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March 16, 2009

Michael J. Keating, Esq.
Dughi & Hewit
340 North Avenue
Cranford, New Jersey 07016

Re: Betancourt v. Trinitas Hospital
Docket No. UNN-C 12-09

Dear Mr. Keating:

Enclosed please find transcripts of the Order to Show Cause Hearings held on January 22, February 17, and February 23, 2009, in this matter.

Very truly yours,

RLevy

Rebecca A. Edelman Levy

RAL:jed
Enclosures
cc: Sam Germana, Esq. (Via First Class Mail)(enclosures)

SUPERIOR COURT OF NEW JERSEY
CHANCERY DIVISION
GENERAL EQUITY PART
UNION COUNTY, NEW JERSEY
DOCKET NO. UNN-C-12-09

BETANCOURT

Plaintiff

vs.

TRINITAS HOSPITAL

Defendant

TRANSCRIPT

OF

ORDER TO SHOW CAUSE

HEARING

Place: Union County Courthouse
Two Broad Street
Elizabeth, New Jersey 07207

Date: January 22, 2009

BEFORE THE HONORABLE JOHN MALONE, J.S.C.

TRANSCRIPT ORDERED BY:

REBECCA A. EDELMAN LEVY, ESQ. (Garfunkel Wild & Travis)

APPEARANCES:

JAMES MARTIN, ESQ. AND TODD DRAYTON, ESQ.
Attorneys for the Plaintiffs, Betancourt Family

PHIL CHRONAKIS, ESQ. AND REBECCA A. EDELMAN LEVY, ESQ. (Garfunkel Wild & Travis)
Attorneys for the Defendant, Trinitas Hospital

LYNN COHEN-MOORE
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P.O. Box 2230
Laurel Springs, New Jersey
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I N D E X

January 22, 2009

ARGUMENT

THE COURT **PAGE**

THE COURT: This is the matter of Betancourt v. Trinitas Hospital. The Docket is C-12-09.

Counsels, may I have your appearance for the record, please. We'll start here to my right.

MR. MARTIN: Good afternoon, Judge. James Martin and Todd Drayton on behalf of the Betancourts.

THE COURT: Uh hum.

MR. DRAYDEN: Good afternoon, Your Honor.

THE COURT: Uh hum.

MR. CHRONAKIS: Good afternoon, Your Honor. Phil Chronakis and Rebecca Levy from Garfunkel Wild & Travis on behalf of Trinitas Hospital.

THE COURT: All right, this is an application for a temporary restraining order in connection with this matter, brought the plaintiff, a daughter of Reuben Betancourt who is a patient at Trinitas Hospital.

The plaintiff seeks in this temporary restraining -- in this Order To Show Cause that the court enter an order that would require the hospital to show cause why it should not be enjoined from terminating or discontinuing treatment for Mr. Betancourt, also seeks the appointment of a guardian.

And the purpose of today's order is to

consider the plaintiff's application that pending further proceedings in connection with this matter, that the court enter a temporary restraining order. That temporary restraining order would restrain the hospital from terminating or discontinuing life support treatment for Mr. Betancourt.

I guess the first question that I have, Mr. Martin is what is Mr. Betancourt's current condition and what treatment is he receiving?

MR. MARTIN: Judge, I have to tell you that I have been involved in this matter now for all of three days or so. So I have no medical records, nor do I have much medical information --

THE COURT: That was another concern I was going to express, but I just wanted to know what you, what you did know now.

MR. MARTIN: My understanding in speaking with the family that as a consequence of a, -- one year ago today, coincidentally, Mr. Betancourt had surgery at Trinitas Hospital.

As a consequence of that surgery, something occurred in recovery where he was, needed oxygen for some period of time, lapsed into a coma, and my understanding is that he has not responded or come out of that as yet.

How this fits in sequentially, I don't know, but he's also experienced renal failure.

So he is currently on a ventilator as I understand it and also receiving dialysis treatment for the, with the ventilator.

The family understands in speaking fairly and formally with one or more of the doctors that the intention of the hospital was to discontinue the dialysis.

My understanding medically is the consequence of that is that gentleman's potassium level will increase. Eventually his kidneys will shut down, leading to multi-organ system failure and ultimately death.

THE COURT: Uh hum.

MR. MARTIN: We are here today to ask that the hospital be restrained from taking that action until such time as we could have a hearing.

I was informed this afternoon that that action has already been taken.

So I guess I need to amend my petition and ask the court if it views us favorably, to order the hospital to re-institute that treatment which he should have received today and was denied.

THE COURT: Uh hum.

MR. MARTIN: Again, my understanding is that the proposed action is to discontinue and not re-institute any of the dialysis treatments.

THE COURT: Okay.

I think perhaps I'm not sure what's your view on behalf of the hospital. Is that, -- Mr. Martin's understanding accurate as to the current treatment? Has treatment and/or dialysis or ventilator been discontinued? Is that the situation at the moment?

MR. CHRONAKIS: Judge, Mr. Martin is accurate up until Tuesday, and he's aware that there's been a change since then.

As of Tuesday, the hospital discontinued Mr. Betancourt's dialysis which additionally involved the removal of essentially of a tube from a port, the reinsertion of which would require a surgical procedure to continue the dialysis treatment.

But so that the court's aware importantly and had Mr. Betancourt's dialysis continued from Tuesday, his next treatment so to speak would have been today.

So essentially over the last two days, Mr. Betancourt has not, not received any dialysis treatment that he otherwise would have, but the hospital has

taken the step based on the judgment of the physicians treating Mr. Betancourt to remove the port and to discontinue dialysis.

MR. MARTIN: Judge, may I res… --

THE COURT: And I've had the opportunity to read the papers that were submitted by both sides, and I do understand that Trinitas is taking -- it is their position of the medical staff at Trinitas that the, any further treatment is not warranted in Mr. Betancourt's case, that the continuation of treatment, given his medical condition, his status, would be futile.

And it is the hospital's staff position, the treating physician, that any -- that the treatment is simply medically inappropriate.

MR. CHRONAKIS: Judge, if I might.

And that's certainly essentially the hospital's position except for this I think significant point, especially with Mr. Betancourt's family here.

A lot of the staff at the hospital asked me to make sure the court understood something which doesn't really come through in the papers, which is it is not the case that the physicians at Trinitas are saying this is futile or this is unnecessary as much as it is their belief, as much as they obviously want Mr. Betancourt to improve if he could, and as I know the

family certainly does, it is their belief that continuing dialysis and continuing other life support treatment is actually harming Mr. Betancourt's body. It is causing his dignity to suffer, to the extent that the court would recognize a public interest in dignity when death is inevitable.

It is their professional judgment that Mr. Betancourt cannot improve from his current condition, and we're addressing questions of quality of life, and the judgment in medical practice.

So it is not a matter of saying this isn't going to change the outcome. It is a very difficult but unfortunate matter that Mr. Betancourt's body is deteriorating and suffering and that continued life support as counterintuitive as this might sound to the court, is having at least an immediate harm on other interests of Mr. Betancourt that the hospital and the physicians are trained to address and are reluctant to put it gently to continue that course of treatment over their medical training and judgment.

THE COURT: Okay.

Mr. Martin, you did touch upon and that is, and I appreciate the short period of time that you've had to deal with the matter and not having in hand medical records puts you at somewhat of a

disadvantage.

I guess a concern that I have, though, is the application here is not supported by any medical certifications. It is supported by a family member who is not a medical expert.

I can certainly understand the position being taken by the family, but there is no supporting medical evidence for this application.

MR. MARTIN: Judge, there's been little or no opportunity to obtain -- Judge, all of the physicians that have been involved in his care as I understand it are staff physicians at Trinitas.

The family has identified at least one physician who may be willing to intercede. He'd have to, I guess I don't know the procedure, obtain permission to come onto the Trinitas property because he's not on staff there and he doesn't have privileges.

But that's part of what we would like the restraining order to allow us to accomplish.

I met these folks this afternoon so I've had no prior contact with them but I did speak to an attorney from the hospital yesterday who assured me that no actions were going to be taken pending this hearing.

I'm hearing now for the first time that dialysis has, in fact, been stopped, and that in order to re-institute it, there's some portal that has been removed that requires surgical implantation.

My understanding was that was not going to be done.

THE COURT: Uh hum.

MR. MARTIN: -- until we had an opportunity to air our differences here.

Judge, as -- I mean I understand the -- I haven't had a chance to digest these affidavits, but I understand the position of the physicians. The court needs to understand the position of the family.

They contend that this gentleman, their husband, their father, is indeed responsive.

He's not on and off with responses, that is being suggested to the court, that he does respond to certain stimuli.

They would like an opportunity for some physician at the very least to come in and have the opportunity to confirm that or refute it.

They also believe whether this is -- they will suggest to Your Honor at a hearing that there may be other motivations beyond this myth, frankly, some economic motivation.

There is a sizable medical bill that remains unpaid. They are not people of means, and they question -- they question whether or not that's the true motivation as opposed to some medical motivation for the reactions that are being suggested.

That's something I would suppose we'll air in a hearing, but all they're asking at this point, is that necessary treatment not be suspended or terminated until such time as we have an opportunity to get our act together, if you will, to get a medical affidavit if we can and prepare for, you know, where the arguments of the hospital are.

But to leave this decision in the hands of the hospital seems to me to be a terrible precedent for this court or any other.

THE COURT: All right, thank you, sir.

Counsel.

MR. CHRONAKIS: Judge, just to address a couple of things that Mr. Martin said and to clarify the record.

No action was taken by the hospital subsequent to the filing of the Betancourt's family's papers which I understand came here in yesterday morning or Tuesday night.

There was action taken early in the day

Tuesday at the hospital, and certainly not in response to the prospect of a lawsuit, which I don't know the hospital's aware of.

Judge, regarding the financial motivation, I can assure you having represented Trinitas Hospital for the last nine years at two law firms, that serving an underserved population as Trinitas does here in Elizabeth, there are many cases, countless cases, in which Trinitas provides healthcare services regardless of the financial outcome, and Your Honor must know this.

And certainly in Mr. Betancourt's case, that's no different.

You have affidavits from three physicians, none of whom are addressing anything -- none of whom would be allowed to as licensed professionals, address anything that equates what the proper course of treatment is with what the financial outcome to their hospital is.

The motivation that these physicians have from my dealings with them is that they uniformly believe that Mr. Betancourt unfortunately will not improve from his current position. And the responsiveness to stimuli does not contradict that fact, Judge.

There is medical evidence and it's addressed in the certifications that certain patients have limited reaction to stimuli, especially their eyes will move in response to light. That has nothing to do with the level of brain activity, the ability to be conscious again. And as you're aware, Mr. Betancourt, from reading the certifications, he doesn't respond to pain or the more immediate stimuli.

So what we have here, Judge, as I indicated earlier, is the situation in which unfortunately where I can't, Ms. Levy can't, these good attorneys can't, Mr. Betancourt's family unfortunately can't, you can't, assess or even order that somebody's medical condition be viewed as this or that.

Unfortunately for a number of months before counsel came on the case, Mr. Betancourt's family was given an opportunity to have another physician assess his condition, but I don't know that this needs to become a battle of the experts, so to speak, when you have the un-contradicted, over a number of months, but now before Your Honor, medical testimony.'

The only people who do know are saying that this situation, unfortunately, is not going to improve but it can get worse in terms of Mr. Betancourt's dignity and his internal suffering if the court orders,

and Judge, I hope -- I know you're aware, but I want to emphasize for the record, we don't have a situation where Your Honor would be issuing a restraint against the hospital's actions at this point.

Although some life support continues, it would the situation in which Your Honor was issuing affirmative injunction, and there is a line of authority suggesting that a court should not substitute it's own judgment over the judgment of medical professionals on healthcare issues, that is, to force them to follow a course of conduct that contradicts their medical training and their medical ethics.

And I would, if the court would allow, Ms. Levy could address more specific facts and regulations and authority that the court might consider when addressing this application.

THE COURT: Ms. Levy.

MS. LEVY: I think I also just want to address a little bit more on the certifications.

There were four certifications submitted to the court, one from a neurologist, one from a nephrologist, one from the attending physician and also one from the Medical Director of the hospital.

Each one of these people say the continued treatment of this patient is medically and ethically

inappropriate. They say it is not within the standard of care. In fact, two of the physicians go so far as to categorize any continued treatment as inhumane.

You know, you saw the papers. The doctors describe the patient's condition. It's not just being on a vent. He is septic. He has ulcers on his bone. This is not -- he's in very bad shape.

Unfortunately, there are not cases in New Jersey that address the issue exactly on point that deal with whether physicians should be required to provide surgeries that are against their standard of care.

There was a case, however, that I cited in our papers in Louisiana. It was an Appellate Court, court case, and actually it cites Quinn language which we're all familiar with, a New Jersey case, and the facts are actually very similar.

Although the patient there was only 31, the patient was comatose with end stage renal failure.

And in that case, the physicians decided to remove the dialysis and to take out the ventilator and the patient passed away.

What followed was the court's review of what happened, and in that case the court emphasizes the importance of acknowledging the standard of care in

that particular case, and if I may I'd like to read what the court held or what the court said.

The court said,

"Physicians are professionals and occupy a special place in our community. They're licensed by society to perform this special role. No one else is permitted to use life prolonging technology which is considered by many as fundamental health care.

The physician has an obligation to present all medically acceptable treatment options for the patient or her surrogate to consider and either choose or reject.

However, this does not compel a physician to provide intervention that in his view would be harmful without affect or medically inappropriate."

We have four treating physicians here all who say this treatment is medically inappropriate.

In addition, the American Medical Association The Council on Ethical and Judicial Affairs did publish a report entitled 'Medical Futility and End of Life Care.' And this report discusses the complex issues in dealing with futility.

In fact, I looked for a definition of futility and it's quite hard to find because it's such a value, based on values, and it's really impossible to

find a definition.

But what this report does is in an effort to avoid judicial intervention, it talks about steps that a hospital should take when these situations occur where a family disagrees and is pushing medical personnel to perform medical procedures that the doctors believe is not within the standard of care. And these steps include, and I would like to say that Trinitas has done all the steps.

They've met with the family. They've attempted to transfer to a facility where another physician would care, care for this patient.

The problem is that, the physicians, and I spoke to them, they find it very hard to believe that a physician would take this case at this point. And the family has had time to look for a transfer or another physician.

They've had Ethics Committee meetings. They've had other meetings with hospital personnel.

At the end of the report, it says, if you've tried all these steps and there's still a conflict, it says, and I quote, "the intervention will not be offered." And that's, and that's where we're at right now.

MR. MARTIN: Judge, with all due respect. I

don't know that group is, but who are they to make that decision? And I, I mean I didn't come here to argue the merits, but to just touch upon a response to that.

Well let me start at the beginning.

First of all, in response to one of Phil's comments, I didn't have this conversation with the hospital lawyer yesterday as I was filing the papers. I had it with her on Friday and Monday long before this action was taken on Tuesday.

So the court shouldn't find itself in the position now and have to order some affirmative act that should have never been acted upon, the removal of this port, et cetera.

I had a conversation with a gentleman, I want to say his name was Samuel Germana, Germana, and the last conversation was Monday.

And I realized that we had time constraints and so on. I told him that I would meet with the family one more time, and that if we intended to file this action, I would let him know and I did, in fact, let him know. And then before we ever came here yesterday, I faxed him copies of all of the papers that we proposed to present to Your Honor.

So finding yourself in a position now where

you have to order something affirmative should never, ever have happened.

Insofar as, you know, the medical motivation behind this, how would the doctor -- unless the economics were considered by this committee, how would that doctor who eventually reported to one of the, one of children of the Betancourt family had known that there's a 1.6 million dollar hospital bill outstanding? How would he know that unless that was discussed in that, in that hearing or that meeting that they had?

But the fact of the matter is these are the people that know best.

They've lived with this man, they've maintained a visual for a year. It's a year to day. And who is the hospital to decide that his life should be terminated?

We're not asking for the institution of treatment. We're asking that he be maintained on the treatment he's received.

And what you see happening here; I've seen all the seminars and the video clips on how we're going to handle these matters. The New Jersey Supreme Court in particular has always chosen to air of the side of the patient.

What's happening now is the medical community is trying to conjure a way to combat that.

So instead of saying we're maintaining treatment and we're terminating treatment that sustains life, now we're going to argue that what the court is really doing is forcing us to offer treatment that we shouldn't have to offer. That's just the same horse by a different color.

All we're asking this court to do is to let the man live long enough to conduct a hearing to decide whether or not they have a right to kill him, and that's what this is all about.

MR. CHRONAKIS: Judge. Certainly I can appreciate this is a difficult argument because of how sensitive this is and if it's, if at all for me, it's undoubtedly you know, agonizing for a family to sit here.

If this were my dad or my grandfather or my spouse, I wouldn't be able to maintain the decorum that Mr. Betancourt's family is, and there have been a lot of difficult decisions in how to approach this even over the last 48 hours.

But I have to take issue with the suggestion that what Trinitas Hospital is doing is trying to, you know, hasten or harm Mr. Betancourt or, you know,

unless that's some of the language used by Mr. Miller, it's these physicians have cared for Mr. Betancourt as best they know how as he approaches, you know, as he's in this end of life stage which is difficult for anybody. And they are the only ones among us who can assess with any medical expertise what is happening to Mr. Betancourt.

I would want instinctively any relative of mine to stay alive at all costs.

That is not the only interest before the court, and that is actually not the only interest as to Mr. Betancourt when you have medical professionals swearing before the court that the continuation of life support as much as that might seem paramount to every other consideration is doing active harm to Mr. Betancourt's organs and to Mr. Betancourt's dignity. And certainly those are interests that the family has as well.

I only want to reemphasize one point in response specifically to something that was said which is certainly physicians may be aware of a financial bill.

I am sure, and I'm up here advocating on behalf of the client, that no physician at this hospital and no physician that I know would change his

or her medical judgment depending on the bill.

It's easy enough to understand that given that attorneys generally would not do that, an attorney's bill make people live or die, they just affect people's fortune sometimes and you still wouldn't give different advice to a client depending on if she owed you $1,000 versus $100,000. But physicians, you know, as Ms. Levy pointed out, they're the only members of society who really can sustain life or make decisions regarding life.

This isn't a judgment based on economics, Your Honor. It is a judgment based on what is happening to Mr. Betancourt and the medical training and education and expertise that these physicians alone among the parties have.

Thank you, Judge.

THE COURT: Okay.

The issue before the court at this moment is whether the defendant hospital should be required to reinstate the provision of medical care, namely, dialysis pending some further proceedings in connection with this matter.

Whatever understandings might have been, that is, the state of facts at the moment, there is medical care that has been not provided in the normal

course.

It would have been, I guess, today would have been the day for dialysis.

It is the opinion of the treating physicians as expressed in the opposition papers that medical care is futile. In fact, the provision of it would be harmful and thus violate the standard of care under which the physicians must operate.

The issue before the court is not one that is the subject of reported decisions in this case.

The reported decisions in the case, namely the Conroy case, In Re: Conroy, indicate that the right to make medical decisions in the case of an incapacitated person rests with the guardian or the next of kin.

Here, the next of kin has made a decision, notwithstanding the medical advice that they have received, that treatment should be continued.

What the court is being urged to do by the hospital is to override that choice, the choice made by the next of kin.

On the basis that as I pointed out treatment is medically inappropriate, it is against the standard of care, it is harmful to the patient. For the court to answer the question ultimately as to what needs to

be done, the court needs to be able to determine if those answers given by the hospital that treatment is inappropriate against the standard of care and harmful is accurate.

What I'm presented with by the moving party, the party that has the burden of proof here, is an expression of a belief that the hospital's position expressed through the physicians is incorrect.

It is the belief of the family that treatment is appropriate. It is the belief of the family that treatment would not be harmful. It is their belief that physicians could satisfy and meet their standard of care by providing treatment in this situation.

I'm also mindful of that line of cases which talk about mandatory injunctive relief requiring a party to do something is to be reserved for extreme situations. It is rare that a court using the temporary restraining order procedure should be directing affirmative relief.

Having said all of that, the court's faced with a situation that there is no ability, no opportunity provided to the court to wait and see.

This is an extreme situation. Certainly those standards of Crowe v. DeGioia that talk about

irreparable harm and balancing of hardships weigh very heavily in favor of the plaintiff.

The difficulty that the plaintiff faces by way of proof is that standard in Crowe v. DeGioia that talks about the settled legal right and reasonable probability of success on the merits.

That's not been presented to the court but the circumstances here are, they're extreme.

Mr. Betancourt would have been due for dialysis today as I understand it. That has not been provided based on the medical decision reached by the hospital. Any inaction on the part of the court I fear would be, in and of itself, a decision against the interest of the Betancourt family.

I think we need to move and we need to move quickly but something needs to be done in the meantime to get us to what was the status quo a few days ago.

I'm going to grant the request for the temporary relief.

I am going to reestablish the status quo and require the hospital to resume the treatment that was being provided, the level of treatment that was being provided at the beginning of this week.

I'm also -- I don't think we're in a position

now where I'm going to be setting this matter down for a hearing on the application for maintaining the injunction until the plaintiff provides further information.

So while the order will be in place, I want to give the plaintiff an opportunity to provide more information, obtain physician certification that support the position that the treatment should be continued, sort of join the issue, so to speak.

Get us something from a doctor that indicates that the belief expressed by the Betancourt family that treatment should be continued, that it's appropriate, not harmful, satisfies the standard of care, is in fact true.

With that in hand, I think then I'll be in a better position to address an appropriate time period to set this matter down for a hearing on whether or not to continue the restraint.

I would like, Mr. Martin, to see that, to have that information within a week.

I would like counsel to return here in a week so that we can all then with that information in hand discuss again, so to speak, the continuation, the appropriateness of continuing the restraints, and setting the matter down for a further proceeding.

So I'm going to grant the temporary restraint with the direction that the plaintiff provide supporting information from a physician or physicians with respect to their position and ask that counsel return here a week from today, next Friday, two o'clock, and we'll see where we go from there.

MR. MARTIN: Can I ask one additional consideration?

THE COURT: Yeah.

MR. MARTIN: I don't know how much, if not all of the record will be necessary for a physician's review. But in my experience, if I were to request a copy of the hospital record, it's going to understandably take time.

Is there some way that we could suggest that it be expedited?

THE COURT: It probably wouldn't hurt to have it.

Can records be made available to plaintiff's physician for review?

MR. CHRONAKIS: Certainly if you order that, Judge.

THE COURT: They'll be -- then they'll be available.

MR. MARTIN: Thank you, Judge.

MR. CHRONAKIS: Judge, in the interest of candor, and so that your order can be complete, it's my understanding that there is an DNR issued by the hospital or not issued but directed by the hospital.

MS. LEVY: By the doctor.

On January 14, the physician, Dr. Millman, entered a DNR order on the patient's medical records. So there's been some question about whether they should continue with the DNR or whether that should also be removed.

THE COURT: That should be removed for this week while we're operating under this temporary restraining order.

MS. LEVY: Thank you.

THE COURT: Mr. Martin, you think perhaps you can craft an order? Get that to me. I'll enter it as soon as I get it and fax it right back to you.

So you're going to fax it in and I'll fax it back, and I think counsel understand what the order will be. So as soon as you get it to me, I'll get back to you.

MR. MARTIN: Will do, Judge. Thank you.

THE COURT: Okay.

All right, thank you everyone. See you next week.

MR. MARTIN: Thank you, Judge.

MR. CHRONAKIS: Thank you, Your Honor.

* * *

(Whereupon, proceedings of 1-22-09 concluded)

* * *

CERTIFICATION

I, Lynn Cohen-Moore, the assigned transcriber, do hereby certify that the foregoing transcript of proceedings in the matter of BETANCOURT V TRINITAS HOSPITAL, heard in the Union County Superior Court, Chancery Division, General Equity Part, on January 22, 2009, Tape dated same date, Index Number 15:08:43 to 15:42:08, is prepared in full compliance with the current Transcript Format for Judicial Proceedings and is a true and accurate non-compressed transcript of the proceedings as recorded.

AUTOMATED TRANSCRIPTION SERVICES

BY: *Lynn Cohen-Moore*

Lynn Cohen-Moore A.O.C. #368

Dated: March 11, 2009

SUPERIOR COURT OF NEW JERSEY
CHANCERY DIVISION
GENERAL EUITY PART
UNION COUNTY, NEW JERSEY
DOCKET NO. UNN-C-12-09

BETANCOURT

Plaintiff

vs.

TRINITAS HOSPITAL

Defendant

TRANSCRIPT

OF

HEARING

Place: Union County Courthouse
Two Broad Street
Elizabeth, New Jersey 07207

Date: February 17, 2009

BEFORE

THE HONORABLE JOHN MALONE, J.S.C.

TRANSCRIPT ORDERED BY:

REBECCA A. EDELMAN LEVY, ESQ. (Garfunkel Wild & Travis)

APPEARANCES:

JAMES MARTIN, ESQ. AND TODD DRAYTON, ESQ.
Attorneys for the Plaintiffs, Betancourt Family

PHIL CHRONAKIS, ESQ., REBECCA A. EDELMAN LEVY, ESQ.
AND SAM GERMANA, ESQ. (Garfunkel Wild & Travis)
Attorneys for the Defendant, Trinitas Hospital

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Laurel Springs, New Jersey
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MR. MARTIN: Judge, just by way of organization.

THE COURT: Okay.

MR. MARTIN: So we'll get some direction from Your Honor, I suppose.

I have one physician, Dr. Goldstein, who as you suggested last time we were here, would be allowed to testify by phone. I have him ready anytime after about 10:30.

THE COURT: Okay.

MR. MARTIN: I have family members who are here today and prepared.

Phil mentioned that perhaps there's some doctors that need to get back to the hospital, so we'll need to do them first.

THE COURT: We had also mentioned that we'd be taking witnesses out of order to accommodate people's active schedules, so --

MR. CHRONAKIS: Of course, Your Honor. And we have Drs. Millman and McHugh available to testify. There's one other housekeeping note that I mentioned to Mr. Martin which is Dr. Khazaei who is Mr. Betancourt's nephrologist and therefore key to the dialysis issues is out of the country today, and she will be back tomorrow afternoon.

We were going to ask the court's permission just for her testimony since it is essential to the hospital's position, if the court would continue this hearing possibly on Thursday morning just for, just for her testimony if that works with Your Honor and if that works with counsel or as quickly as possible if we get exigency in this matter, Your Honor.

THE COURT: All right, well I'll have to review the, review the schedule and see what we can work out with that.

But if we've got a witness available, you may as well as begin there, take care of the doctor, and let him testify, so he can get on his way.

Okay.

MR. CHRONAKIS: Thank you, Judge.

THE COURT: Uh hum.

MR. CHRONAKIS: Your Honor, at this time, Trinitas Hospital will call Arthur Millman to the stand, please.

A R T H U R E. M I L L M A N, M.D., DEFENDANT'S WITNESS, SWORN:

SERGEANT-AT-ARMS: Please state your full name.

THE WITNESS: Arthur Edward Millman.

SERGEANT-AT-ARMS: Okay, spell your last

name.

THE WITNESS: M-I-double L-L-M-A-N.

SERGEANT-AT-ARMS: Thank you. Please be seated.

THE COURT: Mr. Chronakis.

MR. CHRONAKIS: Thank you, Your Honor.

DIRECT EXAMINATION BY MR. CHRONAKIS:

Q Good morning, Doctor.

A Good morning.

Q Doctor, can you tell us where you went to college and medical school, please.

A Undergraduate, I went to City College of New York and for medicine, the Albert Einstein College of Medicine.

Q And Doctor, do you have any board certification?

A I'm boarded in Internal Medical and in Cardiovascular Diseases.

Q And how long have you been practicing medicine, Doctor?

A Since 1969.

Q Doctor, what is your specialty?

A Cardiovascular diseases.

Q And can you briefly describe your professional experience since you started practicing

medicine?

A Well, I do general cardiology, noninvasive cardiology and also invasive cardiology, and probably the only cardiac teacher at the moment at the hospital in the training program.

Q How long have you been instructing other physicians?

A Since 1969.

Q Okay. Doctor, where are you currently employed?

A At Trinitas Hospital.

Q And with respect to -- are you familiar with the subject of this matter, Mr. Reuben Betancourt?

A Yes.

Q Do you have any financial interests in the outcome of this case or in Mr. Betancourt's disposition?

A No.

Q And if you can, describe your relationship with Trinitas Hospital in terms of your tenure there?

A I was originally brought in in '77 to be the Associate Director of Cardiovascular Diseases, and in time I became the Chief of Cardiology where I've been ever since.

Q What is your medical relationship with Mr.

Betancourt?

A He's my patient.

Q He's your patient. Are you, -- is it correct to say you're his treating physician?

A I'm the doctor of record at the moment.

Q And how long have you worked with Mr. Betancourt?

A It's got to be about a year by now.

Q Why did you take over Mr. Betancourt's treatment? Or how did you come to --

A Well originally I saw him before he was hospitalized. And then on his most recent hospitalization, he was under the care of the doctors who were taking care of him in the convalescent area elsewhere before he was transferred back to Trinitas, and then the family asked at a later time that I take over his care instead of the doctors who were there and I agreed.

Q Okay, do you know why you were asked to take over his care?

A Well, they knew me. That's part of it, I suppose. But the other part was the doctor was relatively insistent that advanced life support and full resuscitative measures were futile and that he really didn't want to do any more of that.

Q How did -- if you know, how did the Betancourt family know you?
A Oh, I suppose through Jackie.
Q Who is Jackie?
A She's Mr. Betancourt's daughter. She works for me.
Q And what does she do for you?
A She's a medical assistant/secretary.
Q How long has she worked for you?
A I think about two years, I think.
Q Have you ever made Mrs. Betancourt, Jackie Betancourt, aware of your opinions about her father?
A Yes.
Q When was that?
A On multiple occasions.
Q How long ago was the first time?
A Probably eleven months ago, something like that when it became clear that he had a permanent anoxic encephalopathy without any hope of recovery.
Q And does Ms. Betancourt still work with you and for you?
A Yes.
Q What is Mr. Betancourt's current diagnosis?
A Well he has multi-organ system failure. His kidneys have failed, his lungs have failed. He's

intermittently septic.

He has an underlying malignant thymoma which was brought into surgery in the first place, and he has hypertensive heart disease, intermittent congestive failure which is currently under control. And the overwhelming problem is of course the permanent anoxic encephalopathy with total loss of cognizant function.

Q That last part of Mr. Betancourt's diagnosis, Doctor, can you explain that in --

A Well he had an anoxic episode in the hospital after his surgery. He lost all his cognizant brain function.

And initially he was treated aggressively in the hope that perhaps that would come back which sometimes it does.

But if you don't see any change for the better within a few days, the likelihood of return to cognizant function is virtually zero, particularly in the older adult. It's different in children.

Q How old is Mr. Betancourt?

A 73, I think.

Q And Doctor you described an, I believe, an anoxic episode. Can you explain what that is?

A He was -- he extubated himself when he was in the Intensive Care Unit after his operation, and it was a

-- by the time they could get him re-intubated and resuscitated, there had been enough time for lack of oxygen to permanently damage his brain.

Q Doctor, in your medical opinion, what is Mr. Betancourt's prognosis?

A He's terminally ill. He's been dying slowly and painfully.

Q Can you describe the mechanical measures that Trinitas Hospital is using to keep Mr. Betancourt alive currently?

A He's on a ventilator that supports the breathing. He's being dialyzed at least three times a week, that supports the kidneys. He gets antibiotics for treatment of some truly horrific decubitus ulcers and continued antibiotics.

He's receiving nourishment via a peg tube, it's a tube that goes into the stomach and provides access for food, medicines, things like that.

And he gets really aggressive nursing care. They're always turning him from one side or another, desperately trying to treat the decubiti with which he was unfortunately admitted on the current admission which is, must be something like seven months old, something like that.

Q Doctor what, in your medical opinion, is Mr.

Betancourt's neurological state?

A He's in a non-cognitive state. That is there's no higher mental function. None of the things that make us human are present. All that's left is brain stem function and the nervous system, nothing that is aware.

Q Is -- in your opinion, is Mr. Betancourt permanently unconscious?

A Yes.

Q And do you know whether this has been confirmed by any other physician?

MR. MARTIN: Then that would be hearsay I would think?

MR. CHRONAKIS: Beg your pardon?

MR. MARTIN: I would object. That would be hearsay, Judge.

THE COURT: If it's records that he relied upon in reaching his opinion, then indicate what it is, what information he had available to render his opinion.

MR. MARTIN: Judge, if it were records, I would imagine it would be records wherein these physicians have expressed their opinions which would be objectionable if they are complex medical opinions. Additionally, as I understand it, there are a legion of

physicians are going to testifying following. And I would imagine a neurologist, a pulmonologist, et cetera will probably be here to express those opinions. To ask the doctor to simply regurgitate what --

THE COURT: I'm assuming you're right about who we're going to hear from.

MR. CHRONAKIS: Well, Judge, we're not necessarily going to hear from all those types of physicians that you unwrap a mystery. The two-physician assessment is part of not only the guardianship regulations but several cases that are cited in both parties' briefs. But if Your Honor prefers, we can tie this in later based on the testimony of --

THE COURT: We'll just wait for other witnesses then.

MR. MARTIN: Thank you, Judge.

BY MR. CHRONAKIS:

Q Dr. Millman, in your medical opinion, is there any treatment that will improve Mr. Betancourt's condition as you've described it?

A No.

Q Doctor, you made reference, I believe, to problems both with Mr. Betancourt's internal organs as well as with his skin. Can you elaborate on the

latter?

A Well the skin is breaking down, and there are multiple huge ulcers that the wound service at the hospital has been treating aggressively, but despite that, he's developed infection into the bone, that's called osteomyelitis which is a very pernicious thing, and with poor serum proteins and with his general debilitated state, he just doesn't heal, which makes it very difficult.

When someone is at -- always in bed, which, of course, he has to be, since he couldn't possibly stand, since he doesn't function, you get a catabolic state, that is, things start to break down, particularly proteins.

Even when you nourish the patient with food, you still generally have a negative nitrogen balance so that the patient still doesn't feel as well as someone who could move about, can get out of bed, can be ambulated, and this becomes all the worse if you're on dialysis or if you're on a ventilator, or both, and it's compounded by generalized episodes of sepsis and pneumonia, urinary tract infections, all of which he's had.

The skin becomes virtually parchment like and falls apart at the slightest touch.

MR. CHRONAKIS: Judge, may we approach?

THE COURT: Yeah.

(At sidebar)

MR. CHRONAKIS: Judge, we have one photograph, we have several photographs of Mr. Betancourt that we feel are probative, but I'm concerned with at least introducing in the normal course and the way the family might see them because they may be upsetting.

So I would like to first show them to counsel who hasn't seen them and then to Your Honor, and of course then to Dr. Millman to authenticate and testify.

But if nothing else, I want to make the court aware that I just don't want the family to be unnecessarily impacted by photographs which are rather graphic, and I'm only going to introduce one, because I think they may be cumulative after one.

THE COURT: Well, maybe you can just ask the doctor that if he's testifying about the photographs that's shown to him, that he just keep it down on the -- I don't want him holding it up when he's testifying or pointing to anything.

MR. CHRONAKIS: Sure. We're going to ask him that on the record, Judge?

MR. MARTIN: You could just tell him.

THE COURT: Just tell him at this point.

(Sidebar concluded)

MR. CHRONAKIS: Your Honor, I've provided Dr. Millman with a photograph that I'm marking for identification as Defendant's Exhibit 1.

(D-1 marked for identification)

BY MR. CHRONAKIS:

Q Dr. Millman, when was the last time you saw Mr. Betancourt?

A Yesterday.

Q Doctor, if you could turn your attention to the photograph marked as Defendant's Exhibit 1. I ask you if you can determine when that photograph was taken.

A Some time within the last few months. I don't know if it has a date on it. Yeah, it does, 2/13/09.

Q Now Doctor, there's a -- well, do you see the, a label on the photograph with Mr. Betancourt's name?

A Yes.

Q Now what is the July 2008 date on that label?

A Oh, that would be the date of admission.
Q Okay.
And what do you understand this photograph to depict?
A This is a decubitus ulcer, Stage 4.
Q Okay.
A It's as bad as they get.
Q Doctor let me ask you.
What part of Mr. Betancourt's body we're looking at in this picture?
A I think, I can't tell which one but it looks like one of his buttocks, going over the ileac crest, and you can see the bone peeping through.
Q Okay.
What -- when you last saw Mr. Betancourt, did his skin condition look substantially similar to what you're seeing in Defendant's Exhibit 1?
A Yes.
Q Um.
A He has others that are like this. This is only one.
Q Okay, is this -- what is the medical name for what we're looking at?
A It's a decubitus ulcer. It comes from pressure. People who are cognizantly aware usually don't stay in

one spot. They'll move.

If you stay in one spot, something will sure to start hurting and you'll move just so that you'll feel better.

But if you stay in one spot because you have to, then this sort of thing is very common.

You see it particularly in spinal cord injuries and quadriplegics, paraplegics.

Q Doctor, does Mr. Betancourt, I think you mentioned he has more than one. Where else, if any, are?

A They're on both sides. They're present on both sides.

Q Okay.

Where on his body are other ulcers?

A Well sir, it might make it easier if I show you. Over here. They're very large.

Q Are they on any other part of his body besides the buttocks?

A Nothing like this. There are other areas that are more modest.

Q Where are those?

A Well on the arms, the legs, back.

Q And what is -- when you mention the stage 4 ulcer, what is the significance of that?

A That means that it's gone through the entire skin into the subcutaneous tissue. And in this case, it's gone into the bone.

Q And are the ulcers that you described elsewhere on his body of a different stage?

A The other one on the other side is about the same. The others are much milder. The nurses spend an awful lot of time treating this. They're very good at it, and so they limit it as much they can.

Q What do they do to treat it?

A Well they irrigate it, they clean it, they move him off of pressure spots. He's always being rotated from one side to another side.

They keep it very clean and the wound service does a lot of very active care.

Q Doctor, how long have you observed ulcers at any stage on Mr. Betancourt's body?

A From July 3, 2008.

Q Are these ulcers going to heal with time?

A No.

Q Why not?

A He is too debilitated, has too many things wrong with him for this to ever get better.

He's getting the best treatment he can possibly get for this and it really hasn't helped that

much.

Q Doctor, I want to ask you about the dialysis treatment for Mr. Betancourt and start by asking whether in your professional medical opinion, you believe continued dialysis for Mr. Betancourt is medically appropriate.

A It's futile, it won't help.

Q Do you believe that continued dialysis is consistent with generally accepted standards of medical practice?

MR. MARTIN: Judge, I would object. I think the doctor's now testifying outside of his specialty.

BY MR. CHRONAKIS:

Q Doctor.

MR. CHRONAKIS: I'm sorry, Judge. Dr. Millman has testified regarding his vast experience, training and actually educational background in all aspects of internal medicine.

We will have a nephrologist, but Dr. Millman if you prefer me to further back on, is certainly competent to testify regarding dialysis especially in a big picture question like the one that's pending.

MR. MARTIN: Judge, he's being asked to express a standard of care opinion in the area of nephrology in which he has no credentials. There's an

nephrologist who's scheduled to testify.

MR. CHRONAKIS: Judge, again. Internal medicine covers all areas of the internal body, one of which is the kidneys. So I don't know if this is really a legal objection as much as an area of, (clears throat), excuse me, an area, if you'd like me to lay a further foundation.

But I do believe Dr. Millman is competent to testify on the effect of dialysis and the propriety of dialysis as part -- as within his scope of expertise and experience in internal medicine.

MR. MARTIN: Judge, unless there's some foundation laid that he has administered dialysis, treated --

THE COURT: If we could just get some additional evidence with respect to his experience in the area, we'll move on from there then.

MR. CHRONAKIS: Yes, Your Honor.

BY MR. CHRONAKIS:

Q Doctor, are you able to estimate how many patients you've treated or cared for in your nearly 40 year career?

A Tens of thousands. It's a long time.

Q Were any of those patients on dialysis?

A Yes.

Q Can you approximate how many?
A Well it's in the hundreds. It may be higher than that. But it's certainly in the hundreds.
Q And have you had patients on dialysis where both you and a nephrologist are working with a patient?
A Oh certainly.
Q Okay.
Now in your experience in Internal Medicine, do you observe and evaluate issues with patient's kidneys and the use of dialysis?
A Certainly.
Q Did you receive education and training related to treatment of the kidneys and dialysis?
A Yes.
Q In terms of assessing Mr. Betancourt's condition, are you aware of the condition of his kidneys?
A Yes.
Q Are you aware that he has been on dialysis?
A Yes.
Q Are you able to, (clears throat), excuse me, establish a professional medical opinion related to Mr. Betancourt's kidneys and the benefit of dialysis?
A Yes.

MR. CHRONAKIS: If the court would agree that a sufficient foundation has been laid, I would like to resubmit the pending question to Dr. Millman.

MR. MARTIN: Judge, I would -- obviously I would disagree and I would continue my objection.

THE COURT: I'll overrule the objection. I think there is a sufficient foundation established that the doctor is familiar with treating patients with kidney disease and the nature of that treatment. So --

MR. CHRONAKIS: Thank you, Your Honor.

BY MR. CHRONAKIS:

Q Dr. Millman, in your professional medical opinion, is it consistent with generally accepted standards of medical practice to continue dialysis treatment for Mr. Betancourt?

A No.

Q Doctor, are you aware whether a Do Not Resuscitate or DNR order is in place for Mr. Betancourt?

A Not at the moment, it had been.

Q It had been.

Can you explain to the court how that came to be.

A We placed him in the Do Not Resuscitate Capacity

because it was futile to produce cardiopulmonary resuscitation.

It would not offer anything for the better in his case. And then when the court ordered that that be reversed, we followed the court's order.

Q Now when was the Do Not Resuscitate order placed by the hospital?

A Must be about a month ago or something, maybe more.

Q And has it been lifted or --

A Yes.

Q -- not in place since the time of the court's order.

A Yes, once we got the court's order, that's what we did.

Q And just so the record is clear, what is the effect of a DNR order?

A All it means is that if the patient's heart stops or if he has a problem with blood pressure or his breathing becomes worse than it already is, that nothing active be done to change that, that being the natural history of his illness.

Q And, Doctor, in your professional medical opinion, is it consistent with generally accepted standards of medical practice to have a DNR order in

place for Mr. Betancourt?

A It's hard to conceive of a patient who had the problems he has who wouldn't have one.

Q Doctor, do you believe that Mr. Betancourt's illness is irreversible?

A Yes.

Q And do you believe the risks and burdens of continued dialysis outweigh the benefits of such dialysis for this patient?

A I can't think there's any benefit.

Q What in your opinion will happen to Mr. Betancourt if he's continued, if he's continued to be sustained by the medical, excuse me, by the mechanical processes you describe?

A He'll continue in his present course which has been inexorably downhill. All we are doing is prolonging his dying in a painful fashion.

Q In the event that Mr. Betancourt suffered heart failure, do you believe that efforts to resuscitate him would be consistent with generally accepted standards of medical practice?

A Heart failure is probably the wrong word.

Even if the heart had stopped that trying to bring him back that a) probably would be futile, but also would be, I think, contrary to proper medical

care.

Heart failure we have treated from time to time when it appears, and that's not a major intervention. That's just giving a modest medication.

DNR doesn't mean you don't treat. It means that treatment is limited to things that are not so-called heroic in nature.

Q Doctor, do you --

(Phone rings)

MR. CHRONAKIS: I'm Sorry, Judge.

BY MR. CHRONAKIS:

Q Doctor --

(Phone rings three more times)

MR. CHRONAKIS: I don't know what button to press to make this stop ringing, but I will turn the phone off.

BY MR. CHRONAKIS:

Q Doctor. Do you believe that continued care of Mr. Betancourt as you've described, that is the dialysis, the lifting the DNR order, the ventilator, et cetera, do you believe that that continued care is against your professional ethics?

A Yes.

Q Is it against your professional practices?

A Yes.

Q Do you believe it's appropriate?

A I don't think any of these things should be done.

MR. CHRONAKIS: Judge, may I have a moment?

THE COURT: Yes.

MR. CHRONAKIS: Your Honor, I have no further questions at this time.

THE COURT: Mr. Martin.

MR. MARTIN: Thank you, Judge.

CROSS-EXAMINATION BY MR. MARTIN:

Q Dr. Millman, you are the patient's attending physician.

A Yes.

Q Correct? What does that mean?

A Well he's the one who's supposed to coordinate the care, because principally he has so many problems that there are multiple -- a multiplicity of specialists involved in his care, and the doctor of record is supposed to try and coordinate all that.

Q By coordinate, does that include calling in different specialties?

A Yes.

Q To address different medical problems?

A Yes.

Q Are you actively treating him for a cardiac condition?
A No. He's not really had a bad heart.
Q How is it then that a cardiologist becomes the attending physician for a man with these other varying problems?
A The family asked me.
Q When did you become the attending?
A Probably a month or two ago, something like that.
Q And who was attending before that?
A Dr. Kassarochi and Dr. Drew (phonetics). There's a -- they have a formal name which I don't remember but Dr. Kassarochi is the head of their group.
Q And what's their specialty?
A Internal Medicine.
Q When you took over, you took over at the family's request?
A Yes.
Q And that was, I'm sorry, you said a couple of months ago?
A A month or two, something like that.
Q So it was during this particular admission.
A Oh yes.
Q And did you say that when Mr. Betancourt was

admitted, he was admitted with the decubitus ulcers?

A He already had decubiti.

Q He had developed those at a different site.

A Exactly.

Q Have they improved, gotten worse, gotten --

A Worse.

Q And that is despite the treatment that's been given.

A Exactly.

Q Who's treating those, what specialty?

A Dr. Losman, he's a wound care specialist.

Q And I'm sorry, what's his name?

A Losman, L-O-S-M-A-N. Losman.

Q Dr. Losman specializes in the treatment of this condition.

A Yes.

Q Are there protocols in place that the patient is rotated every couple of hours?

A He sees to that and we see it all the time. It's a lot of nursing work and the nurses are very good about that.

Q And are you responsible for bringing that particular physician in?

A He was brought in by Dr. Kassarochi before I

assumed control. But if I had been the doctor of record at that time, I would have done the same thing.

Q Okay.

Now who is responsible for the treatment of this patient's kidney condition?

A Dr. Khazaei.

Q And Dr. Khazaei is a nephrologist.

A Yes.

Q Was Dr. Khazaei already in place when you took over?

A Yes.

Q Who's responsible for his, for the ventilator?

A Dr. Garth (phonetic)?

Q And what's his --

A Specialty, a pulmonologist.

Q And I understand there's G-tube in place.

A Yes.

Q Who's responsible for that?

A I think Dr. Veiana's group put that in. It was either he or his covering doctor if I remember right. He's been there a long time.

Q What's his specialty?

A Gastroenterology.

Q The patient is also seen by a neurologist.
A Yes.
Q And is that Dr. Schanzer.
A Schanzer.
Q Schanzer. What other specialties consult?
A Well Infectious Disease, Dr. Scherer and Dr. Faraz (phonetics) have been seeing him.
Q Tell me then what other than coordinating those particular consults, what direct care do you provide the patient?
A Most of what he needs is provided by the consultants.
From a cardiac standpoint, apart from occasional episodes of heart failure, there's nothing that much for me to do.
Q Did you know this patient before a couple of months ago?
A Yes.
Q How did you know him?
A I saw him in the office.
Q For what condition?
A He was having a chronic cough (inaudible).
Q I take it that you're familiar with the record, the hospital record, in this particular case.

A Yes.

Q Did this patient have a Living Will, an Advanced Directive, any of that?

A I don't remember that.

Q Have you ever discussed that circumstance with this patient?

A I did not.

Q Have you ever discussed it with the family?

A I've mentioned what I thought the proper standards ought to be for the family, yes.

Q I understand from reading the hospital record that was supplied I think it was January 14, you had a conversation with Jacqueline and perhaps other family members, correct?

A I don't remember but we have had such discussions.

Q Were you designated by the hospital to talk to the family prior to discontinuing the dialysis?

A Yes.

Q You were the hospital representative.

A Yes, and I did mention that.

Q Have you had conversations with the family prior to this about --

A Mostly --

Q -- continuing treatment?

A Mostly with Jackie, yes.

Q And what was her expression or her feeling?
A She was very upset about this, which I can understand, and she mostly preferred that her brothers make the decisions.
Q Have you ever talked directly to the brothers?
A Yes.
Q And what is their feeling concerning discontinuing treatment?
A They want all treatment continued.
Q Has any member of the family adopted the position of the hospital insofar as discontinuing dialysis or any of the other necessary treatment.
A No.
Q And you've not had a discussion with the patient himself about his wishes or desire in a circumstance such as this.
A It would be a one-sided discussion.
Q Who gave you permission to place the DNR in the patient's record?
A The hospital said that that could be done without the family's consent.
Q So no one ever discussed that with the family.
A It had been discussed before, and has actually

been placed before, but that was by Dr. Kassarochi's people.

Q And when it was placed before, the family insisted upon it being removed. Isn't that true?

A I don't know.

Q And it was placed without their knowledge on that occasions. Isn't that true?

A I don't believe so. I believe I spoke with Dr. Kassarochi about it and he told me that they did discuss that with the family and that they did obtain consent verbally.

Q Who insisted that it be removed?

A The family.

Q And they insisted that an order that was in place be removed because they never authorized it to be placed in the first place. Isn't that correct?

A That was their position but it's not the position of the doctors who spoke to them.

Q So --

A We have a he said/she said sort of thing.

Q So we find ourself in a circumstance where you don't know what the patient's wishes would be. Correct?

A (No response).

Q Because you never discussed it with him.

A No, I haven't seen him long enough to have such a discussion.

Q You don't whether he had an Advanced Directive or a Living Will yourself. Correct?

A Not to my current knowledge. I would have to look back at the records to find out because we keep things like that.

Q Wouldn't that be something you'd want to know in this circumstance?

A At this point, no, because it wouldn't make any difference.

Q And you've never talked to a family member who ever expressed concern or a willingness to go forward with these, with discontinuing any of these treatments. Correct?

A No. I've spoken with them about discontinuing treatment, making him DNR, and each time I brought this up, I get this resistance.

Q Because the family is not inclined to adopt that position, correct?

A Correct.

Q So we're here because you and/or the hospital wish to impose your standards or beliefs on this family, correct?

A No.

Q Have you taken into consideration that the family doesn't wish to discontinue the treatment?
A Yes.
Q Despite that, you're going ahead on one occasion and stopped the dialysis.
A We would not want to do therapies that are against proper medical practice or against the ethical bases set forth in the statements that the American Medical Association has so nicely codified.

When you have futile therapy in a hopeless case, it is inappropriate to push forward with further therapy, knowing that this can only make things worse.

Q Doctor I appreciate that answer but your answer to my question would be we intend -- we are attempting to impose our wishes over the wishes of the family. Isn't that correct?
A No.

MR. CHRONAKIS: Objection, Your Honor.

THE COURT: Overruled.

BY MR. MARTIN:

Q This man is not brain dead, is he?
A He has no cognitive function. That means that he functions on the level of a microscopic organism. He can react to pain, and that's about it.

Q Have you seen the affidavit of Dr. Schanzer?
A Yes.
Q And you disagree with Dr. Schanzer who says this patient does not respond to pain.
A Yes, he does respond to pain. I know it because I've seen it.
Q You disagree with the neurologist who's treating with him, Dr. Schanzer.
A I have to disagree on that one point.

He doesn't have an cognitive, cognizant response to pain which I think is the way he phrased it in that consultation.

But in terms of the flesh reacting to being irritated, that he stopped.

Q So you disagree with Dr. Schanzer when he says he patient does not respond to pain.
A I told you that I don't think that's what it says there.
Q Well that's what his affidavit says.
A He says he doesn't have any cognizant response to pain.
Q Do you have any special training in neurology?
A No.
Q Do you have any special training in

nephrology?
A Yes.
Q What training is that?
A I did an awful lot of nephrology. I ran a dialysis unit for two years in the service.
Q Do you have any training in wound care, special training?
A No.
Q Any special training in pulmonology?
A No.
Q And the extent of your nephrology is treating patients while you were in the service.
A Then and since but I don't initiate dialysis myself anymore because the field has progressed. I call a nephrologist for that.
Q So you do you hold yourself out as a specialist in nephrology?
A No.
Q An expert in nephrology?
A No. That's why we have people to help us.
Q A PGY-2 is a resident.
A Yes. It means post graduate year 2.
Q I'm sorry?
A It means post graduate year 2.
Q Is this patient awake from time to time?

A There's no cognitive function so he cannot be said to be awake.

Q So if a pulmonology resident visited him on January 22 of this year and found him to be awake, you would disagree with that assessment I take it?

MR. CHRONAKIS: Objection, Your Honor. And there's no foundation for this question. It's not an expert witness. There's nothing in the record to establish what Dr. Millman's being asked to respond to.

MR. MARTIN: Your Honor, I'm going to present him with this. This is a part of the hospital record that I was provided with.

THE COURT: I'm going to overrule the objection.

BY MR. MARTIN:

Q Doctor, I'm going to show it to you because we're at that point.

This is a part of the hospital record for the admission of July of 08 and it's part of the progress record.

Now what is a progress record?

A What the doctor did that day.

Q And this is a pulmonology resident, a PGY-2 pulmonology.

A Yes. It's his pulmonary note.

Q And he would ordinarily make rounds.

A Well with a pulmonologist, yes. I don't know. I can't decipher the handwriting. That's what the number is for because each of them has a number.

Q Okay.

A But the patient has never been awake since his anoxic encephalopathy.

Q I haven't asked -- I haven't asked you a question yet.

This is a round that this pulmonology resident made at ten a.m., correct?

A Uh hum.

Q An S with a circle means subjective.

A Um, yes.

Q What does that mean in this context?

A What they are observing, what they see? And the resident is not trained at the level to be able to assess --

Q You know what? Stop volunteering information. If you could, just please stick with the question. All right.

I know you want to criticize the pulmonologist because he disagrees with you, correct?

A No.

Q Well he says he was at bedside and observed the patient to be awake.

A He does not.

Q What does it say there?

A It says, Number 706 observed the patient to be awake.

Q What did I just say that you say that he does not? I don't understand your answer.

A That's not the pulmonologist. That's the resident trying to learn pulmonology.

Q This is a resident in pulmonology, correct?

A Yes.

Q This is a gentleman who has presumably graduated medical school, correct?

A Yes.

Q He's in his second year of residency, correct?

A Yes.

Q Which means I take it it's a rotating residency at Trinitas.

A (Inaudible).

Q So he is a permanent resident in pulmonology?

A No.

Q Does he round in different specialties?

A Yes.

Q We don't know how long he's been in pulmonology, but we know this is his second year of residency.

A I know how long he's been in pulmonology.

Q And would you think that a medically trained second year resident wouldn't be able to tell the difference between a patient who is awake and not awake?

MR. CHRONAKIS: Objection, Your Honor. I don't mean to be standing in front of you.

THE WITNESS: That's okay.

MR. CHRONAKIS: I want to apologize for that --

Your Honor, Dr. Millman is called as a fact witness to testify regarding his assessment of Mr. Betancourt.

We're now -- certainly he can be confronted with the hospital's record and ask to explain. But we're now having Dr. Millman sort of explain what some pulmonologist who has not testified thought about some record that Dr. Millman did not testify to.

So we're either way outside the scope of direct examination or certainly beyond what a fact witness should be asked.

MR. MARTIN: Judge, first of all if I knew he was a fact witness, I would have had 100 objections to most of his testimony. I thought he was here as an expert.

But be that as it may, I'm asking him to comment on this particular part of the hospital record.

This is not some sophisticated medical opinion. This is a medical doctor's observation of the condition of the patient.

THE COURT: I'm going to overrule the objection. I think it's, I think it's fair cross examination.

The doctor on direct examination indicated in his opinion the patient was not cognitive and is simply being confronted with something in the record to question that opinion.

BY MR. MARTIN:

Q Doctor, is it not the consultant physicians that you called in unless there is some untoward event that requires their attention, would make periodic visits to the patient. Is that how it generally works procedurally?

A It depends on whether their services are still needed.

For Dr. Garth who's the pulmonologist he will see him regularly because he's still on the ventilator. For Dr. Khazaei, who's the nephrologist, she will see him regularly because he's still on dialysis.

For treatment of his infections, both Drs. Losman and the infectious disease people will see him regularly because that's still an active problem.

For treatment of anything else, I would have to call someone else in if there was something that requires someone else's attention.

Q What I'm trying to establish though. What is regularly?

A It varies.

Q Once a day.

A No, it varies with the attending and how often they feel they need to see them.

The infectious disease people, often it's not daily, it's sometimes every other day. You know they have to judge based on the individual patient.

But the nephrologist, it would be at least three times a week. And for the pulmonologist, probably varies. For me, it's daily.

Q The resident then, are they responsible for the day-to-day care of the patient.

A No, he's not on the teaching service.

Q Is the resident someone who routinely or regularly visits the patient?

A No.

Q How is it that this PGY-2 would have seen the patient on January 22?

A He was rotating through pulmonary for that month and would see the patients as part of that rotation just like he would if he were rotating through rheumatology or cardiology or infectious disease, whatever patients were on that service being followed by the doctor who is teaching him, he or she would see on a daily basis as long as they were still being followed by the specialty.

Q Let me show another record on January the 9 of 2008 at 1:26 p.m.

It appears to be -- first of all, do you see a number? Again, this is a PGY-2 pulmonary service.

A Yes. Right. It's the same one.

Q Okay.

A The same doctor. This is the same number.

Q And I'll give you this in a moment.

But the record says that at 1:26 the patient was seen at beside. "He was responsive to touch and verbal stimulus." What does that mean?

A I have no idea since I didn't do it.

Q Well when a patient is responsive to touch, what does that mean to the medical professional?
A If the patient is cognizant, then you'll be able to interpret that.

If they are simply responding in a vegetative manner, then touch response will be if I touch you will --

Q When they say he responded to verbal stimuli, stimulus, what does that mean?
A Ever since his anoxic encephalopathy, I'm assuming here, what I would mean by that is ever since his anoxic encephalopathy he has responded to noise.

So if you call his name or make a sound, drop something, he will turn towards that.

Q Can he communicate?
A No.
Q Does he have a regular sleep cycle?
A No.
Q And he's never awake.
A He's never awake because he's never cognizant. The eyes are open but that doesn't mean you're awake.
Q So when this physician says that he observed on one occasion to be awake, and on another occasion he responded to verbal stimulus and was responsive to

touch, do you disagree with those observations?
A Yes.
Q Doctor, would you -- the same physician, I'm going to show you, talks on another note on January 9 as the patient being arousable. What does arousable mean in this context?
A I don't know.
Q Well do you agree that this patient is arousable?
A No.
Q On January the 19 at 8:25 a.m. this physician says that the patient was awake and responsive.
You wouldn't, in your estimate, find this patient ever to be awake and responsive, would you?
A No, not since the anoxic encephalopathy, unfortunately.
Q Is there a difference between being comatose and being in a persistent vegetative state?
A Neither of them -- I mean persistent vegetative state is a well-defined term.
Comatose there are different levels and it also depends on what you mean by that.
When you don't have any cognitive function, comatose doesn't apply as a concept.

Q What does semi-comatose mean?
A That means that someone is arousable and does have cognizant function. When you don't have cognizant function, people don't talk about coma.
Q I'm going to show you a note from the hospital record on 12/17/08.
Do you recognize who that physician is?
A Yes, that's Dr. Losman.
Q And Dr. Losman says that this patient was non-responsive, was in a semi-comatose state. You would disagree with that I take it.
A I would just put it as vegetative. That's what I would call it.
Q Well there is a medical difference between semi-comatose and persistent vegetative state, is there not?
A Uh hum.
Q And Dr. Losman is what type of a physician?
A He is a wound care specialist.
Q Doctor, as I understand it, strike that. When a physician says that a patient is stable, what does that mean?
A Well it means that their current situation isn't changing, better, worse. It's about the same.
Q Is this patient stable?

A No. There are times when he is. At the moment, he's less stable because he's becoming more septic again, at least as of yesterday.

Q This is something called an inpatient interdepartmental hand-off report. What does that mean?

A You got me.

Q And this physician, -- this person in the interim says that this patient is stable for transfer. What does that mean?

A I don't know. You'd have to ask them.

Q And then on January the 6 of this year, someone entered that this patient was stable for transfer. You don't know what that means.

A Nope.

Q You are his attending physician, correct?

A Uh hum.

Q If this patient were to be transferred, would that not have to be under your auspices?

A It depends on where you're transferring him.

Q Well if he were to be transferred to another institution, would you have to sign off on that

would you participate in that?
A Usually.
Q Have you been actively been participating in trying to transfer this patient to another facility?
A Not any more. The hospital made exhaustive efforts to try and find a place that would accept him for months without success.
So nobody's been trying anymore since they can't find anybody who will take him.
Q Let me show you a note dated January 21, 2009. And I will represent to you that the hospital record that I have I think stops on January 23. So this is the most current that I have.
That there is a social worker by the name of Jessica Oliva or Oliva trying to place him at a facility in New York called Resorts.
A They have tried off and on since he was ready for that sort of thing. But --
Q But you just said that they haven't -- they gave up a couple of months ago.
A Uh hum.
Q Certainly as of January 21, she's still communicating with a place.
A So they --
Q Let me finish the question, Doctor.

She's communicating with a place, that's telling her that they just don't have a bed available.

A The administration told me that no place was willing to take him, bed or no bed. They've tried.

Q The administration is you, is it not?

A No.

Q Are you not part of the administration?

A Nope.

Q You're the chief of cardiology.

A Yup, but that has nothing to do with the hospital.

Q You have privileges at Trinitas Hospital and no other hospital, correct?

A No.

Q Well else do you have privileges?

A Beth Israel, Saint Michaels, UMDNJ.

Q Do you admit patients routinely at either of those physicians (sic).

A No.

Q Facilities?

A No.

Q You admit patients to Trinitas.

A Yes.

Q Your practice is limited to Trinitas.

A Basically.

Q You were designated by Trinitas to speak to the family on behalf of Trinitas.

A No, they asked me to speak on behalf of what his doctors thought was best, not anything having to do with Trinitas, per se.

Q Who asked you to speak with them?

A Mr. Veran (phonetic).

Q Who's that?

A He's CEO.

Q The guy who runs the hospital?

A Yes.

Q What us poor folk would consider the administration, correct?

A He's the administrator for the hospital.

Q This patient doesn't currently have pneumonia, does he?

A Not as of yesterday.

Q He was admitted back in July because they either had or they were concerned that he might have pneumonia.

A He was pneumonia and he had sepsis.

Q Which is a complication of ventilation.

A Can be but it can also be just his underlying chronic lung disease. So --

Q Well in this case do you have an opinion one way or the other?
A No.
Q In the event they did arrest or bring under control that condition.
A At that time.
Q There is nothing, Doctor, as I understand it, correct me if I'm wrong, insofar as his ventilation is concerned. While I realize that ventilation is not -- strike that.
There is nothing extraordinary about that treatment with this patient, is there?
A What --
Q What I mean if there's no conditional machinery, additional personnel required, any additional efforts. He's receiving ventilation as it would be administered to any other patient in need of ventilation?
A Yes.
Q The same thing is true of the dialysis, is it not?
A Yes.
Q He's receiving routine maintenance dialysis.
A Yes, it's not quite the same as it would be for someone else, because there's much more nursing work

that's involved because where he is, he has to go down three flights. Obviously he can't walk. He -- a stretcher, and you can't use the ventilator that way and so they have to have a respiratory therapist ventilate him by hand while this is taking place. So it's a lot of nursing work. I mean they do it three times a week.

Q But that would be true of any patient who would find themselves having to travel three floors.

A If they were on a ventilator. We --

Q So there's nothing --

A I don't think we've ever had this. I don't think we've ever had a patient in his condition who was undergoing chronic dialysis, at least I've never seen it.

Q But other than having to transport him to three floors, there's nothing unusual about the type of dialysis he's receiving.

A Oh no.

Q Or the manner in which --

A It's quite routine.

Q It is your belief, is it not, Doctor, that this, this gentleman will, will die in a matter of months?

A Yes.

Q Regardless of whether or not this treatment is discontinued or not.

A Yes.

Q That's all I have, Doctor. Thank you.

THE COURT: Counsel.

MR. MARTIN: Thank you, Judge.

THE COURT: Redirect.

MR. CHRONAKIS: Your Honor, first of all at this time I would request to move D-1 into evidence.

THE COURT: Okay.

MR. MARTIN: Did you give it to the Judge.

MR. CHRONAKIS: Well I'm asking.

MR. MARTIN: I don't have an objection.

THE COURT: No objection.

MR. MARTIN: No objection.

THE COURT: Okay.

(D-1 placed into evidence).

REDIRECT EXAMINATION BY MR. CHRONAKIS:

Q Dr. Millman, does an attending physician make the final call on patient treatment issues?

A Yes.

Q And you do that for Mr. Betancourt?

A Yes.

Q Now if Mr. Betancourt were awake but in his

condition as you described in terms of his -- if this could be that he were awake and requested dialysis, would you, based on medical judgment and training, would you provide it?

A I would argue against it.

But I don't think that considering his multiple other illnesses that even if his brain were functioning that he would be able to be awake to the point where he could communicate this sort of information. And even had that been true --

MR. MARTIN: Judge, that's way outside of a hypothetical. So I would object.

THE COURT: If you would could confine your answer to the question that was asked.

THE WITNESS: Yeah, I would argue against dialysis under those circumstances.

BY MR. CHRONAKIS:

Q And I want to ask you this doctor.

You were shown part of Trinitas Hospital's record where a PGY-2, a post-graduate year 2 entered some notations on the record.

What, what level of medical experience is a PGY-2.

A It's a second post-graduate year. PGY-1 is the year after medical school. PGY-2 is the second year

after medical school.

Q Is this physician considered a student still?

A Yes, you know, in training.

Q In training.

Are these like the youngest physicians for example on the TV shows they depict in the hospitals are the interns.

A Yes.

Q Doctor, how many years, if you could remind me from your direct testimony, did you say you practiced medicine?

A Since '69.

Q And I know Mr. Martin posed the difficult question of whether Mr. Betancourt would pass in a matter of months no matter what treatment he were or were not provided.

What I want to ask is what condition his body would be in if he were allowed to persist for another few months.

A Things will continue to deteriorate. There would be more ulcers, more pain.

Q What happens if this ulcer gets work. Is there a stage 5?

A No, this is as bad as it gets.

Q All right, in your medical opinion, would the other ulcers increase towards stage 4?
A The nurses will do their damnedest to try and prevent it. My guess is that they probably will be successful. That's a guess.
MR. CHRONAKIS: No further questions, Your Honor.
RECROSS-EXAMINATION BY MR. MARTIN:
Q Doctor, you, you answered counsel's question by saying you would argue against, if you were having a conversation with Mr. Betancourt, you would argue against continuing dialysis.
A Yes.
Q You would not refuse it to that man, would you?
A I've never had a patient in that situation, so it's really hard to know for certain what I would do, but I would strongly argue against it, because it would be a way of prolonging his dying, prolonging his suffering.
And every time this comes up where we have a treatment that's possible, the families and patients, they usually elect to suffer less.
Q In this case, they have not agreed with your --

A No.

Q -- view of the state of affairs.

A Yes.

Q Have you ever participated in a situation like this before, where a family has disagreed and you've gone to court and tried to --

A No.

Q -- force the issue.

And this poor PGY-2, I wish I knew the poor guy's name. For all you know, he's top of the class at Harvard.

A I can answer that one. He is not, or she is not, I'm not sure which it is.

Q Why is that?

A Because (clearing throat) excuse me. We've never had a resident from Harvard -- the attending staff, we have a number of people from Harvard yeah, but not on the residency staff.

Q Whether they're from Harvard or UMDNJ, these physicians are certainly trained in how to assess a patient, make observations of whether he's awake or asleep.

A They're being trained in that. Are they finished? No.

Q All right, Doctor, that's all I have.

Thanks.

THE COURT: I thank you, Doctor, you may step down.

Mr. Chronakis.

MR. CHRONAKIS: We have another witness ready, Your Honor. We have two others, but maybe we can call one other at this time and then discuss --

MR. MARTIN: Judge, could we just -- I have no problem with that.

Could I just have a minute to call Dr. Goldstein and just give him an idea when we're going to get to him which is probably after this witness?

THE COURT: Why don't we just take five minutes, make a call, see about availability and work out a schedule from there.

We'll take five minutes.

(Brief Recess from 10:46:24 to 10:57:02)

SERGEANT-AT-ARMS: Court's in session, remain seated.

THE COURT: All right, Mr. Chronokis, we have another witness of yours available in court?

MR. CHRONAKIS: Yes, Your Honor.

THE COURT: Mr. Martin, your telephone witness still, still available?

MR. MARTIN: I didn't speak directly to the

witness, but as far as I know, yes.

THE COURT: Okay, we'll take, we'll take the witness in the courtroom.

MR. CHRONAKIS: Thank you, Judge.

At this time Trinitas Hospital will call Dr. William McHugh.

SERGEANT-AT-ARMS: Watch your step, please.

Place your left hand on the Bible and raise your right.

W I L L I A M J. M C H U G H, M.D., DEFENDANT'S WITNESS, SWORN:

SERGEANT-AT-ARMS: Please state your full name.

THE WITNESS: William J. McHugh, M-C- capital H-U-G-H.

SERGEANT-AT-ARMS: Thank you.

DIRECT EXAMINATION BY MR. CHRONAKIS:

Q Good morning, Doctor. Please tell the court your educational background, college and medical school?

A Holy Cross College, Down Street (phonetic) University and Medical School in Brooklyn. I did my internship and residency in the Air Force. I remained in the Air Force ten years.

Subsequently, Medical Director at Bell Labs

for a couple of years, and then private practice for the last 30 years.

Q And how long in total, Doctor, have you been practicing medicine?

A If you include med school, 50 years now.

Q And what specialty do you have, if any?

A Internal medicine.

Q How are you currently employed? How are you currently employed? What's your --

A I work four hours a day as Medical Director at the Hospital and six hours a day in my private office with three partners.

Q You're Medical Director of Trinitas Hospital?

A Yes, sir.

Q How long has, have you held that position?

A Four to five years.

Q Can you please explain your involvement with Mr. Betancourt's case.

A My initial involvement was I was assigned to the Prognosis Committee. There were some issues about his remaining in the Intensive Care Unit.

So myself, Dr. Veiana, -- a Prognosis Committee with some input from Dr. Bresher (phonetic) who is Chief of the Intensive Care Unit.

Q Doctor what does the Prognosis Committee at

Trinitas Hospital do?

A Any nurse or doctor can ask for a prognosis consult when the question of liability or likelihood of success for a treatment comes up.

In this case, the patient was in the Intensive Care Unit in a vegetative state, and normally we have three or four patients waiting for Intensive Care beds and the issue came up as to whether he should really remain there when acutely ill people with better survival possibilities were waiting for a bed.

Q Okay. Doctor, when is the last time you saw Mr. Betancourt?

A I actually went to see him yesterday.

Q And does Trinitas Hospital keep physicians' notes and patients' records in the normal course of functioning the hospital?

A Yes, sir.

Q Have you reviewed those physician notes and patient records related to Mr. Betancourt?

A The records are enormous.

I reviewed them last year when I did the Prognosis Committee Review and I reviewed them to some extent yesterday but the entire record is too voluminous to read.

Q And with respect to your role as Medical

Director, how have you been involved with Mr. Betancourt's case?

A Actually, my initial involvement through the Prognosis Committee it's probably because I was Medical Director and not too many people want to spend the time to do that.

And subsequently when the issue of continued treatment came up which was probably in the last month, I became re-involved.

Q Okay.

What -- from your awareness what is Mr. Betancourt's current diagnosis?

A He's in a persistent vegetative state, he's diabetic, he has chronic obstructive pulmonary disease, he has renal failure. He has hypertensive cardiovascular disease with past congestive heart failure, he has multiple major decubiti and osteomyelitis of the bone.

Q In your professional opinion, what is the outlook for Mr. Betancourt?

A There is no outlook. He cannot regain consciousness at this state.

Q Now besides the life support, if you will, to use a layman's term, the ventilator, the dialysis, feeding tube, is there any affirmative treatment that

would improve Mr. Betancourt's condition?

A No. There's nothing possible.

Q In your 50 years of medical experience, have you seen a patient that's been in a persistent vegetative state for as long as Mr. Betancourt has, improve?

A No. This is probably a record. I mean we deal with persistent vegetative state often.

Usually treatment is withdrawn after several days or a week of no responsiveness. It's unusual to see -- I've never seen anyone go quite this long.

Q And in your professional medical opinion, is continuation of the mechanical assistance, the ventilator, the feeding tube, the dialysis, is that medically appropriate in Mr. Betancourt's case?

A Can I comment freely?

This is a state that didn't exist when I started in medicine. These people were dead. He's neither alive nor dead at this point.

We have him on lung support, kidney support, nutritional support, support for his recurrent infectious processes.

We couldn't do this when I started. It's kind of an artifact of modern medicine that this could be continued.

Q In your opinion, is Mr. Betancourt's condition terminal?

A Yes, but it may take some time. And he's been terminal for the last, frankly for the last year.

Q What will happen between now and that time to Mr. Betancourt?

A It depends on how much we continue to intervene.

Q Well let's assume things stay the way they are today, you know, whatever the mechanical sustaining treatment is provided. What will happen to Mr. Betancourt otherwise?

A This could go on for quite a while. I think he'll continue to deteriorate, continue to break down, he will not wake up. He will not become conscious. He'll basically get no better and likely slowly get worse.

Q And what -- Doctor, what specifically will get worse?

A The skin will break down further. You have to realize that the only organ that's functioning really is his heart. Everything else is mechanically supported at this time.

His brain is irreparably damaged. His kidneys don't work. His lungs don't work. His skin is broken down. I guess his liver is working, but everything is irreparably damaged.

MR. CHRONAKIS: Your Honor, may I have a moment?

THE COURT: Beg your pardon?

MR. CHRONAKIS: May I have a moment?

THE COURT: Oh yeah.

MR. CHRONAKIS: Your Honor, I have no further questions at this time.

THE COURT: Mr. Martin.

CROSS-EXAMINATION BY MR. MARTIN:

Q Doctor, in your opinion, is any of the treatment that's currently being administered to this patient doing him harm?

A Only in the sense that we're continuing to treat a hopeless situation.

Q Other than your opinion on that score, there's nothing about the treatment that's ineffective or doing harm.

A It all seems to be ineffective because it's not getting us anywhere.

Q Is any of the treatment doing him harm?

A Yes. I think we're doing damage here.

Q What damage is -- what treatment is doing him damage?

A We're allowing the man to lay in bed and really deteriorate --

Q That's not treatment, is it?
A -- virtually right under our eyes.
Q That's not treatment, is it, Doctor?
A That's because of the treatment.
Q So your opinion is that to continue to keep this man alive is doing him harm.
A Yes.
Q The fact that you need the bed didn't enter into your decision, did it?
A No. In the Intensive Care Unit, yes, sir.
Q That was the motivating force --
A But not on the floor.
Q -- behind the DNR order and attempting to convince the family to discontinue the treatment, wasn't it?
A No.
Q Who's paying his bills?
A I don't know his insurance.
Q Do you know whether or not Medicare is continuing or Medicaid is --
A He's in his 70s. I imagine he has Medicare. I don't know what else he has.
Q Do you know if they're paying the bills?
A Don't. I doubt if the bill would go out until he either passes or is discharged.

Q The record that you say is too voluminous to read, when were you called upon to read it? What stage?

A I think I saw him back in August and I've looked at it periodically in the last week.

Q And why?

A Because I was coming to testify in the last week.

Q Have you -- other than been sitting on this committee that you've described, do you have any direct involvement in his care?

A No, sir.

Q Have you directed any of his cares?

A No, sir.

Q So you've had neither hands on nor participating in calling in consults or directing his care in any way.

A No, I have not.

Q And you've not read his entire record.

A A very good part of it but I haven't read the recent notes.

Q You've read all of the non-recent notes.

A Yes.

Q So are you aware that there are at least some physicians and others in this case that take the

position that he does have some level of responsiveness?

A To my knowledge, people in vegetative --

Q But my question was, are you aware?

A Yes, I am.

Q Have you talked to any of those people?

A No.

Q Have you talked to any of the nurses that are caring for him?

A Yes.

Q Have you talked to any of the family members?

A No.

Q Have you talked to this PGY-2, this poor gentleman --

A I don't know who that was. I might have.

Q Well do you recall speaking to someone who described in the record that he's found this patient on multiple occasions to be awake?

A Wakefulness --

Q Doctor, have you spoken to this particular physician?

A No, I have not spoken to anyone who said he was awake.

Q So you have not called into question this physician's observations.

A No, I would not.

Q And have you spoken to the physician that indicated that on several occasions that this, that he was observably responsive to verbal or verbal stimulus?

A No, I have not.

Q Have you spoken to anyone who's entered into the record his observation that he was responsive to touch?

A He withdraws.

Q I asked you doctor whether or not you've spoken to the individual who's made those observations?

A No, because I'm not sure who made those observations.

Q Because you have not read the entire record.

A No, I've spoken to nine doctors on the case.

Q Doctor, the physicians -- some of the physicians that have signed affidavits or certifications in this case are of the opinion that regardless if this treatment, all of the current treatment is continued, this poor gentleman is going to expire in a matter of months. Do you share that opinion?

A Only in the broader sense. I'm not sure it's a matter of months.

I think he will expire of this condition, but it may take quite a while. They've been successful for the last year in keeping him going.

Q And he's fought right along, hasn't he? He's had all sorts of horrific treatments that he's managed to endure and he continues to thrive, survive rather. Correct?

A He's not fighting. He's just being treated. They're fighting.

Q Well he survived longer than any patient I think you said you've ever seen.

A Longer than anyone I have ever seen.

Q This question is not meant to be offensive so please don't take it that way. I don't know how else to phrase it.

Why are you here? What is your role in this particular proceeding?

A I think my initial involvement was with the Prognosis Committee. I was asked to testify by the hospital lawyer. And that's about it.

Q Have you participated at all in trying to place this patient in another facility?

A No. Those attempts go on regularly. They're done by Social Service.

Q And in this particular case, have those

attempts been ongoing for some time?

A Yes.

Q And there's been difficulty, has there not, finding a facility that's capable of taking a dialysis and ventilator-dependent patient. Is that not true?

A I don't know of any in Jersey. I've been told there's one in New York.

Q And is it after that, what's found to be the state of facts that the hospital decided that perhaps it was time to terminate his treatment?

A No.

In fact, I doubt if anyone in administration is aware of, you know, the social service work.

Q Well.

A That's ongoing, sorry. They continue their work.

Q His treating physicians would certainly be aware that there were attempts to transfer him to some other facility, wouldn't they?

A I would think so.

Q And many of his treating physicians are part of the administration, aren't they? Director of Medicine, Director of Cardiology, Director of Nephrology.

A The Director of Nephrology has nothing to do with the hospital.

Q Well.
A The nephrologists get together and appoint a director. It has nothing to do with the hospital. There's no salary. There's no --
Q Leaving the nephrologist out of it, many of these physicians are intimatately involved in the higher levels of the hospital administration, aren't they?
A Actually no. None of them are administrators.
Q Is the Director of Cardiology --
A They work for the teaching --
Q -- up there in the scheme of things?
A He never comes to or is invited to administrative meetings. He's a teaching physician.

So I wouldn't consider him an administrator. His job is to teach cardiology. He runs a private practice.

Q So you're saying then, Doctor, that there are attempts to transfer this patient to some other facility, and nobody in the administration of the hospital are either aware of it or participating in it?
A The social service workers do their job on a regular basis. I'm sure administration is aware -- well they know he's still there. So obviously no place

was found.

Would they liked to have transferred? I'm sure they would. He's been there quite a while.

Q And has he been stable for transfer since the middle and late January?

A He could probably be transferred.

Q And if he were transferred, it would be to a facility that had to be capable of administering both dialysis and continuing the vent.

A Yes.

Q Okay.

MR. MARTIN: That's all I have for him.

MR. CHRONAKIS: Your Honor, the hospital has no further questions.

THE COURT: Thank you, Doctor.

THE WITNESS: Thanks, Your Honor.

MR. CHRONAKIS: Your Honor, we have another witness ready, but I defer to the court as I would like to proceed. But certainly if we can get the physicians back to the hospital.

THE COURT: That's fine.

MR. MARTIN: As far as I know, my -- Dr. Goldstein is back in his office. So it's not critical that we get him at a particular time.

THE COURT: All right, we'll take the

witnesses here then so they can get back.

MR. CHRONAKIS: Your Honor, we would call Dr. Bernard Schanzer to the stand, please.

SERGEANT-AT-ARMS: Remain standing.

Place your left hand on the Bible and raise your right.

B E R N A R D S C H A N Z E R, DEFENDANT'S WITNESS, SWORN:

SERGEANT-AT-ARMS: Please state your full name.

THE WITNESS: Bernard Schanzer, S-C-H-A-N-Z-E-R.

DIRECT EXAMINATION BY MR. CHRONAKIS:

Q Good morning Doctor. Can you tell the court about your education, please.

A I went to City College. After that, I went to the University of Brussels in Belgium. I did a residency in Internal Medicine, and then I was in the service. And then I completed my residency in neurology.

Q You are a neurologist.

A Correct.

Q And how long have you been practicing medicine that focused on neurology?

A Thirty-nine (39) years.

Q Thirty-nine (39) years. Are you familiar

with Mr. Betancourt who is the subject of today's hearing?

A Yes.

Q And how did you -- well, I'm sorry. Strike that.

What's your current employment status?

A I'm in private practice within a group and we practice in the area.

Q Okay, what's your relationship with Trinitas Hospital?

A I am the Chief of Neurology at Trinitas.

Q Okay, and how long have you held that position?

A Thirty (30) years.

Q Um.

A Nobody else wants the job.

Q Doctor, how did you become familiar with Mr. Betancourt?

A As part of our group, we -- our neurologists were affiliated with Trinitas and also with Rahway Hospital and after the tragic event that occurred to Mr. Betancourt, we were asked to see him in consultation and the initial consultation was, I think, last year, by one of my partners, Dr. Cow (phonetic), who saw him after he had had a anoxic event.

That's where he had been extubated and developed a, went into coma.

Q Were you asked to conduct a neurological consultation after that?

A We've seen him periodically and the last time I saw him was last December.

Q And when would you say the first time you saw him was, Doctor?

A Possibly last January after my partner had seen him initially and after he saw him subsequently on several occasions.

Q Have you ever spoken with Mr. Betancourt's family?

A Yes.

Q Do you remember who?

A As part of the Prognosis Committee and the last time at the urging of the Director of Affiliated (phonetic) Care, where the family, there was a family meeting in which I was present.

Q Okay.

What's your -- you know, please describe your relationship with Mr. Betancourt's family.

A This is a very difficult situation for all of us who are concerned here.

And in terms of my relationship with them, I

would go and see him and unfortunately we did not have any good news, and the last time that I saw them in December, which was the first time that they made me aware that they thought that we were terrorizing them when they saw me, because whenever I would see them, I'd give them bad news.

And, you know, unfortunately, it's a very bad situation and you know, I really felt very bad about that, you know, because our intent as physicians is to inform people and you know, to alleviate, if we can, suffering and pain.

You know, obviously there are suffering and I think the family is suffering. The patient is in a vegetative state. I don't think that he is aware of any, of his environment and he's not in any pain. But the family is in a great deal of pain.

And after that last session, you know, we had made recommendations at that time, that you know, they would -- they should either seek outside opinions, if possible, you know, just to reassure them that what was being done was fair and in the best interest of all concerned.

Q Thank you, Doctor.

Can you describe for the court your findings and conclusions from your neurological evaluations with

Mr. Betancourt?

A I don't have my last note. If anybody has it, it was probably in December, in December of '08.

Q Doctor, I have part of the medical record that was produced in this case which is a consultation record from you but I believe it's a July 2008 consultation. Would that be of any assistance?

A Right, because his status really has not changed significantly.

Q Do you feel that you would be able to recall more about your neurological evaluation if you were able to see these documents?

A It would help.

MR. CHRONAKIS: Your Honor, may I --

MR. MARTIN: I don't have an objection to refreshing his recollection.

THE COURT: Show the Doctor, then.

MR. CHRONAKIS: Yes, July 16.

THE WITNESS: So that --

BY MR. CHRONAKIS:

Q Well Doctor, after you've had an opportunity to read it, let me know when you're done.

(Doctor is reading over his notes)

A Yes.

Q Doctor, does reading your notes from July,

2008, does that refresh your recollection of your findings as to Mr. Betancourt's neurological condition?

A Yes.

Q Okay, and can you describe for the court what that is.

A I felt that he was in a vegetative state, and I think that as was mentioned before, he's been in a persistent vegetative state.

And at this point, looking at a year after, we can say that he's in a permanent vegetative state.

And you know what is the difference?

A vegetative state is somebody who's unaware of self and of his environment.

It become persistent by definition if it lasts for more than a month.

And then the question comes in as to in terms of prognosis. So that when we talk about a permanent vegetative state, then we're making a statement of prognosis beyond the descriptive term of the patient's condition.

So that at this point, he's in a permanent vegetative state having continued to be this for over a year.

Q Doctor, in your 39 years as a neurologist, have you seen a patient in a vegetative state for a year whose condition has improved?

A No.

Q Now there's been some testimony and some dispute, if you will, about whether Mr. Betancourt is awake at points.

What's your opinion as a neurologist?

A So that by definition he's awake, but he's not alert.

Q All right, and what does that --

A Or that there's no awareness and that's important. He's got some brain stem function.

If he did not have any brain stem function, which is the criteria for awakeness, he would not be able to sustain any type of survival, okay, would have remained in a coma.

The fact that he's gone into a vegetative state, indicates that there's been -- that there's some brain stem function, and this is part of the function that remains.

Q When Mr. Betancourt is awake as you've defined it, is he able to respond to verbal stimulus?

A No.

Q Is he able to speak?
A No.
Q When Mr. Betancourt is awake in your terms, does he respond to pain?
A There are some reflex responses to pain. There are no awareness of, as far as we can tell, of pain.
Q And from a neurological prospective, what's the difference between those two, between a reflex response and an awareness of pain?
A The very fact that you have brain stem function, right, you have some basic reflexes which are still present.

For example, I described a sucking response when I saw him in July which is a reflex response that if you apply something -- something about his lips, for example a child when you apply a nipple or, it will suck on it. So that this is a very basic reflex and it does not have anything to do with consciousness.

Q Does this sucking sound or the sucking reflex or the awareness of pain, or excuse me, the reflex response to pain, does that indicate that Mr. Betancourt may be improving?
A It's not -- he's not improving. He's -- you know, the important question here is, you know, is that this

is a status. Time is the best guide as to what's happening to him, and he's been in this state for a year. There has been no improvement and the chances of his improving, you know, coming back to a cognizant sleeping (phonetic - accent) state are nill.

There are reported cases of somebody coming out and awakening after ten years. And all of these events have to be investigated.

But in our experience and, you know, this is not -- nothing is 100 percent. When you say probability we're talking about 90 percent, 95 percent, 99 percent. In this case, 99.9 percent the probability of his ever coming back to a cognitive state are nill.

Q How does Mr. Betancourt respond to touch?

A When I examined him in July, and as to this note, I applied pressure to his nailbed which is a significant stimulus and a pain stimulus, there was no response.

So but at times you may find that there may be some withdrawal, right, but these are again basic reflexes that you may see.

As an example, somebody who's brain dead and that's considered, and this is not the case here. But somebody who is brain dead may have some basic spinal

reflexes. That does not mean that that patient is alive or has a prognosis of coming back, because in New Jersey at least, brain dead is considered dead. But you can still see some spinal reflexes being present. So that this is not a significant factor here.

Q I want to go back, if you will, Doctor, to the discussion about whether Mr. Betancourt is awake.

First of all, just to put it in lay person's terms, is Mr. Betancourt permanently unconscious?

A At this point, at this point, he is in a permanent vegetative state and by this we mean that he has sustained significant injury to his cortical part of the brain. That's the thinking brain. That's the part of the brain that makes you aware, makes you, makes us look at each other, talk to each other, communication with each other, and that has been irreversibly damaged.

Q Doctor, when you say he's awake but not alert, does that have any correlation with Mr. Betancourt waking up?

A By awake, we mean that there's, you know, a -- he will open his eyes, for example. All right.

But that doesn't mean that he sees or I mean maybe he sees, but there's no appreciation of his environment. There's no appreciation of self.

Q Now, Doctor there was a review of Mr. Betancourt's medical record in which a second year post-graduate resident or intern at the hospital made a notation on his chart that Mr. Betancourt was awake.

Are you able to give an opinion on what this would mean in the context of neurology?

MR. MARTIN: I object. Judge, we're asking him now to interpret what someone else meant by that observation.

THE COURT: I'm going to sustain the objection as to what somebody else meant by the word "awake." Perhaps the doctor has -- if he were to use the word "awake" what he would mean but --

MR. CHRONAKIS: Your Honor, I feel like we went through a series of questions in which Mr. Martin was able to pose that exact line of inquiry to Dr. Millman, that is, what does this mean here? Why would this person say this? I'm only asking to receive the same latitude that the court previously granted.

THE COURT: I'll -- sustaining the objection.

BY MR. CHRONAKIS:

Q Doctor, what would you understand if you saw Mr. Betancourt's chart and there was a notation by a PGY-2 that indicated that Mr. Betancourt was awake?

MR. MARTIN: I'm objecting to it. Perhaps

the question should be is there some medical significance to the term "awake," or asking his opinion on what it would mean to him.

THE COURT: Well I think time it was phrased what it would mean to him but --

MR. MARTIN: But we're still asking what this particular author meant when he --

THE COURT: What does the word "awake" mean to this witness, and I'll allow him to answer that.

THE WITNESS: What -- you know, what somebody else sees and observe and the term that we use sometimes are really vague, so that, and I would hope I was not one of the preceptors, you know, you have two eyes. You know, when somebody says he's awake, what did you see? You know, you say somebody's awake. What does that mean? Right. So I really am not sure. Did he -- you know, he walked in, he saw something.

MR. MARTIN: Again, he's reading the mind of the author. What does "awake" mean to you, Doctor?

THE COURT: The question, Doctor, is what does --

THE WITNESS: To me, awake is somebody who opens his eyes.

BY MR. CHRONAKIS:

Q And with seeing the reference in Mr.

Betancourt's medical chart to someone observing him as "awake," would that contradict your assessment of Mr. Betancourt?

A No.

MR. CHRONAKIS: May I have a moment, Judge?

THE COURT: Yeah.

MR. CHRONAKIS: Your Honor, no further questions at this time.

THE COURT: Mr. Martin.

CROSS-EXAMINATION BY MR. MARTIN:

Q Doctor, I, I'm sorry. I have your note. I think you may have it in front of you. But the note of 7/16/08, it's called a consultation report, and I take it when you see the patient, you were asked to see the patient.

A Yes.

Q Because your specialty was unavailable, the other physicians, you obtained a history, and I take it you got that from the chart because you weren't able to communicate with the patient.

A Correct.

Q And you did a neurological exam.

A Correct.

Q How long were you in this patient's presence?

A Fifteen, twenty minutes.

Q Did you speak to the family at that point?

A I have no recollection if I did.

Q I was unable to find another consultation note from you. That doesn't mean that it's not there because everybody's described the hospital records as three feet high. But --

A So you haven't read it either.

Q Pardon?

A So you haven't read the chart either.

Q But you did mention that you saw him in December.

A Yes.

Q And would you have made a consultation note? Should there be a note in December somewhere?

A There should be a note in the chart, yes.

Q Any other notes other than those two?

A And there were some other notes by my partners.

Q How many times have you personally seen this patient?

A The last time was in December.

Q Would that the second time since this admission in July?

A I may have seen him another few times. But --

Q And on those occasions, did you make notes?

A Every time that I would have seen him, I would have made a note.

Q So then since July you may have seen him how many times?

A Maybe two or three times.

Q Now you've also indicated you talked to the family.

A We had a meeting with the family, with some members of the family in December.

Q Have you talked to them before that at all?

A I had spoken to them because there had been a previous meeting also with the Affiliated Care Committee and we had spoken to them. So that we have spoken to them on more than one occasion.

Q On that previous meeting, the meeting before December, did that -- was the subject matter of that meeting terminating life support?

A It was -- from my -- my input, my input is not to terminate or not terminate life support but to inform them as to the condition of the patient.

Q Was the purpose of meeting, was one aim or the topic of the meeting, was that the subject of discussion?

A From the patient about their choices and that

there are -- and what the prognosis was.

Q Did the family make it clear that their wishes were not to terminate?

A Correct.

Q And have you discussed with the family their impressions of the observations they've made of their husband and father?

A As of our last meeting, I don't remember. I remember their opinion of what they wanted, but not as to their observations.

Q They expressed to you, for instance, that they believe that Mr. Betancourt does respond to certain verbal stimuli.

A This is -- unfortunately the misconception that people may have --

Q Have they expressed that?

A Wait, wait.

Q No, no.

A You asked me a question. Let me answer it.

Q No, you're not answering it so I would object to your answer.

THE COURT: The question is what did the family say?

BY MR. MARTIN:

Q Have they expressed that to you?

THE COURT: Whether you agree with it or not, it's a question of what did they say.

THE WITNESS: Can you ask your question again then?

BY MR. MARTIN:

Q Has the family expressed to you that they believe that Mr. Betancourt does respond to verbal stimuli?

MR. CHRONAKIS: Objection, Judge.

THE WITNESS: Okay, I don't remember.

MR. CHRONAKIS: Doctor.

THE WITNESS: I don't remember.

MR. CHRONAKIS: It's either this will be discarded as hearsay and the family can come testify or the doctor should be allowed to testify to the content of the conversation, not limited to a yes or no that allows Mr. Martin to put in the family's testimony.

MR. MARTIN: Judge, he wasn't responding to the content of the conversation. He was about to express his views or explanation for what he thinks I'm getting at. That's --

MR. CHRONAKIS: Judge, the question provides the content of the conversation. That's why it's either hearsay or should be allowed a full response.

MR. MARTIN: First of all, it's not hearsay.

Secondly, the family -- I fully intend to put the family on, they would have testified to all of this by now.

THE COURT: With that, I will allow the answer.

BY MR. MARTIN:

Q And your answer was you don't recall.

A Correct.

Q You say in your note that he has no response to pain.

A Correct.

Q Meaning that when you attempt to inflict some, in this case you squeezed his fingernail bed.

A Right.

Q Which would ordinarily elicit a pain response.

A You could try it on yourself. Take a pin and apply pressure to your nailbed. It's a significant stimulus.

Q And he had no response to that.

A Correct.

Q Doctor, in your opinion, he's not experiencing pain.

A There is a reflex to pain and there may be and I did not get a response when I saw him then, but his

perception of pain, he has no perception of pain. So it may induce a reflex, but they are not -- and at the time when I (inaudible) him, it did not induce any response. And by this I meant a reflex response.

Q It means he doesn't feel pain, is that what you're saying?

A And there's no perception of pain, correct.

Q Okay.

What kind of treatment are you administering, what specific treatment?

A In this case, prognosis.

Q All right, so you're not actively directing any --

A Correct.

Q -- of his day-to-day care.

A Correct.

Q And your observations of this patient's care would be limited to those visits that you made.

A Correct.

Q During the 15 or 20 minutes that you spend examining him.

A Correct.

Q And at some point in time, you came to the conclusion that he's in a permanent vegetative state, correct?

A Well I said persistent. At this point, I'm saying permanent, permanent vegetative state.

Q Persistent and permanent are interchangeable.

A No, they're not.

Q What's the difference then?

A Persistent is a description of what's happening. Permanent is a prognosis, a prognosis statement.

Q Okay -- understand that there are progressions, that patients oftentimes progress from a vegetative state to a persistent vegetative state, correct?

A Well, if the vegetative state persists, okay, for over a month, then it becomes persistent.

Q So after a period of time that a patient is deemed to be in a vegetative state, after the expiration of some period of time, whether it be a month or somewhat longer, it's then deemed to be persistent.

A Correct.

Q And persistent, does that mean irreversible?

A Persistent does not mean irreversible.

Once it becomes permanent, then in our experience, then it becomes permanent. In other words, irreversible.

Q What's the difference between persistent and

permanent?

A Persistent is that yes some people have awakened from persistent vegetative states. From permanent, probably, in our experience, none.

Q This hospital record or some of the affidavits and if you care, I'll show them to you, describe this patient as being in a persistent vegetative state.

A Correct.

Q Would you agree with that?

A Yes.

Q Okay.

Now have there been documented cases of people emerging from persistent vegetative states?

A Yes.

Q They are few and far between, correct?

A Correct.

Q But nonetheless there are records of that occurring.

A Correct.

Q And I take it on some occasions that may a result of a misdiagnosis.

A Correct.

Q And would that mean to correctly to assume that there are occasions when neurologists perhaps will

examine the same patient and reach different conclusions as to the state of that client neurologically?

A They may.

Q So are we saying, Doctor, that whether we use the term permanent or persistent, really it's a prediction.

A No. No. I'm going to repeat myself, okay. Permanent means after a period of time. In this instance, after a year's time we have somebody who's been in a persistent vegetative state and now he's in a permanent state.

The chances of this becoming reversible are nill.

Q Yet there have been people who have come out of it after many more years than this patient has been in that condition?

A Correct.

Q Correct?

A There is hearsay and, you know, the anecdotal events but --

Q Well there are documented events in the literature.

A Correct.

Q And we're talking about patients that have

been in a persistent vegetative state much longer than Mr. Betancourt, correct?

A Correct.

Q And --

A Did they say --

Q I conclude from that --

A I'm sorry.

Q -- because that prediction, that estimation, whatever the prognostication, is not -- you can't be absolute, can you?

A I can be absolute that somebody who's been in a persistent vegetative state will remain in a persistent vegetative state and it will be permanent. They may survive in that vegetative state and the question is, do you want to continue that?

But in terms of prognosis, in terms of what to do, right, you've gotta be aware of that. You cannot say you know, he's in a persistent vegetative state after one year and he's going go out, get up and walk and talk.

You have to realize that this patient is in a permanent vegetative state at this point and this is where you're at and you have to decide what you want to do.

Q And that is your opinion that he is in

permanent vegetative state and will not respond, correct?

A Correct.

Q And in those other documented cases where the patient has emerged from that condition, there were physicians who enjoyed the same opinion as you in those circumstances, correct?

A Wouldn't -- now --

Q Can you answer that yes or no.

A No, I cannot say yes or no because I've got to clarify, I wish to clarify.

Q The question is this.

Have there been neurologists involved in the treatment or care of those patients who have shared your opinion, that that particular patient would never emerge?

MR. CHRONAKIS: Objection, Judge. I don't know that Doctor, excuse me.

THE WITNESS: Schanzer.

MR. CHRONAKIS: Yeah, Schanzer. Thank you, sir, is here to qualify --

THE COURT: I'm going to sustain the objection. I don't know that he's not testified that he's familiar with the facts and details of those other cases.

BY MR. MARTIN:

Q Are you? Are you? I mean these are documented cases. I can go to the literature today and find them, correct?

A Yes, you may, and there is a case of someone who stayed in a persistent vegetative state for 25 years.

Q In that particular -- you're familiar with that case.

A It was a case that was followed by Dr. Posner for -- who's a very well-known neurologist. But that patient stayed in a permanent vegetative state.

Q And emerged.

A He did not emerge. He remained in that state.

Q I'm asking you about cases, documented cases, where the patient was in that condition and emerged from that condition.

A The -- I don't know any of those cases which have been well-documented.

Q Okay.

Those patients who have emerged from that condition, some of them have done it spontaneously, some of them have done it gradually.

A You're talking about spectrum and it depends when. We know that people who have been in a vegetative state who have awakened from it. But that's usually most of

the time with trauma, with children, and not going on this length of time.

In this condition, and --

Q I'm sorry. With due respect, I didn't ask you that.

A No.

Q I didn't ask you anything other than do patients who emerge sometimes spontaneous and sometimes it's gradual.

A It may be either.

Q Okay.

So in those cases where it's gradual, what period of time -- when does the recovery process begin? Is there some predictable length of time that they will gradually emerge?

A It depends on several factors, what was the cause of the persistent vegetative state and how much injury has occurred.

Q Is this patient stable neurologically?

A What do you mean by stable neurologically?

Q Is the condition worsening, improving or remaining the same?

A As of July, and my recollection is the evaluation in December, there have been no change neurologically.

Q You may not be able to answer this. If you

can't, tell me.

In a given month, how many medical professionals, and I'm including in that, physicians, nurses, technologists, nurses aides, et cetera, how many medical professionals come in contact with this patient? Do you have any idea?

A I have no idea.

Q In a given day. There are three shifts. How many per shift? Any idea?

A I think probably like three to four per shift. There are three shifts. Multiply it, right.

Q Three or four nurses.

A Right.

Q Then we have residents. We have consulting physicians, attending physicians, et cetera, right.

A (No verbal response).

Q You have to say verbally just so it comes out.

A Yes.

Q Okay.

Would I be correct in assuming that nurses and residents who see the patient more frequently, do see the patient more frequently than perhaps you as a consulting neurologist?

A Correct.

Q You indicated that this patient does not react to verbal stimulus.
A Correct.
Q Cannot speak or communicate.
A Correct.
Q And is that because of the vent?
A No. Because there are people who are on the vent who can communicate.
Q If one of the nurses charged with this man's care says that he cannot always communicate, how would you -- would you agree with that?
A I would say re-evaluate the patient.
Q I'm sorry.
A I would say re-evaluate the patient. It does not make sense.
Q So suggesting that the patient may communicate, you would disagree with that.
A Correct.
Q And there are different ways of communicating either --
A Right.
Q -- verbally or with eye contact or movement, et cetera, correct?
A I think that, you know, you could answer the question by simply going to the patient's bedside and

not only I but all of you would be convinced.

Q Well this person apparently wasn't. So I'm just asking you whether or not -- in your opinion that's not possible.

A I cannot comment on anybody else's observation.

Q Have you ever talked to Mrs. Betancourt about any response her husband may have when she's present?

A We went through with that once more and I don't remember any specific communication.

Q Doctor, just bear with me a minute. I think I'm finished.

Doctor last question.

The fact that in your opinion he's in a permanent vegetative state does not translate to brain death, does it?

A Correct.

Q Okay. That's all I have, thanks.

REDIRECT EXAMINATION BY MR. CHRONAKIS:

Q Doctor, since the first time you evaluated Mr. Betancourt in 2008, has his neurological activity changed in your assessment?

A There has been no improvement in his neurological status.

Q Now I believe we're going to hear testimony that people who have visited, strike that actually.

Doctor if your neurological evaluation is inconsistent with a nurse's, who usually wins out in that conflict?

A You know, I'm responsible for my observations and our training is a little different so that you know I've seen people who are totally unresponsive and somebody has routinely written awake and alert. And, you know, that's you smile and you, you know, go on.

Q Doctor, I believe we're going to hear testimony and understandably convinced and convincing testimony, if you will, that members of the patient's family have seen Mr. Betancourt let's say respond to music or maybe move when music is played.

Are you able to explain something like that consistent with your evaluation?

A In a vegetative state there may be some responses but they are not purposeful, they're not repetitive so that if you're going to make a sound, then the eyes are going to open. But this is a reflex response. This is not a cognitive response.

Q What about if somebody walked into Mr. Betancourt's room and yelled, "Dad" or something to get Mr. Betancourt's attention while he's in the condition he's in now and his eyes moved, you know, towards the speaker's voice, how would you reconcile that with your

assessment?

A Very often patients who are in a vegetative state, and this is the mistake that is often made and I think by the nursing staff, the PGY-2, is that you say something and there's a response that occurs. The eyes open and you say you think that there is cognition. These are really reflex responses, reflex responses to sound.

Which if you hear a bell and the telephone rings, you wake up, you go and you answer the phone. You're able to carry on a conversation.

In this situation, what you hear maybe is the bell, but there's no awareness that the telephone rang and there's no ability even if you could talk, okay, if he wasn't on a vent, if he didn't have a trach, he still would not be able to carry on a conversation.

Q Doctor, Mr. Martin asked you some questions regarding other cases of patients in persistent vegetative states. Are you aware of the medical history of any of those patients to whom Mr. Martin was referring?

MR. MARTIN: He's already testified that he's not aware of them.

THE WITNESS: No.

MR. MARTIN: He hasn't read the case studies.

BY MR. CHRONAKIS:

Q In your medical opinion, if a patient were in a persistent vegetative state who couldn't eat on his own, couldn't breathe on his own, couldn't expel waste on his own, whose skin was breaking down, is this the type of case where the patient would then awake from the persistent vegetative state in your opinion?

MR. MARTIN: Object, Judge. Same thing. If he doesn't know the condition of those patients that have emerged, then how can he answer?

MR. CHRONAKIS: Judge, this is not one of the supposedly documented but undocumented for this hearing cases that Mr. Martin referred to.

I'm asking in his opinion of a separate patient in a persistent vegetative state.

MR. MARTIN: Well then that's been asked and answered as to this patient. We can't get any more conclusive than that.

THE COURT: I think that's -- we've covered that. He has answered that.

MR. CHRONAKIS: Judge, I have no further questions at this time.

MR. MARTIN: I just have one, Doctor.

RECROSS-EXAMINATION BY MR. MARTIN:

Q You were, you were just talking about reflex

responses. Earlier you said they are not repetitive, they are not purposeful. That's why you describe them as reflex, neurologically reflex responses, correct?

A Correct.

Q Okay. If they were repetitive, they would be something other than that, wouldn't that?

A Well then they would become purposeful. If you see that occurring then they may be significant.

Q Okay.

MR. MARTIN: That's all I have. Thanks.

MR. CHRONAKIS: Thank you, Doctor.

THE WITNESS: Thank you.

THE COURT: Thank you.

All right, I'd like to figure out for a moment where we are schedule-wise.

You still have your witness.

MR. MARTIN: We can call him.

MR. CHRONAKIS: I have Dr. Veiana from the hospital here in the Courtroom. I would think it's a fairly short testimony on the level of Dr. McHugh's, the previous witness.

MR. MARTIN: That's fine.

THE COURT: Well, my concern is I have available this morning for you and there is something

scheduled this afternoon.

I know you talked about having a witness available but not until the latter part of the week, till after Wednesday.

MR. MARTIN: Yes, Your Honor. Yes.

THE COURT: And I'm looking at my schedule as to when I can next fit you in and it's looking like Monday.

I'm just -- I hear that we have family members. You have a doctor that we're going to be doing on -- after Wednesday, another doctor to do for the plaintiff and we have a physician in the courtroom. So I'm just trying to figure out scheduling everybody, getting everybody in.

I'm assuming the family could be available some day other than today.

MR. MARTIN: Yes.

THE COURT: Okay.

Now the defense has -- your witness is after Wednesday.

MR. CHRONAKIS: We have one after Wednesday. We have one who is ready here.

THE COURT: How about Mr. Martin?

MR. MARTIN: Cover by phone and that is I was supposed to start a trial in Middlesex today. They're

holding it until tomorrow.

THE COURT: Uh hum.

MR. MARTIN: If I start -- it's a medical malpractice case. It'll go about three weeks, two weeks.

And then they're holding a case in Trenton for me. It's supposed to start Monday after that.

The Middlesex judges are nice people. I just have to talk to them.

THE COURT: Beg your pardon?

MR. MARTIN: I said they're generally nice people who will work with you. I could probably ask them to have Monday morning off or something but I just need to find out what judge I'm assigned to and work with him or her.

The Trenton judges are totally unreasonable, but the Middlesex people are okay.

THE COURT: (Laughter). We're going to put this together one other time. I guess we just need to pick out when that's going to be. And like I said, for me, Monday's looking good.

MR. MARTIN: I just need to maybe over the lunch hour, the break, whatever, if I can find out who the judge is, I can call and say can I have Monday morning off. They generally accommodate us.

THE COURT: Okay. We need probably a couple more hours.

MR. CHRONAKIS: Most of that will be at Mr. Martin's discretion although I'm hopeful if the court has the time to get Dr. Veiana in, I think we'll be quick and it's somewhat hard to schedule although I appreciate --

THE COURT: I'm thinking we can get him in now and then everybody else will have to be some other time and the some other time will be Monday.

Just again looking at the schedule, I can do like 9:30 to 11:30 on Monday or the entire afternoon. So I don't know whether the two-hour block that's available on Monday morning is going to do it, or would it be better just to leave it, start in the afternoon and have -- of course you need to find out from my colleague how kind he or she is going to be to you.

MR. MARTIN: I mean I just need to make a -- I hope I can identify who that is and just make a phone call.

THE COURT: All right, let's get the doctor on now.

MR. CHRONAKIS: Thank you.

THE COURT: We've got a witness in the courtroom. We'll have him testify.

MR. CHRONAKIS: Thank you, Your Honor.

Trinitas Hospital will call Dr. Paul Veiana.

SERGEANT-AT-ARMS: Watch your step please. Place your left hand on the Bible and raise your right.

P A U L V E I A N A, M.D., DEFENDANT'S WITNESS, SWORN:

SERGEANT-AT-ARMS: Please state your full name.

THE WITNESS: Paul Veiana, V-E-I-A-N-A.

SERGEANT-AT-ARMS: Thank you.

DIRECT EXAMINATION BY MR. CHRONAKIS:

Q Good morning, Doctor.

A Good morning.

Q Can you tell the court about your educational background, please.

A I graduated from Brooklyn College and Touro College in New York. I went to VA (phonetic) School and I went to Medical School in Mexico. I did a residency in Texas and three years at Saint Elizabeth Hospital, and I've practiced in the area since 1985.

Q Okay.

And what is your specialty?

A Internal Medicine.

Q Internal Medicine, thank you.

What's your current relationship with

Trinitas Hospital?

A I am an active medical staff member. I also happen to be the President of the Medical staff.

Q Are you employed by Trinitas Hospital?

A No, I'm not.

Q Do you have any financial interests in the outcome of this hearing?

A None whatsoever.

Q And are you familiar with Mr. Betancourt, the subject of this hearing?

A I am somewhat familiar.

Q Okay, how did you become familiar with Mr. Betancourt?

A Throughout my -- ~~one of my~~ duties is to go through the Prognosis Committee. I was asked to render an opinion about his medical condition somewhere's in I guess August or so.

And then again I was asked to render another opinion about his care. Since there were multiple physicians who were involved on the care and we felt that there was some inappropriate care that we were doing to Mr. Betancourt, and so as part of our medical staff I would try to support our physicians making what we consider to be moral decisions in order to provide the best care for our patients.

Q Okay, did you have the opportunity to evaluation Mr. Betancourt?

A I did that yesterday.

Q Okay.

And have you reviewed Mr. Betancourt's patient records?

A No, sir. I only reviewed maybe two or three weeks of laboratory works.

I am aware when it first came up for discussion what they were then and what they are now, and my evaluation yesterday compared to what was discussed in the previous meetings that I had.

Q Okay.

And based on your evaluation and those documents you reviewed in those meetings, what was your professional medical opinion of Mr. Betancourt's diagnosis?

A Well there were multiple diagnoses. One that he is in a persistent vegetative state. He also has --

MR. MARTIN: Judge, I --

THE WITNESS: I'm sorry.

MR. MARTIN: I'm sorry, Doctor, I don't mean to interrupt you but Judge I would object because now we're just repeating the diagnosis of other people.

This physician has examined the patient and

has an opinion of his own. Obviously I don't object to it.

THE COURT: That's the question based upon review of the record and his own evaluation, what is his opinion as opposed to what do the records say.

MR. CHRONAKIS: Yes, Your Honor.

MR. MARTIN: But he said he didn't review the records, just some lab --

THE COURT: Reviewed some records, some lab reports over the last several weeks and had done a previous review of some records.

MR. MARTIN: Yes, Your Honor.

THE WITNESS: If I may clarify what my job is as an internist. I look at the patient as a total person, not as a brain, not as a heart, not as a kidney, but I look at him as Mr. Betancourt.

I evaluated him on Tuesday which, I'm sorry, on Monday while he was wheeling down to dialysis which took four people while he was being ventilated by hand. He was stuck several times which he did not flinch.

For us to maintain what I consider to be a normal homeostatic electrolyte balance and to keep his body warm and really not treating Mr. Betancourt, we are treating just a body, because Mr. Betancourt, at least in my opinion, from examining yesterday, he has

contractures of both lower extremities. He's got flexion of both lower extremities. He cannot move his hands.

His eyes open but they're not purposeful movement. He has sagging of the skin. He has three large decubitus ulcers. He has a, his albumin level which tells about nutrition is 1.7. He's getting 2500 calories a day. He's being dialyzed. Essentially, we are very good in keeping a body at a homeostasis without having the person be able to respond to the environment. This is essentially what we have done.

As an internist, I deal with the family, and unfortunately I did not deal with this family, but we need to keep in mind it is very difficult, at least in my opinion, because anything that a patient does a family interprets as a purposeful movement. I do that myself with my own father.

So it's very difficult to detach ourselves from reality and really what it is that the patient has.

So in my opinion as an internist looking at Mr. Betancourt as a total person, there is no reason to think that he'll come out from this state.

As of yesterday, he had three blood cultures done because he spiked a temperature. His decubitus

ulcers are going into his bones. And I'm sure he has osteomyelitis of those areas.

The skin is sagging. It has no muscle tension whatsoever. So whatever reflexes or, that we've talked about are totally inappropriate because it depends on the state of the metabolic state that he's in.

If you examine him the day before he gets dialysis, you're going to get one kind of response because B1/creatine (phonetic) is elevated so it's (inaudible).

If you do it right after dialysis, then you'll get a different response. That's because we have done such a good job in maintaining his homeostatic state, but we're not keeping Mr. Betancourt alive. We're keeping a body that we are everyday violating by doing blood, blood cultures, sticking needles and I don't know what the outcome is.

As a Christian, I believe that there is some value that we should hold very dearly. We don't like to desecrate a body if we don't have to, if there is no chances that there is going to be any hope of recovery.

BY MR. CHRONAKIS:

Q Thank you, Doctor.

Doctor, in your professional medical opinion,

would continuing dialysis and the ventilator, the feeding tube, would this as you call it, desecrate Mr. Betancourt's body while keeping him alive?

A Maybe the best way that I can do this because we can go on forever because the definition what a family sees and what we as a professional see is different.

But as a doctor I can tell you that this is not going to change. We're only actually desecrating the body by sticking needles and drawing blood, then we need to give blood, because we're taking so much and we can't address the problem.

If it was my father, I would have stopped this seven months ago because I don't think this is appropriate at least from my belief and this is what I tell my patients when we come to this.

It's a very difficult decision, and what I usually say it takes no luck to say it's time to stop and then to continue. And it's a decision, it's a personal decision.

No matter what we do, no matter how good we are in keeping the electrolytes in balance, and the ulcers we cannot make it go away because his nutritional state is not going to improve. No matter how many calories we give him, it's not going to improve. He's not absorbing it. So we can give him

10,000 calories a day, it is not going to help.

Q And Doctor while you're on that point, why is it that the patient is not absorbing nutrients even though he's being, he's provided them?

A His body is in a catabolic state. Your GI tract is made of miles and miles absorbant (phonetic) area. On this particular patient that area has decreased significantly so no matter what we give him through the tube, it goes right through and that causes the ulcers to get worse, the infections to get more aggravated, and there is no other way, at least as or right now that we can improve that nutritional state.

And just by looking at his albumin, even though we're giving him all this, we haven't been able to budge it in the past, at least through the ones that I looked at which is six to eight weeks.

Q Doctor, in your experience at Trinitas and otherwise, are you trained or required by your profession to maintain a certain standard of care for your patients?

A Yes, we are.

Q And does the continued mechanical support of Mr. Betancourt meet or is consistent with that professional standard of care?

A No it's not because there's no -- at least from my

opinion, there is no chance that he's going to recover. We are just in a sense doing something that we should not be doing.

MR. CHRONAKIS: Your Honor, no further questions at this time.

Thank you, Doctor.

CROSS-EXAMINATION BY MR. MARTIN:

Q Doctor, that's your view based upon one examination which was yesterday, correct?

A Yes, sir.

Q And a limited review of the records which were some recent lab results, correct?

A Yes, sir.

Q That's the extent of the involvement you've had with this patient?

A In some things you don't need to be involved for a year to know that -- that the --

Q That is the extent, Doctor?

A But that is the extent, sir.

Q Believe me, I'm not trying to argue with you. I just want to understand your testimony.

A Uh hum.

Q And I'd like you to understand that my clients -- and that's why we're here.

A Uh hum.