to breath for him, still not able to fully oxygenate his blood, right?

A That actually can't be answered as a yes or no because the O2 stat of 85 --

Q Shows some oxygenation, fair enough.

A Shows just essentially the first level below --

Q Fair enough.

A -- it's normal oxygenation, that is, you get supplemental oxygen with O2 or O2 starts at 88. So that it is low but it's certainly allows you to perfuse.

Q Doctor, you got to -- that's fine on your own if

you're breathing and you're only breathing in an oxygenation saturation of 88, but when somebody is breathing for you and forcing oxygen in, isn't at a hundred percent oxygen --

A Yes, it is.

Q A hundred percent oxygen which we don't breath in?

A No, we don't.

Q All you can get to is 85 percent. You would agree that is very suboptimal?

A Yes.

Q You would agree that the whole respiratory picture is consistent with respiratory failure, correct?

A Yes, correct.

Q The respiratory system is in failure, yes?

A Yes.

Q You would agree, would you not, that the electrocardiogram that was performed in ED is one of the first measures -- by the way, that's good practice, right?

A Yes.

Q It was good practice for Dr. Farmer to be there waiting for the patient, correct?

A Absolutely.

Q Do an EKG right away?

A Absolutely.

Q And intubate the patient as soon as possible?

A Absolutely.

Q Show careful aggressive attention to the patient?

A Yes.

Q You would agree that the electrocardiogram that was done showed widespread abnormalities of the heart?

A That's correct.

Q In addition to the ventricular tachycardia that happened in the field, we know that the heart is not being perfused and is in dysfunction?

A Correct.

Q And that was proven when the cardiac fellow came down with an echocardiogram.

By the way, an echocardiogram -- am I asking too many questions?

An echocardiogram is an ultrasound too?

A Yes, it is.

Q When the cardiac fellow from the CCU coronary care unit comes down and looks at the heart, and that way you can see if there's fluid around the heart, if there's some compression, if, very importantly, if the walls of the left ventricle are actually pumping and squeezing?

A That is correct.

Q And tell the jury what they found.

A They found diminished left ventricle function. Diminished -- I would have to look at their exact terminology. Basically diminished squeeze. They look at

the ventricle normally, expect it to go like this and it was going like this, less squeeze than you would expect (indicating).

Q It was in dysfunction?

A Yes.

Q And that can have serious consequences for the patient?

A Absolutely.

Q Taken together with the EKG findings and the electrical dysfunction with ventricular tachycardia in the field, this man is in potential for a cardiac arrest, correct?

A Correct.

Q And so that you wouldn't consider an insignificant situation in a patient?

A That's correct.

Q If you knew at the time that he had -- well, withdrawn.

The electrocardiogram findings, in fact, demonstrate that there was likely a proximal blockage of the left anterior descending?

A It was one of the possibilities.

Q It was high on the list of possibilities?

A I'm not sure. I would say that given the total picture that Mr. Long had of hemorrhagic shock --

Q I am just asking you about the --

A Not knowing anything about the history, yes, you worry about an LED lesion.

Q A proximal LED lesion?

A Yes.

Q That's proximal. We don't make our --

A Correct.

Q So you wouldn't criticize Dr. Farmer for aggressive attention to the cardiac system that was in failure, correct?

A That's correct. I would not criticize her for that.

Q And you would insist that a cardiac failure, cardiac ischemia and alike, perhaps dysrhythmia disease, be on the differential diagnosis?

A That's correct.

Q And being the heart, which would you agree is the most important organ that we have?

A I don't know if I can answer that question. Brain.

Q That ones, according to what we've already decided -- let me withdraw that. Let me withdraw that.

It's one of the most important organs?

A Yes, it's one of the most important organs.

Q Now, you saw also, did you not, that the initial

bloods that were done also looked for what you call initially screening as to the assessment of the liver and hematologic system?

A I believe they did that too.

Q And they found that the values for blood clotting were elevated, not normal, correct?

A I actually don't remember the INR.

Q The INR was 2.3 or four.

A Yes, that is abnormal.

Q PTT was 24 or thereabouts?

A I have to see what their normal is for PTT.

Q You would agree that the hematologic system was in dysregulation as well?

A Yes, there was dysregulation of the hematologic system.

Q And it was in failure, correct?

A It was in dysfunction, yes.

Q You know, do you not, that the kidneys also were not putting out urine?

A I'm looking at my chart. I don't think I had the urine outputs on the sections of my chart, but I'll accept that there was.

Q You'll accept it because you know that the kidneys are one of the most sensitive organs to decrease perfusion?

A To decrease perfusion, I'll accept it.

Q One of the first things that goes long before your brain or your heart, the kidneys shut down?

A Correct.

Q The fact that things prioritize in our body is -- let me start again.

It's well-known, is it not, that there is a preferential conduction by the autonomic nervous system when a patient is having cardiogenic shock or shock from another source which causes peripheral perfusion, IE, blood vessels on the periphery to less essential organs, to clamp down --

A Right.

Q -- to constrict and try and funnel all the resources to the main organs of the brain, the heart, the lungs and the rest, correct?

A That is correct.

Q And we know that happened in this gentleman, correct?

A That is correct.

Q And we know it happened before anyone got or before he ever got to the hospital, correct?

A Correct.

Q That his autonomic system, central nervous system, had gone into an outline effort to save this man. He was that close in the throws of death?

A That is correct.

Q Before he got to the hospital?

A Correct.

Q And that means that they were -- the blood was being shunted to those main organs?

A That is correct.

Q But in addition to that, what we know those main organs were also in dysfunction?

A Correct.

Q So we know that before Mr. Long ever got to the hospital. He had been in dysfunction for some time. His problems had been affecting him for some period of time?

A Correct. From the time that he had his abdominal pain and collapsed forward, yes.

Q Or before that?

A No, he went to work. I'm confused.

Q Sir --

A I am confused.

Q You don't know as you're sitting here when he started to have dysfunction, correct?

A On a more likely than not basis I do.

Q Well, you would consider passing out a later sign of somebody experiencing the substrates for shock, right? It wouldn't be the first sign? It would be one of the later signs? Doctor, if you --

THE COURT: Can you let the doctor answer.

He has three questions. There hasn't been one answer, please.

A You can have shock in which you pass out. You can have transient hypotensive or arrhythmia in which you can pass out and then you can come back. I really don't understand the question.

Q I understand that.

MR. CREAN: I move to strike it because that's not what I was asking.

Q I'm saying that we know from the PCR sheets at 9:25, about a half an hour before he got to the hospital, we know that he was showing signs -- and by history we know that he was passing out, right? That's why they got the ambulance people to come in the first place?

A Correct.

Q Okay. And what I'm saying is it's more likely that that process that was going on had existed for some period of time before that, before he passed out, before he felt the symptoms?

A No. Oh, okay.

Q Is that your answer, no? Your answer is no?

A No, it started when he had the abdominal pain.

Q But you don't know when that started.

A I do. It started around 9:20. He went to work. He had said --

Q Doctor, are you saying people don't go to work with abdominal pain?

A If you want me to --

Q Doctor, I just don't want you to make it up.

A I'm going just by the chart.

Q It doesn't say anything in there about 9:20 and abdominal pain, does it?

So, in fact, you are not going by the chart. You're making it up, isn't that true?

MR. CRAFA: Objection, your Honor.

THE COURT: Sustained. Let the witness look at the chart, please.

A I'm just looking. Complaining of abdominal pain and weakness. This was sudden abdominal pain. I'm looking for the words for it, and then it was a sudden event is my reading of this. By "sudden" I mean he went to work and then he had an event around nine o'clock. I can't tell you how much before, but certainly wasn't, you know, when he was driving in. We have no evidence that it was when he was driving in. It was a sudden event with severe abdominal pain which was described as ten out of ten going to the right lower quadrant, right flank, with loss of consciousness. That was the event and this was a sudden event.

Q You say around nine o'clock?

A Right.

Q We'll accept that but just with the caveat that you don't know really if it was 8:30 or some other time, right?

A I will accept that. I'm going by what's in the record.

Q Fair enough. Now, doctor, cardiac -- withdrawn.

Abdominal pain can be a non-specific finding, correct?

A That's true.

Q You see lots of people come in at the emergency department with abdominal pain, and they have everything from exams the next day to far more severe issues involved, right? So somebody with severe ten out of ten abdominal pain, they might have a kidney stone, right?

A That is correct.

Q They might have diverticulitis?

A They could.

Q They might have bleeding in the gastrointestinal system?

A That is true.

Q They might have cancer?

A They could.

Q They might have gastric ulcer?

A They could.

Q And if you thought about it, you could list a wide range of other things that can cause it, right?

A That is correct.

Q So by no means is abdominal pain indicative by itself of abdominal bleeding?

A That's correct.

Q Okay. But it's something you should think about?

A That is correct.

Q And you know Dr. Farmer indicated that she thought about that from the beginning?

A That is correct.

Q And you know that's good practice?

A It is good practice.

Q And you know that she immediately began testing for it?

A That is correct.

Q And you know that she performed, given the clinical circumstances of the patient being in the ED with the conditions that we've already discussed, that she attempted to do screening tests to see if she could identify whether this was more cardiac, whether this was more something else, like a cancer or a bleed or something else?

A That's correct.

Q And that's good practice?

A It is good practice.

Q And that she had performed after -- and we'll get to all the steps that were done. After some of the initial critical steps that you people call the ABCs, she had a fast study done?

A That's correct.

Q And you told us that's a focused abdominal sonogram which originally arised out of the trauma people?

A That is correct.

Q And what that does is it allows sound waves to be able to look throughout the abdominal cavity, up the aorta, the vena cava, around the heart, right? Yes, sir?

A So you were describing a little bit expanded from fast. Fast is really --

Q You're quite correct. Let me stop.

Fast is a name given to a certain protocol of a test?

A That is correct.

Q But what people do, people like yourself and people like Dr. Farmer, what they do is they use that test to look at a variety of other organs?

A That is correct.

Q And that would be good practice?

A It is good practice.

Q So you see in the notes the doctor examined for the aorta?

A That's correct.

Q And the heart. The reason you look at the heart, the sac that's around the heart, peritoneum, could have fluid in there depressing the heart. Could very well be a significant factor, right?

A Absolutely.

Q So she's looking there because you don't have -- withdrawn.

Because an emergency department person when a patient comes in with literally no real history about his comorbidities and his past history, you have to work with what you have?

A That is correct.

Q And sometimes it can take time to parcel out the various signs and symptoms to be able to make it more likely to be one thing versus the other, correct?

A That is correct.

Q And you teach your residents differential diagnosis, just that process where you think about what is most likely and then you start to work toward ruling something in and ruling something out, correct?

A With the caveat that sometimes you have to do more than one thing at the same time.

Q That could very well be the case. That's why you guys are skilled.

A Yes.

Q You do a great deal of things as you can.

And so that's good practice to start off with a differential that might include intra-abdominal bleeding, severe cardiac event, aortic dissection or aortic aneurysm because those aortic diseases would be more common in the bleeding world?

A Absolutely.

Q And so the doctor was right to think about all those things right from the start, yes?

A Absolutely.

Q And she was right to use the fast device, the ultrasound device to examine each of those organs we just talked about, and then also into the recesses, Morison's Pouch, and in between the kidney and liver and the different locations there, all the way down into the pelvis?

A Correct.

Q That's good practice?

A It is.

Q And it's a very good test?

A It is a very good test.

Q And it's a test you people in the emergency department rely on all the time?

A Yes, it is.

Q And so when one receives -- in this setting when

one receives a negative fast back and at the same time is receiving the electrocardiogram and the ultrasound echocardiogram from the cardiac fellow, you would agree cardiac has to stay very much in the differential, and the bleeding goes down just a bit, you wouldn't go away with bleeding but you just run a study and it's proving negative --

A It doesn't go down significantly, no.

Q But I didn't say significantly, I said down a bit.

A Okay. I'll accept that.

Q And like you say, things are being done simultaneously, abdominal exam, feeling is there a mass there that might be bleeding, is there blood in there that you can feel, right?

A Correct.

Q You people rely a lot on your abdominal exam?

A That's correct.

Q People in your business feel that they can do an awful lot with a good abdominal exam?

A Yes.

Q And so it's good practice for Dr. Farmer to rely on that as an additional screening, looking for what the differential is?

A Yes.

Q And of course, she sent the blood work out. She

had blood drawn. Speaking of simultaneously, she had nurses draw many vials of blood. They get sent off for a whole variety of things, for a CPC, metabolic profile? You have to say yes or no.

A Oh, yes.

Q A metabolic profile, cross and match?

A Yes.

Q In case future blood may be needed. And there's several other things that are done --

A Yes.

Q -- simultaneously. And that's for screening as well?

A That's correct.

Q That's how you work your way through the differential diagnosis?

A Correct.

Q And so all those steps are taking some time, happening rapidly, but you know everything takes some time. Intubation takes some time, right?

A That's correct.

Q So that process that has been described here, we don't need to go through it in detail, but the instruments need to be there, the patient needs to be intubated, needs to be connected to a ventilator, the ventilator settings need to be set, you need to see that the patient finally is

getting oxygenated?

A That is a correct statement.

Q That means oxygen in and withdrawing the carbon dioxide so you can get the proper acid balance?

A Correct.

Q And so those things are being done and now the patient, which I'm sure you've experienced many times, experienced a significant loss of blood pressure, right?

A That is correct.

Q 10:30sh?

A Yes.

Q By the way, if I'm sitting with you and I drop my blood pressure, you know, down somewhat, you're not going to give me Dopamine, are you, or maybe you would but --

A No, no. I'm going to try to find out why you dropped your blood pressure.

Q So initially that's what's done, but you are evaluating somebody for cardiovascular failure because of the heart --

A Absolutely.

Q -- demonstration?

A Absolutely.

Q That's absolutely genuine, the heart situation?

A Yes.

Q So when he loses his blood pressure, the first

thing one does is try and address the blood pressure?

A Correct.

Q Try and treat it?

A Yes.

Q Because if the drop in blood pressure went to the 50's, goes to the 40's, which it did, and to the 30's, you're in a full code and probably --

A Not in a full code but you're very sick.

Q You're very sick. I mean, when you drop to the 30's there, you are almost in a complete code, wouldn't you say?

A Correct. You do, again, continue to have carotid pulses. So there is an issue with the accuracy of peripheral blood pressures. He didn't have an A line in. He had peripheral blood pressures in.

Q Let me ask you about that. When he came in, he had a heart rate in the 120s, right?

A I think it was 130 but I will accept 120.

Q I know in the field he was 130. He had high blood pressure?

A Correct.

Q And we understand the heart rate is the pumping of the heart, and that's what infuses the blood and creates pressure in the pipes or the blood vessel?

A Yes.

Q Which is measurable as the blood vessel?

A Correct.

Q So when one's blood pressure starts to fall, thankfully from this amazing system that's been given to us, our cardiovascular system picks it up and the heart beats harder to be able to raise the pressure to maintain the perfusion to our brain and central organs?

A Correct.

Q But when the heart is sick and diseased and not functioning for a variety of reasons, which in this case it had already demonstrated, it then can lose it's ability to keep the blood pressure up?

A That's correct.

Q And so what happened in Mr. Long's case was not long after being in the hospital, those heart rates were 130 which was keeping the blood pressure up in the 150's, no longer could do the job, correct?

The heart and the heart wall was in, as we said before, dysfunction and so it couldn't do it. So now the blood pressure starts to go down?

A That is absolutely correct.

Q And the heart rate is, of course, dropping too because it's in dysfunction?

A Correct.

Q And so what you have now is a cardio catastrophe

to use your word?

A Yes.

Q As we just said, all hands have to try and get that blood pressure back up?

A Correct.

Q You people call that resuscitation?

A Yes, we do.

Q And you people are very good at it, right? You have to do it a lot?

A That's correct.

Q Because a lot of patients come in and they are in cardiovascular catastrophe, bleeding catastrophe, trauma catastrophe and you try the best you can?

A Absolutely.

Q And even with historic efforts, many people are not able to survive?

A Unfortunately, that's true.

Q And by the way, when patients come in and they have one or two organs that are in failure, the mortality rate goes up substantially, correct?

A That's correct.

Q It's known by you people in your studies that with one or two organs in dysfunction, the mortality rate is as high as 40 percent?

A It can be.

Q And we know further, do we not, that -- you know further, do we not, that when there's four organ systems in failure, that the mortality rate is usually about a hundred percent?

A It can be very high. It depends on what's causing the dysfunction.

THE COURT: I'm going to stop you right now. I'm sorry.

MR. CREAN: Could I finish this?

THE COURT: Yes.

Q Could you answer my question, sir? Isn't it well-known that four organs in failure statistically has close to a hundred percent mortality?

A It's very high. I would have to take a look at the studies. I will accept that it's very high.

Q Extremely high?

A I'll accept that.

Q Close to a hundred percent?

A I don't know the exact percentages, extremely high and it depends on what's causing the dysfunction.

Q Sir, I'm talking about multi-organ failure itself, be it trauma, be it sepsis, be it something else cardiogenic shock, just the fact that you had the four organs fail, these people are studied, right? You're aware of the studies?

A Correct.

Q There are many studies that indicate when you have one, what the mortality turns out to be; two, three, four but with four you know that it is essentially a hundred percent mortality rate with four organs failing?

A No, I don't because it depends on what's causing the multi-organ dysfunction. Overwhelming sepsis is markedly different than hemorrhagic shock that has transient organ dysfunction.

THE COURT: Okay. Could I stop you now, please?

MR. CREAN: Can I be so far as to just go two more questions?

THE COURT: If you're quick.

MR. CREAN: Okay.

Q Doctor, do you consider -- well, would you agree that as an organ system fails, the shock state is further worsened by the time the four organs fail, the mortality rate is essentially a hundred percent?

A As I said, it depends on what's causing the organ failure. No, I don't believe that that's an accurate statement that can be used in all patients.

Q Do you agree that cardiovascular failure in the form of a cardiogenic and septic shock can only occasionally be reversed?

A No, I'm not sure that I agree with that either.

MR. CREAN: Thanks, Judge.

THE COURT: Sure. I will see everyone back here at 2:15. Thank you.

(Whereupon, the jury steps out of the courtroom.)

THE COURT: Watch your step getting down.

Please don't talk to counsel about your testimony. I have to admonish you. I'm sorry.

(Whereupon, the witness steps down.)

MR. CREAN: Your Honor, can I say something? I just want to say, so I understand, and that is, I don't mean to be disrespectful when I say can I ask another question, so if it's your preference --

THE COURT: No, I don't think that you were. Remember what I told you yesterday, that when I start to lose one or two, when I see the potential dose.

MR. CREAN: You're the boss.

THE COURT: I am just helping you.

MR. CREAN: You're the boss. I am only saying that if I do ask and you don't think it's appropriate.

THE COURT: That's why I said, Can I stop you now? I didn't want to interrupt your train of thought. I got it. Totally not a problem. You weren't being

disrespectful at all.

(Whereupon, the luncheon recess is taken.)

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

(The trial continues.)

(Whereupon, the witness resumes the stand.)

THE CLERK: Doctor, come up, please.

(Whereupon, the witness resumes the stand.)

THE CLERK: You're reminded you're under oath, doctor.

COURT OFFICER: Jury entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: Good afternoon, counsel. You want to continue?

MR. CREAN: Yes, please, Judge.

CONTINUED CROSS-EXAMINATION

BY MR. CREAN:

MR. CREAN: Your Honor, at the break the doctor was good enough to let me look at his file which I've done just to speed things up. If it's okay, I just want to re-present it to him and then ask him about a question about that.

(Handing)

A Okey dokey.

MR. CREAN: Thanks.

Q Doctor, in your file there where you have the hospital chart and then you have some testimony, you have a handwritten note that says, surgical consult called right after the third fast was positive for bleeding, correct?

A Correct.

Q At 11:30?

A Correct.

Q You would agree that that surgical consult being called immediately after the first evidence of bleeding was good practice?

A Yes. Calling after the first evidence of bleeding, yes, absolutely.

Q Now, you would agree that it would be dangerous and not standard practice to send an unstable patient in transport around the hospital if avoidable?

A If avoidable, yes.

Q Yes. And the reason why it's not done is because an unstable -- the term "unstable" relates to the fact that the patient's cardiovascular system is no longer predictable, the patient's cardiovascular system will perform in any particular way?

A That's correct.

Q Meaning -- and you see this with unstable hemodynamically unstable patients. One minute they can have a blood pressure of X, then it can shoot way up or it can

shoot way down?

A That is correct.

Q Without notice?

A Correct.

Q And that term "instability" to critical care physicians, to emergency medicine physicians is, you know, the ultimate red flag. This in the patient is very concerning?

A Absolutely.

Q And so you give great attention to it because you don't know in the next three minutes, five minutes, six minutes when you turn your head, the blood pressure crashes, and the patient then is in a code which very often means death, right?

A That's correct.

Q And so the same thing applies if one were to take an unstable -- there's no question.

Mr. Long was hemodynamically unstable throughout the time he was in the hospital?

A That's correct.

Q And so the prospect existed that in any minute, two minutes, nine minutes, seven minutes, 30 seconds from any given time period, that Mr. Long could completely collapse into death?

A That's true.

Q And the reason why emergency departments are built and established as they are is to give them the capacity to be the strongest place to resuscitate someone probably in the hospital, right?

A That's absolutely not true in the sense it depends on -- it depends on what the cause of the hemodynamical instability is. In fact, the OR for massive intra-abdominal bleeding is a better place.

MR. CREAN: I move to strike, Judge.

THE COURT: I'm not striking. That was his answer.

MR. CREAN: Mine was a yes or no question.

THE COURT: But he didn't answer it yes or no. Doesn't have to be yes or no.

Q So when a patient comes in and is hemodynamically unstable and you have limited history and the patient is in multi-organ failure, you send him to the operating room for the best course of treatment?

A If it is likely.

Q No, no, that's my question. Do you always send them all that way?

A It can't be answered as yes or no.

Q Right. Now, the fact is the emergency department is a location which is what you people call a controlled environment, a heavily monitored setting so that you can

bring most of the resources that exist to bear in an unstable patient that needs resuscitation, true?

A Yes.

Q And you have highly skilled people and many of them typically to be able to provide resuscitation if they are to arrest or have a, you know, very bad turn for the worst, right?

A Correct.

Q You have even testified when patient takes a turn for the worst, the first thing that should be done is try and regain stability on the patient, correct?

A Correct.

Q And so that was what Dr. Farmer did when this patient was brought into the hospital, correct?

A Correct.

Q And in that sense she was performing all the efforts that should be performed by an emergency department physician in an unstable, cardiovascularly unstable patient?

A In that sense, yes.

Q And so to transport the patient to a CT scanner, for instance, is a judgment to be made by the physician in charge, correct?

A To be made by the physician who's going to provide the therapeutic intervention.

Q Can you answer my question?

A It can't be answered as a yes or no. It cannot be answered as a yes or no.

Q So the physician in charge is the person who calls the shots. You're in charge when you have patients in the emergency department, right?

A Again, can't be answered as a yes or no.

Q Then you're not in charge.

In the case of Dr. Farmer who testified she was in charge, you would agree with me that it's her judgment to decide whether or not this hemodynamically unstable patient should benefit by going to the CT scanner in any present condition or choose to be kept and resuscitated to make them stronger so that they can withstand what other testing they may need, wouldn't you agree with that?

A These can't be answered as a yes or no.

Q Okay. Is it your position that there's a book where you just send a patient to a CT scanner regardless of the hemodynamic stability of the patient, is there? If it's not a judgment, doctor, is it something that you know?

A It's something that we know is the standard of care.

Q To send an unstable patient out of the emergency department without full consideration of the risk benefit analysis; is that what you're saying?

A No, that's not what I'm saying.

Q So you're saying you do perform a risk benefit analysis before sending a patient out?

A As the standard. As the standard of care you do perform a risk benefit analysis.

Q Thank you.

A And you in order to perform --

MR. CREAN: Judge, I mean, that's all I asked: Does he perform a risk benefit analysis? Obviously, they were at lunch talking about the case, and he's now not going to answer my questions. Everything is another statement.

THE COURT: As a matter of fact, that's not true.

MR. CREAN: Well, Judge, then I don't understand why he can't just answer yes or no.

THE COURT: I happen to be in the same room.

MR. CREAN: Doesn't matter, Judge. My point is: Why can't I get a yes or no to my question?

THE COURT: Because there was an answer and it wasn't a yes or no. There was another part to it, that's why.

MR. CRAFA: I'm going to object to counsel's comments. We abided by your instructions, Judge. We talked about baseball. That's unfair.

MR. CREAN: I withdraw it and I accept his

statement. If he says it, I believe it.

THE COURT: Thank you.

MR. CREAN: I withdraw that.

Q Doctor, forgive me but if you can try and answer my questions, okay.

A I will definitely try.

MR. CRAFA: May he finish the answer, Judge?

THE COURT: Yes.

MR. CREAN: He finished the answer.

THE COURT: He didn't. You cut him off.

Can you read back the question, please, Robin.

MR. CREAN: If it's his own question then why is there an --

THE COURT: Cause the question is just one part. You're asking him something that can't be answered yes or no.

MR. CREAN: Then he should tell me. I'll ask a new question.

THE COURT: Can you read back the last question, please.

(The last question was read back by the court reporter.)

THE COURT: Can you answer that yes or no?

THE WITNESS: You can't answer it yes or no.

THE COURT: Then don't answer it. Thank you.

Q Do you not perform a risk benefit analysis before sending an unstable patient out of the controlled setting of the emergency department?

A It can't be answered as a yes or no, but I would be happy to answer it for you.

Q No, please just tell me it can't be answered yes or no.

A Cannot be answered as a yes or no.

Q Doctor, when you first learned about this case, how did you learn about it? Did you get a call from Mr. Crafa?

A I believe I did, yes.

Q And did he tell you a little something about the case?

A I'm sure he did.

Q He told you that this case involved a death of Mr. Long related to a mesh migration, and after short time in the emergency department, something of that nature?

A Something of that nature, yes.

Q And then after you agreed to review it?

A I did.

Q And after some period of time, I assume he sent you records?

A Yes.

Q And you reviewed the records?

A Yes.

Q In a view towards giving an opinion, right?

A That's correct.

Q So when you reviewed the records in this case and you first got the information as to what was taking place by Dr. Farmer and with Mr. Long and the other participants, you would agree, would you not, that you already knew the outcome, that their already had been the death of Mr. Long under the circumstances that the Court has learned about and you had the benefit of hindsight in your evaluation of these materials; isn't that true?

A Yes, I did, yes.

Q And so when you went through the records, you had the benefit of something that Dr. Farmer and her colleagues didn't have, as the patient arrives in the emergency department and then step-by-step through those three and a half hours or thereabouts, approaching four hours, you already knew the end of the book cover?

A I did know the end of the book.

Q Now that you know is not something that Dr. Farmer had the benefit of when she had to in realtime deal with what information was available, and had to make decisions step-by-step based on the available information at the time; isn't that true?

A That is true.

Q And that's what physicians do everyday in the difficult world of emergency medicine, they have to make judgments, right, yes or no?

A They have to follow the standards of care.

Q They have to make --

A They have --

Q Do they make judgments?

A In certain circumstances.

MR. CREAN: Judge, I'm asking --

THE COURT: Can you answer?

THE WITNESS: It cannot be answered yes or no.

Q You don't make judgments, okay, fine.

When emergency department physicians treat incoming patients, they don't have the benefit of hindsight, knowing how the case will turn out, correct?

A That's correct.

Q You would agree that knowing that Mr. Long had a mesh migrate into his common iliac artery and causing bleeding would give you a certain perspective in the way in which you looked at the records, true?

A I didn't -- I did not look at the --

Q It's a yes or no.

A Again, can't be answered as a yes or no.

Q Okay then, just tell me.

You know he died. You had the records related to some bleeding event and cardiac event, correct?

A Correct. That he bled to death, yes.

Q And you had that information when you started to look at the materials?

A That's correct.

Q And that informed your ability to look at these materials and the judgments that were made by Dr. Farmer, correct?

A Totally incorrect. I reviewed the case --

Q I didn't ask another question.

You would agree with me, would you not, that knowing the outcome of a case before you look at it has an affect on the way in which you see information and the test results and the developing story through the records?

A Not at all. Not at all.

Q Okay. When you treat your patients, do you have the benefit of knowing what the outcome is going to be?

MR. CRAFA: Objection, asked and answered, your Honor.

MR. CREAN: I didn't ask that.

THE COURT: I will allow it.

A No, I don't.

Q In fact, you've had cases, have you not, where you

treated patients that came in presenting one way and turned out to have aortic dissection and die?

A Aortic dissection and die, not that I know about so you're going to have to advise me.

Q Sir, the last time you and I were in a courtroom you told us about the fact that you had three or four aortic dissection cases, one of which died that you cared for.

A Right. Maybe I'm misunderstanding your question.

Q Maybe. Maybe. I can be obtuse. I'm sorry. If the question is not right, I'll be happy to rephrase it.

Sadly, you've had patients that come in and you treated them and they died?

A Right. We had a diagnosis --

Q Yes or no?

A Yes.

Q And you're even aware of cases of aortic dissection where the presenting symptoms were not fully appreciated, the patient was discharged and went home and died?

A That's correct.

Q That's part of the problem about not knowing the end of the story. When you have to treat patients prospectively, correct, you have to deal with the information that you have in front of you?

A Correct.

Q You testified that if your concern is an aortic injury, you still treat the shock first to stabilize the patient because the shock is the single most important thing?

A Correct.

Q You're aware, are you not, that a physician can treat a patient properly according to the standard of care and a patient can still have a bad outcome?

A Absolutely.

Q And you agree that Mr. Long could very well have died regardless of what time in that timeline that he got to surgery?

A That's true.

Q And would you agree that a fast is the standard of care -- fast study is the standard of care. It can be done in the resuscitation area faster and less invasive, and being faster and less invasive it's more sensitive and specific -- I will start again.

The more sensitive and specific CAT scan of the abdomen should wait until the patient has been stabilized because the CT may be time consuming and take the patient out of a resuscitation environment?

A In general that's true.

Q You also had experiences where a patient has presented with pain in the stomach and it turned out to be a

cardiovascular event?

A Yes.

Q So abdominal pain, stomach pain can certainly be part of the presentation for a cardiovascular event?

A Absolutely.

Q You agree that once there's an episode of acute respiratory failure, the mortality rate goes up significantly?

A I would think that's true.

Q Would you agree that when a patient is in a hemodynamically unstable situation, the prospect exists in resuscitation that one can improve the patient's hemodynamic situation by continuing resuscitation?

A True.

Q So to continue resuscitation for a further period of time, in your experience, very often you can get the patient to turn to a more stable state, in which case they can tolerate the transport to a CT scanner?

A True.

Q And that's why it's very common for emergency room physicians to want to accomplish resuscitation before putting the patient at further jeopardy by sending them in transport to a CT scanner?

A That's true.

Q And you would agree that reasonable physicians

could agree as to the judgment of Dr. Farmer to continue resuscitation rather than send the patient off immediately for a CT scan?

A It actually can't be answered as a yes or no cause there's another component to it.

Q Okay. You would agree that in Mr. Long's case, it would in the making the decision to -- withdrawn.

We agree that it's a risk benefit analysis to decide whether to send Mr. Long to a CT scanner or not?

A Correct.

Q And that that's what physicians do, they consider the risk on one side and the benefit of taking this step on the other, and they exercise their professional judgment and then they decide on a course of action, correct?

A Again, it can't be answered as a yes or no cause there's another component in this case which is a key component.

Q Okay. I'm speaking generally, that's what physicians do, they weigh the risk and the benefit? If the risks are higher than the benefits to be obtained, they have to exercise their judgment and when they do -- that's what they do sometimes?

A They are required in certain circumstances to bring in another individual who is an expert in a particular area, such as surgery, in order to make the appropriate

decision about whether to go to CT scan or to go directly to the OR. Since it is the surgeon who is going to make the determination as to whether the CT scan is useful or whether they want to take this unstable patient directly to the OR where they can do an angiogram --

MR. CREAN: Judge, I move to strike. I move to strike. Why is he giving this speech? This isn't my question. I asked about a risk benefit analysis. I move to strike.

THE COURT: I'm not going to strike it. He answered. He specifically said what was required to do.

MR. CREAN: I didn't ask that question. Isn't the answer supposed to be close, somewhat resemble my question?

THE COURT: Can you read back the question please?

(The last question was read back by the court reporter.)

MR. CREAN: He gives a soliloquy about something that --

MR. CRAFA: Judge --

THE COURT: You will have an opportunity to redirect.

Can you answer the question?

MR. CREAN: Judge, I move to strike.

THE COURT: No, you cannot answer?

MR. CREAN: That's an unresponsive answer.

THE COURT: I will strike it.

THE WITNESS: It cannot be answered as a yes or no.

THE COURT: Very good. Thank you, sir.

Q Risk benefit analysis, doctor, by definition includes potential for risk and potential for benefit, right?

A Correct.

Q And so when, in fact, in most of the interventions that you provide to your patients there's a risk?

A Absolutely.

Q I mean, you decide such and such is the problem and you give a medication or an intervention, and the chances they could have a bad reaction, it could be incorrect, it could cause some other type of organ system to be affected, right?

A That's absolutely true.

Q And that's what you have to do?

A Yes.

Q But your hope is that the benefit will outweigh that, that's why you're using your experience to give to make that recommendation?

A That's correct.

Q And in terms of going to the CT scanner, emergency department physicians make those decisions everyday, correct?

A Correct.

Q And they make decisions as to the safety or lack of safety of being transported to a CT scanner, correct?

A Correct.

Q And so in that sense, they make a risk benefit analysis as to whether it's safe save or unduly dangerous at a given point in time for a patient to be transported out of the secure controlled setting of the emergency department to the CT scanner, correct?

A That's correct.

Q And so one of the things that can happen when you decide to transfer a hemodynamically unstable patient is they can go out in the hallway and they can arrest?

A That's absolutely true.

Q And you have seen that many times?

A I have seen that several times, yes.

Q And you have seen people that by the time they get into the CT scanner, and I am not even talking about the gantry, I am talking about into the room, that it's well-known that patients will on occasion arrest?

A That's correct.

Q And the setting upon which to try and resuscitate or run a code in a hallway or in the CT scanner, you would agree is most disadvantaged to the patient?

A Absolutely.

Q And as a result, your skills as a resuscitator and whomever else is involved is greatly hampered?

A True. That's absolutely true.

Q You don't have, generally don't have the same level of devices that you would like. You may not have the personnel to assist and you may -- and they may not have the support, the respiratory support, the cardiac support, correct?

A That's absolutely true.

Q So before someone sends somebody out of the emergency room in a controlled setting when they are hemodynamically unstable, one thinks very carefully about whether to make such a step?

A Absolutely.

Q And if the thought is that by further resuscitation they could improve the status of the patient so that the patient would be in a better position to withstand the risks of transfer out of the room to CT scanner or the hallway, you would consider that to be a professional judgment by the individual?

A Again, there's another factor.

Q There may be but yes or no?

A Can't be answered as a yes or no.

Q As a matter of fact, doctor, even in patients where there's bleeding, decisions are often made to stay here, let's resuscitate to get them stronger so that they will be able to sustain the transfer to the CT scanner to identify the source of the bleeding and then to the operating room, so they will be in a better position to withstand the operation, true?

A True.

Q It's well-known that unstable patients do very badly in surgery, correct?

A They do worse than stable patients, yes. I'm not sure what your question is.

Q Maybe it was a bad question.

Well, I just mean that the mere fact of giving the agents that are given for surgery can have very negative cardiovascular impacts?

A Yes, absolutely.

Q Those medications can vasodilate?

A That's correct. That's correct.

Q So in a patient who has a very low blood pressure, part of the reason is that their blood vessels are not contracting -- constricting as much as you would like. So that they are given pressors, inotropes that are

vasoconstrictors in an effort to get the blood vessels to constrict so they can force the blood to the heart and brain?

A That's correct.

Q And in this case you knew there were four different inotropes?

A I believe -- in this case there were four inotropes or pressors given, I believe that's correct.

Q And you do that in a patient who's very close to dying as a means of being redundant in trying to get cardiac activity and vasoconstriction?

A That's correct.

Q But by going to the operating room -- and you give the medications that are given in relation to an operation, you then would be giving vasodilators?

A If the anesthesiologist decided to do that.

Q Yes, that's one of the problems with operations, that has to be done and then the patient dies?

A Well, doesn't have to be done, that's the point.

Q Chosen to be done?

A Right, but he was at that point unresponsive and so it's unclear what anesthesia are going to be using.

Q But there's a whole variety -- we can spend, you know, spend some time talking about them. There's a whole variety of risks. A patient going to the operating room,

hemodynamically stable or unstable, clearly the unstable adds significant risk of dying under that circumstances?

A Absolutely.

Q And you know that Mr. Long just in getting to the operating room, they had to do CPR to get him there?

A That's correct.

Q And so you would agree that the decision to take the patient out of the operating room -- I'm sorry, out of the emergency department to send to the CT scanner is not an easy decision?

A That's correct.

Q And to do it earlier could well have been a fatal decision for Mr. Long?

A That's correct.

Q You indicated that blood be given even before the blood values came back. What I'd like to ask you is: Transfusions have risks?

A They do.

Q And they can have substantial risks?

A That's true.

Q And there's certain aspects about Mr. Long that may have made it very dangerous, indeed, to transfuse, correct?

A That's true.

Q And so transfusions that you know can cause

catastrophic activity and cause severe lung failure?

A True.

Q And can cause reactivity which cause hemolysis?

A Hemolysis.

Q Hemolysis?

A Yes.

Q And hemolysis can be fatal?

A Yes.

Q So, again, the decision whether to provide transfusion, one would fall onto that category of professional judgments in which physicians weigh the risks and benefits of taking that step, correct?

A Not in a patient who is --

Q Could you answer my question?

A Can't be answered as a yes or no.

Q If the answer is no, that it's not a risk benefit analysis, then please say so. If the answer is I want to say something about a different patient, then that's different story.

MR. CRAFA: I object to instructing the witness. The witness should -- the witness should answer the questions. He can't be instructing the witness how to answer the questions.

MR. CREAN: I agree with that. We're in unification on that.

A Can't be answered as a yes or no.

Q Thank you.

Now, doctor, what did you review before testifying?

A I reviewed the ambulance call report. I reviewed the Weill Cornell Medical Center Emergency Department records, including the lab reports, the x-ray reports, the operative reports. I reviewed the EKG that went along with it. I reviewed the autopsy. I reviewed disc of radiological studies. I reviewed the deposition transcript of Lesly Carey. I reviewed the deposition transcript, examination before trial I should say, of Brenna Farmer, and I reviewed the examination before trial of Dr. Raquel Ferrer Harrison.

Q Did you review the trial testimony before this jury?

A No.

Q Wouldn't it have been interesting to you or wouldn't it have been important to you to know what Dr. Farmer said about the decision making that she made?

A I'll listen to anything that she says.

Q Did you ask counsel before coming here to Court to criticize a professional involved in the care of Mr. Long that you'd like to know what she had to say about the entire picture before you get on the stand and offer criticism?

A As I said, I reviewed all of the records and I made my determination is based on those records in her deposition.

Q Okay.

A She said she didn't remember anything about the case except what was in the chart.

MR. CREAN: Move to strike, Judge.

MR. CRAFA: I think that answers the question.

MR. CREAN: It doesn't answer the question. Could I have the question read back?

THE COURT: Sure. Can you read it back, please.

(The last question was read back by the court reporter.)

THE COURT: Can you answer?

THE WITNESS: No, I can't answer yes or no.

Q Now, doctor, you get to court to testify quite a bit and review matters for lawyers quite a bit?

MR. CRAFA: That was asked and answered.

THE COURT: Sustained.

Q Have you ever been reviewing cases since 1984?

A That's correct.

Q Do you testify two to three times at least per year?

A That's correct.

Q And you've testified in court greater than 60 or 70 times?

A Yes.

Q You testified for plaintiffs against physicians?

A I've been retained by both sides.

Q You have never testified in court against a plaintiff; is that correct?

A I've never testified -- I don't testify for or against anyone. I talk about what the standard of care --

Q Answer my question.

A Yes, I can. The defense attorneys --

Q That's not my question.

A Repeat the question, please.

Q You never testified in court on behalf of a physician, true?

A False.

Q And you've testified to that, have you not?

A No. I've testified in court. I've testified for Kaufman Borgeest. I've testified for Wilson Elser.

Q That's not the question I asked.

THE COURT: He answered yes, he testified for doctors.

MR. CREAN: He answered yes and then he's still talking.

THE COURT: That's enough. Thanks.

Q You testified that you receive over 20 percent of your annual income from reviewing cases and testifying, correct?

A I believe it averages between ten and 20 percent.

Q You have been involved with professional referral services that connect you with plaintiffs' attorneys planning to bring a lawsuit against physicians, correct?

A That's correct.

Q And you've been doing that for how many years?

A Since 1984.

Q And those referral services take part of the compensation for themselves, correct?

A I would assume so.

Q And then they advertise for you effectively?

A I would assume so.

Q And so as a means of advertising to plaintiffs' attorneys who are looking for someone to come into court to testify against physicians in malpractice cases, correct?

MR. CRAFA: Objection.

A It can't be answered yes or no, and I want to clarify one of the answers.

THE COURT: You can't. You can't. They'll be redirect.

THE WITNESS: Okay.

Q But I'm correct that that's what effectively occurs. There's advertisement to obtain plaintiffs' lawyers who are going to bring lawsuits against physicians, and that -- for what is that, 30 years, you've been involved in that and sharing the fees with these advertisement referral services, true?

A Again, can't be answered as a yes or no. I don't believe that anybody advertises for me.

Q Okay. The referral services that you're involved with, does MediQuest sound --

A I have received --

Q Just yes or no, sir.

A Repeat the question, please.

Q Is MediQuest one of the referral services that has your name and connects you with plaintiffs' lawyers bringing lawsuits against physicians?

A Yes.

Q Is Medical Review Associates an organization that puts you together with plaintiffs' lawyers preparing to bring lawsuits against physicians?

A Yes.

Q And you derive ten to 20 percent of your income from that, correct?

MR. CRAFA: Objection, asked and answered.

THE COURT: Sustained.

MR. CREAN: No, I am asking about with the referrals. Different question. I could withdraw it if you don't want me to ask it. It's a different question.

THE COURT: The other point was about testimony?

MR. CREAN: Yes, general testimony.

THE COURT: Then you can answer.

THE WITNESS: I am sorry?

THE COURT: Answer the question.

A The total amount for my reviews, all of the review activity that I do, it's between ten and 20 percent of my income. Certainly the testimony part of it is not ten or 20 percent, it's much, much less.

Q And so you review about how many cases a year where you review records or give deposition testimony?

A I'm sorry?

Q Where you review records and/or give deposition testimony?

A And/or give deposition? I go to depositions, again, probably about two or three times per year. I review on average about a case per month, sometimes it's more, sometimes it's less.

Q Have you testified that since 2000, the year 2000, that you have a substantial increase in this side business

of yours?

A As compared to 1984, I probably said that.

Q Sir, you have testified in a number of different states, correct?

A That's correct.

Q You've testified in New Jersey?

A That's correct.

Q New York?

A That's correct.

Q Connecticut?

A That's correct.

Q Pennsylvania?

A That's correct.

Q Florida?

A Again, it was a Florida case and I testified in New York, yes.

Q Illinois?

A Again, I testified in New York in an Illinois case.

Q Let me ask you: In these other states that you testified in, are you licensed to practice medicine?

A No.

THE COURT: The witness said he testified here.

MR. CREAN: I heard that last part, yes, your

Honor. I am asking: In the other states where he went there to testify, was he licensed to practice?

THE WITNESS: I'm only licensed in New York.

Q You also testified throughout the Counties of New York, Brooklyn, Queens, Nassau, Suffolk, correct?

A That's correct.

Q Orange county?

A Correct.

Q Ulster County?

A That's correct.

Q Now, doctor, your academic accomplishment is assistant professor?

A That's correct.

Q And to become promoted in the academic ranks, one needs to do academic work, research, writing, teaching and things of that nature, correct?

A You actually have to do publications and I don't do publications, that is correct.

Q So you have no publications in the area of specialty?

A There are two publications which I believe have my name on them, and I am not primary author of either of them.

Q But it's not just publications that results in promotion, it also has to do with academic and teaching services contributed to the university setting, correct?

A Well, I teach, have done extensive teaching both in emergency medicine and in internal medicine. Without publications you will not be promoted.

Q So you have not been promoted?

A No, I'm happy as the assistant professor. I am a clinician.

Q Maybe your happy. You may be happy and we like you to be happy. But it's been 35 years that you've been in an assistant professor?

A That's true. Again, I take care --

Q You have the time and interest to go to courts all over the east coast and to work with lawyers bringing lawsuits against doctors, and you don't have the interest -- well, maybe not the interest, but you haven't done the publications and academic work required for promotion in your --

MR. CRAFA: Objection.

Q -- institution, just a yes or no?

MR. CRAFA: Objection and it's an argument.

A Can't answer as a yes or no.

THE COURT: I was going to sustain the objection. Thank you.

MR. CREAN: Can I ask: What's wrong with the question? You just don't want him to answer? I won't ask it if --

THE COURT: He already answered he can't answer yes or no, so it doesn't matter what I was going to say. It's immaterial.

MR. CREAN: Okay.

Q And do you agree, sir, that the emergency room physician can meet the standard of care but a diagnosis may still not be reached?

A Correct.

Q You indicated that coronary artery disease is common in society. Tell the Court and jury in the hierarchy of things that kill men, where does coronary artery disease fall?

A I believe it's the lead cause of death in men.

Q So your answer to the question of, oh, he had coronary artery disease which is described as -- marked as severe by the medical examiner is, It's all right. Everybody walking around has coronary artery disease. Yet, sir, it's the number one killer of men in the United States, true?

A I'm not sure what the question is. Yes, coronary artery disease is the number one killer of men in the United States.

Q And sir, the absence of chest pain does not rule out a cardiac event, correct?

A That's correct.

Q And abdominal pain can be a manifestation of ischemia, correct, cardiac ischemia?

A Correct.

MR. CREAN: Thank you, your Honor.

Thank you.

THE WITNESS: Thank you.

THE COURT: We're going to take a recess before redirect. Thank you.

(Whereupon, the jury steps out of the courtroom.)

(Whereupon, the witness left the stand.)

(Whereupon, a brief recess is held.)

(After the recess the following occurred:)

(Whereupon, the witness resumes the stand.)

COURT OFFICER: Jury entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: Okay. We're in our final hour of the day.

MR. CRAFA: May I, Judge?

THE COURT: Very, of course.

REDIRECT-EXAMINATION

BY MR. CRAFA:

Q Doctor, forgive me but I am going to jump around a little bit with respect to some of the questions you were asked on cross-examination.

Tell us a little bit about your review of cases that lawyers may bring to you.

A Certainly. When I review a case, it's the same as when I review a case for quality improvement for my quality improvement committee from Montefiore Medical Center. I do know the outcome of the case, but what I do is I put myself in the treating physician's role. I look at the information that's available to them contemporaneously and look to see if the decisions met the standard of care based on the information that was available to the physician at the time.

While we know what the outcome is, it doesn't affect how we determine whether the decisions that were made met standard or not given the information that was given to -- available to them, and that's the way I reviewed this case. That's the way I review all of the cases that are up for review for my quality improvement activities and from my review of cases both for plaintiffs and for defendants.

MR. CREAN: My only objection is that's a jury question, Judge. The conclusion that he's drawing is not an appropriate conclusion. It's one to be drawn by the jury.

THE COURT: He's just telling you how he evaluates the case and his conclusions for his purposes, not our purposes.

MR. CREAN: Okay.

Q Doctor, you were asked about a patient you had with an aortic dissection that passed away. Doctor how did that experience compare to what happened with Jerry Long?

MR. CREAN: I object to that, Judge.

THE COURT: I'm afraid you opened up the door, counsel.

MR. CREAN: I did but as a comparison to the facts of this case, if we are going to go into that, then we get to go into it fully.

MR. CRAFA: May we have a sidebar?

THE COURT: Why don't you just rephrase your question.

Q Doctor, I don't want to lead, doctor, but time to time patients pass away in the emergency department?

A That's true.

Q That happens to every emergency room physician?

A Yes.

Q All right. You were asked questions about the risk benefit analysis as to whether or not a hemodynamically unstable patient can be brought to CAT scan. You were saying that there's a component in this case that needs to be factored into your answer to those questions. Would you please explain?

A Absolutely. This is the key part to it. That Mr. Long came in with signs and symptoms of a catastrophic

intra-abdominal bleed. The more likely than not treatment is going to be a surgical intervention, that is going to the OR and either stopping the bleeding by putting a catheter in, which is what they did in this case, or going to the OR and opening him up and actually directly, putting pressure in closing the wound.

What I said the standard of care is is that you must bring the surgeon in early. When Mr. Long came in, he had signs and symptoms of an intra-abdominal catastrophic bleed. Most common ones would have been an abdominal aortic aneurysm. He did not have that kind of bleed. He had a bleed from another vessel, but the treatment is still the same, in that, it is a surgical treatment.

Mr. Long got transfused two units and then didn't get anymore transfusions after about 11:30. The treatment for exsanguination is continued aggressive packed red blood cells which wasn't done and early surgical intervention, that is, calling the attending surgeon down to come in and that's the standard of care.

When the question that was asked: Should the patient go to CAT scan or go to directly to the OR for what is called scoop and run to the OR? That decision actually should be made as a standard of care by the surgeon cause the surgeon will determine whether he has enough information to go to the OR or whether he wants to risk some time to go

to CAT scan. In a case like this, it is the surgeon who makes that determination, it's not the emergency physician, and the deviation from the accepted standards of care was --

MR. CREAN: Objection, your Honor.

A -- to call --

MR. CREAN: Objection, your Honor. May we approach? Beyond the scope of the question and the inquiry.

THE COURT: I'll strike the last portion of the answer.

Q We'll get to that. I think, doctor, you were asked a question as to whether or not in your view physicians can differ as to Dr. Farmer continuing to resuscitate the patient, instead of taking the patient to the CAT scan. You said that was not a yes or no question. Could you please explain?

A Yes, because the decision to take Mr. Long to CAT scan is a decision that should have been made by the surgeon who should have been called down as the standard of care cause it's the surgeon who's going to determine whether he needs the information that the CAT scan would provide or whether he could get that information by bringing the patient directly up to the OR and to continue to aggressively transfuse him and in the OR do an angiogram, if it was necessary, which is what was done here, or do a

laparoscopy or laparotomy. It is the surgeon that's going to make the decision about whether to do the CAT scan or not because it's the surgeon who's going to give the definitive care.

Q Dr. Farmer testified that she called for surgical consult as soon as she recognized free fluid upon her view of the abdominal ultrasound that was sometime between 11:34 and 12:20 or so in the morning and called surgery at that time. Do you have an opinion to a reasonable degree of medical certainty as to whether surgery should have been called?

MR. CREAN: Objection, your Honor. Beyond the scope. May we approach?

THE COURT: Sure.

(Whereupon, a bench conference is held off the record between the Court and counsel.)

THE COURT: I'll allow it.

Q Do you have the question in mind, doctor?

MR. CRAFA: Could you repeat the question, please.

THE COURT: Yes, Robin, please.

(The last question was read back by the court reporter.)

MR. CREAN: Objection, your Honor, to the content. I guess I should be heard. I mean, just the

fact the question that we just discussed --

THE COURT: Rephrase, counsel. I agree, it's beyond the scope.

Q Doctor, you were asked on cross-examination, you were told and upon review of your record that you were aware that Dr. Farmer has testified that a surgical consult was called by a resident upon her looking at the abdominal ultrasound and finding free fluid and I think you said that you were okay with that?

A Yes.

Q Do you have an opinion, doctor, as to when, with respect to Mr. Long's case, that you think surgery should have been called?

A He should have -- surgery should have been called basically upon arrival, that is, this is a patient who had signs and symptoms of an intra-abdominal catastrophic bleed with abdominal pain, flank pain, syncope. The patient transmuted. The blood pressure came up. While the initial fast was non-diagnostic, that is, it didn't show free fluid, it doesn't at all rule out a retroperitoneal bleed and that is a surgical emergency. So you call the surgeon down early. The earlier the surgeon comes down, the more options the surgeon has to make a determination about whether he's going to go and have Mr. Long go to CAT scan or if Mr. Long becomes hemodynamically unstable, bringing the patient up to

the OR so that you have all of that added time in which to resuscitate in the OR Mr. Long with aggressive packed red blood cells, transfusions and do the things that I talked about either an angiogram where you basically in OR put a catheter up --

MR. CREAN: Your Honor, all of this is his direct testimony. I object to it. Move to strike it. Way beyond the scope of the cross.

THE COURT: I'm going to stop the answer now. You answered counsel's question.

Q Doctor, you were asked some questions on cross-examination about multi-organ failure and mortality and morbidity status and how that's approaching a hundred percent in that case. Given those questions and answers, doctor, why is it you say that Mr. Long was deprived of the substantial opportunity for a cure to survive his condition?

A Because --

MR. CREAN: Objection, your Honor, that was -- I withdraw it.

THE COURT: Thank you.

A Because Mr. Long had an acute event. The multi-organ failure often described in the literature that I have looked at over time is people who have overwhelming --

MR. CREAN: Objection, move to strike. Anything about the literature I object.

MR. CRAFA: He was asked about literature on cross.

THE COURT: He was asked a specific question about specific literature. He's prohibited from referring to literature that counsel can't see.

MR. CRAFA: Okay.

Q Leave literature out of it.

THE COURT: Listen to counsel's question and try to answer it a bit more directly. Thank you.

Q You got the question?

A Right. It is my experience that the outcome of patients with multi-organ failure is going to depend on what was causing the multi-organ failure. Mr. Jerry Long went to Duane Reade to do his shift at the pharmacy, and then had a sudden event that was a exsanguination, he was bleeding to death. Because he was bleeding to death, he did have dysfunction of his heart, he did have dysfunction of his lungs, and he did have dysfunction of his brain and he did have dysfunction of his kidneys. All of those things, because it's a very short period of time, are reversible to bring them back to baseline by aggressive transfusion, much more than was given here and by control of the bleeding, by taking the patient, Mr. Long, up to the OR and stopping his bleeding. Given that those multi-organ dysfunctions acute onset directly related to the exsanguination, you would

fully expect, more likely than not, that all of those organ dysfunctions would return back to his baseline.

Q And doctor, you had mentioned you were asked some questions on cross-examination about the potential dangers of a blood transfusion in any patient.

Why do you say that Mr. Long should have received blood upon arrival in the emergency department as opposed to waiting until the blood value studies came back at 11:05?

MR. CREAN: May we approach? I didn't discuss that at all. This is beyond the cross.

THE COURT: Do you have a specific question you're referring to? I remember that answer distinctly on cross about blood to be given and transfusions. You do not remember a question about them?

MR. CREAN: I don't.

THE COURT: I have to go look through my notes. Do you have a specific question you're referring to?

MR. CRAFA: Yes. Counsel asked several questions about transfusions s and the potential dangers of transfusions.

MR. CREAN: Risk of it, yes.

MR. CRAFA: The risks of transfusions.

MR. CREAN: I did.

MR. CRAFA: So based upon those questions and

those answers --

THE COURT: Well then, your question is limited to the risk and the answers. You can rephrase the question you just asked, please.

Q Doctor, if you can, given the cross-examination about blood transfusions and the risks, what would be the analysis in Mr. Long's case given his presenting symptoms when he arrived at the hospital as to whether or not and whether he should get blood?

A Given that he had signs --

MR. CREAN: Objection, that's a different question.

MR. CRAFA: I think you asked me to rephrase it.

MR. CREAN: But I object to that question. You just asked the same question over again. I object to it.

THE COURT: The question counsel asked had was not with respect to a timeline. It was talking about risks of giving transfusions under certain circumstances.

MR. CRAFA: Right.

THE COURT: Particularly --

MR. CRAFA: I'm sorry, Judge.

THE COURT: -- the plaintiff's.

MR. CRAFA: Yes. My question referred to that cross to this witness's opinion.

THE COURT: It wasn't about the timeline.

MR. CRAFA: I understand that but since we're talking about risks of transfusing patients.

THE COURT: Then rephrase your question.

MR. CRAFA: Let me think about that.

THE COURT: Yes. You have to rephrase it so it falls within the bounds of redirect.

MR. CRAFA: Right.

Q Doctor, you were asked questions about the -- I guess it's a precipitous drop in the blood pressure that we see from 10:25 in the morning when the blood pressure was 129 over 82 and then at 10:35 we see it drop to 56 over 42 and it stays that way, do you recall that?

A Yes.

Q Doctor, do you have an opinion to a reasonable degree of medical certainty as to whether or not this circumstance could have and should have been anticipated?

A Based on the presentation, yes, it should have been anticipated, and that's the reason you call the surgeon in.

Q And can you do anything proactively in an effort to offset this anticipation?

A Yes, call the surgeon in early and aggressive

transfuse the patient.

Q When you say "aggressive transfuse"?

A Pack cells, pack cells, pack cells to make sure --

MR. CREAN: Move to strike, Judge.

THE COURT: Strike what?

MR. CREAN: The answer that he's obviously trying to wedge in here inappropriately about the transfusion, your Honor just ruled it wasn't discussed in a timeline and that's my objection. So he answered the question about calling a surgeon and then proceeded outside the question to continue.

THE COURT: I'm trying to find the exact question. Tell me the question counsel asked. Do you remember specifically?

MR. CRAFA: Counsel spent a lot of time talking about the hemodynamic stability and the drop in the blood pressure.

THE COURT: Yes.

MR. CRAFA: So address that aspect of the cross through redirect. I'm asking Dr. Schechter about that and whether or not that could be anticipated.

MR. CREAN: And he answered that.

THE COURT: You know, I'm going to allow it because you specifically asked about improving hemodynamics and about stabilization and resuscitation

before transfer and whether or not there be further jeopardy and that all led into the transfusion. I'm going to allow the answer.

MR. CREAN: Right and your Honor --

THE COURT: Yes, sir.

MR. CREAN: My objection at this time was to the fact that the question was answered. He was asked whether that blood pressure drop should have been anticipated. He said yes, that's why he called the surgeon, and then proceeded, you know, to go on and on and on.

THE COURT: I'm going to allow counsel to explore where you asked the questions about transfusion and about his professional judgment in weighing the risks and benefits. The doctor said he couldn't answer yes or no.

MR. CREAN: Right, that's what your Honor indicated before and gave him the opportunity.

THE COURT: Right.

MR. CREAN: That's something different but that's not what's going on here.

THE COURT: Rephrase the best you can. Well, the problem is it's not too much, the question. It's that the witness is going beyond your question in his answer and the last three answers.

MR. CRAFA: So I will ask this question perhaps, if I can?

Q Doctor, given your answer that a precipitous drop in blood pressure can be anticipated in view of Mr. Long's presenting symptoms, what does the standard of care require of emergency department physicians with respect to that?

MR. CREAN: My objection, your Honor, that was all on direct. That's what his direct testimony was.

THE COURT: But you asked questions about this. I'm going to allow it, absolutely.

A In order to stabilize the patient, what you need to do, since the patient is presenting with signs and symptoms of an intra-abdominal bleed, is to aggressively transfuse the patient. While pressors will bring up the blood pressure, it won't do anything for the blood loss, and the blood loss needs to be repleted. It's repleted with packed cells. The standard of care, even though there's a risk for transfusion for each of those units, is that you have to give them cause. The standard of care is we don't let people bleed to death.

Q And doctor, you were asked questions about brain injury or permanent organ damage as a result of a very low blood pressure or the heart not being able to pump adequately, and therefore, to perfuse the organs, that the

blood needs to get to, was Mr. Long getting oxygen?

A He was getting oxygen and he was getting his brain perfused. It wasn't being perfused optimally or enough to keep him awake, but it was being perfused. There are comments that he's getting carotid pulses. As was discussed these peripheral blood pressures will be low, while the core perfusion, that is, the perfusion pressure to the chest, the heart, the lungs and the brain is enough because all of the blood volume, essentially, is going to those areas.

Q And doctor -- strike that.

You were asked a lot of questions, doctor, about coronary artery disease and the evidence on autopsy of Mr. Long's coronary artery disease.

I am going to ask you: Does Mr. Long's coronary artery disease have anything to do with his death on December 23, 2011?

MR. CREAN: Objection.

A No, he bleed to death.

THE COURT: Wait, wait. What's the ground? Excuse me, grounds for the objection?

MR. CREAN: Direct exam. He did the autopsy on the direct exam and discussed coronary artery disease and the cause of death. All we are doing on redirect is just re-going over the same topic, that's my objection.

THE COURT: I'm going to allow it because you questioned about it on cross, and counsel has the right to ask it in a different way to prevent any confusion on behalf of the Court.

Q Do you have the question, doctor?

THE COURT: The witness answered.

MR. CRAFA: Oh.

Q Doctor, the history that we have here of Mr. Long -- of sudden onset of lower right side abdominal pain, the inguinal area, radiating to the flank, is that a specific complaint that is of use to the emergency room physicians or is it a generalized abdominal pain?

MR. CREAN: Beyond the scope, objection.

MR. CRAFA: A lot of questions are asked about --

MR. CREAN: Not once talked about right lower quadrant pain.

MR. CRAFA: A lot of questions were asked on cross-examination about abdominal pain; whether that could be a heart attack, whether that could be something else. So now we are getting specific with this particular case.

THE COURT: Well then, address it to the questions that were asked. Rephrase your question.

Q On cross-examination you were asked questions

about what could the potential causes be of generalized abdominal pain and you answered those questions, meaning, it could be heart, right, things of that nature. In this particular case, do we have generalized abdominal pain?

A No, we don't.

Q What do we have here?

A We have localized pain in the right lower quadrant which was described as ten out of ten with flank pain, acute flank pain and then a loss of consciousness.

Q And how is that important to the emergency room physicians?

A That is an intra-abdominal bleed until proven otherwise.

Q And when you say "until proven otherwise," how do you prove it otherwise?

A You start with the fast exam but if the fast exam --

MR. CREAN: Beyond the scope, Judge, my objection.

MR. CRAFA: This is following up on his answer, Judge.

THE COURT: You went into this on direct. It was explained on direct. I don't think there was a follow-up question on cross. I think the witness was unable to answer with a yes or no beyond what he did

answer.

MR. CRAFA: So you're sustaining the objection, Judge?

THE COURT: Yes.

MR. CRAFA: Thank you, doctor.

THE WITNESS: You're welcome.

RECROSS-EXAMINATION

BY MR. CREAN:

Q Doctor, the history that the EMS gave to the emergency department people when they brought the patient in was right abdominal pain, was it not?

A Yes.

Q Nothing about inguinal pain, correct?

A I'm just looking at the notes. Yeah, there's no word about inguinal pain, that's correct.

Q And so what physicians were informed of in the emergency department was abdominal pain, not inguinal pain, correct?

A We only have what is recorded in the chart.

Q It's a yes or no answer.

A Again, can't be answered as a yes or no.

Q It can't be answered yes or no that the history says abdominal pain, and I'm asking you whether that's what it says and that's what they knew?

MR. CRAFA: Objection, argumentative, Judge.

THE COURT: Well, sustained. We just said that. The chart says right abdominal pain. You're not saying that in your question.

MR. CREAN: Well, that's abdominal pain right or --

THE COURT: Well, that's why the witness is saying --

MR. CREAN: If that's so, then I stand corrected.

Q Right abdominal pain was the history that was given, correct?

A You asked me a different question. I'm not meaning to be argumentative. You're asking me what the EMS pre-hospital provider said, and I am telling you what's written in the chart.

Q I know. So why would we do that? Why would I ask you what they said and why would you answer a different question? I'm asking you because you know this.

Everyday EMS providers come in and then they give you the oral history that they give you, then they go over somewhere else and fill out their sheets, right?

A No. Often they give you -- often they give you the sheets at exactly the same time they fill them out.

Q They may but in a case where the minutes before they were trying to resuscitate a patient, and they brought

in a notification patient in a matter of five minutes that they are breathing for, other than perhaps some core information, you would agree that it's unlikely that they had filled out their sheets at that time, yes or no?

A Again, it can't be answered as a yes or no.

Q Okay. If you can't answer it yes or no, you can't, but the history recorded by the physicians is right, abdominal pain, right?

A Correct.

MR. CREAN: Thank you.

THE COURT: Counsel?

MR. CRAFA: Thank you, Judge.

THE COURT: Do you have anything else?

MR. CRAFA: No, thank you.

THE COURT: Thank you, sir. Watch your step.

(Whereupon, the witness left the stand.)

THE WITNESS: Thank you very much.

THE COURT: Do we need to chat about tomorrow before I send the jury away?

MR. CRAFA: Yes, if you don't mind.

THE COURT: Okay. Can we go in the back?

MR. CRAFA: Sure.

THE COURT: Can you sit for one second, please? Thank you.

(Whereupon, a discussion is held off the

record between the Court and counsel outside the presence of the jury.)

THE COURT: So we were discussing what's going on for tomorrow. We are just going to work for the morning. Is that okay if you guys have Friday afternoon off?

(Head gestures)

THE COURT: Yes?

A JUROR: Which leads me to believe Monday we'll be back?

THE COURT: Yes. Oh, we are not going to be finished by tomorrow. I'm hoping we finish next week cause the week after the Court is closed two days and I'm not available one of the days cause I have a chambers day. So we're going to attempt to see if we can wrap it up.

MR. CRAFA: Do the best we can, Judge.

THE COURT: Next week, yes?

MR. CRAFA: We'll do the best we can.

THE COURT: We'll see how it goes. I'm not going to -- both sides are entitled to their day in court. I'm not going to rush anybody. It will go as long as it goes.

We thank you for your service very much.

COURT OFFICER: Ten tomorrow?

THE COURT: Yes, we said ten.

MR. CRAFA: Ten is good.

(Whereupon, the jury exits the courtroom.)

(Whereupon, the trial is adjourned to October 27, 2017 at 10 a.m.)

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