In The Matter Of:

J. Colon v.

October 10, 2017

Richmond Supreme Court

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SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF RICHMOND: CIVIL TERM PART DCM1

JUAN COLON,

Plaintiff

V.

LEONARD LEFKOVIC, MD. RICHMOND CARDIOLOGICAL SERVICES, PC AND ISLAND MEDICAL SPECIALISTS

Defendants

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Index #150443-2015

18 Richmond Terrace

Staten Island, New York 10301

October 10, 2017

B E F O R E: ORLANDO MARRAZZO, JR., Judge

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

KRENTSEL & GUZMAN
17 Battery Place
New York, New York

BY: CLASA M. VILLARREAL, ESQ.
Appearing on behalf of the Plaintiff

GLENN W. DOPF, ESQ.
440 Ninth Avenue
New York, New York

Appearing on behalf of the Defendants

Tammy Rodriguez, Court Reporter

THE CLERK: DCM 1 of Richmond Supreme Court the Honorable Orlando Marrazzo presiding. This is the continued matter of Juan Colon versus Leonard Lefkovic M. D., Richmond Cardiological Services P. C., and Island Medical Specialists. Index 150443 of 2014. All appearances remain the same.

MR. DOPF: Yes.

MS. VILLARREAL: Thank you.

THE COURT: Counsel, what's your application?

MR. DOPF: Yes, your Honor. If you'll recall we submitted a memorandum of law on the issue of new claims. I would like the witness to leave the courtroom, the expert. Thank you.

We discussed the issue of new claims, claims that were interposed by Plaintiff's counsel during jury selection -- actually Judge Minardo said get me a list of your departures and counsel provided a list of 50, 60 departures of which there were four new ones, which were identified in our memorandum of law, and I'd ask that the expert not be asked any questions relating to the four new departures disclosed during jury selection. That's application number 1.

THE COURT: Let's take one at a time. Were they ever exchanged prior to jury selection?

MR. DOPF: Well, 95 percent was exchanged before.

It's the five percent that I'm objecting to.

MS. VILLARREAL: I would like to know what specifically they are?

MR. DOPF: It's in the memo of law that I provided counsel with.

They're as follows paragraph 4, Negligently failing to generate accurate quality cardiac tests, imagining, and reports.

MS. VILLARREAL: I have no problem excluding that.

MR. DOPF: Great.

THE COURT: That will be excluded.

MR. DOPF: Number 5, which is pretty much the same, Negligently interpreting poor quality echocardiograms.

I have no problem with any comments relating to the echocardiogram, but poor quality is in the claim.

MS. VILLARREAL: Well from the standpoint that those records were in they were interpreted, so we have a right to voir dire and actually cross examine on that whole issue of the basis of his diagnosis, which is the echocardiogram, and the quality of the echocardiogram.

So obviously that's part of -- that's always been part of our claim. That's nothing new.

MR. DOPF: Show us in the BP or 3101 (D). Show us.

MS. VILLARREAL: Failure to interpret.

MR. DOPF: That's fine. No problem with that failing to interpret, but quality I object to.

THE COURT: The issue is similar. What is in the Bill of Particulars?

MS. VILLARREAL: It's part of the failure to --

THE COURT: Was that language brought out?

MS. VILLARREAL: The failure to interpret was and I supplemented at least 30 days.

THE COURT: That's allowed. He's not going to say poor quality. You want to work around that I'll allow you to do that. Do not use the term poor quality.

Next one.

MR. DOPF: Number 6, Negligently interpreting and rendering an inaccurate diagnosis and report based upon poor quality echocardiogram images.

I don't have any problem with everything up to poor quality echocardiogram images.

And, your Honor, if you say "work around it" if counsel asks the question, Doctor can you comment on the quality of the echocardiograms that's not working around it.

MS. VILLARREAL: It's about interpreting what is there. We have every right to interpret. It's part of our BP from the beginning even before we supplemented that. It was there. That's part it.

THE COURT: Ask the question failure to --
MS. VILLARREAL: It's about the interpretation.
THE COURT: He's not --
MS. VILLARREAL: It encompasses the interpretation.
THE COURT: Not going to say poor quality.
MS. VILLARREAL: I won't say the words "poor quality".
MR. DOPF: What if he asks the open question.
THE COURT: Let's see what the question is.
MR. DOPF: Number 40, Negligently failing to consider mitral valve tricuspid and pulmonary regurgitation.
MS. VILLARREAL: I'll withdraw that.
THE COURT: Okay. Anything else?
MR. DOPF: Yes, Judge. There is a lady in the back. I have no problem if she stays here unless she's going to be a witness. Maybe I can get guidance.
MS. VILLARREAL: That's his girlfriend.
MR. DOPF: Is she going to testify?
MS. VILLARREAL: She may.
MR. DOPF: Then out she goes. If she's going to testify.
MS. VILLARREAL: Okay. Sure.
THE COURT: She has been here before by the way during testimony.

MR. DOPF: Yeah.

MS. VILLARREAL: No problem.

THE COURT: If you say maybe you know that.

MS. VILLARREAL: Absolutely.

MR. DOPF: Judge, we've had a lot of back and forth on the issue of what we've agreed to in terms of authentication and my need to bring somebody from the outside.

I think that one thing that counsel has made abundantly clear that any cardiology or internal medicine records she's not going to make me bring in a medical record librarian. Her concern relates to neck issues.

The question that I have for your Honor, are we in agreement when Plaintiff rests that Dr. Tirado's records come in, the internist and Dr. Tamburrino he's the new cardiologist.

If counsel is going to go back on the stip on that then I have to drag people in from their offices.

MS. VILLARREAL: I never -- first off, the stipulation is not about them going into evidence, going in. They're about failure to authenticate. I have no problem. My position has been anything related to cardiac treatment. I have no problem with -- I stipulate to not having to bring somebody in to authenticate them.

MR. DOPF: So if I understand when counsel rests

there's no objection to me offering them into evidence. If counsel has an objection in terms of relevance to something it's preserved. You're not fighting me on authentication?

MS. VILLARREAL: No.

MR. DOPF: I'll not bring the medical record librarian. If she wants to argue about something else it's preserved.

MS. VILLARREAL: Now I want to be completely clear as to the scheduling issues.

THE COURT: Me too.

MS. VILLARREAL: I agree. Just want to make sure. We have our expert here to testify today. I anticipate that we should finish with him today, but I want to make clear that counsel is going to have his expert tomorrow.

THE COURT: I don't know.

MR. DOPF: That's correct.

MS. VILLARREAL: I want to make sure and then my client will continue his cross examination on Thursday.

MR. DOPF: Maybe this afternoon when I finish.

MS. VILLARREAL: That I don't know. That's what I don't know what the story is.

THE COURT: We're going full days. This is lasting longer than I thought it would, and the jurors are having issues. They were told five or six days. It's

longer than that. I don't want to hold them. I would like to work the whole day if we can do so.

MS. VILLARREAL: Sure.

MR. DOPF: So, Judge, the agreement that counsel and I have, of course, if counsel wants to breach it so be it --

THE COURT: Don't say that.

MR. DOPF: I've basically said you give me the afternoon with your expert, and I'll get him out of here today. I won't bring him back. I'll give you the afternoon more, than the afternoon. I'll probably be hour and a half, an hour with my expert that was the agreement.

I'm hoping that the baton will be passed.

THE COURT: Let's see what time we finish.

MS. VILLARREAL: Judge, the other thing that I would like to make sure is that we do not have a claim for lost earnings or incapacitation.

Counsel, when he did do his -- the entire cross examination of my client went into the lost earnings, the incapacitation, the inability to work. Your Honor did sustain those objections, but I want to make sure that counsel is not allowed to go into that, even asking the question.

This is completely improper incendiary comments. Asking why he can't be a toll collector is completely

incendiary. He cannot get into something we have not claimed. Also, specifically, there's no connection with the cervical injuries.

What was brought out during cross examination with respect to cervical injuries -- these are cervical injuries, range of motion issues that have nothing to do with the heart attack condition or anything like that.

The range of motion with respect to his neck and movement that is not the issue in this case.

Again, if counsel can make sure that nothing comes back.

THE COURT: He said a couple of things lost wages and range of motion.

MS. VILLARREAL: Range of motion, cervical limitation with respect to the range of motion.

THE COURT: Let's talk about that right now.

Do you have any issue with that?

MR. DOPF: Lost earnings no issue with that. I have a big issue -- I've submitted a brief on it, a memorandum on it on my ability to cross examine on preexisting injuries.

In other words, if this gentleman testified under oath that he can no longer play racquetball, no longer can have sex, touch football, no longer can enjoy his granddaughter in the park, but said all the same things a

year before to the United States government there's something wrong.

That goes to credibility, your Honor. I'm going to renew my application for the disability form that was marked for identification to be admitted into evidence.

MS. VILLARREAL: Your Honor, we vigorously object to any of this stuff coming in, Social Security Disability records coming in because it brings into issue the incapacitation issue, which was not part of our claim.

But if, in fact, counsel wants to open the door to incapacitation then we should have a right to then get into that and specifically the fact that the heart attack has effected his ability to even consider seeking new employment.

MR. DOPF: I have no problem with that.

MS. VILLARREAL: It's really never been part of our claim, so we can't get into a lost of incapacitation inability. One thing he's impeached him with what he indicated with a document that I think is improper for him to have utilized, and then to specifically identify the document before it was introduced into evidence all that was highly incendiary, highly improper, and we made our record with respect to that making sure that, that is out.

He made reference to the document that it was a disability federal government record. He can't make

representations to a document that is not in evidence. Now he made reference to it, and he continues to go down that road, your Honor, then if there is a mistrial we're going to request cost and sanctions against counsel for going after something that he knows is completely improper.

THE COURT: Does it goes to credibility?

MS. VILLARREAL: It does not go to credibility. He asked him specifically -- first off, on my direct of my client I didn't bring up all those issues. Certainly he could have brought them up what he's testified, but it was improper the whole impeachment process because it wasn't brought up. It was outside the scope first off. It was basically running and jogging that was specifically testified to. With respect to credibility it doesn't go to credibility.

He testified that this is what he -- when he was disabled from his employment, these are the things that he specifically could not do, and again the issue of disability of his Social Security Disability benefits should not be part of this case.

If counsel refers to that document again I consider it to be highly prejudicial to my client and I'm going to have to make a motion for a mistrial again in the middle, once we've incurred the cost of bringing this trial and counsel does so then we request cost and sanctions

against counsel for doing so.

MR. DOPF: I'm going to request costs and sanctions against not the law firm, but against this attorney for pursuing a case where there's clearly some horrific lying and perjury going on.

You can't fill out an eight page report under the penalties of perjury, he admitted it was his signature, and say you can't do these things as a result of your neck racquetball, sex, touch football, playing with the granddaughter, you can't say that and then a year later give a deposition and say oh, all that started after my heart attack. That's in his deposition. It's in the Bill of Particulars all of those things.

Now if Plaintiff wants to walk away from it I don't see how Plaintiff can in good faith pursue this case when it's clear that lies have been perpetrated against the Court and the jury.

He said black in a deposition and white in his report, in the report he filled out for the federal government.

Yes, your Honor that absolutely goes to credibility a hundred percent goes to credibility. Somebody lying on an application or somebody lying at a deposition certainly goes to credibility.

So I'll be seeking sanctions if counsel persists

with this meritless lawsuit.

THE COURT: We're not talking about sanctions.

MS. VILLARREAL: I believe what counsel just engaged in is an effort to intimidate my client in testifying. He is doing so openly and doing so with my client present. This is an effort for him to intimidate my client, intimidate me, and I consider what counsel is doing to be highly improper.

The incapacitation issue is not an issue in this case. The fact that my client testified two years before, not one year before, two years is when his disability claim was brought up, and that was because of work related issues that he could no longer work.

We're not claiming that he can no longer work as a result of his heart attack. So counsel cannot now bring in the employment disability claim, Social Security Disability claim as part of this case.

It is highly improper and we ask your Honor that he be instructed to not go into it again. He did enough damage as it is with respect to bringing up what he claims to be perjurious commentary. He tried to intimidate my client to specifically not say certain things. It's outrageous. I find it to be -- what counsel is doing to be highly reprehensible.

MR. DOPF: Counsel asked for sanctions, I replied

I would be seeking sanctions also.

Had counsel not brought up the subject of sanctions I would not have stood up and talked about the subject of sanctions. What's good for the goose is good for the gander.

I ask that Plaintiff's counsel tell witness Charash, he may not reference the quality or lack thereof of the echocardiogram.

THE COURT: I ruled on that.

MR. DOPF: I'm asking that she tell her expert.

THE COURT: I ruled on that. I'm sure she's not going to mention.

MR. DOPF: I'm worried he's going to mention it. I'm asking that she instruct him.

THE COURT: It will be stricken from the record.

MS. VILLARREAL: The other thing I wanted to mention, Friday there were little things that were going on in this courtroom that I need to make sure it does not happen today.

When I was doing my direct examination of my client the court report interrupted my direct examination to take a phone call that was two minutes or whatever minutes it was, and then went back on the record. That was completely improper for her to do so.

After she finished and she switched with the

reporter that is here now, in front of the jury, as she walked by she was coddling, I should say with Mr. Dopf and said, Okay Mr. Dopf now make sure you project.

She said it in front of the jury for the jury's purpose too. I want to make sure that none of this happens again. This is all stuff that really shouldn't be happening. We have enough problems that I heard a juror say --

THE COURT: Who denies saying it.

MS. VILLARREAL: I'm an officer of the court. I'm standing next to her and I heard her say it.

THE COURT: For the record I did ask her and she denies that.

MS. VILLARREAL: She denied saying it, of course, she's going to deny saying it.

THE COURT: Don't say that. You're telling me she lied to me?

MS. VILLARREAL: I heard her. I heard what she said. She was sitting -- I was sitting right next to her when she said it. So yes.

THE COURT: You're telling me that she lied to me.

MS. VILLARREAL: She's not telling the truth.

THE COURT: Same thing.

MS. VILLARREAL: Correct.

MR. DOPF: Sadly officers of the court have been known to lie.

THE COURT: Let's not get into --

MR. DOPF: I'm not saying -- for this lawyer to cloak yourself with the garment, I'm an officer of the Court I would never say anything inaccurately, I don't think it's right Judge. There's plenty of lawyers that have gone down the wrong road for not being honest.

THE COURT: That issue is over with. To be honest with you I didn't see the court reporter taking a phone call or saying anything to Mr. Dopf. I didn't see it. I don't know if she said anything to you.

Did she say anything to you?

MR. DOPF: I heard her say keep your voice up. The phone call, I must say, I don't remember. I'm not denying it. I don't remember.

THE COURT: She's not here. Go get the jury. For the record jurors mentioned to Chris, my court officer, they're concerned about how much longer this trial will take. What should I tell them? Since it's longer than what you told them it was going to take.

MR. DOPF: I'm going to give you my thoughts and counsel can give you her thoughts.

THE COURT: We're going to lose them.

MR. DOPF: If counsel rests at some point

tomorrow and my expert finishes tomorrow then that pushes us into Thursday. I think I can put the rest of my case on Thursday and sum up on Friday.

THE COURT: I would like to end this case this week.

MR. DOPF: I think it's doable if the witness, this witness is turned over to me by 2 o'clock.

MS. VILLARREAL: I just need to know who Mr. Dopf is intending on calling. He still hasn't told me. He indicated at the beginning of the trial that he had a bunch of witnesses he's going to call.

THE COURT: Who are you calling?

MR. DOPF: I'm calling my expert who she knows about and Dr. Chapman because counsel is making me bring somebody in to authenticate records.

MS. VILLARREAL: Judge, I will absolutely move to have Dr. Chapman not brought in. He is the pain management cervical doctor. This is not -- we're not litigating his cervical injuries. So to bring in the cervical injuries and bring in the treating doctor on the cervical injuries is quite outrageous.

So I'm moving to preclude that testimony and to have that doctor come and testify. I think it's an effort also to delay this trial.

Those records, Dr. Chapman's records, have not

come into the subpoena record room at no point. So they're not here. It's completely improper for him to try to bring in the cervical doctor on this case.

MR. DOPF: There's a great deal of relevance to him for an abundance of reasons. One of the reasons is that Mr. Colon saw him twice after Dr. Lefkovic's last office visit in February 2013, and before the heart attack.

Mr. Colon says I have all these symptoms everyday right up to the heart attack. I would like to see what Dr. Chapman says about that number one.

Number two, if Mr. Colon is fatigued or seems to be one of his primary complaints, I'm entitled to bring out the fact that this doctor is prescribing large amounts of narcotic medications the side effect -- one side effect of which is drowsiness that's two.

Number three, it goes to credibility. The Plaintiff testified at his deposition that he couldn't do all of those things because of the heart attack. When we go over Dr. Chapman's record it shows just the opposite.

So there's no reason at all to preclude him from testifying. As a practical matter, Judge, I'm going to try to limit my direct to 15 minutes. Why? Because of that note. So I don't intend -- I intend to get his records into evidence 10, 15 minutes and call it a day.

MS. VILLARREAL: Your Honor, first off, defense

has not at any point indicated in any of his pleadings, affirmative defenses, and Bill of Particulars specifically that the types of injuries relating to fatigue and drowsiness had anything to do with the cervical injuries or complaint that he made to Dr. Chapman.

He is limited to what he pled. At no point has he supplemented those pleadings. So anything to do with drowsiness related to narcotics this is brand new, never brought up before.

The fact that he's talking about fatigue related to the narcotics is something brand new, never brought up before.

The fact that he's also relating it to the complaint that he was making of fatigue to Dr. Chapman has nothing to do with the cardiac injuries.

These are cardiac symptoms. This is outrageous for counsel to be bringing it in delaying this trial. I think it's being done on purpose in an efforts to delay the trial and possibly lose the jury.

MR. DOPF: I don't want a mistrial. I want a verdict, so I have no interest in delaying a darn thing.

THE COURT: I'm going to reserve on that. We'll see where we go.

THE COURT OFFICER: Jury entering.

(At this time the jury enters the courtroom.)

THE CLERK: Jury present and properly seated both sides stipulate?

MR. DOPF: So stipulated.

MS. VILLARREAL: Stipulated.

THE CLERK: Case on trial continues.

MS. VILLARREAL: At this time we call Dr. Bruce Charash to the stand.

BRUCE CHARASH, 205 East, 63rd Street, New York, New York 10065, having been first duly sworn, was examined and testified as follows:

THE COURT: Counsel proceed.

MS. VILLARREAL: Thank you, your Honor.

DIRECT EXAMINATION

BY MS. VILLARREAL:

Q. Good morning, Dr. Charash?

A. Good morning.

Q. Are you a physician dually licensed to practice medicine?

A. Yes.

Q. Would you please provide the jury with the benefit of your medical education, training, and experience?

A. Of course.

I graduated from Cornell Medical School in 1981 getting my M. D. degree.

From 1981 to '84, I trained in the field of internal

medicine, which is primary care for adults, but not using surgery at Mount Sinai Hospital.

The first year is universally called internship. The second, third years are called residency. In 1984 after completing that training, I was eligible to take, and I did take a two day national written test called the board of internal medicine. By passing that I was designated a Board Certified internist.

From 1984 to '87 I trained at the New York Hospital in the subspecialty of heart disease. Again nonsurgical heart disease in the field called cardiology. The training was a fellowship. In 1987, when I completed, I took and passed the two day written test, the board of cardiology becoming a Board Certified cardiologist.

From 1987 to '91 I was on the full-time medical school faculty of Cornell as an assistant professor of medicine, and I was the assistant chief of the cardiac intensive care unit.

In 1991 until February 1, 2005 I became the chief of the cardiac care unit at Lenox Hill Hospital. I was also a clinical associate professor of medicine at NYU Medical School from February 1, 2005 to July 1, 2006.

I spent 17 months as a full-time member of the Columbia University Medical School faculty as an assistant professor of clinical medicine and then July 1, 2006 I went into private practice where I've been since then.

I have admitting privileges at Lenox Hill Hospital and I'm still a clinical associate professor of medicine at NYU.

Q. Thank you, Doctor. Dr. Charash, have you received any awards or honors in your career?

A. Yes. When I graduated from medical school I was inducted into a national medical honorary society called Alpha Omega Alpha.

In my second year of fellowship I received an award called the Dan and Elaine Sergeant Fellow of Cardiology, which was an award for the highest ranking cardiac training for my year and basically a scholarship that funded my position in 2008.

An organization called The Greater New York Hospital Association gave me the Doctor of the Year award for New York State.

And most recently, I think 2012, a Washington D. C. institute called The Caring Institute that promotes the ideals of patient care communication and ethics, they gave me their Caring Person of the Year award for the United States in 2012.

Q. Thank you, Doctor.

Dr. Charash, are you involved in any international medical work?

A. Yes. Very briefly for the last 11 years I started my own organization that collects surplus medical supplies in the United States. We end up sending to landfills seven tons a day

of unused medical supplies or reusable equipment.

We refurbish everything up and we send them to hospitals in Africa and Caribbean to reestablish healthcare systems.

I've made 14, 15 trips to different hospitals for education as well as evaluation.

Q. Doctor, this is not the first time you're in court, is that right?

A. Correct.

Q. Nor is it the first time we've been involved in what we call a medical/legal case, is that right?

A. That's correct.

Q. Would you please provide the jury with the benefit of your medical/legal experience?

A. I was first approached by a lawyer in 1987 after I passed my board certification in cardiology to be an expert. I had been a practicing Board Certified internist for three years at that time and a newly admitted cardiologist.

Since 1987, I guess, in the last 30 years I've reviewed in the range of 900 cases from lawyers in as many as 40 states.

The overall majority of the cases comes from local states, but over 30 years I've received one case from Texas six years ago, one case from Louisiana three years ago. Most of the cases are more localized.

In some cases I've given opinions about healthcare providers outside of my own field including surgeons, gynecologist, emergency room doctors, but never in their field. Good heavens I'm not qualified to discuss the operating room, but if a surgeon gives a patient an antibiotic to take at home and I give the same, we shared the same possibility to recognize the allergies of that medicine.

So whenever I've given an opinion about a doctor that is not in my field, it's always been in an area of common practice that we would share basic medical school training not subspecialties the other doctor works with.

About 85 percent or so of the cases that I have reviewed come from lawyers like yourself who represent families or family members and like 15 percent of the cases that I've reviewed come from lawyers that defend doctors or hospitals.

I've given testimony outside of a courtroom called a deposition under oath averaging about 11 times a year, and I have testified in court like I am today averaging around seven times a year.

Where as 15 percent of what I review come from lawyers defending doctors or hospitals for many different reasons the amount of times I'm asked to testify in those cases is much less, so 15 percent of my review are defense cases, but under 5 percent of my testimony are defense cases.

Q. Dr. Charash, tell the jury what is your day to day

practice?

A. I have an office-based practice. I see patients weekdays. I would say that 50 percent of my patients are cardiac patients that came to me who have their own primary care doctor.

Twenty-five percent of my patients were sent to me to be their cardiologist and then over time they ask me to also become their primary care doctor which I did.

And 25 percent of my patients came to me strictly for primary care, and over the years over half of them have developed some form of heart disease because it's the biggest disease in the United States.

I perform EKGs in my office, echocardiograms in my office, and stress test and stress echocardiograms.

Q. Dr. Charash, do you treat patients that have chest pain?

A. Very frequently.

Q. Would you explain?

A. Chest pain is the number one symptom that drives people to the emergency room. Not more than 50 percent of the biggest single reason why people go to the emergency room is chest pain. The biggest single complaint that people ask for an added visit to a doctor much less a heart doctor is chest pain.

Chest pain is the number one symptom of concern and, of course, because chest pain carries the possibility of heart

disease, which can be fatal it is obviously a very important area of evaluation.

For 20 years when I ran the cardiac care unit between Cornell and Lenox Hill I was evaluating patients in the emergency room with chest pain. Frequently admitted patients that had chest pain I frequently recommended interventional cardiology with patients with chest pain.

Clearly, with chest pain you have to make decisions as to whether it could be a heart attack or whether it can be nonheart attack chest pain, angina. It can be stable or unstable. There's a fair number of decisions made when a person says they have chest pain.

I had to say that, that's been the biggest single part of my clinical career.

I deal with other problems like pacemakers, arrhythmias, people losing consciousness, but the majority of what I've done for 30 years involving well over 20,000 patients has been evaluate chest pain.

Q. Dr. Charash, do you perform exercise stress tests on patients?

A. Yes, I do.

Q. Explain that, please?

A. Well, if you do -- if a person has any form of chest pain there are noninvasive and invasive ways to tell whether or not the pain may or may not be cardiac.

One way is a stress test. A stress test just means that you -- when most people exercise you're increase working at higher, faster speeds to get the heart to pump faster harder to push the need for fuel, with the assumption if the fuel lines are clogged at a higher level of exercise the heart will become miserable.

That cardiac misery we call ischemia. Can be reflected by the EKG, by changes in the EKG, which are like satellites looking at the electricity of the heart.

An EKG is 12 leads. Each lead is looking over one part of the heart like satellites looking down.

An echo is one to look at the motion of the heart muscle. If you do a stress echo you both get the advantage of the EKG information, which is totally independent from the echo information, so you have two sources of information about the heart, the EKG and the imagining. Then you can combine the two and based on the nature of the patient's symptoms make an appropriate clinical decision as to what comes next.

Q. So, Dr. Charash, you do perform resting echocardiograms as well?

A. Yes. Resting echocardiograms is probably second to EKG in terms of the most common tests that heart doctors do.

Q. Exercise echocardiograms as well?

A. Yes.

Q. Can you explain that to us?

A. I can.
Q. Now you treat patients who have a diagnosis, previous diagnoses of coronary artery disease?
A. Yes.
Q. Please explain that?
A. Well, a large percentage of my practice are people who have previously been diagnosed with coronary disease. So if you think about it you have two populations.

One population of people who may have symptoms where you don't know anything about their heart.

Another population of people have symptoms where there is previous experience in studying the heart. So I would say that's 60 percent of my practice or 70 percent are people who have had previous proven coronary artery disease and their approach is slightly different from people who have no previous history of coronary disease.

Q. Can you please explain to us what is coronary artery disease?
A. Certainly. The heart is a pump. It's pumping blood up through the aorta the highway that takes all the blood to the body.

The heart pumps upward in the chest. The aorta rises, forms an arch and descends eventually down in the pelvis. Divides to the legs femoral arteries, gives off branches to every vital organ. At the peak of the arch there are branches

that go to the brain carotid arteries, down the arm which is where we can feel you pulses in the midarm and near the thumb, the radial artery.

The very first branches that come off the aorta are the coronary arteries. The heart has plumbing and electricity. There is the strength of the heart muscle, the status of the plumbing, the coronary arteries, and the disease in the western world is sludge, cholesterol building up in a coronary artery blocking the amount of blood flow, so you can have a blockage that grows progressively, so you can say it's 60 percent blocked, which means it's 40 percent open or 70 percent blocked or 80 percent blocked. That's cholesterol sludge blocking one of the coronary arteries reducing blood flow to a section of the heart muscle. That is the largest disease in the United States and the biggest cause of death in the United States.

The electrical system means the heart has to pumping regularly and has electricity spreading through the muscle to make it beet. If you want to understand the heart all you need to know about the given person is the strength of the muscle, the status of the plumping and whether the electricity is working well.

Coronary disease is again the cholesterol build up inside the arteries that fill the heart muscle.

Q. Dr. Charash, can you tell us what an acute coronary syndrome is?

A. I can and it would be helpful if I can potentially draw something.

Q. Yes. I have a pad and some pens there.

Would you like to do it from there or come here?

A. I think it would make more sense if I stand. Is that okay, your Honor?

THE COURT: Yes.

THE WITNESS: Thank you, sir.

A. I'm going to draw a blow up of a coronary artery. One of the three arteries on the surface of the heart that delivers oxygen to the heart muscle.

There are three separate arteries each going to separate territories of the heart, three rivers, garden hoses, fuel lines. So if you blow up a fuel line -- this is an artery bringing blood to the heart. It has a wall. When cholesterol builds up it starts to penetrate the wall. It grows into what we call a plaque.

This plaque, which blocks the artery, in this case you're going to argue that's 70 percent blocked. Now this plaque, which may be 70 percent blocking an artery is filled with chaotic bodily tissue. It has cholesterol inside, free fatty acids, cell debris, scar tissue , inflammatory cells. It's a hodgepodge of a battle as the plaque grows.

If blood were to come into contact with the meat of the plaque, the blood would misinterpret that as a knife wound

because material is so chaotic that from the blood's point of view it thinks it's an injury. When the blood thinks it's an injury it forms a blood clot abruptly in place, but fortunately the cholesterol plaque as it grows has an outer layer, which I'll consider similar to an egg shell that separates the blood as it flows through the artery from the material inside.

Because of this egg shell type layering over the plaque, blood travels threw it although may be limited because the blood has to go through a more narrow passage, but it's completely separated from the chaotic material inside of that plaque.

Now, every year in the United States two million people suffer a crack in that egg shell. Two million people a year who have plaque will have a plaque rupture where the egg shell cracks, which means that blood traveling down the artery abruptly comes into contact with that inflammatory material and forms an acute blood clot.

Now an acute blood clot, if it forms can abruptly take a 70 percent blockage to a hundred percent within seconds as the clock rapidly seals on the remaining artery.

Of the two million people a year that have a ruptured plaque one million of them immediately have heart attacks, and we call them ST elevation heart attacks because the EKG goes crazy when it happens.

There are segments that rise up. Those million people

when that blood clot forms it's there to stay. Unless they get to a hospital where either catheter can be put in to smoosh it open or drugs given to dissolve the clot, they will feel, if the clot never went away, severe unremitting pain for 18 to 24 hours. Then the pain will go away on it's own because everything downstream is dead.

Now of the million people who get this ruptured plaque and a complete closure there's say 100,000 of them die before they ever get to the hospital.

Arrythmia usually a short circuit of the electrical system 900,000 get admitted through emergency room where they primarily go to a lab where a balloon is put in to smoosh it open, interrupting the heart attack or get clot busting drugs.

One million people when the plaque ruptured you get an abrupt heart attack. There's another million people that when a plaque ruptures, a blood clot does form just like the ST elevation major heart attack people, but in the other million, the other 50 percent the body fights back.

Within the cells of the arteries of the heart there is natural blood dissolving agents and blood thinners that can fight the clot. Now the interesting thing is it becomes a battle because once a clot forms it keeps trying to grow, but for these million people what we call an acute coronary syndrome as opposed to a full heart attack, the body dissolves the clot allowing even a small opening that will relieve the symptoms.

So it's like an arm wrestling competition when the clot has you pinned you'll feel pain, the pain can last for three minutes, ten minutes, 20 minutes. Usually it occurs at crazy times because stable coronary disease would be you have a 70 percent blockage when you run full speed up a hill you're working your heart so hard that you develop chest pain.

Here this isn't about what you do anymore. Chest pain is coming and going based on the battle that's occurring on the surface of that plaque.

Of the million people a year every pattern imaginable has been seen. People can have on again off again chest pain for hours, days, and potentially weeks before they have a heart attack.

So the million people who have an acute coronary syndrome have ruptured a plaque, formed a blood clot, but they're engaged in a critical struggle within the coronary artery where the body is doing everything positive to dissolve that clot and that clot is doing everything possible to grow and block the artery.

The most common symptom is of an acute coronary syndrome is the development of chest pain while doing nothing. Which demonstrates that the problem in your heart isn't related to the work you're doing, but it's related to the artery collapsing on itself. Like I said pain can be three times a day, 30 times a day. Pain can be extremely intensive,

moderately intense. So you can have any pattern, any duration because a million people a year get this problem the nature of how they present is so diverse that virtually any pattern fits into this.

But once a person complains of chest pain at rest if it's coronary, it's a big if, if a person is having chest pain at rest, and if it is coming from the coronary artery it is by definition an acute coronary syndrome where they're engaged in a struggle where they can lose at any time.

Somebody with chest pain at rest that comes and goes if it's not cardiac it's not nothing. If it is cardiac they're life is on the line because most people lose the battle, eventually they lose the battle in an hour, in a day in a week and sometimes in a couple of months.

So it can extend over a really long period of time depending how strongly the bodies ability to resolve the clot. You're virtually facing a high probability of losing the battle and then you become one of the heart attack patients.

That's all I need to draw.

Q. Thank you.

Dr. Charash, you did review Juan Colon's medical records specifically the medical records of Dr. Lefkovic, is that correct?

A. Correct.

Q. Doctor, I'm going to take you to the stress test of

February 5, 2013 that was performed by Dr. Lefkovic on Mr. Colon.

Can you please -- Did you have an opportunity to review that before you came here today?

A. I did.

Q. Now, I would like you to assume, Doctor, that when Mr. Colon presented for the stress echocardiogram to Dr. Lefkovic's office for the stress echo he had already been diagnosed with coronary artery disease in 2008, having had a positive stress echo test done then, and having had a cardiac catheretization performed on November 4, 2008.

I would like you to further assume that at that point Dr. Snyder, Dr. Lefkovic's partner, diagnosed that there was a 60 percent stenosis of the first diagonal branch of the left anterior descending artery.

When Mr. Colon presented on February 5, 2013 he had also began to complain of chest pain, on and off chest pain.

How is that significant?

A. Well, it's significant on several levels. Mr. Colon had shown a 60 percent blockage in a branch of one of the bigger arteries and he had some irregularity in his right corner artery called luminal irregularity early atherosclerosis.

In cardiology the understanding is that over the course of a year, over the course of three months coronary disease doesn't usually change very much, but over the course of

a year it can radically change.

So it's five years in 2013, under five years from when he was demonstrated to have some blockages. Five years is a long time and as a result he was certainly vulnerable to having advanced coronary disease.

So he wasn't just a patient who is presenting for the first time in his life with chest pain. He's somebody who has proven as of five years ago he had a blockage and whether or not you do aggressive measures to try and prevent cholesterol growth you have to always work under the assumption it's going to progress no matter what you do. If you're lucky it doesn't.

But the physician treating you, if somebody has chest pain, must worry that your heart disease has gotten much worse in five years. When he presented with on again/off again chest pain, which resulted in him getting a stress test that ultimately raises the concern of coronary symptoms.

And then if he's having coronary symptoms, depending on whether they're presenting at maximum activity, which would be stable or minimal activity or rest, which would be unstable would texture what you need to do in terms of the diagnosis.

Obviously if you're having unstable coronary pain time is your enemy. When he presented for a stress test he's high risk for having advanced coronary disease, having recurring chest pain. So a stress test at this point is very important.

Q. I would also like you to assume, Doctor, when he

presented for the stress test on February 5, 2013 that he did not have -- I would like you to assume that Dr. Lefkovic at no point in 2008 to 2013 provided any type of medical therapy to the patient, nor did he participate, nor did he record any type of active treatment, any risk factor modifications, so when he presented on that day what is a resting 25 on the EKG?

A. Sorry.

Q. You had an opportunity to look at the 2013 EKG?

A. Yes.

Q. Doctor, can you tell us what that February 5, 2013 suggests?

A. Okay. On February 5, 2013 before he underwent exercise Mr. Colon had a regular EKG done, which is called baseline EKG before you exercise somebody.

So that's the first piece of medical information. What does your EKG look like before you exercise?

In his case his EKG was correctly interpreted as showing inversions of what we call T waves in the inferior leads. The actual interpretation is T wave abnormality consider inferior ischemia.

Inferior ischemia, which this EKG suggests is a possibility, even before you exercise the EKG is saying he may be experiencing a battle going on in his heart. It's telling you it's the bottom wall of the heart.

The bottom wall of the heart is most commonly

providing blood flow from the right coronary artery. As a clinical cardiologist when you see an EKG at rest before they even exercise that says there's T wave inversions in the inferior leads. You begin with a bias that there is a likelihood of a blockage in the right coronary artery or at least with that as a clinical concern.

Q. Going to direct you to this screen. There is that resting EKG of February 5, 2013. I'll give you the date at the bottom. You can see it there, February 5, 2013?

A. Yes. Well, that's the interpretation you're showing. It does say T wave abnormality consider inferior ischemia and that's because there are T waves inverted in leads 3 and ADF.

Of the 12 satellites some of the leads look at the bottom of the heart and in his case a T wave, which should be up right was inverted that's a potential now, it doesn't prove it's a coronary, but in the back drop of him having chest pain this type of EKG would be concerning for ischemia.

Q. Now explain to the jury what ischemia is?

A. Well, the heart doesn't really care how blocked your artery is, it doesn't know how blocked your artery is. The heart only cares if it's getting oxygen and nutrition. So if the heart is not getting enough oxygen and nutrition to work that's what I say is misery of the heart because it's working in the absence of oxygen, and we call that ischemia which is the heart having to perform work without enough oxygen to create the

energy.

So if the heart isn't getting enough oxygen to create the energy to work. Without oxygen that builds up acid which then causes pain or pressure. So if the heart is at rest not getting enough oxygen that would be a sign of potential unstable disease.

If the heart at maximum activity shows a lack of oxygen that would indicate a higher risk for stable disease.

Q. Now, on February 5, 2013 Mr. Colon also underwent exercise EKG, is that correct?

A. Yes, he did.

Q. Doctor, can you tell us what the results were regarding the stress EKG results?

A. I want to give a prospective. He went through a stress echo, which means before he exercised there was a sonogram taken of his heart to look at the muscle. He's attached to it 12 leads, EKG.

He exercises until he can no longer exercise. Every minute that he exercises an EKG is taken to look for evidence of EKG exchanges. At the end of the exercise, as soon as he stops as quickly as logistically possible, he's put on the table and echocardiogram is performed at the end of exercise. So you have two ways of evaluating the heart.

One is the presumption that the arteries are really terrible, the heart wall might weaken during exercise that would

be an abnormal finding.

The other way we evaluate the heart is looking at the EKG and see if there are classic EKG changes that are consistent with ischemia.

Again, both the EKG, these electrical satellites, and the echo are independent measurements of the heart that are occurring simultaneously. So you get two sets of information the imagining study and the EKG. In his case his EKG showed classic abnormalities for ischemia according to the report and there are called ST segments that drop down. In ischemia one millimeter is the magical number.

There was one millimeter of ST depression in the following leads 2, 3 AVF, V5 and V6 that means in five of his 12 EKG satellites there were classic findings for oxygen depravation to the heart during exercise. So if he just had the treadmill and the EKG was the only thing done you would conclude that this was an abnormal stress test and that it was likely he had coronary disease that's what the EKG would tell you.

Q. What are the segments of ST depressions on those five leads?

A. One milliliter suggests ischemia. If it's found in two leads that becomes significant. If it's found in five leads it's very significant. They would be classically read as a stress test positive, which is a bad thing, positive for coronary artery disease.

So if you took the echo out of the equation this stress test would be said that it's abnormal and that he has blocked arteries.

Q. That's my next question what would the positive stress test suggest?

A. It would suggest that he is being attacked by coronary disease and, of course, later on based on his symptoms it would lead to a more aggressive intervention.

Q. Now, in addition to the EKG aspect of the stress echocardiogram what else is done during that process?

A. Well he had the echocardiogram done at rest and at the end of exercise. What you do is you compare -- by the way the programs are based as Dr. Lefkovic had in his office you can see side by side.

When you do an echocardiogram you look at the heart from different angles to get different slices of the left ventricle.

What you do is you look at certain predetermined angles of the heart and then you look at the same places at rest and exercise and on the screen you can project the rest imagine and the exercise imagine side by side.

From each of the different views you can see whether or not the heart muscle is showing any fragility during exercise or whether it strengthens. Most of us the heart muscle gets stronger, stronger, harder and harder with exercise.

Presumably with blocked plumbing some part of the heart muscle might weaken that's what you look for. When you do an echocardiogram there's a special caveat that is that an echocardiogram is a test that sends you sound waives from your chest wall that must penetrate your skin, bone to look at the heart.

Some people the way their body is build you see the heart wall perfectly well. Other people the way their body is formed it's not. It's not the doctor or technician's fault you can't see the heart very well.

So walls just can't be seen with clarity. So every echo can be scored in terms of how technically effective it was.

A perfect stress echo would be perfect clarity of the walls seeing them strengthen. If there is difficulty in envisioning the wall that changes things.

What I mean by the wall, I can draw it here. Is if you see the heart muscle you want to see the outer and inner wall. You want to see them both beat. If you have a view that delineates a wall with both the outer and inner rim and watch it beat that is a perfect echo imagine.

If you on the other hand get an imagine that looks like this and you can't see the wall it's not delineated, then you cannot consider that a valid imagine to make a determination because sometimes a wall will be just haze. You're not really seeing the wall. If that's the case, and the more that's the

case the less effective the echo test is in being reliable because you really need to see the clarity of the walls if you don't that would limit the stress echo portion.

Q. Now, if you have an abnormal EKG, but you have a normal echocardiogram what does that mean specifically?

A. If a patient has let's say they have the perfect echo stress test and you see all the walls perfect well and they get better with exercise and then you have conflicting information that the EKG, which again is independent, shows ischemia that's a mixed result. One part of the test says you're normal one part of the test says you're not. You would have to individualize the patient based on their risk and the nature of their system.

If a person is very high risk for coronary disease such as Mr. Colon having previous coronary disease five years earlier, and if they're having pain at rest and pain at rest means the struggle to close the artery then with a mixed exercise test you have to err on the side of coronary disease.

You cannot dismiss the EKG that's if the stress test were perfect on both ends because you're dealing with a high risk patient with the highest risk symptom.

That would mean with a mixed result, perfect echo that's normal and EKG with classic ischemia in five leads you would have to work on the assumption that he has coronary disease and submit him for a catheretization and angiogram

because it's not like a low risk patient with low risk symptoms, which would then in a lower risk environment have less consequences in a high risk patient.

You cannot be higher risk than Juan Colon from the fact -- even though he had major disease, clear disease five years earlier and if his pain was at rest that's life threatening. If it's coronary even with a perfect split between the echo and EKG you have to err on the side of safety and catheterize him.

Q. What you're stating is that the echocardiogram portion of the stress test does not override the EKG abnormal stress test, is that correct?

A. Because again they're unrelated to each other. They're totally independent evaluations. Even if the echo is better in terms of adding more information it's certainly not perfect and there are things called false negatives.

About five to ten percent of all stress echoes even if they're normal people have major coronary disease. So if the EKG lights up and the echo doesn't in a high risk patient with a high risk symptom the standard of care says you must assume it's coronary disease because their life depends on it.

Q. What is the significance that you mentioned earlier of not visualizing the walls of the heart on the echocardiogram?

A. Well, the less information seen on the echo by poor visualization the even weaker your conclusion is that the echo

is normal.

In Mr. Colon's case as we will demonstrate there are many views where the heart wall cannot be seen at all. There are some views you see it great other views there's no visualization of the wall and key images are missing. The wall in that case, the technical limitation by failing to see critical sections of the heart muscle wall means that you can't call the echo normal. It's incomplete.

So even if it were normal the EKG changes were so significant and rest pain is so concerning, but in this case the echo is far from perfect because there are a number of clear and critical views of the heart wall including the lateral wall, which was involved that you just don't see the wall at all. There's no clear visualization. You're guessing at the wall and that weakened the ability to say the echo was normal.

Q. So it's vital to see all the critical views on the echocardiogram?

A. It's a sliding scale from perfection to complete snowing in Buffalo. We use that term when we see a white out.

There's an in between. In this case there were well visualized views of the heart wall where you see the full thickness, a valid view to compare it, and other crucial views where the wall is invisible.

Q. Would you like to show the jury at this point?

A. Yes. Is there a way to dim the lights?

THE COURT: It's possible, but I would rather not. They might not come back on.

A. I'll do the best we can with what we have.

It's hard to see with the lights on. You can see here that actually in this view you're seeing the heart wall thickness very well. I wish we could see better than that, but this is the thickness of the heart wall. You're seeing an inner and outer edge, which is a good image.

Likewise here you're seeing the inner and outer wall of the heart, which means that these rest and exercise images when compared are effectively looking at the heart muscle and when it moves you can see the heart muscle more effectively than what you can see with the lights on.

When you get to a view such as this here on the rest image, it's hard to see. You can see a wall here a wall here. On the exercise image over here it's hard to see. You don't see the complete wall. I'm just sorry it's hard to show better than this, but there's a more important view, this is a perfect comparison. I just will use this as an example. There's no point in seeing every image.

At this view at rest you see the walls effectively in here you can see the walls effectively. Here on the exercise image you can see the wall almost all the way around, but here you can see that there's nothing. It's just complete white out of the wall. This is the lateral wall of the heart. You can't

see the wall at all. You can vaguely see a wall at rest and you cannot see any wall at all at exercise.

So I think that the only point I want to make from -- I'm not showing every image of the stress test, there are clear moments in the stress test where due to Mr. Colon's body build there were views where you could not see the heart wall at all, which means that the echo was incomplete.

I agree with Dr. Lefkovic that the images that he saw where you saw the walls were good images because the heart muscle did get stronger from rest to exercise, which is a good response, but there were too many images like this one where you could not visualize the wall, and that may well be the wall that was showing the trouble. And if you can't see the wall you cannot conclude the test was complete.

Again, that's the nature of echo. Some people you see sharper better views of every part, some people everything is like this and it's totally useless. I would say Mr. Colon was in between. There were some critical views of his heart where the wall could not be evaluated, not established as a result. You can't call this as a normal stress test because too many vital walls were just not visualized.

Thank you, sir.

Q. Dr. Charash, I would like you now to assume that after Mr. Colon left Dr. Lefkovic's office on February 5, 2013 that he continued to present with complaints of chest pain and the

symptoms became more intense, and I would like you to assume that he made an appointment and called Dr. Lefkovic for an office appointment to see Dr. Lefkovic for the first time in his office since he had seen him in 2008 because of the complaint of chest pain that he was feeling.

Specifically, Doctor, I would like you to assume that when he made that phone call he was able to obtain an appointment for February 21, 2013 at which appointment he presented to Dr. Lefkovic's office and his complaints were chest pain at rest, palpitations, shortness of breath, dyspnea, dizziness, slight headedness. I would like you to assume that, Doctor.

And I would like you to also assume that Dr. Lefkovic was aware and had already confirmed that the patient, Mr. Colon, already was diagnosed five years earlier for coronary artery disease.

What is the significance of that presentation, Doctor?

A. You left out one of the symptoms, which was exercise intolerance.

Q. Yes.

A. So what's documented in the note is short of breath. Short of breath can be for a lot of reasons. It could be lung disease, heart disease, it can be being out of shape, but when someone says they're short of breath they're usually meaning at a time that they don't expect it.

We all know what will make us short of breath and consider normal if you're complaining of shortness of breath to a doctor. If you're writing that down that means not at your maximum work when you should be getting short of breath like running up five flights of stairs.

He had exercise intolerance. Although it's not clear whether the exercise intolerance is caused by the shortness of breath or not and how much limitation to exercise is not recorded, how intolerant is he, how bad is it.

Light headedness and palpitations are very concerning for cardiac symptoms. Palpitations is the feeling of the heart beating harder, faster, which carries with it arrythmia and whenever somebody has symptoms and palpitations is added it raises the coronary artery disease that there's instability in the heart.

Again, we know that Mr. Colon is a diabetic and he had coronary disease as a result, five years later it's going to be worse. So before you even integrate the stress test results into this office visit the note says, Stable chest pain at rest. Denies exertional chest pain.

Well, I'm not sure how to interpret "stable chest pain at rest" other than to say there is chest pain at rest.

Now if a person is having chest pain at rest if it's coming from the heart the clock is ticking because they have a ruptured plaque and they're about to close the artery that's the

only reason why you get cardiac pain at rest. It's the only reason. There is something going on in the artery that's driving your problems.

Given his stress test result where there was unquestionable ST segment depression a marker of ischemia, given the stress test result that showed concern for inferior wall ischemia on the EKG before the exercise began, which again predicts the right corner artery, which is the artery that acted up, and given the incomplete echo even though, even if it were complete the standard of care required to refer him to catheretization.

He knows he has coronary disease. It's going to progress pain at rest, palpitations, light headedness, short of breath. The note is incomplete. It doesn't tell you how long the episodes are, how frequent they are, if there was a pattern, if there was a change.

The word stable indicates that whatever was going on with the rest pain it wasn't dynamically changing. I would accept that, that the pattern of rest pain was not changing day to day. There's still pain at rest in a man who is statistically going to have much more disease than he did five years ago. Inferior ischemia on the EKG, clear ST depression, and like I said even with a perfect echo, but in this case not a perfect echo you have to then send him for catheretization to much is at stake.

The standard of care required referral for interventional cardiology to diagnose the blocked artery.

Q. When you say interventional cardiologist that's basically doing a cardiac catheretization and going in and seeing what exactly is blocked?

A. Yes you have a diagnostic study where you inject contrast material, see it flow. If it narrows down you can tell it's a blockage. Then the intervention where you put in a balloon. I didn't train in interventional cardiology. I have not done intervention since my fellowship, so I don't do the procedure, but I refer people for this procedure regularly and probably done it over 5,000 times or 10,000 times in my career, so as a result he's a man that needed referral for the procedure.

THE COURT: Let's take a minute.

(At this time Elaine Forlenza relieves Tammy Rodriguez as the court reporter.)

Q Dr. Charash, I am going to ask you to now, do you have an opinion to a reasonable degree of cardiac certainty whether Dr. Lefkovic departed from good and accepted medical practices on February 21st, 2013 for failure to diagnose Mr. Juan Colon with an acute coronary syndrome because the patient had presented with pain -- chest pain at rest, dizziness, light-headedness, exercise intolerance, fatigue, palpitations, shortness of breath, who had been previously diagnosed with coronary artery disease five years previously, and who had presented to his office weeks before -- two weeks before on February 5th, 2013, with a positive EKG which showed one millimeter ST depressions in the five leads specific to the inferior portion of the heart? Do you have an opinion, Doctor?

A Yes.

Q And what is that opinion?

A That he deviated from the standard of care by failing to recognize that Juan Colon was suffering from at least a very high risk for acute coronary syndrome and failing to refer him for cardiac catheterization for the diagnosis.

Q And what is the basis of your opinion, Doctor?

A Well, pretty much everything we have said. His previous known coronary disease, his abnormal EKG suggesting the right coronary artery was in trouble even

before the exercise began, the EKG being abnormal under stress test, the echo being incomplete, and the symptoms that we've discussed when he came in of pain at rest. Pain at rest meaning if it's cardiac it's unstable.

So for those reasons and because it's the equivalent of a ticking package, you don't know when the heart is going to blow, time is against the patient, so you have to refer speedily for a cardiac catheterization.

Q Did Dr. Lefkovic also deviate from the standard of medical care in obtaining proper diagnostic notes as to the patient's presentation of his chest pain, including the frequency pattern and magnitude of the resting chest pain?

A Yes. I believe he deviated by having an inadequate note because there are pieces of information that would be important. But that doesn't really change my over all opinion.

Q Now following this acute presentation Dr. Lefkovic, at that point, February 21st of 2013, ignored the symptoms of Mr. Colon, ignored the positive EKG findings and told the patient to go home and exercise. At which point, on March 30th of 2013, he now presents to the emergency room of Staten Island University Hospital with a presentation of acute coronary syndrome.

Doctor, have you been able to review those

records?

A Yes.

Q And can you tell us what were the significant complaints that Mr. Colon presented with on that date?

A Well, on March 30th he presented via EMS for acute chest pain, presented to Staten Island University Hospital with chest pain. Had ST segment depressions in the emergency room. And there were two things that occurred. One is they measured things called cardiac enzymes.

Cardiac enzymes are certain proteins and the most important one is called troponin. Troponin is a protein that lives inside the heart muscle cell and it's really is not found in the body. If there is heart damage of any magnitude heart cells die, explode open and release this protein into the blood.

And it's like a bell curve. It rises up if there is heart damage and it comes down. And we look at the peak of that bell curve to get an idea of how much heart damage. Normally the amount of troponin is so low it's almost zero and if there is heart muscle damage you can follow the troponin.

And what was clear on Mr. Colon's presentation on March 30th are two things. He had a rise of his troponin from the low baseline of .09 up to a number greater than ten, which started to drop again. And then he had a second

rise in his troponin to another peak of eleven and dropped again suggesting he had a heart attack in two waves which happens.

Because he wasn't having the acute ST elevations. He was having what we call non ST segment elevation. It's a stuttering heart attack which means it was in pieces. The artery closed and opened, closed and opened, leading to a double-dip heart attack which resulted in permanent damage of heart muscle cells.

He also was noted to have recurrent chest pain in the hospital which required morphine from the time he was admitted. So what you can see is he didn't come in with a classic ST elevation heart attack. Instead, he came in with this much more intense stuttering heart attack which is kind of a double dip in the enzymes which we can show you.

Until he was finally catheterized which of course showed that the culprit artery was the right coronary artery which was the artery you would have predicted medically based on that first EKG, the stress test, which showed inferior wall ischemia. The stress test condition predicted the artery accurately.

Q The stress test of February 5th, 2013 specifically predicted the area of the heart that would be affected and where the heart attack would actually occur; is that correct? EF

MR. DOPF: Objection, leading, answer in the question.

A Yes.

THE COURT: Already answered. Overruled.

MS. VILLARREAL: Thank you, your Honor.

Q Now, Doctor, I am going to ask you Page 200 LL and it shows specifically Staten Island University Hospital records that the troponin level on March 30th was .09.

Doctor, can you tell us first what is troponin?

A I think I have explained it. It's a protein of the heart muscle.

Now if you look where it says reference the range of normal is zero. Troponin in the blood which a lot of people have zero to .5 and that's in nanograms per milliliter. Now you notice his is not even at the upper limit of the reference range. It's .09. That's a very low number.

So he had when he came in the door even though he was engaged in a heart attack it takes hours for those enzymes to rise. So his first enzymes tell you his baseline .09. It's low. It's where most people are. It's very common to have in that range. It could be less, it could be more but that's about normal.

Q Doctor, someone a patient who is presenting in

the emergency room with cardiac symptoms, is it protocol for there to be an order of troponin?

A Of course.

Q And it's done -- it has to be done hours later because it doesn't come up in the bloodstream; is that correct?

A You repeat it in intervals of hours because, yes, it takes hours for cells that have died or to actually explode and it takes hours for the protein to seep out of the heart attack zone to seep into the bloodstream. So it takes approximately 12 to 18 hours for troponin to reach its peak after an attack.

Q And when the troponin reaches its peak what is it indicative of?

A Well, the peak of a bell curve gives you an idea of how much total death there was. So we use the ballpark of how much damage occurred.

Q When you say death you are talking about death to the actual heart muscle into the areas affected by the heart attack?

A Yes. How many cells died because if two cells die that's double the amount of troponin then one cell dying. So watching the rise of the troponin reaching a peak gives you an idea.

We use the peak as an assessment of the total

damage. Because that's absolutely reflective of death of the heart muscle cells.

Q And in addition to the troponin indicating there was a heart attack, what other indicators and what other treatment was given to Mr. Colon when he presented to the emergency room with respect to his heart attack?

A I do not understand your question.

Q Okay. I am going to strike that and we're going to stick to this at this point.

Now on March 31st the troponin levels, can you tell us what was occurring on March 31st at approximately 1747?

A You mean at 5:06.

Q Correct.

A Well, again, we saw his first troponin when he came in was at 0.09. By five in the morning, on March 31st the next morning, he reached his peak for this peak because there is a second peak, of 10.51. You have to realize that that is 116 times higher than his initial level. So this is indicative of substantial heart muscle death. His troponin rose 116 times from when he came in the door.

Then you can see the troponin starts to drop again. And by midnight on March 31st it's coming down to 4.12. Again, it's a bell curve so as the cells die it releases and then the release rate slows down and it

literally forms a curve. And you see a very clear bell curve of him reaching a peak of 10.51.

Q So based on those records, Dr. Charash, these records indicate that Mr. Colon experienced heart muscle death and a heart attack on March 31st; is that correct?

MR. DOPF: Objection, leading, answer in the question.

THE COURT: Overruled.

A It showed a heart attack occurred on March 30th because the troponin peaked in the morning of the 31st.

Q It already started?

A So because the peak usually is 18 hours -- 12 to 18 hours after the heart attack that proves that that peak level is reflecting the pain he had when he came to the hospital on the 30th.

Q And at this time on March 30th you reviewed the records he had not been taken immediately to the cath lab on March 30th; is that correct?

A Correct.

Q And on March 31st also he was not taken immediately to the cath lab at that time; is that right?

A That's correct.

Q Now we have troponin levels, Dr. Charash, that occurred on April 1st. Would you please explain to the jury

what we are seeing on the screen?

A Sure. We are seeing his troponins dropping from the initial curve because the second to the bottom April 1st at 1347, which is 1:47, it's down to 3.85. That's dropping from the heart attack from the 30th peaking on the 31st and coming down again on the 1st.

But then he rises again to a new peak of 11.47 at 1651, or 4:51 p.m. A second peak that's higher than the first peak. That would mean that 12 to 18 hours earlier there was a second wave of a heart attack that led to a second rise and fall.

So he had a clear curve that occurred when he came in on the 30th. The records show that he continued to have pain on the 31st and as a result again he was probably having what we call a stuttering heart attack, going back and forth and it led to a second peak which does happen. Not often but it does occur.

Q So in this situation Mr. Colon experienced two heart attacks from March 30th to April 1st?

MR. DOPF: Objection.

THE COURT: Overruled.

A You could look at it that way. The real way to look at it is he had a stuttering on again off again heart attack with two peaks. So it's all one acute coronary process with two major components where there was major

damage over the course of those two days.

Q Okay. And during the time that he presented to the hospital, Dr. Charash, do you know if Dr. Lefkovic was still his treating cardiologist?

A According to the records he was.

Q And pursuant to the hospital records did Dr. Charash -- did Dr. Lefkovic, I'm sorry, specifically accept service of this patient?

MR. DOPF: Accept service? Objection.

THE COURT: Sustained. I don't understand the question.

Q The term accept service, Dr. Charash, can you please explain that to us in the hospital records when a patient is being admitted?

A Well, the term we would use typically would be Dr. Lefkovic became his cardiologist of record. So he became the principle cardiologist in charge of his case.

Q So he became principle cardiologist and would be able to control his treatment at the hospital; is that correct?

MR. DOPF: Objection.

THE COURT: Overruled.

A Yes.

Q And, in fact, Dr. Lefkovic, at no point from the beginning of when Mr. Colon presented to Staten Island

University Hospital South and then was transferred by EMS to Staten Island University North to the critical care unit, and from the time he had the diagnosis of an acute myocardial infarction and accept service of this patient, he did not direct that an emergency catheterization be conducted on Mr. Colon until April 1st, 2013?

MR. DOPF: Objection, timing, bill of particulars.

THE COURT: I will allow it.

A Correct.

Q Thank you. And, Doctor, I am going to just refer you briefly to where it says here that the attending emergency room doctor, Christopher Niles, stated, "in discussion with Dr. Lefkovic and El-Sayegh will transfer patient to North CCU. Specifically he continues to state, "still waiting for primary doctor call." I will refer you to the top. "Contact Lefkovic, primary doctor cardiologist." Do you see that?

A Yes.

Q So the attending physician at the ED, Christopher Niles, confirmed that Dr. Lefkovic was the primary medical doctor for the patient, his treating cardiologist, and attempted to call him when he was admitted to the emergency room. At which point it took four phone calls to Dr. Lefkovic. And then, finally, Dr. Niles

indicates, "initial admit patient intermittently symptoms"; is that correct, doctor?

A Yes.

Q "Initial admit to hospital as primary medical doctor with no call back times four has now called back admit changed to his service."

Does that indicate, Doctor, that specifically Dr. Lefkovic, when he accepted service of this patient, agreed to conduct and control the treatment of this patient --

MR. DOPF: Objection.

THE COURT: Overruled.

Q -- at the hospital?

A Yes.

Q Thank you.

Now, Dr. Charash, do you have an opinion to a reasonable degree of medical certainty whether the patient Juan Colon should have been brought as an emergency basis to the cardiac catheterization lab?

A I do.

MR. DOPF: Objection.

Q What is that opinion, sir?

MR. DOPF: Objection, bill of particulars, time.

THE COURT: I will allow it subject to

connection.

MR. DOPF: And 3101(d), failure to state, 3101.

THE COURT: I will allow it subject to connection.

A Well, I believe that once Mr. Colon presented to the emergency room on the 30th with chest pain and very quickly was determined to be having a heart attack, once you come in and you continue to have chest pain even without a classic EKG, that's an absolute indication for emergency catheterization. Because, you know, as it showed he had a stuttering heart attack.

The initial wave of damage couldn't have been prevented because that already happened when he arrived. But that second wave of damage would have been prevented had he had an emergency catheterization and angioplasty.

Q And do you have an opinion, Doctor, whether Dr. Lefkovic deviated from the standard of care when he failed to direct the emergency catheterization of the patient?

MR. DOPF: Objection. No claim, bill of particulars, 3101(d) and bill of particulars limits scope of time and allegations.

THE COURT: Sustained, unless you can prove otherwise.

Q Doctor, do you have an opinion as to whether Dr. Lefkovic deviated from good and accepted medical practices when he accepted service of this patient?

MR. DOPF: Objection. Same objection, same basis.

THE COURT: Sustained, unless you can show otherwise.

MS. VILLARREAL: Judge, may we approach?

THE COURT: Sure.

(Discussion held off the record at the bench.)

THE COURT: Why don't we take a ten-minute break, ladies and gentlemen?

(Jury left the courtroom.)

THE COURT: Show me where or where not it appears in the bill of particulars.

MS. VILLARREAL: Judge, I don't think I have a copy.

THE COURT: I have one right here.

MS. VILLARREAL: And it's the end of departures. It's right in the first departures.

MR. DOPF: Which document are we looking at?

THE COURT: Bill of particulars I am assuming. EF

MR. DOPF: We are looking at the bill of particulars? Okay.

(Pause in proceedings.)

MS. VILLARREAL: It's the supplemental bill of particulars, Judge. The first one and it's the first departure that I mention.

THE COURT: Just looking at the bill of particulars.

MS. VILLARREAL: Okay.

THE COURT: Hold on.

MS. VILLARREAL: It's --

THE COURT: Are you ready?

MR. DOPF: Do you mind if I look on?

THE COURT: I have three of them here.

MS. VILLARREAL: Okay, great.

THE COURT: Why you gave me three I don't know.

MS. VILLARREAL: Try to be nice. Here we go.

MR. DOPF: This is supplemental.

MS. VILLARREAL: The supplemental specifically says --

THE COURT: What are you referring to?

MS. VILLARREAL: The first paragraph departed from good and accepted medical practice

in negligently misdiagnosing and failing to diagnose plaintiff's cardiac presentation.

Do you see that?

THE COURT: No. Where are you reading from?

MS. VILLARREAL: Supplemental verified --

THE COURT: Hold on.

MS. VILLARREAL: First paragraph, number one.

THE COURT: Go ahead.

MS. VILLARREAL: And then couple of -- one, two, three, four, five, six sentences, six lines down, Judge.

"And departed from good and accepted medical practice in negligently misdiagnosing and failing to diagnose the plaintiff's cardiac presentation, acute cardiac symptoms, acute coronary syndrome, myocardial infarction, coronary occlusion; and in failing to properly record and evaluate the plaintiff's symptoms and complaints on clinical examination; defendants were careless and departed from good and accepted medical practice failing to properly evaluate and record the plaintiff's symptoms and complaints, and to take into consideration the plaintiff's past

medical history."

It goes on to the next page. "In failing to offer the plaintiff medical treatment to alter the progression of his disease, and to follow up with diagnosis and treatment of the plaintiff's medical condition; failure to promptly prescribed, order or perform additional tests including cardiac catheterizations, angiograph, angiogram, nuclear stress tests, echo-stress test, EKG" -- it's all in there, Judge.

MR. DOPF: It doesn't make it, Judge, because if you look at the bill of particulars, Paragraph 7, counsel meticulously outlines the dates of alleged departures. And to be very specific it says, quote, beginning in or about November 2011 and continuing until plaintiff's myocardial infarction on March 30th, 2013.

I will show it to you, Judge.

MS. VILLARREAL: It continues if I can with the same supplemental bill of particulars on the second page at the bottom. It's one, two, three, four, five, six --

MR. DOPF: What page?

MS. VILLARREAL: It's the second page.

MR. DOPF: Second page.

MS. VILLARREAL: Second page. One, two, three, four, five, six from the bottom, Judge. There is a double colon that's like the marker.

MR. DOPF: I see it.

MS. VILLARREAL: "Failing to properly refer the patient to the emergency room for emergency cardiac assessment including cardiac catheterization; in failing to obtain necessary blood work, an interventional cardiology consult; in failing to properly and adequately evaluate and monitor the progress of the plaintiff's cardiac arterial disease, or lack thereof; in failing to order and/or perform necessary diagnostic tests and procedures including appropriate blood work including cardiac enzyme studies; in failing" -- the next page.

"In failing to timely order necessary and indicated consultations and make timely and proper referrals; in failing to obtain medical records and consult with pulmonologist -- that's different.

"In failing to heed and/or take note of risk factors, clinical presentation and plaintiff's complaints, and EKG results for myocardial infarction."

This is all part of it, Judge. It's all part of it. This is all the lack and then the first -- the first very first thing that I say in my departures if you have that in front of you, Judge, and then it goes on. I say it again in the same page here.

MR. DOPF: Judge, I have a very simple question. How is counsel going to get around the fact that there is a bill of particulars that was served and Paragraph 7 brings the garage door down on the date of the myocardial infarction?

To quote, Beginning in or about November 2011 and continuing until -- continuing until plaintiff's myocardial infarction on March 30th, 2013, end quote.

All of the allegations that counsel just read to you would arguably have application before the heart attack. There are claims that we should have gotten a cardiac catheterization, for example, before the heart attack. So every one of those claims was completely and is completely applicable to anything on the day up to the heart attack and going backwards.

There is no way to go around this. We have the right to rely on a bill of particulars

which brings the garage door down on March 2013.

MS. VILLARREAL: Well, the supplemental bill of particular does not bring the garage door down.

MR. DOPF: Show us a date.

MS. VILLARREAL: I just indicate there is no --

THE COURT: There is no date.

MS. VILLARREAL: There is no date. So that's the reason it's specifically brought up to encompass the fact that he failed to immediately send him for emergency catheterization, which is stated in there.

It is the first line of my departures, Judge.

THE COURT: I understand that but I don't see a date in there.

MS. VILLARREAL: Because there is no date, Judge. It encompasses not only the first time when he made -- when he presented to his office on the 21st, but also when he presents continually in the emergency room now that he had a myocardial infarction which specifically it's in there.

So they're all in there, Judge. It

doesn't -- it doesn't limit in any way as to limiting it only to the 21st and up to the 30th. It continues.

That's why the supplemental was done because it's broader. It's broader and it continues the same issue which is that he should have been referred to emergency catheterization. It's there and if I can read your Honor from my departures because I don't have them in the front of me. Either it's the first one --

MR. DOPF: These are the departures that were provided during jury selection. So what. And that's not a 3101(d).

MS. VILLARREAL: And specifically it was part of the 3101(d) and it was --

THE COURT: I haven't seen the 3101(d).

MR. DOPF: Judge, very simply we served demand for a verified bill of particulars with the answer. And one of the questions, Question 7, was in effect, set forth the dates of the alleged negligence and those are the dates set forth.

I don't see how in the world plaintiff can now come in and say, oh, we can go past those dates. There is nothing in writing putting us on notice to that. And as I said every single claim

that plaintiff just read from could apply to things before.

MS. VILLARREAL: Judge, they apply to things before, they apply to things after. That's why it was broad and that's why we served a supplemental bill of particulars, and that's why it's in the 3101(d). It doesn't specify a date. That's what was omitted in the supplemental and 3101(d) -- the supplemental 3101(d) because it was -- specifically it was a continuous process of failing to send him to have emergency catheterization.

That's why those dates were omitted. And it is a continuous process. It starts on the 21st and it continues all the way through until he had the catheterization. And he is in his service. So the jury has every right to hear that question, Judge, and to get a response from the expert.

THE COURT: Then why did you put dates down in the original?

MS. VILLARREAL: I didn't do it, Judge.

THE COURT: I am not saying you in particular.

MS. VILLARREAL: But that's why there was a supplemental bill of particulars. That's why

there was a supplemental 3101(d).

THE COURT: But they didn't have supplemental dates.

MR. DOPF: Correct, Judge.

MS. VILLARREAL: I didn't. The dates were not included in the supplemental 3101(d).

THE COURT: I understand that which is the problem.

MS. VILLARREAL: Well, it's not a problem, Judge, because it specifically shows that it's a continuous process of failing. It's not limited to that date. It goes -- it continues into --

THE COURT: But it doesn't say that.

MS. VILLARREAL: Well, it doesn't have to, Judge. As soon as it says the failure to diagnose myocardial infarction, every level, every time the plaintiff presents to him. And basically he has the the opportunity to treat the patient with an emergency catheterization is the point.

He was the treating doctor. That was continuous treatment and the continuous treatment included his service at the hospital. And that's why -- that's why the dates were omitted because it's a continuous treatment. It doesn't have to

be on --

THE COURT: How do you know that? You said you didn't prepare that. How did you know what they were thinking when they prepared it?

MS. VILLARREAL: I am not talking about the first one. I am talking about the supplemental and the 3101(d).

THE COURT: Okay.

MR. DOPF: Why are there no dates?

MS. VILLARREAL: It's continuous treatment. It's continuous treatment.

MR. DOPF: That's a disingenuous argument. That means it goes on forever.

THE COURT: Hold on. One at a time.

MS. VILLARREAL: If counsel had any problem with the supplemental bill of particulars and the 3101(d) it would have been incumbent upon him to raise those issues at the very beginning of this trial. Not in the middle of my cross -- my direct examination of my expert cardiologist.

These were broadened supplemental bill of particulars and 3101(d) was specifically there was no date set forth because it was continuous treatment and the failure of this doctor at every point to send the patient for emergency

catheterization is the entire case, Judge. At every point.

THE COURT: I know it's the entire case which is why we're having this argument.

MR. DOPF: Judge, just so we're clear. Another episode of disingenuosity. I have been complaining about the fact that questions have been allowed for stuff that happened after the admission for the heart attack. So I have been bringing to the Court's attention literally from day one that the stop sign when we're finished is the heart attack up until. Until. Oxford dictionary, Webster dictionary, until, it means it's done, over, and I am entitled to rely upon that.

MS. VILLARREAL: Judge, counsel is not entitled because he decided to ignore the supplemental bill of particulars and to ignore the supplemental 3101(d), which did not provide a date. And specifically it was done purposely to not provide a date because it was continuous treatment. And every time the patient presented to this doctor and he had the ability to direct his catheterization, it was not done.

That's why the supplemental was done and

it was incumbent upon counsel to raise any objections to the supplemental bill of particulars and the supplemental 3101(d) at the beginning of the trial, not in the middle of my cross-examination of this doctor.

MR. DOPF: Judge, counsel just mentioned that she purposely -- she or her firm purposely left out the dates, purposely left out the dates. Why? Why would you? If you have to give notice and you are going to correct or amend or supplement a prior term limitation or period of time, why not put a date in?

Counsel just admitted, We purposely did not put a new date in.

MS. VILLARREAL: Because it was continuous treatment, Judge. And, again, counsel had every opportunity, reviewed the supplemental 3101(d), reviewed the supplemental bill of particulars. At no point did he raise this issue that it was in conflict, that no date was provided until I am in the middle of my cross-examination -- I mean my direct examination of my expert.

That is blatantly unfair and improper, Judge.

THE COURT: You are only allowed to ask

questions based on --

MS. VILLARREAL: It's in there. It's not limited. It's not limited, Judge. It's in my supplemental. It's there.

THE COURT: Tell me exactly where it's there because to be honest with you I still don't see it.

MS. VILLARREAL: Judge --

THE COURT: Yes.

MS. VILLARREAL: It's in there.

THE COURT: Where?

MS. VILLARREAL: I just went over it, Judge.

THE COURT: I still don't get it.

MS. VILLARREAL: Okay.

THE COURT: So.

MR. DOPF: Give us a date. Give us a date.

MS. VILLARREAL: There is no date. The date I just indicated --

THE COURT: Where does it say this goes on infinitum?

MS. VILLARREAL: Significant --

THE COURT: Show me where.

Show me the exact --

MS. VILLARREAL: We'll start from the beginning.

THE COURT: No. Show me the exact language where it goes on beyond March 30th.

MS. VILLARREAL: It doesn't give a date.

THE COURT: Tell me where it goes on after that.

MS. VILLARREAL: It doesn't.

THE COURT: Without a date.

MS. VILLARREAL: The whole supplemental bill of particulars does not provide a date.

THE COURT: I understand that. That's my question. So how could you get this in?

MS. VILLARREAL: Because, Judge, it's continuous treatment.

THE COURT: Give me that exact language, continuous treatment.

MS. VILLARREAL: This is -- here we go.

MR. DOPF: Continuous treatment has to do with statute of limitations. That's where that term comes in. Why bother even asking for alleged days of malpractice or negligence? Why even put it in your demand for a bill of particulars?

If counsel is going to say it's all continuous treatment why should we even have the

question?

MS. VILLARREAL: "Careless, negligent, and de parted from good and accepted medical practice in negligently misdiagnosing and failing to diagnose the Plaintiff's cardiac presentation, acute cardiac symptoms, acute coronary syndrome, myocardial infarction, coronary occlusion."

That's myocardial infarction, Judge, is when he presents at the hospital. That's exactly then. That's why it was not limited.

Counsel had an opportunity to review this. He had every opportunity. If he had any objections and wanted more specificity as to this supplemental bill of particulars he could have requested it. He did not.

It goes on. "Defendants were negligent and departed from good and accepted medical practice failing to properly evaluate and record the plaintiff's symptoms and complaints, and to take into consideration" --

THE COURT: Where specifically does it say beyond March 30th? That's all I'm asking.

MS. VILLARREAL: What, Judge?

THE COURT: Where does it say beyond March 30th? EF

MS. VILLARREAL: The supplemental bill of particulars.

THE COURT: I got it.

MS. VILLARREAL: Right. It doesn't say --

THE COURT: I still haven't heard it.

MS. VILLARREAL: Okay. Okay, here we go.

"Including his confirmed -- and to take into consideration the plaintiff's past medical history, including his confirmed coronary arterial disease and progression of his disease over a significant period of time; in failing to offer the plaintiff medical treatment to alter the progression of his disease, and to follow up with diagnosis and treatment of the plaintiff's medical condition; failure to promptly prescribed, order or perform additional tests including cardiac catheterizations, angiograph, angiogram, nuclear stress test, echo-stress test, EKG and/or a stress test, echocardiogram, nuclear testing, chest CT; in failing to render proper care and treatment, including failing to prescribe, order and follow up re: Cardiac medications, angiogram, angiography balloon angioplasty, anticoagulants, anti-platelet agents, clot dissolving drugs".

It goes on. Okay. And then it goes on.

"Percutaneous coronary intervention, that's specifically cardiac catheterization and angioplasty or a combination of treatments; in negligently failing to diagnose the plaintiff's heart disease and acute cardiac condition; in negligently failing to diagnose plaintiff's myocardial infarction", that is a presentation in the hospital.

"In failing to appreciate the significance and fully evaluate and record the plaintiff's signs, symptoms and complaints including shortness of breath at rest and on exertion/rest and chest pain or discomfort; in failing to consider and interpret EKG results including ST depressions" -- it goes on, Judge.

There is no limitation. Counsel had this supplemental bill of particulars since August and at no time objected. He objected to the specific departures that were submitted during jury selection. The first departure that is mentioned there was not mentioned before the witness took the stand this morning.

And that was specifically -- if you can read from it, Judge, because I don't have it in

front of me what that is and that the failure to diagnose the myocardial infarction and send the the plaintiff for immediate emergency catheterization. It's continuous. There is no limit.

I don't say only on the 21st. I don't say on the 21st and March 30th and April 1st and April 3rd and April 4th. I don't say that. So it specifically omitted the dates because our allegation is broad.

If he, in fact, had any problems with those with the lack of specificity it was incumbent upon counsel to make those objections at the very beginning of the trial and certainly before my expert testified, it was not mentioned, it was not raised. And now in the middle of cross-examination he is not being allowed to answer a question that is clearly in here. The lack of to immediately refer the patient for emergency catheterization at another point in time.

MR. DOPF: May I be heard? This is all repetition. It's perseveration. May I be heard?

THE COURT: You will be.

MS. VILLARREAL: It is prejudicial. My

client has clearly set forth the allegations. The allegations were that at every level this continued. This is why the failure to diagnose the myocardial infarction, this is a presentation at the hospital. That's clearly at the hospital. That's when he is there.

So he was on notice there was no dates, Judge. If he wanted specificity it was incumbent upon him to request specificity at the very beginning and not in the middle of my cross-examination.

MR. DOPF: I had specificity, Judge. The Oxford living dictionary defines the word until as, quote, up to the point in time or the event mentioned. As preposition, quote, The kidnappers have given us until October 11th to deliver the documents. Or, quote, he held the office until his death. Until is a simple word. That's when the garage door came down. I had the right to rely upon it.

THE COURT: I am not going to allow it.

MS. VILLARREAL: Judge --

MR. DOPF: Can we take a break now, Judge?

THE COURT: Yes.

MS. VILLARREAL: Note my exception, your Honor. This is extremely adverse and prejudicial. It is clear in the supplement bill of continuation, Judge, and really I don't see how --

THE COURT: Your exception is noted.

MR. DOPF: Thank you. May we take a break, Judge? Five minutes okay?

THE COURT: Yes.

(Recess taken.)

COURT OFFICER: Jury entering.

(Jury entered courtroom.)

THE CLERK: The jury is present and properly seated. Do both sides stipulate?

MR. DOPF: Stipulated.

MS. VILLARREAL: Stipulated.

THE CLERK: Case on trial continued. The the parties remain the same.

THE COURT: Thank you.

Q Dr. Charash, I am going to direct your attention to the transthoracic echocardiogram that was conducted on March 31st of 2013 at the hospital of patient Juan colon and specifically in the document here. Could you tell us what the findings were?

You had an opportunity to review this document; is that correct, Doctor?

A Yes.

Q And specifically tell us where it says, clinical question ACS, could you start there and tell us the significance of what is denoted in that report?

A Well, ACS means acute coronary syndrome which Mr. Colon was suffering from. And this is a sonogram of the heart measuring it's size and strength. And it says the ventricle, meaning the left side, the big pump was mildly dilated. Systolic function which is the strength, the beating, moderately reduced. Ejection fraction is estimated to be 35 percent.

Q Could you explain to us what that means?

A If you take a water balloon the best way to understand ejection fraction, fill it with water, hold the lip closed. If you release the closed lip and squeeze as hard as you can, it's obviously impossible to squeeze out one hundred percent of the water.

Let's say you squeeze out 95 percent of the water and you would say that squeeze you ejected out of the water balloon 95 percent of the water. So the fraction you ejected 95 percent is what we call the ejection fraction.

The normal left heart when it fills up with blood squeezes ejecting blood into the aorta. Normally when the heart squeezes most people the normal normal is 60 percent. Most of us sitting here when the heart squeezes

one squeeze 60 percent of the blood inside gets sent out to the aorta, and 40 percent remains behind. Then more blood mixes in and then it squeezes again 60 percent of that out.

So the normal ejection fraction is 60. We say the range of normal is 50 to 70 but most people live at 60. If it's under 50 it is unquestionably clinically reduced, but people can have varying responses to changes of ejection fraction. Some people with very dilated hearts can actually tolerate low ejection fractions because the heart is triple in size, then a lower ejection fraction is still squeezing a lot of blood.

So people respond differently to ejection fraction changes. But here it is 35 percent which is moderately severe in terms of how much damage there was.

Q And what is the significance of ejection fraction that was 35 percent on March 31st, 2013 compared to when Mr. Colon had his last echocardiogram on February 5th, 2013 where the echocardiogram resulted indicated he had an ejection fraction of greater than 55 percent?

A Right. I mean he was probably closer to 60 as almost everybody is. Now it's reduced to 35. Clearly his ejection fraction recovers because after a heart attack and you have an angioplasty some of the muscle that looks dead is actually asleep or hibernating and it can recover. But at this moment in time this is the weakest his heart

appeared and it was down to 35.

Q And this is a marker -- another marker that the medical community has in order to determine if the person had, in fact, a myocardial infarction?

A Yes.

Q So if the ejection fraction is moderately reduced or reduced from 55, 60 to 35 that would be another indication the person suffered damage to his heart?

MR. DOPF: Objection leading.

THE COURT: Overruled.

A Yes.

Q In addition -- on this echocardiogram in addition to the finding that his ejection fraction had been moderately reduced from 35 percent to the normal of 60, it also indicates that there was a kinesis of the inferior and hypokinesia of the inferolateral wall. Can you explain what that means, Doctor?

A Well, inkinesia means the wall isn't moving, the bottom wall had the heart attack which is supplied by the right artery. And the inferolateral wall, is the bottom side wall of the ventricle was weakened.

Q And that all is evidenced in this echocardiogram was the result of the myocardial infarction?

A Correct.

Q And, Doctor, following this result I'd like

you to assume that Mr. Colon continued to have cardiac presentation and was catheterized again following this 4/1 catheterization.

And I would like you to assume that since his heart attack he experienced increased fatigue which did not permit him to play with his granddaughter, to go jogging, to go walking, to generally enjoy the things that he would do around the house and helping out.

What is the fatigability specifically following the myocardial infarction?

A Fatigability at any time is evidence that the heart is not producing enough general blood flow for the activities that you want to perform. When his ejection fraction was 35 percent that was when it was at its weakest which would be severely limiting in terms of the activities that a person can perform.

We know Mr. Colon's ejection fraction over the next few years improved. It rose on echocardiogram, nuclear images and catheterizations in the future to the 45, 50 percent range or around 50.

Now 50 percent is not a terrible ejection fraction. If it is 50 it's in the range of normal but he was higher than 55 when he started. Some people at 50 percent can carry on a normal day. I have seen people with ejection fraction of 40 percent with very little limits.

Other people with 50 percent especially with the amount of enzymes he lost, it may be 50 at rest, but he may not be able to mount an increase that's supposed to happen after activity.

So sitting in a chair with 50, 60 when he would get up to goes up to 70. So some heart attacks you are really not that damaged but you then don't have the ability to mount the cardiac response needed for activities. It's very variable based on individual response to a heart attack and potential comorbidity. So the point is people vary.

If Mr. Colon suffers from fatigability and a limitation in certain daily activities that he used to participate in, certainly the damage he had quantified by the enzymes that are released and the fact that his heart is resting at a low 50 that it certainly would mean that he can't mount the cardiac response to activity. He may be okay at rest and moderate activity, but it can vary from person to person. There are some people tolerate the same ejection fraction far better. Others far worse.

Q Given the damage that was done to Mr. Colon's heart are his symptoms and his presentation consistent with the damage that he sustained?

A Well, yes. There is no question that the heart attack that brought him by ambulance on March 30th,

2013 resulted in permanent damage to his ventricle. There is just no doubt we measured two peaks of enzymes and his ejection fracture was lower than where it was.

So unquestionably the heart attack that occurred between his office visit with Dr. Lefkovic in February to his heart attack in the end of March resulted in permanent damage.

Q And I'd like you to assume, Doctor, that two years before Mr. Colon's heart attack of 2013 -- heart attacks of 2013 he was disabled due to a cervical injury. Would you tell us, Doctor, what would be the significance of a heart attack occurring in 2013 on those cervical injuries preexisting condition?

A In medicine and I think in people who have experienced more than one medical problem understand that there is a term we call synergy. Where it's one plus one equals two, one plus one equals three or four. And that means if you have one chronic medical problem you are adjusting to even if it limits you, if you develop a second serious medical problem, the combination of the two can result in a far worse, over all physical ability than the sum of the two of them individually. Because they add on to each other.

People who have severe musculoskeletal problems often need higher cardiac outputs because they are

in pain, their body is under stress. So if you add to that a heart attack the impact of the heart attack might be more profound on a man like Mr. Colon because he has both problems, than a man who didn't have a cervical problem or a preexisting disability.

So there is a frequent concept of synergy. If you get more than one serious medical problem, the two of them are more destructive than either one individually when you add them together.

Q Doctor, do you have an opinion to a reasonable degree of medical certainty whether the damage that was done to Mr. Colon's heart, symptoms that he experienced and the problems that he's continuing to experience as a result of that permanent damage to his heart were because of the negligence and the departures of Dr. Lefkovic?

MR. DOPF: Objection.

THE COURT: Overruled.

A Yes. Yes. I believe Dr. Lefkovic's failure to refer Mr. Colon for an emergency cardiac catheterization in February of 2013 resulted in him suffering an otherwise totally preventable kind of double-dip heart attack starting on March 30th, 2013. And I think that he would have had his right coronary artery repaired without any damage to his ventricle. And with the current state of stents and coronary repair then he would not have any cardiac injury

today.

MS. VILLARREAL: Thank you very much, Doctor. I have no further questions.

MR. DOPF: May I, Judge, just for a few minutes? Three minutes?

THE COURT: About five minutes. Then we have to break.

CROSS-EXAMINATION

BY MR. DOPF:

Q Sir, are you aware of the fact that Mr. Colon testified that in February of 2013 when he went to Dr. Lefkovic and up until his heart attack he continuously suffered from shortness of breath, chest pain, palpitations among other things? Are you aware of that testimony?

MS. VILLARREAL: Objection. I don't understand what he's talking about.

THE COURT: Overruled.

Q Are you aware of that testimony? Yes, sir or no, sir?

A I'm sorry, are you talking about deposition or trial?

Q I will take either. Have you read the trial testimony?

A No.

Q Then why ask me about trial? Deposition.

A I don't know if there is --

MS. VILLARREAL: Objection.

A I only ask because I don't know if there was testimony that I am unaware of.

Q So back to my question. Are you aware of the fact from reading his deposition that he had continuous complaints of pain, sweating, fatigue, palpitations, shortness of breath from the February visit to Dr. Lefkovic up until the heart attack? Are you aware of that?

A Yes.

Q Now tell our jurors have you mastered the facts of this case? Do you have a good understanding of the facts of this case?

A I have a good understanding but I haven't memorized all the materials.

Q Right. You need a good understanding because you never want to come into Court under oath and swear or affirm another physician committed malpractice if you didn't have a good, basic understanding of the facts. Fair statement?

A I think more important --

Q Is that a fair statement?

A It's an incomplete statement.

Q Sir, did doctor -- excuse me, did Mr. Colon see any physicians from his last office visit to

Dr. Lefkovic in February of 2013 up to his heart attack? Did he see any physicians?

A I am not aware of any.

Q Who is Dr. Chapman?

A I think his primary care physician.

Q Wrong.

A Okay.

Q Who is his primary care physician?

A Doctor -- I am just going -- Dr. Tamburrino was his new cardiologist.

Q Who was his primary care physician?

A I could look it up here. I know I have it here.

Q Are you telling us you don't remember as you sit here?

MS. VILLARREAL: Let him finish the question. Objection.

THE COURT: Wait until you get an answer.

MR. DOPF: Okay.

A Dr. Tirado I think actually was his primary care physician.

Q Okay. Now let's go to Page 63 of the hospital chart. It would be that thick binder there.

MS. VILLARREAL: Note my objection, your Honor. May we approach?

MR. DOPF: Why? I am cross-examining.

THE COURT: No. He's entitled to cross-examine.

MS. VILLARREAL: Your Honor, with respect to Dr. Chapman we didn't have a ruling on that.

THE COURT: I know.

MS. VILLARREAL: That's why we need to approach.

MR. DOPF: I am moving on, Judge. I am moving on to a totally different subject.

THE COURT: You are not mentioning anything about Dr. Chapman.

MR. DOPF: No, I'm not.

Q Are you there, Page 63?

A Yes, sir.

Q In a loud, clarion voice would you tell our jurors where it says private physician, the upper left hand corner, private physician whose name is that?

A Dr. Tirado.

Q Now what do the initials PMD stand for?

A Private medical doctor.

Q Okay. And can we agree, sir, that Dr. Tirado was the private medical doctor of this patient, Mr. Colon? Do we agree or do we disagree, sir?

MS. VILLARREAL: Objection. One of the

private medical doctors.

MR. DOPF: We don't need coaching, Judge. We don't need coaching.

THE COURT: Overruled. If you know answer the question, Doctor.

A He was.

Q And when we talk about PMD or private medical doctor, as a general proposition it's generally the internist, the family doctor, those are generally the primary care physicians, correct?

A I agree.

Q How many times did the primary care physician not call back according to that page?

MS. VILLARREAL: Objection. He is completely distorting the facts and the record.

MR. DOPF: She is not allowed to make these statements, Judge.

MS. VILLARREAL: Objection, your Honor. There is no foundation for that question.

THE COURT: It's cross-examination. He is allowed to ask.

A According to this it said initial admit to hospital as PMD with no call back times four pages.

Q So the four times when there was no call back it was Dr. Tirado who didn't call back, correct? PMD, am I

correct or incorrect?

MS. VILLARREAL: Objection.

THE COURT: Overruled.

Q Am I correct or incorrect?

A I don't know if that can be determined by that sentence alone.

Q Didn't we agree a moment action that PMD means private medical doctor? Didn't you just tell our jury that?

A Yes.

Q Didn't you tell the jury that private medical doctor is typically the internist? Didn't you say that just a minute ago?

MS. VILLARREAL: Objection. That's not what he testified to.

THE COURT: Objection sustained. Let's break for lunch.

MR. DOPF: Judge, before --

THE COURT: Hold on.

(Jury left the courtroom.)

THE COURT: You could step down, Doctor.

THE WITNESS: Thank you, sir.

MR. DOPF: I don't want him to leave. I have a question.

THE COURT: Wait until after lunch.

MR. DOPF: I thought you would like me to

do it during lunch so I could get ready.

THE COURT: What are you talking about?

MR. DOPF: If the doctor has any notes or report. I see he has Post-its, could I see them over the lunch period?

MS. VILLARREAL: No.

MR. DOPF: Otherwise I am going to need to take a break at 2 o'clock to read them. I am entitled to see any notes, Post-its, stickers, underlines that he has done.

THE COURT: Ask the questions. You can ask him after lunch. If you need time to read them --

MR. DOPF: I am going to ask that none of the stickers, Post-its be taken off during the lunch break.

THE COURT: Just leave them the way they are.

THE WITNESS: I will leave them here. No one is touching them.

THE COURT: Right now regarding Chapman I am inclined not to preclude him from testifying.

MS. VILLARREAL: Not to preclude him?

MR. DOPF: Not to.

THE COURT: To preclude him from

testifying.

MS. VILLARREAL: Thank you, Judge.

THE COURT: I think that's only going to be piling on.

MR. DOPF: Only be what?

THE COURT: Piling on.

MR. DOPF: Well, Judge, I would like to at least admit his records into evidence because his records have two visits between the heart attack and the last time.

THE COURT: I am just telling you where I am leaning to.

MS. VILLARREAL: Judge, if he wants to look at the records during lunch he can look at the records during lunch. Whatever he wants to do so he doesn't have to break at any point during the testimony.

MR. DOPF: Are you saying I can take them to lunch?

MS. VILLARREAL: Yes.

(Lunch recess taken.)

(Elaine Forlenza was relieved by Tammy Rodriguez, as official court reporter.)

MS. VILLARREAL: I want to make sure that there is no further questioning regarding Dr. Chapman. Regarding that your Honor has ruled.

THE COURT OFFICER: Jury entering.

(At this time, the jury enters the courtroom.)

THE CLERK: Jury is present and properly seated.

MS. VILLARREAL: So stipulated.

MR. DOPF: So stipulated.

CROSS-EXAMINATION

BY MR. DOPF:

Q. Sir, we can agree that you are no stranger to the courtroom. You've been in the courtroom hundreds of times, as an expert, correct?

A. Yes.

Q. You realize that in a courtroom setting as an expert witness you can be asked to answer questions yes or no or tell us you can't answer yes or no, you're familiar with that routine?

A. Yes.

Q. So I'm going to ask you to adhere to that routine for the purposes of my questions.

Can we agree, sir, that you've been asked by defense attorneys like me on many occasions to estimate your total earnings for all of your medical, legal activities over the past roughly 30 years, would you agree with me, you've been asked

that before I asked you today?

A. Yes.

Q. Sir, would you agree with me that you've earned at least $2 million in your medical/legal reviews and testimony, if we go back to the beginning and up to today?

A. No.

Q. Sir, state a number, tell this jury how much you've earned from medical/legal work whether it be testifying, reviewing, or whatever, how much have you earned in total, just give us a number or a range?

A. Well, I've been doing this for 30 years.

MR. DOPF: Judge --

A. I'm trying.

Q. I asked for a number or a range?

THE COURT: Overruled.

A. Doing this for 30 years the average income is probably been between 30 and 50 over those 30 years, so I would say $900,000.00 to $1.2 million.

Q. Did you say the average was somewhere between 30 and 50,000?

A. If you talk about over 30 years, yes.

Q. So 50,000 times 30 years would be 1.5 million?

A. Yes.

Q. Have you met with Plaintiff's counsel before coming to court today?

A. Yes.
Q. Did you meet over lunch?
A. No.
Q. Lunch separately?
A. I went on my own way.
Q. How many times did you meet with counsel?
A. Twice.
Q. By the way what will your total earnings be or your total invoice be for your review time in this case, conference time, and time in court about?
A. Time in court is $4,000.00 for a full day away from work, and prep time probably was including meeting time 8 hours over three years, $450.00 an hour. I can't do it, eight times $450.00, but that's under $4,000.00, so I would say it would be about $8,500.00.
Q. So trial review time, conference time, about eight and a half thousand dollars?
A. Yes.
Q. Sir, you testified in a courtroom more than 230 times haven't you, yes or no?
A. Probably.
Q. Now if we do 230 times not times eight and a half thousand for the whole review and the testimony lower, we'll make it $5,000.00. If you got $5,000.00 for review of a file and testifying in court, and you did it 230 times, what would

that add up to?

A. I don't know.

Q. $1,150,000.00 just on those cases that you've testified, fair statement?

A. No because many --

Q. Is it fair or unfair?

MS. VILLARREAL: Objection. Let him answer the question.

A. Unfair.

Q. Sir, in addition you've given over 330 depositions under oath, meaning in a lawyer's office or in a courtroom where there's no Judge and jury?

A. That's accurate.

Q. Sir, your minimum for many years for a deposition has been two hours, fair statement?

A. Unless we agree that it's less.

Q. Your typical deposition with prep time and going to the deposition is at least four hours, fair statement, including prep time?

A. Probably.

MS. VILLARREAL: Note my objection to the deposition, no foundation.

THE COURT: Overruled.

Q. So let's do your depositions now. If it's four hours let's just take a lower number $400.00 that would be $1,600.00

per deposition, times 330 depositions that's over half a million dollars?

A. My rates were under $300.00 an hour. They only went up to $400.00 an hour in the last five years. Some of those depositions were much quicker. I reviewed many of the trials were four hours not eight. They were local New York although I know you're trying to come up with an honest assessment of what my 30 years income is, the way you're projecting it is not exactly accurate.

Q. Let's do this journey together. You reviewed about a thousand medical malpractice cases over your career 950 to 1,000?

A. Close to 950 I don't know the number.

Q. Wouldn't you estimate that you get at least $500.00 on average going back 30 years sometimes $2,000.00 sometimes $300.00, but you get at least $500.00 per lawsuit review, fair statement?

A. Unfair. The average time was one and a half hours for the majority of cases when my rates were well under $300.00.

I know you're trying to micro do it. I've never been able to calculate 30 years of income. I don't have tax forms going back that far. I certainly have made a lot of money doing this. It's obviously evident.

Q. You've told jurors up to one quarter of your income is derived from this kind of work, fair statement?

A. I've said two or three years where it reached 25 percent mostly 20 percent of income.

Q. When was the last time that you were an admitting cardiologist for a private patient at the hospital you're affiliated at Lenox Hill?

A. Two weeks ago.

Q. Can you tell us, sir, you agree with what we talked about before lunch that Mr. Colon had testified that the symptoms he presented with to Dr. Lefkovic in February of 2013 persisted and, in fact, you can assume in the trial testimony he says it got worse up until the heart attack, you don't dispute that, correct?

A. Of course not.

Q. Now, who is Dr. Tirado?

A. Dr. Tirado is his primary care doctor.

Q. Did you look at Dr. Tirado's record to see if Dr. Tirado saw Mr. Colon between February and the heart attack?

A. I did not see a note during that period of time.

Q. Did you look at Dr. Tirado's records?

A. I had, yes.

Q. Okay. Let me hand them up to you?

MS. VILLARREAL: Note my objection, your Honor. May we approach.

Q. You did master the facts before you concluded that Dr. Lefkovic committed malpractice, fair statement?

A. I don't think that I can answer the question the way you're phrasing it limited to a simple yes or no.

Q. Do you have a good working knowledge and understanding of Mr. Colon's medical history, yes or no?

A. I don't think that I can answer that question the way you phrase it.

Q. Let's try it again. Let's keep trying. Do you think you have a good understanding now, stop me if you don't like the word good or understanding, if you have a good understanding of Mr. Colon's medical history before the heart attack, yes or no?

MS. VILLARREAL: Objection, asked and answered.

THE COURT: Overruled.

A. I think.

Q. Yes or no?

A. I don't believe I can answer the question the way you're phrasing it limited to a yes or no without explanation.

Q. Who is Dr. Nunez?

A. I don't recall Dr. Nunez.

Q. Did the patient ever see a Dr. Nunez?

A. I was never sent records.

Q. What records were you sent?

A. I was sent a record from Dr. Tirado, your client, Staten Island.

Q. That's it?

A. Yes.

Q. You're sure?
A. Yes.
Q. So you never saw the records of Dr. Tamburrino, fair statement?
A. And Dr. Tamburrino after the heart attack --
Q. I just asked --
A. Yes, I have Dr. Tamburrino in front of me. Yes, I've seen his records too.
Q. Tell us from your review of the records how many times did Mr. Colon see a physician after Dr. Lefkovic in February and before the heart attack, how many physician visits did he have?
THE COURT: Overruled.
A. I do not know. I have not seen any visits.
Q. How much time did you devote to medical records review and learning this case about five hours, ten hours?
A. Six hours.
Q. Okay. Would it be fair to say that you -- strike that.
When did you first get retained approximately to review this case?
A. 2015.
Q. Two years ago roughly?
A. Yes.
Q. Sir, you have a collection of lots of cases that are under review consistently, fair statement?

MS. VILLARREAL: Objection.

A. I don't know what lots means to you, but maybe 30 cases that may be active.

Q. You were in another medical malpractice case testifying last week, weren't you and you were asked about this case?

A. Eight days and I was asked about this case.

Q. There is no cardiologist in America to your knowledge who has testified more times against physicians than you, fair statement?

A. I have no knowledge of how many times anyone has testified other than myself.

Q. Have you heard of any expert in cardiology testify against physicians more than you?

MS. VILLARREAL: Objection.

A. I have not heard of any cardiologist who do testimony other than myself. I'm unaware of any other cases.

Q. Sir, 97 percent of your trial testimony over the past 30 years has been against physicians and/or hospitals, fair statement?

A. No, because some of them have not always been about medical cases, but 95 percent have been for Plaintiff's, yes. Over 95 percent have been for Plaintiff's, yes.

Q. If we were to collect all the testimony that you've given over the years this being just some of it --

MS. VILLARREAL: Objection to the reference. Move to strike.

THE COURT: Let me hear the question.

Q. Would we be able to fill this jury box with your testimony, sir?

MS. VILLARREAL: Objection.

THE COURT: Overruled.

A. I doubt it.

Q. Do you remember testifying in a case called Brenner versus Dr. Saxena and others in Brooklyn in front of a jury in 2014?

A. I remembered the name of the case, but I don't remember anything about it.

Q. In that case did you testify quote, "So only like three percent of the cases that I receive are defense cases where I end up testifying, where very few Plaintiff's cases revolve before I'm asked to testify."

Did you ever give that testimony about three percent meaning 97 percent to another jury, yes or no?

MS. VILLARREAL: Objection, no inconsistency.

THE COURT: Overruled.

A. Yes.

Q. You've told other jurors that 97 percent of your testimony in court as an expert witness has been against physicians and hospitals, correct?

A. Not always against physicians and hospitals, but 97 -- again, I said over 95, but 97 are on Plaintiff's cases, but they're not always about hospitals or doctors and they're not always talking about the standard of care.

Q. Sir, of the cases that the Plaintiff's attorney sent for you like counsel people that are representing the patient you've told other jurors that you find 95 percent of them have merit, true?

A. After our phone call, yes.

Q. Now, you've also told jurors of the defense cases that you've reviewed after the phone call you only find half of them to have merit you've told jurors that too?

A. Half of them are defensible, yes you're right.

Q. The other half are indefensible?

A. In my opinion, yes.

Q. So it's 50/50. When you're reviewing for or asked to review for a defense attorney, but it's 95 percent you find malpractice if you're asked to do it by a patient's attorney is that a fair statement yes, fair no, unfair?

A. Very fair.

Q. Have you reviewed any depositions in this case?

A. Yes, but only two.

Q. Which ones?

A. Your client's and Mr. Colon.

Q. Does Mr. Colon have any problems today that you're

aware of?

A. I don't understand your question medical problems.

Q. Medical sure, medical?

A. Only as far as his deposition testimony.

Q. Okay. What problems does he have today?

A. As of the time of his deposition he had fatigability, weakness, limited ability to do certain things.

Q. Couldn't have sex?

A. I don't recall that.

Q. Couldn't play with the granddaughter?

A. That part I think I was told or read.

Q. Couldn't play racquetball. I'll move on. So you've reviewed his deposition and who else?

A. Your client's I haven't read, Mr. Colon's deposition in a few months.

Q. Did you make any notes as you reviewed these documents over the years?

A. No.

Q. The reason you don't make notes is because if you do I'm allowed to see them and cross examine you on your notes you know that?

A. I don't write notes. I have post its to remind me of what's in the record, so I don't need notes.

Q. You reviewed in 30 years a thousand cases, are you saying that you never make notes as you review your cases?

A. No. The only time I do approach notes are in cases where I'm required to write a report.

Q. In cases where you're not required to write a report you don't write notes because you know that you can be cross examined on them, correct or incorrect?

A. No, because this works, post it's and highlighting works for me. I don't need to write notes. It's all here.

Q. Do you have any of Dr. Lefkovic's testimony in that file?

A. No, I do not.

Q. How many times did you examine Mr. Colon?

A. I never examined Mr. Colon.

Q. No?

A. No.

Q. Any reason why you didn't?

A. I'm not his treating doctor.

Q. Not for treatment purposes, but to see how he's doing?

A. I was not asked to evaluate him.

Q. If you're going to testify to his injuries wouldn't it be best if you examined him yourself?

MS. VILLARREAL: Objection.

THE COURT: Sustained.

Q. Why didn't you examine him?

MS. VILLARREAL: Objection.

THE COURT: Sustained.

Q. Who's his treating cardiologist at the moment based upon your review of the records?

A. Dr. Tamburrino.

Q. What was the last ejection fraction record in Dr. Tamburrino's records?

A. I have to look. I have one 50 percent in 2014, one 50 percent from nuclear in 2015 October 28th, and an EF of 50 to 55 percent by an echo on November 28, 2015, and I think that's the last I was September.

Q. Did you ever see him with a better ejection fraction than 55 percent, any records?

A. Since before.

Q. Any time from birth?

A. I have to look back at the earlier studies.

Q. Tell us if he ever had a better ejection fraction and you can start out when he was a child if you like, did he ever get better than 55?

MS. VILLARREAL: Objection.

THE COURT: Overruled.

A. We know he was better than 55 during the stress test.

Q. Okay. 55 is a very good score, isn't it?

A. Very good score.

Q. When did you first see the echocardiogram that was projected to the jury today, in other words when were you first presented with that piece of evidence, was it within the last

couple of weeks?

A. I would say between two to four weeks ago.

Q. Between two and four weeks ago was the first time that you saw the echocardiogram projected to our jurors?

A. I believe so.

MS. VILLARREAL: I just want to be clear on the record the images is he talking about those images.

THE COURT: Ask the question again try to be more specific.

Q. The 2013 echocardiogram that was projected, correct? The images that were projected 2013, right?

A. Correct.

Q. You got those images for the first time four to six weeks ago, fair statement?

A. Two to four weeks ago.

Q. But you had concluded a year ago without having ever seen those films that Dr. Lefkovic committed malpractice, you concluded that more than a year ago, didn't you?

A. Absolutely, I did.

Q. Without seeing all the evidence, sir, correct?

A. The echo made it worse.

Q. Without seeing all the evidence you made a conclusion, correct?

MS. VILLARREAL: Note my objection counsel let him answer the question.

Q. Yes or no this is cross?
A. That question I can't answer as a simple, yes or no.
Q. Have you been paid in full, sir, by counsel's law firm?
A. No.
Q. When you're done you'll send the bill?
A. Yes.
Q. Have you testified for the Krentsel and Guzman law firm, the firm that's brought this action?
A. Yes.
Q. Have you also reviewed cases for them?
A. Yes.
Q. How many cases have you reviewed for them about?
A. Probably eight cases in the last ten years.
Q. On average $1,000.00 a review?
A. No.
Q. How many times have you testified at the request of the Krentsel and Guzman law firm?
A. I'm not sure if it's my second or third time. I don't remember actually.
Q. How many catheretization has Mr. Colon had in his life to your knowledge, based upon your review of the records?
A. I'm aware of three.
Q. You're aware of three. What are the dates of the three that you're aware of?

A. The November 2, 2008, the catheretization on April 1, 2013, and then there was a catheretization in 2014. There may be one more actually 9/22/14 there was a catheretization.

Q. So there were four?

A. Yes.

Q. Did you look at the catheretization reports and the films?

A. No, just the reports.

Q. Just the reports. Is there any reason you didn't say to counsel I would like to look at the films?

A. There was no apparent dispute about the accuracy of the reports, and they didn't impact my opinion.

Q. What medicine was Mr. Colon taking in February and March of 2013 relating to heart issues?

A. He was on Statin.

Q. Who prescribed it?

A. Primary care doctor, Dr. Tirado.

Q. Is that typical that the primary care physician will prescribe Statin. I'm not saying universally, but typical?

A. It can be either the primary care or cardiologist as long as someone does.

Q. From your review of the chart who's Dr. Snyder?

A. Dr. Snyder was, he may have been one that catheterized him in 2008, but I'm not sure.

Q. Who catheterized him in 2013?

A. I don't remember. I have to look. I haven't memorized every name on every appointment, so I don't remember that. I have it here I can look it up. I don't remember.

Q. You spent how many hours reviewing this file?

A. Six.

Q. When was the last time that you reviewed it?

A. Last night.

Q. What happened a month after the cath, roughly a month after the catheretization done in 2013, meaning was the patient admitted to the hospital again roughly?

A. He had chest pain again.

Q. And do you recall it being chest pain and being described as identical to the chest pain that he had before the first heart attack, do you recall that?

A. Yes.

Q. The chest pain went up to his jaw and his neck and Dr. Snyder said, Go to the emergency room. We need to admit you. Do you remember that?

A. I remember him going to the emergency room.

Q. Now, with those complaints I have this burning sensation in my chest, my jaw, my neck. It was good practice for Dr. Snyder to say go to the emergency room good practice?

MS. VILLARREAL: Note my objection outside the scope.

MR. DOPF: It's foundational.

THE COURT: Overruled.

A. Correct.

Q. With those symptoms in hand was another catheretization done at some point after the second admission, want me to restate that?

A. I don't remember the dates. I know he had a second catheterization.

Q. Let's call it the second catheretization?

A. Okay.

Q. What were Dr. Snyder's findings a month after the cath where he stented?

A. Everything was open.

Q. Everything was open?

A. Yes.

Q. Again he had terrible debilitating chest pain and sweating and palpitations and pain going into his jaw and neck, but when they looked inside his blood vessels feeding his heart everything was open, fair statement?

MS. VILLARREAL: Objection, no foundation as to any of it.

THE COURT: Rephrase the question.

Q. A cardiac catheretization was done about a month after the one done for the infarct, fair statement?

A. Fair.

Q. The doctor injected dye, which doctor did this?

A. I have to look at the report.
Q. You don't remember?
A. I don't remember every doctor that did what. I did not memorize that. I'm sorry.
Q. That's where notes might come in handy, right?
MS. VILLARREAL: Objection.
THE COURT: Sustained.
MS. VILLARREAL: May the witness utilize the chart actually at this point.
THE COURT: He's asking. It's cross examination.
MS. VILLARREAL: Note my objection.
THE COURT: Overruled.
Q. What did Dr. Snyder find when he injected dye the second time?
A. The artery was open.
Q. Even though this gentleman had all these horrible symptoms everything was open, is that true or false?
A. True. He's probably --
Q. Sir, yes or no.
THE COURT: Next question, counsel.
Q. You'll agree with me that there's no way in the world that you can testify with any degree of certainty that had a cardiac catheterization been done in February that it would have shown that there was a lesion and had to have been acted upon immediately, agreed or disagree?

A. I could state with near medical certainty that, that right coronary artery would have been 95 percent and I can state with reasonable medical certainty it would have to have been acted on.

Q. Sir, if he had that then wouldn't you expect when he went to physicians between Dr. Lefkovic and the heart attack, he would be crying I'm short of breath, I'm sweating, I have pounding chest pain going up to my neck, my jaw wouldn't you expect that when he saw those physicians those three visits in between Dr. Lefkovic and the heart attack he would have had the same symptoms, would you have expected that yes or no?

A. I expect the opposite if he was falsely reassured that his heart was okay. It would be natural for him to stop bringing up a symptom that he was told was safe.

Q. Tell us, sir, what did Mr. Colon say under oath to this jury about whether the pain was everyday?

A. I don't know.

Q. Why don't you know? Did you ask to look at the trial testimony?

THE COURT: Sustained.

Q. Did you ask to look at the trial testimony?

MS. VILLARREAL: Objection.

THE COURT: Sustained.

Q. Do you know the reporters are typing trial testimony?

MS. VILLARREAL: Objection.

THE COURT: Sustained.

Q. In other litigations have you looked at trial testimony?

MS. VILLARREAL: Objection.

THE COURT: Sustained. Come on, counsel.

Q. For the most part your customers for your business of medical/legal reviews and testifying are the attorneys representing the patient, fair statement?

A. The majority, yes.

Q. Do narcotic medications cause fatigue?

A. They can.

Q. Was Mr. Colon on any narcotic medicine before his heart attack to your knowledge?

A. After his neck problem.

Q. After what?

A. His neck problems.

Q. For how many years was he on narcotic medicine?

A. I don't know how many years.

Q. More than ten?

A. I don't know.

Q. More than two?

A. I don't know. I think it was a couple of years before, but I don't recall the exact time.

Q. By the way if you look at the hospital chart, which is to your right, there are these stamps on the top, a graph stamp,

hospital stamp. Tell us a couple of the names stamped. Pick random pages we will not go through every page?

A. ER is Dr. Niles.

Q. You know what I'm asking for the stamp?

A. The stamp, Dr. Tirado.

Q. Dr. Tirado that's what you would expect. You would expect the private physician to be the admitting physician, correct?

MS. VILLARREAL: Objection.

THE COURT: Overruled.

A. It could go either way. Sometimes the primary care doctor is the admitting physician sometimes the cardiologist is.

Q. In any event here is Dr. Tirado, fair statement?

A. Yes.

Q. Does Dr. Lefkovic do catheterizations?

A. I don't remember.

Q. I'm sorry.

A. I don't remember.

Q. There's something known as an interventional cardiologist, which would be somebody who to make it simple injects dye to look at the heart?

A. There are invasive cardiologists that do diagnostic studies and interventional cardiologist that do procedures. You wouldn't call it an intervention if it's diagnostic study.

Q. From your review of the records and your review of

Dr. Lefkovic's testimony, does he do any of those kinds of studies -- is he trained to do those studies where you inject dye whether it's for diagnosis or treatment?

A. I don't remember without certainty. I thought he did diagnostic catheretization, but I'm not a hundred percent sure.

Q. You're guessing?

A. I'm not guessing. I'm not a hundred percent sure.

Q. To your knowledge did Mr. Colon ever have problems before the heart attack and because of his neck playing with his granddaughter, playing racquetball, enjoying sex, do you know one way or the other?

A. No.

Q. No, meaning you don't know?

A. I don't know.

Q. Good advise for Mr. Colon following his heart attack and up to today would be to stay as active as you can without overdoing it, would that be a fair statement?

A. Yes, it would.

Q. You don't want your patient in this scenario to be a couch potato?

A. Fair enough.

Q. Do you know if Mr. Colon has been following doctor's advise on keeping active, do you know one way or the other?

MS. VILLARREAL: Can we have a timeline, your Honor.

Q. Following the heart attack up to today do you know one way or the other?

A. I can't answer the question the way you phrase it limited to a simple yes or no without explanation.

Q. Did Dr. Tamburrino make any recommendations in terms of activity? You said that you reviewed his chart, what did he say?

A. Be active, exercise.

Q. Has Mr. Colon complied with that request?

A. Well, the word comply implies that you're capable of complying with the request. There are two reasons why you wouldn't do it either one, you chose not to or two, you don't physically have the stamina to do it. You have to separate those two because if the person can't physically do it, it's not a lack of compliance. It's a lack of capability.

Q. You haven't done any stamina testing on Mr. Colon, have you?

A. I have not.

Q. You don't know whether it's a question of stamina or laziness or something else?

MS. VILLARREAL: Objection.

THE COURT: Overruled.

A. I can't testify to that part.

Q. Would you agree with the statement, sir, you can have a heart attack and have a completely normal life expectancy with

clean arteries and minimum muscle damage, would you agree with that?

A. Of course I agree with that.

Q. That's because most people, the vast majority of people recover from their heart attacks and go on with their lives, fair statement?

A. And they're being watched by cardiologists for future disease.

Q. Let's go back to the yes or no again, so we have a clean record if you would.

Most patients who have heart attacks under the supervision of their cardiologist go on to live life fully, most the majority?

MS. VILLARREAL: Objection asked and answered.

THE COURT: Overruled.

A. I can't answer your question as you phrase it as a simple, yes or no.

Q. Do you know what majority means?

A. It's the word fully, living life fully.

Q. Do you know, understand what that means living life fully?

A. In terms of the majority of people have had heart attacks and progress to have disease and requires treatment, I don't know if anyone can say that the majority of people that have heart attacks go back to a carefree life full and

unlimited.

The majority of people who survive heart attacks with good care can get the best they can. They would not live carefree unlimited lives, but there are many among them that do, but I wouldn't say the majority.

Q. How about the majority of those with the 55 percent ejection fraction three, four years after he has a heart attack, would you expect in general that they go back to their prior life in general with some exception?

A. I would say that a large number of people would go back to a normal life and a large number of people wouldn't depending on comorbidities and other factors.

Q. Have you testified to the reverse?

A. I've testified in many cases that people have an ejection fraction of 55 percent can have normal life expectancy and function EF of 30 percent have been functional it's oddly variable.

Q. Can we go back to yes or no. You have rules at the hospital --

THE COURT: Sustained.

Q. I'm going to ask you to go by our rules of yes or no if you. Would you agree, sir, as a general proposition that the echocardiogram is the workhorse of cardiology?

A. Yes.

Q. Would you agree, sir, that the other type of test that

is universal with cardiologist in a person having chest pain would be an exercise stress test, fair statement?

A. Fair.

Q. Both of them done here in 2013 by Dr. Lefkovic, yes or no?

A. Yes.

Q. Now, do you remember testifying in a case called Lamonsoff versus Lanos in February of this year, Suffolk County, do you remember doing that?

A. Yes.

Q. Do you remember telling the jury that your fee for that case was seven and a half thousand dollars meaning review time and court time, do you recall that?

A. Now I do.

Q. If we start to do the multiplication, the number of testimony you've given both at deposition and at trial at these numbers were easily over $2 million?

MS. VILLARREAL: Objection.

THE COURT: Sustained.

Q. Sir, is it any medical specialty, withdrawn.

You've testified against obstetricians correct?

A. Yes.

Q. Radiologist, correct?

A. Yes.

Q. Vascular surgeons, correct?

A. Yes.
Q. Nurses, correct?
A. Yes.
Q. P. A. physician's assistant, correct?
A. Yes.
Q. Neurosurgeons, correct?
A. I think so.
Q. Anesthesiologist, correct?
A. Yes.
Q. In fact, without naming everyone you testified against 16 to 20 different specialty physicians in their capacity as defendants?
A. It may be.
Q. Do you know how many times you testified at depositions in 2014?
A. 2014.
Q. Three years ago?
A. Fifteen maybe.
Q. If I told you 17 to 18 you wouldn't argue with me?
A. No.
Q. If I told you, you testified at trial eight or nine times, you wouldn't argue with that either?
A. No.
Q. So that's a total of roughly 26 or 27 testimonies in one year, sir, fair statement, is the math correct?

A. I'm trying to get the math, but I would assume so.

Q. Retrospective bias, retrospective, one of the things that you have the benefit of in any case like this is you know what happened you know the end result and there's something in medicine known as retrospective bias, true?

A. I cannot answer the question the way you phrase it as a simple yes or no.

Q. Let's go to your testimony in the Lanos case on page 73. Reading from your testimony from a case of this year February 2017 out in Riverhead, February 1st?

MS. VILLARREAL: Objection to counsel reading from documents not in evidence and stating what they are. He can ask questions without doing so.

MR. DOPF: I never heard of such a thing. I'm allowed to read from prior consistent or inconsistent testimony.

THE COURT: Overruled.

Q. Question in front of that jury line 22 page 72.

"Question: Are you familiar with the term, have you ever heard the term retrospective bias?

"Answer: Yes.

"Question: Does that mean that since you know what happened at the end you're bias looking backwards?

"Answer: That's what the term means, yes."

Did you give those answers to those questions, yes or no.

A. Yes.
Q. Those were correct answers, weren't they?
A. Yes.
Q. Now you know through the help of this testimony what retrospective bias is?
A. I know what it is. You asked a slightly different question, which I could not answer as a simple yes or no.
Q. Two doctors can be faced with the same data and one decides one thing and one decides the other thing and they can both be correct, can't they?
A. As long as they're both within the standard of care.
Q. And they can both be correct. Sir, have you ever testified that a departure from accepted standards of care is not necessarily mentioned have you ever said that, sir?
A. Depends on the context. I may have if I said that a departure may not have led to any damage, so it wouldn't be negligence. Negligence may be a legal term. I don't know. Depends on the context of that.
Q. Can certainly be negligent without causing damage, can't you?
A. I guess.
Q. Can't you?
A. I don't know if negligence means a legal word or not make a mistake without consequence. That's certainly true.
Q. Chest pain can be due to many different things,

correct, sir?

A. Yes.

Q. Did this patient have a history of any disease process that would cause chest pain?

A. Yes, he had coronary disease since 2008.

Q. As the master of the fact of the history, what else did he have that might cause chest pain?

A. It depends on the nature of the chest pain, but in theory cervical pain or compression of the spinal column can cause chest pain.

Q. What you're saying as a master of the fact is that the cervical pain could cause chest pain?

A. Could cause chest pain.

Q. Was there anything else about him, about his medical history from your review of the records and his testimony that would account for chest pain other than coronary artery disease and the neck?

A. GERD reflux disease can cause it.

Q. How long did he have GERD for?

A. Long term, but I don't remember when.

Q. What medicine, if any, was he taking for it?

A. I think carafate or one of the equivalents. He was on anti protein medicine. I don't recall.

Q. The effect that GERD can have in terms of pain on the chest can absolutely mimic pain from a heart attack, correct?

A. Not absolutely, but it can mimic it.

Q. I think you've testified on other occasions that there's no way that every person who comes into the ER with chest pain is going to get an echocardiogram you've said that, haven't you?

A. Yes.

Q. Would you agree that you've testified under oath in 2014 with an injection fraction of 40 percent quote, "you can still have a productive life" close quotes?

A. Yes.

Q. The last ejection fraction for Mr. Colon was 55 percent or higher?

A. 50 to 55 is less I have.

Q. Cases where you've reviewed cases for attorneys Massachusetts, Florida, New Jersey, Pennsylvania, Connecticut, Illinois, Washington D. C., Georgia, Kansas, Virginia, New Mexico, Colorado, Maryland, New Hampshire, Vermont, Missouri, West Virginia, Texas, Arizona, Kentucky, Louisiana, Maine, Michigan, Mississippi, Rhode Island, Washington State, and North Carolina that would be some of the jurisdictions where you have reviewed cases. I don't mean that you went there, but cases coming from those jurisdictions, fair statement?

A. Correct.

Q. Now, in addition to those cases where you've looked at records to form opinions from roughly 40 other states, 45 other

states, you've also actually traveled to give testimony to places such as New Mexico, Kansas, Illinois, Washington D. C., Massachusetts, Pennsylvania, Maryland, Georgia and Florida, fair statement?

A. Yes.

Q. You know any other cardiologist in America that has done as much travel as you for the purpose of giving expert testimony?

MS. VILLARREAL: Objection.

THE COURT: Sustained.

Q. In the year 2014, three years ago, would it be fair to say that when you testified at those depositions we've identified the 17 or 18 and the trials we've identified the eight or nine for 2014, each and every one was against a physician or hospital, agree or disagree?

A. I don't know.

Q. Reading from your testimony in Knote versus Dr. Mark Kirshner and others, a case where you testified in court in May of 2015 out in Suffolk county, did you give this answer to this question page 102?

"Question: So let's be technically accurate, if you want to split hairs a hundred percent of the cases you testified at deposition or trial last year were cases where you testified on behalf of the Plaintiff?

"Answer: Last year that would be true."

Did you give that answer to that question?

MS. VILLARREAL: Objection, no foundation.

THE COURT: Overruled.

A. Yes, but your question was different.

Q. Yes or no, sir?

A. But some of those Plaintiff's were not necessarily doctors -- some of those Plaintiff's were not against doctors or hospitals, which was the question that you asked me. Many of those cases --

MR. DOPF: Judge there's no question.

THE COURT: Ask a question.

Q. You did give that testimony that a hundred percent of your testimony in 2014 was on behalf of Plaintiff's, you did give that testimony, didn't you?

A. I fully accept that. I didn't remember now, but if I testified to that then they were all Plaintiffs.

Q. Have you ever testified in a case called Wildermuth versus Johnson in Florida that if an artery is 40 percent blocked a person will not get chest pain even if they run a marathon, have you said that under oath?

A. Yes.

Q. Have you ever testified under oath that it's your position that a patient has a duty to follow the doctor's advise?

A. Yes.

Q. Do you know one way or the other, yes or no, whether Mr. Colon is following the advise of Dr. Tirado and Dr. Tamburrino concerning activity, do you know?

MS. VILLARREAL: Timeline please.

Q. From heart attack to present?

A. I don't know.

Q. You've also testified, sir, that stress tests are not perfect tests?

A. Correct.

Q. That marathon runners have had multiple severe blockages, but no symptoms you've said that under oath also?

A. I have.

Q. You also said under oath that about half of the heart attacks that occur in America occur suddenly?

A. Yes.

Q. Did you give this answer to this question in the case of Ferraro versus Fuller in this county, Richmond County in 2009 page 452?

"Question: Doctor, if you have a burn as cardiac in origin or burning from GERD or heartburn, how does a doctor following good and accepted practice distinguish between the two?

"Answer: Answer sometimes they can't. Sometimes good practice it's confusing. It depends on the circumstances. Sometimes based on the symptoms alone you

can't tell the difference and you can't chase everybody down for heart disease who has reflux."

Did you give that answer to that question, sir.

A. Yes of course.

Q. Did you also testify, sir, in the very same case that plaque surface in an artery can change abruptly. You also gave that testimony, didn't you?

A. About rupture yes, they can rupture abruptly.

Q. So a rupture can happen at any time and can happen suddenly, correct?

A. Yes.

Q. In the case of Jennings versus Dr. Fausett and others a deposition in 2007 for a case venue in Georgia, did you state under oath quote "so that's why I've always testified in court that standard of care deviation doesn't necessarily mean negligence."

Did you give that testimony in that case yes or no, sir?

A. I have no idea what that means I need to know the surrounding question to see if there's a context to that. Out of context it makes no sense.

Q. That's why I've always testified in court that standard of care deviation doesn't necessarily mean negligence. Did you ever give -- make such a statement in a courtroom under oath?

MS. VILLARREAL: Objection, your Honor. There's no context. There's no question. It's being given before --

THE COURT: Sustained.

MR. DOPF: He's testified that Dr. Lefkovic departed that's what I'm asking.

THE COURT: Sustained.

Q. Would you tell our jurors what textbooks in cardiology in your opinion are authoritative? Name the ones that you allowed me to read from as being a authoritative?

A. They're not authoritative when they come to the treatment of medicine, but they are when it comes to reference and road fact any books from Braunwauld to Topol are authoritative. None of them are written about how to treat patients because general principles must be applied to the facts of every single given case. They're authoritative and not --

Q. Do you understand, sir, that unless you tell our jurors that the book is completely authoritative I can't read from it, do you know that, sir, yes or no?

THE COURT: Overruled.

A. I --

Q. No from all your testimony 500 plus pieces of testimony you know that in New York State if you say a book is not authoritative I can't read it to the jury, you know that, don't you?

A. I don't know if I know it. I may have heard it before. I don't know, but the books are not.

Q. But, there's no but. Most people who have a negative stress test will not have a heart attack in the future, do you agree with that statement?

A. Yes.

Q. Most people who have a negative stress test will not have a heart attack in the future?

A. Most.

Q. You also agree that a patient can have a legitimately normal stress test one day and even a day later have a heart attack?

A. Of course.

Q. You've said that?

A. Of course.

Q. So a beautiful, beautiful, stress test on Tuesday, textbook beautiful wall being shown all the time it's gorgeous and even though it's a beautiful stress test and properly declared or interpreted to be negative, there are patients who drop dead the next day, fair statement?

A. Correct.

Q. The classic chest pain of a heart attack, sir, we know there are different variations, but the classic one is in effect, I feel like an elephant is sitting on my chest. That would be at least one of the classic presentations?

A. Yes.
Q. Did Mr. Colon ever make such a statement to anyone either in a deposition, in the courtroom, or in the records?
A. Not to my knowledge.
Q. Would you agree with the statement that with an ejection fraction of 40 and 50 percent the patient probably would never know it, and the patient could run a marathon, play tennis, and have a normal life with very little impact on his or her life, do you agree with that statement, sir?
A. Yes, probably.
Q. Did you say publically?
A. Probably.
Q. This group of patients 40 to 50 percent ejection fraction you've testified could run a marathon?
A. Some could.
Q. You've gone down to Florida a bunch of times to testify against physicians?
A. Yes.
Q. In one year from one law firm you recovered about $50,000.00 in medical/legal fees for your work?
A. There was one year over a decade ago, yes.
Q. In Florida?
A. Yes.
Q. Did you tell or did you testify under oath last year that the ability to fix coronary disease and give a patient back

a normal life is so powerful, did you ever say that under oath?

A. Probably.

Q. Did you in the case which was Kulcuzza versus New York Hospital, Queens, 2016. Did you ever say, People who have blocked arteries they get fixed and they go back to work in a matter of days, did you say that under oath?

A. Absolutely.

Q. Predictive value of a stress test about 95 percent?

A. 95 percent for a maximum thelium for echocardiogram it can range from 70 to 95 percent depending on the quality of the image and quality of the viewer.

There are published studies showing it from 70 to 95. It can vary based on the ability to see the heart.

Q. You wrote a book a number of years ago, I think it's not in print anymore about the heart?

A. A quarter of a century ago.

Q. Twenty-five years ago about the heart. In that book did you indicate quote, "Reading some of my opinions may have been seen controversial because they represent alternative view point." Did you write that?

A. In that book I say they may be seen as controversy because they're showing complete information what the whole forward says.

Q. Did you say, "Reading some of my opinions may have been seen controversial because they represent alternative view

point"?

A. Yes, absolutely that's why I wrote the book.

Q. Sir, you answered yes?

A. I'm sorry. Yes.

Q. There have been years you earned $100,000.00 a year or more from your medical/legal --

MS. VILLARREAL: Objection.

THE COURT: Sustained.

Q. Would it be fair to say that you've told other jurors and given testimony that no one knows the answer to the question of what causes a plaque to rupture?

A. Correct.

Q. No one knows the answer as to what causes a plaque to rupture?

A. We don't know why it ruptures.

Q. Correct?

A. Correct.

Q. In February of this year in Nassau County in the case of Zuluga versus Angelopolous February 2nd of 2017, do you recall being asked whether this type of work, which does not involve direct patient care by you as a physician represents 25 percent of your income and on February 2nd of this year you said yes?

A. I would have to see that because it's been 25 percent of my income two years out of 35.

Q. Let's see if we can find it. Reading from your testimony February 2, 2017 at page 370 line nine.

Okay. Do you remember in the same case in the Knote case on page 81 being asked, Does this type of work, which doesn't involve direct patient care by you as a physician represent 25 percent of your income. And your answer was yes. Do you recall giving that testimony?

MS. VILLARREAL: Note my objection again, your Honor. Move to strike.

THE COURT: Overruled.

A. I cannot answer the question the way you phrase it yes or no. It sounds like you're referring to a case within a case.

Q. Read the question and read your answer right here just the question, just the answer in a loud clarion voice?

A. Well again.

Q. Sir, I'm not asking that --

THE COURT: Counsel, please.

A. Read the question beforehand. My answer says that most years it's 15 to 20, but occasionally 20 to 25. It's right there.

Q. Let's see what's right there, sir.

MS. VILLARREAL: Objection.

THE COURT: Sustained.

Q. You're asked if the Knote case whether it was 25 percent and you said yes?

THE COURT: Sustained.

(At this time Elaine Forlenza relieves Tammy Rodriguez as the court reporter.)

COURT OFFICER: Ready for the jury?
THE COURT: Let's go.
COURT OFFICER: Jury entering.
(Jury entered courtroom.)
THE CLERK: The jury is the present and properly seated. Do both sides stipulate?
MS. VILLARREAL: Stipulated.
MR. DOPF: Stipulated.
THE CLERK: Case on trial continues. All parties remain the same.

Q Sir, if I heard you correctly your fee for today is 450 an hour?
MS. VILLARREAL: Objection.
MR. DOPF: I want to do a calculation, Judge.
THE COURT: Sustained.

Q Sir, I want you to assume that based upon your earlier testimony your fee for today will be $3,600?
MS. VILLARREAL: Objection.
MR. DOPF: May I finish?

Q Is that more than you earn in your daily practice at Lenox Hill?
MS. VILLARREAL: Objection.
THE COURT: Overruled.

A Some days, yes. Some days, no.

Q So, sir, at $3,600 a day, if you do that math if you did it every day, you'd earn about 900,000 a year. Cardiologists like you don't earn anywhere near 900,000.

MS. VILLARREAL: Objection.

THE COURT: Sustained.

Q It's much more lucrative for your wallet to come in and testify --

MS. VILLARREAL: Objection.

THE COURT: Sustained.

Q -- than it is to see patients?

MS. VILLARREAL: Move to strike.

Q Is a 75 percent blockage of an artery critical in your book?

A In its simple context it's not, but it can be.

Q A narrowing of 75 percent is generally not the stuff of heart attacks?

A Not of heart attacks, unless they are unstable.

(Pause in proceedings.)

Q Did you testify, sir, in the case of Gonzalez versus Dr. Veloso, V E L O S O and others? This is a case from Florida, Dade County, in 1995. Did you ever testify in sum and substance, quote, I am saying that a heart attack is characterized by one hundred percent blockage of an artery, not a 75?

A Yes.

Q And that testimony was correct when you gave it and it still is correct, fair statement?

A Yes. You can't have a heart attack if it's 75 open.

Q You cannot?

A If it remains 75.

Q Correct.

A Close and open, close and open.

Q You need one hundred percent or darn close to it?

MS. VILLARREAL: Objection to counsel testifying.

A True.

THE COURT: Sustained.

Q Would you agree with the statement, sir, that medicine is not to be approached by getting a list of everything that's possible and then thinking that you must test each and every one of them. That's not what medicine is about. Have you ever testified to that affect under oath?

A Of course.

MS. VILLARREAL: I just want to make an objection for the record if I can, Judge.

MR. DOPF: I'm sorry, I didn't hear.

MS. VILLARREAL: This is everything that he stated is like way off of my direct and outside of the scope if he could limit to what was testified to.

THE COURT: Overruled.

Q Sir, would you agree, sir, that you've also said under oath that there are twenty million people walking around with plague in their bodies, plague in there hearts, atherosclerotic disease who don't know it and angiograms are not done on all of them. Have you ever said something like that?

A Of course.

Q Well, when you say of course, you know it's of course, but the jury doesn't know it's of course, do they?

MS. VILLARREAL: Objection.

THE COURT: Sustained.

Q Have you ever told other jurors that there is no standard of care for the record or for record keeping? Have you ever made such a statement, sir?

A It depends on the context into that there are times record keeping doesn't reflect care and care is what matters. And other circumstances where record keeping does affect care. So I would have to see the context of that.

Q I will give it to you. This is another Florida case, Dade County, Gonzalez versus Dr. Veloso.

Deposition, March 3. 100 East 77th Street. That's the address of Lenox Hill Hospital, correct?

A Yes.

Q Would it be fair to say, sir, that you were doing depositions as part of your medical legal business at Lenox Hill Hospital? In other words the attorneys would come to the hospital and you would find a room for them and they would take your deposition. Did that ever happen?

A No. I had an office, permanent office there. That was permanent office and did depositions there.

Q So you did depositions there while you were on hospital time, correct or incorrect? Did you ever do a deposition at Lenox Hill Hospital on hospital time when you were a hospital employee, yes or no?

A I cannot answer the question as you phrased it yes or no.

Q You were an employee at Lenox Hill Hospital for how many years about?

A 14.

Q 14?

A At Lenox Hill.

Q Yes, as an employee, correct?

A Yes.

Q And you had an office in Lenox Hill Hospital for how many years about?

A 14.

Q 14. And over those fourteen years can we agree that you gave at least twenty depositions in your office while you were being paid by Lenox Hill Hospital to be there?

MS. VILLARREAL: Objection.

THE COURT: Overruled.

A No. I was paid not by the hour. I was paid to get the job done and some nights I would stay until eleven or twelve. I never -- they never failed to get the hours out of me and if there was an emergency I would leave because I was the cardiac floor. But I was not being paid by Lenox Hill during that hour. I was paid to run the cardiac care unit.

Q Do you know what yes or no means?

THE COURT: Counsel --

MS. VILLARREAL: That was not a yes or no.

THE COURT: Sustained.

MS. VILLARREAL: Let the witness finish if he can.

THE COURT: Ask another question.

Q Reading from Page 95.

"QUESTION: Isn't there a standard with respect to record keeping?

"ANSWER: I think that there are legal issues in terms of one's ability. You know, someone's word against anothers to show what they did. But to me the standard of care is how he practices medicine. His record keeping is a matter of how he can support to you and perhaps to a jury what he did, but there was no standard of care for the record. If the patient lives and the record dies I will be happy."

Did you ever give that testimony, yes or no, sir?

A Yes.

Q Would you agree, sir, that plague rupture and thrombosis, the forming of a clot, is often generated by events that cardiologists can't understand, fair statement?

A Yes.

Q Have you also taken the position, sir, repeatedly that a stress test can be considered reliable, the results, for about up to one year after it and then after that you can't attest to the reliability of it going forward? It has a shelf life of about a year?

A Yes.

Q How many stress tests whether they were echos or stress tests did Mr. Colon have before his heart attack?

A I don't recall. There were a number of them but I don't remember the number.

Q More or less than ten?
A I don't remember if it was more.
Q More or less than five?
A I would think. I don't remember the number but I would imagine it's in the range of three to six but you don't know the number.
Q You know that answer is wrong?
A Well, then I am wrong. I didn't memorize.
Q Why are you guessing, sir? You are under oath. Why are you guessing?
MS. VILLARREAL: Objection.
THE COURT: Sustained.
MS. VILLARREAL: And specifically if he is going to ask that question the witness should be allowed to actually look at the record like his client did.
Q Have you ever testified, sir, that with an ejection fraction above 50 the patient is as strong as they were at fifteen years of age?
A Many patients, yes.
Q Now in the case that you testified in Queens County, October 2 of this year, so that's --
A Eight days ago.
Q -- eight days ago. Did you tell the jurors that you charge $500 an hour for court time?

A Yes.

Q What are you charging here for court time?

A $500 an hour.

MS. VILLARREAL: Objection, your Honor. Asked and answered.

MR. DOPF: I thought you said 450. Okay.

THE COURT: Overruled.

Q In the case that you testified to seven days ago, whatever, Mirmelstein versus Garrison, once again it was against a physician or physicians, fair statement?

A It is.

Q And did you testify, sir, that $10,000 is a typical amount that you collect or charge for cases that go to trial?

A In recent years, yes.

Q Agree that generally speaking if an artery is less than 50 percent blocked the patient can run a marathon without trouble?

A Yes.

(Pause in proceedings.)

Q Do you have a closet back in your office or your home where you keep all of your testimony, sir?

A I don't keep my -- I usually don't get my testimony so I don't have transcripts.

(Pause in proceedings.)

Q Sir, in 2005 in this courthouse in front of the Honorable Joseph Maltese, did you give testimony in a case called Barnick, B A R N I C K, versus Dr. Labarbera, L A B A R B E R A? Do you recall that, sir, February 2, 2005?

A The name is familiar, but that's a long time ago. I don't recall the case.

Q And, sir, would it be fair to say that you told that jury that in general you've earned $70,000 a year as a ball park figure for your medical legal work? Do you recall that?

MS. VILLARREAL: Note my objection.

THE COURT: Overruled.

A In those years at that period of time I was earning around 70 a year.

Q And that was twelve years ago, right?

A Yes.

Q So, sir, if we do the math at 70,000 a year times 30 years that's easily over two million bucks; isn't it?

A That was only --

MS. VILLARREAL: Objection, your Honor. It's been over and over and over.

THE COURT: Sustained.

Q Would you agree, sir, that most chest pain in

general is not cardiac?

A Yes.

Q You don't do angioplasty, do you?

A I do not.

Q And never have?

A I have never.

Q Do you do diagnostic catheterizations?

A No.

Q Meaning in simple language you don't inject die into any of your patients to look at their heart, fair statement?

A Correct.

Q And when you need to have an angiogram done for whatever purpose in general, you refer the patient to a cardiologist who has expertise in that which you don't have, fair statement?

A Correct.

Q Do you remember testifying in a case called Hinlicky, H I N L I C K Y, versus Frank, County of Broom, New York State, December 8th, 2003? Do you remember that at all, sir?

A Just the name.

Q Just the name?

(Pause in proceedings.)

Q In the case of Hinlicky in front of the

Honorable Walter Relihan, R E L I H A N, on December 8th of 2003, you testified that you read the deposition of Dr. Ilioff, I L I O F F. Do you recall that?

A No.

Q Do you recall after you told the jury that you read the deposition of Dr. Ilioff, the attorney said how could you do it, he never gave a deposition? Do you remember that?

A No.

Q Let me ask you if you gave this testimony on Page 87.

"QUESTION: Good afternoon, Doctor. I am Kevin Hunt. I represent the anesthesiologist Dr. Ilioff in the corner. Did you review deposition transcript by Dr. Ilioff?

"ANSWER: Yes.

"QUESTION: You did?

"ANSWER: Yes, back in 2002.

"QUESTION: Excuse me?

And do you have that here?

"No.

"QUESTION: Anywhere here? Is that in the briefcase or anywhere here?

"ANSWER: No.

"Back in your office?

"ANSWER: Yes.

"QUESTION: Okay. Would it surprise you to know that Dr. Ilioff never gave a deposition in this case?

"ANSWER: Then I didn't read his. I thought I did."

Did you give those answers to those questions sir, yes or no?

A I must have.

Q So, sir, why would you tell a jury that you read the deposition of a physician when you knew you didn't? Why would you make it up?

A I was obviously confused with someone else. I would not make something up but I have made mistakes in representing the names of certain people. But not in medicine. But, yes, I have gotten names confused.

Q So that's what you say you got the name Ilioff -- Ilioff is kind of a name like Smith or White or Black, common name?

A Oh sure.

MS. VILLARREAL: Note my objection, Judge.

THE COURT: Sustained.

Q In your book did you write that we measure the strength of a heart, of a patient's heart by counting how much blood is squeezed out with each beat?

A Yes.
Q Fair statement?
A Yes.
Q And how much blood is squeezed out with each beat is what we have been calling ejection fraction, correct?
A Correct.
Q And you wrote that we cardiologists can determine the strength of a patient's heart by counting how much blood is squeezed out, correct?
A Yes.
Q And we know that at least in the most recent records of Dr. Tamburrino, 2016, 2017 records, the cardiologist, Mr. Colon had a magnificent ejection fraction, you know that, right?
A I haven't seen 2017 but I don't know your definition of magnificent.
Q 50 percent or better.
A Depends on how much better. Depends how much on whether it can amount up to further activity or stuck there. There is context to what you're asking.
Q Bigger the heart attack, the weaker the heart resulting in a lower ejection fraction and a gloomier prognosis for the patient. Did you write that in your book, sir?

A Yes.

Q So let's break it down. The bigger the heart attack, the weaker the heart, the lower the ejection fraction and the gloomier outlook for the patient, correct?

A Yes.

Q Did you also write that if the ejection fraction is greater than 45 percent the outlook for the patient is to quote you excellent. Did you ever write that in your book?

A Yes.

Q 45 percent prognosis is excellent. Did you write or didn't you, sir?

A I did.

Q And did you also write that not all the chest pain coming from the heart or coming from the chest means that there is death of heart muscle. You've written that too, haven't you, in your book?

A Right. Not all chest pain is a heart attack.

Q And did you also write, sir, in your book, Page 120, but minimal plague can abruptly occlude -- occlude means block, right?

A Yes.

Q -- leading to a heart attack. These minimal narrowings will not affect the result of a stress test, but they can still rupture --

A Yes, you can.

Q I need to finish. They can still rupture, form blood clots and result in a heart attack. Did you write that?

A Yes.

Q And when you said minimal plague can abruptly occlude resulting in a blood clot and a heart attack, when we say abruptly occlude, it could be as fast as the snap of a finger, correct?

A Yes.

Q And, sir, you also wrote at Page 121, that most people who pass a stress test will not have heart attacks in the future. A favorable test offers a statistical reassurance that things should be okay. Did you write that?

A Yes.

Q And, sir, Mr. Colon had stress test, after stress test, after stress test, dating back to something like 2002 that were all reported to be negative, except one in 2008 that resulted in a catheterization. Did you know that?

A Well --

Q Did you know? That's all --

A There was the one that was positive.

Q Sir -- EF

MS. VILLARREAL: Objection. Objection, let him answer.

Q If you knew that, yes, I knew, or, no, I don't.

THE COURT: Let him answer the question.

A I cannot answer the question as you phrased it.

Q Most people after a heart attack can go back to their good old sex life, right?

A Most people.

Q It's the formation of the clot that's ultimately responsible for blocking the artery and starting the heart attack, fair statement?

A Yes.

MR. DOPF: Judge, I need a moment but I think I have no further questions of this witness.

(Pause in proceedings.)

Q On average when you have your office practice running, how many patients do you see a day?

A Range from five to eleven.

Q And on average there is no way that you earn $4,000 a day for seeing those five to eleven patients on average, fair statement?

A Most days you're right.

Q So then doing what you do here and reviewing

cases is much more lucrative, better for your wallet then seeing patients, is that a fair statement?

A Yes. But most of my trial days are actually my vacation days. But that said, yes, it makes more money.

MR. DOPF: Nothing further, Judge.

THE COURT: Redirect?

MS. VILLARREAL: Yes, your Honor, briefly.

REDIRECT EXAMINATION

BY MS. VILLARREAL:

Q Dr. Charash, besides ejection fraction are there any other indicators of how well a person is doing and whether they're in fact still -- whether they sustained damage after a heart attack?

A Well, you look at the ejection fraction and clearly if it's terribly low most people are in really bad shape. If you have an ejection fraction where there is clear heart muscle damage, if your ejection fraction 50, some people could be limited by the failure of heart to rise ten or twenty points of activity.

Many people who have normal ejection fraction of 55, never suffered death, when they get to do activity the heart ejection fraction goes up. Many people have heart attacks remain flat at 50 so they could become limited.

Q And, Dr. Charash, you are aware that following

the heart attack in 2000 -- heart attacks in 2013 of Mr. Colon, he continued to treat with his treating cardiologist Dr. Frank Tamburrino, who performed various tests for his heart, including one more than a year and a half following the heart attack performed a nuclear stress test exercise. And that would have been on -- this one was on July 23rd, 2014. Are you aware of that one, Doctor?

A Pardon me?

Q Are you aware of that one?

A Yes, I am.

Q And, specifically, I am going to ask you to assume that the nuclear stress -- first off, could you please explain to the jury what a nuclear stress test is?

A You inject into the body a nuclear isotope that gets absorbed by the heart muscle so you can see the heart wall beat and see where the muscles are not working.

Q How would you compare a nuclear stress test comparatively to an echocardiogram?

A Nuclear stress tests are measured very actively by nuclear levels in the heart muscle. You can actually measure the counts. Most are done by relative estimates. Some great quality echos can be quantitative but in general nuclear are more specific, the numbers.

A nuclear test might come up with 46 where an echo would normally be 45 or 50.

MR. DOPF: Objection to any further on nuclear because I didn't go into it, scope. I don't think the word nuclear came out of my mouth.

MS. VILLARREAL: He talked about Dr. Tamburrino's records.

THE COURT: Sustained.

Q Dr. Tamburrino's records specifically indicated on this stress test that he did, that specifically the left -- a year and a half after the heart --

MR. DOPF: I am going to object to reading anything not in evidence and those records are not in evidence.

MS. VILLARREAL: I am not reading anything.

THE COURT: Let me hear the question.

MR. DOPF: As long as she is not reading something --

MS. VILLARREAL: Judge, this is ridiculous.

Q Are you aware, Doctor, that following a year and a half there was still left ventricle hypotrophy following the heart attack?

A Yes, there was still weakened heart muscle.

Q And hypotrophy exactly is what?

A Are you talking about the heart muscle not

beating with a normal strength.

Q And if you're talking about mild global hypokinesis, explain that?

A Hypokinesis means the heart muscle not moving with normal strength.

Q And that's approximately a year and a half following the heart attack, Mr. Colon was still exhibiting problems with the heart muscle movement; is that correct?

MR. DOPF: Objection, leading.

THE COURT: Sustained.

Q Doctor, are you aware that Mr. Colon sustained heart muscle movement irregularity following the heart attack for more than a year and a half recorded on a stress test done by Dr. Tamburrino?

MR. DOPF: Objection, leading, answer in the question.

THE COURT: Sustained.

MS. VILLARREAL: It's not leading, your Honor.

THE COURT: Yes, it is.

MS. VILLARREAL: It's an open question.

THE COURT: Yes, it is.

Q Are you aware that Dr. Tamburrino performed a stress test more than year and a half following the heart attack?

A Yes.
Q Are you aware, Doctor, that there was still global hypokinesis noted on those resting images?
MR. DOPF: Objection.
THE COURT: Sustained.
What did it show, Doctor?
THE WITNESS: It showed permanent damage to heart muscle with weakening of the bottom wall.
Q And specifically it showed that the left ventricle ejection fraction at stress, meaning at exercise, was 50 percent.
MR. DOPF: Objection.
Q Correct?
THE COURT: Sustained.
Q What was the ejection fraction at stress, Doctor?
A I need the report.
Q Okay.
MS. VILLARREAL: May I?
THE COURT: Yes.
(Handed to the witness.)
A The ejection fraction was 50 percent at stress.
Q And what was it at rest?
MR. DOPF: That's not in evidence, Judge.

THE COURT: Overruled. He can answer the question.

A 35 percent at rest.

Q So the ejection fraction at rest a year and a half following the heart attack was still 35 percent?

MR. DOPF: Objection.

Q Is that correct?

MR. DOPF: Objection, asked and answered.

THE COURT: Asked and answered.

Q What was the significance of an ejection fraction a year and a half following two heart attacks being 35 percent?

MR. DOPF: Objection.

THE COURT: Sustained.

Q Doctor, what is the significance of those findings?

MR. DOPF: Objection.

THE COURT: Sustained.

Q Doctor, can you tell us what the significance of those findings are?

MR. DOPF: Same question, same objection.

THE COURT: Sustained.

MS. VILLARREAL: Judge, may we approach?

THE COURT: No.

Q The findings that are recorded in that record

does that change or does that confirm your opinion that Mr. Colon sustained permanent damage to his heart muscle following his heart attacks of 2013?

MR. DOPF: Objection.

THE COURT: Sustained.

MS. VILLARREAL: Judge --

THE COURT: Sustained.

Q Doctor, anything that was stated during the cross-examination by Mr. Dopf, the various cases that you talked about have nothing to do with this case, does that in any way change your opinion as to the permanent damage that was sustained to Mr. Colon's heart?

MR. DOPF: Objection, form and substance.

THE COURT: I will allow it.

A No, none of it did.

MS. VILLARREAL: Thank you very much, Dr. Charash. No further questions.

MR. DOPF: I just need one second, Judge.

(Pause in proceedings.)

RECROSS-EXAMINATION

BY MR. DOPF:

Q Sir, when did Dr. Tamburrino -- strike that.

MS. VILLARREAL: Note my objection, your Honor, to counsel conferring with his client in the middle of cross-examination.

MR. DOPF: Why is that wrong?

THE COURT: Middle of cross. I am limiting it to what counsel asked.

MR. DOPF: Sure.

Q Back to on the issue of heart damage and ejection fraction, when was the last time that dye was injected into this gentleman's heart to see if there were blockages and assess the vitality of his muscle?

MS. VILLARREAL: Objection.

Q When? All I am asking is when?

THE COURT: Overruled.

MR. DOPF: I will take a year.

MS. VILLARREAL: Beyond the scope of my redirect.

THE COURT: Overruled.

A Well, are you talking about nuclear or contrast?

Q Cardiac cath?

A I thought it was 2014, but I am not sure.

Q 2014?

A Or '15. I need to look back at the records to get the dates.

THE COURT: He says he doesn't recall. Next question.

Q How many cardiac catheterizations, if any, did

--

MS. VILLARREAL: Objection.

MR. DOPF: I am not finished.

Q -- did Dr. Tamburrino do?

THE COURT: Sustained. Beyond the scope.

Q The most recent cardiac catheterization done by Dr. Tamburrino showed a really beautiful heart, didn't it?

THE COURT: Sustained, beyond the scope.

Q The last cardiac catheterization done by Dr. Tamburrino doesn't show any permanent heart damage, agree or disagree?

MS. VILLARREAL: Objection.

THE COURT: Sustained, beyond the scope.

MR. DOPF: We were talking about heart damage.

THE COURT: Come on, no.

MR. DOPF: Nothing further.

THE COURT: Folks, that's it. As far as this witness.

MS. VILLARREAL: Yes.

THE COURT: Please step down.

THE WITNESS: Thank you, sir.

(Witness dismissed.)

MR. DOPF: Can Mr. Colon be called? I

will continue.

THE COURT: How much time?

MR. DOPF: I probably need an hour.

THE COURT: No.

MR. DOPF: Understood.

THE COURT: Quarter after four as I told you we have to break.

Ladies and gentlemen, we're going to adjourn for the day. Just so you know after conversations with the attorneys we are hoping to sum up at the end of the week. So that's where we're at right now. Okay?

Have a good night. See everybody tomorrow morning.

(Jury left the courtroom.)

(Court stood in recess until Wednesday, October 11, 2017.)

* * * *

It is hereby certified that the foregoing is a true and accurate transcript of the proceedings.

_____
TAMMY RODRIGUEZ
OFFICIAL COURT REPORTER

_____
ELAINE FORLENZA
OFFICIAL COURT REPORTER

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