

**CROSS-EXAMINATION
OF PLAINTIFF'S
EXPERT**

1 SUPREME COURT OF THE STATE OF NEW YORK
 2 COUNTY OF WESTCHESTER: CIVIL TERM: PART LJL

3 -----x
 4 KATHLEEN NOCERA, as Administratrix for the
 5 Estate of GARY NOCERA and KATHLEEN NOCERA,
 6 individually,

Plaintiff,

-against-

Index#61337/2014

7 LINDA CUOMO, MD, BENJAMIN BERNSTEIN, MD,
 8 WESTCHESTER COUNTY HEALTH CARE CORPORATION
 9 and WESTCHESTER MEDICAL CENTER,

Defendants.

10 -----x
 11 Trial (Cont'd)

February 13, 2018

12 B E F O R E:

HONORABLE LEWIS J. LUBELL,

Supreme Court Justice, and a jury.

(Appearances same as previously noted.)

Nicole Ameneiros

Senior Court Reporter

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13 THE COURT: On the record. Case on trial.

14 The Court, having previously remitted before
 15 counsel, I would like to do so on the record this date.

16 It has -- it had come to my attention earlier in
 17 the trial that Dr. Bruce Charash was going to be called as a
 18 witness for the plaintiff. As I have done in previous
 19 trials, in 2003, more specifically in September, Dr. Charash
 20 was the chief of the CICU at Lenox Hill Hospital. At that
 21 time my father was admitted, and Dr. Charash was overseeing
 22 his care and treatment. One evening, Dr. Charash and I did
 23 have a conversation relative to my dad's treatment and care.
 24 We had never met, and we had never spoken after that date.

25 Subsequently, Dr. Charash has appeared before me as

1 a witness in both Orange County and in Dutchess County on
2 two separate matters where I remitted same. That being
3 said, those were the only occasions that I have met and
4 spoken to Dr. Charash after that one evening's conversation.
5 It has absolutely no bearing on my ability to sit fairly and
6 impartially in case.

7 Are there any applications?

8 Ms. Weisman?

9 MS. WEISMAN: No, your Honor. I'll trust that you
10 will be fair in this case.

11 THE COURT: Mr. Vigorito?

12 MR. VIGORITO: None whatsoever.

13 THE COURT: Mr. Venditto?

14 MR. VENDITTO: None on that issue, Judge.

15 THE COURT: Okay. Are we ready on that issue?

16 MR. VENDITTO: Yes, Judge.

17 THE COURT: Have you some other issues or
18 something?

19 MR. VENDITTO: I do, Judge. In reading prior
20 transcripts pertaining to Dr. Charash, there have been
21 occasions where he has testified to --

22 MR. VIGORITO: Hold on a second. Maybe Dr. Charash
23 should be excused.

24 MR. VENDITTO: Okay.

25 THE COURT: Doctor, could you step out for a

1 minute?

2 DR. CHARASH: Of course.

3 (Doctor steps out.)

4 MR. VENDITTO: There have been occasions where he's
5 testified to a charity that he runs called Docs to Docks --
6 so I think it's D-O-C-S to D-O-C-K-S -- in which they take
7 medications and supplies to countries in need of medical
8 care --

9 THE COURT: So it's like Doctors Without Borders?

10 MR. VENDITTO: Something along those lines, Judge.
11 Although it's a very nice thing that he does, and I'm sure
12 it's very helpful, I don't believe that's testimony that
13 would be relative or pertinent to his credentials as an
14 expert or to any opinions he may put forth.

15 MS. WEISMAN: Your Honor, I believe his background
16 and experience is totally appropriate and relevant to his
17 qualifications.

18 THE COURT: You want to weigh in, Mr. Vigorito?

19 MR. VIGORITO: Certainly, Judge. I think that
20 we've all heard many, many times in our careers, especially
21 your Honor presiding over trials, the litany and the laundry
22 list of qualifications of experts in myriads of fields of
23 medicine. And I think it's safe to say that there's a line
24 of demarkation that can be drawn between what is relevant to
25 their ability to give testimony on a given subject matter in

1 medicine before a jury as opposed to all the other things
2 that may have been going on in their professional career.
3 Some of them might be quite laudatory but have absolutely no
4 relevance to their ability to give opinion testimony in this
5 case. I think this is clearly one of those instances.

6 Certainly we haven't produced any experts yet, but
7 if your Honor rules in favor of this application by
8 Mr. Venditto, joined in by myself, we will obviously tailor
9 our direct examinations of our experts to be in line with
10 that so that we don't run into a ten-minute soliloquy by
11 experts where they tell you, you know, of all their, you
12 know, badges and awards and ribbons that they've received
13 throughout the years.

14 THE COURT: Well, over my tenure in both as a trial
15 attorney and as a presiding jurist, I don't think a trial
16 goes by where a proponent of an expert doesn't go, Doctor,
17 have you received any awards or, you know, accolades in your
18 profession? And the jury can do what they want with it.

19 Your application is considered, Mr. Venditto, and I
20 will consider you as joining in on it. Your application is
21 denied. Not -- it may not be relevant to the doctor's
22 ability or what he does, but like I said, there are
23 questions that are always, you know, posed to a witness
24 about anything that elevates them, you know, in their
25 profession, whether it's by talent or contributions to the

1 medical profession. You can do with it as you deem
2 appropriate.

3 To the extent that this is adverse to your
4 application, Mr. Venditto, and Mr. Vigorito, you have an
5 exception noted on the record.

6 MR. VENDITTO: Thank you, Judge.

7 MR. VIGORITO: Your Honor, I have one other
8 application before we start. It's in regards to the expert
9 witness disclosure for Dr. Charash, and in particular on the
10 issue of the chest x-ray. And I will read in part at
11 page 3, if I'm not mistaken, of Ms. Weisman's disclosure.
12 Second full paragraph down, quote, that the chest x-ray
13 should not have been relied upon and further testing should
14 have been done to evaluate the structures. The reliance on
15 this x-ray and the failure to order further testing was a
16 deviation from accepted medical practice and procedure.
17 That's the relevant part of it, Judge.

18 So my point is that while we fully expect
19 Dr. Charash to comment on the alleged failure not to have
20 obtained a CAT scan, what is putting us on notice is not
21 that the chest x-ray was misread, but that it should not
22 have been the only radiological object that was relied upon
23 by the defendants in the case. That's not such a fine line,
24 I would say. I think it's a broad line of difference.

25 So I am asking for a ruling in limine that

1 Dr. Charash not, based upon that disclosure, give testimony
2 that the chest x-ray was misread, because that's not what
3 that says. What it says is that you shouldn't have just
4 relied on that, you should have gotten other things, too.
5 That is different than misread. So I would appreciate that
6 we not hear language from Dr. Charash that it was misread or
7 that there's a negligent read of the chest x-ray or that it
8 was over read or under read.

9 THE COURT: Me-too?

10 MR. VENDITTO: As well as the fact that Dr. Charash
11 cannot offer any negative opinions as to Dr. Bernstein that
12 would overlap what Dr. Sixsmith --

13 THE COURT: We already went over that.

14 MR. VENDITTO: Yes, Judge.

15 THE COURT: And that's already been ruled upon.

16 MR. VENDITTO: Correct.

17 THE COURT: Can I see the 3101(d)?

18 MS. WEISMAN: Sure, your Honor.

19 MR. VIGORITO: Sure.

20 MS. WEISMAN: Your Honor, I don't believe he's
21 going to testify as to whether it was misread. That's --

22 THE COURT: You don't believe?

23 MS. WEISMAN: Yeah, that's not our claim.

24 THE COURT: Are you taking him there?

25 MS. WEISMAN: No.

1 THE COURT: Okay, then.

2 MS. WEISMAN: It's the fact that it was relied upon
3 and it was not...

4 MR. VIGORITO: I'm satisfied with Ms. Weisman's
5 representation, and I trust her implicitly on that.
6 However, and this is by no means a --

7 THE COURT: Let me stop you there.

8 MR. VIGORITO: -- a caveat or a slight --

9 THE COURT: Mr. Vigorito, we all know that at times
10 a physician may go beyond the scope of the question in
11 feeling that they are answering it appropriately. I'm sure
12 that you and Mr. Venditto are going to pay strict and --
13 attention to every word that comes out of Dr. Charash's
14 mouth in testifying. If you believe that something went
15 beyond, (A), the scope of the question or the scope of the
16 3101(d), I anticipate and have no doubt that I will see you
17 standing with one word emanating towards the bench.

18 MR. VIGORITO: You're a thousand percent correct,
19 as usual, your Honor. All I'm saying is that why must I
20 have to put the horse back in the barn --

21 THE COURT: Mr. Vigorito.

22 MR. VIGORITO: -- because with Dr. Charash we all
23 know that that is a more-than-likely scenario. With other
24 experts I might not say that, but with a gentleman who has
25 testified 600 times, and I dare say I've read most of those

1 transcripts at this point, I see a pattern of volunteerism
2 here of opinions that were not in the original question.

3 THE COURT: Mr. Vigorito, as an officer of the
4 court I take Ms. Weisman's comment to heart that she is not
5 going there. Now, if somebody becomes a loose cannon, then
6 that is -- the onus is going to be on you, Mr. Vigorito. I
7 can only rely upon Ms. Weisman doing her job and maintaining
8 steadfast on her representation to the Court. If -- I
9 cannot hold her accountable for something that might be an
10 oops, unless it's her oops.

11 MR. VIGORITO: It's all appreciated, Judge. Thank
12 you.

13 THE COURT: As is all of your professionalism.

14 MR. VIGORITO: Well, thank you.

15 MS. WEISMAN: Your Honor, can I talk to him for a
16 second so I can tell him?

17 THE COURT: Sure.

18 MS. WEISMAN: Thank you.

19 (Recess taken.)

20 THE COURT: Bring them in.

21 COURT OFFICER: Jury entering.

22 THE COURT: Jurors, you may be seated as you enter.
23 Counsel, ladies and gentlemen, please be seated. Good
24 morning, Jurors.

25 JURORS: Good morning.

1 THE COURT: Hope you had a wonderful weekend. I
2 see everybody has their coffee, tea, their beverages, and
3 they all have lids. Very attentive jury.

4 You will recall, ladies and gentlemen, that when we
5 released on Friday we had completed receiving the testimony
6 of Dr. Sixsmith as part of the plaintiff's case. We will
7 now continue with the presentation of the plaintiff's case.

8 Ms. Weisman, call your next witness.

9 MS. WEISMAN: Okay. Thank you, your Honor.
10 Plaintiff calls Dr. Bruce Charash.

11 THE COURT: Doctor.

12 COURT OFFICER: Right this way, sir. Just remain
13 standing for a moment. The judge is going to swear you.

14 B R U C E C H A R A S H,
15 called as a witness on behalf of the Plaintiff, having been
16 first duly sworn, was examined and testified as follows:

17 THE WITNESS: I do.

18 THE COURT: Doctor, please have a seat. I'm going
19 to ask you to state and spell your full name for the record.
20 Give your business address, and please speak loudly and
21 clearly so that every juror receives the benefit of your
22 testimony.

23 THE WITNESS: My name is Bruce Charash,
24 C-H-A-R-A-S-H, 205 East 63rd Street, New York, New York
25 10065.

1 THE COURT: You may inquire.

2 MS. WEISMAN: Thank you, your Honor.

3 DIRECT EXAMINATION

4 BY MS. WEISMAN:

5 Q Good morning, Dr. Charash.

6 A Good morning.

7 Q Dr. Charash, are you licensed to practice medicine in
8 the State of New York?

9 A Yes.

10 Q And when did you become licensed?

11 A 1982.

12 Q And would you provide the jury and the Court your
13 medical education and training that you have received?

14 A Of course. I graduated from Cornell Medical School in
15 1981, getting my MD degree. From 1981 to 1984 I trained at
16 Mt. Sinai Hospital in New York in the field of internal
17 medicine, which is treating adults for all illnesses, but not
18 the surgical approach but the medical approach.

19 In 1984 -- the first year, by the way, is called an
20 internship and the second two years are called residency. In
21 1984, when I completed my training, I was eligible to take a
22 two-day national written test called the boards of internal
23 medicine, and by passing that I became a board-certified
24 internist in 1984.

25 From 1984 to 1987 I trained at the New York Hospital in

1 the subspeciality of heart disease called cardiology -- which
2 again, is the nonsurgical approach to heart disease -- in a
3 training known as a fellowship. And in 1987 I likewise took and
4 passed the boards of cardiology, becoming a board-certified
5 cardiologist in 1987.

6 From 1987 to 1991 I was on the full-time medical school
7 faculty of Cornell Medical School as an assistant professor of
8 medicine and the assistant director of the cardiac intensive
9 care unit.

10 Then from 1991 to 2005 I was the chief or director of
11 the cardiac intensive care unit at Lenox Hill Hospital in
12 New York and was a clinical associate professor of medicine at
13 NYU Medical School.

14 For 17 months, February 1st, 2005 to July 1st, 2006, I
15 joined the medical school faculty at Columbia University as an
16 assistant professor of clinical medicine. And then July 1st,
17 2006, I went into private practice where I am today.

18 I have admitting privileges at Lenox Hill Hospital, and
19 am still a clinical assistant professor of medicine at NYU.

20 Q When you say "admitting privileges," can you just
21 describe what that means.

22 A It means it's the hospital where I'm allowed to see and
23 admit patients in consultation, or the admitting doctor.

24 Q Have you held any board positions?

25 A I'm sorry?

1 Q On professional boards. Okay. Have you done any kind
2 of international work?

3 A Well, I started my own nongovernment organization where
4 we collect surplus medical supplies in the U.S. that get sent to
5 landfills, thousands of tons a day, and redirecting to hospitals
6 in Africa, Haiti and the Caribbean to rebuild health care
7 institutions.

8 Q And have you been honored -- received any honors or
9 awards?

10 A Yes. When I graduated from Cornell Medical School, I
11 was inducted into a national medical school honorary society
12 called Alpha Omega Alpha. In 1986, beginning my second year of
13 my cardiology fellowship, they gave an award for the outstanding
14 cardiology fellow for every academic year, and it was basically
15 a scholarship that funded my position. So I was given the title
16 of the Dan and Elaine Sargent Fellow of Cardiology.

17 In 2008 an organization called the Greater New York
18 Hospital Association, which represents 300 hospitals in New York
19 State, gave me the doctor of the year award for New York State.
20 And in 2012, most recently, a national organization based in
21 Washington, D.C. called the Caring Institute that promotes the
22 ethics of patient management communication and care gave me
23 their Caring Person of the Year in the United States in 2012.

24 Q Thank you, Doctor. Doctor, have you been asked to come
25 to court to testify on behalf of Gary Nocera's family?

1 A Yes, I have.

2 Q And I have asked you to render an opinion with respect
3 to the care and treatment by the cardiologist, Dr. Cuomo, in
4 this case, right?

5 A Yes, you have.

6 Q And is this the first time you've been involved in any
7 kind of medical-legal issues?

8 A No.

9 Q Can you just describe your medical-legal experience.

10 A I was first approached by a lawyer to review a case in
11 1987, the second part of '87, after I completed my board
12 certification in cardiology. I had been practicing as a
13 board-certified internist for three years. So there was -- that
14 was 1987.

15 So now it's 31 years, and in that period of time I have
16 reviewed over 900, maybe 950 cases from lawyers across the
17 United States, probably spanning 40 of the 50 states, although
18 the majority have come from a handful of states. I've gotten
19 one case from a different state now and then. I've given
20 opinions about health care providers outside of my own field,
21 including surgeons, gynecology, allergy doctors, ER doctors.
22 But whenever I've testified against a doctor or about a doctor
23 in another field, it's not within their speciality but in
24 general medicine.

25 So if a surgeon gives an antibiotic to a patient to

1 take home and I give the same antibiotic, we share the
2 day-to-day responsibilities to recognize an allergy. So only if
3 I've ever talked about another health care provider that's not
4 my field, it's only been in common medicine that we both would
5 have shared responsibility.

6 I have reviewed -- about 85 percent of the cases that
7 I've received come from lawyers, like yourself, who represent
8 family members, and about 15 percent come from lawyers who
9 defend doctors and hospitals. I have given testimony under oath
10 in something called a deposition before trial in states where
11 that's a requirement. And I've probably averaged 11 a year
12 since I started doing this in 1987. And I've appeared in court
13 averaging seven times a year since I began doing this work as
14 well.

15 Whereas, 15 percent of the cases I reviewed come from
16 defense lawyers. For a number of different reasons, the times
17 I'm asked to testify for defense cases is much less than in
18 cases from lawyers representing family members. So less than
19 five percent of my total testimony in deposition or trial had
20 been for defense cases.

21 Q And since January have you testified in trials?

22 A Yes. In this year -- it's odd, they come in
23 clusters -- I will probably testify ten times this year. But
24 this is my third trial in 2018. There may be a fourth trial
25 coming up within the next week or two, but then I have nothing

1 scheduled, to my knowledge, till June or July. So they tend to
2 come in clusters. Usually at the beginning of the year and the
3 end of the year there's like three in a row and then a few in
4 the middle.

5 Q All right. Doctor, are you presently practicing
6 medicine?

7 A Yes.

8 Q Okay. And can you tell us about your day-to-day
9 practice.

10 A Yeah. For the first 20 years of my career, 90 percent
11 of my time was in the hospital and 10 percent was in the office
12 where I ran the cardiac intensive care unit.

13 MR. VIGORITO: Your Honor, I just have an
14 objection. I think, with all due respect to Dr. Charash,
15 the question was talking about what he's doing right now,
16 not a historical prospective.

17 THE COURT: Read me back the question.

18 (Record read.)

19 THE COURT: I'm going -- I'm just going to sustain
20 the question as to form. I'm going to strike the doctor's
21 answer.

22 I'm going to ask you to focus your questions on
23 specific time periods so we avoid any objections.

24 MS. WEISMAN: Okay.

25 THE COURT: And the doctor can answer as accurately

1 as possible to your specific question.

2 MS. WEISMAN: Okay.

3 Q Doctor, can you tell us presently what is your
4 day-to-day practice?

5 A I have -- 90 percent of my time is in an office where I
6 see patients Monday through Friday. The majority of my patients
7 are cardiac patients, but I also provide primary care to a
8 certain number of patients. I see patients in Lenox Hill
9 Hospital. That's about 10 percent of my clinical time is in the
10 hospital where I'm engaged in patient care and education of
11 doctors in training. I see people in the emergency room as
12 well, of course.

13 Q Okay. So you're still treating patients?

14 A Yeah.

15 Q Doctor, can you tell us do you have any experience
16 diagnosing and treating patients with aortic dissections?

17 A Yes, I do.

18 Q Can you tell us about that.

19 A Aortic dissection is a life-threatening disease that
20 involves a tearing of the aorta. And in my clinical experience,
21 I've probably treated three a year for the first 20 years of my
22 practice, so 60 during the first 20 years. And in the last 11
23 or 12 years, I've probably only taken care of two patients with
24 dissection. So it's been between 60 and 70 patients total in my
25 career.

1 MS. WEISMAN: And your Honor, I'd like to offer
2 Dr. Charash as qualified to offer opinions on this matter
3 with respect to Dr. Cuomo.

4 THE COURT: Mr. Vigorito?

5 MR. VIGORITO: I have no objection to that, Judge.

6 MR. VENDITTO: No objection, your Honor.

7 THE COURT: All right. There being no objection
8 thereto, doctor -- the Court deems Dr. Charash to render
9 opinions to the current extant issues before the Court.

10 You may proceed.

11 Q Doctor, have you reviewed records in preparation for
12 your testimony here today?

13 A Yes, I have.

14 Q And what records would those be?

15 A Well, I reviewed records concerning Gary Nocera -- and
16 I brought them down -- from the Westchester Medical Center from
17 January 18th, 2013, that ER visit.

18 Q September 18th?

19 A Pardon, September 18th, 2013. The Hudson Valley
20 Hospital Center when he presented on September 21st in the state
21 of cardiac arrest; multiple previous hospitalizations at Hudson
22 Valley Medical Center that are not related to this issue; his
23 primary care doctor, Dr. Prestiano, and the autopsy report.

24 I reviewed deposition testimony taken before trial of
25 Dr. Linda Cuomo, of Benjamin Bernstein, the ER doctor, and

1 Kathleen Nocera, his widow. And I had the opportunity to review
2 the trial transcripts of Dr. Cuomo and Dr. Bernstein.

3 Q Now, was Dr. Nocera (sic) seen by any cardiologist in
4 the emergency room September 18th, 2013?

5 A Yes.

6 Q And have you evaluated patients in the emergency room
7 that come in with chest pain?

8 A Yes.

9 Q Okay. And in your clinical experience, do you have an
10 understanding of the standard of care of a cardiologist who sees
11 a patient in the emergency room with chest pain?

12 A I do.

13 Q Okay. Can you tell us that.

14 A Well, chest pain is the most common single reason why
15 people come to the emergency rooms. It's the plurality. So the
16 single most common reason why people go to emergency rooms is
17 chest pain. The diagnosis of chest pain, of course, acute chest
18 pain, includes life-threatening diagnoses first. Heart attack,
19 there are about nine hundred thousand admissions a year for
20 heart attack in the United States.

21 The second most common life-threatening diagnosis for
22 chest pain is called pulmonary embolism, which is a clot to the
23 lungs. That occurs about seven hundred thousand times a year in
24 the United States. And much lower on the list in terms of
25 frequency, but equally life-threatening, is a tearing of the big

1 aorta or an aneurysm, and that's about 12,000 cases a year in
2 the United States.

3 I have seen thousands of patients in the emergency room
4 with chest pain over the course of my career. I mean, the
5 majority of them in the first 20 years when I was hospital
6 based, but in the last 12 years, I've seen dozens upon dozens of
7 people. And the job of a cardiologist is to determine whether
8 or not a patient, you know, basically needs to be admitted and
9 tested further or can go home. And the cardiology standard of
10 care is to make sure that a patient is appropriately evaluated
11 and completely evaluated to determine whether or not you can
12 exclude a life-threatening diagnosis or not.

13 So that's the role of a cardiologist. It's very basic.
14 There are some basic tests that can be done, but the job is to
15 make sure you don't send someone home who has a potentially
16 catastrophic illness and will die.

17 Q And you indicated an aortic dissection is one of those
18 life-threatening illnesses.

19 A Yes.

20 Q Okay. And can you tell us are there particular signs
21 and symptoms of an aortic dissection that a cardiologist will be
22 looking for in a patient in the emergency room?

23 A Yeah, aortic dissection doesn't have a unique
24 fingerprint that -- it has its own special symptoms that make it
25 unique for dissection, but there's a constellation of symptoms

1 that would be concerning.

2 First, if someone comes in with chest pain that's
3 worrisome enough to be a heart attack, then dissection's
4 automatically in the differential diagnosis. And if you have a
5 normal EKG and normal enzymes, which means it's not a heart
6 attack, then you automatically have to start considering other
7 causes of chest pain that are life-threatening. So the lack of
8 a heart attack with chest pain in the emergency room raises the
9 concern about dissection.

10 The other element that is a very strong concern for
11 dissection is any time pain radiates to the back. That can
12 occur in heart attack, but that's probably the single biggest
13 red flag if a person has back pain associated with their chest
14 pain at any point in their illness, because dissection pain goes
15 away, it's a tearing of the aorta. And after it tears, it's a
16 physical tear, it's self-terminating and it can occur again. If
17 back pain is an element, that is a major red flag.

18 If there's evidence of disease to the aortic valve,
19 including a new murmur, that would be a high level of concern
20 for aortic dissection. And finally, if the chest x-ray shows
21 what we call the mediastinum, which is the heart and big blood
22 vessels, you can see irregularities on the chest x-ray that
23 would make you worry more about the dissection. Of course, the
24 x-ray must be of acceptable quality to be able to read it for
25 that.

1 So the elements would be back pain, probably the single
2 biggest red flag, valve disease, chest pain without a heart
3 attack and potentially an abnormal x-ray.

4 Q You mentioned earlier about the EKG. With respect to
5 aortic dissections, would the EKG be normal?

6 A Most people who have an aortic dissection, which is a
7 tearing of the big blood vessel, have normal EKGs and have no
8 cardiac enzymes, meaning they don't have a heart attack. A
9 small number of people with dissections, the dissection tears
10 back to the coronary arteries and they can have a heart attack.
11 So, I would say under 10 percent of people with aortic
12 dissection have abnormal EKGs and have positive cardiac enzymes.
13 That's usually a much more catastrophic dissection which is
14 causing imminent hemodynamic trouble. But the point is that the
15 majority of people would have a normal EKG.

16 Q And Doctor, could you, if necessary, if you need to
17 illustrate for us what an aortic dissection is and how it
18 relates to Gary Nocera.

19 A Of course. May I draw on the diagram?

20 THE COURT: Yes you may, Doctor.

21 THE WITNESS: Thank you, sir.

22 THE COURT: Mr. Vigorito, Mr. Venditto, if
23 observing the doctor's demonstration requires you to
24 relocate yourself, please do so without further instructions
25 from the Court.

1 A So basically I'm making this very schematic. The heart
2 is a pump. The left ventricle is the main pump, and it pumps
3 blood up to your chest into the aorta, which is the highway for
4 blood to travel through the body. Medical diagrams are drawn
5 like you're looking at the person. So your right is the left of
6 the patient.

7 When the heart pumps into the aorta, it goes out a
8 valve called the aortic valve, which is like a saloon door that
9 swings open and then shuts closed to let blood not go back to
10 the heart. There are branches. Everyone has heard of carotid
11 arteries that break the aorta and divides at the feet into
12 femoral arteries, and every part of our body gets oxygen from
13 some branch of the aorta coming out of the left ventricle.

14 The aorta is a high pressure tube, and it has a wall
15 that has three layers. All arteries have three layers. Now,
16 you have to see them under a microscope. Under visual you'll
17 never see the three levels, but the inner layer of the aorta,
18 the inner layer of the aorta can sometimes get a tear in it and
19 blood can seep behind the wall, which can cause havoc, and
20 that's a dissection.

21 A dissection is when the inner wall tears, blood can --
22 red is probably more appropriate. Blood can seep into the wall
23 and that can tear anywhere. It's identified with chest pain
24 generally severe enough to bring a person to an emergency room.
25 And it can jeopardize the aortic valve, and it's very common in

1 aortic dissection to have blood flow back into the left
2 ventricle called aortic regurgitation. The valve opens but
3 instead of closing normally, it doesn't close normally, it lets
4 blood go back into the heart.

5 Now, that has two interesting features to it. The
6 first is that there are two ways aortic regurgitation can occur.
7 One is by destruction of the valve, which you would see on
8 autopsy or during surgery when the heart's collapsed. The other
9 is a physiological dilation, meaning that the preparation just
10 expands the entire aorta allowing blood to go back. And on
11 autopsy or the operating room, when the blood isn't pumping, you
12 wouldn't see the problem because it's a dynamic stretching.

13 When a person has acute aortic regurgitation, which is
14 one of the most common findings of aortic dissection, two things
15 happen: One is that the most common murmur -- a murmur is the
16 sound of blood -- is actually a systolic murmur rather than a
17 diastolic murmur. So I'll have to explain the systolic murmur
18 and the diastolic murmur, and I have to explain the pulse
19 pressure.

20 Q Okay. Just, yeah, why don't you first explain the
21 aortic regurgitation itself and how that is related to an aortic
22 dissection.

23 A Well, again, it's because the aorta -- with the
24 pressure, dissection can just expand while blood is pumping,
25 letting the valve separate a little bit, even though it's

1 intact, and let's blood go back into the heart.

2 Now, there is something that -- the sound of blood
3 going back in the heart occurs when the heart -- the heart beats
4 pumping by the aorta. When the heart is refilling it's
5 diastole. Systole is the pumping. Diastole is relaxing.
6 Aortic regurgitation occurs in diastole when the heart is
7 filling up again. Blood goes in and there's a very soft
8 diastolic murmur associated with aortic regurgitation. It's
9 very often difficult to hear, especially in the emergency room,
10 but the most common, and there's a great deal of understanding
11 in medicine that if blood enters the heart backwards and blood
12 is filling the heart forwards, the heart is getting super
13 filled. So when it beats, it's pumping out more blood than
14 normal because of this filling from two directions. So a murmur
15 is hearing blood flow.

16 If you have a stream in your backyard, you may not hear
17 it, but if it rains and floods, the rapids you'll hear. Well,
18 that's what a systolic murmur is. To many people it's rapids
19 because there's so much blood in the heart when it pumps it
20 makes a sound of blood leaving the heart. And sometimes with
21 acute aortic regurgitation, although you might hear the actual
22 murmur of the diastolic sound, what's more common is to hear
23 just a loud sound of blood leaving the heart when it pumps
24 because of the increased volume of blood.

25 So a systolic murmur, which was found in this case in

1 Mr. Nocera, which was described three out of six -- most people
2 have a one or two out of six murmur. Three is relatively loud.
3 Often that is the murmur you hear first with acute aortic
4 regurgitation, a new murmur, systolic or diastolic, raises a
5 heightened concern that there is acute aorta regurgitation,
6 which is one of the hallmarks of aortic dissection. And the
7 other is the pulse pressure.

8 Q Can you tell us about the pulse pressure and how is
9 that related to Gary Nocera with respect to his diagnosis?

10 A Yeah. The blood pressure in our --

11 MR. VIGORITO: Your Honor, I'm just not sure we
12 need to be standing for this.

13 THE WITNESS: I need to just show one thing, if you
14 don't mind.

15 MR. VIGORITO: Sure.

16 A When the heart beats into the aorta, and when you get a
17 blood pressure you have a systolic and a diastolic, which means
18 the systolic is when the pressure beats pumping blood into the
19 aorta, that's peek pressure. Then, as blood travels through the
20 body, that pressure begins to drop and then the heart beat's
21 again shooting it up. So the lowest pressure you have before
22 the heart beats again is called your diastolic. So you have
23 your systolic, which is the peek heart beating, and as blood
24 travels through the aorta, you get the lowest number, diastolic.
25 That number would continue to drop if the heart didn't beat

1 again. But the heart beats again. So you have your upper
2 number, systolic, and lower number, diastolic.

3 In patients with acute aortic regurgitation, because
4 blood is traveling not only forward but backwards, that lower
5 number collapses to a much bigger difference. So, normally, the
6 difference between the systolic and diastolic, which is called
7 the pulse pressure, if you have a blood pressure of 120 over 70,
8 your pulse pressure is 50, that's the difference between the
9 upper and lower number. Most people have a pulse pressure
10 between 40 and 50. Over 70 is almost universally pathological.
11 50 over 80, that is extremely concerning.

12 Now, it doesn't prove that you have aortic
13 regurgitation, but it's very strongly supportive of aortic
14 regurgitation. And Mr. Nocera's initial pulse pressure when he
15 walked in the door was 86, which is a very large pulse pressure.
16 So given that a new aortic murmur, even though it was systolic,
17 that is common in people with aortic regurgitation and such a
18 large pulse pressure of 86, clinically his valve sounded like he
19 was a highly likely candidate for aortic regurgitation. And the
20 only way to tell would be to get an echocardiogram immediately.

21 The fact that his autopsy didn't show any damage to the
22 valve just means that his aortic --

23 MR. VIGORITO: Move to object, Judge, and stop the
24 answer at that point.

25 THE WITNESS: I'm finished.

1 MR. VIGORITO: Move to strike that last sentence,
2 Judge.

3 THE COURT: Let me hear the last sentence.

4 (Read record.)

5 THE COURT: That was it? It wasn't a complete
6 response.

7 MR. VIGORITO: I just move to strike that
8 incomplete sentence. It's not responsive to the question.

9 THE COURT: Sustained. You'll strike that
10 particular last response by the doctor. The jury will
11 disregard it. It will come up somewhere else.

12 MS. WEISMAN: Like now.

13 Q Doctor, did you read the autopsy report?

14 A I did.

15 Q Okay. And in the autopsy report does it show any
16 damage to the aortic valve?

17 A No.

18 Q And the fact that the autopsy shows no damage to the
19 aortic valve, does that conclude your finding of aortic
20 regurgitation?

21 A No, it doesn't.

22 MR. VIGORITO: Objection.

23 THE COURT: Well, he hasn't made that finding yet,
24 is that what your objection is?

25 MR. VIGORITO: That's my objection. It's also not

1 in the 3101(d).

2 THE COURT: Let's go.

3 (Sidebar held off the record.)

4 THE COURT: Let the record reflect that an
5 off-the-record conference was held with counsel outside the
6 presence of the witness and the jury. Mr. Vigorito's
7 objection is overruled.

8 You may continue, consistent with the colloquy held
9 at sidebar.

10 MS. WEISMAN: Okay.

11 Q Doctor, did you review Dr. Cuomo's testimony from last
12 week?

13 A I did.

14 Q Okay. And Dr. Cuomo testified that Mr. Nocera had a
15 normal aortic valve on his autopsy, so his widened blood
16 pressure was not widened because of dissection. Do you agree
17 with that testimony?

18 A I agree that was her testimony, but I disagree with the
19 content of the testimony.

20 Q Can you tell us why you disagree with that?

21 A Well, as I said, there are basically two categories by
22 which you can have aortic regurgitation. One category is
23 demonstrable permanent damage to the valve. And I agree
24 Mr. Nocera did not have that. The autopsy did not show
25 permanent damage to the valve. So he did not suffer from a

1 structural catastrophe to the aortic valve.

2 But it is equally well understood that there's some
3 people who have a dynamic cause of aortic regurgitation due to
4 dilation of the root during the actual flow of blood. The
5 pressure of the dissection can extend the ring of the aortic
6 valve, and you can functionally have aortic regurgitation, but
7 when there's no blood flowing, you won't see any damage. So you
8 do not require permanent structural damage to have aortic
9 regurgitation.

10 In fact, given that his disease was aortic dissection,
11 given the new systolic murmur, which is the most common auditory
12 finding with aortic regurgitation, and given his large pulse
13 pressure, within a reasonable degree of medical certainty he was
14 suffering from significant aortic regurgitation that day in the
15 emergency room.

16 Q And given that your opinion is that he was suffering
17 from an aortic regurgitation, what would have been the
18 appropriate course of the cardiologist in the emergency room?

19 A Well, that's also based on other factors, because he
20 had back pain, which Dr. Cuomo was unaware of, and yet very
21 important that a nurse reported that he had back pain, and
22 Dr. Cuomo did not know that fact, even though it was in the
23 record, and that's one of those major red flags. So in the
24 company of back pain and chest pain without a heart attack, in
25 the company of a pulse pressure that was 86, which is quite

1 large, and a loud new systolic murmur, the standard of care was
2 to be concerned about an acute aortic dissection.

3 Now, you don't get -- there's two ways to evaluate the
4 patient. One is an echocardiogram, which is a very common
5 noninvasive test. It's the second most common cardiac test
6 after the regular EKG. It's done all the time. And within
7 reasonable medical certainty, if an echocardiogram had been
8 done, it would have shown acute aortic regurgitation which would
9 have then made dissection very likely.

10 But the other test is a CAT scan. Now, a CAT scan is
11 one test that can look for pulmonary embolism and dissection.
12 It excludes number two and three of the most fatal cardiac
13 conditions. The most common is heart attack, but then pulmonary
14 embolism, a clot to the lung, or dissection are both diagnosed
15 by CAT scan. We don't get CAT scans only in patients when you
16 know with certainty they have aortic dissection. You get CAT
17 scans when it's enough of a clinical concern that a patient's
18 life depends on it. So you don't have to have complete proof
19 that a person has a dissection, just enough suspicions.

20 In Mr. Nocera's case, he had chest pain, back pain,
21 which again is a major finding that was not even detected by
22 Dr. Cuomo, which is unacceptable not to know that a patient had
23 back pain if it's in the notes, a new systolic murmur --

24 THE COURT: Go ahead, Doctor.

25 A -- new systolic murmur and widened pulse pressure, the

1 standard of care required a CAT scan to look for dissection, but
2 a minimum of an echo, which would have shown the same thing.

3 THE COURT: We are going to take our mid-morning
4 recess. I'm going to excuse you to the jury room. Please
5 don't discuss the case amongst yourselves.

6 Doctor, you may step down.

7 THE WITNESS: Yes.

8 THE COURT: Please don't discuss your testimony
9 during the break.

10 (Recess taken.)

11 COURT OFFICER: Jury entering.

12 THE COURT: Jurors may be seated as you enter.
13 Counsel, ladies and gentlemen, Doctor, please be seated.

14 THE WITNESS: Thank you, sir.

15 THE COURT: Welcome back, Jurors. You'll recall
16 when we took our recess Ms. Weisman was conducting her
17 direct examination of Dr. Charash, which we will begin our
18 next session along the same lines.

19 Let the record reflect that Dr. Charash has retaken
20 the stand. Doctor, I remind you you are still under oath or
21 affirmation.

22 You may inquire.

23 MS. WEISMAN: Thank you, your Honor.

24 DIRECT EXAMINATION (Cont'd)

25 BY MS. WEISMAN:

1 Q Dr. Charash, when you see a patient in the emergency
2 room, do you review the notes in the chart prior to seeing that
3 patient?

4 MR. VIGORITO: Objection to the leading.

5 THE COURT: Overruled.

6 A Yes, I do.

7 Q And is it important to review all the notes in a
8 patient's chart prior to seeing a patient for cardiac consult in
9 the emergency room?

10 A It is critical to read all the preceding notes before
11 you see a patient.

12 Q And for what reason?

13 A Well, when patients come to the emergency room, most of
14 the time the first health care provider they meet are nurses.
15 There's triage nurse and admitting nurse, and they usually see
16 the patient before the doctor. But when a person sees more than
17 one health care provider, often they provide information about
18 their symptoms at one time and then don't bring it up again.

19 For example, in this case a nurse reported back pain.
20 The patient's back pain may have gone away and the patient may
21 just not bring it up again. You have to read the notes -- and
22 it's not a lot of notes -- you just need to read the notes to
23 see what other information everyone achieved. And if you get
24 information from one of their notes, like back pain, and the
25 patient did not tell you they had back pain, then you have to

1 reconcile that and say to the patient you told Nurse "X" that
2 you had back pain, but you didn't report it to me. What's the
3 reason? And the patient would explain either -- whatever reason
4 that they forgot to bring it up again. But you have to work on
5 the assumption that if they report a symptom to a different
6 health care provider that it was legitimately reported. If it
7 wasn't, then you can reconcile that too, but you can't just work
8 on your history alone because it's very common for people to
9 report isolated symptoms without them understanding what's
10 really important to different providers. And that's why there
11 are notes, and that's why the first contact notes are very
12 important.

13 Q So, now, there has been testimony that Dr. Cuomo was
14 unaware of the pain radiating to the back when she saw Gary
15 Nocera, and she didn't recall reading the triage notes or the
16 nursing documentation or Dr. Bernstein's notes before she saw
17 Gary Nocera.

18 Do you have an opinion, based upon a reasonable degree
19 of medical certainty, whether the failure to review the hospital
20 record prior to seeing the patient was a deviation from accepted
21 practice?

22 A I do.

23 Q Okay. And what is that opinion?

24 A It was a deviation not to read the other notes. It was
25 a very clear deviation to be unaware of back pain that was in a

1 nursing note, especially given how high risk back pain is with
2 regard to dissection.

3 Q And do you have an opinion, based upon a reasonable
4 degree of medical certainty, whether Dr. Cuomo's failure to
5 review the hospital record caused an injury to Gary Nocera?

6 A Yes, I do.

7 Q And what is that opinion?

8 A Well, Dr. Nocera -- pardon me -- Dr. Cuomo allowed
9 Mr. Nocera to go home where he had already demonstrated multiple
10 reasons to work up for a dissection. And by failing to do so,
11 he died days later after dissection. Her history was
12 incomplete, at best.

13 MR. VIGORITO: Objection. Beyond the scope.

14 THE COURT: Of what?

15 MR. VIGORITO: It was a causation question I
16 believe, Judge.

17 THE COURT: Overruled.

18 A Anyway, her history was incomplete. She missed key
19 markers, and the patient should have been diagnosed if the
20 standard of care was adhered to with a dissection, which would
21 have required emergency surgery.

22 Q Assume Defendant Dr. Cuomo testified that Gary Nocera
23 had no pain when she was seen in the -- when she actually saw
24 Gary Nocera and in the hospital chart there were signs of -- the
25 pain notations were signs of five, and then there were three

1 notations of zero, and then five as the last notation of pain in
2 the hospital. Is there any significance to those findings?

3 A Yes.

4 MR. VIGORITO: Objection.

5 Q What is that?

6 THE COURT: Grounds?

7 MR. VIGORITO: Started out the question linking
8 Dr. Cuomo to -- Dr. Cuomo's testimony clearly is that she
9 was unaware of that last five, Judge. She was no longer
10 present and was not alerted to it. So it's an unfair
11 question the way it's phrased.

12 THE COURT: Read me back the question.

13 (Record read.)

14 THE COURT: Sustained as to form.

15 Q Assume that Dr. Cuomo testified that Gary Nocera had no
16 pain when she saw Gary Nocera. Is there any significance to
17 those findings?

18 A Yes.

19 Q And what is that?

20 A Any -- a heart attack pain tends to be sustained, and
21 if not treated, if you're having a full-fledged heart attack,
22 you're going to have severe pain that will last 12 to 18 hours
23 until every cell of the heart muscle dies. So heart attack pain
24 is typically a severe, sustained pain. If the arteries open,
25 the pain goes away.

1 Aortic dissection is different in that there is tearing
2 of the aorta and that tearing is what causes pain, but it
3 usually goes away on its own. Now, it can recur as well.

4 The fact that Dr. Cuomo examined the patient at a time
5 that he was pain free, although he came in with five out of ten
6 pain -- that's the scale we use, zero to ten for how much pain
7 you have -- means that his pain was gone. Now, that's good in
8 the sense that the -- there was no active tearing going on, but
9 there's always a threat with dissection or pulmonary embolism
10 that you could have recurrent pain.

11 Now, when she left, the patient did not have recurrent
12 pain, but that danger exists for recurrent pain because
13 dissections -- it's like tearing a fabric. It could be one
14 giant tear and death, or it could be a series of small tears
15 until death. The aorta can tear in pieces or in one giant fatal
16 tear. Most people who come to the emergency room with
17 dissection, they haven't had a fatal tear, they're coming in
18 with pieces of a tear.

19 So the fact the patient was pain free is good, but the
20 patient was always in danger of having recurrent pain.

21 Q And the fact that the patient left the hospital on his
22 last note with pain of five, does that have any significance to
23 you?

24 A Well, for Mr. Nocera it meant that he probably had
25 another small level of tear of his aorta, and he left with the

1 same pain he came in with, even though he had a gap of no pain.
2 So in terms of what was happening to him, it indicates that his
3 dissection was having another piecemeal tear.

4 Q I just want to go to the chest x-ray a little bit. You
5 mentioned that you had reviewed the chest x-ray.

6 A I reviewed the films as well as the reports.

7 Q Okay. And what would a cardiologist be looking for if
8 somebody comes in with chest pain in an x-ray?

9 A Well, there are several things you look for. One is to
10 see if the lungs are intact to make sure that one lung isn't
11 collapsed. That is a form of disease that can cause chest pain,
12 it's called a pneumothorax. So you look to see if that was
13 collapsed, which it wasn't. You look for evidence of fluid in
14 the lungs called pleural effusions, which could be related to
15 cardiac illness. That was not present. You look for evidence
16 of congestive heart failure, which is fluid in the airways,
17 which wasn't present. You look to see in terms of aortic
18 dissection whether the heart and major blood vessels show any
19 irregularity.

20 Now, in order to do that you need an x-ray that can
21 adequately show the mediastinal region. Again, in this case the
22 radiologist read the x-ray as saying there was too much
23 distortion of the mediastinum because it was taken at the
24 bedside, which is not ideal. It's often what we do first, but
25 the conclusion was that the x-ray's quality of looking at the

1 major structure in the center of the chest was not adequate to
2 be able to read it effectively. So even though it didn't show
3 any acute abnormality, it was clear that the radiologist was
4 reporting that the x-ray was not of adequate quality to be able
5 to make a determination.

6 Q Okay. And based upon the x-ray indicating that there
7 was a limited evaluation of the mediastinum structure, is there
8 a standard of care for a consulting cardiologist with respect to
9 further evaluation?

10 A Well, you always have the option, once the patient is
11 at least temporarily stable, to doing a standing up x-ray. When
12 you're sitting in a chair --

13 MR. VIGORITO: Your Honor, I'm sorry to interrupt
14 Dr. Charash. I'm going to object now based on the 3101(d).
15 We've reviewed it already. This is far beyond what has been
16 spelled out in the 3101(d), I believe.

17 THE COURT: I think it's consistent with the
18 original objection about what Dr. Charash was going to be
19 permitted to testify to with regard to the x-ray. The
20 objection is sustained.

21 Q Now, you talked about a CAT scan and that a CAT scan
22 would have shown an aortic dissection if there was one there.
23 Was a CAT scan ordered in the emergency room by Dr. Cuomo?

24 A No.

25 Q Can you tell us your opinion, based upon a reasonable

1 degree of medical certainty, whether the failure to order the
2 CAT scan was a deviation from accepted practices with respect to
3 Dr. Cuomo?

4 A Yes, I can.

5 Q And what is that?

6 A Well, that it was a deviation not to order a CAT scan.

7 Q And why is that?

8 A Well, for all the reasons I've given: Primarily chest
9 pain that was not a heart attack; radiation to the back; a new
10 systolic murmur that was loud and the patient never reported it
11 before, meaning something's happening at the aortic valve. And
12 as I said, regurgitation or back flow is commonly found first to
13 have a systolic murmur. And finally, the very large pulse
14 pressure of 86 millimeters of mercury between the upper and
15 lower numbers on his first beep. All of those suggest aortic
16 regurgitation. Again, the threshold to getting a CAT scan is
17 not absolutely certain, but enough concern that a person's life
18 depends on it.

19 Q So based upon this failure to order the CAT scan, do
20 you have an opinion, based upon a reasonable degree of medical
21 certainty, whether it caused injury to this patient?

22 A Yes, I do.

23 Q And what was that?

24 A That the failure to get a CAT scan and the failure to
25 diagnose him with an aortic dissection resulted in him

1 experiencing basically a major tear of the aorta and death
2 three days later on September 21st, 2013.

3 Q And you talked a little bit about the echocardiogram as
4 well. Was an echocardiogram ordered by Dr. Cuomo?

5 A For -- to be performed after discharge but not in the
6 hospital.

7 Q Can you tell us your opinion, based upon a reasonable
8 degree of medical certainty, whether the failure to order an
9 echocardiogram in the hospital deviated from accepted practices
10 with respect to Dr. Cuomo?

11 A Yes, I can.

12 Q And can you tell us the basis of that opinion?

13 A Well, it was a deviation to not get an echocardiogram
14 for all the reasons I just gave.

15 Q And may I ask you this, with respect to the not
16 admitting the patient for further evaluation, did you have an
17 opinion as to whether the failure to admit this patient on
18 September 18th, 2013 was a deviation from accepted medical
19 practices?

20 A Yes, I do.

21 Q And what is your opinion?

22 A Well, clearly the standard of care required a workup
23 that would have proven he had an aortic dissection and he'd be
24 admitted and have surgery. Certainly if you were admitted, he
25 could have had the CAT scan hours later. We know that he didn't

1 die for three days, so he had plenty of time to have his life
2 saved.

3 Q Is that the same if they would have done an
4 echocardiogram?

5 A Yes. Echocardiogram or CAT scan.

6 Q And Doctor, did you review the autopsy?

7 A Yes, I did.

8 Q Okay. Can you tell us what the cause of death was as
9 reflected in the autopsy?

10 A The dissection, the tearing of the aorta, eventually
11 tore back -- the heart is surrounded by a bag called the
12 pericardium. It's like a lubricated baggy that the heart beats
13 inside. It protects the heart from physical injury, from
14 infection. And that baggy around the heart has a lubricating
15 fluid in it, and the heart beats inside the baggy. If you
16 operate on the heart, you have to cut into the pericardium. An
17 aortic dissection can go back and bleed massively into the
18 baggy. If it does, the baggy can't stretch. So what happens is
19 the blood goes into that space and collapses the heart into a
20 little ball which is associated with sudden cardiac death. The
21 heart can't beat.

22 Q With respect to the autopsy, were there more than one
23 tear -- was there more than one tear that had shown up?

24 A No. There was a tear in the first part of the aorta
25 and a distal part of the aorta, which occurs. People can have

1 tears in more than one place.

2 Q Is there any significance to the multiple tears?

3 A No, other than the fact that the tear in the beginning
4 of the aorta is what needed surgical replacement. The tear
5 downstream can usually be treated medically. The one that
6 threatens your life is the one right above the aortic valve.
7 That's the one that leads to death.

8 Q Is that the ascending aorta?

9 A That's called the ascending or rising aorta, yes.

10 Q And a tear in the ascending aorta is a life-threatening
11 condition?

12 A Yes. It's a surgical emergency.

13 Q So do you have an opinion, based upon a reasonable
14 degree of medical certainty, whether the pain that caused
15 Mr. Nocera to go to the emergency room on September 18th, 2013
16 was caused by the aortic dissection?

17 A Yes, I do.

18 Q And what is your opinion?

19 A That it was caused by an aortic dissection.

20 Q And what's the basis of that opinion?

21 A Well, his aortic dissection was the cause of death
22 three days later. There were chronic and inflammatory changes
23 in the aorta which means -- if you have an aortic dissection and
24 die instantaneously, there isn't enough time for inflammatory
25 cells to gather. Inflammation in the aorta means that it was at

1 least several days old.

2 He went to the ER with pain, it radiated to his back,
3 he had a high pulse pressure, he had a new systolic murmur. It
4 was clear when you look at all the information that with close
5 to medical certainty, close to 100 percent medical certainty, he
6 was dissecting in the ER on the 18th and died of that same
7 dissection on the 21st.

8 Q Do you have an opinion, based upon a reasonable degree
9 of medical certainty, that the dissection progressed from
10 September 18th through September 21st when he died?

11 A Yes, I do.

12 Q And what is that opinion?

13 A Well, again, it's clear when he left the hospital he
14 was alive. The final tear killed him. So he clearly -- and the
15 fact that he had recurrent pain when he left means that he
16 probably had a small tear when he left the hospital. We have no
17 information to tell us what occurred between the 18th and 21st.
18 But it's not uncommon for someone to feel well and then finally
19 have a fatal tear days later.

20 MR. VIGORITO: I'm sorry, Judge, can I have that
21 last question and answer read back?

22 THE COURT: The question and answer?

23 MR. VIGORITO: Yes, please.

24 THE COURT: Nicole.

25 (Record read.)

1 MR. VIGORITO: Thank you, your Honor.

2 THE COURT: You're welcome.

3 Q The testimony that has been presented by Kathleen
4 Nocera was that the patient had pain.

5 MR. VIGORITO: I object now, Judge. That's trying
6 to refresh her own witness' ability to testify. He just
7 gave an answer just a second ago, which we read back, saying
8 there was no information to tell what happened between the
9 18th and the 21st. So now I object to any effort by
10 counsel, who brought Dr. Charash here, to lead him and put
11 words in his mouth on this.

12 THE COURT: I don't know where she's going with
13 this question.

14 MS. WEISMAN: Complaints of pain and whether that
15 would make a difference.

16 MR. VIGORITO: Your Honor, with all due respect,
17 the beginning of the question is Kathleen Nocera testified
18 about things, and those things are going to be what happened
19 between the 18th and the 21st for which this --

20 THE COURT: Are you sure?

21 MR. VIGORITO: The witness has now said he has no
22 information. He had Ms. Nocera's deposition. He said that
23 at the very outset today.

24 (Sidebar held off the record.)

25 THE COURT: Let the record reflect that a sidebar

1 was held with counsel outside the presence of the witness
2 and jury. Mr. Vigorito's objection is overruled. You may
3 ask the question.

4 Q Assume that Kathleen Nocera testified that there was
5 pain for the three days from September 18th to September 21.
6 Does that change your opinion?

7 A No, because --

8 MR. VIGORITO: Object. I just want my objection on
9 the record, Judge.

10 THE COURT: Your objection is noted. Overruled.

11 A No, because that's not medical history. She can only
12 be aware of what her husband tells her. But we don't really
13 have the details of what occurred between his discharge and his
14 death. As a spouse, she could be aware of what he told her --

15 MR. VIGORITO: Objection.

16 MR. VENDITTO: Join.

17 THE COURT: Sustained. I think that's --

18 MS. WEISMAN: Okay.

19 THE COURT: -- that's enough.

20 MS. WEISMAN: Thank you.

21 Q Doctor, have you treated patients who have had surgical
22 repairs of aortic dissection?

23 A Yes.

24 Q And have you referred patients for surgical repairs of
25 aortic dissections?

1 A Yes.

2 Q Can you describe what that repair would be.

3 A Well, the surgeon would operate and replace the aortic
4 root and redirect the arteries to this graft they put in. The
5 aortic valve would be determined whether it needs replacement.
6 Given that there was no structural damage on autopsy, it would
7 probably not need replacement.

8 MR. VIGORITO: I'm going to object. Move to
9 strike, Judge, based on the 3101(d), your Honor.

10 THE COURT: Point me to where.

11 MR. VIGORITO: I'm sorry?

12 THE COURT: Point me to where.

13 MR. VIGORITO: Well, that's just it, I mean --

14 THE COURT: There is no where to point.

15 MR. VIGORITO: I can't point you anywhere because
16 it's just not in there.

17 MS. WEISMAN: It's regarding causation, your Honor.

18 THE COURT: Where are you referring me,
19 Ms. Weisman?

20 (Sidebar held off the record.)

21 THE COURT: Read me the question, please, Nicole.

22 (Record read.)

23 THE COURT: I'm going to sustain the objection. I
24 don't find it anywhere that would warrant the doctor or
25 permit the doctor or place anybody on notice that the doctor

1 was going to testify as to what would occur during the
2 aortic dissection. I -- so far I agree and sustain the
3 departures and substantial factor questions which the doctor
4 has answered.

5 I think this goes beyond the scope. Your -- the
6 objection by Mr. Vigorito is sustained. The response by the
7 doctor is stricken. The jury will disregard it.

8 Whose is it?

9 MR. VIGORITO: Mine, Judge.

10 MS. WEISMAN: Thank you.

11 Q Do you have an opinion, based upon a reasonable degree
12 of medical certainty, as to what the patient's prognosis would
13 have been had the diagnosis been made in the emergency room and
14 had proper management been given?

15 MR. VIGORITO: Same objection.

16 MR. VENDITTO: Join, Judge.

17 THE COURT: Is that under the 3101(d)?

18 MR. VIGORITO: I believe so, your Honor. I mean,
19 it's not there.

20 THE COURT: Well, I didn't see that either, but I'm
21 also going to sustain it as speculative.

22 You have an exception, Ms. Weisman.

23 MS. WEISMAN: Thank you.

24 Q Doctor, do you -- I'm just going to get something out
25 of the way for a second. Were you paid to testify here today?

1 A Yes.

2 Q Okay. And were you paid to review the materials?

3 A Yes.

4 MS. WEISMAN: Okay, Doctor, thank you.

5 THE COURT: All right, ladies and gentlemen, we're
6 going to take a brief recess to allow Mr. Vigorito and
7 Mr. Venditto to get their ducks in a row for
8 cross-examination, but I promise you it will be brief. So
9 please don't discuss the case amongst yourselves.

10 Doctor, you may step down. Please don't discuss
11 your testimony during the recess.

12 THE WITNESS: Thank you, sir.

13 (Recess taken.)

14 COURT OFFICER: Jury entering.

15 THE COURT: Jurors, be seated as you enter. Ladies
16 and gentlemen, Doctor, please be seated. Welcome back,
17 Jurors.

18 You'll recall that when we took our recess
19 Ms. Weisman had completed her direct examination of
20 Dr. Charash. We will begin our final session for the
21 morning beginning with cross-examination of the doctor by
22 Mr. Vigorito.

23 Let the record reflect that Dr. Charash has retaken
24 the stand. Again, Doctor, I remind you you are still under
25 oath or affirmation. You may inquire.

1 MR. VIGORITO: Thank you, your Honor. Good morning
2 jurors.

3 CROSS-EXAMINATION

4 BY MR. VIGORITO:

5 Q Good morning, Dr. Charash.

6 A Good morning, sir.

7 Q Dr. Charash, my name is Alfred Vigorito. I represent
8 Dr. Linda Cuomo and Westchester Medical Center, sometimes
9 referred to as Westchester County Health Care Corporation. And
10 I'm pretty sure that you and I have never crossed paths before,
11 either in a courtroom or outside. Does that sound accurate to
12 you?

13 A Yes.

14 Q Okay. Doctor, are you familiar with the term
15 retrospective bias?

16 A Yes.

17 Q You've heard of that term before?

18 A Of course.

19 Q And you know that it essentially means that since you
20 know what happened at the end a person might be biased looking
21 backward?

22 A Yes.

23 Q When you evaluate judgments made -- that people make,
24 you have to evaluate them based upon the facts available when
25 they make those judgments. That would certainly hold true for a

1 physician like yourself evaluating Dr. Cuomo, my client, in this
2 case, true?

3 A I agree.

4 Q That would be the only fair way to do it, in fact,
5 right?

6 A Of course.

7 Q And two doctors can be faced with the same day and that
8 one decides to do one thing and the other a different thing, and
9 both can be within the standard of care; that is a possibility
10 as you sit here now, true?

11 A Yes, as long as it's within the standard of care, yes.

12 Q And Doctor, up until this point in time you have been
13 on the witness stand many times before and testified about many
14 depositions, true?

15 A Yes, sir.

16 Q I think that the number, based upon a trial that
17 happened about two and a half, three weeks ago in Kings County
18 in Brooklyn, New York with my partner Jeffrey Nichols -- do you
19 recall Mr. Nichols --

20 A I do.

21 Q -- asking you some questions?

22 You acknowledged that you have now testified, combined
23 trial and deposition, if not 600 times in total, you're getting
24 there pretty quickly, true?

25 A Over 30 years, yes.

1 Q Okay. And would you agree with me that some of your
2 opinions might be viewed as controversial because they might
3 represent an alternative viewpoint?

4 A You're only referring to what I said about my book
5 written for the public where I was trying to explain medicine.

6 Q Okay, Doctor, I'm going to cut you off for a simple
7 reason. In those times that you have testified primarily at
8 trial, probably not at deposition, you were probably given a
9 friendly instruction from an adversarial counsel like myself
10 that if you could answer the question with a simple yes or no,
11 would you try to accommodate the question. You've heard that
12 before?

13 A Of course.

14 Q Okay. So let's assume that my saying it now in the
15 form of that question is me asking that of you for the purposes
16 of the rest your testimony here today. Fair enough?

17 A Yes, of course.

18 Q If you can answer it yes or no, please do so. I will
19 endeavor to try to ask my questions in a way that would call for
20 a yes-or-no answer, which is my prerogative on
21 cross-examination. And if you can't answer it yes or no, just
22 tell me that and I'll either let you answer it the way you see
23 fit or I'll move on to something else. Fair enough?

24 A Of course.

25 Q Doctor, at this point in your career have you reviewed

1 a thousand cases?

2 A It's possible. I think it's less, but it's possible.

3 Q And would you say that your testimony here today is
4 based on assumptions that you have made based on the records
5 that you have reviewed and your knowledge from your years of
6 practicing medicine, primarily cardiology?

7 A Yes.

8 Q And would you agree with me that if your assumptions --
9 at least those that are based on facts -- that you discern from
10 your review of the records and the depositions and the trial
11 testimony, if those facts were not as you thought them to be
12 when you formed your assumptions, then the underpinnings for
13 those assumptions might fail, true?

14 A Well, I can't answer the question the way you phrase it
15 limited to a simple yes or no.

16 Q It's kind of like a hypothetical.

17 THE COURT: Hold it, hold it. Let the doctor
18 finish. You asked him a question.

19 Doctor, as I'm sure you're aware, and we may have
20 even had this discussion at other trials, wait for
21 Mr. Vigorito or any counsel to completely finish asking the
22 question before you commence your answer. This way we'll
23 avoid, you know, any confusion as to what the true nature of
24 the question may be.

25 With equal emphasis and equal courtesy, I'm going

1 to direct counsel that if you're in the process of an answer
2 that they wait until you completely finish your answer, and
3 then I will entertain any applications to the extent that
4 there may be.

5 THE WITNESS: Yes.

6 THE COURT: Go ahead, Mr. Vigorito.

7 MR. VIGORITO: I'm not sure, Judge, if the doctor
8 got to answer the question. Your original objection was
9 that I cut the doctor off, so I'm not sure if he answered my
10 question.

11 THE COURT: Read the question and answer up to the
12 point of Mr. Vigorito's commentary, and then I'll determine
13 whether or not, or I'll ask the doctor if he had completed
14 his answer.

15 (Record read.)

16 THE COURT: Is that it, Doctor?

17 THE WITNESS: Yes, sir.

18 THE COURT: Thank you.

19 Q Well, for example, Doctor, a little while ago
20 Ms. Weisman asked a question and you said that you don't know,
21 there's no information about what happened with Mr. Nocera from
22 the time he left the hospital on the 18th until the day of death
23 on the 21st. Do you recall giving that answer?

24 A I do.

25 Q About 20 minutes ago?

1 A Of course.

2 Q Okay. And as you sit here now, that's not entirely
3 accurate, is it?

4 A Well, I meant it from a medical point of view. What
5 Mrs. Nocera reported is her understanding of what he told her,
6 but we don't have a medical history of the pattern, the
7 duration. That's what I was referring to. We don't have an
8 interval medical history.

9 Q Okay. Because he didn't see any doctors between the
10 time that he left and the time of his death, true?

11 A Correct.

12 Q He died essentially in his sleep and woke up basically
13 asystole and pulseless?

14 MS. WEISMAN: Note my objection.

15 Q Correct?

16 MS. WEISMAN: That's assuming facts in evidence.

17 THE COURT: He said he died in his sleep and then
18 woke up.

19 MR. VIGORITO: When they woke up in bed, Judge.

20 Q He was essentially dead, right?

21 A Yes.

22 THE COURT: But your question -- your question was
23 not who woke up.

24 MR. VIGORITO: I understand, Judge, I'll --

25 THE COURT: So I'm going to sustain the objection

1 as confusing and allow you to rephrase it.

2 MR. VIGORITO: Okay.

3 Q The judge is right, Doctor, you realize I'm talking
4 about Mr. Nocera never woke up, he died in his sleep; you agree
5 with that?

6 MS. WEISMAN: Note my objection, your Honor.

7 THE COURT: Overruled.

8 A Yes.

9 Q He woke up presumably, as we've heard in testimony we
10 rely on, with Mrs. Nocera next to him, she heard a gurgle and
11 looked at him and there was no response; you're aware of that?

12 A Yes.

13 Q You got that all from Mrs. Nocera's deposition
14 testimony, right?

15 A Correct.

16 Q Okay. In addition to her deposition testimony, did you
17 have the benefit of reading another transcript of Mrs. Nocera's
18 testimony in this case besides her deposition?

19 A No.

20 Q Are you aware that in addition to the formal deposition
21 that was taken in the case, which presumably you were supplied
22 with and did read, there is a transcript from what we call a
23 statutory hearing? Because in a case against Westchester County
24 Health Care Corporation there's a notice of claim requirement
25 and people, litigants, have to give a -- almost like a

1 pre-deposition. Were you aware that such a transcript existed?

2 A I'm not sure I even understood what you were saying,
3 but I've only read her deposition transcript.

4 Q Just one transcript?

5 A Yes, sir.

6 Q How about her trial testimony that she's given thus far
7 in this case, did you read that?

8 A No.

9 Q Okay. And so when you say you didn't have the benefit
10 of any medical knowledge between the 18th and the 21st, it's
11 because he didn't see a doctor after he left Westchester. And
12 by the time they took Mr. Nocera to Hudson Valley Hospital in
13 Cortlandt Manor he was essentially pronounced when he got there?

14 A Yes.

15 Q But there is knowledge of what Mr. Nocera was feeling
16 between the 18th and the time he went to bed the evening of the
17 20th going into the morning of the 21st?

18 A Yes.

19 Q And that it is within the province of either
20 Mrs. Nocera, perhaps a little bit of one or more of the children
21 who may have had contact with him in those couple of days?

22 A Yes.

23 Q Did you have occasion to read any of the testimony of
24 the three Nocera children in this case?

25 A No.

1 Q Okay. So, as you sit here now, would you not be in
2 possession of any knowledge of any contact or observations that
3 the children made of their father over that course of time?

4 A Correct.

5 Q So you would be limited to whatever your recall is of
6 what Mrs. Nocera said?

7 A Yes.

8 Q Okay. And now, as you sit here now, do you have
9 specific recall of what Mrs. Nocera said her husband's condition
10 was from the moment he left Westchester Medical Center on the
11 18th until that unfortunate happenstance of waking up and
12 finding your husband to be pulseless?

13 A Only that he had reported some pain to her, but I don't
14 have a cogent history.

15 Q When you say reported some pain to her, can you
16 elaborate on that, or is that the sum total of your
17 understanding?

18 A It's the sum total. By memory, that's my sum total of
19 my understanding.

20 Q Did you know that Mrs. Nocera, both in her deposition,
21 the one that you had, and in her trial testimony -- and when I
22 say did you know, I mean did Ms. Weisman tell you or did you
23 learn it from anywhere else, that her testimony under oath, both
24 of those times, in court and out of court in a deposition,
25 stands for the proposition that her husband was in a significant

1 amount of pain the entirety of the time from when he left
2 Westchester Medical Center until he did not wake up on the
3 morning of the 21st? Were you aware of that fact, yes or no?

4 A Only if it was in her deposition, but not any other
5 form of testimony.

6 Q If I were to tell you that is her testimony, both at
7 trial and at deposition, and I'd ask you to accept that, based
8 upon the testimony that you've given thus far, if I heard you
9 correctly, would that necessarily mean that Mr. Nocera was
10 experiencing a tearing of the aorta over that entire period of
11 time because he had significant pain?

12 A The answer would be that you need a more detailed
13 history. Somebody can say they spent the weekend vomiting the
14 entire weekend, but it doesn't mean it was a sustained vomitus.
15 She might believe that he was constantly in pain, but many
16 people relate recurrent pain as always being there.

17 We don't have a medical history on Mr. Nocera. There
18 are very few conditions which lead to 24/7 pain without any
19 change or interruption. She's not a trained health care
20 professional and she's not the doctor. So her being aware that
21 he had pain is only her awareness of pain, but she can't know
22 what the pattern was. There wasn't a medical history taken.

23 Q Do you know, as you sit here now, whether Mrs. Nocera
24 recounted, either in her deposition, which you read, or her
25 trial testimony, which you haven't seen yet, that from the time

1 that Mr. Nocera left Westchester Medical Center's emergency
2 department on the 18th until not waking up on the morning of the
3 21st that he was complaining of back pain? Do you know, yes or
4 no?

5 A No, I don't know.

6 Q Do you know if her recounting of his pain was limited
7 to his saying that he had chest pain? Just a yes or a no.

8 A I don't recall the specifics.

9 Q Do you know, as you sit here now, whether her
10 recounting of pain, on both of those occasions, included any
11 complaint of pain radiating from the chest to any other anatomic
12 part of his body? Just a yes or a no.

13 A No.

14 Q So you wouldn't know if it radiated to his neck,
15 correct?

16 A Correct.

17 Q To his shoulder, correct?

18 A Correct.

19 Q To his back, correct?

20 A Correct.

21 Q Between his shoulder blades, correct?

22 A Correct.

23 Q By the way, did Mr. Nocera have a history of back pain?
24 Just a yes or no.

25 A I'm trying to think back to his primary care. He may

1 have had some back pain at some point, but his problems were
2 more GI and reflux disease.

3 Q He had been diagnosed with gastroesophageal reflux
4 disease, commonly called GERD.

5 A Yes, he had.

6 Q And he was taking a medication for that?

7 A Yes.

8 Q And do you know which medication he was taking?

9 A I don't recall which one. I'd have to look at the
10 chart.

11 Q Okay. What about chiropractic care? Sometimes people,
12 especially tradespeople, as Mr. Nocera was a fully credentialed
13 carpenter, might develop joint pain, back pain, leg, knee pain
14 just from the wear and tear of what they do for a living. Are
15 you aware of whether or not Mr. Nocera saw a chiropractor?

16 A I don't recall seeing records from a chiropractor's
17 office, so I don't have an opinion one way or the other.

18 Q Okay. If I told you that we have the records of
19 Biffer, B-I-F-F-E-R, Chiropractic in evidence, because they are
20 care and treatment records for Mr. Nocera, would that be the
21 first time you're hearing about the mere existence of
22 chiropractic records?

23 A Yes.

24 Q And as you sit here now, obviously with that as a
25 backdrop, you wouldn't know whether those records speak to the

1 issue of whether Mr. Nocera had a history of back pain?

2 A Not offhand, but, I mean, that wouldn't change the
3 opinions in court.

4 Q Getting back to a question I asked you earlier, I think
5 there might have been an objection. I just want to see if I can
6 clear it up.

7 If the facts upon which your assumptions were changed,
8 if they're not as you found them to be when you made your
9 assumptions, might that change your opinions? Just a yes or no.
10 If you can't answer that yes or no, you can tell me.

11 A It will depend on the facts.

12 Q Let's talk about the amount of testimony, Doctor, when
13 I say 600 times combined trial and deposition, you know that
14 that's now a pretty accurate number, true?

15 A I think it's a little under 600, but I think it's
16 generally accurate.

17 Q And each of those times you've been compensated for
18 your testimony, whether it's trial or deposition?

19 A Yes.

20 Q And out of those 600 times thereabouts, it breaks down
21 somewhere on the orders of 250 times in court and about 350
22 times at a deposition, accurate?

23 A Yes.

24 Q And you've reviewed over a thousand cases at this point
25 in your career, as you said, over 30 years, right, starting

1 what, 1987?

2 A Yes.

3 Q And 95 percent of the time you're testifying in court
4 or at a deposition for a plaintiff, a litigant who's suing a
5 doctor or a hospital in a medical malpractice case, true?

6 A Ninety-five percent are plaintiff, not all of them are
7 malpractice. I've dealt with a fair number of cases of injuries
8 from accidents affecting the heart, and I've dealt with a number
9 of cases about drugs affecting people. So not all of them have
10 been malpractice, but 95 percent of my testimony has been for
11 plaintiff-related cases.

12 Q So if it was 600 times, if we use that as the number --
13 and I understand you might think it might be a tad under that --
14 90 percent of 600 is 540, 95 percent would be nine -- would be
15 575. So out of 600, 575 times have been for the litigant, the
16 person bringing the lawsuit?

17 A Yes.

18 Q And you started doing that the very same year you
19 finished your cardiology training in 1987, true?

20 A Yes.

21 Q And you would agree that doing that kind of work, the
22 review and the testimonial work, that has nothing to do with
23 your actual patient care, it's in addition to it?

24 A Yes, it is.

25 Q Doctor, you didn't testify when counsel asked about the

1 rate of compensation for this case, so let me ask that now. Are
2 you being compensated monetarily for your time in court today?

3 A Yes.

4 Q Is that a flat fee or an hourly fee?

5 A An hourly fee.

6 Q And what is the rate of compensation per hour to be
7 away from the practice of medicine and be with us today?

8 A \$500 an hour from 9:00 to 5:00. I got here before
9 9 o'clock, but I don't charge for travel time since I wouldn't
10 be working. So it depends on how many hours in the 9 to
11 5 o'clock, 8-hour interval I miss due to the trial.

12 Q Okay. And I take it that you charge either the same
13 rate or perhaps a slightly reduced rate for the review of
14 materials and for meetings and telephone conversations, things
15 of the like, maybe emails, to get ready for and to have reviewed
16 the materials to be able to come to court and testify?

17 A Yes.

18 Q And what is the rate of compensation for that?

19 A \$450 an hour, all of this is since 2015.

20 Q Okay. That's when the rate went up?

21 A Yes.

22 Q Prior to that it wasn't 500 per hour for court, 450 per
23 hour for review, it was slightly less than that?

24 A It was.

25 Q And what were the numbers prior to 2005, did you say?

1 A '15.

2 Q Oh, '15. What were the numbers prior?

3 A Well, it started, I think, at \$200 an hour or 250 an
4 hour in the early years. Eventually, it went up to \$400 an hour
5 for all testimony, and then 450 and 500.

6 Q I think you've testified in the past that in 2015 you
7 took a look around you and saw what the industry standard kind
8 of was and you reviewed some, maybe some transcripts of other
9 witnesses and decided that you were not charging an appropriate
10 rate, so to speak, and you raised your rate; is that accurate?

11 A That was part of it. The other part was I had not
12 raised my rate in over a decade.

13 Q So tell us, Doctor, based on the items that you were
14 given that you enumerated today, how much time have you spent
15 reviewing those records, depositions and meetings with counsel,
16 which I'll ask you about in a moment, right up to the 9 o'clock
17 hour today? How many hours had you accumulated on the Nocera
18 case?

19 A Probably eight hours.

20 Q Okay. And those were billed at 450 per --

21 A Yes.

22 Q Okay. So that's \$3,600, I think, if my math is
23 correct, eight times 450?

24 A Okay.

25 Q All right. And now the clock is running from 9 o'clock

1 this morning for whatever time you're here today. And do you
2 charge for your travel time going back into the City at all?

3 A Only 9:00 to 5:00. If I leave here at 5:00 I won't
4 charge for the travel time.

5 Q Okay. But if you get out of here today at 4:00 and you
6 don't get home until 5:00?

7 A Then I missed 9:00 to 5:00 work, so it's eight hours.

8 Q Okay. So eight times five conceivably could be another
9 \$4,000?

10 A Yes, sir.

11 Q With the 3600 it would be up to \$7600 for this case?

12 A Yes.

13 Q And the amount of materials that you reviewed in this
14 case, it wasn't a lot of records I don't think, was it?

15 A No, it was not.

16 Q Okay. Would you say that this was a smaller amount of
17 records than the average case that you do review out of those
18 thousand cases that you've reviewed?

19 A It was a smaller amount of records but more meeting
20 time than normal.

21 Q Okay. Let's talk about the meeting time. How much
22 time did you meet with counsel to discuss the case?

23 A Three and a half hours.

24 Q Okay. And when was that taking place?

25 A Couple weeks ago.

1 Q Was it all at once, one session or more than one
2 session?

3 A Well, we had phone discussions that were factored into
4 the billing earlier, but we met for about three and a half hours
5 to discuss this trial.

6 Q And have you been compensated for that prep time so
7 far?

8 A Yes.

9 Q You've already received payment for that?

10 A I have.

11 Q Okay. Have you already received payment for your time
12 in court today?

13 A No.

14 Q Because you have to bill that separately per hour?

15 A Yes.

16 Q Okay. Did you bring with you any materials, any notes
17 that you might have made in this case?

18 A I didn't make any notes, but I brought Post-Its of some
19 of the records that we would be discussing.

20 Q How about billing records, did you bring any billing
21 records, a bill for the \$3,600 that you billed so far?

22 A Well, it wasn't a single invoice, obviously. It was
23 spread out over different points of time. But no, I did not.

24 Q Now, Doctor, there's a firm in Florida that you've
25 testified for on several occasions, and you would acknowledge

1 that you've actually earned \$50,000 in one year from testifying
2 for that one firm in Florida, true?

3 A Yes.

4 Q And in 2014, would you acknowledge -- and you have in
5 the Shanoff case -- that you've testified 27 times in one year,
6 true?

7 A Combining trial and deposition, yes.

8 Q And you would acknowledge that 100 percent of those 27
9 testimonies in that year 2014 were all for the litigant, all for
10 the plaintiff bringing the lawsuit, true?

11 A Probably. I don't -- I don't have independent memory,
12 but if I testified to that it would be true.

13 Q And you recall testifying in the Knote case, K-N-O-T-E,
14 that you have given more than 24 depositions in some calendar
15 years, true?

16 A In the past -- I -- what year? Which is the Knote
17 deposition? I just --

18 Q Well, just that thought, Doctor, that you have given 24
19 or more depositions in one calendar year, you recognize that to
20 be a true statement?

21 A Probably. I mean, there was a peak about a decade ago,
22 so it may have been true. I just don't have an independent
23 memory.

24 Q And that same case you acknowledged that you had
25 testified in court 15 times in one year, true?

1 A Yes.

2 Q And you would agree that \$10,000 is a typical amount
3 you collect on cases that go to trial in recent years, you gave
4 that testimony in the Colon case, true?

5 A Yes, for out-of-state cases, but a lot of the cases in
6 New York are half days.

7 Q Let's talk about out of state for a second. I think
8 you did mention to this Court and our jury earlier today that
9 you have testified in was it 40 different states?

10 A No, I reviewed cases from lawyers in as many as 40
11 states. I've probably only traveled to 12 for testimony.

12 Q And in some of those cases that are out of state, they
13 have what they call federal rules where you have to give a
14 deposition, true?

15 A I don't know what rules they are, but I know that there
16 are states where I'm deposed.

17 Q Okay. And sometimes you can do those depositions right
18 here in New York that might be done with a video link or by
19 telephone link of some kind, true?

20 A They're almost always done in New York.

21 Q So you don't even have to leave New York to give that
22 kind of deposition?

23 A That's correct.

24 Q Sometimes you might have to travel for the actual trial
25 following the deposition to another state, true?

1 A Yes.

2 Q Okay. And how many states would you say you've
3 testified in?

4 A Twelve.

5 Q Okay. And a couple weeks ago did my partner,
6 Mr. Nichols, establish with you that you've testified
7 essentially in every state along the eastern seaboard of the
8 United States; is that true?

9 A Probably. I'm not sure it was every state.

10 Q Did you tell Mr. Nichols --

11 THE COURT: Hold it.

12 MR. VIGORITO: I'm sorry, Judge. I apologize.

13 THE COURT: Did you finish your answer, Doctor?

14 THE WITNESS: No.

15 A I'm not 100 percent sure it's been every state on the
16 eastern seaboard, but the majority of the times I've testified
17 have been locally.

18 Q And Doctor, you have testified, and did so again
19 three weeks ago in Brooklyn, that you will find a meritorious
20 cause of action in 95 percent of the matters that are submitted
21 to you by plaintiff attorneys, true?

22 A You've stated it incorrectly. I do find --

23 Q No, it's a yes or a no.

24 A Well, you said I will find. That's a future statement.
25 I have found after the first level of screening by telephone

1 that after reviewing the case, after telephone screening, that
2 about 95 percent of the times I'm sent a case I find it
3 meritorious after our telephone screen.

4 Q Now, when you told us initially this morning that
5 sometimes you do actually do work on behalf of the defense, is
6 that in a medical malpractice action?

7 A Yes.

8 Q When was the last time you testified in defense of a
9 doctor in New York State? Was it this year?

10 A No.

11 Q Was it in 2017?

12 A No.

13 Q Was it in 2016?

14 A No.

15 Q Can you name the case?

16 A There was a Staten Island case for New York State
17 testifying was probably 2015.

18 Q Do you know the name of the attorney that you worked
19 with on that case?

20 A I think it was a Mr. Lopresti, and it was in Staten
21 Island.

22 Q When you say it was a New York case, do you mean it was
23 like a Court of Claims case against the State of New York?

24 A I don't know what you're talking about. It was just
25 that I've done defense cases in New York State, in Florida, and

1 a few other states. So the last time I recall testifying in a
2 New York-based case in a trial would have been probably 2015.

3 Q In addition to this case, Doctor, you testified
4 recently in the Shanoff case back on January 22nd of this year
5 where Mr. Basichas called you as a witness, true?

6 A Yes.

7 Q And that was for the plaintiff in this case with my
8 partner, Mr. Nichols, along with several other attorneys, true?

9 A Correct.

10 Q And how about a case called Fishon, F-I-S-H-O-N, versus
11 Richmond University Medical Center, have you testified in that
12 case yet, or is that case on the future agenda for you?

13 A I actually don't recognize the case.

14 Q Okay. How about the case of Goodwin versus
15 St. Francis; do you recognize that case?

16 A Not off the top of my head, no.

17 Q How about the case of Wilson versus Rite Aid
18 Corporation where you were noticed as a witness up in Fulton
19 County, New York; do you recognize that case?

20 A I don't recall being called in Fulton. There is a Rite
21 Aid case, but that's not the name of the case, as I remember it.

22 Q Doctor, when you gave the address earlier this morning
23 that you did give us for the record, the 205 East 63rd Street,
24 is that an office address or a residential address?

25 A Both.

1 Q Is that a -- an office that you practice medicine out
2 of?

3 A Yes.

4 Q Is it also an apartment that you live in?

5 A Yes.

6 Q Is that in an apartment building on the Upper East Side
7 of Manhattan?

8 A It is.

9 Q Is it a ground floor apartment or somewhere on an upper
10 floor?

11 A The 16th floor.

12 Q Does it have an apartment designation?

13 A Yes.

14 Q What is it?

15 A 16G.

16 Q Is there a reason why when you give the address you
17 don't say Apartment 16G? Just a yes or a no. Is there a reason
18 why you do not give the apartment, yes or no?

19 A No.

20 Q Isn't it true that at this time, Dr. Charash, you do
21 not maintain a separate office just for the practice of
22 medicine? True or false?

23 A I can't answer the question the way you phrased it. I
24 lived --

25 Q Let me try to make it more specific.

1 THE COURT: Hold it. Let the doctor finish.

2 MR. VIGORITO: Absolutely, Judge.

3 THE COURT: Please.

4 A I cannot answer the question the way you phrased it
5 limited to a simple yes or no.

6 MR. VIGORITO: Okay.

7 THE COURT: Thank you. Go ahead, Mr. Vigorito.

8 Q Isn't it true that other than this address that we've
9 just mentioned again and Apartment 16G, you, Bruce Charash, MD,
10 do not maintain another separate office exclusively for the
11 practice of medicine, true?

12 A I can't answer that question limited to a simple yes or
13 no.

14 Q Do you have a -- withdrawn.

15 In addition to this address that I just recited to you,
16 Apartment 16G, do you have another office address?

17 A At Lenox Hill Hospital there's an outpatient facility
18 for cardiology which sees patients.

19 Q You realize that you are not listed on the Lenox Hill
20 Hospital directory, you realize that, right, Doctor?

21 A Yes. That's voluntary.

22 Q And you don't go there very often, you don't go there
23 at all; isn't that true, Doctor?

24 A Go where?

25 Q To Lenox Hill outpatient.

1 A I go there two days a week to see patients as an
2 outpatient and three days a week out of my home office.

3 Q And you don't admit patients to Lenox Hill very often
4 anymore; isn't that true, Doctor?

5 A Well, I have about three to five patients a month in
6 the hospital. Some of them are admitted by primary care doctors
7 and I'm the consultant. Others are admitted in my name.
8 Depends on the circumstance.

9 Q Doctor, would you say that \$450 per hour is
10 significantly more money than you would make seeing patients for
11 office visits at 205 East 63rd Street? Just a yes or no.

12 A Yes.

13 Q Would you say, Doctor, that it's a fair statement by me
14 to suggest to you that at this stage of your career as a
15 medical-legal expert you have made in excess of \$1 million; is
16 that fair?

17 A You're talking about adding up 31 years of income?

18 Q Yeah.

19 A Probably.

20 Q And is it fair that in some cases you've testified that
21 you have made in excess of \$150,000 in one tax year from your
22 legal-medical activities; is that fair? Yes or no?

23 A I do not recall it ever being that high.

24 Q Is it fair, Doctor, that you have derived 15 to
25 20 percent of your yearly income from your activities in

1 medical-legal work?

2 A Yes, that's correct.

3 Q Is it fair that in certain years, as many as two or
4 three, that percentage has reached as high as 25 percent of your
5 total income for those years?

6 A Yes.

7 Q Doctor, page 460 of your testimony just a couple of
8 weeks ago in the Elena Shanoff case, at page 460 you were asked
9 these questions and you gave these answers. I'm just going to
10 ask you to listen along for a second. Question, line 13:

11 "Doctor, you have, in the course of offering your
12 opinion in a nonpatient setting in medical-legal cases like
13 this, earned upwards of \$1.2 million dollars, correct?

14 Answer: Are you talking about adding my income for
15 30 years? Yes.

16 Question: Okay. And Doctor, better years you would
17 characterize between upwards of \$100,000, true?

18 Answer: There were two years where it reached that
19 level."

20 Do you recall being asked those two questions and
21 giving those two answers three weeks ago?

22 A Yes.

23 Q So there are at least two years where you earned at
24 least \$100,000 per year, true?

25 A Yes.

1 Q Doctor, you're only licensed to practice medicine in
2 the State of New York; is that accurate?

3 A Yes.

4 Q But you have been contacted, I think you mentioned now,
5 by lawyers from at least 40 states, true?

6 A Yes.

7 Q And that would include not only trial matters but
8 deposition cases?

9 A Well, no, no. I mean, I've reviewed cases for lawyers
10 in 40 states. I've appeared in 12 or so states for trial and
11 probably have done depositions in another 10 states. So
12 probably half of the states that have contacted me I've done
13 nothing more than review a case.

14 Q Doctor, you're not licensed in the State of
15 Massachusetts, correct?

16 A That is correct.

17 Q And you have reviewed in excess of 50 cases in that
18 state for the law firm of Lubin & Meyer, true?

19 A Yes.

20 Q You're not licensed in the State of Florida, correct?

21 A Correct.

22 Q You have reviewed at least 50 cases for the law firm of
23 Morgan & Morgan, true?

24 A Yes.

25 Q In the State of Florida alone you have given 60

1 depositions and testified in 30 trials, true?

2 A Over the 30 years, yes.

3 Q You have physically traveled to upwards of 15 states to
4 give testimony, true?

5 A Yes, probably 12 to 15, but yes.

6 Q You've testified in Pennsylvania, yes?

7 A Yes.

8 Q Arizona?

9 A I think so.

10 Q New Jersey at least a dozen times?

11 A Yes.

12 Q Connecticut?

13 A I never appeared in court in Connecticut.

14 Q Gave depositions in Connecticut cases?

15 A I gave one deposition --

16 Q There was one case from Danbury, I think.

17 A I don't remember where in Connecticut.

18 Q Okay, fair enough. Illinois?

19 A Yes.

20 Q Washington, D.C.?

21 A Yes.

22 Q Georgia?

23 A Yes.

24 Q Kansas?

25 A Yes.

1 Q Virginia?

2 A Yes.

3 Q New Mexico?

4 A Yes.

5 Q The five boroughs of New York City, right?

6 A Yes.

7 Q Westchester County?

8 A Yes.

9 Q Rockland County?

10 A Yes.

11 Q Orange County?

12 A Yes.

13 Q Nassau and Suffolk?

14 A Yes.

15 Q I don't want to offend any of our friends in Ulster
16 County or Dutchess County.

17 A I'm not sure.

18 Q Have you testified there as well?

19 A I believe in Dutchess County once.

20 THE COURT: All right. I'm going to break for the
21 lunch hour. We're going to have a little treat today. For
22 example, I'm not going to have you back until 2:30. I have
23 a very brief proceeding that I need to conduct at 2 o'clock,
24 so I don't want to have everybody just sitting in the jury
25 room wondering why are we still here.

1 So, that being said, I'd like everybody in the jury
2 room at 20 after 2:00 so we can start at 2:30, and I would
3 like to insure that we complete Dr. Charash's testimony by
4 the end of the day. So, that being said, please don't
5 discuss the case amongst yourselves, don't discuss it with
6 anybody else. Have a wonderful lunch and I'll see you at
7 2:30.

8 Doctor, you can step down. Please don't discuss
9 your testimony during the lunch hour.

10 THE WITNESS: Of course, sir. Thank you.

11 (Lunch recess taken.)

12 COURT OFFICER: Jury entering.

13 THE COURT: Jurors may be seated. Counsel, ladies
14 and gentlemen, Doctor, be seated. Welcome back, Jurors. I
15 hope you had a pleasant lunch, and thank you again for
16 always being so prompt and ready to serve when we start.

17 You will recall that when we took our lunch recess
18 Mr. Vigorito was in the process of conducting his
19 cross-examination of Dr. Charash. We will begin the
20 afternoon session with a continuation of Mr. Vigorito's
21 cross-examination.

22 Let the record reflect that Dr. Charash has retaken
23 the stand. Doctor, as redundant as it may be, I remind you
24 again you are still under oath or affirmation.

25 Mr. Vigorito, you may inquire.

1 MR. VIGORITO: Thank you, Judge.

2 Q Good afternoon, Dr. Charash. Good afternoon, Jurors.

3 A Good afternoon.

4 Q Dr. Charash, can you and I agree, have you ever given
5 any thought to how much time, in your so far 30-year career
6 since you finished your fellowship, you've actually spent
7 involved and invested in this medical legal process?

8 A About probably 10 to 15 percent of my time on average.

9 Q Let's see if we can, you know, deal with the numbers a
10 little bit and see what it turns out to be from a logical
11 standpoint. Six hundred testimonies, just about, right?

12 A Yes.

13 Q Okay. So if we budgeted a day for testimonies --

14 A They're two hours. Most of the depositions are
15 two hours.

16 Q But you never know that going in --

17 A Well, no.

18 Q -- to testimony?

19 A I usually budget two hours for a deposition.

20 Q Like today, you can't tell how long this was going to
21 be?

22 A Trial?

23 Q Right.

24 A I assume it would be a day, but most of my depositions
25 have been two hours.

1 Q Bear with me. If you had 600 testimonies and you
2 reviewed a thousand cases, and I think in the past you've
3 testified that on average you spend sometimes between, what,
4 like five to seven hours --

5 A No.

6 Q -- reviewing a case?

7 A No.

8 Q What -- would you say it's less than that?

9 A Many of those cases were an hour or two hours, the ones
10 that I didn't testify in. Many of the cases where I did
11 depositions I also testified in so they were the same case so
12 there is a lot of overlap. But many cases the initial review is
13 an hour to two hours, and at least 30 percent of my cases never
14 resulted in testimony.

15 Q If you did a thousand cases at three hours that would
16 be 3,000 hours, right, of time?

17 A Yes.

18 Q And if you did 600 cases and they took a half a day
19 each --

20 A That's not fair.

21 Q -- or at least took up enough time that it affected
22 your schedule to the opportunity of a half a day each, if we
23 added all that up and divided it the hours to come up with days
24 and we say that there are, you know, be generous, 250 days in a
25 year to work, it would turn out that you spent over two years of

1 your professional life of the last 30 doing what you're doing
2 today, true?

3 A I would have to calculate it and see if that's
4 legitimate. The first ten years was only five percent of my
5 time, but that said, if you want to average it to 10 to
6 15 percent of my professional life I might make sense of it over
7 30 years. I've not added it up like that.

8 Q Doctor, when you were working at Lenox Hill Hospital on
9 the east side of Manhattan for a period of time you were a
10 salaried employee paid by the hospital, true?

11 A Yes.

12 Q And that's no longer the case, true?

13 A That is correct.

14 Q And then at some point you moved to Columbia
15 Presbyterian, true?

16 A Yes.

17 Q And did you leave Columbia Presbyterian on your own
18 accord?

19 A Yes.

20 Q And at some point you were -- were you at New York
21 Cornell as well?

22 A My original career was at New York Cornell.

23 Q Were you ever a full-time attending at New York
24 Cornell?

25 A Yes.

1 Q Yes?

2 A I was -- well, full-time medical school faculty member.

3 Q Doctor, I would be accurate that you have not published
4 anything in any peer review since 1991?

5 A Absolutely.

6 Q And we haven't talked about this topic yet, but peer
7 review is something -- the term is something you recognize?

8 A I do.

9 Q And that's when a medical professional, in this
10 particular situation a fellow like yourself, might submit a
11 writing to a journal and the editorial board of the journal, the
12 peer review, will read that article and make a determination
13 whether or not they want to accept it and publish it, true?

14 A Yes.

15 Q And you haven't done that since 1991, true?

16 A Correct.

17 Q You have testified that the American College of
18 Cardiology guidelines are not authoritative? Just a true or
19 false.

20 A True.

21 Q You did not recertify in internal medicine when you
22 were able to, true?

23 A I was not required to. I was given a lifelong
24 certification.

25 Q You have an option to sit every 10 years for

1 recertification; is that true?

2 A It may be true, I don't know, but I was grandfathered
3 in. All my colleagues from my years we were given lifetime
4 certifications.

5 Q And the last time you taught in a medical school was in
6 2004; is that true?

7 A Yes.

8 Q Doctor, you testified this morning that there are
9 12,000 cases a year of aortic dissection; do you recall that?

10 A Yes.

11 Q Where did you get that data from?

12 A Just my understanding of it from the years of reading
13 literature, but I don't have a specific source.

14 Q Do you recall testifying in the case of Helene Andrews,
15 Administrator of the Estate of Mary Degross (ph), against
16 Dr. Suresh Dhumale, D-H-U-M-A-L-E, on January 5th, 2007? Here's
17 that case in Danbury. It's Superior Court of Connecticut,
18 Danbury District Court. Do you recall that case, Doctor?

19 A I don't recall the case.

20 Q Do you recall the case of Nancy Jollie, the Estate of
21 Fred Jollie, in Orange County, you testified on October 29th,
22 1992, against St. Luke's Cornwall Hospital, Drs. Woude,
23 W-O-U-D-E, Hulihan, H-U-L-I-H-A-N, Crawshaw, C-R-A-W-S-H-A-W,
24 and George; do you recall that case?

25 A From 1992, no. The name is familiar, but I certainly

1 don't recall anything about the case.

2 Q Okay. Page 14 of your testimony, you testified there
3 are 2,000 dissections in the United States. Do you recall
4 saying that in that case?

5 A No. Not in 1992.

6 Q You don't remember 1992?

7 A I don't remember the testimony from 1992. I remember
8 the year.

9 Q Do you think that in 1992 you were of the opinion that
10 there were only 2,000 aortic dissections in the United States?

11 A I can't relate to why '92 I would think there were
12 2,000. The number is closer to 10 to 12 thousand.

13 Q Now, you just said 10 to 12 thousand I noticed, but
14 when you testified on direct examination when Ms. Weisman was
15 asking you questions you said 12,000. Do you recall that?

16 A No one knows the exact number. We're talking about a
17 relative ballpark national so I'm giving a range.

18 Q I understand that, Doctor. But when you testified on
19 direct you didn't qualify your answer as bracketing it and
20 giving a 10 to 12 thousand, you said 12,000, true?

21 A Yes.

22 Q You recall that?

23 A I do.

24 Q Now, a moment ago you now said 10 to 12 thousand, you
25 just said it, right?

1 A I did.

2 Q And I just read your testimony where in 1992 you said
3 it was 2,000. Now I'm going to read you testimony from 2007 in
4 the case of Andrews against Dhumale. You were asked this
5 question and you gave the following answer. I just ask you to
6 listen along with me for a second and then I'll ask you a
7 question.

8 "And there are a lot of other diseases and conditions
9 that are not associated with the heart that those patients get
10 diagnosed with as well, correct?

11 Answer: Well, at our level it's less than half. The
12 majority of our patients who we admit, based on story and risk
13 factors, have heart disease. Many of them we don't have an
14 answer. Once we prove it's not heart disease we acknowledge --
15 I mean, short of an aortic aneurysm and pulmonary embolism and
16 is life-threatening and that's actually eight hundred thousand a
17 year in this country, compared to 1.2 million heart attacks, so
18 pulmonary embolism is big. Dissection is only about 10,000 a
19 year. Once you get past that you don't have too many
20 life-threatening."

21 Do you recall being asked those questions and giving
22 that answer?

23 A No.

24 Q Do you recall that case at all, Doctor?

25 A Not from 11 years ago.

1 Q Andrews versus Dhumale in Danbury you said there was
2 only one time you testified in Connecticut before the lunch
3 break?

4 A That was 11 years ago. I would need something to
5 remind me of the facts of the case.

6 Q That was the same case where you, on examination by the
7 defense witness, acknowledged that obtaining two sets of
8 troponin levels for a patient that presented to an emergency
9 room was in fact excellent practice, true?

10 A Yes -- well, I don't remember saying that, but it would
11 be. If you get two sets it would be appropriate and excellent.

12 Q And that if a doctor, whether it's an emergency room
13 doctor or cardiology consultant, coming in obtaining just one
14 troponin level, also known as a cardiac enzyme, without
15 following it up with a repeat study in six to eight hours that
16 would be negligence, true?

17 A Yes, that would be.

18 Q And how many troponin levels were obtained in our case
19 at the behest of my client, Dr. Cuomo, do you know?

20 A Yes, two sets.

21 Q You also testified in that case that obtaining an EKG
22 would be proper and good practice, true?

23 A Yes.

24 Q And that was done in our case as well, true?

25 A It was.

1 Q You also said in that same case, Doctor, see if this
2 refreshes your recollection, that sending any patient home from
3 an emergency department with instructions to come back if they
4 are not feeling well or having additional pain is not good
5 practice; do you remember saying that?

6 A Well, you have to understand the context --

7 Q Doctor, the question is not contextual. It's do you
8 remember saying it?

9 A Well, I don't remember directly saying it, but I have
10 said things like that in certain circumstances.

11 Q Let me read to you, Doctor, from page 188 of that
12 transcript. The question was:

13 "All right. I will rephrase it. Doctor, I don't get
14 insulted if you don't understand my question, trust me. So just
15 let me know and I'll rephrase it as many times as necessary for
16 you to understand. Are you saying, Doctor, that it is
17 inappropriate for an emergency medicine physician to advise an
18 85-year-old woman, in whom he has made a diagnosis of gastritis,
19 to return to the emergency room if her symptoms got worse?

20 Answer: It depends on what the reasons are for why he
21 wants her to return. It depends on if there are any other
22 circumstances. An ER is a very inappropriate place for anyone
23 to go unless they have to be there."

24 Do you remember being asked that question and giving
25 that answer? It's just a yes or no.

1 A I don't recall it.

2 Q And you went on on the next page, page 189, to answer a
3 question where you said:

4 "So unless there is a specific reason why they need to
5 return to the emergency room, identified as a reason why
6 emergency room intervention is needed, it's highly inappropriate
7 to have people come back, especially when they have a treating
8 doctor."

9 Do you recall saying that in that case?

10 A I don't recall saying that in that case, but it would
11 seem appropriate to that case.

12 Q And in the same transcript at page 190 you said, under
13 oath:

14 "Why go back to the ER and register and have an
15 intravenous line put in and get all this crap for gastritis.
16 It's a dangerous combination to do this. There are bacterial
17 infections. We don't casually introduce people into the portal
18 of the hospital for no reason, and you can't give a rational
19 reason for doing it, other than he knew he had not evaluated the
20 heart completely."

21 Do you recall being asked a question and giving that
22 answer?

23 A I don't recall it, but that answer sounds like me.

24 Q Doctor, when did Mr. Nocera experience his initial tear
25 of the aorta in your opinion, just when?

1 A When he first complained of his pain.

2 Q Which was when?

3 A I'll have to look to see exactly. It began the day
4 before he came to the ER so it would have been on
5 September 17th, 2013.

6 Q What time?

7 A I'm not sure if the time is reported. I have to find
8 it.

9 Q Would the amount of time that elapsed from the
10 inception of the pain to his presentation to the ED be a piece
11 of information that might be of significance to people treating
12 Mr. Nocera, yes or no?

13 A I can't answer the question the way you phrase it
14 limited to a simple yes-no reply.

15 Q Can you and I agree, Dr. Charash, that as you sit here
16 now, looking at whatever documents you have in front of you, I
17 guess -- is the hospital record?

18 A It's the ER chart.

19 Q That that does not give you that piece of information
20 that I'm asking about, what time of day the inception of the
21 pain started?

22 A Yes, that's correct.

23 Q Okay. Let's go at it a different way. Do those
24 records give you the location where Mr. Nocera was when the pain
25 started that day?

1 A Yes, I think it does. I have to find it.

2 Q Take your time.

3 A I can't find a note referring to where he was when it
4 occurred. I thought there was one. At this point I can't find
5 one.

6 Q In addition to reading or looking at the WMC Hospital
7 chart now, specifically the emergency department record, was
8 there some other piece of information that was given to you to
9 facilitate your review of this case and enable you to come to
10 court and give opinions before these nice people and this judge
11 that might have that information in it?

12 A I don't understand your question.

13 Q Okay. Let me make it easier. Did you tell us earlier
14 today that you were provided, when you first got this case from
15 Ms. Weisman, with the deposition testimony of Kathleen Nocera?

16 A Yes.

17 Q Did you review that deposition testimony within the
18 last week or so?

19 A No.

20 Q When was the last time you reviewed the deposition of
21 Kathleen Nocera?

22 A When I first got the case, probably over a half year
23 ago.

24 Q When was that? How long ago?

25 A Over a half year ago.

1 Q Six months ago?

2 A Yes.

3 Q Do you have any correspondence that you brought with
4 you today from counsel or anything that you sent in response to
5 counsel that might corroborate when you got the case for the
6 first time six months ago, as you say?

7 A Well, it's my estimate six months ago, but I have
8 nothing to corroborate exactly when I received it.

9 Q Is there a piece of paper that exists in Apartment 16G
10 that would corroborate what you've told this Court and jury?

11 A No.

12 Q Is there a file in Apartment 16G?

13 A No, I brought my records here. Everything was sent
14 electronically, so I guess on my home computer I might be able
15 to find out what day it arrived.

16 Q So what you brought today doesn't contain even a cover
17 letter from the attorney who retained you in this case, true?

18 A That's correct.

19 Q And you have no correspondence, not even a copy of an
20 email, going back to her or anyone else regarding this case,
21 true?

22 A Correct.

23 Q And in preparation for your testimony here today,
24 knowing that the only person who could shed light on where
25 Mr. Nocera was at the outset of the pain was Mrs. Nocera, and

1 she was the only person who could shed light on the time of the
2 onset of the pain or the general condition of her husband, you
3 didn't read her testimony before coming here today, true?

4 A Well, I didn't reread it, but that's true.

5 Q The first time you read it was six months ago?

6 A Or whenever I first got the case. That's the ballpark.

7 Q Well, Dr. Charash, we're relying on you to tell us when
8 you got the case because you don't have anything in writing. Is
9 it six months ago, or do you want to hedge on that?

10 A I'm not hedging on that. That's my best estimate.

11 Q I'll accept it. I want to know when you say if it was
12 six months you believe it was six months ago?

13 A Yes. I think that's my best estimate.

14 Q Okay. Fair enough. Does any of this discussion that
15 you and I are having right now, does it serve to refresh your
16 recollection as to where Mr. Nocera was when he first
17 experienced chest pain?

18 MS. WEISMAN: Note my objection, your Honor. It's
19 been asked and answered.

20 THE COURT: I'm going to give him one more chance.

21 A No, I don't recall where he was when he first had chest
22 pain.

23 Q If the circumstances were that Mr. Nocera was doing
24 something of a physical nature when the pain first exhibited
25 itself and was limited to his chest without any complaint of

1 radiating to any other part of his body, would that be an
2 important piece of information for the clinicians, for Dr. Cuomo
3 and Dr. Bernstein, to know?

4 A Yes.

5 Q And yet you don't know it?

6 A I don't recall it. I have a vague memory of it --
7 there being physical activity. But it would not change your
8 differential diagnosis. Dissections are often brought on by
9 physical activity that leads to a blood pressure surgery that
10 tears the vessel. So in terms of the approach to him,
11 memorizing that, and they're in the -- in the records in the
12 hospital, but memorizing that wouldn't change the differential
13 diagnosis with the information he had when he came in.

14 Q Was Mr. Nocera working on his car at the time that the
15 pain started?

16 A That sounds familiar.

17 Q Where do you get that from?

18 A It sounds familiar. I had read the depositions, I just
19 don't remember it.

20 Q Did Mr. Nocera position himself in an awkward way while
21 he was doing some mechanical work of some nature and then
22 experienced the chest pain for the first time?

23 A I don't recall.

24 Q Was Mr. Nocera standing straight up, lying on the
25 ground, on his back or side --

1 A I --

2 Q -- kneeling or in some other position?

3 MS. WEISMAN: Note my objection, your Honor. It's
4 already asked and answered. He does not know.

5 THE COURT: Can I hear Mr. Vigorito's question.

6 (Record read.)

7 THE COURT: Overruled. Can you answer the
8 question, Doctor?

9 THE WITNESS: I don't recall. I don't know if
10 anyone knows.

11 THE COURT: Doctor, I'm not -- no one here is
12 asking you to guess.

13 THE WITNESS: I don't recall.

14 THE COURT: And that's perfectly an acceptable
15 answer to the Court.

16 THE WITNESS: Very good.

17 Q Dr. Charash, with all due respect, saying I don't
18 recall intimates that at one time you did know it. So my
19 question to you is: Do you think, as you sit here now, you knew
20 at one time what position he was in when the pain first started?

21 A No. I know that I had read Mrs. Nocera's deposition.
22 I don't recall the details, and there's certainly no
23 documentation of it in the emergency room chart. With that
24 said, I don't recall what was described about the events the day
25 before that resulted in him coming in on the 18th to the

1 emergency room.

2 Q It's your testimony now under oath before this Court
3 and jury that there is no information in the Westchester Medical
4 Center emergency room record that would shed any light on that
5 particular point?

6 A No. I said right now I couldn't find it. I don't
7 recall.

8 Q If we wait five minutes more can you find it?

9 A I don't know --

10 MS. WEISMAN: Your Honor, objection.

11 A -- if I have the complete chart, but if you give me the
12 original --

13 THE COURT: Doctor --

14 THE WITNESS: I'm sorry.

15 THE COURT: -- there is an objection. I'm going to
16 ask that you hold off until I sustain or overrule.

17 Can I hear the question again, please.

18 (Record read.)

19 THE COURT: Doctor, if I give you a few minutes to
20 peruse or review the chart, would that be helpful?

21 THE WITNESS: I would need the original chart,
22 because I don't think I have the complete chart here with
23 me.

24 MR. VIGORITO: Your Honor, it's a digital chart.
25 We have a copy of it. The only way to have an original is

1 to have a projection of it. I can project the record up --
2 there is no original chart.

3 THE COURT: Does -- Mr. Vigorito?

4 MR. VIGORITO: Judge, you know what, Judge? I want
5 to save five minutes myself because I have other things to
6 ask.

7 THE COURT: I'll tell you what, is there -- is
8 Plaintiff's Exhibit 12, which is in evidence, the full chart
9 of Westchester Medical Center concerning Mr. Nocera?

10 MR. VIGORITO: There's a consult note as well. It
11 should be in evidence and it should be there.

12 THE COURT: Do you wish to continue with this line
13 of questioning, Mr. Vigorito, or do you wish to change
14 gears?

15 MR. VIGORITO: No, I'm not changing gears just yet,
16 Judge, but I will ask a different question so we don't have
17 to take any time to look. Let me ask a different question.
18 Court's permission?

19 THE COURT: It's your examination.

20 MR. VIGORITO: Thank you.

21 Q Dr. Charash, in addition to the record that you've been
22 looking at, did you ever read the cardiac consultation note that
23 was compiled in this case?

24 A I did, the one written by a fellow, yes.

25 Q Right. And is that note, does it bear any writing from

1 Dr. Cuomo on it?

2 A There's some writing by her at the end of the note.

3 Q Where she acknowledges that she read the note and spoke
4 to the fellow that first examined Mr. Nocera, which, by the way,
5 would be customary practice?

6 A Yes, it would be.

7 Q And when you read that note -- withdrawn.

8 Did you ever say to counsel, gee, this note, it's tough
9 to read? Can you get me a better copy of it so I can know
10 exactly what it says? Did you ever say that or words to that
11 effect? Yes or no.

12 A I don't recall. I thought that that was covered in
13 Dr. Cuomo's deposition.

14 Q Okay. Do you remember what you read in that consult
15 note?

16 A I would rather see the note rather than try and
17 remember what I had.

18 Q I'm not trying to make this a memory test for you,
19 trust me, but I'm just asking you, as you sit here now, is that
20 something that you saw recently, or like the transcript of
21 Ms. Nocera, is it something you haven't seen for, you know, six
22 months perhaps?

23 A No, I've dealt with Dr. Cuomo's testimony where she
24 read her note or at least discussed that note in her deposition,
25 and I had read that right before trial. I just don't remember

1 what's exactly in the note without seeing a copy of it.

2 THE COURT: Time out.

3 MR. VIGORITO: May I?

4 THE COURT: Yes, you may.

5 MR. VIGORITO: Thank you.

6 Q Dr. Charash, are you reading the consult note?

7 A I found a copy of the consult note.

8 Q Okay, great. So looking at that two-page note, does it
9 refresh your recollection that you ever asked Ms. Weisman,
10 during the past six months that you may have been involved in
11 this case, for, you know, an enlargement of it or a translation
12 of it because it's a little tough to read? Did you ever do
13 that?

14 A No.

15 Q Okay. Are you able to read it?

16 A Much of it.

17 Q Okay. Do you see anything in that note that sheds any
18 light on what Mr. Nocera was doing at the time of the onset of
19 the chest pain?

20 A Well, this says he was doing light work that began
21 yesterday. Patient was doing light, and then this word is cut
22 off, work.

23 Q Uhm-hum. Do you see anything in there that he was in
24 an awkward space or he positioned himself in a difficult
25 position?

1 A Yes.

2 Q Do you see anything about what he was doing, whether he
3 was working on a car or doing something else?

4 A I can't see the word car in here.

5 Q Do you see anything about the onset of the pain
6 occurring --

7 A It's --

8 Q -- when --

9 A Sorry.

10 THE COURT: Hold on. One at a time, please.

11 THE WITNESS: I apologize. I apologize.

12 Q I'm sorry. You were still going, Doctor?

13 THE COURT: No, he wasn't. You were in the middle
14 of a question and the doctor started to answer when I
15 stopped him. So please continue with did you see anything.

16 MR. VIGORITO: Right. Thank you, Judge.

17 Q Did you see anything, Doctor, in the note about him
18 getting up off the ground and standing up and then experiencing
19 the chest pain?

20 A Yes.

21 Q And you know that that in fact is something that
22 Mrs. Nocera has testified to as well?

23 A Yes.

24 Q And you know that that happened sometime the day before
25 when he was working at home, whether he was working on a car or

1 something else, that was really the onset of the chest pain?

2 A Yes.

3 Q And you can agree with me, I think, Doctor, that based
4 on this consult note and based on what Mrs. Nocera said in her
5 deposition, at least initially, that his complaint was limited
6 to chest pain across his chest, yes?

7 A From what she was aware of, yes.

8 Q And she would be aware of it because her husband might
9 have expressed that verbally? That's one way, right?

10 A Yes.

11 Q Or the other way would be if she made some observations
12 of him over a period of time of where his pain was located and
13 she gave her impression.

14 A Yes.

15 Q Like a present sense impression, right?

16 A Yes.

17 Q And at least from the day before, Doctor, whatever time
18 it was that he was working on whatever it was, whether it's a
19 car or something else, when he got up off the floor he had chest
20 pain across his chest, and that was his initial complaint to the
21 triage at Westchester Medical Center on page 1 of the
22 Westchester Medical Center record, true?

23 A Yes.

24 Q Okay. Up until at least that point in time, which we
25 know to be the afternoon, the early afternoon of the 18th,

1 right?

2 A Yes.

3 Q There is -- there has yet to be a mention at all about
4 any type of back pain, true? Only page 1, up to page 1 of the
5 Westchester record.

6 A Meaning up to page 1 or on page 1? I'm a little
7 confused.

8 Q Including page 1. And you can look at page 1 again if
9 you need to.

10 A I'm sorry. I'm not understanding. The reference to
11 back pain is not on page 1. Is that what you're asking me?

12 Q The indication of anything other than chest pain is not
13 in the initial triage note on page 1.

14 A That's correct.

15 Q You know that as you sit here now, you knew that when
16 you came in today, right?

17 A Of course.

18 Q You know that there's only one mention in the entire
19 record of back pain, right, and that's on page 2?

20 A Yes.

21 Q Okay. And that's for the first time when Mr. Nocera
22 gives a history that the pain radiated from his chest to his
23 neck, his jaw and his back, true?

24 A Yes.

25 Q Okay. And it's the only time, true?

1 A Yes.

2 Q And you know, Doctor, and you would agree, that the
3 constellation of symptoms, classic for aortic dissection, are
4 number 1, a patient with high blood pressure chronically; isn't
5 that true?

6 A That's not a symptom. Chronic high blood pressure is
7 the --

8 Q Doctor, it's a yes or no.

9 A You asked me about symptoms. It's not a symptom of
10 dissection. One of the biggest risk factors for dissection is
11 hypertension, but that's not a symptom of a dissection.

12 Q Well, Doctor, in the transcript of your testimony in
13 the case of Jollie against St. Luke's at page 14 you said the
14 following:

15 "Chest pain is the most nonspecific, nonlocalized
16 comment a patient can make. The constellation of symptoms
17 classic for dissection are one, a patient with high blood
18 pressure chronically, as a -- by the way, Fred Jollie."

19 Do you remember saying that?

20 A No. That's terrible wording because that's not a
21 symptom, that's a chronic risk factor. So I said it very poorly
22 there. No one would consider -- hypertension is not a symptom.

23 Q By the way, Doctor, while we're on this particular
24 page, did you ever testify that there were only 2,000
25 dissections in the states?

1 MS. WEISMAN: Note my objection. Asked and
2 answered.

3 THE COURT: Asked and answered.

4 MR. VIGORITO: I don't think from this transcript,
5 Judge.

6 MS. WEISMAN: Yes.

7 THE COURT: That transcript.

8 MR. VIGORITO: Okay, okay. It's all right.

9 THE COURT: Thank you for your approval.

10 Q Did you testify in the same case that it's a severely
11 terrifying feeling to have an aortic dissection?

12 A Yes. It often is.

13 Q Did you testify that one of the symptoms is a tearing
14 back pain of tremendous pain and it's quite traumatic for the
15 patient?

16 A Yes, that's a very common symptom for it.

17 Q And can you and I agree that Mr. Nocera did not have a
18 terrifying tearing back pain when he got to Westchester Medical
19 Center? Can we at least agree on that?

20 A Well, I don't know if it was terrifying. The back pain
21 wasn't well characterized, although Dr. Cuomo did testify that
22 the pain was sharp, which is more consistent with dissection.
23 But I agree he didn't have a dramatic severe pain that made him
24 collapse, which is often seen in dissection.

25 Q Do you remember testifying in this same case, Doctor,

1 that other symptoms would be a sense of sweatiness, yes or no?

2 A Yes.

3 Q Shortness of breath, yes or no?

4 A Very commonly, yes. I mean, I don't recall that
5 transcript but, yes, that is a common symptom.

6 Q A sense of dreadness or concern, yes or no?

7 A Yes, very -- well, I'm sorry. I agree that's a
8 symptom. I don't recall that testimony. But I agree that is a
9 common symptom.

10 Q And when asked this question: This condition for a
11 cardiologist or an internist, is this a highly unusual
12 condition? Your answer was it's not highly unusual because
13 there are 2,000 cases a year. Do you remember being asked that
14 question and giving that answer?

15 A No.

16 Q Would you like me to show it to you?

17 A No. I mean, if you showed it to me -- I don't recall
18 testifying in 1991, but the real number is closer to 10 to 12
19 thousand. No one knows the exact number. But if I said 2,000,
20 I don't know if that's a typo, whether I corrected it or whether
21 or not I had an opportunity, but -- or whether that time the
22 number was that. I don't recall from 25 years ago what I
23 testified. But the number of aortic dissections in the United
24 States is around 10 to 12 thousand. That's been at least for
25 the last decade.

1 Q Well, Doctor, if I told you that -- and I stand by the
2 judge's ruling, and Ms. Weisman's quite correct, it was 2,000 on
3 page 14 -- and there you go again answering a question saying
4 it's 2,000 on page 16. You seem to be the kind of fellow who
5 speaks pretty clearly. You think it was a typo in that
6 transcript?

7 A I don't know. Or whether the number I was lowballing
8 then. I don't know.

9 Q You used the term "lowballing." In this case are you
10 highballing the number by saying it's 10 to 12 thousand?

11 A No, nor does the number really matter whether it were
12 2,000 or 10,000. It wouldn't change the standards of care or
13 what was found because this man was having a dissection and was
14 easily diagnosable, but the number is --

15 MR. VIGORITO: Move to strike as nonresponsive to
16 the question, Judge.

17 THE COURT: Overruled.

18 Q Doctor, if you could accommodate me with a yes or a no,
19 that would be great. If you can't, just tell me that, as I said
20 before, and I'll move on or I'll let you answer the question.

21 A Of course.

22 Q Okay. You didn't make it 12,000 in this case because
23 you thought that that would sound like a more significant number
24 and lead credence to your opinions that it should have been
25 diagnosed because it should have been more obvious?

1 MS. WEISMAN: Just note my objection, your Honor.

2 Q Yes or no?

3 A No.

4 THE COURT: Overruled.

5 A Absolutely not.

6 Q You have testified in the past, Dr. Charash, and I've
7 read it, I have it here, that oftentimes, if not every time, the
8 best information that you get from a patient or a loved one with
9 a patient is that initial triage information when they first get
10 to the hospital. Sounds --

11 A Yes.

12 Q -- right?

13 A Yes, close.

14 Q You've said it countless times in testimonies, true?

15 A I don't know if it's countless, but when it comes the
16 first information given to the earliest health care providers
17 provides insight that sometimes you don't get from later notes.

18 Q Okay. And if we look at the triage note, and if --

19 MR. VIGORITO: Could you put that up, Ed?

20 Q On page 1, the history of present illness, that would
21 serve as the first piece of information given by Mr. Nocera --
22 by the way, when he got to Westchester he walked in, right?

23 A Yes.

24 Q He didn't come in by ambulance, right?

25 A Correct.

1 Q Where did he come from, by the way?

2 A I don't recall.

3 Q What was he doing immediately before he came in and set
4 foot in the ER at Westchester Medical Center?

5 A I don't recall.

6 Q Did he drive himself to Westchester Medical Center?

7 A I don't recall.

8 Q Did someone else drive him to Westchester Medical
9 Center?

10 A I don't recall.

11 Q Did he need to be escorted or helped in any way into
12 the ER because of the chest pain he was having?

13 A There's no evidence of that.

14 Q Did he go to work that day?

15 A I don't recall.

16 Q Did you ever know it?

17 A Probably. I had read Mrs. Nocera's deposition.

18 Q When was the first time you knew this --

19 THE COURT: Again. I'm not going to say it again.

20 MR. VIGORITO: Judge, I apologize, Judge. I'm
21 sorry. I truly am.

22 Q Go ahead, Doctor, you were going to answer.

23 A I had read Mrs. Nocera's deposition, but I don't
24 recall. None of those facts would have any bearing on my
25 testimony to that.

1 MR. VIGORITO: Judge, now I move to arrest the
2 answer and strike that answer because that's not responsive
3 to my question.

4 THE COURT: We're going to take a five-minute
5 recess, ladies and gentlemen. Please don't discuss the case
6 amongst yourselves.

7 Doctor, you can stand down. I will ask that you
8 not discuss your testimony --

9 THE WITNESS: Of course, sir.

10 THE COURT: -- with anyone.

11 (Witness excused.)

12 (Jury exits.)

13 THE COURT: Nicole, can I just hear the question
14 and answer.

15 (Record read.)

16 (Recess taken.)

17 COURT OFFICER: Jury entering.

18 THE COURT: Jurors, you may be seated. Ladies and
19 gentlemen, Counsel, Doctor, you may be seated. Welcome
20 back, Jurors.

21 We're going to go into our last session. We may go
22 a little past 4:30. I hope not. Just so you know, we may
23 wind up going to a quarter to 5:00, so, but I do not want to
24 have to bring the doctor back tomorrow for 15 minutes.

25 So, that being said, you'll recall that when we

1 took our recess, Mr. Vigorito was still conducting his
2 cross-examination of Dr. Charash, which we will continue.

3 Let the record reflect that Dr. Charash has retaken
4 the stand. Doctor, again, I remind you you are still under
5 oath or affirmation.

6 THE WITNESS: Thank you, sir.

7 Q Dr. Charash, before we look --

8 THE COURT: Excuse me. There was an objection.
9 There was an application to strike the doctor's testimony.
10 I have reheard it. Under the circumstances, overruled.

11 MR. VIGORITO: Okay.

12 CROSS-EXAMINATION (Cont'd)

13 BY MR. VIGORITO:

14 Q Doctor, before we take a look at the highlighted triage
15 note, in light of the testimony that you've given so far, the
16 onset of the aortic dissection, in your opinion was the onset of
17 the pain from the day before?

18 A That's the first tearing of the aorta, but it's a
19 stuttering process.

20 Q Right.

21 A Where you get muscle tears.

22 Q And if there's no pain, if there's a significant period
23 of no pain, would you be of the opinion that the tearing has
24 subsided, at least during that period of time?

25 A No, that --

1 Q Just a yes or no.

2 A Well --

3 Q Is it a no?

4 A I can't answer the question the way you phrase it,
5 limited --

6 Q Okay.

7 A -- to a simple yes, no.

8 Q All right. You realize that there may be an
9 opportunity for counsel to ask you more questions on something
10 called redirect; you know that, right?

11 A Yes.

12 Q Okay. So if the pain is continuing from the onset of
13 the pain, does that mean that there's a continuing tearing
14 process going on?

15 A No.

16 Q Just a yes or no.

17 A No, that doesn't mean that, no.

18 Q But the initial complaint of chest pain in your mind,
19 at least your opinion, is that that's when the aortic dissection
20 begins to tear?

21 A That was the initial tear.

22 Q And if there is continuous pain over the next,
23 whatever, 12 hours, that's not an indication of the tear ongoing
24 and continuing? Just a yes or no.

25 A No.

1 Q But when the pain stops and there's a significant
2 period of time, five or six hours or more, of non-pain, that's
3 not a sign that the tearing has stopped either, true?

4 A I cannot answer the question the way you phrase it --

5 Q Okay.

6 A -- limited to a simple yes, no.

7 Q Let's take a look at -- and if you can follow either up
8 there, if you can see it, or on your page, this is the initial
9 note, the first thing that Mr. Nocera said when he got to
10 Westchester Medical Center, right?

11 A Yes.

12 Q Chief complaint, patient complaining of mid-chest
13 pain --

14 A Moderate. Oh, mid-chest pain.

15 Q Mid-chest pain starting yesterday. Primary triage
16 dysphagia. Patient complains of moderate chest pain that began
17 yesterday. The symptoms are constant. Let me stop there for a
18 second.

19 The fact that it started yesterday and the symptoms are
20 constant, are you not of the opinion that the tearing was
21 continual up to the moment he said those words? Yes or no,
22 Doctor.

23 A I cannot answer the question the way you phrase, the
24 way you limit it to a simple yes, no.

25 Q That's fair enough. That's your answer.

1 The patient describes the pain as a five dash ten. The
2 pain is described as squeezing. So that word squeezing, that's
3 a word that Mr. Nocera chose. You would ascribe to that, right?

4 A Yes, I would.

5 Q Okay. That's not the same adjective as tearing?

6 A I agree.

7 Q So when he first comes in he's not complaining of any
8 back pain whatsoever, to triage?

9 A He's not reporting it in his initial statement.

10 Q Right. But you and I have already agreed these initial
11 statements the patient say are critically important because it's
12 the first thing the patient tells somebody what they've been
13 feeling for the past half a day or day now. This has been going
14 on for quite some time, right?

15 A No, right, it's very important what he says when he
16 first comes in, but obviously anything reported later has to be
17 considered equally valid.

18 Q All right.

19 A The point is you might -- if you don't read these
20 notes, you might miss something.

21 Q Okay. You're right. So let's read the very next note.
22 The pain is located in the mid-sternal area. Can you
23 demonstrate where that would be on you?

24 A Right under the breastbone.

25 Q Okay. That's where he's saying he's feeling the pain,

1 right?

2 A Yes.

3 Q That's important, right?

4 A Yes, it is.

5 Q Okay. That's not radiating to the back yet, right?

6 A It's not being reported as radiating to the back yet.

7 Q Okay. He then reports the pain radiates to his left
8 shoulder, his neck and his left jaw. All comes from Mr. Nocera,
9 right?

10 A Right. We don't know whether those were prompted by
11 questions or not.

12 Q Right.

13 A Because it's not all in a quotation mark that the
14 patient came in saying I have the following.

15 Q Right. Now, this note tells us how he got there that
16 day, right?

17 A I don't understand what you mean.

18 Q It says, arrival, patient arrived ambulatory via
19 automobile from home.

20 A Yes.

21 Q Do you know if that's accurate as you sit here right
22 now?

23 A I don't recall.

24 Q Do you know if there is an alternative fact pattern as
25 to where he arrived from that day?

1 A No.

2 Q Would you think and ascribe to the notion that where he
3 arrived from and how he got to the hospital was told to somebody
4 by himself, by Mr. Nocera?

5 A I'm sorry, I don't understand what you're saying.

6 Q Sure. Bad question. Let me rephrase it.

7 Where it says arrival, the patient arrived ambulatory
8 via automobile from home, the patient was accompanied by, colon,
9 immediate family member, would you think that that came from
10 Mr. Nocera, that information?

11 A Presumably.

12 Q ABCs, what does ABC stand for, Doctor?

13 A Airway, breathing, circulation.

14 Q Okay. And the nurse wrote there the airway is open and
15 patent. Breathing is spontaneous and nonlabored. Radial pulse
16 is equal and normal bilaterally. Those are normal findings,
17 true?

18 A Yes.

19 Q LOC, what does that stands for, Doctor?

20 A I'm not sure what that acronym means here.

21 Q Okay. The patient is awake, alert with a calm affect.
22 Would you agree with me that patients in the throws of an aortic
23 dissection rarely have a calm affect? Just yes or no.

24 A I think most have a calm affect. They might be in pain
25 but their affect is often calm. It depends on the patient's

1 threshold for pain.

2 Q The patient is oriented to place and time. Skin color,
3 the patient's skin is normal for age and race. The skin is warm
4 and dry, has good turgor. What does that mean, turgor?

5 A Turgor means the fluid content of the skin if you pinch
6 it, how long it rises and whether or not you feel there's
7 adequate fluid in the tissue.

8 Q Now, it tells us who the historian is for this entire
9 note because they have a category on this that says historian,
10 colon, the patient is the historian, so we know it comes from
11 Gary Nocera?

12 A Yes.

13 Q And now we have some nursing documentation below that,
14 and if you could roll that up and highlight nursing
15 documentation.

16 He's got a blood pressure, a heart rate, and an O2
17 saturation monitor or probe in place. And under general, his
18 level of consciousness is age appropriate. And now at
19 12:46 p.m. on the date of arrival, September 18th, he verbalizes
20 or demonstrates a symptom of pain. The pain is acute, new
21 onset. They use a numerical scale, and his pain level or his
22 pain at that moment at 12:46 is a four, and his pain is a six on
23 average. And the goal was to get it to zero. And then they
24 have these categories behavioral indicator of pain. It says
25 positive vocal expression. So he's speaking, telling the nurse?

1 A Yes.

2 Q Okay. Description of pain, positive pressure.

3 Location of pain, chest radiating to his neck. True?

4 A Yes.

5 Q Still no mention on page 1, I think it's the end of

6 page 1, there's no mention of it radiating to his back?

7 A Correct.

8 Q He certainly didn't present with that as an initial
9 complaint which typifies a patient in the throws of an aortic
10 dissection; you would agree?

11 A Well, I can't answer that as yes or no. Back pain is a
12 typical finding --

13 Q Okay.

14 A -- of a dissection.

15 Q Neurologic, the patient's neurologic assessment shows
16 no acute neurologic issues. His respirations are relaxed and
17 unlabored.

18 Do you normally find relaxed unlabored respiration in a
19 57-year-old man who's having an aortic dissection? Yes or no?

20 A It depends on how much pain he's in and how he
21 tolerates pain. Usually respirations go up because of pain.
22 Some people respond differently than others.

23 Q Doctor, before we switch over to the next page, earlier
24 today when you testified on direct examination about the
25 frequency with which you've had some experience with aortic

1 dissection patients, you were talking about your treatment of
2 patients who had aortic dissections, I take it?

3 A Yes.

4 Q The treatment of those patients is not the same as the
5 diagnosis of those patients; you and I can agree on that, right?

6 A Yes.

7 Q So all the answers that you gave this morning on direct
8 to Ms. Weisman related to you coming in after the dissection was
9 diagnosed and rendering some level of treatment, whatever it
10 was, aftercare treatment or management of the patient, true?

11 A Yes.

12 Q Okay. Let's go to page 2. So, Doctor, at the very
13 top -- this is a continued rundown of physical findings by the
14 nurse -- it starts with ears, and he denies auditory
15 disturbances. Nose, there's no discharge, no deformity. Mouth
16 seems to be normal. And then neck.

17 So let's read this one. Neck is free of surface
18 trauma, no markings on the neck that would lead the nurse to
19 suspect that he sustained any type of trauma, right?

20 A Correct.

21 Q Scars or enlarged areas, no tenderness noted. The
22 trachea is midline. That's a normal finding, right?

23 A Yes.

24 Q No jugular vein distension. Other, chest pain three
25 dash six slash ten radiates to throat and back. Denies nausea,

1 dizziness or diaphoresis. No shortness of breath or
2 palpitations. Tell us what diaphoresis is.

3 A Sweatiness.

4 Q Okay. SOB is shortness of breath, right?

5 A Yes.

6 Q Okay. Now, this note does say radiates to throat and
7 back. And this is the first time in the chart that we see an
8 indication of a radiation to the back, right?

9 A Correct.

10 Q And do you know, as you sit here now, whether we're
11 going to see any other note in this entire chart until he's
12 discharged at around 7:30 that indicates he ever experienced a
13 radiation to the back again?

14 A No, that's the only location.

15 Q They examine his abdomen, his pelvis, his arms, his
16 legs, his skin, and they don't find anything unusual, true?

17 A Correct.

18 Q And then they go down to pain assessment, and the pain
19 score now is a five because this is something that's constantly
20 being monitored by the nurses, right, they want to know from the
21 patient how you're feeling now, right?

22 A Yes.

23 Q Okay. And the goal is to get it down to a two because
24 that would be, you know, a pretty low score and he'd be feeling
25 better, right?

1 A Yes.

2 Q And the score acceptable to the patient, he says, or at
3 least you would think this is coming from the patient, the pain
4 score is acceptable to the patient. And that would refer to the
5 five, right? He's not uncomfortable even with five out of ten
6 pain?

7 A Well, it just means --

8 Q Is that your read of it?

9 A -- that he's able to handle five out of ten pain.

10 Q Okay. We go down into history. We see the meds that
11 he's getting for his gastroesophageal reflux is Nexium. Okay,
12 so we did have that. I remembered this morning you weren't sure
13 what it was, right?

14 A Correct.

15 Q He has no surgical history or past surgical history, no
16 past surgeries. Was that accurate, do you think? You read some
17 of his records.

18 A He had a hernia problem at one point. I don't recall
19 if he had surgery for it.

20 Q Okay. He had a vasectomy at one point, hernia surgery
21 at one point, right?

22 A Yeah.

23 Q Now we get down to vital signs at the bottom of the
24 page.

25 MR. VIGORITO: Ed, if you could highlight that

1 block for me.

2 Q So at 12:34, very soon after he arrives on the 18th,
3 he's got a pulse of 76, respiratory rate of 18, systolic is 143,
4 diastolic is 57. I'm not talking to you now about pulse
5 pressure at all, but just in general there's 143 over 57. Is
6 that considered a high blood pressure?

7 A It's a high systolic and low diastolic.

8 Q Okay. And a little while ago I read to you from a past
9 transcript where you said one of the symptoms was, I think --
10 and correct me if I'm wrong -- of an aortic dissection would be
11 a sustained high blood pressure, right?

12 A One -- again, since I obviously use the word symptom,
13 which is a poor word, hypertension has two roles. Chronic
14 hypertension significantly predisposes for a dissection, one of
15 the reasons for it. The other is if a person has an acute
16 dissection they can be either hypertensive, hypotensive or
17 normal. But if somebody has a hypertensive crisis coming in,
18 that would add to the concern for dissection.

19 Q So, Doctor, if he had a pain level of five when he came
20 in, and there it is recorded at 12:34, and you believe he had
21 the beginnings of an aortic dissection the day before when he
22 first felt the pain at 12:34, a pain score of five and a report
23 to the nurse of constant chest pain, do you have an opinion,
24 with a reasonable degree of medical certainty, is he still
25 dissecting at that time?

1 A I cannot answer the question the way you phrase it --

2 Q Okay.

3 A -- limited to a simple yes/no format.

4 Q That's the answer. That's fine.

5 When his pain scale score goes to zero at 1:29 p.m., is
6 he dissecting at that time, within a reasonable degree of
7 medical certainty?

8 A He's not --

9 Q Yes or no?

10 A He's not tearing at that moment.

11 Q Okay. And you can say that because it's a zero pain
12 scale; is that the primary reason? Because what else has really
13 changed here?

14 A When you have a dissection, when you get a tear, it
15 doesn't just hurt the moment it tears but the pain carries on.
16 It's like being hit in the shoulder with a baseball bat. The
17 bat might be finished, but you might feel pain for several
18 hours.

19 Dissections typically have an initial pain which then
20 takes time to resolve. If someone goes down to zero pain, that
21 means that they're not tearing that moment and they haven't torn
22 since the last time they tore. When pain comes back from zero
23 to five, that generally indicates another episode of tearing,
24 and that pain could last for hours.

25 So the point is that at the time you're zero pain, it

1 means that you're not tearing at that moment, nor are you on the
2 tail end of the pain from your last tear. So people have two or
3 three tears in a row, you could have pain, it could drift down
4 possibly to zero, and then you get another tear and your pain
5 will be there and eventually drift down, but it could keep
6 tearing and keep recurring. So it just depends. But the pain
7 can last for multiple hours after a tear.

8 Q Doctor, that initial systolic and diastolic 143 over
9 57, looking at the case in a vacuum with just chest pain and
10 that blood pressure reading, are you of the opinion that that
11 warranted the performance of a CAT scan? Just a yes or no.

12 A No.

13 Q Had Mr. Nocera received -- withdrawn.

14 Would the administration of any type of pain medication
15 necessarily have any effect on the pain emanating from an aortic
16 dissection?

17 A Well, anti-inflammatories like Motrin can help the
18 pain, but it wouldn't be very rapid. Like any physical pain, it
19 takes time. Narcotics would have an immediate effect.

20 Q So if Mr. Nocera had been given Motrin at or around
21 12:34, hypothetically, some period of time thereafter it might
22 have a saltatory effect on his pain level?

23 A It might. It helps all pain, but generally it's a mild
24 remedy. But it's also an anti-inflammatory, and tearing is
25 inflammatory. So it could help, just like a shoulder if you

1 were hit with a baseball bat, it might help.

2 Q Sure. Are you of the opinion in this case, having
3 reviewed it in the last six months, that the administration of
4 any pain medication contributed to the reduction of his pain to
5 a zero at 1:29 p.m.?

6 A It would be difficult.

7 MS. WEISMAN: Let me object. I don't think we have
8 a timeframe as to when the Motrin was given. That's not
9 what the evidence states.

10 MR. VIGORITO: Judge, that's interrupting my cross
11 and trying to suggest an answer to a witness, quite frankly,
12 and highly inappropriate.

13 THE COURT: Is there a question pending?

14 MR. VIGORITO: There was, and it was interrupted by
15 the objection.

16 THE COURT: Answer the question, Doctor.

17 A Certainly. Motrin, whether it was given or not, would
18 not act that rapidly in reducing pain from a dissection. There
19 would be no reasonable way that Motrin would help any pain that
20 rapidly, so any reduction that takes place in less than one hour
21 would be its own resolution, not any pharmacological therapy.
22 The only thing that would work that rapidly is a narcotic, which
23 he did not get.

24 Q Do you know, since it's now been brought up, do you
25 know when Mr. Nocera received Motrin in this case?

1 A I don't remember the exact time, but it was at some
2 point in that afternoon.

3 Q Do you know if he received it before or after his
4 1:29 p.m. pain scale score of zero?

5 A I have to look. I mean, I don't recall the exact time.
6 But I never factored the Motrin as being the reason for his pain
7 relief.

8 Q Do you know if he received it before or after the pain
9 scale score of zero at 3:12 p.m.?

10 A I'll have to look and see what time it was
11 administered, which is right here, so give me a moment.

12 Q Sure.

13 THE COURT: Counsel, approach.

14 (Sidebar held off the record.)

15 A I am unable to find the time the Motrin was given on a
16 quick review of these records.

17 Q I'm sorry, Doctor, you couldn't find it?

18 A I'm unable to determine the time based on the records I
19 have here.

20 Q Okay. I'd like you to accept we've established, I
21 think, in this case it was ordered around 4:00 p.m., given
22 around that time. So in terms of the 1:29, the 3:12 and even
23 the 4:32, if it was given at -- if it was given at 4 o'clock,
24 the 1632 would be 4:32, you wouldn't think the Motrin would have
25 a contributory effect of his pain going to zero?

1 A I agree it couldn't possibly even if it were given when
2 he came in.

3 Q Doctor, I asked you this morning -- I know you said you
4 hadn't reviewed the records of Biffer Chiropractic. Over the
5 lunch break did you have a chance to look at those records?

6 A No.

7 Q Do you know if those records, which are in evidence,
8 indicate that Mr. Nocera had a history of back pain?

9 A No.

10 Q Doctor, on this page, nursing procedures under comfort
11 measures, about four lines down, the patient was informed of
12 status. The patient was given a warm blanket. Explanation of
13 wait provided to patient. A TV was provided for the patient.
14 The patient was repositioned to a position of comfort. That's
15 all noted at 12:49.

16 And then on the plan of care, plan of care discussed
17 with the patient. Care plan includes universal precautions.
18 Call bell in reach. Input outpatient, observe, reassure and
19 position of comfort. He's being monitored with an automatic
20 blood pressure cuff. There's a cardiac monitor and a pulse ox
21 that's measuring his oxygenation level, right?

22 A Yes.

23 Q Okay. EKG was completed, right?

24 A Yes.

25 Q And that was normal, you read that?

1 A Yes.

2 Q You looked at the actual EKG printout?

3 A Yes.

4 Q And you found it to be satisfactory?

5 A Yes.

6 Q That, combined with the normal cardiac enzymes, the
7 troponins that do ultimately come back, that would be reassuring
8 to the clinicians, like Dr. Cuomo and Dr. Bernstein, that this
9 gentleman was not having an acute coronary syndrome?

10 A Not having a heart attack. It couldn't completely
11 exclude an acute coronary syndrome.

12 Q Now, I want to go down to nurse's progress note where
13 it says notes. Patient sitting upright on stretcher. No
14 complaints offered. Patient's wife at bedside. And that was
15 entered at 3:14 p.m. So that's pretty much an hour before he
16 ever got the Motrin for the first and only time. You see that
17 note, right?

18 A Yes.

19 Q Would that kind of information, would that be
20 reassuring to the doctors as well that his pain is now subsided,
21 it's been a zero, it's not radiating anymore, he doesn't have
22 any pain at all, if they were thinking of acute coronary
23 syndrome, it's kind of now been lessened on the scale of
24 differential diagnosis?

25 A I can't agree with that statement. It's better to be

1 pain free, but it doesn't provide you insight as to what the
2 diagnosis is because acute coronary syndrome, pulmonary embolism
3 or dissection are well-known to have pain-free intervals. But
4 of course it's better to be pain free.

5 Q And Doctor, you talked a little bit about the fact that
6 a chest x-ray was done, right?

7 A Yes.

8 Q And it was a portable chest x-ray?

9 A Yes.

10 Q And were you provided with the x-ray?

11 A Yes.

12 Q How -- what format did you get the x-ray in?

13 A As an actual film.

14 Q A flat film?

15 A Yes.

16 Q Not a disc?

17 A No.

18 Q Did you bring that with you today?

19 A No.

20 Q Where is it now?

21 A Ms. Weisman gave it to me and took it.

22 Q And you have some familiarity with looking at chest
23 x-rays, although you're not a radiologist, right?

24 A Correct.

25 Q On Friday we had Dr. Diane Sixsmith, a board-certified

1 emergency room doctor, tell us that she would defer the reading
2 of that x-ray to a board-certified radiologist. So I'll ask you
3 the same question, would you defer to the reading by a
4 board-certified radiologist as to what that film shows?

5 A I can't answer the question the way you phrase it
6 limited to a simple yes, no. I will --

7 Q Okay. That's your answer.

8 A Okay, yes.

9 Q You don't have to go any further.

10 Would you defer to a board-certified radiologist as to
11 his or her opinion of the quality of that film? Just a yes or a
12 no.

13 A I can't answer the question the way you phrase it
14 limited to a simple yes, no.

15 Q Would you defer to a board-certified radiologist
16 working in a hospital setting as to what should or should not
17 have been done as a result of the read of that chest x-ray?
18 Just a yes or a no.

19 A That's a clinical decision, not a radiology decision.

20 Q But would you defer to the opinion of a radiologist?

21 A No.

22 Q And do you sometimes see radiologists write in their
23 reports clinical correlation needed or warranted or recommended?

24 A Yes, frequently.

25 Q So those are radiologists making a recommendation, at

1 least a limited recommendation, as to what should be done, what
2 follow-up might be necessary?

3 A Well, when they say clinical correlation, they're
4 saying it's up to the clinician to correlate it, which is always
5 understood.

6 Q Was that included in this radiology report, if you know
7 without looking at it?

8 A I don't recall.

9 Q Do you remember testifying in the Jollie case, Doctor,
10 that you suspect an aortic dissection when a patient appears in
11 an emergency room who is a chronic hypertensive, whose chief
12 complaint includes a significant portion of their problem being
13 back pain, and I didn't mention this before, classically when
14 they come to the emergency room initially their blood pressure
15 is usually higher than usual? Did you say that in the Jollie
16 case? Just a yes or no.

17 A Yes.

18 Q Did you further say in the Jollie case that the
19 diagnosis at that point was a constellation of symptoms, mainly
20 his back pain, shortness of breath and ultra high blood pressure
21 in a patient who has been chronically hypertensive that is a
22 signal for dissection? Did you say that, yes or no, in that
23 case those were the signals, yes? Are you remembering the
24 Jollie case now?

25 A Well, the language --

1 Q Just a yes or no, Doctor. Are you remembering the
2 Jollie case now that I've read you significant statements that
3 you've made from that case? Just a yes or no.

4 A No, but the tense by which you --

5 Q You've answered the question, Doctor. Thank you.

6 Did you also say in the Jollie case that back pain in a
7 hypertensive, that's a red flag, it has to be a red flag? Did
8 you say that, yes or no?

9 A I'm certain I did.

10 Q Did you also say in the Jollie case in 1992 that what
11 you want to do in these cases is lower their blood pressure, the
12 whole essence of treating dissection is right away to lower the
13 blood pressure? Did you say that, yes or no?

14 A Well, if it's elevated, yes.

15 Q And did you say in the Jollie case at page 143:

16 "Question: And not just severe pain, but excruciating
17 pain; is that true?

18 Answer: In some patients it's extremely excruciating."

19 Did you say that, yes or no?

20 A I'm certain if you're reading it.

21 Q Did Mr. Nocera give the fellow that came in for the
22 cardiac consultation information that he felt the pain for the
23 first time when he got up off the floor? Did he say that?

24 A Yes.

25 Q After he was working on something?

1 A Yeah.

2 Q Did he say that?

3 A Yes.

4 Q You looked at the autopsy report you told us earlier --

5 A Yes.

6 Q -- right?

7 There's no sign in that autopsy report of any problem
8 with the valve, true?

9 A True.

10 Q Now, I want to talk about murmur. You know that there
11 are two different kinds of murmurs: There is systolic ejection
12 murmur and diastolic ejection murmur, and that in medical
13 literature, taught in every medical school in this country, it's
14 the diastolic murmur, not the systolic murmur, that is linked to
15 aortic dissection occurrence. You know that, don't you,
16 Dr. Charash?

17 A No.

18 Q Yes or no, Doctor?

19 Doctor, I'd like you to answer it any --

20 THE COURT: Mr. Vigorito.

21 MR. VIGORITO: Yes.

22 THE COURT: The doctor is trying to.

23 MR. VIGORITO: It's a yes or no, quite simple.

24 THE COURT: I understand that. I'll allow the
25 doctor to answer. Go ahead, Doctor.

1 A I cannot answer the question the way you phrase it
2 limited to a simple yes, no.

3 Q Doctor, systolic ejection murmurs are simply not linked
4 to aortic dissection, true?

5 A No, where there's aortic regurgitation --

6 Q It's true or false.

7 A -- it's --

8 Q Not no and then answer.

9 A Systolic murmurs are --

10 Q Doctor, please.

11 MR. VIGORITO: Judge.

12 THE COURT: Let's move on.

13 MR. VIGORITO: I'm trying to.

14 THE COURT: Keep trying.

15 Q Was there ever a finding of a diastolic ejection murmur
16 in this case?

17 A They're not called ejection murmurs, but no one
18 reported a diastolic murmur, which are harder to hear.

19 Q And you said to us earlier today that a three out of
20 six is on the grade scale is what, you said, slightly louder or
21 slightly more prominent than what?

22 A Most people who have a mundane ejection murmur are one
23 or two out of six. Three out of six is a little bit more
24 prominent, and because it is new and because systolic murmurs
25 are often the first audible finding of acute aortic

1 regurgitation, that would be a red flag that needs resolution.

2 Q Did Mr. Nocera express the desire to leave the
3 emergency department and go home?

4 A I would hope so.

5 Q Did he feel well enough to express that he -- he didn't
6 think that he needed to stay there overnight and wanted to go
7 home? Do you know?

8 A I don't know offhand, but, I mean, he's not making a
9 diagnosis. If his pain had gone down to zero I wouldn't blame
10 him. I don't know if anyone asked him when his pain went back
11 up to five.

12 Q Doctor, was he given any discharge instructions?

13 A I'm certain of it. I've seen them, but there were a
14 lot of pages of discharge instructions.

15 Q Well, whether there were a lot of pages or a little
16 amount of pages, did you read those pages as carefully as you
17 seemingly read the rest of this chart? Yes or no?

18 A Yes.

19 Q Did you take note of the fact when you read those pages
20 so carefully that they were telling Mr. Nocera that if you have
21 any increase in pain, new onset of pain, chest pain, because we
22 really are not sure at this stage what was causing your chest
23 pain, we think it might have been musculoskeletal, that you
24 should return to an emergency department or to a physician? Did
25 you read that?

1 A Yes.

2 Q Are you -- withdrawn.

3 Do you ascribe to the belief that Mr. Nocera was in
4 pain, had chest pain for the next two full days after he left
5 the emergency room? Do you ascribe to that?

6 A I ascribe that he had pain over those two days. No one
7 knows what the real pattern was.

8 Q Do you know what he did over the next two days?

9 A Not by memory.

10 Q Did you see it anywhere in any of the records or
11 testimony thus far what he did over the next 48 hours?

12 A I said not by memory.

13 Q Do you know if he went home and sat in his easy chair
14 and watched TV?

15 A I said I don't remember.

16 Q So you wouldn't be able to answer the question at all?

17 A That's what I'm saying.

18 Q And if he had chest pain and it was increasing, and he
19 had instructions that he signed off on at the hospital to return
20 to the hospital, would you be of the opinion that by not
21 returning to seek medical treatment Mr. Nocera may have
22 contributed to his own demise?

23 A I would --

24 Q In that respect, just a yes or no.

25 A -- I would entirely blame the hospital for that. If

1 somebody --

2 Q Doctor, it was a yes or no. It wasn't an explanation.

3 A No, the hospital would be entirely at fault.

4 MR. VIGORITO: I have no further questions.

5 THE COURT: Mr. Venditto?

6 MR. VENDITTO: Thank you, Judge.

7 CROSS-EXAMINATION

8 BY MR. VENDITTO:

9 Q Good afternoon.

10 A Good afternoon, sir.

11 Q My name is Anthony Venditto. I'm with the law firm of
12 Furman Kornfeld & Brennan, and I represent Dr. Bernstein.

13 Doctor, you and I have never met before; isn't that
14 true?

15 A Yes.

16 Q And would I be correct, Doctor, that you have testified
17 at trial in New York on approximately how many occasions? You
18 tell me.

19 A In trial in New York State?

20 Q Yes.

21 A Forty, 50 times.

22 Q Okay. And you would agree with me that the instruction
23 that counsel usually gives during cross-examination to a witness
24 is for the witness to answer the questions either yes or no, and
25 if he or she can't do it to let the attorney know. You've heard

1 that numerous times, true?

2 A Yes.

3 Q And you can do that for me right now?

4 A Yes.

5 Q Okay. You know, as a result of being an expert
6 witness, that, thanks to the hard work of court stenographers,
7 we get transcripts of the testimony, true?

8 A Yes.

9 Q You have been cross-examined by other defense lawyers
10 in malpractice cases with the use of your prior testimony, true?

11 A On occasion, yes.

12 Q Would we say -- when we say on occasion in the number
13 of trials that you've testified in this state in medical
14 malpractice cases, would you agree with me that in each and
15 every one of those cases you were cross-examined with prior
16 testimony?

17 A No, I wouldn't say in each case.

18 Q Would you say 90 percent?

19 A I would say probably over 50, but not 90.

20 Q Do you know how many transcripts exist concerning your
21 prior testimony as an expert, just in this state?

22 A No.

23 Q Do you know how many transcripts exist in other states,
24 whether it be depositions or trials?

25 A Not exactly, no.

1 Q Would I be correct, Doctor, that because you know that
2 there are transcripts with your prior testimony that you phrase
3 your answers in such a way to prevent defense attorneys from
4 confronting you with what you have said before; isn't that true?

5 A No.

6 Q You are a cardiologist, correct?

7 A Yes.

8 Q You are affiliated with Lenox Hill Hospital?

9 A Yes.

10 Q Can you tell the members of our jury how many other
11 cardiologists are affiliated with Lenox Hill Hospital?

12 A I don't know the exact number.

13 Q Give me an approximate.

14 A Forty.

15 Q How many are affiliated with Montefiore Medical Center?

16 A I don't know.

17 Q How about Northwell?

18 A Northwell is a giant network. I don't know. There
19 must be hundreds.

20 Q You would agree they have cardiologists, correct?

21 A Of course.

22 Q How about Montefiore, do you know?

23 A I don't know the number for Montefiore.

24 Q Albert Einstein?

25 A I don't know the number of any other institution.

1 Q How many in the State of New York? How many
2 board-certified cardiologists exist in the State of New York?

3 A I don't know.

4 Q More than 100?

5 A Obviously.

6 Q More than 500?

7 A I would think so. I think it would be in the
8 thousands, but I don't know the number.

9 Q In the states that you have offered expert opinion as a
10 cardiologist, in those particular states, can we agree that
11 there are board-certified, licensed cardiologists who actually
12 work in those states?

13 A Yes.

14 Q Who actually treat patients in those states?

15 A Yes.

16 Q Aside from testifying against physicians, can we agree,
17 Doctor, that you've offered negative comments, departures
18 against nurses, true?

19 A Yes.

20 Q And before offering a negative opinion against a nurse,
21 Doctor, while you were at Lenox Hill Hospital did you ever go to
22 the department of nursing and say, you know, before I criticize
23 a nurse, let me shadow a nurse for a day and see what it is that
24 he or she does? Did you ever do that?

25 A I did more than that, I did peer review of the nurses.

1 I wrote up --

2 Q I asked you if you shadowed a nurse in doing her or his
3 exact job. Yes or no?

4 A Every day in the cardiac care unit, all the nurses I
5 followed.

6 Q You shadowed them?

7 A Yes.

8 Q Now, you have an office you told us that's part of your
9 home, correct?

10 A Yes.

11 Q And that's in a residential building in Manhattan,
12 true?

13 A Yes.

14 Q And do you have a receptionist that works at your
15 office?

16 A Yes.

17 Q And do you have an examination room?

18 A Yes.

19 Q Do you have an EKG machine?

20 A Yes.

21 Q And this is all on the 16th floor?

22 A Yes.

23 Q And do you have those little boxes outside your office
24 where people put samples, whether it be blood tests and the
25 like?

1 A No, I send them to Lenox Hill for blood.

2 Q That's a co-op, correct, that you live in?

3 A Yes.

4 Q Do you have board approval to operate an office out of
5 your apartment?

6 MS. WEISMAN: I'm going to object, your Honor.

7 THE COURT: Sustained.

8 Q You were questioned about your fee in medical
9 malpractice cases as an expert witness, true?

10 A Yes.

11 Q We can agree also, Doctor, can we not, that this
12 certainly was not the first time you were questioned about how
13 much money you have made as an expert witness, true?

14 A Correct.

15 Q And we are here in the month of February 2018, correct
16 me if I'm wrong, federal and state tax would be due April 15th
17 of this year, correct?

18 A Well, I'm filing it October. I have an extension.

19 Q Okay. Are you aware, as you sit here right now, how
20 much money you made last year as a result of being an expert
21 witness?

22 A Not exactly.

23 Q You have an accountant who does your taxes?

24 A Yes.

25 Q And you knew you were going to be questioned about how

1 much you make, you get questioned about it all the time, true?

2 A Not all the time, but frequently.

3 Q Isn't it true, Doctor, that you were once questioned at
4 a deposition to give the name of your accountant, correct?

5 A Yes.

6 Q And you refused to do so, correct?

7 A I said that if the judge asked me I would, but I've had
8 people harassed in my life, and that's not fair to them.

9 Q I'm not asking about harassment. I'm just asking have
10 you been asked to find out from your accountant how much money
11 you have made as an expert witness. True?

12 A I can tell you how much I made on a year after taxes
13 are filed.

14 Q So how much did you make last year?

15 A I haven't gotten all my W-9 forms. I haven't
16 calculated. I can tell you --

17 Q How much did you make the year before?

18 A In medical-legal work?

19 Q Correct.

20 A \$72,000.

21 Q 72,000?

22 A Yes. More -- I mean, roughly. Well, I mean 72,800. I
23 don't know what the exact amount was.

24 Q And that would be for calendar year what, Doctor?

25 A 2016.

1 Q Now, when you're testifying here in court, you can't
2 see patients back at your apartment, true?

3 A Correct.

4 Q And when you're meeting with lawyers to go over the
5 materials to prepare, you can't be seeing your patients and
6 treating them, correct?

7 A Well, I try and have my meetings at night. And most of
8 my trials are vacation days.

9 Q Okay. So you scheduled your vacation day trial -- I'm
10 sorry, you scheduled today as a vacation day, correct?

11 A Correct.

12 Q Who do you work for?

13 A Myself.

14 Q So really scheduling a vacation day is really
15 irrelevant, because who do you -- what do you do, you call up
16 yourself and say I'm not coming to work today?

17 MS. WEISMAN: Objection.

18 THE COURT: Sustained.

19 A I just don't take off vacation days.

20 MR. VENDITTO: I'll withdraw it, Judge. I'll
21 withdraw it, Judge. My apologies, Judge. I'll withdraw
22 that. I need a moment, Judge.

23 THE COURT: You need one or you're having one?

24 MR. VENDITTO: No, I'm not having one yet. We
25 haven't begun, Judge.

1 Q When you received the materials in this case
2 you reviewed, in what order? What items?

3 A I'm not sure I understand. I think I would have looked
4 at the Westchester Medical Center chart first.

5 Q Okay. What else did you review?

6 A Well, I got pretty much everything altogether, the
7 autopsy report, the admission to Hudson Valley when he came in
8 after his cardiac arrest, previous Hudson Valley admissions,
9 transcripts of the two defendant physicians and Mrs. Nocera.

10 Q Are you aware that a nurse gave deposition testimony in
11 this case, Doctor?

12 A I never saw it.

13 Q I'm not asking you if you saw it --

14 A Unaware of it.

15 Q Doctor, if you were aware of it would that have been
16 something you would have wanted to have read prior to coming
17 here and offering opinions?

18 A If it had any new information, yes.

19 Q Well, you don't know if it has new information or not
20 unless you review it, true?

21 A But I didn't know it existed.

22 Q We're going around in circles here, correct?

23 A I'm just --

24 Q I'm asking you to assume that a nurse gave deposition
25 testimony in this case, okay? Had you been informed of that

1 would you have said I want to read this testimony, yes or no?

2 A I would first ask whether it -- whether it discussed
3 anything that was not available on the chart. And if there was
4 information that was not available on the chart, yes.

5 Q Let me see if I understand you correctly, and just
6 correct me if I'm wrong, you would ask a plaintiff's lawyer to
7 tell you whether there was information that a nurse testified to
8 that was significant or not? Would you rely on the lawyer
9 rather than yourself?

10 A No, I said --

11 MS. WEISMAN: Note my objection. That's not what
12 his answer was.

13 A There was information beyond what was written in the
14 chart.

15 Q And you wanted to read it for yourself rather than rely
16 upon the lawyer, yes or no?

17 A I can't answer the question the way you phrase it
18 limited to a simple yes, no.

19 MR. VENDITTO: Nothing further, Judge. Thank you.

20 THE COURT: Ms. Weisman?

21 MS. WEISMAN: In the interest of letting everybody
22 go, I have no questions.

23 THE COURT: Your courtesy, I'm sure, is greatly
24 appreciated by everybody. However, the time is not a
25 preclusion for you to extend a redirect if you deem

1 appropriate or necessary.

2 MS. WEISMAN: Okay. Thank you, your Honor. I
3 don't think it's necessary.

4 THE COURT: Okay. Doctor, you can step down, with
5 the thanks of the Court.

6 THE WITNESS: Thank you.

7 (Witness excused.)

8 THE COURT: Well, ladies and gentlemen, that
9 concludes our session for the day. I want to thank you for
10 your patience; it's been a long day. And as you can see
11 when we do have medical experts on the stand, as we did with
12 Dr. Sixsmith and Dr. Charash, and I'm sure when we put the
13 other experts on for Mr. Vigorito, it gets to be a vigorous
14 and rigorous day, and you guys have been great. And I will
15 thank you on behalf of the parties as well as counsel.
16 There isn't one moment that I haven't seen any of you not
17 paying attention, and we are all gracious and thankful for
18 that. The service can't be done without you and your
19 assistance, and your cooperation is greatly appreciated by
20 the Court and others.

21 So, tomorrow half day 9:30 to 12:30. I'd like you
22 up at 20 after 9:00, and we will take the box promptly with,
23 I will gather, a continuation of Mrs. Nocera.

24 MS. WEISMAN: I think so.

25 THE COURT: Barring any unforeseen circumstances.

1 So get home safely. Have a wonderful evening. Please don't
2 discuss the case amongst yourselves or with anybody else.
3 We'll see you tomorrow morning.

4 (Proceedings so concluded.)

5 * * *

6

7 THIS IS TO CERTIFY THAT THE ABOVE TRANSCRIPT IS A TRUE AND
8 ACCURATE TRANSCRIPTION OF MY STENOGRAPHIC NOTES.

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10 -----X
11 Nicole Ameneiros
12 Senior Court Reporter

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---------------	---	---	---	--

<p>445:22, 485:6 able [9] - 461:24, 479:2, 479:4, 504:16, 524:22, 533:14, 540:15, 561:9, 576:16 abnormal [2] - 462:3, 462:12 abnormality [1] - 479:3 ABOVE [1] - 588:7 absolutely [6] - 443:5, 445:3, 480:17, 514:2, 524:5, 548:5 academic [1] - 453:14 accept [4] - 499:7, 524:13, 534:11, 566:20 acceptable [4] - 461:24, 536:14, 561:2, 561:4 accepted [5] - 446:16, 474:20, 480:2, 481:9, 481:18 accidents [1] - 503:8 accolades [1] - 445:17 accommodate [2] - 492:11, 547:18 accompanied [1] - 556:8 accord [1] - 523:18 accountable [1] - 449:9 accountant [3] - 582:23, 583:4, 583:10 accumulated [1] - 505:17 ACCURATE [1] - 588:8 accurate [10] - 490:11, 495:3, 502:14, 502:16, 502:22, 505:10, 517:2, 524:3, 555:21, 561:16 accurately [1] - 456:25 achieved [1] - 473:23 acknowledge [4] - 507:25, 508:4, 508:8, 527:14 acknowledged [3] - 491:22, 508:24, 528:7 acknowledges [1] - 539:3 acronym [1] - 556:20 act [1] - 565:18 action [2] - 510:20,</p>	<p>511:6 active [1] - 477:8 activities [2] - 515:22, 515:25 activity [2] - 535:7, 535:9 actual [6] - 465:21, 470:4, 503:23, 509:24, 568:2, 569:13 acute [17] - 459:17, 464:13, 465:21, 466:3, 466:5, 467:3, 471:2, 471:8, 479:3, 557:20, 558:16, 562:15, 568:9, 568:11, 568:22, 569:2, 574:25 add [1] - 562:18 added [2] - 522:23, 523:7 adding [2] - 515:17, 516:14 addition [7] - 496:16, 496:20, 503:23, 512:3, 514:15, 532:6, 538:21 additional [1] - 529:4 address [8] - 450:20, 512:22, 512:24, 513:16, 514:8, 514:15, 514:16 adequate [3] - 479:1, 479:4, 557:7 adequately [1] - 478:21 adhered [1] - 475:20 adjective [1] - 554:5 administered [1] - 566:11 administration [2] - 564:14, 565:3 Administrator [1] - 525:15 Administratrix [1] - 442:2 admission [1] - 585:7 admissions [2] - 459:19, 585:8 admit [4] - 452:23, 481:17, 515:3, 527:12 admitted [6] - 442:21, 460:8, 481:24, 515:6, 515:7 admitting [5] - 452:18, 452:20, 452:23, 473:15, 481:16 adults [1] - 451:17 adversarial [1] -</p>	<p>492:9 adverse [1] - 446:3 advise [1] - 529:17 affect [4] - 556:21, 556:23, 556:24, 556:25 affected [1] - 522:21 affecting [2] - 503:8, 503:9 affiliated [3] - 579:8, 579:11, 579:15 affirmation [4] - 472:21, 489:25, 520:24, 551:5 Africa [1] - 453:6 aftercare [1] - 559:10 afternoon [9] - 520:20, 521:2, 521:3, 542:25, 566:2, 577:9, 577:10 age [2] - 557:3, 557:18 agenda [1] - 512:12 ago [24] - 485:7, 491:17, 494:19, 494:25, 506:25, 508:21, 510:5, 510:19, 516:8, 516:21, 526:24, 527:25, 528:4, 532:23, 532:24, 532:25, 533:1, 533:6, 533:7, 534:5, 534:9, 534:12, 546:22, 562:8 agree [31] - 469:16, 469:18, 469:23, 488:2, 491:3, 492:1, 493:8, 496:4, 503:21, 509:2, 521:4, 531:15, 542:3, 544:2, 545:17, 545:19, 545:23, 546:7, 546:8, 554:6, 556:22, 558:10, 559:5, 567:1, 568:25, 577:22, 578:14, 579:20, 580:10, 580:16, 582:11 agreed [1] - 554:10 ahead [5] - 471:24, 494:6, 514:7, 549:22, 573:25 Aid [2] - 512:17, 512:21 airway [2] - 556:13, 556:14 airways [1] - 478:16 Albert [1] - 579:24 alert [1] - 556:21 alerted [1] - 476:10 Alfred [1] - 490:7</p>	<p>alive [1] - 484:14 alleged [1] - 446:19 allergy [2] - 454:21, 455:2 allow [3] - 489:6, 496:1, 573:24 allowed [2] - 452:22, 475:8 allowing [1] - 464:10 almost [3] - 467:10, 496:25, 509:20 alone [2] - 474:8, 517:25 Alpha [2] - 453:12 alternative [2] - 492:3, 555:24 altogether [1] - 585:6 ambulance [1] - 548:24 ambulatory [2] - 555:18, 556:7 Ameneiros [2] - 442:11, 588:10 American [1] - 524:17 amount [9] - 499:1, 502:12, 506:13, 506:16, 506:19, 509:2, 531:9, 575:16, 583:23 anatomic [1] - 500:11 AND [1] - 588:7 Andrews [3] - 525:14, 527:4, 528:1 aneurysm [2] - 460:1, 527:15 answer [69] - 456:21, 456:25, 467:24, 484:21, 484:22, 485:7, 492:10, 492:18, 492:20, 492:21, 492:22, 493:14, 493:22, 494:1, 494:2, 494:8, 494:11, 494:14, 494:23, 499:12, 502:10, 510:13, 513:23, 514:4, 514:12, 516:14, 516:18, 526:19, 527:5, 527:11, 527:14, 527:22, 529:20, 529:25, 530:2, 530:22, 530:23, 531:13, 536:7, 536:15, 541:14, 546:12, 546:14, 547:20,</p>	<p>549:22, 550:2, 550:14, 552:4, 553:4, 553:23, 553:25, 558:11, 563:1, 563:4, 565:11, 565:16, 570:5, 570:7, 570:13, 572:18, 573:19, 573:25, 574:1, 574:8, 576:16, 577:24, 586:12, 586:17 answered [7] - 488:4, 494:9, 534:19, 536:4, 545:2, 545:3, 572:5 answering [2] - 448:11, 547:3 answers [4] - 516:9, 516:21, 559:7, 579:3 Anthony [1] - 577:11 anti [2] - 564:17, 564:24 anti-inflammatories [1] - 564:17 anti-inflammatory [1] - 564:24 antibiotic [2] - 454:25, 455:1 anticipate [1] - 448:16 anyway [1] - 475:18 aorta [33] - 457:20, 460:1, 461:15, 463:3, 463:7, 463:11, 463:13, 463:14, 463:17, 463:18, 464:10, 464:23, 465:4, 466:5, 466:16, 466:19, 466:24, 477:2, 477:15, 477:25, 481:1, 482:10, 482:24, 482:25, 483:4, 483:8, 483:9, 483:10, 483:23, 483:25, 499:10, 530:25, 551:18 aortic [88] - 457:16, 457:19, 460:17, 460:21, 460:23, 461:18, 461:20, 462:5, 462:6, 462:11, 462:17, 463:8, 463:25, 464:1, 464:2, 464:6, 464:13, 464:14, 464:21, 465:6, 465:8, 465:21, 466:3, 466:6, 467:3, 467:12, 467:13, 467:16, 467:17, 467:19, 467:22,</p>
---	--	---	---	--

<p>468:16, 468:19, 469:15, 469:22, 470:1, 470:3, 470:5, 470:6, 470:8, 470:10, 470:12, 470:14, 470:17, 471:2, 471:8, 471:16, 477:1, 478:17, 479:22, 480:11, 480:15, 480:25, 481:23, 482:17, 483:6, 483:16, 483:19, 483:21, 483:23, 486:22, 486:25, 487:3, 487:5, 488:2, 525:9, 526:10, 527:15, 544:3, 545:11, 546:23, 551:16, 552:19, 556:22, 558:9, 558:19, 558:25, 559:2, 562:10, 562:21, 564:15, 571:10, 573:15, 574:4, 574:5, 574:25</p> <p>apartment [7] - 513:4, 513:6, 513:9, 513:12, 513:18, 582:5, 584:2</p> <p>Apartment [5] - 513:17, 514:9, 514:16, 533:9, 533:12</p> <p>apologies [1] - 584:21</p> <p>apologize [4] - 510:12, 541:11, 549:20</p> <p>Appearances [1] - 442:10</p> <p>appeared [4] - 442:25, 455:12, 517:10, 518:13</p> <p>application [6] - 445:7, 445:19, 445:20, 446:4, 446:8, 551:9</p> <p>applications [2] - 443:7, 494:3</p> <p>appreciate [1] - 447:5</p> <p>appreciated [3] - 449:11, 586:24, 587:19</p> <p>approach [5] - 451:18, 452:2, 535:10, 566:13</p> <p>approached [1] - 454:10</p> <p>appropriate [9] - 444:16, 446:2,</p>	<p>463:22, 470:18, 505:9, 528:11, 530:11, 557:18, 587:1</p> <p>appropriately [2] - 448:11, 460:10</p> <p>approval [2] - 545:9, 582:4</p> <p>approximate [1] - 579:13</p> <p>April [1] - 582:16</p> <p>area [1] - 554:22</p> <p>areas [1] - 559:21</p> <p>Arizona [1] - 518:8</p> <p>arms [1] - 560:15</p> <p>arrest [3] - 458:21, 550:1, 585:8</p> <p>arrival [3] - 555:18, 556:7, 557:19</p> <p>arrived [5] - 533:15, 555:18, 555:25, 556:3, 556:7</p> <p>arrives [1] - 562:2</p> <p>arteries [6] - 462:10, 463:11, 463:12, 463:15, 476:24, 487:4</p> <p>article [1] - 524:12</p> <p>ascending [3] - 483:8, 483:9, 483:10</p> <p>ascribe [5] - 554:3, 556:2, 576:3, 576:5, 576:6</p> <p>aside [1] - 580:16</p> <p>assessment [2] - 558:15, 560:18</p> <p>assistance [1] - 587:19</p> <p>assistant [4] - 452:7, 452:8, 452:16, 452:19</p> <p>associate [1] - 452:12</p> <p>associated [4] - 461:13, 465:8, 482:20, 527:9</p> <p>Association [1] - 453:18</p> <p>assume [6] - 475:22, 476:15, 486:4, 492:14, 521:24, 585:24</p> <p>assuming [1] - 495:16</p> <p>assumption [1] - 474:5</p> <p>assumptions [6] - 493:4, 493:8, 493:12, 493:13, 502:7, 502:9</p> <p>asystole [1] - 495:13</p> <p>attack [16] - 459:18, 459:20, 461:3, 461:6, 461:8, 461:12, 462:3,</p>	<p>462:8, 462:10, 470:24, 471:13, 476:20, 476:21, 476:23, 480:9, 568:10</p> <p>attacks [1] - 527:17</p> <p>attending [1] - 523:23</p> <p>attention [3] - 442:16, 448:13, 587:17</p> <p>attentive [1] - 450:3</p> <p>attorney [4] - 445:15, 511:18, 533:17, 577:25</p> <p>attorneys [3] - 510:21, 512:8, 579:3</p> <p>audible [1] - 574:25</p> <p>auditory [2] - 470:11, 559:14</p> <p>authoritative [1] - 524:18</p> <p>automatic [1] - 567:19</p> <p>automatically [2] - 461:4, 461:6</p> <p>automobile [2] - 555:19, 556:8</p> <p>autopsy [16] - 458:23, 464:8, 464:11, 467:21, 468:13, 468:15, 468:18, 469:15, 469:24, 482:6, 482:9, 482:22, 487:6, 573:4, 573:7, 585:7</p> <p>available [3] - 490:24, 586:3, 586:4</p> <p>average [5] - 506:17, 521:8, 522:3, 523:5, 557:23</p> <p>averaged [1] - 455:11</p> <p>averaging [1] - 455:13</p> <p>avoid [2] - 456:23, 493:23</p> <p>awake [1] - 556:21</p> <p>award [2] - 453:13, 453:19</p> <p>awards [3] - 445:12, 445:17, 453:9</p> <p>aware [14] - 486:12, 486:14, 493:19, 496:11, 496:20, 497:1, 499:3, 499:20, 501:15, 542:7, 542:8, 582:19, 585:10, 585:15</p> <p>awareness [1] - 499:21</p>	<p>awkward [2] - 535:20, 540:24</p> <p>B</p> <p>backdrop [1] - 501:25</p> <p>background [1] - 444:15</p> <p>backward [1] - 490:21</p> <p>backwards [2] - 465:11, 467:4</p> <p>backyard [1] - 465:16</p> <p>bacterial [1] - 530:16</p> <p>bad [1] - 556:6</p> <p>badges [1] - 445:12</p> <p>bag [1] - 482:11</p> <p>baggy [5] - 482:12, 482:14, 482:15, 482:18</p> <p>ball [1] - 482:20</p> <p>ballpark [2] - 526:17, 534:6</p> <p>barn [1] - 448:20</p> <p>barring [1] - 587:25</p> <p>baseball [2] - 563:16, 565:1</p> <p>based [28] - 447:1, 453:20, 460:6, 470:19, 474:18, 475:3, 479:6, 479:14, 479:25, 480:19, 480:20, 481:7, 483:13, 484:8, 487:9, 488:11, 490:24, 491:16, 493:4, 493:9, 499:7, 505:13, 512:2, 527:12, 542:3, 542:4, 566:18</p> <p>basic [2] - 460:13, 460:14</p> <p>Basichas [1] - 512:5</p> <p>basis [2] - 481:12, 483:20</p> <p>bat [3] - 563:16, 563:17, 565:1</p> <p>bear [2] - 522:1, 538:25</p> <p>bearing [2] - 443:5, 549:24</p> <p>beat [2] - 466:25, 482:21</p> <p>beat's [1] - 466:20</p> <p>beating [1] - 466:23</p> <p>beats [8] - 465:3, 465:13, 466:16, 466:18, 466:22, 467:1, 482:12, 482:15</p>	<p>became [1] - 451:23</p> <p>become [1] - 451:10</p> <p>becomes [1] - 449:5</p> <p>becoming [1] - 452:4</p> <p>bed [2] - 495:19, 497:16</p> <p>bedside [2] - 478:24, 568:14</p> <p>beep [1] - 480:15</p> <p>began [4] - 455:13, 531:3, 540:20, 553:16</p> <p>begin [3] - 472:17, 489:20, 520:19</p> <p>beginning [5] - 453:12, 456:2, 483:3, 485:17, 489:21</p> <p>beginnings [1] - 562:21</p> <p>begins [2] - 466:20, 552:20</p> <p>begun [1] - 584:25</p> <p>behalf [4] - 450:15, 453:25, 511:5, 587:15</p> <p>behavioral [1] - 557:24</p> <p>behest [1] - 528:19</p> <p>behind [1] - 463:19</p> <p>belief [1] - 576:3</p> <p>bell [1] - 567:18</p> <p>below [1] - 557:13</p> <p>bench [1] - 448:17</p> <p>benefit [3] - 450:21, 496:17, 497:9</p> <p>BENJAMIN [1] - 442:5</p> <p>Benjamin [1] - 458:25</p> <p>Bernstein [6] - 447:11, 458:25, 459:2, 535:3, 568:8, 577:12</p> <p>BERNSTEIN [1] - 442:5</p> <p>Bernstein's [1] - 474:16</p> <p>best [4] - 475:12, 534:10, 534:13, 548:8</p> <p>better [5] - 516:16, 539:9, 560:25, 568:25, 569:4</p> <p>between [16] - 444:24, 457:24, 467:6, 467:8, 467:10, 480:14, 484:17, 485:8, 485:19, 486:13, 495:9, 497:10, 497:16, 500:21, 516:17, 522:3</p> <p>beverages [1] - 450:2</p>
--	--	--	---	---

<p>beyond [6] - 448:10, 448:15, 475:13, 479:15, 488:5, 586:13</p> <p>bias [1] - 490:15</p> <p>biased [1] - 490:20</p> <p>Biffer [2] - 501:19, 567:4</p> <p>BIFFER [1] - 501:19</p> <p>big [4] - 459:25, 461:21, 462:7, 527:18</p> <p>bigger [1] - 467:5</p> <p>biggest [3] - 461:12, 462:2, 544:10</p> <p>bilaterally [1] - 556:16</p> <p>bill [2] - 507:14, 507:21</p> <p>billed [2] - 505:20, 507:21</p> <p>billing [3] - 507:4, 507:20</p> <p>bit [7] - 464:25, 478:4, 481:3, 497:20, 521:10, 569:5, 574:23</p> <p>blades [1] - 500:21</p> <p>blame [2] - 575:9, 576:25</p> <p>blanket [1] - 567:12</p> <p>bleed [1] - 482:17</p> <p>block [1] - 562:1</p> <p>blood [52] - 461:21, 462:7, 463:3, 463:4, 463:9, 463:19, 463:21, 463:22, 464:1, 464:4, 464:10, 464:11, 464:16, 464:24, 465:1, 465:2, 465:7, 465:11, 465:13, 465:15, 465:19, 465:20, 465:23, 465:24, 466:10, 466:17, 466:18, 466:19, 466:23, 467:4, 467:7, 469:15, 470:4, 470:7, 478:18, 482:19, 535:9, 544:4, 544:6, 544:17, 557:16, 562:6, 562:11, 564:10, 567:20, 571:14, 571:20, 572:11, 572:13, 581:24, 582:1</p> <p>board [14] - 451:23, 452:4, 452:24, 454:11, 454:13, 524:11, 569:25, 570:2, 570:4, 570:10, 570:15, 580:2, 580:11, 582:4</p>	<p>board-certified [10] - 451:23, 452:4, 454:13, 569:25, 570:2, 570:4, 570:10, 570:15, 580:2, 580:11</p> <p>boards [3] - 451:22, 452:4, 453:1</p> <p>body [5] - 463:4, 463:12, 466:20, 500:12, 535:1</p> <p>book [1] - 492:4</p> <p>Borders [1] - 444:9</p> <p>boroughs [1] - 519:5</p> <p>bottom [1] - 561:23</p> <p>box [1] - 587:22</p> <p>boxes [1] - 581:23</p> <p>bracketing [1] - 526:19</p> <p>branch [1] - 463:13</p> <p>branches [1] - 463:10</p> <p>break [5] - 463:11, 472:9, 519:20, 528:3, 567:5</p> <p>breaks [1] - 502:20</p> <p>breastbone [1] - 554:24</p> <p>breath [4] - 546:3, 560:1, 560:4, 571:20</p> <p>breathing [2] - 556:13, 556:15</p> <p>Brennan [1] - 577:12</p> <p>brief [3] - 489:6, 489:8, 519:23</p> <p>bring [9] - 449:20, 463:24, 473:18, 473:21, 474:4, 507:16, 507:20, 550:24, 569:18</p> <p>bringing [2] - 503:16, 508:10</p> <p>broad [1] - 446:24</p> <p>Brooklyn [2] - 491:18, 510:19</p> <p>brought [8] - 458:16, 485:10, 507:18, 533:3, 533:13, 533:16, 535:8, 565:24</p> <p>Bruce [4] - 442:17, 450:10, 450:23, 514:9</p> <p>budget [1] - 521:19</p> <p>budgeted [1] - 521:13</p> <p>building [2] - 513:6, 581:11</p> <p>business [1] - 450:20</p> <p>BY [5] - 451:4, 472:25, 490:4, 551:13, 577:8</p>	<p>C</p> <p>calculate [1] - 523:3</p> <p>calculated [1] - 583:16</p> <p>calendar [3] - 508:14, 508:19, 583:24</p> <p>calm [4] - 556:21, 556:23, 556:24, 556:25</p> <p>candidate [1] - 467:19</p> <p>cannon [1] - 449:5</p> <p>cannot [7] - 447:11, 449:9, 514:4, 553:4, 553:23, 563:1, 574:1</p> <p>car [5] - 535:14, 541:3, 541:4, 541:25, 542:19</p> <p>cardiac [19] - 452:8, 452:11, 456:12, 457:7, 458:21, 462:8, 462:12, 471:5, 471:12, 473:8, 478:15, 482:20, 528:14, 538:22, 567:20, 568:6, 572:22, 581:4, 585:8</p> <p>cardiologist [13] - 452:5, 454:3, 459:3, 459:10, 460:7, 460:13, 460:21, 470:18, 478:7, 479:8, 546:11, 579:6, 580:10</p> <p>cardiologists [4] - 579:11, 579:20, 580:2, 580:11</p> <p>Cardiology [2] - 453:16, 524:18</p> <p>cardiology [10] - 452:1, 452:4, 453:13, 453:14, 454:12, 460:9, 493:6, 503:19, 514:18, 528:13</p> <p>care [39] - 442:22, 442:23, 444:8, 452:9, 452:11, 453:6, 453:22, 454:3, 454:20, 455:3, 456:12, 457:7, 457:10, 457:23, 458:23, 459:10, 460:10, 471:1, 472:1, 473:14, 473:17, 474:6, 475:20, 479:8, 481:22, 491:9, 491:11, 499:19, 500:25, 501:11, 501:20, 503:23,</p>	<p>515:6, 547:12, 548:16, 567:16, 567:17, 581:4</p> <p>CARE [1] - 442:5</p> <p>Care [2] - 490:9, 496:24</p> <p>career [9] - 445:2, 456:10, 457:25, 460:4, 492:25, 502:25, 515:14, 521:5, 523:22</p> <p>careers [1] - 444:20</p> <p>carefully [2] - 575:16, 575:20</p> <p>Caribbean [1] - 453:6</p> <p>Caring [2] - 453:21, 453:23</p> <p>carotid [1] - 463:10</p> <p>carpenter [1] - 501:13</p> <p>carries [1] - 563:15</p> <p>case [117] - 442:13, 443:6, 443:10, 445:5, 446:23, 450:6, 450:7, 454:4, 454:10, 454:19, 465:25, 471:20, 472:5, 473:19, 478:21, 489:9, 491:2, 496:18, 496:21, 496:23, 497:7, 497:24, 503:5, 504:1, 505:18, 506:11, 506:14, 506:17, 506:22, 507:17, 508:5, 508:13, 508:24, 509:4, 511:1, 511:2, 511:15, 511:16, 511:19, 511:22, 511:23, 512:2, 512:3, 512:4, 512:7, 512:10, 512:12, 512:13, 512:14, 512:15, 512:17, 512:19, 512:21, 516:8, 517:13, 518:16, 520:5, 522:6, 522:11, 523:12, 525:14, 525:17, 525:18, 525:19, 525:20, 525:24, 526:1, 526:4, 527:4, 527:24, 528:5, 528:6, 528:18, 528:21, 528:24, 529:1, 530:9, 530:10, 530:11, 532:9, 532:14, 532:22, 533:5, 533:17, 533:20, 534:6, 534:8,</p>	<p>538:23, 540:11, 544:13, 545:10, 545:25, 547:9, 547:22, 550:5, 564:9, 565:2, 565:25, 566:21, 571:9, 571:16, 571:18, 571:23, 571:24, 572:2, 572:3, 572:6, 572:10, 572:15, 574:16, 578:17, 585:1, 585:11, 585:25, 588:2</p> <p>cases [40] - 454:16, 455:6, 455:15, 455:17, 455:18, 455:20, 460:1, 493:1, 502:24, 503:7, 503:9, 503:11, 506:18, 509:3, 509:5, 509:10, 509:12, 511:25, 515:20, 516:12, 517:8, 517:9, 517:17, 517:22, 518:14, 522:2, 522:9, 522:10, 522:12, 522:13, 522:15, 522:18, 525:9, 546:13, 572:11, 578:10, 578:14, 578:15, 582:9</p> <p>casually [1] - 530:17</p> <p>CAT [18] - 446:20, 471:10, 471:15, 471:16, 472:1, 479:21, 479:23, 480:2, 480:6, 480:16, 480:19, 480:24, 481:25, 482:5, 564:11</p> <p>catastrophe [1] - 470:1</p> <p>catastrophic [2] - 460:16, 462:13</p> <p>categories [2] - 469:21, 557:24</p> <p>category [2] - 469:22, 557:9</p> <p>causation [2] - 475:15, 487:17</p> <p>caused [5] - 475:5, 480:21, 483:14, 483:16, 483:19</p> <p>causes [2] - 461:7, 477:2</p> <p>causing [2] - 462:14, 575:22</p> <p>caveat [1] - 448:8</p> <p>cell [1] - 476:23</p> <p>cells [1] - 483:25</p> <p>CENTER [1] - 442:6</p> <p>center [1] - 479:1</p>
--	---	---	---	--

<p>Center ^[18] - 458:16, 458:20, 458:22, 490:8, 498:10, 499:2, 512:11, 537:4, 538:9, 542:21, 542:22, 545:19, 549:4, 549:6, 549:9, 553:10, 579:15, 585:4</p> <p>Center's ^[1] - 500:1</p> <p>certain ^[7] - 457:8, 480:17, 516:3, 529:10, 572:9, 572:20, 575:13</p> <p>certainly ^[9] - 444:19, 445:6, 481:24, 490:25, 525:25, 536:22, 558:8, 565:17, 582:12</p> <p>certainty ^[15] - 470:13, 471:7, 471:16, 474:19, 475:4, 480:1, 480:21, 481:8, 483:14, 484:5, 484:9, 488:12, 562:24, 563:7</p> <p>certification ^[2] - 454:12, 524:24</p> <p>certifications ^[1] - 525:4</p> <p>certified ^[10] - 451:23, 452:4, 454:13, 569:25, 570:2, 570:4, 570:10, 570:15, 580:2, 580:11</p> <p>CERTIFY ^[1] - 588:7</p> <p>chair ^[2] - 479:12, 576:13</p> <p>chance ^[2] - 534:20, 567:5</p> <p>change ^[8] - 486:6, 499:19, 502:2, 502:9, 535:7, 535:12, 538:13, 547:12</p> <p>changed ^[2] - 502:7, 563:13</p> <p>changes ^[1] - 483:22</p> <p>changing ^[1] - 538:15</p> <p>characterize ^[1] - 516:17</p> <p>characterized ^[1] - 545:21</p> <p>Charash ^[48] - 442:17, 442:19, 442:21, 442:22, 442:25, 443:4, 443:20, 443:22, 446:9, 446:19, 447:1, 447:6, 447:10, 448:22, 450:10,</p>	<p>450:23, 451:5, 451:7, 456:14, 458:2, 458:8, 472:17, 472:19, 473:1, 479:14, 479:18, 485:10, 489:20, 489:23, 490:5, 490:7, 513:20, 514:9, 520:19, 520:22, 521:2, 521:4, 531:15, 534:7, 536:17, 538:21, 540:6, 548:6, 551:2, 551:3, 551:7, 573:16, 587:12</p> <p>CHARASH ^[2] - 444:2, 450:24</p> <p>Charash's ^[2] - 448:13, 520:3</p> <p>charge ^[4] - 504:9, 504:12, 506:2, 506:4</p> <p>charging ^[1] - 505:9</p> <p>charity ^[1] - 444:5</p> <p>chart ^[21] - 473:2, 473:8, 475:24, 501:10, 531:18, 532:7, 536:23, 537:11, 537:20, 537:21, 537:22, 537:24, 538:2, 538:8, 560:7, 560:11, 575:17, 585:4, 586:3, 586:4, 586:14</p> <p>chest ^[64] - 446:10, 446:12, 446:21, 447:2, 447:7, 459:7, 459:11, 459:14, 459:17, 459:22, 460:4, 461:2, 461:7, 461:8, 461:13, 461:20, 461:22, 462:2, 463:3, 463:23, 470:24, 471:20, 478:4, 478:5, 478:8, 478:11, 479:1, 480:8, 500:7, 500:11, 534:17, 534:21, 534:25, 535:22, 540:19, 541:19, 542:1, 542:6, 542:19, 542:20, 543:12, 543:22, 544:15, 549:12, 552:18, 553:12, 553:14, 553:15, 553:16, 558:3, 559:24, 562:23, 564:9, 569:6, 569:8, 569:22, 570:17, 575:21, 575:22, 576:4, 576:18</p> <p>chief ^[4] - 442:20,</p>	<p>452:10, 553:12, 571:11</p> <p>children ^[3] - 497:20, 497:24, 498:3</p> <p>chiropractic ^[2] - 501:11, 501:22</p> <p>Chiropractic ^[2] - 501:19, 567:4</p> <p>chiropractor ^[1] - 501:15</p> <p>chiropractor's ^[1] - 501:16</p> <p>chose ^[1] - 554:3</p> <p>chronic ^[5] - 483:22, 544:6, 544:21, 562:13, 571:11</p> <p>chronically ^[3] - 544:4, 544:18, 571:21</p> <p>CICU ^[1] - 442:20</p> <p>circles ^[1] - 585:22</p> <p>circulation ^[1] - 556:13</p> <p>circumstance ^[1] - 515:8</p> <p>circumstances ^[5] - 529:10, 529:22, 534:23, 551:10, 587:25</p> <p>City ^[2] - 506:2, 519:5</p> <p>CIVIL ^[1] - 442:1</p> <p>claim ^[2] - 447:23, 496:24</p> <p>Claims ^[1] - 511:23</p> <p>classic ^[2] - 544:3, 544:17</p> <p>classically ^[1] - 571:13</p> <p>clear ^[5] - 474:25, 479:3, 484:4, 484:13, 502:6</p> <p>clearly ^[6] - 445:5, 450:21, 476:8, 481:22, 484:14, 547:5</p> <p>client ^[2] - 491:1, 528:19</p> <p>clinical ^[10] - 452:12, 452:16, 452:19, 457:9, 457:20, 459:9, 471:17, 570:19, 570:23, 571:3</p> <p>clinically ^[1] - 467:18</p> <p>clinician ^[1] - 571:4</p> <p>clinicians ^[2] - 535:2, 568:8</p> <p>clock ^[1] - 505:25</p> <p>close ^[4] - 464:3, 484:4, 484:5, 548:13</p> <p>closed ^[1] - 463:9</p> <p>closer ^[2] - 526:12,</p>	<p>546:18</p> <p>closing ^[1] - 464:3</p> <p>clot ^[2] - 459:22, 471:14</p> <p>clusters ^[2] - 455:23, 456:2</p> <p>co ^[1] - 582:2</p> <p>co-op ^[1] - 582:2</p> <p>coffee ^[1] - 450:2</p> <p>cogent ^[1] - 498:14</p> <p>collapse ^[1] - 545:24</p> <p>collapsed ^[3] - 464:8, 478:11, 478:13</p> <p>collapses ^[2] - 467:5, 482:19</p> <p>colleagues ^[1] - 525:3</p> <p>collect ^[2] - 453:4, 509:3</p> <p>College ^[1] - 524:17</p> <p>colloquy ^[1] - 469:8</p> <p>Colon ^[1] - 509:4</p> <p>colon ^[2] - 556:8, 557:10</p> <p>color ^[1] - 557:2</p> <p>Columbia ^[3] - 452:15, 523:14, 523:17</p> <p>combination ^[1] - 530:16</p> <p>combined ^[3] - 491:22, 502:13, 568:6</p> <p>combining ^[1] - 508:7</p> <p>comfort ^[3] - 567:10, 567:14, 567:19</p> <p>coming ^[11] - 455:25, 463:13, 477:17, 528:13, 534:3, 536:25, 559:8, 561:3, 562:17, 584:16, 585:16</p> <p>commence ^[1] - 493:22</p> <p>comment ^[3] - 446:19, 449:4, 544:16</p> <p>commentary ^[1] - 494:12</p> <p>comments ^[1] - 580:17</p> <p>common ^[18] - 455:4, 459:14, 459:16, 459:21, 463:25, 464:14, 464:15, 465:10, 465:22, 467:17, 470:11, 471:4, 471:5, 471:13, 474:8, 545:16, 546:5, 546:9</p> <p>commonly ^[3] -</p>	<p>480:12, 501:4, 546:4</p> <p>communication ^[1] - 453:22</p> <p>company ^[2] - 470:24, 470:25</p> <p>compared ^[1] - 527:17</p> <p>compensated ^[3] - 502:17, 504:2, 507:6</p> <p>compensation ^[3] - 504:1, 504:6, 504:18</p> <p>compiled ^[1] - 538:23</p> <p>complained ^[1] - 531:1</p> <p>complaining ^[3] - 500:3, 553:12, 554:7</p> <p>complains ^[1] - 553:16</p> <p>complaint ^[8] - 500:11, 534:25, 542:5, 542:20, 552:18, 553:12, 558:9, 571:12</p> <p>complaints ^[2] - 485:14, 568:14</p> <p>complete ^[5] - 468:5, 471:18, 520:3, 537:11, 537:22</p> <p>completed ^[6] - 450:5, 451:21, 454:11, 489:19, 494:13, 567:23</p> <p>completely ^[5] - 460:11, 493:21, 494:2, 530:20, 568:10</p> <p>computer ^[1] - 533:14</p> <p>conceivably ^[1] - 506:8</p> <p>concern ^[8] - 461:9, 461:10, 461:19, 466:5, 471:17, 480:17, 546:6, 562:18</p> <p>concerned ^[1] - 471:2</p> <p>concerning ^[5] - 458:15, 461:1, 467:11, 538:9, 578:20</p> <p>conclude ^[1] - 468:19</p> <p>concluded ^[1] - 588:4</p> <p>concludes ^[1] - 587:9</p> <p>conclusion ^[1] - 478:25</p> <p>condition ^[5] - 483:11, 498:9, 534:2, 546:10, 546:12</p>
--	--	---	--	--

<p>conditions [3] - 471:13, 499:18, 527:8</p> <p>conduct [1] - 519:23</p> <p>conducting [3] - 472:16, 520:18, 551:1</p> <p>conference [1] - 469:5</p> <p>confronting [1] - 579:4</p> <p>confused [1] - 543:7</p> <p>confusing [1] - 496:1</p> <p>confusion [1] - 493:23</p> <p>congestive [1] - 478:16</p> <p>Connecticut [6] - 518:12, 518:13, 518:14, 518:17, 525:17, 528:2</p> <p>consciousness [1] - 557:18</p> <p>consider [2] - 445:20, 544:22</p> <p>considered [3] - 445:19, 554:17, 562:6</p> <p>considering [1] - 461:6</p> <p>consistent [3] - 469:8, 479:17, 545:22</p> <p>constant [3] - 553:17, 553:20, 562:23</p> <p>constantly [2] - 499:15, 560:19</p> <p>constellation [4] - 460:25, 544:3, 544:16, 571:19</p> <p>consult [6] - 473:8, 538:10, 539:14, 540:6, 540:7, 542:4</p> <p>consultant [2] - 515:7, 528:13</p> <p>consultation [3] - 452:23, 538:22, 572:22</p> <p>consulting [1] - 479:8</p> <p>Cont'd [3] - 442:7, 472:24, 551:12</p> <p>contact [3] - 474:11, 497:21, 498:2</p> <p>contacted [2] - 517:4, 517:12</p> <p>contain [1] - 533:16</p> <p>content [2] - 469:19, 557:5</p> <p>context [1] - 529:6</p> <p>contextual [1] - 529:7</p> <p>continual [1] -</p>	<p>553:21</p> <p>continuation [2] - 520:20, 587:23</p> <p>continue [6] - 450:7, 466:25, 469:8, 538:12, 541:15, 551:2</p> <p>continued [1] - 559:13</p> <p>continuing [3] - 552:12, 552:13, 552:24</p> <p>continuous [1] - 552:22</p> <p>contributed [2] - 565:4, 576:22</p> <p>contributions [1] - 445:25</p> <p>contributory [1] - 566:25</p> <p>controversial [1] - 492:2</p> <p>conversation [2] - 442:23, 443:4</p> <p>conversations [1] - 504:14</p> <p>cooperation [1] - 587:19</p> <p>copy [5] - 533:19, 537:25, 539:9, 540:1, 540:7</p> <p>Cornell [6] - 451:14, 452:7, 453:10, 523:21, 523:22, 523:24</p> <p>Cornwall [1] - 525:22</p> <p>coronary [5] - 462:10, 568:9, 568:11, 568:22, 569:2</p> <p>CORPORATION [1] - 442:5</p> <p>Corporation [3] - 490:9, 496:24, 512:18</p> <p>correct [57] - 447:16, 448:18, 495:11, 495:15, 496:15, 498:4, 500:15, 500:16, 500:17, 500:18, 500:19, 500:20, 500:21, 500:22, 505:23, 509:23, 512:9, 516:2, 516:13, 517:15, 517:16, 517:20, 517:21, 523:13, 524:16, 527:10, 531:22, 533:18, 533:22, 543:14, 547:2, 548:25, 558:7, 559:20, 560:9, 560:17, 561:14,</p>	<p>562:10, 569:24, 577:16, 579:1, 579:6, 579:20, 581:9, 582:2, 582:14, 582:15, 582:17, 583:4, 583:6, 583:19, 584:3, 584:6, 584:10, 584:11, 585:22, 586:6</p> <p>corrected [1] - 546:20</p> <p>correctly [2] - 499:9, 586:5</p> <p>correlate [1] - 571:4</p> <p>correlation [2] - 570:23, 571:3</p> <p>correspondence [2] - 533:3, 533:19</p> <p>corroborate [3] - 533:5, 533:8, 533:10</p> <p>Cortlandt [1] - 497:13</p> <p>counsel [20] - 442:15, 449:23, 469:5, 472:13, 485:10, 486:1, 492:9, 493:21, 494:1, 503:25, 505:15, 506:22, 520:13, 533:4, 533:5, 539:8, 552:9, 566:13, 577:23, 587:15</p> <p>Counsel [1] - 550:19</p> <p>countless [2] - 548:14, 548:15</p> <p>countries [1] - 444:7</p> <p>country [2] - 527:17, 573:13</p> <p>County [13] - 443:1, 490:9, 491:17, 496:23, 512:19, 519:7, 519:9, 519:11, 519:16, 519:19, 525:21</p> <p>COUNTY [2] - 442:1, 442:5</p> <p>couple [4] - 497:21, 506:25, 510:5, 516:7</p> <p>course [22] - 444:2, 451:14, 457:12, 459:17, 460:4, 461:23, 462:19, 470:18, 490:18, 491:6, 492:13, 492:17, 492:24, 495:1, 498:3, 516:11, 520:10, 543:17, 547:21, 550:9, 569:4, 579:21</p> <p>court [17] - 449:4, 453:25, 455:12,</p>	<p>498:24, 502:3, 502:21, 503:3, 504:2, 504:16, 504:22, 507:12, 508:25, 518:13, 532:10, 578:6, 584:1</p> <p>COURT [139] - 442:1, 442:13, 443:11, 443:13, 443:15, 443:17, 443:25, 444:9, 444:18, 445:14, 447:9, 447:13, 447:15, 447:17, 447:22, 447:24, 448:1, 448:7, 448:9, 448:21, 449:3, 449:13, 449:17, 449:20, 449:21, 449:22, 450:1, 450:11, 450:12, 450:18, 451:1, 456:17, 456:19, 456:25, 458:4, 458:7, 462:20, 462:22, 468:3, 468:5, 468:9, 468:23, 469:2, 469:4, 471:24, 472:3, 472:8, 472:11, 472:12, 472:15, 473:5, 475:14, 475:17, 476:6, 476:12, 476:14, 479:17, 484:22, 484:24, 485:2, 485:12, 485:20, 485:25, 486:10, 486:17, 486:19, 487:10, 487:12, 487:14, 487:18, 487:21, 487:23, 488:17, 488:20, 489:5, 489:14, 489:15, 493:17, 494:6, 494:11, 494:16, 494:18, 495:17, 495:22, 495:25, 496:7, 510:11, 510:13, 514:1, 514:3, 514:7, 519:20, 520:12, 520:13, 534:20, 536:5, 536:7, 536:11, 536:14, 537:13, 537:15, 537:19, 538:3, 538:7, 538:12, 538:19, 540:2, 540:4, 541:10, 541:13, 545:3, 545:7, 545:9, 547:17, 548:4, 549:19, 550:4, 550:10, 550:13, 550:17, 550:18,</p>	<p>551:8, 565:13, 565:16, 566:13, 573:20, 573:22, 573:24, 574:12, 574:14, 577:5, 582:7, 584:18, 584:23, 586:20, 586:23, 587:4, 587:8, 587:25</p> <p>Court [18] - 442:10, 442:12, 442:14, 449:8, 451:12, 458:8, 458:9, 462:25, 509:8, 511:23, 525:17, 525:18, 533:10, 536:15, 537:2, 587:5, 587:20, 588:11</p> <p>court's [1] - 538:18</p> <p>courtesy [2] - 493:25, 586:23</p> <p>courtroom [1] - 490:11</p> <p>cover [1] - 533:16</p> <p>covered [1] - 539:12</p> <p>crap [1] - 530:15</p> <p>Crawshaw [1] - 525:23</p> <p>CRAWSHAW [1] - 525:23</p> <p>credence [1] - 547:24</p> <p>credentialed [1] - 501:12</p> <p>credentials [1] - 444:13</p> <p>crisis [1] - 562:17</p> <p>critical [1] - 473:10</p> <p>critically [1] - 554:11</p> <p>criticize [1] - 580:22</p> <p>cross [10] - 489:8, 489:21, 492:21, 520:19, 520:21, 551:2, 565:10, 577:23, 578:9, 578:15</p> <p>CROSS [3] - 490:3, 551:12, 577:7</p> <p>cross-examination [7] - 489:8, 489:21, 492:21, 520:19, 520:21, 551:2, 577:23</p> <p>CROSS-EXAMINATION [3] - 490:3, 551:12, 577:7</p> <p>cross-examined [2] - 578:9, 578:15</p> <p>crossed [1] - 490:10</p> <p>cuff [1] - 567:20</p> <p>Cuomo [25] - 454:3, 458:3, 458:25, 459:2, 469:14, 470:20, 470:22, 471:22,</p>
--	---	---	--	--

<p>474:13, 475:8, 475:22, 476:8, 476:15, 477:4, 479:23, 480:3, 481:4, 481:10, 490:8, 491:1, 528:19, 535:2, 539:1, 545:21, 568:8 CUOMO [1] - 442:5 Cuomo's [5] - 469:11, 475:4, 476:8, 539:13, 539:23 current [1] - 458:9 customary [1] - 539:5 cut [4] - 482:16, 492:6, 494:9, 540:21</p>	<p>508:21, 546:25 decided [1] - 505:9 decides [1] - 491:8 decision [2] - 570:19 deem [2] - 446:1, 586:25 deems [1] - 458:8 defend [1] - 455:9 defendant [1] - 585:9 Defendant [1] - 475:22 defendants [1] - 446:23 Defendants [1] - 442:6 defense [9] - 455:16, 455:17, 455:20, 511:5, 511:8, 511:25, 528:7, 578:9, 579:3 defer [5] - 570:1, 570:3, 570:10, 570:15, 570:20 deformity [1] - 559:15 degree [12] - 451:15, 470:13, 474:18, 475:4, 480:1, 480:20, 481:8, 483:14, 484:8, 488:11, 562:24, 563:6 Degross [1] - 525:15 demarkation [1] - 444:24 demise [1] - 576:22 demonstrable [1] - 469:23 demonstrate [1] - 554:23 demonstrated [1] - 475:9 demonstrates [1] - 557:20 demonstration [1] - 462:23 denied [1] - 445:21 denies [2] - 559:14, 559:25 department [6] - 500:2, 529:3, 532:7, 575:3, 575:24, 580:22 departures [2] - 488:3, 580:17 deposed [1] - 509:16 deposition [41] - 455:10, 455:19, 458:24, 485:22, 491:23, 492:8, 496:13, 496:16, 496:18, 496:20, 497:1, 497:3, 498:20, 498:24, 499:4, 499:7,</p>	<p>499:24, 502:13, 502:18, 502:22, 503:4, 508:7, 508:17, 509:14, 509:22, 509:25, 517:8, 518:15, 521:19, 532:15, 532:17, 532:20, 536:21, 539:13, 539:24, 542:5, 549:17, 549:23, 583:4, 585:10, 585:24 depositions [14] - 491:14, 493:10, 505:15, 508:14, 508:19, 509:17, 517:11, 518:1, 518:14, 521:14, 521:24, 522:11, 535:18, 578:24 derived [1] - 515:24 describe [3] - 452:21, 454:9, 487:2 described [3] - 466:1, 536:24, 554:2 describes [1] - 554:1 description [1] - 558:2 designation [1] - 513:12 desire [1] - 575:2 destruction [1] - 464:7 detailed [1] - 499:12 details [2] - 486:13, 536:22 detected [1] - 471:21 determination [2] - 479:5, 524:12 determine [4] - 460:7, 460:11, 494:12, 566:18 determined [1] - 487:5 develop [1] - 501:13 deviated [1] - 481:9 deviation [8] - 446:16, 474:20, 474:24, 474:25, 480:2, 480:6, 481:13, 481:18 Dhumale [3] - 525:16, 527:4, 528:1 DHUMALE [1] - 525:16 diagnosable [1] - 547:14 diagnose [1] - 480:25 diagnosed [6] -</p>	<p>471:14, 475:19, 501:3, 527:10, 547:25, 559:9 diagnoses [1] - 459:18 diagnosing [1] - 457:16 diagnosis [14] - 459:17, 459:21, 460:12, 461:4, 466:9, 488:13, 529:18, 535:8, 535:13, 559:5, 568:24, 569:2, 571:19, 575:9 diagram [1] - 462:19 diagrams [1] - 463:4 Diane [1] - 569:25 diaphoresis [2] - 560:1, 560:2 diastole [2] - 465:5, 465:6 Diastole [1] - 465:5 diastolic [17] - 464:17, 464:18, 465:8, 465:22, 466:4, 466:17, 466:22, 466:24, 467:2, 467:6, 562:4, 562:7, 564:8, 573:12, 573:14, 574:15, 574:18 die [3] - 460:16, 482:1, 483:24 died [6] - 475:11, 484:6, 484:10, 495:12, 495:17, 496:4 dies [1] - 476:23 difference [5] - 446:24, 467:5, 467:6, 467:8, 485:15 different [13] - 447:5, 454:19, 455:16, 474:5, 474:10, 477:1, 491:8, 507:23, 509:9, 531:23, 538:16, 538:17, 573:11 differential [4] - 461:4, 535:8, 535:12, 568:24 differently [1] - 558:22 difficult [3] - 465:9, 540:24, 565:6 digital [1] - 537:24 dilation [2] - 464:9, 470:4 DIRECT [2] - 451:3, 472:24 direct [8] - 445:9, 472:17, 489:19, 494:1, 526:14,</p>	<p>526:19, 558:24, 559:7 directions [1] - 465:14 directly [1] - 529:9 director [2] - 452:8, 452:10 directory [1] - 514:20 disagree [2] - 469:18, 469:20 disc [1] - 569:16 discern [1] - 493:9 discharge [5] - 481:5, 486:13, 559:15, 575:12, 575:14 discharged [1] - 560:12 disclosure [3] - 446:9, 446:11, 447:1 discuss [12] - 472:5, 472:8, 489:9, 489:10, 506:22, 507:5, 520:5, 520:8, 550:5, 550:8, 588:2 discussed [3] - 539:24, 567:16, 586:2 discussing [1] - 507:19 discussion [2] - 493:20, 534:14 discussions [1] - 507:3 disease [11] - 452:1, 452:2, 457:19, 461:18, 462:2, 470:10, 478:11, 501:2, 501:4, 527:13, 527:14 diseases [1] - 527:8 disregard [2] - 468:11, 488:7 dissecting [3] - 484:6, 562:25, 563:6 dissection [8] - 457:19, 457:24, 460:17, 460:21, 460:23, 460:25, 461:9, 461:11, 461:14, 461:20, 461:23, 462:6, 462:9, 462:12, 462:13, 462:17, 463:20, 463:21, 464:1, 464:14, 464:22, 464:24, 466:6, 469:16, 470:5, 470:10, 471:2, 471:9, 471:11, 471:14, 471:16, 471:19, 472:1, 475:2, 475:10,</p>
D				
<p>D.C [2] - 453:21, 518:20 dad's [1] - 442:23 damage [8] - 467:21, 468:16, 468:18, 469:23, 469:25, 470:7, 470:8, 487:6 Dan [1] - 453:16 Danbury [4] - 518:16, 525:17, 525:18, 528:1 danger [2] - 477:12, 477:20 dangerous [1] - 530:16 dare [1] - 448:25 dash [2] - 554:1, 559:25 data [1] - 525:11 date [3] - 442:15, 442:24, 557:19 day-to-day [3] - 455:2, 456:8, 457:4 days [18] - 475:11, 481:2, 482:1, 483:22, 484:1, 484:19, 486:5, 497:21, 509:6, 515:1, 515:2, 522:23, 522:24, 576:4, 576:6, 576:8, 584:8, 584:19 dead [1] - 495:20 deal [2] - 465:10, 521:9 dealt [3] - 503:7, 503:8, 539:23 death [10] - 477:14, 477:15, 481:1, 482:8, 482:20, 483:7, 483:21, 486:14, 494:22, 495:10 decade [3] - 505:12,</p>				

459:22, 471:11,
471:14, 477:9,
527:15, 527:18, 569:2
emergency [40] -
457:11, 459:4, 459:6,
459:11, 459:15,
459:16, 460:3,
460:22, 461:8,
463:24, 465:9,
470:15, 470:18,
473:1, 473:9, 473:13,
475:21, 477:16,
479:23, 483:12,
483:15, 488:13,
500:1, 528:8, 528:12,
529:3, 529:17,
529:19, 530:5, 530:6,
532:7, 536:23, 537:1,
537:4, 570:1, 571:11,
571:14, 575:3,
575:24, 576:5
emphasis [1] -
493:25
employee [1] -
523:10
enable [1] - 532:9
end [6] - 456:3,
490:20, 520:4, 539:2,
558:5, 564:2
endeavor [1] -
492:19
engaged [1] - 457:10
enlarged [1] - 559:21
enlargement [1] -
540:11
enter [3] - 449:22,
472:12, 489:15
entered [1] - 568:15
entering [5] - 449:21,
472:11, 489:14,
520:12, 550:17
enters [1] - 465:11
entertain [1] - 494:3
entire [6] - 464:10,
499:10, 499:14,
543:18, 557:8, 560:11
entirely [3] - 495:2,
576:25, 577:3
entirety [1] - 499:1
enumerated [1] -
505:14
enzyme [1] - 528:14
enzymes [4] - 461:5,
462:8, 462:12, 568:6
episode [1] - 563:23
equal [3] - 493:25,
556:16
equally [3] - 459:25,
470:2, 554:17
ER [11] - 454:21,

458:17, 458:25,
484:2, 484:6, 529:22,
530:14, 531:4,
531:18, 549:4, 549:12
escorted [1] - 549:11
especially [5] -
444:20, 465:9, 475:1,
501:12, 530:7
essence [1] - 572:12
essentially [5] -
490:19, 495:12,
495:20, 497:13, 510:7
establish [1] - 510:6
established [1] -
566:20
Estate [3] - 442:3,
525:15, 525:20
estimate [3] - 533:7,
534:10, 534:13
ethics [1] - 453:22
evaluate [4] -
446:14, 471:3,
490:23, 490:24
evaluated [4] -
459:6, 460:10,
460:11, 530:19
evaluating [1] -
491:1
evaluation [3] -
479:7, 479:9, 481:16
evening [3] - 442:22,
497:16, 588:1
evening's [1] - 443:4
events [1] - 536:24
eventually [3] -
482:10, 505:4, 564:5
evidence [10] -
461:18, 478:13,
478:15, 495:16,
501:19, 538:8,
538:11, 549:13,
565:9, 567:7
exact [7] - 526:16,
546:19, 566:1, 566:5,
579:12, 581:3, 583:23
exactly [6] - 531:3,
533:8, 539:10, 540:1,
578:25, 582:22
examination [14] -
472:17, 489:8,
489:19, 489:21,
492:21, 520:19,
520:21, 526:14,
528:6, 538:19, 551:2,
558:24, 577:23,
581:17
EXAMINATION [5] -
451:3, 472:24, 490:3,
551:12, 577:7
examinations [1] -

445:9
examine [1] - 560:15
examined [5] -
450:16, 477:4, 539:4,
578:9, 578:15
example [3] -
473:19, 494:19,
519:22
excellent [2] - 528:9,
528:11
exception [2] -
446:5, 488:22
excess [3] - 515:15,
515:21, 517:17
exclude [2] - 460:12,
568:11
excludes [1] -
471:12
exclusively [1] -
514:10
excruciating [2] -
572:16, 572:18
excuse [2] - 472:4,
551:8
excused [3] -
443:23, 550:11, 587:7
Exhibit [1] - 538:8
exhibited [1] -
534:24
exist [3] - 578:20,
578:23, 580:2
existed [2] - 497:1,
585:21
existence [1] -
501:21
exists [2] - 477:12,
533:9
exits [1] - 550:12
expand [1] - 464:24
expands [1] - 464:10
expect [1] - 446:18
experience [7] -
444:16, 454:9,
457:15, 457:20,
459:9, 530:24, 558:25
experienced [3] -
534:17, 535:22,
560:12
experiencing [3] -
481:1, 499:10, 541:18
expert [11] - 444:14,
445:16, 446:8,
515:15, 578:5,
578:21, 580:9, 582:9,
582:13, 582:20,
583:11
experts [7] - 444:22,
445:6, 445:9, 445:11,
448:24, 587:11,
587:13

explain [5] - 464:17,
464:18, 464:20,
474:3, 492:5
explanation [2] -
567:12, 577:2
express [2] - 575:2,
575:5
expressed [1] -
542:9
expression [1] -
557:25
extant [1] - 458:9
extend [2] - 470:5,
586:25
extension [1] -
582:18
extent [2] - 446:3,
494:3
extremely [2] -
467:11, 572:18

F

fabric [1] - 477:13
faced [1] - 491:7
facilitate [1] - 532:9
facility [1] - 514:17
fact [19] - 447:10,
448:2, 467:21,
468:18, 470:10,
470:22, 477:4,
477:19, 477:21,
483:3, 484:15, 491:4,
499:3, 528:9, 541:21,
553:19, 555:24,
569:5, 575:19
factor [2] - 488:3,
544:21
factored [2] - 507:3,
566:6
factors [3] - 470:19,
527:13, 544:10
facts [8] - 490:24,
493:9, 493:11,
495:16, 502:7,
502:11, 528:5, 549:24
faculty [3] - 452:7,
452:15, 524:2
fail [1] - 493:13
falling [1] - 475:10
failure [11] - 446:15,
446:19, 474:19,
475:4, 478:16, 480:1,
480:19, 480:24,
481:8, 481:17
fair [16] - 443:10,
491:4, 492:16,
492:23, 503:7,
515:13, 515:16,
515:20, 515:22,

515:24, 516:3,
518:18, 522:20,
534:14, 553:25, 583:8
fairly [1] - 443:5
false [3] - 513:22,
524:19, 574:6
familiar [4] - 490:14,
525:25, 535:16,
535:18
familiarity [1] -
569:22
family [4] - 453:25,
455:8, 455:18, 556:9
far [9] - 479:15,
488:2, 497:6, 499:8,
507:7, 507:21, 521:5,
551:15, 576:11
fatal [4] - 471:12,
477:15, 477:17,
484:19
father [2] - 442:21,
498:3
fault [1] - 577:3
favor [1] - 445:7
features [1] - 464:5
February [3] - 442:8,
452:14, 582:15
federal [2] - 509:13,
582:16
fee [4] - 504:4, 504:5,
582:8
feet [1] - 463:11
fellow [6] - 453:14,
524:10, 538:24,
539:4, 547:4, 572:21
Fellow [1] - 453:16
fellowship [3] -
452:3, 453:13, 521:6
felt [2] - 562:22,
572:22
femoral [1] - 463:12
few [4] - 456:3,
499:18, 512:1, 537:19
field [4] - 451:16,
454:20, 454:23, 455:4
fields [1] - 444:22
file [1] - 533:12
filed [1] - 583:13
filing [1] - 582:18
filled [1] - 465:13
filling [3] - 465:7,
465:12, 465:14
film [4] - 569:13,
569:14, 570:4, 570:11
films [1] - 478:6
final [2] - 484:14,
489:20
finally [3] - 461:20,
480:13, 484:18
findings [5] - 464:14,

476:2, 476:17,
556:16, 559:13
fine [2] - 446:23,
563:4
fingerprint [1] -
460:24
finish [5] - 493:18,
493:21, 494:2,
510:13, 514:1
finished [4] - 467:25,
503:19, 521:6, 563:17
firm [5] - 507:24,
508:2, 517:18,
517:22, 577:11
first [52] - 450:16,
451:19, 454:6,
454:10, 456:10,
457:21, 457:22,
459:18, 460:5, 461:2,
464:6, 464:20, 466:3,
473:14, 474:11,
478:24, 480:12,
480:15, 482:24,
501:21, 510:25,
523:4, 531:1, 532:14,
532:22, 533:6, 534:5,
534:6, 534:16,
534:21, 534:24,
535:22, 536:20,
539:4, 543:21, 548:9,
548:16, 548:21,
549:18, 551:18,
553:9, 554:7, 554:12,
554:16, 560:7,
562:22, 568:16,
572:23, 574:25,
582:12, 585:4, 586:2
Fishon [1] - 512:10
FISHON [1] - 512:10
fit [1] - 492:23
five [25] - 455:19,
475:25, 476:1, 476:9,
477:5, 477:22, 503:6,
506:8, 515:5, 519:5,
522:4, 523:4, 537:8,
538:5, 550:4, 553:2,
554:1, 560:19, 561:5,
561:9, 562:19,
562:22, 563:23,
575:11
five-minute [1] -
550:4
flag [6] - 461:13,
461:17, 462:2, 572:7,
575:1
flags [1] - 470:23
flat [2] - 504:4,
569:14
fledged [1] - 476:21
floods [1] - 465:17

floor [6] - 513:9,
513:10, 513:11,
542:19, 572:23,
581:21
Florida [5] - 507:24,
508:2, 511:25,
517:20, 517:25
flow [4] - 464:1,
465:15, 470:4, 480:12
flowing [1] - 470:7
fluid [5] - 478:13,
478:16, 482:15,
557:5, 557:7
focus [1] - 456:22
follow [2] - 553:7,
571:2
follow-up [1] - 571:2
followed [1] - 581:5
following [5] -
509:25, 527:5,
528:15, 544:14,
555:14
follows [1] - 450:16
foot [1] - 549:4
forgot [1] - 474:4
form [5] - 456:20,
476:14, 478:11,
492:15, 499:5
formal [1] - 496:20
format [2] - 563:3,
569:12
formed [1] - 493:12
forms [1] - 583:15
forth [1] - 444:14
forty [2] - 577:21,
579:14
forward [1] - 467:4
forwards [1] - 465:12
four [2] - 557:22,
567:11
fourth [1] - 455:24
Francis [1] - 512:15
frankly [1] - 565:11
Fred [2] - 525:21,
544:18
free [6] - 477:5,
477:19, 559:17,
569:1, 569:3, 569:4
frequency [2] -
459:25, 558:25
frequently [2] -
570:24, 583:2
Friday [3] - 450:5,
457:6, 569:25
friendly [1] - 492:9
friends [1] - 519:15
front [1] - 531:16
full [8] - 446:12,
450:19, 452:6,
476:21, 523:23,

524:2, 538:8, 576:4
full-fledged [1] -
476:21
full-time [3] - 452:6,
523:23, 524:2
fully [2] - 446:18,
501:12
Fulton [2] - 512:18,
512:20
functionally [1] -
470:6
funded [1] - 453:15
Furman [1] - 577:12
future [2] - 510:24,
512:12

G

gap [1] - 478:1
GARY [1] - 442:3
Gary [12] - 453:25,
458:15, 462:18,
466:9, 474:14,
474:17, 475:5,
475:22, 475:24,
476:15, 476:16,
557:11
gastritis [2] - 529:18,
530:15
gastroesophageal
[2] - 501:3, 561:11
gather [2] - 483:25,
587:23
gears [2] - 538:14,
538:15
gee [1] - 539:8
general [4] - 454:24,
534:2, 557:17, 562:5
generally [4] -
463:24, 502:16,
563:23, 564:23
generous [1] -
522:24
gentleman [2] -
448:24, 568:9
gentlemen [9] -
449:23, 450:4,
472:13, 489:5,
489:16, 520:14,
550:5, 550:19, 587:8
George [1] - 525:24
Georgia [1] - 518:22
GERD [1] - 501:4
GI [1] - 501:2
giant [3] - 477:14,
477:15, 579:18
given [37] - 444:25,
453:15, 454:19,
455:9, 467:16,
470:10, 470:11,

470:12, 470:16,
475:1, 480:8, 487:6,
488:14, 492:8, 497:6,
499:8, 505:14,
508:14, 508:18,
517:25, 521:4,
524:23, 525:3, 532:8,
548:16, 548:21,
551:15, 564:20,
565:8, 565:17,
566:15, 566:21,
566:23, 567:1,
567:12, 575:12
goal [2] - 557:23,
560:23
Goodwin [1] -
512:14
gracious [1] - 587:17
grade [1] - 574:20
graduated [2] -
451:14, 453:10
graft [1] - 487:4
grandfathered [1] -
525:2
great [4] - 465:10,
540:8, 547:19, 587:14
Greater [1] - 453:17
greatly [2] - 586:23,
587:19
ground [3] - 513:9,
535:25, 541:18
grounds [1] - 476:6
guess [3] - 531:17,
533:14, 536:12
guidelines [1] -
524:18
gurgle [1] - 496:10
guys [1] - 587:14
gynecology [1] -
454:21

H

Haiti [1] - 453:6
half [12] - 491:17,
506:23, 507:4, 509:6,
517:12, 522:18,
522:22, 527:11,
532:22, 532:25,
554:13, 587:21
hallmarks [1] - 466:6
handful [1] - 454:18
handle [1] - 561:9
happenstance [1] -
498:11
harassed [1] - 583:8
harassment [1] -
583:9
hard [1] - 578:6
harder [1] - 574:18

havoc [1] - 463:19
head [1] - 512:16
HEALTH [1] - 442:5
health [8] - 453:6,
454:20, 455:3,
473:14, 473:17,
474:6, 499:19, 548:16
Health [2] - 490:9,
496:24
hear [12] - 447:6,
465:9, 465:16,
465:17, 465:21,
465:22, 466:3, 468:3,
536:5, 537:17,
550:13, 574:18
heard [8] - 444:20,
463:10, 490:17,
492:11, 496:9,
496:10, 499:8, 577:25
hearing [3] - 465:15,
496:23, 501:21
heart [60] - 449:4,
452:1, 452:2, 459:18,
459:20, 461:3, 461:5,
461:8, 461:12,
461:21, 462:2, 462:8,
462:10, 463:1, 463:7,
463:10, 464:4, 465:1,
465:3, 465:4, 465:6,
465:11, 465:12,
465:19, 465:20,
465:23, 466:16,
466:20, 466:22,
466:23, 466:25,
467:1, 470:24,
471:13, 476:20,
476:21, 476:23,
478:16, 478:18,
480:9, 482:11,
482:12, 482:13,
482:14, 482:15,
482:16, 482:19,
482:21, 503:8, 527:9,
527:13, 527:14,
527:17, 530:20,
557:16, 568:10
heart's [1] - 464:8
hedge [1] - 534:9
hedging [1] - 534:10
heightened [1] -
466:5
held [8] - 452:24,
469:3, 469:5, 469:8,
485:24, 486:1,
487:20, 566:14
Helene [1] - 525:14
help [4] - 564:17,
564:25, 565:1, 565:19
helped [1] - 549:11
helpful [2] - 444:12,

537:20
helps [1] - 564:23
hemodynamic [1] - 462:14
hernia [2] - 561:18, 561:20
high [13] - 461:19, 463:14, 475:1, 484:3, 515:23, 516:4, 544:4, 544:6, 544:17, 562:6, 562:7, 562:11, 571:20
highballing [1] - 547:10
higher [1] - 571:15
highlight [2] - 557:14, 561:25
highlighted [1] - 551:14
highly [5] - 467:19, 530:6, 546:11, 546:12, 565:12
highway [1] - 463:3
Hill [13] - 442:20, 452:11, 452:18, 457:8, 514:17, 514:19, 514:25, 515:3, 523:8, 579:8, 579:11, 580:21, 582:1
himself [4] - 535:20, 540:24, 549:6, 556:4
historian [3] - 557:8, 557:9, 557:10
historical [1] - 456:16
history [18] - 474:8, 475:11, 475:18, 486:11, 495:6, 495:8, 498:14, 499:13, 499:17, 499:22, 500:23, 502:1, 543:22, 548:20, 561:10, 561:15, 567:8
hit [2] - 563:16, 565:1
hold [9] - 443:22, 449:9, 490:25, 493:17, 510:11, 514:1, 537:16, 541:10
home [16] - 455:1, 460:9, 460:15, 475:9, 506:6, 515:2, 529:2, 533:14, 541:25, 555:19, 556:8, 575:3, 575:7, 576:13, 581:9, 588:1
Honor [31] - 443:9, 444:15, 444:21, 445:7, 446:7, 447:18, 447:20, 448:19, 449:15, 450:9, 451:2,

456:13, 458:1, 458:6, 466:11, 472:23, 479:13, 485:1, 485:16, 487:9, 487:17, 488:18, 490:1, 496:6, 534:18, 536:3, 537:10, 537:24, 548:1, 582:6, 587:2
HONORABLE [1] - 442:9
honorary [1] - 453:11
honored [1] - 453:8
honors [1] - 453:8
hope [4] - 450:1, 520:15, 550:22, 575:4
horse [1] - 448:20
hospital [27] - 452:22, 456:11, 457:10, 460:5, 474:19, 475:5, 475:24, 476:2, 477:21, 481:6, 481:9, 484:13, 484:16, 494:22, 503:5, 515:6, 523:10, 530:18, 531:17, 535:12, 548:10, 556:3, 570:16, 576:19, 576:20, 576:25, 577:3
Hospital [17] - 442:20, 451:16, 451:25, 452:11, 452:18, 453:18, 457:9, 458:20, 497:12, 514:17, 514:20, 523:8, 525:22, 532:6, 579:8, 579:11, 580:21
hospitalizations [1] - 458:21
hospitals [3] - 453:5, 453:18, 455:9
hour [17] - 504:6, 504:8, 504:19, 504:22, 504:23, 505:3, 505:4, 505:17, 507:14, 515:9, 519:21, 520:9, 522:9, 522:13, 565:20, 568:15
hourly [2] - 504:4, 504:5
hours [25] - 476:22, 481:25, 504:10, 505:17, 505:19, 506:7, 506:23, 507:4, 521:14, 521:15, 521:19, 521:25,

522:4, 522:9, 522:13, 522:15, 522:16, 522:23, 528:15, 552:23, 553:2, 563:18, 563:24, 564:7, 576:11
Hudson [5] - 458:19, 458:21, 497:12, 585:7, 585:8
Hulihan [1] - 525:23
HULIHAN [1] - 525:23
hum [1] - 540:23
hundred [4] - 459:19, 459:23, 521:11, 527:16
hundreds [1] - 579:19
hurt [1] - 563:15
husband [5] - 486:12, 498:12, 498:25, 534:2, 542:8
husband's [1] - 498:9
hypertension [4] - 544:11, 544:22, 562:13, 562:14
hypertensive [5] - 562:16, 562:17, 571:11, 571:21, 572:7
hypotensive [1] - 562:16
hypothetical [1] - 493:16
hypothetically [1] - 564:21

I

ideal [1] - 478:24
identified [2] - 463:23, 530:5
Illinois [1] - 518:18
illness [4] - 460:16, 461:14, 478:15, 548:20
illnesses [2] - 451:17, 460:18
illustrate [1] - 462:17
immediate [2] - 556:9, 564:19
immediately [2] - 467:20, 549:3
imminent [1] - 462:14
impartially [1] - 443:6
implicitly [1] - 448:5
important [8] - 470:21, 473:7,

474:10, 474:12, 535:2, 554:11, 554:15, 555:3
impression [2] - 542:13, 542:15
inappropriate [4] - 529:17, 529:22, 530:6, 565:12
inception [2] - 531:10, 531:20
include [1] - 517:7
included [2] - 500:10, 571:6
includes [3] - 459:18, 567:17, 571:12
including [3] - 454:21, 461:19, 543:8
income [4] - 515:17, 515:25, 516:5, 516:14
incomplete [3] - 468:8, 475:12, 475:18
incorrectly [1] - 510:22
increase [1] - 575:21
increased [1] - 465:24
increasing [1] - 576:18
independent [2] - 508:11, 508:22
Index#61337/2014 [1] - 442:4
indicate [1] - 567:8
indicated [1] - 460:17
indicates [3] - 478:2, 560:12, 563:23
indicating [1] - 479:6
indication [3] - 543:12, 552:23, 560:8
indicator [1] - 557:24
individually [1] - 442:3
inducted [1] - 453:11
industry [1] - 505:7
infection [1] - 482:14
infections [1] - 530:17
inflammation [1] - 483:25
inflammatories [1] - 564:17
inflammatory [4] - 483:22, 483:24, 564:24, 564:25
information [27] - 473:17, 473:23, 473:24, 484:4, 484:17, 485:8,

485:22, 494:21, 531:11, 531:19, 532:8, 532:11, 535:2, 535:13, 537:3, 548:8, 548:9, 548:16, 548:21, 556:10, 568:19, 572:22, 585:18, 585:19, 586:4, 586:7, 586:13
informed [2] - 567:11, 585:25
initial [14] - 467:14, 522:12, 530:24, 542:20, 543:13, 548:9, 552:18, 552:21, 553:8, 554:9, 554:10, 558:8, 563:19, 564:8
injuries [1] - 503:7
injury [3] - 475:5, 480:21, 482:13
inner [3] - 463:17, 463:18, 463:21
input [1] - 567:18
inquire [4] - 451:1, 472:22, 489:25, 520:25
inside [2] - 482:13, 482:15
insight [2] - 548:17, 569:1
instances [1] - 445:5
instantaneously [1] - 483:24
instead [1] - 464:3
Institute [1] - 453:21
institution [1] - 579:25
institutions [1] - 453:7
instruction [2] - 492:9, 577:22
instructions [5] - 462:24, 529:3, 575:12, 575:14, 576:19
insulted [1] - 529:14
insure [1] - 520:3
intact [2] - 465:1, 478:10
intensive [3] - 452:8, 452:11, 456:12
interest [1] - 586:21
interesting [1] - 464:5
internal [3] - 451:16, 451:22, 524:21
international [1] - 453:2
internist [3] - 451:24,

<p>454:13, 546:11 internship [1] - 451:20 interrupt [1] - 479:13 interrupted [1] - 565:14 interrupting [1] - 565:10 interruption [1] - 499:19 interval [2] - 495:8, 504:11 intervals [1] - 569:3 intervention [1] - 530:6 intimates [1] - 536:18 intravenous [1] - 530:15 introduce [1] - 530:17 invested [1] - 521:7 invoice [1] - 507:22 involved [3] - 454:6, 521:7, 540:10 involves [1] - 457:20 irregularities [1] - 461:22 irregularity [1] - 478:19 irrelevant [1] - 584:15 IS [2] - 588:7 Island [2] - 511:16, 511:21 isolated [1] - 474:9 issue [5] - 443:14, 443:15, 446:10, 458:22, 502:1 issues [4] - 443:17, 454:7, 458:9, 558:16 items [2] - 505:13, 585:2 itself [2] - 464:21, 534:25</p>	<p>joined [2] - 445:8, 452:15 joining [1] - 445:20 joint [1] - 501:13 Jollie [12] - 525:20, 525:21, 544:13, 544:18, 571:9, 571:15, 571:18, 571:24, 572:2, 572:6, 572:10, 572:15 journal [2] - 524:11 judge [9] - 450:13, 496:3, 532:10, 538:4, 549:20, 550:1, 565:10, 574:11, 583:7 Judge [39] - 443:14, 443:16, 443:19, 444:10, 444:19, 446:6, 446:17, 447:14, 449:11, 458:5, 467:23, 468:2, 475:16, 476:9, 484:20, 485:5, 486:9, 487:9, 488:9, 488:16, 494:7, 495:19, 495:24, 510:12, 514:2, 521:1, 538:4, 538:16, 541:16, 545:5, 547:16, 549:20, 577:6, 584:20, 584:21, 584:22, 584:25, 586:19 judge's [1] - 547:2 judgments [2] - 490:23, 490:25 jugular [1] - 559:24 July [3] - 452:14, 452:16, 456:1 June [1] - 456:1 jurist [1] - 445:15 juror [1] - 450:21 jurors [6] - 449:22, 472:12, 489:15, 490:2, 520:13, 550:18 Jurors [6] - 449:24, 472:15, 489:17, 520:14, 521:2, 550:20 JURORS [1] - 449:25 jury [22] - 442:10, 445:1, 445:18, 449:21, 450:3, 451:12, 468:10, 469:6, 472:4, 472:11, 486:2, 488:7, 489:14, 509:8, 519:24, 520:1, 520:12, 533:10, 537:3, 550:12, 550:17, 579:10 Justice [1] - 442:10</p>	<p>K</p> <p>Kansas [1] - 518:24 Kathleen [6] - 459:1, 485:3, 485:17, 486:4, 532:15, 532:21 KATHLEEN [2] - 442:2, 442:3 keep [3] - 564:5, 564:6, 574:14 key [1] - 475:18 killed [1] - 484:14 kind [10] - 453:1, 454:7, 493:16, 503:21, 505:7, 509:19, 509:22, 547:4, 568:19, 568:23 kinds [1] - 573:11 Kings [1] - 491:17 knee [1] - 501:13 kneeling [1] - 536:2 Knote [2] - 508:13, 508:16 KNOTE [1] - 508:13 knowing [1] - 533:24 knowledge [5] - 456:1, 493:5, 497:10, 497:15, 498:2 known [3] - 452:3, 528:14, 569:3 knows [4] - 526:16, 536:10, 546:19, 576:7 Kornfeld [1] - 577:12</p>	<p>law [3] - 517:18, 517:22, 577:11 lawsuit [2] - 503:16, 508:10 lawyer [4] - 454:10, 586:6, 586:8, 586:16 lawyers [10] - 454:16, 455:7, 455:8, 455:16, 455:18, 509:10, 517:5, 517:9, 578:9, 584:4 layer [2] - 463:17, 463:18 layers [2] - 463:15 lead [4] - 485:10, 499:18, 547:24, 559:18 leading [1] - 473:4 leads [2] - 483:7, 535:9 learn [1] - 498:23 least [20] - 479:11, 484:1, 493:9, 516:23, 516:24, 517:5, 517:22, 518:10, 522:13, 522:21, 539:24, 542:5, 542:17, 542:24, 545:19, 546:24, 551:24, 552:19, 561:3, 571:1 leave [4] - 506:3, 509:21, 523:17, 575:2 leaving [2] - 465:20, 465:23 left [19] - 463:2, 463:5, 463:13, 464:1, 477:11, 477:21, 477:25, 484:13, 484:15, 484:16, 494:22, 495:10, 497:11, 498:10, 499:1, 500:1, 555:7, 555:8, 576:4 leg [1] - 501:13 legal [8] - 454:7, 454:9, 515:15, 515:22, 516:1, 516:12, 521:7, 583:18 legal-medical [1] - 515:22 legitimate [1] - 523:4 legitimately [1] - 474:6 legs [1] - 560:16 Lenox [13] - 442:20, 452:11, 452:18, 457:8, 514:17, 514:19, 514:25, 515:3, 523:8, 579:8,</p>	<p>579:11, 580:21, 582:1 less [7] - 455:17, 455:18, 493:2, 504:23, 522:8, 527:11, 565:20 lessened [1] - 568:23 letter [1] - 533:17 letting [2] - 464:25, 586:21 level [12] - 461:19, 477:25, 510:25, 516:19, 527:11, 528:14, 557:18, 557:21, 559:9, 562:19, 564:22, 567:21 levels [3] - 463:17, 528:8, 528:18 LEWIS [1] - 442:9 licensed [6] - 451:7, 451:10, 517:1, 517:14, 517:20, 580:11 lids [1] - 450:3 life [17] - 457:19, 459:18, 459:21, 459:25, 460:12, 460:18, 461:7, 471:18, 480:17, 482:1, 483:6, 483:10, 523:1, 523:6, 527:16, 527:20, 583:8 life-threatening [10] - 457:19, 459:18, 459:21, 459:25, 460:12, 460:18, 461:7, 483:10, 527:16, 527:20 lifelong [1] - 524:23 lifetime [1] - 525:3 light [7] - 533:24, 534:1, 537:4, 540:18, 540:20, 540:21, 551:15 likely [3] - 448:23, 467:19, 471:9 likewise [1] - 452:3 limine [1] - 446:25 limit [1] - 553:24 limited [17] - 479:7, 493:15, 498:5, 500:6, 514:5, 514:12, 531:14, 534:25, 542:5, 552:5, 553:6, 563:3, 570:6, 570:14, 571:1, 574:2, 586:18 LINDA [1] - 442:5 Linda [2] - 458:25, 490:8</p>
<p>J</p> <p>January [4] - 455:21, 458:17, 512:4, 525:16 jaw [2] - 543:23, 555:8 Jeffrey [1] - 491:18 jeopardize [1] - 463:25 Jersey [1] - 518:10 job [4] - 449:7, 460:7, 460:14, 581:3 join [2] - 486:16, 488:16</p>		<p>L</p> <p>lack [1] - 461:7 ladies [9] - 449:23, 450:4, 472:13, 489:5, 489:15, 520:13, 550:5, 550:18, 587:8 landfills [1] - 453:5 language [2] - 447:6, 571:25 large [5] - 467:15, 467:18, 470:12, 471:1, 480:13 last [26] - 457:22, 460:6, 468:1, 468:3, 468:10, 469:11, 476:1, 476:9, 476:22, 477:22, 484:21, 511:8, 512:1, 523:1, 525:5, 532:18, 532:20, 546:25, 550:21, 563:22, 563:24, 564:2, 564:7, 565:3, 582:20, 583:14 laudatory [1] - 445:3 laundry [1] - 444:21</p>		

<p>line [7] - 444:23, 445:9, 446:23, 446:24, 516:10, 530:15, 538:12</p> <p>lines [3] - 444:10, 472:18, 567:11</p> <p>link [2] - 509:18, 509:19</p> <p>linked [2] - 573:14, 574:3</p> <p>linking [1] - 476:7</p> <p>list [2] - 444:22, 459:24</p> <p>listed [1] - 514:19</p> <p>listen [2] - 516:10, 527:6</p> <p>litany [1] - 444:21</p> <p>literature [2] - 525:13, 573:13</p> <p>litigant [3] - 503:4, 503:15, 508:9</p> <p>litigants [1] - 496:25</p> <p>live [2] - 513:4, 582:2</p> <p>lived [1] - 513:24</p> <p>living [1] - 501:14</p> <p>LJL [1] - 442:1</p> <p>LOC [1] - 556:19</p> <p>locally [1] - 510:17</p> <p>located [2] - 542:12, 554:22</p> <p>location [3] - 531:24, 558:3, 560:14</p> <p>logical [1] - 521:10</p> <p>look [20] - 471:11, 472:1, 478:9, 478:12, 478:13, 478:15, 478:17, 484:4, 501:9, 505:7, 531:3, 538:17, 543:8, 548:18, 551:7, 551:14, 553:7, 566:5, 566:10, 567:5</p> <p>looked [4] - 496:11, 568:2, 573:4, 585:3</p> <p>looking [12] - 460:22, 463:5, 478:7, 478:25, 490:20, 531:16, 532:6, 538:22, 540:8, 564:9, 569:22, 571:7</p> <p>loose [1] - 449:5</p> <p>Lopresti [1] - 511:20</p> <p>loud [4] - 465:23, 466:2, 471:1, 480:10</p> <p>louder [1] - 574:20</p> <p>loudly [1] - 450:20</p> <p>loved [1] - 548:8</p> <p>low [2] - 560:24, 562:7</p> <p>lowballing [2] - 547:7, 547:9</p>	<p>lower [7] - 459:24, 467:2, 467:4, 467:9, 480:15, 572:11, 572:12</p> <p>lowest [2] - 466:21, 466:24</p> <p>LUBELL [1] - 442:9</p> <p>Lubin [1] - 517:18</p> <p>lubricated [1] - 482:12</p> <p>lubricating [1] - 482:14</p> <p>Luke's [2] - 525:22, 544:13</p> <p>lunch [7] - 519:21, 520:6, 520:9, 520:15, 520:17, 528:2, 567:5</p> <p>Lunch [1] - 520:11</p> <p>lung [2] - 471:14, 478:10</p> <p>lungs [3] - 459:23, 478:10, 478:14</p> <p>lying [1] - 535:24</p>	<p>504:14, 504:16, 506:13, 507:16, 584:5, 585:1</p> <p>math [1] - 505:22</p> <p>matter [3] - 444:25, 458:2, 547:11</p> <p>matters [3] - 443:2, 510:20, 517:7</p> <p>MD [4] - 442:5, 451:15, 514:9</p> <p>me-too [1] - 447:9</p> <p>mean [21] - 460:4, 487:13, 488:18, 498:22, 499:9, 499:14, 502:2, 508:21, 511:22, 517:9, 527:15, 546:4, 546:17, 552:13, 552:17, 555:17, 557:4, 566:5, 575:8, 583:22</p> <p>meaning [4] - 462:8, 464:9, 480:11, 543:6</p> <p>means [16] - 448:6, 452:21, 452:22, 461:5, 466:17, 467:22, 477:7, 483:23, 483:25, 484:15, 490:19, 556:20, 557:5, 561:7, 563:21, 564:1</p> <p>meant [2] - 477:24, 495:4</p> <p>measures [1] - 567:11</p> <p>measuring [1] - 567:21</p> <p>mechanical [1] - 535:21</p> <p>mediastinal [1] - 478:21</p> <p>mediastinum [3] - 461:21, 478:23, 479:7</p> <p>MEDICAL [1] - 442:6</p> <p>Medical [22] - 451:14, 452:7, 452:13, 453:10, 458:16, 458:22, 490:8, 498:10, 499:2, 500:1, 512:11, 537:3, 538:9, 542:21, 542:22, 545:18, 549:4, 549:6, 549:8, 553:10, 579:15, 585:4</p> <p>medical [51] - 444:7, 446:1, 446:16, 451:13, 451:18, 452:6, 452:15, 453:4, 453:11, 454:7, 454:9, 463:4, 470:13, 471:7,</p>	<p>474:19, 475:4, 480:1, 480:20, 481:8, 481:18, 483:14, 484:5, 484:9, 486:11, 488:12, 495:4, 495:6, 495:8, 497:10, 499:17, 499:22, 503:5, 511:6, 515:15, 515:22, 516:1, 516:12, 521:7, 524:2, 524:9, 525:5, 562:24, 563:7, 573:12, 573:13, 576:21, 578:13, 582:8, 583:18, 587:11</p> <p>medical-legal [6] - 454:7, 454:9, 515:15, 516:1, 516:12, 583:18</p> <p>medically [1] - 483:5</p> <p>medication [4] - 501:6, 501:8, 564:14, 565:4</p> <p>medications [1] - 444:7</p> <p>medicine [22] - 444:23, 445:1, 451:7, 451:17, 451:23, 452:8, 452:12, 452:16, 452:19, 454:24, 455:4, 456:6, 465:11, 492:5, 493:6, 504:7, 513:1, 513:22, 514:11, 517:1, 524:21, 529:17</p> <p>meds [1] - 561:10</p> <p>meet [2] - 473:14, 506:22</p> <p>meeting [3] - 506:19, 506:21, 584:4</p> <p>meetings [3] - 504:14, 505:15, 584:7</p> <p>member [2] - 524:2, 556:9</p> <p>members [3] - 455:8, 455:18, 579:10</p> <p>memorizing [2] - 535:11, 535:12</p> <p>memory [7] - 498:18, 508:11, 508:23, 535:6, 539:18, 576:9, 576:12</p> <p>mention [6] - 509:8, 543:3, 543:18, 558:5, 558:6, 571:13</p> <p>mentioned [4] - 462:4, 478:5, 514:9, 517:4</p> <p>mercury [1] - 480:14</p> <p>mere [1] - 501:21</p> <p>meritorious [2] -</p>	<p>510:19, 511:3</p> <p>met [4] - 442:24, 443:3, 507:4, 577:13</p> <p>Mexico [1] - 519:3</p> <p>Meyer [1] - 517:18</p> <p>microscope [1] - 463:16</p> <p>mid [5] - 472:3, 553:12, 553:14, 553:15, 554:22</p> <p>mid-chest [3] - 553:12, 553:14, 553:15</p> <p>mid-morning [1] - 472:3</p> <p>mid-sternal [1] - 554:22</p> <p>middle [2] - 456:4, 541:13</p> <p>midline [1] - 559:22</p> <p>might [34] - 445:3, 448:24, 449:9, 465:21, 490:20, 492:2, 493:13, 499:15, 501:13, 502:5, 502:9, 503:13, 507:17, 509:18, 509:24, 523:6, 524:10, 531:11, 532:11, 533:5, 533:14, 542:8, 554:19, 554:20, 556:24, 563:17, 564:21, 564:23, 565:1, 571:2, 575:23</p> <p>mild [1] - 564:23</p> <p>millimeters [1] - 480:14</p> <p>million [3] - 515:15, 516:13, 527:17</p> <p>mind [2] - 466:14, 552:18</p> <p>mine [1] - 488:9</p> <p>minimum [1] - 472:2</p> <p>minute [3] - 444:1, 445:10, 550:4</p> <p>minutes [5] - 494:25, 537:8, 537:19, 538:5, 550:24</p> <p>misread [5] - 446:21, 447:2, 447:5, 447:6, 447:21</p> <p>miss [2] - 504:11, 554:20</p> <p>missed [2] - 475:18, 506:7</p> <p>mistaken [1] - 446:11</p> <p>moderate [2] - 553:14, 553:16</p>
M				
<p>machine [1] - 581:19</p> <p>main [1] - 463:2</p> <p>maintain [2] - 513:21, 514:10</p> <p>maintaining [1] - 449:7</p> <p>major [6] - 461:17, 470:23, 471:21, 478:18, 479:1, 481:1</p> <p>majority [6] - 454:18, 457:6, 460:5, 462:15, 510:16, 527:12</p> <p>malpractice [7] - 503:5, 503:7, 503:10, 511:6, 578:10, 578:14, 582:9</p> <p>man [2] - 547:13, 558:19</p> <p>management [3] - 453:22, 488:14, 559:10</p> <p>Manhattan [3] - 513:7, 523:9, 581:11</p> <p>Manor [1] - 497:13</p> <p>mark [1] - 555:13</p> <p>markers [1] - 475:19</p> <p>markings [1] - 559:18</p> <p>Mary [1] - 525:15</p> <p>Massachusetts [1] - 517:15</p> <p>massively [1] - 482:17</p> <p>materials [7] - 489:2,</p>				

<p>moment ^[13] - 450:13, 498:10, 505:16, 526:24, 553:21, 557:22, 563:10, 563:15, 563:21, 564:1, 566:11, 584:22, 587:16</p> <p>Monday ^[2] - 457:6, 508:5</p> <p>monetarily ^[1] - 504:2</p> <p>money ^[4] - 515:10, 582:13, 582:20, 583:10</p> <p>monitor ^[2] - 557:17, 567:20</p> <p>monitored ^[2] - 560:20, 567:19</p> <p>Montefiore ^[3] - 579:15, 579:22, 579:23</p> <p>month ^[2] - 515:5, 582:15</p> <p>months ^[11] - 452:14, 533:1, 533:6, 533:7, 534:5, 534:9, 534:12, 539:22, 540:10, 565:3</p> <p>more-than-likely ^[1] - 448:23</p> <p>Morgan ^[2] - 517:23</p> <p>morning ^[20] - 449:24, 449:25, 451:5, 451:6, 472:3, 489:21, 490:1, 490:5, 490:6, 497:17, 499:3, 500:2, 506:1, 511:4, 512:22, 525:8, 559:7, 561:12, 567:3, 588:3</p> <p>most ^[23] - 448:25, 453:20, 459:14, 459:16, 459:21, 462:6, 464:14, 464:15, 465:10, 466:1, 467:9, 470:11, 471:5, 471:12, 471:13, 473:13, 477:16, 521:14, 521:24, 544:15, 556:24, 574:22, 584:7</p> <p>Motrin ^[10] - 564:17, 564:20, 565:8, 565:17, 565:19, 565:25, 566:6, 566:15, 566:24, 568:16</p> <p>mouth ^[3] - 448:14, 485:11, 559:15</p> <p>move ^[9] - 467:23,</p>	<p>468:1, 468:7, 487:8, 492:23, 547:15, 547:20, 550:1, 574:12</p> <p>moved ^[1] - 523:14</p> <p>MR ^[91] - 443:12, 443:14, 443:16, 443:19, 443:22, 443:24, 444:4, 444:10, 444:19, 446:6, 446:7, 447:10, 447:14, 447:16, 447:19, 448:4, 448:8, 448:18, 448:22, 449:11, 449:14, 456:13, 458:5, 458:6, 466:11, 466:15, 467:23, 468:1, 468:7, 468:22, 468:25, 473:4, 475:13, 475:15, 476:4, 476:7, 479:13, 484:20, 484:23, 485:1, 485:5, 485:16, 485:21, 486:8, 486:15, 486:16, 487:8, 487:11, 487:13, 487:15, 488:9, 488:15, 488:16, 488:18, 490:1, 490:4, 495:19, 495:24, 496:2, 510:12, 514:2, 514:6, 521:1, 537:24, 538:4, 538:10, 538:15, 538:20, 540:3, 540:5, 541:16, 545:8, 547:15, 548:19, 549:20, 550:1, 551:11, 551:13, 561:25, 565:10, 565:14, 573:21, 573:23, 574:11, 574:13, 577:4, 577:6, 577:8, 584:20, 584:24, 586:19</p> <p>MS ^[42] - 443:9, 444:15, 447:18, 447:20, 447:23, 447:25, 448:2, 449:15, 449:18, 450:9, 451:2, 451:4, 456:24, 457:2, 458:1, 468:12, 469:10, 472:23, 472:25, 485:14, 486:18, 486:20, 487:17, 488:10, 488:23, 489:4, 495:14, 495:16, 496:6, 534:18, 536:3, 537:10, 545:1, 545:6,</p>	<p>548:1, 565:7, 582:6, 584:17, 586:11, 586:21, 587:2, 587:24</p> <p>Mt ^[1] - 451:16</p> <p>multiple ^[4] - 458:21, 475:9, 483:2, 564:7</p> <p>mundane ^[1] - 574:22</p> <p>murmur ^[31] - 461:19, 464:15, 464:16, 464:17, 464:18, 465:8, 465:14, 465:18, 465:22, 465:25, 466:2, 466:3, 466:4, 467:16, 470:11, 471:1, 471:23, 471:25, 480:10, 480:13, 484:3, 573:10, 573:12, 573:14, 574:15, 574:18, 574:22</p> <p>murmurs ^[5] - 573:11, 574:3, 574:9, 574:17, 574:24</p> <p>muscle ^[2] - 476:23, 551:21</p> <p>musculoskeletal ^[1] - 575:23</p> <p>must ^[3] - 448:19, 461:24, 579:19</p> <p>MY ^[1] - 588:8</p> <p>myriads ^[1] - 444:22</p>	<p>559:18</p> <p>need ^[16] - 444:7, 462:16, 466:12, 466:13, 473:22, 478:20, 487:7, 499:12, 519:23, 528:4, 530:4, 537:21, 543:9, 549:11, 584:22, 584:23</p> <p>needed ^[4] - 483:4, 530:6, 570:23, 575:6</p> <p>needs ^[3] - 460:8, 487:5, 575:1</p> <p>negative ^[3] - 447:11, 580:17, 580:20</p> <p>negligence ^[1] - 528:16</p> <p>negligent ^[1] - 447:7</p> <p>network ^[1] - 579:18</p> <p>neurologic ^[3] - 558:15, 558:16</p> <p>never ^[12] - 442:24, 463:17, 480:10, 490:10, 496:4, 518:13, 521:16, 522:13, 566:6, 577:13, 585:12</p> <p>New ^[32] - 450:24, 451:8, 451:16, 451:25, 452:12, 453:17, 453:18, 453:19, 491:18, 509:6, 509:18, 509:20, 509:21, 511:9, 511:16, 511:22, 511:23, 511:25, 512:2, 512:19, 517:2, 518:10, 519:3, 519:5, 523:20, 523:22, 523:23, 577:17, 577:19, 580:1, 580:2</p> <p>NEW ^[1] - 442:1</p> <p>new ^[14] - 461:19, 466:4, 467:16, 470:11, 471:1, 471:23, 471:25, 480:9, 484:3, 557:20, 574:24, 575:21, 585:18, 585:19</p> <p>Nexium ^[1] - 561:11</p> <p>next ^[11] - 450:8, 455:25, 472:18, 496:10, 530:2, 552:22, 554:21, 558:23, 576:4, 576:8, 576:11</p> <p>nice ^[2] - 444:11, 532:10</p>	<p>Nichols ^[5] - 491:18, 491:19, 510:6, 510:10, 512:8</p> <p>Nicole ^[5] - 442:11, 484:24, 487:21, 550:13, 588:10</p> <p>night ^[1] - 584:7</p> <p>nine ^[2] - 459:19, 503:14</p> <p>ninety ^[1] - 503:6</p> <p>ninety-five ^[1] - 503:6</p> <p>NOCERA ^[3] - 442:2, 442:3</p> <p>Nocera ^[81] - 458:15, 459:1, 459:3, 462:18, 466:1, 466:9, 469:14, 469:24, 474:15, 474:17, 475:5, 475:8, 475:9, 475:22, 475:24, 476:15, 476:16, 477:24, 483:15, 485:4, 485:17, 486:4, 494:21, 495:5, 496:4, 496:10, 497:12, 497:15, 497:20, 497:24, 498:6, 498:9, 498:20, 499:9, 499:17, 499:23, 500:1, 500:23, 501:12, 501:15, 501:20, 502:1, 505:17, 530:24, 531:12, 531:24, 532:15, 532:21, 533:25, 534:16, 534:23, 535:14, 535:20, 535:24, 538:9, 539:4, 539:21, 540:18, 541:22, 542:4, 543:21, 545:17, 548:21, 553:9, 554:3, 555:8, 556:4, 556:10, 557:11, 564:13, 564:20, 565:25, 567:8, 572:21, 575:2, 575:20, 576:3, 576:21, 585:9, 587:23</p> <p>Nocera's ^[9] - 453:25, 467:14, 471:20, 485:22, 496:13, 496:17, 536:21, 549:17, 549:23</p> <p>non ^[1] - 553:2</p> <p>non-pain ^[1] - 553:2</p> <p>none ^[3] - 443:12, 443:14, 549:24</p>
N				
<p>name ^[10] - 450:19, 450:23, 490:7, 511:15, 511:18, 512:21, 515:7, 525:25, 577:11, 583:4</p> <p>Nancy ^[1] - 525:20</p> <p>narcotic ^[1] - 565:22</p> <p>narcotics ^[1] - 564:19</p> <p>Nassau ^[1] - 519:13</p> <p>national ^[4] - 451:22, 453:11, 453:20, 526:17</p> <p>nature ^[3] - 493:23, 534:24, 535:21</p> <p>nausea ^[1] - 559:25</p> <p>necessarily ^[2] - 499:9, 564:15</p> <p>necessary ^[5] - 462:16, 529:15, 571:2, 587:1, 587:3</p> <p>neck ^[7] - 500:14, 543:23, 555:8, 558:3, 559:16, 559:17,</p>				

<p>nongovernment ^[1] - 453:3</p> <p>noninvasive ^[1] - 471:5</p> <p>nonlabored ^[1] - 556:15</p> <p>nonlocalized ^[1] - 544:15</p> <p>nonpatient ^[1] - 516:12</p> <p>nonresponsive ^[1] - 547:15</p> <p>nonspecific ^[1] - 544:15</p> <p>nonsurgical ^[1] - 452:2</p> <p>normal ^[16] - 461:5, 462:5, 462:7, 462:15, 465:14, 469:15, 506:20, 556:16, 557:3, 559:16, 559:22, 562:17, 567:25, 568:6</p> <p>normally ^[4] - 464:3, 467:5, 558:18</p> <p>Northwell ^[1] - 579:17</p> <p>northwell ^[1] - 579:18</p> <p>nose ^[1] - 559:15</p> <p>not.. ^[1] - 448:3</p> <p>notation ^[1] - 476:1</p> <p>notations ^[2] - 475:25, 476:1</p> <p>note ^[40] - 475:1, 477:22, 495:14, 496:6, 532:3, 534:18, 536:3, 538:10, 538:22, 538:25, 539:2, 539:3, 539:7, 539:8, 539:15, 539:16, 539:24, 540:1, 540:6, 540:7, 540:8, 540:17, 541:17, 542:4, 543:13, 545:1, 548:1, 548:18, 551:15, 553:9, 554:21, 555:15, 557:9, 560:6, 560:11, 568:12, 568:17, 575:19, 586:11</p> <p>noted ^[5] - 442:10, 446:5, 486:10, 559:21, 567:15</p> <p>NOTES ^[1] - 588:8</p> <p>notes ^[18] - 471:23, 473:2, 473:7, 473:10, 473:21, 473:22, 473:24, 474:11,</p>	<p>474:15, 474:16, 474:24, 507:16, 507:18, 548:17, 554:20, 568:13</p> <p>nothing ^[5] - 455:25, 503:22, 517:13, 533:8, 586:19</p> <p>notice ^[3] - 446:20, 487:25, 496:24</p> <p>noticed ^[2] - 512:18, 526:13</p> <p>notion ^[1] - 556:2</p> <p>number ^[32] - 455:16, 457:8, 462:9, 466:24, 466:25, 467:2, 467:5, 467:9, 471:12, 491:16, 502:14, 503:7, 503:8, 503:12, 526:12, 526:16, 544:4, 546:18, 546:19, 546:22, 546:23, 547:7, 547:10, 547:11, 547:14, 547:23, 578:12, 579:12, 579:23, 579:25, 580:8</p> <p>numbers ^[4] - 480:15, 504:25, 505:2, 521:9</p> <p>numerical ^[1] - 557:21</p> <p>numerous ^[1] - 578:1</p> <p>nurse ^[16] - 470:21, 473:15, 473:19, 556:14, 557:25, 559:14, 559:18, 562:23, 580:20, 580:23, 581:2, 585:10, 585:24, 586:7</p> <p>Nurse ^[1] - 474:1</p> <p>nurse's ^[1] - 568:12</p> <p>nurses ^[5] - 473:14, 560:20, 580:18, 580:25, 581:4</p> <p>nursing ^[6] - 474:16, 475:1, 557:13, 557:14, 567:10, 580:22</p> <p>NYU ^[2] - 452:13, 452:19</p>	<p>oath ^[8] - 455:9, 472:20, 489:25, 498:23, 520:24, 530:13, 537:2, 551:5</p> <p>object ^[9] - 446:22, 467:23, 479:14, 485:5, 485:9, 486:8, 487:8, 565:7, 582:6</p> <p>objection ^[35] - 456:14, 458:5, 458:6, 458:7, 468:22, 468:24, 468:25, 469:7, 473:4, 475:13, 476:4, 479:18, 479:20, 486:2, 486:8, 486:10, 486:15, 487:23, 488:6, 488:15, 494:8, 495:14, 495:25, 496:6, 502:5, 534:18, 536:3, 537:10, 537:15, 545:1, 548:1, 551:8, 565:15, 584:17, 586:11</p> <p>objections ^[1] - 456:23</p> <p>observations ^[2] - 498:2, 542:11</p> <p>observe ^[1] - 567:18</p> <p>observing ^[1] - 462:23</p> <p>obtained ^[2] - 446:20, 528:18</p> <p>obtaining ^[3] - 528:7, 528:13, 528:21</p> <p>obvious ^[1] - 547:25</p> <p>obviously ^[6] - 445:8, 501:24, 507:22, 554:16, 562:12, 580:5</p> <p>occasion ^[3] - 497:23, 578:11, 578:12</p> <p>occasions ^[6] - 443:3, 443:21, 444:4, 500:10, 507:25, 577:17</p> <p>occur ^[4] - 461:12, 461:16, 464:6, 488:1</p> <p>occurred ^[3] - 484:17, 486:13, 532:4</p> <p>occurrence ^[1] - 573:15</p> <p>occurring ^[1] - 541:6</p> <p>occurs ^[4] - 459:23, 465:3, 465:6, 482:25</p> <p>October ^[2] - 525:21, 582:18</p> <p>odd ^[1] - 455:22</p> <p>OF ^[4] - 442:1, 442:1,</p>	<p>588:8</p> <p>off-the-record ^[1] - 469:5</p> <p>offend ^[1] - 519:15</p> <p>offer ^[3] - 447:11, 458:1, 458:2</p> <p>offered ^[3] - 568:14, 580:9, 580:17</p> <p>offering ^[3] - 516:11, 580:20, 585:17</p> <p>offhand ^[2] - 502:2, 575:8</p> <p>office ^[14] - 456:11, 457:5, 501:17, 512:24, 513:1, 513:21, 514:10, 514:16, 515:2, 515:11, 581:8, 581:15, 581:23, 582:4</p> <p>officer ^[1] - 449:3</p> <p>OFFICER ^[6] - 449:21, 450:12, 472:11, 489:14, 520:12, 550:17</p> <p>often ^[11] - 465:9, 466:3, 473:17, 478:24, 514:22, 515:3, 535:8, 545:12, 545:24, 556:25, 574:25</p> <p>oftentimes ^[1] - 548:7</p> <p>old ^[1] - 484:1</p> <p>Omega ^[1] - 453:12</p> <p>once ^[6] - 479:10, 507:1, 519:19, 527:14, 527:19, 583:3</p> <p>one ^[83] - 442:22, 443:4, 445:5, 446:7, 448:17, 454:19, 460:17, 464:7, 464:14, 464:15, 466:2, 466:6, 466:13, 469:22, 470:23, 471:4, 471:11, 473:17, 473:18, 473:24, 477:13, 477:15, 478:9, 478:10, 479:22, 482:22, 482:23, 483:1, 483:5, 483:6, 483:7, 491:8, 497:4, 497:20, 498:21, 501:9, 501:17, 507:1, 508:1, 508:2, 508:6, 508:19, 508:25, 515:21, 518:15, 518:16, 526:16, 528:2, 528:13, 532:4, 532:5, 534:20,</p>	<p>536:11, 536:18, 536:20, 538:24, 541:10, 542:9, 543:18, 544:10, 544:17, 544:22, 545:13, 546:19, 548:8, 559:17, 561:18, 561:20, 561:21, 562:9, 562:12, 562:14, 565:20, 574:17, 574:22, 576:6, 578:15, 584:23, 584:24, 587:16</p> <p>ones ^[1] - 522:9</p> <p>ongoing ^[1] - 552:23</p> <p>onset ^[9] - 534:2, 540:18, 541:5, 542:1, 551:16, 552:12, 557:21, 575:21</p> <p>onus ^[1] - 449:6</p> <p>oops ^[2] - 449:10</p> <p>op ^[1] - 582:2</p> <p>open ^[3] - 463:9, 476:24, 556:14</p> <p>opens ^[1] - 464:2</p> <p>operate ^[3] - 482:16, 487:3, 582:4</p> <p>operating ^[1] - 464:11</p> <p>opinion ^[36] - 445:4, 454:2, 470:16, 474:18, 474:23, 475:3, 475:7, 479:25, 480:20, 481:7, 481:12, 481:17, 481:21, 483:13, 483:18, 483:20, 484:8, 484:12, 486:6, 488:11, 501:17, 516:12, 526:9, 530:25, 551:16, 551:23, 552:19, 553:20, 562:23, 564:10, 565:2, 570:11, 570:20, 576:20, 580:9, 580:20</p> <p>opinions ^[12] - 444:14, 447:11, 449:2, 454:20, 458:2, 458:9, 492:2, 502:3, 502:9, 532:10, 547:24, 585:17</p> <p>opportunity ^[4] - 459:1, 522:22, 546:21, 552:9</p> <p>opposed ^[1] - 445:1</p> <p>option ^[2] - 479:10, 524:25</p> <p>Orange ^[2] - 443:1,</p>
<p style="text-align: center;">O</p>				
<p>o'clock ^[6] - 504:9, 504:11, 505:16, 505:25, 519:23, 566:23</p> <p>O2 ^[1] - 557:16</p>				

<p>525:21 orange [1] - 519:11 order [7] - 446:15, 478:20, 480:1, 480:6, 480:19, 481:8, 585:2 ordered [3] - 479:23, 481:4, 566:21 orders [1] - 502:21 organization [3] - 453:3, 453:17, 453:20 oriented [1] - 557:2 original [8] - 449:2, 479:18, 494:8, 523:22, 537:12, 537:21, 537:25, 538:2 out-of-state [1] - 509:5 outpatient [4] - 514:17, 514:25, 515:2, 567:18 outset [2] - 485:23, 533:25 outside [5] - 454:20, 469:5, 486:1, 490:11, 581:23 outstanding [1] - 453:13 overlap [2] - 447:12, 522:12 overnight [1] - 575:6 overrule [1] - 537:16 overruled [10] - 469:7, 473:5, 475:17, 486:2, 486:10, 496:7, 536:7, 547:17, 548:4, 551:10 overseeing [1] - 442:21 own [8] - 453:3, 454:20, 460:24, 477:3, 485:6, 523:17, 565:21, 576:22 ox [1] - 567:20 oxygen [1] - 463:12 oxygenation [1] - 567:21</p>	<p>547:3, 547:4, 548:20, 553:8, 558:5, 558:6, 558:23, 559:12, 561:24, 567:10, 572:15 pages [5] - 575:14, 575:15, 575:16, 575:19 paid [3] - 488:25, 489:2, 523:10 pain [21] - 459:7, 459:11, 459:14, 459:17, 459:18, 459:22, 460:4, 461:2, 461:7, 461:8, 461:11, 461:13, 461:14, 461:17, 462:1, 462:2, 463:23, 470:20, 470:21, 470:24, 471:20, 471:23, 473:19, 473:20, 473:24, 473:25, 474:2, 474:14, 474:25, 475:1, 475:23, 475:25, 476:1, 476:16, 476:20, 476:22, 476:23, 476:24, 476:25, 477:2, 477:5, 477:6, 477:7, 477:10, 477:12, 477:19, 477:20, 477:22, 478:1, 478:8, 478:11, 480:9, 483:14, 484:2, 484:15, 485:4, 485:14, 486:5, 498:13, 498:15, 499:1, 499:11, 499:15, 499:16, 499:18, 499:21, 500:3, 500:6, 500:7, 500:10, 500:11, 500:23, 501:1, 501:13, 502:1, 529:4, 531:1, 531:10, 531:21, 531:24, 533:25, 534:2, 534:17, 534:22, 534:24, 535:15, 535:22, 536:20, 540:19, 541:5, 541:19, 542:1, 542:6, 542:12, 542:20, 543:4, 543:11, 543:12, 543:19, 543:22, 544:15, 545:14, 545:18, 545:20, 545:22, 545:23, 549:12, 551:17, 551:22, 551:23, 552:12,</p>	<p>552:13, 552:18, 552:22, 553:1, 553:2, 553:13, 553:14, 553:15, 553:16, 554:1, 554:2, 554:8, 554:22, 554:25, 555:7, 556:24, 557:1, 557:20, 557:21, 557:22, 557:24, 558:2, 558:3, 558:11, 558:20, 558:21, 559:24, 560:18, 561:3, 561:6, 561:9, 562:19, 562:22, 562:23, 563:5, 563:11, 563:15, 563:17, 563:19, 563:20, 563:22, 563:24, 563:25, 564:2, 564:3, 564:4, 564:6, 564:9, 564:14, 564:15, 564:18, 564:22, 564:23, 565:4, 565:18, 565:19, 566:4, 566:6, 566:8, 566:25, 567:8, 568:20, 568:22, 569:1, 569:3, 569:4, 571:13, 571:20, 572:6, 572:16, 572:17, 572:22, 575:9, 575:10, 575:21, 575:23, 576:4, 576:6, 576:18 pain-free [1] - 569:3 palpitations [1] - 560:2 paper [1] - 533:9 paragraph [1] - 446:12 pardon [2] - 458:19, 475:8 part [12] - 446:10, 446:17, 450:6, 454:11, 463:12, 482:24, 482:25, 500:12, 505:11, 535:1, 581:8 PART [1] - 442:1 particular [7] - 446:9, 460:20, 468:10, 524:10, 537:5, 544:23, 580:10 parties [1] - 587:15 partner [3] - 491:18, 510:5, 512:8 passed [1] - 452:4 passing [1] - 451:23 past [11] - 505:6, 508:16, 522:2,</p>	<p>527:19, 540:10, 548:6, 550:22, 554:13, 561:15, 561:16, 562:8 patent [1] - 556:15 pathological [1] - 467:10 paths [1] - 490:10 patience [1] - 587:10 patient [69] - 453:22, 454:25, 457:10, 459:11, 460:8, 460:10, 460:22, 463:6, 471:4, 471:22, 473:1, 473:3, 473:8, 473:11, 473:16, 473:20, 473:25, 474:1, 474:3, 474:20, 475:19, 477:4, 477:11, 477:19, 477:20, 477:21, 479:10, 480:10, 480:21, 481:16, 481:17, 485:4, 503:23, 528:8, 529:2, 540:21, 544:4, 544:16, 544:17, 545:15, 548:8, 548:9, 553:12, 553:16, 554:1, 554:11, 554:12, 555:14, 555:18, 556:7, 556:8, 556:21, 557:2, 557:10, 558:9, 559:10, 560:21, 561:2, 561:3, 561:4, 567:11, 567:12, 567:13, 567:14, 567:17, 568:13, 571:10, 571:21 patient's [8] - 471:17, 473:8, 473:20, 488:12, 556:25, 557:3, 558:15, 568:14 patients [33] - 452:23, 457:6, 457:7, 457:8, 457:13, 457:16, 457:23, 457:24, 459:6, 460:3, 467:3, 471:15, 473:13, 486:21, 486:24, 514:18, 515:1, 515:3, 515:5, 515:10, 527:9, 527:12, 556:22, 559:1, 559:2, 559:4, 559:5, 572:18, 580:14, 584:2, 584:5 pattern [5] - 449:1,</p>	<p>495:6, 499:22, 555:24, 576:7 pay [1] - 448:12 paying [1] - 587:17 payment [2] - 507:9, 507:11 peak [1] - 508:21 peek [2] - 466:19, 466:23 peer [4] - 524:4, 524:6, 524:12, 580:25 pelvis [1] - 560:15 pending [1] - 565:13 Pennsylvania [1] - 518:6 people [30] - 457:11, 459:15, 459:16, 460:7, 462:6, 462:9, 462:11, 462:15, 465:18, 466:1, 467:9, 467:17, 470:3, 474:8, 477:16, 482:25, 490:23, 496:25, 499:16, 501:11, 503:9, 530:7, 530:17, 531:11, 532:10, 558:22, 564:2, 574:22, 581:24, 583:8 per [7] - 504:6, 504:22, 505:20, 507:14, 515:9, 516:24 percent [27] - 448:18, 455:6, 455:8, 455:15, 455:19, 456:10, 456:11, 457:5, 457:9, 462:11, 484:5, 503:3, 503:6, 503:10, 503:14, 508:8, 510:15, 510:20, 511:2, 515:25, 516:4, 521:8, 522:13, 523:4, 523:6, 578:18 percentage [1] - 516:4 perfectly [1] - 536:14 performance [1] - 564:11 performed [1] - 481:5 perhaps [3] - 497:20, 504:13, 539:22 pericardium [2] - 482:12, 482:16 period [8] - 454:15, 499:10, 523:9, 542:12, 551:22, 551:24, 553:2, 564:21 periods [1] - 456:23 permanent [3] -</p>
<p>P</p>				
<p>p.m [7] - 557:19, 563:5, 565:5, 566:4, 566:9, 566:21, 568:15 page [32] - 446:11, 516:7, 516:8, 526:2, 529:11, 530:2, 530:12, 540:8, 542:21, 543:4, 543:6, 543:8, 543:11, 543:13, 543:19, 544:13, 544:24,</p>				

<p>469:23, 469:25, 470:8 permission [1] - 538:18 permit [1] - 487:25 permitted [1] - 479:19 Person [1] - 453:23 person [11] - 461:13, 463:5, 463:24, 464:13, 471:19, 473:16, 490:20, 503:16, 533:24, 534:1, 562:15 person's [1] - 480:17 pertaining [1] - 443:20 pertinent [1] - 444:13 peruse [1] - 537:20 ph [1] - 525:15 pharmacological [1] - 565:21 phone [1] - 507:3 phrase [11] - 493:14, 531:13, 552:4, 553:4, 553:23, 563:1, 570:5, 570:13, 574:1, 579:2, 586:17 phrased [3] - 476:11, 513:23, 514:4 physical [7] - 461:16, 482:13, 534:24, 535:7, 535:9, 559:13, 564:18 physically [1] - 518:3 physician [4] - 448:10, 491:1, 529:17, 575:24 physicians [2] - 580:16, 585:9 physiological [1] - 464:9 piece [6] - 531:10, 531:19, 532:8, 533:9, 535:2, 548:21 piecemeal [1] - 478:3 pieces [2] - 477:15, 477:18 pinch [1] - 557:5 place [7] - 483:1, 487:25, 506:24, 529:22, 557:2, 557:17, 565:20 Plaintiff [1] - 450:15 plaintiff [9] - 442:4, 442:18, 450:10, 503:4, 503:6, 503:11, 508:10, 510:21, 512:7 Plaintiff's [1] - 538:8</p>	<p>plaintiff's [3] - 450:6, 450:7, 586:6 plaintiff-related [1] - 503:11 plan [3] - 567:16, 567:17 pleasant [1] - 520:15 plenty [1] - 482:1 pleural [1] - 478:14 plurality [1] - 459:15 pneumothorax [1] - 478:12 point [27] - 446:18, 449:1, 461:14, 462:14, 467:24, 487:10, 487:12, 487:14, 487:15, 491:12, 492:25, 494:12, 495:4, 501:1, 502:24, 523:14, 523:20, 532:4, 537:5, 542:24, 554:19, 561:18, 561:20, 561:21, 563:25, 566:2, 571:19 points [1] - 507:23 poor [1] - 562:13 poorly [1] - 544:21 portable [1] - 569:8 portal [1] - 530:17 portion [1] - 571:12 posed [1] - 445:23 position [7] - 453:15, 535:20, 536:2, 536:20, 540:25, 567:14, 567:19 positioned [1] - 540:24 positions [1] - 452:24 positive [3] - 462:12, 557:25, 558:2 possession [1] - 498:2 possibility [1] - 491:9 possible [3] - 457:1, 493:2 possibly [2] - 564:4, 567:1 Post [1] - 507:18 Post-Its [1] - 507:18 potentially [2] - 460:15, 462:3 practice [16] - 446:16, 451:7, 452:17, 456:9, 457:4, 457:22, 474:21, 504:7, 513:1, 513:21, 514:11, 517:1, 528:9,</p>	<p>528:22, 529:5, 539:5 practices [3] - 480:2, 481:9, 481:19 practicing [3] - 454:12, 456:5, 493:6 pre [1] - 497:1 pre-deposition [1] - 497:1 precautions [1] - 567:17 preceding [1] - 473:10 preclusion [1] - 586:25 predisposes [1] - 562:14 prep [1] - 507:6 preparation [3] - 458:11, 464:9, 533:23 prepare [1] - 584:5 prerogative [1] - 492:20 Presbyterian [2] - 523:15, 523:17 presence [2] - 469:6, 486:1 present [6] - 476:10, 478:15, 478:17, 542:15, 548:20, 558:8 presentation [2] - 450:7, 531:10 presented [3] - 458:20, 485:3, 528:8 presently [2] - 456:5, 457:3 presiding [2] - 444:21, 445:15 pressure [40] - 463:14, 464:19, 464:24, 466:7, 466:8, 466:10, 466:17, 466:18, 466:19, 466:20, 466:21, 467:7, 467:8, 467:9, 467:14, 467:15, 467:18, 469:16, 470:5, 470:13, 470:25, 471:25, 480:14, 484:3, 535:9, 544:4, 544:6, 544:18, 557:16, 558:2, 562:5, 562:6, 562:11, 564:10, 567:20, 571:14, 571:20, 572:11, 572:13 Prestiano [1] - 458:23 presumably [3] - 496:9, 496:21, 556:11 pretty [7] - 490:10,</p>	<p>491:24, 502:14, 547:5, 560:24, 568:15, 585:6 prevent [1] - 579:3 previous [3] - 442:18, 458:21, 585:8 previously [2] - 442:10, 442:14 primarily [3] - 480:8, 492:7, 493:6 primary [6] - 457:7, 458:23, 500:25, 515:6, 553:15, 563:12 printout [1] - 568:2 private [1] - 452:17 privileges [2] - 452:18, 452:20 probe [1] - 557:17 problem [4] - 464:12, 561:18, 571:12, 573:7 problems [1] - 501:1 procedure [1] - 446:16 procedures [1] - 567:10 proceed [1] - 458:10 proceeding [1] - 519:23 Proceedings [1] - 588:4 process [5] - 494:1, 520:18, 521:7, 551:19, 552:14 produced [1] - 445:6 profession [3] - 445:18, 445:25, 446:1 professional [6] - 445:2, 453:1, 499:20, 523:1, 523:6, 524:9 professionalism [1] - 449:13 professor [4] - 452:7, 452:12, 452:16, 452:19 prognosis [1] - 488:12 progress [1] - 568:12 progressed [1] - 484:9 project [1] - 538:1 projection [1] - 538:1 prominent [2] - 574:21, 574:24 promise [1] - 489:8 promotes [1] - 453:21 prompt [1] - 520:16 prompted [1] -</p>	<p>555:10 promptly [1] - 587:22 pronounced [1] - 497:13 proof [1] - 471:18 proper [2] - 488:14, 528:22 proponent [1] - 445:16 proposition [1] - 498:25 prospective [1] - 456:16 protects [1] - 482:13 prove [2] - 467:12, 527:14 proven [1] - 481:23 provide [4] - 451:12, 457:7, 473:17, 569:1 provided [4] - 532:14, 567:13, 569:10 provider [4] - 455:3, 473:14, 473:17, 474:6 providers [3] - 454:20, 474:10, 548:16 provides [1] - 548:17 province [1] - 497:19 public [1] - 492:5 publish [1] - 524:13 published [1] - 524:3 pulmonary [7] - 459:22, 471:11, 471:13, 477:9, 527:15, 527:18, 569:2 pulse [18] - 464:18, 466:7, 466:8, 467:7, 467:8, 467:9, 467:14, 467:15, 467:18, 470:12, 470:25, 471:25, 480:13, 484:3, 556:15, 562:3, 562:4, 567:20 pulseless [2] - 495:13, 498:12 pump [2] - 463:2 pumping [6] - 464:11, 464:24, 465:4, 465:5, 465:13, 466:18 pumps [4] - 463:2, 463:7, 465:19, 465:23 purposes [1] - 492:15 put [8] - 444:14, 448:20, 485:10, 487:4, 530:15, 548:19, 581:24,</p>
--	---	---	---	--

587:12 putting [1] - 446:20	rains [1] - 465:17 raised [2] - 505:10, 505:12 raises [2] - 461:8, 466:4 ran [1] - 456:12 range [1] - 526:17 rapid [1] - 564:18 rapidly [3] - 565:18, 565:20, 565:22 rapids [2] - 465:17, 465:18 rarely [1] - 556:23 rate [11] - 504:1, 504:6, 504:13, 504:18, 504:20, 505:10, 505:12, 557:16, 562:3 rather [5] - 464:16, 539:16, 586:9, 586:15 rational [1] - 530:18 ray [25] - 446:10, 446:12, 446:15, 446:21, 447:2, 447:7, 461:20, 461:22, 461:24, 462:3, 478:4, 478:5, 478:8, 478:20, 478:22, 479:4, 479:6, 479:11, 479:19, 569:6, 569:8, 569:10, 569:12, 570:2, 570:17 ray's [1] - 478:25 rays [1] - 569:23 reach [1] - 567:18 reached [2] - 516:4, 516:18 read [69] - 446:10, 447:7, 447:8, 448:25, 456:17, 456:18, 461:24, 468:4, 468:13, 473:10, 473:21, 473:22, 474:24, 476:12, 476:13, 478:22, 479:2, 484:21, 484:25, 485:7, 487:21, 487:22, 494:11, 494:15, 496:22, 497:3, 497:7, 497:23, 499:24, 524:12, 527:2, 527:3, 529:11, 534:3, 534:5, 535:18, 536:6, 536:21, 537:18, 538:22, 539:3, 539:7, 539:9, 539:14, 539:24, 539:25, 540:12, 540:15, 548:7, 549:17, 549:23, 550:15,	554:19, 554:21, 559:17, 561:8, 561:16, 562:8, 567:25, 570:17, 572:2, 575:16, 575:17, 575:19, 575:25, 585:16, 586:1, 586:15 reading [10] - 443:19, 474:15, 496:17, 525:12, 532:6, 540:6, 564:10, 570:1, 570:3, 572:20 ready [3] - 443:15, 504:15, 520:16 real [2] - 546:18, 576:7 realize [4] - 496:3, 514:19, 514:20, 552:8 really [8] - 474:10, 486:12, 542:1, 547:11, 563:12, 575:22, 584:14 reason [14] - 459:14, 459:16, 473:12, 474:3, 492:7, 513:16, 513:17, 530:4, 530:5, 530:18, 530:19, 563:12, 566:6 reasonable [13] - 470:13, 471:7, 474:18, 475:3, 479:25, 480:20, 481:7, 483:13, 484:8, 488:11, 562:24, 563:6, 565:19 reasons [6] - 455:16, 475:10, 480:8, 481:14, 529:20, 562:15 reassure [1] - 567:18 reassuring [2] - 568:7, 568:20 rebuild [1] - 453:6 received [13] - 445:12, 445:17, 451:13, 453:8, 455:7, 507:9, 507:11, 533:8, 564:13, 565:25, 566:3, 566:8, 585:1 receives [1] - 450:21 receiving [1] - 450:5 recent [1] - 509:3 recently [3] - 453:20, 512:4, 539:20 receptionist [1] - 581:14 recertification [1] - 525:1 recertify [1] - 524:21	recess [13] - 449:19, 472:4, 472:10, 472:16, 489:6, 489:11, 489:13, 489:18, 520:11, 520:17, 550:5, 550:16, 551:1 recited [1] - 514:15 recognize [6] - 455:2, 508:19, 512:13, 512:15, 512:19, 524:7 recollection [3] - 529:2, 534:16, 540:9 recommendation [2] - 570:25, 571:1 recommended [1] - 570:23 reconcile [2] - 474:1, 474:7 record [37] - 442:13, 442:15, 446:5, 450:19, 456:18, 468:4, 469:3, 469:4, 469:5, 470:23, 472:19, 474:20, 475:5, 476:13, 484:25, 485:24, 485:25, 486:9, 487:20, 487:22, 489:23, 494:15, 512:23, 520:22, 531:17, 532:7, 536:6, 537:4, 537:18, 538:1, 538:21, 542:22, 543:5, 543:19, 550:15, 551:3, 566:14 recorded [1] - 562:20 records [27] - 458:11, 458:14, 458:15, 493:4, 493:10, 501:16, 501:18, 501:20, 501:22, 501:25, 505:15, 506:14, 506:17, 506:19, 507:19, 507:20, 507:21, 531:24, 533:13, 535:11, 561:17, 566:16, 566:18, 567:4, 567:5, 567:7, 576:10 recounted [1] - 499:24 recounting [2] - 500:6, 500:10 recur [1] - 477:3 recurrent [6] - 477:10, 477:11,	477:12, 477:20, 484:15, 499:16 recurring [1] - 564:6 red [8] - 461:13, 461:17, 462:2, 463:22, 470:23, 572:7, 575:1 redirect [3] - 487:4, 552:10, 586:25 redirecting [1] - 453:5 reduced [1] - 504:13 reducing [1] - 565:18 reduction [2] - 565:4, 565:20 redundant [1] - 520:23 refer [1] - 561:4 reference [1] - 543:10 referred [2] - 486:24, 490:9 referring [4] - 487:18, 492:4, 495:7, 532:3 refilling [1] - 465:4 reflect [6] - 469:4, 472:19, 485:25, 489:23, 520:22, 551:3 reflected [1] - 482:9 reflux [3] - 501:2, 501:3, 561:11 refresh [3] - 485:6, 534:15, 540:9 refreshes [1] - 529:2 refused [1] - 583:6 regard [2] - 475:2, 479:19 regarding [2] - 487:17, 533:20 regards [1] - 446:8 region [1] - 478:21 register [1] - 530:14 regular [1] - 471:6 regurgitation [27] - 464:2, 464:6, 464:13, 464:21, 465:6, 465:8, 465:21, 466:4, 466:5, 467:3, 467:13, 467:14, 467:17, 467:19, 468:20, 469:22, 470:3, 470:6, 470:9, 470:12, 470:14, 470:17, 471:8, 480:12, 480:16, 574:5, 575:1 reheard [1] - 551:10 relate [2] - 499:16, 526:11 related [6] - 458:22,
Q				
qualifications [2] - 444:17, 444:22 qualified [1] - 458:2 qualify [1] - 526:19 quality [4] - 461:24, 478:25, 479:4, 570:11 quarter [1] - 550:23 questioned [5] - 582:8, 582:12, 582:25, 583:1, 583:3 questioning [1] - 538:13 questions [14] - 445:23, 456:22, 488:3, 491:21, 492:19, 516:9, 516:20, 526:15, 527:21, 552:9, 555:11, 577:4, 577:24, 586:22 quick [1] - 566:16 quickly [1] - 491:24 quite [7] - 445:3, 470:25, 545:14, 547:2, 554:14, 565:11, 573:23 quotation [1] - 555:13 quote [1] - 446:12				
R				
race [1] - 557:3 radial [1] - 556:15 radiated [3] - 484:2, 500:14, 543:22 radiates [4] - 461:11, 555:7, 559:25, 560:6 radiating [8] - 474:14, 500:11, 535:1, 555:5, 555:6, 558:3, 558:6, 568:21 radiation [3] - 480:9, 560:8, 560:13 radiological [1] - 446:22 radiologist [8] - 478:22, 479:3, 569:23, 570:2, 570:4, 570:10, 570:15, 570:20 radiologists [2] - 570:22, 570:25 radiology [2] - 570:19, 571:6				

464:21, 466:9,
478:14, 503:11, 559:8
relates [1] - 462:18
relative [3] - 442:23,
444:13, 526:17
relatively [1] - 466:2
relaxed [2] - 558:16,
558:18
relaxing [1] - 465:5
released [1] - 450:5
relevance [1] - 445:4
relevant [4] - 444:16,
444:24, 445:21,
446:17
reliance [1] - 446:14
relied [4] - 446:13,
446:22, 447:4, 448:2
relief [1] - 566:7
relocate [1] - 462:24
rely [4] - 449:7,
496:10, 586:8, 586:15
relying [1] - 534:7
remain [1] - 450:12
remedy [1] - 564:24
remember [20] -
512:21, 518:17,
526:6, 526:7, 528:10,
529:5, 529:8, 529:9,
529:24, 535:19,
539:14, 539:17,
539:25, 544:19,
545:25, 546:13,
566:1, 571:9, 576:15
remembered [1] -
561:12
remembering [2] -
571:23, 572:1
remind [5] - 472:20,
489:24, 520:23,
528:5, 551:4
remitted [2] - 442:14,
443:2
render [2] - 454:2,
458:8
rendering [1] - 559:9
repair [1] - 487:2
repairs [2] - 486:22,
486:24
repeat [1] - 528:15
rephrase [4] - 496:1,
529:13, 529:15, 556:6
replace [1] - 487:3
replacement [3] -
483:4, 487:5, 487:7
reply [1] - 531:14
report [11] - 458:23,
468:13, 468:15,
474:2, 474:5, 474:9,
562:22, 571:6, 573:4,
573:7, 585:7

reported [11] -
470:21, 473:19,
474:6, 480:10, 495:5,
498:13, 498:15,
531:7, 554:16, 555:6,
574:18
Reporter [2] -
442:12, 588:11
reporting [2] - 479:4,
554:9
reports [3] - 478:6,
555:7, 570:23
repositioned [1] -
567:14
reliance [4] -
455:7, 490:7, 492:3,
577:12
representation [2] -
448:5, 449:8
representing [1] -
455:18
represents [1] -
453:18
require [1] - 470:8
required [4] - 472:1,
475:21, 481:22,
524:23
requirement [2] -
455:11, 496:24
requires [1] - 462:23
reread [1] - 534:4
residency [1] -
451:20
residential [2] -
512:24, 581:11
resolution [2] -
565:21, 575:1
resolve [1] - 563:20
respect [13] - 454:2,
456:14, 458:3, 462:4,
466:9, 479:8, 480:2,
481:10, 481:15,
482:22, 485:16,
536:17, 576:24
respiration [1] -
558:18
respirations [2] -
558:16, 558:21
respiratory [1] -
562:3
respond [1] - 558:22
response [5] - 468:6,
468:10, 488:6,
496:11, 533:4
responsibilities [1] -
455:2
responsibility [1] -
455:5
responsive [2] -
468:8, 550:2

rest [2] - 492:16,
575:17
result [3] - 570:17,
578:5, 582:20
resulted [3] - 480:25,
522:14, 536:25
retained [1] - 533:17
retaken [4] - 472:19,
489:23, 520:22, 551:3
retrospective [1] -
490:15
return [5] - 529:19,
529:21, 530:5,
575:24, 576:19
returning [1] -
576:21
review [26] - 454:10,
459:1, 469:11, 473:2,
473:7, 474:19, 475:5,
482:6, 489:2, 493:10,
503:22, 504:13,
504:23, 506:17,
517:13, 522:12,
524:4, 524:7, 524:12,
532:9, 532:17,
537:20, 566:16,
580:25, 585:5, 585:20
reviewed [25] -
454:16, 455:6,
455:15, 458:11,
458:15, 458:24,
478:5, 478:6, 479:15,
492:25, 493:5,
502:24, 504:15,
505:8, 506:13,
506:18, 509:10,
517:9, 517:17,
517:22, 522:2,
532:20, 565:3, 567:4,
585:2
reviewing [3] -
505:15, 511:1, 522:6
ribbons [1] - 445:12
Richmond [1] -
512:11
rigorous [1] - 587:14
ring [1] - 470:5
rises [1] - 557:6
rising [1] - 483:9
risk [4] - 475:1,
527:12, 544:10,
544:21
Rite [2] - 512:17,
512:20
Rockland [1] - 519:9
role [1] - 460:13
roles [1] - 562:13
roll [1] - 557:14
room [35] - 457:11,
459:4, 459:6, 459:11,

460:3, 460:22, 461:8,
463:24, 464:11,
465:9, 470:15,
470:18, 472:4, 473:2,
473:9, 473:13,
477:16, 479:23,
483:15, 488:13,
519:25, 520:2, 528:9,
528:12, 529:19,
530:5, 530:6, 536:23,
537:1, 537:4, 570:1,
571:11, 571:14,
576:5, 581:17
rooms [2] - 459:15,
459:16
root [2] - 470:4,
487:4
roughly [1] - 583:22
row [3] - 456:3,
489:7, 564:3
ruled [1] - 447:15
rules [3] - 445:7,
509:13, 509:15
ruling [2] - 446:25,
547:2
run [1] - 445:10
rundown [1] - 559:13
running [1] - 505:25
runs [1] - 444:5

S

safe [1] - 444:23
safely [1] - 588:1
salaried [1] - 523:10
saloon [1] - 463:8
saltatory [1] - 564:22
samples [1] - 581:24
Sargent [1] - 453:16
sat [1] - 576:13
satisfactory [1] -
568:4
satisfied [1] - 448:4
saturation [1] -
557:17
save [1] - 538:5
saved [1] - 482:2
saw [9] - 474:14,
474:16, 475:23,
476:16, 501:15,
505:7, 539:20,
585:12, 585:13
scale [8] - 477:6,
557:21, 563:5,
563:12, 566:4, 566:9,
568:23, 574:20
scan [16] - 446:20,
471:10, 471:15,
472:1, 479:21,
479:23, 480:2, 480:6,
480:16, 480:19,
480:24, 481:25,
482:5, 564:11
scans [2] - 471:15,
471:17
scars [1] - 559:21
scenario [1] - 448:23
schedule [1] -
522:22
scheduled [3] -
456:1, 584:9, 584:10
scheduling [1] -
584:14
schematic [1] -
463:1
scholarship [1] -
453:15
School [4] - 451:14,
452:7, 452:13, 453:10
school [6] - 452:6,
452:15, 453:11,
524:2, 525:5, 573:13
scope [5] - 448:10,
448:15, 475:13, 488:5
score [8] - 560:19,
560:24, 561:2, 561:4,
562:22, 563:5, 566:4,
566:9
screen [1] - 511:3
screening [2] -
510:25, 511:1
seaboard [2] - 510:7,
510:16
seat [1] - 450:18
seated [10] - 449:22,
449:23, 472:12,
472:13, 489:15,
489:16, 520:13,
520:14, 550:18,
550:19
second [14] - 443:22,
446:12, 449:16,
451:20, 453:12,
454:11, 459:21,
471:5, 485:7, 488:25,
509:7, 516:10, 527:6,
553:18
see [54] - 447:17,
448:16, 449:1, 450:2,
452:22, 457:6, 457:8,
457:11, 461:22,
463:16, 463:17,
464:7, 464:12, 470:7,
473:1, 473:11,
473:15, 473:23,
478:10, 478:12,
478:17, 488:20,
492:22, 495:9,
497:11, 502:5, 515:1,
520:6, 521:9, 521:10,

<p>523:3, 529:1, 531:3, 539:16, 540:17, 540:23, 541:2, 541:4, 541:5, 541:15, 541:17, 553:8, 560:7, 560:11, 561:10, 566:10, 568:16, 570:22, 576:10, 580:23, 584:2, 586:5, 587:10, 588:3 seeing [7] - 473:2, 473:8, 474:20, 501:16, 515:10, 540:1, 584:5 seek [1] - 576:21 seem [2] - 530:11, 547:4 seemingly [1] - 575:17 seep [2] - 463:19, 463:22 sees [3] - 459:10, 473:16, 514:18 self [1] - 461:16 self-terminating [1] - 461:16 send [2] - 460:15, 582:1 sending [1] - 529:2 Senior [2] - 442:12, 588:11 sense [5] - 477:8, 523:6, 542:15, 546:1, 546:6 sent [4] - 453:4, 511:2, 533:4, 533:13 sentence [3] - 468:1, 468:3, 468:8 separate [4] - 443:2, 464:25, 513:21, 514:10 separately [1] - 507:14 September [14] - 442:19, 458:18, 458:19, 458:20, 459:4, 481:2, 481:18, 483:15, 484:10, 486:5, 531:5, 557:19 series [1] - 477:14 serve [3] - 520:16, 534:15, 548:21 service [1] - 587:18 session [7] - 472:18, 489:20, 507:1, 507:2, 520:20, 550:21, 587:9 set [1] - 549:3 sets [3] - 528:7, 528:11, 528:20 setting [2] - 516:12,</p>	<p>570:16 seven [3] - 455:13, 459:23, 522:4 several [5] - 478:9, 484:1, 507:25, 512:8, 563:17 severe [5] - 463:24, 476:22, 476:24, 545:23, 572:16 severely [1] - 545:10 shadow [1] - 580:23 shadowed [2] - 581:2, 581:6 Shanoff [2] - 512:4, 516:8 share [1] - 455:1 shared [1] - 455:5 sharp [1] - 545:22 shed [3] - 533:24, 534:1, 537:4 sheds [1] - 540:17 shooting [1] - 466:21 short [1] - 527:15 shortness [4] - 546:3, 560:1, 560:4, 571:20 shoulder [5] - 500:17, 500:21, 555:8, 563:16, 564:25 show [8] - 466:13, 467:21, 468:15, 469:24, 478:18, 478:21, 479:2, 546:16 showed [1] - 546:17 shown [4] - 471:8, 472:2, 479:22, 482:23 shows [4] - 461:20, 468:18, 558:15, 570:4 shuts [1] - 463:9 sic [1] - 459:3 Side [1] - 513:6 side [2] - 523:9, 535:25 sidebar [6] - 469:3, 469:9, 485:24, 485:25, 487:20, 566:14 sign [2] - 553:3, 573:7 signal [1] - 571:22 signals [1] - 571:23 signed [1] - 576:19 significance [5] - 476:2, 476:16, 477:22, 483:2, 531:11 significant [9] - 470:14, 498:25, 499:11, 547:23, 551:22, 553:1, 571:12, 572:2, 586:8</p>	<p>significantly [2] - 515:10, 562:14 signs [4] - 460:20, 475:24, 475:25, 561:23 simple [15] - 492:6, 492:10, 493:15, 514:5, 514:12, 531:14, 552:7, 553:6, 553:24, 563:3, 570:6, 570:14, 573:23, 574:2, 586:18 simply [1] - 574:3 Sinai [1] - 451:16 single [5] - 459:14, 459:16, 461:12, 462:1, 507:22 sit [16] - 443:5, 491:10, 495:2, 498:1, 498:8, 499:23, 500:9, 501:24, 524:25, 531:15, 536:19, 539:19, 543:15, 555:21, 560:10, 582:19 sitting [3] - 479:12, 519:24, 568:13 situation [1] - 524:10 six [20] - 466:1, 466:2, 521:11, 528:15, 533:1, 533:6, 533:7, 534:5, 534:9, 534:12, 539:21, 540:10, 553:2, 557:22, 559:25, 565:3, 574:20, 574:23 Sixsmith [4] - 447:12, 450:6, 569:25, 587:12 skin [5] - 557:2, 557:3, 557:5, 560:16 slash [1] - 559:25 sleep [3] - 495:12, 495:17, 496:4 slight [1] - 448:8 slightly [4] - 504:13, 504:23, 574:20, 574:21 small [4] - 462:9, 477:14, 477:25, 484:16 smaller [2] - 506:16, 506:19 SOB [1] - 560:4 society [1] - 453:11 soft [1] - 465:7 soliloquy [1] - 445:10 someone [5] - 460:15, 461:2,</p>	<p>484:18, 549:8, 563:20 something's [1] - 480:11 sometime [1] - 541:24 sometimes [10] - 463:18, 465:20, 490:8, 501:11, 509:17, 509:24, 511:5, 522:3, 548:17, 570:22 somewhere [3] - 468:11, 502:21, 513:9 soon [1] - 562:2 sorry [14] - 452:25, 479:13, 484:20, 487:11, 510:12, 537:14, 541:9, 541:12, 543:10, 546:7, 549:21, 556:5, 566:17, 584:10 sound [7] - 464:16, 465:2, 465:20, 465:22, 465:23, 490:11, 547:23 sounded [1] - 467:18 sounds [4] - 530:23, 535:16, 535:18, 548:10 source [1] - 525:13 space [2] - 482:19, 540:24 spanning [1] - 454:17 speaking [1] - 557:25 speaks [1] - 547:5 special [1] - 460:24 speciality [1] - 454:23 specific [6] - 456:23, 457:1, 498:9, 513:25, 525:13, 530:4 specifically [2] - 442:19, 532:7 specifics [1] - 500:8 speculative [1] - 488:21 spell [1] - 450:19 spelled [1] - 479:16 spend [1] - 522:3 spent [4] - 499:13, 505:14, 521:6, 522:25 spoken [2] - 442:24, 443:4 spontaneous [1] - 556:15 spouse [1] - 486:14 spread [1] - 507:23 squeezing [2] -</p>	<p>554:2 St [3] - 512:15, 525:22, 544:13 stable [1] - 479:11 stage [2] - 515:14, 575:22 stand [9] - 472:20, 489:24, 491:13, 520:23, 547:1, 550:7, 551:4, 556:12, 587:11 standard [10] - 459:10, 460:9, 471:1, 472:1, 475:20, 479:8, 481:22, 491:9, 491:11, 505:7 standards [1] - 547:12 standing [6] - 448:17, 450:13, 466:12, 479:11, 535:24, 541:18 standpoint [1] - 521:11 stands [2] - 498:25, 556:19 start [4] - 446:8, 461:6, 520:2, 520:16 started [11] - 453:3, 455:12, 476:7, 503:18, 505:3, 531:21, 531:25, 535:15, 536:20, 541:14, 553:19 starting [2] - 502:25, 553:15 starts [1] - 559:14 STATE [1] - 442:1 state [14] - 450:19, 454:19, 458:20, 509:5, 509:7, 509:12, 509:25, 510:7, 510:9, 510:15, 517:18, 578:13, 578:21, 582:16 State [14] - 451:8, 453:19, 511:9, 511:16, 511:23, 511:25, 517:2, 517:14, 517:20, 517:25, 577:19, 580:1, 580:2 statement [5] - 508:20, 510:24, 515:13, 554:9, 568:25 statements [2] - 554:11, 572:2 Staten [2] - 511:16, 511:20 States [9] - 453:23, 454:17, 459:20,</p>
--	--	---	--	---

459:24, 460:2, 510:8,
526:3, 526:10, 546:24
states [21] - 454:17,
454:18, 455:10,
509:9, 509:11,
509:16, 510:2, 512:1,
517:5, 517:10,
517:11, 517:12,
518:3, 544:25, 565:9,
578:23, 580:9,
580:10, 580:12,
580:14
status [1] - 567:12
statutory [1] - 496:23
stay [1] - 575:6
steadfast [1] - 449:8
stenographers [1] -
578:6
STENOGRAPHIC [1]
- 588:8
step [5] - 443:25,
472:6, 489:10, 520:8,
587:4
steps [1] - 444:3
sternal [1] - 554:22
still [11] - 452:19,
457:13, 472:20,
489:24, 519:25,
520:24, 541:12,
551:1, 551:4, 558:5,
562:24
stop [3] - 448:7,
467:23, 553:17
stopped [2] - 541:15,
553:3
stops [1] - 553:1
story [1] - 527:12
straight [1] - 535:24
stream [1] - 465:16
Street [3] - 450:24,
512:23, 515:11
stretch [1] - 482:18
stretcher [1] - 568:13
stretching [1] -
464:12
stricken [1] - 488:7
strict [1] - 448:12
strike [8] - 456:20,
468:1, 468:7, 468:9,
487:9, 547:15, 550:2,
551:9
strong [1] - 461:10
strongly [1] - 467:13
structural [3] -
470:1, 470:8, 487:6
structure [2] - 479:1,
479:7
structures [1] -
446:14
study [1] - 528:15

stuttering [1] -
551:19
subject [1] - 444:25
submit [1] - 524:10
submitted [1] -
510:20
subsequently [1] -
442:25
subsided [2] -
551:24, 568:20
subspeciality [1] -
452:1
substantial [1] -
488:3
sudden [1] - 482:20
suffer [1] - 469:25
suffering [2] -
470:14, 470:16
Suffolk [1] - 519:13
suggest [3] - 480:15,
515:14, 565:11
suing [1] - 503:4
sum [3] - 498:16,
498:18
super [1] - 465:12
Superior [1] - 525:17
supplied [1] - 496:21
supplies [2] - 444:7,
453:4
supportive [1] -
467:13
SUPREME [1] -
442:1
Supreme [1] -
442:10
Suresh [1] - 525:16
surface [1] - 559:17
surgeon [2] - 454:25,
487:3
surgeons [1] -
454:21
surgeries [1] -
561:16
surgery [6] - 464:8,
475:21, 481:24,
535:9, 561:19, 561:20
surgical [7] - 451:18,
483:4, 483:12,
486:21, 486:24,
561:15
surplus [1] - 453:4
surrounded [1] -
482:11
suspect [2] - 559:19,
571:10
suspensions [1] -
471:19
sustain [6] - 456:19,
487:23, 488:2,
488:21, 495:25,

537:16
sustained [12] -
468:9, 476:14,
476:20, 476:24,
479:20, 486:17,
488:6, 499:14,
559:19, 562:11,
582:7, 584:18
swear [1] - 450:13
sweatiness [2] -
546:1, 560:3
swings [1] - 463:9
switch [1] - 558:23
sworn [1] - 450:16
symptom [12] -
474:5, 544:6, 544:9,
544:11, 544:21,
544:22, 545:16,
546:5, 546:8, 546:9,
557:20, 562:12
symptoms [15] -
460:21, 460:24,
460:25, 473:18,
474:9, 529:19, 544:3,
544:9, 544:16,
545:13, 546:1,
553:17, 553:19,
562:9, 571:19
syndrome [4] -
568:9, 568:11,
568:23, 569:2
Systole [1] - 465:5
systolic [26] -
464:16, 464:17,
465:18, 465:25,
466:4, 466:17,
466:18, 466:23,
467:2, 467:6, 467:16,
470:11, 471:1,
471:23, 471:25,
480:10, 480:13,
484:3, 562:3, 562:7,
564:8, 573:11,
573:14, 574:3, 574:9,
574:24

T

tad [1] - 503:13
tail [1] - 564:2
tailor [1] - 445:8
talent [1] - 445:25
taught [2] - 525:5,
573:13
tax [2] - 515:21,
582:16
taxes [2] - 582:23,
583:12
tea [1] - 450:2
tear [29] - 461:16,

463:18, 463:23,
477:14, 477:15,
477:16, 477:17,
477:18, 477:25,
478:3, 481:1, 482:23,
482:24, 483:3, 483:4,
483:10, 484:14,
484:16, 484:19,
501:14, 530:24,
552:20, 552:21,
552:23, 563:14,
564:2, 564:4, 564:7
tearing [24] - 457:20,
459:25, 461:15,
462:7, 477:1, 477:2,
477:8, 477:13,
482:10, 499:10,
545:13, 545:18,
551:18, 551:23,
552:13, 553:3,
553:20, 554:5,
563:10, 563:21,
563:23, 564:1, 564:6,
564:24
tears [10] - 461:15,
462:9, 463:21,
477:14, 483:1, 483:2,
535:10, 551:21,
563:15, 564:3
telephone [5] -
504:14, 509:19,
510:25, 511:1, 511:3
temporarily [1] -
479:11
ten [9] - 445:10,
455:23, 477:5, 477:6,
523:4, 554:1, 559:25,
561:5, 561:9
ten-minute [1] -
445:10
tend [1] - 456:1
tenderness [1] -
559:21
tends [1] - 476:20
tense [1] - 572:4
tenure [1] - 445:14
TERM [1] - 442:1
term [4] - 490:14,
490:17, 524:7, 547:9
terminating [1] -
461:16
terms [5] - 459:24,
478:2, 478:17,
535:10, 566:22
terrible [1] - 544:20
terrifying [3] -
545:11, 545:18,
545:20
test [6] - 451:22,
471:5, 471:10,

471:11, 539:18
tested [1] - 460:9
testified [48] -
443:21, 444:5,
448:25, 450:16,
454:22, 455:21,
469:14, 475:22,
476:15, 485:17,
486:4, 491:13,
491:22, 492:7, 505:6,
507:25, 508:5,
508:12, 508:25,
509:9, 510:3, 510:6,
510:16, 510:18,
511:8, 512:3, 512:11,
515:20, 518:1, 518:6,
519:18, 522:3,
522:11, 524:17,
525:8, 525:21, 526:2,
526:14, 526:18,
528:2, 528:21,
541:22, 546:23,
548:6, 558:24,
577:16, 578:13, 586:7
testify [15] - 447:21,
453:25, 455:17,
455:23, 479:19,
485:6, 488:1, 488:25,
503:25, 504:16,
522:10, 544:24,
545:10, 545:13,
545:21
testifying [12] -
448:14, 503:3, 508:1,
508:13, 511:17,
512:1, 525:14,
545:25, 546:18,
571:9, 580:16, 584:1
testimonial [1] -
503:22
testimonies [5] -
508:9, 521:11,
521:13, 522:1, 548:14
testimony [71] -
444:12, 444:25,
445:4, 447:1, 450:5,
450:22, 455:9,
455:19, 458:12,
458:24, 469:11,
469:17, 469:18,
469:19, 472:8,
474:13, 476:8, 485:3,
489:11, 492:16,
493:3, 493:11, 496:9,
496:14, 496:16,
496:18, 497:6,
497:23, 498:21,
498:23, 499:5, 499:6,
499:8, 499:25,
502:12, 502:18,

<p>503:10, 505:5, 509:4, 509:11, 516:7, 518:4, 520:3, 520:9, 521:18, 522:14, 526:2, 526:7, 527:2, 527:3, 532:15, 532:17, 533:23, 534:3, 537:2, 539:23, 544:12, 546:8, 549:25, 550:8, 551:9, 551:15, 576:11, 578:7, 578:10, 578:16, 578:21, 579:2, 585:10, 585:25, 586:1</p> <p>testing [2] - 446:13, 446:15</p> <p>tests [2] - 460:14, 581:24</p> <p>thankful [1] - 587:17</p> <p>THAT [1] - 588:7</p> <p>THE [155] - 442:1, 442:13, 443:11, 443:13, 443:15, 443:17, 443:25, 444:9, 444:18, 445:14, 447:9, 447:13, 447:15, 447:17, 447:22, 447:24, 448:1, 448:7, 448:9, 448:21, 449:3, 449:13, 449:17, 449:20, 449:22, 450:1, 450:11, 450:17, 450:18, 450:23, 451:1, 456:17, 456:19, 456:25, 458:4, 458:7, 462:20, 462:21, 462:22, 466:13, 467:25, 468:3, 468:5, 468:9, 468:23, 469:2, 469:4, 471:24, 472:3, 472:7, 472:8, 472:12, 472:14, 472:15, 473:5, 475:14, 475:17, 476:6, 476:12, 476:14, 479:17, 484:22, 484:24, 485:2, 485:12, 485:20, 485:25, 486:10, 486:17, 486:19, 487:10, 487:12, 487:14, 487:18, 487:21, 487:23, 488:17, 488:20, 489:5, 489:12, 489:15, 493:17, 494:5, 494:6, 494:11, 494:16, 494:17,</p>	<p>494:18, 495:17, 495:22, 495:25, 496:7, 510:11, 510:13, 510:14, 514:1, 514:3, 514:7, 519:20, 520:10, 520:13, 534:20, 536:5, 536:7, 536:9, 536:11, 536:13, 536:14, 536:16, 537:13, 537:14, 537:15, 537:19, 537:21, 538:3, 538:7, 538:12, 538:19, 540:2, 540:4, 541:10, 541:11, 541:13, 545:3, 545:7, 545:9, 547:17, 548:4, 549:19, 550:4, 550:9, 550:10, 550:13, 550:18, 551:6, 551:8, 565:13, 565:16, 566:13, 573:20, 573:22, 573:24, 574:12, 574:14, 577:5, 582:7, 584:18, 584:23, 586:20, 586:23, 587:4, 587:6, 587:8, 587:25, 588:7</p> <p>therapy [1] - 565:21</p> <p>thereabouts [1] - 502:20</p> <p>thereafter [1] - 564:21</p> <p>thereto [1] - 458:8</p> <p>they've [2] - 445:12, 554:12</p> <p>thinking [1] - 568:22</p> <p>third [1] - 455:24</p> <p>THIS [1] - 588:7</p> <p>thousand [16] - 448:18, 459:19, 459:23, 493:1, 502:24, 506:18, 522:2, 522:15, 526:12, 526:13, 526:20, 526:24, 527:16, 546:19, 546:24, 547:10</p> <p>thousands [3] - 453:5, 460:3, 580:8</p> <p>threat [1] - 477:9</p> <p>threatening [10] - 457:19, 459:18, 459:21, 459:25, 460:12, 460:18, 461:7, 483:10, 527:16, 527:20</p> <p>threatens [1] - 483:6</p> <p>three [28] - 454:13,</p>	<p>456:3, 457:21, 463:15, 463:17, 466:1, 466:2, 471:12, 475:25, 481:2, 482:1, 483:22, 486:5, 491:17, 497:24, 506:23, 507:4, 510:19, 515:2, 515:5, 516:4, 516:21, 522:15, 559:24, 564:3, 574:19, 574:23</p> <p>threshold [2] - 480:16, 557:1</p> <p>throat [2] - 559:25, 560:6</p> <p>throughout [1] - 445:13</p> <p>throws [2] - 556:22, 558:9</p> <p>timeframe [1] - 565:8</p> <p>tissue [1] - 557:7</p> <p>title [1] - 453:15</p> <p>TO [1] - 588:7</p> <p>today [28] - 452:17, 458:12, 485:23, 488:25, 492:16, 493:3, 504:2, 504:7, 505:14, 505:17, 506:1, 506:5, 507:12, 509:8, 519:21, 521:20, 523:2, 532:14, 533:4, 533:16, 533:23, 534:3, 543:16, 558:24, 569:18, 574:19, 584:10, 584:16</p> <p>tolerates [1] - 558:21</p> <p>tomorrow [3] - 550:24, 587:21, 588:3</p> <p>tons [1] - 453:5</p> <p>took [10] - 452:3, 472:16, 489:18, 497:12, 505:7, 520:17, 522:18, 522:21, 551:1, 569:21</p> <p>top [2] - 512:16, 559:13</p> <p>topic [1] - 524:6</p> <p>tore [2] - 482:11, 563:22</p> <p>torn [1] - 563:21</p> <p>total [7] - 455:19, 457:24, 491:23, 498:16, 498:18, 516:5</p> <p>totally [1] - 444:16</p> <p>tough [2] - 539:8, 540:12</p> <p>towards [1] - 448:17</p> <p>trachea [1] - 559:22</p>	<p>tradespeople [1] - 501:12</p> <p>trained [3] - 451:15, 451:25, 499:19</p> <p>training [5] - 451:13, 451:21, 452:3, 457:11, 503:19</p> <p>transcript [14] - 496:17, 496:22, 497:1, 497:3, 497:4, 529:12, 530:12, 539:20, 544:12, 545:4, 545:7, 546:5, 547:6, 562:9</p> <p>TRANSCRIPT [1] - 588:7</p> <p>TRANSCRIPTION [1] - 588:8</p> <p>transcripts [9] - 443:20, 449:1, 459:2, 505:8, 578:7, 578:20, 578:23, 579:2, 585:9</p> <p>translation [1] - 540:11</p> <p>trauma [2] - 559:18, 559:19</p> <p>traumatic [1] - 545:14</p> <p>travel [5] - 463:4, 504:9, 506:2, 506:4, 509:24</p> <p>traveled [2] - 509:11, 518:3</p> <p>traveling [1] - 467:4</p> <p>travels [2] - 466:19, 466:24</p> <p>treat [2] - 519:21, 580:14</p> <p>treated [4] - 457:21, 476:21, 483:5, 486:21</p> <p>treating [7] - 451:17, 457:13, 457:16, 530:7, 531:11, 572:12, 584:6</p> <p>treatment [9] - 442:22, 442:23, 454:3, 501:20, 559:1, 559:4, 559:9, 559:10, 576:21</p> <p>tremendous [1] - 545:14</p> <p>triage [9] - 473:15, 474:15, 542:21, 543:13, 548:9, 548:18, 551:14, 553:15, 554:8</p> <p>Trial [1] - 442:7</p> <p>trial [33] - 442:13, 442:17, 445:14, 445:15, 455:10,</p>	<p>455:19, 455:24, 458:24, 459:2, 491:16, 491:23, 492:8, 493:10, 497:6, 498:21, 499:7, 499:25, 502:13, 502:18, 504:11, 507:5, 508:7, 509:3, 509:24, 512:2, 517:7, 517:10, 521:22, 539:25, 577:17, 577:19, 584:9</p> <p>trials [8] - 442:19, 444:21, 455:21, 493:20, 518:1, 578:13, 578:24, 584:8</p> <p>troponin [3] - 528:8, 528:14, 528:18</p> <p>troponins [1] - 568:7</p> <p>trouble [1] - 462:14</p> <p>true [91] - 490:25, 491:2, 491:10, 491:14, 491:24, 493:13, 493:23, 495:10, 502:14, 503:5, 503:19, 508:2, 508:6, 508:10, 508:12, 508:15, 508:20, 508:22, 508:25, 509:4, 509:14, 509:19, 509:25, 510:8, 510:21, 512:5, 512:8, 513:20, 513:22, 514:8, 514:11, 514:23, 515:4, 516:17, 516:24, 517:5, 517:18, 517:23, 518:1, 518:4, 523:2, 523:10, 523:12, 523:15, 524:13, 524:15, 524:18, 524:20, 524:22, 525:1, 525:2, 525:6, 526:20, 528:9, 528:16, 528:22, 528:24, 533:17, 533:21, 534:3, 534:4, 542:22, 543:4, 543:23, 543:25, 544:5, 548:14, 553:3, 556:17, 558:3, 559:10, 560:16, 572:17, 573:8, 573:9, 574:4, 574:6, 577:14, 578:1, 578:7, 578:10, 579:4, 580:18, 581:12, 582:9, 582:13, 583:1, 583:3, 583:11, 584:2, 585:20</p>
---	---	---	---	---

<p>TRUE ^[1] - 588:7 truly ^[1] - 549:21 trust ^[4] - 443:9, 448:5, 529:14, 539:19 try ^[5] - 492:11, 492:19, 513:25, 539:16, 584:7 trying ^[8] - 485:5, 492:5, 500:25, 539:18, 565:11, 573:22, 574:13, 574:14 tube ^[1] - 463:14 turgor ^[3] - 557:4, 557:5 turn ^[1] - 522:25 turns ^[1] - 521:10 TV ^[2] - 567:13, 576:14 twelve ^[1] - 510:4 two ^[41] - 443:2, 451:20, 451:22, 455:25, 457:23, 464:5, 464:6, 464:14, 465:14, 466:2, 469:21, 471:3, 471:12, 491:7, 491:17, 515:1, 516:3, 516:18, 516:20, 516:21, 516:23, 521:14, 521:15, 521:19, 521:25, 522:9, 522:13, 522:25, 528:7, 528:11, 528:20, 540:8, 560:23, 562:13, 564:2, 573:11, 574:23, 576:4, 576:6, 576:8, 585:9 two-day ^[1] - 451:22 two-page ^[1] - 540:8 type ^[3] - 543:4, 559:19, 564:14 typical ^[2] - 509:2, 558:12 typically ^[2] - 476:24, 563:19 typifies ^[1] - 558:9 typo ^[2] - 546:20, 547:5</p>	<p>unable ^[2] - 566:15, 566:18 unacceptable ^[1] - 471:22 unaware ^[5] - 470:20, 474:14, 474:25, 476:9, 585:14 uncomfortable ^[1] - 561:5 uncommon ^[1] - 484:18 under ^[19] - 447:8, 455:9, 462:11, 463:16, 472:20, 488:17, 489:24, 498:23, 502:15, 503:13, 520:24, 530:12, 537:2, 551:4, 551:10, 554:24, 557:17, 567:10 underpinnings ^[1] - 493:12 understood ^[3] - 470:2, 497:2, 571:5 unfair ^[1] - 476:10 unforeseen ^[1] - 587:25 unfortunate ^[1] - 498:11 unique ^[2] - 460:23, 460:25 unit ^[4] - 452:9, 452:11, 456:12, 581:4 United ^[9] - 453:23, 454:17, 459:20, 459:24, 460:2, 510:8, 526:3, 526:10, 546:23 universal ^[1] - 567:17 universally ^[1] - 467:10 University ^[2] - 452:15, 512:11 unlabored ^[2] - 558:17, 558:18 unless ^[4] - 449:10, 529:23, 530:4, 585:20 unusual ^[3] - 546:11, 546:12, 560:16 up ^[56] - 455:25, 463:3, 465:7, 466:21, 468:11, 473:18, 473:21, 474:4, 475:10, 479:11, 482:23, 491:12, 494:11, 495:12, 495:18, 495:19, 495:23, 496:4, 496:9, 498:11, 499:2, 500:2, 502:6, 504:20, 505:4,</p>	<p>505:16, 506:11, 512:18, 515:17, 522:21, 522:23, 523:7, 528:15, 535:24, 538:1, 541:18, 542:19, 542:24, 543:4, 543:6, 548:19, 550:23, 553:7, 553:21, 557:14, 558:21, 565:24, 571:2, 571:4, 572:23, 575:11, 581:1, 584:15, 587:22 upper ^[4] - 467:1, 467:9, 480:14, 513:9 Upper ^[1] - 513:6 upright ^[1] - 568:13 upwards ^[3] - 516:13, 516:17, 518:3 usual ^[2] - 448:19, 571:15</p>	<p>463:13, 464:2 verbalizes ^[1] - 557:19 verbally ^[1] - 542:9 versus ^[4] - 512:10, 512:14, 512:17, 528:1 vessel ^[2] - 462:7, 535:10 vessels ^[2] - 461:22, 478:18 via ^[2] - 555:18, 556:8 video ^[1] - 509:18 view ^[1] - 495:4 viewed ^[1] - 492:2 viewpoint ^[1] - 492:3 vigorito ^[1] - 443:11 Vigorito ^[22] - 444:18, 446:4, 448:9, 448:21, 449:3, 449:6, 458:4, 462:22, 488:6, 489:6, 489:22, 490:7, 493:21, 494:6, 514:7, 520:18, 520:25, 538:3, 538:13, 551:1, 573:20, 587:13 VIGORITO ^[75] - 443:12, 443:22, 444:19, 446:7, 447:19, 448:4, 448:8, 448:18, 448:22, 449:11, 449:14, 456:13, 458:5, 466:11, 466:15, 467:23, 468:1, 468:7, 468:22, 468:25, 473:4, 475:13, 475:15, 476:4, 476:7, 479:13, 484:20, 484:23, 485:1, 485:5, 485:16, 485:21, 486:8, 486:15, 487:8, 487:11, 487:13, 487:15, 488:9, 488:15, 488:18, 490:1, 490:4, 494:7, 495:19, 495:24, 496:2, 510:12, 514:2, 514:6, 521:1, 537:24, 538:4, 538:10, 538:15, 538:20, 540:3, 540:5, 541:16, 545:4, 545:8, 547:15, 548:19, 549:20, 550:1, 551:11, 551:13, 561:25, 565:10, 565:14, 573:21, 573:23, 574:11, 574:13, 577:4 Vigorito's ^[5] -</p>	<p>469:6, 486:2, 494:12, 520:20, 536:5 vigorous ^[1] - 587:13 Virginia ^[1] - 519:1 visit ^[1] - 458:17 visits ^[1] - 515:11 visual ^[1] - 463:16 vital ^[1] - 561:23 vocal ^[1] - 557:25 volume ^[1] - 465:24 voluntary ^[1] - 514:21 volunteerism ^[1] - 449:1 vomiting ^[1] - 499:13 vomitus ^[1] - 499:14</p>
W				
<p>W-9 ^[1] - 583:15 wait ^[4] - 493:20, 494:2, 537:8, 567:13 wake ^[1] - 499:2 waking ^[2] - 498:11, 500:2 walked ^[2] - 467:15, 548:22 wall ^[4] - 463:14, 463:19, 463:21, 463:22 wants ^[1] - 529:21 warm ^[2] - 557:3, 567:12 warrant ^[1] - 487:24 warranted ^[2] - 564:11, 570:23 Washington ^[2] - 453:21, 518:20 watched ^[1] - 576:14 ways ^[2] - 464:6, 471:3 wear ^[1] - 501:14 week ^[5] - 455:25, 469:12, 515:1, 515:2, 532:18 weekend ^[3] - 450:1, 499:13, 499:14 weeks ^[6] - 491:17, 506:25, 510:5, 510:19, 516:8, 516:21 weigh ^[1] - 444:18 Weisman ^[15] - 443:8, 449:7, 450:8, 472:16, 487:19, 488:22, 489:19, 494:20, 498:22, 526:14, 532:15, 540:9, 559:8, 569:21, 586:20 WEISMAN ^[42] -</p>				