APPELLATE COURT
STATE OF CONNECTICUT

NO. A.C. 37821 AND 37822

CLARENCE MARSALA, ADMINISTRATOR OF THE ESTATE OF HELEN MARSALA, ET AL., PLAINTIFFS-APPELLANTS,

- **VS –**

YALE-NEW HAVEN HOSPITAL, DEFENDANT-APPELLEE

APPENDEX II TO BRIEF OF PLAINTIFFS-APPELLANTS

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TO BE ARGUED BY:
JEREMY C. VIRGIL

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v.	:	
YALE-NEW HAVEN HOSPITAL	:	OCTOBER 7, 2014

DOCKET NO.: AAN-CV12-6011711-S	:	SUPERIOR COURT
CLARENCE MARSALA, ADMINISTRATOR OF THE ESTATE OF HELEN MARSALA	:	JUDICIAL DISTRICT OF MILFORD/ANSONIA
v.	:	AT MILFORD
YALE-NEW HAVEN HOSPITAL, INC. d/b/a YALE NEW HAVEN HOSPITAL	:	OCTOBER 7, 2014

AFFIDAVIT OF GARY MARSALA

1. I am over the age of 18 and understand the obligation of an oath.
2. I make this affidavit based on personal knowledge of Yale New Haven Hospital's medical treatment of Helen Marsala, my mother.
3. I am one of Helen Marsala's sons.
4. When my mother was alive, she indicated that, if necessary, she wished to have life saving measures in place to maintain her life.
5. It was not part of my mother's wishes to have intubation and/or life saving measures discontinued while she was at Yale New Haven Hospital.
6. Yale New Haven Hospitals' discontinuation of intubation and/or life saving measures for my mother was performed against my mother's wishes.

7. Yale New Haven Hospitals' discontinuation of intubation and/or life saving measures for my mother was performed over the objection of my mother's family.
8. Yale New Haven Hospital did not afford my mother's family the opportunity to transfer my mother to an institution that would continue intubation and/or life saving measures.
9. Yale New Haven Hospital did not afford my mother's family the opportunity to resolve the life or death dispute in Probate Court.
10. As a result of Yale New Haven Hospital's discontinuation of intubation and/or life saving measures for my mother, my mother died.
11. As a result of Yale New Haven Hospital's discontinuation of intubation and/or life saving measures for my mother, Yale New Haven Hospital killed my mother.
12. Yale New Haven Hospital's discontinuation of intubation and/or life saving measures for my mother was extreme, outrageous and shocking to me.
13. Yale New Haven's Hospital's discontinuation of intubation and/or life saving measures for my mother, which was: against my mother's wishes; over the objection of my mother's family; and done without affording my mother's family the opportunity to transfer my mother, caused me to suffer shock, amazement, depression, confusion, anger, sadness, grief and disappointment.
14. Yale New Haven's Hospital's discontinuation of intubation and/or life saving measures for my mother, which was: against my mother's wishes; over the

objection of my mother's family; and done without affording my mother's family the opportunity to transfer my mother, caused me to suffer severe emotional distress.

15. My severe emotional distress was not due to merely the natural grief of the loss of my mother but; rather, was due to my belief that the suffering and death of my mother was due to Yale New Haven's Hospital's improper treatment of my mother.

GARY MARSALA

The foregoing individual appeared before me
and swore to the truth and accuracy of the
foregoing this 7th day of October, 2014.

Notary Public/Commission of the Superior Court

DIANE W. BARRETT
NOTARY PUBLIC
MY COMMISSION EXPIRES JUNE 30, 2017

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AFFIDAVIT OF KEVIN MARSALA

1. I am over the age of 18 and understand the obligation of an oath.
2. I make this affidavit based on personal knowledge of Yale New Haven Hospital's medical treatment of Helen Marsala, my mother.
3. I am one of Helen Marsala's sons.
4. When my mother was alive, she indicated that, if necessary, she wished to have life saving measures in place to maintain her life.
5. It was not part of my mother's wishes to have intubation and/or life saving measures discontinued while she was at Yale New Haven Hospital.
6. Yale New Haven Hospitals' discontinuation of intubation and/or life saving measures for my mother was performed against my mother's wishes.

7. Yale New Haven Hospitals' discontinuation of intubation and/or life saving measures for my mother was performed over the objection of my mother's family.
8. Yale New Haven Hospital did not afford my mother's family the opportunity to transfer my mother to an institution that would continue intubation and/or life saving measures.
9. Yale New Haven Hospital did not afford my mother's family the opportunity to resolve the life or death dispute in Probate Court.
10. As a result of Yale New Haven Hospital's discontinuation of intubation and/or life saving measures for my mother, my mother died.
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objection of my mother's family; and done without affording my mother's family the opportunity to transfer my mother, caused me to suffer severe emotional distress.

15. My severe emotional distress was not due to merely the natural grief of the loss of my mother but; rather, was due to my belief that the suffering and death of my mother was due to Yale New Haven's Hospital's improper treatment of my mother.

Kevin Marsala
KEVIN MARSALA

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and swore to the truth and accuracy of the
foregoing this 7th day of October, 2014.

Diane W. Barrett
Notary Public/Commission of the Superior Court

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AFFIDAVIT OF MICHAEL MARSALA

1. I am over the age of 18 and understand the obligation of an oath.
2. I make this affidavit based on personal knowledge of Yale New Haven Hospital's medical treatment of Helen Marsala, my mother.
3. I am one of Helen Marsala's sons.
4. When my mother was alive, she indicated that, if necessary, she wished to have life saving measures in place to maintain her life.
5. It was not part of my mother's wishes to have intubation and/or life saving measures discontinued while she was at Yale New Haven Hospital.
6. Yale New Haven Hospitals' discontinuation of intubation and/or life saving measures for my mother was performed against my mother's wishes.

7. Yale New Haven Hospitals' discontinuation of intubation and/or life saving measures for my mother was performed over the objection of my mother's family.
8. Yale New Haven Hospital did not afford my mother's family the opportunity to transfer my mother to an institution that would continue intubation and/or life saving measures.
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10. As a result of Yale New Haven Hospital's discontinuation of intubation and/or life saving measures for my mother, my mother died.
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objection of my mother's family; and done without affording my mother's family the opportunity to transfer my mother, caused me to suffer severe emotional distress.

15. My severe emotional distress was not due to merely the natural grief of the loss of my mother but; rather, was due to my belief that the suffering and death of my mother was due to Yale New Haven's Hospital's improper treatment of my mother.

Michael Marsala
MICHAEL MARSALA

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foregoing this 7th day of October, 2014.

Diane W. Barrett
Notary Public/Commission of the Superior Court

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AFFIDAVIT OF RANDY MARSALA

1. I am over the age of 18 and understand the obligation of an oath.
2. I make this affidavit based on personal knowledge of Yale New Haven Hospital's medical treatment of Helen Marsala, my mother.
3. I am one of Helen Marsala's sons.
4. When my mother was alive, she indicated that, if necessary, she wished to have life saving measures in place to maintain her life.
5. It was not part of my mother's wishes to have intubation and/or life saving measures discontinued while she was at Yale New Haven Hospital.
6. Yale New Haven Hospitals' discontinuation of intubation and/or life saving measures for my mother was performed against my mother's wishes.

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objection of my mother's family; and done without affording my mother's family the opportunity to transfer my mother, caused me to suffer severe emotional distress.

15. My severe emotional distress was not due to merely the natural grief of the loss of my mother but; rather, was due to my belief that the suffering and death of my mother was due to Yale New Haven's Hospital's improper treatment of my mother.

RANDY MARSALA

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and swore to the truth and accuracy of the
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NOTARY PUBLIC
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AFFIDAVIT OF TRACEY MARSALA

1. I am over the age of 18 and understand the obligation of an oath.
2. I make this affidavit based on personal knowledge of Yale New Haven Hospital's medical treatment of Helen Marsala, my mother.
3. I am Helen Marsala's daughter.
4. When my mother was alive, she indicated that, if necessary, she wished to have life saving measures in place to maintain her life.
5. It was not part of my mother's wishes to have intubation and/or life saving measures discontinued while she was at Yale New Haven Hospital.
6. Yale New Haven Hospitals' discontinuation of intubation and/or life saving measures for my mother was performed against my mother's wishes.

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15. My severe emotional distress was not due to merely the natural grief of the loss of my mother but; rather, was due to my belief that the suffering and death of my mother was due to Yale New Haven's Hospital's improper treatment of my mother.

TRACEY MARSALA

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and swore to the truth and accuracy of the
foregoing this 7th day of October, 2014.

Notary Public/Commission of the Superior Court

DIANE W. BARRETT
NOTARY PUBLIC
MY COMMISSION EXPIRES JUNE 30, 2017

JUDICIAL DISTRICT OF MILFORD/ANSONIA AT MILFORD

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v.	:	CV12-6010861s
YALE-NEW HAVEN HOSPITAL, INC.	:	

Deposition of CLARENCE MARSALA, taken pursuant to the Connecticut Practice Book, before Melissa J. Kelly, RMR, CRR, Licensed Shorthand Reporter #00307, and Notary Public within and for the State of Connecticut, held at the offices of Zeldes, Needle & Cooper, P.C., 1000 Lafayette Boulevard, Bridgeport, Connecticut, on February 27, 2014, at 10:06 a.m.

DEL VECCHIO REPORTING SERVICES, LLC
PROFESSIONAL SHORTHAND REPORTERS
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203 245-9583 800 839-6867

APPEARANCES:
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STIPULATIONS

IT IS HEREBY STIPULATED AND AGREED by and between counsel representing the parties that each party reserves the right to make specific objections at the trial of the case to each and every question asked and of answers given thereto by the deponent, reserving the right to move to strike out where applicable, except as to such objections as are directed to the form of the question.

IT IS HEREBY STIPULATED AND AGREED by and between counsel representing the respective parties that proof of the official authority of the Notary Public before whom this deposition is taken is waived.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing the respective parties that the reading and signing of the deposition by the deponent is not waived __x__.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing the parties that all defects, if any, as to the notice of the taking of the deposition are waived.

Filing of the Notice of Deposition with the original transcript is waived.

CLARENCE MARSALA,
of 22 Greenwood Circle, Seymour, Connecticut, having first been duly sworn, deposed and testified as follows:

DIRECT EXAMINATION

BY MS. SEAMAN:

Q. Mr. Marsala, good morning again.
A. Yes.
Q. I introduced myself off the record but I'm Penny Seaman. I represent Yale-New Haven Hospital. I assume you met Ben Cheney from my office.
A. Yes, I have.
Q. We're here to ask you some questions today about the lawsuit that you filed against Yale. We'd like to make this as comfortable as we can for you, so if you need a break or you don't understand one of my questions, just let me know. Okay?
A. I will.
Q. Have you ever been through this process before?
A. Yes.
Q. Under what circumstances?
A. Different things.
Q. How many times do you think you've been

deposed?
A. Couldn't begin to tell you.
Q. More than five?
A. I'm involved in union business so there's a lot of depositions.
Q. Okay. So were you a representative for the union, is that --
A. At different times.
Q. Tell me a little bit about your background. First of all, what's your date of birth?
A. 7/2/32.
Q. And can I assume you're retired?
A. Yes.
Q. How long have you been retired, sir?
A. Three, four -- four years.
Q. Okay. And before, what, say 2010, did you retire in 2010?
A. Funny situation. I don't know if retired is the right word. You know, I'm going to arbitration for a case of not being called back to work. So are you retired or are you not is up in the air.
Q. What kind of work were you in?
A. School bus driver.
Q. Okay. And when was the last time you drove

a school bus?
A. July of 2010.
Q. And I take it from your earlier statement that you thought you should have been called back to drive school buses after July of 2010?
A. It's a union. So they don't want you back, you file a grievance; and that's the process we're in.
Q. And you filed a grievance about not being called back after July of 2010?
A. Correct.
Q. And what is the status of that grievance?
A. It's in arbitration.
Q. Do you have a lawyer for that?
A. Yes.
Q. Who's your lawyer?
A. He's out of Washington.
Q. D.C.?
A. Yeah. I don't -- I really don't know his name. I know his name but what is last name is -- his name is Paul, I know, but I don't ...
Q. Okay. Is he a lawyer for the union? No?
A. Yes.
Q. So the union files a grievance against the bus company or the district, is that what happened?

A. Correct.
Q. And is it a bus company or school district that's on the other side of that case?
A. The bus company.
Q. What's the name of that company?
A. First Student.
Q. How long had you been a bus driver for First Student?
A. Almost 20 years.
Q. I'm not really good at math, but would that have been --
A. 1994.
Q. How old were you then, sir?
A. Sixty-two.
Q. And before you started driving the bus for First Student in 1994, were you employed?
A. Yes.
Q. What kind of work were you doing before bus driving?
A. Drove a truck.
Q. Like a tractor-trailer?
A. No.
Q. What kind of truck did you drive?
A. Electric company, Wonder Bread.
Q. So you had a delivery route?

A. Yeah.
Q. And how long did you do that?
A. I couldn't begin to tell you.
Q. Most of your adult life?
A. A couple of years or whatever it was.
Q. Had you had any kind of employment before that?
A. I'm 72 years old. I must have had 20 jobs.
Q. Other than bus driving and truck driving, what other kind of work have you done?
A. Primarily that's it.
Q. And what union are you a member of?
A. ATU.
Q. Can you tell me what that stands for?
A. Amalgamated Transit Union.
Q. How long have you been a member of that union?
A. When it got organized, 2000/2001.
Q. Had you been a union member before that?
A. At different places, yes.
Q. Different unions depending upon where you were working at the time?
A. Exactly.
Q. Have you ever been involved as a union rep?
A. At what stage?

Q. Ever.
A. Well, as a union president, yes.
Q. When were you a union president?
A. 1960, '70. Sixties.
Q. What union was it that you were the president of?
A. IUE, electrical workers.
Q. Are you a trained electrician?
A. No.
Q. Okay. So I'm sorry, but how did you become the president of an electrical union?
A. I was in the factory and that's the union that was there, and then I ran for president and won.
Q. Okay. Had you ever been a union president since the '60s?
A. No.
Q. Have you ever done any negotiation for the union at any time?
A. Yes.
Q. And would that have been in the '60s or some other time?
A. Some other time.
Q. When were you a negotiator for the union?
A. I definitely won't pin down time but it had

to be 2005.
Q. And was that for the union that you were in as a driver for First Student?
A. Yes.
Q. And what kind of negotiation did you do?
A. All kinds of negotiations for a labor agreement.
Q. Okay. But for contracts with the First Student company?
A. Of course.
Q. And how long were you a negotiator?
A. The negotiations probably lasted on and off for six, seven, eight months.
Q. And was it just one contract that you negotiated?
A. For them, yes.
Q. Sir, you said you were 72 years old.
A. Eighty-two. I'm sorry.
Q. I told you I was bad at math. I'm sitting here thinking is that possible.
Do you get a pension from anyone?
A. Yes.
Q. Who do you get a pension from?
A. Teamsters.
Q. And when were you a member of the

Teamsters?
A. Teamsters, your seniority goes on. So I started way back in the '70s, maybe even earlier.
Q. Is the pension you get from the Teamsters enough for you to live on?
A. No.
Q. What other income do you have?
A. Social Security.
Q. Anything else?
A. No.
Q. You have five children; is that right?
A. Correct.
Q. And would you tell me, what's the name of your oldest?
A. Michael.
Q. Where does he live?
A. With me.
Q. How long have you lived at that Greenwood address?
A. Probably twelve years.
Q. And how long has Michael lived with you?
A. On and off.
Q. Pretty much his whole life?
A. Comes – yeah.
Q. How long has he been living with you this

time?
A. Comes and goes.
Q. Has he been there for more than a year?
A. At one time?
Q. This time.
A. No.
Q. Okay. How long has he been there this time?
A. I couldn't tell you. Six months, two months. Who knows.
Q. Does he work?
A. No.
Q. Is he married?
A. No.
Q. Has he ever worked?
A. Not to my knowledge.
Q. How does he support himself?
A. I have -- that's his business, not mine.
Q. Does he pay any of the household expenses?
A. Whenever he can, if he can.
Q. Does he do odd jobs to make money?
A. I have no idea. That's his business, not mine.
Q. Is he healthy?
A. Yes.

Q. And he's not disabled?
A. No.
Q. Does he get any state assistance?
A. I got no idea.
Q. Do you own the home on Greenwood?
A. My daughter does.
Q. And you only have one daughter; is that right?
A. Correct.
Q. And that's Tracey?
A. Yes.
Q. How old is Tracey?
A. Forty-five.
Q. Does she work?
A. No.
Q. Has she ever worked?
A. No.
Q. Is she able to hear?
A. No.
Q. Does she have any other disabilities?
A. Almost blind.
Q. Anything else?
A. No.
Q. Is she able to drive?
A. No.

Q. Her eyesight is too bad to let her drive?
A. Yes.
Q. How long has she been almost blind?
A. A few years, I guess.
Q. Was there a time when she could drive?
A. Yes.
Q. Okay. So she's lost her sight over the years?
A. Yes.
Q. Since she's been an adult?
A. Oh, yeah.
Q. And how about her hearing, has she been unable to hear for her whole life?
A. Fourteen on.
Q. Did she go to school?
A. Yes, she did.
Q. Graduate from high school?
A. Yes.
Q. Any other education?
A. No.
Q. And has she owned the house on Greenwood for twelve years?
A. Approximately, yes.
Q. And you've lived there with her for twelve years?

A. Yes.
Q. Has she lived with you her whole life?
A. Yes.
Q. Before Greenwood where did you live?
A. Balance Rock in Seymour.
Q. Balance Rock. Was that a house you owned or rented?
A. Rented.
Q. And did you rent that house as opposed to Tracey?
A. Yes.
Q. And does Tracey have some income?
A. That's Tracy's business. I'm not going to discuss her business.
Q. Okay. Do you know that business or you just don't know?
A. I don't know.
Q. Does she pay all the household expenses?
A. We all do.
Q. You and she share them?
A. Right.
Q. Does anyone else live with you there besides Tracey and Michael on and off?
A. Kevin.
Q. Kevin. And age-wise, how old is Michael?

A. Michael is 57.
Q. And Tracey?
A. Forty-five.
Q. Kevin?
A. Kevin is born in '72 so ...
Q. I explained I was bad on math.
A. About 41, I would say.
Q. Thank you.
And does he work?
A. Not at the present time.
Q. What field is he in?
A. He's a chef.
Q. How long has it been since he worked?
A. No idea.
Q. Was he working in 2010?
A. I don't know.
Q. When your wife was in the hospital, the year she died, was he working?
A. I don't know.
Q. Was he living with you then?
A. No.
Q. How long has he been living with you and Tracey on the Greenwood Drive address?
A. Approximately a year or so, I guess.
Q. Is he married?

A. Divorced.
Q. Does he have children?
A. No.
Q. And if I asked you, I apologize.
Has Michael ever been married?
A. Yes.
Q. Is he divorced?
A. Yes.
Q. Does he have children?
A. One.
Q. How old is that child, just about?
A. Thirty-three.
Q. Okay. And where does that child live?
A. Don't know.
Q. Connecticut?
A. I don't know.
Q. You haven't been in touch with that child for some time?
A. Yes.
Q. Okay. And has Tracey ever been married?
A. No.
Q. Children?
A. No.
Q. Tell me the names of your other children.
A. Gary and Randy.

Q. Which one's older?
A. Gary.
Q. How old is he?
A. Born in '65; 49.
Q. And does he work?
A. Yes.
Q. What kind of work does he do?
A. He's a truck driver.
Q. Local or long distance?
A. Local.
Q. Where does he live?
A. He lives in Seymour.
Q. And is he married?
A. Yes.
Q. Children?
A. Yes.
Q. How old are they?
A. One daughter; 7, I think.
Q. Does his wife work?
A. Yes.
Q. What does she do?
A. She works in New York.
Q. Healthcare field?
A. Yes.
Q. Is she a nurse?

A. No. Some kind of paralegal, I think. I'm only guessing. I don't really know this.
Q. And Randy, how old is he?
A. Thirty-nine.
Q. Where does he live?
A. Beacon Falls.
Q. Does he work?
A. Yes.
Q. What kind of work does he do?
A. He works in the automobile field. He's a painter.
Q. Is he married?
A. Yes.
Q. Children?
A. One, boy.
Q. How old is that boy?
A. Nine, I think.
Q. What does his wife do?
A. At the present time I don't think she's working.
Q. Has she ever worked in the healthcare field, nurse or technician --
A. No.
Q. -- technologist. Do you know what kind of work she did do?

A. No.
Q. Did all of your children graduate from high school?
A. No.
Q. Who did not?
A. I don't think Gary did, and I don't think Kevin did.
Q. Any have education beyond high school?
A. No.
Q. Are you a high school graduate, sir?
A. No.
Q. How far did you go in school?
A. It's so far back I can't remember. I don't know. Twelfth grade, eleventh grade, something.
Q. And your wife Helen, was she a high school grad?
A. No.
Q. How far did she go in school?
A. I don't know either.
Q. How long were you married?
A. Fifty-seven and a half years.
Q. What was the date of your marriage?
A. November the 8th, 1952.
Q. And I take it she's the mother of all your children?

A. Yes.
Q. In 2010, I know you told me where you were living but would tell me again. In the Greenwood address?
A. 22 Greenwood Circle.
Q. And Tracey was living with you and your wife at that address at that time?
A. Yes.
Q. And were any of your other children living there with you at that time?
A. My children sort of drift in and out.
Q. Okay.
A. So yes and no.
Q. Okay. And had Helen worked since your marriage?
A. Oh, yes.
Q. What kind of work did she do?
A. She like watched children and -- I don't know what you would call her.
Q. In the home, in your home?
A. No.
Q. She went to a daycare center or ...
A. No. She had a steady employer. They'd go to the house and watch her kids and she'd go to work.

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Q. Oh, so she would go to somebody else's house and watch the children?
A. Yes.
Q. And was that the kind of work that she did most of the time that she worked during your marriage?
A. She worked in a couple of factories way back.
Q. Anything else, any other kind of work?
A. Not that I could recall right now.
Q. And in 2010, say January of 2010, how was her health?
A. How was her health? How do I grade it?
Q. Did she have any medical issues that you knew of?
A. I knew that she had sugar.
Q. Did she have diabetes?
A. Yeah.
Q. Okay. Anything else that you were aware of?
A. She had fell down and broke her hip. I know that.
Q. When was that?
A. I can't tell you.
Q. Was it 2010?

A. I don't know that either. It could have been 2009. I don't know.
Q. But it was that time frame, 2009/2010?
A. I don't know. I can't swear to that.
Q. Okay. In January 2010, how was your health?
A. Mine, excellent.
Q. Okay. Do you have any chronic medical conditions?
A. I've got high blood pressure.
Q. Anything else?
A. No.
Q. Okay. And do you still have a driver's license?
A. Yes.
Q. And do all your children except Tracey have a driver's license?
A. I hope so.
Q. Did you drive here this morning?
A. Yes.
Q. Did you come alone?
A. Yes.
Q. And how long a trip is that from where you live?
A. Half hour.

Q. There came a time when Helen was admitted to Griffin Hospital, right?
A. Yes.
Q. In April? Do you recall that it was in April?
A. Yes.
Q. And why was she admitted to Griffin at that time?
A. She fell down and broke her wrist.
Q. Where did she fall, do you know?
A. In the house.
Q. At your house?
A. Yes.
Q. And just her wrist she broke?
A. I believe so.
Q. And when she fell, at the time of that fall she had been living at the house in Greenwood, on Greenwood?
A. Oh, yes.
Q. And as far as you knew at that time, other than diabetes she was in good health?
A. Her eyes. She would have trouble with her eyes.
Q. What kind of problems had she had with her eyes?

A. I don't know.
Q. No. I mean what is it that causes you to say she had trouble with her eyes?
A. Well, she couldn't see too good.
Q. Okay. Could she see well enough to drive?
A. At one point she had to stop driving.
Q. Do you remember how long before 2010 she stopped driving?
A. No.
Q. Was it that year?
A. I don't know.
Q. Do you recall that she drove at all in 2010?
A. I don't recall.
Q. How about 2009?
A. I don't know.
Q. Okay. At some point did she have surgery on her eyes?
A. Yes.
Q. Do you recall when that was?
A. No.
Q. After this --
A. Wait a minute. Yes, I do.
Q. Okay.
A. She did have -- I believe it was the day

she fell.
Q. She had had surgery?
A. I think so. What you mean by surgery, something no big deal, something they put weights in her eye or something.
Q. Okay. Do you remember where she went to have that done?
A. Yeah. Bridgeport Hospital.
Q. And I don't know if you're going to know this: Did that help her eyesight, do you know?
A. She was able to see. To what degree I don't know.
Q. What's confusing me is at some point her eyesight was too bad for her to drive; is that right?
A. Yes.
Q. After the time that whatever Bridgeport Hospital did with her eyes, did her vision come back well enough that she could have driven? Do you know that or you don't know how much improvement, if anything?
A. I don't know what Motor Vehicle requires.
Q. Okay. Could she read, before she fell was her eyesight that good?
A. Yeah.

Q. Was she able to maintain the household?
A. Absolutely.
Q. Could she get out into the community?
A. Sure.
Q. How did she get around?
A. Either with me or one of my other children.
Q. And what did she do with her time? Was she still working at that time in early 2010?
A. No.
Q. When do you recall her last working?
A. Probably ten years before that or so.
Q. So what did she do with her time?
A. She maintained her house and took care of her daughter.
Q. Okay. Anything else?
A. And me.
Q. I'm sure you took a lot of her time. How about her daughter?
A. All of her time.
Q. Does your daughter need someone to take care of her?
A. Well, she's just about blind. She can walk, yeah, but she couldn't walk by herself because she'd be too afraid.
Q. Because she can't see?

A. Well, with the illness she had was neofibrosis [sic] or something.
Q. She had an illness when she was 14?
A. That's when they discovered tumors.
Q. In her eyes or somewhere else?
A. In her head.
Q. And did that affect things other than her eyesight?
A. Other than not being stable. Her hearing, of course, she lost that.
Q. So she became unstable on her feet or unsteady on her feet?
A. Yeah.
Q. So she would need at least some assistance to get around?
A. She's been determined by the state as being blind.
Q. Okay. But in addition to that does she have trouble walking?
A. Yes, because she can't see.
Q. But some blind people use a cane or a guide dog. She's never done that?
A. She's never done it.
Q. How about cognitively, can she hold a conversation?

A. She could barely talk but she couldn't hold a conversation because she can't hear you.
Q. Okay. Does she do sign?
A. Yes.
Q. And she can have a conversation with somebody who can sign with her?
A. Yes.
Q. She finished school after her illness?
A. Yes.
Q. And did she go to a regular school or she went --
A. Trumbull High School.
Q. And I take it she had a sign language interpreter to help her through high school?
A. No.
Q. How did she get through high school?
A. Lip reading, I assume.
Q. Okay.
A. She also went to Hartford School for the Deaf, all that, while she was in school.
Q. Is she able to maintain the house now?
A. To what degree? I mean, she takes care of herself. She can -- she has to be watched, you know. You know, I don't stop her. You know, she might try to make coffee or do something like that

but she couldn't possibly because she can't see.
Q. Okay. She wouldn't make her own meals?
A. She does sometimes.
Q. Does she do the laundry?
A. Oh, yeah.
Q. And she would clean your house?
A. Yes.
Q. But when you say she has to be watched, do you have somebody there with her all the time?
A. Just us.
Q. Who would be with her if you're not there?
A. One of my sons or my daughter-in-law.
Q. Who's there with her today?
A. My son Kevin.
Q. Okay. And household chores, does she do most of them?
A. She does some. She cleans. She does the laundry and -- I guess her and my wife were a team.
Q. Okay. Who does most of the cooking in your household now?
A. Now? My son the chef and me.
Q. Okay.
A. And her, of course.
Q. And most of the other chores inside the house she's able to do?

A. Moderately.
Q. Did your wife have any hobbies or interests outside the home? I realize you told me that she took care of you and took care of Tracey. Were there other things your wife did?
A. We did a lot of things together, you know. We would go out to dinner a lot, always Tracey included.
Q. Tracey included?
A. Well, wherever my wife went.
Q. Tracey went; is that right?
A. You --
Q. You have to answer out loud because otherwise Melissa can't take it down.
A. Oh, yes.
Q. Okay. And I interrupted you. I apologize.
A. We would spend a lot of time together, and especially we were both soap opera fans.
Q. Okay. So in addition to her soaps, when you did things together, what would you do?
A. We'd go to dinner, we'd go on vacation, we'd go to the casino once in a while. We'd do anything we wanted to do.
Q. Okay. Were you working at that time?
A. What time are we talking about?

Q. Say in the ten years since she stopped working, so 2000 to 2010.
A. I'd be driving a school bus.
Q. Okay. And was that roughly 7 to 3, is that what shift or --
A. I worked like from 5 in the morning to 9:30 and then 1:30 to 4:30. Unless I went on charters or something, it could tie up all your day, part of your day or ...
Q. Okay. And where did you go on vacation?
A. When?
Q. How about 2009.
A. 2009, I don't recall.
Q. Tell me the most recent vacation that you recall with your wife and Tracey.
A. I couldn't pin down a time.
Q. Can you tell me anyplace you recall going with her?
A. Atlantic City we went a lot, we went to the Poconos, went to Florida, Disney World, any other amusement park, Pennsylvania, whenever.
Q. Ever been to Knoebel's Grove?
A. Where?
Q. Pennsylvania.
A. No. I'm originally from Pennsylvania.

Q. Where are you from?
A. Near Scranton. A place called Old Forge.
Q. That's about where Knoebel's Grove is, between Scranton and Wilkes-Barre.
A. Williamsport?
Q. So you know that back road you can take from Scranton to Williamsport?
A. No. Wilkes-Barre is a lot closer than Williamsport.
Q. That's true.
So when she fell in 2010 and broke her wrist she was having some trouble with her eyes. Did she break anything other than her wrist?
A. I believe she hit her head.
Q. And was she immediately hospitalized after that fall?
A. Yes.
Q. And she went to Griffin?
A. Yes.
Q. Did you take her there?
A. No.
Q. How did she get there?
A. Ambulance, I think.
Q. And she was admitted that day?
A. Oh, yes.

Q. How long did she stay in the hospital that time?
A. That day?
Q. No, that time.
A. I don't know.
Q. A few days?
A. No. No. Actually, now that I think about it, she never came out.
Q. Well, it looked to me like she was admitted on April 8th and then she was discharged and then she came back towards the end of May. Am I wrong on that?
A. Say again.
Q. I thought the records indicated that she was admitted on April 8th for her fractured arm and then she was discharged and she was readmitted May 24th.
A. She could have been. I really don't remember.
Q. Do you remember that she was in a nursing home for sometime?
A. Yes. She was in there when she had broke her hip.
Q. Okay. And what time frame are we talking about?

A. I don't remember. I can't pin down a time.
Q. Before or after she broke her -- you said wrist. When did she break her hip?
A. A couple of years, a year, six months. I don't know.
Q. Before the wrist though?
A. Before the wrist.
Q. So at some point she broke her hip and she went into a nursing home?
A. She went into the hospital.
Q. Right.
A. And they sent her for therapy. Not a nursing home. It's where she gets therapy.
Q. A rehabilitation place?
A. Rehabilitation, right.
Q. What was the name of that place?
A. I don't recall. It's right across the street almost from the hospital.
Q. Is that the only time you remember her being in that facility?
A. No.
Q. When else had she been in that facility?
A. Well, after she went back to the hospital -- you say she was home. Then she went back, and they treated her for I don't know how

long. And then they'd shift her over to the rehabilitation center again.
Q. Okay.
A. But she had to be on a breathing tube.
Q. Feeding tube?
A. Breathing.
Q. Breathing. Sorry.
A. They were upset about it and said we can't really take care of her; she's not ready to come here. I said that's got nothing to do with me; call the hospital. They shipped her back.
Q. And are we now talking 2010?
A. Yes.
Q. Okay. So she broke her hip, was hospitalized, was discharged from the hospital, went into a rehabilitation center, correct?
A. Yes.
Q. Did she come home after that?
A. I believe she did, yes.
Q. And how long was she home before she broke her wrist?
A. I have no idea.
Q. Did she have any other injuries between the time she was discharged from the rehabilitation hospital for the broken hip and the time she was

admitted with the broken wrist?
A. Not to my knowledge.
Q. Okay. And the only time you recall prior to the time she broke her wrist that she was in a nursing home or a rehab facility would have been with the broken hip; is that right?
A. Yes.
Q. And that's the only time you recall?
A. That's all I can recall.
Q. Okay. But your recollection is she fell and broke her wrist on April 8, 2010, and she never came home again after that. Is that your recollection?
A. Yes.
Q. And during part of that time --
A. Excuse me. Say that again. Broke her hip or her wrist?
Q. Wrist.
A. Yup.
Q. Hip she came home. Broke her wrist and that was -- she didn't come home after she broke her wrist?
A. Best as I recollect right now, yes.
Q. And from the time she broke her wrist you recall that she was in Griffin Hospital, correct?

A. Yes.
Q. And then she was in a rehab facility across the street from Griffin Hospital?
A. Well, yeah. Not exactly -- in the rehab. I'm sure the record will show you which one.
Q. And then she went back into Griffin Hospital?
A. Yes.
Q. And then she was transferred to Yale?
A. Then she went in, yes.
Q. But that would be the progression of where she was, correct?
A. Yes.
Q. And when she broke her wrist on April 8th, were you home at the time?
A. Yes.
Q. And how did she fall?
A. How did she fall, she went to go to the bathroom and ...
Q. And?
A. She fell.
Q. What did she hit her arm on?
A. The floor.
Q. All right. Do you remember what time of the day it was?

A. No.
Q. And your recollection is she went by ambulance to Griffin?
A. Yes.
Q. Did you meet her at the hospital that day?
A. I must have, yeah.
Q. Do you remember seeing her at the hospital that day?
A. I don't actually remember but I must have.
Q. Was there somebody who stayed with Tracey when you went to the hospital?
A. I don't remember that either.
Q. Would Tracey have gone to the hospital with you?
A. She could have.
Q. Do you recall if Tracey saw her at all at Griffin Hospital?
A. Oh, yes.
Q. Okay. How long was she in the hospital at Griffin with her fractured wrist?
A. Until she got transferred to New Haven.
Q. Well, I thought you said she was in the hospital, then she was discharged to some kind of rehabilitation facility?
A. For a few days, yes.

Q. How long had she been in Griffin Hospital before they transferred her to the rehab facility?
A. I don't remember that.
Q. And you say you think she hit her head when she fell?
A. I think so.
Q. Do you recall talking to any of her doctors while she was at Griffin Hospital about whether or not she had injured her head?
A. We had talked but I don't remember really anything with her head.
Q. Was she put on a ventilator when she broke her wrist?
A. Yes.
Q. So when she went into Griffin Hospital on April 8th, she was put on a ventilator?
A. Not right there, right then.
Q. How long? When was it she was put on a ventilator?
A. Well, she contracted some disease and -- whatever that was.
Q. What disease did she contract?
A. Something. I don't know the name of it but ...
Q. What's your understanding of what kind of

disease it was?
A. That most people over 50 do not recover.
Q. And was it an infection, was it something in the brain, was it a heart issue?
A. I don't know. Whatever that entails. Then she eventually went into a coma.
Q. When did she go into a coma?
A. I don't know that either.
Q. Who told you that she had some kind of an illness from which most people over the age of 50 don't recover?
A. Her doctors or nurse or somebody.
Q. During that April admission at Griffin Hospital did they tell you that?
A. In her admission, how would I know that?
MR. VIRGIL: I think he's caught up with the question being admission meaning the intake at the beginning.
MS. SEAMAN: Sorry. Thank you.
BY MS. SEAMAN:
Q. I'm just trying to figure out when somebody told you that she had a disease that most people over the age of 50 don't recover from. Was that before she was transferred to the rehabilitation facility after she broke her wrist?

A. I believe before and after.
Q. Okay. So whatever this illness was, she contracted it when she was in the hospital because of her broken wrist; is that right?
A. Correct.
Q. Okay. And because of that illness she needed to be put on a ventilator; is that right?
A. Yes.
Q. And once she was put on that ventilator, did she ever come off the ventilator?
A. Not to my knowledge, no.
Q. And you're not able to remember how many days went by after she went to Griffin with her broken wrist before they put her on the ventilator; is that right?
A. Correct.
Q. Okay. And from your perspective, as I understand what you're telling me, she was discharged from Griffin Hospital but only for a few days in the rehab facility, and then she was readmitted to Griffin; is that right?
A. That's approximately right.
Q. Okay. I'm sorry it's taken me so long to catch up with you on that.
Can you tell me the name of the doctor who

was primarily responsible for her when she was in Griffin Hospital?
A. I don't remember her name.
Q. Can you remember the name of anyone who took care of her while she was at Griffin?
A. No.
Q. Can you recall the name of any of the nurses?
A. No.
Q. And none of the doctors?
A. No.
Q. I think you told me that you believe you must have gone to the hospital on the 8th, the day that she was admitted; is that right?
A. Yes.
Q. And do you remember speaking to someone at the hospital at that time?
A. Sure.
Q. But you don't remember who that person was?
A. No.
Q. Did you have an understanding at that time what the plan for her care was?
A. Plan was they wanted to -- they didn't think she would survive and they wanted to know if we had a -- what do you call it, living will or

whatever you call that.
Q. That was when she was first admitted on April 8th?
A. When you keep saying "first admitted," you confuse me.
Q. I was just trying to distinguish between time periods. So I was thinking about the first time she was went to Griffin with her fractured wrist and she stayed there for a while; I know you don't remember how many days. Then she was discharged to a rehabilitation and then she went back to Griffin. Okay? That's right, right?
A. Yes.
Q. Okay. So I was thinking about the first time she was at Griffin, then she went to the rehab and then the second time she was at Griffin. Okay?
A. You got me again.
Q. I'm confusing you. I'm just trying to date when it was --
A. Let me tell you the sequence.
Q. Maybe that would help.
A. She went to the hospital with a broken wrist, before that with her hip. She was in the hospital, went to the rehab, came home. When she broke her wrist she went back to the hospital.

Eventually they transferred her to rehab. Rehab sent her back, then she came here.
Q. To Yale?
A. I sent her back there, to Yale.
Q. Okay. But you can't give me time frames, right?
A. No.
Q. You can't tell me how long she was home between the time she was released from rehab with her broken hip and the time she fractured her wrist?
A. No.
Q. And once she was put on the ventilator, whenever that was at Griffin Hospital, she never came off the ventilator until very late in her stay at Yale-New Haven Hospital, right?
A. Yeah. The best I could remember, right.
Q. Okay. So I take it once she was put on the ventilator she didn't speak to you anymore?
A. At?
Q. Griffin.
A. At Griffin, yes, she did speak to me.
Q. She did. So tell me when it is that you remember the last time she spoke to you.
A. That time. I would visit her quite often

and so would my kids and we were able to talk to her.
Q. You talked to her or she could talk back?
A. She could talk back.
Q. Even though she was on the ventilator?
A. Well, I guess she wasn't always on it. I don't know. She was certainly able to talk to me because when they asked me about, you know, did you have a living will and I had told them that never, never, never. And they started talking about pulling the plug on her.
And I said, Look, no way can you do that.
Well, how do you know she didn't want to.
And I said, Why don't you ask her.
Q. And she was talking at that time?
A. Yeah.
Q. Had you ever talked to her about that?
A. Many times.
Q. And tell me what those conversations, tell me what you recall from those.
A. Well, primarily what it was, there's times when you go in the hospital nowadays anyway, that's the first thing they want to bring up, a living will. And I told them we would never do that. I would never do it when I went and she would never

do it for various reasons, and the main reason being Tracey. You know, we wanted to live as long as we could live and promising each other we would never do that to each other, no.
Q. So you and your wife talked about the fact that if you ended up on life support, you wanted to be maintained on life support?
A. Absolutely.
Q. Because then Tracey could take care of you?
A. No. No. We could take care of her.
Q. Well, how would you take care of Tracey if you were on life support?
A. Well, I don't know if I'd be home. I don't know where I would be. But at least one of us, and if she wasn't, she's got four brothers that can. I was talking about us, her and I.
Q. You and Helen?
A. That's right.
Q. But you have a recollection of talking with Helen and having her tell you that if she ended up on life support, she wouldn't want you to terminate that support?
A. Not at that time we didn't discuss that. We had discussed that for ten years.
Q. And you felt the same way?

A. Absolutely.
Q. Why?
A. Because you can always come home. You can always be cured, in my opinion. And as far as I'm concerned, I was hoping my wife and I would live for a hundred. But I would never do anything to pull a plug on her. She knew that. I knew that. The hospital bugged me to death with that and I told -- they sent a clergyman to talk with me one time, whoever he was, and I told him the same thing. And no, we never wanted that, we never will and don't ever do it.
Q. And you think that your wife would have wanted to be maintained on the machines like she was on at Griffin and Yale?
A. What's the difference what I think?
Q. I'm just asking you: Is that what you think?
A. We had said don't ever do that. I don't know -- I'm not a doctor. I don't know whether -- as far as I'm concerned, let's hope that she comes home and that we had a promise to each other.
Q. Do you remember telling the people at Yale that she would never have wanted to live like that?
A. Of course.

Q. So you didn't --
A. Not -- what was your question again, whether she wanted to live like that?
Q. Right. On the machines.
A. No. I don't ...
Q. You don't remember telling them that?
A. I just remember telling them that I didn't want her -- I would not -- just don't ever pull the plug on her. And in my opinion that's what she would want because we had discussed that many times.
Q. Okay. When you discussed that with her, did you talk with her about what it would mean to have dialysis?
A. No.
Q. Did you talk with her about what it would mean for her skin to break down if you're on --
A. No.
Q. Did you talk with her about the inability for her to talk to anybody?
A. No.
Q. Do you still feel, sir, that if something happens to you and you go on life support machines, that you would never want to be taken off of them?
A. Never.

Q. Okay. So can you tell me, you say that when she went to Griffin Hospital you can recall that you saw her the first day she got there.
A. Yeah.
Q. Did you go see her the second day?
A. I don't know.
Q. Can you give me any idea of when it was that you saw her after her admission?
A. No, I can't.
Q. Can you tell me any conversation you had with her after she went in the hospital?
A. No. Other than how you doing, this and that, hurry up, come on home. I thought she was going to be fine.
Q. And do you recall at least one time when you went to the hospital that she could talk with you?
A. Say again.
Q. That at least one time after she went to Griffin you recall that she could speak to you?
A. Quite a few times.
Q. How many days was it before she was put on the ventilator?
A. I don't know.
Q. Do you have any notes or anything that

would allow you to say that?
A. No.
Q. You never kept a diary, anything like that?
A. No.
Q. You never wrote anything about that?
A. No.
Q. Okay. When you went to the hospital did Tracey go with you sometimes?
A. Yes.
Q. Did she ever go without you, Tracey?
A. Not unless she was with somebody else.
Q. Okay. Who else saw your wife while she was at the hospital?
A. My sons.
Q. All of them?
A. I know Gary did; I know Randy did. Whether Michael ever did, I don't know.
Q. Okay. Did they ever share with you anything that your wife told them when they saw her at the hospital?
A. They haven't discussed it with me other than she looks good, maybe she's coming hope. Hopeful.
Q. When was the last time you thought she looked good?

A. When we got married.
Q. I don't think we should put that on the record.
A. No. When she looked good, well, going into the hospital with a broken wrist, I don't think anybody's in serious trouble.
Q. She looked good then?
A. So you've got a broken wrist, so what. The whole thing is as she contracted this so-called disease, she got worse. And evidently they didn't think she was going to live because they kept bothering me with living will. And that was always our conversation and then, like I said, send the clergyman to talk to me. And, look, that's the way it is. That's all there is to it.
Q. Okay. When she was in Griffin Hospital, they talked to you about terminating the life support, right?
A. Absolutely.
Q. And how long after she got there did they first approach you about that?
A. I don't know.
Q. Who was it who approached you?
A. Don't know that either.
Q. Did they talk with anyone in addition to

you about that issue? Did they talk to your sons?
A. I don't know.
Q. And you don't recall the name of anybody who took care of her while she was at Griffin?
A. I'm trying to think of her primary doctor but I can't get her name. It was a woman.
Q. So she was there for over two months, right?
A. I can't testify to that either.
Q. Well, from April 8th when she fractured her wrist and June 18th she went to Yale, right?
A. Sometime in June she went to Yale.
Q. Our records reflect June 18th.
A. Yeah, if the records show that.
Q. So that's a little more than two months, right?
A. Right.
Q. How many times do you think you saw her during that two-month period?
A. Both of them together or just Yale?
Q. No, just Griffin. I'm only asking about from April 8th when she was admitted to Griffin until she was transferred to Yale.
A. Whenever I could.
Q. Ten times, do you think?

A. I'm not going to guess.
Q. I'm not asking you to guess. Give me an estimate.
A. I can't.
Q. Okay. Could it have been as few as ten times?
A. I can't give you an answer, Counselor.
Q. Okay. But you don't remember one person that you spoke with at the hospital?
A. I still can't talk to nobody there or New Haven either.
Q. You don't remember the name of anybody at Yale-New Haven Hospital?
A. I don't concentrate on that stuff. That's not important to me. You're a doctor, you can tell me Dr. Smith this morning and I may not know him this afternoon. I'm not a name-keeper in my head. But I really don't know of any doctor at both hospitals. I can't remember her primary doctor. It was a lady doctor in Beacon Falls. That's all I can remember. That's her doctor.
Q. Okay. And do you remember any of the nurses who took care of her?
A. No.
Q. Do you remember the name of the clergy who

approached you in either hospital?
A. No.
Q. How about the social workers?
A. Social worker, the only one I can remember that is when she got admitted to Yale, we had to go there and fill out all the necessary papers.
Q. For the admission?
A. Yeah.
Q. Why do you think that was a social worker?
A. Well, that's why I don't want to get a misunderstanding between you and I.
Q. That's why I'm asking you.
A. You say "social worker"; you say "rehabilitation." Somebody. I don't care -- I don't know what her title was, but they sent me to her to fill out the paper.
Q. The papers that you needed to fill out when she was admitted to the hospital?
A. Yes.
Q. Do you have a copy of those papers?
A. I don't believe so.
Q. Okay. Do you remember the name of that person?
A. No.
Q. I thought you told me the only person whose

name you remember is the person that they sent you to to fill out the papers.
A. I didn't say that.
Q. Okay. So you don't remember the names of anybody at Yale?
A. No.
Q. Do you remember Dr. Siegel?
A. No.
Q. Pisani?
A. No, none of them.
Q. Peter Herbert?
A. The only doctor I remember is a guy with a beard sort of like mine when she first went there.
Q. All right. When she went to Yale you had asked that she be transferred, right?
A. Yes.
Q. And you asked that she be transferred because Griffin Hospital had recommended that you terminate life care?
A. Yes.
Q. Did you go with her to Yale on that first day?
A. I think I did. I really don't remember. I must have. I don't see letting her go without me.
Q. Did you drive her there?

A. No. She went by ambulance.
Q. Were you there when she arrived?
A. Yes.
Q. And where was it that you saw her first after she got to Yale?
A. In her room.
Q. And do you remember what room that was?
A. No.
Q. Do you remember what floor that was on?
A. No.
Q. Do you remember where in the hospital she was?
A. No.
Q. Who was with you that day?
A. I believe myself.
Q. And you drove yourself, you think?
A. Oh, yes.
Q. And what was her condition when you first saw her at Yale?
A. She was still in a coma.
Q. And how long did you stay that day?
A. I couldn't answer that either.
Q. Do you remember if you did speak to anybody at Yale while you were there?
A. The girl in the office about wanting to

know what kind of insurance you had and all that stuff.
Q. Paperwork. Okay. Did you have health insurance at that time?
A. Medicare.
Q. And did your wife have Medicare also?
A. Yes.
Q. And then you don't remember how long you stayed. When did you next go see your wife?
A. Whenever I could.
Q. And what were you doing that kept you from going there sometimes when you might have wanted to?
A. Probably Tracey.
Q. So you didn't want to leave her alone?
A. That's correct.
Q. Did you go see her once a week while she was at Yale?
A. Counselor, I don't know. That's my answer.
Q. Do you remember being called on the phone by physicians at Yale?
A. The night she died, yeah.
Q. How about before that?
A. I don't remember any of that.
Q. You don't remember being called?

A. No.
Q. Do you remember people at Yale asking you to come to a family meeting with staff at Yale?
A. Yes.
Q. Do you remember when the first one was?
A. No.
Q. Do you remember who was there?
A. Not names. The best that I could remember there was three people there, two doctors and --
Q. And a head nurse? Yes?
A. Nurse.
Q. Because if you just nod to me, Melissa can't get your answer. I apologize. I'm not trying to put words in your mouth.
A. That's fine.
Q. And did anyone else from your family go to that first meeting?
A. Yes.
Q. Who?
A. Gary and Randy.
Q. Okay. And can you remember what they said to you at that meeting and what you said to them?
A. Well, basically I could tell you what the conversation was.
Q. Perfect.

A. They were more or less trying to convince my two kids, you know, bring them up to date because they couldn't get anywhere with me because I just said don't ever do that, don't ever pull the plug. So I guess they wanted family there and got their feelings and they got it. And both of them reiterated that, no, don't ever pull the plug. Don't ever do that.
Q. Did they tell you anything about her diagnosis?
A. Well, they said that she probably wouldn't recover and the best thing for her to be -- you know, to let her go. That was their professional opinion. And I had told them once again at all of the discussions that me and my wife had about that many, many times. I promised her and she promised me, and I will never tell you to pull the plug, never.
Q. Okay. Do you remember telling them that you and your family were still deciding about end-of-life issues?
A. No.
Q. How many times did they ask you to sit down with Yale and talk about her condition?
A. Once the best I can remember. One time.

Q. If the records reflected that -- let me find my note. I'm sorry.
(Off the record.)
BY MS. SEAMAN:
Q. Do you remember Dr. Deshpande?
A. I've told you, Counselor, I don't remember anyone.
Q. Sometimes you know if you don't remember something, something might trigger your recollection, right? So I'm not trying to aggravate you. I'm just trying to make sure that the names that I have, that they don't trigger a recollection from you.
A. That's fine.
Q. Does that sound reasonable to you?
A. It certainly does.
Q. Okay. So my notes indicate that within a few days after the time your wife was transferred to Yale the doctor called to talk to you about her condition.
A. I don't recall that.
Q. Do you have a cell phone?
A. No.
Q. And I take it you didn't have a cell phone then?

A. No.
Q. But you had a home phone?
A. Yes.
Q. And typically if you weren't with your wife, you would have been at home with Tracey?
A. If I wasn't with my wife.
Q. In the hospital.
A. I might be home, I might not.
Q. Okay. What kinds of things were you doing in that time frame?
A. Whatever I wanted to do. I don't know exactly what I did. I could have went shopping, I could have went to visit my kid, I don't know.
Q. You could have went shopping or visited one of your children?
A. Or anything.
Q. Did you go to casino after your wife got sick?
A. When?
Q. From April 2010 through the time she was at Yale.
A. Sure.
Q. Did you and Tracey go or you went alone?
A. The best I can remember is by myself, but Tracey might have went with me a few times. I

don't know. I don't remember.
Q. Okay. My friends, one of my friends goes to the casino, I think it's every Wednesday because there's something she likes to do Wednesday afternoon at one of the casinos.
Did you go to the casinos with some regularity on a certain day?
A. No.
Q. Did you go during the day as opposed to night?
A. Both.
Q. Either one. Which casino or both?
A. Both.
Q. Do you have a preference?
A. Yes.
Q. Which one?
A. Foxwoods.
Q. And do you do the slots at Foxwoods?
A. Sometimes.
Q. What else do you do?
A. Play poker.
Q. Okay.
A. Play horses, whatever.
Q. You can play horses?
MR. VIRGIL: You've got to answer out

loud.
THE WITNESS: Yes.
BY MS. SEAMAN:
Q. They have them on video?
A. Yeah.
Q. And how often were you going to the casino during that time frame?
A. Couldn't tell you.
Q. More than once a week?
A. I don't know.
Q. How about now, how often do you go?
A. Whenever I get a chance.
Q. Is it once a week, twice a week?
A. Could be. Who knows. I don't know. I don't keep records.
Q. How about this week, have you been to the casino this week?
A. This week, no.
Q. How about last week?
A. We're not going to get into that, Counselor.
Q. Why not?
A. I don't know.
Q. Okay. If the records – strike that.
So do you recall that within a week of your

wife getting to Yale you were called and told that she was reaching the time where she couldn't stay orally intubated?
A. I don't understand that.
Q. She was intubated, right?
A. Yup.
Q. And do you recall the doctors telling you that she couldn't stay like that forever?
A. No.
Q. You don't recall talking with them about a tracheostomy?
A. No. I never to my recollection ever talked to them on the phone.
Q. Never?
A. Other than them calling me and telling me she passed.
Q. And if the hospital records indicate that on June 23rd one of the doctors called you, would you say that that was in error?
A. I would say that I don't remember talking to them.
Q. Okay. Do you remember that you were told that she had ischemic colitis?
A. I wouldn't possibly remember medical terms.
Q. Okay. Do you remember they told you that

she had skin breakdown?
A. No.
Q. Did you ever see evidence of skin breakdown?
A. I wouldn't know what it looked like.
Q. Do you know what a skin ulcer looks like?
A. No.
Q. Did you ever see anything on her face, a sore on her face?
A. No.
Q. Did you ever see a sore on any other part of her body?
A. When she was in the hospital?
Q. Yeah. I'm not asking before that. Sorry.
A. No.
Q. I know you told me you didn't remember the names of the doctors who were at the first family meeting that you recall. Do you remember what kinds of doctors they were?
A. I wouldn't know.
Q. If the records indicate that there was a family meeting on June 29th and another family meeting on July 5th, would you have any reason to think that was not right?
A. It certainly is not right.

Q. Okay. Because you only had one meeting?
A. Yes.
Q. Do you remember at some point being told that the doctors were going to go to the ethics committee to discuss your wife's condition?
A. They were going to go to the ethics committee, no, I didn't know that.
Q. Tell me any conversation you recall with anyone at Yale any time that your wife was in the hospital.
A. Sure.
Q. Okay.
A. I just can't give you names. But every time you went there a doctor would be there, and most of the time he'd have three or four other people with him. And they would talk to you and they would discuss with me medical terms which I don't even know what they're talking about.
But the whole idea is it always came down to you should consider pull -- they wouldn't say pull the plug, disconnect her. And then they would tell me they would take the tube away for a little while and then she had difficulty, they would put it back. And evidently they've done that a few times. And whether it be one doctor or two doctors

or -- they always more or less had the same conversation.
Q. And the conversation was that they were speaking in medical terms, you had no idea what they were talking about because you didn't understand the medical terms and they told you that they would take the tube away for a little while, then put it back?
A. And they've done that for a while.
Q. Okay. Anything else you recall at any time that your wife was there about any conversation with anyone at Yale?
A. The night that she died. I was at the hospital, went to see my wife, then I asked to see the doctor. The doctor came down. Who it was I have no idea.
Q. But it was a he?
A. It was a he. And he said how he was going to pull the plug. I hate using that term but --
Q. And that's not what he said?
A. No. He said disconnect the ventilator, I guess, the breathing tube. We're going to take her off and we've been doing that, putting her back on, this and that. But tonight we're taking her off. If she makes it, she makes it. I said, whoa,

that's -- isn't that against the law to do that? He said yes but the ethics committee can overrule. And I said overrule anything you want but don't ever, ever, ever do it. That it was my conversation with him.
Came home -- Gary was with me. Came home. I must have got home 11 o'clock. I don't really know the time. But sometime after 12 the phone rang and said your wife passed away. I immediately called my son Gary and my son Randy.
Q. So your recollection is that the night that she died you went to the hospital. I take it that she was on the ventilator when you got there?
A. Yes.
Q. You asked to see the doctor?
A. Yup.
Q. Why did you ask to see the doctor?
A. I always ask to see the doctor.
Q. Every time you got there?
A. As best I could recall.
Q. Okay. Do you know whether you had seen that doctor before?
A. No.
Q. No. Bad question so I don't understand your answer. Sorry.

Can you tell me whether you had ever seen that particular doctor before that night, the night that your wife died?
A. Not that I can remember.
Q. You think that was the first time you met him?
A. I think so.
Q. Okay. He said to you, I'm taking her off of the breathing tube and I'm not going to put her back on.
A. Yeah. If she makes it, she makes it.
Q. And you said, Isn't that illegal?
A. Yes.
Q. And he said, Yes, but the ethics committee can overrule it?
A. Yes.
Q. Then you left?
A. I just said, Look, don't ever, ever do that.
Q. And then you left?
A. And I left. And I --
Q. And when you left was it your understanding that he had changed his mind?
A. In my wildest imagination would I believe that he would do that.

Q. You thought not?
A. No. Who would kill somebody?
Q. Did you talk to him about the ethics committee?
A. No.
Q. Did you know that the ethics committee had met?
A. He just mentioned the ethics committee.
Q. But not that they had met or what the ethics committee had said?
A. No.
Q. Just that there was an ethics committee?
A. Yeah.
Q. And do you remember anyone telling you -- strike that.
You recall that was the night she died that you had this conversation?
A. Yes.
Q. And when you arrived at the hospital she was still on the ventilator?
A. I believe so, yes.
Q. And you didn't ask to see the doctor for any particular reason, just that that was your standard course?
A. No, that's not the reason. My son Gary who

went there quite often said, Dad, you better go up to the hospital because they were talking about they were going to take the tube away from mommy. And which, of course, then I went to the hospital. That's when I went there and that's why I wanted to see a doctor regardless of who it was.
Q. Okay. But she was still on the tube then?
A. I really don't remember that. I don't know.
Q. You're saying that it was the night she died?
A. Yup.
Q. The last time you saw her alive?
A. Yup.
Q. You went to the hospital because Gary told you they were talking about taking the tube out?
A. Yes.
Q. And you don't remember whether or not the tube was in when you got there?
A. I'm really not a person that stays and studies. Somebody's, you know, in a coma, they're in a coma. The only thing that I can recall, because of conversations with Tracy's doctors, that when you're in a coma, you could hear. So I wasn't going to talk to the doctor where possibly she

could hear. So we went out of the room, and that's when the conversation -- and Gary told me that that night -- see, because he works in New Haven so he's always there. And he was upset. He said they said they were going to pull the plug that night, and then I went to the hospital with him.
Q. You went to the hospital with Gary?
A. Yes.
Q. So Gary went back to New Haven with you?
A. Yes.
Q. Had he called you on the phone or he came home and told you?
A. He called me on the phone, I think.
Q. And he had already been in the hospital that night?
A. That day.
Q. That day. And it was that day that they told him they were going to pull the plug?
A. Yes.
Q. Where is it that Gary works in New Haven?
A. Turtle & Hughes. They deliver electrical stuff, I think.
Q. Okay. And does he work a day shift?
A. Yes.
Q. And you don't recall the name of the

doctor?
A. No.
Q. Did Gary tell you the name of anyone with whom he spoke?
A. No.
Q. Do you recall asking for a second opinion from anyone at the hospital?
A. No.
Q. And you don't recall the chief of staff calling you?
A. No.
Q. You don't recall anyone from the ethics committee calling you?
A. No.
Q. And can you remember any other conversations at any time while you were at Yale?
A. I don't know exactly how many conversations but it all came down to one thing: disconnect the tube and let her go.
Q. But you can understand that it's important from my perspective to be comfortable that I have learned as much as I can learn about what the people at the hospital told you. And I recall you telling me that you recall one family meeting where you recall that there were three people from the

hospital present and they talked to you about, I guess, the prognosis and their suggestion that you should think about removing life support, right?
A. Basically, yes.
Q. And then you recall a second conversation the night that she died after Gary told you that you should go because they were going to pull the plug. You talked to a doctor and told him you didn't want him to. You understood they were planning to do that. And when you got home, you got a call around midnight that she had died?
A. A little after midnight, yes.
Q. And those are the only two conversations that you can tell me about with any kind of specificity?
A. At this time, yes. That's all I recollect.
Q. And you have nothing that would allow you to refresh your recollection; is that right?
A. No.
Q. At any time did you read the medical records?
A. Medical -- no, not that I can remember.
Q. From the hospital?
A. No.
Q. Okay. And you --

A. I -- no, not that I can remember.
Q. You never asked to look at them and you didn't read them?
A. No.
Q. And you can't think of anything that would refresh your recollection about any other conversations that you had?
A. Not at this time, no.
Q. In the complaint there is an allegation that at some point you filled out documents saying that you couldn't afford to pay for the care.
A. Yes.
Q. And when was it that you filled that out?
A. The day she went in the hospital, that's where they sent me to see her.
Q. Okay. Well, you filled out regular admission documents at that time?
A. I don't recall that.
Q. No? Did you tell them she was on Medicare?
A. Yes.
Q. And did Medicare pay for the Griffin Hospital bill?
A. I would assume.
Q. Did you see that bill?
A. From Griffin? They sent me a bill.

Q. Did you pay them?
A. No. Medicare paid them.
Q. Okay. And did you ever apply for free bed funds at Griffin?
A. Not that I recall, no.
Q. So why was it that Medicare would pay for Griffin and not for Yale?
A. You'd have to ask them.
Q. Did you ever talk to Medicare about them not being willing to pay for Yale?
A. No.
Q. What makes you think they didn't pay Yale?
A. I don't.
Q. You don't know?
A. I don't know.
Q. Okay. So are you saying that the first night she was there you had to fill out certain paperwork for Yale and in that paperwork you said you were on Medicare?
A. Counselor, let's discuss it. Let me tell you what happened. That's the best way to handle it.
Q. Good.
A. She went by ambulance. I got to the hospital, go down to see so and so. I went down

and seen so and so and that she discussed what your insurance was and how many members in your family, where you are with your salary and what bracket that you're in. That's what we discussed. And I know that I had Medicare at that time and so did my wife and there was no other insurance. And they weren't concerned about that. They just wanted that and that's what I made out. Whether Medicare paid, didn't pay, don't know.

Q. Okay. And you never worried about it again after that night?

A. No.

Q. You have no reason to think that anybody at Griffin Hospital made any decisions about your wife's care because she did or did not have any money, do you?

A. I never discussed that.

Q. Okay. You don't think anyone at Yale-New Haven Hospital did anything in connection with the care of your wife because you did or did not have money?

A. That never entered my mind.

Q. Okay. You don't think that anyone at Yale made the decisions, for instance, recommending to you that you should terminate life support because

they knew you were on Medicare?

A. I never discussed that, no.

Q. You don't think that's why they recommended that, right?

A. I don't remember that conversation.

Q. Okay. And you don't think that anyone at Yale told you that they thought they should terminate life support and the reason they did that was because she didn't have any money, right?

A. I never had that conversation either.

Q. And you don't think that that's what motivated them to recommend that you terminate life support?

A. You would have to ask them.

Q. You don't have any knowledge about that one way or the other, right?

A. No.

Q. Do you know who Dr. Bindu Dey is?

A. That's her doctor.

Q. Okay. Her primary care?

A. Bindu Dey.

Q. And do you know what Birmingham Health Center is?

A. That's where she went.

Q. After the wrist, she broke her wrist?

A. Both times, both the wrist and hip.

MS. SEAMAN: We're going to need those records. Can we get an authorization?

MR. VIRGIL: Yeah.

MS. SEAMAN: Okay.

MR. VIRGIL: And whatever you get it, you'll just send me a copy of it.

MS. SEAMAN: Well, here's what I do. We don't need to put this on the record unless you want it.

MR. VIRGIL: No.

(Off the record.)

BY MS. SEAMAN:

Q. I think I've asked you this but in case I didn't: When she broke her wrist in April, her mental status had been good up to that period in time?

A. Yes.

Q. And she didn't have any kind of infection, anything that could explain that illness she got after she was admitted to the hospital as far as you know?

A. No.

Q. No relationship of anything even in hindsight you can think of?

A. I don't recall any of that.

Q. Okay. And when you saw her in Birmingham I think it is. Yeah. Birmingham Health Center, you visited her there?

A. Yes.

Q. Did you notice that she was having more and more problems, physical problems?

A. The second time that she went there.

Q. After the wrist?

A. After the wrist. She was -- you know, she was on a breathing machine in there, and I guess they're not accustomed to having anybody with a breathing -- they weren't too familiar with it. And that's why I could hear them talking that this is ridiculous, she doesn't belong here and they were going to notify the hospital and blah, blah, blah, blah.

Q. So they made the decision to send her back?

A. They sent her.

Q. Did they consult you about that decision?

A. No. They just sent her back.

Q. Do you remember being asked to give your consent for Yale to do a lumbar puncture?

A. I remember that discussion, yup.

Q. Tell me what it is that you remember about

that.
A. Well, they had mentioned they wanted to do exactly what you just said, and I didn't even know what that was. Then he started telling me something about they would do a needle in her spine or something. And I said, Look, in your professional opinion would that help her or not?
He says, Well, probably not but it could be.
And I said, Look, you're the doctor, not me. I don't know what -- if that's going to help her, not going to help her. That's you; not me. I didn't say don't do that. I just said, Do whatever you can for my wife to bring her back.
Roughly that was the basis of the conversation.
Q. If the records indicated that you refused to consent to have that done would the records be wrong?
A. In my opinion it would be, yes.
Q. At any time after your wife was put on the ventilator at Griffin Hospital --
A. At Griffin Hospital, okay.
Q. Any time after that.
A. Okay.

Q. When the doctors told you that her prognosis was not good, did you disagree with them?
A. I can't disagree with a doctor. I am not a doctor.
Q. Okay. So would it be fair to say that from the time she got put on the ventilator until the very end you were hopeful that she would get better?
A. Of course.
Q. But the doctors were telling you she was not going to get better?
A. They were saying because of the illness that she had, what her chances were. And they would keep bugging me about -- that's one of the reasons I got her the hell out of there. That's all they were interested in is, look, in our opinion she's not going to make it, you should definitely pull the plug, in so many words. And once again, I told them. So it got to the point they kept bugging me about it. And that's me using my common sense, they don't have any faith in themselves curing her. To my knowledge the best hospital around was New Haven. I said ship her up there.
Q. And the doctors at New Haven told you the

same thing, that she was not going to get better?
A. Not at that time. After some later time but not ...
Q. If the records indicated that three days after she was admitted to Yale the doctor told you in so many words that she was not going to get better, would you say that's wrong?
A. No, that's wrong.
Q. Okay. Do you remember Dr. Siegel?
A. Is he the guy with the beard?
Q. I don't know.
A. Then I don't remember Dr. Siegel.
Q. The guy with the beard is the one that you saw the last night?
A. No.
Q. I'm sorry. Tell me again --
A. First night. First night.
Q. What do you recall about that?
A. Nothing other than saying, Okay, she's stable and we'll take care of her. And that's the basics of that.
Q. That's all you recall. Do you recall Dr. Marshall?
A. No.
Q. Do you remember talking to the doctors

about switching her from the kind of ventilation she was on to a tracheostomy where they put a hole in your neck?
A. No.
Q. And I take it you don't recall being asked to attend an ethics committee meeting?
A. Definitely not.
Q. And you don't recall anyone calling you and telling you what happened at the ethics committee meeting?
A. No, I don't.
Q. And you don't recall anyone telling you that if you wanted you could ask for a second opinion?
A. No.
Q. And you don't recall asking for a second opinion?
A. No.
Q. At any time did you talk with your children after she was admitted to the hospital about whether your wife would want to be continued in the condition she was in?
A. We've had that discussion so many times it's sickening.
Q. And none of your children disagreed?

A. No.
Q. None of your children said she wouldn't want to stay like this?
A. No.
Q. At any time after she got to Yale did your wife make any sign that indicated to you that she recognized you?
A. No.
Q. Did she ever make any sign that indicated to you that she could hear what was going on around her?
A. She was in a coma.
Q. Okay. She never blinked her eyes, squeezed your hand, smiled at you, nothing?
A. No.
Q. Did you know that her kidneys were failing her?
A. I have no idea.
Q. Okay. And I take it you didn't know that her liver was failing her?
A. Never heard the word liver, period.
Q. Did you hear hemodialysis?
A. I don't know.
MS. SEAMAN: Could you mark this for me, please.

(Defendant's Exhibit No. 1: Marked for identification.)
BY MS. SEAMAN:
Q. Showing you, sir, what's been marked as Exhibit 1 which is the same as you were looking at.
A. Okay.
Q. On the top of this is a letter signed by Giralda Silva-Lanier from Yale-New Haven Health to your wife care of your family dated 4/6/11. Have you ever seen that before?
A. This particular letter?
Q. Yes.
A. No.
Q. Can you just look, leaf through this and see if you recall ever seeing any of these documents before.
A. If this is -- if this is just -- let me read it.
No, I never saw anything with money on it. I mean, it does look like something that she was asking me, you know, but I don't remember actually seeing that. She was asking me about income and all that stuff. What's on the next page.
Q. You're now looking at page?
A. Five.

Q. At the top it says "page 005," right?
A. Right.
Q. Is that your handwriting?
A. No.
Q. Do you know whose handwriting that is?
A. Whoever the girl was.
Q. But you don't know whose handwriting that is?
A. No.
Q. Is that your wife's social?
A. Where is it?
MR. VIRGIL: Right there.
THE WITNESS: 045 -- yes, it is.
BY MS. SEAMAN:
Q. And is that your phone number?
A. Yes, it is.
Q. And is that your social at the bottom of the page, 049?
A. Yup.
Q. Okay. And do you see on page 6, at the top of page 6, was Helen receiving SSI in the amount of 522?
A. She was receiving Social Security. Whether it was SSI or not, I don't know.
Q. How about did she also have an annuity or

pension in the amount of $218?
A. Yes.
Q. What was that?
A. Pension in there because she worked for the school system.
Q. And then the next page? Have you ever seen any of this before?
A. No.
Q. And on the last page -- no. No. I'm sorry. The last page of this packet. At the top it says page 9.
A. Yup.
Q. Is that your wife's signature?
A. No.
Q. And on June 21, 2010, she wasn't in a condition to sign anything, correct?
A. She was in a coma.
Q. Is this your handwriting?
A. I think it is.
Q. And you think you signed this?
A. I think so.
Q. Why do you think you signed this?
A. It looks like my signature.
Q. Okay. And you think you signed it on or about June 21, 2010?

A. If that's what it says.
Q. Do you have a recollection of doing it?
A. I don't remember -- I know doing this when I first went there. So she went there whatever date that was. I think she went there on the 20th, I think. So this is probably right. I don't know.
Q. Okay. And there's some checks in here. Page 11. Do you know what that is?
A. This is page 11, yeah. I'm trying to think if we had insurance with First Student. Not that I -- I can see it but I don't recognize it. I don't remember getting anything from First Student.
Q. Okay. Do you remember giving any checks to Yale?
A. Oh, I've never done that.
Q. Okay. And did you at some point, were you notified that --
A. Where are we now, Counselor?
Q. Thirteen.
A. Yes.
Q. -- that application for medical assistance had been denied for May, June, July and August?
A. No.
Q. Have you ever seen that last document?
A. No, not that I recall.

Q. When did you first consult a lawyer about this claim?
A. I couldn't tell you that either.
Q. Can you tell me the year?
A. Probably 2011 or 2012.
Q. Not the year that she died?
A. No. It wouldn't be the year -- it could be '12 or '13, I guess. It couldn't have been '14. It had to be a couple of years.
Q. You have no idea?
A. No.
Q. Since your wife died have you been on vacation?
A. Vacation, no.
Q. Have you and Tracey gone anywhere other than to the casino?
A. Oh, visit the kids, visit the grandkids, whenever she wanted to go, you know. She's mostly at home.
Q. But do you still take her out to dinner?
A. Occasionally, yes.
Q. Take her out to restaurants?
A. Yes.
Q. What damages do you claim in this case?
A. What damages? Well, I lost a lot when you

took my wife. You know, certainly companionship.
Q. Well, she hadn't been your companion for several months, right?
A. It depends what kind of companionship you're talking about.
Q. Well, what type are you talking about?
A. My wife and I are always companions all of our lives since we've been married whether I'm in the room with her or whether I'm driving a truck.
Q. But as far as --
A. Emotional stuff. Every time I do something in the house, cook or clean or -- this always comes back to her and it's a great emotional strain on me.
Q. That you miss her?
A. That I miss her and that would remind me. And stuff with the soap operas, same thing. The fact that we spent so much time together talking, whatever. And then just thinking how could they kill my wife in my opinion, never giving me a chance to say good-bye, my kids, my grand -- I can't handle that.
Q. Well, you were there the night that she died, right?
A. Yes.

Q. Did you say good-bye to her that night?
A. No.
Q. And when had your grandchildren gone to see her?
A. I don't know. I don't know. I don't think they ever did. I don't think so.
Q. So they hadn't seen her since early April when she was hospitalized with her broken wrist and whatever it was that made her so sick as far as you know; is that true?
A. That's true.
Q. Okay. And had Tracey ever gone to see her at Yale?
A. No.
Q. And I know you said Gary had because he was working in New Haven and he was in there the day that she died, right?
A. He was in there quite frequently.
Q. And one of those was the day that she died, right, because she called you -- he called you --
A. Not the day she died. No. No. She died on a Friday. It must have been Friday or Thursday or some other time that he called me. He wouldn't be in there on that Saturday because he works Monday through Friday.

Q. I thought your testimony was that he had gone in to see her, he called you to say that they were going to pull the plug, you went down there, you asked to see the doctor --
A. Not that same day.
Q. Oh, when he called you and said that they were going to pull the plug, that was several days before you went down?
A. No.
Q. I'm sorry, sir.
A. Yeah. A couple of days before I went down he called me and said, look, I just visited mommy and they're talking about pulling the plug on her.
Q. And then was it two days between the time he told you that and the time you actually went to the hospital?
A. Whether it was one day or two days, I don't know.
Q. But it wasn't the same day?
A. No.
Q. And then you don't think he saw her again after that?
A. Well, if he called me on Thursday then he possibly could have seen her on Friday. If he called me on Friday, then the next day was

Saturday.
Q. You just don't know?
A. I don't know.
Q. But you saw her definitely the night that she died; is that true?
A. Both of us did.
Q. You and Gary?
A. Yes.
Q. I'm so confused. I'm sorry. I probably shouldn't say that.
All right. What I had heard -- would you just tell me that again just so I get it straight in my head.
A. Sure. I got a phone call from Gary, whether it be Thursday or whether it be Friday, I have no idea: Dad, you better get your butt up to the hospital, they're going to turn around and pull the plug on her.
And while he was there he observed her reaching for her. And then the nurse said, See, she's trying to tell you she wants to die. That's what the nurse says.
Now, whether it be Friday or Thursday, I don't know. But Saturday we went to the hospital.
Q. You and Gary together?

A. Yes.
Q. And it was Saturday night that she died?
A. The Saturday night she died, yes.
Q. Okay. So you both saw her on the day that she died?
A. Absolutely.
Q. How about Michael, when had he last seen her?
A. He saw her I believe only one time, I think. I don't know. I think. It was with me.
Q. He went one time as far as you know and that was a time with you?
A. Yes.
Q. Tracey, I asked you, she never went. How about Kevin?
A. Kevin I believe went but I can't really testify to it.
Q. And do you think he went once?
A. I don't know.
Q. So I take it you and Kevin talked about how she looked when Kevin was there?
A. No.
Q. How about Randy, did he see her at all at Yale?
A. He seen her definitely the time we had the

meeting. Any other time, I don't know.
Q. And had Tracey gone to visit her at Griffin Hospital?
A. Yes.
Q. How many times?
A. I don't know.
Q. How about Michael, had he seen her at Griffin?
A. Yes.
Q. How many times?
A. Don't know.
Q. How about Kevin, had he seen her at Griffin?
A. He did but I don't know how many times.
Q. And Randy?
A. Yup.
Q. And you don't know?
A. Yes, he did, and I don't remember.
Q. Okay. But you don't think any of the grandchildren had gone to Griffin or Yale; is that right?
A. I don't know if they went to Griffin, but I know they definitely didn't go to New Haven.
Q. Okay.
A. That I know about anyway.

Q. And how has your life changed, if at all, sir, since she was hospitalized at Griffin and subsequent to that, from that time until now how has your life changed?
A. It changed about as much as it possibly could because I was married to an ideal woman who I had pretty much of a free life.
Q. A what?
A. You know, as far as going where I wanted to. I never had to worry about my children.
Q. She did all of that?
A. As long as I had my wife or my -- God bless her soul, my mother-in-law. I've never worried about my children. Now I can't make a move, you know. I've got to always put Tracey in front of me.
I realize regardless of what happened I'd have still been in that boat. I understand that. But I mean, to ask me how much it changed my life now, it brought me from a person who could do whatever he wanted whenever he wanted to a person who can't do nothing unless I -- I either got to take Tracey. Not that I -- don't misunderstand me that I regret taking Tracey. But the whole idea is naturally Tracey was a lot more comfortable with

her mother as far as going and visit because they would stay hours, whatever. You know. And she never refused to go or anything.
But with me it's just a whole different life thing. It just changed my life. But I understand that could have happened anyway. But they took that from me. They took from me.
Q. Well, her illness took that from you, right?
A. Yes, it did.
Q. Because you'd been --
A. Yeah, of course. I understand that.
Q. Anything else? I realize that from the time that she became ill, never came out of that coma, your whole life changed. You had to take care of Tracey, you worry more about your children.
But with respect to the decision by the people at Yale to terminate the life support, how have you been injured by that?
A. Emotionally most of all how I've been injured by that and, you know, the fact that they -- it's constantly on my mind how could they do that, how could they deprive me of seeing my wife of 57 years, to say good-bye, getting my children, getting my grandchildren, you'd better go

see your grandmother, blah, blah. How could they think to do that. That amazes me until today.
Q. Okay. Anything else that you can think of?
A. That I'm emotionally shook up about all of it and it's always on my mind.
Q. At any time after your wife became ill in April when she got that disease that put her in the coma, did you say to your kids you better get the grandkids down to see her?
A. No.
Q. Did you say to Michael I think you ought to go to New Haven to see your mom?
A. My kids, yes, but not my grandchildren.
Q. Michael?
A. Yeah.
Q. But he only went --
A. As best that I can remember him being there with me once.
Q. And did you ever say to Tracey do you want to go see your mom?
A. I definitely did not want her to see her mom.
Q. Why?
A. Tracy's had seven brain tumors. Seven that she's had to have taken out.

Q. At one time or at different times?
A. No, over --
Q. They keep coming back?
A. -- ten years or whatever it is. Tracey has never been afraid of a hospital, never been afraid of a doctor. And I never want her to go there and see -- all she can remember is her mother fell down and died. That's all she could remember. And to this day that scares her so much that she watches me. Before she goes to bed at night, she checks my bedroom. When I get up in the morning she checks. And an odd thing just happened. Whenever Tracey had a problem, let's say the lights would go out, I'd run faster than my dogs and make sure she had a flashlight. Last week she runs in to give me a flashlight afraid I'm going to fall down. I didn't want to put that image in her because I don't know how many operations are in front of her, and I really didn't know what to do about that. I made a decision that better off as it is, but naturally I now told her.
Q. You told her that she had died?
A. No. I told her that they pulled the plug on her in New Haven.
Q. Why did you tell her that?

A. Because that's what they did.
Q. But why would that be better for Tracey?
A. Well, because now I know she's in a lawsuit, she has to see a lawyer, she has to whatever, take a deposition. I'm not going to hit her with complete surprise as to why the hell are they questioning me.
Q. Until you knew that we wanted to take her deposition was Tracey aware or had you already told Tracey that Yale had made the decision to terminate the life support?
A. No.
Q. It wasn't until we served the notice of deposition a month or so ago that you told her?
A. No.
Q. When did you tell her?
A. Gary told her a few days ago.
Q. Gary told her just a few days ago from now?
A. Yeah.
Q. Okay. And up until then she was not aware of that?
A. No.
Q. I'm sorry. I know you told me this and I just don't remember.
Had Tracey gone to see her at Griffin?

A. Oh, yes.
Q. After she was in a coma?
A. She went to see her. Whether she was in the coma or not, I don't know.
Q. I don't understand why you wouldn't have wanted Tracey to see her in a coma at Yale but it would have been okay with you for her to see her in a coma at Griffin.
A. Well, because of the prognosis they were telling me, that she's not going to make it, this and that. I didn't want to put that image in Tracy's head. Now, whether I was right or wrong, I don't know.
Q. But that was the same prognosis you were getting at Griffin, right?
A. What kept coming back to my mind at Griffin, the girl went in there with a broken wrist. She wasn't going to die. And as things got worse, now I don't know whether I had Tracey there before she went in the coma or after. I don't remember any of that.
Q. Okay. And Gary knew that Yale had terminated life support. Did Michael know?
A. Yes.
Q. Because you told him?

A. He was there one time with me when -- he was -- see, when you go to Yale, you get a different doctor all the time. You don't always get the same doctor. There's people walking around. That's all they do. And he was with me one time when a doctor not in my wife's room, outside, he come and talk to me. And Michael was present. That's when he was saying, you know, Clarence, she's not going to make it, you're better off for her, all of the stupid reasons why you should do it.
Michael was there and he asked Michael and Michael said, No, don't ever do that. My mother would never want that and I know my father doesn't want that. He was present for that conversation.
Q. But that was the one time he was at Yale?
A. That I can remember.
Q. Okay. And he wasn't there the day that they actually terminated the life support?
A. Oh, no.
Q. So how did he learn that Yale had terminated the life support?
A. Talking to his brothers or talking to me.
Q. You don't remember?
A. No.

Q. Did you tell him?
A. I may have. I assume. I don't --
Q. But you don't remember that conversation?
A. No.
Q. And you don't know how long ago that conversation was?
A. No.
Q. Did he know at or about the time that it happened?
A. I think so, yes. Yes. Definitely. He should have.
Q. But you don't have a --
A. He was living home at that time.
Q. But you don't have a specific recollection?
A. No. No.
Q. Did you have a funeral for Helen?
A. She was cremated.
Q. Okay. Did you have any kind of service?
A. No.
Q. You're not religious people?
A. That was her wishes as well as mine.
Q. Okay. But you're not religious people?
A. To what degree religious?
Q. Was she a churchgoer?
A. Back in her day, yeah. Whatever, we still

went to church now and then. But it's what -- we had discussed that as well as we did about pulling the plug. I said what I want to happen to me when I die, and that's what she wanted to happen to her when she died.

Q. She wanted to be cremated and not have a service?

A. No service, no laying out, none of that stuff.

Q. Did you ever make an attempt to transfer your wife from Yale-New Haven Hospital?

A. No, never as my memory.

Q. When you were unhappy with the care at Griffin you decided to have her transferred to Yale, right?

A. Yeah.

Q. And were you unhappy with the care at Yale?

A. I don't know what you mean was I unhappy with the care. I am not a doctor. I don't know whether her care was right, was wrong. How do I know? I'm not a doctor.

Q. You felt as if all they ever talked to you about was --

A. I never said --

Q. -- the recommendation that you should agree

to discontinue the life support because her prognosis was so bad?

A. Basically, yes.

Q. And that would have made you unhappy because that's what made you unhappy at Griffin, right?

A. Yes.

Q. And when the doctors at Griffin told you that you ought to consider terminating the life support because the prognosis was grim, you decided to have her transferred elsewhere, correct?

A. Correct.

Q. And you made that decision known presumably to the people at Griffin that you wanted her to be shipped to Yale, right?

A. Immediately.

Q. And when the same thing happened to you at Yale, that is when the physicians told you that they thought you should terminate life support because the prognosis was so grim, you made no attempt to transfer her from Yale-New Haven Hospital, did you?

A. I never requested that, no.

Q. You never requested that?

A. Neither did they, never mentioned that.

Q. Well, did Griffin request that you get her out?

A. No.

Q. That was your decision?

A. Absolutely.

Q. And you knew how to get her transferred from one hospital to the other because you got her transferred to Yale, right?

A. By ambulance, yes.

Q. And if you wanted to you could have presumably made arrangements to transfer her from Yale-New Haven Hospital to another facility if you were frustrated with the physicians at Yale's recommendations about her care, couldn't you?

A. I could have but that's --

Q. But you didn't --

A. Let me explain it. I didn't. The reason I didn't do that with Yale, Tracy's operations were all in New York, not in Connecticut. And them doctors told me down there many times you have the best hospital around right in Connecticut, Yale. And when I transferred Tracey [sic] from there to Yale, in my opinion remembering what her doctors had said, that's the best around. Never did I think somebody was better.

And on top of that, they would never even talk about that and never -- that night they -- they just said we're pulling the plug, in so many words, whether you like it or not. You know. And as I said, in my wildest imagination I never, never thought they would do that. If they had discussions with me and says look, blah, blah, blah, maybe I could find someplace.

At that particular time I certainly couldn't say pack up her clothes and go home. I don't have any means to take care of her at home. She's on a ventilator. I don't have a ventilator. What can I do at 11 at night from 12:15. And I was very confident that they would never do that. And I talked about that with Gary and he said, No, I don't think they would do that. I said, No, they wouldn't. And the phone rang.

As far as I'm concerned, New Haven's reputation, at least as it was explained to me, they've got a very good reputation. They wondering probably why I took her to New York for brain tumors.

Q. Did Tracey have all her surgeries at about the same time?

A. No. No.

Q. When is the most recent one?
A. 2000 maybe.
Q. So these tumors come back?
A. Yeah.
MS. SEAMAN: I don't have any further questions.
I'm going to retain the original exhibits. You have a copy, right?
MR. VIRGIL: I do.
MS. SEAMAN: I appreciate your time.
THE WITNESS: Thank you very much, Counselor.
(Whereupon the proceedings concluded at 12:10 p.m.)

CERTIFICATE

I hereby certify that I am a Notary Public, in and for the State of Connecticut, duly commissioned and qualified to administer oaths.

I further certify that the deponent named in the foregoing deposition was by me duly sworn, and thereupon testified as appears in the foregoing deposition; that said deposition was taken by me stenographically in the presence of counsel and reduced to typewriting under my direction, and the foregoing is a true and accurate transcript of the testimony.

I further certify that I am neither of counsel nor attorney to either of the parties to said suit, nor am I an employee of either party to said suit, nor of either counsel in said suit, nor am I interested in the outcome of said cause.

Witness my hand and seal as Notary Public this ____ of _____, 2014.

_____
Melissa J. Kelly, RMR, CRR
Licensed Shorthand Reporter #00307

My Commission expires: September 30, 2018

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* Original exhibits were retained by Defendant's counsel.

I have read the foregoing 110 pages and hereby acknowledge the same to be a true and correct record of the testimony.

_____
CLARENCE MARSALA

Subscribed and sworn to
Before me this ____ day of _____, 2014.

_____
Notary Public

My Commission Expires:

STATE OF CONNECTICUT: SUPERIOR COURT

JUDICIAL DISTRICT OF MILFORD/ANSONIA

AT MILFORD

----------x
CLARENCE MARSALA, :
ADMINISTRATOR OF THE ESTATE OF:
HELEN MARSALA, :
:
Plaintiff : AAN-CV12-6010861-S
:
-versus- :
:
YALE-NEW HAVEN HOSPITAL, :
:
Defendant :
----------x

Deposition of DR. MARGARET PISANI, taken pursuant to Section 13-1 through 13-32 of the Connecticut Practice Book, held at the offices of Yale Legal Office, 2 Howe Street, New Haven, Connecticut, before Julia Flynn Cashman, LSR 250 and Notary Public in and for the State of Connecticut, on September 4, 2014, at 10:00 a.m.

APPEARANCES:

ATTORNEY FOR PLAINTIFF:
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1000 Lafayette Boulevard, 5th Floor
Bridgeport, Connecticut 06604
BY: JEREMY C. VIRGIL, ESQUIRE

ATTORNEY FOR DEFENDANT:

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BY: ATTORNEY PENNY Q. SEAMAN
-and-
BENJAMIN W. CHENEY, ESQUIRE

STIPULATIONS

IT IS HEREBY STIPULATED AND AGREED by and between counsel for the respective parties hereto that all technicalities as to proof of the official character before whom the deposition is to be taken are waived.

IT IS FURTHER STIPULATED AND AGREED by and between counsel for the respective parties hereto that the reading and signing of the deposition by the deponent are not waived.

IT IS FURTHER STIPULATED AND AGREED by and between counsel for the respective parties hereto that all objections, except as to form, are reserved to the time of trial.

*****

DR. MARGARET PISANI,
having been first duly sworn by Julia Flynn Cashman, a Notary Public in and for the State of Connecticut, testified on her oath as follows:

DIRECT EXAMINATION

BY MR. VIRGIL:

Q. Good morning, Dr. Pisani. My name is Jeremy Virgil. I represent the Marsalas in case brought Yale-New Haven Hospital. I'm going to be taking your deposition here this morning. I'm sure that you've gone over the ground rules with your lawyer. And in the beginning, let me tell you I don't want to know anything that you talked with your lawyers about, but I'm just going to go over the ground rules again anyway.

The court reporter over here is taking down everything that's said. So to facilitate that, a couple things have to happen. I'll try and let you finish your answer to my question before I begin asking another question. And also, although in ordinary conversation, you're doing going to anticipate the remainder of my question and begin to answer it before I finish, I need you to wait for me to finish it.

You're also doing a lot of nodding of your head in agreement to what I'm saying. Nods and gestures are not going to get recorded. So I need you to answer

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things verbally, okay?
A. Yes. I have a tendency to, off the record, to blah, blah, blah, blah, blah, so I'm trying to --
MS. SEAMAN: Nothing is off the record. If you say it, it's on the record. You just want to answer his questions, okay?
THE DEPONENT: Okay.
Q. Also, if there's anything about my question that you don't understand, if there's anything that's ambiguous, please let me know and I'll try to rephrase the question for you. And you're nodding your head again. I need you to -- I'm going to probably have to do this a couple times, but --
A. Yes.
Q. And if you do answer my question, I'm going to assume that you understood it. Is that fair?
A. Correct.
Q. If you need to take a break at any point, just let me know. The only thing I ask is that you answer any question that's pending before we take that break.
A. Yes.
(PLAINTIFF'S EXHIBIT 1 FOR IDENTIFICATION Received and Marked.)
MS. SEAMAN: I brought with me, your CV. That's what he has. The one that you just sent me.

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THE DEPONENT: Okay.
Q. I'll just show this to you. I'm showing you what's been marked as Plaintiff's Exhibit 1. What is Plaintiff's Exhibit 1?
A. My CV.
Q. And is it accurate and up to date?
A. As of July 15, 2014.
Q. And did you prepare this yourself?
A. Yes.
Q. And did you review any documents in preparation for today's deposition?
A. No.
Q. And I know that I have your CV, but can you tell me generally about your education?
A. So, I'm a physician, so I have a medical degree.
Q. Okay. Where did you get your medical degree from?
A. Temple University.
Q. And when did you get your medical degree?
A. 1994.
Q. And when did you come to Yale?
A. 1994.
Q. And what did you do for Yale?
A. I was an intern.
Q. Have you been at Yale since you were an intern?

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A. Correct.
Q. What is your area of medicine that you practice?
A. Pulmonary and Critical Care.
Q. And how long have you done that for?
A. Since I finished my fellowship.
Q. And when was that?
A. 2001.
Q. And I see that you have three board certifications?
A. Correct.
Q. Board certified in Internal Medicine?
A. Yes.
Q. And then subspecialty certification in Pulmonary Medicine?
A. Yes.
Q. And also a subspecialty certification in Critical Care Medicine?
A. Yes.
Q. And those are all current and active certifications?
A. Yes.
Q. And what is your position at Yale?
A. I am an associate professor.
Q. Professor of what?
A. Medicine.

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Q. Just generally medicine, or are there any specific areas that you're a professor for?
MS. SEAMAN: I'm going to object to the form. I think it's confusing. I think -- you're asking her her title, or are you asking her what she does?
Q. What do you do?
MS. SEAMAN: That's what I find confusing.
A. So you're an associates professor under the Department of Medicine. My subspecialty is Pulmonary and Critical Care.
Q. Are those the areas that you work as a professor?
A. That's what I practice.
Q. Do you teach any classes?
A. I don't teach classroom classes, no.
Q. When you say not classroom classes, what do you teach?
A. Well, I'll give lectures.
Q. Do you do anything else?
MS. SEAMAN: As far as teaching?
MR. VIRGIL: Yes.
A. I mean, we teach all the time, so -- we teach on rounds, we teach -- we give lectures to outside hospitals. We give lectures to the house staff, to the fellows. I'm the program director for the fellowship.
Q. Do you have interns or residents or fellows that

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are assigned to you?
A. Yes.
Q. And what's your role in their internship?
A. Specifically for their internship?
Q. Yes.
A. So you're the supervising attending for a team.
Q. What does that mean?
A. So it means usually there's a team that consists of and intern, a resident, sometimes a fellow, and an attending. And we all round together and discuss the patients.
Q. And are you responsible for the team?
A. Correct.
Q. So that's the same responsibility of whether it's an intern or resident or fellow?
A. Correct.
Q. Are you a member of the American Medical Association?
A. No.
Q. And you have a license to practice medicine in the State of Connecticut?
A. Correct, yes.
Q. Do you have to do anything to keep up that medical license?
A. You have to do CMEs, and have to pay money.

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Q. Do you know how many CMEs you have to do?
A. What the state requires -- it changes all the time, so I'm not sure. But typically, we're always well above it.
Q. How do you fulfill your CME requirements?
A. Going to national meetings, going to CME courses and lectures.
Q. Are those on areas -- typically on areas of Pulmonary or Critical Care Medicine?
A. Yes.
Q. Have you ever gotten any CMEs related to the removal of life support?
A. Not that I specifically recall.
Q. Have you ever taken any courses on -- taken any CMEs on medicine in the law?
A. Not that I recall.
Q. At any point during your education, did you have to take any courses on medicine and the law?
A. It's a long time ago. Not that I recall.
Q. Have you at any point done any independent research on the law of Connecticut related to the removal of life support?
A. No. I call the Legal Office when I have a question.
Q. And the Legal Office at Yale is your counsel?

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A. When you say "counsel," what do you mean; counseling, for like questions, or --
Q. They are your attorneys, as well?
A. I don't particularly have an attorney, do I?
MR. VIRGIL: Well, let me just ask. Is there a privilege that --
MS. SEAMAN: If she has a communication with legal counsel, I believe so.
MR. VIRGIL: Okay. I'm just making sure.
Q. Do you have any other titles, other than associate professor with Yale?
A. What do you mean, titles?
Q. Well, do have you a position as a clinical physician at Yale, or is that part of being an associate professor?
MS. SEAMAN: I'm going to object to the form. Are you asking Yale meaning Yale University, I take it? Is that your --
MR. VIRGIL: Well, let me ask a better question.
Q. Do you work at Yale-New Haven Hospital?
A. Yes.
Q. Okay. And do you have a position specific to Yale-New Haven Hospital?
A. You mean does my salary get paid by Yale-New

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Haven.
Q. Well, my question is a little bit different than that. My question is, do you have a position --
A. I have privileges to practice at Yale New Haven. Is that what you're asking?
Q. That's part of it.
A. But I'm not employed by the hospital. Is that what you're asking?
Q. Yes. Generally, is there a department that you work in at Yale-New Haven Hospital?
A. What do you mean by "department"?
Q. Is there a part of the hospital that you work in, whether it is the Surgical ICU, or the Medical ICU, the rehab floor, anything like that?
A. Well, so if I'm assigned to the Medical ICU, I worked in the Medical ICU. But if I am assigned as the Pulmonary consult, it could be anywhere in the hospital, seeing consults.
Q. Okay. Outside of your consult work, do you work in any other area of Yale -New Haven Hospital, other than the Medical ICU?
MS. SEAMAN: Other than the consults she just told you about?
Q. Other than the Pulmonary consults that could be anywhere.

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A. No.
Q. And what is the work that you do in Medical ICU?
A. We -- I serve as the attending for patients who get admitted to the Medical ICU.
Q. What does it mean to be the attendant?
A. You supervise the team of interns, residents, maybe a fellow. You round with the team. You examine the patients every day. You write notes on the patients, take care of the patients. You also teach when you're the attending there.
Q. Does that mean that you're the person responsible for the patient when they're admitted?
A. If I'm the attending of record.
Q. And if a patient needs to be intubated in the Medical ICU, are there specific physicians that do that?
A. Anybody who's certified to do intubation. So it could be the anesthesiologist; ER doctors, if they are up there and they're certified; the Pulmonary doctors, if they are certified to intubate.
Q. Are you certified to intubate?
A. Not anymore.
Q. When was the last time you were certified to intubate?
A. I don't know. You have to do so many a year, and typically we call the anesthesiologist to do it because

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they do it every day.
Q. What is the last time that you did intubation?
A. I don't remember.
Q. Were you certified to intubate in 2010?
A. I don't remember.
Q. Is there anything on your CV that would refresh your memory?
A. No, I'd have -- you'd have to look at privilege records, you know, you have to apply for privileges from the hospital.
Q. So whether or not you were certified to intubate would be on the privilege records that you have at the hospital?
A. Right. And you update those every time you renew your privileges.
Q. And similarly, in the medical ICU, who would do tracheotomies?
A. Again, it could be the surgeons, it could be the interventional Pulmonary doctors.
Q. And do you have to have any certification to do a tracheotomy?
A. Yeah, you needs to be trained.
Q. Have you been trained to do tracheotomies?
A. No.
Q. What is the process that you go through to get

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privileges at Yale-New Haven Hospital?
A. I don't know all the exact steps. The admins take care of it. But you need to, I think, provide your licenses and proof of that you've done -- met the, you know, there are numbers for privileges. And I think you need to provide your board certification.
Q. Do you remember the process that you had to go through the first time that you had to get privileges at Yale-New Haven Hospital?
A. No. That was a long time ago.
Q. And have you had any involvement personally in obtaining your privileges since then?
A. Well, just filling out the forms they give me.
Q. Do you keep any of those forms?
A. My admin probably has them.
Q. Have you ever done a tracheotomy?
A. No.
Q. Do you know how many times you've intubated a patient?
A. Over the course of my whole career?
Q. Yes.
A. Probably 15, 20.
Q. And that was under the supervision of someone who was certified in intubation?
A. So for however many you need, to then prior to

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doing them on your own.
Q. And you don't remember how many you need to do before you can do them on your own?
A. No. The rules change all the time.
Q. As part of your work on the Medical ICU, I think you called -- you had a phrase for it, I'm forgetting it. But it's like a round table, where you brought the interns and the residents together to discuss a patient?
A. Rounding.
Q. Rounding. And how often would that happen for a patient?
A. Formally, it happens every day. And then informally, we touch base usually in the afternoons, at the end of the day. And then they do a sign-out round.
Q. And what is the sign-out round?
A. To touch base on the plan, what was supposed to happen for the patient for the day, make sure it's happened, see if there's anything new that comes up during the day that needs to be addressed and, you know, making sure they know what to tell the people taking care of the patient overnight.
Q. And what would typically happen during the formal once per day rounding?
A. That intern usually -- we stand outside the patient's room or go into the patient's room. The

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intern would present the patient, so a little bit of background, anything that happened overnight. Nursing, we have multidisciplinary rounds, so nursing is involved. If the family is there, they participate, if they choose to. If we need social work, sometimes we have social work. If the patient is an on breathing plan, we have respiratory therapy. And we go over all aspects of the patient's care, discuss the patient, do some teaching related to the physiology of the patient, or particulars of the case. And then we come up with a plan for the day.

Q. And generally, how do you come up with a plan for the day?

A. Well, it's patient specific, but it depends on what is going on with the patient, so...

Q. And you say "We come up with a plan." That's the group that's doing the rounding comes up with the plan?

A. Mm-hmm, yes.

Q. Do you have to approve the plan?

A. Yes.

Q. And then who implements the plan?

A. Usually, the primary responsibility is the intern. But we try to work as a team, so the residents will help the intern, the fellow will help the team. If they're all crazed and busy, I'll pitch in.

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Q. And administer some of the treatment yourself, when you pitch in?

A. If necessary.

Q. Do you supervise the administration of the treatment by the intern?

MS. SEAMAN: Object to the form. Are you meaning like visually?

MR. VIRGIL: Generally, visually supervise the intern in administering treatment.

A. No, I don't typically follow him around for every patient. If there's something that requires a procedure, yes, we visually supervise them. I don't stand above them while they enter orders into the computer.

Q. If the treatment plan -- well, withdrawn. On occasion, has the treatment plan for a patient necessitated obtaining the consent of the patient?

A. Yes.

Q. And who would obtain the consent of the patient?

A. Whoever is available.

Q. And I just want to be clear, I'm asking from the people involved in the rounding, one of them would be the person who went to the patient and got their consent?

A. It depends on each situation. It's variable.

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Q. It could be the intern?

A. It could be the intern. It could be the resident. It could be the fellow. It could be myself.

Q. And is there any procedure that's generally used to obtain that consent?

A. Again, it depends on the specific thing you're talking about. So certain things, you know, require you know, we get verbal consent for; certain things require written consent.

Q. Do you know what the distinction is between when you can get verbal consent versus when you need written consent?

A. For certain things. And if not, it's all outlined in the hospital Website. There's a policy of what needs written consent, what needs verbal, what you can get verbal consent for. In emergencies, you can get verbal consent for certain things.

Q. Sitting here today, do you know the difference between what needs verbal consent versus what needs written consent?

A. Well, there's so many --

MS. SEAMAN: Objection to form.

A. -- things that I couldn't sit here and list them all for you. We do so much.

Q. And do you know why you need to get consent?

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A. You mean do I know the ethical principles of Informed Consent.

Q. No, I'm asking, do you know why you need to get the patient's consent for any generic procedure?

A. So they're informed of the risks and the benefits.

Q. And is that so that the patient can make a decision about their treatment?

A. So they can be informed of the risk it is or the benefit. So they have the right to refuse the treatment if they decide the risk outweighs the benefit.

Q. Does the Informed Consent process also include a discussion of reasonable alternatives?

MS. SEAMAN: I'm going to object to the form. I think it's too broad. Because as the witness has told you, I think there's a spectrum. So I think you either have to narrow it down, because I think the question is too broad.

Q. Okay. Do you understand my question?

A. I kind of agree, it's really broad, based on the scope of our practice. So if you have a specific question, it would be more helpful.

Q. Does the process of obtaining a patient's Informed Consent involve a discussion of reasonable alternatives to a proposed treatment?

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A. If reasonable --
MS. SEAMAN: Object to the form.
A. -- alternatives as exist.
Q. And that involved a discussion of the pros and cons of the alternatives as well, correct?
A. If they exist.
Q. Are you on any committees at Yale University?
A. At the university level?
Q. Yes.
A. I don't think I'm on any currently. I used to be on this research committee. But when the section chief left -- the division chief, the committee kind of fell apart, so...
Q. Research onto what?
A. It was just a research oversight committee for the Department of Medicine.
Q. Do you remember when you were on that committee?
A. It may be on my CV. It may not be. I don't know.
No, I actually don't -- hold on, Section Committees.
Internal Medicine Research Advisory Panel, it says 2007 to 2012.
Q. Oh, I'm sorry, which page was that on?
A. I don't know. Eleven. Departmental.

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Q. Right there at the bottom?
A. Well, no, that's ten, but it goes onto the other page.
Q. I'm sure this will help you. Were you on any committees at the hospital?
A. Yes, I have been on hospital committees. Where is it. There was a section for hospital -- yeah, so in the past, the Alcohol Withdrawal Treatment Committee, Delirium Treatment Protocol, and Sedation Protocol.
Q. Does Yale have a Bioethics Committee?
MS. SEAMAN: University or hospital?
Q. Yale-New Haven Hospital.
A. There's an Ethics Committee. I don't know if they're hospital or university based, actually.
Q. Have you ever been on the Ethics Committee?
A. No.
Q. Do you know who's on the Ethics Committee?
A. Currently, I know people who have been on it at some point in time, so I know one of my fellows has been on it at one point. Some of the other faculty have been on it at some point.
Q. Do you know who was on it in 2010?
A. Not off the top of my head.
Q. Do you know what the Ethics Committee does?
A. Yes.

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Q. What do they do?
A. They meet to discuss situations that are of an ethical nature.
Q. Do they have regular meetings?
A. I have no idea.
Q. Do they have any role in patient care?
MS. SEAMAN: Object to the form.
A. I don't think -- no, they don't.
Q. Do you know if there are any lawyers on the Ethics Committee?
A. I have no idea.
Q. And when you say that the Ethics Committee has no role in the patient care, that means that they're not making decisions for patients?
A. They don't make decisions on a day-to-day basis regarding patient care. They provide advice, expert opinions, recommendations, about a whole host of things.
Q. They give opinions, you said?
MS. SEAMAN: Object to the form.
A. They meet and they discuss issues related to patients.
Q. And do they generate opinions?
MS. SEAMAN: Objection to form.
A. They generate recommendations.
Q. Okay. And why do you call them recommendations?

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A. Because they'll come up with a document, or -- that gives recommendations about what was discussed, and what is recommended.
Q. Is there a reason that you're choosing the word "recommendation"?
A. Because I'm bad at English? I don't have my thesaurus with me.
Q. Well, are they -- are they instructions for you to follow?
MS. SEAMAN: Objection to form.
A. It's a recommendation.
Q. It is not an order?
A. No.
Q. Do you agree with me that when it comes to medical care, the patient is the ultimate decision maker?
MS. SEAMAN: Objection to form.
A. Do I have to agree with you?
Q. No.
A. It depends on the situation.
Q. Okay. What situations would there be when the patient is not the ultimate decision maker for their medical care?
A. Do you want me to give you a hypothetical example?

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Q. I want you to answer the question as best as you can.
MS. SEAMAN: If you can't answer, you can't answer the question. So you can ask him to rephrase it if you can't understand him. You really don't want to ask him questions back.
THE DEPONENT: Sorry.
MS. SEAMAN: Okay? Because he gets the questions, you get the answers. So you want to try to get --
A. Yeah, I can't answer that.
Q. You don't know a situation -- you can't think of situations when the patient would not be the ultimate decision maker for their medical care?
MS. SEAMAN: Objection to form.
A. If the patient had no mental status, they couldn't make a decision. So somebody else would have to make it. That's an example.
Q. In that situation, who would then be the ultimate decision maker for their medical care?
A. Depends on the patient and what's been decided for them in advance.
Q. Okay. So if, for instance, if there's an advance directive that the patient has completed prior to the treatment, then that would be what the ultimate

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decisions are made from, from that advance directive the patient has completed, correct?
MS. SEAMAN: Objection to form.
A. It depends on what the advance directive said, when it was made, a whole host of things.
Q. Okay, what things does -- what are the whole host of things that it depends on?
MS. SEAMAN: Objection to form. I think you're asking general questions that are too broad to be answerable.
Q. Okay. What are the whole host of things that it depends on?
MS. SEAMAN: Objection to form.
A. I don't know.
Q. Is there a situation where the physician is the ultimate decision maker related to a patient's medical care?
MS. SEAMAN: Objection to form.
A. I don't know.
Q. Have you ever experienced situations where you were the ultimate decision maker of a patient's medical care?
MS. SEAMAN: Objection to form.
A. No.
Q. What is an advanced directive?

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A. Generally, it's when somebody says "This is what I want done in these situations."
Q. And what role does that play in the patient's care?
A. Depends on the situation.
Q. Do you agree with me that it's a hospitals's job to ensure that a patient's preferences as expressed in advance, in an advance directive, are respected and adhered to by the medical staff?
MS. SEAMAN: Objection to form.
A. It depends on the situation.
Q. What nuances of the situation are there that would exist that you wouldn't respect or adhere to a patient's advance directive?
MS. SEAMAN: Objection to form.
A. I don't really want to speculate.
Q. You don't -- why do you say you'd be speculating?
A. Because medicine is really complicated. And when you practice in the ICU, there's three million scenarios. So I can't give you a general answer that's going to answer the whole point of the question. So a specific question, or a specific situation, I can give an opinion on. But generally, in general, there are, you know, after taking care of hundreds and hundreds of patients, everyone is different. And everything is very

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nuanced. It's not black and white.
Q. Can you think of a situation -- any situation, where you would disregard a patient's advance directive?
A. Well, if a patient had an advance directive that said they wanted everything done, and they came in and they met criteria for brain death, I wouldn't perform CPR.
Q. Okay. Any situations where a patient is not yet at brain death, where you would disregard their advance directive?
A. Not that I can think of.
Q. When a patient is unable to express or make decisions for themselves, how do you determine what care to administer?
A. Based on what their clinical situation is, we provide what is the appropriate care for the patient, based on their medical condition. And then we go down the chart of who is the next decision maker in line, based on what -- whoever their relations are, if they have family, don't have family, et cetera.
Q. Do you know the order of the chart?
MS. SEAMAN: I just didn't hear.
Q. Do you know the order of the chart of the decision makers?
MS. SEAMAN: I'm sorry, I'm still not

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hearing.
Q. Do you know --
MS. SEAMAN: Orders of?
Q. -- know the order of the chart of the decision makers?
MS. SEAMAN: Objection to form.
A. What does that mean, order of the chart?
Q. I believe you referenced a chart with decision makers, and you go down the chart.
A. I said there's a -- there's a hierarchy of who decision makers are. Legally. And so we usually ask the social worker to determine for us who is the person to make decisions for these patients.
Q. Is determining who the decision maker is part of the social worker's job, or part of your job?
MS. SEAMAN: Objection to form.
A. It's really anybody's job who can, you know -- whoever sees the patient, we always try to identify who the contact person is. So if he rolls right up from the nurses there, she'll try to figure it out. And then the social worker will determine if that really is who the decision maker is.
Q. Why do you need to know who the decision maker is?
A. Because somebody need to be updated about what is

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going on about the patient.
Q. And to make the decisions about their care?
A. If decisions need to be made.
Q. And that's the person that you would contact to find out what the patient's wishes are with respect to ongoing care?
A. Correct.
Q. What is a DNR?
A. Do not resuscitate.
Q. And was there a procedure or a policy at Yale-New Haven Hospital in 2010 for the entry of a DNR?
A. Yes.
Q. And what is that procedure or policy?
MS. SEAMAN: What was it?
Q. Yes, what was it in 2010?
A. Honestly, I mean, I don't know if -- it's probably changed. I mean, we've always entered -- in 2010, I can't be sure. Because now --
MS. SEAMAN: Okay --
A. Okay, I just can't be sure. I was going to say I know what we do now, but I don't remember if we did it exactly the same way in 2010.
Q. What do you do you know?
A. We enter an order into the computer.
Q. Is there anything else involved?

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A. To physically make the patient DNR, like put the order in?
Q. Well, is there anything that comes before? Do you need to get the patient's consent to do a DNR?
A. Well, we always talk as a team. We talk to the patient, we talk to the family, and then we make a decision.
Q. When you say "We make a decision," who makes the decision?
A. We do it as a team. We try to do everything as a team.
Q. Does the team include the patient?
A. Yes, we would talk to the patient.
Q. Okay. Do you need the patients's consent to enter a DNR?
A. No.
Q. Has that been true for the entire period that you've been at Yale-New Haven Hospital?
A. I have no idea.
Q. Are you aware of any changes to the process to the entry of a DNR since you've been at Yale-New Haven Hospital?
A. Well, the way you physically enter it in the computer has changed. We have a new medical record, but...

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Q. Has the process whereby the physicians make the decision to make a patient DNR, has that changed?
MS. SEAMAN: Objection to form.
A. I'm not sure.
Q. Was there any point since you have been at Yale-New Haven Hospital, where you require a patient's consent to enter a DNR?
A. I don't know.
Q. Can the residents, interns or fellows enter a DNR for a patient admitted to the Medical ICU that you're the attending for, without you signing off?
A. They can physically enter it into the computer, but I have to approve of it.
Q. And what is a DNI?
A. Do not intubate.
Q. And what is the difference between a DNR and a DNI?
MS. SEAMAN: Objection to form.
A. They typically go together, but they don't have to.
Q. Is there a policy or procedure at Yale for the entry of a DNI?
MS. SEAMAN: I assume you mean the hospital.
MR. VIRGIL: I do mean the hospital, I'm sorry.

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A. You enter it into the computer, the same as you do a DNR.
Q. And to do a DNI, do you need to get the patient's consent?
A. I don't know.
Q. And do you remember if there's been any change in the process at the hospital since you've been there, related to DNIs?
A. I don't know.
Q. There's a phrase in the medical records, it says "Comfort Care." What is Comfort Care?
A. We let all our patients be comfortable, so we provide Comfort Care to all of them. But if you're referring to Comfort Care where you're not going to do CPR on a patient, or you're not going to do measures to prolong their life, then we kind of focus on that. We focus on things that are going to truly make sure they're comfortable. That means we're not going to prolong their life by using machines.
Q. And who decides when a patient is put on specifically that Comfort Care that we're talking about here?
MS. SEAMAN: Could we talk about Comfort Care Only, to distinguish it from all the Comfort Care they provide all the patients?

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MR. VIRGIL: Yes.
MS. SEAMAN: Is that a terminology you use, Comfort Care Only?
THE DEPONENT: Yeah, Comfort Care Only.
MS. SEAMAN: I don't want to take over your deposition.
MR. VIRGIL: No, no. I'm just fine with that phrasing.
A. Again, we do it as a group, so we talk about it as a team.
Q. Does the patient have to consent to that?
A. I don't think so.
Q. And is that process whereby a patient is put on Comfort Care Only, the same now as it was in 2010?
A. No. I don't know. I think we're better at it now, but I don't know.
Q. Is the patient advised at the time that the physicians have decided to put them on Comfort Care Only?
MS. SEAMAN: Objection to form.
A. Yeah, if they're with -- if they can understand, they're advised. Oftentimes, they're the ones asking for it.
Q. When a patient is -- when a DNI is entered for a patient, is the patient advised of that?

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A. If they can understand.
Q. Is the patient's decision maker, if the patient is unable to understand, made aware?
A. Yes.
MS. SEAMAN: Objection to form.
Q. And similarly, for a DNR, if a DNR is entered, is the patient advised of that?
A. If they can understand.
Q. And if they can't understand, the patient's decision maker is?
A. Yes.
Q. What happens if a patient or their decision maker objects to being put on Comfort Care Only?
A. It doesn't usually happen. I guess --
MS. SEAMAN: He doesn't wants you to guess.
A. It doesn't usually happen.
Q. Is there any specific policy or procedure as to what's done when a patient objects to being put on Comfort Care Only?
A. We'd meet with the family and talk to them, or talk to the patient. You know, if there's a specific person, they have a relationship, try to get them involved. You know, have family meetings. And then we could always call the Ethics Committee.
Q. Is there any point where they're advised to go to

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another hospital?
A. They could be.
Q. Is that part of the procedure?
MS. SEAMAN: Object to the form.
A. I'm not sure.
Q. Is that something you've done?
MS. SEAMAN: I just didn't hear it, again, I'm sorry.
A. I didn't hear what you said. I can only hear in one ear as it is, so --
MS. SEAMAN: I'm having just a little trouble, I'm sorry.
A. And you're sitting on my bad side and I'm trying to keep my head this way.
MS. SEAMAN: You don't have to listen to me. Every so often I can't hear one of your words, I'm sorry. Did you say "Have you dealt with"?
Q. Have you ever advised a patient, or the decision maker who's objected to a patient being placed on Comfort Care Only, to go to a different hospital?
A. We have done that in the ICU.
Q. Have you specifically done that?
A. Not that I remember.
Q. Under what circumstances did it happen in the ICU?

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A. Unrelated to this case?
Q. Yes.
A. Is that relevant?
MS. SEAMAN: Well --
A. I know I'm not supposed to ask questions. I have a problem.
MS. SEAMAN: Well, he can ask you, he can ask you --
A. I can tell you examples, is that what you want?
MS. SEAMAN: Were you involved with them?
A. So the problem, since I'm not supposed to be talking out of turn, but, you know, we switch every two weeks. And so -- or even more frequently than that. So I may have picked up a case where it was -- the recommendation was made before I got on service. So there's lots of people who care for these patients when they're there for a long time.
And so, yes, we've had, you know, somebody with cancer who wanted a treatment that the oncologist didn't want to offer, and said "You're free to go to another place if someone else will offer it."
Q. But you can't remember ever doing that to one of your patients?
A. No.
Q. And when a patient or the patient's decision

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maker objects to Comfort Care Only, you listed a couple of things that would happen. And one of them was you said you'd meet with the family and the patient?
A. Correct.
Q. What does that entail?
A. Well, ideally, we like to have a meeting with as many people who are involved or have interest in the patient. So if there's a spouse, children, if the patient can participate. Oftentimes, the patient can't participate. So we gather them together to explain the medical, what is going on medically, and where we -- what we think the options are. And we make our recommendations.
Q. And is part of that meaning to persuade the family and the patient that your opinions are correct, or this is the appropriate treatment?
MS. SEAMAN: Objection to form.
A. It's not my opinion. It's based on the medical facts.
Q. Is the purpose of the meeting to explain the reasoning behind the decision to put the patient on Comfort Care Only?
A. Yes.
Q. And what happens if the patient or the patient's decision maker persist in their objection to Comfort

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Care Only following that meeting?
A. Again, it depends on the situation. Usually, we'll meet again. If that doesn't work, we'll meet again. If that doesn't work, we'll call the Ethics Committee.
Q. And when you call an Ethics Committee, what is involved in that?
A. Well, it depends on why you're calling them.
Q. All right. If you're calling the Ethics Committee because a patient or a patient's decision maker is objecting to Comfort Care Only, what is involved in that?
A. They'll convene, they'll look -- they'll read through the charts, they'll look at all the medical data. They'll talk to everybody who's cared for the patient; nurses, social work, physicians. The family is invited to come to the Ethics Committee. And then they'll make a recommendation after.
Q. And what happens with that recommendation?
A. It's related to the family.
Q. How is it told to the family?
A. Usually, whoever is in charge of the Ethics Committee -- someone from the Ethics Committee usually will tell them.
Q. And what is the point of going, explaining the

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recommendation of the Ethics Committee to the patient or the patient's decision maker?
MS. SEAMAN: Objection to form.
A. So they can have more information.
Q. What happens -- well, withdrawn. What is the point of the additional information?
A. To hope that families understand the reality of the medical facts.
Q. To persuade them that Comfort Care Only is the appropriate treatment?
MS. SEAMAN: Objection to form.
A. Those were your words.
Q. Okay. Do you disagree with them?
MS. SEAMAN: Objection to form.
A. It's not persuasion. It's getting them to see the reality.
Q. And what happens if the patient or the patient's decision maker continues to persist in their objection to you following the recommendation of the Ethics Committee to do Comfort Care Only?
A. It depends on the situation.
Q. How so?
A. If I had an example, I could answer.
Q. Well, hypothetically, you're treating a patient. It's your opinion that after examination, you have the

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round with the team, and you decide "We should put this patient on Comfort Care." The patient or the patient's decision maker objects to that. You have multiple meetings, they continue to object. You have the Ethics Committee, they make a recommendation to go to comfort -- that Comfort Care Only is appropriate, and the patient and the patient's decision maker continue to object. What happens then?

MS. SEAMAN: Object to the form.

A. I think I would consult with Legal. And if Legal says it's okay, we would make the patient comfortable.

Q. And why would you consult with Legal?

A. To make sure we're within the Statutes of the law of Connecticut.

Q. Why?

A. Because every state has different Statutes.

Q. Would you do anything else?

A. Other than talk to the patient and family, and make sure that the patient really is comfortable?

Q. There's nothing else that you would do?

MS. SEAMAN: Objection to form.

A. I'm not sure what you're getting at.

Q. You'd keep them on Comfort Care Only, correct?

MS. SEAMAN: Objection to form.

A. If the Ethics Committee recommended it, and Legal

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said we were within our legal rights, yes.

Q. If that situation comes up, do you always consult with Legal?

MS. SEAMAN: Object to the form.

A. It rarely comes up.

Q. Okay. Every time that it's come up, have you consulted with the Legal Department?

MS. SEAMAN: Object to the form.

A. Yes.

Q. And other than making sure that the patient is actually comforted by the Comfort Care Only, is there anything else that you do?

A. I don't understand the question.

Q. Okay.

A. Like for the patient, for -- it's too general. There's a lot of things we do, but exactly what are you asking.

Q. Well, let me back up. First, at what point in this process is the patient made Comfort Care Only? Is it when you make the decision that the patient should go on Comfort Care, or is that at the end of this process, after you ever consulted with the Legal Department?

MS. SEAMAN: Objection to form.

A. It's situation specific.

Q. So sometimes it's at the beginning, and sometimes

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it's in the middle, and sometimes it's at the end?

MS. SEAMAN: Object to the form.

A. I'm not even sure I understand your question.

Q. Okay. This is the scenario, you've reviewed all of the medical data that you have, and decided that this patient should be made Comfort Care Only. At that moment, is an order entered that makes the patient Comfort Care Only?

A. If everybody is in agreement.

Q. Okay. If the patient or the patient's decision maker objects, is the order to make the patient Comfort Care Only delayed?

MS. SEAMAN: Object to the form.

A. It can be.

Q. Are there situations where even though the patient and the patient's decision maker object, that the order is entered at that moment anyway?

A. I don't know.

Q. And in the same scenario where you've decided that the patient should be on Comfort Care Only, the patient, or the patient's decision maker has objected, you have a meeting with the -- with them to discuss it, right, that was the next step in the process. And if that happens, and they persist in their objection, is the Comfort Care Only order entered at that point after

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the meeting with the family, or with the patient and the patient's decision maker?

MS. SEAMAN: Objection to form.

A. So in general -- you're talking about when we're actually putting the order in the computer. In general, we strive to have everybody on the same page before we ever enter an order in. And so when we need to, whenever one isn't on the same page, and people need either more time, more understanding, it may not be put in right at that time. Sometimes we wait because, to give you an example, so-and-so's brother is flying in from DC and wants to see them before they pass away. So we wouldn't put the Comfort order in until that person gets there and gets to say good-bye, even though we all know that that's what we're going to do. So you're talking about the physical timing of when it's entered into the computer. That's a hard thing to answer.

Q. Does the patient, or the patient's decision maker's objection to being placed on Comfort Care Only, change when the order is actually entered into the computer?

A. That didn't make sense to me.

Q. When the -- when you make the decision to put a patient on Comfort Care Only, does the patient's objection, or the patient's decision maker's objection,

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play any role in when that order is physically --
A. Yes.
Q. -- entered into the computer. And how does it impact when the order is entered into the computer?
A. It's situation dependent. Can I -- I know I'm not supposed to say anything. Sorry, never mind.
Q. And following the -- in the hypothetical, where you made the decision to put a patient on Comfort Care Only, the patient, or the patient's decision maker, objects to it, they continue to object after a meeting, and they continue to object after the Ethics Committee recommendation, after you've consulted with Legal, at that point, do you advise the patient to -- or the patient's decision maker, to go to another hospital?
MS. SEAMAN: Object to the form.
A. I suppose you could.
Q. That's not something that you have ever done, though?
A. I answered that already.
Q. Right. And you said no.
A. (Affirmative nod.)
MS. SEAMAN: Object to the form.
A. Yes.
Q. And when this situation comes up, do you delay the entry of the Comfort Care Only order to provide the

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patient and the patient's decision maker with time to locate another facility?
A. You can.
Q. Is that something that you have ever done?
A. I don't recall.
Q. Is there a specific amount of time that the entry of the order is delayed to permit a patient or patient's decision maker to locate a facility to transfer to?
A. I have no idea.
Q. Have you ever gone to the Probate Court related to end of life decision making for a patient?
A. Not that I recall.
Q. Do you know if the probate court has ever been involved in any end of life decision making for a patient that you provided care for at Yale-New Haven Hospital?
MS. SEAMAN: Object to the form.
A. Not that I recall.
Q. Have you ever been asked to put together materials or submission for the Probate Court related to the care and treatment and recommendations of one of your patients at Yale-New Haven Hospital?
MS. SEAMAN: I'm going to instruct you not to answer any questions concerning any instructions that you received from the Legal Office. Got that?

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THE DEPONENT: (Affirmative nod.)
MS. SEAMAN: So other than any instructions by any lawyers, have you put together --
MR. VIRGIL: Your lawyers, right? Yale and -- there might be other lawyers.
MS. SEAMAN: Oh, if some foreign lawyer called you, or some lawyer you didn't know called and told you something, you can answer his question. But so his question is, other than any direction you received from lawyers, in connection with a Probate proceeding, have you put together any information --
A. No.
MS. SEAMAN: -- for any Probate proceeding.
Q. Okay, just -- I don't think this is privileged. Have you put together any material to be submitted to the Probate Court for the -- related to a patient that you were the attending for at Yale-New Haven Hospital?
MS. SEAMAN: How is that not privileged?
MR. VIRGIL: She's putting together potentially a writing of her opinions for the court.
MS. SEAMAN: Let me ask you --
A. I have no clue. I may have.
MS. SEAMAN: If you have no clue, that's fine.
A. I have put -- I don't know if conservator, we put

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together a lot of stuff for the court to get people to be conserved, so, but...
Q. My hypothetical and my questions were dealing with just Comfort Care Only before. Is that the same process that's used if a patient objects to the entry of a DNI?
A. Yes.
Q. And is that the same process that's used if a patient objects to the entry of a DNR?
A. It can be, yes.
Q. Is there a different process that's used if a patient objects to a DNR?
A. Not that -- I don't know.
Q. Have you used a different process when a patient objected to the entry of a DNR?
MS. SEAMAN: Objection to form.
A. Not that I recall.
Q. Has a patient ever objected to the entry of a DNR?
A. Not that I recall.
Q. Do you have any memory of treating Helen Marsala?
A. Yes.
Q. Can you describe her?
A. Physically?
Q. Yes.

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A. She was a small, thin, older woman, with gray hair. She had lots of sores and swelling on her skin, and as well as in her tissues.
Q. Anything else?
A. Nothing that I could specifically remember.
Q. And what was your role in her treatment?
A. At some point, I was the attending on the ICU team taking care of her.
Q. And do you remember who was on the team?
MS. SEAMAN: Can I just ask, was there --
A. Not really.
MS. SEAMAN: Well, was there just one team while you were the attending? I don't know --
A. No, we switched. So the attending and the house staff switch on different days to provide continuity so it's not a new team every day. Like not everybody is new on one day. So I may have had one intern and one resident for a few days, and then they may have switched. If there was a fellow, the fellow may have switched. I would have switched. There may have been somebody different on the weekend completely.
Q. Do you remember when Helen Marsala came into your care?
A. No.
Q. Do you know how she was doing when she came into

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your care?
A. From reading the records at Griffin and talking to the physician there, before she -- after she was transferred, I was not the accepting physician. But when I picked her up, I called over there to get my own personal knowledge of what happened. And according to them and the records from Griffin, she had not been doing well. Hence, the need for the transfer, apparently.
Q. Who did you speak to at Griffin?
A. I have no idea.
Q. What did they tell you?
A. That she -- I don't know how long, I don't remember how long she was there, but she had been there for awhile. She was not getting better. They had talked to the family about making her comfortable and wanted to transfer to us to make sure that there was nothing else at all that could be done for her.
Q. Do you remember anything that was said?
A. That she had -- one of the things was that she was coming to us because she had an altered mental status, and so just trying to get a sense of how long that had been altered.
Q. Do you remember what they said?
A. No.

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Q. Was she intubated when she was transferred?
A. I believe so.
Q. And do you remember what you did?
MS. SEAMAN: Object to the form.
A. No. Sorry, no.
Q. Do you remember what was wrong with her?
A. There were a lot of things. So she had multiorgan failure.
Q. Okay. Can you tell me what some or all of those things were that were wrong with her?
A. If I start from top to bottom, she had an altered mental status, meaning that, you know, she did not have a level of consciousness where she was awake and interactive. Occasionally, randomly, she would squeeze or wiggle her toes, but was never following other commands. Did not track with her eyes usually, which is a sign of -- a way we check for attention and consciousness. Her kidneys weren't working. So her markers of her kidney function were abnormal, and we thought maybe that was playing a role in her mental status, hence one of the reasons to transfer her. So her kidneys weren't working, her lungs weren't working. She was on the breathing machine. I don't remember, but she may have been in heart failure as well. She did have a lot of volume overload, and she was clearly

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malnourished.
Q. She was malnourished?
A. Yes. And that's indicated by the fact that she had a lot of breakdown on her skin. Typically when you're malnourished, your skin does not heal and you get breakdown.
Q. Were there times where Mrs. Marsala would track with her eyes?
A. Not that I recall.
Q. Do you remember what treatments were administered?
A. Well, I remember she got started on dialysis with the thought that maybe that would help improve her mental status if they brought her blood marker down, something calls an BUN, to normal. Sometimes when that's high, especially in older people, they get confused.
Q. In the records, is that also referred to as hemodialysis?
A. Yes.
Q. And also abbreviated HD?
A. Yes.
Q. And were you able to bring her BUN score down to normal?
A. I believe so.

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Q. And what does BUN stand for?
A. Blood urea nitrogen.
Q. And what is that representative of?
MS. SEAMAN: I'm sorry, represent what? I just didn't hear.
Q. Yes, what is the --
A. It's a marker of the kidney dysfunction.
MR. VIRGIL: What's that representative of, the BUN.
MS. SEAMAN: Representative of. I just didn't hear the word, sorry.
A. It's a marker of kidney function, or one of the markers of kidney function. It's something that your body makes.
Q. All right. So with the hemodialysis, you were able to bring the BUN score to normal, correct?
A. Yes.
Q. And did you do any other treatment?
A. We did a lot of evaluation to figure out, or try to figure out, why she was not awake.
Q. Do you remember what those evaluations were?
A. I don't remember details specifically. I think we did head imaging. I don't remember specifically if we consulted with neurology. We may have.
Q. Do you know what was wrong with her -- well,

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withdrawn. Were there any other evaluations that you did related to her mental status that you can remember?
MS. SEAMAN: I'm going to object to the form.
A. Yeah, I'm sure it's probably in the medical records, but I'm -- I think we did what's called a metabolic workup, to look for other things that may cause altered mental status.
Q. What other things?
A. Lots of things. Would you like the whole medical list?
Q. Yes.
A. So syphilis, B12 or folate deficiency, I don't know, lots of -- medications, infection, liver not working, heart not working, kidney not working. There's probably more; that's not an exhaustive list.
Q. Did she have syphilis?
A. Not that I recall.
Q. Any B12 issue?
A. I don't remember.
Q. Did she have an infection?
A. I don't remember.
Q. Do you remember if she was septic?
A. She may have been.
Q. Did she have any problems with her liver?

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A. I don't remember.
Q. Any problems with her heart?
A. She had a history of it. I don't remember.
Q. Do you remember any other findings for the metabolic workup?
A. Not off the top of my head.
Q. At some point, you reviewed some medical records of Mrs. Marsala, correct?
A. Yes.
MS. SEAMAN: The Griffin Hospital, are we talking about?
MR. VIRGIL: I'm just asking generally.
A. Since her thing, no.
MS. SEAMAN: Objection to form.
A. I haven't seen any records since I took care of her, no.
Q. So you haven't seen any records of Mrs. Marsala's treatment at Yale-New Haven Hospital in 2014?
A. I don't think so.
Q. Do you remember if at any point, Mrs. Marsala was alert or responsive?
A. I don't remember that she was ever alert or responsive, to my examination.
Q. She could open her eyes, though?
A. Oftentimes, her eyes could be open when you went

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in the room.
Q. Would she open her eyes?
MS. SEAMAN: Objection to form.
A. I don't remember that she opened them on command.
Q. Did she open them spontaneously?
MS. SEAMAN: Objection to form.
A. I don't remember.
Q. Do you remember if at any point during your care of Mrs. Marsala, her mental status improved?
A. I don't remember.
Q. And do now why Mrs. Marsala was intubated?
MS. SEAMAN: I'm going to object. But my only question is, I think the record is she was intubated at Griffin. So are you asking her from her review of the records? I don't know how she would know that.
MR. VIRGIL: If she had a conversation with the people at Griffin. She also said she looked at records from Griffin. But she may also independently know why she was intubated and I'm just asking that question.
A. I don't remember --
MS. SEAMAN: Object to the form.
A. -- why she was intubated.
Q. Did she remain intubated for a period of time at

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Yale-New Haven Hospital?
A. I'm sure she did.
Q. Do you know why?
A. I don't remember why she -- as I said, we -- people took care of her before I came on. I remember putting her on breathing trials to see if we could take her off of the breathing machine, which we have like a standard protocol for.
Q. It's called weaning trials?
A. Correct.
Q. And what is involved in the weaning trial?
A. The patient still has the breathing tube in, and but the machine isn't doing any of the breathing for them; they're breathing on their own. And we make sure that when they're doing that, that they're getting large enough titer volumes, that their respiratory rate doesn't go too fast, that their heart rate doesn't go too fast, that their blood pressure doesn't drop, that they're stable, breathing on their own before we take the tube out. It's standard protocol that we do for everyone usually before we take out a breathing tube.
Q. How did she do on those trials?
A. From my recollection, she would pass the trials from a respiratory standpoint.
Q. Are there other standpoints that are involved in

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the trial --
MS. SEAMAN: Object to the form.
Q. -- other than respiratory?
MS. SEAMAN: Sorry. Object to the form.
A. Well, from a respiratory standpoint there aren't other objectives we look at.
Q. Are you looking at anything other than respiration when you're doing these weaning trials?
MS. SEAMAN: Other than what she's just said?
MR. VIRGIL: She just said only respiratory, and she made some comment about -- the way she phrased it suggested there was something else, and I'm just trying to find out what it was.
MS. SEAMAN: I'm going to object.
A. From a breathing trial standpoint, we look at the respiratory numbers and the hemodynamics.
Q. All right. What are hemodynamics?
A. Like heart rate, blood pressure.
Q. And do you remember how she did on those?
A. She passed several weaning trials, I think.
Q. Were you ever able to determine why Mrs. Marsala had a depressed mental status?
A. No.
Q. So it's fair to say that you do not know what the

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cause of Mrs. Marsala's depressed mental status was?
A. No, she would have needed an autopsy to determine.
Q. And did you have any meetings with Mrs. Marsala's family members?
A. Yes.
Q. Do you remember any of those meetings?
A. I remember one specific meeting with her husband and nursing and myself. I'm not clear if social work was at that meeting.
Q. And what do you remember from that meeting?
A. We updated Mr. Marsala about his wife's medical condition; talked to him about what he thought her wishes were.
Q. Was Mr. Marsala, Mrs. Marsala's decision maker?
MS. SEAMAN: Object to the form.
A. I don't remember. I assume so, but...
Q. Okay. So you have this meeting, and you update Mr. Marsala related to Mrs. Marsala's condition. Do you remember what you said?
A. I don't remember the specifics of what I said. I remember the gist of what we said, that we had done an extensive workup, that she wasn't waking up, despite us putting her on dialysis, despite us treating any infection she could have had, despite us looking for

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other reasons for it, despite us trying to minimize any meds that potentially could cause her to be confused, you know, or obtunded. And I think we told them about the breathing trials and how she had done well, and that we thought from a respiratory standpoint, she'd be okay to come off of the ventilator control.
Q. Do you remember if there was a DNI that was entered for Mrs. Marsala?
A. I don't remember.
Q. And were there any other reasons that you can remember that you thought it was okay for Mrs. Marsala to come off the ventilator?
A. Other than the medical data suggested that she could breathe on her own?
Q. Yes.
A. No.
Q. Okay.
A. Oh, actually, can I add something?
Q. Yes.
A. One of, I think one of the -- now that -- one of the thoughts I had was that maybe, if we took her off the ventilator, she would perk up. Like maybe part of being on the ventilator in older people, they're sleep deprived, they get confused, she doesn't understand why she had has a tube in her throat, and maybe somehow

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that's causing her, in the setting of an older brain, to not be as awake as she should be. I think my hope was taking her off, she would maybe wake up. But unfortunately, I don't remember that happening.
Q. And do you remember what Mr. Marsala said to you when you approached him about taking her off the ventilator?
A. No, I don't remember what he said specifically about that. But I do remember that he did not want any of his other family to be involved in the decision making. He was clear that he was the only one that would make any decision regarding her care, and he didn't want a family meeting with her children involved.
Q. Do you have any memory about anything else that Mr. Marsala said during that meeting?
A. No. I just -- I remember feeling sad for him because I want -- you know, usually people like their family around to have support. And he was determined, he was going to struggle through this all on his own.
Q. And did Mr. Marsala give his consent to remove the ventilator?
A. I don't remember.
Q. Did you --
A. But -- well, never mind.
Q. Did you need Mr. Marsala's consent to remove the

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ventilator?
A. No, not if she had been passing her weaning trials.
Q. Did you have any discussion during that meeting regarding re-intubating Mrs. Marsala?
A. I don't remember.
Q. At some point during your treatment of Mrs. Marsala, did you make the decision not to re-intubate Mrs. Marsala?
A. I don't remember.
Q. Was Mrs. Marsala extubated at some point?
A. She was extubated.
Q. And how did she do?
A. I don't actually remember the details of how she did. I think I probably went off service not long after that.
Q. What do you mean, you went off service?
A. Meaning I wasn't on either for the weekend, or somebody else came over and covered for several days.
Q. Do you know how long before you went off service it was that Mrs. Marsala was extubated?
A. I'm old; my memory is not that good. I'm lucky if I could remember what day of the week it is. Early onset dementia.
Q. Do you actually have early onset dementia?

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A. No, I'm kidding.
MS. SEAMAN: Let's take a minute if you're going to move into another area.
MR. VIRGIL: We can take a break now.
(R E C E S S)
BY MR. VIRGIL:
Q. Before we took the break, we were talking about a meeting that you had with Mr. Marsala prior to taking Mrs. Marsala off the ventilator. And you had a discussion with him and --
A. Was that meeting before or after? I don't know.
Q. You know what, I don't know either. So you had a meeting with him to discuss her coming off the ventilator, correct?
A. (Affirmative nod.) No, I don't -- no. I don't know that that was what the meeting was about. We had a family meeting. I don't know if it was before or after she was off the ventilator.
Q. Okay.
A. I'd have to look at the records to tell you that.
Q. Was there anyone from the family there other than Mr. Marsala?
A. At that meeting?
Q. Yes.
A. No.

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Q. At any point, did you have any interaction with anyone else from the family, other than Mr. Marsala?
A. I think I spoke to one son, maybe. I don't remember how many children she had. I remember there was a daughter who required care, so I never met her. But most of the time, the family was not there.
Q. You were aware that Mrs. Marsala had children?
A. Yes.
Q. And do you know how many children she had?
A. Like I said, I think I saw one son, one time. And Mr. Marsala mentioned a daughter.
Q. And do you have any memory of Mr. Marsala objecting to the removal of the ventilator?
A. No.
Q. Do you have any memory of Mr. Marsala insisting on re-intubating Mrs. Marsala following extubation, if necessary?
A. No.
Q. Do you have any memory of discussing re-intubating Mrs. Marsala with Mr. Marsala?
A. No. The only thing I remember clearly is that one family meeting.
Q. And you don't remember him objecting, or he didn't object to the removal of the ventilator at that meeting?

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MS. SEAMAN: Objection to form.
A. I don't remember.
Q. And at the meeting, you didn't discuss re-intubating, or you don't remember discussing re-intubating?
A. I don't remember. I don't even remember, like I said, if she was intubated or extubated at that point.
Q. What is a tracheotomy?
A. It is a hole in your neck, through the trachea.
Q. What is it for?
A. Lots of things. So you put a hole in there if somebody has acutely obstructed their airway in a trauma situation. You could put a hole in there if somebody has cancer and you take out a piece of the cancer, you can put a hole in there if they need to be connected to breathing machine, you could ventilate them that way, as opposed to putting the tube down their throat the other way.
Q. So the tracheotomy is an alternative, can be used as an alternative way of ventilating a patient?
A. Well, you don't ventilate them with a tracheotomy. You ventilate them with the breathing machine. The tracheotomy provides the access for the breathing tube. So people can have a tracheotomy and not need a breathing machine.

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Q. Do you remember if Mrs. Marsala ever received a tracheotomy?
A. She did not.
Q. Do you know why not?
MS. SEAMAN: I just didn't hear.
Q. Do you know why not?
A. I don't know why she didn't receive one.
Q. Did you ever discuss a tracheotomy with Mr. Marsala?
A. I don't remember.
Q. Is a tracheotomy one of the treatment options for Mrs. Marsala?
A. Typically, not something that we would offer for somebody who didn't have any mental status.
Q. Why not?
A. Because usually, they're indicated if somebody has, like I said, a cancer, or something else in their trachea. If she -- somebody like who has ALS, who has muscle weakness, who can't breathe on their own because of that, may opt to get a tracheotomy. Again, like somebody who's had trauma, and can't -- facial trauma, needs the hole here because they can't go this way (indicating.)
Q. Are there any concerns with a patient being intubated for a prolonged period?

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A. Intubated, you mean by -- orally intubated?
Q. Orally intubated.
A. There's risks for oral intubation at any time. So you can damage the vocal cords, that's the biggest one. I mean, there's lots of -- you can get ulcers that bleed. You can get bleeding, you can get infection.
Q. Do you remember specifically what the risks were for continued intubation of Mrs. Marsala?
A. All the risks for intubation or anybody. So ventilator associated pneumonia, infection, bed sores because she can't move, blood clots because she can't, you know -- isn't moving. She can't eat, she can't talk.
Q. Do you remember if Mrs. Marsala had a lumbar puncture?
A. I don't remember.
Q. Do you know why Mrs. Marsala might have needed a lumbar puncture?
A. Lumbar punctures are typically done in the workup of an altered mental status. Usually, when the altered mental status is acute, so when it first happens, to make sure there's no infection or other things potentially causing the altered mental status.
Q. And what were the other things that might be

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detectible through a lumbar puncture that might be causing altered mental status?
A. Bleeding. Autoimmune processes.
Q. Anything else?
A. I mean, that's what I can think of off the top of my head.
Q. Are there ways to check that, other than a lumbar puncture, ways to check for infection, bleeding or autoimmune issue?
A. Sometimes you can see them on a CT scan or a MRI. Certain infections can be picked up by EEG. They are suggested by EEG, not diagnostic, but suggested by EEG.
Q. Any other ways to make -- to determine if there's infection, bleeding or autoimmune, other than the -- other than the lumbar puncture and the things that you just said?
A. Not that I can think of.
Q. Did you ever recommend a lumbar puncture for Mrs. Marsala?
A. I don't remember.
Q. And I think you indicated that you went off service after Mrs. Marsala was extubated?
A. Well, went off service at some point, because I was not there when she died.
Q. Do you remember how she was doing after she was

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extubated, before she passed?
A. I remember that she didn't wake up, which is what we had hoped for. But other than that, I don't really remember.
Q. Did she continue to breathe on her own after being extubated?
A. Yeah. If she had stopped breathing, she would have passed right then and there. So she could breathe.
Q. Do you know how long it was from when she was extubated until she passed?
A. I don't remember.
Q. Do you know what she passed from?
A. Not without an autopsy.
Q. Did she have any breathing difficulties that you're aware of after being extubated?
A. I don't remember.
Q. Did she require BIPAP?
A. She may have.
Q. Why would a patient require a BIPAP?
A. Again, lots of reasons. But if they're having trouble breathing, if their oxygen is low, we'll put BIPAP on them.
Q. Just to be clear, what is BIPAP?
A. Bilevel positive pressure.
Q. What does it do?

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A. It's a mask that you wear that gives you a little bit of pressure to help keep the airways open. People who have obstructive sleep apnea will use it at night because their airways tend to collapse.
Q. For Mrs. Marsala, what would be the pros and cons of using BIPAP to provide or to keep her airway working?
MS. SEAMAN: Object to the form.
A. I don't really remember. I don't remember the decision to put her on BIPAP or what the medical indications were at the time.
Q. Following the extubation, was Mrs. Marsala ever reintubated?
A. Not that I remember.
Q. Do you know why not?
A. No.
Q. Is re-intubation a treatment option for a patient who's having difficulty breathing on their own?
A. In some cases.
Q. Is Mrs. Marsala, if she had had a breathing difficulty following extubation, is she one of the patients who would have had re-intubation as a treatment option?
MS. SEAMAN: Object to the form.
A. I don't remember.
Q. Was Mrs. Marsala on hemodialysis at the hospital?

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A. Did she ever receive hemodialysis at Yale-New Haven Hospital? Yes.
Q. And did she continue to receive hemodialysis until her passing?
A. I don't remember.
Q. Were there any logistical issues with her receiving hemodialysis and being intubated?
A. No.
Q. Any issues with the staffing requirements to provide both hemodialysis and intubation for Mrs. Marsala at the hospital?
MS. SEAMAN: Object to the form.
A. No. We do it all the time.
Q. And are there any staffing issues with -- withdrawn. Are there any equipment issues that would be presented providing hemodialysis to a patient who was being ventilated through a trachea?
A. No.
Q. No logistical issues with doing that at the hospital, correct?
MS. SEAMAN: Objection to form.
A. No.
Q. What is the different between ventilating a patient through the use of BIPAP, and/or AI intubation?
MS. SEAMAN: Object to the form.

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A. You can't as easily suck out secretions if somebody has BIPAP sometimes. You don't have direct access to the airway like you do with an oral ET tube. So if somebody had a big pneumonia and lots of secretions, you know, BIPAP wouldn't be the best choice necessarily.
Q. Are there any other -- well, in what situations would a BIPAP be preferable to intubation?
A. I don't know. I could create lots of scenarios.
Q. Are they scenarios that generally where there's less secretions?
MS. SEAMAN: Object to the form.
A. Could be less secretions. You know, could be somebody who took an overdose. It just depends on the individual patient and what their history is, and their medical history, and their underlying lung pathology. If you're asking about the -- nerve mind.
Q. Is it easier to ventilate a patient using oral intubation, than BIPAP?
MS. SEAMAN: Object to the form.
A. No, not necessarily.
Q. For a patient who's having difficulty breathing, is it easier to maintain oxygen saturation using oral intubation, instead of BIPAP?
A. No.

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Q. Why not?
A. Well, again, it depends on the etiology. So you can't broadly say "No, it's easier with this," because sometimes you can do it equally as well.
Q. Would a BIPAP ventilation have worked as well as oral intubation for Mrs. Marsala?
MS. SEAMAN: Object to the form.
A. I don't remember. I'd have to look at the medical data.
Q. Do you remember if you ever formulated the opinion that Mrs. Marsala should not be re-intubated?
A. Did I ever formulate the opinion that she should not be re-intubated. So you're asking me about my opinion or the medical facts?
Q. Your opinion.
A. Yeah, I think probably she probably should not have been re-intubated because she -- there was nowhere to go with her treatment.
Q. If there had be somewhere to go, would that have changed your opinion?
A. Yes.
Q. At some point, did you have the opinion that Mrs. Marsala was not someone who should receive a tracheotomy?
A. I don't really remember specifically thinking

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about tracheotomy.
Q. Did you ever have any discussions with Mr. Marsala regarding the entry of a DNR for Mrs. Marsala?
A. I don't remember.
Q. Did you ever have any discussions with Mrs. -- or Mr. Marsala regarding the entry of a DNI for Mrs. Marsala?
A. I don't remember.
Q. Did you ever have any discussions about moving or changing Mrs. Marsala to Comfort Care Only with Mr. Marsala?
A. I don't remember.
Q. And I think you said this before, but you don't remember whether the discussions you had with Mr. Marsala about the extubation was before or after Mrs. Marsala had been extubated?
A. I'm not even sure I said that we had a discussion about extubation. You were asking about the family meeting.
Q. Okay. Well, what was discussed at the family meeting?
A. We talked about her prognosis, what we had done for her, you know, and where we thought we should go.
Q. Did you talk about -- do you remember the specifics of what --

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A. No.
Q. Do you remember the specifics of where you should go?
A. No.
Q. Do you remember any specifics of what Mr. Marsala said?
A. No, other than that he did not want his family involved, and he was going to be the one to be the decision maker of her.
Q. Okay. And do you remember what his decisions were related to efforts to resuscitate Mrs. Marsala?
A. Not from that meeting.
Q. Do you, from your review of the records or any discussion with Mr. Marsala, know what the wishes were related to the resuscitation of Mrs. Marsala?
A. I don't remember. And I haven't seen the records since when they were done.
Q. So at the time of treatment in 2010.
A. (Affirmative nod.)
Q. Correct?
A. Correct.
Q. And do you remember what Mr. Marsala expressed as the wishes of Mrs. Marsala related to intubation?
MS. SEAMAN: I'm sorry, would you read that back?

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(DISCUSSION HELD OFF THE RECORD.)
MS. SEAMAN: Object to the form.
A. I have some vague recollection, in one of our conversations, that he had said she -- he didn't think she would really want this.
Q. To remain intubated?
A. To be on life support, to be living like this.
Q. Do you have any specific recollection related to the wishes to be intubated?
A. No.
Q. Do you have any specific recollection as to the wishes related to being re-intubated?
A. No.
Q. And do you have any specific recollection as to the wishes related to being Comfort Care Only?
A. No.
Q. Do you have any recollection of providing Mr. Marsala with notice that treatment options were not going to be pursued at the hospital?
MS. SEAMAN: Object to the form.
A. At what point during her care?
Q. At any point.
A. I remember trying to reach him several times, and he didn't answer the phone. I don't remember exactly what I was trying to reach him about at those points.

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And if you're referring to the Ethics Committee, the Ethics Committee was going to contact him after the Ethics Committee meeting.
Q. What I'm asking is a little bit more specific than that. What I'm saying is do you remember having any discussion with Mr. Marsala about the -- well, about having to seek treatment at another facility, that the hospital was not going to provide for Mrs. Marsala?
MS. SEAMAN: Objection to form.
A. No. We already discussed that, didn't we?
Q. So at no point did you tell Mr. Marsala that he needed to take Mrs. Marsala somewhere else to receive treatment?
A. I did not.
Q. And at no point did you go to the Probate Court related to the treatment of Mrs. Marsala, correct?
A. Not that I remember.
Q. And you mentioned that just a second ago, there was an Ethics Committee meeting convened related to Mrs. Marsala?
A. Yes.
Q. And what do you remember from that?
A. I remember that whoever was on the committee was there. I remember the nephrologist came because they felt that continued dialysis was not appropriate. And I

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remember that the Ethics Committee felt that it -- we did not need to provide ongoing intubation, given the fact that we had done an exhaustive workup and she had shown no signs of recovery over the whole time she had been in the hospital, and had essentially continued to deteriorate.
Q. I'm going to try and take this piece by piece. First, do you know why dialysis was supposedly -- continued dialysis was determined to be non-appropriate?
A. Because dialysis, again, is usually something we do to fix problems that are acute. So if your kidneys really don't work well and you're not making urine, if you're -- there are specific indications for dialysis, which she did not meet. She actually probably didn't meet them initially, but we thought maybe it would help her mental status, given her high BUN. But she didn't meet what we would call urgent criteria for dialysis, like "If you don't do dialysis now, you're going to die."
Q. Did the recommendation that dialysis was not appropriate have anything to do with the difficulty in administering the dialysis to Mrs. Marsala?
A. Not at all. She didn't have any problem with the dialysis treatments.
Q. Did she have any issues with the dialysis

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treatment after being extubated?
A. I don't remember specific pre, post.
Q. Do you remember if the dialysis was discontinued because her breathing became labored during dialysis treatment?
A. No.
Q. Do you remember if there was any discussion about her not continuing with the dialysis because of the breathing problems that she was having?
A. No. The two usually don't go together. Like dialysis doesn't cause breathing problems. Oftentimes people will get dialysis if they have breathing -- you know, heart failure or other problems.
Q. Now, how was the Ethics Committee meeting arranged?
A. Somebody called an Ethics consult.
Q. Who?
A. I don't remember.
Q. Was it you?
A. I mean, we discussed it as a team. Who actually physically placed the call, I don't remember.
Q. Was it a team decision to have the Ethics Committee meeting?
A. Yes.
Q. And was that something that was requested by the

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family?
A. No.
Q. Was that something that was requested by Mrs. Marsala?
A. No, not that I remember.
Q. And who attended that meeting?
A. Like I said, whoever the members of the Ethics Committee were at that time, which I don't remember. Myself, I think the nephrologist was there. And I know Mr. Marsala wasn't because we had specifically tried to invite him.
Q. And at that meeting, did you discuss what the wishes of Mr. Marsala were related to the care and treatment of Mrs. Marsala?
A. I don't remember, but maybe there's a documentation of it.
Q. If you had discussed the patient's wishes, would that have been documented in a note?
A. Well, it was hard to discuss the patient's wishes since she couldn't tell us her wishes.
Q. Were the wishes of the patient as articulated by Mr. Marsala discussed?
MS. SEAMAN: Object to the form.
A. They may have been.
Q. Would that have been documented in the note?

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A. It may have been documented. I didn't write the note.
Q. And why was it inappropriate to continue intubation of Mrs. Marsala?
A. Why was it inappropriate.
Q. Yes.
A. Well, she passed her breathing trials. So we wouldn't keep her intubated when she passed her breathing trials.
Q. Was there any decision made at that point related to re-intubating Mrs. Marsala?
A. Right when she was extubated? I don't remember.
Q. No, at the Ethics Committee meeting.
A. I think the Ethics Committee recommended that she should not be re-intubated.
Q. And why was that?
A. I think it was based on the medical facts of the case.
Q. Okay. Which one specifically?
A. Not just one medical fact. There's a lot of medical facts. So I think, from recall, I think it was based on the fact that she had no mental status, despite us taking the tube out and trying to get her to be awake and follow, you know, being interactive. And she still had multiorgan failure.

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Q. In relationship to the extubation, do you know when this Ethics Committee meeting was?
A. No.
Q. In relation to her passing, do you know when this Ethics Committee was?
A. In relation to what? I'm sorry.
Q. Her passing.
A. No.
Q. Now, was this the first Ethics Committee meeting that you had related to end-of-life treatment decision making?
MS. SEAMAN: For Mrs. Marsala?
Q. Well, sure, for Mrs. Marsala.
A. I don't remember. I think so.
Q. Okay. And had you ever had Ethics Committee meetings for end-of-life decision making for patients other than Mrs. Marsala?
A. I don't remember.
Q. Do you remember ever being part of an Ethics Committee that recommended treatment that was contrary to the patient or the patient's decision maker's wishes?
A. I don't remember.
Q. At the time that you extubated Mrs. Marsala, did you think that she would be able to breathe on her own indefinitely?

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MS. SEAMAN: Object to the form.
A. I thought she could breathe on her own based on the weaning trials that we did several days in a row that indicated she could breathe without the ventilator.
Q. Did she think that she would continue to breathe on her own without the assistance of BIPAP or intubation?
A. Based on the weaning trials, I thought that she would be able to breathe on her own when we took the breathing tube out.
Q. If she failed to continue to breathe on her own, what are the options to continue to ventilate1 her?
A. You could put a breathing tube back in. You could try noninvasive ventilation.
Q. And what would noninvasive ventilation be?
A. BIPAP, or CPAP. There's just different modes of it.
Q. Anything else?
A. Any other ventilators, are you asking about?
Q. Any other --
A. There's lots of modes of ventilation.
Q. Okay. What are the other modes of ventilation?
A. Well, there's just different ways to set up the ventilator to ventilate somebody.
Q. And was Mrs. Marsala was switched to Comfort Care

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Only during your time as an attending for her?
A. I don't remember.
Q. Do you know why, if she were switched to Comfort Care Only, why that would have been?
A. Because it was felt to be the medically appropriate thing to do.
Q. Sitting here today, thinking back on what you remember, was it the medically appropriate thing to do to switch Mrs. Marsala to Comfort Care Only?
A. I don't have the facts ing front of me now.
Q. And you haven't reviewed her records recently?
A. No.
Q. So you don't – do you remember if the recommendation not to re-intubate Mrs. Marsala was against the wishes of Mr. Marsala?
A. No.
Q. No, you don't remember?
A. No, I don't remember.
Q. And did Mrs. Marsala, if she had been re-intubated, have any chance of recovery?
A. Define what you mean by "recovery."
Q. Well, if she had been intubated, would her passing have been delayed?
MS. SEAMAN: Object to the form.
A. It could have been.

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Q. Why do you say that?
A. Because we -- if we breathe for her, she may have lived a little bit longer. But there's no -- I don't have a crystal ball, so I can't necessarily tell you that. She would have died either way.
Q. Well, we're all going to die at some point, right?
MS. SEAMAN: Object to the form.
Q. Do you have any estimate as to how much longer she would have lived if she had been re-intubated?
MS. SEAMAN: Object to the form.
A. Not without my crystal ball.
Q. And were there any other tests or -- well, any other tests that could have been done on Mrs. Marsala prior to her passing?
A. Not that I can recall.
Q. Were there any other procedures that could have been done to Mrs. Marsala prior to her passing?
A. Not that I recall.
MS. SEAMAN: I'm going to object to the form. If you don't recall...
Q. If Mrs. Marsala had been re-intubated, did she have any chance of recovery?
MS. SEAMAN: Object to the form.
A. I can't say.

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Q. Why not?
A. Excuse me?
Q. Why not?
A. Because I don't know exactly what you mean by "recovery."
Q. Okay. Well, if she had been re-intubated, I asked you earlier, and you said she could have continued to be alive with the ventilation, correct?
MS. SEAMAN: Objection. We'll have to go back. If you want her to read it back, we'll have her go back.
MR. VIRGIL: No, it's fine.
MS. SEAMAN: So you're withdrawing that question?
MR. VIRGIL: Sure.
Q. If Mrs. Marsala had been re-intubated, was there any chance that she would have had improved mental status?
MS. SEAMAN: Object to the form.
A. In my opinion, no.
Q. Were there any potential treatments that could have been administered to her that -- to address her mental status, that could have been administered if she had been re-intubated, that had not been tried before?
A. Not that I can recall.

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Q. Prior to the Ethics Committee meeting, was it your opinion that there was no chance of Mrs. Marsala's mental status improving?
A. I think she -- I think I remember thinking that she had zero -- close to zero chance of getting a mental status recovery.
Q. What do you mean by close to zero?
A. Well, nothing is a hundred percent.
Q. Okay. So she had some chance of having improvement?
MS. SEAMAN: Object to the form.
A. Unlikely.
Q. Okay, but she had some chance?
MS. SEAMAN: Objection; asked and answered.
A. No. In my opinion, actually, no.
Q. She didn't have a chance?
A. Based on having seen lots of these patients in ICU, based on years of research, no.
Q. In your work at the hospital, are you aware of what the treatments you provide cost?
A. I have no idea.
Q. Do you know how patients pay for services they receive at the hospital?
A. I have no idea.
Q. Are you aware of whether patients have insurance

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or not?
A. I have no idea. They all get --
MS. SEAMAN: You're meaning a particular patient, right?
A. -- treated equally.
MR. VIRGIL: Yes.
MS. SEAMAN: They all get treated equally. I'm sorry, go ahead.
Q. Have you ever reviewed Connecticut's law related to the removal of life support?
A. No. I call the Legal Office.
Q. And are you still working in the medical ICU at Yale-New Haven Hospital?
A. Yes.
Q. And do you still have privileges there?
A. Yes.
MS. SEAMAN: Well, at Yale, right?
MR. VIRGIL: At the hospital.
Q. And do you have privileges at any other hospital?
A. No.
Q. Have you ever had privileges at any other hospital?
A. The VA.
Q. In 2010, did you have privileges at the VA?
A. I don't remember.

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Q. Do you work for anyone as a physician, other than Yale or Yale-New Haven Hospital, or Yale University?
A. No.
Q. What was your expectation for Mrs. Marsala following her extubation?
MS. SEAMAN: Objection; asked and answered. Go ahead.
THE DEPONENT: What does that mean, "asked and answered"?
MS. SEAMAN: He's asked you the same question several times.
A. Oh. What was my expectation? My hope, I don't know if it was my expectation, my hope was that she would become more alert without the breathing tube.
Q. What was the likely outcome of the extubation?
A. Are you asking from a respiratory standpoint?
Q. Yes.
A. Well, the likely outcome, based on the weaning trials, was that she'd be able to breathe on her own.
Q. What was the likely outcome from a respiratory standpoint when she began to have breathing difficulties following the extubation?
MS. SEAMAN: Object to the form.
A. Yeah, I don't really remember.
MS. SEAMAN: I don't understand what that

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means.
Q. Well, earlier, you said that the Ethics Committee's recommendation was that Mrs. Marsala was not re-intubated, correct?
A. Can you repeat that?
Q. Yes. Earlier, we talked about the Ethics Committee and the meeting that was held. And you told me that the recommendation was that she not be re-intubated. Correct?
A. Correct.
MS. SEAMAN: We've been here for a while. I don't think you can keep asking her whether what she said before is whatever you're going to rephrase it to be. I think you have every right to ask her every question you have. But you can't keep asking it over and over and over.
THE DEPONENT: Or I may throw up on you.
Q. I'm trying to get to the point here.
A. Well, ask specifically what you want to know. The vague questions are really hard to answer, especially given the facts that it's so long ago.
Q. Was the recommendation of the Ethics Committee not to re-intubate Mrs. Marsala followed?
MS. SEAMAN: Objection; asked and answered.
A. Like I said, I went off service. As far as I

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know, she did not get re-intubated.
Q. If the recommendation not to re-intubate Mrs. Marsala was followed following her extubation, if she had difficulty breathing, what is the likely outcome?
MS. SEAMAN: Objection.
A. If she had difficulty breathing?
Q. Yes.
A. It depends. I don't know.
Q. Okay. You take the breathing tube out of her mouth. There's a recommendation that she is not going to be intubated. Isn't the likely outcome when she has breathing difficulty that she's going to expire, that she's going to pass because she can't breathe?
MS. SEAMAN: Object to the form.
A. It depends on what is causing her breathing difficult.
Q. Do you know what was causing Mrs. Marsala's breathing difficulty?
A. No.
Q. Did anyone ever determine what was causing Mrs. Marsala's breathing difficulty?
A. I don't remember.
Q. If Mrs. Marsala passed away because she was not re-intubated at the recommendation of the Ethics Committee, because she was having breathing difficulty

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following the extubation, and that was against the wishes of Mr. Marsala, wouldn't you expect her passing to cause Mr. Marsala emotional distress?
MS. SEAMAN: Object to the form.
A. Everyone's passing of a family member causes emotional distress.
Q. Well, under those circumstances, where it is against the patient's or the patient's decision maker's wishes, doesn't that cause emotional --
A. More emotion distress? I mean I don't --
MS. SEAMAN: Objection.
A. I don't -- I can't answer that.
Q. Well, wouldn't you expect it to cause more emotional distress?
MS. SEAMAN: Objection.
A. Not necessarily. You are saying that the passing of my loved one is going to cause me less emotional distress than the passing of someone else's?
Q. I'm saying that it's going to cause you more emotional distress because the hospital is acting contrary to the wishes that you're expressing, causing the passing.
MS. SEAMAN: That's not a question. Go ahead.
Q. And that is going to cause you more emotional

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distress than simply the natural passing of someone.
MS. SEAMAN: Objection.
Q. Correct?
A. I disagree.
Q. Why?
A. Because I think it's hard for anybody to lose a family member or a loved one. And we see it every day, day in and day out, whether they're accepting of it or not accepting of it.
Q. So it's not going to cause more emotional distress when the passing is caused by the hospital acting contrary to the patient's wishes?
MS. SEAMAN: I'm going to object. You've already asked that. She's answered now three times.
MR. VIRGIL: But they are not responsive answers.
MS. SEAMAN: Absolutely they are.
MR. VIRGIL: All right.
A. No.
Q. Okay. Had your license to practice medicine in the State of Connecticut ever been suspended?
A. No.
Q. Any disciplinary action?
A. No.
Q. Have you ever been sued for malpractice?

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A. No.
Q. Have you ever been deposed before?
A. No.
Q. Do you know what an affidavit is?
MS. SEAMAN: I'm sorry, I just didn't hear you.
Q. Do you know what an affidavit is?
A. Well, since I just signed one, now I do.
Q. Okay. And did you prepare the affidavit that you signed?
A. The attorneys prepared the affidavit and I reviewed it.
Q. And did you make any changes to it?
A. I don't think so. I mean, just grammar changes.
Q. Did you review any medical records before signing the affidavit?
A. No, they went through the records and put the record information in.
Q. You yourself never reviewed the records that that material was taken from?
A. Mm-mm.
(PLAINTIFF'S EXHIBIT 2 FOR IDENTIFICATION Received and Marked.)
Q. Is this the affidavit that you signed?
A. Yes.

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Q. And you didn't go back and check the medical records before signing the affidavit, to make sure that the information contained within was accurate?
A. No.
Q. Was this affidavit made exclusively based on your personal knowledge?
A. No, it was made based on the medical record.
Q. But you didn't review the medical record?
A. That's what I have lawyers for.
Q. So you signed this under oath as being truthful and accurate, correct?
A. Yes.
Q. But does it contain information related to the care and treatment of Mrs. Marsala that you do not have a personal recollection of?
A. That looks right. That all looks right. That's right, too, she got -- we actually got a second opinion in addition to the Ethics Committee.
Q. Okay. So do you have a recollection of Mrs. Marsala receiving BIPAP?
A. Not really.
Q. Well, in your affidavit, you swore that Mrs. Marsala received BIPAP and discussed her BIPAP treatment.
A. I remember that she had BIPAP, but I don't

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remember the settings, the details, the times. I don't think it says anything about settings in there.
Q. Okay. Number 12, "Unfortunately, extubation did not have a significant impact on her mental status."
A. And I've told you that.
Q. "Within a short time after extubation, she started to have breathing difficulty and clearing her see secretions. Supplemental oxygen was provided through the BIPAP mask."
A. Correct.
Q. Do you remember that?
A. Mm-hmm.
Q. You remember now that she had breathing difficulty following extubation?
MS. SEAMAN: Objection.
A. It's in the medical record.
Q. Did you check the medical record?
A. The attorneys checked the medical record. I assumed they didn't make it up, and they document it from my notes. And unfortunately, we don't even have access to that medical record anymore. It's an old...
Q. All right. Number 13. In number 13, it says "I told him that I did not believe it was appropriate to re-intubate Mrs. Marsala if she became unable to breathe on her own," referring to Mr. Marsala.

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A. Correct.
Q. You did that?
A. Yes.
Q. Was it expected that Mrs. Marsala was going to -- withdrawn. Was it a likely outcome that Mrs. Marsala would be unable to continue to breathe on her own following extubation?
MS. SEAMAN: I'm sorry, what paragraph are you reading?
THE DEPONENT: I don't know.
MR. VIRGIL: 13.
MS. SEAMAN: I'm not seeing --
MR. VIRGIL: Second sentence.
MS. SEAMAN: "I advised Mr. Marsala that I had discussed this" --
MR. VIRGIL: The one before.
MS. SEAMAN: Do I have a different affidavit? Hold on one second.
MR. VIRGIL: I hope not.
MS. SEAMAN: "I advised Mr. Marsala that I had discussed the situation with my colleagues, and we felt that further treatment was futile and not in the best interests of his wife."
MR. VIRGIL: Next sentence.
MS. SEAMAN: "I told him that I did not

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believe it was appropriate to re-intubate her if became unable to breathe on her own."
MR. VIRGIL: Yes.
MS. SEAMAN: No, no, your question was something about a significant likelihood.
MR. VIRGIL: Yes, I asked first about this, and then I asked about the likelihood of needing to re-intubate her.
MS. SEAMAN: I'm sorry.
A. I don't know.
Q. I direct your attention to paragraph nine.
MS. SEAMAN: I have a clean copy. Let me just see. So you want -- so you can look at paragraph -- no, never mind, never mind. Go ahead.
Q. Paragraph nine relates to the entry of a "Do Not Resuscitate" order?
A. Yes.
Q. Were you personally involved in the discussions with Mr. Marsala?
A. I don't remember.
Q. Would you have documented in the note if you were the one who personally discussed that with Mr. Marsala?
A. I would have.
Q. Okay. Showing you paragraph 15.
A. Yes.

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Q. In paragraph 15, it refers to the recommendations of the Ethics Committee being that Mrs. Marsala be moved to Comfort Care Only.
A. I'm sorry, what was the question?
Q. Sure. In paragraph 15, does that indicate that Mrs. -- that the Ethics Committee recommended that Mrs. Marsala be placed on Comfort Care Only?
A. That her care should not be escalated. Is that what you're asking about? It says right here, Comfort Care Only should be provided.
Q. So was that an additional recommendation of the Ethics Committee?
MS. SEAMAN: Object to the form.
A. I'd have to look exactly at the Ethics Committee note to look at their wording. And this actually happened on the weekend when I was -- after I had left, another physician came on the weekend.
Q. What specifically happened on the weekend?
A. Another -- in addition to the Ethics Committee, a private Critical Care Pulmonary physician came in and wrote -- evaluated her and wrote a note and opinion.
(PLAINTIFF'S EXHIBIT 3 FOR IDENTIFICATION Received and Marked.)
Q. If you could just review, starting there at the bottom, I believe it is the Ethics Committee note.

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Does that refresh your recollection as to the Bioethics Committee meeting related to Mrs. Marsala?
A. It does. And it reminds me of how sick she really was, that she'd been in the hospital since May. I had completely forgotten that.
Q. Are there any additional things that you remember from the meeting?
A. No.
Q. Can you identify from this note specifically what discipline the participants are representing?
A. Well, there's two physicians here. It says there's a chaplain. There's another physician who is the nephrologist. Myself, Nursing and Social Work.
Q. And this first physician, Grace Jenq, --
A. Mm-hmm.
Q. -- do you know what Dr. Jenq's practice or specialty is?
A. I think she's a geriatrician.
Q. And why was Dr. Jenq involved in this?
A. She must have been on the Ethics Committee.
Q. And Dr. Dugdale?
A. I'm not sure.
Q. And why was a chaplain involved?
A. Because chaplains are often members of the Ethics Committee. So if you see here, where it says "Members

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present," I think that means Ethic Committee members, and then "Staff present" are the people who are caring for the patient.
Q. Okay. And were those all of the people who were present?
A. I don't remember.
Q. Okay. And is the note here accurate? As you remember it the meeting going, does it reflect your memory of the meeting?
A. I don't remember.
Q. And it says, on the second page, which is stamped 42 at the bottom, there's a sentence here that begins, "However, he states that he still wants her to be intubated if necessary." Does that refresh your recollection as to whether or not Mr. Marsala wanted Mrs. Marsala to be re-intubated?
A. Apparently.
Q. Do you have any memory of any discussion with Mr. Marsala regarding re-intubating her following the extubation?
A. No.
Q. And if that was the wish of Mr. Marsala, that she been re-intubated, were the recommendations of the Bioethics Committee contrary to his wishes?
MS. SEAMAN: Objection.

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A. The Bioethics Committee makes a recommendation based on the medical facts, so it's a medical decision.
Q. Okay. So it's not the patient or the patient's representative's decision?
A. It depends on the situation.
Q. And down here, there's a sentence that says, "If the patient's husband does not agree with the plan, he has the option of seeking transfer of care to a different hospital and/or going to the Probate Court." Does that refresh your memory as to whether or not there was any discussion with Mr. Marsala related to transferring to a different hospital or going to Probate Court?
A. As I said, I -- and you've asked this several times -- have not, did not speak to him about transferring the care. I do not know if anybody else did.
Q. And do you know if anyone went to Probate Court?
A. No idea.
Q. And was it the understanding of the Ethics Committee that Mr. Marsala was the one who had to go to Probate Court?
MS. SEAMAN: Objection.
A. I don't know.
(PLAINTIFF'S EXHIBIT 4 FOR IDENTIFICATION

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Received and Marked.)
Q. There's a note here in the middle. What is a hypotension?
A. When your blood pressure is low.
Q. And what does respiratory failure mean?
A. Means you're having trouble breathing.
Q. And then am I correct, this indicates that because there was trouble breathing following extubation, that BIPAP was used?
A. Correct.
Q. And it indicated in this -- well, first, this note is dated July 22nd, 2010?
A. Yes.
Q. And it's at 2352?
A. Yes.
Q. So that would be 11:52 on July 22nd, 2010?
A. Yes.
Q. And it says "The patient's respiratory status did not improve this evening." Do you know if that was following the BIPAP?
A. I have no idea.
Q. And does this indicate that Mrs. Marsala was having oxygen desaturation despite the BIPAP?
A. Without seeing numbers from the medical records chart, it's hard to say. If you actually read it, it

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says a few minute break from BIPAP resulted in a desaturation.
Q. And it also says that "The patient faces re-intubation or family decision regarding not to provide this therapy given her continued critical illness and in particular, depressed mental status, refractory to plan of care," correct?
A. Yes.
Q. Why does this indicate that the patient faces the decision of re-intubating or not?
A. It's a nurse's note.
Q. The nurse is wrong?
MS. SEAMAN: Objection; lack of foundation.
A. No opinion.
Q. At this point, absent re-intubation, was the patient going to pass away?
A. I can't answer that.
(PLAINTIFF'S EXHIBIT 5 FOR IDENTIFICATION Received and Marked.)
Q. Showing you what's be marked as Plaintiff's Exhibit 5. What is Plaintiff's Exhibit 5?
A. It looks like a printout from the medical record. That is a DNR order.
Q. Was that for Mrs. Marsala?
A. It says "Helen Marsala" at the top.

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Q. Is that your signature?
A. Nope.
Q. Do you know whose signature it is, as the attending physician?
A. Nope.
Q. Were you involved in any way in the entry of this DNR?
A. Not that I remember.
Q. And you don't have any memory of the entry of this DNR, do you?
A. No.
(PLAINTIFF'S EXHIBIT 6 FOR IDENTIFICATION Received and Marked.)
Q. Showing you what's been marked as Plaintiff's Exhibit 6. What is Plaintiff's Exhibit 6?
A. Another DNR order for Helen Marsala.
Q. Is this your signature on this one?
A. Yes.
Q. And what is it dated?
A. July 23rd, 2010.
Q. Okay. And well, first, is there a change between the DNR which is marked as Plaintiff's Exhibit 5 dated July 4, 2010, and the DNR that's marked as Plaintiff's Exhibit 6 dated July 23rd 2010?
A. Yes. The one on the 23rd now includes a "Do Not

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Intubate."
Q. And do you remember if this was before or after Mrs. Marsala had been extubated?
A. Well, based on what you just showed me, she was extubated on that note on the 22nd. So I guess this would be after the extubation.
Q. Okay. Now, the DNR for July 4th that's marked as Plaintiff's Exhibit 5 has a house officer signature on it?
A. Yes.
Q. Why is there a house officer signature?
A. Because if the house officer's around or has entered the order, they'll sign it. It's not required.
Q. What is a house officer?
A. It's one of the trainees.
Q. And was Dr. Boyd an intern at that time?
A. Yes.
Q. And is there a reason why there wasn't a house officer's signature on the July 23rd DNR?
A. I don't know. They may have been gone for the day.
Q. Do you remember if Mr. Marsala consented to this DNR?
A. I don't know.
MS. SEAMAN: I'm going to object. I just

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think it's confusing. Could we call this the July 23rd one a DNI?
MR. VIRGIL: Yes, absolutely.
MS. SEAMAN: Just to distinguish it from --
THE DEPONENT: This actually should be call DNR/DNI and this should be call DNR.
MS. SEAMAN: Okay, so then your question --
Q. Do you remember if Mr. Marsala consented to the DNR/DNI on July 23rd?
A. No.
Q. Okay. Would you have a note that reflected that in the records if Mr. Marsala had consented?
A. Well, in this case, we probably know that he didn't consent because we have the Ethics Committee note saying that it was against his wishes.
Q. So the July 23rd, 2010 DNR/DNI was entered against Mr. Marsala's wishes?
A. Yes.
Q. Did you ever see the Death Certificate for Mrs. Marsala?
A. No, I was off service.
(PLAINTIFF'S EXHIBIT 7 FOR IDENTIFICATION Received and Marked.)
MS. SEAMAN: Are you going to ask her to look at it?

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MR. VIRGIL: Yes.
THE DEPONENT: I just can't read any of it, but... why is there no name on here? The "Decedent's Name," there's no name. Sis this the legal Death certificate?
MS. SEAMAN: I'm sorry, but you can't ask him questions.
THE DEPONENT: Oh.
MS. SEAMAN: But you also can't answer questions about something that you don't know anything about, so...
THE DEPONENT: Okay.
Q. Having reviewed this, do you know what caused Mrs. Marsala's passing?
MS. SEAMAN: I'm going to object. There's no foundation that -- the witness is right, there's no foundation this has anything to do with Mrs. Marsala, or anyone else.
THE DEPONENT: And it's not filled out appropriately for me to answer.
Q. Okay. Independent of the document, do you know what caused Mrs. Marsala to pass?
A. I wasn't there when she passed, but I assume she died, what everybody dies from, that their heart stops.
Q. Would your heart stop if you were unable to

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breath?
A. It could stop if you were unable to breathe.
Q. Okay.
(PLAINTIFF'S EXHIBIT 8 FOR IDENTIFICATION Received and Marked.)
MS. SEAMAN: This is page 48 from your affidavit.
MR. VIRGIL: And 49.
THE DEPONENT: What is this?
MS. SEAMAN: This is one of the attachments to the affidavit.
THE DEPONENT: Do you have a question?
Q. I do. First, who is Dr. Sanders?
A. I have no idea.
Q. Do you remember if you had an intern, a resident, Dr. Sanders?
A. I could have. Like I said, they switched services all the time.
Q. Okay. Do you typically dictate the Discharge Summary?
A. No, the house staff would.
Q. So that would include the interns and residents?
A. Typically, the resident does it, but it could be the intern.
Q. Now, page two indicates that it was

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electronically signed by you?
A. Yes.
Q. Does that mean that you reviewed it at the time?
A. At the time, I read it, I'm sure.
Q. And that it was accurate?
MS. SEAMAN: Objection.
A. I don't know.
Q. Well, what does your signature on that document mean?
A. It means that I read the document.
Q. Okay. If you had disagreed with the document --
A. I would have edited it before I signed it.
Q. Okay. And have you had a chance to review the contents of the entire documents?
A. No, but ask your question.
Q. Well, my question is after having reviewed the contents of the entire document, does it refresh your recollection as to any of the care and treatment of Mrs. Marsala?
MS. SEAMAN: Objection; argumentative. Do you have any other question?
MR. VIRGIL: I'm waiting to see if she has an answer.
MS. SEAMAN: We've been here since 10:30 with her telling you, without your bothering to show any

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of the thousands of pages of medical records that have been produced, anything. And she's been telling you about her recollection. So what precisely is your question?
A. Now I remember that she had GI bleeding, which is even more -- another forgotten detail. Oh, and the lumbar puncture you were asking about, her husband declined. I didn't remember that. Hmm. "Didn't want to pursue lumbar puncture as aggressive, but wanted" --
MS. SEAMAN: Can we take a minute?
(R E C E S S)
BY MR. VIRGIL:
Q. Does that refresh your recollection -- after reviewing Plaintiff's Exhibit 8, does that refresh your recollection as to whether or not you had any discussions with Mr. Marsala about the use of the tracheotomy?
A. No, because it just says that it was discussed with him, that a tracheotomy was not pursued for her poor prognosis. July 7th, that would have been before I was the attending.
Q. Okay. And does this document refresh your recollection as to any of Mr. Marsala's insistence that aggressive measures be undertaken to resuscitate Mrs. Marsala?

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A. I don't think there was any doubt that he wanted her to have things done. It says right there.
Q. Have you ever reviewed the regulations related to the entry of a DNR under Connecticut law?
A. Not that I recall.
Q. Have you ever given any lectures on end-of-life care?
A. No.
Q. Have you ever attended any seminars related to end-of-life care?
A. You asked that before and I said I didn't remember.
MR. VIRGIL: I have no further questions.
MS. SEAMAN: I have just a few. I'd like to mark this as 3A.
(PLAINTIFF'S EXHIBIT 3A FOR IDENTIFICATION Received and Marked.)
CROSS-EXAMINATION
BY MS. SEAMAN:
Q. Doctor, these are the documents that were attached to the exhibit --
A. Mm-hmm.
Q. -- on your affidavit that's been marked as Exhibit 3. And excerpts from Exhibit 3A have been used by Attorney Virgil in connection with some questioning.

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Could you look at those, that stack, and verify that they are indeed all Yale-New Haven Hospital records?.
A. You want me to read them all --
Q. Ask you to just leaf through them and make sure.
A. Yes. This is how they print out?
Q. I know.
A. It's confusing. Because when you are on, you don't see all this. It looks like duplicative.
Q. Things get printed, it looks like over and over, so...
A. These look all like nursing notes.
(DISCUSSION HELD OFF THE RECORD.)
A. Where do you see the date on here?
Q. They're at different places. Keep going and I'll show you in he next one?
A. This is the date it was printed, it looks like.
Q. Yes. So here's the date.
MR. VIRGIL: Would you like me to stipulate that they're all Yale-New Haven Hospital records of Mrs. Marsala.
MS. SEAMAN: Are you comfortable doing that?
MR. VIRGIL: I have reviewed all of them. They are.
MS. SEAMAN: Okay.
Q. You testified -- hold on one second. You

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testified that when you took over the care of Mrs. Marsala, you talked to physicians at Griffin Hospital, is that correct?
A. Yes.
Q. And it was your understanding that she had been admitted to Griffin with altered mental status and acute renal failure?
MR. VIRGIL: Objection.
A. I don't remember.
Q. Okay. You're looking at a note --
A. I'm trying to see if this is the admission note. "History and Physical 6/19," but she -- I guess she was in Griffin 5/24 and came to us on 6/19.
Q. I think that's right. And this note is written by Dr. Siegal, is that correct?
A. Yes.
Q. And on page 16, Dr. Siegal notes that "She was admitted to Griffin in late May with abdominal pain, and found to have colitis. She has had a long hospital course, which has included prolonged respiratory failure and failure to wean. And GI bleeding thought to be due do ischemic colitic," correct?
A. Yes. And shock required vasopressors, which I had forgotten as well.
Q. The medical records from Yale-New Haven Hospital

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indicate that the plan on admission was to conduct a workup with the hope that the cause of her altered mental status could be identified and reversed. Is that correct?
A. Yes.
Q. Were you successful in the efforts to identify the cause of her altered mental status?
A. No.
Q. Were you able to reverse her comatose state?
A. No.
Q. Does the fact that she had been comatose and intubated for over a month, does that have a prognosticating -- is there any prognosis that can be made from the fact that somebody has altered mental status for a long time?
A. Well, there's literature that looks at it. But it is usually in patients with stroke. But in general, yes, the longer you are obtunded, the less likely you're going to ever come around.
Q. And you testified that you thought that there was no meaningful possibility that she could have recovered as of the date that you were treating her in late July 2010. Correct?
MR. VIRGIL: Objection.
A. Yes.

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Q. And what is the basis for that opinion?
A. The medical record, examining the patients --
Q. No, but what in her medical history, or in her records, suggested that she wasn't going to get better?
A. The medical facts.
Q. Okay. I'm going to try again. As of the time you were treating her in late July, when you decided to go to the Ethics Committee, you went because Mr. Marsala didn't want to discontinue her care and you thought further care would be futile, --
MR. VIRGIL: Objection.
Q. -- is that correct?
A. Correct.
Q. Because you thought there wasn't a meaningful possibility that she was going to get better?
MR. VIRGIL: Objection.
A. Correct.
Q. And what was it about her condition that caused you to believe there was no meaningful possibility she would get better?
A. Because she had multiorgan failure and altered mental status that didn't get better, despite us doing everything we could possibly think of.
Q. Okay. We all have heard stories about people who were in a coma for a while, and then they wake up,

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they're either fine forever or fine for awhile, right? You've heard those stories?
A. I wish I could see those patients.
Q. Okay. Why wouldn't this patient do that?
A. Multiple reasons. Do you want them?
Q. Yes.
A. Her age, the time that it had been going on, and her multiple comorbidities. She had had multiple infections. She had had GI bleeding. She had -- her heart wasn't working; she was requiring vasopressors to keep her blood pressure up intermittently, now that I get to look at the records. Those are the reasons that we speculated on.
Q. Those were the reasons you were speculating was causing her mental status to remain --
A. Well, no, those were all the reasons that we thought she wasn't going to get better. So typically, you know, we do everything we can to get somebody better. And at some point, there's nothing left to do.
Q. And were you comfortable that you had reached the point that there was nothing left that could be done for Mrs. Marsala?
A. I personally was comfortable.
Q. Okay. And the Ethics Committee was comfortable, is that true?

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A. Yes.
Q. And the second opinion, do you know Dr. Rodrigues?
A. Yeah, I know him.
Q. And he was -- he gave the second opinion, correct?
A. I think so. Like I -- I wasn't there when that happened, but I think I remember hearing that.
Q. Let me show you a document. Directing your attention to pages 46 and 47 in Exhibit 3A, this is consultation requested by Dr. Tenuey (phonetic), right?
A. Yes.
Q. She's another pulmonologist, is that correct?
A. Yes.
Q. And this is a note that runs on a page and a half, and it's signed by Dr. Rodrigues, correct?
A. Yes.
Q. And this is the second opinion that you had referred to before?
A. Yes.
Q. And Dr. Rodrigues says that he concurs with the decision of the primary team. That would be you and your treatment team, correct?
A. Yes. Well, actually, it would have been Dr. Tenuey and the treatment team at that point, because I

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was off of the service, she was making the consult.
Q. Okay. And he concurs with the Ethics Committee, correct?
A. Yes.
Q. And that "Further attempts at therapeutic intervention do not offer a chance of a better outcome." You see that?
A. Yes.
Q. Essentially, he's saying further attempts would be futile, correct?
MR. VIRGIL: Objection.
A. Yes.
Q. "Re-intubation, ongoing use of BIPAP, based on both asynchrony" -- what does that mean?
A. Asynchrony, it means that the machine is trying to provide the back breath, and the patient is fighting against it, or breathing out as the machine is trying to breathe in.
Q. So what Dr. Rodrigues says is re-intubation, ongoing use of BIPAP, is not warranted, correct?
A. Yes.
Q. And he agreed that comfort would -- Comfort Care Plan would be the most appropriate, correct?
A. Yes.
Q. And there's a note here that he tried to reach

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the husband on the cell phone and was unable to do that, correct?
A. Yes.
Q. And on occasion, you recall trying to reach the husband and being unable to reach him on the cell phone, correct?
A. Yes.
Q. I think you've testified that you don't have a specific recollection of a time prior to the time you were taking care of Mrs. Marsala, when you and a family disagreed upon the appropriate course of treatment and you then went to the Ethics Committee. Is that correct?
A. Yes.
Q. Is that a common occurrence in your practice, that is, that the family and the treatment team cannot come together in a decision about what is best for the patient?
A. No, because we try to avoid it at all costs.
Q. And what did you do in this case to try to avoid having to go to the Ethics Committee instead of reaching an agreement about the appropriate course for Mrs. Marsala's care?
A. Well, we met with the husband and, you know, explained the situation, and then tried to continue to update him. Unfortunately, at some point, he stopped

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answering our phone calls and had stopped coming in.
Q. And you did have several conversations with him, is that correct?
A. Well, the one I remember really is the one I've already told you about, which is the one meeting that we had with Nursing, just because I can picture that meeting.
Q. Okay. But you made attempts to reach him on other occasions to try to discuss, as you call them, the medical facts, --
A. Yes.
Q. -- is that correct? Let me show you another page. Let me show you a document that's dated July 16, 2010, 1403, and ask if you can identify that as one of your notes contained within the medical record?
A. Yes.
Q. Okay. And in that note, you talk about your family meeting with Mr. Marsala, correct?
A. Yes.
Q. And that's on or about July 16, 2010, correct?
A. Yes.
Q. And is this the not -- or is this the meeting that you're remembering?
A. Let me read it.
Yes.

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Q. Okay. And this note says that he does not -- "Mr. Marsala does not feel ready to let Mrs. Marsala go," correct?
A. Yes.
Q. And he told you that he didn't want the children to bear the burden of having to make the decision to terminate her care. Correct?
A. Yes.
Q. He felt it was his decision to make?
A. Yes. That's the one specific thing I remember. Clearly, I -- forget it, you're not asking me a question. Never mind.
Q. But you understood that he didn't want to burden his children with having to make the decision to terminate the supportive care that their mother was receiving, correct?
A. Yes.
Q. Your note says that you told him she was never going to leave the hospital, correct?
A. Yes.
Q. And you explained the medical situation, you did your best to explain to him what was going o, correct?
A. Yes.
Q. And in that meeting, you talked about a tracheostomy?

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A. Yes.
Q. And would it be correct that you told him at that time that a tracheostomy wasn't going to work because she had multiple organs that were not working at the time?
A. Yes.
Q. Right, because she had so many things going on, that it wasn't just a matter of having something breathe for her, correct?
A. Yes.
Q. And you asked him whether -- you asked him whether Mrs. Marsala wanted -- would have wanted to be maintained in the condition that she was in. Correct?
A. Yes.
Q. And among other things, her limbs were contracting by that time, is that true?
A. Oh, I don't remember.
Q. Do you recall? Let me ask you to assume that the Nursing Notes talk about her limbs contracting, and at least at some point being unable to move her lower extremities. Assume that to be true. What would cause somebody who is comatose to have contraction in their limbs?
A. Malnutrition, not, you know -- just being bed bound for so long. Could be a central nervous system

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process.
Q. Once your limbs start contracting, in a comatose patient, are they likely to recover their muscle function?
A. No.
Q. Mrs. Marsala also had skin breakdown pretty much all over her body, is that correct?
A. Yes.
Q. Why is that?
A. Probably malnutrition, and she had been on, now that I look at the record, had been on vasopressors, or blood medicine to keep your blood pressure up, which also then affects the blood profusion to parts of your -- certain parts of your body, so it diverts it from your skin to your internal organs, so you get skin breakdown, you get like necrosis of your digits from them.
Q. Okay. And the records indicate that during the time she was at Yale-New Haven Hospital, she developed more and more areas on her skin where there was breakdown. Is that consistent with somebody who is getting worse?
A. Yes.
Q. Once the skin breakdown happens, is that something that should be reversed, or reversible, if the

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patient is on a ventilator?
A. Well, the ventilator doesn't affect the skin breakdown. You need to improve nutrition, you need to get somebody mobilized, you know, fix the hypotension so they're not on the vasopressors.
Q. Okay. Was there any realistic possibility that a patient like Mrs. Marsala could have been transferred in late July to another facility?
A. I'm not sure who would have taken her.
Q. In fact, she had been transferred from Griffin to Yale, correct?
A. Yes. She was sent to us for further -- now that I look at Dr. Siegal's note in this packet, for altered mental status.
Q. And she was transferred, at least partially, because Griffin had recommended to the family that they terminate care there, correct?
A. Yes.
Q. So in essence, Mr. Marsala asked to have her transferred to Yale New Haven Hospital to try another facility that might help to reverse her bad condition, correct?
A. Yes.
Q. Given that Griffin Hospital had recommended a termination of care, Yale-New Haven Hospital recommended

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a termination of care, what facility in the state would have been likely to take this patient if Mr. Marsala had tried to transfer her?
MR. VIRGIL: Objection.
Q. Based on your experience?
A. Well, none, because usually, they flow to us, and not away from us.
Q. So usually, Yale-New Haven Hospital --
A. Usually we're the accepting for everything else nobody wants.
Q. And based on your opinion, it's more likely than not there would be no other institution in the state that would accept a patient who was transferred after almost two months of a coma with multiorgan failure, who was dependent on a ventilator, and who required hemodialysis. Is that --
MR. VIRGIL: Objection.
A. I'm -- I couldn't see being able to sell that transfer as the transferring physician to somebody else.
Q. The note in the record indicates that Dr. Jeng -- is it Grace Jeng?
A. Jenq. There's a Q at the end, Jenq.
Q. Jenq, sorry. Attempted to reach Mr. Marsala to explain to him the decision of the Ethics Committee. And Dr. Rodrigues, who gave the second opinion, also

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attempted to reach Mrs. Marsala. Typically, would you also contact the family of the patient to explain the Ethics Committee recommendation, or the second opinion recommendation, if those -- if the Ethics --
A. No, they usually -- I mean, I don't -- I would give him my recommendations, but whoever else makes their other recommendations should talk to the person directly.
Q. Okay. You were asked whether Mrs. Marsala ever received a tracheostomy. For somebody who is having skin breakdown, are there any risks in a tracheostomy?
A. Well, there's risks regardless of the skin breakdown. You know, there's risks of bleeding, there's risk of infection. There's risks of injuring the airway.
Q. For a patient like Mrs. Marsala, who's already having skin breakdown, is that a contraindication to doing a surgical procedure?
A. The skin breakdown in itself is not a contraindication. But the contraindication from the surgeon's standpoint would be, you know, again, end point, what is our end point, like what are we hoping to achieve by doing it. So they don't do surgical procedures on people without end point.
Q. If a patient has passed a weaning trial, would

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there ever been a reason you'd put her -- give her a tracheostomy?
A. So if they had -- you just want me to speculate again?
Q. No. Let me ask it a different way. In this case, after Mrs. Marsala had been intubated awhile, she passed the weaning trials, correct?
A. Yes.
Q. And the standard approach is that for an intubated patient, if she passes weaning trials, that would be an indication that she could be safely extubated. Is that --
A. Yes.
Q. -- correct? For a patient where there are indications that they can be safely extubated, is there a reason you would give them a tracheostomy?
A. No.
Q. All things being considered, you'd rather be extubated than have a tracheostomy or be ventilated, right?
A. Yes.
Q. The Ethics Committee states in the note, "No escalation of care. Specifically, don't re-intubate Mrs. Marsala." But they don't necessarily say Comfort Care Only. Is there a difference? Can you explain what

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the difference to that, between those two things, would be?
A. Well, "no escalation" could mea -- like say she was already on a blood pressure medicine, but we weren't going to increase it, we'd just keep her at that same level. Whereas Comfort Care could mean if she were on it, and we decided to not -- to withdraw it. So in her case, we didn't withdraw anything. We just didn't add anything back on. That's kind of -- no escalation is don't add anything new on that's not currently present.
Q. The records indicated that several hours after the Ethics Committee note, the BIPAP was discontinued. They also indicate that there was skin breakdown around the mask of the BIPAP. Is the removal of the BIPAP something that would be consistent with Comfort Care Only?
A. I'm not sure I understand the question.
Q. You said that Comfort Care Only doesn't mean you remove anything. In this case, the BIPAP --
A. You can, you do remove stuff, you can remove stuff for someone's comfort. I mean, it's just a wording issue. Like no escalation, versus Comfort Care Only. It's individualized.
Q. Okay. Why would the BIPAP be removed for a patient who is Comfort Care Only?

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A. Because it can be uncomfortable.
Q. Okay.
A. And if the goal is to not escalate care, we want to do everything to make them comfortable.
Q. Okay.
A. And if you -- I don't know, whoever the Nursing Note was, whatever note -- oh, Dr. Rodrigues, where she was not synchronizing with the BIPAP, she was asynchronous, that's an indication of discomfort.
Q. That the patient is in discomfort?
A. (Affirmative nod.)
Q. Are there other ways that a physician can tell whether a comatose patient is having discomfort or is in pain?
A. It's really hard.
Q. Any signs at all?
A. No. We used to think that you could look at vital signs and assess it. But there's some studies now that suggest that that doesn't really correlate so well.
Q. Your affidavit states, paragraph 17, that "The decision to extubate Mrs. Marsala and recommend to the Ethics Committee that she not be reintubated was made only with concern for the best course of treatment for her." Is that true?
A. Yes.

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Q. Did you at any time intend to cause the Marsala family emotional distress?
A. No. I mean, typically, we try to avoid it by, you know, helping them come to terms with the fact that it's the end of the patient's life, with meeting, you know, with them, with providing support through social work, or chaplain, or whatever, depending on the situation. So it's one of the things we actually pride ourselves on, I think, is that we try really hard, A, first thing, is our obligation too the patient, to do what's best for them; and then the second thing is to make sure, you know, that the family is taken care of as well.
Q. And you did that in this case, that is, you tried to make your best effort to communicate with Mr. Marsala, correct?
A. Yes.
MR. VIRGIL: Objection.
Q. And he's the only family member that you recall, as you sit here now, where you were unable to reach agreement as to the care of his loved one. Is that true?
A. Ever?
Q. In your -- yes.
A. The only one who never, ever, came around, yes.

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Other times, it takes several meetings for people to accept things. But, yes.
Q. And in this case, the records indicate there were numerous contacts with Mr. Marsala in an effort to have him come around to understand the recommendations, correct?
A. Yes.
Q. So he wasn't deprived of the opportunity for conversation to learn about the medical facts and the basis for the recommendation, correct?
A. No.
Q. Did you do everything you could to try to avoid any kinds of distress to Mr. Marsala?
MR. VIRGIL: Objection.
A. Yes.
MS. SEAMAN: I have nothing further.
REDIRECT EXAMINATION
BY MR. VIRGIL:
Q. Mrs. Marsala didn't have a opportunity -- well, withdrawn.
There wasn't an opportunity to find out if Mrs. Marsala would be one of those patients who spontaneously came out of a coma months after being in one because that opportunity was taken away from her when she was extubated and there was a refusal to intubate her --

MS. SEAMAN: Objection.
Q. -- re-intubate letter, correct?
A. Can you say that again?
Q. Sure. Mrs. Marsala was denied the opportunity to find out if -- denied the opportunity to become one of those -- potential become one of those patients who spontaneously comes out of a coma, because she was extubated and then there was a refusal to re-intubate her, correct?
A. I think if anybody thought there was any chance that she would be one of those spontaneous patients, we would have kept doing everything we could have.
Q. Right. But any opportunity to find out if she would have been was denied when the decision was made not to re-intubate her?
MS. SEAMAN: Objection; argumentative.
A. I don't know.
Q. And you don't know whether or not another facility would have taken her as a transfer because you never called another facility?
A. I did not call another facility.
Q. You didn't make any efforts to have Mrs. Marsala transferred, did you?
A. Not to the best of my knowledge.
MR. VIRGIL: That's all I have. Thanks for

your time, Doctor.
(PLAINTIFF'S EXHIBIT 9 FOR IDENTIFICATION Received and Marked.)
(WHEREUPON, the deposition was concluded at 2:30 p.m.)

WITNESS INDEX

PLAINTIFF'S EXHIBIT INDEX

(Exhibits maintained in possession of Attorney Virgil.)

JURAT

_____
Deponent: DR. MARGARET PISANI

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority, on this the _____ day of _____, 2014.

_____
Notary Public

My commission expires:

CERTIFICATE

I hereby certify that I am a Notary Public in and for the State of Connecticut duly commissioned and qualified to administer oaths.

I further certify that the deponent named in the foregoing deposition was by me duly sworn and thereupon testified as appears in the foregoing deposition; that said deposition was taken by me stenographically in the presence of counsel and transcribed by means of computer-aided transcription by the undersigned, and the foregoing is a true and accurate transcript of the testimony.

I further certify that I am neither of counsel nor attorney to either of the parties to said suit, nor of either counsel in said suit, nor related to or employed by any of the parties or counsel to said suit, nor am I interested in the outcome of said cause.

Witness my hand and seal as Notary Public this 12th day of September, 2014.

Julia Tupper Cashman

NOTARY PUBLIC

My commission expires: 11/30/17

SUPERIOR COURT
JUDICIAL DISTRICT OF MILFORD/ANSONIA
AT MILFORD

CLARENCE MARSALA, Administrator of the Estate of HELEN MARSALA, et al., Plaintiffs	:	
VS	:	CV12-6010861S
YALE-NEW HAVEN HOSPITAL, INC., Defendant	:	

Deposition of GARY MARSALA taken at the offices of Zeldes, Needle & Cooper, 1000 Lafayette Boulevard, Bridgeport, Connecticut 06601-1740, before Clifford Edwards, LSR, Connecticut License No. SHR.407, a Professional Shorthand Reporter and Notary Public, in and for the State of Connecticut on June 16, 2014, at 11:52 a.m.

DEL VECCHIO REPORTING SERVICES, LLC
PROFESSIONAL SHORTHAND REPORTERS
117 RANDI DRIVE
MADISON, CT 06443

HARTFORD NEW HAVEN STAMFORD

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

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STIPULATIONS

IT IS HEREBY STIPULATED AND AGREED by and between counsel representing the parties that each party reserves the right to make specific objections at the trial of the case to each and every question asked and of the answers given thereto by the deponent, reserving the right to move to strike out where applicable, except as to such objections as are directed to the form of the question.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing the respective parties that proof of the official authority of the Notary Public before whom this deposition is taken is waived.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing the respective parties that the reading and signing of this deposition by the deponent is not waived.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing parties that all defects, if any, as to the notice of the taking of the deposition are waived.

Filing of the Notice of Deposition with the original transcript is waived.

GARY MARSALA

residing at 15 Glen Circle, Seymour, Connecticut, having first been duly sworn, deposed and testified as follows:

DIRECT EXAMINATION

BY MR. CHENEY:

Q Hi, Gary. We just met off the record --

A Hi.

Q -- but I just wanted to introduce myself again. My name is Ben Cheney. A few things to go over first just to make this whole thing go smoother is that Cliff is going to be writing down everything we say.

A Okay.

Q So he can't take down a shake of the head or a nod of the head, so if you would just answer verbally?

A Right. Got you.

Q The second thing is that I'm going to be asking you a series of questions. If you could wait for me to finish before answering that will, again, make it a cleaner transcript later.

A Okay.

Q The third thing is if I ask you a question and you don't understand it, just ask me to repeat it --

A Okay.

Q -- and I will.

And if you need a break at any point, just let me know and we'll take a break.

A Okay.

Q I don't anticipate us being here too long.

A Okay.

Q So to get started let me just get some background information about you.

What's your date of birth?

A 5/14/65.

Q And you live at 15 Glen Circle in Seymour, Connecticut?

A Yes.

Q And how long have you lived at 15 Glen Circle?

A Seven years.

Q So you were living there in 2010?

A Correct.

Q How far away is your house from your father's house in Seymour?

A Two minutes driving.

Q Are you over there a lot?

A Yeah.

Q You are married to Fran?

A Correct.

Q How long have you and Fran been married?

A Ten years.

Q And you have a daughter?

A Correct.

Q Julia?

A Correct.

Q And how old is Julia?

A Seven.

Q Where do you work?

A Turtle & Hughes.

Q And what do you do there?

A Truck driver, sales.

Q What kind of company is Turtle & Hughes?

A It's an electrical distributor.

Q How long have you lived there -- worked there?

A Technically, I do live there.

May it will be 15 years.

Q Okay. So you were working there in the summer of 2010?
A Correct.
Q And where is Turtle & Hughes?
A Union Street, New Haven.
Q How long is your commute from Seymour to Union Street?
A Twenty minutes.
Q Did you go to high school?
A Yes.
Q Where did you go?
A Trumbull High.
Q What year did you graduate?
A Unfortunately, I didn't graduate.
Q Okay.
A But I would have been graduated in '93.
Q Any other education besides Trumbull High?
A No.
Q Are you close with your brothers and sister?
A Yes.
Q How often do you see Michael?
A When he's at my father's, basically. I don't -- he's the one I see the least.

Q Once a month?
A Yeah, once a month.
Q Okay. And how often do you see Kevin?
A Kevin I see all -- you know, a couple times a week. Talk to him on the phone.
Q Okay. Same with Clarence, your father?
A Every day. Not --
Q Every day?
A I talk to him every day, I don't see him every day.
Q And your sister, Tracy?
A I don't know if you know the situation but she can't hear or hardly see so we do most of our communications e-mails, Facebook, and that kind of stuff. I see her when I'm over there.
Q All right. Okay.
A But I mean, I communicate with her, you know, every other day.
Q Are you able to sign with her or anything with --
A I don't know sign language, she knows sign language.
Q Okay.
A I usually, like I said, she can see the computer somehow but I'll, like, write notes to her

and stuff like that.
Q Okay. And how about Randy?
A Randy I see a lot because he has a -- is his son nine? Yeah, a nine year-old son so --
Q So Julia and Anthony --
A Right. Yeah.
Q -- get together?
A Correct.
Q Is anyone in your family employed in the medical field?
A No.
Q Does anyone have any medical education or training?
A No.
Q Have you ever been involved in litigation besides from this case?
A I think, like, years ago there was a car accident that went on. That was probably 30 years ago.
Q Can you be more specific?
A It didn't go to like trial or court or anything like that. It was just some kind of settlement.
Q Were you injured in that accident?
A I was injured, yes.

Q Did you have your deposition taken?
A Yes, I think there was a deposition taken.
Q Do you remember any more specifics about where that case was filed or what year it was?
A I know my attorney's name was Zanella, Vincent Zanella. I mean, it had to be 15 years ago, at least. Maybe not quite 30 but --
Q Okay. And the case --
A It was in Bridgeport. I mean, I think I took a deposition in Bridgeport maybe.
Q And the case settled, you said?
A Yeah. They paid for my car or something like that. There was nothing major.
Q Okay. Were you compensated for any injuries?
A No, I don't think so. No.
Q Okay. Have you ever been arrested?
MR. VIRGIL: Let's stop. All right. He's not going to answer about arrests but if you want to ask him about felony convictions you can go right ahead.
BY MR. CHENEY:
Q Have you ever been convicted of a felony?

A No.
MR. CHENEY: I'm going to mark your Notice of Deposition as Defendant's Exhibit 1.
(THEREUPON, DEFENDANT'S EXHIBIT NO. 1, NOTICE OF DEPOSITION, WAS MARKED FOR IDENTIFICATION.)
BY MR. CHENEY:
Q So I've marked your Notice of Deposition as Defense Exhibit 1. And I see you are looking at the second page, which has a list of things that we asked you to bring with you here today.
Did you bring anything with you here today?
A No. I don't have any -- none of this.
Q And you don't have any of these?
A No. This would all be with my father, if anybody.
Q Do you keep a diary?
A No.
MR. VIRGIL: That's it.
THE WITNESS: Yeah. No to all of them.
BY MR. CHENEY:
Q Do you remember your mother breaking her

hip?
A Vaguely but, yes, I do remember it.
Q Do you know what year that was?
A It must have been 2009, 2010.
Q Okay.
A Somewhere in there.
Q Prior to that, how was your mother's health?
A Other than diabetes, she was fine.
Q And when she broke her hip that first time, she went to Griffin Hospital.
Correct?
A Correct. In the emergency room.
Q And then she was admitted and stayed at the hospital for --
A Correct.
Q Did you visit her in the hospital when she was in with the broken hip?
A Yes.
Q And how frequently did you visit her?
A Well, I was -- we are talking with the broken hip now?
Q Yeah. Just with the broken hip?
A Well, she was only in there with the broken hip for like two days.

Q Oh, okay.
A The only reason why they kept her is because of her age, I guess.
Q And you saw her in the hospital?
A I was there, you know, both days, you know.
Q And was she discharged home after that? Did she go home after that?
A She went home, yes.
Q Okay. And then later on she went back to Griffin Hospital.
Correct?
A Correct.
Q And why did she go back to Griffin Hospital?
A I think she had some -- something with her wrist or something. She might have broke her wrist or something or she hurt her wrist or something.
Q When she broke her hip were you present?
A No.
Q Were you present when she broke her wrist?
A No.
Q Do you know how long she was home between

the time when she broke her hip and when she went to Griffin Hospital for the broken wrist?
A No. I'd be guessing.
Q How long was she in the hospital when she broke her wrist?
A I think just another day, I think.
Q And then where did she go -- did she go home after that?
A She went home, yes.
Q Did she go to Griffin Hospital again?
A I don't think so. She might have not went home that second time with the wrist, I don't really know for sure. She might have stayed there. Because she caught something while she was in there or something.
Q Do you remember going to a rehabilitation facility?
A Yes. That was way after the -- way after the wrist thing.
Q After the wrist?
A After the wrist thing, yeah.
Q So I'm not trying to test your memory, I'm just trying to get a chronology for my own sake.
So she -- to your recollection, she broke her hip, she went home, she broke her wrist and then

what happened?
A I don't think she ever went home after she broke her wrist.
Q Okay. But then she went into a rehabilitation facility at some point after she broke her wrist?
A Yes, way after.
Because she caught some -- from what they are telling us, she caught some C. diff --
Q Okay.
A -- while she was in there with her wrist. So that's why I don't think she ever went home with the wrist because she started getting sick in there, you know, and that didn't have anything to do with her wrist.
Q So is it --
A They just kept her in there from that point on.
Q Okay.
A The wrist, I think.
Q And is it your impression that she went to the rehabilitation facility for the broken wrist?
A No.
Q She went there for a different reason?

A She went there because they thought they had beat the C. diff and it was time to move on to rehabilitate.
Q Okay.
A And then she went to rehabilitation and then, like, about, I don't know, about two weeks later they sent her back to the hospital. So I guess the symptoms started coming on with the C. diff again.
Q Thank you. That's helpful.
So when she was in the rehabilitation facility, what's the name of that facility?
A Oh, God. I don't remember. It's in Derby though.
Q Did you visit her when she was there?
A Yeah. I was there every day. You know, it's only ten minutes from my house.
Q Okay. And what about before that when she -- the Griffin Hospital admission where she had broken her wrist and then caught the C. diff --
A Right.
Q -- did you visit her then?
A Yeah. Often.
Q How often?
A Every day.

Q How did she seem to you during that -- we'll call it the broken wrist admission just to make things easier.
A She was fine during all that and the broken wrist thing.
Q Okay.
A It wasn't until the C. diff where, you know, she started getting sick.
Q And how did -- what did you notice about her that made you think that she was getting sick?
A Well, she wasn't eating, for one thing.
Q Okay.
A But other than that, I mean, it was just all, you know, medical stuff that I didn't, you know, know nothing about. They were basically telling us what was, you know, what was the matter with her.
Q Okay. And then at the rehabilitation center, how did she seem to you there?
A She wouldn't eat then. She wasn't eating. So that might be why they sent her back, I think, or -- she was fine except for, you know, not eating.
Q You were able to talk to her?
A Oh, yeah.

Q Okay.
A Yeah.
Q Did you see any other family -- during the broken wrist admission did you see any other family members at the hospital visiting?
A My dad, my sister, Kevin, and Randy. Like I said, Michael I don't see too often.
Q Did you ever see Michael visiting your mother at any point?
A Yeah, a couple times.
Q Okay.
A He was with my father.
Q Okay.
A And, you know, my wife and daughter, obviously.
Q Would they go with you to the hospital?
A I didn't take my daughter too often.
My wife went, I didn't take my daughter too often because I was afraid that -- because they told her what -- they told us what she caught, you know, infants and, you know, child, it's easy for them to get it so I kept my daughter away. You know, a couple times she went but other than that --
Q Okay. And what's your understanding of

why your mother was sent from rehab back to Griffin Hospital?
A From what I understand, the symptoms from C. diff.
Q Were you surprised that she was sent back or did it make sense to you?
A I think it made sense why they sent her back. I was surprised that they let her go to rehab so soon.
Q Okay. Was it your impression that she wasn't ready to go home at that point?
A Well, kind of, yeah. I mean, I think -- if it was me I would have kept her there a little longer just to make sure. But she was fine when they sent her there, talking, you know, she -- basically we thought she recovered from the C. Diff.
Q All right. And then how were her symptoms when they sent her back?
A I don't really know because they just did it and they called us and said, We sent your mother back to Griffin.
Q Okay.
A So I don't really know what her symptoms were. The last time I seen her in the

rehabilitation place the only thing I know for sure is she didn't want any --
Q Okay. But she was -- you were talking to her --
A Yeah, absolutely.
Q And --
A It was around Mother's Day, we bought her flowers and, you know --
Q And she was making sense --
A Yeah.
Q -- cognitive --
A Absolutely.
Q Okay. And then she went to Griffin Hospital.
And did you visit her at Griffin Hospital at the -- let's call it -- the last Griffin Hospital admission?
A Yes.
Q And how frequently did you visit her?
A Every day. Pretty much every day, yeah.
Q You were working in New Haven at the time?
A Yes.
Q So did you have a routine as to when you

would visit her?
A Excuse me.
I work really strange hours so I'd go to work at four in the morning and get out at noon. So I would -- I -- I had plenty of time to go over there --
Q Okay.
A -- after I get out of work so --
Q Okay. Did you talk to any doctors at Griffin Hospital during that last Griffin Hospital admission?
A I don't think so.
My father did, you know, talked to most of the doctors. I mean, I heard him talking but I didn't really talk to them personally just, you know, him and, you know, I.
Q Right. Do you remember any conversations between your father and the doctors that you overheard, any specifics regarding those conversations?
A No.
Q Do you know generally what they were talking about?
A That I've -- that they couldn't really do anything else for her. So that's how she ended

up -- my father decided to send her to Yale.
Q How long do you recall those conversations happening at Griffin before she was sent to Yale?
A I don't remember.
Q Did you talk to your dad about transferring her to Yale before she was transferred?
A We -- I think we just -- yes, we discussed it. I think we all agreed on it to try to send her somewhere else.
Q And why did you reach that determination?
A Well, I think because she wasn't getting better.
Q Why Yale?
A Reputation, I guess.
Q Had Tracy been in -- excuse me.
Had Tracy been at Yale-New Haven Hospital earlier in her life?
A I don't know. It's possible.
Q Prior to your mother's hospitalizations how frequently did you see her?
A Couple times a week. I talked to her every day, every morning.
Q And what sorts of things did you do

together?
A Dinner, mostly. Out to dinner. Casino once in a while. She would want to see my daughter too so I would take her over, you know, and let her see my daughter.
Q Your dad likes going to the casino. Right?
A He likes the casino, yes.
Q Would he often go alone or did you go with him and your mother go with him sometimes?
A My mother would go with him sometimes. I don't -- I don't go with him too often.
Q And your mother was a lunch lady back when she used to work?
A She was, like, some kind of lunchroom supervisor or something like that.
Q And do you know when she stopped doing that, approximately?
A No, I would definitely be guessing at that.
Q Was that her full-time job?
A Well, school year. So I guess --
Q Right.
A -- summers she had off.
Q Did she ever work as a child care

provider that you remember?
A We are talking 40 years ago, probably.
Q Okay.
A She used to work for a private family, I think, something like that. Just like a nanny kind of thing.
Q Okay. Got you. I think I asked you this but just to make sure: You -- did you have any conversations with any doctors at Griffin Hospital about your mother's care?
A No, not at Griffin.
Q Were you aware of any conversations at Griffin Hospital about removal of life support?
A No.
Q Do you remember your mother being on a ventilator, that is having a breathing tube?
A Yes.
Q And when during her admission was she put on a ventilator?
A I'd be guessing at that too. Not too long I don't think but I would be guessing for sure.
Q When she was on the ventilator were you able to talk with her?

A No. Because the tube was in her mouth but she understood -- her eyes were open and stuff.
Q And you could tell that she could understand what you were saying?
A Yes.
Q She would nod her head?
A Uh-huh. Yes.
Q Okay. What else would you do when you visited her at Griffin Hospital?
A Well, I would just talk. She couldn't talk back because of the thing in her mouth. She would listen, nod her head. Just sit with her.
Q Okay. Did you educate yourself in any manner about what C. diff is?
A I checked it out, yes. The best I could on-line.
Q Okay. Was that the only medical issue that you were aware of your mother having at that time?
A Other than diabetes, yeah.
Q Do you -- did you see doctors at Griffin Hospital?
A I would see them, I mean, come in and check on her and that kind of thing. I didn't

really talk to them too much.
Q You never asked them about what's this C. diff?
A Yeah, I asked them about that. I mean early -- early in the stages, you know, they told me and I went home and checked it out.
Q Did you tell any of your family members about C. diff?
A I'm not sure I told them but they all knew about it eventually. I'm -- I'm -- I probably told them, you know. I definitely told my father.
Q Based on your research and conversations with doctors, did you think that C. diff was a serious --
A Yes.
Q -- illness?
A Uh-huh.
Q Did you discuss the possibility of recovery or chances of recovery with any of the doctors?
A No. But she did recover from it because she went to -- well, they recovered -- she recovered enough for them to send her to rehab.

Q Okay. And then she went back to Griffin hospital after that?
A Correct.
Q But not for C. diff?
A Yes, for C. diff --
Q Okay.
A -- because the symptoms started coming back when she was in rehab.
Q Okay.
A She made it off life support at Griffin Hospital.
Q So just to clarify, she was on life support and had C. diff at Griffin Hospital?
A Right. She beat it enough to go to rehab.
Q She went to rehab and was not on life support?
A No.
Q When we are saying life support, we are talking --
A Well, breathing -- yeah, life support, breathing tube. She couldn't breathe on her own at Griffin Hospital.
Q Then she could?
A Then she could. They took her off of it,

she made it back enough to go to rehab.
Q And then she went back to Griffin Hospital without any sort of breathing tube?
A I don't know because I wasn't there when they sent her back.
Q Okay.
A They just said, your mother has started to get, you know, symptoms back from C. diff, we sent her to -- her blood pressure was going crazy or something. They -- we sent her back to Griffin.
Q And --
A And the next thing I knew she had the breathing tube again.
Q So the first time you saw her when you went -- when she was readmitted to Griffin Hospital, she had a breathing tube again?
A Correct. By the time I got there she was already back on the breathing tube.
Q And you saw her every day?
A Every day.
She was off breathing tube for probably a month --
Q Oh, okay.
A -- at the rehab place.
Q Okay. And aside from the C. diff, that's

the only medical issue you were aware of your mother having before her transfer to Yale?
A Yes.
Well, diabetes.
Q Okay. Asked and answered.
Do you remember any specific conversations you had with any family members during that time when he was at Griffin Hospital?
A Well, I'm sure I had some conversations I'm -- I don't really remember what they were.
Q Did you have any conversations about removal of life support at that time?
A She didn't want to come off life support. I didn't -- we decided, you know, from her wishes that we weren't going to take her off of life support.
Q And you said, "we decided," was that done in the context of a conversation, a family meeting, or anything like that?
A Oh, I wouldn't call it a family meeting but, you know, just there in the waiting room -- in the room with her.
Q And was she on life support at that time when you had that conversation?
A Yes.

Q Had you had similar conversations --
A This is all at Griffin now.
Q All at Griffin.
A Uh-huh.
Q Had you had similar conversations about removal of life support before that?
A Before she was sick?
Q Yeah.
A Yes. She said if she was ever in that situation, on life support, to make sure we keep her on life support.
Q She said that to you?
A Yes.
Well, she -- yes. She said it to me but she said it to, you know, everyone else too.
Q What was the context of her talking about that?
A Basically, I think she was more worried about my sister, about leaving my sister, you know. She was worried about who was going to take care of my sister.
Q Right.
A So --
Q So taking care of your sister, was her -- your understanding of her primary rationale for

wanting to stay on life support?
A I would say so, yes.
Q Were you aware of any religious convictions that she had that would influence that opinion?
A I -- she mentioned that, you know, like, God will decide what happens a few times. But other than that, you know --
Q Do -- to your knowledge, do you and all your family members hold similar views about removal from life support?
A I don't know about the other -- I don't know about, you know, my brothers or sister but I would want to stay on life support.
Q No matter what?
A No matter what.
Q Even if you knew that there was no chance of recovery?
A Well, there's always a chance of recovery as far as I'm concerned. I've seen -- my mother actually recovered, she came off life support.
Q In the time before your mother came off life support when she was at Griffin Hospital, do you remember there being any discussions amongst medical providers about removing life support?

A No. I don't think -- no.
Q Do you think that the physicians at Griffin Hospital were aware of her views on life support?
A I think so. Because a couple of her doctors were her, like, normal doctors.
Q She had treated with them previously?
A Right. For diabetes and, you know, I'm sure she must have discussed it at some time with them.
Q Right.
A I don't know for sure but I'm sure it come up. You know, I'm thinking it would have come up.
Q Were you involved at all in the process of transferring your mother from Griffin Hospital to Yale-New Haven Hospital?
A I just told my dad, I think it's a good idea to get her out -- to see if somebody else could help her.
Q Did you fill out any paperwork in conjunction with that?
A No. I didn't, no.
Q Did you ever pay any of your mother's medical bills or see any of your mother's medical

bills?
A No.
Q Were you aware of any sort of -- any application for financial assistance?
A No.
Q The medical records show that your mother was transferred to Yale-New Haven Hospital on June 18, 2010. Do you remember if you visited her that day?
A No, I don't remember if I visited her that day. That day --
Q Do you --
A I would say there's a good chance, yes, but I don't know for sure.
Q And you worked in New Haven at the time so once she was transferred to Yale, would you -- did you normally leave work and go directly to the hospital?
A Correct. Every day.
Q So when she was first transferred, do you remember where in the hospital she was located?
A In Yale?
Q Yeah.
A She was in the cancer the new part over there --

Q Smilow?
A Smiley -- Smilow.
Q Yeah.
A Yeah.
And the only reason I know is because I delivered a lot of electrical stuff there when they were building it.
Q Oh, okay.
A So that's where she was, ninth floor.
Q And you said that you normally -- during those -- during that time you were working from 4 a.m. until noon.
Is that correct?
A Correct.
Q So you would normally -- would you normally end up visiting her around the same time of day --
A Yes.
Q -- when you would visit her?
Would that be around lunchtime?
A Correct.
Q Did you see the same staff or personnel on duty at that time? Did you recognize people from day to day?
A I mean, I recognized some people but it

wasn't the same people every day.
Q Do you recall seeing family members visit your mother at Yale-New Haven Hospital?
A Yeah. My dad, Kevin, Randy, my sister -- well, you know, she went as best as she could.
Q Do you remember seeing Tracy there?
A Yeah, she was there.
Q Do you remember seeing Michael there?
A I saw Michael there maybe twice.
Q Do you remember any specific conversations you had with any of your family members when your mom was at Yale?
A No. Not specific conversations.
Q Do you remember discussing life support with any of your family members when your mom was at Yale?
A Before she got to Yale, like I say -- like we said, she didn't want to be taken off so we discussed that. We got to keep her -- that's her wishes so we got to keep her on it as long as we can.
Q All right. But not at Yale?
A Well, I mean, it's possible. But, I mean, sitting in the room, I mean, I'm sure we discussed it.

Q Right. And I'm not trying to test your memory, I just -- I guess in a way I'm just trying to -- I am testing your memory. I'm trying to see if -- I'm just trying to find out what you remember and any specifics you remember. So I apologize if any of this seems tedious or --
A That's all right. I understand.
Q Do you remember speaking with any doctors at Yale-New Haven Hospital?
A We had a meeting with the doctors -- I don't know -- I don't know none of their names -- but we had meeting -- one meeting with the doctors where they were basically, I think they were trying to tell us that she wasn't going to get better, we would have to thinking about starting -- you know, thinking about taking her off life support.
By the end of that meeting, we left there saying that we are keeping her on life support. We don't want to take her off no matter what and basically, they agreed to it.
Q Do you remember the date of this meeting?
A I couldn't give you an exact date but I would guess it was maybe a week before she passed,

something like that, two weeks -- two weeks at the most.
And then I had one other conversation with a doctor, a female doctor. It wasn't really a conversation, it was in the room with my mother. We were both standing there at her bedside and my mother was actually awake. She opened her eyes and she was tugging on the life -- on the tube.
And I said to the doctor, What's that all about? Why is she doing that?
And she said to me, That's your mother telling us that she doesn't want to live anymore. We are going to try taking her off, you know, off the breathing machine tonight.
And I went outside, called my father and I'm not exactly positive what he did from there. I know he went right there, whether it was that night or the day before.
Q Okay. So I want to ask you a little more about both these meetings so we'll start with the first one.
The meeting with the doctors, you said, a week or two before your mom passed?
A I would guess about a week or two, yeah.

Q And you said you don't remember any of the names of the doctors?
A No.
Q But how many doctors were there?
A I would be guessing at three.
Q And who else besides you and these three doctors were at this meeting?
A Myself, my father, I think Randy and Kevin were there. I don't really -- I'm not positive. I know Michael wasn't there and I know my sister wasn't there. I would say the rest of us were there.
Q Were you aware of this meeting before it happened?
A A day before.
Q How did you find out that this meeting was going to happen?
A My father.
Q He called you?
A Yeah, he called me.
Q And what did he tell you about what this meeting was going to be about?
A He didn't really tell us anything. He just said, The doctors want to talk to us about your mom's situation.

I just left it at that and met him at the hospital.
Q Did they give you any reasons why they were saying that -- they were raising the issue of removing her from life support?
A I don't remember.
They must have -- I don't know. No, I don't remember.
Q Did they give you any medical explanation for what was happening with her that was prompting this conversation?
A They just -- they were -- I guess they were just telling us that they don't think she was going to get better, the C. diff was -- basically took over her body. That was the gist of what I got out of it. I didn't do much talking, my father did all the talking.
Q Okay. Do you think there ever would have been a point where you would have been in favor of removing life support from your mother if she carried on in the same fashion as she was carrying on?
A No.
Q Where did this meeting occur?
A It was in like a little -- like a room

like this.
Q A conference room?
A A conference room, yeah.
Q Did you write anything down during this meeting?
A No.
Q Did any of your family members, did you see anyone writing anything down?
A I don't remember.
Q This -- the second conversation you said you remembered was with a female doctor?
A Correct.
Q And it was in your mother's room?
A Correct.
Q And your mother was present and you were present and the female doctor was present; anyone else in the room?
A No.
Q And so was this -- this wasn't a formal meeting?
A No.
Q Were you present and the female doctor walked in? I'm just trying to figure out how the conversation started.
A I think she was there and I walked in.

Q Okay. So was it around the middle of the day?
A It had -- yeah, it was probably between 12 and 12:30.
Q And was she -- what was she doing when you came in?
A I don't know. She was just, like, standing there, I guess. She wasn't doing nothing.
Q Okay.
A She was just looking at my mother.
Q Okay. And do you remember, specifically -- did you -- did you guys talk at all before your mother started --
A No.
Q -- pulling on the --
A No. This was the first time I saw this doctor, ever.
Q Okay. And you said at some point your mother was pulling on her tube?
A When I walked in she must have recognized my voice because she opened her eyes and she looked at me and then she started pulling on the tube.
Q And --
A And that -- she was -- the doctor was

standing there. And I said, you know, that's a good sign. Right? What's that all about?
And that's when she said, That's your mother saying that she doesn't want to live anymore.
Q Did your mother have any reaction to that?
A I don't think so. I mean, I don't know. I was looking at the doctor, I wasn't looking at my mother at that point but --
Q Right.
A I know her eyes were open and I know she recognized my voice.
Q What did you say when the doctor said that to you?
A I didn't say anything. I was basically stunned.
I went outside and called my father. And I told my father that I think they are thinking of taking mommy off of life support. And like I said, he took it from there.
Q Besides saying that that was an indication that your mother didn't want to live anymore, did the doctors say anything else to you?
A No. I don't remember, no.

Q And so you left the room and called your father?
A Right. Well, she said, I think we are going to take her -- I think we are going to try taking her off the machine tonight. And that was the last thing that doctor said to me.
Q And that was --
A Right after that she said, That's your mother trying to tell us she don't want to live anymore.
Q And that was the day before your mother passed away?
A Oh, that was no more than two days before.
Q Okay. And so you called your -- you left the room and called your father.
Correct?
A Correct.
Q And you explained to him this interaction you just had with the nurse?
A Correct.
Q And what did he say to you?
A He said, I'm coming right down there.
I don't know if he meant then. I don't know if he went right that day or he might have went

the next morning. That's kind of blurry what time -- when he went, exactly, there.
Q So you didn't wait to see if he came down or not?
A I stayed there for another, like, 45 minutes and then I left.
Q Okay.
A But he didn't show up in the next 45 minutes.
Q Okay. When the nurse -- sorry.
When the doctor said to you, We are thinking about taking her off life support; is that what she said?
A She said we are going to take her off -- she didn't say life support. She said, We are going to try taking her off the breathing machine, I think she called it, tonight see -- and see if she makes it, is basically what she said.
Q Were you aware that they had tried to take your mother off the breathing machine previously to see if she was going to be able to breathe on her own?
A I don't remember that. Not at -- not at -- not at Yale, they did that at Griffin a couple times.

Q But you weren't aware of that happening at Yale?
A No.
Q And when -- so when you left the hospital 45 minutes after this conversation, did you think that they were going to take your mother off the breathing machine?
A I would say yes because my father didn't get there yet. After my father went there he -- the next time I talked to my father after that conversation on the phone, he told me that he -- you know, he talked to the doctors and the people at Yale and they are going to keep your mother on life support.
Q Okay.
A Until we -- I made it clear to them we wanted to stay on life support.
Q Okay.
A And that was it.
Q So was it that night that you talked to him, do you remember?
A I don't know if it was that night or it could have been -- like I said, he could have went the next morning. But it wasn't no more than, you know, 48 hours after that point of meeting the

doctor.
Q That's when he called you and said I have straightened everything out?
A I straightened it out.
Q Okay. Had you been down to visit your mother between the time when you left after that conversation and when you had the phone conversation with your father?
A I don't remember. I don't think so, no.
I think that was the last time that I -- I -- I don't know. I don't think so.
Q Did you see your mother again after that conversation with the doctor?
A I don't remember. No, I -- if I have to say, I would say no. I'm not positive but I don't think so.
Q And when did you -- how did you find out that your mother had passed away?
A My dad called me.
Q And that was a separate phone conversation than the one where you said this whole thing has been straightened out?
A Yes.
Q How long after the "it's all been

straightened out" conversation did the other conversation occur?
A I don't remember. Like I said, two days at the most.
Q Okay.
A If that. I mean, I -- I don't know.
Q Okay. I have a calendar if you think that would help you --
A No.
Q -- but if you don't --
A That's not going to help.
Q Okay.
A No, that's not going to help.
Q Okay. Do you remember what time of day you got the call from your father saying that your mother had passed away?
A It was like -- it was, like, one in the morning, something like that. Just before one in the morning.
Q And what did he tell you during that conversation?
A He just said, Your mom passed away. It looks like they might have taken her off life support.
Q Were you surprised that he had said that

they might have taken her off life support?
A Yes.
Q Why?
A Because we left it with them -- well, not -- well, he was basically the last person to talk to them, to the doctors. He left it that no matter what she wants to stay on life support.
Q So earlier you said you would go to see your mother ever day --
A Yes.
Q -- after work when you were in New Haven but you think that a day or two might have passed where you didn't see your mother in between talking to this doctor and hearing that your mother was -- had been taken off life support?
A I'm not sure. It's possible but I'm not sure.
Q Okay. What was your reaction when you got this phone call from your father saying your mother had passed away?
A Well, first I was shocked and then upset. And I could see my wife and daughter visually getting upset. So a bunch of emotions running around, basically.
Q Were they -- were they awake?

A My daughter wasn't, my wife was laying right next to me.
Q All right.
A And then my daughter, I guess she must have heard -- she heard me crying or something and she was, like, What's the matter, Daddy? So we had to tell her then. Eventually she was awake at, you know, 1:30 in the morning.
Q Right.
A So we told her and she kind of understood. She was only four at the time, three at the time.
Q Right.
A So I was mad a little bit, you know.
Q Did you talk to any of your brothers or your sister after that about the fact that your mom had passed away?
A I called Kevin, I think, right after I finished talking to my father.
Q Okay.
A Because he couldn't get ahold of Kevin. And it turns out that I didn't get ahold of him either. I don't think Kevin knew until actually daylight, morning.
Q Okay. Did you leave Kevin a message?

A I'm sure I left him a message, yeah. I must have. I'm -- my father must have left a message too.
Q Right. Aside from the meeting with the doctors and the conversation with the female doctor, do you remember any other specific conversations with any doctors at Yale-New Haven Hospital?
A No.
Q Aside from exchanging pleasantries, do you remember any conversations with any nurses at Yale-New Haven Hospital?
A Not about her condition, no.
Like, I remembered one time the nurse was saying, you know, you could hold her hand while she was like changing or her or something like that. And the nurse said, you can hold her hand while I do this if you want. Just that kind of stuff.
Q Did you notice any sores on your mother's body?
A Just on her wrist from where I guess, you know, like IVs and stuff for having -- but that's -- I mean, that's normal.
Q Right. You don't know of any other sores that she had from being immobilized for so long, from not being able to move?

A No. I think somebody might have mentioned something about bed sores or something along -- but no. No.

No one ever came up to me and said your mother has got some sores on her or anything like that.

Q Right. Right. Were you aware of any issues your mother was having with her kidneys?

A Nope.

Q Or her liver?

A No.

Well, I mean, that -- I mean, I think that disease affected all that stuff.

Q Okay.

A From what I understand. I don't know for sure but --

Q What was your understanding of why your mother was on a breathing tube?

A Because she couldn't breathe on her own, which was kind of strange because she was awake a lots of the times while she was on the breathing tube.

Q So --

A Eyes open, I mean, by awake.

Q Right. During her admission at Yale-New

Haven Hospital you said she was able to make eye contact with you?

A A few times, yes.

Q A few times. Do you remember those specific times?

A Well, one was definitely the time that I was there with the doctor and she was saying about that, you know, your mother doesn't want to live and a couple other times before that.

She would recognize my voice. It had to be because of that.

Q Would you say more often she was able to make eye contact or more often she wasn't able to make eye contact?

A I would say it was about 50/50.

Q And would you you hold her hand when you went there?

A Yes.

Q And would she hold your hand back?

A Yes. She would squeeze.

She would -- as soon as I got there every day I would be, like, Mom, can you hear me?

And she would open her eyes and she would look at me and squeeze my hand. For the most -- sometimes she did it like every other day it seems

like it would happen.

Q Okay. Was there any sort of pattern to her recognition? As in was it getting better or was it getting worse?

A I think it was getting better.

Q You think that she was more responsive near the end of her time at Yale than she was at the beginning?

A Yes.

Q Okay. And what is that opinion based on?

A She opened her eyes two days before she passed away and -- I mean, if she would -- she would have said something to me if the tube wasn't down her mouth.

Q Back to this meeting with the female doctor or the conversation with the female doctor, she had said -- indicated to you that they were going to take your mom off life support and see she did.

Correct?

A She didn't say life support, she said "breathing machine."

Q Okay.

A "We are going to take your mom off

breathing machine tonight and see if she makes it," is exactly what came out of her mouth.

Q Okay. Did you say anything to her at that point?

A I think I said, I'm -- I -- I said, You better check with my father first, that's what I said.

Q Okay. Your father was mostly the one who communicated with the doctors.

Is that correct?

A Yeah. When my father says -- I learned long ago, when my father says, I'll take care of it, I stopped there.

Q Fair enough. I met your father so I --

A Then you know.

Q -- I understand.

So the doctors and nurses at Yale-New Haven Hospital probably knew that your father was the spokesperson for your family?

A Oh, yeah. Oh, yeah.

Q Okay. Has this event had an emotional impact on you?

A Yes.

Q In what way?

A I think about -- I think about it every

day about how my -- well, how I didn't get a chance to say goodbye, for one thing, my daughter didn't get a chance to say goodbye, and my wife didn't get a chance to say goodbye. Like I said, I used to call her every morning, sometimes I still pick up the phone and, you know, catch myself.

Every morning I called her, What are you doing, Ma?

Same thing I'm doing every other day, she would say.

Q Aside from, obviously, missing your mother, has it -- has this event had any other effect on your life?

A Well, I -- you know, I get angry once in a while, I get mad. The main thing is my daughter, she asks about her all the time. So it keeps coming, you know, Why didn't I get a chance to meet her?

Well, actually, she did meet her but she doesn't remember because she was like, you know, two and three but, you know, What happened -- she asks all the time, What happened to Noni, (phonetic) she used to call her. Around the holidays, you know, she'll ask, you know, so it comes up a lot now with my daughter.

Q Do you tell her about the whole lawsuit --

A No -- no. No.

Q And the removal of life support?

A No. No. No. Absolutely not.

Q Did you see anyone professionally about --

A No.

Q Why not?

A I don't know why not. I just figured I'd deal with it myself and my wife.

Q Did you take any time off of work?

A I missed almost a week of work, yes.

Q Did you have a funeral service for your mother?

A No.

Q Why not?

A My mother didn't like funerals, didn't believe in them. You know, my father is the same way. They both want to be, you know, cremated when the time comes, they didn't want a wake or none of that stuff. Just cremate me and, you know, that's it.

And that's what we did.

Q Did you get together as a family?

A Oh, yeah. Yeah.

Q Just not public?

A Just not public.

Q At the Greenwood Circle house?

A I think it was at my house, actually.

Q Okay.

A And then we all went to a funeral home and made the arrangements of her getting cremated and all that stuff.

Q Okay. Did you scatter her ashes?

A No. We put her ashes -- well, yeah, we put her ashes with her parents.

Q Okay. Was that a ceremonial event?

A It wasn't really ceremonial. We just all met at the hospital -- I mean, not at the hospital. I mean we met at the big cemetery down there in Bridgeport, Saint Michaels.

So we all met down there, put her ashes there, scattered her ashes, you know, said a prayer and basically that was it.

Q When you said "all," who all went?

A My father, my -- all of us except -- no, we were all there except my wife -- no, my wife was there too.

We were all there except Michael. I

don't think Michael was there.

Q So your father, Tracy --

A Yeah. Kevin --

Q Kevin --

A -- Randy --

Q -- Randy --

A -- my wife, my daughter was there too.

Q Anthony?

A I don't think Anthony was there.

Q Heather?

A I don't remember.

Q Okay. Did you ever have any sense of relief after life -- your mother was taken off life support?

A Relief? No.

Q Did you think that she was in pain?

A No.

Q And if she had remained in that condition, would you have ever advocated for the removal of life support?

A No, that's not what she wanted.

MR. CHENEY: Did I miss anything?

MR. VIRGIL: Nothing big.

MR. CHENEY: Okay. I think I'm all set.

THE WITNESS: All right.
MR. CHENEY: Thank you.
THE WITNESS: Thank you.
(THEREUPON, THE DEPOSITION WAS CONCLUDED AT 12:52 p.m.)

INDEX OF EXAMINATION

INDEX OF EXHIBITS

(Reporter's Note: Exhibits retained by counsel.)

CERTIFICATE

I hereby certify that I am a Notary Public, in and for the State of Connecticut, duly commissioned and qualified to administer oaths.

I further certify that the deponent named in the foregoing deposition was by me duly sworn, and thereupon testified as appears in the foregoing deposition; that said deposition was taken by me stenographically in the presence of counsel and reduced to typewriting under my direction, and the foregoing is a true and accurate transcript of the testimony.

I further certify that I am neither of counsel nor attorney to either of the parties to said suit, nor am I an employee of either party to said suit, nor of either counsel in said suit, nor am I interested in the outcome of said cause.

Witness my hand and seal as Notary Public this _____ day of _____, 2014.

_____
Clifford Edwards
Notary Public
My commission expires: 9/30/2016

JURAT

I have read the foregoing 61 pages and hereby acknowledge the same to be a true and correct record of the testimony.

_____
GARY MARSALA

Subscribed and sworn to
_____.
Before me this _____ day of _____, 2014.

_____
Notary Public
My Commission Expires:

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SENT TO: MR. VIRGIL on 6/30/14

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JUDICIAL DISTRICT OF MILFORD/ANSONIA
AT MILFORD
----------x
CLARENCE MARSALA, ADMINISTRATOR
OF THE ESTATE OF HELEN MARSALA, ET AL,

Plaintiffs,

vs. Case No. AAN-CV-12-601086-S
Date: March 25, 2014
YALE-NEW HAVEN HOSPITAL, INC.,
ET AL,
Defendants.
----------x

DEPOSITION OF KEVIN MARSALA

The deposition of Kevin Marsala was taken on March 25, 2014, beginning at 1:05 p.m., at the offices of Zeldes, Needle & Cooper, 1000 Lafayette Boulevard, Bridgeport, Connecticut, before Susan Wandzilak, Registered Professional Reporter and Notary Public in the State of Connecticut.

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NEW HAVEN STAMFORD HARTFORD

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Attorney for Defendants

STIPULATIONS

IT IS HEREBY STIPULATED AND AGREED by and between counsel representing the parties that each party reserves the right to make specific objections at the trial of the case to each and every question asked and of answers given thereto by the deponent, reserving the right to move to strike out where applicable, except as to such objections as are directed to the form of the question.

IT IS HEREBY STIPULATED AND AGREED by and between counsel representing the respective parties that proof of the official authority of the Notary Public before whom this deposition is taken is waived.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing the respective parties that the reading and signing of the deposition by the deponent is not waived.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing parties that all defects, if any, as to the notice of the taking of the deposition are waived.

Filing of the Notice of Deposition with the original transcript is waived.

KEVIN MARSALA,

having been first duly sworn, testified as follows:

THE COURT REPORTER: Would you please state your full name and address for the record.

THE WITNESS: Kevin, middle name Paul, last name Marsala. 22 Greenwood Circle, Seymour, Connecticut 06483.

DIRECT EXAMINATION

BY MR. CHENEY:

Q. Hi, Kevin. My name is Ben Cheney. We met off the record. I'm not sure whether you have ever been through this before. Have you ever had your deposition taken before?

A. I have not.

Q. So just a couple of things to keep in mind that will make this go easier. If you need a break at any point, just let me know. I'd ask that if a question is pending, that you answer the question and then take a break.

But if I ask you a question and you don't understand, please let me know that you don't understand it. Sometimes I ask terrible questions so they can be hard to understand.

A. All right.

Q. So just let me know that. And if we can try to talk one at a time just so that we can -- because everything is being written down.
A. Okay.
MR. CHENEY: So I'm going to start by showing you your notice of deposition.
(Whereupon, Defendant's Exhibit No. 1 was marked for identification.)
BY MR. CHENEY:
Q. So, Kevin, this is your notice of deposition. Have you seen this before?
A. No.
Q. It's basically just the thing that we sent your attorney requesting that you be here today. If you flip to page 2 of it, there are a list of things that we requested that you bring with you if you have them. If you would take a minute and read over that quickly?
A. Okay. Okay.
Q. I don't see anything. Did you bring anything with you today?
A. No.
Q. And do you possess anything on this list?
A. No.
Q. You didn't make any writings contemporaneous

with -- about your mother's hospitalization?
A. I did not.
Q. And do you keep a diary?
A. No.
Q. Okay. What is your date of birth?
A. 8/4/72.
Q. And where do you live?
A. Seymour, Connecticut.
Q. And who do you live with?
A. My father and my sister.
Q. And that's the Greenwood Avenue --
A. Greenwood Circle.
Q. And did you live there in July of 2010?
A. No, I did not.
Q. Where did you live in July of 2010?
A. In Newtown, Connecticut.
Q. And who did you live with?
A. My ex-wife.
Q. When did you get divorced?
A. July of last year.
Q. Do you have any children?
A. I do not.
Q. Did you go to high school?
A. I did.
Q. Where?

A. Trumbull High School.
Q. Did you go to college?
A. I went to a culinary school.
Q. And where is that?
A. Shelton, Connecticut?
Q. What was its name?
A. Center for Culinary Arts. I believe now it's called Lincoln.
Q. And when did you graduate the Center of Culinary Arts?
A. 2008, I believe.
Q. Did you get a job after that?
A. I did.
Q. And where was that?
A. Woodbridge Country Club?
Q. And what did you do at Woodbridge Country Club?
A. I was a grill cook and a snack bar manager.
Q. When did you get that job?
A. Right after I graduated from school.
Q. And how long did you work at Woodbridge Country Club?
A. About a year and a half.
Q. What did you do for work after Woodbridge Country Club?

A. I worked at the hotel.
Q. What hotel?
A. Courtyard by Marriott.
Q. And what were your duties there?
A. Cook.
Q. Where is the Courtyard by Marriott?
A. In Shelton, Connecticut.
Q. And how long did you work there?
A. About two years.
Q. So that would bring us to -- doing the math -- the middle of 2011?
A. Approximately.
Q. And what did you do after that for work?
A. I worked at a place called Trader Joe's.
Q. Grocery store?
A. Um-uh. In Danbury, Connecticut.
Q. And what did you do for Trader Joe's?
A. I was called a crew member.
Q. And how long did you work there?
A. About a year.
Q. And what did you do for work after Trader Joe's?
A. I worked at a bar as a cook. I, actually, had a few jobs jumping around being a cook in a few different places.

Q. A month, two months, sort of?
A. Well, more like five or six months.
Q. So the bar in Shelton, what was the name of the bar?
A. Jeremiah's.
Q. And where else?
A. A place called Danny O's.
Q. Anywhere else?
A. No.
Q. Okay. And so Danny O's was the last place you worked?
A. Yes.
Q. And when did you stop working at Danny O's?
A. I'm sorry. After Danny O's, I worked at a place called 160 Main Street in Newtown, Connecticut. And that ended in last July.
Q. And so if I can get the timeline straight, you left 160 last July at the same time that you got divorced from your ex-wife?
A. Yes.
Q. And then you moved to Greenwood Circle?
A. Correct.
Q. All around the same time, July of 2012?
A. Yes.
Q. Some family background just to make sure I

have got my facts straight.
A. Um-uh.
Q. We have talked to your father and your brother Michael so far.
A. All right.
Q. So I'm trying to piece together some of your family history. Did Michael go to -- I didn't ask him. Did he go to high school; do you know?
A. I'm sure he went to high school, yeah. Yeah, he went to high school, of course.
Q. And where was that?
A. Trumbull High.
Q. Did he go to college?
A. I'm not sure of that.
Q. Are you close with Michael?
A. Somewhat.
Q. How often do you see him?
A. I don't see him really a whole lot. I'm more closer with my other brothers and sisters.
Q. Okay. He lives at Greenwood Circle sometimes also, right?
A. Sometimes.
Q. You're close with Kevin?
A. I am Kevin.
Q. You are Kevin. I'm sorry.

A. So I'm pretty close with me.
Q. I'm sorry. I'm going down my list. You're close with Gary?
A. Correct.
Q. How often do you see Gary?
A. A couple of times a week.
Q. Okay.
A. He lives in Seymour, too.
Q. How far away does Gary live from the Greenwood Circle house?
A. Two miles.
Q. Okay. So does he help out with care of Tracy sometimes?
A. He does, yes.
Q. And Gary is married, correct?
A. He is.
Q. What is his wife's name?
A. Fran.
Q. Does Fran help out with care of Tracy sometimes, too?
A. No.
Q. They have one daughter?
A. They do.
Q. And what's her name?
A. Julia.

Q. And she is approximately seven?
A. Yeah.
Q. Are you close with Tracy?
A. I am.
Q. And do you sometimes take care of her? I'm sorry if I already asked that.
A. No, no. Sometimes I do take care of her, yes.
Q. And when you take care of Tracy, what does that entail?
A. Just pretty much watching her, cooking for her, because she is deaf and blind.
Q. Right.
A. So just kind of watching over her, make sure she is okay and doesn't do anything that she can't do. Cook for her. Stuff like that.
Q. Are you close with Randy?
A. I am.
Q. He is the youngest, correct?
A. He is.
Q. And he lives in Beacon Falls?
A. He does.
Q. How far away is Beacon Falls from Seymour?
A. Seven miles, eight miles.
Q. All right. And so does he help out in caring

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for Tracy also?
A. He does.
Q. And he is married?
A. He is.
Q. What is his wife's name?
A. Heather.
Q. And does Heather help out taking care of Tracy, too?
A. She does.
Q. How long have he and Heather been married?
A. I don't know exactly. I guess somewhere in the range of -- well, Anthony is eight -- probably seven, eight years, something like that. I'm not 100 percent sure, though.
Q. I'm just trying to get --
A. Yeah, it's in the ballpark of seven, eight years.
Q. A little background helps me.
A. Okay.
Q. Of the folks we just talked about in your immediate family, is anyone employed in the medical field?
A. No.
Q. Does anyone have any medical education or training?

A. Not that I'm aware of.
Q. Have you personally ever been involved in any litigation?
A. No.
Q. Before this case, obviously.
A. No.
Q. Has anyone in your family ever been involved in any litigation?
A. You would have to ask them. I'm not sure.
Q. I believe I remember Clarence saying that your mother might have been involved in an auto accident years ago. Did she ever talk to you about that?
A. I don't remember.
Q. Okay. And I believe that discovery responses might have revealed that Tracy was involved in some sort of litigation at some point in her life. Do you know anything about that?
A. It rings a bell, yeah.
Q. What can you tell me about that?
A. I don't know the details, to be honest with you.
Q. Do you know the nature of the case?
A. I don't.
Q. Do you know approximately --

A. It was something with a medical, I think.
Q. Did it have to do with her illness?
A. Yes -- well, not really her illness, no. She was ill before the -- that happened, actually. It led to her being blind.
Q. Was there a malpractice suit?
MR. VIRGIL: All right, can we just stop.
(Brief discussion was off the record.)
MR. CHENEY: I'm just going to put on the record what we just discussed.
MR. VIRGIL: Sure. I'm advising my client to answer the question only related to felony pleas, felony convictions. And then he's not going to answer questions generically.
MR. CHENEY: Okay. And can you read back the last question.
(Whereupon, the question was read back.)
MR. VIRGIL: And we also had a discussion off the record regarding the existence of a confidentiality clause within that medical malpractice case and that based on where the line of questions is headed, it appears that it is about to infringe upon the confidentiality clause.
And we have discussed it and agreed that we

will reserve those and if those questions generally need to be answered, that they will be addressed at Tracy's deposition.
MR. CHENEY: Exactly.
THE WITNESS: Okay.
BY MR. CHENEY:
Q. So have you ever been convicted of a felony?
A. I have been arrested of a felony, yes.
Q. And what was that felony?
A. Back in 1992, I sold some pot to an undercover police officer.
Q. And did you go to trial on that?
A. No.
Q. Did you plead out?
A. I don't remember exactly if I pled out. I know I ended up just getting probation for it.
Q. And since 1992, have you ever been arrested?
MR. VIRGIL: Objection. The question is about felony conviction, felony pleas. Those are the only ones he is going to answer.
BY MR. CHENEY:
Q. Have you ever been convicted of a felony since 1992?
A. No.
Q. And have any other members of your family, to

your knowledge, been convicted of felonies?
A. I don't have that information. I don't know.
Q. So turning to your mother, what did your mother do for work?
A. She worked at a high school in the cafeteria.
Q. Her whole life?
A. Most of her life. And then she was a -- like a housekeeper early on in her life.
Q. So she was a housekeeper early on and then she worked at the cafeteria later?
A. Correct.
Q. And when did she stop working at the high school cafeteria?
A. I don't remember that.
Q. Was it prior to 2010?
A. Yes. Oh, yes.
Q. Significantly? Several years?
A. Yes.
Q. When did Tracy start requiring full-time care?
A. I believe her first surgery was 1982 or 1983. I don't know the exact date to be honest with you. Somewhere in that area when she was 13 or 14. So 1969, 1979, yeah, somewhere around 1983 or 1984.

Q. And right after that first surgery, she needed someone to be with her all the time?
A. After the first surgery she was deaf.
Q. So could she be alone?
A. Not really.
Q. So --
A. She could be more alone than she can now.
Q. Okay.
A. She was able to be more alone.
Q. And she went to school, right?
A. Yes.
Q. She finished high school?
A. Yes.
Q. So when your mother was working and your father was working at that time and Tracy required full-time care, who would take care of her?
A. Well, my grandmother was living at our house. And one of our uncles.
Q. And is your grandmother still alive?
A. She is not.
Q. And is that uncle still alive?
A. He is not.
Q. And your mother first went to Griffin Hospital in April of 2010. Does that sound right?
A. It could be. I'm not exactly sure of the

date that she went there.
Q. Do you remember the circumstances surrounding first time she went to the hospital?
A. The first time I believe she fell and broke her hip.
Q. And I'm not trying to test your memory or anything, but if I told you that the medical records seem to reflect April of 2010 was when she was admitted, would that sound accurate?
A. I don't know. I mean, if that's what it reflects, then....
Q. So from that first admission when she broke her hip, when she was discharged from the hospital, where did she go?
A. A place called Shady Knoll's.
Q. Shady Knoll's. And is that a rehabilitation facility?
A. It is.
Q. And is that different than Birmingham Medical Center?
A. I don't know what Birmingham Medical Center is.
Q. Okay. Okay, so she went from Griffin Hospital to Shady Knoll's. And how long was she at Shady Knoll's?

A. I want to say a couple of months.
Q. And when she was discharged from Shady Knoll's, where did she go?
A. Home.
Q. And how long was she home?
A. She was home until -- I don't know exactly how long -- until she fell again.
Q. And in that period of time when she was home, how did she seem healthwise?
A. She was good.
Q. So after Griffin Hospital and then Shady Knoll's and then going home, she fell again?
A. She did.
Q. And then she went to Griffin Hospital?
A. I believe so, yes.
Q. And when she fell again, what was wrong with her? Did she break something?
A. She broke her hip again.
Q. And after that Griffin Hospital stay, where was she discharged to?
A. She went back to Shady Knoll's.
Q. And from the second visit to Shady Knoll's, where was she discharged to?
A. Home.
Q. And where did she go next? I know it's

terrible. Did she go back to Griffin Hospital again?
A. She had fell a third time, yes.
Q. Okay, she fell a third time?
A. And she went to Griffin Hospital.
Q. Did she break something when she fell the third time?
A. I'm not exactly sure. I wasn't there when she had fallen and I don't remember if it was again with her hip, her shoulder, or her wrist. I'm not 100 percent sure.
Q. And after the third time in Griffin Hospital, where was she discharged to?
A. She left -- that's when she went from Griffin Hospital to Yale.
Q. Okay, so just to make sure I have got the -- a little bit of chronology down. She went to Griffin Hospital, broken hip.
A. Um-uh.
Q. Discharge to Shady Knoll's for rehab.
A. Um-uh.
Q. Went home, fell again, broke her hip. Went to Griffin Hospital. Discharged to Shady Knoll's. Home again. Fell again. Broke something possibly. We are not sure, but something -- there was a reason for her to go to Griffin Hospital.

A. Correct.
Q. Went to Griffin Hospital and then from there went directly to Yale.
A. Correct.
Q. Okay, thank you.
A. You're welcome.
Q. So I would like to talk about each of these time periods individually. But before that, we will just discuss -- before her first fall, how was her health generally before the first time she fell?
A. It was good.
Q. Was she diabetic?
A. She was.
Q. Was she on insulin?
A. No.
Q. Did she have cataract surgery at some point?
A. She might have.
Q. Was there any other medical issues that you can recall at this time?
A. Not that I can recall.
Q. Prior to that initial admission to Griffin Hospital, how often would you see her?
A. Probably four or five times a week. Sometimes seven days a week.
Q. And what would you do together?

A. I would a lot of times just go and spend time with her, talk to her, go to movies with her, take her to dinner, shopping. Just I was with her a lot, talked to her a lot.
Q. What else did she like to do?
A. She liked going on vacations. You know, spending time with her family, dinner, holidays.
Q. Where did she like to go on vacation?
A. Lake George. She went there quite often. Florida.
Q. Would she go with your father to Lake George?
A. Sometimes with my father. Sometimes with my wife and I.
Q. Would Tracy go along?
A. Sometimes.
Q. And when she went to Florida, would she go with your father?
A. My mother?
Q. Yes. Would your mother go with your father?
A. Yes.
Q. Would she go with Tracy as well?
A. Yeah, she went most of the times.
Q. Anyone else go on those trips?
A. I went on a few. I believe Randy went on a few.

Q. Were there any other trips, vacations she liked to take?
A. You want me to take all the vacations she has taken in her life. I mean, I don't know. I know she has been to Canada, Lake George, Florida, California. I mean, I don't remember all the vacations my mom went on.
Q. Right. I guess how about in the last, say, five years before she went to Griffin Hospital?
A. She went to Florida probably twice and Lake George a couple of times.
Q. When she first fell and broke her hip the first time, were you living at home at that point?
A. No.
Q. Were you there when she fell?
A. No.
Q. How did you find out that she fell?
A. My father had called.
Q. Was your mother already in the hospital when your dad called and let you know?
A. No.
Q. He called before they left to go to the hospital?
A. Yes.
Q. And how did she get to the hospital that

first time?
A. I believe an ambulance.
Q. Okay. Did you go with her to the hospital?
A. Did I? No.
Q. Did you visit her in the hospital that first time she was in Griffin?
A. Of course.
Q. And how long would you say that she -- estimate that she was in Griffin for that first admission?
A. I don't remember. I don't know. I don't remember.
Q. How often did you visit her during that first admission?
A. Whenever I could. It was a couple of times a week, a few times a week.
Q. Were you working at that time?
A. I was.
Q. And where were you working?
A. At that time, it was at one of the bars, I believe it was. Or Trader Joe's, actually, I think.
Q. What shifts were you working when you were at Trader Joe's?
A. It would vary.
Q. And where was Trader Joe's? I'm sorry. I

know I asked you this.
A. Danbury.
Q. Oh, Griffin is in Danbury?
A. No.
Q. Where is Griffin?
A. Seymour -- or no, maybe not Seymour.
MR. VIRGIL: Derby?
THE WITNESS: Derby.
BY MR. CHENEY:
Q. How far is Danbury from Derby?
A. Twenty miles maybe.
Q. Okay.
A. It just seems like an odd question. I don't know exactly mileage-wise how far it is.
Q. I'm just trying to get an idea of what you're --
A. Okay, I'd say approximately 20 miles.
Q. So you would go before work or after work to visit her?
A. Yes, but I wasn't living in Danbury. I was living in Newton. So I was going from Newtown to the hospital.
Q. Okay. Do you remember any specific conversations you had with any of the doctors during that first admission?

A. I do not.
Q. Do you remember any specific conversations you had with any family members during that first admission to Griffin Hospital?
A. I don't remember.
Q. Were you concerned about your mother's more serious -- I'm sorry. This is a terrible question.
Aside from the broken hip, did you have greater concerns about your mother's health at that time?
A. No.
Q. Did you have any conversations with her at that time about end-of-life decisions?
A. Not at that time, but I'd had numerous conversations with her.
Q. Prior to that time, had you had conversations?
A. I had.
Q. And when was the first time you talked about end-of-life care decisions with her?
A. Ten, twelve years ago.
Q. And where were you?
A. Where was I?
Q. When you had that conversation, do you remember?

A. I don't remember, actually. Where we were at when we had the conversation?
Q. Yeah.
A. I don't remember. Probably at the house, I would imagine, but I don't remember exactly.
Q. And what did she say to you during that conversation?
A. She had said to me that she needed to live to be 100 to take care of her daughter.
Q. And what did you say to her in response?
A. I said, I hope you do, mom.
Q. Did she say anything else during that conversation?
A. No.
Q. Did you interpret that conversation to mean anything with regard to end-of-life care decisions?
A. I did.
Q. And what was your interpretation of what that conversation implied?
A. That she would never want anything like that to happen. She actually -- at other times, she had told me that she would not want that, if she went into the hospital and that happened, she wouldn't want the plug to be pulled on her or anything. She actually said that quite a few times to me. Again, because of

Tracy.
Q. How many times over the years did your mother and you have a conversation where she mentioned not wanting life support to be terminated?
A. Thirty.
Q. Can you give me any specific -- specifics from those conversations, what she said to you and what you said to her.
A. Basically, that if she ever was on life support she would never want to be taken off it because there is always a hope of getting better and that was -- you know, she believed in that.
Q. Did you ever discuss the possibility of being on life support without the prospect of getting better?
A. Did we ever discuss it?
Q. Yes.
A. No.
Q. During that first Griffin Hospital admission, did you see any other family members at the hospital?
A. Yes.
Q. And who did you see?
A. Gary, Randy, Heather, Julia, Anthony, my dad, Mike, Fran. Pretty much everybody. A couple of aunts and uncles.

Q. And estimates of -- I know I asked you how long she was in and you don't remember, but was it longer than a week?
A. Yes.
Q. Was it longer than two weeks?
A. I don't remember. It could have been.
Q. Was she only receiving treatment for her broken hip at that time?
A. That I'm aware of, yes.
Q. Are you aware of any conversations that any other family members had with her about end-of-life care during that admission to Griffin Hospital?
A. Yes.
Q. And what conversations are you aware of?
A. Just I discussed it with my dad, Randy, Gary. That day she had mentioned the same thing to them about never would want to be taken off life support.
Q. And this is during that first Griffin Hospital admission, right?
A. What's that?
Q. That you had these discussions with your dad and Gary and Randy?
A. No, I've had those conversation with my dad and Randy since they have been going on, for 10, 12,

15 years.
Q. Okay, when you had conversations specifically with your mother about this issue, this end-of-life care issue, was it always just you and her or sometimes other family members there?
A. There was probably some other family members there. It happened a lot of times. So, I mean, I can't remember exactly every time someone was there, but I'm sure there were times that there were other people there.
Q. And would your father share his thoughts about his end-of-life care decisions?
A. Yes.
Q. And what were his views?
A. The same thing, that he would never want to be taken off life support.
Q. Is it your -- strike that.
What's your impression of what your mother and father's rationale is for never wanting to be taken off life support?
A. What's my opinion of it?
Q. Yeah. What did you understand from what they would tell you during these conversations?
A. Well, that they didn't believe in that and that they needed to -- they wanted to stay alive as

long as they can for my sister.
Q. When you say didn't believe in that, what do you mean by that?
A. That's what they said. I don't know. You would have to ask them what their words were, what they meant by that.
Q. After she was discharged from Griffin Hospital the first time, she went to Shady Knoll's for rehab. How long was she at Shady Knoll's?
A. I don't know exactly, but I would probably say rehab, probably two or three months.
Q. And did you visit her while she was at Shady Knoll's?
A. I did.
Q. How often did you visit her?
A. Three for four times a week.
Q. Do you remember any specific conversations you had with her while she was at Shady Knoll's that first time that she was at Shady Knoll's?
A. No.
Q. Do you remember discussing end-of-life care decisions during that first time that she was at Shady Knoll's -- with her?
A. I do not.
Q. Did you see other family members visiting her

at Shady Knoll's during that first time that she was at Shady Knoll's?
A. Yes.
Q. Who did you see visiting her?
A. The same people, all the people.
Q. Did you have any conversations with your family members about your mother's end-of-life care during that time that, that first time that she was at Shady Knoll?
A. No, we didn't. But we all knew. I mean, we didn't really need to discuss it more and more and more. We all knew what her thoughts were so we didn't really discuss it over and over and over again.
Q. Were you concerned that that decision might be looming given her current health?
A. No, she had a broken hip. Why would we be concerned about that?
Q. How did she seem medically when she was at Shady Knoll's that first time?
A. What do you mean how did she seem?
Q. Aside from the fact that she was rehabbing from her broken hip, were there any other medical concerns?
A. No.
Q. And after she was discharged from Shady

Knoll's, she went home, correct?
A. Yes.
Q. How long was she at home? That period of time when she was at home.
A. Before she fell again?
Q. Before she fell again.
A. I'm not sure.
Q. Were you living at home at that time?
A. The second time she had fell, no.
Q. How did you hear she had fallen the second time?
A. I was with her when she had fallen.
Q. Where did she fall the second time?
A. In the backyard.
Q. Can you describe how she fell.
A. Yes. She was just walking down the stairs and she missed a stair.
Q. What happened next?
A. We called the ambulance. I called the ambulance. Actually, my brother Mike was there, too.
Q. Was anyone else there?
A. Tracy, but she was inside.
Q. And you called the ambulance?
A. I did.
Q. And did you go with her to the hospital?

A. I don't remember if I went in the ambulance with her or I drove there, but I'm pretty sure I did go there.
Q. Did Michael go to the hospital?
A. I don't recall. You would have to ask him.
Q. Was your dad home at the time?
A. No, I believe he was working.
Q. Did you call him and let him know that your mother had fallen?
A. Yes.
Q. And did he go to the hospital after work?
A. That's something you would have to ask him. I don't know.
Q. When she fell the second time, were you concerned that there was something else going on aside from the fact that she just missed a step?
A. No.
Q. Okay. And how long was she in the hospital the second time she was admitted to Griffin?
A. I don't know exactly.
Q. More than a week?
A. I think 7 to 10 days, something like that. But I don't know exactly.
Q. Okay. And did you visit her?
A. I did.

Q. During that second admission?
A. Yes.
Q. And how often did you visit her?
A. A couple of times.
Q. Do you remember any specific conversations you had with any of her doctors during that second admission to Griffin Hospital?
A. Just talked about how her hip was doing and stuff like that, that she was doing well, rehabbing well from her hip.
Q. Do you remember any of the doctor's names who you spoke with?
A. No.
Q. Did you see other family members visit her during that second admission to Griffin Hospital?
A. Um-uh.
Q. Who did you see?
A. All the same people.
Q. All the same people visited her every time she went to the hospital?
A. Her family. Yeah, all the same people.
Q. And do you remember any specific conversations you had with any of your family members during that second admission to Griffin Hospital?
A. About?

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Q. Any specific conversations that you had with your family members during that second admission to Griffin Hospital?
A. Pertaining to my mom or just conversations in general?
Q. Just conversations in general.
A. We probably talked about the Yankees and stuff like that. I mean, I don't know.
Q. Do you remember anything specifically, any specific conversations?
A. No.
Q. Okay. Do you remember discussing end-of-life care issues with anyone during her second admission to the Griffin Hospital?
A. No. But, again, we discussed it a million times so we didn't really feel we needed to.
Q. Right. And you weren't concerned about anything greater going on with her health at that time aside from the fact that she had a broken hip, correct?
A. Correct.
Q. So after she was discharged from Griffin Hospital the second time, she went back to Shady Knoll's, correct?
A. Yes.

Q. And how long was she at Shady Knoll's the second time she was there?
A. I think a couple of months, but I'm not 100 percent sure.
Q. How was her mobility during her second visit to Shady Knoll's?
A. It was getting better. She was rehabbing so she was able to move along with a walker. And then eventually she was able to walk without one.
Q. And I'm assuming that you visited her when she was at Shady Knoll's the second time?
A. I did.
Q. How often did you visit her?
A. Probably a few times a week.
Q. Do you remember speaking with any of the personnel at Shady Knoll's during that time?
A. Just some of the nurses that were taking care of her.
Q. Do you remember any of the specific conversations?
A. Just that my mom was a nice lady and they liked her and stuff like that.
Q. And I assume that all the same people, all the same family members visited her when she was at Shady Knoll's that second time?

A. Yeah.
Q. Do you remember any specific conversations you had with them during that second time she was at Shady Knoll's?
A. No.
Q. Where were you working when she was at Shady Knoll's the second time?
A. The second time, I believe it was Trader Joe's.
Q. How long were you working at Trader Joe's total?
A. A year and a half or so.
Q. After her second admission to Shady Knoll's, she was discharged home, correct?
A. Um-uh.
Q. Do you remember approximately what month and year that was?
A. I don't.
Q. Okay. And I apologize. This isn't supposed to be a memory test. I just -- we don't have all the records yet so I'm trying to piece together a timeline.
A. Okay.
Q. Do you remember how long she was at Shady Knoll's or how long she was at home between her second

stay at Shady Knoll's and her third admission to Griffin Hospital?
A. I do not. I don't remember.
Q. Was it a month?
A. I don't really remember.
Q. Okay. She went Griffin Hospital a third time, correct?
A. Yes.
Q. And why did she go that third time?
A. Again, I don't know whether -- what the third time was, whether for hip again or wrist or shoulder.
Q. She had fallen again?
A. Yes.
Q. You weren't with her when she fell this time?
A. No.
Q. Do you know who was with her when she fell that time?
A. My father.
Q. How did you find out that she had fallen the third time?
A. He called me.
Q. What did he say to you when he called you?
A. That mom had fallen in the kitchen.
Q. Where were you living at that time?
A. In Newtown.

Q. Did he tell you anything about going to the hospital?
A. I don't remember.
Q. How did you find out that she was going to Griffin Hospital?
A. How did I find out? Eventually my dad had told me that a she was in Griffin Hospital.
Q. Do you know how long after she had been admitted the third time that he told you that she had been admitted?
A. The same day that she was admitted.
Q. Okay. When did you first go see her in a third -- during that third admission to Griffin Hospital?
A. Either the day of or the day after.
Q. And how did she seem when you visited her?
A. She seemed okay. She just seemed a little upset that she had fallen for the third time.
Q. Did you talk to your dad about how she fell?
A. He said she had just fallen in the kitchen. He didn't really get into any more detail about it.
Q. Did she seem mentally coherent when you saw her the day or two after she had --
A. She did.
Q. Okay. At any point did you notice a mental

status change in talking to her?
A. No.
Q. Okay. How many times -- she was intubated during her stay at Griffin Hospital, correct?
A. I'm not sure what that means.
Q. Intubated is put on a breathing machine.
A. In where, Griffin?
Q. In Griffin.
A. She was on a breathing machine.
Q. How long after she was admitted that third time did she get placed on a breathing machine. Do you recall?
A. I don't.
Q. Do you remember talking to her before she was placed on a breathing machine, right?
A. Oh, yes. Absolutely.
Q. How many times did you see her before she was placed on a breathing machine during that third admission to Griffin Hospital?
A. I don't remember.
Q. How many times a week would you go visit her -- did you go visit her during that third admission to Griffin Hospital?
A. A few.
Q. Were you able to visit her more than once

when she wasn't on a breathing machine during that third admission?
A. Yes.
Q. Do you remember any of those visits, any specifics from any of those visits?
A. No.
Q. During that third admission to Griffin Hospital, do you remember talking to any doctors?
A. No.
Q. Do you remember any doctor's names?
A. I do not. I'm sorry.
Q. No, that's fine. Do you remember seeing other family members there?
A. Yes.
Q. The same family members?
A. The usual suspects.
Q. How often did -- did you get the impression that they visited her often?
A. Yes.
Q. During that third admission, did you and any family members have any conversations about end-of-life care?
A. Eventually, yes, because it turned to where it got to that point.
Q. When were you first concerned that it had

turned and gotten to that point?
A. When were we first concerned?
Q. Right.
A. When they put her on the breathing machine.
Q. And so after she was put on the breathing machine, you had conversations with who about end-of-life care decisions?
A. Randy, Gary, and my father.
Q. Do you remember any of those conversations specifically?
A. Well, we would just discuss that to the point that we were all on the same page that she had told us about not ever wanting to be put off life support and that would be the decision we would make.
Q. Do you remember how soon after she was put on the breathing machine that you had --
A. Probably that day.
Q. Do you remember specifically having a conversation the day she was put on the breathing machine?
A. I don't remember specifically if it was that day or the day after, but one of those days right in that area.
Q. You had a conversation?
A. I specifically had a conversation with my

dad, Randy, and Gary.
Q. Was it one conversation with the four of you or individual conversations?
A. I think one time it was with the four of us. And then I might have discussed it again with my -- well, actually, I discussed it quite a few times with my father. And I'm trying to think -- I think Randy and Gary a few times, too.
Q. It seemed like you had actual memory of several specific conversations with your father about this topic. Can you tell me the first time what you two discussed?
A. We discussed that -- what her wishes were, that she didn't want to be taken off the breathing machine, that that was pretty much -- like I said, we discussed it a million times so we kind of already knew that was the decision. That was it. I mean, we -- it's pretty much as far as it went.
Q. And then you discussed it subsequently?
A. With Randy, Gary, and my father again. Discussed it, meaning that we just stated what my mom had said. We didn't get -- actually, we did get into discussions, yes.
Q. Do you remember any specifics from any of those -- aside from restating that your mother

wouldn't want to be removed from life support?
A. Just that, you know, like I said, she wanted to be alive as long as she can for her daughter Tracy.
Q. Is there anything else you remember from those conversations?
A. No.
Q. And you said you didn't speak to any doctors during this third admission to Griffin Hospital, correct?
A. I did not.
Q. Did you speak to any nurses during the admission -- the third admission to Griffin Hospital?
A. Just like casual How you doing? and stuff like that. You know, how is my mom doing and stuff like that. She is doing a little better. She is doing worse. She is doing better. Stuff like that.
Q. Were you aware of any conversations that your father had with any doctors during that third admission to Griffin Hospital?
A. I'm aware that he had conversations, yes.
Q. Were you aware at the time that he had the conversations or did you learn about them afterward?
A. I'm not sure I understand what you mean.
Q. When did you -- okay, what conversations are you aware that your father had with doctors at Griffin

Hospital? What was the content of the conversations?
A. That I had with my father?
Q. That you learned that your father had with doctors at Griffin Hospital.
A. He had conversations a lot with the doctors. He was there all the time so, I mean, you would have to ask him more what the conversations were about. I know some of them were about the life support.
Q. Did he tell you about those conversations, about the life support?
A. He had, yes.
Q. And what did he tell but those conversations?
A. That they were trying to talk him into taking her off life support and that he was very adamant that he didn't want that. He was surprised when it actually happened that they would kill her like that. It took -- struck him by shock, really.
Q. Just to back up and be clear, we are still talking about the third admission to Griffin Hospital time frame.
A. Yeah.
Q. Okay. So is there anything else you remember about what your father told you about these conversations he had with the doctors about life support?

A. Just that he was going to stick to my mom's wishes and not take her off life support.
Q. Did he ever discuss with you what they told him about her condition?
A. No.
Q. When she was at Griffin Hospital that third time and these conversations about life support started with doctors between your father and the doctors, when did you -- how soon after she was placed on the ventilator do you remember him telling you that these conversations had begun?
A. I don't remember exactly.
Q. But you were still at Griffin Hospital at the time?
A. We were still at Griffin Hospital, yes.
Q. And did you -- your father eventually sought transfer to Yale-New Haven Hospital?
A. He did.
Q. Why did he do that?
A. Well, he wanted -- he had heard that Yale was one of the best hospitals in the country so he wanted to bring her there.
And he was -- to be honest with you, he was tired of them trying to get him to take her off the machine. They bothered him every day about it. Every

couple of hours they called and asked him. He just got sick of it. He wasn't going to do it. He didn't want to do it so he moved her to Yale.

Q. Approximately how long had this -- had these conversations gone on between Griffin Hospital personnel and your father before he decided to transfer?

A. I'm not sure.

Q. Two days?

A. I don't know. I don't know.

Q. Would he tell you about the conversations as they happened or did he sort of tell you --

A. There were so many of them. He told me of some of them, but he said it was an everyday occurrence. Every day he went there someone tried to talk him into it.

Q. And he never told you why they were trying to talk him into it?

A. Well, she was in a coma, I guess. I guess that's why they were trying to do it. I mean, I don't know.

Q. So when you would go see your mom at Griffin Hospital, you weren't able to speak with her?

A. No, I spoke to her. And she held my hand and, you know, moved her head and stuff like that,

yeah.

Q. So she wasn't in a coma?

A. At some point I think she went into a coma, yes, but I'm not 100 percent sure.

Q. So do you remember the last time that you and your mother -- that she was able to make eye contact and hold your hand?

A. In Yale, probably two days before it ended.

Q. Did you ever find out why she was put on a breathing machine?

A. I'm not sure I understand that.

Q. Do you know why she was put on a breathing machine?

A. I would imagine because she was having trouble breathing. I mean, I don't know specifically.

Q. Do you ever talk to your dad about why she was put on a breathing machine?

A. No. I mean, I just assumed it was because she was having trouble breathing. I mean -- no, I didn't get into any more detail, I mean, about it. I assume that's why you go on a breathing machine.

Q. That third time that your mother was at Griffin Hospital, did it seem accurate that she might have been there for three weeks to a month? Is that a rough time frame?

A. I'm not sure.

Q. But when she was transferred to Yale, she was still on the breathing machine, right?

A. I believe so.

Q. Okay. And she had been on the breathing machine for some time before that?

A. Some time, yeah. I don't know exactly how long, but sometime, yes.

Q. Okay. Was anyone else in your family -- aside from your father who was obviously frustrated by the conversations he was having at Griffin Hospital, was anyone else in your family frustrated with the care at Griffin Hospital?

A. With the care in general?

Q. Yes.

A. Well, I know that Gary and Randy were there a lot of times with my dad when they would have discussions so I'm sure they were pretty much -- had enough of it too about trying to convince them to pull the plug on her.

Q. Did you have any conversations with Gary and Randy about the care at Griffin Hospital?

A. They just told me that they were saying to dad about pulling the plug on her, but that's about it.

Q. They didn't relay any specific conversations they had had with the doctors to you?

A. I think Gary might have had a couple of conversations with the doctor about having -- pulling the plug on her. Again, you would have to ask Gary that. I'm not 100 percent sure. But I think I remember talking with him about that.

Q. You are using the term pulling the plug. Was it your understanding that if they stopped with the breathing machine that she was going to die?

A. Yes.

Q. And did a doctor tell you that?

A. No.

Q. How did you come to that understanding?

A. Well, a doctor had told me she was breathing because of the machine so I kind of assumed if he was to undue the machine, that she would stop breathing.

Q. Okay. Were you involved in seeking the transfer to Yale-New Haven Hospital at all?

A. I was not.

Q. Did you know that your father planned on seeking transfer to Yale-New Haven Hospital before he did?

A. I think I did, yeah.

Q. Okay. Do you remember how long the process

took between when he first decided he wanted to transfer her and when she was actually transferred?
A. The exact amount of time I don't remember, but it wasn't long.
Q. Okay. And do you remember any conversations you had with your father about the transfer process?
A. No.
Q. And after she was admitted to Yale-New Haven Hospital, did you visit her there?
A. I did.
Q. How often did you visit her?
A. I would say probably between five, six, seven times, something like that. I don't know the exact amount of times.
Q. Total?
A. Yeah, she wasn't in Yale too long.
Q. Would you say you went to Yale with less frequency than you had gone to Griffin during her third admission?
A. Yes.
Q. And why?
A. Just because it was a little bit further to drive to and I just had other commitments at that point. I mean, I still had seen her, but I started working a little bit more. And I did have a wife at

this point, so I was spending time with her and stuff. But -- and it was if you went to see her in New Haven, it was just an all day thing because it was a pretty far ride from there.
Q. Were you still working at Trader Joe's at that time?
A. I believe I was, yeah.
Q. And you said you were working more. They had given you more shifts?
A. They did.
Q. What shifts were you working at that time?
A. Sometimes 4:00 at night till midnight. Sometimes 4:00 in the morning until 12:00 in the afternoon or 10:00 in the morning until 6:00 at night. It varied.
Q. You have a driver's license, right?
A. I do.
Q. So when you would go see her at Yale-New Haven Hospital, you would drive?
A. Um-uh.
Q. Would you go with anyone?
A. I think I went once with my wife and the other times by myself.
Q. When you would go to Yale or when you did go to Yale-New Haven Hospital to visit your mother, did

you see any other family members there?
A. At Yale, I saw Gary once. It's like I said. I was working different hours so they were there more in the morning and I was there more towards the afternoon.
Q. Do you remember when you saw Gary did you -- do you remember having a conversation with him?
A. No.
Q. Did you ever see your dad at Yale-New Haven Hospital?
A. No.
Q. Do you talk to your dad during the time your mom was admitted to Yale-New Haven Hospital?
A. Was I talking to my dad?
Q. Yeah.
A. Yeah.
Q. Were you living at home at that time -- oh, no, because you were married, right?
A. Yes.
Q. But how often would you talk to your dad during that time that she was admitted to Yale-New Haven Hospital?
A. Three or four times a day.
Q. And what would you talk about?
A. In general or just -- we would talk about all

sort of stuff. We had conversations about Mommy, how is she doing and stuff like that.
Q. Did you talk to any doctors while she was at Yale-New Haven Hospital?
A. No.
Q. Did your father talk to any doctors while she was at Yale-New Haven Hospital?
A. You would have to ask him that. I would imagine he did, but I can't answer that for him. I don't know. I'm sure he did.
Q. You say you just -- you had conversations with him about how she was doing?
A. Um-uh.
Q. Was that him telling you how she was doing or you telling him how she was doing?
A. Depending on whether I was there that day or whether he was there that day.
Q. Okay. Did you notice her status change at all during her time at Yale-New Haven Hospital?
A. No. When she got there it was pretty much the same the whole time she was there.
Q. And how long would you estimate she was at Yale-New Haven Hospital?
A. I don't know exactly, but I think it was maybe five or six weeks at most.

Q. Were you hopeful that she would improve?
A. Of course.
Q. When was the last time -- between the time she was intubated and the time when she passed away, when was the last time you had seen any improvement in her status?
A. I'm not really sure what you mean by improvement. I don't understand that.
Q. Did she ever have good days?
A. Good days -- again, I'm not sure how to answer that. I don't know if she had a good day. If she was here, we could ask her. What do you mean by a good day?
Q. Were there any days that you visited her that you thought that she looked better than she did on other days?
A. Yes.
Q. And what would -- how did she look that made you feel that she was doing better?
A. Well, just she would be able to move around a little bit more, squeeze my hand a little bit more, shake her head, move her eyes. Some days she'd be able to do that more than other days. I guess if that's a good day, then yes, that's a good day.
Q. Was there -- did you notice any pattern with

that?
A. No.
Q. Was she having more good days near the end or more good days near the beginning?
A. I don't -- it seemed steady.
Q. Did you talk to any other of your family members during the time that she was at Yale-New Haven Hospital about her situation?
A. About her situation, meaning?
Q. About her care, the fact that she was in the hospital, how she was doing.
A. No, just conversation about how she was squeezing our hands and moving her eyes and stuff like that. Just conversations like that you had with -- because it happened when Gary went Randy went and my father went. She did that to them, too.
Q. And did -- so you know that Gary, Randy, and your father and yourself all went. And you said that -- did anyone -- do you know, did any other family members visit her when she was at Yale-New Haven Hospital?
A. I'm not sure. I mean, Randy, Randy probably went with his wife -- or Gary probably went with his wife, I would imagine. But, again, that's a question you would have to ask them. I don't know.

Q. Were you talking to Michael during this time frame?
A. Yeah.
Q. And did you ever talk about your mother with Michael?
A. Not really.
Q. So do you know if he went to Yale-New Haven Hospital?
A. I do not know.
Q. Do you know if Gary brought his daughter to Yale-New Haven Hospital?
A. You would have to ask him.
Q. And you don't know if Randy's son --
A. You would have to ask him.
Q. Do you remember what department your mother was in at Yale-New Haven Hospital?
A. I don't.
Q. Do you remember what building she was in?
A. Just the main building, I thought it was. I don't know.
Q. Do you know what floor?
A. I don't recall.
Q. And what wing in the --
A. I don't remember that.
Q. And you think you never spoke to any doctors

while she was at Yale-New Haven Hospital?
A. No.
Q. Did you speak to any nurses while she was at Yale-New Haven Hospital?
A. No.
Q. Did you try to avoid speaking to doctors and nurses while she was at Yale?
A. Did I try to avoid it?
Q. Yeah.
A. No.
Q. They just weren't around?
A. No, sometimes they were around. But, I mean, I spoke to them, yeah. How you doing and stuff like that. Yeah, you want to know that? Yeah, I spoke to them. How is she doing. But, I mean, nothing more than that.
Q. How long did you stay when you visited your mother at Yale?
A. Anywhere from an hour to three hours.
Q. And what would you do during that time?
A. I would sit next to her and talk to her and, you know, hold her hand and tell her I loved her and missed her. And, you know, I was kind of upset, really upset.
Q. Do you remember talking to your -- after she

was admitted to Yale-New Haven Hospital, do you remember talking to any of your family members about end-of-life care?
A. When she was in Yale?
Q. Yeah.
A. Yes.
Q. And who did you talk to?
A. My father, Gary, and Randy.
Q. Do you remember any specific conversations you had with your father while -- about end-of-life care while your mom was at Yale?
A. Just again that they were asking him to pull the plug on her.
Q. When was the first time that your dad told you that they were asking to pull the plug?
A. I don't recall.
Q. Had she been at Yale more than a week?
A. I don't remember.
Q. Was it near the end of her life, within a couple of days of the end of her life?
A. There was a discussion, you know, a few different times while she was there.
Q. Did your dad ever convey to you the doctor's reasons for wanting to, as you said, pull the plug?
A. Did he ever convey to me the reasons?

Q. The reasons why the doctors were telling him that.
A. No.
Q. Did you ever ask?
A. No, I didn't really ask him that. It didn't really matter to me what the doctor thought the reason was. I mean, I knew what she wanted so I really -- what the doctor told me was irrelevant.
Q. And I'm sorry. I forget. I have got too many dates in my head. You were living at home at that time?
A. At what time?
Q. You were living in Newtown at that time?
A. I'm sure you know that.
Q. I honestly -- I forgot.
A. Okay.
Q. How many conversations would you estimate you had with your dad about end-of-life care during the time that she was at Yale?
A. During the time that she was at Yale, probably four to five.
Q. And you don't remember when any of those conversations occurred, correct?
A. When, meaning what? Like what time of day?
Q. Dates.

A. No. A specific date? No, I don't remember.
Q. Or rough estimates within the time frame of her Yale stay. For example, I remember a weekend having a conversation. Anything like that.
A. No.
Q. Anything that would help me reference.
A. I don't remember the specific days.
Q. Or anything that would help me reference it as in it was near to the beginning of her time or near to --
A. It was pretty much throughout the whole time.
Q. And so do you remember -- do you remember the first conversation you had with your dad while she was at Yale about end-of-life care?
A. No. The exact first time, no. The day, no.
Q. No, what was said, what the conversation was about.
A. That they wanted him to take her off life support.
Q. And what did you say in response to that?
A. What did I say?
Q. Yes.
A. I said, Well, dad you're not going to do that.

He said, no, I'm not going to do that.
That's not what mommy wanted. And that's not a decision that they had made.
Q. And was there anything else discussed about end-of-life care during that first conversation you had with your dad?
A. No, not that I remember.
Q. During the second conversation you had with your dad, what was the content of that conversation?
A. All the conversations were pretty much the same, that they wanted him to take her off the life support and he wasn't going to do it. And that was it, really.
Q. Do you remember him discussing the phone calls that he would get from Yale?
A. No, I don't remember that.
Q. Do you remember him discussing conversations he had with the doctors while at Yale?
A. Just that they wanted him to take her off life support.
Q. You said you also spoke with Gary and Randy about end-of-life care during the time she was at Yale?
A. Um-uh.
Q. How many times did you speak with Gary?

A. I don't know the exact number.
Q. Do you remember any specific conversations you had with Gary about end-of-life care while your mom was at Yale?
A. Just that she didn't want that to happen.
Q. Was that him telling you that?
A. It was just we all knew. I mean, I was telling him that and he was telling me that.
Q. Okay. And is that roughly the same answer if I asked you for Gary?
A. Yes.
Q. Okay.
A. I thought you just asked me for Gary, though.
MR. VIRGIL: Randy.
BY MR. CHENEY:
Q. Randy. I apologize.
A. That's okay. It would be the same answer, yes.
Q. Did you ever attend any meetings with your mother's doctors or nurses while you were at -- while she was at Yale?
A. Did I, no.
Q. Were you aware that the doctors had wanted to do a lumbar puncture at one point during her time at Yale?

A. I don't remember that.
Q. It was a procedure that they wanted to do and your family refused to do it. Does that ring a bell at all?
MR. VIRGIL: I just object to the form. But you can answer.
THE WITNESS: Can you say the question again?
BY MR. CHENEY:
Q. Do you remember there being a procedure that the doctors wanted to do that the family, yourself included, possibly didn't want to have done?
A. I don't remember that.
Q. Were you aware that there was an ethics committee meeting on July 23rd, 2010?
A. I was aware of -- yes, that there was a meeting. I was aware of it after the fact, that my dad had told me.
I wasn't aware that it was going on, nor any of that kind of stuff. Because I don't know if it was an impromptu type thing. I don't know.
But I think Gary and Randy and my dad were there. But again I'm not 100 percent sure on who was there. I know my dad was. You would have to ask Gary and Randy. I know I was not there.

Q. And did you discuss this meeting -- you discussed this meeting with your dad after the fact?
A. I didn't really discuss it. I mean, he had just mentioned that they wanted again to pull the plug on her. And that was pretty much -- I think that was pretty much the gist of the meeting.
But I don't know. I wasn't there for the meeting. But that's about all of the meeting I discussed with my father.
Q. And then are you aware that the day before, a day or two before your mother passed away that there was a meeting, an ethics committee meeting at the hospital?
A. Was I aware of that?
Q. Yes.
A. No.
Q. Did you ever discuss the existence of that meeting with any family members?
MR. VIRGIL: Objection. You can answer.
I just told you he didn't know it existed so how could he discuss it? So that's fine.
MR. CHENEY: I'm sorry. That's my misunderstanding.
BY MR. CHENEY:
Q. So as you sit here today, you are not aware

of any meeting that occurred the day before, a day or two before your mother passed away?
A. No, I know my dad and Randy, and Gary I believe, had a meeting with them, yes. I don't know what the meeting was about.
Q. You are not aware of any other meeting?
A. No.
Q. How did you learn that your mom had passed away?
A. On the following Monday morning, which was a Sunday, my father had called me up and told me that Mommy was gone. And then he proceeded to tell me that when he was at the hospital that night that they, the doctor told him that they were going to pull the plug on her and it really didn't matter what he said.
And he said, you know, please don't do that. And he didn't think they would in a million years. And an hour and a half later they called him up and said that they did.
So then he called me the next morning and he discussed this with me. And, you know, I was going crazy. I mean, it was ridiculous. Mad, furious, upset that they would do something like that.
Q. And so when they called -- just so I can get the timeline right, you said that Sunday night your

dad was in the hospital?
A. No, Sunday -- I believe it happened on a Saturday night and I got the phone call Sunday morning.
MR. CHENEY: Can I mark this. It might just be easier.
(Whereupon, Defendant's Exhibit No. 2 was marked for identification.)
BY MR. CHENEY:
Q. So I have marked a calendar for the year 2010 that I got off the Internet. And I'm assuming accuracy. I've marked that Defendant's Exhibit Number 2 just to help with the days here as we were talking about the last few days of your mother's life.
You said that on Saturday night you believe?
A. I believed it was, but, I mean, I don't know. It could have been a different day. I don't know exactly. I thought it was -- yeah, on the Saturday night I believe it was.
Q. Saturday night your father was in the hospital. I'm not trying to --
A. I'll just put it this way: I don't know the exact day or date, but the night before, the night before he told me what had happened, that's when he was there. I don't know exactly if it was a Saturday

night or a Friday night. I think it was a Saturday night.
Q. So to the best of your recollection, you believe that your father was in the hospital Saturday night and a doctor said to him what?
A. That he -- Gary was with my father at that point.
Q. Okay.
A. And they had told them that they were going to pull the plug on her. They had some kind of ethics meeting or something and pretty much they didn't really care what he said anymore.
Q. And you said that your father didn't believe them?
A. No. He never thought in a million years they would do something like that. Why would you think something like that?
Q. And when they were saying pull the plug, is that the term that he used when he conveyed this conversation to you?
A. I think that might have been the term he used, yeah.
Q. Did you take that to mean removing her breathing machine?
A. Did I take it to mean that?

Q. Yes.
A. Yes.
Q. Were you aware of any other instances since she was originally intubated that they had removed her breathing machine?
A. I'm not aware of that.
Q. So your dad left the hospital Saturday night believing that they would never do it and then --
A. Again, I don't know if it was a Saturday night, but that night, yes. What was the date? I guess we could figure out right here if it was a Saturday night, right?
Q. Yes, I'm just trying to -- I'm using it more as a -- I'm not going to hold you to Saturday night.
MR. VIRGIL: It's Saturday night. I mean, it's July 24th.
MR. CHENEY: Is it? I just can't remember off the top of my head.
THE WITNESS: No, I -- it's Saturday night, right?
MR. VIRGIL: Yes, as the calendar shows.
MR. CHENEY: As the calendar shows.
THE WITNESS: Right, and I got it on that -- right, exactly.
BY MR. CHENEY:

Q. So you heard -- when did you next talk to your father? On the 25th?
A. Yes, that morning of the 25th.
Q. And what did he tell you?
A. That mom had passed. And then he proceeded to tell me that the doctor told him that night that they were going to pull the plug on her. And he said to them don't do that.
And he left there and an hour and a half later she was gone. And he also stated that he never thought that they would do something like that.
Q. So when he talked to you on the 25th, he was talking about a conversation when he told you -- sorry. When he talked to you on the 25th, he told you that your mother had passed away?
A. Correct.
Q. And he was referencing a conversation that he had had that morning?
A. Not that morning. The night before, the Saturday night. He was referencing the conversation he had with the doctors.
Q. And the conversation that he had on that Saturday night was a telephone call?
A. No, he was at the hospital with Gary.
Q. When they told him that they were going to

pull the plug.
A. Yes.
Q. But he left and didn't believe that they were going to pull the plug?
A. Correct.
Q. And then he called you Sunday morning and said your mom has passed away?
A. Um-uh.
Q. So how did he find out that she had passed away?
A. How did he find out?
Q. Yes.
A. They called him.
Q. Okay. Do you know when he got that phone call?
A. The exact hour? No, I don't.
Q. Sometime between when he left the hospital and when he talked to you, obviously.
A. I think he went on to tell me that it was about an hour, hour and a half after he had left the hospital. But I don't remember exactly what time it was. But he said it wasn't long after he had left the hospital he received a phone call.
Q. Do you remember him -- when you were discussing when he was at the hospital on the Saturday

night, was your mother on the breathing machine at that time?
A. On the night that --
Q. When he was there.
A. Yes. I would assume she was.
Q. So do you remember the last time that you saw your mother?
A. I believe it was that Thursday.
Q. How long did you stay that Thursday?
A. Probably a couple of hours.
Q. Do you suffer any emotional consequences as a result of this incident?
A. Well, yeah. I mean, I think about it every day. I, you know, spent a lot of time crying. I miss her. Sometimes I have pains in my chest just thinking about it.
Yeah, it's just I miss her and stuff like that. And I think about it all the time and I think about how, you know, I let her down in the sense that, you know, I couldn't do anything for her and they did it and I couldn't do anything about it. It wears on me every day.
Q. Do you ever see anyone professionally about these feelings?
A. No.

Q. Do you think that your loss of employment has anything to do with the emotional feelings that you felt since your mother passed away?
A. It possibly could have. I mean, I was -- my mind was preoccupied thinking about her a lot of time and thinking about the situation, what had happened. So, I mean, maybe it started to reflect some of the work I was doing.
Q. Were you fired from your last job?
A. Yes.
Q. Was your last job Trader Joe's?
A. No.
Q. Okay, what was your last job? Was that 160?
A. Yes.
Q. Danny O's before that?
A. Um-uh.
Q. Were you fired from Danny O's?
A. No.
Q. You left voluntarily to go work at 160?
A. I did.
Q. What about your previous employment? Were you fired from any of those jobs?
A. Was I fired from.... Well, Jeremiah's, it was kind of a disagreement, yeah.
Q. And Trader Joe's?

A. They just let me go.
Q. The Marriott?
A. The Marriott I just wanted to move on.
Q. Woodbridge Country Club?
A. They went out of business.
Q. Were you ever involved in the paying of any of your mother's medical bills?
A. In paying any of them?
Q. Yeah.
A. No.
Q. Did you ever have any discussions about your mother's medical bills with your father?
A. No.
MR. CHENEY: I think I'm all set.
MR. VIRGIL: All right, we're all done.
THE COURT REPORTER: How about reading and signing?
MR. VIRGIL: Yes.
(Whereupon, at 2:40 p.m., the taking of the deposition concluded.)
* * * * * * *

CERTIFICATE

I, Susan Wandzilak, hereby certify that I am a Registered Professional Reporter and Notary Public in and for the State of Connecticut, commissioned and qualified to administer oaths.

I further certify that the deponent named in the foregoing deposition was by me duly sworn, and thereupon testified as appears in the foregoing deposition; that said deposition was taken by me stenographically in the presence of counsel and reduced to typewriting under my direction, and the foregoing pages are a true and accurate copy of the original transcript of the testimony.

I further certify that I am neither of counsel nor attorney to either of the parties to said suit, nor am I an employee of either party to said suit, nor of either counsel in said suit, nor am I interested in the outcome of said cause.

Witness my hand and seal as Notary Public this 4th day of April 2014.

_____

SUSAN WANDZILAK

INDEX

EXHIBITS

(marked for identification)

(Exhibits retained by Attorney Cheney.)

I have read the foregoing 76 pages and hereby acknowledge the same to be a true and correct record of the testimony.

_____

KEVIN MARSALA

Subscribed and Sworn to
before me this ___ day of _____ 2014.

_____

Notary Public

My Commission Expires:

Marsala vs. Yale Hospital
Kevin Marsala
March 25, 2014

SUPERIOR COURT
JUDICIAL DISTRICT OF ANSONIA/DERBY
AT MILFORD
----------x
CLARENCE MARSALA, ET AL,

Plaintiffs,

vs. Case No. AAN-CV-12-6010861-S
Date: March 10, 2014
YALE-NEW HAVEN HOSPITAL, INC.,

Defendant.
----------x

DEPOSITION OF MICHAEL JOSEPH MARSALA

The deposition of Michael Joseph Marsala was taken on March 10, 2014, beginning at 10:015 a.m., at the offices of Zeldes, Needle & Cooper, 1000 Lafayette Boulevard, Bridgeport, Connecticut, before Susan Wandzilak, Registered Professional Reporter and Notary Public in the State of Connecticut.

Susan Wandzilak License No. 377
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NEW HAVEN STAMFORD HARTFORD

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Attorney for Defendant

S T I P U L A T I O N S

IT IS HEREBY STIPULATED AND AGREED by and between counsel representing the parties that each party reserves the right to make specific objections at the trial of the case to each and every question asked and of answers given thereto by the deponent, reserving the right to move to strike out where applicable, except as to such objections as are directed to the form of the question.

IT IS HEREBY STIPULATED AND AGREED by and between counsel representing the respective parties that proof of the official authority of the Notary Public before whom this deposition is taken is waived.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing the respective parties that the reading and signing of the deposition by the deponent is not waived.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing parties that all defects, if any, as to the notice of the taking of the deposition are waived.

Filing of the Notice of Deposition with the original transcript is waived.

MICHAEL JOSEPH MARSALA,
having been first duly sworn, testified as follows:

THE COURT REPORTER: Would you please state your full name and address for the record.

THE WITNESS: My full name is Michael Joseph Marsala, M-A-R-S-A-L-A. My address is, technically, 22 Greenwood Circle, Seymour, Connecticut.

MR. VIRGIL: Usual stipulations and we will read and sign.

MR. CHENEY: Okay.

DIRECT EXAMINATION

BY MR. CHENEY:

Q. Good morning, Mr. Marsala.

A. Good morning, how are you?

Q. We met off the record. I will introduce myself again. My name is Ben Cheney. Have you ever had your deposition taken before?

A. Once.

Q. And when was that?

A. In the late seventies.

Q. What was it pertaining to?

A. A motor vehicle accident in which I was a passenger.

Q. So were you a plaintiff in a lawsuit?

A. Yes.

Q. Just to refresh your memory, since it has been a while, there is a few things to keep in mind when having a deposition taken. One is Susan is taking down everything we say.

A. Right.

Q. So please let me finish my questions and I will let you finish your answers so everything is nice and clean.

A. Good.

Q. The second is, as you're doing, please make sure your answers are verbal so that she can take it down. She can't take down nods of the head or shakes of the head or anything like that.

A. Okay.

Q. The last thing is I don't anticipate us being here all afternoon, by any means, but if you do need a break, just let me know.

A. No problem.

Q. But I would ask you if a question is pending, please answer it and then we will take a break.

A. Good enough.

MR. CHENEY: I am going to mark your notice of deposition.

(Whereupon, Defendant's Exhibit 1 was marked for identification.)

BY MR. CHENEY:

Q. I have marked your notice of deposition Defendant's Exhibit Number 1. Have you reviewed this before today?

A. (After review.) Okay.

Q. Did you have a chance to look at this before coming here today?

A. This individual thing, no.

Q. Page 2, which is the back side of page 1 because is it is double-sided --

A. Okay.

Q. -- it requests that you bring some documents pertaining to this case. Did you bring any documents with you today?

A. I did not.

Q. Do you have any documents pertaining to this case?

A. I do not.

Q. Did you write anything down in conjunction with this case, pertaining to this case?

A. I did not.

Q. Do you keep a diary?

A. I do not.

Q. What's your date of birth?
A. 9/12/57.
Q. And you stated that you live at 22 Greenwood Circle?
A. Correct.
Q. In Seymour?
A. Correct.
Q. When you were talking to Susan about that you said that technically that's your address?
A. Oh, yeah, that's what my license says.
Q. Why do you say technically?
A. Because I move around a lot. That's my father's home so it will always be mine.
Q. Okay, where do you go?
A. Where do I go? What do you mean by where do I go?
Q. You said that you move around a lot.
A. I have lived in Milford and I have lived in Stratford. I have lived in Bridgeport.
Q. Okay. But you haven't established residence at any of those places?
A. Temporarily.
Q. And where were you living in July of 2010?
A. July of 2010, I was living at 22 Greenwood Circle.

Q. Was that technically your address or you were actually --
A. No, no, I was living there then.
Q. Where did you live prior to that?
A. Stratford, Bridgeport, Milford.
Q. And do you stay with friends or --
A. No, apartments.
Q. And are they leased under your name?
A. No.
Q. Are they leased under a friend's names?
A. Girlfriend's.
Q. But just to reiterate, in the summer of 2010, you were living at 22 Greenwood Circle in Seymour?
A. I was.
Q. Did you go to high school?
A. Yes.
Q. Where did you go?
A. Trumbull High School.
Q. And did you go to college?
A. No.
Q. And no other secondary education, technical school?
A. No.
Q. Where do you work currently?
A. I am unemployed.

Q. And when was the last time you had a job?
A. Many years ago.
Q. Before 2010?
A. Yes.
Q. So you were unemployed in 2010?
A. Yes.
Q. The last time you had a job, what was it?
A. In a machine shop.
Q. And what were your duties there?
A. Just basically -- I don't know how to explain it, really. It was for a newspaper so it was like stacking, you know, the newspapers up as they came through the machine.
Q. Oh, got you. Okay. You have three brothers?
A. Gary, Randy -- Gary, Randy, Kevin. Yeah, three brothers.
Q. And one sister?
A. And one sister.
Q. And that's Tracy?
A. Yes.
Q. And Tracy lives at home with you?
A. Yes. Well, home with my father.
Q. Where does Gary live?
A. Gary lives also in Seymour. I don't know his

address, though.

Q. And where does Kevin live?

A. Kevin lives at 22 Greenwood Circle.

Q. And Randy?

A. Randy lives in Naugatuck, I believe.

Q. So Clarence, your father?

A. Yes.

Q. Kevin, Tracy, and yourself all live at 22 Greenwood Circle, currently?

A. Not currently, in July of 2010.

Q. Those four people lived at 22 Greenwood Circle in July of 2010?

A. Yes.

Q. And who doesn't live there anymore?

A. I do not.

Q. Where do you currently live?

A. Milford.

Q. And with who do you live?

A. I live with myself for now.

Q. And where do you live?

A. In a motel room.

Q. When did you move out of 22 Greenwood Circle?

A. August of 2013.

Q. Have you been living in a motel room in Milford since August of 2013?

A. Pretty much, yes. Between there and my girlfriend's.

Q. Why did you leave home?

A. No reason in particular.

Q. Gary still lives at 22 Greenwood Circle?

A. No, Gary lives somewhere in Seymour, but I don't know the address. Gary is married, has a child.

Q. What is his wife's name?

A. Gary's wife -- it's not sticking out in my mind. Gary's wife's name. You know, give me a minute to think about that. Can we go back to that one?

Q. Yeah, we can go back to that. I can also just ask Gary when I talk to him.

A. That's true.

Q. And his kid's name? Just one kid?

A. Julia.

Q. And it's just the one child?

A. It is.

Q. And is Kevin married?

A. Kevin is now divorced.

Q. Does he have any children?

A. No.

Q. And is Randy married?

A. Yes.

Q. And what is his wife's name?

A. Heather.
Q. And do they have any children?
A. One.
Q. And their child's name is?
A. Anthony.
Q. And Tracy is not married?
A. She is not.
Q. And she has no children?
A. No.
Q. Are you close with your brothers?
A. Yeah.
Q. How often do you see them?
A. Three or four times a year, I guess.
Q. Is anyone in your family employed in the medical field?
A. No.
Q. Any medical education or training?
A. That I know of, no.
Q. Do you have a car?
A. No.
Q. Are you licensed to drive?
A. Yes.
Q. Did you have a car in 2010?
A. No.
Q. How did you commute in 2010?

A. 2010, I didn't really commute too much. I pretty much hung around the house. If I did, either my father brought me or one of my brothers.

Q. Okay.

A. Or the bus.

Q. In 2010, would you care for Tracy at home?

A. Yeah, I would watch over her, sure. She is handicapped.

Q. She is deaf?

A. And blind. Well, she is totally deaf. And she has -- I think, but I'm not sure -- got five percent sight in just one eye and blind in the other one. Don't quote me on that. I don't know for sure. But she is definitely deaf and very blind.

Q. Does she have any cognitive disabilities?

A. Meaning?

Q. Meaning aside from being deaf and mostly blind, does she have any mental disabilities?

A. Mental disabilities, no. She has a disease, which I'm not sure of the name of it, where tumors grow which is what took her hearing and her eyesight away. She has had brain tumors.

Q. And when was she diagnosed with that disease?

A. She was 12, I think -- 10, 11, 12, somewhere in that age bracket.

Q. And has she been in and out of the hospital several times since then?

A. Yes. Yes.

Q. When did she lose her hearing?

A. She lost her hearing, 12, 13, the first operation. They did one ear at a time. They did one ear and she lost it and then the next, about a year or so later, the other ear. So by 14, she was totally deaf. Approximately.

Q. And has her sight been steadily worsening?

A. I don't know. I don't know. I have to say I don't know whether or not.

Q. Do you remember a time when she could see?

A. Yes.

Q. And when was that?

A. That was 2000 -- 1999-2000.

Q. And would she drive then?

A. No.

Q. You mentioned that you were party to a lawsuit in the seventies.

A. Um-uh.

Q. A motor vehicle?

A. Yes.

Q. And were you injured?

A. Yes.

Q. What injuries did you sustain?

A. I got a scar underneath my lip which you can't see because of the beard. And I had broken ribs and glass in my left eye.

Q. Okay. Did that lawsuit settle?

A. Yes.

Q. Do you have a criminal record?

MR. VIRGIL: Stop. If you want to ask him about felonies, that's fine. But not about just a criminal record generally.

MR. CHENEY: Okay.

BY MR. CHENEY:

Q. Do you have a felony -- have you ever been convicted of a felony?

A. I have been convicted of a felony, but the appellate court overturned the conviction.

Q. And what was the felony you were convicted of?

A. Possession of narcotics and possession of narcotics with intent to sell.

Q. And what year was that?

A. Oh, '86, 1986.

Q. Did you go to jail?

A. No, I was out on bond. I also went to trial.

Q. What was your sentence?

A. Six years.
Q. What was the -- why did the appellate court overturn your conviction?
A. The first appellate court decision came out because the warrant was invalid.
Q. You said the first appellate court decision?
A. Um-uh.
Q. After the appellate court issued that decision, was there further court matters about your felony?
A. Yes, it ended up -- all together it took 10 years to finally settle. The state Supreme Court decision twice.
Q. Did you testify at trial?
A. Yes.
Q. Is that the only time that you have testified in court?
A. I --
Q. Let me take that back. Did you testify more than once at trial?
A. I don't remember, to be honest with you.
Q. And can you remember another litigation where you testified at trial?
A. No.
Q. Have you been arrested since then?

MR. VIRGIL: No, he is not answering that question.

BY MR. CHENEY:

Q. Your mother was admitted to Griffin Hospital in 2010, right?

A. Yes.

Q. Do you remember why?

A. Originally, for breaking her hip.

Q. And do you remember what month it was?

A. No.

Q. If I said April, does that sound right?

A. I don't know. I would be literally guessing and I don't want to guess.

Q. Okay, fair enough. When she was first admitted for her broken hip, did you visit her in the hospital?

A. Yes.

Q. Do you recall how long she was there?

A. Not really. Not really.

Q. Okay, do you remember how many times you visited her?

A. A few.

Q. Would you say more than five?

A. I don't know. I can't really say. She wasn't there that long for just the broken hip.

Q. And where did she go when she was discharged?
A. To a rehabilitation center, I believe it was.
Q. Birmingham rehabilitation center?
A. I don't know. That's something my father can answer for you better. Or somebody else could. I don't know.
Q. Did you visit her at the rehabilitation center?
A. Yes.
Q. Do you remember how long she was at the rehabilitation center?
A. It didn't seem long, but I can't say for sure.
Q. And did she go home after that?
A. Yes.
Q. And how long was she at home before -- because then subsequently she was admitted to Yale-New Haven Hospital or back to Griffin Hospital, correct?
A. Yes.
Q. How long was she at home in between?
A. I would be guessing again. I'm guessing again. I don't know. I really don't know.
Q. But you were living at home at the time?
A. I was.
Q. And do you remember why she was admitted the

second time to Griffin Hospital?

A. Something to do with her wrist, I believe. She broke her wrist or hand or arm.

Q. Okay. I'm sorry. We don't have the Griffin Hospital records yet so I'm trying to get information. I'm not trying to test your memory or anything like that.

A. They would have a better memory of it.

Q. They would. So she broke her wrist in --

A. I believe it was her wrist, yes.

Q. And do you remember when that was?

A. No, not really. I can't say for sure exactly what date.

Q. Did she go home again after breaking her wrist?

A. I believe so, but I'm not completely sure. But I think so, yes.

Q. Did she go to the rehabilitation center again?

A. I'm not sure of that either. I'm not sure, to be totally honest with you. It's all one big lump.

Q. Right. Right. Do you remember any specific doctors who you spoke with at Griffin Hospital?

A. Do I remember their names? No.

Q. Do you remember any specific conversations

you had with anyone at Griffin Hospital?

A. No, I didn't really have any conversations too deeply with anybody at Griffin Hospital. No.

Q. Would you talk to your mother when you visited her?

A. Yeah, she was pretty much alert with the hip. Which time are you talking about? Are you talking about her hip or when she went back and was in a coma.

Q. Originally, the first time.

A. Yeah, talked constantly.

Q. And who did you go there with?

A. My dad, my brother.

Q. You didn't have a car at that time?

A. No.

Q. So you were relying on a ride to get to the hospital?

A. Pretty much, yeah. But we were all going.

Q. But you lived with your dad and your brother?

A. Um-uh.

Q. Would Tracy go?

A. No, actually I don't think Tracy went.

Q. So who would watch Tracy when you --

A. Somebody. Either me, my brother -- somebody.

Q. Someone always stayed home with Tracy?
A. Of course, we have to.
Q. Okay. Do you remember at some point your mother wasn't doing as well mentally in the hospital?
MR. VIRGIL: Objection.
THE WITNESS: What do you mean by mentally?
BY MR. CHENEY:
Q. Sorry. That's a terrible question.
The medical records reflect that your mother was admitted to Griffin Hospital on May 24, 2010, and had altered mental status. Does that sound correct?
A. I have no idea of it.
Q. Do you remember her at some point being less sharp?
A. No.
Q. Do you remember her being intubated?
A. What does that mean?
Q. A breathing tube.
A. Oh, yes. Of course. Both at Griffin and Yale.
Q. And she was intubated at Griffin originally, correct?
A. Yes.
Q. And was she ever taken off the breathing tube after that as far as you can remember?

A. Yeah, Yale-New Haven Hospital pretty much killed my mother.

Q. Was she ever taken off until the very end of her time at Yale-New Haven Hospital?

A. I don't believe so, no. Wait a minute. Hold it. You are talking about from when she went -- when she was put on it in Derby -- I mean in Griffin Hospital and then transferred over to Yale, was she ever taken off in between? The breathing.

Q. In May 26, 2010, when she was originally put on the breathing tube until the last few days of her life, was she ever off the breathing tube?

A. I don't believe so, no.

Q. Could she talk to you when she was on the breathing tube?

A. No.

Q. Do you remember when the last time you talked to your mother was?

A. Just -- it was at home just before then, before she had gone -- or one of our visits before she went into needing the breathing tube would be my best guess. What date, time? Who knows that stuff.

Q. Right. Do you remember what she said to you?

A. Do I remember what she said to me? No, not really.

Q. And do you remember what you said to her?
A. No.
Q. Were you pleased with the care she was receiving at Griffin Hospital?
MR. VIRGIL: Objection. You can answer.
THE WITNESS: Oh, I could answer?
MR. VIRGIL: Yeah.
THE WITNESS: Was I pleased? I wasn't very happy.
BY MR. CHENEY:
Q. Why not?
A. It was upsetting.
Q. What specifically was upsetting?
A. Well, the whole situation about -- and the -- do that (indicating).
Q. I'm sorry. Susan can't --
A. Oh, yeah, that's right. You told me that. Pulling the plug.
Q. There were discussions with medical personnel at Griffin Hospital about pulling the plug?
A. I believe so, yes. In front of me, no.
Q. You weren't part of any of those discussions?
A. Not at Griffin but at Yale.
Q. At Griffin, how were you aware that those discussions had taken place?

A. My father, brothers. I'm not sure.
Q. Do you remember specifically anything that they said to you about those discussions?
A. Basically they wanted to pull the plug.
Q. And what was -- what was your family's reaction to that?
A. Very bad, very negative. That would be totally against my mother's wishes?
Q. Were you aware of your mother's wishes?
A. Yes.
Q. And how were you aware of your mother's wishes?
A. We had spoken about it over the years. I'm the oldest child so I have known my mother the longest.
Q. And how many times approximately would you say that you discussed it?
A. Quite a few.
Q. Ten?
A. I don't know exactly.
Q. And what did she tell you in those conversations?
A. That she was against that idea. She even went as far as to say if it happened to any of us, she would never allow it.

Q. Again, what idea? I'm sorry?
A. Of -- if she was ever in that situation for anybody to pull a plug on her.
Q. Did she ever mention a breathing tube, what she would want to do in that situation?
A. She may have. It's possible.
Q. Do you remember that conversation?
A. Offhand, no. I think it was just life support, basically life support. If she was ever put on that.
Q. And it was your impression that she would want to stay on life support indefinitely?
A. Yes, absolutely.
Q. And she told you that herself?
A. Yes.
Q. She was transferred to Yale-New Haven Hospital on June 19, 2010. Does that sound correct?
A. Perhaps. You've got to remember, you don't have -- I don't either -- dates.
Q. I know. I'm just trying to -- sometimes I interject that in my question because it might help to jog your memory.
A. Okay, fair enough.
Q. So does that sound correct that it was summertime?

A. It could be. It could be correct.
Q. Why was she transferred from Griffin Hospital?
A. I believe that was because my father got tired of them harassing him.
Q. When you say harassing him?
A. Trying to convince him to kill my mother.
Q. And were you present for any of those conversations?
A. No.
Q. But your father told you about them?
A. Yes.
Q. So did your father request that your mother be transferred to Yale-New Haven Hospital?
A. I'm not sure now. It's possible.
Q. Did you visit your mother when she first arrived at Yale-New Haven Hospital?
A. Pretty much so, yes.
Q. And did you have any conversations with any doctors at Yale-New Haven Hospital?
A. Yes, once.
Q. And do you remember who you were speaking with?
A. Which particular doctor, no.
Q. Do you remember what the doctor looked like?

A. Sort of. It's been a long time.

Q. Would you feel comfortable describing the doctor's physical appearance?

A. Not really, because I could be wrong and I wouldn't want to be wrong.

Q. Fair enough. Do you remember the content of the conversation?

A. Yes. He was trying to convince my father to take her off life support, that she would never return to the same in his opinion and that she would probably live a long time in a rehabilitation center or whatever. That was his way of trying to convince my father. It was the conversation I was in on and I heard.

Q. Do you remember how soon after she arrived at Yale-New Haven Hospital this conversation occurred?

A. Not really, no. I can't really give you an exact date. I wish I could. Believe me, I wish I could.

Q. I understand. Your mother was at Yale-New Haven Hospital from -- according to the medical records from June 19 to July 24, I believe.

A. Okay.

Q. So that's approximately five weeks.

A. Okay.

Q. Do you remember, was it near to the beginning of her time there or near to the end of her time there?

A. My best guess would be towards the beginning.

Q. Okay, do you remember anything else that the doctor said to you in that conversation?

A. Well, he wasn't saying it to me. He was saying it to my father. I just witnessed the conversation.

Q. Do you remember anything else the doctor said to your father in that conversation?

A. No, that was the bulk. That was the main issue.

Q. Do you remember if he used the terms pulling the plug?

A. No, I think he used life support.

Q. Do you remember what your father said to the doctor in that conversation?

A. Yes, he said no. He said do not.

Q. Do not?

A. Take her off life support.

Q. Do you remember any other conversations with any other -- did you have any other conversations with any other doctors at Yale-New Haven Hospital?

A. No.

Q. Did you visit your mother at Yale-New Haven Hospital?

A. Yes.

Q. How many times over the course of that five-week period approximately did you visit your mother at Yale-New Haven Hospital?

A. Two to three times a week.

Q. So 10 to 15 times?

A. I guess. Yeah, two or three times a week.

Q. Do you specifically remember not talking to any doctors during those -- during your visits?

A. I'm not understanding your question.

Q. Because it's a terrible question.

A. Yeah.

THE WITNESS: At least he is honest.

MR. VIRGIL: Yes, he gave you that double negative in there.

BY MR. CHENEY:

Q. You said that you don't specifically remember any conversations besides the one conversation you witnessed between your father and the doctor, correct?

A. Correct.

Q. Did you speak to any doctors during any of your visits to Yale-New Haven Hospital?

A. No, I did not.

Q. Did you speak to any nurses?

A. Hello. How are you? Have a good day. That kind of stuff.

Q. Who did you go with when you visited your mother?

A. It depended. Whomever. My brother, my father, somebody.

Q. When you say your brother, you mean which brother?

A. Any one of them. Could have been any one of them.

Q. Did you go to Yale-New Haven Hospital with Kevin?

A. I may have. I may have, but I'm not sure.

Q. Did you go to Yale-New Haven Hospital with Gary?

A. Yes, I believe so, but I'm not sure. I have to retreat on that. I'm not sure exactly whom and when, but we all did do our share of going.

Q. Did you go -- aside from that one time, did you go with your father?

A. I have gone with my father, yes. And there were times we would all meet there. It was always a different set of circumstances.

Somebody always had to take care of Tracy so

somebody was eliminated. Somebody did not go each time. Sometimes it was a few of us. Sometimes it was just me and my dad. It was always a different situation.

Q. Did you always get a ride to the hospital when you went?

A. Yes.

Q. You never took the bus?

A. No.

Q. Do you remember any specific conversations you had amongst your family during those visits?

A. Specifically? Meaning?

Q. Do you remember anything that you talked about with regard to your mother's end-of-life care?

A. We were all against it, all very upset, very depressed, angry. And it's something that I will never, personally, forget.

Q. Those 10 to 15 times that you said that you were at Yale-New Haven Hospital, did a doctor ever approach you to discuss your mother's care?

A. No, he did not.

Q. Did you talk to your father about his conversations with doctors about your mother's end-of-life care?

A. Yes.

Q. Do you remember any of those conversations?
A. That I had with my father over it?
Q. Yes.
A. Yes, it was pretty much the same thing. They were trying to convince him to go along with the idea. It was basically the same thing over and over. Once they started with it, they didn't stop.
They were actually annoying, harassing, upsetting us, making me very upset, angry, depressed, everything. And I don't think I will ever forget it.
Q. Specifically, they were making you angry and depressed?
A. Yes, they were.
Q. But you didn't have any conversations with them personally?
A. With them personally, no.
Q. But from what your father --
A. Correct.
Q. -- was telling you.
Did you get the impression from your father that these conversations were occurring often?
A. Yes, I would say.
Q. Do you know how often your father went to the hospital during those five weeks?
A. Numerous times. A lot.

Q. How often would he talk to you about conversations he had with physicians at the hospital?

A. Pretty often. It was a pretty popular topic at the time amongst all of us.

Q. Was the content of what he relayed to you, the content of those conversations pretty much what you have already said?

A. Yes.

Q. Do you remember getting any phone calls at the house from any Yale-New Haven Hospital personnel?

A. My father got them.

Q. How many phone calls did your father get?

A. Oh, boy. That's like picking a number out of the lotto. I don't know.

Q. But you remember more than one?

A. Yeah, I'm sure more than one.

Q. And were you home when he got these phone calls?

A. Sometimes.

Q. And would you discuss the calls with him after he got off the phone?

A. If I was there. Or when I got there if I was not.

Q. And what did your father tell you about these phone calls?

A. Pretty much the same thing: that you're basically saying more or less the same thing we have been through. It was a topic of conversation no matter what. Through visits, through his phone calls, whatever the case may be, it was a constant deal going on. Actually, took over our whole lives, to be honest with you.

Q. Do you remember any explanation given to you by the doctors as to why they wanted to withdraw life support?

A. Given to me personally, they never did.

Q. Do you remember any explanation -- did your father ever tell you about any explanation given to him about why they wanted to withdraw life support?

A. Yeah, that it wouldn't be worth it, that she would never come back to the way she was before, and that she would probably live many years if not the rest of her life in a rehabilitation center and probably on life support is what I got from my father. Personally, they never told me that, no.

Q. Did receiving that information about your mother's prognosis change your opinion at all about whether she should remain on life support?

A. No.

Q. Why not?

A. Because it's my mother, that's why. And I know my mother, what she would want.

Q. You believe that she would have wanted to be kept on life support?

A. Yes, she believes in God.

Q. Did withdrawing life support violate her religious conviction?

A. I guess you could put it that way.

Q. How so?

A. I don't know how to say how so. This is my mom and how she thinks and what she believes in.

Q. Would your father try to avoid talking to hospital personnel at Yale-New Haven Hospital?

A. I can't see him avoiding it. He may have because he was upset from time to time. It's a possibility. Basically that's a better question for him than for me to answer it.

Q. Would you try to avoid talking to the doctors when you were there?

A. They never tried to talk to me.

Q. Were you aware that there was an ethics committee meeting at the hospital?

A. I believe my father told me about that. Is that the one where Gary and Randy attended as well?

Q. No. No. Were you aware of any family

meetings at the hospital?

A. Family meetings meaning amongst ourselves?

Q. Amongst yourselves and hospital personnel.

A. I wasn't at any meeting with personnel. Amongst ourselves, yes.

Q. You just mentioned a meeting with Randy and your father.

A. I think, but they would be able to answer that one better than me. Randy and Gary would. Or maybe it was Kevin. I'm not sure. But I think my father and two of my brothers had a meeting with doctors. But, again, don't quote me on that. I wasn't there. They would be able to answer that better during their depositions.

Q. Fair enough. Do you remember getting a phone call from Yale-New Haven Hospital saying that your mother would not be reintubated?

A. Reintubated, meaning?

Q. Meaning that they were not going to -- basically, they were going to withdraw life support?

A. I remember my father getting the call, yes.

Q. Were you at home?

A. I was not.

Q. How do you remember your father getting the call?

A. He told me. He called me and told me.
Q. Had he spoken with the folks at Yale-New Haven Hospital recently when he called you? Did he call you that night?
A. I believe so, yes.
Q. What did he say to you when he called you?
A. Just exactly what you just said to me, the same words, that they had gone through with it.
Q. Did he indicate whether he was going to go to the hospital?
A. I'm not sure -- I don't know. I don't know. I imagine he would have to at that point. Again, that's a better question for him to answer versus me.
Q. I'm just trying to remember what your side of the conversation was. Do you remember what you said to your father in that phone call?
A. Yeah. I was upset. I was crying. How could they?
Q. Did you go to the hospital?
A. I did not, no.
Q. Why not?
A. I didn't want to.
Q. Did you know that your mother was still alive at that point?
A. Did I know that my mother -- now you've got

me all confused. I thought you said after.

Q. At the time of the phone call.

A. Yes, at the time of the phone call telling my father that they took her off life support and she has now passed away. That's the phone call you're talking about?

Q. At the time of the phone call, your father was told that she was passed away?

A. Which one are you asking me?

Q. Well, did your father receive a phone call saying that your mother had passed away?

A. Yes, I am sure he has.

Q. And is that the phone call we were just discussing?

A. That's what I thought we were discussing. You said how did I find out and how did I know. And he had called and told me that they had went ahead and did it.

Q. Did your father receive a phone call before that saying that they were going to withdraw life support?

A. On that particular day?

Q. Within two days before that?

A. Oh, I'm sure. Like I said, that was a constant topic. They didn't stop with that. They

kept on. They would not accept our answer of no. They kept going and going and going with it. And that's a fact, what they did.

Q. Is it your impression that once they removed the breathing tube which we have been referring to as life support --

A. Life support. Okay, breathing tube.

Q. Is it your impression that your mother died instantly?

A. I have no idea. I'm not a doctor. I have no idea, you know, if you take life support off whether you die instantly or you don't. I wish I could answer that question. Would you be able to answer that question?

Q. The medical records reflect that she lived, she lived for a period of time after they removed her breathing tube.

A. Oh, boy. Wow.

Q. You were not aware of that?

A. I don't know if I was aware of it or not, but being aware of it now doesn't make me very happy. That means she was suffering. She was smothered to death. That's what you are telling me. If they did that, if that's what actually happened, correct?

MR. CHENEY: Can we go off the record for a

second.

(Brief discussion was had off the record.)

BY MR. CHENEY:

Q. You said that after your mother was intubated, you never spoke with her again, correct?

A. Intubated means?

Q. Well, when she was put on the breathing tube at Griffin Hospital?

A. Right.

Q. Was she responsive when you would visit her?

A. Not that I was able to detect, but I'm not a doctor.

Q. As far as making eye contact or holding your hand?

A. Yes, that we did. Held hands, eye contact, yes.

Q. Was that -- did she have the same level or ability to make eye contact with you throughout her stay at Yale-New Haven Hospital?

A. Yes.

Q. Were you aware of any problems with her skin that she was having?

A. No, I was not.

Q. And what was your understanding of her underlying medical condition while she was at Yale-New

Haven Hospital?

A. My understanding of it? I think, but again I'm not sure, she contacted something in the hospital, some kind of disease or whatever.

Q. When she was at Griffin?

A. Either -- somewhere along the line. I'm not sure where. And don't even quote me on that because, again, that's a doctor's answer --

Q. Right, I'm trying to --

A. -- more so than me.

Q. I'm trying to understand what your understanding was as to why she was in the hospital at Yale-New Haven.

A. Okay, she was at Yale-New Haven Hospital because I believe my father got too aggravated with Griffin over them trying to convince him to do that and he would not.

Q. Right. But did you have any idea of why your mother was sick?

A. I think she caught a disease.

Q. In which ways?

A. In which way or how?

Q. Right.

A. I don't know how anybody catches a disease or how -- somewhere along the line in the hospital, I

assume.

Q. Okay, let me try this a different way. Were you aware that your mother was having problems with her liver?

A. No, not specifically. Not specifically.

Q. Were you aware that she was having problems breathing?

A. Yes, she was needed help breathing.

Q. Did you know anything more about that?

A. No.

Q. Were you aware that she was having problems with her kidneys?

A. Not specifically. I imagine all of that was more than likely part of the disease that she had picked up. But again I'm not a doctor. Who am I when it comes to that?

Q. Just to make sure: You mentioned the one conversation at Yale-New Haven Hospital where you witnessed your father and the doctor talking about end-of-life care and termination of life support, correct?

A. Yes.

Q. And just to make crystal clear, you were not involved in that conversation?

A. Was the conversation pointed directly at me,

no.

Q. And you didn't participate in that conversation?

A. No, I basically just listened.

Q. Did you have any other conversations with any other Yale-New Haven Hospital personnel aside from that one?

A. I did not, no. That was my father's responsibility. They spoke to him mostly all the time.

Q. Are you aware of any free bed application?

A. No, not offhand.

Q. Any application to not have to pay Yale-New Haven Hospital for her stay, anything like that?

A. Medicare maybe, I think my father mentioned.

Q. Did you ever become less optimistic about your mother's prognosis?

A. Exactly what do you mean?

Q. At any point after she was intubated, did you think that she had a chance to survive?

A. Yes.

Q. And at any point after that, did you become less optimistic about her chances of survival?

A. No, to me, that's in God's hands. That's how

we all think. And in particular my mother.

Q. Are you aware of any writing that your mother wrote expressing her desires to -- with regard to end-of-life care?

A. Meaning? I'm not following you again.

Q. Did your mother ever write anything about her wishes pertaining to end-of-life care?

A. I'm not sure. That's another question my father would be better off answering than me.

Q. But you are not aware of any?

A. I'm not aware of any. I'm going to go ahead and say if it was, she would say no.

Q. This incident has upset you?

A. Yes, very much.

Q. And in what ways?

A. A lot of ways. One, not being able to say goodbye. Two, angry, depressed a little bit, crying constantly, speaking to God all the time. Yeah.

Q. Have you seen anyone to professionally to discuss these issues?

A. No.

Q. Have you thought about that?

A. No. A little, but not enough to react on it.

Q. Have you ever lost anyone close to you

before?

A. My grandma.

Q. Did you have similar feelings when she died?

A. Not as bad, because she died naturally, the way you are supposed to. So I was -- was I upset about my grandmother, yeah, but not like my mother.

Q. You mentioned your brothers Randy and Gary both have a child, Julia and Anthony, I believe.

A. Yes.

Q. Did Julia and Anthony ever go to Yale-New Haven Hospital? Did you ever see them there?

A. Anthony. I seen Anthony. Perhaps Julia.

Q. You remember seeing Anthony at Yale-New Haven Hospital?

A. That might have been Griffin. It could have been Griffin. I think it was one time Heather had showed up. Something about picking him up after school, in between.

It basically consumed all of our lives. We had to like adjust around that per se. You know, in their cases, their children being -- Anthony with -- I don't want to say school for sure, but something to do with Anthony, where he had had to go for one reason or another.

Heather picked him up and then went to visit

with Anthony. It could have been that. Or she was in charge of maybe watching Tracy that day or something. It's, it's kind of hard to -- it's all one big (indicating).

Q. I understand.

MR. CHENEY: I think I'm all set.

MR. VIRGIL: Then we are all done. Thank you.

(Whereupon, at 12:15 p.m., the taking of the deposition concluded.)

* * * * * * *

C E R T I F I C A T E

I, Susan Wandzilak, hereby certify that I am a Registered Professional Reporter and Notary Public in and for the State of Connecticut, commissioned and qualified to administer oaths.

I further certify that the deponent named in the foregoing deposition was by me duly sworn, and thereupon testified as appears in the foregoing deposition; that said deposition was taken by me stenographically in the presence of counsel and reduced to typewriting under my direction, and the foregoing pages are a true and accurate copy of the original transcript of the testimony.

I further certify that I am neither of counsel nor attorney to either of the parties to said suit, nor am I an employee of either party to said suit, nor of either counsel in said suit, nor am I interested in the outcome of said cause.

Witness my hand and seal as Notary Public this 28th day of March 2014.

SUSAN WANDZILAK

I have read the foregoing 46 pages and hereby acknowledge the same to be a true and correct record of the testimony.

_____

MICHAEL MARSALA

Subscribed and Sworn to
before me this ___ day of _____ 2014.

_____

Notary Public

My Commission Expires:

Yale Hospital vs. Marsala
Michael Marsala
March 10, 2014

I N D E X

E X H I B I T S
(marked for identification)

SUPERIOR COURT
JUDICIAL DISTRICT OF MILFORD/ANSONIA
AT MILFORD

CLARENCE MARSALA, Administrator of the Estate of HELEN MARSALA, et al., Plaintiffs	:	
VS	:	CV12-6010861S
YALE-NEW HAVEN HOSPITAL, INC., Defendant	:	

Deposition of RANDY MARSALA taken at the offices of Zeldes, Needle & Cooper, 1000 Lafayette Boulevard, Bridgeport, Connecticut 06601-1740, before Clifford Edwards, LSR, Connecticut License No. SHR.407, a Professional Shorthand Reporter and Notary Public, in and for the State of Connecticut on June 16, 2014, at 9:43 a.m.

DEL VECCHIO REPORTING SERVICES, LLC
PROFESSIONAL SHORTHAND REPORTERS
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HARTFORD NEW HAVEN STAMFORD

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STIPULATIONS

IT IS HEREBY STIPULATED AND AGREED by and between counsel representing the parties that each party reserves the right to make specific objections at the trial of the case to each and every question asked and of the answers given thereto by the deponent, reserving the right to move to strike out where applicable, except as to such objections as are directed to the form of the question.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing the respective parties that proof of the official authority of the Notary Public before whom this deposition is taken is waived.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing the respective parties that the reading and signing of this deposition by the deponent is not waived.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing parties that all defects, if any, as to the notice of the taking of the deposition are waived.

Filing of the Notice of Deposition with the original transcript is waived.

RANDY MARSALA

residing at 114 Foxton Court, Beacon Falls, Connecticut, having first been duly sworn, deposed and testified as follows:

DIRECT EXAMINATION

BY MR. CHENEY:

Q Hi, Randy. My name is Ben. We met off the record.

A Yes, sir.

Q Just a few things to go over before we get started to make things go smoother. One is that Cliff is going to be writing down everything that we say --

A Okay.

Q -- so when I ask you a question if you could respond verbally --

A Okay.

Q -- instead of shaking or nodding your head and --

A Okay.

Q -- that will make things easier.

The other thing is I'm going to be asking you a series of questions. Wait until I finish before you answer, that will make it easier for the transcript.

A Okay.

Q I don't anticipate us being too long but if you do need a break, just let us know, that's fine.

A Okay.

Q If you don't understand the question let me know and I'll rephrase it --

A Okay.

Q -- in a way that you can understand.

So I'd like the to start by getting some background information on you and some of your family members. We -- you've answered discovery responses so I know a little bit about your background but just to fill in some loose ends.

What's your date of birth?

A 2/6/75.

Q And I know you just told Cliff, but I wasn't paying attention, whats' your current address?

A 114 Foxton Court Beacon Falls Connecticut.

Q How long have you lived there?

A Two years in February.

Q So you moved there in 2011?

A Yes.

Q Where did you live before that?

A Twenty-two Greenwood Circle.

(THEREUPON, THE COURT REPORTER REQUESTS CLARIFICATION.)

A Greenwood.

BY MR. CHENEY:

Q And that address rings a bell because that's your father's home?

A Father's address, yes.

Q And Greenwood Circle -- twenty-two Greenwood Circle is in what town?

A Seymour.

Q So were you living at 22 Greenwood Circle in the summer of 2010?

A No.

Q Where were you living in the summer of 2010?

A Naugatuck, 151 Andrew Avenue.

Q And so how long were you living at 22 Greenwood Circle?

A Not long.

Q A month --
A Eight months-ish.
Q So when did you move out of the 151 Andrew Avenue, Naugatuck?
A It -- exact date?
Q As close as you can remember.
A I really couldn't tell you. I don't remember. It had to be October-ish.
Q October of --
A 2010.
Q And why did you leave 151 Andrew Avenue?
A To go help with my sister.
Q And so you were there for eight months in helping with your sister and then you decided to move to Beacon Falls?
A No. I moved somewhere before Beacon Falls.
Q Oh, where did you move before Beacon Falls?
A Sixty-seven Balance Rock Road.
Q And what town is that in?
A Seymour.
Q And when, approximately, did you move there?
A I don't know. I don't even know

approximately.
I could call my wife and ask her.
Q I don't think we need to do that.
A Okay.
Q I'm just trying to get a timeline for --
A Okay.
Q -- for where you were when.
A All right.
Q So if I -- just to make sure I'm straight in my head, you were living at 151 Andrew Avenue during the summer of 2010.
Is that correct?
A Yes, sir.
Q In Naugatuck?
A Yes, sir.
Q And after October 2010, you decided to go move back to your father and take care of your sister -- help take care of your sister?
A Yes.
Q You moved to Balance Rock Road and lived there briefly?
A Yes.
Q Couple months?
A A year.
Q A year. And then some time around --

some time in 2011 --
A Yes.
Q -- you moved to your current address which is 114 Foxton Court in Beacon Falls?
A Yes.
Q Okay. Excellent. Thank you.
A You're welcome.
Q And you are married to Heather.
Is that correct?
A Yes, sir.
Q And how long have you been married to Heather?
A Six years. It will be six years July 17th.
Q And you have one child?
A Yes, sir.
Q And who is that?
A Anthony Marsala.
Q How old is Anthony?
A Nine.
Q Are you currently employed?
A Yes, sir.
Q What do you do?
A I'm an auto body painter.
Q And where do you work?

A Sabo Auto Body, in Seymour.
Q How do you spell Sabo?
A S-a-b-o.
Q Oh, there you go.
How long have you worked at Sabo?
A January was three years, so three and a half years.
Q So were you working there in the summer of 2010?
A No, sir.
Q Where did you work before you worked --
A Unemployed.
Q What was your last job before Sabo Auto Body?
(THEREUPON, MS. GORSUCH ENTERS THE ROOM.)
A Last job was Crowley Auto Body.
BY MR. CHENEY:
Q And where is that?
A Bristol, Connecticut.
Q When were you hired at Sabo Auto Body?
A January 2011.
Q And when were you hired at Crowley Auto Body?
A I don't remember.

Q When did you leave Crowley Auto Body?
A I don't remember that either. I wasn't there long.
Q Oh, okay. Was it in the -- in 2010?
A Was it in --
Q Were you employed at Crowley Auto Body in 2010?
A Yes.
Q But you weren't employed in the summer of 2010?
A No.
Q Okay. Do you know what time, approximately, what month you might have left Crowley?
A No, sir.
I didn't leave, they fired me.
Q They fired you?
A So --
Q Why did they fire you?
A I have no clue.
Q Where did you work before Crowley Auto Body?
A European Motors.
Q How long did you work there?
A I don't remember.

Q A year?
A Huh?
Q A year?
A Less than a year.
Q Why did you leave there?
A I was laid off. Slow.
Q How long between European Motors and Crowley Auto Body were you unemployed?
A I don't remember that, a few months.
Q Where did you work before European Motors?
A J & A Auto Body.
Q And how long did you work there?
A A few years.
Q And why did you leave J & A Auto Body?
A More money somewhere else.
Q At European Motors?
A Yeah.
Q Where did you work before J & A Auto Body?
A I -- I don't know.
Q Okay.
A There's been so many of them, so --
Q All in the auto body --
A Yes, sir.

Q -- auto painting field?
A Yes, sir.
Q And did you go to high school?
A Yes, sir.
Q Where did you go to high school?
A Trumbull High School.
Q Did you graduate?
A Yes, sir.
Q What year?
A 1993.
Q Did you do any -- did you have any other education after Trumbull High School?
A No, sir.
Q Any trade schools --
A No, sir.
Q -- in auto --
A No, sir.
Q I brought with you or with me your notice of deposition which I'd like to mark.
(THEREUPON, DEFENDANT'S EXHIBIT NO. 1, NOTICE OF DEPOSITION, WAS MARKED FOR IDENTIFICATION.)
BY MR. CHENEY:
Q So I've marked your notice of deposition for today and I see that you are already looking at

page two, which is the list of materials that I requested you bring.
Did you bring any of these materials with you today?
A No.
Q Do you have any materials listed here?
A I believe so. I have photos.
Q You have photos. What do you have photos of?
A My mother.
Q From when she was in the hospital?
A No.
Q Just --
A Growing up photos.
Q Just family photos?
A Family photos.
Q Is there anything else on this list that you have possession of?
A I really can't see the list without my glasses.
Q Do you have your glasses with you?
A No, sir.
I wasn't told I was going to be reading something.
Q That's fair enough. So the first is:

Any medical records, documents, files, notes, letters, calendar, diaries, chronologies, tapes, memoranda or reports relating to the care and treatment of Helen Marsala with regard to the above-captioned manner?
A No.
Q "Matter."
A No.
Q Any photographs, recordings, videotapes or other documents intended to be offered into evidence at trial in this matter?
A No.
Q Any documents relating to the damages alleged in the complaint, including evidence of -- regarding collateral source payments?
A No.
Q Any documents, photographs, writings, reports, or notes pertaining to the incident described in the complaint?
A No.
Q Any and all applications, records, evidence, and documents indicating a permanent disability from any and all employers or health care providers?
A No.

has no kids.
Is that correct?
A Yes.
Q Is anyone in your family employed in the medical field?
A No, sir.
Q Does anyone have any medical education or training?
A No, sir.
Q Have you ever been involved in litigation --
A No, sir.
Q -- aside from this case?
Have any -- have any of your family members ever been involved in litigation, aside from this case?
A I don't know.
Q Are you aware of a lawsuit that your sister was involved in many years ago?
A Yes.
Q Are you aware of anything -- any other lawsuits aside from that one?
A Not that I remember.
Q Are you close with your brothers and sister?

Q A copy of any and all nonprivileged documents or materials pertaining to any lawsuits testimony, depositions, convictions or claims in which you've been involved?
A No.
Q A copy of any and all nonprivileged documents relating to any Workers' Compensation claim, unemployment claim, Social Security Disability benefit claim, government insurance benefits or bankruptcy filings --
A No.
Q -- involving you?
A No.
Q A copy of any videotapes that depict your mother or you engaging in any physical activity relating to the damages claimed in the complaint?
A No.
Q Great.
MR. VIRGIL: There is so much wildly-irrelevant stuff on that list.
BY MR. CHENEY:
Q So a little bit of background about your brothers and sister, just to make sure I've got my information correct on that. Your brother, Kevin,

A Yes.
Q All of them?
A Yes.
Q How often do you see Michael?
A Michael, probably the least amount of all of them.
Q How often?
A Once every few months.
Q How often do can you see Kevin?
A Once a week.
Q And how often do you see Gary?
A Once a week.
Q And how often do you see Tracy?
A A few times a week.
Q And so I assume you see your father a few times a week also?
A Yes, sir.
Q Have you ever been arrested?
MR. VIRGIL: On that one, objection.
Look, you can ask him about felony convictions. We've been down this road before. He's not going to answer about arrests.
MR. CHENEY: So you are instructed him not to answer?

MR. VIRGIL: Yes.
BY MR. CHENEY:
Q Okay. Have you ever been convicted of a felony?
A No.
Q What did your mother do for work?
A When my mother was working she was a lunch lady.
Q And for how many years did she do that?
A Twelve-ish.
Q And then so approximately what year would you say she stopped doing that?
A What -- I don't know.
Q Okay. Was she also a day care provider?
A As far as what?
Q As far as employment?
A No.
Q Okay. When did Tracy start requiring full-time care?
A I don't remember.
Q She's a few years older than you. Correct?
A Sure. That's -- yeah. How many years? I don't know.
Q Okay. Your mother went to Griffin

Hospital a few times near the end of her life. Is that correct? 2010?
A I don't know if it was a few times.
Q What do you remember about her going to -- the circumstances surrounding her going to Griffin Hospital?
A I remember her going to Griffin Hospital once with a broken hip and then once with a broken wrist.
Q Which came first?
A The hip.
Q And approximately when was that?
A I don't know.
Q So he -- she went into Griffin Hospital with a broken hip and then from there did she go home?
A Yes, sir.
Q She didn't go to a rehabilitation facility?
A I don't remember.
Q Okay. Do you remember her being in a rehabilitation facility?
A Yes.
Q Okay. Do you remember when that was?

A Right after she broke her wrist.
Q So you recollect that she went from Griffin Hospital with a broken hip to home, to Griffin Hospital with a broken wrist, to the rehabilitation facility?
A Yes, sir.
Q Okay. And from there where did she go?
A Back to Griffin.
Q And why did she go to Griffin that third time?
A I don't know.
Q Did you visit her when she was at Griffin Hospital at any of the three --
A Yes, sir.
Q -- times? How frequently did you visit her when she was in with the broken hip?
A With the broken hip I -- a few times a week. I don't really remember.
Q Did you have a routine about visiting her, going before work or going after work?
A No, sir.
Q And I'm sorry, you were employed at that time?
A At what time?

Q When she was in with the broken hip?
A I don't remember. I don't remember when she broke her hip.
Q Okay. How long did you stay when you visited her at Griffin Hospital when she was in with a broken hip?
A Hours.
Q Two hours, seven hours?
A Sure.
Q Closer to two?
A Closer to -- really, I don't remember.
Q Okay. I'm just trying to get an idea. Would you -- did you go alone when you went to visit her?
A No.
Q Who did you go with?
A My wife sometimes, sometimes alone.
Q Did you have a driver's license at that time?
A Did I?
Q Yes.
A Yes.
Q Would you drive to the hospital --
A Yes.
Q -- when you went to see her?

You said that you don't recall her being in a rehabilitation facility after that initial broken hip.
Correct?
A Yes.
Q She went to 22 Greenwood Circle?
A Sure.
Q Okay. Were you living at Greenwood Circle at that time?
A After the broken hip?
Q After the broken hip?
A No.
Q You were living in Beacon Falls?
No?
Where were you living?
A I don't know where I was living. I don't know -- remember when she broke her hip.
Q Okay. But it wasn't -- you weren't living at 22 Greenwood Circle?
A No.
Q Do you recall how long she was home before she broke her wrist?
A No.
Q Do you recall how she broke her hip?
A She fell.

Q You weren't -- were you present?
A No.
Q Do you remember how she broke her wrist?
A She fell once again.
Q Were you present?
A No, sir.
Q How was her mental state during that period of time when she fell?
MR. VIRGIL: Objection.
You can answer if you understand.
A Her mental state was perfect.
BY MR. CHENEY:
Q Okay. It was with not your impression that either of her falls was related to her neurological functioning?
A No.
Q Okay. How was her health otherwise?
A Good.
Q Did she have diabetes?
A Yes, sir.
Q And she had had cataracts surgery?
A Yup.
Q Is there any other medical issues like that that you can remember that she had?
A No.

Q Prior to her falling and breaking her hip, how often did you see her?
A I tried to every day.
Q And what did you do together?
A Anything and everything.
Q Can you be a little bit more specific?
A No.
What do you do with your mother?
Q I can't answer questions, sorry. I can only ask them.
A Well, you name it, I did it with her and I can't no more.
Q Okay. When she was in the hospital with a broken wrist, did you visit her then?
A Yes, sir.
Q How often did you visit her?
A A few times, every other day.
Q Do you remember speaking with any doctors at Griffin Hospital?
A No. I don't remember.
Q Did you speak to any hospital personnel?
A No.
Q So describe what you would do when you visited your mother?
A When she had the broken wrist?

Q Yes.
A Just sat with her. Just be in her presence.
Q Did you see other family members when you'd visit her?
A Yes.
Q Who did you see?
A Deb and Gary, my father.
Q Did you guys talk about who would go visit her when?
A No.
Q Did you see Michael there?
A No.
Q Did you see Tracy there?
A Yes.
Q How did Tracy get there?
A I don't know.
Q Did you ever take Tracy --
A No.
Q -- to Griffin Hospital?
After he was discharged from Griffin Hospital for a broken wrist you remember her going to a rehabilitation facility.
Is that correct?
A Yes.

Q Do you remember the name of that rehabilitation facility?
A No.
Q Do you remember where it's located?
A Derby, Ansonia, I don't know.
Q Do you remember how long she was in the rehabilitation facility?
A No.
Q Did you visit her in the rehabilitation facility?
A Yes.
Q How often did you visit her?
A Every other day, every day.
Q Do you remember where you were working at that time?
A Nope.
Q So you don't --
A I wasn't working at that time.
Q Okay. Who -- did you speak with any staff members from the -- at the rehabilitation facility?
A No.
Q Any doctors?
A No.
Q Did you see any family members at the

rehabilitation facility visiting your mother?
A Yes.
Q Who did you see?
A Gary.
Q Anyone else?
A I don't remember.
Q Do you remember anything specific about visiting with Gary when you were at the rehabilitation facility?
A No.
Q You just remember seeing him there?
A Yes, sir.
Q Okay. Where did your mother go after the rehabilitation facility?
A Back to Griffin.
Q Why?
A Don't know.
Q Were you surprised that she had gone back to Griffin?
A Yeah, I guess.
Q Did you speak with any doctors about why she was back at Griffin?
A No.
Q Did you speak with any family members about what they thought about why she was back in

Griffin?
A No.
Q Did you visit her when she was back at Griffin?
A Yes, sir.
Q How often did you visit her?
A A lot.
Q I think she -- I think she was there for four weeks, approximately.
A Okay.
Q How often -- how many times during those four weeks would you say that you visited her?
A I don't remember exact times.
As much as -- I don't know. You just want to see your mother.
Q Did you visit her more than twice?
A Yes.
Q Did you visit her every day?
A No.
Q So somewhere in between those?
A Yes, sir.
Q Did you visit her every other day?
A I don't know.
Q Okay. Fair enough. That -- during that admission to Griffin, Griffin Hospital, did you

speak to any doctors?
A No, sir.
Q Okay. How was your mother's cognitive functioning during that admission to Griffin Hospital?
A I don't understand what that --
Q How did your mother seem to you when you visited her at Griffin Hospital during that admission?
A She seemed okay.
Q Was she able to talk to you?
A Sometimes.
Q Was she able to make eye contact?
A Yes, sir.
Q Was her ability to talk to you, did that change at some point during that admission?
A I don't remember.
Q Some days she could talk and some days she couldn't.
Is what you remember?
A Yes.
Q Do you remember her being intubated?
A What --
Q And by that I mean having a breathing tube?

A Yes.
Q Do you remember when that occurred --
A No.
Q -- during that admission?
Could she speak when she had that breathing tube in?
A I don't know.
Q Do you remember -- strike that.
Once she had the breathing tube put in do you ever remember it coming out?
A I don't -- I don't remember, no.
Q Okay. You don't remember.
During that admission to Griffin Hospital did you get a sense of whether she was getting better or getting worse?
A Getting better.
Q In what ways was she getting better?
A I don't know. She just looked like she was getting better.
Q From the time that she was admitted this last time, from the time that she was admitted to Griffin Hospital to the time she went to Yale, your general impression was that she was getting better?
A From the time when?

A I don't -- no.
Q You said that some days your mother would be able to talk and some days she -- and that she was able to make eye contact. Describe to me how else she was during that admission to Griffin Hospital?
A I can't describe it.
What do you mean "describe it to you"?
Q Well, what would you do during your visit with her?
A I'd sit there.
Q Okay. Would you hold her hand?
A Yeah.
Q Do you remember any specific conversations you had with any of your family members --
A No.
Q -- during that admission?
A No.
Q Do you remember ever discussing end-of-life care during that admission with your family members?
A Not then, no.
Q Do you remember discussing end-of-life care with any of your family members before that

Q From when -- during the last Griffin Hospital admission --
A Okay.
Q -- from the day that she went there from the rehabilitation facility until the day she left to go to Yale-New Haven Hospital, was it your general impression that she was getting better?
A Oh, I don't know.
Q Did she seem about the same?
A Yes.
Q Okay. You said you remembered speaking with her during that admission?
A I don't remember.
Q Okay. Did you see any family members there during that last admission to Griffin Hospital?
A Yup.
Q Who did you see?
A I saw my father, Kevin, and Gary.
Q Did you see Tracy?
A At that time, I don't remember.
Q Did you see Michael?
A No.
Q So you never drove Michael to the hospital, to Griffin Hospital?

admission?
A Yes.
Q Can you please tell me about those conversations?
A As far as the whole conversations I don't remember, but I believe none of us wanted to be taken ever off of life support.
Q When you say "none of us," who are you referring to?
A My whole family.
Q Do you remember any specific conversations you had with anyone in particular about that?
A No. We were all on the same page.
Q And why -- why didn't -- why does -- strike that.
It was your impression that your mother didn't want to be taken off life support?
A Definitely didn't want to be taken off life support.
Q And how do you know that?
A Because we have all talked about it.
Q Did you speak about it with your mother?
A Years ago, sure.
Q Do you remember that conversation at all?

A No. As far as she needed to be there for my sister.
Q With --
A She wanted to see my grandson grow up, her grandson grow up, my son and she's not. And that's a problem.
Q It was your impression that the basis for your mother wanting to stay on any life support measures was to see your sister --
A To take care of my sister.
Q To take care of your sister and see your son grow up?
A And her granddaughter too.
Q Do you know if she had any religious basis for --
A No.
Q -- not wanting to be removed?
A No.
Q No, she didn't or no, you don't know?
A No, I don't know.
Q Okay. Did you ever discuss with any family members a situation that might arise when she would be removed from life support -- you would favor removal from life support?
A I don't -- explain that.

Q You said that, generally speaking, you and all your family members would never want to be removed from life support.
Is that correct?
A Yes, sir.
Q Did you ever discuss any scenario in which any one of your family members would want to be removed from life support?
A No.
Q During that last admission to Griffin Hospital, was your mother awake?
A I don't remember.
Q Your mother was transferred to Yale-New Haven Hospital.
Correct?
A Yes, sir.
Q And do you know why?
A Don't remember why.
Q Do you remember talking to your father about that?
A Yeah.
Q Do you remember if he had any reason for wanting to transfer her to Yale-New Haven Hospital?
A No.

Q Were you pleased with the care she was receiving at Griffin Hospital?
A Was I pleased? I don't know.
Yeah, I was pleased.
Q What's your understanding of why she was transferred to Yale-New Haven Hospital?
A To get better.
Q Were you employed when she went to Yale-New Haven Hospital?
A No, sir.
Q So how often did you visit her when she was at Yale-New Haven Hospital?
A I don't remember.
Q Do you remember speaking with any doctors at Yale-New Haven Hospital?
A Yes, sir.
Q Who did you speak with?
A Don't know their names.
Q Do you remember any specific conversations you had with any doctors at Yale-New Haven Hospital?
A Yes, sir.
Q Tell me about the first specific conversation?
A There was only one.

Q Okay.
A And they wanted to take my mother off life support. And that was a no-no.
Q When you said "they," was it several doctors you spoke with?
A There were three doctors in the room.
Q Were they male or female?
A Both.
Q Can you be more specific?
A There were males and females.
Q Two and one; two males one female?
A There was two and one; which one it was, I don't remember.
Q And you don't remember any of their names?
A No, sir.
Q Are you sure that they were all doctors?
A Yes. Do I -- am I a hundred percent sure? No.
Q Okay.
A One could have been a nurse.
Q Okay.
A I don't know.
Q Was one of the three doctors primarily speaking on behalf of the doctors?

A I don't remember.
Q Were all -- did all three speak --
A Yes.
Q -- to you?
A Yes.
Q So to the best you can remember, can you tell me what they told you?
A To the best I remember is they wanted to take my mom off life support.
Q When did this conversation occur?
A As far as?
Q As far as your mother was admitted to Yale-New Haven Hospital on June 18, 2010 and she passed away on July 24, 2010. So was it closer to the beginning of her admission or closer to the end of her admission?
A I don't remember.
Q Was it the day she was admitted?
A No.
Q Was it the day before she passed away?
A No.
Q So it was some time in the middle?
A Yes, sir.
Q Okay. So back to specifically the conversation, the three doctors communicated to you

that they wanted to remove your mother from life support?
A Yes, sir.
Q Did they say why?
A They probably said why, but I chose to block it out.
Q Why did you chose that?
A Because that's not even a thought.
Q It didn't matter to you what they said?
A No.
Q Nothing they could have said --
A Nothing.
Q Do you remember who else was present --
A Yes.
Q -- at this conversation besides these three doctors and you?
A Yes, sir.
Q Who else was present?
A My father and my brother Gary.
Q Did you say anything specifically during this conversation?
A Yes. I said "no."
Q "No" as in no, don't remove --
A No as in don't.
Q Got you.

Did your father say anything during this conversation?
A Yeah. All three of us said, No, that's it. Forget about it.
Q Was this the first time you had been approached about removal of your mother's life support?
A Yes.
Q Was this the first time you were aware that it was something that was being discussed between the doctors and your family?
A Yes.
Q Were you aware that some end-of-life conversations had occurred at Griffin Hospital?
A No.
Q Do you remember any other specific conversations with any doctors at Yale-New Haven Hospital?
A No, sir.
Q Do you remember specifically that there were no other conversations with any doctors at Griffin Hospital?
A There were no other conversations with me.
Q Thank you. Did you hear about this

topic, this end-of-life decision-making topic again after that conversation?
A No.
Q Not from any -- no family member talked to you about it?
A No.
Q Did your father ever tell you about any phone calls that he was receiving from the hospital?
A I don't remember.
Q Did any Yale-New Haven Hospital personnel attempt to contact you again about removal of life support?
A No.
Q What time of day did you visit your mother when you visited her at Yale-New Haven Hospital?
A No specific time.
Q And how long did you stay?
A A few hours.
Q And I know I've asked you this, so I apologize, but just to get a better idea --
A That's okay.
Q -- I'm going to ask you again.
Over that five week period do you have an

estimate of how many times you visited your mother?
A No.
Q Would you avoid speaking to doctors when you went there?
A No, I didn't avoid.
Q But you -- would you seek out a doctor to ask about your mother's condition?
A No.
Q Why not?
A Just who I am.
Q Did you get an impression as to whether your mother was getting better during her time at Yale-New Haven Hospital?
A No.
Q Did she seem better to you?
A I really didn't go in the room much.
Q What would you do when you visited?
A Wait outside in the room -- outside the room.
Q In the hallway?
A Uh-huh.
Q You said "wait outside," were you waiting for family members to visit or --
A No.
Q Just being there?

A Yup.
Q Was she in the intensive care unit at that time?
A I don't remember.
Q Were the hallways busy with a lot of activity?
A I don't -- I don't remember.
Q Would you see nurses rounding?
A Sure.
Q Did you say hello to them?
A Sure.
Q So did you occasionally have brief conversations with them?
A No.
Q Okay. How did you find out that your mother had passed away?
A My father called me.
Q When did your father call you and tell you that?
A I'm assuming as soon as he find out.
Q Do you remember what time of day it was?
A No.
I choose not to remember any of it.
Q Why is that?
A Because it's my mother and Yale took her

and I got a problem with that.
Q What did your father say to you when he called?
A I don't -- I couldn't tell you.
Q Was your wife home?
A Yes, sir.
Q And your son?
A Yup.
Q Did you speak to them after you spoke to your father?
A I don't remember.
Q Sorry, I know this isn't easy.
MR. VIRGIL: Let's take a break.
(THEREUPON, THERE WAS A RECESS TAKEN FROM 10:34 a.m. TO 10:38 a.m.)
BY MR. CHENEY:
Q Were you involved in paying any of your mother's medical bills?
A No.
Q Are you aware of any payments that were made to Yale?
A No.
Q Did you ever discuss the issue of medical bills with your father at all?
A No, sir.

Q Did this event have an emotional impact on you?
A Yes.
Q Can you just please describe how this has affected you?
A It's affected me in a lot of ways, that's my mom. She was there for everything, you know. My son asks his mother every day.
Q Did you take your son to see her --
A No.
Q -- when she was at Yale or at Griffin?
A No.
Q Have you seen anyone, any professional about this event?
A No, sir.
Q Why not?
A That's not me.
Q When did you find out that Yale had removed life support from your mother?
A When did I -- I don't remember. When my father told me.
Q Was that the same day that he told you that she passed away?
A I don't -- it's all a blur after that.
Q Do you remember that any -- the

conversation where you learned about -- that Yale had removed life support from your mother?
A Do I remember the conversation? No.
Q Do you have any feelings about that that are distinct from your mother passing away?
A Explain.
Q You are upset that your mother has passed away.
Correct?
A Yes, sir.
Q Do you have feelings about Yale's role in that event that are different than the feelings that you have because your mother passed away?
A I have feelings as far as Yale took her away and it makes me upset and mad and angry.
Q Why does it make you angry?
A Once again, I'll ask you, what would you do if someone took your mother? How would it make you feel?
Not good; right?
You know, it's my mom. There ain't no amount of money that's going to make it go away. She ain't ever coming back.
MR. CHENEY: I think I'm all set.
MR. VIRGIL: All right. All done.

MR. CHENEY: Thank you.
(THEREUPON, THE DEPOSITION WAS CONCLUDED AT 10:42 a.m.)

INDEX OF EXAMINATION

INDEX OF EXHIBITS

(Reporter's Note: Exhibits retained by counsel.)

CERTIFICATE

I hereby certify that I am a Notary Public, in and for the State of Connecticut, duly commissioned and qualified to administer oaths.

I further certify that the deponent named in the foregoing deposition was by me duly sworn, and thereupon testified as appears in the foregoing deposition; that said deposition was taken by me stenographically in the presence of counsel and reduced to typewriting under my direction, and the foregoing is a true and accurate transcript of the testimony.

I further certify that I am neither of counsel nor attorney to either of the parties to said suit, nor am I an employee of either party to said suit, nor of either counsel in said suit, nor am I interested in the outcome of said cause.

Witness my hand and seal as Notary Public this _____ day of _____, 2014.

_____
Clifford Edwards
Notary Public
My commission expires: 9/30/2016

JURAT

I have read the foregoing 50 pages and hereby acknowledge the same to be a true and correct record of the testimony.

_____
RANDY MARSALA

Subscribed and sworn to
_____.
Before me this _____ day of _____,
2014.

_____
Notary Public
My Commission Expires:

CORRECT PAGE

NAME OF CASE:
MARSALA V. YALE-NEW HAVEN HOSPITAL

NAME OF WITNESS:
RANDY MARSALA

PAGE	LINE	NOW READS	SHOULD READ

DEL VECCHIO REPORTING SERVICES, LLC
117 RANDI DRIVE
MADISON, CT 06443
203-245-9583

CASE NAME: MARSALA V. YALE-NEW HAVEN HOSPITAL
DEPOSITION OF: RANDY MARSALA TAKEN 6/16/14
SENT TO: MR. VIRGIL on 6/30/14

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THANK YOU.

SUPERIOR COURT
JUDICIAL DISTRICT OF MILFORD/ANSONIA
AT MILFORD

CLARENCE MARSALA, ADMINISTRATOR OF THE ESTATE OF HELEN MARSALA, ET AL.

VS. AAH CV12-6010861S

YALE-NEW HAVEN HOSPITAL, INC.

Deposition of TRACEY MARSALA, taken in accordance with the Connecticut Practice Book at the law offices of Zeldes, Needle & Cooper, P.C., 1000 Lafayette Blvd., Bridgeport, Connecticut, before Deborah Gentile, RPR, a Registered Professional Reporter and Notary Public, in and for the State of Connecticut, on June 20, 2014 at 10:02 a.m.

DEBORAH GENTILE, RPR

DEL VECCHIO REPORTING SERVICES, LLC
PROFESSIONAL SHORTHAND REPORTERS
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MADISON, CT 06443
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Hartford Stamford

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

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ALSO PRESENT:

HEATHER BOHMAN, INTERPRETER

KRYSTIN LEMAY, INTERPRETER

CLARENCE MARSALA

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NO EXHIBITS WERE MARKED

S T I P U L A T I O N S

IT IS HEREBY STIPULATED AND AGREED by and between counsel representing the parties that each party reserves the right to make specific objections at the trial of the case to each and every question asked and of the answers given thereto by the deponent, reserving the right to move to strike out where applicable, except as to such objections as are directed to the form of the question.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing the respective parties that proof of the official authority of the Notary Public before whom this deposition is taken is waived.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing the respective parties that the reading and signing of this deposition by the deponent is not waived.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing parties that all defects, if any, as to the notice of the taking of the deposition are waived.

Filing of the Notice of Deposition with the original transcript is waived.

HEATHER BOWMAN, having first been duly sworn, interpreted in sign language as follows:

TRACEY MARSALA, having first been duly sworn, was deposed and testified as follows:

DIRECT EXAMINATION

BY MR. CHENEY:

Q Hi Tracey. My name is Ben Cheney. I represent Yale-New Haven Hospital. I'm going to ask you a few questions. If you don't understand a question, please let me know and I'll ask it in a different way.

A Okay.

Q If you need a break, that is fine. Please let me know. I know this is not easy to talk about and some of my questions may seem straightforward, but I have to ask you.

A All right.

Q We spoke with your father about this case. Did you know that?

A Yes.

Q And your father told us that you are deaf; is that true?

A Yes.

Q He also told us that you are most likely

blind; is that true?

A Yes, that's right.

Q He told us that you were involved in a lawsuit many years ago; is that true?

A Yes, that's right.

Q The settlement from that lawsuit is confidential, correct?

A What suit? Which suit?

Q Were you involved in multiple lawsuits?

INTERPRETER: She's asking for clarification on the sign.

THE WITNESS: Yes, I did file suit on someone else before, yes.

INTERPRETER: She was asking for clarification on the sign.

BY MR. CHENEY:

Q And you settled that case, correct?

A Correct.

Q And the settlement from that case is confidential, correct?

A Right.

Q Your father told us that you own a house on 22 Greenwood Circle in Seymour, Connecticut; is that correct?

A Right.

Q And your father lives with you?
A Right.
Q And your mother lived there before she passed away, right?
A Right.
Q Do you remember your mother falling and breaking her wrist in 2010?
A Yes. Yes.
Q Your father told us you visited her at Griffin Hospital; is that true?
A Right.
Q And he told us that you never visited your mother at Yale-New Haven Hospital; is that true?
A Right.
Q He told us that you learned earlier this year that Yale-New Haven Hospital removed your mother's life support; is that true?
A Yes.
Q He said that Gary told you; is that true?
A Right.
Q And that before Gary told you that Yale-New Haven Hospital removed your mother's life support, you did not know that Yale-New Haven Hospital had removed your mother's life support; is that true?
A That is right.

Q Your father said Gary told you about your mother being removed from life support a few days before we spoke with him, which was February 27th, 2014; does that sound right?

INTERPRETER: Interpreter would like the date repeated, please.

MR. CHENEY: February 27th, 2014.

THE WITNESS: That seems right.

BY MR. CHENEY:

Q Was that conversation the first time you found out that your family had sued Yale-New Haven Hospital?

A When I found out what?

Q That your family had brought a lawsuit against Yale-New Haven Hospital.

A Yes.

Q That was the same time that you found out that you had sued Yale-New Haven Hospital?

INTERPRETER: Could the interpreter get a clarification on the question?

MR. CHENEY: Sure.

INTERPRETER: Are you asking about this lawsuit?

MR. CHENEY: Yes.

INTERPRETER: That's when she found out she

was involved, is that what you're asking?

MR. CHENEY: Yes. When she spoke with Gary around February 27th, 2014, was that the first time she learned that she was involved in this lawsuit.

INTERPRETER: Okay. Thank you.

THE WITNESS: Yes, that seems right.

BY MR. CHENEY:

Q Tracey, do you ever stay home alone?

A Yes.

Q How often are you home alone?

A A lot. Couple times, two, three times a week. It depends. I -- I like to stay home alone.

Q And how long a period of time do you stay home alone?

A Can you clarify that, please?

Q Sure. You said that you stay home alone a few times a week. When you're home alone those times, how many hours are you home alone for?

A Well, it depends. Sometimes it's just an hour, sometimes two, sometimes 15 minutes.

Q Do you cook meals at home?

A Yes. I cook and bake.

Q What do you like to cook?

A Well, what do you mean? I mean . . .

Q I'm just wondering if there's anything in

particular you enjoy cooking or baking?

A Oh, anything. I cook and bake, so anything. I just love baking.

Q Do you do laundry at home?

A Yes. I clean the house.

Q Do you do any other chores?

A I make the bed. I vacuum.

Q Okay. Do you do more chores now that your mother has passed away?

A Yes. A lot of work.

Q Did you and your mother used to do chores together?

A That's right.

Q When your mother was alive, did she do anything to help you around the house?

A She helped me with everything.

Q Can you give me some examples of things that she would help you with?

A She helped me cook. She helped me with the laundry. And I would help her as well.

Q Do you -- aside from chores, was there anything that your mother helped you with?

A Um, like, I guess I don't know what you're meaning.

Q Do you require any special assistance given

that you're mostly blind and deaf?

A No.

MR. VIRGIL: Can we go off the record one second?

(A discussion was held off the record.)

BY MR. CHENEY:

Q Tracey, do you get dressed yourself?

A Yes.

Q Tracey, can you move freely around the house without assistance?

A Yes. I can move about.

Q And can you bathe yourself?

A I can. Myself.

Q You and your mother were very close; is that right?

A Yes.

Q What did you do together?

A Go to the store. We'd go out to eat. We'd go on vacation.

Q Where did you go on vacation?

A Oh, my goodness. California, Florida, Long Island, the casinos.

INTERPRETER: And she's giving me a specific place on Long Island that I can't quite catch the spelling of.

BY MR. CHENEY:

Q What was your favorite vacation?

A California.

Q Have you gone on any vacations since your mother passed away?

A No. Not with the family.

Q Have you gone on any vacations without the family since your mother passed away?

A Yes. I used to go on vacation to Kansas once a year to visit friends, but since mom has died, I've stopped.

Q Do you want to go to Kansas still?

A Well, now I don't want to leave home.

Q Why not?

A Oh, I don't know.

Q Okay. When you went to Kansas, who did you go to Kansas with?

A I went by myself. I flew alone. My dad -- my dad was chicken to fly. I don't know why that is.

Q Do you go shopping since your mother has passed away?

A Well, with dad, he takes me or my brother.

Q Which brother?

A Kevin.

Q Are you close with your brothers?

A No. We're not that close.

Q Okay. Have any of your friends from Kansas come to visit you since your mother passed away?

A One time.

INTERPRETER: But the interpreter is asking can we clarify that, before or after mom's death?

MR. CHENEY: After.

THE WITNESS: About the time of mom's death they came.

BY MR. CHENEY:

Q Okay. Do you still go out to eat since your mother passed away?

A Not really, no.

Q Why not?

A I end up staying home and cooking.

Q Do you miss your mother?

A Yes.

Q How has your life changed since she passed away?

A What do you mean?

Q I understand that you've lost someone. How else has your life changed now that your mother is not around?

A I don't know if I can explain. It is changed because I have to do everything by myself now.

I have to take care of the house by myself. I have to do laundry by myself. It's just not the same.

Q Are you lonely?

A Yes. I feel alone.

Q When you visited your mother in Griffin Hospital, did you communicate with any doctors?

A One time.

Q Who did you communicate with?

A I don't know his name.

Q What did you talk about?

INTERPRETER: She says no.

BY MR. CHENEY:

Q When you communicated with the doctor at Griffin Hospital, did you communicate about your mother?

A I didn't talk to the doctor.

Q Okay. When you visited your mother in Griffin Hospital, did you communicate with your mother?

A Not in the hospital.

Q Do you know if your mother was on a machine to help her breathe?

INTERPRETER: The interpreter is asking for a time frame. Ever? Any specific hospital?

MR. CHENEY: Ever.

THE WITNESS: Yes.

BY MR. CHENEY:

Q Do you know if she was on that machine at Griffin Hospital when you visited?

A No, I didn't see that.

Q Did you know that your mother was transferred from Griffin Hospital to Yale-New Haven Hospital?

A Yes, I knew that.

Q When did you learn that?

A I don't know when. But Gary told me in an email on the computer.

Q When she was still alive?

A Yes.

Q When your mother was at Yale-New Haven Hospital, did you communicate with any family members about how she was doing during that time?

A Yes.

Q Who?

A Dad, Kevin, Gary.

Q What did they tell you?

A What was going on with mom.

Q Your brother Gary told me that you had a service for your mother and scattered her ashes on her parents' graves. Is that true?

A Could you explain that, please?

Q After your mother passed away, your family got together at the cemetery and scattered your mother's ashes. Is that true?

INTERPRETER: The interpreter is using a sign for "funeral", but she's saying mom didn't have a funeral. So can you give me some different language?

MR. VIRGIL: Service.

MR. CHENEY: Service.

INTERPRETER: Okay.

MR. CHENEY: Thank you.

THE WITNESS: Yes, we scattered her ashes. Yes.

BY MR. CHENEY:

Q Did you go?

A No. I didn't see that.

Q Why not?

A I was in bed. They went very early in the morning.

Q How did you feel after your mother died?

A I was not happy. I was very depressed. I was angry. I was very sad. It was a very serious situation. I missed her.

Q How did you feel when you found out that Yale-New Haven Hospital had removed your mother's life

support?

INTERPRETER: We're clarifying a sign. Do you mind if the interpreter tries again? Same question.

MR. CHENEY: No. Please.

THE WITNESS: Oh, I was very unhappy. Yale was wrong.

BY MR. CHENEY:

Q Are you glad that Gary told you?

A Yes.

Q Why?

A Why?

Q Why are you glad to know now?

A That's not clear. The question is not clear.

Q Okay. Tell me about your mother. What kind of lady was she?

A What would you like to know?

Q Was she funny?

A Yes.

Q Was she caring?

A Yes.

Q Can you think of any other words you'd like to tell me to describe her?

A Wow.

Q It's okay if you'd rather not. I know this is difficult. And I apologize that I had to ask you such difficult questions. Thank you for taking the time to come talk to me.

MR. VIRGIL: There are actually two things. There are just two things that I need to clarify.

CROSS-EXAMINATION

BY MR. VIRGIL:

Q When you saw your mom at the hospital, were you able to communicate with her by writing?

A Yes.

Q And did you do that when you visited her at Griffin?

A No.

Q And you were asked earlier if you ever spoke with a doctor. You first said "yes," then you said "no." Were you thinking of the time --

A Well, it wasn't a doctor. It was a nurse. And that's who I talked with about mom.

Q Do you remember what you talked about with the nurse?

A I don't remember.

Q Okay. Thank you.

MR. CHENEY: I have one more question.

REDIRECT EXAMINATION

BY MR. CHENEY:

Q Jeremy asked you about writing notes to your mother. Did you often write notes to your mother to communicate with her?

A In Yale?

Q At any time.

A Many times we would write.

Q Do you have any of the notes that you and your mother wrote to each other?

A No, I tossed them a long time ago.

Q Okay. Thank you, Tracey.

(Deposition concluded at 10:41 a.m.)

C E R T I F I C A T E

I hereby certify that I am a Notary Public, in and for the State of Connecticut, duly commissioned and qualified to administer oaths.

I further certify that the deponent named in the foregoing deposition was by me duly sworn, and thereupon testified as appears in the foregoing deposition; that said deposition was taken by me stenographically in the presence of counsel and reduced to typewriting under my direction, and the foregoing is a true and accurate transcript of the testimony.

I further certify that I am neither of counsel nor attorney to either of the parties to said suit, nor am I an employee of either party to said suit, nor of either counsel in said suit, nor am I interested in the outcome of said cause.

Witness my hand and seal as Notary Public this 8th day of July, 2014.

Deborah Gentile
Notary Public

My commission expires: October 31, 2016

205486 eb

DOCKET NO.: AAN-CV-12-6010861-S * SUPERIOR COURT
*
CLARENCE MARSALA, ET AL * J.D. OF MILFORD/
* ANSONIA AT MILFORD
VS. *
*
YALE-NEW HAVEN HOSPITAL * AUGUST 28, 2014

DOCKET NO.: AAN-CV-12-6011711-S * SUPERIOR COURT
*
CLARENCE MARSALA, ADMINISTRATOR * J.D. OF MILFORD/
OF THE ESTATE OF HELEN MARSALA * ANSONIA AT MILFORD
*
VS. *
*
YALE-NEW HAVEN HOSPITAL, INC. *
D/B/A YALE NEW HAVEN HOSPITAL * AUGUST 28, 2014

DEPOSITION OF LOUIS MARC HAMER, MD

UPON RECEIPT OF SIGNATURE, THE ORIGINAL OF THIS DEPOSITION WILL BE IN THE CUSTODY OF:
Penny Q. Seaman, Esquire
Wiggin and Dana LLP
One Century Tower, 265 Church Street
P.O. Box 1832
New Haven, Connecticut 06508-1832

Date Edith A. Boggs, CSR

10-3-14 HOUSTON, TEXAS

DEPOSITION OF LOUIS MARC HAMER, MD

DEPOSITION AND ANSWERS of LOUIS MARC HAMER, MD, taken before Edith A. Boggs, a certified shorthand reporter in Harris County for the State of Texas, taken at the offices of Esquire Deposition Solutions, 1001 McKinney, Suite 805, Houston, Texas, on the 3rd day of October, 2014, between the hours of 10:31 a.m. and 4:24 p.m.

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By: Penny Q. Seaman, Esquire

REPORTED BY:

Ms. Edith A. Boggs

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PROCEEDINGS

MR. VIRGIL: Usual stipulations?

MS. SEAMAN: Yes. Does he want to read and sign?

MR. VIRGIL: Yes, let's read and sign.

LOUIS MARC HAMER, MD

was called as a witness and, being first duly sworn by the notary, testified as follows:

EXAMINATION

Q. (BY MS. SEAMAN) My name is Penny Seaman. I represent Yale-New Haven Hospital in an action filed by Clarence Marsala and others arising out of the death of Helen Marsala at Yale-New Haven Hospital in 2010.

You've been designated by the plaintiff as a possible expert witness, and I'm here to ask you some questions about the materials you've reviewed and the opinions that you've formed.

A. Yes.

Q. Have you ever been through this process before?

A. I've been deposed, yes.

Q. So, you understand the court reporter is here to take down my questions and your answers. She can't take down body language, no nods or shakes of the head. So, you need to answer audibly.

We need to try not to speak over each other

because she's trying to make an accurate recording of what we're saying. So, we need to let the other one finish speaking before we start.

And if you don't understand one of my questions, you need to tell me because if you answer it, I'm going to assume you understood it. Does that seem reasonable?

A. That seems reasonable.

Q. Okay. I can see that you have brought a lot of things with you. Would you tell me what you have, please?

A. I tried to comply with the subpoena duces tecum.

(Exhibit 1 marked.)

Q. (BY MS. SEAMAN) So, just to be clear, you're talking about a notice of deposition that's been marked as Exhibit 1 --

A. Yes.

Q. -- if you look at the second --

A. That's correct.

Q. Okay.

A. Okay. You asked for a copy of my current curriculum vitae, which is on the computer but I don't have it printed out because I was under the impression you already had that.

(Exhibit 2 marked.)

Q. (BY MS. SEAMAN) Let me show you Exhibit 2, which

is the CV, I believe, that was produced to me by plaintiffs' counsel, and I'll ask if you can identify that?
A. Yes, I can. It needs some updates.
Q. Would you tell me what changes would need to be made to Exhibit 2 to make it accurate and complete as of today?
A. Well, I was recertified in internal medicine in 2013.
Q. Is there a ten-year recertification requirement?
A. Yes.
Q. Okay. Anything else?
A. The last two pages are missing.
Q. What are the last two pages? Or what information is contained on the last two pages, I mean, just generally? I'm not asking verbatim but is it publications? Is it jobs? Is it appointments?
A. I believe there were some publications, and there may have been some information about consulting work.
Q. Do you have that on your computer with you today?
A. Yes, I do.
Q. Can you pull it up, please?
A. Sure.
MS. SEAMAN: Off the record.
(Off the record.)

Q. (BY MS. SEAMAN) What else did you bring with you today?
A. This says, "A copy of any nonprivileged statements, as defined in Practice Book Section 13-1 of any party in this lawsuit concerning this action or its subject, that would basically be the letters sent to me from plaintiffs' counsel.
Q. May I see those, please?
A. There might be some more.
(Exhibits 3-10 marked.)
A. That's all I see.
Q. (BY MS. SEAMAN) Okay. And I note that in the transmittal letters, it refers to providing you with certain transcripts of depositions; is that correct?
A. That's correct.
Q. And have you reviewed those transcripts?
A. I did not review all of them, no.
Q. Which ones did you review?
A. I reviewed the transcript of Dr. Pisani and Dr. Burke.
Q. Could that be Boyd?
A. Boyd. Boyd. Excuse me. And then I looked through Mr. Clarence Marsala's deposition, although I didn't read it in detail, and I did not get to the other family members.

Q. Okay. And other than the transcripts of the deposition and the transmittal letters that we've marked, do you have any other statements as set forth in paragraph 2?
A. I have no other statements.
Q. And how about number 3? You brought with you a box of medical records; is that correct?
A. Yes.
Q. Are there any notes in those medical records?
A. I have the notes separately.
Q. Okay. And is this package of notes notes that you made?
A. Yes, I made those.
Q. Is it all in your handwriting?
A. Yes, that's my handwriting.
Q. When did you make them?
A. As I was reviewing the medical records during the last week and a half in preparation for this deposition.
Q. Had you reviewed the medical records prior to the last week and a half?
A. Yes.
Q. When was the first time you reviewed them?
A. I reviewed some of them initially when I was first contacted by plaintiffs' counsel.
Q. And which ones did you review at that time?

A. I don't recall. I'd have to look at my report because the records that were reviewed are listed on the report.
Q. Did you make any notes the first the time you reviewed the medical records?
A. No, I didn't make any notes.
Q. Did anyone look at these notes prior to this morning when I looked at them?
A. Other than me?
Q. Yes.
A. No.
Q. Okay.
A. Let me make sure there's not a blank page at the end.
Q. Sure.
A. I would like to refer to those during the deposition, if possible.
Q. I thought what I would do, if you have no objection, is I'll mark them and then I'll ask to have copies made, and then I can look at them while you're looking at them, and I will make one for Jeremy. Is that okay?
A. That would be fine.
Q. And you have no other notes?
A. No, those are the notes.

Q. And when you looked at the medical records, did you put notes on the medical records themselves?
A. No, I don't.
Q. The next thing you were asked to bring is all the correspondence, and I believe that that's what you've already given me; is that right?
A. Yes. That's correct.
Q. Do you have any other correspondence?
A. No, I have no other correspondence.
Q. The next item is all materials you reviewed in forming your opinions in this matter. Do you have any documents responsive to that?
A. Yes.
Q. Okay. All right. So let me show you what's been marked as Exhibit 5. And you can look at the whole thing if you want. It's the disclosure of expert, but I'm going to show you what I wanted to refer to. I think it's the third page. Attached to the expert witness disclosure that's been marked as Exhibit 5 is what I believe to be your report dated October 20, 2012; is that correct?
A. That's correct.
Q. And in connection with writing this report, was this report indicative of the first opinions you formed in connection with this case?

A. They were indicative of my initial opinions. There have been some changes to my opinions.
Q. On the first page of your report is a list of the records reviewed, and I'm asking whether any of this stack of papers that you just gave me are reflected on that list?
A. The only one that's in that stack of papers is the Connecticut General Statutes Section 19a-571.
Q. Okay. And that was something that was provided to you by counsel for the plaintiff?
A. That was provided to me by counsel, yes.
Q. Okay. And until plaintiffs' counsel provided you with that statute, you weren't familiar with that, would that be fair to say?
A. With Connecticut's statute?
Q. Yes.
A. No.
Q. No, you were not familiar with the statute in Connecticut before --
A. In Connecticut. I wouldn't have any reason to be familiar with Connecticut's statute. I'm familiar with Texas' statute.
Q. I'm sorry, but I just need to get my question out for the record.
Before counsel for the plaintiff provided you

with the Connecticut statute, you weren't knowledgeable about the Connecticut statute; is that correct?
A. I had not seen it before, no.
Q. Okay. And you say you're familiar with the Texas statute, what is the Texas statute?
A. There's a Texas Advance Directives Act. It's referred to a lot in literature about the end of life care because it's rather unique among the state statutes in that it has a procedure for withdrawal of care in cases of futility.
Q. And the Connecticut statute authorizes the withdrawal of care in cases of futility without the consent of the patient or the patient's surrogate?
MR. VIRGIL: Object to form.
A. Did you say Connecticut or Texas?
Q. (BY MS. SEAMAN) I meant to say Texas, so, let me ask you again.
A. The Texas statute is more well defined. First of all, it defines futility. Futility is when there's no hope of achieving the physiologic goals.
Q. Physiologic what?
A. Goals.
Q. Goals. Sorry. But my question was a little different.
A. Let me finish. I was in the middle of answering

it.
Q. Okay.
A. And it also has a procedure for due process when the ethics committee decides that a case is futile over the objection of family members, and their due process requirements require that the institution assist the family in locating another facility or provider to take over the care.
And the reason they require the facility to assist the patients is because patients would probably not be able to do that on their own. I mean, it requires physician-to-physician communication. It requires a case manager calling the other hospital to facilitate a transfer, and that's one of the reasons that's written in the statute.
The statute also requires at least ten days for the family members to have the option of trying to transfer care. If they need longer than ten days, they have the option of filing a motion with the probate court.
It also requires the institution to inform the family of their rights, of the right to counsel and of how to go about filing a motion with the probate court. It has to be a little bit more detailed than just you can call an attorney if you want.

Q. Who pays for that counsel?
A. That's not specified in the statute but my guess would be that the family would pay. Also, the statute does specify that the family must pay for the transfer of the patient to the new facility.
Q. All right. So, when you say that the Texas statute defines futility as no hope of achieving physiological goals, is that a quote from the statute?
A. No, that's a paraphrase, but the statute itself is in that stack of materials I gave you, and if you wanted to get the exact wording from the statute, we could.
Q. And what the Texas statute provides is a method or a process by which a healthcare provider can terminate life support without the consent of the patient; is that true?
A. I would say that it provides for due process for patients so that ethics committees cannot easily withdrawal against their wishes.
Q. So, your answer is no, the Texas statute does not provide a process whereby a healthcare practitioner can withdraw life support without the consent of a patient or its surrogate?
A. No, I just rephrased it.
Q. My question for you is a little different. Would

you agree that the Texas statute provides a procedure for a healthcare provider to terminate life support without the consent of a patient's surrogate?
A. I just believe that that answer requires more than yes or no.
Q. So, your answer is you can't say that that's what it provides for?
A. I think it's a little bit more detailed than that. That's one of the things it provides for but it provides for other things as well, and I wouldn't want to take that in isolation because it could be misleading.
Q. One of the things that the Texas statute provides for is a process whereby a healthcare provider can terminate life support for a patient without the consent of the patient's surrogate; is that correct?
A. That is correct.
Q. Okay. And you say that the Texas statute is in this stack of papers that you've brought with you?
A. Yes, it is.
Q. Okay.
MS. SEAMAN: Off the record.
(Off the record.)
MS. SEAMAN: For the record, can we just agree that this is a DRG Desk Reference dated 2013,

optumcoding.coding, and it says Ingenix?
MR. VIRGIL: Agreed.
Q. (BY MS. SEAMAN) Doctor, will you tell me why you brought the DRG coding book?
A. I brought it because I looked at it as I was reviewing the materials, and that's what the subpoena duces tecum asked me to.
Q. Why did you look at the DRG coding book?
A. I just wanted to refresh my memory about how hospitals are reimbursed for patients because I thought that that was an important issue in this case.
Q. And can you show me where in the DRG book it shows you how Yale-New Haven Hospital is reimbursed for a patient such as Ms. Marsala?
A. It wasn't that helpful.
Q. Okay.
A. I looked at it but there is a discussion about how DRGs work in general, and the basic idea is that the hospital receives a certain amount of payment for each patient based on their diagnoses, not just one diagnosis but multiple diagnoses, and that that's the total payment that the hospital will receive regardless of how many services they provide.
So, a patient with say respiratory failure and renal failure, they will probably be a high DRG but the

hospital will be paid the same whether the patient stays for one week or six weeks or two months, and that's a very important financial incentive for hospitals.
Q. When, in your professional career, have you used DRG coding?
A. Every day of my life.
Q. Okay. And do you do your own coding?
A. I do my own coding in the office for the -- that's a little bit different than DRG. That's CPT, which CPT is how providers are reimbursed. They use CPT codes, and for the hospital, they use DRG codes.
And, you know, I'm on the utilization review committee at one of the hospitals, and we review the DRGs and the length of stays. And in my notes, I usual usually put down the ICD9 codes for different diagnoses in order to help the coders.
And also, sometimes the coders from the hospitals will query us if they have a question about, for example, what type of pneumonia it is. That would make a difference in which ICD9 code they use, and they will sometimes send us a query that we're supposed to respond to.
Q. All right. So, in your professional practice, your use of the DRG codes is with respect to your participation in the utilization review committee at one

of the hospitals that you work with?
A. As far as hospital bills, yes, but, you know, there's other coding that's done in our office that I'm completely responsible for that, you know, I'm very involved in but it's not hospital coding. It's for the providers.
Q. Right. So, what did Yale-New Haven Hospital receive on a daily basis for Ms. Marsala during the month of June? She was in in June and July, can we agree on that, 2010?
A. Yes.
Q. And what you have with you is the 2013 DRG coding book, correct?
A. That's correct.
Q. So, how did the 2013 coding book differ from the 2010 coding book?
A. That I haven't reviewed in detail.
Q. And what was the total amount of reimbursement that Yale-New Haven Hospital received for its care of Helen Marsala during her hospitalization in June and July of 2010?
A. I didn't look that up because that really wasn't what I was interested in. I was just interested in the generic process and making sure that I had the basic idea right.

Q. So, as you sit here today, you have no knowledge as to the amount of money that Yale-New Haven Hospital received for providing her care; is that correct?
A. I do not know the exact amount that they received, no.
Q. Give me the best estimate you have, the best approximation.
A. I don't think the dollar amount is important. I think what's important is that their coding -- their reimbursement, rather, is independent of the length of stay, and that's the important principle. Whether they received 20,000 or 40,000, 30,000, I don't think that's particularly relevant. I think it's just the fact that their reimbursement is tied to the diagnoses and not the services provided that's important in this case.
Q. All right. So, is it correct to say you cannot give me any approximation of the amount of reimbursement that Yale-New Haven Hospital received for the care of Helen Marsala?
A. I don't want to because such an opinion would be beyond, you know, a reasonable medical probability. It would be a guess at this point. I would have to go and look it up.
Q. Okay. What were the DRGs for her hospitalization?

A. Well, respiratory failure when the --
Q. What number is that, sir?
A. The DRG or the ICD 9? The ICD 9 code for that is -- 518.81 is respiratory failure.
Q. Okay.
A. And then for ARDS, I usually use 518.82. And ARDS is adult respiratory distress syndrome.
Q. And she had both?
A. I would say she would fall more into the category of respiratory failure.
Q. Any other ICD 9 codes?
A. Yes. The fact that she received dialysis is an important ICD 9 code because that's a major complicating condition. So, that increases your reimbursement.
Q. Any other ICD 9 codes that she had?
A. There must be 15 of them. There's altered mental status. May I look at my notes again?
Q. Sure.
A. Okay.
Q. Do you have them listed there?
A. No, I don't because I wasn't expecting this line of questioning.
So, altered mental status. I can't remember the exact number for that one. Aortic stenosis is 424.1. Coronary artery disease, there's different ICD 9 codes

for coronary artery disease. The most generic one, I think, is 414.3, which is the one I usually use.
Diabetes, there's a range of different ICD 9 codes for diabetes depending on whether it's type 1, whether it's type 2, whether there's neurological complications, whether there's acidosis associated with it or not. Hers would probably be 250.00, which is just diabetes.
And then she had metabolic acidosis, which is an ICD 9 code. I think that one is 276.2. And she had hypertension. That one is 401.9.
She had a healing comminuted fracture of the proximal humerus. I have no idea what the ICD 9 code would be for that because that's an orthopedic problem. It's not something I usually deal with.
She had a urinary tract infection with pseudomonas. She had some aspergillus that grew from her sputum, which depending on the opinion of the physicians might just be a fungus that's colonizing in the airways. It might not be a codeable diagnosis but it might be.
She also had some vancomycin resistant Enterococcus. That would be an ICD 9 code. She had deep vein thrombi of her lower extremities, and that's an ICD 9 code. She had a decubitus ulcer. I think that

was 707.0, I believe.
Q. She had skin breakdown between her fingers and toes; is that correct? Do you remember reading that?
A. I saw a record about some skin breakdown on the toe.
Q. Is that an ICD 9 code?
A. I don't think so because I think once you use a decubitus ulcer, I think that covers all of them.
Q. Okay.
A. I don't believe it matters how many decubitus ulcers the patient has.
Q. Her decubitus ulcer was a stage 4 on her back; is that correct?
A. That's correct.
Q. And is that a different code than a stage 3?
A. I would have to look that up.
Q. Anything else?
A. She had anemia. That's all I see right now. There might be something I'm forgetting.
Q. She had ischemic colitis?
A. That's right, she had ischemic colitis that resolved, yeah.
Q. It resolved?
A. It looked like it to me.
Q. She had tubular necrosis of the kidney; is that

right?
A. That would be the same as acute renal failure. We already mentioned that one. That's the major complicating condition where she required dialysis.
Q. She had evidence of infarct on a brain scan; is that correct?
A. It looked like an infarct of indeterminate age.
Q. Does that get an IC --
A. There's an ICD 9 code for that but it's not going to affect the hospital's reimbursement because what's important is is there a major complicating factor, and that's important in the reimbursement, and there is because there's dialysis.
Q. She was fed through a G tube?
A. There are codes for malnutrition but I don't think that you can meet that criteria just by being fed through a feeding tube. I think we would have to look at what her nutritional parameters were.
Q. All right. But she was being fed through a tube, correct?
A. Yes, she was being fed through a tube, correct.
Q. Have you ever been in a position where you issued the ICD 9 codes for a hospitalized patient?
A. What do you mean by issued?
Q. Sent them out, decided what the correct codes

were, coded a hospital chart.
A. Yes.
Q. Okay.
A. Because if I put down respiratory failure, very often I'll put in parentheses 518.81 next to it, well, that's what the coders are going to use. I may not be physically the one that pushes the button to send it on the computer terminal but I'm the one that wrote it down in the chart. That's what they're using.
Q. So, every time you chart, you put the ICD 9 code for your diagnosis, is that what you're telling me?
A. No, I don't do it every time.
Q. All right.
A. I do it sometimes, particularly if it's related to pulmonary or critical care. Of course, there are many of them that I'm not familiar with, like that humerus fracture, I wouldn't want to put that down because I might not be the best person to make that decision.
Q. Okay. Let me ask you to go back and tell me what, if any, other documents you've brought with you today. I've marked these and I'll ask you about them but I want to make sure I don't get lost.
A. I think you asked me for a list of my prior testimonies.

(Exhibits 11-19 marked.)
Q. (BY MS. SEAMAN) All right. What else do you have?
A. I think one of the questions was every case that I've ever been a party to.
Q. Yes.
A. And that was the first time I had ever been asked to provide that.
Q. We wanted to just mix it up a little for you.
A. I wasn't able to get you a complete list but the other ones, I can tell you basically what they were.
Q. Okay. How many case have you been a party to? Wait, I think this is -- I think this might not be right.
A. This is one of the things that I reviewed.
(Exhibits 20-21 marked.)
A. I'm counting 11 lawsuits that were actually filed. And would you count dissolution of marriage? Is that one?
Q. (BY MS. SEAMAN) Your marriage?
A. Yes.
Q. I'm not interested in that. If you brought it, that's fine, but I'm not going to ask you any questions about your marital status, future, present or past.
A. Thank you. I appreciate that.

Q. But I would like the case list.
A. How about administrative hearings, do you count that?
Q. Sure, that I will take, please.
A. Now, the old ones I don't have. For example, I was in a car accident in 1985. I don't have any way of getting that. And then these two medical malpractice cases that I was involved in that were old --
Q. Wait. I'm looking -- I wanted to take out your divorce. Is that in here?
A. I didn't give you any details about it. It's just listed.
Q. If it won't bother you, fine. I'll just mark that whole stack. And then this is -- all right. So, I'm going to mark the litigation as one.
(Exhibit 22 marked.)
Q. (BY MS. SEAMAN) And then the Texas Medical Board, just tell me what this is, sir.
A. That was a hearing before the Texas Medical Board where I received a reprimand from the Texas Medical Board.
Q. All right.
(Exhibit 23 marked.)
Q. (BY MS. SEAMAN) Did you bring anything else with you today?

MR. VIRGIL: The box.
Q. (BY MS. SEAMAN) The medical records and the only thing in that box is medical records?
A. Depositions.
Q. Did you make any notes on the depositions?
A. No. I made my notes here so I could access them. Now, there are notes when they were sent to me. This was highlighted when it was sent to me.
Q. Okay. You received it highlighted?
A. Yes. It's just basically highlighting who the deponent was.
Q. That's fine. And have we now covered everything you brought with you?
A. That's everything.
Q. Okay. So, here's what I'd like you to do, just to make this short, would you confirm for me that everything in this stack is a document that you brought with you here today?
MS. SEAMAN: You can do it if you want to stipulate to it but I just want to make sure that all of those exhibits are indeed documents you brought with you.
MR. VIRGIL: What's the last number?
THE COURT REPORTER: 23.
MR. VIRGIL: What was the one we started

with? 7?
MS. SEAMAN: Yes.
A. These are separate documents because I didn't have a list of the prior things. These are separate cases.
Q. (BY MS. SEAMAN) Did you want them all separate?
A. I don't know. Do you really care about these things? This is the dissolution of marriage. Do you want to discard that?
Q. That's fine with me.
A. We'll discard that one. And most of these have nothing to do with medicine.
Q. Okay. I will ask you, but I'd like to just keep them -- I'm happy to mark them all as one unless there's a reason you want them marked separately.
A. No.
MR. VIRGIL: I will happily agree Exhibits 7 through 23 are all of the exhibits that were brought today.
MS. SEAMAN: By the witness.
(Off the record.)
(Exhibits 24-29 marked.)
MS. SEAMAN: Back on the record.
Will you stipulate that Exhibits 24 through 29 are also documents which the witness brought with him

today?
MR. VIRGIL: I do.
Q. (BY MS. SEAMAN) Dr. Hamer, what is your business?
A. I'm a pulmonary and critical care physician.
Q. And are you currently employed?
A. I'm employed by my own practice, which is Southeast Houston Pulmonology.
Q. How long have you been employed at Southeast Houston Pulmonology?
A. That's been in existence since 1999.
Q. And have you been working there full-time since 1999?
A. There was a period of time where I did my billing through my brother's office. So, I would have been an employee of my brother's practice technically.
Q. Exclusively?
A. No.
Q. Or you had two --
A. No, because the other entity still exited. See, my brother is a cardiologist, and when I moved to Houston, the idea was that we would work together, and initially, when we were sharing office space, we were using the same billing personnel, and I was billing through their tax ID number.

Q. All right. And since 1999, have you billed through your brother's tax ID number?
A. No.
Q. Okay.
A. It's confusing. I'm confusing you. Since 1999 is when that entity, Harlingen Critical Care doing business as Southeast Houston Pulmonology was formed. There was a period from 2003 to 2010 when most of my billing was done through Southeast Houston Cardiology, which is the name of my brother's practice.
Q. And why is it that between 2003 and 2010 the majority of your billing was done through Southeast Houston Cardiology?
A. That's a good question.
Q. Have you ever been investigated or has Southeast Houston Pulmonology ever been investigated?
A. No. No. It has nothing to do with that. It has to do with the fact that my father was involved in the business, and he was doing my brother's billing, and that's the way he wanted to do it. So, it really doesn't have anything to do -- there's nothing nefarious behind it. It's just family interactions.
Q. Between 2003 and 2010, did you do any billing for services through Southeast Houston Pulmonology?
A. Yes, it filed a tax return every year. I did

bill through it.
Q. And did you earn money from Southeast Houston Pulmonology between 2003 and 2010?
A. Yes, but not as an employee because then it would be an owner's draw.
Q. Okay. And do you currently get an owner's draw from Southeast Houston Pulmonology?
A. No, I stopped that. Now I use it in the way that I'm paid as a salaried employee.
Q. Are you the only physician employed by Southeast Houston Pulmonology?
A. Yes, I am.
Q. Has there ever been another physician associated with Southeast Houston Pulmonology?
A. No, there hasn't.
Q. And do you currently perform any services for or through Southeast Houston Cardiology?
A. No.
Q. And have you received any compensation for services rendered from Southeast Houston Cardiology since 2010?
A. No, I haven't.
Q. Are all of the medical services you provide currently compensated through Southeast Houston Pulmonology?

A. No, not a hundred percent.
Q. What other professional services do you provide for which you are compensated outside of Southeast Houston Pulmonology?
A. There is some consulting, a little bit of consulting work that's goes through a different corporation.
Q. I'm going to ask that the CV that you printed off for us be marked as Exhibit 2A, because the original one was 2.
(Exhibit 2A marked.)
Q. (BY MS. SEAMAN) Is that consulting work reflected on your CV?
A. Some of it.
Q. What is it?
A. Some of it is too minor to even put on a CV.
Q. Tell me.
A. For example, sometimes pharmaceutical companies will pay us to take surveys over the Internet. I mean, that's nothing I would want to put on my CV but I usually declare that on my taxes but I don't put it through Southeast Houston Pulmonology.
And then there's an attorney that owes me money from a case several years ago that occasionally pays, and that's through a different corporation.

Q. What's the name of that corporation?
A. The name of the corporation is Emil Hamburger Investments, LLC.
Q. I'm sorry, tell me again.
A. I'll write it down for you if you want.
(Exhibit 30 marked.)
Q. (BY MS. SEAMAN) And what kind of case is it that Emil Hamburger Investments, LLC pays you periodically?
A. It doesn't pay me. I'm not an employee of the company.
Q. Do you receive money from this company?
A. I own it.
Q. What does Emil Hamburger mean?
A. It was a relative.
Q. Okay. And what does Emil Hamburger Investments, LLC do?
A. Basically, whatever I need it to do. It holds some leases for medical equipment that it gets paid for. It owns a mortgage, and the mortgagee pays every month. It collects the interest on that. It owns some judgments that some day it might collect on.
I do a little bit of consulting work through it, like I mentioned those surveys from the drug companies, and there's another company that sometimes calls me to consult with venture capital funds and marketing

research funds and things like that, and if I do that kind of work, it usually goes through there.

Q. Does that last category of work have anything to do with medicine?

A. Yes, it's about pulmonology. So, they might call me and get my input about a product that they are thinking of bringing to market or maybe it's a venture capital fund that's thinking of investing in a certain technology. They will hire consultants to discuss it with them. You know, I wouldn't be the only consultant. Obviously, there would be other people that they would consult, too, and I get paid for that.

Q. Are you the only principal with Emil Hamburger Investments, LLC?

A. Yes. I'm the only member, yes.

Q. And what medical equipment does Emil Hamburger Investments get paid on leases for?

A. It owns an x-ray machine. It owns pulmonary function testing equipment. It owns an EKG machine. That's all I can think of right now.

Q. Is all of the medical equipment for which Emil Hamburger Investments, LLC receive lease payment equipment being used through Southeast Houston Pulmonology?

A. Yes, it is.

Q. And what property does Emil Hamburger Investments, LLC get mortgage payments on?

A. A property in California.

Q. And what's the address of that property?

A. I don't remember it because I wasn't expecting to be asked about this. So, I didn't bring it with me.

Q. Is it a residence or commercial business?

A. It's a residence.

Q. Have you ever lived there?

A. No.

Q. How is it that you came to acquire a residence in California?

A. It's not a residence. I own the mortgage.

Q. I misunderstood.

A. The company owns the mortgage.

Q. You just hold the mortgage on it?

A. Right. Right.

Q. Got it. So, somehow or another, you provided a mortgage to somebody who bought a house, and Emil Hamburger Investments is receiving those mortgage payments?

A. Actually, I didn't originate the mortgage. This company bought it on the secondary market, to be more accurate.

Q. Judgments, the judgments which Emil Hamburger

Investments might at some point get paid on, are those judgments from lawsuits in which you were a party?

A. One of them is. One of those lawsuits was a plumber that absconded with some money, and he pays periodically.

Q. Okay.

A. And then there are a couple of judgments that were purchased on the secondary market that they were having difficulty enforcing.

Q. Other than your work through Southeast Houston Pulmonology and Emil Hamburger Investments' income, do you have any other business income?

A. Depends, I guess, what you mean by business income but --

Q. I'm not asking for bank interest or interest that you receive on your investments. I'm asking whether you have any other business income. Do you own a commercial building?

A. Okay. I have a law practice but I wouldn't say that I make income on it because it breaks even.

Q. And where is the law practice?

A. It's in California.

Q. Do you have an office there?

A. I share an office. I rent space in the office.

Q. How long have you had a law practice?

A. Since -- I can't remember if it's 2009. I think it's 2009.

Q. And in what area of the law do you practice?

A. Well, I don't do a whole lot of practicing but my main client is involved in mortgages. They purchase mortgages on the secondary market, and when they have trouble, then I help them. That's my main client. Then I've done a few other things here and there helping people with business disputes.

Q. Have you ever filed a lawsuit --

A. Yes.

Q. -- on behalf of a client?

A. Yes, I've filed lawsuits on behalf of a client.

Q. Have you filed them in state or federal court?

A. In both.

Q. And on what client -- on whose behalf have you filed a lawsuit?

A. Well, the most recent lawsuit that I filed was for a copyright infringement, and it was on behalf of this Southeast Houston Cardiology.

Q. Your brother?

A. It's my brother's company, yes, but he's not the only physician in that. It's a pretty big company.

Q. And did you file that in California?

A. No. I filed that in Federal Court in Texas.

Q. Are you admitted to the Texas Bar?
A. No, but I'm admitted to the Federal Court, the Southern District and the Eastern District.
Q. Of Texas?
A. Yes.
Q. Okay. You don't have to be admitted to the State Bar to be admitted to the Federal Court in Texas?
A. No. Do you in Connecticut?
Q. I don't have any idea because I'm admitted to the State Bar. I don't have any idea.
A. My understanding was that that was not a requirement of most Federal Courts, that you can be a member of a Bar in any jurisdiction and be admitted to most Federal Courts.
Q. I'm not arguing with you. I don't know.
A. I've only investigated it in Texas.
Q. Aside from the copyright infringement case that you filed on behalf of your brother's group, what other clients have you filed lawsuits on behalf of?
A. Well, let's see. There's -- I filed -- in Orange County, California, I think I filed three. One was for a deficiency judgment after a foreclosure. And one was for fraud. Basically, this business where they buy mortgages on the secondary market, someone had basically made up the payment schedule and submitted it as if it

were true. So, that was a case that I had.
And then I also a case of conversion where someone absconded with some money that they were entrusted with.
Q. And did you have the same client in each of those lawsuits?
A. Yes. It's Bay Area Home Financing, LLC.
Q. Any other lawsuits that you filed on behalf of a client?
A. On behalf of a client? No. I mean, I've written letters and been involved in adjudications but they haven't gone to an actual lawsuit.
Q. And is all of your legal practice litigation related?
A. Well, it's -- no, not at all. It's a very small practice. I mean, it's unlikely that I would get much business. I mean, it's not my full-time profession.
For example, there was an entertainer that had a contract dispute that I helped him get his money back but it didn't involve an actual lawsuit.
There was a physician I remember that I had gone to medical school with that was having some problems in a business dispute.
There was another physician that was having some problems in a business dispute but I didn't actually

file lawsuits for them.
Q. You wrote letters and resolved those issues?
A. Right.
Q. And were all of those disputes in California?
A. No, they weren't.
Q. Where were they?
A. My friend was in New Jersey. And then the one with the entertainer was kind of interstate because he lives in Pennsylvania.
Q. You're not admitted to the Bar in Jersey or Pennsylvania?
A. No, but that was a Federal issue.
Q. Now have you told me all the sources of business income that you have, that is, Southeast Houston Pulmonology, your law practice and Emil Hamburger Investments, LLC?
A. No, because there's also some other companies that I'm involved in, too.
Q. What are those?
A. There's a company called Pieritz Plaut.
Q. I'm sorry, what?
A. I'll write it down for you. Do you want the ones where I'm a limited partner, too? I mean, how interested are you in all this stuff?
Q. I'm interested in services that you provide. So,

in any of the businesses in which you're a limited partner, do you provide any services?
A. No.
Q. Do you spend any time in connection with the business of those entities?
A. No.
Q. Okay. Then I don't need to know those. So, the one is Pieritz Plaut Properties?
A. It's Pieritz Plaut.
Q. And what's the business of that?
A. They just own a strip mall.
Q. And do you do anything to manage that strip mall?
A. I look at the books.
Q. Are you the only owner of that company?
A. Yes, I am.
Q. And I'm sorry, just tell me what this last one is?
A. Benavides and Frank.
Q. What does that do?
A. It's an embroidery business.
Q. Are you the only owner of that?
A. No.
Q. Who else is involved in that business?
A. I'm a 70 percent shareholder.
Q. You are 70?

A. (Witness indicated by nodding his head affirmatively.) And then Teresa Wildman is a 30 percent shareholder.
Q. And what do you do for that business?
A. I put up the money basically.
Q. Okay. You don't do embroidery yourself?
A. No, I don't do embroidery.
Q. All right.
A. I don't even do the books for that business or anything. I mean, I just really put up the capital. That's how I got involved.
Q. Any other sources of business income that you haven't told me about?
A. I mean, I own some mortgages personally.
Q. I'm not interested in investment income. I'm not interested in --
A. You're trying to figure out how I spend my time?
Q. Professional time and professional income, yes.
A. Okay. I was pointing out the law practice doesn't make any money.
Q. Okay.
A. I work a lot. I mean, I -- that's pretty much all I do.
Q. Okay. What is your schedule at Southeast Houston Pulmonology?

A. Well, we have clinic or office patients six days a week.
Q. What hours?
A. 9:00 to 5:00 on weekdays, generally, and 9:00 to 1:00 on Saturdays. Now, there might be a time when I might not be available. For example, we do these bronchial thermoplasties. If I'm busy doing that, we wouldn't be available to see patients for those two hours, or if I'm very busy in the hospital, you know, we might not be available at some time but we try and be as available as we can.
Q. When you say that your office schedule is six days a week, 9:00 to 5:00 on weekdays and 9:00 to 1:00 on Saturdays, is it your testimony that those are the hours during which you schedule patient visits?
A. Yes. Those are the hours that we advertise as being open, and those are the hours that we schedule outpatient visits. Does that mean that we're open every single Thursday afternoon? No. Does it mean that there might be a day when I might be too busy at the hospital to see people in the morning? Yes, but those are the hours that we are generally open.
Q. What is a bronchial thermoplasty?
A. It's a new procedure that's being used to treat refractory asthma.

Q. And is it done in the office?
A. No, that's done at the hospital.
Q. What hospital do you currently have privileges at?
A. I currently have privileges at the St. Luke's Patients Medical Center, Bayshore Medical Center, which has two campuses, Bayshore Medical Center and East Houston Medical Center. Then I also have privileges at Kindred Hospital, which is a long-term acute care facility. And I have privileges --
Q. Long-term acute care?
A. Yes. Sometimes they use the acronym LTAC.
Q. Okay. I'm sorry, I interrupted you. Any others?
A. Yes. Clear Lake Regional Medical Center, I have privileges but I really don't go very often. I haven't been there in six months.
Q. Any others?
A. Those are the only ones that I have active privileges at.
Q. I'm not familiar with long-term acute care. What does that mean?
A. Long-term acute care is for a patient similar to Helen Marsala, who would be on a ventilator, who isn't doing well, who needs further time potentially for rehab or to be weaned from a ventilator, and those are called

long-term acute care facilities.
Q. Are you saying that Helen Marsala would have been a candidate for admission at Kindred in July of 2010?
A. Well, it would depend a little bit on her insurance status but assuming she were a Medicare patient, they would have taken her in a heartbeat.
Q. And if she wasn't on Medicare?
A. They would have had to apply to the insurance company for permission, and most insurance companies in that case would grant it, other than Medicaid. Texas Medicaid would not.
Q. I'm just confused. You mean her private insurance they would have to apply for?
A. For example, I can't remember how things have changed between 2010 because there's been a lot of changes recently but as of right now, many Medicare patients that are in the Medicare age group have what are called Medicare advantage plans. And these Medicare advantage plans basically take over control of the payments and the reimbursements for that patient, and they make decisions about what resources patients can have and what they can't.
Those Medicare advantage plans tend to be adverse to these long-term acute care hospitals because it's not in their financial interest but -- and they require an

appeal and a discussion with the medical director to get the patients admitted or transferred, but my experience, someone like Helen Marsala they would all agree to.

Q. Okay. And what's the charge for somebody like Helen Marsala being in Kindred long-term acute care?

A. What happens is it becomes a separate DRG. It becomes a new hospitalization. That's one of the reasons that the Medicare advantage plans don't like it because they are paying two DRGs now instead of one.

Q. And how long will they pay for Kindred to keep someone like Helen Marsala?

A. Well, Medicare will ask long-term acute care hospitals to have an average length of stay of 26 days. They want the average length of all patients over the year to be 26 days.

Q. And if she --

A. Private insurance, such as, for example, Aetna or Cigna, they will probably monitor it per day. So, they might approve it for a week. Then after a week, they reassess it, see if they can move her to a SNF or get her home or do something less expensive.

Q. SNF is skilled nursing facility?

A. SNF is skilled nursing facility.

Q. And SNF is cheaper than long-term acute care?

A. Significantly.

Q. So, after a patient such as Helen Marsala stays there for 26 days, then Kindred wouldn't get paid any more, so, they would discharge her to a skilled nursing facility, is that the idea?

A. Well, I'm not saying they would discharge someone who was unstable but if they were stable and able to go, then they might be able to send them home, they might send them to a skilled nursing facility.

Q. And what is it that qualifies a patient to go to one of these long-term acute care? Is it that they are rehabilitatable, that they need rehabilitation? What defines whether they go to the long-term acute care or to a skilled nursing facility?

A. Based on the Medicare guidelines, in order to qualify for a long-term acute care hospital, the patient has to require daily physician visits and they have to have either one of the diagnoses such as respiratory failure and on a vent or a decubitus ulcer with a Wound VAC that automatically entitles them to go or they need to have a combination of other problems, such as requiring two intravenous antibiotics, physical therapy, speech therapy, telemetry. There's probably some other things -- wound care. There's some other things that I'm forgetting. And if they have the right combination of those requirements, then they will qualify.

Q. So, is the idea that a long-term acute care facility is less expensive than a traditional acute care hospital but more expensive than a skilled nursing facility?

A. I don't know if that's the idea behind it but that's probably true.

Q. Why would somebody want to be in a long-term acute care facility rather than a regular hospital?

A. Well, if you were to ask Kindred, they would claim that, "We specialize in weaning people from ventilators. We specialize in wound care. We specialize in physical therapy." So, that would be their claim.

Q. It sounds like it's more of a combination of a rehabilitation facility for patients who are on ventilators; is that right?

A. Not all the patients are on ventilators. It's basically an acute care hospital for people that have to stay a longer period of time than a couple of weeks.

Q. Okay. And do you see patients in each of these hospitals you've just listed for me?

A. Yes. The only one that I haven't been too active at is Clear Lake Regional.

Q. And have you admitted patients say to St. Luke's Patients in the past week?

A. Yes.

Q. And do you have any patients hospitalized there now?

A. Yes, I do.

Q. How many?

A. Right now in the hospital, I have three.

Q. Okay. And do you admit to Bayshore and East Houston?

A. Well, at Bayshore, usually the hospitalist admits the patient, and usually I'm a consultant there.

Q. That means you don't chart?

A. No. I chart.

Q. You chart as a consultant?

A. It just means that the hospitalist is kind of like the primary care doctor, I guess, for the hospital.

Q. So, for Bayshore and East Houston, you're called in to consult on patients who require a pulmonology consult; is that true?

A. Or a critical care.

Q. Does Bayshore or East Houston have a critical care department?

A. They have ICUs.

Q. They both do?

A. Yes.

Q. Open or closed?

A. They're open.
Q. Open?
A. Open.
Q. And do you cover a shift on the ICU at Bayshore or East Houston?
A. No. Shifts are something that they do at tertiary care university hospitals. Most community hospitals don't have inpatient critical care physicians, no.
Q. So, you would be called in by the hospitalist to see a patient who was in the ICU at Bayshore or East Houston?
A. Usually they call me before they make it to the ICU. Usually they are having respiratory problems on the floor, and usually they just call a pulmonary consult, the same way they would call any other consult, and then I follow that patient with them.
Q. But does the hospitalist continue as the physician in charge for patients at Bayshore and East Houston who are in their critical care units?
A. Yes, but just -- I wanted to just tell you that at East Houston, my practice there is pretty much limited to reading sleep studies and doing procedures. I don't see the patients in the ICU because it's pretty far, and I need to be available for people in the ICU.

So, my ICU patients are going to be at the St. Luke's Patients Medical Center and the Bayshore Medical Center and, I guess, Kindred, they have an ICU, too.
Q. But, again, when you see those patients, you're seeing them for pulmonary issues?
A. Some of them. At St. Luke's Patients Medical Center, which is right across the street from my office, a lot of times I'm the primary physician, I'm the attending, and then I'm responsible for all their problems. If I need help, then I have to call a consultant.
Q. And Kindred has an ICU?
A. They have a 12-bed ICU.
Q. And do they have an attending assigned there?
A. Each patient has an attending assigned.
Q. And in the ICU, do they have an attending covering the ICU or each patient has their own?
A. No. The only place that you would really see an attending as an intensivist would be at a place like Yale, a very large tertiary care hospital.
Q. Like MD Anderson?
A. Well, MD Anderson is specialized in cancer care. They do have an ICU. They probably have intensivists that they hire, yes.
Q. Okay. Sorry, I'm just looking for something.

On what schedule do you see patients at St. Luke's?
A. I guess I'm a little confused by that. I mean, I have to round on my patients every day.
Q. If you have patients, then you go round, if you don't have patients admitted there, you don't go, is that safe to say?
A. I can't think of a patient where I haven't had a patient there.
Q. So, you round there every day?
A. Yes.
Q. And you just round on your patients?
A. Yes.
Q. And would that be the same with Bayshore and Kindred?
A. Yes, that would be the same.
Q. Okay. Do you serve in any administrative positions on any of those institutions?
A. I'm on a couple of committees. I'm on the utilization review committee where I learned about the DRG coding and so on.
Q. What is the function of the utilization review committee?
A. We just review the length of stay for the patients.

Q. For what purpose?
A. Well, because the hospital wants to have a length of stay that meets the predicted length of stay for those diagnoses. For example, a patient with pneumonococcal pneumonia with parapneumonic effusion and no other problems might have an expected length of stay of five days. So, we don't want our length of stay to be 14 days. If it's 14 days, we'd like to know why. Was it because we had a catheter in there that became infected? Is it because we had a complication we shouldn't have? So, generally, we want the length of stay to be pretty close to the predicted length of stay.
Q. How many people serve on that committee?
A. Well, there's three physicians and the CEO of the hospital, he always goes, and there's the head of case management, she always goes. There's two people from the coding department that go. The CFO, sometimes he goes and sometimes he doesn't. He's probably officially on the committee but he doesn't make it all the time.
Q. How long have you served on that committee?
A. I think a couple of years.
Q. And I'm sorry, did you say that was at St. Luke's?
A. St. Luke's Patients Medical Center, yeah.
Q. Any other committees that you currently serve on

at any of these facilities?
A. I'm not on any other committees right now, no.
Q. When was the most recent time you've been on another committee?
A. I was at Triumph East, which was bought out by Kindred.
Q. Triumph East? Sorry.
A. Yes, Triumph East. They were bought out by Kindred. And I used to be on their utilization review committee and their ethics committee.
Q. During what timeframe were you on Triumph's ethics committee?
A. It's on my CV. I don't remember.
Q. Do you have it in front of you? I think you might have it upside down there.
A. This would also give you the time I was on the utilization review committee, when I started.
Q. So, you were on the utilization review committee at St. Luke's Patients Medical Center from 2012 through the present; is that correct?
A. Right.
Q. And 2009 through 2011, you were on the utilization review and medical records committee at Triumph, correct?
A. Correct.

Q. And Triumph turned into Kindred long-term acute care?
A. They were bought out by Kindred, yes.
Q. At the time that you were on the utilization review and medical records committee at Triumph, was it a long-term acute care hospital?
A. Yes, it was.
Q. And from 2009 through 2011, you were on the ethics committee at Triumph; is that correct?
A. Yes.
Q. And how frequently did the ethics committee at Triumph meet?
A. It only would meet when called.
Q. And how frequently were you called during the three years that you were on the ethics committee?
A. Not very frequently.
Q. Were you ever called?
A. Yeah, I can remember a couple of cases.
Q. What do you remember about the cases that you were called on at Triumph East Hospital?
A. I remember the most memorable case was a 26 year old woman who had this severe problem with anorexia and bulimia, and her mother was her legal guardian, and she was just uncontrollable. We just couldn't control her. She was so manipulative and so angry and so psychotic,

we could never control her.
Q. Did she die of her disease?
A. Not under our watch but some day, I think she will.
Q. Why did it go to the ethics committee?
A. I think it went to the ethics committee because of what to do with her because we couldn't control her behavior.
And she had a private physician from somewhere near Austin who would write letters about what he wanted for her care, and he didn't have privileges there. And I guess there was concern about whether we should give credence to his recommendations or not.
Q. When you worked on the ethics committee, did you find that other committee members took their responsibility seriously?
A. I have to think about that for a moment.
Q. Okay.
A. No, I guess I wasn't that impressed, no.
Q. What was the composition of that ethics committee?
A. Well, the chief of staff was on it, and he's a rather controlling individual. He used to really kind of dominate the decisions, along with the CEO. And I felt that most of the decisions were made based on their

financial interest.
Q. It seems like one of your interests has to do with an interest in excessive bills from hospitals?
A. It's something that bothers me, yes. I might point out that that is on my website, which I think you're reading it from, but I never have represented anyone or done any work in that area.
Q. But you hold yourself out as somebody who is willing to represent everyday people trapped and smothered in the intricacies of our complicated healthcare system; is that right?
A. I would like to do that if I had the opportunity.
Q. And you represent yourself as somebody who can help people fight excessive medical bills, right?
A. I believe I could do that, yes.
Q. Understanding healthcare fraud, correct?
A. That's on my website, yes. But I don't want to represent myself as a, you know, renowned expert in that area. I have had a couple of cases that involved healthcare fraud but, you know, I'm sure there's lots of people that have much more experience and expertise than I do.
Q. You've had a couple of cases involving healthcare fraud?
A. Yeah.

Q. In California?
A. No, they weren't in California because all healthcare fraud is Federal. Those are Federal statutes.
Q. So, where were those cases?
A. Well, one was under seal and has never been taken out, so, I'd rather not discuss it, if possible. And then the other ones were more like consultations, what do you think, that sort of thing.
Q. Has any healthcare provider ever consulted you in connection with a charge of healthcare fraud?
A. Not to be represented. Not to be represented as defense counsel, no, but they have contacted me asking me if I thought this was fraudulent or that was fraudulent.
Q. If a physician was under investigation for healthcare fraud and contacted you for assistance, would you consider yourself experienced enough to represent that physician?
A. I don't think I would do that because the potential ramifications of that could be devastating. I think I would try and help them find someone that was more experienced or qualified.
Q. You say one of the things that you became involved in with respect to healthcare fraud is under

seal and was never taken out. Can you tell me what that means?
A. Under seal? That means it's not public information.
Q. Well, who sealed it?
A. The United States attorney.
Q. So, you were involved in an investigation by a U.S. attorney into healthcare fraud?
A. But I wasn't the defendant.
Q. I'm not asking you. You wouldn't have been a defendant, right, if it was under seal, there would have been no defendant?
A. No, you could be a defendant because these cases are under seal initially as the government investigates them, and then depending on where they want to go from there, they may make it public information or they may have litigation.
Q. Are you saying that the federal government has the right to file a lawsuit alleging healthcare fraud under seal?
A. No. The way it works is when you file a qui tam action, you file your initial petition with the Federal Court, it's automatically put under seal, and then it's deferred to the U.S. attorney for that jurisdiction, and they conduct an investigation, and then at the end of

the investigation, they decide what to do with it.
Q. Were you the complainant in a qui tam action?
A. Like I said, it's under seal. I don't really want to discuss any more of it.
Q. But my question for you was were you the person who complained in connection with a qui tam action?
A. I'm not going to answer that because it's under seal, and I feel that's privileged.
Q. Okay.
MS. SEAMAN: Let's go off a minute.
(Short recess.)
MS. SEAMAN: So, at the break, I suggested we try to short circuit this. Shall I assume we have been unable to do that?
MR. VIRGIL: Correct.
Q. (BY MS. SEAMAN) So, I'm going to ask you a few more questions, and if you don't want to answer them, then we'll let someone else decide.
My understanding is that a qui tam action can be filed in Federal Court in a way that allows the U.S. government to pick up the action. Is that your understanding also?
A. Yes.
Q. Okay. And are you aware of a qui tam action that was actually filed in court that you had some

involvement with?
A. I really don't want to talk about it any more.
Q. You refuse to answer? You just have to refuse to answer because I don't want to waste everybody's time.
A. I refuse on the basis that it's privileged information.
Q. Were you the complainant in that action?
A. I refused to answer based on the fact it's privileged information.
Q. Was the action in connection with some other healthcare provider?
A. I refuse to answer that because it's privileged information.
Q. Okay. Is there any way that one could find, in the public record, a record of any action -- any qui tam action that you were personally involved with?
A. No.
Q. Can you tell me whether the U.S. attorney who was involved in that action was in Texas?
A. I just won't discuss the case any more. Not only do I feel that it's privileged information, I also feel that I have a duty not to discuss it.
Q. Are you under a court order not to discuss it?
A. I don't know the answer to that.
Q. Okay. All right. Have you ever been

investigated for healthcare fraud, to your knowledge?
A. No.
Q. Have you ever been investigated by authorities for any reason, to your knowledge?
A. That --
Q. The Texas Medical Board?
A. The Texas Medical Board over this incident where my friend went to the emergency department.
Q. And that's the only time you're aware of that you were investigated for any matter?
A. Yes, aware of. If I were investigated, I should know, right?
Q. I would think so.
A. I hope so at least.
Q. What percentage of your medical practice is conducted in a hospital?
A. I've never sat down and really calculated it but I'm just going to guess 50 percent.
Q. And of that 50 percent, what percentage is providing services to patients who are in an ICU?
A. I would say of that 50 percent, maybe 50 percent of that time is spent. So, that would be 25 percent of total time.
Q. Okay. And of those patients that you see in the ICU, are the vast majority of those patients patients

for whom you are asked to consult on pulmonary issues?
A. The majority, for certain, but sometimes patients that I've known and followed for a long time will end up in the ICU, and I will be the attending, and I will take care of other things as well.
Q. In the past year, how many times have you been the attending physician, as you are using that term, to contrast it with a consultant, for a patient in the ICU?
A. I'd have to look it up. I have no --
Q. More than 5?
A. Yes.
Q. More than 10?
A. Yes.
Q. More than 20?
A. I think so. But I just want to add this corollary, though. There's seven days in a week, right? And there's 24 hours in a day, right? People sleep a certain amount of time but the rest of my life I spend working. I don't have any children. I'm not married. I don't have any close family. I haven't been on any vacation since 2006. So, the number of hours is important as well, as well as the percentage of time. So, 25 percent of 100 is 25. 25 percent of 40 is 10, and there's a big difference.
Q. Are you saying that you average a hundred hours a

week with the practice of medicine?
A. I think I average a hundred hours a week working total, yeah, probably.
Q. And what percentage of that is the practice of medicine?
A. I probably spend 80 hours a week practicing medicine.
Q. And how many patients do you see in an average week in your office?
A. 60 to 70.
Q. And in an average week, how many patients do you see in a hospital?
A. My census in the hospital is usually around 10 to 15. That's my daily census. I don't know how to convert it to a weekly census because some people stay two days, some people stay three weeks.
Q. Do you get a different reimbursement for those patients who stay two days versus those patients who stay three weeks?
A. Yes.
Q. Is all your reimbursement done through DRGs?
A. No.
Q. Which reimbursements are done through DRGs?
A. DRGs is how the hospital is paid. Physicians are paid through CPT codes. So, I get paid a fee for

service. So, if I see a person every day for three weeks, I get paid 21 times as much as if I saw them, you know, one time, not exactly, though, because there's different levels of involvement. You can code it based on how much time you spent. So, it's not exactly like that but that's the basic idea.
Q. Is all hospital reimbursement through DRGs?
A. No.
Q. Who pays through DRGs?
A. Anything that's connected with the federal government. So, that would be Medicare or Medicare advantage plans, Texas Medicaid, the HMOs that are associated with Texas Medicaid, MedCal.
Q. MedCal?
A. California Medicaid. Probably most of the Medicaids pay that way. Aetna pays with a DRG, Cigna, Blue Cross Blue Shield, all the major commercial insurers, United.
Q. And how is it that you know that hospitals' payments do not fluctuate by length of stay?
A. Well, I would like to just add a corollary to that. There was a point where hospitals could use what's called an outlier status. So, if someone were so sick that they had to stay, you know, two months or something like that, they could be paid for an outlier,

and I can't remember which year they changed that but I think outlier status was still available in 2010.

And also, the DRG reimbursement, I believe, also depends on how the hospitalization ends. If it ends in a death, I believe it's a little bit less.

Q. I missed what you said. Eggs?

A. I believe if the hospitalization ends with a death or a person leaving against medical advice, that may reduce the DRG to some extent. I don't know the details of that. So, I don't want to say too much more about it.

Q. Okay. And do you know whether the DRG varies from hospital to hospital?

A. Yes.

Q. And does the DRG vary with respect to what's reimbursable from hospital to hospital?

A. It might. My understanding is that certain hospitals were entitled to higher DRGs based on their location, whether they are a center of excellence, I guess what services they provide, that sort of thing.

Q. And do you know how Yale-New Haven Hospital gets reimbursed?

A. Well, Yale-New Haven sounds very prestigious to me.

Q. They will be happy to hear that.

A. So, I would imagine that they are paid at the highest rate.

Q. And do you know whether their DRGs are limited based on codes versus length of stay?

A. In all fairness, I've never been to Yale, neither the university nor the hospital, and I've only been to Connecticut to visit Mystic. So, it would be kind of presumptuous of me to say that I know for sure but I just read the rules that are published for Medicare, and that's where I come up with my information.

Q. Okay. Would it be fair to say then that the basis of your opinion that Yale-New Haven Hospital had a financial disincentive to continue to care for Ms. Marsala is based on your reading of the Medicaid statutes?

A. Medicare?

Q. I thought you said Medicaid. I'm sorry. Medicare statute.

A. It would be based on my reading of the rules for reimbursement in general.

Q. Under Medicare?

A. Under Medicare. But I also want to point out that, you know, this is an institution, to me, that sounds like they make a lot of money. There's a lot of money going in and out. I don't believe one patient would really affect their bottom line that much.

Q. So, then do you withdraw your opinion that there was -- that the decision on how to treat Ms. Marsala was motivated by the financial interest of Yale-New Haven Hospital?

A. I don't believe that was my opinion. Was it my opinion that it was a conflict of interest? Because I would rather say that there's an inherent conflict of interest when the institution has a financial involvement in the outcome.

Now, I can't say that the people on the ethics committee are influenced one way or another. Hopefully, they wouldn't be, but my opinion would be just that it's an inherent conflict of interest.

Q. So, would that be the case every time there's a patient in the hospital?

A. I think to have an ethics committee that's composed of individuals that work with and are associated with that medical community is a conflict of interest every time.

Q. And are you aware of any hospital ethics committee that does not consist, in whole or in part, of people associated with that medical community?

A. I'm not aware of any, but I still hold the opinion that it is an inherent conflict of interest, and

I don't think we would see a judge taking a case where he or she had any financial interest in the outcome, even if it were a very small financial interest. I think most of them would recuse themselves, and I think that's a standard that we should hold ourselves to in the medical profession.

Q. But you would agree that the standard at least currently is that ethics committees generally are comprised of people, at least some of whom are involved in that medical community?

A. Usually it's -- almost exclusively people from the medical community with a couple of, quote, lay people on the committee that are, you know, there as volunteers. Even sometimes -- the chaplain will usually be the hospital chaplain, for example. The attorney is usually going to be the in-house counsel or someone who represents the hospital.

Q. But the part that I'm interested in, that's the standard practice across the country these days; is that correct?

A. Well, I have a little bit of problem with standard because that can be interpreted different ways. That's what happens the majority of the time but standard seems to imply that it's acceptable or right, and I don't really think it is.

Q. Do you understand the term standard of care?
A. Standard of care means what a prudent physician would do in the same or similar circumstances. It doesn't mean what everyone is doing. It means what a reasonably prudent physician would do. So, if every physician in Beijing is agreeing to harvest kidneys from executed prisoners, is that what a reasonably prudent physician would do? I don't think so.
Q. So, if every --
A. Just because everyone is doing it, that doesn't make it reasonably prudent. They're not the same thing. That's my point.
Q. Are you saying that if every physician does the same thing, whatever it is, that's not the standard of care necessarily?
A. The standard of care is what a reasonably prudent physician would do. Every physician that worked for Dr. Mengele in Nazi Germany participated in experimenting on humans. Otherwise, they wouldn't have been in that department. Since they were all doing it, one could say that's the standard but is it what a reasonably prudent physician would do? Not by any means. It's what a criminal would do.
Q. Would you agree with me that the vast majority of hospitals have ethics committees that are comprised

largely of people who have affiliations with that hospital?
A. That's correct. Yes.
Q. And accordingly, the standard of care for hospital ethics committees would be to have members that are affiliated with that medical community, correct?
A. No, because the problem is standard of care means what a reasonably prudent physician would do in the same or similar circumstances, and just because every physician that's working with Dr. Mengele in Nazi Germany is experimenting on people, that doesn't make it reasonable. That doesn't make it okay.
Q. All right. Are you equating Yale-New Haven Hospital's ethics committee with the Nazis operating in Germany?
A. No. I'm giving you an extreme example to show that reasonably prudent doesn't necessarily correlate with what everyone is doing. Just like when you were in junior high school and your mother told you if everyone jumps off the Brooklyn Bridge, you don't have to do it as well, that's the same basic idea.
Q. Would it be fair to say then that you equate the standard of care with what should be done, not necessarily what is being done by the majority of similarly situated physicians given the same

circumstances?
A. I would say the standard of care is what a reasonably prudent physician would do in the same or similar circumstances, and it's a term that's used in negligence cases, and negligence means it's a mistake. That's what negligence is, a mistake.
It doesn't apply to intentional actions. Okay? Someone that breaks into a house can't say, "Well, this is the standard of care for breaking into a house. Well, the other robbers were doing this, so, I was doing it, too, therefore, it's okay." No, it doesn't apply to intentional actions.
And this isn't a mistake. This is intentional. Even by their own admissions, they agree that they were withdrawing care against the family's wishes, and by their own admission, they administered a morphine drip, which causes respiratory depression and probably helped lead to the person's death.
Q. Okay. I don't think that's in your report, is it?
A. No, it's not because I discovered that as I read through the records and thought about it more. And that's a very, very important point.
Q. Have you ever been the physician responsible for executing comfort care on a terminal patient?

A. Yes. I'm assistant medical director for hospice. I think it's in my CV.
Q. And is morphine a drug that you use on occasion for terminal patients whose status has been converted to comfort care only?
A. I've never had a patient whose status was converted to comfort care against their wishes, never.
Q. That might be a little different. I asked you whether you have been the physician responsible for executing a comfort care only plan?
A. Yes.
Q. Okay.
A. Most hospices have comfort care plans for people who want hospice --
Q. Right.
A. -- who want that course of treatment.
Q. But my question is in those cases, have you ordered morphine?
A. Yeah, morphine is part of the comfort pack that we use, yes.
Q. And administering morphine to a patient whose status is legitimately comfort care only is certainly within the standard of care, is that your --
A. It depends on the situation. I don't think it should be used to hasten death. I don't agree with

euthanasia. I don't think that's a good policy for the medical profession to be involved in, and that's very close to what we have here.

Q. Are you prepared to offer an opinion to a reasonable degree of medical certainty that this case involves euthanasia?

A. Can I think about that for a moment?

Q. Sure.

A. Can we -- actually, if we could just go off the record for a moment, I just want to --

Q. Talk to Jeremy?

A. Just think about it.

Q. Okay.

A. Maybe go to the bathroom or something.

Q. Okay.

(Off the record.)

Q. (BY MS. SEAMAN) Go ahead.

A. Yes, I believe this is euthanasia.

Q. Okay. And what is it that causes you to believe that?

A. There's several things. Okay? I define euthanasia as the bringing about of someone's death for the purposes of alleviating their suffering, and there's several things that lead me to believe that this is a case of euthanasia.

Q. And what is that?

A. First of all, they're going against the family's wishes and not only the family's wishes but the actual patient's wishes because she had multiple discussions with her husband and other family members, saying that they wanted to stay alive at all costs to care for their handicapped daughter.

So, those were her wishes. They're not the wishes of her husband or an adult child or someone else with ulterior motives. Those are her actual wishes. So, the fact that it's against the patient's wishes removes it from comfort care and brings it into the area of euthanasia.

Second of all, we're administering morphine, and we're administering it as a continuous drip, not just on an as-needed basis. We're continuously infusing it from the time that they decide she's going to be comfort care until the time that she passes.

And morphine is a very potent respiratory depressant, and this woman was just removed from the ventilator. So, she had respiratory problems. So, we're giving a drug to a patient that we know has difficulty breathing that causes cessation of respiration. So, that hastens her death. So, that is euthanasia.

And then, thirdly, we decide that we're not going to use BiPAP. BiPAP isn't even usually considered heroic measures. It's just a mask that goes over the face that assists in breathing.

And the reason that we're not going to administer BiPAP is because there's a little bit of a sore next to the nose. Well, which would the person rather have, irritation of their sore next to their nose or a death because they don't breathe? I think most people would take the sore next to their nose. So, the fact that they're not even giving BiPAP, now, that's really, really trying to hasten her death.

Q. Is that it or is there more?

A. Let me just look because -- I'm just looking to see if any benzodiazapines were administered along with the morphine.

Well, there's also this issue that her blood count is dropping and they are not giving blood transfusion or addressing that but I think that probably just goes along with the general idea that we're not going to treat her any more, we're going to let her die.

Q. Is it common when comfort care only is ordered in the situations that you've been involved in that those things that cause skin breakdown or discomfort are removed?

A. Well, even in comfort care, the patient has a choice, and the patient may prefer not to have a feeling of suffocation as opposed to irritation of the skin breakdown.

So, even in comfort care, the patient has a choice. Even patients that are admitted against their will in psychiatric facilities have a choice about which medicines can be administered to them.

Q. So, your answer is yes?

A. To what?

Q. The question that I asked you.

A. No, it's not really.

Q. Okay.

A. It's not really yes because you're asking me hypotheticals about a totally different scenario. This is apart from the comfort care and hospice because this is against a person's wishes. This is battery.

Q. Did you learn battery in law school?

A. I'm sure it was in law school somewhere, yes.

Q. And --

A. But I'm pretty sure I knew that word before I went to law school.

Q. In the context of medical care, what's battery?

A. Well, it's kind of removed from the legal realm, the physicians, at least in Texas, because they can no

longer be sued for battery apart from medical malpractice. If it's in the context of giving medical care, it all counts as medical malpractice but, traditionally, battery in medicine was doing a surgery without a patient's consent or doing some procedure, some offensive or harmful touching without their consent.

And whether this is legally battery or not, I can't tell you but from a layperson's perspective, it sure looks like battery to me. The patient is asking for help, and they are giving them drugs to hasten their death.

Q. So, this is your layperson's opinion, it's not your medical opinion --

A. No. No.

Q. -- or your legal opinion? Sorry.

A. No. I was just pointing out how a layperson might view it, that's all.

Q. Okay.

A. It's my medical opinion that --

Q. And your legal opinion?

A. I was really called as a medical expert, and I would just keep it to that medical opinion. It's my medical opinion that this falls way outside the norm and that they are giving her medications against her will

that are hastening her death.

Q. So, as I understand your testimony, comfort care, as you are used to comfort care only, does not include the removal of equipment that is perceived to be uncomfortable or cause skin breakdown; is that true?

A. No. My opinion is that the term comfort care only applies if it's done with the patient's consent.

Q. I understand that but --

A. Everything else is secondary to that.

Q. So, as long as she didn't sign a consent, everything else that Yale did was wrong, is that basically your opinion?

A. I don't even know if she has to sign a consent but the fact that she's actively and her representatives are actively objecting to the care being delivered, that's not comfort care.

Q. So, you --

A. That's causing pain.

Q. Okay. So, your understanding is over the objection of a surrogate -- because you agree in this case, she never spoke from the time she --

A. I don't agree with that.

Q. Okay.

A. Because in the deposition of the husband and the family members, apparently the couple had an agreement

that they were going to stay alive as long as possible to care for their invalid daughter.

Q. But my question is a little different.

A. So, they were expressing her wishes. This is not a man that's keeping her alive so he can get the Social Security check. This isn't someone keeping her alive so they can bring their relatives in from Mexico. This is someone that's keeping the person alive because that's what she wanted.

Q. Okay.

A. He's truly acting in her interest.

Q. Okay. Can we agree that she didn't speak from before the time she got to Yale?

A. We can agree that she didn't verbalize her wishes from when she arrived at Yale on the 19th until she passed away on the 24th or 25th. It's a little unclear to me if she passed away at 10:45 on the 24th or 3:15 on the 25th. I was a little confused about that.

Q. 3:15 in the afternoon or the morning?

A. In the morning. I was a little confused about that because there's two notes but I don't think it really matters.

Q. And when was it that she first went into the -- was she in a coma, is that what you think?

A. No, she was not in a coma because a coma is a

neurological condition in which a patient is unresponsive.

Q. And was she responsive?

A. Yes.

Q. Okay. Throughout the time that she was at Yale?

A. Her mental status waxed and waned but there are repeated notes from nurses, social workers that she responded to voice, that she opened her eyes to voice. There was a question from the attending physician about whether she even followed his commands and squeezed his fingers. And the family believes that she had purposeful communication.

Q. I may --

A. So, she's clearly not unresponsive. She's not in a coma.

Q. I may have missed that. Where did the family say that she had purposeful communication?

A. In the social worker's note.

Q. Can you show me?

A. You better give me a few minutes.

Q. I might be able to help you. Don't take -- oh, you have it in your note maybe?

A. I might.

Q. Is this at the time that the social worker called them about going to the ethics committee, that note?

A. There were a couple of different notes with social workers. Here's a note from nursing on the 10th. "Ms. Marsala is awake most of the time and able to follow commands. Appears comfortable."
Q. That's June 10th?
A. Yeah. Being awake, well, you're not in a coma if you're awake. Here is nursing on the 11th, "Able to wiggle toes and" -- something -- "to command at times." "Able to wiggle toes and" --
Q. July 10th or June 10th?
A. July 11th.
Q. Okay.
A. The nursing says, "Able to wiggle toes and" -- something -- "to commands at times." So, she was responding to commands according to that nurse's note.
MR. VIRGIL: I know your question was about June but his note says July.
A. July, yeah.
Here's one July 13th from nursing, "Patient has been alert with eyes open for most part of the shift. Unable to determine if patient is actually following commands." Well, she's got a question about whether the patient is following commands.
Here's a social worker from the 14th, "Family has been coping, as to be expected during this time. They

have a close support system."
Q. I think the question that you're looking for is what is the basis for stating that there was purposeful conversation with the family after admission to Yale, and I think you're looking for a social work note that I believe you said says that.
A. Right. I'll find it. It was somewhere in the social worker's note. One of the sons thought that he was purposefully communicating with her, responding. Here it is on the 8th.
Q. July 8th?
A. July 8th, "Son states she nods her head in response to his questions."
Q. Did you see any references by any of the medical team that she nods her head in response to questions?
A. That's usually not something that we ask the patients to do. Very often we ask them to squeeze our fingers. And there was an attending note where he thought that she squeezed his fingers but he wasn't a hundred percent sure.
Q. And did you see any other support for a statement that at any time after July 8th, 2010 Ms. Marsala was capable of purposeful communication?
A. Yeah, here is the nursing note from July 11, "Able to wiggle toes and does so to command at times."

Here's on the 13th, it says, "Unable to determine if patient is actually following commands."
And here's a contradictory note, physician progress note on the 13th that says, "Awakens to voice, squeezes hand on the right, does not follow other commands." I guess it's not contradictory. The physician is saying that the patient squeezed his hand on the right side. She followed his command. It's on the 13th.
Q. I'm sorry, did he say that she followed commands or that she was able to squeeze his hand?
A. Squeeze his hand on right.
Q. Okay.
A. That is a very specific command, "Squeeze my hand," and she does it.
Q. Okay. All right. Go ahead.
A. That's the last mention of it that I have in my notes is on the 13th.
Q. And you would have written all of those down because that's one of the things that you were looking for when you were going through the record, correct?
A. I agree with that, yeah.
Q. So, it would be fair to say that between July 13th and July 24th, there's nothing that would suggest that Ms. Marsala was capable of purposeful

communication; is that correct?
MR. VIRGIL: Objection.
A. I didn't see anything in the medical record, no.
Q. (BY MS. SEAMAN) So, I'm trying to separate consent from comfort care. Would you agree with me that comfort care only typically involves the administration of medications so the patient is not in pain and the discontinuation of uncomfortable machines or other kinds of equipment?
A. I would define comfort care as making the main priority of care to avoid pain and discomfort, even if it means decreasing the length of survival.
Q. You say that you understood that Ms. Marsala wanted to stay alive at all cost to care for her adult daughter; is that correct?
A. That was supposedly the agreement that the two spouses had.
Q. And what was the likelihood that Ms. Marsala would have recovered sufficiently to be able to take care of her adult daughter?
A. Well, that's a really hard question to answer because we don't have a diagnosis. There's no diagnosis as to why she had an altered mental status. So, if the person doesn't know the diagnosis, how can they possibly opine on what the treatment would have been or whether

the treatment would have been effective. The number one step is getting a diagnosis.

Q. And what should have been done to get a diagnosis?

A. Well, one thing that jumped right out at me was the fact that one of her x-rays had described possible cirrhosis and that she has an elevated ammonia level of 43, and hepatic encephalopathy is one of the things that's in the differential for toxic metabolic encephalopathy, and that was never really addressed.

Q. Cirrhosis meaning cirrhosis of the liver?

A. Yes.

Q. And is that treatable?

A. Yes. Is it curable? No. But is it treatable? Yes.

Q. Did the ammonia stabilize after her admission?

A. I have one from the 19th as being 43.

Q. What's normal?

A. I can't remember what the top limit of normal is. It might be 10. I don't know. I'd have to look it up.

Q. And what is hepatic encephalopathy?

A. Hepatic encephalopathy is when the liver is unable to clear ammonia that's going through the enterohepatic circulation from the intestine. It's unable to clear it from the bloodstream, and it is able

to make its way up to the central nervous system and affect the person's level of conscious.

Q. So, would hepatic encephalopathy be another DRG code?

A. Well, it would be but there's a couple of issues. One is we don't know for certain that's what it is because we haven't investigated it and we haven't tried to treat it and, number two, after a certain number of codes, it's superfluous because it's only the major code that matters and then the major complicating factors.

Q. But in addition to the other problems that she had that you listed, she also had hepatic encephalopathy, in your opinion?

A. I don't know if she did. I just know it wasn't checked for it.

Q. How do you work it up?

A. One of the things you do is you give Lactulose.

Q. What is it?

A. Lactulose, L A C T U L O S E. So, usually that's the first line of treatment is Lactulose. We also use a medication called Rifampicin sometimes. And I'm sure that Yale has hepatologists on staff that could give an opinion. I even remember someone in my residency program that was head of their transplant program for a while. I don't know if he's still there.

Q. What's his name?

A. Navarro. So, I know they have a liver -- they have a liver department. I mean, I know that they have expertise in that area.

Q. Okay. So, have you ever treated hepatic encephalopathy?

A. Yeah, all the time.

Q. That falls within pulmonology?

A. It falls within critical care. It falls within internal medicine. It's fairly common.

Also, one of the things that can make hepatic encephalopathy worse is bleeding, intestinal bleeding. That's one of the things that triggers it, and apparently she had some ischemic colitis.

Q. So, you're unable to say to a reasonable degree of medical probability that Ms. Marsala would not likely have improved to the point where she could be discharged from the hospital and returned to care for her daughter; is that correct?

A. I can say that I don't know what would have happened because it wasn't investigated and it wasn't treated.

Now, there's other potential causes of her altered mental status as well. There are certain types of encephalitis as well that can cause altered mental

status. Herpes simplex is a virus that sometimes causes encephalitis. There are other viruses, West Nile virus and St. Louis Equine that can cause encephalitis. I don't know the epidemiology of Southern Connecticut. I mean, I know Lyme disease was named because of Lyme, Connecticut, and Lyme disease is one of the things that can cause an altered mental status.

So, really not a whole lot has been done to look for infections other than the fact that they wanted to do the LP and the husband declined, because that would have been a good way of looking for infections.

And then also, she was treated for a while with an antifungal medicine that would have potentially killed, you know, fungal infections like Cryptococcus meningitis.

Q. So, are you critical of the treatment that she received up to July 20th?

A. I'm not critical of the treatment. I'm critical of the decision to withdraw the life support --

Q. I understand that but you're not prepared to offer an opinion that there was an insufficient workup of her presenting condition from the time of her admission, I think it was June 19th, up until July 20th, are you?

A. I'm not prepared to say that the workup fell

below the medical standard of care but I can tell you that it falls below the standard of care for deciding that someone -- that the treatment is futile because futility is a higher standard. Futility means that we have to be certain that the person cannot recover, and how can we be certain if we don't know what the diagnosis is.

Q. So, you're looking at something as you're saying that. What do you rely on in support of that?

A. The definition of futility is here in the UpToDate database. Here, I'm going to read the definition.

Q. Is UpToDate authoritative, in your opinion?

A. In my opinion, it is.

Q. May I just look at it before you read it, if you don't mind. You printed this on 9-20-2014; is that correct?

A. I guess so, yeah.

Q. Did you look at UpToDate before you wrote your opinion in this case?

A. Which opinion?

Q. How many opinions have you written in this case?

A. Well, we have this preliminary opinion that was based only on those things that I looked at in the front. I didn't look at anything else. And now we have

my revised opinion that I'm giving in deposition after having reviewed the records more thoroughly and after having consulted supplemental texts and literature.

Q. Okay. Under our rules, you were required to produce this two weeks ago. Has anyone ever told you that?

A. I had no idea about that.

Q. Okay. And so, UpToDate -- do you believe in the principal of futility as it applies to end of life decisions?

A. Personally?

Q. Yes.

A. No, not really, but I don't think that's relevant because it's not really my personal opinion that's important.

Q. Okay. You understand that there's several schools of thought about end of life decision making, correct?

A. I am able to entertain and understand an idea without adopting it.

Q. Okay.

A. So, I can entertain and understand the idea of futility and the argument for not providing futile medical care but that doesn't necessarily mean that I choose to agree with it. That would be a personal

decision.

Q. So, what is your definition of futile medical care as you are using that term?

A. Just as it states in that article.

Q. So, you rely on UpToDate for the definition of futile medical care, correct?

A. Yes.

Q. So, futile means treatment that simply cannot accomplish the intended physiological goals, correct?

A. Correct.

Q. Do you believe that there is medical treatment that ethically physicians should not provide?

A. I think there probably would be cases like that, yes.

Q. Do you agree that if patients or their surrogates request treatment that the clinician feels are potentially inappropriate, efforts to find a negotiated agreement should be made through both direct engagement and the involvement of expert consultants, hospital ethic committees, palliative care consultants or mediation experts?

A. I think that the most important point of that is the first. If there's conflict, the conflict should be negotiated between the parties.

Q. Okay.

A. The parties in this case are the treating physician or physicians and the patient and the patient's family.

Q. Okay.

A. Now, I think that's where conflict resolution starts, a negotiation between the parties. I don't put too much credence in the ethics committee because, like I mentioned before, that's an inherent conflict of interest that wouldn't be tolerated in any other venue in our society, and why we accept it in our profession is beyond me.

Q. So, you disagree with UpToDate on that one?

A. I agree with the first part, certainly between the physician and the patient and the family. And that's where the conflict is usually resolved. I mean, I can't remember ever resolving any conflict with a family over end of life care by going to an ethics committee or by bringing in an outside consultant other than maybe clergy.

Q. Do you agree that clinicians should not simply acquiesce to requests for treatment that they believe violate accepted medical practice since this violates the ethical obligations to practice with professional integrity?

A. Well, that's a broad statement. And I think if a

patient says, you know, "I'd like to have my gallbladder removed just because I don't like it there," well, I don't think we should just go and remove the person's gallbladder. So, that would be a perfect example of where we wouldn't want to acquiesce to the person's request.

The person may say, "I'd like to take, you know, 16 hydrocodone tablets every morning and 16 more every evening because it makes me feel good." Well, it wouldn't be ethical to respect that request. So, yes, there are cases where it's not ethical to respect it.

Q. And you agree with that?

A. There are cases, yes.

Q. Do you agree that the term potentially inappropriate should be used to describe treatments that clinicians believe go against their best understanding of their professional obligations, this includes treatment that is exceedingly unlikely to accomplish the patient's goal?

A. Right, and I agree with that, and I think there's a big distinction between potentially inappropriate and futile because there's a difference in the degree of certainty.

Q. Would you agree in this case the clinicians providing care to Helen Marsala spent sufficient time

attempting to negotiate an agreement with Clarence Marsala about the steps that should be taken in her care?

A. Yes and no because the problem isn't necessarily time because conflict resolution is about more than just how much time is spent. It's also in the manner that it's approached. Okay?

And if you look at the records, two or three days after she arrives there, they are already asking the family to withdraw. They are not talking to the family about what they can do to help. They are talking to the family from the very start about what they can do not to give more care. So --

Q. Can you show me that note on the second or third day, please? That would be on the 20th or the 21st of June?

A. Wait. Maybe that's an exaggeration. From very early on in the hospitalization, there were discussions about withdrawing life support, very early.

Q. So, show me where you see that.

A. Okay. I'd have to go back and look at the records because it's not something that I wrote down. Can we take a break and have me go through the records?

Q. Do you want to take a break or do you just want to find it?

A. Well, I'd like to be off the record.

Q. That's fine.

(Off the record.)

A. On 6-29 --

Q. (BY MS. SEAMAN) Do you want to just give me that note? It's probably easier if we just mark it.

A. No, because it might not be the earliest. We can go off the record so I can organize better if you want.

Q. But before you lose that page, do you want to put a clip on it.

(Off the record.)

Q. (BY MS. SEAMAN) Go ahead, Doctor.

A. I'm sorry, just let me finish looking through the records.

Okay. Here's a record, a note from 6-28.

Q. All right.

A. Okay. It's from -- it's a summary and plan. It's not clear to me which physician entered this but, "Patient admitted from Griffin Hospital. Prognosis is poor. Asked to assist family with support. Nursing feeling that husband is, quote, in denial about patient's condition. Spoke with patient's husband, Clarence, via telephone to elicit his understanding of patient's condition. Mr. Marsala presented as optimistic and religious, holding faith that patient

will get better. He reports that patient is doing a hundred percent better than at other hospital, she's able to nod her head and that she hears him. Per chart, patient is unable to communicate. Mr. Marsala reported that patient was very active prior to going to the hospital several months ago, though legally blind and one year secondary to diabetes. He describes her as very feisty, independent and a giver. He states that they have been married 57 years and they have 5 children. He has -- he has a very good support system. He has declined spiritual support at this time for his wife since he feels if she sees it, she will think she's checking out. There will be a family meeting tomorrow at 5:00 p.m. to discuss goals of care. Will be unavailable at that time."

Q. So, who signed that note, sir?

A. I can't tell.

MS. SEAMAN: Can you look, Jeremy?

MR. VIRGIL: Yes. This is Donna -- well --

A. Well, it looks like she's entering afterwards, isn't she?

Q. (BY MS. SEAMAN) So, this is the social worker, 6-28-2010?

A. I'm not sure if it is a social worker. I think the social worker's entry might be following that. I'm

not sure.
Q. So, you don't know who entered that note. Do you believe it was entered on June 28th?
A. What do you mean, do I believe it?
Q. I think we started going down this track because you testified that you didn't know whether Yale had conducted negotiations with Mr. Marsala in an attempt to come to an agreement on a plan of care in a reasonable fashion. You testified that you believed it was premature the way they did it. So, you're looking for those entries that suggest that the conversations about plan of care with Mr. Marsala took place too quickly after she was admitted to the hospital on June 19th. That's what I believe you're looking for. Is that what you think you're looking for?
A. No. I guess there's a little bit of miscommunication because my point is that when developing a rapport with someone, the first thing that a person should do is show concern. The first thing you want to do is listen. What is the other person thinking? What does the other person want? What are his goals?
And my impression is that he came to this tertiary care hospital hoping that they could find a way to treat his wife. Okay? And very early on, it seems

like the physicians and the staff are just telling him that, you know, it's hopeless and he's in denial, which I think is kind of pejorative to say that someone is in denial.
Q. So, you think that this social worker's note is pejorative?
A. In my opinion, denial is a pejorative term because it's implying that the person's thinking isn't a hundred percent rational, that they don't really understand, that they are denying the truth. Right?
Q. And do you disagree that if Mr. Marsala believed that she is able to nod her head and hear him when the staff reported that the patient is unable to communicate that denial might be a legitimate description?
A. Denial is a defense mechanism that's well accepted.
Q. And pejorative?
A. It could be there. It's pejorative. And also, it's the way that the person is approached. If the person is approached right from the beginning, "We think it's hopeless and we're just doing this because you're pushing us," well, that's not going to create a good relationship.
Q. Okay.
A. Okay?

Q. So, you're saying that this social worker, who came here nine days after the admission, was not here to try to support Mr. Marsala?
A. No, I'm not really saying that. I'm just saying that the word denial is pejorative. Let's just leave it at that.
Q. What evidence is there in the record to support your testimony that Yale did not appropriately handle Mr. Marsala in connection with discussions about end of life decision making during his wife's admission to Yale-New Haven Hospital?
A. Well, he expressed frustration that there were multiple physicians. He didn't have one physician that he knew that was responsible for his wife.
Q. If this person was hospitalized in Texas, would you have a single attending physician for six weeks?
A. If the person were hospitalized under my care, he would have a single attending for six weeks.
Q. When was the last time that happened, sir, that is, that you were responsible for the care of a patient who was in the ICU for six weeks?
A. Well, it's unusual for my patients to be in the ICU for six weeks but certainly they can be ill for six weeks.
Q. No. No. When was the last time you were the

attending physician in charge of a patient in the ICU for six weeks?
A. It would be -- because six weeks is a long time to be in the ICU. So, I'm trying think of -- either three or four months ago.
Q. Which hospital was that?
A. Bayshore Medical Center.
Q. And what was the condition for which the patient was in the hospital in the ICU for six weeks?
A. She had a number of problems. She had total body anasarca, which means swelling, that we thought might have been from ovarian cancer because her CA 125, which is a marker for ovarian cancer, was elevated, but we weren't able to find any.
She also had severe vascular disease, which required amputation of her right hand. She developed respiratory failure. She was on the ventilator. She also had anemia and kidney problems as well.
Q. And you were her attending physician?
A. I was her attending physician.
Q. Okay. All right. So, can you tell me any place in the record that you rely on in support of your testimony that the approach, the attitude or anything else about the practitioners at Yale-New Haven Hospital deviated from the standard of care in connection with

the attempts to negotiate an agreement with Mr. Marsala about the plan of care other than this social worker's note that I will have marked as the next exhibit number?

(Exhibit 31 marked.)

A. I don't want to say deviation from the standard of care because, once again, I don't think it a hundred percent applies in this case because we're not really talking about a mistake.

Now, you asked me did they spend sufficient time talking to the husband, and the answer is yes, they did spend a lot of time. The question is was there approach correct because he seemed to have complaints that there were multiple physicians, he didn't know who was in charge, he didn't know who to go to. He also became less and less responsive to the their phone calls and began not to communicate with them as much.

Q. Was that different than the situation at Griffin Hospital?

A. I don't know. I don't have the records from Griffin Hospital.

Q. All right. So, can you identify any caregiver who you believe did not follow the correct approach in his or her dealing with Mr. Marsala?

A. Yes.

Q. Okay.

A. Dr. Pisani.

Q. Okay. Any others?

A. There was a physician that came on service after Dr. Pisani left.

Q. Who was that?

A. I don't know the name. It started with a T. And I believe that physician is the one that actually initiated the morphine drip.

Q. And did you see interaction between that physician and Mr. Marsala?

A. It says, "Attending Tanove, Dr. Sanders and Dr. Burke spoke husband."

Q. When was this?

A. 24th.

Q. Okay. All three of them?

A. Yes.

Q. Okay.

A. I don't necessarily see that as a positive thing because I think that the rapport is better and more personal if it's the attending physician with the family. I think when the residents, interns, nurses come in and there's a whole group of people, I think that's intimidating. So, I don't think that's necessarily a positive thing.

Q. Do you have residents at the hospitals at which

you work?

A. No.

Q. Okay. And Dr. Sanders, Dr. Burke, Dr. T -- sorry, I didn't write down the whole name -- any of them residents?

A. I have no way of knowing but I think that Dr. Tanove was a critical care physician. I don't know who the other people are.

Q. And is it your understanding they spoke to Mr. Marsala by phone?

A. It says, "Spoke with husband." It doesn't say by phone or in person.

Q. That's your note?

A. Right. Yeah, it doesn't say. And also, even if Dr. Sanders and Dr. Burke were not residents, I think having a whole group of people descend on you in a time of emotional distress isn't optimal.

Q. He wasn't in the hospital on July 24th, Mr. Marsala, right?

A. If you tell me that, I take your word on it. It says spoke with, it could be over the phone.

Q. That's your note, though, right?

A. I think I copied it from the other note.

Q. Okay.

A. I mean, I'm happy to agree that it was over the

phone. It doesn't matter.

Q. That three different people were on the phone with him at one time, that's what your note is telling you?

A. I guess the fact that there's three people would more imply that it was in the hospital, right?

Q. Mr. Marsala doesn't testify that he was there on the 24th, does he?

A. I don't remember that one way or another.

MR. VIRGIL: I think it's unclear.

Q. (BY MS. SEAMAN) I just want to make sure that I have all of the information on which you rely in support of your testimony that Yale did not appropriately communicate with Mr. Marsala around the end of life decisions involving his wife. I understand, number one, you're relying on Mr. Marsala's testimony that he was frustrated at the number of providers that communicated with them. I understand, number two, you're relying on documentation from July 24th that, based on your notes, say that three different people communicated with Mr. Marsala. I understand that you are saying that the social worker exhibited an inappropriate attitude by saying that the husband is in denial about the patient's condition and your concern that the practitioner may not have had the right approach to dealing with Mr. Marsala.

Other than those things, is there anything else you rely on in support of your opinion that Yale-New Haven Hospital did not appropriately communicate with Mr. Marsala?

A. Okay. There's some miscommunication here.

Q. Okay.

A. I'm not opining that this is a deviation from the standard of care. Okay?

Q. Okay.

A. So, I'm only opining that the approach with which the people communicate with the person that's grieving is important, and it seemed like there was not a good rapport between the physicians at Yale and Mr. Marsala, and that's based on the fact that he was complaining that there were multiple physicians, based on the fact that they had to go to a committee to do things against his wishes, based on the fact that the record keeps saying that there's a disagreement, it's pretty clear to me that they didn't get along all that well. And I'm not alleging that that's a deviation from the standard of care or that's the basis of this suit in any way. I'm not opining that that's a deviation from the standard of care, so, I'm a little confused why we're going into all this.

Q. Well, would you agree with me that

notwithstanding the best efforts on behalf of healthcare providers, there are some circumstances in which a surrogate and the healthcare provider do not agree on the appropriate steps to be taken?

A. Well, certainly people are not always going to agree.

Q. And would you agree that virtually every jurisdiction has established a process that can be followed in the case of such a disagreement?

MR. VIRGIL: Objection.

A. I don't -- first of all, I don't think I would be qualified to know that because, you know, I haven't reviewed every jurisdiction in the country.

Second of all, I think that the Texas statute is much clearer than the Connecticut statute.

Q. (BY MS. SEAMAN) Okay.

A. It's much more precise. It gives you exact timelines, specific things that need to be done. I think that the Connecticut statute is a little bit more vague.

Q. Okay. Do you know the Texas statute because of your work on this case?

A. No, because it has received a lot of notoriety in the press and so on because it was, I guess, the first state statute that really, you know, specified the

timeline and gave a real specific format as to how to deal with this problem.

Q. Okay. Have you ever had to rely on the Texas statute in connection with the care of a patient?

A. Well, this patient that I was telling you about that was in the hospital for four weeks or six weeks, whatever it was --

Q. Was it six weeks or four weeks?

A. I don't remember exactly.

Q. Okay.

A. She was in the hospital more than one time. She got admitted, she went home, then she came back. Okay?

Q. Okay.

A. So, it was a long period of time. And the ICU manager was upset with the amount of time that the patient was in the hospital, and we did have an ethics consult on that case.

And Dr. Hawk was the head of the ethics committee, and he went to the family and told them that the attending was to find another provider and hospital or else we were going to withdrawal support against their wishes.

And there was no formal meeting that we attended but he was the head of the ethics committee and he did that. And I called him and told him, you know, that

that wasn't really my hope, that, you know, he would, you know, revert to doing something against their wishes. I just had wanted someone else to speak to the family and, you know, see if they could have a better rapport with them. I really didn't intend for him to invoke that statute.

And then I told him that I wouldn't support him in that, and then he agreed that, well, that wasn't -- he didn't understand, there was some miscommunication, and we both agreed just to drop it from there.

Q. So, am I understanding that you went to Dr. Hawk to ask him to talk to the family?

A. I went to the ethics committee because I thought it's just a general committee to help resolve conflicts and ethical issues. I didn't necessarily want him to invoke this statute and kick the people out or pull the plug on the woman.

Q. What was the conflict that you went to the ethics committee about?

A. Well, there was a problem in that -- it was similar to the Marsala case because her chances of survival were very, very small, and the family didn't really have a good understanding of that.

They were kind of suspicious of us and of the healthcare community. There were also some ulterior

motives that might have been involved because several family members lived with this individual who was receiving a Social Security check, and it's possible that they may have been relying on that Social Security check to pay the rent.

And then there was also an issue about family members coming in from Mexico because while they have a right to come in and visit their sister or their mother but the problem is that sometimes that's used as a way for people to come in the country and not leave. So, if an inordinate amount of relatives are asking for letters for the border patrol, one has to be concerned about an ulterior motive like that.

Q. So, you were concerned that the family was making treatment requests at least partially because they were trying to get other family members into the country from Mexico?

A. And also because of this problem with the Social Security check, and also there was just a general distrust that the family had of the medical profession in our country.

Q. And were you the person who up until the time you went to the ethics committee, you were having most of the conversations with the family because you were the attending?

A. I pretty much had all of them because there was also a language barrier. So, you know, in order to communicate, they pretty much needed to speak Spanish.

Q. Do you speak Spanish?

A. Yes.

Q. So, even though you were the healthcare provider who had virtually all of the communications with the family, they remained suspicious of the healthcare system or, I take it, your care?

A. Well, what they told me was everything in our country revolves around money.

Q. And you, I guess, kind of agree with him at least with respect to hospital care; is that true?

A. Well, I said that I didn't feel it was any different in Mexico because I had seen pictures on YouTube of people being beheaded through drug wars and it seemed like money was pretty important there, too. So, yeah, they said they agreed that money seemed to be pretty important there, too.

Q. So, I'm not quite sure, is it your recollection that you and the family disagreed with respect to what were the appropriate steps and even though you had virtually all of the communication with the family, they remained suspicious of your recommendations?

A. I don't -- there were other people that

communicated with them as well. They just seemed overall suspicious. They seemed to feel that because they, you know, were not born and raised in the United States that they were susceptible to be taken advantage of, and I think that's true, they are kind of susceptible. They don't have as much information or as much access to information as people who grew up here and lived here their whole lives.

And there were also a lot of them, and they didn't agree amongst themselves. That was another problem and it was not a problem in the Marsala case but in this case we've got nine children.

Q. In your case?

A. Yes. Nine adult children, no spouse, a sister, a couple of in-laws, grandchildren. Sometimes it's hard to even figure out who is who. It's a new person every time. So, there's a lot of family members, and they don't all agree.

Q. So, in this case, did the woman recover and go home?

A. No, she passed away.

Q. Did she pass away in your hospital?

A. Yes.

Q. And you went to the ethics committee in hopes that they could talk to the family and help to bridge a

relationship between you and the family?

A. Yeah, and just to get another opinion. Maybe there's someone else that has something to offer, that's all. I was just looking for advice.

Q. Okay. Had you recommended that care be withdrawn in that case?

A. I had told the family that, you know, if it were my mother, that I wouldn't continue with the ventilator.

Q. Did you recommend that they transfer her somewhere else?

A. No, because I wasn't going to go against their wishes because I don't believe in that.

Q. And did the hospital transfer her against the family's wishes?

A. No.

Q. Was there another facility that would have been more likely to take a more aggressive approach than you did with this patient?

A. No, because we were doing everything -- there's other facilities that would have taken her but the problem is the treatment would have been the same.

Q. Okay. And I'm sorry if you told me, what was the timeframe that you had this patient?

A. Five or six months ago, four or five months ago. I don't remember exactly.

Q. 2014?
A. It was 2014.
Q. And other than reading about it in the popular press and this year going to the head of the ethics committee about your own personal patient, have you ever had any other experience with the Texas Advance Directive Act?
A. No.
Q. Okay. And the only experience you have with the Connecticut statute is reading them in connection with your review of this case, correct?
A. Correct.
Q. And what knowledge do you have about California advance directive statutes or end of life statutes?
A. I have not reviewed those.
Q. And do you know what Massachusetts statutes are with respect to end of life or advance directives?
A. No. And I might point out that Massachusetts, I think, is one of those states that has -- it has universal healthcare. So, it's kind of unique.
Q. How does universal healthcare impact end of life decision making?
A. Just that sometimes they're on the vanguard of certain changes, that's all.
Q. Would it be fair to say that as a medical doctor

practicing in Texas, you do not have knowledge or experience with respect to the application of Connecticut statutes to end of life decision making?
A. No, I wouldn't say that.
Q. Okay. Under what circumstances, as a physician, have you developed expertise on Connecticut statutes with respect to end of life decision making?
A. Well, I think I'm here as a medical expert. So, my expertise is in critical care medicine and, obviously, in critical care medicine, I've dealt with many people that are terminally ill. I have dealt with many people who have wanted to pursue comfort care. I've dealt with people that have wanted aggressive measures. And I've dealt with conflicts and so on and so on. So, I think that's what my area of expertise is.
I think I'm perfectly capable of reading the statutes and applying the facts to it. I don't think that requires that much expertise.
Q. Okay. So, you don't claim that reading the Connecticut statute or whatever opinions you have about the Connecticut statute really has anything to do with your practice of medicine?
A. I guess I'm a little confused by that question. Why would the Connecticut statutes influence me if I'm not living in Connecticut?

Q. I don't know. I just want to make sure. You don't claim that as part of your training or experience in medicine, pulmonology, internal medicine, critical care medicine or sleep medicine you have gained knowledge and experience with respect to Connecticut statutes for end of life decision making?
MR. VIRGIL: Objection.
A. No. No. I've read them.
Q. (BY MS. SEAMAN) You have said several times that you're a critical care medicine physician, and I read this to be that you were a pulmonologist and sleep medicine specialist. Am I wrong in that?
A. I am board certified in pulmonology and sleep.
Q. Do you consider yourself a pulmonologist and sleep medicine specialist?
A. I mean, I'm board certified in those fields, yes. I would say I'm a specialist in those areas, yes.
Q. Okay. Let me show you Exhibit 23, and specifically where it says -- I can't read upside down. Let me just look at it one more second. And you can read the whole thing. You brought this with you. "Respondent is primarily engaged in the practice of pulmonary disease and sleep medicine." Do you see that? Is that accurate?
A. Yeah, but I didn't write that.

Q. So, that's inaccurate?
A. I don't know why they put that in. I mean, I -- I do pulmonary medicine, I do critical care, and I do sleep medicine. I can tell you that a lot of people in the community don't really draw a distinction between pulmonary and critical care. There is a big distinction at a tertiary care hospital like Yale-New Haven but in the general community, there really isn't that much of a distinction because pulmonologists take care of the people on the ventilator, critical care physicians take care of the people on the ventilator.
It's not a credential that's heavily sought after in the community. Usually pulmonary is what they call it. Even when they consult me in the ICU, they write consult pulmonology. They don't write consult critical care.
Q. And you've never worked in a facility like Yale-New Haven Hospital, have you?
A. Well, as a fellow, obviously, through my training, I worked at a facility like that.
Q. At Dartmouth?
A. Yeah, at Dartmouth, they had a rotation for critical care physicians where there were attendings in the intensive care unit. They didn't stay at night in those days but they were assigned to the ICU and made

rounds every day.
Q. Okay. But since you've completed your training, you've not worked in a facility like Yale-New Haven Hospital, correct?
A. I've not worked in a facility that had a closed intensive care unit, no.
Q. All right. Would it be fair to say that with this patient that you had in 2014 where the family appeared to be suspicious notwithstanding the fact that you were the primary communicator with the family and you went to the ethics committee, that you had done everything you could do to forge a good relationship with the family before you went to the ethics committee?
A. I think I had a good relationship with the family.
Q. And notwithstanding that good relationship, they were suspicious of the recommendations, correct?
A. No. They were suspicious of our healthcare system in general. They were kind of suspicious that they would be taken advantage of because they didn't grow up and they weren't raised in the United States. And I think that's very understandable, and I've run into that before. That's not that uncommon.
Q. Would you be of the view that any time a healthcare provider cannot reach agreement with a

surrogate about the best steps to be taken for a patient, it indicates that the healthcare provider has not appropriately communicated with the surrogate?
A. No, I wouldn't agree with that.
Q. In this case, the record reflects that even prior to the time Ms. Marsala was transferred to Yale, Ms. Marsala's treating physicians had recommended that Mr. Marsala consider end of life care. Do you agree with that?
A. I noticed that mentioned but I didn't want to say too much about the Griffin Hospital records because I hadn't reviewed them.
Q. And I take it you didn't ask to review them?
A. I did but they're just not available, I guess.
Q. I didn't ask you this before. How much time have you spent getting ready for this deposition?
A. A lot.
Q. Are you billing for any of that time?
A. Yes.
Q. And how many hours are you billing for?
A. I don't know but I think I billed about 4,000, $5,000 in preparation.
Q. You issued a bill for that?
A. No, I haven't billed them yet but I think that's how much it comes to.

Q. At what rate?
A. 250 an hour.
Q. And you had already received payment for $750?
A. I've received 750, right.
Q. And that 750 included the original review and the preparation of your report?
A. Yes.
Q. And now you've spent an additional $4,000?
A. Well, in all fairness, I never believed that this case would be that controversial. It seemed very open and shut to me.
Q. To me, too, and to the people at Yale.
A. I mean, I was really surprised to find that it was being contested. So, once I knew it was being contested, I decided I better review the records more thoroughly and I better look at the appropriate literature and make sure that I do the best job that I can.
Q. Do you practice in Pasadena?
A. Pasadena, Texas, yes. It's kind of a suburb of Houston but it's surrounded by Houston on a couple of sides. There's really no equivalent in Connecticut.
Q. Okay. Is that the only --
A. It was there before Houston and then Houston grew around it.

Q. Is that the only place that you practice?
A. No. East Houston Regional Medical Center is in Houston. Clear Lake Regional Medical Center is in Houston. The boundaries are just obscured. I mean, my brother's house is in Houston but my house is in Pasadena. So --
Q. Would it be fair to say that you practice in Houston or its environs, is that fair to say?
A. Yeah, I guess so but these cities are more spread out than the northeastern cities. They're not as scrunched up.
Q. Are you familiar with the multi-institutional policy in Houston concerning end of life decision making?
A. No, I'm not.
Q. Are you familiar with the American Thoracic Society's publications on end of life decision making?
A. No, but I think in the records that I reviewed, I included the American Medical Association guidelines and the critical care medicine guidelines.
Q. Okay. And when was the first time you read the American Medical Association guidelines?
A. I read them in preparation for this.
Q. This deposition today?
A. Yes.

Q. And have you ever had to rely on those guidelines in connection with the care of any of your patients?
A. No.
Q. All right. I'm just looking for them. Do you have more? Maybe it's in here. Can you show me what you're referring to, the AMA guidelines?
A. I think they were published in JAMA. Here's the Consensus statement of the Society of Critical Care Medicine's --
Q. What number?
A. No. 17.
Q. Wait, this is the Society of Critical Care?
A. Right.
Q. Had you ever read Exhibit 17 or the Consensus statement of the Society of Critical Care Medicine before your preparation for this deposition here today?
A. No. I did it in preparation.
Q. And this document is dated May of 1997; is that correct?
A. That's correct. And I checked to see if there was any revision, and I didn't find any.
Q. Okay. And you said you had the AMA in there?
A. I did just want to correct that. It's the Council on Ethical and Judicial Affairs, American Medical Association. It was published in JAMA.

Q. What is the Council on Ethical and Judicial Affairs?
A. I don't know.
Q. Okay. And I take it you hadn't read this in 1999 when it was initially published?
A. No. I read it in preparation for this.
Q. This deposition, correct?
A. Correct.
Q. Okay. I think the way I started here was to ask you whether you agree that in virtually every jurisdiction, there's a process by which a healthcare provider can withdraw life support without the consent or over the objection of a surrogate?
MR. VIRGIL: Objection.
Q. (BY MS. SEAMAN) Do you agree with that?
A. Like I said, obviously, I haven't reviewed the statutes of 50 United States.
Q. Okay. You know that in Texas, there's a process by which a healthcare provider can withdraw care over the objection of a surrogate, correct?
A. Right, but it's done in a different way. It's done with due process.
Q. Texas has a different process than Connecticut has, correct, or you don't know that?
A. I'm telling you not a different process. I'm

talking about due process.
Q. No, I'm talking about Texas process. Correct?
A. I'm telling you that there are rules built into that statute to protect the civil liberties of those patients and their families.
Q. Okay. That sounds --
A. Now, I didn't see that in this statute. I saw it as more vague.
Q. So, you can compare and contrast the Texas statute and the Connecticut statute, correct?
A. Yes, because I read them.
Q. And you're a lawyer, correct?
A. I don't even think one has to be a lawyer to do that.
Q. Up until the time that you were retained in this case, you had never taken steps in connection with the care of the patients in reliance on either the Texas or the Connecticut statute, correct?
A. And furthermore, I don't think that I would in the future.
Q. Okay.
A. I don't think that that's something that I wish to do.
Q. In fact, you have no experience in your medical practice with either the Texas statute, the Connecticut

statute or any other statute that pertains to the termination of life support; is that true?
A. That's not true because, like I said, the ethics committee had tried to invoke the statute on that other case, and I didn't want it. And there also used to be another gentleman that was the head of our ethics committee before who was always trying to invoke it, too, and I -- I didn't really think he understood it.
Q. Okay. Tell me what Harlingen Critical Care PA is.
A. That's the name of a company.
Q. That's not your company?
A. Yeah, that's -- Harlingen Critical Care PA d/b/a Southeast Houston Pulmonology.
Q. I asked you about all the companies that you were providing services through, and I don't remember you mentioning Harlingen.
A. I think I called it by its d/b/a, which is Southeast Houston Pulmonology but it's the same company. D/b/a is doing business as.
Q. What is a PA in Texas?
A. Professional association.
Q. How long has Harlingen Critical Care PA been in existence?
A. Since 1999.

Q. You founded them at the same time?
A. No, there's only one entity. D/b/a is just using an assumed name. The official name is Harlingen Critical Care. I think I referred to it as Harlingen Critical Care d/b/a Southeast Houston Pulmonology before.
Q. Who do you get paid by?
A. I get paid by Harlingen Critical Care.
Q. Okay. Can you tell me, Exhibit 22, what is this first packet and is it -- are these all the same?
A. No. You asked me to bring every lawsuit.
Q. I know. I'm just asking you what they are.
A. These are three different lawsuits. This is the cover sheet that comes when they're printed out on the Internet.
Q. Fine. It just looks different than I'm used to. What is this lawsuit?
A. This is Louis Marc Hamer versus Law Office of Donald Hecker and Donald Hecker.
Q. And what was the issue in that case?
A. The issue was that the attorney was contracted to do a job, and he didn't show up, and I thought I was entitled to a refund.
Q. And did you get your refund?
A. Yes.

Q. What was he contracted to do?
A. He was contracted to defend my friend in a criminal matter.
Q. Okay. And what was your friend's name?
A. My friend's name is -- does that matter, though?
Q. I'm sorry, I --
A. Because he's not involved in this.
Q. Well, what was the name of the person -- I take it you paid the criminal bill?
A. I paid his bill for his attorney, which is why I was entitled to sue, because I contracted with the attorney, he was a third party beneficiary, and I think the man ought to show up at the courthouse.
Q. What was the name of the person that he represented?
A. He represented Mark Trevino.
Q. And did you get your money back?
A. Yes, I did.
Q. What's this one?
A. This one is Louis M. Hamer against Venancio Gonzalez.
Q. And what was that case about?
A. Some money was given to the plumber to buy supplies and then the money was missing.
Q. How much money?

A. $37,000.
Q. Okay. Did you get your money back?
A. No. He's paying in installments.
Q. And what's this one?
A. This is Louis M. Hamer versus Homero Rolando Escamilla.
Q. And what's the issue in that case?
A. He borrowed some money and he signed a promissory note, and then he decided he didn't need to pay it back.
Q. Did you get your money back?
A. No. I have a judgment against him but --
Q. How much had you loaned him?
A. I think I loaned him $3,000.
Q. What is the case of Hamer versus Lawrence Wedekind?
A. Well, there were multiple plaintiffs in that case. Lawrence Wedekind ran an IPA, independent practice association, that we had invested in, and we wanted our money back.
Q. And the case was dismissed for failure to prosecute?
A. No. That's not the lawsuit. What happened with the Venancio and the plumber is that we went to settlement --
Q. Wait, I'm on this case. I'm on Wedekind.

Doesn't it say --
A. Oh, yeah, I didn't know about that but I can tell you how that happens.
Q. Well, was it dismissed for failure to prosecute?
A. No.
Q. Okay.
A. I was going to explain it to you. But the way it works is we went to mediation. We had a mediated settlement agreement, right? But sometimes in Harris County, even though you record the settlement agreement with the Court, they don't get it to the judge in time, and then when the attorney for the plaintiff doesn't show up, they dismiss it for want of prosecution. And in order to have that corrected, you're supposed to file a motion to vacate that order, and I guess no one ever did it.
Q. What was the amount in controversy in this action?
A. One problem with this case is that I signed a confidentiality agreement.
Q. You refuse to answer?
A. I don't know if I refuse to but I signed a confidentiality agreement, you know. That was part of our agreement when we got our money back was we weren't going to discuss his business practices.

Q. So, you refuse to answer the question?
A. I hate to use the word refuse.
Q. Well, you're not answering. Either answer it or refuse to answer.
A. Why does it have to be refuse? I agreed to sign a confidentiality agreement. I'd like to respect that. I'm respecting my confidentiality. I'm not refusing to be cooperative. There's a difference. Refusing seems adversarial.
Q. You decline answer?
A. I choose to respect my confidentiality agreement.
Q. You're not answering the question; is that correct, sir?
A. I guess so.
Q. Okay. What's this one?
A. This is Louis Hamer versus The Law Office of Tarlow & Valdez.
Q. And what's the issue?
A. They represented me once, and I didn't -- wasn't too satisfied with them.
Q. And so, you sued them, too?
A. Yes.
Q. And what was the amount in controversy?
A. There was no clear set amount. There was no clear amount defined.

Q. Did you get your money back?
A. I got part of it back.
Q. How much did you get back?
A. $2,000.
Q. And how much had you paid altogether?
A. 15.
Q. Okay. What's this one?
A. This is in the expunction.
Q. Pardon me?
A. Expunction.
Q. And what is being expunged?
A. This was related to that case, which is related to the Texas board.
Q. Wait a minute. Related to Louis Hamer versus Gonzalez?
A. No. Tarlow & Valdez, the lawyers that I wasn't too happy with.
Q. Okay.
A. So, it's all related to this problem that my friend went to the emergency department, he had psychiatric problems, and we wanted to go to a different hospital, and they decided that they were going to hold him against his will, and they grabbed him.
And when I tapped this man on the shoulder -- all I did was tap him on the shoulder and ask him to pay

attention, "Hey, you know, look what you're doing," and then he accused me of hitting him.
And I thought that the fact that the lawyers didn't show up for that or do a better job -- I wasn't very impressed, so --
Q. Was it the lawyer who was going to represent you before the licensing board?
A. No. It's because it's a Class C misdemeanor that they were accusing me of. So, I ended up firing her and representing myself, and I got it dismissed, and then I wanted my money back.
Q. What is that?
A. These are the two malpractice suits I had.
Q. And is this a form that you fill out when you renew your license?
A. No. It's an application for privileges. I couldn't find the original suits.
Q. So, you were sued in 1993 and 2002, correct?
A. But the incidents occurred in 1991 and 2000.
Q. Right. And the one claim against you was a delay in diagnosis of testicular cancer?
A. That's correct.
Q. What does that have to do with pulmonology, sleep medicine or critical care?
A. The gentleman had some metastases that were in

the lung.
Q. What happened to that lawsuit?
A. I was dismissed.
Q. Did it continue on against others?
A. The family doctor settled.
Q. Okay. What's the Texas Medical Liability Trust? Is it just an insurance company for doctors?
A. It's an insurance company that was run by the Texas Medical Association. It was supposed to be a not for profit trust.
Q. Is it still in effect?
A. I don't know because I switched insurance companies a long time ago. So, I don't know. They might still be around.
Q. Exhibit 24, why do you have that with you?
A. Which one?
Q. Exhibit 24.
A. I wanted to see what the Connecticut statutes regarding homicide were.
Q. And is it relevant to your opinions in this case?
A. You asked me to bring what I had reviewed.
Q. I know. And I'm asking you now whether any of your opinions are based on, rely on or are influenced by --
A. No, I didn't really rely on this to make my

opinion.
Q. And Exhibit 26?
A. This is the Constitution of the United States.
Q. I figured that. Are any of your opinions influenced by that?
A. Yes.
Q. And which ones are those?
A. The ones that have to do with due process.
Q. Okay. And you know that the Federal Constitution requires state action to be applicable, right?
MR. VIRGIL: Objection.
Q. (BY MS. SEAMAN) Are you saying that you think Yale-New Haven Hospital was a state actor?
A. I'm not sure it does. I'm a little confused on that point. So, I think you're wrong.
Q. Okay.
A. That's why I tried to look at it because I thought that life was one of the fundamental liberties that was protected in the 14th amendment, and I thought it applied to the states through the 14th amendment.
I thought due process was a liberty right that was mentioned in the 14th amendment and that was applied to the states through the 14th amendment and the 5th amendment was the one that applied due process through the federal government but if I'm wrong, I would

certainly defer to your expertise.
Q. So, you think Yale-New Haven Hospital is a state?
A. Well, I don't know if they're a state but they receive federal funding and they probably receive state funding, too. They may be. In certain circumstances, they might be.
Q. And you think the receipt of state or federal funding makes you a state or federal actor for purposes of the Constitution?
A. In some statutes, it does. For example, that Civil Rights Act of 1964, if you receive federal funding, you have to abide by Title VII, you know, you can't discriminate against employees based on their race or ethnicity. It applies to Article 6 of that law. If you receive federal funds, then you're held to the federal standards. So, sometimes it does, I think.
Q. It makes you a state actor?
A. Sometimes, I believe, but you can correct me if I'm wrong because I'm deferring to your expertise.
Q. Okay. I'd like to know about your prior testimony. Testimony at trial or hearing for the defense, 9-15-2011, Fenton versus Presbyterian Health Care?
A. Yes.
Q. You testified in New Mexico?

A. Yes, Albuquerque.
Q. And what was the medical issue on which you testified?
A. Pneumonia.
Q. What --
A. Well, the claim was that they delayed in diagnosing and treating pneumonia.
Q. And you concluded that there was no delay in the diagnosis?
A. No. I concluded that there was no deviation from the standard of care.
Q. That they complied with the standard of care with respect to the diagnosis of pneumonia or the treatment?
A. And the treatment.
Q. Both?
A. Yes, because the patient had both heart failure and pneumonia.
Q. Was a pulmonologist a defendant?
A. Yes, I believe so.
Q. Or an emergency room physician?
A. There were multiple defendants but the pulmonary critical care defendant was one of them.
Q. Were you retained on behalf of that pulmonologist?
A. I -- I guess I'd have to ask the lawyer.

Probably but I'm not sure that their laws require the experts to, you know, be exactly the same specialty.
Q. Did you ever give a deposition in that case?
A. Yes.
Q. Do you know who took your deposition in that case?
A. Let me see. I'll figure it out. No, I don't because all I have written down is the attorney that retained me.
Q. Okay.
A. But here I've got the case number if you want it.
Q. Okay. I'm sorry, I forgot the name. Fenton?
A. Yes. The case number should be up here on the top, too.
Q. Okay. Fenton.
You testified in a workers' compensation case about occupational asthma; is that right? Rocio Lavera. I only have one copy, I'm sorry.
A. Yes.
Q. In Texas, did you testify as an expert for the tribunal or as an expert retained by one of the parties?
A. For the defense, for the insurance company.
Q. Okay. And you testified, I take it, that the asthma -- to the extent that the patient had asthma, it wasn't attributable to his occupation?

A. It really wasn't. She had allergic asthma. She had a whole bunch of allergies, and she had asthma before the incident.
Q. USICS, deportation hearing, what was the issue on which you testified?
A. United States Immigration and Citizenship Services. Well, Mr. Tucker was going to be deported but he had some medical problems that prevented his deportation, and I just opined on his pulmonary problems.
Q. On his behalf or on behalf of USICS?
A. On behalf of Mr. Tucker.
Q. Okay. Rony Shelton versus Alan Ritchey, another workers' comp case?
A. Yes.
Q. And what was the medical issue on which you testified?
A. Whether his COPD exacerbation was from the job or not.
Q. Okay. If I look at this list, is the only case you have on this list that's medical malpractice is Fenton?
A. Fenton, right, but then for the plaintiff, this one is medical malpractice.
Q. Number 1?

A. Number 1, number 2, this one, this one is medical mal. Do you want me to go through the depositions, too?
Q. Sure. That would be helpful.
A. This one was medical malpractice. I checked them off.
Q. Okay. Have you ever been called upon to review records in a case involving end of life decision making?
A. No. This is the first time it's come up.
Q. Exhibits 25 and 28, is there anything in those articles that influence your opinions in this case?
A. I like this article.
Q. Counterpoint: The Texas Advance Directives Act is Ethically Flawed: Medical Futility Disputes Must Be Resolved by a Fair Process. That's Truog's article?
A. Yes.
Q. You like it because it goes through a discussion of --
A. Because it's well thought out.
Q. Okay.
A. I mean, I'm not saying I agree with everything. I just think it's well thought out.
Q. How about 28?
A. I think there's -- this one is pretty good, too. There's a lot of truth to this one, yeah.
Q. And is it your opinion that Mr. Marsala did not

consent to the DNR that was ordered early in July?
A. No, I believe he consented. I think the issue was over whether she would be reintubated or not, what they called the DNI, and whether comfort care would be initiated, I mean, that was clearly over his objections.
Q. Okay. And you agree that Mr. Marsala testified that he was advised by Dr. Pisani that she intended to remove the ventilator because the patient had passed the weaning trials, correct?
A. I don't remember that specifically from his deposition but that's true, the patient did pass the weaning trials.
Q. And was it appropriate, in your view, for Dr. Pisani to remove the ventilator in the hope that that might help regain some of her mental status?
A. I don't -- I think it's appropriate because the patient could breath on her own. I don't think it was going to help her mental status, no.
Q. Mr. Marsala testified that at the time he was told of the decision to extubate, he was told that they would not reintubate her if she failed -- if it ended up that she couldn't breathe on her own. Do you recall that?
A. I don't recall specifically but it sounds right.
Q. Okay. And that occurred on July 20th, correct?

A. That's correct.
Q. Are you aware of anything that Mr. Marsala did after July 20th in an attempt to get a transfer for Ms. Marsala?
A. He didn't try to get the patient transferred, no.
Q. What kind of facility would have been required to take care of Ms. Marsala after July 20th, 2010?
A. She certainly could have gone to one of these long-term acute care facilities.
Q. Are there any in Connecticut?
A. Probably because they're federal -- or I mean, the same Medicare rules, so, I would think so.
Q. Did you look into that?
A. No, but I remember one in New Hampshire.
Q. Okay. Any others?
A. I didn't specifically look for long-term acute care facilities in the area.
Q. Why do you have this UpToDate, 16 and 13?
A. This is just about hepatic encephalopathy.
Q. You were just getting some background information about it?
A. Just reviewing it, right.
Q. And 18?
A. The only reason I reviewed this is because in the deposition of Dr. Pisani, they kept using the word

tracheotomy, and I always use the word tracheostomy. So, I thought I would investigate why that was.
Q. Do they name it both?
A. I think that the tracheotomy is just the process of making an incision, making a hole. Cholecystomy means that they have to drain it, to make a hole, otomy. If you connect an internal lumen to the outside of the body, that's a stoma, like a tracheostomy or an ileostomy.
Q. 21?
A. Yeah, I reviewed this one.
Q. Why?
A. Because it was available, it was on the topic.
Q. Anything on which you rely in support of your opinions, sir?
A. No.
Q. Was it your intention to pull all of the articles you could find on end of life decision making?
A. No. It was my intention to give you everything that I looked at.
Q. But I take it you did some kind of a literature search to find these articles?
A. Yes, I did do a literature search. What I used first was the UpToDate. I used the UpToDate as my basis.

Q. And then you looked for the citations that are referenced on UpToDate and pulled some of them?
A. Right.
Q. 14?
A. This is a complaint filed by the district attorney in New Orleans against a physician who decided to euthanize several patients during the Katrina storm.
Q. I think I heard about that. You're not drawing some analogy between this story, Exhibit 14, and what happened in this case, are you?
A. Not really, no. I just -- the only analogy is that, you know, people have been prosecuted criminally for euthanizing patients. That's the only analogy but I don't think the two circumstances are similar, no.
Q. Exhibit 15?
A. This is just a NEW YORK TIMES article that talks about that same case.
Q. The Louisiana?
A. Yes.
Q. And how about 12?
A. This is the Cruzan case, which is a landmark case, which gave people the right to refuse life sustaining measures if they so chose. And one thing that -- I am relying upon this because one thing that's really important about Cruzan is that the husband was

relying upon his wife's wishes. He wasn't just acting based on his wishes because he wanted to get an inheritance or because he wanted her out of the picture or anything like that. He was told by his wife that she did not want to be kept alive by machinery artificially.
And the ruling was based on the fact that he was acting as her surrogate, promoting her wishes, and I think that's very similar to this case because Mr. Marsala knows what his wife's wishes were and he's acting based on that.
Q. Let me ask you to assume that a patient says to you, "My spouse wanted to be kept alive through all possible means so that she could go back and hike the mountains in New Hampshire." Okay? Assume that to be true. And assume that even if than spouse had the possibility of surviving, there was no way that spouse was going to hike the mountains in New Hampshire.
A. Okay.
Q. Under those circumstances, would you say that the important point is that the wife wanted to stay alive forever or the important point was here was her goal of care?
MR. VIRGIL: Objection.
A. I mean, I certainly see the point of your analogy is that even those were her wishes, there's no hope in

achieving that goal.
Q. (BY MS. SEAMAN) Right. And if there's no hope in achieving the goal, and assume that the surrogate is faithfully repeating what the goal was, if there's no hope, totally futile of achieving that goal, under those circumstances, would it be appropriate for a healthcare provider to say, "This is not reasonable care," and take steps to act, notwithstanding the lack of consent of the surrogate?
A. It just totally depends upon what those steps are.
Q. Because you're into process, it's not so much you're saying it can't be done but you have to follow the right process?
A. I think that due process is so important because it protects an individual who has a minority opinion from being overwhelmed by people who feel differently.
Q. And in the Texas statute, the difference in the Texas statute than what you've read about Connecticut anyway is that it requires certain written notification and a ten-day period for the family to effectuate a transfer should they choose; is that right?
A. It also requires the hospital to assist the person in the transfer. It requires the hospital to inform the person of his right to counsel.

Q. You keep saying that. I don't know that one.
A. Maybe I'm making a mistake then. I thought it did.
Q. We'll agree if it does or it doesn't, either way. Okay. Go ahead.
A. And also, there is a procedure, and everyone can see what the procedure is. The problem with this statute is it's a little more vague. It's pretty clear what to do if the person has an advance directive saying, "I don't want heroic measures," but it's not very clear about what to do with people who do want more done and the physician doesn't want -- wants less done.
Q. Right.
A. It's, obviously, drafted thinking about Karen Ann Quinlan or a case like that in mind where the physicians wanted to keep the person alive but the patient wanted to withdraw.
Q. Okay. During the ten-day period that Texas requires to transfer a patient, does the facility have to escalate care?
A. I'm not sure what you mean by escalate.
Q. Well, in this case, she's extubated, right?
A. They would have to reintubate her, yes.
Q. And if she developed a need for dialysis during that ten-day period, would they have to give her

dialysis?
A. I don't know the answer to that.
Q. Do you --
A. But -- go ahead.
Q. Did you have anything something else?
A. No.
Q. Do you think -- strike that.
I did look and you do say that Yale-New Haven Hospital had a financial disincentive to continue to care for her. You're not suggesting, are you, that Dr. Boyd, Dr. Pisani, Dr. Siegel, Dr. Herbert, Dr. Jang, any of those individuals were influenced by the financial interests of Yale-New Haven Hospital, are you?
A. Certainly not consciously because from their depositions, Dr. Boyd's deposition and Dr. Pisani's deposition, I don't know if they were even aware of that. So, certainly not consciously, but their behavior could be, sadly, manipulated through their employer through rules and regulations at the hospital that they're not aware of, and that's pretty common.
Q. And Dr. Pisani's employer, your understanding, is Yale-New Haven Hospital?
A. Well, it didn't sound like she was a hundred percent certain who her employer was but I imagine it's probably some entity that's affiliated with Yale, like a

physicians group or something like that.
Q. Or Yale University?
A. Or Yale University, right.
Q. Okay. And so, you think that an employee of Yale University would take steps in order to watch out for the financial well-being of Yale-New Haven Hospital?
A. I don't think so, no.
Q. All right.
MS. SEAMAN: I need a few minutes.
(Short recess.)
Q. (BY MS. SEAMAN) Doctor, I'm looking for ammonia values. When was it that you found an elevated ammonia?
A. It looks like on the 19th.
Q. That's when it was 40, I think you said?
A. 43, it says.
Q. And would you agree that the normal range is 15 to 45?
A. I think it depends on the laboratory.
Q. Okay.
A. I mean, if that's what it is at Yale-New Haven, if that's what it says, I'll take your word on it.
Q. Okay. That sounds reasonable to you?
A. I mean, in our hospital, 40 would be elevated.
Q. And do you see subsequent measurements of the ammonia? That's essentially at the time of admission,

right?
A. That's essentially at the time of admission. I don't recall a lot of subsequent measures. Were there subsequent measures?
Q. That's what I'm asking you.
A. I would have to look through all the labs. Here's one on the 19th that was 38.
Q. June 19th or July 19th?
A. June 19th. It's 38. Now, they have the normal values as 11 to 35 micromoles per liter.
Q. Okay. What page of the records are you on?
A. The Bates number? There's no Bates number on here. I'll just show it to you because here there's one that's 43 and one that's 38, and they have the top normal as 35.
Q. Okay.
A. And here's a bilirubin that's elevated. That's another marker of liver function, and that's on this page.
Q. What date?
A. On the 19th. 2.13 is the total bilirubin.
Q. What's the range?
A. The range is less than 1.2 milligrams per deciliter.
Q. Would it be fair to characterize your notes that

are Exhibit 11 as a rough chronology of what you noted upon your review of the medical records?
A. It was intended to be an outline so that I would have in my head what happened each day and that I would have a framework that I could hang things on. That's what it was intended to be, more of an outline.
Q. And is it intended to be factual, that is, it repeats what's in the medical record?
A. I wrote down the numbers and things from the medical record directly.
Q. I don't see much in the way of comment on what you found in the medical record. Would that be fair?
A. It wasn't intended to be a comment.
Q. Okay.
A. It was to try and organize my thinking.
Q. Okay. Can you look at this for me and just read this for me, please?
A. "Aborted early due to" -- something.
Q. "Aborted early due to"?
A. Something. And then "BP and respiratory difficulty." I'm sorry, I can't read my own writing. It's terrible, isn't it?
Q. Okay. And how about this nursing note, what does this say?
A. "She follows some commands."

Q. Okay. Thank you.
I'm showing you Exhibit 5 but let me just get you another copy of Exhibit 5.
A. Did you want me to finish looking for any other ammonia levels?
Q. Sure.
A. I'm not finding any but I did note that the CT scan that I was talking about that showed the irregular contour of liver suggesting hepatic cirrhosis, that's right here.
Q. Okay.
A. Okay.
Q. I'm just going to mark all the records that you have pulled out as one exhibit, please.
(Exhibit 32 marked.)
Q. (BY MS. SEAMAN) All right. Exhibit 5. Attached to Exhibit 5 is your report. Did you write that report?
A. No. What happened was we had a couple of conversations on the phone, and then Mr. Virgil thought that it had to meet certain statutory requirements and that he would put my opinions into that format and then I would review it and make corrections.
Q. Okay. So, the last seven pages of Exhibit 5, which bears the letterhead of Southeast Houston Pulmonology, Attorney Virgil wrote this, sent it to you

and you reviewed it for accuracy, is that fair?
A. I also think I made a few changes.
Q. Do you have old versions with you?
A. No, I don't have any old versions.
Q. Okay.
A. But he was the one that put together the general format, yes.
Q. Well, he wrote it?
A. He wrote it after several conversations with me, yes.
Q. Okay. Have you ever appeared before a peer review committee?
A. Not formally, no.
Q. Do you have peer review committees here?
A. Yes.
Q. Have you ever served on a peer review committee?
A. Well, in a way because they just do the peer review after the medicine meeting. So, if you are there, you participate.
Q. And none of your cases have ever been presented before a peer review committee, to your recollection?
A. My cases have been discussed, sure.
Q. In a grand rounds situation or peer review, formal peer review?
A. We might be using the word differently.

Q. Maybe.
A. There's a formal peer review process that can be implemented if they think a physician is problematic in some way, maybe isn't up to date on his skills, maybe has a personal problem of some sort.
No, I've never formally been brought before any peer review committee, but we also have a situation where we discuss cases that have bad outcomes.
Q. In the ordinary course, you discuss cases with bad outcomes?
A. After the department meeting, right.
Q. Do you run a sleep laboratory?
A. I'm the medical director for a sleep lab.
Q. Where is that?
A. It's in La Porte, Texas.
Q. La Porte?
A. It's one of these other things that's kind of part of the Houston area.
Q. What's it called?
A. Sleep Diagnostics of America. They have different labs. I'm only the medical director for one lab.
Q. Have you ever run an outpatient endoscopy center?
A. No.
Q. Outpatient surgery center?

A. I've never run one, no.
Q. Have you ever worked in one?
A. No, I don't think so because -- if it's physically connected to the hospital, it's part of the hospital, right?
Q. Have you ever been involved in a residency training program other than as a resident?
A. Yes.
Q. When was that?
A. When I lived in Harlingen, Texas, we had residents. They sometimes would rotate with me, and sometimes I would give them a lecture like on chest x-rays or something like that.
And then also when I was an emergency department physician in the early '90s, we used to have residents from a couple of medical schools that would rotate with us.
Q. Your website says that you came to believe that the system valued finances over patient needs. Is that the healthcare system here in Texas that led you to believe that?
A. I don't remember. It was just written so many years ago, I don't really remember but since you've been reviewing it so thoroughly, I think I'm going to go back and take a good close look at it.

Q. Did you think that the Dartmouth system valued finances over patients' needs?
A. I wasn't very impressed with their system, no.
Q. How about Penn?
A. Penn, I was too early in my career to be attentive to those kind of things.
Q. So, would it be fair to say that every facility or healthcare system with which you are familiar you believe values finance over patient needs?
A. No, I don't think I would say that.
Q. Which one does not?
A. I think that that website is probably a little bit of an embellishment because, obviously, you know, there are people who place more emphasis on finances and there are people who place less emphasis on finances. It was just intended to give some background, that's all.
Q. Puffing?
A. Sales puffing, right.
Q. Have you had a client named Steve?
A. Steve?
Q. A contracts client.
A. Oh, yes. Yes. Yes.
Q. And what kind of matter did you work for him on?
A. He had a contract dispute.

Q. And what happened to that dispute?
A. We got his money back.
Q. File a lawsuit?
A. No, we got it back with a letter.
Q. Do you know Bruce Friedman?
A. Yeah, I know him.
Q. How do you know him?
A. He was in that law program with me.
Q. Okay. He was a fellow student?
A. Yes.
Q. Did you ever represent him?
A. No.
Q. Did you ever provide medical care to him?
A. I remember giving him advice about some medical issues.
Q. Okay.
A. But I wasn't his doctor, no.
Q. I know we've been over this a little bit, and I just want to make sure I'm clear. I want to ask about the standard of care. I realize that you disagree with the decision not to reintubate Ms. Marsala or to convert her to comfort care but in connection with her hospitalization at Yale-New Haven Hospital from June 19th until July 24th, setting aside the decision not to reintubate her, do you think the practitioners deviated

from the standard of care?
MR. VIRGIL: Objection.
A. I do, yes.
Q. (BY MS. SEAMAN) In what ways?
A. The most important way is they instituted comfort care without consent.
Q. I'm sorry, I don't want to interrupt you and I'm sorry if you feel like, in fairness, you need to finish it but I'm trying to separate that out.
A. Okay.
Q. So, for the period June 19th when she was admitted until any time between July 20th through July 24th when they converted her to comfort care, aside from that decision, is there anything else, in your view, that constitutes a deviation from the standard of care?
A. No, the deviations occur after the 20th.
Q. So, would it be fair to say that the deviation from the standard of care, in your view, was deciding not to reintubate Ms. Marsala in light of her husband's objection to not reintubating?
A. And also without a definite diagnosis --
Q. Okay.
A. -- because I think that's important. If we're going to say it's futile, we need to know what the problem is.

Q. And with respect to the diagnosis, I understand you raised a question about the elevated ammonia. What tests -- aside from the lumbar puncture that Mr. Marsala refused, what tests or workup would you believe would be necessary following say July 20th in order to come up with a diagnosis?

MR. VIRGIL: Objection.

A. Well, there are cases where we can't find a diagnosis. Sometimes you can't.

Q. (BY MS. SEAMAN) Sometimes no matter if you do everything right --

A. I mean, we could look for different types of encephalitis. I've seen them do a brain biopsy sometimes to rule out different times of encephalitis and things. So, you know, there's -- there's more that they could have done. Would they have found a diagnosis? Maybe not.

Q. Okay. So, are you able to say with a reasonable degree of medical probability that if they had conducted a brain biopsy, they would have been able to identify a diagnosis for Ms. Marsala?

MR. VIRGIL: Objection.

A. No, that's not my point at all.

Q. (BY MS. SEAMAN) Are you able to say with a reasonable degree of medical probability that any

further workup would have led to a diagnosis?

MR. VIRGIL: Objection.

A. I don't know the answer to that.

Q. (BY MS. SEAMAN) So, you're not able to say that with a reasonable degree of medical probability, correct?

A. That's correct.

Q. And your view is, notwithstanding the fact that there's not a reasonable probability that further workup would have led to a diagnosis, without a diagnosis, it's not appropriate to terminate care over the objection of the surrogate, correct?

MR. VIRGIL: Objection.

A. Well, I -- my objection is that they terminated their efforts and instituted critical care over the objections of the surrogate without respecting his rights.

Q. (BY MS. SEAMAN) I understand that.

A. And I think that a physician, just like anyone else, has an obligation to obey and abide by the law. Okay? So, I think that's one deviation.

Another important deviation is the continuous morphine drip was given, and that hastened her death, and they knew that that wasn't what she wanted and what her family wanted but yet they chose to hasten her

death, and I think that that's a deviation from the standard of care.

I think failure to institute BiPAP was a deviation from the standard of care because under the pretense of, you know, comfort and not irritating that sore that she had, they weren't going to use the BiPAP but I would contend that not being able to breathe is pretty uncomfortable, too.

Q. So, three things, failure to reinstitute BiPAP, prescription of the morphine drip and failing to follow the direction of the surrogate are the three things that you're critical of, correct?

MR. VIRGIL: Object.

A. And failing to follow the direction of the surrogate has a couple of parts to it because it's failing to follow the directions of the surrogate without any respect for his rights or his dignity.

Q. (BY MS. SEAMAN) The surrogate's rights?

A. He's acting on behalf of that patient. He's legally acting on her behalf. So, he has -- you're right, I shouldn't be saying --

Q. Her rights?

A. Right. So, without respecting the rights of the patient and without having some form of due process, and I just think that's wrong.

Q. Okay. Are you able to state with a reasonable degree of medical probability that it was a deviation from the standard of care to prescribe a morphine drip under these circumstances?

A. Yes.

Q. And the same with not reinstituting the BiPAP?

A. Yes.

Q. Okay. Even though you would concede that a morphine drip and the removal of the BiPAP are typically steps that are taken when comfort care only is appropriate; is that true?

MR. VIRGIL: Objection.

A. Sometimes. BiPAP isn't always removed because BiPAP can make the person's breathing more comfortable. That's not a tube or a needle or anything. I mean, that could go either way. It could make them more comfortable or I guess if they have a sore, maybe less comfortable.

Q. (BY MS. SEAMAN) She had a stage 2 decubitus ulcer that developed within roughly 24 hours of the initiation of the BiPAP, right?

A. She had a stage 2 decubitus ulcer they called it. I don't think how quickly it developed, but I think that's a fancy way of saying a sore. I think that's what most people -- it was an abrasion from the mask

rubbing against the skin. The fact that it's stage 2 just means it goes into the epidermis, the very thin portion of the skin.

Q. Okay. I am looking at Exhibit 5 again, and you should feel free to look at it if you want to but you might not need to.

Your first opinion is that Yale-New Haven Hospital and the treating physicians failed to reintubate Marsala and place her back on mechanical ventilation on the evening of July 24th when she ceased breathing on her own. Is there anything about that opinion that you haven't already told me?

A. No.

Q. Okay. That really just has to do with your view that the appropriate process was not followed in connection with the disagreement between the family and Yale-New Haven Hospital, correct?

A. That's correct.

Q. And is the next of kin in this case the husband?

A. Yes.

Q. Okay. Is it your opinion that reintubating Ms. Marsala would have resulted in recovery of her mental status?

A. I can't tell you that with certainty but I can tell you that she probably wouldn't have died on July

24th.

Q. How long would she have survived had she been reintubated on July 24th, in your opinion?

A. I don't know the exact answer to that but it certainly would have been more than a couple of days. She would have been able to breathe, and she certainly would have lived a finite amount of time longer.

Q. More than a week?

A. I would guess more than a week, yes.

Q. More than two weeks?

A. That would be my guess, yes.

Q. Are you able to say with a reasonable degree of medical certainty that if Ms. Marsala had been reintubated on July 24th, 2010, she would have recovered to the extent that she could have been discharged from care to home?

A. I can't say that with certainty because I don't know what the future would have held.

Q. Right. Are you able to say to a reasonable degree of medical probability that Ms. Marsala's life would have been measured in weeks had she been reintubated on July 24th?

A. I think within a reasonable degree of medical probability, it would have been longer than weeks.

Q. Notwithstanding her renal failure?

A. Well, I think she should have been continued on dialysis, too.

Q. They had decided to terminate dialysis because of the blood pressure and respiratory issues, right?

A. No. That was that one occasion when they couldn't continue the dialysis on that day but if she's not urinating and she's in renal failure, then dialysis would have been indicated.

Q. Are you able to say to a reasonable degree of medical probability that Ms. Marsala would have lived for a month if she had been reintubated on July 24th?

A. I believe so, yes.

Q. Okay. And what's the basis for that?

A. The basis is that she was surviving as it was, you know, for six weeks in worse conditions, under worse circumstances, and she probably would have continued to survive had she continued to receive the dialysis and the mechanical ventilation. She would have probably lived a long time like that, yes.

Q. Well, she was getting worse, right?

A. No. I think she was getting better.

Q. And what evidence is there in the record that she was getting better?

A. She was able to be taken off the ventilator. Okay? She had completed treatment for the Morganella

pneumonia. The ischemic colitis was no longer causing any bloody diarrhea. She -- let's see. She had completed treatment for the C. diff that she supposedly had at the other hospital. She completed treatment for the fungal illness. The main thing that was not getting better was the mental status.

Q. She had sepsis, correct?

A. The sepsis, I believe, is gone because the sepsis was treated.

Q. Didn't the death certificate say she had sepsis?

A. Anyone can write -- the doctor can write whatever he wants on the death certificate.

Q. But you know better?

A. The death certificate isn't authoritative. That's all I'm saying.

Q. So, you would disagree with those who said she had sepsis?

A. She had sepsis when she first came there, yes, but I don't think she still had sepsis at the point of her death, no. Sepsis is the result of an overwhelming infection. It's the body's immune system's reaction to an overwhelming infection, and that infection was treated. She came off the ventilator. She wasn't hypertensive any more. She was on pressors when she first came in. She wasn't on pressors at the end. The

thing that really wasn't improving was her mental status.
Q. And how long could she have remained on the ventilator if she was reintubated on July 24th?
A. Years. I mean, Christopher Reeve lived for years on a ventilator. Stephen Hawking has been on a ventilator most of his adult life. So, people can live for years and years on a ventilator.
Q. Stephen Hawking has lived on oral intubation for years?
A. No. He has a trach. He has a tracheostomy.
Q. And how about Reeve?
A. He also had a tracheostomy.
Q. She didn't have a trach?
A. Because they chose not to put one in. Her husband asked for it.
Q. And was there any contraindication for a trach?
A. The main contraindication for the trach was that they didn't think that she was going to do well and they didn't think the resources should be used for that.
Q. How about somebody who has a problem with skin breakdown, is that a contraindication for a trach?
A. It might be a relative contraindication. It's not an absolute contraindication. There's lots of people who have decubitus ulcers who get trachs.

Q. And if she had had a trach, would it mean she had to be institutionalized forever?
A. Not necessarily. Christopher Reeve wasn't institutionalized. Stephen Hawking isn't institutionalized. I have patients that are home on ventilators who have home ventilators.
Q. You have patients who are on a trach and require hemodialysis?
A. I have a patient that requires hemodialysis that's on a trach, yes.
Q. At home?
A. She's at home, yes.
Q. Okay.
A. Her situation is a little bit different, though, because she's not on a ventilator, too. She has what's called subglottic stenosis, which is a narrowing of her airway, and the trach is put below that. And then for her dialysis, she goes to West Houston, which is about 25 minutes away, for her dialysis.
Q. So, she's not ventilator dependent?
A. She has a trach but she's not ventilator dependent, right.
Q. Your report says, "Yale-New Haven Hospital failed to receive consent from the patient, the patient's spouse or family prior to executing do not resuscitate

orders for Helen Marsala." I think you already told me that you're not contending that the 7-04 order was without consent, are you?
A. No. I think the problem was the second order.
Q. The DNI?
A. The DNI, the instituting of the morphine, the not putting the BiPAP, the whole --
Q. I'm only asking the DNR, DNI.
"The hospital and treating physicians unilaterally decided to withhold life support from the patient in the absence of a written directive from the patient or properly ascertaining her wishes from her spouse or next of kin." I'm interested in the unilateral. You recognize, do you not, that there was an ethics committee convened in this case who approved of the decision not to reintubate, correct?
MR. VIRGIL: Objection.
A. So, basically what you're telling me is that the treating physician wanted to remove care and a committee of her co-workers and associates that she knows and works with every day agreed with her and, therefore, it's not unilateral? It certainly is unilateral because unilateral means only one side of the controversy. In order for it to be bilateral, it would have to involve someone from the other party , right? The attorney

representing the family, an independent physician, you know, who has an interest in the family, something like that, or maybe the family members themselves if they're capable.
Q. Well, the family members declined participation in the ethics committee, correct?
A. I don't blame them. I mean, they were going to be browbeaten by ten individuals to change their mind as their loved one is dying. Who would want to go through that?
Q. What is the composition of the ethics committee in this case?
A. I think there were a couple of physicians on there, there was a chaplain, there were two lay people. I believe there was a hospital attorney or someone on there as well.
Q. And do you know for a fact that they work on a daily basis with the ICU physicians?
A. I know that they work at the same institution and that there's a good chance that they know one another and they have a common workplace, a common interest. They are not disinterested parties.
Q. And we've been through all this. You agree that that's the standard practice throughout the country, even though you believe it doesn't satisfy due process;

is that correct?
A. No, I'm not using the word standard because -- we had gone through that -- because standard is then going to be switched to standard of care, which means what a reasonably prudent physician would do in the same or similar circumstance. And in this case, it's just what is done but that doesn't make it reasonably prudent.
Q. My question --
A. So --
Q. Sorry.
A. So, I'm not using the word standard.
Q. Would you agree that most ethics committees associated with healthcare institutions are comprised at least partially of people from that medical community?
A. Yes.
Q. Okay. "The Yale-New Haven Hospital, the ethics committee and the treating physicians failed to adhere to the laws of the State of Connecticut, General Statutes 19a-580d." Do you see that?
A. Yes.
Q. Can you tell me in what way 19a-580D applies here?
A. Can I see the statute? I think that's the one that requires a transfer.
Q. The transfer, the DNR order, I think you're

right.
A. Or that could be the probate court. There's one about the probate.
Q. I don't think I marked the statute.
MR. VIRGIL: He gave it to you.
Q. (BY MS. SEAMAN) I lied. Sorry. Exhibit 20.
MR. VIRGIL: It stands out to me.
A. We're talking about --
Q. (BY MS. SEAMAN) 580d. The statute says, "The Department of Public Health shall adopt regulations in accordance with Chapter 54 to provide for a system governing the recognition and transfer of do not resuscitate orders between healthcare institutions licensed pursuant to Chapter 368v and upon intervention by emergency medical services providers certified or licensed pursuant to Chapter 368." You're not contending that sentence was not complied with?
A. No. No.
Q. "The regulation shall include but not be limited to," you're not suggesting that that portion was not complied with, are you?
A. This is the problem here, "Shall assist the patient or his authorized representative in utilizing the system."
Q. "The regulations shall specify that upon request

of the patient or his authorized representative, the physician who issued the do not resuscitate order shall assist the patient or his authorized representative in utilizing the system that we're talking about in this statute," which is the system to transfer the DNR order from one institution to the next, correct?
A. Actually, I see your point. This statute -- this section is for people who don't want heroic measures, and the physician is supposed to assist them in that regards.
Q. Would you agree that Section 19a-580d has nothing to do with the issues in this case?
A. Yeah, I agree.
Q. Okay. The next paragraph says that, "Yale-New Haven Hospital, the treating physicians and the ethics committee failed to address or even consider the fact that the hospital possessed a strong economic incentive for discontinuing life sustaining therapy." Do you have any knowledge about what the ethics committee did or did not consider?
A. Well, they didn't write it down.
Q. It's not written anywhere. Okay.
A. And they didn't mention it in -- it wasn't mentioned in the depositions of the physicians either. It's just not mentioned.

Q. Did you see anybody asked about what the ethics committee considered?
A. No, but, I mean, people should volunteer conflicts of interest. For example, every time a speaker speaks at a forum, if they have a conflict of interest and they are going to be promoting potentially some therapy or some benefit, they reveal their conflicts of interest.
If you look at the UpToDate, every author reveals what their conflicts of interest are. Every judge, if they have a conflict of interest, they recuse themselves. Attorneys have databases of conflicts of interest to see if their firm might have a conflict of interest.
I mean, the rest of our society is taking this very seriously to make sure that people are objective, and the ethics committees are totally ignoring this principle that's present in the whole rest of our system.
Q. Okay. All the ethics committees that you're familiar with are ignoring it?
A. Right.
Q. But we have agreed that in the scheme of things, the economic impact to Yale-New Haven Hospital of Helen Marsala is de minimis; is that true?

A. In a way, it's de minimis, yes, because it doesn't really affect the hospital but the fact that they're not even aware of it, that they don't mention it is the part that bothers me the most.
Q. That the ethics committee doesn't mention it?
A. Or the doctors because they may not be aware of how they're being subtly manipulated into behaving or treating people that's in the best interest of the hospital. And there's many ways that hospitals can do that.
Q. Do you feel like you have been manipulated by the hospitals at which you have privileges to treat patients in a way that is in the best interest of the hospital?
A. Yes.
Q. Okay. And under what circumstances has that happened?
A. For example, they have this thing called core measures.
Q. C O R E?
A. Right, core measures, right, where the hospital is going to be judged based on whether or not they meet certain preestablished guidelines by JCAHO.
So, for pneumonia, for example, one of the criteria is to institute antibiotics within four hours of the patient's arrival to the emergency department,

and they want the physicians to institute antibiotics that cover for community acquired pneumonia. When my patients go to the hospital, that may not be appropriate for them but there's no way that I can prevent the emergency department physician from giving them those antibiotics even they are the wrong antibiotics. I can't do it, and the hospital would never back me because they need to check off on that form that 98 percent of patients that came in with pneumonia got those antibiotics because that's how they're going to be judged by JCAHO and that's how they are going to be judged by CMS. So, I'm being subtly influenced.
Another way that I'm subtly influenced and manipulated by the hospital is length of stay, for example. If I have a person that's at this Kindred facility that needs to stay past the 26 days, I'll get calls constantly from the case manager, "Can they leave? Can they leave? Can they leave? When can they leave?"
And if I don't play ball, they have other ways of making my life miserable. Peer review, for example, is one of the things that's used to make people play ball.
Q. Have you found that true in your own practice?
A. I tell you, peer review is very often used for that. I can think of so many examples where people have gone to peer review on supposed other issues but the

real conflict was they weren't doing what the hospital wanted.
Q. Your next paragraph says, "19a-571 sets forth a procedure to be followed by physicians during the decision making process of whether to withhold or remove lift support systems," and it sets forth three requirements that must be met. The first one, the decision must be based on the best medical judgment of the attending physician. Do you have any reason to believe that the decision to terminate life support in this case was not based on the best medical judgment of the intensivist who had been caring for Helen Marsala?
A. No. The problem is with the third prong. So, we can just jump right to the third prong.
Q. So, you agree that the attending physician appropriately deemed Ms. Marsala to be in a terminal condition?
A. That's not where the problem is.
Q. But you agree that they satisfied one and they satisfied two, correct?
A. They satisfied one and they satisfied two.
Q. The attending physician has considered the patient's wishes, would you agree with me that the record is replete with references to communications between Ms. Marsala's treating physicians, nurses and

Clarence Marsala?
A. I would agree that the record documents the difference of opinion very well, yes.
Q. And it documents numerous contacts between the clinicians at Yale-New Haven Hospital and Mr. Marsala?
A. Just disagreements.
Q. Right.
A. It doesn't say anywhere, "We understand Mr. Marsala's position," or, "We're considering his position when we're making this decision." It doesn't give deference to him at all. It just calls him in denial and difficult to get ahold of and, you know, it doesn't say anything positive about him.
Q. I didn't read anything negative about him.
A. I told you, I think deny is a little bit pejorative. I think saying he's difficult to get ahold of is negative because maybe he just got tired of people browbeating him into changing his mind.
Q. And if a surrogate will not communicate with the healthcare providers, then what do they do?
A. Communication is two ways.
Q. Right. So, if they can't get ahold of him, what do they do?
A. They go to the probate court and they file for -- in Connecticut, I guess it's called a conservatorship

but in Texas, it's called a guardianship.
Q. You're not contending the Connecticut General Statute 19a-571iii requires the attending physician to defer to the patient's wishes as expressed by the surrogate, are you?
MR. VIRGIL: Objection.
A. It doesn't say defer. It says consider.
Q. (BY MS. SEAMAN) Consider.
A. I don't see where they give any credence to his opinion, where they say, "We considered his opinion." I don't see any documentation like that. I just see they disagreed.
Q. Let me ask you to assume that no fewer than three attending physicians from the ICU will testify that they considered Mr. Marsala's position, they attempted to give him more time to see if the treatment would be successful in reversing her condition but at the end, notwithstanding their full consideration of what Mr. Marsala wanted, they decided the best interest of the patient was to terminate life support. Assume that to be true. Would you then say the physicians complied with this portion of the statute, iii?
MR. VIRGIL: Objection.
A. I'm just not sure. I guess considered is not a very concrete term. It doesn't really say how much they

have to consider it or what constitutes consideration.
Q. (BY MS. SEAMAN) But you would agree with me the statute does not require consent by the surrogate?
MR. VIRGIL: Objection.
A. It doesn't require consent, and I think that the word considered, I'm taking that to be a stronger -- a higher bar than you are.
Q. (BY MS. SEAMAN) Higher than consent?
A. Not higher than consent, no.
Q. You know the earlier statute required consent in Connecticut?
MR. VIRGIL: Objection.
A. I didn't know that.
Q. (BY MS. SEAMAN) No one told you that?
MR. VIRGIL: Objection.
A. I probably should have known because there's some revisions here and it says on there that it would require consent.
Q. (BY MS. SEAMAN) Right. And the statute was changed to no longer require consent --
MR. VIRGIL: Objection.
Q. (BY MS. SEAMAN) -- agreed?
A. Yes, agreed.
Q. Okay. And so, then considered must mean something less than consent?

MR. VIRGIL: Objection.
A. Right, it means less than consent but it doesn't mean ignoring either, and there's a big variation in between.
Q. (BY MS. SEAMAN) Right. The next paragraph that I have picked up is, "They failed to offer the family care from an alternative facility, take all reasonable steps to transfer care to a different provider who was willing to comply with the wishes of the surrogate," correct?
A. Correct.
Q. And what would have been the reasonable steps, given that Yale-New Haven Hospital was already the transferee hospital, as set forth in these statutes?
A. They could have said, "Mr. Marsala, because of our ethical differences, we can't provide the type of care that you would like and we would like to help you arrange for a transfer to another hospital."
And that involves getting on the phone, seeing which facilities would have a bed available, what physicians would be willing to take her. It involves them making the calls because a patient is not going to be able to effectuate that by himself. He's going to need the assistance of that healthcare team.
Q. How did Mr. Marsala effectuate the transfer to

Yale-New Haven Hospital?
A. He asked the physicians at Griffin, and I'm sure that they called because it's required by EMTALA and by the transfer laws. I'm sure they called Yale. I'm sure that the transfer was approved by an accepted physician and by the hospital, and I'm sure there was physician-to-physician communication like there's supposed to be, and I'm sure there was a memorandum of transfer filled out like there's supposed to be and, you know, that those steps were made. He would not have been able to do it without the assistance of the physicians and healthcare team at Griffin.
Q. Okay. Let me ask you to assume that the clinicians at Yale-New Haven Hospital will testify that there was no facility that was reasonably likely to agree to a transfer of Ms. Marsala given the current clinical situation. Assume that to be true. Would you then still contend that there was a failure to comply with that statute?
MR. VIRGIL: Objection.
A. Yes, because I'd like to know whom they called. Like I said, there's these long-term acute care hospitals. They could have called me. I would have taken her.
Q. (BY MS. SEAMAN) How would she get here?

A. I guess that would be up to the family. It says that the family is responsible for paying for the transport.
Q. How do you get a patient who is ventilator dependent, hemodialysis dependent, stage 4 decubitus ulcers, with the kind of head issues that she had, ischemic colitis, possible issues of sepsis, how would you get her from Connecticut to Houston, Texas?
A. Well, theoretically, it can be done by air ambulance.
Q. She has deep vein thrombosis.
A. It can be done by air ambulance. I'm not saying that should have been done or it would be necessary because I would be very surprised if there wasn't some LTAC in the area or some other facility that would be willing to accept her.
Q. Are all LTACs called LTAC? I've never heard the term before, which is why I'm asking you that.
A. Maybe they use a different term. I don't know.
Q. Okay.
A. That's the term that I've always used, long-term acute care facility. I mean, I know there's one in Manchester, New Hampshire.
Q. What's it called?
A. I can't remember the name of the one in

Manchester.
Q. Is it Dartmouth associated?
A. Well, the thing is that Dartmouth has kind of taken over the state now in the last decade and apparently everything is Dartmouth associated now.
Q. Another one of your paragraphs say, "The hospital failed to notify the deceased's family of their unwillingness to provide life sustaining therapy to Helen Marsala within a reasonable period of time." What is a reasonable period of time as you're using that term?
A. I think that it goes back to this notice of due process. Part of due process is notice and the opportunity to be heard, and it takes time for a person to get their case together, to find, you know, people to speak to, representatives to help them and so on. So, a reasonable period of time, it's hard to get a clear-cut number. I would think it should be a week at least. I would think a week would be fair.
Q. So, on July 20th, they advised Mr. Marsala that they were going to extubate and would not reintubate if she failed breathing; is that correct?
A. They advised her verbally.
Q. Him verbally?
A. Him verbally, right. They didn't give him that

in writing. I think if it's given in writing, there's more emphasis. I think people take it more seriously. And part of having it in writing is that you're also able to tell a person what his options are. It's not clear to me that he was even ever told what his options were.
Q. Okay. Other than the writing, would you agree that notifying him on July 20th, notifying him of the ethics committee, the opportunity for a second opinion, would that be consistent with standard practice in other hospitals --
A. No.
Q. -- throughout the country?
A. No, because the most important thing is helping him get a transfer if he wants it, and the other important thing is telling him, you know, that he can get an attorney, that he can go to the probate court.
And I find it hard to believe that a Dr. Pisani told him that because she didn't seem like she really understood that herself. So, it's unlikely that she told him that, I think.
Q. Are you saying that other than Texas, where institutions are operating under the Texas Advance Directives Act, hospitals notify patients in writing of their unwillingness to continue certain kinds of therapy

for a patient?
A. Sure. When they're going to discharge a patient because they no longer meet medical criteria, there's a letter that's given to the patient telling them how they can appeal the decision, how to appeal it, if they do appeal it during the appeal time, they're not responsible for the bill but if the appeal process goes against them, then they're responsible for the bill. That's a standard practice. It's a federal practice. CMS is a federal agency.
Q. So, if you discharge a patient, you have to give them -- I'm sorry, I think I missed what you started.
A. Suppose a patient no longer meets criteria to be in the hospital.
Q. Okay.
A. For example, suppose Mr. Smith had a pneumonia, and he came in and he was coughing and he had a fever and he couldn't breathe well, and he receives antibiotics, and five days later, he no longer has a fever, he feels better, he's not coughing up any phlegm and they say, "Well, Mr. Smith, it's time for you to go home."
And Mr. Smith says, "No, I don't want to go home. I'm scared. I could get another pneumonia. I don't think I'm breathing right and my foot hurts," then they

give him a letter telling him that he no longer meets the guidelines to be hospitalized and that he will be discharged and that if he continues to stay in the hospital after the discharge, then he's going to be personally responsible for the bill. And a representative usually from the finance office is going to come by every day to give him the bill.

And in that letter, there's an explanation of the appeals process by which he can appeal the decision to an impartial body, and during that time that the appeal is going on, he won't be charged for the hospitalization. It's going to be covered by Medicare but if the review and the appeal goes against him, then from that point on, he's going to be responsible for the bill. And I have seen hospitals do that, and even when the attending physician is on the side of the patient, they can still do that.

Q. Okay. My question, though, is a little different. Setting aside your experiencing in Texas where the decision is governed by the Texas Advance Directives Act, correct?

A. Uh-huh.

Q. Yes?

A. Yes.

Q. Do you have any experiences that would allow you

to say that common practice in hospitals outside of Texas is to provide written notice to a surrogate of the hospital's unwillingness to provide life sustaining therapy?

MR. VIRGIL: Objection.

A. Well, I think that's kind of a rhetorical question because, obviously, I've been working in Texas for 17 or 18 years. So, I mean, I haven't worked in any other state, so, how would --

Q. So, you don't know how they do it in other states?

A. I feel that I'm being manipulated a little because these are Federal Rules. I mean, some of these things are Federal. The Medicare guidelines are Federal.

Q. Wait. We're talking about your statement that the hospital failed to notify the surrogate of their unwillingness to provide care, and you're telling me that among the deficiencies was the failure to provide it in writing. So, my question for you is I'm not asking about Medicare, CMS, I'm asking about the practice of hospitals, other than those governed by the Texas Advance Directives Act, to provide written notification to a surrogate of a decision to suspend life support. Do you have any experience with that at

all?

A. I guess -- I mean, I guess I don't.

Q. Okay. And you don't have any experience with a requirement, again, outside of facilities controlled by the Texas Advance Directives Act, to notify patient surrogates of a right to counsel?

A. I just think that it's inherent within our healthcare system, within our legal system, within our society that when there's a conflict of this magnitude for the party with superior power and resources to inform the party with less resources and less information of their rights, and that's just commonly done in our society.

Q. Okay.

A. It's done by police officers when they read the Miranda Act. It's done in mental health facilities when people are committed. It's done even in debt collection. I mean, there's a little warning that they read telling them that anything they say can be used to collect the debt. So, it's just inherent in the American society.

Q. So, it's common sense, it's not something you've learned from your education or experience in the field of medicine --

MR. VIRGIL: Objection.

Q. (BY MS. SEAMAN) -- correct?

A. It's both. I would say it's both.

Q. So, setting aside your education and experience in Texas, what is it that forms the basis of your opinion that hospitals that are not subject to the Texas Advance Directive Act commonly notify patient surrogates of a right to counsel?

MR. VIRGIL: Objection.

A. Hold on. Commonly is the wrong adjective because this is not a common situation. This is a very unusual situation. Okay? And I can tell you that this type of situation where physicians and healthcare providers take the law into their own hands and decide who is going to live and who is going to die, that that is objected to in other states besides Texas.

And I think I gave you an example in Louisiana where they brought charges against that woman for administering morphine and Versed to people that she thought was terminally ill without notifying them and without their consent. Okay?

And I think you probably read about other cases where charges have been brought against people for, you know, administering potentially fatal medications without informing people.

Q. I think the problem you and I are having is that

the law in our jurisdiction is that for a medical expert to provide opinions, it has to be based on the standard of care, and so, if you are prepared to offer an opinion that Yale-New Haven Hospital deviated from the standard, failed to comply with applicable rules and regulations in that it failed to give written notice of a right to counsel, I have a right to know the basis of that opinion. If the law is different in Connecticut than it is in Texas, if it's different in Louisiana than it is in Texas or in Connecticut, fine. But as a medical doctor, I am asking you what is the basis, aside from how you interpret the Texas Advance Directives Act, that causes you to reach the opinion that a healthcare provider in Connecticut has an obligation to advise a surrogate of his or her right to counsel in connection with the termination of life support?

MR. VIRGIL: Objection.

A. Okay. I'm going to answer that. Okay?

Q. (BY MS. SEAMAN) Fine.

A. The standard of care is what a reasonably prudent physician would do in the same or similar circumstances, and it is my opinion that a reasonably prudent physician would do that, and that's based on my experience, education and training.

Q. Okay. And how many times, in your experience,

has a physician notified a patient's surrogate of a right to counsel, in your experience?

A. In my experience, well, certainly the people that are committed to mental health facilities, every one is advised of their right to counsel, so, that right there would be a huge number.

Q. That's pretty analogous, isn't it, to this?

A. I think it is because it's a fundamental liberty issue.

Q. Other than -- how many times have you committed a patient to a psychiatric institution?

A. Personally? Well, I wouldn't commit them. All I would do is write the initial -- fill out the paper to get the emergency detention warrant.

Q. The PEC?

A. We call it an emergency detention warrant. And then the psychiatrist would probably come by and evaluate and make the final decision about how to handle.

Q. When was the last time that you did the initial -- not a PEC, I'm sorry, whatever the --

A. Emergency detention warrant?

Q. When was the last time?

A. I don't remember. It's been a couple of years.

Q. More than ten?

A. No, it hasn't been more than ten.

Q. When was the last time you worked in an emergency room?

A. 1997, but it's come up in other places.

Q. In what context would you be the physician who writes one of those papers?

A. When people are in the hospital and they want to leave with active tuberculosis, and they want to leave and go home and take care of their infant child.

I remember a man that had no short-term memory, and we went to the probate court and we got him a guardian ad litem.

Q. And you papered him?

A. Right. So, it comes up periodically, yes.

Q. How many times in the past ten years have you done it?

A. I don't have an exact number. It's not a tremendous amount.

Q. Five?

A. I'd say five would be the most, right.

Q. And the same question with respect to your understanding of a physician's obligation to notify a patient's surrogate of a right to counsel.

A. Patients are notified of it every time -- of their rights every time they come to the hospital. They

get a little sheet about what their rights are. And one of them, for example, is the EMTALA laws. There's a sign about EMTALA right on the front of the hospital, that you can't be refused treatment based on your ability to pay in an emergency situation. It's right there.

Q. So, the hospital notifies the patient on admission that they have a right to counsel, is that what you're saying?

A. No, not necessarily but they advise them of their rights, for example, their right to receive treatment regardless of their ability to pay in an emergency situation, they're notified of that.

Q. The part that I'm having trouble understanding is what is the basis for your opinion that it is the practice of hospitals that are not subject to the Texas Advance Directives Act to notify a patient's surrogate of a right to counsel in connection with end of life decision making?

MR. VIRGIL: Objection.

A. Okay. Let me point this out. I've never encountered physicians that have intentionally euthanized a patient before. Okay? So, my opinion is based on what a reasonably prudent physician would do in the same or similar circumstances based on my education,

training and experience, and I cannot imagine a reasonably prudent physician administering lethal medications to a patient who expressly asked that it not be done. I just can't -- it's the first time I've ever seen it.

Q. (BY MS. SEAMAN) So, you have no basis to state as you sit here today that it is the practice --

A. I didn't say that.

Q. That's what I'm trying to get. I understand --

A. This is going around in circles.

Q. I know.

A. Because how could I have that much experience when this is the first time I've ever seen anyone have the audacity to do it?

Q. Okay. Do you agree with the articles that suggest that up to 10 percent of every decision on end of life care gets sent to an ethics committee or other party for resolution of disputes?

A. 10 percent?

Q. 10 percent.

A. I haven't seen that.

Q. What percentage, in your experience, goes to some party to try to help to resolve differences between the treater and the family?

A. Extremely small percentages because most of the

time people don't want all these things done. If they really understand, you know, it's going to make their loved one suffer, usually they don't want it done.

Q. Many people, once they get engaged in that resolution process, change their mind and agree with the practitioners; is that correct?

A. They change their mind but it very rarely involves going to an ethics committee. It usually involves some discussions, maybe seeing what happens in an ICU, seeing, you know, the instruments and, you know, learning about what CPR is and how it can break someone's ribs. Those are the kinds of things that usually change their mind.

Q. So, is the only time that you've ever had to go to the ethics committee was the woman earlier this year whose family was suspicious because they were from another country?

A. No. My cases have come up in ethics committee before.

Q. How many times have you gotten to the ethics committee?

A. I don't know. I'm thinking of another woman who was in the hospital for six months, and we didn't know what to do with her. That was before they had this Texas Advance Directives Act.

I'm thinking of another person where they were terminally ill with something else, and we found a small cancer in the bronchial tube, and the question was whether we should notify them or not.

Q. Notify the patient?

A. Yeah. It wouldn't have mattered.

Q. It wouldn't have mattered if the patient knew?

A. Well, the patient was dying from other unrelated things, and this was a very early cancer. So, I guess the question was since it isn't going to affect his treatment or his mortality, do we even mention it.

Q. And did the ethics committee approve your withholding that information?

A. No, I think the decision was that we -- I think in the end, we all decided we should just tell him but tell him that it's a very early stage of cancer and it's really not going to affect anything.

Q. So, three times you recall going to the ethics committee. Any more?

A. I think there have been other cases. They just don't particularly stand out in my mind.

Q. Out of how many cases where you had to deal with end of life decision making for a hospitalized patient?

A. It's a tiny fraction. I mean, it's well less than 1 percent.

Q. And how many patients altogether have you been the attending physician responsible for dealing with end of life decisions for a hospitalized patients?

A. Thousands and thousands. I can't remember.

Q. Thousands and thousands?

A. You're talking -- I graduated from medical school in 1988. It's 2014. Maybe it's an exaggeration thousands and thousands. I mean, I don't know. Over that period of time, there's a lot of patients.

Q. That would be about 150 or so a year?

A. I guess that's too many. I guess maybe -- if there would be 50 a year, that would be about 2 a month. I would think it would be somewhere between 50 and 100 a year.

Q. In the material you were provided by counsel, there's certain information printed off Yale-New Haven Hospital's website; is that correct?

A. Yes.

Q. And do you rely on any of that information in connection with your opinions here?

A. Yes.

Q. And what's that?

A. It's an advisory committee, they make recommendations.

Q. Right. And the recommendation here was not to

escalate the care?
A. But the key thing is recommendation.
Q. Right. Okay. So, what's the problem?
A. Recommendations are not orders. They are not imperatives.
Q. So, the physicians could have decided to ignore them?
A. They could have decided to go to the probate court and get guardianship, and they could have decided to help the patient find alternative hospitals that might accept them. They could have decided to respect the due process of law.
Q. Okay. If in this case they had told Mr. Marsala that they decided that the care was not likely to lead to her having a meaningful existence outside of the hospital, that they had gone to the ethics committee, the ethics committee agreed, that they had gotten a second opinion, the second opinion agreed, that they were not aware of any facility that would accept a transfer of Ms. Marsala given her condition and the fact that she had already been transferred from one facility, assume that to be true, assume that they told him if he wanted to, he could go to probate court, he could get an attorney if he wanted to, assume that's true, would that then be consistent with standard practice, in your mind?

MR. VIRGIL: Objection.
A. No.
Q. (BY MS. SEAMAN) In what way would it not?
A. First of all, the second opinion is from another physician with privileges at the same hospital. Okay? It's not really an independent second opinion. That's one problem.
Okay. The second thing is I'd like to know what hospitals they contacted or tried to facilitate transfer to. I'd like to know which LTACs they called, okay, and whom they spoke to.
And thirdly, the onus of going to probate court falls on the hospital because they're the ones that want to change the guardianship or the conservatorship, as you call it, of the patient. Right? He is the legal guardian at this point. They are the ones that want to take away that guardianship. They are the ones that need to initiate the proceeding and go to probate court, not him.
Q. What's the basis for that statement?
A. The basis for that is the person that initiates the legal proceeding is the person that wants to change the situation.
If I own the house and you contest my right to own that house, my title on that house, I don't have to

go to court to prove that I'm the owner. I have the deed. I'm registered in the county clerk book.
Well, the same thing happens here. He's the guardian. He's the one that's legally the guardian. If you want to change that --
Q. We may have some confusion here. I sorry, I just don't want to go down this course. We've been here a long time. I don't believe he was the guardian. I don't think she was conserved. I don't think she had a guardian. Do you have something that I'm missing?
A. It says when the patient can't speak for herself that the next of kin speaks on her behalf, and it says specifically that the husband is the next in line.
Q. You're pointing to something.
A. The Connecticut statutes say that.
Q. So, you think that's a guardian then, that's what you mean by guardian?
A. I guess. I guess there's a difference in terminology of guardian. You're thinking of someone appointed by the Court, right?
Q. Right.
A. And I'm thinking of someone that they just become the guardian by default because that's the sequence of decision making.
Q. So, you're using guardian just like I'm suing

surrogate, fair?
A. Yeah.
Q. Okay. So, because he's the surrogate, unless Yale-New Haven Hospital is going to do what he says, your interpretation of the law in Connecticut is that Yale-New Haven Hospital has to go to probate court?
A. Yeah. But if you have something to show me otherwise, some case law or something that proves that that's not the case, I would be happy to consider it but that's the way I would interpret it.
Q. The law?
A. Right, from reading that statute.
Q. Okay. You never did a search for cases construing any of these statutes, right?
A. No. I mean, I will if they ask me to, but no, I didn't.
Q. And how about the legislative history?
A. No, I didn't research that.
Q. Have you been asked to do anything else in connection with this case?
A. No.
Q. And is there any other search for literature or law that you wanted to do that you didn't have time to do?
A. Yes, there was -- I mean, it was almost infinite.

For example, I didn't get through all the family's depositions. I think I would have liked to read that. I would have liked to look at the records from Griffin Hospital. I would like to research some of the points that you brought up, you know, about how that Connecticut statute has been interpreted. It could go on forever.

Q. In our jurisdiction, the rules require that one side notify the other side of the substance of their experts' opinions. I don't know if that's different than any place else but that's the rules where we are.

A. That's pretty standard.

Q. So, you understand if you do any more work, you find any more authority, you read any more authority, you read anything different, your opinions change in any way, either to grow stronger or to grow weaker, to add more, you have to an obligation to let us know that, do you know that?

A. Yeah, I know that but I was just responding to your question was there anything that I would like to do, and I just told you things that I would like to do. I'm probably not going to do them because I'm only going to do really what I'm asked to.

Q. And you haven't been asked to do anything else?

A. Right.

Q. Were you asked not to do all the research that you would have liked to have done?

A. No, but I mean, I think I did a lot as it is. No, I wasn't.

Q. Is there anything else that I haven't asked you that you think I should know in order to fully understand your opinions?

A. I can't think of anything right now.

Q. And I know I interrupted you several times.

A. That's okay. It's not a big deal.

Q. Did you think there was any time that you had something to add that I didn't let you answer?

MR. VIRGIL: Objection.

A. No, not really. I think there might have been some confusion about some words. It seemed like you were using surrogate and I was using guardian.

Q. (BY MS. SEAMAN) But we figured that one out, right?

A. Yes. The concerns, to consider the wishes of the patient in that statute, I mean, that's pretty broad.

Q. Okay. Do you agree that patients and families do not have the right to expect that demand for treatment will be met in all circumstances?

A. Well, all circumstances, that's pretty inclusive. So, I would have to agree with that, yes.

Q. Would you agree futile medical care is that which merely preserves the unconsciousness or fails to end the patient's total dependence on the MICU?

MR. VIRGIL: Objection.

A. No. I would say that futile care is when a therapy has no hope of achieving the physiologic goal.

Q. (BY MS. SEAMAN) Physiological goal?

A. Yes.

Q. And was the physiological goal in this case expressed by Ms. Marsala that she live forever so that she can take care of her adult daughter? Is that the physiological goal?

MR. VIRGIL: Objection.

A. No. That's more like a wish.

Q. (BY MS. SEAMAN) What's the physiological goal?

A. I would say the physiologic goal in this case is to keep the person alive on the ventilator and to look for the cause of her altered mental status because one big problem in this case is we don't have a diagnosis.

Q. Would you agree that it was unlikely that Helen Marsala would survive to hospital discharge?

MR. VIRGIL: Objection.

A. No, she probably would have made it to hospital discharge.

Q. (BY MS. SEAMAN) Would you agree that excessive

medical intervention is that which stands little chance of changing the ultimate clinical outcome?

MR. VIRGIL: Objection.

A. I would say that that's part of excessive medical intervention but excessive medical intervention could include lots of things. When I was a kid, every kid in my school got a tonsillectomy. That was excessive. As it turns out, that wasn't necessary. So, I wouldn't say that's an all inclusive excessive but maybe it's part of excessive.

Q. (BY MS. SEAMAN) Would you agree that the patient's right to participate in decision making does not mean that they have the right to demand interventions that are not medically indicated?

A. I'm not sure about that one. I think in the end, the patient is the ultimate decision maker and whether they're indicated or not is often a point of debate. So, I would say in the end, the patient is the ultimate decision maker.

Q. Would you agree that life sustaining intervention may be withdrawn without consent if the intervention is futile?

MR. VIRGIL: Objection.

A. Agree in what way? In that I think it's something I would do or it's okay with the laws in

Connecticut or it's okay with the laws in Texas? In what way is it okay?

Q. (BY MS. SEAMAN) That it is generally acceptable within the medical community.

MR. VIRGIL: Objection.

A. No, I wouldn't say that. I think it's extremely rare. Extremely rare.

Q. (BY MS. SEAMAN) Would you agree that care is futile if reasoning and experience indicate that the intervention would be highly unlikely to result in meaningful survival for the patient?

MR. VIRGIL: Objection.

A. No, because futile means there's no chance of achieving the physiologic goal, and you can't have futile if you have no diagnosis.

Q. (BY MS. SEAMAN) Would you agree that survival in a state with permanent loss of consciousness, that is, completely lacking cognitive or sentient capacity is generally regarded as having no value for a patient?

MR. VIRGIL: Objection.

A. Generally, no, that's, obviously, not true because in Terri Schiavo's case, Governor Bush and all those people felt that her life did mean something.

Q. (BY MS. SEAMAN) Would you agree that providing futile therapy goes against the ethical obligations of

physicians to act to the benefit of their patients and to refrain from harming them?

MR. VIRGIL: Objection.

A. I don't really agree with that because, first of all, we don't agree on futile and -- yeah.

Q. (BY MS. SEAMAN) Would you agree that clinicians have a legitimate interest in safeguarding their profession's integrity and trustworthiness, which would be undermined if clinicians administered interventions that they knew could not achieve the intended physiological goals?

MR. VIRGIL: Objection.

A. I don't know if I -- I guess I agree with that. I'm not sure.

Q. (BY MS. SEAMAN) Do you agree that life sustaining treatment is that which serves to delay death and does not heal or cure the patient?

A. No. Life sustaining means it sustains life. So, persons in the operating room, they are under anesthesia, they are not breathing, they are on the ventilator, it's sustaining their life until the anesthesia wears off. So, no. It could be life sustaining and not be a terminal situation.

Q. Would you agree that it's the standard of medical practice not to provide ineffective medical

technologies?

A. Well, there's that word standard again. I would say a reasonably prudent physician shouldn't do that but is it done? Yeah, it's done, for certain.

MS. SEAMAN: Okay. I have no further questions.

I think I'm going to ask the court reporter to take the exhibits.

MR. VIRGIL: Okay.

(Whereupon at 4:24 p.m. the deposition was concluded.)

ERRATA SHEET

Correction	Page	Line

I, LOUIS MARC HAMER, MD, have read the foregoing deposition and hereby affix my signature that same is true and correct, except as noted above.

_____
LOUIS MARC HAMER, MD

THE STATE OF _____
COUNTY OF _____
Before me, _____, on this day personally appeared LOUIS MARC HAMER, MD, known to me (or proved to me under oath or through _____) (description of identity card or other document) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purposes and consideration therein expressed.
Given under my hand and seal of office this _____ day of _____, _____.

_____
NOTARY PUBLIC IN AND FOR
THE STATE OF _____

STATE OF TEXAS *
COUNTY OF HARRIS *

I, the undersigned certified shorthand reporter and notary public in and for the State of Texas, certify that the facts stated in the foregoing pages are true and correct.

I further certify that I am neither attorney or counsel for, nor related to or employed by, any of the parties to the action in which this deposition is taken and, further, that I am not a relative or employee of any counsel employed by the parties hereto, or financially interested in the action.

SUBSCRIBED AND SWORN TO under my hand and seal of office on this the 13th day of October, 2014.

EDITH A. BOGGS, CSR
Certified Shorthand Reporter and
Notary Public in and for
the State of Texas
Notary Expires: 5-10-2016
Certificate No. 3022
Expiration date: 12-31-2015
Esquire Deposition Solutions, LLC
Registration No. 3

07-26-2010 02:26 Discharge Summary for Visit: 000055818967 MedicalRecords (Other) [Updated by: MedicalRecords on 07-26-2010 04:42], *Complete, General*

YALE-NEW HAVEN HOSPITAL
DISCHARGE SUMMARY

CONFIDENTIAL - DO NOT COPY WITHOUT APPROPRIATE AUTHORIZATION

Name:	Date of Adm:	Service:	Unit No:
Marsala, Helen	06/19/2010	NP9	185-0666
Date of Birth:	Date of Dis:	MEDICINE	
12/17/1934	07/26/2010		

Dictated: 07/26/2010 2:26 A Dictated by: Stephen Sanders, M.D.
Transcribed: 07/26/2010 4:42 A CBY/000321997/1284294

PRINCIPAL DIAGNOSIS:
Multiorgan failure

OTHER DIAGNOSES:
Septic shock
Colitis caused by Clostridium difficile
Diabetes mellitus
Hypertension
Hyperlipidemia
Aortic stenosis

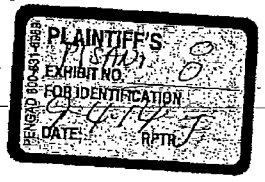
DISPOSITION: Expired

SERVICE: Medical ICU.

PRESENT ILLNESS: The patient was a 75-year-old woman who was transferred to Yale New Haven Hospital on June 19, 2010, after a prolonged stay in the Intensive Care Unit at the Griffin Hospital. She was transferred for further management of multiple medical problems. At Griffin, she had been started on oral vancomycin for treatment of Clostridium difficile associated colitis and had been started on caspofungin after urine and sputum cultures grew fungus. She had been treated with a course of imipenem for Morganella found in her sputum. Diuresis had been attempted because of pulmonary edema and anasarca, but as her blood pressure did not tolerate attempts of diuresis she was started on dopamine. She was intubated at Griffin Hospital presumably due to altered mental status. In this context, she was transferred to the Medical ICU at Yale for further management.

HOSPITAL COURSE AND TREATMENT: The patient arrived in tenuous condition and a Levophed drip was initiated to maintain her blood pressure. Empiric broad-spectrum antibiotics were begun. A CT of her head showed no acute intracranial abnormalities. CT scans of her chest, abdomen, and pelvis revealed bilateral pulmonary ground glass opacities with areas of consolidation, anasarca, and findings consistent with cirrhosis and colitis. A transthoracic echo showed severe aortic stenosis. An EEG revealed no acute seizure activity, and a brain MRI showed a 9-mm ovoid infarct in the right cerebellum with an additional punctate infarct in the right hippocampus.

Her initial BUN was 126 with a bicarbonate level of 12. IV hydration and



bicarbonate were provided to address her systemic acidosis. In addition, her creatinine was 1.8 on arrival and her urine output was inadequate. The Nephrology Service was consulted and they believed her kidney injury was likely secondary to acute tubular necrosis resulting from septic shock. Dialysis was initially withheld given her hypotension and low initial central venous pressure of 2.

She additionally experienced multiple episodes of bright red blood per rectum, for which the GI Service was consulted. They performed a flexible sigmoidoscopy, which revealed colonic ulcerations and edema thought to be due to ischemic colitis in the setting of hypoperfusion and septic shock.

On June 22, 2010, in the context of improved blood pressure and worsening kidney injury progressing to anuria, she was begun on hemodialysis. Hemodialysis was continued for a period of several weeks in an attempt to correct systemic acidosis and electrolyte abnormalities and thereby unmask one or more of those as the etiology for her depressed mental status. She, however, failed to make any significant improvements and dialysis was discontinued after a treatment on July 24, 2010. Likewise although multiple neurological images were obtained and the Neurology Service was involved. No focal neurological cause for her condition could be ascertained. The Neurology Service did recommend a lumbar puncture as part of her workup, but her husband declined the procedure noting at a discussion on July 6, 2010, that he did not think she would want to pursue this kind of aggressive care given her clinical condition. A tracheostomy was not pursued for the same reason given her poor prognosis, and on July 7, 2010, the patient was made DNR. She was extubated on the evening of July 20, 2010, after tolerating several ventilator-weaning trials.

The patient did not make any significant recovery of mental status during her medical ICU stay. As her course lengthened and her response to treatment remained minimal, prospects for improvement were deemed grim. Near the end of her course, her husband despite the conversation on July 6, 2010, noted above continued to insist that aggressive measures be undertaken to resuscitate her. Even after being informed multiple times and by multiple physicians that meaningful recovery was impossible and aggressive measures such as reintubation would be futile, he continued to press for aggressive measures. The Hospital Ethics Committee was therefore contacted, and it recommended no escalation of care. Finally, an additional pulmonologist was consulted to render a second opinion on the case. He too concurred with the opinion of the primary team and of The Hospital Ethics Committee. The patient's goals of care were therefore changed to provide comfort measures. On the evening of July 24, 2010, at 10:45 p.m., the patient passed away.

Electronically Signed
Margaret Pisani, M.D. 08/04/2010 13:10

Margaret Pisani, M.D.
Responsible Physician

cc: Margaret Pisani, M.D.

Ventilator Mode Mode : BIPAP

INTERFACE Interface : Full face

SET PARAMETERS MACHINE # MACHINE # : 26
SET PARAMETERS BACKUP RATE BACKUP RATE : 8
SET PARAMETERS IPAP SET IPAP SET : 10
SET PARAMETERS EPAP SET EPAP SET : 5
SET PARAMETERS PRESS SUPPORT PRESS SUPPORT : 5
SET PARAMETERS FiO2 Set % : 50
SET PARAMETERS RISE TIME RISE TIME : 0.4
SET PARAMETERS TIME INSP. TIME INSP. : 1

MONITORED PARAMETERS TOTAL RATE : 27
MONITORED PARAMETERS VT (estimated) VT (estimated) : 467
MONITORED PARAMETERS VE (estimated) VE (estimated) : 12
MONITORED PARAMETERS PIP PIP : 7
MONITORED PARAMETERS LEAK (LPM) LEAK (LPM) : 110

ALARMS Apnea Time Apnea Time (sec) : 30
ALARMS Peak Press HIGH Peak Press HIGH : 20
ALARMS Peak Press LOW Peak Press LOW : 6
ALARMS LOW PRES DELAY LOW PRES DELAY (sec) : 20
ALARMS VE LOW VE LOW : 3
ALARMS RATE HIGH RATE HIGH : 50
ALARMS RATE LOW RATE LOW : 7

SKIN ASSESSMENT Skin Integrity : No changes
SKIN ASSESSMENT Application Skin Barrier : Mepilex present

Provider Note [07-23-2010 16:07]- for Visit: 000055818967, *Appended, General*

BIOETHIC COMMITTEE NOTE

Members present: Grace Jeng, MD, Lydia Dugdale, MD, Sue Asher, Chaplain
Staff present: Dr. Meron, nephrology, Dr. Margaret Pisani, Primary Nursing Staff, and Social Work

Mrs. Marsala is a 75 yo woman with multiple medical problems including diabetes, aortic stenosis, HTN, and recent fall in spring resulting in left humeral, radial, and pubic ramus fractures. Patient was admitted to Griffin Hospital on 5/24/2010 for altered mental status, hypoxia, and anascarca. During her hospital stay, she was found to have C. diff colitis. She also developed respiratory failure secondary to pneumonia versus ARDS. She had fungemia and GI bleeding as well, and AKI with GFR < 10. She was transferred from Griffin Hospital to YNHH per family request on 6/19/2010 for assessment and treatment of prolonged mental status change. Her mental status work up here included EEG- showing slowing and brain imaging showing no acute

process. The idea of uremia as the cause of mental status change was entertained. A trial of hemodialysis was started to see if her mental status would improve, however over the last several weeks of dialysis, off sedatives and narcotics, she has had no improvement in her mental status. She will occasionally open her eyes, but there is no appropriate tracking around the room or consistent purposeful movement. After several weeks of being intubated, by pulmonary parameters she was ready to be extubated. Dr. Pisani discussed the clinical situation with the patient's husband and the decision was made for extubation. The patient was successfully extubated on Wednesday 7/21/2010, however, because of her continued poor mental status, her respiratory state declined and she has needed to be placed back on BIPAP. She continues to be in respiratory distress, breathing at 40, HR 100's, 02 sats 90's on Fi02 50%. The primary team has discussed with the husband the issue of the patient's poor prognosis. However, he states that he still wants her to be intubated if necessary. The primary team is concerned that we are providing futile care considering she has had multi-organ failure for several weeks now--respiratory failure, poor mental status, kidney failure, and stage IV skin break down over the back, as well as stage II over the bridge of nose from BIPAP use. Unfortunately, the patient's husband does not want his sons to be involved in the decision making. The husband has made comments to the primary team (physician and nursing) that his wife would not want to live this way, but he's not ready to give up. He has declined chaplain services.

The bioethics committee recommends that there be no further escalation of care (meaning no intubation or pressors) considering this is not in the best interest of the patient and we are not providing care that would achieve the patient's goal of going home. We also recommend that the dialysis trial should cease, as it has not shown to be of any meaningful benefit in improving her mental status. We have discussed this with the Chief of Staff, Dr. Peter Herbert. He is in agreement with the recommendation. If the patient's husband does not agree with the plan, he has the option of seeking transfer of care to a different hospital and/or going to the probate court.

I, Grace Jeng, have attempted to call the husband. I was unable to reach him and left a voice message for him to call me through the hospital operator. I will attempt again in a few minutes.

Addendum Section:
Jeng, Grace Yin (MD) (07-23-2010 16:13)
LP was refused by family.

Electronic Signatures:
Jeng, Grace Yin (MD) (Signed 07-23-2010 16:13)
Authored
Last Updated: 07-23-2010 16:13

Intake and Output [07-23-2010 16:00] - for Visit: 000055818967; [Entered by: Follert, Michelle L (RN) 07-23-2010 16:18], *Complete, General*

INTAKE

IV Fluids -Standard Conc (Enter in mLs)

MRN: 1860666 Visit: 000055818967 Age: 75y (12-17-1934)	MARSALA, HELEN Gender: Female	YNHH (Inpatient & Outpatient) Location: NP-MICUC-9-256-A

Pain Assessment #1 Pain Scale : NAPP patient obtunded

RASS

RASS RASS : -4 Deep sedation, no response to voice, but movement or eye opening to physical stumilation

Continuous Medication Infusions (Standard Conc)

Norepinephrine 4 mg/D5W 250 mL Rate: mL/hr, Dose:0.04 mcg/kg/min

---

Daily A&I: Adult [06-19-2010 10:00]- for Visit: 000055818967, [Entered by: Westphal, Daniel (RN) 06-19-2010 17:43.], *Complete, General*

Comment: D. Westphal RN

HEENT ASSESSMENT AND CARE

Head is atraumatic. No visible drainage or swelling. : Agree with normal statement

COGNITION / PERCEPTION / NEUROLOGICAL ASSESSMENT

Patient is alert and oriented x3, pupils normal size and reactive, speech is clear and understandable or developmentally appropriate, no impairment in all extremities. : Disagree, abnormals noted
Motor Strength Left Arm : Rigid
Motor Strength Right Arm : Rigid
Motor Strength Left Leg : Extremity will not move
Motor Strength Right Leg : Extremity will not move

Cognition/Perception/Neurological Abnormal

Pupil Exam Right Eye : 2 mm Sluggish reaction
Pupil Exam Left Eye : Abnormal shape; Nonreactive oblong approx 2-3 mm

Speech Speech : Intubated

[New]

Orientation Disoriented to : unable

LOC - Level of Consciousness : obtunded

Glasgow Coma Scale ...GCS: Eye opening Eye opening : To pain
Glasgow Coma Scale ...GCS: Best verbal response Best verbal response : Intubated
Glasgow Coma Scale ...GCS: Best motor response Best motor response : None

Glasgow Coma Scale ...Glasgow Coma Scale (GCS) Score Glasgow Coma Scale (GCS) Score : 4

Active Problem Active Problem? : Yes, Nurse to add problem to IPOC

Interventions Interventions : Reorient patient

Miscellaneous Miscellaneous : patient opened eyes one time for short period when going from stretcher to bed... no tracking.. otherwise patient really not reacting to painful stimulous.. not breathing above the set vent rate upon arrival to the MICU... per report from outside hospital this has been her baseline for the past 2-3 days... ammonia pending.. CT of head pending

CARDIOVASCULAR / PERIPHERAL VASCULAR ASSESSMENT

No Chest Pain/Discomfort, Pulses 2+, skin warm, no edema, sensation to light touch is present in all extremities, : Disagree, abnormals noted

Cardio/Peripheral Vascular Abnormal

Temperature Temperature : Cool

Edema Edema : R Leg - Pitting, R Arm - Pitting L Arm - Pitting L Leg - Pitting

Active Problem Active Problem? : Yes, Nurse to add problem to IPOC

Interventions Interventions : Telemetry, alarms on, parameters checked, Bedside monitor, alarms on, parameters reviewed, Left Arm Elevated, Right Arm Elevated, Left Leg Elevated, Right Leg Elevated

Miscellaneous Miscellaneous : patient's temp initially 34.8 rectally... bear hugger applied.. HR 80's to 90's NSR with BBB... SBP initally 100's but fell to 70's.. levophed started and dobutamine stopped...

RESPIRATORY ASSESSMENT

Patient has non-labored, clear bilateral breath sounds, with equal chest wall movement and no cough : Disagree, abnormals noted

Respiratory Abnormal

Breath Sounds Breath Sounds : Diminished bilaterally, Rhonchi left, Rhonchi right, bases, ant, ant

Work of Breathing Work of Breathing : vented

Chest Wall Movement Chest Wall Movement : equal

Cough Cough : Productive

Secretions/Sputum Secretions/Sputum : Small amt Tan

MRN: 1850666 Visit: 000055818967 Age: 75y (12-17-1934)	MARSALA, HELEN Gender: Female	YNHH (Inpatient & Outpatient) Location: NP-MICUC-9-256-A

Active Problem Active Problem? : Yes, Nurse to add problem to IPOC

Interventions Interventions : ETT Care, Oral Care

Miscellaneous Miscellaneous : patient stable sats on vent... #8 ETT at approx 20-21 at lip... minimal secretions...

MOBILITY AND ADL ASSESSMENT

Morse Fall Risk Assessment Fall Risk Assessment Fall Risk Assessment :
Morse Fall Risk Assessment History of falling History of falling : Yes
Morse Fall Risk Assessment Presence of secondary diagnosis Presence of secondary diagnosis : Yes
Morse Fall Risk Assessment IV therapy (continuous or intermittent) IV therapy (continuous or intermittent) : Yes
Morse Fall Risk Assessment Type of gait Type of gait : Bedrest
Morse Fall Risk Assessment Use of walking aids Use of walking aids : Bedrest
Morse Fall Risk Assessment Mental status Mental status : Delirium
Morse Fall Risk Assessment MORSE FALL RISK SCORE MORSE FALL RISK SCORE : 75

Patient is independent in all ADL's and mobility, low risk for falls. : Disagree, abnormals noted

Mobility and ADL Abnormal

Fall Risk Assessment Fall Risk Assessment : See Morse Scale

Impaired ADL's Impaired ADL's : Dependent w/ all ADL's
Impaired Strength Impaired Strength : Patient has generalized decondition throughout extremities and trunk
Bed Mobility Bed Mobility : Assist of 2 needed
Active Problem Active Problem? : Yes, Nurse to add problem to IPOC

Interventions Fall Risk Precautions Implemented : High Risk Precautions (Including At Risk and Universal)
Interventions Bed Mobility Interventions : Bedrest
Interventions Transfer Interventions : Assist of 2
Interventions Toileting Interventions : Toilet every 2 hours w/ bedpan

Miscellaneous Miscellaneous : patient's upper extrem very stiff/rigid... bilat LE's very swollen and patient does not move them much at all..

GASTROINTESTINAL ASSESSMENT AND CARE

Abd soft, non-tender/distended; membranes moist, intact; bowel sounds 4 quadrants, flatus; continent : Disagree, abnormals noted

GI Abnormal

Abdomen Abdomen : Distended, soft

Bowel Sounds Bowel Sounds : Hypoactive

Elimination Elimination : Diarrhea, Stoma is purple/maroon

Mucous Membranes Mucous Membranes : Dry

Active Problem Active Problem? : Yes, Nurse to add problem to IPOC

Interventions Interventions : Aspiration precautions, Oral care, Tube site care

Miscellaneous Miscellaneous : patient arrived on unit with OGT... xray read per ICU team and tube is in the stomach... no residuals from OGT... NPO for now.. patient with continuous diarrhea with BRB per rectum... ICU team aware... will trend patient's H/H... blood sugar also found to be 57/63 via bloodwork and fingerstick... patient given 1/2 amp d50... will follow

GENITOURINARY ASSESSMENT

Continent, Urine clear and yellow, genitalia normal : Disagree, abnormals noted

GU Abnormal

Urine Urine : Concentrated, Sediment

Urinary Device Device type : Foley

Active Problem Active Problem? : Yes, Nurse to add problem to IPOC

Interventions Interventions : Foley care

Miscellaneous Miscellaneous : foley catheter replaced upon arrival to MICU... culture sent from both the old foley and the new one... urine output 10-20ml/hr at this time

SKIN ASSESSMENT AND CARE

Braden: Adult Sensory Perception Sensory Perception : Very limited
Braden: Adult Moisture Moisture : Constantly moist
Braden: Adult Activity Activity : Bedfast
Braden: Adult Mobility Mobility : Very limited
Braden: Adult Nutrition Nutrition : Probably inadequate
Braden: Adult Friction/Shear Friction/Shear : Potential problem
WDL : This is a test
Braden: Adult Braden Scale Total Braden Scale Total : 10
Braden: Adult Risk of Pressure Ulcer Risk of Pressure Ulcer : High risk (score 10-12)

Skin is intact including skin in contact with all devices; color is normal for ethnicity : Disagree, abnormals noted
Skin Maintenance/Pressure Ulcer Prevention : Air controlled unit, Specialty Bed, Barrier Ointment/Wipe/Spray, Positioning/Turn, Skin cleanser and moisture barrier after soiling/toileting

Skin Abnormal

Skin Assessment Type : Intact Pressure ulcer

Skin Assessment Location : Coccyx/Sacral
Skin Assessment Discovery Time : Present on admission, patient comes from outside hospital with MULTIPLE pressure sores
Skin Assessment Appearance : 90% Black. 10% Red outside edges
Skin Assessment Surrounding Skin : Maceration
Skin Assessment Drainage Information : None
Skin Assessment Evaluation : Unable to evaluate; new admission... wound present on admission
Skin Assessment Intervention/Dressing : Air Controlled Unit, Barrier Ointment/Wipe/Spray, xeroform to woundbed... ICU team notified to involve plastics, Xeroform/ Done by RN, Nurse
Skin Assessment Staging : Unstageable (as diagnosed)
Skin Assessment Length (cm) (Direction 12 to 6) : 14
Skin Assessment Width (cm) (Direction 3 to 9) : 15

Skin Assessment Type : Non-Intact Pressure ulcer
Skin Assessment Location : Left, Upper, groin
Skin Assessment Discovery Time : Present on admission, patient with this wound present on admission from outside hospital
Skin Assessment Surrounding Skin : Intact, Swollen
Skin Assessment Drainage Information : Serous
Skin Assessment Evaluation : Unable to evaluate; unable as patient is new admit
Skin Assessment Intervention/Dressing : Air Controlled Unit, Skin Cleanser & moisture barrier after soiling or toileting, Soap and Water, Open to Air, Positioning/Turn, keep area clean and dry, open to air
Skin Assessment Staging : Stage II
Skin Assessment Length (cm) (Direction 12 to 6) : 1.25
Skin Assessment Width (cm) (Direction 3 to 9) : 2.5
Skin Assessment Depth (cm) : 0

Skin Assessment Type : Non-Intact Pressure ulcer
Skin Assessment Location : Left, Posterior, Knee
Skin Assessment Discovery Time : Present on admission, patient presents from outside hospital with this wound
Skin Assessment Appearance : 100% Pink
Skin Assessment Surrounding Skin : Intact, Swollen
Skin Assessment Drainage Information : Serous
Skin Assessment Evaluation : Unable to evaluate; unable as patient is new admit
Skin Assessment Intervention/Dressing : Air Controlled Unit, Soap and Water, Skin Cleanser & moisture barrier after soiling or toileting, Positioning/Turn, Open to Air, keep area as clean and dry as possible
Skin Assessment Staging : Stage II
Skin Assessment Length (cm) (Direction 12 to 6) : 1.5
Skin Assessment Width (cm) (Direction 3 to 9) : 1.5
Skin Assessment Depth (cm) : 0

Skin Assessment Type : Non-Intact Pressure ulcer
Skin Assessment Location : Left, Superior, Foot
Skin Assessment Discovery Time : Present on admission, patient presents with this wound from outside hospital
Skin Assessment Appearance : 100% Yellow
Skin Assessment Surrounding Skin : Intact
Skin Assessment Drainage Information : Serous
Skin Assessment Evaluation : Unable to evaluate; unable.. patient is new admit

Skin Assessment Intervention/Dressing : Air Controlled Unit, Barrier Ointment/Wipe/Spray, Elevate, keep area clean dry and free from pressure, open to air
Skin Assessment Staging : Stage II
Skin Assessment Length (cm) (Direction 12 to 6) : 2.5
Skin Assessment Width (cm) (Direction 3 to 9) : 1.5
Skin Assessment Depth (cm) : 0

Skin Assessment Type : Non-Intact Pressure ulcer
Skin Assessment Location : Right, Hip/Trochanter
Skin Assessment Discovery Time : Present on admission, patient presents with this wound from outside hospital
Skin Assessment Appearance : 100% Pink
Skin Assessment Surrounding Skin : Intact
Skin Assessment Drainage Information : None
Skin Assessment Evaluation : Unable to evaluate; unable as patient is new admit
Skin Assessment Intervention/Dressing : Air Controlled Unit, keep area dry and free from pressure, open to air
Skin Assessment Staging : Stage II
Skin Assessment Length (cm) (Direction 12 to 6) : 1
Skin Assessment Width (cm) (Direction 3 to 9) : 0.75
Skin Assessment Depth (cm) : 0

Skin Assessment Type : Non-Intact Pressure ulcer
Skin Assessment Location : Right, Ear
Skin Assessment Discovery Time : Present on admission, patient presents from outside hospital with this wound
Skin Assessment Appearance : 100% Pink
Skin Assessment Surrounding Skin : Intact
Skin Assessment Drainage Information : None
Skin Assessment Evaluation : Unable to evaluate; unable due to patient new admit
Skin Assessment Intervention/Dressing : Off loading, keeping ear off pillow, open to air
Skin Assessment Staging : Stage II
Skin Assessment Length (cm) (Direction 12 to 6) : 1.5
Skin Assessment Width (cm) (Direction 3 to 9) : 1

Skin Assessment Type : Non-Intact Pressure ulcer
Skin Assessment Location : Right, Posterior, Thigh
Skin Assessment Discovery Time : Present on admission, patient presented from outside hospital with this wound
Skin Assessment Appearance : 100% Pink superficial
Skin Assessment Surrounding Skin : Intact, Swollen
Skin Assessment Drainage Information : Serous
Skin Assessment Evaluation : Unable to evaluate; unable... patient is new admit.. wounds present on admission
Skin Assessment Intervention/Dressing : Air Controlled Unit, Off loading, Barrier Ointment/Wipe/Spray, keep area dry as possible, open to air
Skin Assessment Staging : Stage II
Skin Assessment Length (cm) (Direction 12 to 6) : 2.5
Skin Assessment Width (cm) (Direction 3 to 9) : 0.75
Skin Assessment Depth (cm) : 0

Active Problem Active Problem? : Yes, Nurse to add problem to POC

MRN: 1850656 Visit: 000055818967 Age: 75y (12-17-1934)	MARSALA, HELEN Gender: Female	YNHH (Inpatient & Outpatient) Location: NP-MICUC-9-256-A

Miscellaneous Miscellaneous : patient with multiple skin tears/ pressure ulcers all over her body... all present upon admit to MICU at Yale from outside hospital... patient weeping from all extrem.... will turn frequently and attempt to keep her skin as dry and possible...

Vital Signs: Adult (ICU) [06-19-2010 09:30]- for Visit: 000055818967, [Entered by: Westphal, Daniel (RN) 06-19-2010 15:16], *Complete, General*

Vital Signs

Heart Rate Heart Rate Heart Rate/min : 90 per Minute
Heart Rate Heart Rate Location Heart Rate Location : Monitor

Rhythm (ICU) Rhythm (ICU) : Normal sinus

Respiratory Rate Respirations: Breath/min : 18 per Minute

Blood Pressure Systolic: 83 mm Hg
Blood Pressure Diastolic: 47 mm Hg
Blood Pressure Mean BP: Mean BP/mm Hg : 59 mm Hg

Oxygenation

Oxygenation SpO2 : 99

POC Testing

Blood Glucose (mg/dl) Blood Glucose (mg/dl) : 63 mg/dl

Continuous Medication Infusions (Standard Conc)

Norepinephrine 4 mg/D5W 250 mL Rate: mL/hr, Dose:0.02 mcg/kg/min

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Intake and Output [06-19-2010 09:00]- for Visit: 000055818967, [Entered by: Westphal, Daniel (RN) 06-19-2010 11:15], *Complete, General*

INTAKE

Continuous Med Infusions (Enter in mLs)

MRN: 1850666 Visit: 000055818967 Age: 75y (12-17-1934)	MARSALA, HELEN Gender: Female	YNHH (Inpatient & Outpatient) Location: NP-MICUC-9-255-A

INTAKE

Continuous Med Infusions (Enter In mLs)

Norepinephrine 4 mg/D5W 250 mL In:9.5 mL

Vital Signs: Adult (ICU) [06-19-2010 11:00] for Visit: 000055818967, [Entered by: Westphal, Daniel (RN) 06-19-2010 15:16], *Complete, General*

Rounding : Rounded

Vital Signs

Temperature Temp C: : 36.2 degrees C
Temperature Temp F: : 97.1 degrees F
Temperature Temperature Route Temperature Route : Rectal

Heart Rate Heart Rate Heart Rate/min : 90 per Minute
Heart Rate Heart Rate Location Heart Rate Location : Monitor

Rhythm (ICU) Rhythm (ICU) : Normal sinus

Respiratory Rate Respirations: Breath/min : 21 per Minute

Blood Pressure Systolic : 102 mm Hg
Blood Pressure Diastolic : 51 mm Hg
Blood Pressure Mean BP: Mean BP/mm Hg : 68 mm Hg

Oxygenation

Oxygenation SpO2 : 98

POC Testing

Blood Glucose (mg/dl) Blood Glucose (mg/dl) : 92 mg/dl

Continuous Medication Infusions (Standard Conc)

Norepinephrine 4 mg/D5W 250 mL Rate:9.5 mL/hr, Dose:0.04 mcg/kg/min

---

Admission Assessment Nursing: ADULT MED/SURG [06-19-2010 10:42] for Visit:

000055818967, *Complete, General*

PERCEPTUAL PATTERN:
Verbalization/Language:

Verbalization: Able to verbalize clearly	Unable to assess
Patient's PRIMARY language	English
Patient's PREFERRED language	English
Patient has companion present	Yes...
...Companion's PRIMARY language	English
...Companion's PREFERRED language	English
Interpreter services required	No

Hearing:

Patient/Companion is deaf or hard of hearing	No

Vision:

Patient has vision impairment	Yes
...VISION IMPAIRMENT	Other: legally blind

Educational Barriers:

Patient/Caregiver has Educational Barriers (including reading)	No

Infection Control Measures:
Hand and Respiratory Hygiene and Contact Precautions reviewed with: Family. Demonstrates understanding of hand and respiratory hygiene and contact precautions Yes.

HEALTH MANAGEMENT/HEALTH PERCEPTION PATTERN:
Health History:

Patient's Reported Reason for Admission	failure to wean off vent
Information Obtained From	Spouse

Allergies:
- No Known Allergies:

Past History (Health Issues):
Diagnosis:
- 51881 ACUTE RESPIR FAILURE: 51881 ACUTE RESPIR FAILURE

Medical History via Nursing:

Med/Surg History via Nursing	Left eye surgery... bilat broken hips within 2.. broken right wrist
Has a past history of pressure ulcer or skin breakdown (Enter previous location in POC &	Yes

miscellaneous section of Skin Assessment)	
• Pressure Ulcer History Information	Patient with multiple pressure wounds upon admit to MICU at Yale

Advance Directives:

• Has Advance Directive	No
• Advance Directive pamphlet PROVIDED to Patient/Representative	No
• ...Reason Advance Directive Pamphlet not provided:	Patient/Representative refused
• Patient/Representative request assistance regarding Advance Directive	No

Alcohol and Drug Use Assessment (ages 9 and over):

• Drinks alcoholic beverages such as wine, beer or liquor	No
• Drug use history	No

Smoking History Assessment:

• Patient smokes or uses other forms of smokeless tobacco	No...
• ...Patient is/has	Non-smoker

Past History (Health Issues):

Diagnosis:

- 51881 ACUTE RESPIR FAILURE; 51881 ACUTE RESPIR FAILURE

Pneumococcal Vaccine Assessment:

• History of hemophilia or other severe bleeding disorders (ie: Von Willbrand's disease)	No
• Had Pneumococcal vaccine within the last 5 years	No
• ...Has known allergy to Pneumococcal Vaccine	No

Diabetes Mellitus History:

• Has Diabetes Mellitus	Yes...
• ...Diagnosis type	Established diagnosis...
• ...Diabetes Mellitus: Type	Type 2 (Including Steroid-Induced)
• ...Diabetes Mellitus Management	Oral medications
• ...Monitors Blood Glucose at home	Yes...
• ...Blood Glucose Monitoring: FREQUENCY	Other:; once week
• ...The LOWEST and HIGHEST blood glucose levels in the	Does not remember

last 2 weeks were	
...Would like to receive additional information on Diabetes Mellitus	No

Latex Allergy Screening:

LATEX ALLERGY	No
...History of food allergies to: bananas, kiwi fruit, avocado, potato, tomato, chestnuts, celery and/or papya?	No
...History of spina bifida, asthma, atopic dermatitis, eczema or multiple allergies?	No
...Had symptoms of hives, itching of the lips/throat after dental, rectal or gynecologic exam?	No
...Condoms, diaphragms or latex sexual aids cause itching or swelling?	No
...Blowing up balloons cause swelling or difficulty breathing?	No
...Experience symptoms when wearing gloves or around people wearing gloves?	No

Self Management of Health:

Able to take medications as directed by MD	Yes
Current Community Services	Unable to assess
HOME RESPIRATORY SUPPORT	None

NUTRITION/METABOLIC PATTERN:

Nutrition Assessment:

Diet at home is	Regular - solid food
Appetite at home is	Fair
Health factors affecting nutritional status	Loss of appetite greater than 1 week prior to admission
Social factors affecting nutritional intake	None identified
Weight has changed in last 6 months	Significant, unintentional weight loss
...Special feeding instructions	patient being tube fed at this time while intubated

Dysphagia Screening:

Dysphagia Screening: Patient is obtunded or stuporous or comatose or unable to remain alert.

Room Service Appropriate:

- Appropriate for Room Service Program: Other:, tube feeds

ELIMINATION PATTERN:

Urinary Elimination Habits:

- Urinary habits prior to admission: Unable to assess

Bowel Elimination Habits:

- Bowel elimination habits prior to admission: Unable to assess

ROLE/RELATIONSHIP PATTERN:

Patient's Legal Contacts (HIPPA/Privacy Info):

- Patient has the following Legal Contact(s): Other:... Husband
- Additional Contacts: Additional Contact #1...
- ADDITIONAL CONTACT #1: NAME: Clarence
- ...Relationship to the patient #1: Spouse
- ...Contact #1: Home phone number: 203-888-8883 (H)
- ...Contact #1: Cell phone number: 203-910-2424

Living Situation and Primary Care Giver:

- Patient currently lives with: Spouse...
- ...Person Patient lives with is Primary Caregiver: Yes...
- ...PRIMARY CAREGIVER's NAME/PHONE: see spouse
- Is there anyone dependent on patient: No
- Patient/Caregiver has concerns/worries: No

Abuse:

- This patient has been screened for Abuse and Neglect: No further assessment indicated
- This patient has been screened for Domestic Abuse: Due to patient's condition Domestic Abuse screening cannot be completed at this time

Opt Out/Visitor Restriction:

- Opt out: Unknown
- Visitor Restriction: No

SEXUALITY AND REPRODUCTIVE PATTERN:

Pregnant/Lactation/LMP (Female's 9-60 yo only):

• OBSTETRIC ADMISSION	No
Sexuality (Patient's age 9 and over):	
• Use of Birth Control	No
• Questions/Concerns regarding sexual activity	No
COPING/STRESS TOLERANCE PATTERN:	
Anxiety-Depression/Psychosocial Concerns:	
• Mini Assessment for Anxiety/Depression	Unable to assess
Suicide Assessment:	
• Factors that may INCREASE risk for suicide	None
Psycho-Social Concerns:	
• Psychosocial concerns present requiring Social Work assistance	Unable to assess
VALUES/BELIEF HISTORY PATTERN:	
Value/Belief:	
• Spiritual/Religious needs identified for Patient/Family	No
• Nursing Assessment indicates need for Chaplaincy support	No
UNABLE TO ASSESS:	
Unable to Assess:	
• Unable to assess due to	Discussion of Advance Directives contraindicated due to patient's condition Patient verbally unresponsive... Patient with impaired consciousness/cognition...
PERSONAL ITEMS/VALUABLES:	
Equipment With Patient:	
• EQUIPMENT AT HOSPITAL WITH PATIENT	Other:, no belongings with patient from outside hospital
Clothing With Patient:	
• CLOTHING AT HOSPITAL WITH PATIENT	Other:, none
Personal Items:	
• PERSONAL ITEMS AT HOSPITAL WITH PATIENT	Other:, none
Valuables:	
• VALUABLES AT HOSPITAL WITH PATIENT	Other:, none
Electronic Equipment:	
• ELECTRONIC EQUIPMENT AT	Other:, none

HOSPITAL WITH PATIENT

Electronic Signatures:
De Yro, Peachie A (RN) (Signed 07-06-2010 01:28)
Authored: PERCEPTUAL PATTERN, HEALTH MANAGEMENT/HEALTH PERCEPTION PATTERN, NUTRITION/METABOLIC PATTERN, ROLE/RELATIONSHIP PATTERN
Last Updated: 07-06-2010 01:28
Westphal, Daniel (RN) (Signed 08-19-2010 10:55)
Authored: PERCEPTUAL PATTERN, HEALTH MANAGEMENT/HEALTH PERCEPTION PATTERN, NUTRITION/METABOLIC PATTERN, ELIMINATION PATTERN, ROLE/RELATIONSHIP PATTERN, SEXUALITY AND REPRODUCTIVE PATTERN, COPING/STRESS TOLERANCE PATTERN, VALUES/BELIEF HISTORY PATTERN, UNABLE TO ASSESS, PERSONAL ITEMS/VALUABLES

Vital Signs: Adult (ICU) [06-19-2010 10:30]- for Visit: 000055818967, [Entered by: Westphal, Daniel (RN) 06-19-2010 15:16], *Complete, General*

Vital Signs

Heart Rate Heart Rate Heart Rate/min : 91 per Minute
Heart Rate Heart Rate Location Heart Rate Location : Monitor

Rhythm (ICU) Rhythm (ICU) : Normal sinus

Respiratory Rate Respirations: Breath/min : 18 per Minute

Blood Pressure Systolic : 99 mm Hg
Blood Pressure Diastolic : 53 mm Hg
Blood Pressure Mean BP: Mean BP/mm Hg : 68 mm Hg

Oxygenation

Oxygenation SpO2 : 99

Continuous Medication Infusions (Standard Conc)

Norepinephrine 4 mg/D5W 250 mL Rate:9.5 mL/hr, Dose:0.04 mcg/kg/min

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Intake and Output [06-19-2010 10:00]- for Visit: 000055818967, [Entered by: Westphal, Daniel (RN) 06-19-2010 11:15], *Complete, General*

Blood Pressure Systolic: 120 mm Hg
Blood Pressure Diastolic: 54 mm Hg
Blood Pressure Mean BP: Mean BP/mm Hg: 76 mm Hg

Oxygenation

Oxygenation: SpO2: 98

Continuous Medication Infusions (Standard Conc)

Norepinephrine 4 mg/D5W 250 mL Rate:9.5 mL/hr, Dose:0.04 mcg/kg/min

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Intake and Output - (Shift) [06-19-2010 15:00]- for Visit: 000055818967,]Entered by: Westphal, Daniel (RN) 06-19-2010 16:36], *Complete, General*

INTAKE

Continuous Med Infusions (Enter in mLs)

DOBUTamine 500 mg/0.9% NaCl 250 mL In:18 mL
Norepinephrine 4 mg/D5W 250 mL In:57.1 mL

OUTPUT

Urine

Voided (mL) Out:149 mL

History & Physical: Attending - MICU [06-19-2010 14:04]- for Visit: 000055818967, *Appended, General*

Provider/Contact Information:
Provider/Contact Information:
Team: Blue.

Presentation History:
Presentation History:
Source: chart/previous record History as recounted by resident.

Chief Complaint: Respiratory failure, shock, depressed mental status.

MRN: 1850666 Visit: 000055818967 Age: 75y (12-17-1934)	MARSALA, HELEN Gender: Female	YNHH (Inpatient & Outpatient) Location: NP-MICUC-9-255-A

HPI: Ms. Marsala is a 76 year old woman transferred from Griffin hospital for multiple medical problems for further management. She has an extensive past medical history, which includes DM, moderate aortic stenosis, hypertension, hyperlipidemia. She was admitted to Griffin in late May with abdominal pain and found to have colitis, requiring treatment for C difficile (unclear pending further review of records whether this was documented by toxin or empiric, but recent toxin was negative). She has had a long hospital course, which has included prolonged respiratory failure and failure to wean, shock requiring vasopressors, Morganella bacteremia requiring treatment with Imipenem, volume overload, and GI bleeding thought to be due to ischemic colitis. According to the husband, she has been obtunded for approximately one week for unclear reasons, workup unknown.

Allergies:
- No Known Allergies;

Physical Exam:
I have reviewed the patient's relevant flowsheet data from the last 24 hours.

RASS:

RASS (Richmond Agitation Sedation Score)	Deep Sedation (-4)

Exam:

General Appearance	Obtunded elderly woman, moving arms and grimacing to deep pain only.
HEENT	Orally intubated
Chest	Clear
Cardiovascular	RR
Abdomen	Soft, NT
Extremities	Anasarca
Neurological	Extremities stiff but no cogwheeling

Review of Labs:
I have reviewed the patients relevant laboratory/diagnostic imaging data from the past 24 hours.

Other Results:
Chest Xray:
Bilateral opacities; lines and tubes in place.

Assessment:
Elderly woman with multiple medical problems including shock, respiratory failure, depressed mental status, AKI, likely ischemic colitis.

Plan:
1. Keep MAP >65 mmHg given history of HTN (worried about hypoperfusion of gut, kidneys, brain)
2. Titrate NE as necessary
3. Central line for hemodynamic monitoring; difficult to assess volume status- may need cautious trial of fluids to see if we can decrease NE dose
4. Echocardiogram
5. Decrease tidal volume to 6 cc/kg IBW (can come down to 400 ml now)
6. Head CT to rule out stroke, though no focal findings on exam
7. EEG to rule out non convulsive status
8. Support with mechanical ventilation given poor mental status

9. Emplric antibiotics, pending culture
10. CT chest to rule out evidence of aspergillus given reports of mold in sputum
11. CT abdomen to evaluate colon given history of ischemic colitis
12. Cort stim; check thyroid function
13. Enteral feeds if CT allows
14. Follow urine output; likely ATN- hopefully function will improve with better BP.
15. Venodynes

Prognosis is uncertain at best given her multiple medical problems and advanced age. Hopefully we will be able to identify reversible problems to treat. Issues discussed in detail with patient's husband.

Critical Care Billing:
This patient is critically ill as indicated by the following: Respiratory failure Shock/Hemodynamic instability Metabolic acidosis Sepsis Coma. The patient has required 60 minutes of my undivided attention during the past 24 hours for one of the above life threatening diagnoses. Critical Care Interventions have included: Monitoring and adjustment of ventilator settings. Monitoring and adjustment of pressors/treatment of shock. Ongoing metabolic management. Family/patient discussion involving critical decision making and/or counseling.

Addendum Section:
Siegel, Mark D. (MD) (06-19-2010 14:27)
The patient has a soft, II/VI systolic murmur.
We will seek clarification of work up done thus far at Griffin

Electronic Signatures:
Siegel, Mark D. (MD) (Signed 06-19-2010 14:27)
Authored: Provider/Contact Information, Presentation History, Allergies, Physical Exam, Review of Labs, Other Results, Assessment & Plan, Billing
Last Updated: 06-19-2010 14:27

Vital Signs: Adult (ICU) [06-19-2010 14:00] for Visit: 000055818967, [Entered by: Westphal, Daniel (RN) 06-19-2010 16:35], *Complete, General*

Rounding : Rounded
Positioning / Turn : Did not turn EEG

Vital Signs

Temperature Temp C: : 36.9 degrees C
Temperature Temp F: : 98.4 degrees F
Temperature Temperature Route Temperature Route : Rectal

Heart Rate Heart Rate Heart Rate/min : 92 per Minute
Heart Rate Heart Rate Location Heart Rate Location : Monitor

Rhythm (ICU) Rhythm (ICU) : Normal sinus

Respiratory Rate Respirations: Breath/min : 28 per Minute

Oral Liquids (mL) In: mL
Free Water - NG (mL) In:10 mL

--- Tube Feedings (Enter in mLs)

Electrolyte/Fluid Restricted (Nepro) In:20 mL

OUTPUT

Urine

Foley Catheter (mL) Out:10 mL

Progress Note: Intern - MICU [06-22-2010 15:50] - for Visit: 000055818967; *Final, General*

Anticipated Discharge Tomorrow:
Unlikely (Red) Updated: 06-22-2010 15:50:37.

Team Name:
Blue.

Interim History:
75 yo lady with DM, HTN, moderate aortic stenosis admitted from OSH w C-diff colitis, shock requiring pressors, hypoxic respiratory failure, now on minimal vent settings but with depressed mental status.
24 hour events:
-250 NS bolus for low MAP in afternoon
-Flex sig done showing ischemic colitis of descending colon
-Fentanyl 25 x3 and Versed 1 x1 given for agitation and resulting desats, saturation improved after, MAPs held in 60s
-MRI yesterday showed acute ovoid infarct in right cerebellum, second punctate lesion in right hippocampus
-Urine output dropped further yesterday to 10 then to 4 cc/hr, did not respond to 250 NS bolus x2, renal team to do HD.

Review of Current Inpatient Medications:
I have reviewed patient's current inpatient medication list.

Relevant Inpatient Med Info:
Abx: Metronidazole 500 mg q 8
Vancomycin PO 125 mg q 12 hours.

Physical Exam:
I have reviewed the patient's relevant flowsheet data from the last 24 hours.

Relevant Flowsheet Data:
VS: Tc 35.5, Tmax 36.6, BP 114/60 (MAP 76), HR 103, RR 30, SpO2 98%
FS: 220
CVP 7
I/O: 1.0/293 (+732 ml)

Vent: 18/400/40%/5
no pressors.

Respiratory:
- ABG — 7.46/27/74/18.7 (SO2 of 96%)

Exam:
- General Appearance — Intubated, does not respond to verbal stimuli, does not follow commands
- HEENT — Pupils minimally reactive, right pupil with defect
- Neck — No JVD
- Chest — Good air movement, rhonchi auscultated especially at left base
- Cardiovascular — RRR, no m/r/g
- Abdomen — Distended but soft
- Genitourinary — Foley in place
- Extremities — 2+ pitting edema to knees, with SCDs in place
- Skin — Sacral decub

Review of Labs:
I have reviewed the patients relevant laboratory/diagnostic imaging data from the past 24 hours.

Relevant Labs:
Te 35.5; Tm 36.6, BP 114/60, MAP 75
HR 103; RR 30, SpO2 98% on FIO2 of 40, PEEP 5
FS: 220
CVP 7
I/O: 1.0/283 (+732)
Vent: 18/400/40%/5.

Other Cultures: VRE rectal swab pending
MRSA swab pending.

Assessment:
75 yo woman admitted from OSH with C. diff colitis, shock, hypoxic respiratory failure, now off pressors, but with failure to extubate due to poor mental status, also found to have two acute infarcts on MRI, now in oliguric renal failure.

Plan By Issue:
- *ISSUE #1: Pulmonary: On minimal vent settings, but unable to wean/extubate due to poor mental status.
  ABG indicates respiratory alkalosis, possibly due to her overbreathing vent.
  -Decrease Vt to 350.
- *ISSUE #2: CV: Hemodynamically stable during the night and today. MAP goal of 60.
- *ISSUE #3: Renal/metabolic: Oliguric renal failure progressing to anuric renal failure. Not responsive to fluid boluses. Also uremic.
  -Renal to start HD today.
  Potassium is low. Replace but will not do sliding scale due to acute renal failure.
- *ISSUE #4: ID: Treated for morganella from OSH, C diff treatment.
  -D/c cipro since finished course to cover morganella
  -Continue PO Vanc 125 q 12 hrs
  -Continue Flagyl 500 q 8 (Day 1/10)
  -Will check sacral decub today with resident, evaluate for further management.

- *ISSUE #5: GI: Flex sig showed ischemic colitis in descending colon.
  -GI felt that was good source for her bleed.
  -F/u GI biopsies
  -Will call GI to see if EGD also planned.
  Tube feeds on Perative now.
  -Switch to Nepro per renal's recommendation.
  -Nutrition consult to set up rate.
- *ISSUE #6: Neuro: Based on MRI results, strokes could complicate her mental status improvement.
  -Will consult neuro.

Nutrition/Prophylaxis/Code Status/Disposition:
Nutrition: Enteral Nepro.

DVT Prophylaxis: Compression boots.

GI Prophylaxis: Other: and lansoprazole.

Code Status: Full.

Additional Planning:
Restraint orders: Patient continues to meet restraint policy for medically essential therapy for due to cognitive/behavioral impairment.

Author Contact Information:
For questions please page Andrew Boyd, Intern 128 7819.

Electronic Signatures:
Boyd, Andrew Thomas (MD) (Signed 06-22-2010 17:01)
Authored: Anticipated Discharge Tomorrow, Team Name, Interim History, Review of Current Inpatient Medications, Physical Exam, Review of Labs, Assessment & Plan, Author Contact Information
Last Updated: 06-22-2010 17:01

Nursing Progress Note [06-22-2010 15:05] for Visit: 000055818967, *Complete, General*

Neuro: Pt. opens eyes spontaneously, does not follow commands.
CVS: MAP > 60, HR 100'S sinus tach.. Tmax 99.0 CVP 4-8. no s/s of bleeding observed.
Resp: remains intubated, tidal volume decreased to 350, no ABG required at this time. Lungs coarse, minimal secretions suction. SP02> 95% on 40% fi02.
GI: started on nepro tube feeds @v 20cc/hr, minimal residuals. Abd. distended but soft.
GU: foley insitu with minimal urine output > 30cc/hr. Seen by renal team, to start HD, permacath inserted.
Skin: pt. with multiple pressure ulcers, xeroform and silvadene cream applied to areas. Remains on clinitron bed.

Electronic Signatures:
Henry, Alethea N (RN) (Signed 06-22-2010 15:59)

6. Follow mental status
8. Tube feeds
7. Plan family meeting to discuss goals of care as outlined in Dr. Deshpande's note.

Billing:
This patient is critically ill as indicated by the following: Respiratory failure Coma. The patient has required 35 minutes of my undivided attention during the past 24 hours for one of the above life threatening diagnoses. Critical Care Interventions have included: Monitoring and adjustment of ventilator settings. Ongoing metabolic management.

Electronic Signatures:
Siegel, Mark D. (MD) (Signed 06-23-2010 16:59)
Authored: Attending Statement, Billing
Last Updated: 06-23-2010 16:59

Provider Note [06-23-2010 16:10] for Visit: 000055818967, *Final, General*

R2 Addendum

I called Mr. Clarence Marsala today to give him an update with regards to his wife's clinical situation and overall prognosis.

I informed him about the findings on the MRI, and explained the possible clinical significance of the lesions in her hippocampus and cerebellum. I also explained that these lesions do not by themselves explain her generally depressed level of consciousness. Moreover, in light of her hemodialysis and presumed treatment of uremia, one could expect an improved mental status if the uremia was the primary defect. I explained that it is possible to identify specific problems and their possible treatments, but when one takes the longer view, the picture appears more grim.

I emphasized that she is reaching the limits of the time she can be orally intubated, and that her overall clinical situation has not improved. Mr. Marsala asked about a possible tracheostomy; I explained that we often create tracheostomies when we feel that the patient has significant possibility for clinical improvement and rehabilitation. Mr. Marsala seemed to understand that the patient's combination of renal failure, widespread ischemic colitis, infarcts and infections did not portend well. I asked him to notify a nurse when next he was in the hospital so that a physician from the team could speak with him personally.

He also plans to discuss the current situation with his family. He reported that he and his wife had never explicitly discussed her wishes for aggressive interventions with an eye towards life-prolongation. He was concerned about the possibility that she was suffering, and seemed receptive to hearing the views of the team. He seemed to understand that withdrawal of care may be indicated if the clinical situation does not improve. He did not seem to feel that "life" at all costs was consistent with his frame of reference or beliefs.

Electronic Signatures:
Deshpande, Ohm Mohan (MD) (Signed 06-23-2010 16:10)
Authored:
Last Updated: 06-23-2010 16:10

RATE Rate Mechanical : 18
RATE Rate Total Rate Total : 18

VOLUMES Set (ml) Set (ml) : 350
VOLUMES VT Exhaled (ml) VT Exhaled (ml) : 360
VOLUMES Ve Total (L) Ve Total (L) : 6.5
VOLUMES FLOW LPM FLOW LPM : 50
VOLUMES Waveform : Decelerating
VOLUMES I/E : 1:3.9

SENSITIVITY Sens Flow Trigger Sens Flow Trigger : 2
SENSITIVITY Sens Bias Sens Bias : 5
SENSITIVITY Sens Press Sens Press : 3

PRESSURES Peak : 22
PRESSURES Plateau Plateau : 20
PRESSURES Peep : 5
PRESSURES Mean : 9
PRESSURES CL CL : 24
PRESSURES RAW RAW : 11.6
PRESSURES AUTO PEEP AUTO PEEP : Zero

FIO2 FIO2 Set % : 21
FIO2 ANALY % ANALY % : 21
FIO2 %O2 Increase : 79

ALARMS HIGH RATE HIGH RATE : 35
ALARMS Tidal Volume LOW Tidal Volume LOW : 200
ALARMS Tidal Volume HIGH Tidal Volume HIGH : 900
ALARMS VE LOW VE LOW : 3
ALARMS VE HIGH VE HIGH : 14
ALARMS Peak Pressure LOW Peak Pressure LOW : 8
ALARMS Peak Pressure HIGH Peak Pressure HIGH : 45
ALARMS LOW PEEP LOW PEEP : 2
ALARMS Apnea Parameters (sec) Apnea Parameters (sec) : 20

HUMIDIFICATION H2O Level H2O Level : 300
HUMIDIFICATION HUMIDITY TEMP (celcius) HUMIDITY TEMP (celcius) : 37

Transfer/Off-Service Note: Medicine [07-19-2010 19:14]- for Visit: 000055818967, *Final, General*

Anticipated Discharge Tomorrow:
Unlikely (Red) Updated: 07-19-2010 19:15:42.

Brief Synopsis of Hospital Course:
This is a 75 yo woman with PMH of DM, HTN, HL, and moderate AS who was admitted to MICU on 6/19 from Griffin Hospital, where she had been admitted from her ECF with C. diff colitis and septic shock. She arrived to Yale MICU in shock, on pressors, and intubated. She arrived with a

globally depressed mental status which has not improved. She has since developed anuria for which she is maintained on HD. Her goals of care are still being actively discussed with the family.

Pulmonary: Mrs. Marsala has been intubated since her arrival to the MICU, and has remained so for depressed mental status/concern for airway protection. Her gas exchange has been very good: her oxygenation is such that she now breathes room air. For one week, her respiratory rate was in the upper 20s, and blood gases showed a primary respiratory alkalosis. Her rate did not decrease with pain medications or midazolam, and there were no other clinical signs of infection. She now breathes in the low 20s. A CPAP trial of 5/5 was successful, and though the husband may be interested in a tracheostomy for her, the attending is considering extubation to see how she breathes on her own.

CV: Mrs. Marsala was on a levo drip on arrival, but she was rapidly weaned off of it. She has remained off pressors since. For two weeks, she became hypotensive only during dialysis, for which she recovered with midodrine and small NS boluses. For the last week before transfer, she has actually been hypertensive, so she is maintained on Metoprolol 50 bid.

Renal: The patient developed anuria soon after arrival, thought secondary to ATN from hypotension. She became very volume overloaded and anasarcic. She is maintained on HD, but only in the past week before transfer has her blood pressure tolerated volume removal. She now produces about 400-500 cc urine daily, but a repeat 24-hour creatinine clearance shows she is still dialysis dependent. She receives Nephrovite and Aranesp with dialysis.

ID: C. diff: On arrival, Mrs. Marsala had already been diagnosed with C. diff colitis, and she remains on a long vancomycin PO taper. Her current dose is 125 g PO q 72 hours, which she will receive for two weeks starting from 7/17.
Morganella: She grew Morganella at the OSH, so she is s/p course of cipro.
Ischemic colitis: Diagnosed here on 6/21 after brbpr, crit drop. S/p 7 day course of flagyl.
Fungal UTI: s/p 5 day course of fluconazole. Repeat urine culture pending.

GI: BRBPR, crit drop on 6/21, flex sig showed area of ischemic colitis at splenic flexure. S/p flagyl course, has since been hemodynamically stable. She is maintained on nepro tube feeds at 45 cc/hr.

Neuro: Mrs. Marsala has a persistently depressed mental status. It has not improved with resolution of sepsis or with dialysis. Head CT showed two new punctate infarcts, one in the basal ganglia and one in the temporal lobe. EEG done showed diffuse slowing, and repeat two weeks later showed further diffuse slowing. Her mental status depression is otherwise unexplained.

Endo: On glargine 7 units, ssi for glucose control.

Heme: Found to have bilateral DVTs on bilateral dopplers, s/p placement of IVC filter.

Skin: Unstageable sacral decub. PT is following, s/p pulse lavage sessions and placement of wound vac.

Social: DNR. Husband interested in trach, but not in escalation in care.

Review of Current Inpatient Medications:
Pneumococcal (Pneumovax) Vaccine, 25 MCG
IM, Once X 1 Times
Give prior to or on day of discharge, 06-21-2010

Dextrose Inj 50%, 50 mL
IV Push, NOW, PRN Blood Glucose < 50 mg/dL X 1 Times
(50mL jet)
May Infuse at 3mL/minute, 06-24-2010
Regular Insulin - Correction Dosing,
3 Unit(s) If Blood Glucose (mg/dL) 150 - 199
6 Unit(s) If Blood Glucose (mg/dL) 200 - 249
9 Unit(s) If Blood Glucose (mg/dL) 250 - 299
12 Unit(s) If Blood Glucose (mg/dL) 300 - 349
15 Unit(s) If Blood Glucose (mg/dL) 350 - 399
18 Unit(s) If Blood Glucose (mg/dL) > 400
SubCutaneous, Every 6 hours (00-06-12-18)
High dose - NPO-tube feeding patient
Not to be given less than every 6 hours., 06-26-2010
Albumin 25% Inj., 25 gram(s)
IV, Every 30 minutes
PRN hypotension during hemodialysis
Run over: 30 minute(s) at: 200 mL/hr
RFU: Intradialytic hypotension
*** Maximum 75 grams per treatment, 06-28-2010
Midazolam (Versed) Inj, 2 mg
IV Push, Every 3 hours, PRN Agitation
*** agitation as RR of 25
Refrigerated med, 06-30-2010
Potassium Chloride Inj. - Sliding Scale, 10 mEq In Sterile Water 100 mL
IV Every 1 hour PRN K Level of 3.7 - 4.0 --> Give 1 Dose
Run Over: 1 hour(s) at 100 mL/hr, 07-01-2010
Potassium Chloride Inj. - Sliding Scale, 10 mEq In Sterile Water 100 mL
IV Every 1 hour PRN K Level of 3.4 - 3.6 --> Give 2 Doses
Run Over: 1 hour(s) at 100 mL/hr, 07-01-2010
Potassium Chloride Inj. - Sliding Scale, 10 mEq In Sterile Water 100 mL
IV Every 1 hour PRN K Level of 3.0 - 3.3 --> Give 3 Doses
Run Over: 1 hour(s) at 100 mL/hr
*** Call MD for K Level < ?., 07-01-2010
Lansoprazole (Prevacid) Susp, 30 mg
NG Tube, Daily
Refrigerated med, 07-01-2010
Darbepoetin Alfa (Aranesp) Inj, 200 MCG
IV Push, <User Schedule> (every 1 week: Fri/17:00)
RFU: Inpatient: Hemodialysis & Acute Renal Failure, 07-02-2010
Sodium Citrate 4% Inj 5 mL, 1 mL
Intra-Catheter Daily PRN when CVVH catheter not in use
Install 1 mL into each 1 mL of catheter volume as catheter-lock., 07-03-2010
Nephrovite Tab, 1 tablet(s)
PO, Daily, 07-05-2010
Magnesium Sulfate 2 gram(s)/50 mL D5W, 2 gram(s) In D5W 50 mL
IV Every 1 hour PRN Mg Level: 1.7-1.9 x 2 doses
Run Over: 1 hour(s) at 50 mL/hr
Give 2 doses, 07-06-2010
Magnesium Sulfate 2 gram(s)/50 mL D5W, 2 gram(s) In D5W 50 mL
IV Every 1 hour PRN Mg Level: 1.4-1.6 x 3 doses
Run Over: 1 hour(s) at 50 mL/hr

Give 3 doses, 07-08-2010
Magnesium Sulfate 2 gram(s)/50 mL D5W, 2 gram(s) in D5W 50 mL
IV Every 1 hour PRN Mg Level: 1.0 - 1.3 x 4 doses
Run Over: 1 hour(s) at 50 mL/hr
Give 4 doses, 07-06-2010
Magnesium Sulfate 2 gram(s)/50 mL D5W, 2 gram(s) in D5W 50 mL
IV Every 1 hour PRN Mg Level: ≤ 1 x 5 doses
Run Over: 1 hour(s) at 50 mL/hr
Give 5 doses, 07-06-2010
Thiamine Tab, 100 mg
PO, Daily, 07-06-2010
Heparin Inj., 5,000 Unit(s)
SubCutaneous, Every 8 hours, 07-08-2010
Silver Sulfadiazene (Silvadene) Cream, 1 application(s)
Topical, to affected areas (sacrum and toe), Two times a day, 07-11-2010
Glargine Insulin (Lantus) Inj, 7 Unit(s)
SubCutaneous, Daily
Do NOT mix in the same syringe with any other insulin., 07-12-2010
Fentanyl Inj, 50 MCG
IV Push, Every 2 hours, PRN Pain, 07-16-2010
Heparin (Dialysis) Inj, 5,000 Unit(s)
Intra-Catheter, Once X 1 Times
*** Instill 1 mL into each 1 mL of catheter volume as post-dialysis catheter-lock., 07-17-2010
Vancomycin Oral Soln, 125 mg
PO/NG, Every 72 hours
RFU: C.Difficile associated diarrhea in patient receiving warfarin therapy
Refrigerated Med, 07-19-2010
Metoprolol (Lopressor) Tab, 50 mg
PO, Every 12 hours, 07-19-2010
0.9% NaCl, 500 mL, IV Continuous
Infuse at 5 mL/hr KVO, 06-20-2010

Physical Exam:
Relevant Flowsheet Data:
VS: 97.8, hr 77, rr 19, 159/70, 96% on 18/350/21/5
I/o 1450/675 (all urine).

Exam:

General Appearance	asleep, does not open eyes to command or noxious stimuli
Neck	right sided triple lumen
Chest	bilaterally clear
Cardiovascular	rrr, no m/r/g
Abdomen	mildly distended, stably so, +bs
Genitourinary	foley in place
Back	wound vac in place
Extremities	3+ pitting edema in lower and upper extremities bilaterally

Review of Labs:
I have reviewed the patients relevant laboratory/diagnostic imaging data from the past 24 hours.

Relevant Labs:
cbc whites 10.4/crit 28.4/plts 287
chem 7: 138/3.9/99/28.6/53/1.5
ca 8.2, phos 4.0, mg 2.1
U/a with pos leuk est, neg nitrite, 6-10 whites/hpf.

Assessment:
75 yo with multiple medical problems transferred from OSH with Cdiff colitis, shock requiring pressors, and intubation. Here developed anuric renal failure and continues with globally depressed mental status. On HD, uremia has improved. Mental status seems marginally improved. Overall prognosis still seems very poor. s/p IVC filter placement and s/p permacath placement. UOP around 15 cc/hr, still HD dependent. Family interested in trach placement at this point, but did well on cpap 5/5, so may be moving toward extubation to see how she does rather than trach.

Plan By Issue:
- *ISSUE #1: Pulmonary: did well on cpap 5/5 yesterday
  -try again today, leave on as long as she tolerates
  -if does well, may consider extubating her, see how she breathes on her own.
- *ISSUE #2: CV: MAPs have been stable
  -maintained on metoprolol 25 bid.
- *ISSUE #3: Renal: on HD, receiving today
  -on nephrovite, darbepoletin
  -net goal for today is 1.5 L off.
- *ISSUE #4: ID: Cdiff colitis treatment
  -vanco PO taper
  -now on 125 mg q 3 days x two weeks.
- *ISSUE #5: GI: on nepro feeds at goal (45 cc/hr).
- *ISSUE #6: Endo: maintained on glargine 7 and ISS
  -sugars well controlled now (160s).
- *ISSUE #7: Neuro: still with depressed mental status, only marginally improved
  -continue serial neuro exams.
- *ISSUE #8: Skin: Plastics consulted last week
  s/p placement of wound vac, OT/wound nurse is following
  -silvadene to be applied to right great toe eschar.
- *ISSUE #9: Heme: to check labs once daily.

Nutrition/Prophylaxis/Code Status/Disposition:
Nutrition: Enteral.

DVT Prophylaxis: Heparin.

GI Prophylaxis: Other: and lansoprazole.

Code Status: DNR.

Disposition: pending direction of care.

Author Contact Information:
For questions please page Boyd, Intern 7819.

Electronic Signatures:
Boyd, Andrew Thomas (MD) (Signed 07-19-2010 19:49)
Authored: Anticipated Discharge Tomorrow, Brief Synopsis of Hospital Course, Review

of Current Inpatient Medications, Physical Exam, Review of Labs, Assessment & Plan, Author Contact Information
Last Updated: 07-19-2010 19:49

Intake and Output [07-19-2010 19:00]- for Visit: 000055818967, [Entered by: Thomas, Tracy (RN) 07-19-2010 21:00], *Complete, General*

INTAKE

IV Fluids -Standard Conc (Enter in mLs)

0.9% NaCl 250 mL In:5 mL

--- Tube Feedings (Enter in mLs)

Electrolyte/Fluid Restricted (Nepro) In:45 mL

Vital Signs: Adult (ICU) [07-19-2010 19:00]- for Visit: 000055818967, [Entered by: Thomas, Tracy (RN) 07-19-2010 20:02; Ranalli, Jeannie (RN) 07-19-2010 20:09], *Complete, General*

Rounding : Rounded

Vital Signs

Heart Rate Heart Rate Heart Rate/min : 85 per Minute
Heart Rate Heart Rate Location Heart Rate Location : Monitor

Respiratory Rate Respirations: Breath/min : 19 per Minute

Blood Pressure Systolic : 122 mm Hg
Blood Pressure Diastolic : 67 mm Hg
Blood Pressure Mean BP: Mean BP/mm Hg : 85 mm Hg

Oxygenation

Oxygenation SpO2 : 96

- Follow-up Appointment(s) have been made with
- ...MD/Clinic Name, Phone, Date & Time of Appointment #1 Dr. Brand
- ...MD/Clinic Name, Phone, Date & Time of Appointment #2 Dr. Petruzziolo

Reason Hospitalization:
The reason for patient's hospital stay: GI Bleed.

Electronic Signatures:
Canterino, Joseph E. (MD) (Signed 08-08-2010 00:05)
Authored: Physician/Nursing: Follow-Up Appointments, Physician/Nursing: Reason for Hospitalization
Last Updated: 08-08-2010 00:05

Progress Note: Attending - MICU [07-20-2010 09:11]- for Visit: 000055818967, *Final, General*

Team Name:
Team:
Blue.

Interim History:
No acute events overnight. Hemodynamically stable. Stable on ventilator, on room air.

Review of Current Inpatient Medications:
I have reviewed patient's current inpatient medication list.

Physical Exam:
Vital Signs:

Temp F:	97.8 degrees F
Temp C:	36.6 degrees C
Heart Rate	86
Blood Pressure	143/63
Respiration Rate	21
SpO2	96%.

RASS:

RASS (Richmond Agitation Sedation Score).	Drowsy (-1)

Vent Settings:

Mode	Assist Control
TV	350
Rate	18
FIO2	21%
PEEP	5

Exam:

General Appearance	Bitemporal wasting
HEENT	Intubated
Chest	clear anteriorly
Cardiovascular	RRR
Abdomen	+BS, Soft
Rectal	Rectal tube in place
Genitourinary	Foley
Back	Wound vac in place
Extremities	Marked right hand edema, all other extremities with edema
Neurological	Opens eyes spontaneously, wiggles toes on command, intermittently follows commands

Review of Labs:
I have reviewed the patients relevant laboratory/diagnostic imaging data from the past 24 hours.

Other Results:
Chest Xray:
bilateral patchy ground glass opacities.

Assessment:
75 y/o admitted to Griffen hospital on 5/24/10 from an ECF and transferred to YNHH on 6/19/10 for encephalopathy. W/U has been unrevealing and included two EEG's and head CT, LP was refused by the family. She has renal failure and is on HD. DVT s/p IVC filter and refractory C. diff on prolonged vanco taper.

No acute events overnight. Urine culture after a Foley change with enterococcus and mucoid lactose fermentor-susc. pending.

-would repeat urine culture, would treat culture from 7/18
-weaning trial CPA 5/5 and if she does well I would extubate, have called her husband and left a message about the plan
-HD today with 2 liters of fluid removal
-continue tube feeds
-continue po vanco 125mg every three days, plan to stop on July 31st
-does not need daily labs, would check labs with dialysis unless there is a clinical change.

Plan By Issue:

- *ISSUE #1: Respiratory-intubated for airway protection. Maintain current ventilatory settings. Would not place a tracheostomy as it will not change the outcome or course given her poor mental status. On CPAP 5/5 trial 7/17 for 30 minutes she had Vt-280, RR-28 P-84, 97% and Ve-8.5, similar trial on 7/18.

  -from a respiratory standpoint she could likely come off the ventilator.

  I will discuss taking her off the ventilator with her husband and making her DNI.
- *ISSUE #2: Neuro-minimally responsive despite HD, no sedative medications, likely multifactorial.
- *ISSUE #3: Renal-HD per nephrology. HD has not improved her mental status.
- *ISSUE #4: Decubitus-wound vac in place and is changed every other day.
- *ISSUE #5: C. diff-continue vanco taper, she is currently on a every third day dosing

regimen.
- *ISSUE #6: Hypertension-would increase lopressor to 50mg BID.
- *ISSUE #7: Goals of care-had a meeting with Mr. Marsala on Friday and awaiting his further decision regarding comfort care. I have been unable to reach Mr. Marsala and I will try again tomorrow-Tuesday.

Nutrition/Prophylaxis/Code Status/Disposition:
Nutrition: Enteral.

DVT Prophylaxis: Heparin.

Code Status: DNR

Author Contact Information:
For questions please page 370-5248.

Billing:
This patient is not critically ill and I will not be billing critical care time.

Electronic Signatures:
Pisani, Margaret A. (MD) (Signed 08-09-2010 07:14)
Authored: Team Name, Interim History, Review of Current Inpatient Medications, Physical Exam, Review of Labs, Other Results, Assessment & Plan, Author Contact Information, Billing
Last Updated: 08-09-2010 07:14

Intake and Output [07-20-2010 09:00]- for Visit: 000055818967, [Entered by: Raymond, Meghan (RN) 07-20-2010 08:41], *Complete, General*

INTAKE

IV Fluids -Standard Conc (Enter in mLs)

0.9% NaCl 250 mL In:5 mL

--- Tube Feedings (Enter in mLs)

Electrolyte/Fluid Restricted (Nepro) In:45 mL

Vital Signs: Adult (ICU) [07-20-2010 09:00]- for Visit: 000055818967, [Entered by: Raymond, Meghan (RN) 07-20-2010 08:42], *Complete, General*

Rounding : Rounded

Urine

Foley Catheter (mL) Out:20 mL

Vital Signs: Adult (ICU) [07-20-2010 17:00] for Visit: 000055818967, [Entered by: Raymond, Meghan (RN) 07-20-2010 17:27], *Complete, General*

Rounding : Rounded

Vital Signs

Heart Rate Heart Rate Heart Rate/min: 100 per Minute

Rhythm (ICU) Rhythm (ICU) : Sinus tachycardia

Respiratory Rate Respirations: Breath/min : 19 per Minute

Blood Pressure Systolic : 173 mm Hg
Blood Pressure Diastolic : 82 mm Hg
Blood Pressure Mean BP: Mean BP/mm Hg : 106 mm Hg

Oxygenation

Oxygenation SpO2 : 100
Oxygenation % O2 : 40
Oxygenation Mode : Cold steam mask

Additional Information

Comments : sacral drsg change done

Nursing Progress Note [07-20-2010 16:46] for Visit: 000055818967, *Complete, General*

Pt alert but only intermittently following commands, spont moving UE's. Good CPAP 5/5 trial this AM for at least one hour. Meanwhile, discussion was had between Dr. Pisani and pt's son regarding plan for if pt had resp failure following extubation. Ultimately, pt's husband expressed wishes to MD in presence of RN that he wants her to be reintubated in such a case, but she is to remain DNR. Pt was extubated at 1630 to 40% CSM. Will monitor closely, pulm toilet. OGT d/c'd with extubation. Pending assessment of mental status and ability to perform bedside swallow eval, may consider placement of NGT later today for continuation of TF's. TF currently on hold. HD was done this morning, with 2.5L off per HD RN; see flowsheet. PU remains w/out woundvac, continue wet to dry drsgs acc to yesterdays order per MD until further notice and woundvac team can be contacted - sm amnt serous-brown drainage from site.

Electronic Signatures:
Raymond, Meghan (RN) (Signed 07-20-2010 16:45)
Authored
Last Updated: 07-20-2010 16:45

Respiratory Assessment [07-20-2010 16:32]- for Visit: 000055818967, [Entered by: Burks, JR, Mitchell (RT) 07-20-2010 16:33], *Complete, General*

Comment: mike burks RT

ASSESSMENT

Level of Consciousness : awake
Subjective Subjective Information : Patient unable to answer

Vital Signs HR : 100
Vital Signs RR : 33
Vital Signs SPO2 : 100

Breath Sounds Breathing Pattern : Normal
Breath Sounds Breath Sounds : Normal bilateral, Clear bilateral
Breath Sounds Cough : Non-productive

OXYGEN THERAPY

Oxygen Therapy Oxygen Therapy : Aerosol mask, 40%

VENT START/STOP TIME

Vent Start/Stop Time Vent STOP Time : 16:30

Intake and Output [07-20-2010 16:00]- for Visit: 000055818967, [Entered by: Raymond, Meghan (RN) 07-20-2010 17:29], *Complete, General*

INTAKE

IV Fluids -Standard Conc (Enter in mLs)

0.9% NaCl 250 mL in 5 mL

IV Fluids -Standard Conc (Enter in mLs)

0.9% NaCl 250 mL In:5 mL

— Tube Feedings (Enter in mLs)

Electrolyte/Fluid Restricted (Nepro) In:45 mL

OUTPUT

Urine

Foley Catheter (mL) Out:32 mL

Progress Note: Attending - MICU [07-21-2010 08:35] for Visit: 0000558 18967, *Appended, General*

Team Name:
Team:
Blue

Interim History:
No acute events overnight. Hemodynamically stable. Extubated last PM, good SaO2 on 50% Face Mask. More awake today.

Review of Current Inpatient Medications:
I have reviewed patient's current inpatient medication list.

Physical Exam:
I have reviewed the patient's relevant flowsheet data from the last 24 hours.

RASS:

RASS (Richmond Agitation Sedation Score)	Alert and Calm (0)

Vent Settings:

Mode	Assist Control

Exam:

General Appearance	Bitemporal wasting
HEENT	NG tube in place
Chest	clear anteriorly
Cardiovascular	RRR
Abdomen	+BS, Soft
Rectal	Rectal tube in place
Genitourinary	Foley
Extremities	Marked right hand edema, all other extremities with

	edema
• Neurological	Opens eyes spontaneously, , intermittently follows commands

Review of Labs:
I have reviewed the patients relevant laboratory/diagnostic imaging data from the past 24 hours.

Other Results:
Chest Xray:
pulmonary edema.

Assessment:
75 y/o admitted to Griffen hospital on 5/24/10 from an ECF and transferred to YNHH on 6/19/10 for encephalopathy. W/U has been unrevealing and included two EEG's and head CT, LP was refused by the family. She has renal failure and is on HD. DVT s/p IVC filter and refractory C. diff on prolonged vanco taper.

No acute events overnight. Was extubated yesterday and has been more awake. Urine culture after a Foley change with enterococcus and mucoid lactose fermentor-susc. pending.

-continue face mask oxygen, would titrate down as tolerated, chest percussion
-f/u urine culture results
-HD tomorrow with 2 liters of fluid removal
-continue tube feeds
-continue po vanco 125mg every three days, plan to stop on July 31st
-does not need daily labs, would check labs with dialysis unless there is a clinical change.

Plan By Issue:
- *ISSUE #1: Respiratory-Intubated for airway protection. Maintain current ventilatory settings. Would not place a tracheostomy as it will not change the outcome or course given her poor mental status. On CPAP 5/5 trial 7/17 for 30 minutes she had Vt-280, RR-28 P:84, 97% and Ve-6.5, similar trial on 7/18.

  -from a respiratory standpoint she could likely come off the ventilator.

  I will discuss taking her off the ventilator with her husband and making her DNI.
- *ISSUE #2: Neuro-minimally responsive despite HD, no sedative medications, likely multifactorial.
- *ISSUE #3: Renal-HD per nephrology. HD has not improved her mental status.
- *ISSUE #4: Decubitus-wound vac in place and is changed every other day.
- *ISSUE #5: C. diff-continue vanco taper, she is currently on a every third day dosing regimen.
- *ISSUE #6: Hypertension-would increase lopressor to 50mg BID.
- *ISSUE #7: Goals of care-had a meeting with Mr. Marsala on Friday and awaiting his further decision regarding comfort care. I have been unable to reach Mr. Marsala and I will try again tomorrow-Tuesday.

Nutrition/Prophylaxis/Code Status/Disposition:
Nutrition: Enteral.

DVT Prophylaxis: Heparin.

Code Status: DNR.

Author Contact Information:
For questions please page 370-5248.

Billing:
This patient is not critically ill and I will not be billing critical care time.

Addendum Section:
Pisani, Margaret A. (MD) (07-21-2010 14:07)
Urine with klebsiella and VRE, foley changed, and repeat culture pending. Has not been febrile, WBC not elevated, would wait for f/u culture to treat

Electronic Signatures:
Pisani, Margaret A. (MD) (Signed 07-21-2010 14:07)
Authored: Team Name, Interim History, Review of Current Inpatient Medications, Physical Exam, Review of Labs, Other Results, Assessment & Plan, Author Contact Information, Billing
Last Updated: 07-21-2010 14:07

Intake and Output [07-21-2010 08:00]- for Visit: 000055818967, [Entered by: Zarach, Jean (RN) 07-21-2010 10:22], *Complete, General*

INTAKE

IV Fluids -Standard Conc (Enter in mLs)

0.9% NaCl 250 mL In:5 mL

Nutrition

Free Water - NG (mL) In:90 mL
Row Comment : meds, protein supplement, OGT flushes

— Tube Feedings (Enter in mLs)

Electrolyte/Fluid Restricted (Nepro) In:45 mL

OUTPUT

Urine

Foley Catheter (mL) Out:80 mL

MRN: 1850666 Visit: 000055818967 Age: 75y (12-17-1934)	MARSALA, HELEN Gender: Female	YNHH (Inpatient & Outpatient) Location: NP-MICUC-9-256-A

Consult Subseq. Care: Nephrology [07-22-2010 07:17]- for Visit: 000055818967, *Final, General*

Interim History:
No change
Very diaphoretic
Remains extubated
TF-Nepro at 45 cc/hr
No other prob.

Review of Current Inpatient Medications:
I have reviewed patient's current inpatient medication list.

Allergies:
- No Known Allergies: Active

Physical Exam:
I have reviewed the patient's relevant flowsheet data from the last 24 hours.

Additional Assessments:
UOP 357 ML
Unresponsive
Chest-CTABL
CVS-S1+S2+ RRR-3/6 Systolic murmur+
Edema+ both LE
R permcath site-clean.

Review of Labs:
I have reviewed the patients relevant laboratory/diagnostic imaging data from the past 24 hours.

Assessment & Plan:
75 yo F with DM, HTN, AS, C diff colitis, lower GI bleed, ischemic bowel, AKI and altered mental status.
Initiated on dialysis 6/22

-AKI: ATN from hypotension.Creatinine clearance is 4 ml/min in 24 hr collection-UOP 200-400 cc ,on HD -No signs of recovery -HD dependant
-AMS-Unclear origin-No major improvement with HD at all for over 4 weeks -extubated now
-Anaemia-Hb 8.6 -Darbe 200 on HD
-MBD-PTH 144 ,Vit D pending
-Nutrition-Nepro 45 ml/hr
-Access-Permcath 7/8/
-VRE UTI-On no meds-D/C foley.

Suggest
-HD today-1.5 lts UF /3K/2.5 Ca
-Family want to continue current level of care as of this week
-Save Nondominant arm for future access
-D/C foley or change it-UTI now
-Consider transfusion if Hb<8.

Author Contact Information:
For questions please page 4127533.

Attending Note:
I have seen and evaluated the patient and agree with the fellow's Shanmala note with

modifications and/or additions documented below.

Pt seen and examined during HD. She is extubated, but breathing is labored. HD script reviewed. Decision was made to terminate HD 30min early after ~1L UF as pt breathing was becoming more labored, and BP was declining to 80s systolic and lower after having been stable through initial phase of treatment. MICU team notified. Will follow closely; ongoing hemodialysis may not be feasible in light of patient's overall poor condition..

Electronic Signatures:
Marin, Ethan Price (MD) (Signed 07-22-2010 14:02)
Authored: Attending Note
Last Updated: 07-22-2010 14:02
Singanamala, Swathi (MD) (Signed 07-22-2010 08:14)
Authored: Interim History, Review of Current Inpatient Medications, Allergies, Physical Exam, Review of Labs, Assessment & Plan, Author Contact Information

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Intake and Output - (Shift) [07-22-2010 07:00]- for Visit: 000055818967, [Entered by: Riley, Lonna (RN) 07-22-2010 05:13], *Complete, General*

INTAKE

IV Fluids -Standard Conc (Enter in mLs)

0.9% NaCl 250 mL In:35 mL

Nutrition

Free Water - NG (mL) In:300 mL
Row Comment: meds, protein,supplement, OGT flushes

--- Tube Feedings (Enter in mLs)

Electrolyte/Fluid Restricted (Nepro) In:315 mL

OUTPUT

Urine

Foley Catheter (mL) Out:68 mL

Intake and Output - (Daily) [07-22-2010 07:00]- for Visit: 000055818967, [Entered by: Matnick, Sherri A (RN) 07-21-2010 17:19; Zarach, Jean (RN) 07-21-2010 18:15; Riley, Lonna

0.9% NaCl 250 mL In:6 mL

OUTPUT

Urine

Foley-Catheter (mL) Out:0 mL

Other Output

Tube Feed Residual - wasted (mL) Out:0 mL

Nursing Progress Note [07-22-2010 23:52]- for Visit: 000056818967, *Complete, General*

Received Mrs. Marsala who had an eventful day with abort of her dialysis treatment due to hypotension and respiratory failure requiring bipap. Patient's respiratory status did not improve this evening. Discussed with Dr. Kawano that patient is not protecting her airway, a few minute break from bipap for mouth care and skin assessment resulted in desat to mid 80s, and use of accessory muscles rapidly. Patient faces reintubation or family decision regarding not to provide this therapy given her continued critical illness, and in particular depressed mental status refractory to plan of care. LDeVaux, RN

Electronic Signatures:
Devaux, Laura A (RN) (Signed 07-22-2010 23:52)
Authored
Last Updated: 07-22-2010 23:52

Plan of Care Flowsheet [07-22-2010 23:30]- for Visit: 000056818967, [Entered by: Devaux, Laura A (RN) 07-22-2010 23:48], *Complete, General*

Comment: LDeVaux, RN

Disposition

Continuum of Care Related To : Disease process
Continuum of Care Outcomes : Discharge plan acceptable to patient/representative
Continuum of Care Interventions : Care Coordination Consult
Continuum of Care Evaluation : No Change

Education

Knowledge Deficit Related To : Disease process

Intake and Output - (Daily) [07-23-2010 07:00] - for Visit: 000055818967, [Entered by: Devaux, Laura A (RN) 07-22-2010 22:31; Burgos, Dorothy (RN) 07-22-2010 14:19; Vitone, Anthony (RN) 07-23-2010 06:15], *Complete, General*

INTAKE

IV Fluids - Standard Conc (Enter in mLs)

0.9% NaCl 250 mL In:120 mL

Intermittent Med Infusions (Enter in mLs)

Daptomycin (Cubicin) / 0.9% NaCl In:100 mL

Nutrition

Free Water - NG (mL) In:210 mL
Row Comment: meds, protein supplement, OGT flushes

Tube Feedings (Enter in mLs)

Electrolyte/Fluid Restricted (Nepro) In:45 mL

OUTPUT

Urine

Foley Catheter (mL) Out:157 mL

Other Output

Tube Feed Residual - wasted (mL) Out:0 mL
Other Output (mL) Out:955 mL
Row Comment: Hemodialysis

****

Consult Subseq. Care: Nephrology [07-23-2010 06:58] - for Visit: 000055818967, *Appended, General*

Interim History:
On Bipap
Was hypotensive 2.5 hrs into HD yesterday
900 cc taken off and HD stopped
On 50% Fio2
TF stopped ? as on Bipap.

Review of Current Inpatient Medications:

I have reviewed patient's current inpatient medication list.

Allergies:
- No Known Allergies; Active

Physical Exam:
I have reviewed the patient's relevant flowsheet data from the last 24 hours.

Additional Assessments:
UOP 157 ML
eyes open and tracking today
On Bipap
Chest-CTABL
CVS-S1+S2+ RRR-3/6 Systolic murmur+
Edema+ both LE
R permcath site-clean.

Review of Labs:
I have reviewed the patients relevant laboratory/diagnostic imaging data from the past 24 hours.

Assessment & Plan:
75 yo F with DM, HTN, AS, C diff colitis, lower GI bleed, ischemic bowel, AKI and altered mental status.
Initiated on dialysis 8/22

-AKI: ATN from hypotension.Creatinine clearance is 4 ml/min in 24 hr collection-on HD -No signs of recovery -HD dependant
-AMS-Unclear origin-No major improvement with HD at all for over 4 weeks -extubated now
-Anaemia-Hb 7.5 -Darbe 200 on HD
-MBD-PTH 144 ,Vit D <5 -On Ergocal 50,000 q week for 6 weeks
-Nutrition-Nepro 45 ml/hr-Stopped now
-Access-Permcath 7/8/
-VRE UTI-On Dapto and Cipro.

Suggest-
-D/C Cipro if no indication-Recent C diff
-HD in am
-Goals of care need readdressed again next week
-Save Nondominant arm for future acce
-Conskder transfusion if Hb<8.

Author Contact Information:
For questions please page 4127533.

Addendum Section:
Marin, Ethan Price (MD) (07-23-2010 17:38)
Neph attndg
Ethics committee meeting today to address goals and plans of care. She has rec'd dialysis for approximately 4 weeks now. A major factor in the initiation of the dialysis was to eliminated uremia as a cause of her poor mental status. MS has not improved despite the dialysis. We plan to complete the trial of dialysis with a final treatment tomorrow.

Electronic Signatures:
Singanamala, Swathi (MD) (Signed 07-23-2010 07:03)
Authored: Interim History, Review of Current Inpatient Medications, Allergies, Physical Exam, Review of Labs, Assessment & Plan, Author Contact Information

Ventilator Mode Mode : BIPAP

INTERFACE Interface : Full face

SET PARAMETERS MACHINE # MACHINE # : 26
SET PARAMETERS BACKUP RATE BACKUP RATE : 8
SET PARAMETERS IPAP SET IPAP SET : 10
SET PARAMETERS EPAP SET EPAP SET : 5
SET PARAMETERS PRESS SUPPORT PRESS SUPPORT : 5
SET PARAMETERS FiO2 Set % : 50
SET PARAMETERS RISE TIME RISE TIME : 0.4
SET PARAMETERS TIME INSP. TIME INSP. : 1

MONITORED PARAMETERS TOTAL RATE : 27
MONITORED PARAMETERS VT (estimated) VT (estimated) : 467
MONITORED PARAMETERS VE (estimated) VE (estimated) : 12
MONITORED PARAMETERS PIP PIP : 7
MONITORED PARAMETERS LEAK (LPM) LEAK (LPM) : 110

ALARMS Apnea Time Apnea Time (sec) : 30
ALARMS Peak Press HIGH Peak Press HIGH : 20
ALARMS Peak Press LOW Peak Press LOW : 6
ALARMS LOW PRES DELAY LOW PRES DELAY (sec) : 20
ALARMS VE LOW VE LOW : 3
ALARMS RATE HIGH RATE HIGH : 50
ALARMS RATE LOW RATE LOW : 7

SKIN ASSESSMENT Skin Integrity : No changes
SKIN ASSESSMENT Application Skin Barrier : Mepilex present

Provider Note [07-23-2010 16:07]- for Visit: 000055818967, *Appended, General*

BIOETHIC COMMITTEE NOTE

Members present: Grace Jeng, MD; Lydia Dugdale, MD, Sue Asher, Chaplain
Staff present: Dr. Meron, nephrology, Dr. Margaret Pisani, Primary Nursing Staff, and Social Work

Mrs. Marsala is a 75 yo woman with multiple medical problems including diabetes, aortic stenosis, HTN, and recent fall in spring resulting in left humeral, radial, and pubic ramus fractures. Patient was admitted to Griffin Hospital on 5/24/2010 for altered mental status, hypoxia, and anascarca. During her hospital stay, she was found to have C. diff-colitis. She also developed respiratory failure secondary to pneumonia versus ARDS. She had fungemia and GI bleeding as well, and AKI with GFR < 10. She was transferred from Griffin Hospital to YNHH per family request on 6/19/2010 for assessment and treatment of prolonged mental status change. Her mental status work up here included EEG- showing slowing and brain imaging showing no acute

process. The idea of uremia as the cause of mental status change was entertained. A trial of hemodialysis was started to see if her mental status would improve, however over the last several weeks of dialysis, off sedatives and narcotics, she has had no improvement in her mental status. She will occasionally open her eyes, but there is no appropriate tracking around the room or consistent purposeful movement. After several weeks of being intubated, by pulmonary parameters she was ready to be extubated. Dr. Pisani discussed the clinical situation with the patient's husband and the decision was made for extubation. The patient was successfully extubated on Wednesday 7/21/2010, however, because of her continued poor mental status, her respiratory state declined and she has needed to be placed back on BIPAP. She continues to be in respiratory distress, breathing at 40, HR 100's, 02 sats 90's on Fi02 50%. The primary team has discussed with the husband the issue of the patient's poor prognosis. However, he states that he still wants her to be intubated if necessary. The primary team is concerned that we are providing futile care considering she has had multi-organ failure for several weeks now--respiratory failure, poor mental status, kidney failure, and stage IV skin break down over the back, as well as stage II over the bridge of nose from BIPAP use. Unfortunately, the patient's husband does not want his sons to be involved in the decision making. The husband has made comments to the primary team (physician and nursing) that his wife would not want to live this way, but he's not ready to give up. He has declined chaplain services.

The bioethics committee recommends that there be no further escalation of care (meaning no intubation or pressors) considering this is not in the best interest of the patient and we are not providing care that would achieve the patient's goal of going home. We also recommend that the dialysis trial should cease, as it has not shown to be of any meaningful benefit in improving her mental status. We have discussed this with the Chief of Staff, Dr. Peter Herbert. He is in agreement with the recommendation. If the patient's husband does not agree with the plan, he has the option of seeking transfer of care to a different hospital and/or going to the probate court.

I, Grace Jenq, have attempted to call the husband. I was unable to reach him and left a voice message for him to call me through the hospital operator. I will attempt again in a few minutes.

Addendum Section:
Jenq, Grace Yin (MD) (07-23-2010 16:13)
LP was refused by family.

Electronic Signatures:
Jenq, Grace Yin (MD) (Signed 07-23-2010 16:13)
Authored
Last Updated: 07-23-2010 16:13

Intake and Output [07-23-2010 16:00] - for Visit: 000055818967; [Entered by: Follert, Michelle L (RN) 07-23-2010 16:18], *Complete, General*

INTAKE

IV Fluids -Standard Conc (Enter in mLs)

MRN: 1850566 Visit: 000055818967 Age: 75y (12-17-1934)	MARSALA, HELEN Gender: Female	YNHH (Inpatient & Outpatient) Location: NP-MICUC-9-256-A

Skin Consult Note [07-23-2010 18:34] for Visit: 000055818967, *Complete, General*

Service:

Pressure Ulcer 1: Service	Consult Service, skin consult

Skin Not Intact: Pressure Ulcer / Wound:

Not Intact: Skin Assessment 1

Skin Assessment 1: Type	Pressure ulcer caused by device, BiPAP
Skin Assessment 1: Location	Left, Lateral, Nose
Skin Assessment 1: Status	Discovered new wound, 7/23/10
Skin Assessment 1: Appearance	Pale Pink
Skin Assessment 1: Surrounding Skin	Intact
Skin Assessment 1: Drainage Information	None
Skin Assessment 1: Evaluation	Initial assessment
Skin Assessment 1: Interventions	mepilex drsg/gel bipap
Skin Assessment 1: Dressing Information	Non-Adherent, silicone, Done, In place but can be assessed, Nursing, Tolerated Well
Skin Assessment 1: Staging	Stage II
Skin Assessment 1: Length (cm)	2 cm
Skin Assessment 1: Width (cm)	2 cm
Skin Assessment 1: Depth (cm)	0 cm
Skin Assessme 1: Longest Measure (cm)	2
Longest Measure Direction	12 to 6, and 3 to 9
Skin Assessment 1: Tunneling 1 (cm)	0 cm
Skin Assessment 1: Tunneling 2 (cm)	0 cm
Skin Assessment 1: Tunneling 3 (cm)	0 cm
Skin Assessment 1: Undermining 1 (cm)	0 cm
Skin Assessment 1: Undermining 2 (cm)	0 cm
Consult Recommendations	Referral received regarding Stage 2 nose area ulcer secondary to Bipap mask. Bony prominence areas are covered with Mepilex drsg to provide padding under mask contact areas with skin. Stage 2 site is clean and patient is on continuous mask therapy. REC: 1)Dependent on goals, it might be helpful to

have respiratory check as to whether patient might be a candidate for nasal Bipap to off-load pressure from area

2) If not,then double layer of Mepilex in this area and ask Respiratory if another type of gel Bipap might help

Electronic Signatures:
Ryzewski, Jayne H (CNS) (Signed 07-23-2010 18:45)
Authored: Service; Skin Not Intact: Pressure Ulcer / Wound, Consult Recommendations
Last Updated: 07-23-2010 18:45

Daily A&I: Adult [07-23-2010 18:28]- for Visit: 000055818967, [Entered by: Ryzewski, Jayne H (CNS) 07-23-2010 18:45; Flood, Julie A (RN) 07-24-2010 00:18], *Complete, General*

Comment: skin consult

Skin Abnormal

Skin Assessment Type : Skin tear Non-Intact
Site:Right lower buttocks/skin tear
Skin Assessment Location : Right, Buttocks
Site:Right lower buttocks/skin tear
Skin Assessment Discovery Time : Discovered new wound, Daily assessment
Site:Right lower buttocks/skin tear
Skin Assessment Related to a Device : r/t coccyx dressing tape
Site:Right lower buttocks/skin tear
Skin Assessment Appearance : 100% Pink
Site:Right lower buttocks/skin tear
Skin Assessment Surrounding Skin : Intact
Site:Right lower buttocks/skin tear
Skin Assessment Drainage Information : Bloody, Scant
Site:Right lower buttocks/skin tear
Skin Assessment Evaluation : Unchanged
Site:Right lower buttocks/skin tear
Skin Assessment Intervention/Dressing : Positioning/Turn, Allevyn foam
Site:Right lower buttocks/skin tear
Skin Assessment Staging : Not Applicable; Not a Pressure Ulcer
Site:Right lower buttocks/skin tear

SKIN CONSULT NOTE

Consult Note Consult Note :

PSYCHOSOCIAL ASSESSMENT

Patient/family coping effectively, no risks of violence identified : Disagree, abnormals noted

INTAKE

IV Fluids -Standard Conc (Enter in mLs)

D5W/0.45% NaCl 1,000 mL In:400 mL

OUTPUT

Urine

Foley Catheter (mL) Out:51 mL

Nursing Progress Note [07-23-2010 22:52]- for Visit: 000055818967, *Complete, General*

NPN
1500-2300
Ethics committee meeting completed just before this shift started. Per MICU Attending Dr. Pisani and Ethics committee code status changed to DNR/DNI with comfort care as goal and Bipap mask to be removed this shift. Per orders Bipap removed and CSM placed on. For pt comfort Morphine drip ordered and PRN IV Morphine administered while awaiting Morphine infusion from pharmacy. Pt appears comfortable with CSM on however sat remains in low 90's and RR remains high 30's to low 40's. See flowsheet and POC for complete details. Will continue to monitor pt's status.

Electronic Signatures:
Follert, Michelle L (RN) (Signed 07-23-2010 22:52)
Authored
Last Updated: 07-23-2010 22:52

Respiratory Assessment [07-23-2010 22:30]- for Visit: 000055818967, [Entered by: Russo, Gina M (RT) 07-23-2010 22:40], *Complete, General*

ASSESSMENT

Level of Consciousness : unresponsive
Subjective Subjective Information : Patient unable to answer

Vital Signs HR : 105
Vital Signs RR : 36

MRN: 1850566 Visit: 000055818967 Age: 75y (12-17-1934)	MARSALA, HELEN Gender: Female	YNHH (Inpatient & Outpatient) Location: NP-MICUC-9-256-A

Nursing Progress Note [07-24-2010 15:32]- for Visit: 000055818967, *Complete, General*

Pt remains lethargic, RASS -2. Unable to follow commands. Remains on morphine gtt at 1mg/hr for respiratory distress. comfort measures continued. Attending Tanoue, Dr. Sanders, and Dr.Burke spoke with patient's husband and son about plan of care. Clearly reviewed the decision of the ethics committee to make patient DNI/DNR with goal of care to be comfort. Second opinion by an attending to be obtained per request of husband. Goals of care continue to be comfort. Foley d/c'd. No HD today.

Electronic Signatures:
Polihron, Katherine M (RN) (Signed 07-24-2010 15:32)
Authored
Last Updated: 07-24-2010 15:32

Consult Initial: Critical Care [07-24-2010 15:23]- for Visit: 000055818967, *Complete, General*

Consult Information:
Consultation requested by Dr lynn Tanoue.

Reason For Consultation Second Opinion for direction of care.

Presentation History:
HPI: Unfortunate elderly lady with prolonged hospitalization after admission to Griffin Hospital and now after a long icu stay remains in a state of unresponsiveness.She was extubated and remained on bipap and now on face mask and appears comfortable with a resp rate of 18 to20. I have reviewed the notes and the multiple comorbidities but will not be elaborating on this in my note.

Allergies:
- No Known Allergies:

Physical Exam:
Vital Signs:

Heart Rate	93
Blood Pressure	117/54
Respiration Rate	20
SpO2	98
SpO2 measured on:	Face mask (%): 40%

Exam:

General Appearance	elderly ill appearing lady on face mask and in no overt distress
HEENT	Bitemporal wasting ,pupilsreactive with old iridectomy
Neck	no jvd
Chest	bilateral air entry tho diminished
Cardiovascular	S1S2 k no murmurs or gallop noted
Abdomen	soft

Extremities — edema of both lower extremities,area of dry gangrene at bottom of great toe

Impression:
At this time I concur with The decision of Primary team and of the ethics committee and further attempts at therapeutic intervention do not offer a chance of a better outcome. Reintubation, ongoing use of bipap based on both asynchrony and skin breakdown is not warranted.
I agree to moving to a comfort care plan.
I Have left a message for the husband at the cell no I was given.

Author Contact Information:
For questions please page Allan Rodrigues 203 787 5155.

Electronic Signatures:
Rodrigues, Allan J. (MD) (Signed 07-24-2010 15:46)
Authored: Consult Information, Presentation History, Allergies, Physical Exam, Impression & Recommendations, Author Contact Information
Last Updated: 07-24-2010 15:46

Intake and Output [07-24-2010 15:00] - for Visit: 000055518967, [Entered by: Polihron, Katherine M (RN) 07-24-2010 14:53], *Complete, General*

INTAKE

Continuous Med Infusions (Enter in mLs)

Morphine 250 mg/D5W 250 mL In:1 mL

Vital Signs: Adult (ICU) [07-24-2010 15:00] - for Visit: 000055518967, [Entered by: Polihron, Katherine M (RN) 07-24-2010 14:53], *Complete, General*

Rounding : Rounded

Vital Signs

Heart Rate Heart Rate Heart Rate/min : 94 per Minute

Rhythm (ICU) Rhythm (ICU) : Normal sinus

Respiratory Rate Respirations: Breath/min : 94 per Minute

Blood Pressure Systolic : 116 mm Hg
Blood Pressure Diastolic : 73 mm Hg
Blood Pressure Mean BP: Mean BP/mm Hg : 87 mm Hg

07-26-2010 02:26 Discharge Summary for Visit: 000055818967 MedicalRecords (Other) [Updated by: MedicalRecords on 07-26-2010 04:42], *Complete, General*

YALE-NEW HAVEN HOSPITAL
DISCHARGE SUMMARY

CONFIDENTIAL - DO NOT COPY WITHOUT APPROPRIATE AUTHORIZATION

Name:	Date of Adm:	Service:	Unit No:
Marsala, Helen	06/19/2010	NP9	185-0666
Date of Birth:	Date of Dis:	MEDICINE	
12/17/1934	07/24/2010		

Dictated: 07/26/2010 2:26 A Dictated by: Stephen Sanders, M.D.
Transcribed: 07/26/2010 4:42 A CBY/000321997/1284294

PRINCIPAL DIAGNOSIS:
Multiorgan failure

OTHER DIAGNOSES:
Septic shock
Colitis caused by Clostridium difficile
Diabetes mellitus
Hypertension
Hyperlipidemia
Aortic stenosis

DISPOSITION: Expired

SERVICE: Medical ICU.

PRESENT ILLNESS: The patient was a 75-year-old woman who was transferred to Yale New Haven Hospital on June 19, 2010, after a prolonged stay in the Intensive Care Unit at the Griffin Hospital. She was transferred for further management of multiple medical problems. At Griffin, she had been started on oral vancomycin for treatment of Clostridium difficile associated colitis and had been started on caspofungin after urine and sputum cultures grew fungus. She had been treated with a course of imipenem for Morganella found in her sputum. Diuresis had been attempted because of pulmonary edema and anasarca, but as her blood pressure did not tolerate attempts of diuresis she was started on dopamine. She was intubated at Griffin Hospital presumably due to altered mental status. In this context, she was transferred to the Medical ICU at Yale for further management.

HOSPITAL COURSE AND TREATMENT: The patient arrived in tenuous condition and a Levophed drip was initiated to maintain her blood pressure. Empiric broad-spectrum antibiotics were begun. A CT of her head showed no acute intracranial abnormalities. CT scans of her chest, abdomen, and pelvis revealed bilateral pulmonary ground glass opacities with areas of consolidation, anasarca, and findings consistent with cirrhosis and colitis. A transthoracic echo showed severe aortic stenosis. An EEG revealed no acute seizure activity, and a brain MRI showed a 9-mm ovoid infarct in the right cerebellum with an additional punctate infarct in the right hippocampus.

Her initial BUN was 126 with a bicarbonate level of 12. IV hydration and

bicarbonate were provided to address her systemic acidosis. In addition, her creatinine was 1.8 on arrival and her urine output was inadequate. The Nephrology Service was consulted and they believed her kidney injury was likely secondary to acute tubular necrosis resulting from septic shock. Dialysis was initially withheld given her hypotension and low initial central venous pressure of 2.

She additionally experienced multiple episodes of bright red blood per rectum, for which the GI Service was consulted. They performed a flexible sigmoidoscopy, which revealed colonic ulcerations and edema thought to be due to ischemic colitis in the setting of hypoperfusion and septic shock.

On June 22, 2010, in the context of improved blood pressure and worsening kidney injury progressing to anuria, she was begun on hemodialysis. Hemodialysis was continued for a period of several weeks in an attempt to correct systemic acidosis and electrolyte abnormalities and thereby unmask one or more of those as the etiology for her depressed mental status. She, however, failed to make any significant improvements and dialysis was discontinued after a treatment on July 24, 2010. Likewise although multiple neurological images were obtained and the Neurology Service was involved. No focal neurological cause for her condition could be ascertained. The Neurology Service did recommend a lumbar puncture as part of her workup, but her husband declined the procedure noting at a discussion on July 6, 2010, that he did not think she would want to pursue this kind of aggressive care given her clinical condition. A tracheostomy was not pursued for the same reason given her poor prognosis, and on July 7, 2010, the patient was made DNR. She was extubated on the evening of July 20, 2010, after tolerating several ventilator-weaning trials.

The patient did not make any significant recovery of mental status during her medical ICU stay. As her course lengthened and her response to treatment remained minimal, prospects for improvement were deemed grim. Near the end of her course, her husband despite the conversation on July 6, 2010, noted above continued to insist that aggressive measures be undertaken to resuscitate her. Even after being informed multiple times and by multiple physicians that meaningful recovery was impossible and aggressive measures such as reintubation would be futile, he continued to press for aggressive measures. The Hospital Ethics Committee was therefore contacted, and it recommended no escalation of care. Finally, an additional pulmonologist was consulted to render a second opinion on the case. He too concurred with the opinion of the primary team and of The Hospital Ethics Committee. The patient's goals of care were therefore changed to provide comfort measures. On the evening of July 24, 2010, at 10:45 p.m., the patient passed away.

Electronically Signed
Margaret Pisani, M.D. 08/04/2010 13:10

Margaret Pisani, M.D.
Responsible Physician

cc: Margaret Pisani, M.D.

Site:Left IJ/TLC
Row Comment : Placed 06/20/10
Central Venous Access Type : Triple lumen
Site:Left IJ/TLC
Central Venous Access Size : 7
Site:Left IJ/TLC
Central Venous Access Insertion Date (mm-dd-yy) : 06-20-10
Site:Left IJ/TLC
Central Venous Access Site Evaluation : Dressing intact w/o signs of redness edema, swelling or drainage
Site:Left IJ/TLC
Central Venous Access Dressing : Dry & Intact
Site:Left IJ/TLC

Perma Cath Site : Right, SC
Site:right SC ins 7/8
Perma Cath Type : Double lumen, Permcath
Site:right SC ins 7/8
Perma Cath Insertion Date (mm-dd-yy) : 07-08-10
Site:right SC ins 7/8
Perma Cath Site Evaluation : Dressing intact w/o signs of redness edema, swelling or drainage
Site:right SC ins 7/8
Perma Cath Dressing : Dry & Intact
Site:right SC ins 7/8

RASS

RASS Goal : 0
RASS RASS : -3 Moderate sedation, movement or eye opening. No eye contact.

Continuous Medication Infusions (Standard Conc)

Morphine 250 mg/D5W 250 mL Rate:1 mL/hr, Dose:1 mg/hr

****

Daily A&I: Adult [07-24-2010 15:58]- for Visit: 000055818967, Follert, Michelle L (RN)
07-24-2010 21:48, *Complete, General*

Comment: M Follert, RN

HEENT ASSESSMENT AND CARE

Head is atraumatic. No visible drainage or swelling. : Agree with normal statement

COGNITION / PERCEPTION / NEUROLOGICAL ASSESSMENT

Patient is alert and oriented x3, pupils normal size and reactive, speech is clear and understandable or developmentally appropriate, no impairment in all extremities. : Disagree, abnormals noted

Motor Strength Left Arm : Normal movement, but unable to push against resistance
Motor Strength Right Arm : Normal movement, but unable to push against resistance
Motor Strength Left Leg : Extremity will not move
Motor Strength Right Leg : Extremity will not move

Cognition/Perception/Neurological Abnormal

Pupil Exam Right Eye : 3 mm Nonreactive
Pupil Exam Left Eye : 3 mm Nonreactive Abnormal shape:

Speech Speech : Non-verbal

[New]

Orientation Disoriented to : unable to evaluate, non-verbal

LOC Level of Consciousness : Lethargic

Glasgow Coma Scale ...GCS: Eye opening Eye opening : Spontaneous
Glasgow Coma Scale ...GCS: Best verbal response Best verbal response : None
Glasgow Coma Scale ...GCS: Best motor response Best motor response : Withdrawn
Glasgow Coma Scale ...Glasgow Coma Scale (GCS) Score Glasgow Coma Scale (GCS) Score : 9

Interventions Interventions : Reorient patient

CARDIOVASCULAR / PERIPHERAL VASCULAR ASSESSMENT

No Chest Pain/Discomfort, Pulses 2+, skin warm, no edema, sensation to light touch is present in all extremities. : Agree, additional details noted

Cardio/Peripheral Vascular Abnormal

Temperature Temperature : warm

Edema Edema : Anasarca

Interventions Interventions : Telemetry, alarms on, parameters checked, Bedside monitor, alarms on, parameters reviewed

RESPIRATORY ASSESSMENT

Patient has non-labored, clear bilateral breath sounds, with equal chest wall movement and no cough : Disagree, abnormals noted

Respiratory Abnormal

Breath Sounds Breath Sounds : Rhonchi bilaterally, Crackles bilaterally

Work of Breathing Work of Breathing : Dyspnea on exertion

Miscellaneous Miscellaneous : high flow mask

MOBILITY AND ADL ASSESSMENT

Morse Fall Risk Assessment Fall Risk Assessment Fall Risk Assessment :
Morse Fall Risk Assessment History of falling History of falling : Yes
Morse Fall Risk Assessment Presence of secondary diagnosis Presence of secondary diagnosis : Yes
Morse Fall Risk Assessment IV therapy (continuous or intermittent) IV therapy (continuous or intermittent) : Yes
Morse Fall Risk Assessment Type of gait Type of gait : Bedrest
Morse Fall Risk Assessment Use of walking aids Use of walking aids : Bedrest
Morse Fall Risk Assessment Mental status Mental status : Overestimates/forgets own limitations
Morse Fall Risk Assessment MORSE FALL RISK SCORE MORSE FALL RISK SCORE : 75
Morse Fall Risk Assessment FALL RISK STATEMENT (select one) FALL RISK STATEMENT (select one) : HIGH RISK: Score >/= 45 & overestimates abilities/has cognitive defects and/or has fallen during hospitalization

Patient is independent in all ADL's and mobility, low risk for falls. : Disagree, abnormals noted

Mobility and ADL Abnormal

Fall Risk Assessment Fall Risk Assessment : See Morse Scale

ADL's with Devices ADL's with Devices : Assist w/ dressing equipment
Impaired ADL's Impaired ADL's : Dependent w/ all ADL's
Impaired Strength Impaired Strength : Patient has generalized decondition throughout extremities and trunk
Ambulation Ambulation : bedrest
Transfers Transfers : Totally dependent
Bed Mobility Bed Mobility : Totally dependent
Interventions Fall Risk Precautions Implemented : Universal Fall Precautions; High Risk Precautions (including At Risk and Universal); Bed low and locked, bottom side rails down; No clutter, open pathway to bathroom; Assistive devices within reach if applicable; Call bell within reach; Personal items within reach if applicable; Patient instructed on proper foot wear for OOB; Maintain Mobilization Plan; Round hourly; Patient/Family education; Bed against wall; Protective floor mats; Increased visibility of patient
Interventions Bed Mobility Interventions : HOB >= 30 degrees Bedrest
Interventions Transfer Interventions : Assist of 2

Miscellaneous Miscellaneous : stage 4 coccyx

GASTROINTESTINAL ASSESSMENT AND CARE

Abd soft, non-tender/distended; membranes moist, intact; bowel sounds 4 quadrants, flatus; continent : Disagree, abnormals noted

GI Abnormal

Bowel Sounds Bowel Sounds : Hypoactive

Elimination Elimination : Incontinent

Mucous Membranes Mucous Membranes : Dry

Feeding Tube Feeding Tube Type : NJ-Tube
Feeding Tube Tube size : 18
Feeding Tube Position marked at (cm) : 66 cm
Feeding Tube Position marked at (inch) : 26 inch

Interventions Interventions : Oral care, Aspiration precautions

GENITOURINARY ASSESSMENT

Continent, Urine clear and yellow, genitalia normal : Agree, additional details noted, Disagree, abnormals noted

GU Abnormal

Miscellaneous Miscellaneous : minimal UOP, HD discontinued. Pt now comfort care and foley removed durring previous shift.

SKIN ASSESSMENT AND CARE

Braden: Adult Sensory Perception Sensory Perception : Very limited
Braden: Adult Moisture Moisture : Moist
Braden: Adult Activity Activity : Bedfast
Braden: Adult Mobility Mobility : Completely immobile
Braden: Adult Nutrition Nutrition : Very poor
Braden: Adult Friction/Shear Friction/Shear : Problem
WDL : This is a test
Braden: Adult Braden Scale Total Braden Scale Total : 8
Braden: Adult Risk of Pressure Ulcer Risk of Pressure Ulcer : Very high risk (score 9 or less)

Skin is intact including skin in contact with all devices; color is normal for ethnicity : Disagree, abnormals noted
Skin Maintenance/Pressure Ulcer Prevention : Air controlled unit, Speciality Bed, Barrier Ointment/Wipe/Spray, Moisturizer applied to skin, Skin cleanser and moisture barrier after soiling/toileting, Positioning/Turn

Skin Abnormal

Skin Assessment Type : Non-Intact Pressure ulcer
Site:Coccyx/Pressure Ulcer
Skin Assessment Location : coccyx
Site:Coccyx/Pressure Ulcer
Skin Assessment Discovery Time : Daily assessment
Site:Coccyx/Pressure Ulcer
Skin Assessment Related to a Device : no
Site:Coccyx/Pressure Ulcer

Skin Assessment Appearance : 50% Pink 50% Yellow
Site:Coccyx/Pressure Ulcer
Skin Assessment Surrounding Skin : Erythema
Site:Coccyx/Pressure Ulcer
Skin Assessment Drainage Information : Bloody, Scant
Site:Coccyx/Pressure Ulcer
Skin Assessment Evaluation : Unchanged
Site:Coccyx/Pressure Ulcer
Skin Assessment Intervention/Dressing : Positioning/Turn, Moist to damp/ Xeroform/ Done by RN, ABD pad and paper tape to secure
Site:Coccyx/Pressure Ulcer
Skin Assessment Staging : Stage IV (as diagnosed)
Site:Coccyx/Pressure Ulcer

Skin Assessment Type : Non-Intact Pressure ulcer
Site:left superior foot/non-intact pressure ulcer
Skin Assessment Location : Left, superior foot
Site:left superior foot/non-intact pressure ulcer
Skin Assessment Discovery Time : Daily assessment
Site:left superior foot/non-intact pressure ulcer
Skin Assessment Related to a Device : PRESENT ON ADMISSION
Site:left superior foot/non-intact pressure ulcer
Skin Assessment Appearance : 100% Yellow
Site:left superior foot/non-intact pressure ulcer
Skin Assessment Surrounding Skin : Intact
Site:left superior foot/non-intact pressure ulcer
Skin Assessment Drainage Information : None
Site:left superior foot/non-intact pressure ulcer
Skin Assessment Evaluation : Unchanged evaluated; dressing still intact so did not change
Site:left superior foot/non-intact pressure ulcer
Skin Assessment Intervention/Dressing : Allevyn foam/ dressing in place, not changed per protocol
Site:left superior foot/non-intact pressure ulcer
Skin Assessment Staging : Stage II
Site:left superior foot/non-intact pressure ulcer

Skin Assessment Type : Intact Pressure ulcer
Site:right great toe/pressure ulcer
Skin Assessment Location : RIGHT GREAT TOE
Site:right great toe/pressure ulcer
Skin Assessment Discovery Time : Daily assessment
Site:right great toe/pressure ulcer
Skin Assessment Appearance : 90% Black 10% Red
Site:right great toe/pressure ulcer
Skin Assessment Surrounding Skin : Erythema
Site:right great toe/pressure ulcer
Skin Assessment Drainage Information : None
Site:right great toe/pressure ulcer
Skin Assessment Evaluation : Unchanged
Site:right great toe/pressure ulcer
Skin Assessment Intervention/Dressing : Moisturizer applied to skin, Positioning/Turn, Skin Cleanser & moisture barrier after soiling or toileting, Speciality Bed, Silvadine/ Xeroform/ Done by RN

Site:right great toe/pressure ulcer
Skin Assessment Staging : Unstageable (as diagnosed)
Site:right great toe/pressure ulcer

Skin Assessment Type : Non-Intact TOENAIL OFF
Site:right toe-toenail fell off
Skin Assessment Location : RIGHT GREAT TOE
Site:right toe-toenail fell off
Skin Assessment Discovery Time : Daily assessment
Site:right toe-toenail fell off
Skin Assessment Appearance : Clean and Dry
Site:right toe-toenail fell off
Skin Assessment Surrounding Skin : Intact
Site:right toe-toenail fell off
Skin Assessment Drainage Information : None
Site:right toe-toenail fell off
Skin Assessment Evaluation : Improved
Site:right toe-toenail fell off
Skin Assessment Intervention/Dressing : Xeroform/ Moisturizer applied to skin, Positioning/Turn, Skin Cleanser & moisture barrier after soiling or toileting, Speciality Bed, Not Due, Nurse
Site:right toe-toenail fell off
Skin Assessment Staging : Not Applicable; Not a Pressure Ulcer
Site:right toe-toenail fell off

Skin Assessment Type : Non-Intact Pressure ulcer
Site:below left nostril/bulla deroofed
Row Comment : r/t BIPAP mask/skin consult 7/23/10
Skin Assessment Location : Left, Face, to left of left nostril
Site:below left nostril/bulla deroofed
Skin Assessment Discovery Time : Daily assessment
Site:below left nostril/bulla deroofed
Skin Assessment Related to a Device : BIPAP
Site:below left nostril/bulla deroofed
Skin Assessment Appearance : 100% Pink
Site:below left nostril/bulla deroofed
Skin Assessment Surrounding Skin : Intact
Site:below left nostril/bulla deroofed
Skin Assessment Drainage Information : None
Site:below left nostril/bulla deroofed
Skin Assessment Evaluation : Unchanged
Site:below left nostril/bulla deroofed
Skin Assessment Intervention/Dressing : Barrier Ointment/Wipe/Spray, Mepilex
Site:below left nostril/bulla deroofed
Skin Assessment Staging : Stage II
Site:below left nostril/bulla deroofed

Skin Assessment Type : Skin tear Non-Intact
Site:Right lower buttocks/skin tear
Skin Assessment Location : Right, Buttocks
Site:Right lower buttocks/skin tear
Skin Assessment Discovery Time : Discovered new wound, Daily assessment
Site:Right lower buttocks/skin tear

Skin Assessment Related to a Device : r/t coccyx dressing tape
Site:Right lower buttocks/skin tear
Skin Assessment Appearance : 100% Pink
Site:Right lower buttocks/skin tear
Skin Assessment Surrounding Skin : Intact
Site:Right lower buttocks/skin tear
Skin Assessment Drainage Information : Bloody, Scant
Site:Right lower buttocks/skin tear
Skin Assessment Evaluation : Unchanged
Site:Right lower buttocks/skin tear
Skin Assessment Intervention/Dressing : Positioning/Turn, Allevyn foam
Site:Right lower buttocks/skin tear
Skin Assessment Staging : Not Applicable; Not a Pressure Ulcer
Site:Right lower buttocks/skin tear

Skin Assessment Type : Non-Intact Skin tear
Site:left AC skin tear
Skin Assessment Location : Left, AC
Site:left AC skin tear
Skin Assessment Discovery Time : Discovered new wound
Site:left AC skin tear
Skin Assessment Appearance : Clean, 100% Red
Site:left AC skin tear
Skin Assessment Surrounding Skin : Intact
Site:left AC skin tear
Skin Assessment Drainage Information : Bloody, Scant
Site:left AC skin tear
Skin Assessment Evaluation : Unable to evaluate; new wound this shift
Site:left AC skin tear
Skin Assessment Intervention/Dressing : Barrier Ointment/Wipe/Spray, Moisturizer applied to skin, Positioning/Turn, Pull Sheet, Skin Cleanser & moisture barrier after soiling or toileting, Speciality Bed, Allevyn foam/ Done by RN, Nurse, Tolerated well
Site:left AC skin tear
Skin Assessment Staging : Not Applicable; Not a Pressure Ulcer
Site:left AC skin tear
Skin Assessment Length (cm) (Direction 12 to 6) : 1
Site:left AC skin tear
Skin Assessment Width (cm) (Direction 3 to 9) : 1
Site:left AC skin tear

PSYCHOSOCIAL ASSESSMENT

Patient/family coping effectively, no risks of violence identified : Disagree, abnormals noted

Psychosocial Abnormal

Patient Coping Patient Coping : Withdrawn

Family Coping Family Coping : no family at bedside

Interventions Interventions : Active Listening, Provide Support

****

Intake and Output [07-24-2010 15:00]- for Visit: 000055818967, [Entered by: Polihrom, Katherine M (RN) 07-24-2010 14:53], *Complete, General*

INTAKE

Continuous Med Infusions (Enter in mLs)

Morphine 250 mg/D5W 250 mL In:1 mL

****

Vital Signs: Adult (ICU) [07-24-2010 15:00]- for Visit: 000055818967, Polihrom, Katherine M (RN) 07-24-2010 14:53, *Complete, General*

Rounding : Rounded

Vital Signs

Heart Rate Heart Rate Heart Rate/min : 94 per Minute

Rhythm (ICU) Rhythm (ICU) : Normal sinus

Respiratory Rate Respirations: Breath/min : 94 per Minute

Blood Pressure Systolic : 116 mm Hg
Blood Pressure Diastolic : 73 mm Hg
Blood Pressure Mean BP: Mean BP/mm Hg : 87 mm Hg

Oxygenation

Oxygenation SpO2 : 98
Oxygenation % O2 : 60
Oxygenation Mode : Face mask, hi flow

Continuous Medication Infusions (Standard Conc)

Morphine 250 mg/D5W 250 mL Rate:1 mL/hr, Dose:1 mg/hr

****

Intake and Output - (Shift) [07-24-2010 15:00]- for Visit: 000055818967, Polihrom, Katherine M (RN) 07-24-2010 14:53, *Complete, General*

INTAKE

Continuous Med Infusions (Enter in mLs)

Morphine 250 mg/D5W 250 mL In:8 mL

Intermittent Med Infusions (Enter in mLs)

Daptomycin (Cubicin) / 0.9% NaCl In:100 mL

Nutrition

Free Water - NG (mL) In:60 mL
Row Comment : meds, protein supplement, OGT flushes

OUTPUT

Urine

Foley Catheter (mL) Out:14 mL

****

Intake and Output [07-24-2010 14:00]- for Visit: 000055818967, Polihrom, Katherine M (RN) 07-24-2010 14:53, *Complete, General*

INTAKE

Continuous Med Infusions (Enter in mLs)

Morphine 250 mg/D5W 250 mL In:1 mL

Intermittent Med Infusions (Enter in mLs)

Daptomycin (Cubicin) / 0.9% NaCl In:100 mL

Nutrition

Free Water - NG (mL) In:60 mL
Row Comment : meds, protein supplement, OGT flushes

OUTPUT

Urine

Foley Catheter (mL) Out:14 mL

****

Vital Signs: Adult (ICU) [07-24-2010 14:00]- for Visit: 000055818967, Polihrom, Katherine M (RN) 07-24-2010 14:54, *Complete, General*

Rounding : Rounded

Vital Signs

Heart Rate Heart Rate Heart Rate/min : 95 per Minute

Rhythm (ICU) Rhythm (ICU) : Normal sinus

Respiratory Rate Respirations: Breath/min : 19 per Minute

Blood Pressure Systolic : 99 mm Hg
Blood Pressure Diastolic : 44 mm Hg
Blood Pressure Mean BP: Mean BP/mm Hg : 62 mm Hg

Pain Assessment

Pain Assessment #1 Pain Scale : Pain Assessment Protocol for pt's who cannot self report
Pain Assessment #1 Descriptive Pain Score : NAPP
Pain Assessment #1 Descriptive Pain Score Goal : NAPP

Oxygenation

Oxygenation SpO2 : 99
Oxygenation % O2 : 60
Oxygenation Mode : Face mask, hi flow

RASS

RASS RASS : -1 Awakens to voice (eye opening/contact) > 10 sec

Continuous Medication Infusions (Standard Conc)

Morphine 250 mg/D5W 250 mL Rate:1 mL/hr, Dose:1 mg/hr

Additional Information

Comments : foley d/c'd

****

Intake and Output [07-24-2010 13:00]- for Visit: 000055818967, [Entered by: Polihrom, Katherine M (RN) 07-24-2010 13:26], *Complete, General*

INTAKE

Continuous Med Infusions (Enter in mLs)

Morphine 250 mg/D5W 250 mL In:1 mL

****

Vital Signs: Adult (ICU) [07-24-2010 13:00]- for Visit: 000055818967, Polihrom, Katherine M (RN) 07-24-2010 14:53, *Complete, General*

Rounding : Rounded
Positioning / Turn : Onto right side

Vital Signs

Heart Rate Heart Rate Heart Rate/min : 88 per Minute

Rhythm (ICU) Rhythm (ICU) : Normal sinus

Respiratory Rate Respirations: Breath/min : 19 per Minute

Blood Pressure Systolic : 100 mm Hg
Blood Pressure Diastolic : 44 mm Hg
Blood Pressure Mean BP: Mean BP/mm Hg : 62 mm Hg

Oxygenation

Oxygenation SpO2 : 99
Oxygenation % O2 : 60
Oxygenation Mode : Face mask, hi flow

Continuous Medication Infusions (Standard Conc)

Morphine 250 mg/D5W 250 mL Rate:1 mL/hr, Dose:1 mg/hr

****

Intake and Output [07-24-2010 12:00]- for Visit: 000055818967, [Entered by: Polihrom, Katherine M (RN) 07-24-2010 13:26], *Complete, General*

INTAKE

Continuous Med Infusions (Enter in mLs)

Morphine 250 mg/D5W 250 mL In:1 mL

****

Vital Signs: Adult (ICU) [07-24-2010 12:00]- for Visit: 000055818967, Polihrom, Katherine M (RN) 07-24-2010 13:26, *Complete, General*

Rounding : Rounded

Vital Signs

Temperature Temp C: : 35.7 degrees C
Temperature Temp F: : 96.4 degrees F

Heart Rate Heart Rate Heart Rate/min : 88 per Minute

Rhythm (ICU) Rhythm (ICU) : Normal sinus

Respiratory Rate Respirations: Breath/min : 19 per Minute

Blood Pressure Systolic : 97 mm Hg
Blood Pressure Diastolic : 43 mm Hg
Blood Pressure Mean BP: Mean BP/mm Hg : 61 mm Hg

Pain Assessment

Pain Assessment #1 Pain Scale : Pain Assessment Protocol for pt's who cannot self report
Pain Assessment #1 Pain Description : NAPP (no assumed pain present)
Pain Assessment #1 Descriptive Pain Score : NAPP
Pain Assessment #1 Descriptive Pain Score Goal : NAPP

Oxygenation

Oxygenation SpO2 : 99
Oxygenation % O2 : 60
Oxygenation Mode : Face mask, hi flow

RASS

RASS Goal : 0
RASS RASS : -1 Awakens to voice (eye opening/contact) > 10 sec

Continuous Medication Infusions (Standard Conc)

Morphine 250 mg/D5W 250 mL Rate:1 mL/hr, Dose:1 mg/hr

****

Intake and Output [07-24-2010 11:00]- for Visit: 000055818967, [Entered by: Polihrom, Katherine M (RN) 07-24-2010 13:26], *Complete, General*

INTAKE

Continuous Med Infusions (Enter in mLs)

Morphine 250 mg/D5W 250 mL In:1 mL

****

Vital Signs: Adult (ICU) [07-24-2010 11:00]- for Visit: 000055818967, Polihrom, Katherine M (RN) 07-24-2010 11:24, *Complete, General*

Rounding : Rounded

Vital Signs

Heart Rate Heart Rate Heart Rate/min : 88 per Minute

Rhythm (ICU) Rhythm (ICU) : Normal sinus

Respiratory Rate Respirations: Breath/min : 20 per Minute

Blood Pressure Systolic : 97 mm Hg
Blood Pressure Diastolic : 44 mm Hg
Blood Pressure Mean BP: Mean BP/mm Hg : 61 mm Hg

Oxygenation

Oxygenation SpO2 : 98
Oxygenation % O2 : 60
Oxygenation Mode : Face mask, hi flow

Continuous Medication Infusions (Standard Conc)

Morphine 250 mg/D5W 250 mL Rate:1 mL/hr, Dose:1 mg/hr

Additional Information

Comments : Family at bedside. Updated on POC. Paged Dr. Burke per husband request to answer any further questions and concerns

****

Intake and Output [07-24-2010 10:00]- for Visit: 000055818967, [Entered by: Polihrom, Katherine M (RN) 07-24-2010 09:43], *Complete, General*

INTAKE

Continuous Med Infusions (Enter in mLs)

Morphine 250 mg/D5W 250 mL In:1 mL

SUPERIOR COURT JD OF MILFORD/ANSONIA AT MILFORD

DOCKET NO. AAN-CV-12-6010861-S

----------X

CLARENCE MARSALA, ADMINISTRATOR OF THE ESTATE OF HELEN MARSALA,

Plaintiff

vs.

YALE-NEW HAVEN HOSPITAL,

Defendant

----------X

August 20, 2014

11:01 a.m.

DEPOSITION of ANDREW BOYD, M.D., held at the offices of Wiggin and Dana LLP, 450 Lexington Avenue - Suite 3800, New York, New York, pursuant to Notice, before ELIZABETH SANTAMARIA, a Notary Public of the State of New York.

Boyd

MS. SEAMAN: I have no further questions. Thank you.

FURTHER EXAMINATION

BY MR. VIRGIL:

Q You were only trying to improve Mrs. Marsala's care or only trying to improve Mrs. Marsala with treatment for the first two weeks that she was there?

MS. SEAMAN: Object to the form.

A No. Of course we wanted to try to improve her the whole time that she was there. What I mean is that when she arrived, she had a low blood pressure, she had multi-organ system failure and we quickly moved to reverse those things.

Over the next few weeks those things stabilized after interventions and then we were trying to further improve her; namely, to improve her mental status and her kidney function, stop the skin breakdown, improve her nutrition.

What I meant to -- what I intended to imply was that it was only after having the trial of those things for, let's say, two

weeks and stabilization with no demonstrable improvement did it become more difficult to figure out where to go from there.

Q So even beyond the first two weeks you continued to try and provide care to make her better?

A Yes.

Q And you were trying to improve her health so that she could go home?

A Yes.

Q And that continued for the entire period that you were treating her?

A Yes.

Q Was there ever a point where you said, "This is hopeless, we shouldn't give any more care"?

A I can recall that it was a very difficult case in the sense that despite efforts over many days with many experts weighing in that she was not improving.

That was very personally and professionally frustrating and the frustration was made yet worse by the fact that in some ways she was worsening. Specifically her skin

was having further breakdown.

And so there were periods of time when I, as the intern, felt that there was not a lot of chance for improvement. But, again, as the intern it's not my role, and certainly I would not have felt comfortable enough to voice, as explicitly as you mentioned, that this is hopeless.

Q Well, you just said that not a lot of chance, but there was still some chance in your mind. It was just a difficult and frustrating case because you didn't know what to do?

MS. SEAMAN: Object to the form.

A Again, this -- I think it became clearer over time that as the interventions continued with no improvement and in fact with the passage of time in fact in some ways she was worsening would indicate to me that things were not going to improve, no.

Q So she had no chance of recovering?

A I mean it would be very difficult to see in which way she could recover after having that intensive a period of treatment

without demonstrable improvement.

Q I just want to be very explicit. She had zero chance for improvement?

MS. SEAMAN: Object to the form.

A I can't ever say zero chance.

Q And you talked about the difficulty of doing hemodialysis on a tracheotomy and requiring a lot of equipment and a lot of specialized personnel, correct?

A Correct.

Q Did Yale have that equipment and those personnel?

MS. SEAMAN: Object to the form.

A Yale-New Haven Hospital, yes, is able to take care of both tracheotomy and hemodialysis, yes.

Q So the intrinsic difficulties of having a patient who needs hemodialysis and tracheotomy and the tracheotomy could have been dealt with at Yale because they have the appropriate equipment and staff to provide those services, right?

A I would say, again, that the placement of a tracheotomy and maintenance of

2000 WL 728819
Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Superior Court of Connecticut.

Barbara O'CONNELL et al.,
v.
BRIDGEPORT HOSPITAL et al.

No. CV 990362525S. | May 17, 2000.

Memorandum of Decision Re: Motion to Strike (Docket Entry No. 117)

SKOLNICK.

***1** Before the court is defendant Bridgeport Hospital's motion to strike counts three, four and six of the plaintiff's complaint. On or about April 27, 1997, Robert O'Connell, died while an inpatient at Bridgeport Hospital, the defendant. On April 27, 1999, the plaintiff, Barbara O'Connell, as both administratrix of her husband's estate and for herself, filed a six-count complaint alleging the following. In February of 1997, Robert O'Connell was hospitalized in Bridgeport Hospital for various health problems. In March of 1997, he executed a living will in which the plaintiff was appointed his health care agent thereby authorizing her to be the individual to consider and carry out any wishes the decedent had regarding removal of life support. Bridgeport Hospital was provided with copies of these documents. In late April of 1997, the plaintiff traveled out of state to look for a possible long-term health facility for the decedent. The plaintiff left instructions with Bridgeport Hospital as to where and how she could be reached. While the plaintiff was gone, the plaintiff's step-son requested that Dr. Steven Urciuolo, a physician and a co-defendant in this case, remove the decedent's ventilator tube. The plaintiff alleges, inter alia, that Dr. Urciuolo was not the decedent's regular physician. The plaintiff alleges that she neither gave her consent, nor was she consulted as to the removal of the ventilator tube and was not present when the decedent died. The complaint alleges that Bridgeport Hospital was negligent in its conduct by removing the life support system and not consulting the plaintiff or the documents provided to it concerning the living will. As a result of this conduct, the complaint further alleges causes of action for wrongful death, loss of consortium, and negligent infliction of emotional distress against Bridgeport Hospital.

On December 3, 1999, Bridgeport Hospital filed this motion to strike with an accompanying memorandum of law. On December 16, 1999, the plaintiff filed a memorandum in objection thereto.

"Because a motion to strike challenges the legal sufficiency of a pleading ... [it] requires no factual findings by the trial court ... [Before] granting ... a motion to strike, [the trial court] must read the allegations of the complaint generously to sustain its viability, if possible ... [The court] must, therefore, take the facts to be those alleged in the complaint ... and ... construe the complaint in the manner most favorable to sustaining its legal sufficiency."(Citations omitted; internal quotation marks omitted.) *ATC Partnership v. Windham,* 251 Conn. 597, 603, A.2d (1999).

A

Wrongful Death

The defendant, Bridgeport Hospital, argues that the plaintiff does not state a sufficient cause of action in count three for wrongful death because the hospital is statutorily not responsible for removing life support. Furthermore, the defendant contends that the plaintiff has not alleged that Dr. Steven Urciuolo is an agent, servant or employee of the defendant. The plaintiff responds that a hospital, by itself, can be subject to liability for life support removal as a basis for wrongful death and that an agency relationship between Dr. Urciuolo and Bridgeport Hospital can he implied by the circumstances and does not have to be alleged for purposes of this cause of action.

***2** "[T]his court reiterated the one hundred and thirty-one year adherence by the courts of this state to the almost unanimously held principle of law ... that there is no civil right of action at common law for damages resulting from the death of a human being ... With only a few exceptions, courts in America have almost universally accepted, and continue to accept, the rule that a civil action for wrongful death was not recognized at common law, and that no such cause of action may be maintained except under the terms and authority of a statute."(Citations omitted; internal quotation

marks omitted.) *Ecker v. West Hartford,* 205 Conn. 219, 226-27, 530 A.2d 1056 (1987)."A cause of action authorized by [General Statutes] § 52-555, [1] also known as Connecticut's wrongful death statute, does not create a new cause of action. It is a continuation of that which the decedent could have asserted had he lived."*Holzmaier v. Assoc. Internists of Danbury,* Superior Court, judicial district of Danbury, Docket No. 317386 (March 19, 1998) (*Radcliffe, J.*).

In the Removal of Life Support Systems Act, General Statutes §§ 19a-570 et seq., [2] "the legislature, cognizant of a common law right of self-determination and of a constitutional right to privacy, sought to provide a statutory mechanism to implement these important rights."*McConnell v. Beverly Enterprises-Connecticut, Inc.,* 209 Conn. 692, 698-99, 553 A.2d 596 (1989). In *McConnell,* although the action was not for civil damages like the present case, the plaintiff in that case pursued injunctive and declaratory relief against the defendant facility as well as individual medical personnel under the Removal of Life Support Systems Act. (Emphasis added.) See *McConnell v. Beverly Enterprises-Connecticut, supra,* 209 Conn. 695.

"[WIhen the language is plain and unambiguous, we need look no further than the words themselves because we assume that the language expresses the legislature's intent ... [I]t is axiomatic that, where the statutory language is clear and unambiguous, construction of the statute by reference to its history and purpose is unnecessary."(Citations omitted; internal quotation marks omitted.) *Christian Activities Council, Congregational v. Town Council,* 249 Conn. 566, 618, 735 A.2d 231 (1999)."Indeed, [a] basic tenet of statutory construction is that when a statute is clear and unambiguous, there is no room for construction ..." (Citation omitted; internal quotation marks omitted.) *Gural v. Fazzino,* 45 Conn.App. 586, 588, 696 A.2d 1307 (1997).

Here, the plaintiff has stated a sufficient cause of action in wrongful death and Bridgeport Hospital's argument that it cannot be liable under § 19a-571(a) is without merit. According to the plaintiff's complaint, she is the administratrix of the decedent's estate and has been properly authorized to initiate this action on behalf of the estate. Moreover, the plaintiff has alleged sufficient facts for the requisite injuries, damages, and costs associated with wrongful death. See General Statutes § 52-555.

***3** More specifically, the language of General Statutes 19a-571(a) subjects Bridgeport Hospital to liability for negligent removal of life support. The legislature decided to use the clear language "any physician licensed under Chapter 370 *or any licensed medical facility* " to describe the parties who would not be liable unless there was a violation of the ensuing statutory provisions regarding removal of life support. See General Statutes § 19a-571(a). Such language is unambiguous and demonstrates a clear intent on the part of the legislature to include facilities such as Bridgeport Hospital within the meaning of 19a-571(a). See *Christian Activities Council, Congregational v. Town Council, supra,* 249 Conn. 618.

Furthermore, the plaintiff has alleged sufficient facts to state a claim pursuant to § 19a-571(a) against Bridgeport Hospital. The plaintiff has adequately alleged that Dr. Urciuolo was not the decedent's regularly attending physician which the statute requires throughout its provisions. See General Statutes § 19a-571(a). The plaintiff has also sufficiently alleged that there was no consideration of the documents that the decedent executed pursuant to General Statutes §§ 19a-575 [3] and 19a-575a. [4] (See Plaintiff's Complaint, Count Three, ¶ 11.) Moreover, assuming arguendo that the documents were not available for consideration, the plaintiff has alleged sufficient facts from which to conclude that she left information as to where and how she could have been reached since she was the decedent's health care agent. (See Plaintiff's Complaint, Count Three, ¶¶ 7-10.) In addition to Bridgeport Hospital having been provided with this information, the plaintiff has alleged that she was never consulted on the decision to remove life support. (See Plaintiff's Complaint, Count Three, ¶¶ 7-10.) Thus, by construing the complaint in favor of the pleader, the plaintiff has stated a cause of action against Bridgeport Hospital pursuant to the Removal of Life Support Systems Act. See General Statutes § 19a-571(a)(3). Consequently, as Bridgeport Hospital may be subject to liability under § 19a-571(a), and since the plaintiff has sufficiently alleged a cause of action in wrongful death, Bridgeport Hospital's motion to strike the third count of the plaintiff's complaint is denied.

B

Loss of Consortium

Bridgeport Hospital moves to strike count four of the complaint, on the ground that the plaintiff has failed to state a cause of action for loss of consortium. Specifically, Bridgeport Hospital argues that a consortium action is derivative of the injured spouse's action and therefore, if the

plaintiff's wrongful death action in count three is insufficient, the plaintiff's consortium action is insufficient as well. The plaintiff does not specifically address or respond to this consortium argument in its memorandum in opposition to the motion to strike.

The Connecticut Supreme Court "first recognized a common-law claim for loss of spousal consortium in *Hopson v. St. Mary's Hospital,* 176 Conn. 485, 487, 408 A.2d 260 (1979). Therein, we defined consortium as encompassing the services of the [injured spouse], the financial support of the [injured spouse], and the variety of intangible relations which exist between spouses living together in marriage ... These intangible elements are generally described in terms of affection, society, companionship and sexual relations ... These intangibles have also been defined as the constellation of companionship, dependence, reliance, affection, sharing and aid which are legally recognizable, protected rights arising out of the civil contract of marriage."(Citations omitted; internal quotation marks omitted.) *Jacoby v. Brinckerhoff,* 250 Conn. 86, 90-91, 735 A.2d 347 (1999)."[A] cause of action for the loss of consortium is derivative of the injured spouse's cause of action ... [A]lthough it is derivative, it is still a separate cause of action, dependent for its assertion on the legal viability of the cause of action in the injured party ... [I]t is not truly independent, but rather derivative and inextricably attached to the claim of the injured spouse."*Parker v. Shaker Real Estate, Inc.,* 47 Conn.App. 489, 496, 705 A.2d 210 (1998).

***4** "[I]t was in response to *Ladd v. Douglas Trucking Co.,* 203 Conn. 187, 523 A.2d 1301 (1987), that the legislature enacted Public Acts 1989, No. 89-148, now General Statutes § 52-555a, [5] permitting loss of consortium claims in conjunction with wrongful death actions."*Lynn v. Haybuster Mfg., Inc.,* 226 Conn. 282, 296 n. 12, 627 A.2d 1288 (1993)."[T]he general assembly enacted Connecticut General Statutes §§ 52-555a and 52-555b [6] which now allow a claim for postmortem spousal consortium. *Deglin v. Norwich Free Academy,* Superior Court, judicial district of New London at New London, Docket No. 546339 (April 7, 1999) (*Hurley, J .T.R.*)."Because the wrongful death statute is a statute in derogation of common law, creating a liability that theretofore did not exist, and contained no provisions or language that could be interpreted to include a loss of consortium claim, the legislature had to enact General Statutes § 52-555a to include specifically the loss of consortium provision."*Lynn v. Haybuster Mfg., Inc., supra,* 226 Conn. 297 n. 12.

Here, the plaintiff has stated sufficient facts to properly allege a cause of action for loss of consortium in the wrongful death context. Bridgeport Hospital's argument that the plaintiff's claim is insufficient fails for two reasons. First, and most significantly, a spousal loss of consortium action arising out of a wrongful death claim is expressly allowed by statute in spite of its derivative nature. See General Statutes §§ 52-555a and 52-555b; *Parker v. Shaker Real Estate, Inc., supra,* 47 Conn.App. 496. Second this court has already found that the plaintiff stated sufficient facts for a claim in wrongful death in count three of the complaint. Since the plaintiff has stated a viable cause of action for wrongful death in count three, there is an underlying cause of action to support the derivative loss of consortium claim in count four. See *Parker v. Shaker Real Estate, Inc., supra,* 47 Conn.App. 496.

Moreover, the plaintiff alleges specific facts that demonstrate Bridgeport Hospital's alleged negligence, if proven to be true, resulted in the plaintiff being unable to be with her husband at the time of his death and that she suffered the requisite antemortem and postmortem loss of consortium. Therefore, the plaintiff has alleged sufficient facts for spousal loss of consortium in connection with a wrongful death action; consequently, Bridgeport Hospital's motion to strike count four of the plaintiff's complaint is denied.

C

Negligent Infliction of Emotional Distress

Bridgeport Hospital moves to strike count six of the plaintiff's complaint on the ground that the plaintiff does not sufficiently allege a cause of action for negligent infliction of emotional distress. In particular, Bridgeport Hospital contends that the plaintiff has not applied the formal language necessary to demonstrate that Bridgeport Hospital should have realized its conduct involved an unreasonable risk of causing emotional distress for purposes of this tort. The plaintiff responds that no magic words are required as long as the defendant is put on sufficient notice of the facts claimed and the cause of action alleged. The plaintiff asserts that her complaint does just that.

***5** The Connecticut Supreme Court "first recognized a cause of action for negligent infliction of emotional distress in *Montinieri v. Southern New England Telephone Co.,* 175 Conn. 337, 345, 398 A.2d 1180 (1978). [The court concluded] ... that in order to state such a claim, the plaintiff

has the burden of pleading that the defendant should have realized that its conduct involved an unreasonable risk of causing emotional distress and that distress, if it were caused, might result in illness or bodily harm."(Internal quotation marks omitted.) *Parsons v. United Technologies Corp.,* 243 Conn. 66, 88, 700 A.2d 655 (1997). The emotional distress "must be reasonable in light of the conduct of the [defendant]."*Barret v. Danbury Hospital,* 232 Conn. 242, 261, 654 A.2d 748 (1995).

"[W]hat is necessarily implied [in an allegation] need not be expressly alleged ... It is fundamental that in determining the sufficiency of a complaint challenged by a defendant's motion to strike, all well-pleaded facts and those facts necessarily implied from the allegations are taken as admitted ... Indeed, pleadings must be construed broadly and realistically, rather than narrowly and technically ..."*Doe v. Yale University,* 252 Conn. 641, 667 (2000). Furthermore, "[t]he plaintiff need not resort to the incantation of magic words. Instead, its pleading must be held to satisfy the requirement of the Practice Book if the facts set forth herein, including all facts necessarily implied therefrom, support the essential elements of the cause of action."(Internal quotation marks omitted.) *United Illuminating v. Winthrop Health Care, Inc.,* Superior Court, judicial district of New Haven at New Haven, Docket No. 354679 (February 20, 1998) (*Hartmere, J.*).

In the present case, the plaintiff has sufficiently alleged a cause of action for negligent infliction of emotional distress. The sixth count alleges, inter alia, the following facts. On March 28, 1997, the decedent executed a living will in which the plaintiff was appointed health care agent for the decedent which thereby authorized her to be the individual to consider and carry out any wishes that he had regarding removal of life support. The plaintiff provided Bridgeport Hospital with copies of these documents. The plaintiff left instructions with Bridgeport Hospital as to where and how the plaintiff could be reached while she was out-of-state. Without the plaintiff being present, having knowledge or giving consent, Bridgeport Hospital removed the ventilator tube, her husband died the next day and, as a result, she has suffered and continues to suffer emotional distress. This court can imply from these allegations, in count six, that the defendant "should have realized that its conduct involved an unreasonable risk of causing the distress."Thus, the plaintiff did not have to technically apply the phrase "should have realized" to properly allege an action for negligent infliction of emotional distress in this case. Therefore, Bridgeport Hospital's motion to strike count six of the plaintiff's complaint is denied.

***6** For all the foregoing reasons, Bridgeport Hospital's motion to strike the third, fourth, and sixth counts of the plaintiff's complaint is denied.

All Citations

Not Reported in A.2d, 2000 WL 728819

Footnotes

1 General Statutes § 52-555 provides: "In any action surviving to or brought by an executor or administrator for injuries resulting in death, whether instantaneous or otherwise, such executor or administrator may recover from the party legally at fault for such injuries just damages together with the cost of reasonably necessary medical, hospital, and nursing services, and including funeral expenses, provided no action shall be brought to recover such damages and disbursements but within two years from the date of death, and except that no such action may be brought more than five years from the date of the act or omission complained of."

2 For present purposes, the pertinent section of the Removal of Life Support Systems Act is General Statutes § 19a-571(a) which provides: "Subject to the provisions of subsection (c) of this section, any physician licensed under chapter 370 *or any licensed medical facility* who or which withholds, removes or causes the removal of a life support system of an incapacitated patient shall not be liable for damages in any civil action or subject to prosecution in any criminal proceeding for such withholding or removal, provided (1) the decision to withhold or remove such life support system is based on the best medical judgment of the *attending physician* in accordance with the usual and customary standards of medical practice; (2) the *attending physician* deems the patient to be in a terminal condition or, in consultation with a physician qualified to make a neurological diagnosis who has examined the patient, deems the patient to be permanently unconscious; and (3) *the attending physician has considered the patient's wishes concerning the withholding or withdrawal of life support systems. In the determination of the wishes of the patient, the attending physician shall consider the wishes as expressed by a document executed in accordance with sections 19a-575 and 19a-575a, if any such document is presented to, or in the possession of, the attending physician at the time the decision to withhold or terminate a life support system is made.*If the wishes of the patient have not been expressed in a living will *the attending*

*physician shall determine the wishes of the patient by consulting any statement made by the patient directly to the attending physician and, if available, the patient's health care agent, the patient's next of kin, the patient's legal guardian or conservator, if any, and any other person to whom the patient has communicated his wishes, if the attending physician has knowledge of such person.*All persons acting on behalf of the patient shall act in good faith. If the attending physician does not deem the incapacitated patient to be in a terminal condition or permanently unconscious, beneficial medical treatment including nutrition and hydration must be provided."(Emphasis added.)

3 General Statutes § 19a-575 provides in pertinent part: "Any person eighteen years of age or older may execute a document which shall contain directions as to specific life support systems which such person chooses to have administered."

4 General Statutes § 19a-575a provides in pertinent part: "Any person eighteen years of age or older may execute a document which contains health care instructions, the appointment of a health care agent, the appointment of an attorney-in-fact for health care decisions, the designation of a conservator of the person for future incapacity and a document of anatomical gift."

5 General Statutes § 52-555a provides: "Any claim or cause of action for loss of consortium by one spouse with respect to the death of the other spouse shall be separate from and independent of all claims or causes of action for the determination of damages with respect to such death."

6 General Statutes § 52-555b provides: "Any claim or cause of action for loss of consortium by one spouse with respect to the death of the other spouse, which claim or cause of action may include, without limitation, claims for damages with respect to loss of the society of, affection of, moral support provided by, services provided by, sexual relations with or companionship of the other spouse, suffered because of the death of the other spouse, shall be brought with or joined with the claims and causes of action with respect to the death of the other spouse."

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Not Reported in A.2d, 2005 WL 3112881 (Conn.Super.), 40 Conn. L. Rptr. 371
(Cite as: 2005 WL 3112881 (Conn.Super.))

P

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Superior Court of Connecticut,
Judicial District of Hartford.
Elizabeth **VALENTIN**
v.
ST. **FRANCIS** HOSPITAL & MEDICAL CENTER.

No. CV040832314.
Nov. 7, 2005.

Anderson, Reynolds & Lynch LLP, New Britain, for Elizabeth **Valentin.**

Cooney, Scully & Dowling, Hartford, for **St. Francis** Hospital & Medical Center.

HALE, J.T.R.

FACTS

***1** This action is before the court on the defendant's motion to strike the plaintiff's one-count complaint based upon negligent infliction of emotional distress.[FN1] The plaintiff alleges that her father, the decedent, was admitted to the defendant-hospital on May 5, 2002, with epigastric pain. While there, the decedent allegedly suffered cardiac episodes that resulted in significant, anoxio brain damage. The defendant allegedly placed the decedent on life support. The plaintiff alleges that the decedent did not have a living will or other document, nor had he made any statements to the attending physician or a guardian, indicating his final wishes. On May 14, 2002, the defendant allegedly terminated life support, and the decedent died on May 21, 2002. The defendant allegedly was aware of the existence and location of the plaintiff as next of kin and told to contact her, but the plaintiff allegedly was not contacted about the decision to terminate life support. The plaintiff alleges that she became aware of her father's death on May 24, 2002.

FN1. The cause of action is designated as medical malpractice on the summons, and the plaintiff attached a good faith certificate. She only alleges, however, negligent infliction of emotional distress in her revised complaint. Furthermore, in her memorandum of law in opposition to the defendant's motion to strike, the plaintiff specifically argues that her cause of action is not "premised on medical malpractice" but "based upon a statutory duty on the part of the hospital."

On February 27, 2004, the plaintiff filed a one-count complaint for negligent infliction of emotional distress based on the defendant's failure to contact her so she could participate in the decision to terminate life support. On April 14, 2004, the defendant filed a request to revise. The plaintiff responded with a request to amend and an amended complaint on April 28, 2004. The defendant filed a motion to strike the complaint, based upon a failure to state a claim upon which relief may be granted, and a memorandum in support of its motion on September 24, 2004. On November 3, 2004, the plaintiff filed a memorandum in opposition to the motion to strike, to which the defendant filed a reply memorandum on February 28, 2005.

DISCUSSION

"The purpose of a motion to strike is to contest ... the legal sufficiency of the allegations of any complaint ... to state a claim upon which relief can be granted." (Internal quotation marks omitted.) *Fort Trumbull Conservancy, LLC v. Alves,* 262 Conn. 480, 498, 815 A.2d 1188 (2003). "It is fundamental that in

determining the sufficiency of a complaint challenged by a defendant's motion to strike, all well-pleaded facts and those facts necessarily implied from the allegations are taken as admitted." (Internal quotation marks omitted.) *Commissioner of Labor v. C.J.M Services, Inc.*, 268 Conn. 283, 292, 842 A.2d 1124 (2004). "A motion to strike is properly granted if the complaint alleges mere conclusions of law that are unsupported by the facts alleged." (Internal quotation marks omitted.) *Fort Trumbull Conservancy LLC v. Alves, supra,* at 498. In deciding whether to grant the motion to strike, "[t]he court must construe the facts in the complaint most favorably to the plaintiff." (Internal quotation marks omitted.) *Faulkner v. United Technologies Corp.*, 240 Conn. 576, 580, 693 A.2d 293 (1997). "[I]f facts provable in the complaint would support a cause of action, the motion to strike must be denied." (Internal quotation marks omitted.) *Larobina v. McDonald,* 274 Conn. 394, 400, 876 A.2d 522 (2005).

*2 The question before this court is whether the plaintiff has set forth a cause of action for negligent infliction of emotional distress against the defendant based upon a duty, under common law or General Statutes § 19a–571(a),[FN2] to prevent emotional distress to the plaintiff by contacting her prior to the removal of life support so she could participate in the decision to terminate life support. This issue is one of first impression. The defendant argues that it did not owe a duty to the plaintiff. In response, the plaintiff argues that the defendant owed the plaintiff a duty under § 19a–571(a) and under common law.[FN3] The defendant argues in its reply memorandum that § 19a–571(a) does not create a duty to the plaintiff and that no duty exists under common law.

FN2. General Statutes § 19a–571 is titled *"Liability re removal of life support system of incapacitated patient. Consideration of wishes of patient."* Subsection (a), in pertinent part, provides: "[A]ny [licensed] physician ... or any licensed medical facility who or which withholds, removes or causes the removal of a life support system of an incapacitated patient shall not be liable for damages in any civil action or subject to prosecution in any criminal proceeding for such withholding or removal, provided (1) the decision to withhold or remove such life support system is based on the best medical judgment of the attending physician in accordance with the usual and customary standards of medical practice; (2) the attending physician deems the patient to be in a terminal condition or, in consultation with a physician qualified to make a neurological diagnosis who has examined the patient, deems the patient to be permanently unconscious; and (3) the attending physician has considered the patient's wishes concerning the withholding or withdrawal of life support systems. In the determination of the wishes of the patient, the attending physician shall consider the wishes as expressed by a document executed in accordance with sections 19a–575 and 19a–575a, if any such document is presented to, or in the possession of, the attending physician at the time the decision to withhold or terminate a life support system is made. If the wishes of the patient have not been expressed in a living will the attending physician shall determine the wishes of the patient by consulting any statement made by the patient directly to the attending physician and, if available, the patient's health care agent, the patient's next of kin, the patient's legal guardian or conservator, if any, any person designated by the patient ... and any other person to whom the patient has communicated his wishes, if the attending physician has knowledge of such person. All persons acting on behalf of the patient shall act in good faith. If the attending physician does not deem the incapacitated patient to be in a terminal condition or per-

manently unconscious, beneficial medical treatment including nutrition and hydration must be provided ."

FN3. In her memorandum, in opposition to the motion to strike, the plaintiff also argues that she has established causes for negligence and negligence per se. Insofar as negligence is part of the plaintiff's claim of negligent infliction of emotional distress, it is discussed herein. As separate causes of action, the plaintiff has not properly alleged the elements of negligence or negligence per se in her complaint or amended complaint. With regard to negligence per se, it is noted that "to establish liability as a result of a statutory violation, a plaintiff must satisfy two conditions. First, the plaintiff must be within the class of persons protected by the statute ... Second, the injury must be of the type which the statute was intended to prevent." (Citations omitted; internal quotation marks omitted.) *Gore v. People's Savings Bank,* 235 Conn. 360, 375–76, 665 A.2d 1341 (1995). In this case, the plaintiff does not allege or argue that she is within the class protected by the statute nor does she allege or argue that her emotional distress is the kind of injury that the statute was designed to prevent. Even if she had alleged a statutory violation, "[t]here is ... nothing to support negligence per se under ... § 19a–571. The only logical construction of this statute is that it was enacted to implement a terminal patient's common law rights to self determination and privacy ... and, by its express terms, to provide a safe harbor for physicians by insulating them from civil and criminal liability for discontinuing life support measures under certain specified circumstances." (Citation omitted .) *Law v. Camp,* 116 F.Sup.2d 295, 304 n. 4 (D.Conn.2000), aff'd, 15 Fed.Appx. 24 (2d Cir.2001), cert. denied, 534 U.S. 1162, 122 S.Ct. 1172, 152 L.Ed.2d 116 (2002). In this case, the plaintiff was not the patient nor is she a physician or a hospital. Furthermore, it should be emphasized that the plaintiff is not asserting the rights of the decedent. As a result, the question of whether the hospital owed a duty to the decedent under common law or § 19–571 is not discussed here. In sum, a claim for negligence per se would not survive the motion to strike because the plaintiff is not asserting the rights of the decedent, is not part of the protected class and her injury is not of the type the statute was intended to prevent.

Additionally, bystander liability is not an appropriate cause of action in this case. "[A]n action at common law for negligent infliction of emotional distress on a bystander [is recognized], subject to satisfying the following factors: (1) the bystander must be closely related to the injury victim ... (2) the bystander's emotional injury must be caused by the contemporaneous sensory perception of the event or conduct that causes the injury ... (3) the injury to the victim must be substantial, resulting either in death or serious physical injury ... and (4) the bystander must have sustained a serious emotional injury." (Citations omitted; internal quotation marks omitted.) *Craig v. Driscoll,* 262 Conn. 312, 318 n. 8, 813 A.2d 1003 (2003). While the plaintiff was closely related, she was not present at the hospital and did not witness any of the alleged conduct causing injury nor was she immediately aware of her father's death. As a result, the court's decision only addresses the claim of negligent infliction of emotional distress because the plaintiff has not set forth causes of action based upon negligence or negligence per se and because bystander liability is not applicable

in this case.

"In *Montinieri v. Southern New England Telephone Co.*, 175 Conn. 337, 345, 398 A.2d 1180 (1978), [our Supreme Court] recognized for the first time that recovery for unintentionally caused emotional distress does not depend on proof of either an ensuing physical injury or a risk of harm from physical impact." (Internal quotation marks omitted.) *Perodeau v. Hartford,* 259 Conn. 729, 749, 792 A.2d 752 (2002). "[I]n order to prevail on a claim of negligent infliction of emotional distress, the plaintiff must prove that the defendant should have realized that its conduct involved an unreasonable risk of causing emotional distress and that that distress, if it were caused, might result in illness or bodily harm ... This ... test essentially requires that the fear or distress experienced by the plaintiffs be reasonable in light of the conduct of the defendants. If such [distress] were reasonable in light of the defendants' conduct, the defendants should have realized that their conduct created an unreasonable risk of causing distress, and they, therefore, properly would be held liable." (Internal quotation marks omitted.) *Larobina v. McDonald, supra,* 274 Conn. at 410.

"Moreover, the [pleader must] demonstrate the elements necessary to establish negligence ... The essential elements ... are well established: duty; breach of that duty; causation; and actual injury ... If a court determines, as a matter of law, that a defendant owes no duty to a plaintiff, the plaintiff cannot recover in negligence from the defendant ... A duty to use care may arise ... from circumstances under which a reasonable person, knowing what he knew or should have known, would anticipate that harm of the general nature of that suffered was likely to result from his act or failure to act." (Internal quotation marks omitted .) *Sunset Mortgage v. Agolio,* Superior Court, judicial district of New London, Docket No. CV 05 0569833 (June 14, 2005, Jones, J.).

STATUTORY DUTY

The plaintiff argues that § 19a–571(a) establishes a duty that the hospital owed to her and that Connecticut law recognizes the right of family members to pursue damages under the statute.[FN4] No case directly discusses, however, whether a decedent's next of kin is a member of the class of persons protected by § 19a–571(a). "[I]n determining whether a duty of care is owed to a specific individual under a statute, the threshold inquiry ... is whether the individual is in the class of persons protected by the statute." *Ward v. Greene,* 267 Conn. 539, 548, 839 A.2d 1259 (2004). In making this inquiry, the court looks to the statute's policy statement and the entire statutory scheme as enacted. See *id.,* at 549–57.

FN4. In particular, the plaintiff argues that two Connecticut cases support her position. In 1989, the Connecticut Supreme Court provided injunctive and declaratory relief under the statute allowing for removal of a feeding tube from a woman in a permanent vegetative state. *McConnell v. Beverly Enterprises–Connecticut, Inc.,* 209 Conn. 692, 553 A.2d 596 (1989). At the time, the statute required consent of the family. *Id.,* at 708.

This case is distinguishable. Here, the plaintiff is asking for damages. Additionally, a 1991 amendment to the statute, discussed in the main text of this memorandum, struck the requirement of the consent of the family. Thus, *McConnell* does not provide a basis to find that the hospital had a statutory duty to the plaintiff that would allow for damages.

In 2000, a judge of this court denied a defendant's motion to strike a plaintiff's claim for negligent infliction of distress where a hospital disconnected the plaintiff's husband from life support. *O'Connell v. Bridgeport Hospital,* Superior Court, judicial district of Fairfield, Docket No. CV

99 0362525 (May 17, 2000, Skolnick, J.). The court allowed the plaintiff as administratrix to bring a cause of action in wrongful death based on § 19a–571(a). *Id.* On the direct claim of negligent infliction of emotional distress, the defendant challenged the cause of action based upon a failure to use the formal language necessary to establish the claim. *Id.* The court did not address whether a duty to the plaintiff existed under § 19a–571(a). Therefore, these cases do not establish that the plaintiff, as next of kin, is part of a protected class under § 19a–571(a).

*3 No policy statement exists on the face of § 19a–571 or other related statutes. See General Statutes §§ 19a–570 through 19a–580d. The legislative history indicates, however, that statutes concerning the removal of life support were enacted in response to a nationwide movement to provide for living wills. 28 S. Proc., Pt. 12, 1985 Sess., p. 4065. Section 19a–571 was promulgated to give guidelines allowing for appropriate private decision making regarding the termination of life support based upon an individual's right to refuse medical treatment. See *McConnell v. Beverly Enterprises–Connecticut, Inc.*, 209 Conn. 692, 701, 703, 553 A.2d 596 (1989). In honoring patients' choices, hospitals and doctors are protected from liability under this statute. 28 H.R. Proc., Pt. 35, 1985 Sess., p. 12612; 28 S. Proc., Pt. 17, 1985 Sess., p. 5719.

As originally enacted, the statute required the consent of the patient's next of kin before the hospital or physician terminated life support. General Statutes (Rev. to 1991) § 19a–571(a); [FN5] see also *McConnell v. Beverly Enterprises, Connecticut, Inc., supra,* 209 Conn. at 708. In practice, the informed consent requirement allowed the next of kin to veto the patient's wishes. 34 H.R. Proc., Pt. 23, 1991 Sess., p. 8668. In 1991, to change this result, the legislature amended the statute and abolished the requirement of obtaining the consent of next of kin. See *id.* and General Statutes (Rev. to 2005) § 19a–571(a). Thus, the statute does not presently require the consent of the next of kin.[FN6]

FN5. General Statutes § 19a–571(a) originally provided, in relevant part: "Liability re removal of life support system of incompetent patient. Attending physician must obtain consent of next of kin ... Any [licensed] physician or any licensed medical facility which removes or causes the removal of a support system of an incompetent patient shall not be liable for damages in any civil action ... provided (1) the decision to remove such life support system is based on the best medical judgment of the attending physician; (2) the attending physician deems the patient to be in a terminal condition; (3) the attending physician has obtained the informed consent of the next of kin, if known, or legal guardian, if any, of the patient prior to removal; and (4) the attending physician has considered the wishes as expressed by the patient directly, through his next of kin or legal guardian, or in the form of a document executed in accordance with section 19a–575 ..." (Emphasis added.) General Statutes (Rev. to 1991) § 19a–571(a).

FN6. In its current form, § 19a–571(a) requires that a hospital or physician "shall" determine whether the patient expressed his or her final wishes to the next of kin if no living will exists or if no expression of these wishes was made to an attending physician or to the patient's health care agent. General Statutes § 19a–571(a)(3). In the present case, the plaintiff does not allege that any statements were made to her or that she knew what the decedent's final wishes were.

More importantly, and despite changes in the statute, nothing in either the language of the statute or

the legislative history supports the notion that the plaintiff is part of any class protected under § 19a–571. "The only logical construction of this statute is that it was enacted to implement a terminal patient's common law rights to self determination and privacy ... and, by its express terms, to provide a safe harbor for physicians by insulating them from civil and criminal liability for discontinuing life support measures under certain specified circumstances." (Citation omitted.) *Law v. Camp,* 116 F.Sup.2d 295, 304 n. 4 (D .Conn.2000), aff'd, 15 Fed.Appx. 24 (2nd Cir.2001), cert. denied, 534 U.S. 1162, 122 S.Ct. 1172, 152 L.Ed.2d 116 (2002). Thus, the statute appears to protect only physicians, hospitals and patients. Because the plaintiff is not a doctor, hospital or a patient, she is not a protected class member according to the statute's underlying purpose as expressed in its legislative history.

Additionally, nothing can be found in the statutory scheme to support a conclusion that the plaintiff is part of a protected class. "In determining the class of persons protected by a statute, [the court] do[es] not rely solely on the statute's broad policy statement. Rather, [the court] review[s] the statutory scheme in its entirety, including the design of the scheme as enacted." (Internal quotation marks omitted.) *Ward v. Greene, supra,* 267 Conn. at 551. The statutory scheme for removal of life support is encompassed within General Statutes § 19a–570 through § 19a–580d.[FN7]

> FN7. Additionally, the legislature set forth criteria for the determination of death for the purposes of continuing or removing life support in § 19a–504a. See *State v. Guess,* 244 Conn. 761, 777, 715 A.2d 643 (1998). This statute provides in pertinent part: "(b) For purposes of making a determination concerning the continuation or removal of any life support system in a general hospital ... an individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. Determination of death shall be made in accordance with accepted medical standards." General Statutes § 19a–504a. It is not clear how this statute fits in, if at all, with the other statutes involving life support. It was enacted prior to the others, and notification or consent of next of kin is not mentioned in the legislative history. Public Acts 1984, No. 84–261, §§ 1, 2.

*4 "Next of kin" is defined in General Statutes § 19a–570(8) and is referred to in § 19a–571(a) and General Statutes § 19a–580. Section 19a–571 includes the next of kin in the list of people to be consulted in determining the patient's wishes regarding care if no living will exists and the decedent has not expressed the final wishes to the attending physician. Additionally, § 19a–580 requires that the attending physician make reasonable efforts to notify the next of kin prior to the removal of life support.[FN8] Enacted in 1991 as part of the changes to the living will statutes, § 19a–580 appears to replace the requirement that the physician or hospital obtain informed consent of the next of kin. Public Acts 1991, No. 91–283, § 8; 34 H.R. Proc., Pt. 23, 1991 Sess., p. 8668.

> FN8. The issue of whether a duty is owed under this statute is not addressed in this memorandum because the plaintiff does not allege a cause of action based upon § 19a–580. Even if she had alleged a cause of action under this statute, it does not appear from the statutory purpose or the scheme that the legislature intended to make next of kin a protected class.
>
> Further, although originally the plaintiff appeared to make an allegation using some of the language of § 19a–580 in paragraph nine of her original complaint, she re-

> moved it from her amended complaint. Instead, she alleges the defendant had a duty to inform her so she could participate in the decision to terminate life support. She seems to be implying that the defendant had a strict duty to inform her so she could participate. Under the present statutory scheme, a hospital or physician need only make reasonable efforts to inform, not allow the participation of, the next of kin. General Statutes §§ 19a–571(a) and 19a–580. Consequently, even if the plaintiff were part of a protected class, the statutes do not create a duty, strict or otherwise, to inform next of kin so that they may participate.

Nevertheless, the legislative history of the entire scheme does not suggest any intent to make next of kin a protected class. In fact, the legislature intended only to codify existing law, not to create any new duties. 341 H.R. Proc., Pt. 23, 1991 Sess., p. 8736, remarks of Representative Ann P. Dandrow ("I should point out that we really are not changing the law regarding the withdrawal of a life support system. We're only conforming our statutes to what is now the law in Connecticut based on the *McConnell* case and throughout the nation, based on the *Cruzan* case."); Conn. Joint Standing Committee Hearings, Judiciary, Pt. 5, 1991 Sess., p. 1408, remarks of Representative Michael P. Lawlor ("[D]o you understand that all this bill does? It doesn't allow people to do things. I[t] just tells them if they do certain things under certain circumstances they won't be held liable for it and that's all this bill does?"); Conn. Joint Standing Committee Hearings, Judiciary, Pt. 5, 1985 Sess., p. 1614, remarks of Dr. Robert Harkins, Esq. ("Your enactment of the living will statute will not create any new public policy. Your enactment of the living will statute will merely affirm what already exists in the common law.") The court does not find a duty to the plaintiff because the statute's underlying purpose and statutory scheme militate against such a finding.

COMMON–LAW DUTY

The plaintiff also argues in its memorandum of law that the hospital owed her a duty based on common law and the federal constitution. Beyond summarily asserting the decedent's federal constitutional and common-law rights of self-determination and privacy, the plaintiff does not adequately identify the grounds of such a duty.[FN9] The plaintiff asserts a direct cause of action, not a claim based on the decedent's rights. Consequently, any duty to the plaintiff may not be based upon the decedent's federal constitutional rights. Furthermore, "[w]hile ... the Constitution supports a right to reject life-sustaining medical treatment as a function of the fundamental right to bodily integrity under the Due Process Clause ... it does not follow from this ... that an incompetent person ... has a constitutional right to have a surrogate make critical medical decisions, including a decision to withdraw life support. While former proposition finds support in case law, the latter does not ..." (Citation omitted .) *Blouin ex rel. Estate of Pouliot v. Spitzer,* 356 F.3d 348, 359 (2d Cir.2004). Therefore, if the plaintiff's right exists, it is not a federal constitutional right and must be a common-law right based upon a duty owed directly to the plaintiff.

> FN9. In a footnote of her memorandum, the plaintiff asserts that a duty based on the right of the surviving kin to the possession of the decedent's body is "closely analogous." The right to possession of the decedent's body is a quasi-property right based upon physical custody of the body. See *Del Core v. Mohican Historic Housing Associates,* 81 Conn.App. 120, 125, 837 A.2d 902 (2004); *Strachan v. John F. Kennedy Memorial Hospital,* 209 N.J.Super. 300, 311, 507 A.2d 718 (1986), aff'd in part and rev'd in part on other grounds, en banc, 109 N.J. 523, 538 A.2d 346 (1988). "[T]he quasi-right in property of the next of kin ... [does] not vest until the pronouncement of death." *Id.*

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> In this case, the plaintiff is not arguing that she had a right to possess the body *after* the pronouncement of death, but, rather, she attempts to assert a right to participate in the decedent's medical decisions *before* the pronouncement of death. Not only is the timing of the right to possession of the body different, but the degree of control she seeks to assert is more than mere possession. As a result, the duty to give the right to possession over the body is not analogous to the proposed duty of a hospital to inform the plaintiff so that she could participate in the life support decision. Therefore, the court declines to recognize this as a basis for finding a duty to the plaintiff in this case.

*5 "[T]he test for the existence of a legal duty of care entails (1) a determination of whether an ordinary person in the defendant's position, knowing what the defendant knew or should have known, would anticipate that harm of the general nature of that suffered was likely to result, and (2) a determination, on the basis of a public policy analysis, of whether the defendant's responsibility for its negligent conduct should extend to the particular consequences or particular plaintiff in the case ... The first part invokes the question of foreseeability, and the second part invokes the question of policy." (Internal quotation marks omitted .) *Murillo v. Seymour Ambulance Assn.*, 264 Conn. 474, 478–79, 823 A.2d 1202 (2003).

"Duty is a legal conclusion about relationships between individuals, made after the fact, and imperative to a negligence cause of action ... The ultimate test of the existence of the duty to use care is found in the foreseeability that harm may result if it is not exercised ... [In other words], would the ordinary [person] in the defendant's position, knowing what he knew or should have known, anticipate that harm of the general nature of that suffered was likely to result?" (Internal quotation marks omitted.) *Monk v. Temple George Associates, LLC*, 273 Conn. 108, 115, 869 A.2d 179 (2005). "In negligent infliction of emotional distress claims, unlike general negligence claims, the foreseeability of the precise nature of the harm to be anticipated [is] a prerequisite to recovery even where a breach of duty might otherwise be found." (Internal quotation marks omitted). *Perodeau v. Hartford, supra,* 259 Conn. at 754.

In this case, the defendant is a hospital and likely deals with life and death decisions every day involving patients and their families. Recent debates in the press illustrate that the decision to terminate life support is emotionally charged and often controversial with differing points of view leading to bitter disagreements, even within the same family. See A. Goodnough, "Schiavo Dies, Ending Bitter Dispute Over Feeding Tube," *N.Y. Times,* April 1, 2005, p. A1. Even the defendant recognizes, in its memorandum in support of the motion to strike, that emotional distress to next of kin may be anticipated. Therefore, infliction of emotional distress to the known and available next of kin is a foreseeable consequence of a hospital's failure to contact them prior to terminating life support.

"A simple conclusion that the harm to the plaintiff was foreseeable, however, cannot by itself mandate a determination that a legal duty exists." (Internal quotation marks omitted.) *Perodeau v. Hartford, supra,* 295 Conn. at 756. "Many harms are quite literally foreseeable, yet for pragmatic reasons, no recovery is allowed ... A further inquiry must be made, for we recognize that duty is not sacrosanct in itself, but is only an expression of the sum total of those considerations of policy which lead the law to say that the plaintiff is entitled to protection ... While it may seem that there should be a remedy for every wrong, this is an ideal limited ... by the realities of this world ... The problem for the law is to limit the legal consequences of wrongs to a controllable degree." (Internal quotation marks omitted.) *Ward v. Greene, supra,* 267

Conn. at 557–58. "The final step in the duty inquiry, then, is to make a determination of the fundamental policy of the law, as to whether the defendant's responsibility should extend to such results." (Internal quotation marks omitted.) *Murillo v. Seymour Ambulance Ass'n., Inc., supra,* 264 Conn. at 480.

*6 "[I]n considering whether public policy suggests the imposition of a duty, we ... consider the following four factors: (1) the normal expectations of the participants in the activity under review; (2) the public policy of encouraging participation in the activity, while weighing the safety of the participants; (3) the avoidance of increased litigation; and (4) the decisions of other jurisdictions." (Internal quotation marks omitted.) *Monk v. Temple George Associates, LLC, supra,* 273 Conn. at 118. Upon applying these four factors, the court concludes that imposing a duty of care on the defendant under the common law, and in the circumstances of the present case, is consistent with public policy.

Under the first factor, the court looks to the normal expectations of the parties in the activity under review. The activity under review is the decision to disconnect life support. See, e.g., *Monk v. Temple George Associates, LLC, supra,* 273 Conn. at 118 (activity in question is parking in the defendant's lot); *Seguro v. Cummiskey,* 82 Conn.App. 186, 195, 844 A.2d 224 (2004) (activity in question is consumption of alcohol in bars and restaurants). "Generally, life support systems cannot be removed from an incompetent patient with no family or relative to give consent unless an appointed guardian consents." *Benoy v. Simons,* 831 P.2d 167, 171 n. 3, 66 Wash.App. 56, cert. denied, 844 P.2d 435, 120 Wash.2d 1014 (1992). But see *Strachan v. John F. Kennedy Memorial Hospital,* 209 N.J.Super. 300, 317, 507 A.2d 718, aff'd in part and rev'd in part on other grounds, en banc, 109 N.J. 523, 538 A.2d 346 (1988 (1986) ("It seems ... fundamental that the decision whether to withdraw the life support systems from a brain dead patient is a medical decision that can be made only by a physician."). Additionally, § 19a–571(a), enacted in 1985, instructs physicians and hospitals to consider the wishes of the patient by determining whether any statements were made to the next of kin where no living will or other document, or oral statement to the attending physician or to a guardian, are available. See § 19a–571(a). To abide by the statute and to avoid liability, the defendant likely had procedures in place for decades. While the court gives no weight to the defendant's assertion in their memorandum of law in support of the motion to strike that they attempted to contact the plaintiff, it would appear that this attempt does illustrate some recognition of a need to contact her. Thus, where there is no living will or other statement of final wishes of the decedent, the involvement of the next of kin in the decision to remove life support from the decedent would normally be expected.

The second factor requires the court to consider the benefits of encouraging the underlying activity. Cases involving life support termination usually recognize four interests: "(1) the preservation of life; (2) the prevention of suicide; (3) the protection of interest of innocent third parties; and (4) the maintenance of the ethical integrity of the medical profession." *McConnell v. Beverly Enterprises–Connecticut, Inc., supra,* 209 Conn. at 716 (Healey, J., concurring). Recognizing a duty in this case supports these interests.

*7 For example, in terms of preservation of life, the patient's rights may be better protected by encouraging the next of kin's participation in the decision. "[T]he 'only practical way' to prevent the loss of [the incompetent patient's] privacy right ... was to allow [the] guardian and family to decide 'whether [the patient] would exercise it in these circumstances.' " *Cruzan v. Director, Missouri Department of Health,* 497 U.S. 261, 271, 110 S.Ct. 2841, 111 L.Ed.2d 224 (1990) (quoting *In re Quinlan,* 70 N.J. 10, 41, 355 A.2d 647, cert. denied sub nom. *Garger v. New Jersey,* 429 U.S. 922, 97 S.Ct. 319, 50 L.Ed.2d 289 (1976)).

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Looking to maintenance of the integrity of the medical profession, physicians and hospitals may be prevented from becoming the patient's surrogate decision maker when the next of kin's involvement is encouraged. "Common law and statutory law have not given the physician any right to be the incompetent patient's surrogate. Connecticut statues do have provisions by which surrogates can be appointed." Conn. Joint Standing Committee Hearings, Judiciary, Pt. 5, 1985 Sess., p. 1613, remarks of Dr. Robert Harkins, Esq. Moreover, the physician or hospital's judgment may be checked by the judgment of the next of kin. Conn. Joint Standing Committee Hearings, Judiciary, Pt. 5, 1991 Sess., p. 1314. ("[Representative Richard P. Tulisano:] [How do we develop a system in which that M.D.'s judgment is checked? [Attorney Joseph Healey:] ... [Here, one relies on the advocates for the patient.]"). Further, the involvement of the next of kin provides a safeguard against fabrication of a statement of the patient's last wishes. 34 H.R. Proc., Pt. 23, 1991 Sess., pp. 8762–63 ("[Representative Raymond M.H. Joyce:] [W]hat would stop the physician from saying ... [the patient] expressed his wish to die. [Representative Michael P. Lawlor:] [I]f the physician believes he's met the test, he's required to notify the next of kin ... and must allow for a reasonable time to pass for them to become involved in the process."). Moreover, any pressure physicians and hospitals might feel to disconnect a patient from life support based upon financial considerations may be countered by participation of the next of kin. See Conn. Joint Standing Committee Hearings, Judiciary, Pt. 5, 1991 Sess., p. 1307–08, remarks of Representative Richard P. Tulisano; [FN10] and G. Anand, "Who Gets Health Care? Rationing in an Age of Rising Costs; Life Support: The Big Secret in Health Care: Rationing is Here; With Little Guidance Workers On Front Lines Decide Who Gets What Treatment; Nurse Micheletti's Tough Calls," *Wall St. J.*, September 12, 2003, p. A1. Finally, in terms of the next of kin and the grieving process, encouraging participation may help give the next of kin a sense of control. See 28 H.R. Proc., Pt. 30, 1985 Sess ., p. 11178, remarks of Representative Richard D. Tulisano ("It is when that final decision to pull the plug is made that the family should and must be involved, not just for the person. So that they do not have a lonely death, but for those who survive and are involved in that.").

> FN10. Representative Tulisano stated, "Since most health care providers end up being paid for or actually being the state of Connecticut, in our current context, somebody on public assistance. I guess I'm not sure or do I feel very comfortable about giving the guy who's paying the bill, the power to start ... making decisions about terminating life because it's too expensive ... [D]o we now make it easier for the state ... to make decisions, based on its own economic self-interest ... My concern is there's tons of folks [who will not have living wills or made their wishes known to a physician] who will be on public assistance ... who will then [have] some ... illness ... I know you want the health care provider to go back and see what the person wants, that's not real world. That's not what's happening ... [N]ow ... we'll have state sponsored individuals who will make decisions about life based on their own economic self-interest.").

***8** In evaluating the benefits of encouraging the next of kin's involvement, the court is mindful of the paramount duty of the hospital to its patients. The defendant correctly argues that the focus in these situations should be on determining the patient's wishes. In most cases, however, the next of kin is likely to know, better than the hospital where care may have been provided only on an emergency basis, what the final wishes of the patient were, because of the time spent with the family member and the nature of the relationship. Therefore, encouraging the next of kin's involvement would be beneficial to this determination.

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Regarding the third factor, the court considers the possibility of increased litigation. "[T]here are fears of flooding the courts with spurious and fraudulent claims; problems of proof of the damage suffered; [and] exposing the defendant to an endless number of claims." (Internal quotation marks omitted.) *Myers v. Hartford,* 84 Conn.App. 395, 402–03, 853 A.2d 621, cert. denied, 271 Conn. 927, 859 A.2d 582 (2004). In recognizing a duty to next of kin in this case, the possibility of litigation is, however, limited to the person or persons considered to be the next of kin. "Next of kin" would likely be defined as, in order of priority: the spouse, an adult son or daughter, a parent, an adult brother or sister, or a grandparent. See General Statutes § 19a–570(8). While the next of kin could be multiple siblings, both parents, or both grandparents, the class of persons to bring suit over the issue would be sufficiently limited. Furthermore, the number of possible lawsuits are limited to situations where the patient has not expressed his or her final wishes orally or in writing. Thus, physicians and hospitals would not likely experience increased litigation.

Fourth, the court considers what other jurisdictions have done. Research does not reveal any case law from another jurisdiction articulating a duty in a case such as this. It should be noted that Connecticut precedent weighs against finding a duty to a third party .[FN11] No case addresses, however, the issue presented in this case. Therefore, the court finds that the defendant owed the plaintiff a common-law duty in this case.

FN11. For example, the Supreme Court has held "that, for reasons of public policy, a psychiatrist engaged to examine children for possible sexual abuse owed no duty of care to the children's father, who was the suspected abuser; *Zamstein v. Marvasti,* 240 Conn. 549, 559, 692 A.2d 781 (1997); a psychotherapist owed no duty of care to a third party injured by his psychiatric outpatient; *Fraser v. United States,* 236 Conn. 625, 632, 674 A.2d 811 [aff'd, 83 F.3d 591, cert. denied, 519 U.S. 872, 117 S.Ct. 188, 136 L.Ed.2d 126] (1996); a physician owed no duty of care to his patient's daughter, who suffered emotional distress from observing her mother's health deteriorate from the physician's substandard care; *Maloney v. Conroy,* 208 Conn. 392, 399, 545 A.2d 1059 (1988); and an attorney owed no duty of care to his client's intended beneficiaries for failing to arrange for timely execution of estate planning ments. *Krawczyk v. Stingle,* 208 Conn. 239, 244–46, 543 A.2d 733 (1988); see also *Dodd v. Middlesex Mutual Assurance Co.,* 242 Conn. 375, 383, 698 A.2d 859 (1997) ('[t]he ability of someone other than the injured party, e.g., the [injured party's] employer, to bring or to intervene in an action against [the tortfeasor] is a clear deviation from the common law')." *Mendillo v. Board of Education,* 246 Conn. 456, 480–81, 717 A.2d 1177 (1998). See also *Murillo v. Seymour Ambulance Ass'n ., Inc., supra,* 264 Conn. at 480–84 (emergency personnel owed no duty to a bystander, who fainted, while emergency surgery was performed on the bystander's sister). But see *Monk v. Temple George Associates, LLC, supra,* 273 Conn. at 18–22 (duty exists for a parking lot owner to protect a nightclub patron from criminal assault).

See also *Weigold v. Patel,* 81 Conn.App. 347, 358, 840 A.2d 19, cert. denied, 268 Conn. 918, 847 A.2d 314 (2004) (no duty owed by a psychiatrist and a psychologist to an accident victim to warn the patient of the danger of operating a car while on medication); *Stokes v. Lyddy,* 75 Conn.App. 252, 276, 815 A.2d 263 (2003) (no duty owed by a landlord to a pedestrian on a public sidewalk to protect her from tenant's dog); *Ludemann v. East Hartford,*

Superior Court, judicial district of Hartford, Docket No. CV 03 0824930 (November 24, 2004, Lavine, J.) (no duty owed by an employer to an accident victim hit by a hypoglycemic employee to keep the employee from driving). But see *Seguro v. Cummiskey, supra,* 82 Conn.App. at 198 (duty exists between a bar owner and an accident victim to supervise an employee's consumption of alcohol while on the job); *Shackels v. Pfizer, Inc.,* Superior Court, judicial district of New London, Docket No. CV 03 0565313 (December 1, 2003, Hurley, J.T.R.) (duty exists between an employer and plaintiff-employee to keep another employee from harassing plaintiff via employer's e-mail system).

The common-law duty in this case can be informed by the existing statutes. A court can look "to statutes as a source of policy for common-law adjudication, particularly where there is a close relationship between the statutory and common-law subject matters." (Internal quotation marks omitted.) *Ireland v. Ireland,* 246 Conn. 413, 420, 717 A.2d 676 (1998). See also *State v. Guess,* 244 Conn. 761, 779–80, 715 A.2d 643 (1998); *Fahy v. Fahy,* 227 Conn. 505, 514–16, 630 A.2d 1328 (1993); *Newman v. Newman,* 235 Conn. 82, 100, 663 A.2d 980 (1995); accord *New England Savings Bank v. Lopez,* 227 Conn. 270, 281, 630 A.2d 1010 (1993); *Hamm v. Taylor,* 180 Conn. 491, 495, 429 A.2d 946 (1980); *Canton Motorcar Works, Inc. v. DiMartino,* 6 Conn.App. 447, 453, 505 A.2d 1255, cert. denied, 200 Conn. 802, 509 A.2d 516 (1986). The lifesupport statutes are clearly closely related to any common-law duty in this case. "Just as the legislature is presumed to enact legislation that renders the body of the law coherent and consistent, rather than contradictory and inconsistent ... courts must discharge their responsibility, in case by case adjudication, to assure that the body of the law-both common and statutory-remains coherent and consistent." (Internal quotation marks omitted.) *Ireland v. Ireland, supra,* 246 Conn. at 420. To remain coherent and consistent with §§ 19a–571(a) and 19a–580, the hospital's duty to the plaintiff should be construed as a duty to make reasonable efforts to inform the known and available next of kin so that he or she could participate in the decision, based upon what the decedent would have wanted, prior to the removal of life support. In her amended complaint, the plaintiff has alleged that the hospital knew or should have known that ordering termination of the decedent's life support without contacting her involved an unreasonable risk of causing her emotional distress and that this distress might result in illness or bodily harm. Thus, because the plaintiff has alleged the elements of negligent infliction of emotional distress and because a common-law duty exists, the plaintiff has properly alleged a cause of action. Accordingly, the motion to strike is denied.

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